Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
18 September 2019

EPR Programme Update **Submitted by:** Helen Vigne – Head of EPR Programme R Collins – Director of Transformation	**Paper No. Attachment U** **EPR Programme Update** **For Information**

Aims

The aim of this paper is to provide members of the Trust Board with a summary of status of the Electronic Patient Record (EPR) Programme.

Summary

The EPR Programme has moved from the planned 'Stabilisation' phase into the 'Optimisation' phase which will now run until the end of October 2020. The programme status is amber / green recognising that there are still some areas which require further work to fully stabilise and / or where staff require additional time to embed some of the revised workflows. The first major transformation task is to upgrade to the latest version of the Epic software. Epic now issues four functional upgrades per year and the programme will continue to plan and deliver upgrades to ensure that the Trust 'remains current'. This will avoid some of the difficulties faced by CUH and international sites who are now on quite old versions of the software where the upgrade process is far more onerous. Although the transition has been made to Optimisation, there are still significant areas of the system that require work in order for them to be used in the way that management/ project plan intended.

Key areas of focus

Key areas of focus for the EPR and Trust operational / clinical teams since go-live continue to be Pharmacy, the prompt completion of discharge documentation and clinic letters, and clinical documentation compliance and impact on depth of coding.

Pharmacy

The EPR team continue to work closely with the Chief Pharmacist, directorate General Manager and members of the leadership team within pharmacy on working through the stabilisation plan for resolving the outstanding issues. This is tracked weekly with the team and additional input has been sought from Epic. Good progress has been made in several of the workstreams in the past few weeks. A key task is to run a full stock take within pharmacy and this is scheduled for the weekend of 31st August – 1st September. The stocktake will allow us to regain a full understanding of current stock and associated costs for financial balance.

Discharge Summary completion

The EPR team has been working with Directorate General Managers to improve the turnaround time of discharge summaries with end user training, communications via screen savers and review of metrics at the Senior Leadership Team meeting and Directorate Performance Reviews as well as workflow improvements within Epic. The percentage of Discharge Summaries sent within 24 hours has increased from 48% to 59% and the backlog of 1200 documents has been reduced to 526. We will continue to monitor while beginning to focus on clinic letters also this week using a similar approach.

Clinical Documentation/Depth of Coding

Clinicians are not currently entering the level of required clinic data such as problem list required for clinical coding. To tackle the lack of documentation in Epic we have configured deficiency tracking so that we can monitor clinical compliance of documentation. The clinical coders have been given permissions within Epic to carry out some agreed noting / data entry in the records. Shankar Sridharan is developing a plan for Multidisciplinary update of the problem list.

Other Updates

Epic User Group Meeting

The EPR leadership Team have attended the Epic User Group Meeting (UGM), a yearly conference for all Epic customers to gather and network. We presented some of our good work over go-live, and met with several other organisations to share experiences. We have learned that our issues relating to lack of / delays around clinical documentation are common among other Epic sites and we will continue to share and learn to ensure continual improvement.

EPR Team restructure

As described within the EPR Full Business Case, the size of the EPR team reduced slightly following Stabilisation. The consultation and associated restructure of the EPR Team is now complete and permanent contracts have been issued, commencing 1st September. The team have an away day planned for 2nd September to re-set the team focus and priorities. Some staff have unfortunately been lost to other organisations during the process and a recruitment plan to fill any vacancies is underway.

Epic Upgrade

The first of our 6-monthly upgrades will take place on 22ns September. Build is now complete and testing is underway. The upgrade contains relatively minor system changes and is not expected to cause a significant impact to users or require any formal retraining. The system will be available in read only mode between 14:00 18:00 while the upgrade is installed and the EPR team will be onsite to support staff throughout the weekend.

FUTURE PROOF
ELECTRONIC PATIENT RECORDS

Great Ormond Street Hospital for Children
NHS Foundation Trust

Attachment U

Great Ormond Street Hospital

EPR Programme Status Report

SECTION 1 – PROGRESS SUMMARY				
Reporting Period	16 July 2019 – 21 August 2019			
Programme Name	Electronic Patient Records (EPR)			
Programme Stage	Optimisation 19 July 2019 – 30 October 2020 Tranche 1- 17 July – 30 September 2019			
RAG Status	This Period	A/G	Last Period	A/G
RAG Reason	While good progress has been made in the transition to Optimisation, the programme has been rated Green/Amber while we continue to manage some of the watch areas detailed below.			
Overview	Significant focus on improving discharge summary metrics and overall process over the past 4 weeks has seen some improvement (see full update below). The focus is due to shift to Clinic Letters from September Upgrade planning is well underway and on track for the weekend of 21/22 September. The full plan will be presented for review at the early September COAG Group. This will include detail of downtime, training and support and communications. The recent restructure of the EPR team has resulted in a number of unfilled posts within the team and we are working to ensure some handover is undertaken however this may require some reallocation of priority and shift in deliverable across Tranches. The first of the Link Nurse sessions took place on the morning of the 7th August. Around 30 nurses attended (we have recruited about 60 in total) attended and initial feedback and engagement has been very positive. Link nurses will work regularly with the EPR to learn new tips and tricks, and assist with the delivery of messages and training new functions back on the ward. Some nurses have already started engaging their units with the new role and have also started communicating to us and each other. Although the transition has been made to Optimisation, there are still significant areas of the system that require work in order for them to be used in the way that management/ project plan intended.			
WATCH AREAS				
Pharmacy		Issue: Since go-live the pharmacy team have continued to struggle with Medication stock and cost discrepancies impacting on pharmacy purchasing, dispensing workflows and financial reporting. There are		

		also a number of general workflow and internal staffing issues further exacerbating the situation within pharmacy. Action Plan: The pharmacy team are receiving intensive stabilisation support from the EPR team and a stabilisation plan including action activities are themed under: stock control, financial reporting, procurement, homecare, robot, and user support is in place. The EPR and Pharmacy team meet weekly to review progress. Updates for each of the Pharmacy stabilisation work streams are as follows:

Current Status	Topic
	IVL merge All testing and validation completed in week, meaning that the merge is ready from a technical standpoint. A 'go-live' plan is being written to ensure that the activities to merge the inventories are well understood Next steps: • Write a 'go-live' plan due Monday 19/08 • Ensure a contingency is in place in the event of failure of the merge during stock take. • Complete stock count 'dry runs' daily in SUP until merge
	Homecare Homecare stabilisation items now represented on the plan. Some items still require exploration to set onward plans, and some issues require further validation as have not been reproducible. Key willow team members are on leave w/c 19/08 meaning a partial hiatus for these items. Next steps: • Continue to develop the issues and resolutions into the stabilisation plan
	Static Cost Review Manual review of ~3500 prices completed. The review took longer than anticipated so importing the values into live is expected to occur early in the week commencing 19/08. Validation of a subset of prices in SUP has passed. Further validation still required... Next steps: • Costs to be uploaded to production early w/c 19/08, having been validated in SUP.
	Inner/Outer Package Build Updates & Testing Omnicell interface was resolved in week but a simulated robot was not available to test message handling so testing was completed in the live environment. Testing of the phase 1 forms' configuration was successful and all changes were successfully migrated to live Next Steps: • Commence the validation of Phase 2 forms • Reassess the timelines for the Inner/Outer review in the context of slippage, interdependency with September upgrade and Willow Inpatient analyst availability
	Purchase Order Backlog The new discrepant invoice workflow was tested and a SOP was produced. Within the week the pharmacy procurement team successfully cleared the discrepant purchase orders workqueue to zero, such that the new process could be moved to live. While the metrics for open actionable requests declined, the pharmacy team have much improved tracking for the invoice backlog, and have secured Finance support for a further 2 weeks to clear it.

	Next Steps: • Stephen Mathew to provide project management support to the pharmacy procurement team to clear the backlogs

Status	Trend	Metric	More Detail
		**% of prioritised forms that have passed inner/outer testing:** 100% of the prioritised forms have been migrated into production	All of the first wave of prioritised forms (Unit dose eye drops, Sachets, and Test Strips) have been migrated to production as of 16/8. Build for the next phase will begin on Monday 19/8.
	-	**Stock Warnings in Willow:** 28% on 16 August compared with 28% on 9 August	Low or insufficient stock warnings appeared for 28% of prescriptions processed in dispensary. This is the same amount that we were seeing for the previous week. A date is being fixed with pharmacy to train how to select appropriate packages during screening to attempt to mitigate.
		**Open Actionable Purchase Requests:** 1217 total in Dispensary and Robot, compared with 1083 on 9 August	The total number of open Purchase Order Requests went up 134 from the past week.
		**Manual Changes to Dispense Amounts:** 118 last week, an increase from 81 the previous week	Pharmacists needed to manually update dispense amounts during reverification or redispense 118 times last week, an increase from 57 the previous week. This means medication build appeared in the system the way the pharmacist expected less frequently.
		**Manual Correction of Balances:** 29 last week, a decrease from 44 the previous week	One particular user has been spending a significant amount of time correcting the amount of stock we have in our inventory locations. These corrections can be due to incorrect workflows or the inner/outer issue that has been previously described.
		**Backlog of Homecare Invoices:** As of 12/8 there were 904 homecare	An additional metric that we will be tracking, as part of all of these metrics, will be the outstanding amount of Homecare invoices that have yet to be processed into Epic.

		invoices to work through. By 16/8 this number has been reduced to 818.	
Discharge Summaries & Clinic Letters		Issue: Since go-live, over rates of Discharge Summaries and Clinic letters sent has been poor and it its highest count in July, there was a backlog of 1200 discharge summaries and 8,967 clinic letters not marked as sent. Action Plan: The build is being reviewed to determine whether the process to create could be simplified. In conjunction with this the EPR team will continue to work with users by providing training materials and at the elbow support to understand the workflow and responsibilities.	

Update:

A plan for improvement with was submitted to the July EPR Programme Board and is currently being actioned by EPR and operational teams.

Discharge Summaries	22-Jul	29-Jul	05-Aug	12-Aug	19-Aug	26-Aug	02-Sep	16-Sep	23-Sep	30-Sep
CEO Comms										
SLT Focus	Directorate		Specialty							
Targetted support	EPR / GM / SL									
New Junior Doctors										
Metric Goal	48%	60%	80%	90%	100%					
Clinic Letters	22-Jul	29-Jul	05-Aug	12-Aug	19-Aug	26-Aug	02-Sep	16-Sep	23-Sep	30-Sep
Training Material Review										
CEO Comms										
New Junior Doctors										
SLT Focus							Directorate		Specialty	
Targetted support						EPR / GM / SL				
Metric Goal						46%	60%	80%	90%	100%

The EPR team have carried out 6 Epic Education sessions, spanning from the 15th July to current date. Sessions have been successful, this is highlighted by the operational request to continue the sessions without end date. A wide range of management roles (GM, SM, ASM), across all directorates have been present at the Epic Education sessions.

We have agreed a process where upon if a specialty requires clinic codes/wards (departments) to be excluded, they are to be sent and approved by the GM/Performance and raised on Hornbill submitted to EPR. These are then excluded from the dashboards.

Shankar Sridharan, Chris Jephson and Andrew Taylor are developing a SOP around the clinical requirements for completion and delivery and will present this alongside a comms plan at the September COAG meeting.

Discharge Summary Turnaround GOSH Trust

	Dec 18	Jan	Feb	Mar	Apr	May	Jun	Jul	MTD
NHS sent within 24 hours	–	–	–	–	41.65 %	51.99 %	44.02 %	56.55 %	49.88 %
NHS marked as printed	–	–	–	–	98.70 %	94.73 %	94.80 %	94.89 %	87.69 %
NHS with posted date on workqueue	–	–	–	–	98.48 %	97.31 %	95.34 %	94.12 %	79.03 %
NHS not sent yet	–	–	–	–	9	101	117	136	270
Private summaries sent on day of discharge	–	–	–	–	19.15 %	12.57 %	14.38 %	29.33 %	28.79 %
Private not sent yet	–	–	–	–	30	102	107	107	82
Inpatient AVS Printed	–	–	–	–	54.13 %	48.67 %	47.26 %	49.12 %	50.11 %

Discharge Summary Turnaround NHS not sent yet: Directorate

GOSH Trust

Undo

	Dec 18	Jan	Feb	Mar	Apr	May	Jun	Jul	MTD
Body,Bones & Mind	–	–	–	–	–	28	33	53	92
Brain	–	–	–	–	1	8	17	36	79
Cancer & Blood	–	–	–	–	1	38	13	4	40
Heart & Lung	–	–	–	–	1	3	11	2	8
Medicines,Therapies & Tests	–	–	–	–	–	–	–	–	–
Operations & Images	–	–	–	–	6	14	30	26	18
Sight and Sound	–	–	–	–	–	10	13	15	33

The backlog of 1200 has now been reduced to 622

Clinic Letters

Clinic Letter Turnaround GOSH Trust

	Apr	May	Jun	Jul	MTD	WTD
Sent within 7 days	24.92 %	30.55 %	41.28 %	47.04 %	42.29 %	4.24 %
Sent within 10 working days	42.44 %	49.19 %	56.51 %	63.06 %	47.64 %	4.24 %
Sent within 21 working days	55.77 %	62.62 %	70.90 %	75.88 %	48.01 %	4.24 %
Average days to send	30.3	22.2	14.0	8.7	3.7	0.0

Each week has seen reductions in total, and April values for outstanding clinic letters. The backlog of 8967 has reduced to 7992.

There two main issues blocking a number of clinic letters from being sent out are:

1. The letter has been created previously on Epic/Word, however not through the encounter workflow. A workaround has been distributed to resolve this. The encounter (clinic) is part of an assessment period and does not require a clinic letter. Workaround currently being documented, however needs to be discussed as an EPR team as to permanent solution

2. The encounter (clinic) is part of an assessment period and does not require a clinic letter. Workaround currently being documented, however needs to be discussed as an EPR team as to permanent solution Workflow reviews with EPR and Operational staff continue.		
Depth of Coding		Issue: Clinicians are not entering the level of required clinic data such as problem list required for clinical coding. Action Plan: The Coders will be given permission within Epic to carry out some agreed noting / data entry in the records. This will improve the depth of coding and also allow us to identify users or services who need targeting for future improvements. To tackle the lack of documentation in Epic we have configure deficiency tracking so that we can monitor clinical compliance with certain documentation. To date, the deficiencies have been set to 'silent' so clinical teams won't see each deficiency as an in basket reminder. However we are reviewing this plan currently. Shankar Sridharan is working up a plan for Multidisciplinary team update of the problem list. The Training Team will also review training materials and if necessary amend to ensure that adequate emphasis is placed on clinical documentation.
Radiology		Radiology, in particular Interventional Radiology and Sedation are experiencing number of issues around build and the impact of poor usage from users further up the patient workflow. Action Plan: Weekly meetings have been established with EPR and Radiology management to review key issues, fixes and plan messaging to the teams. Update: Weekly meetings continue and the outstanding issues have been prioritised by the department according to a risk rating. From this rating the high risk items are in progress of being completed and we are currently making head-way through the moderate risk items. Radiology still seem happy with our progress on resolving the issues raised. Interventional Radiology and Sedation have been intensively worked on and we have been making advancement in those areas. Some changes have been delay in being implemented in Interventional Radiology due to staff shortage/holidays and so we have been unable to get build sign off. A weekly email is being distributed by the Change Team each week to update Radiology staff of the changes made and the issues that have been resolved.
Missing Blood Products		Issue: Staff are not using Blood Track appropriately (or to policy) when administering blood products. This has led to lost units. This is also in conjunction with poor documentation of blood transfusion within Epic. Action Plan: Each unit of blood, platelets etc. has a tag attached reminding staff to use Blood Track (since 15/07); we will be monitoring this to see if it has an impact. Comms (screen saver) to be issued and the Blood transfusion are contacting the lead educators to see if we can better engage the practice educators on the issue Update:

		The Issue of missing units was discussed at SLT on 8/8. Alison Taberner-Stokes has emailed the slide to managers as a reminder to continue to use Blood Track. Nattallie Alwash also emailed ward sisters and educators the key points of giving transfusions (including use of blood track), and also sent the tips for how to clear blood BPA pop ups. We are still seeing issues with staff using BT but are documenting in Epic which to allows us to find 'missing' units
Other	**n/a**	Regional Genetics Laboratory A significant backlog of reporting of test results in Regional Genetics has been further compounded by several factors including the introduction of Epic. We are working closely with the Genetics Laboratory team to identify where any system changes may be made to help in their recovery plan

SECTION 2 –RISKS AND ISSUES

EPR Programme Board Risks & Issues Summary

	High	Medium	Total	New	Increased	Reduced	Closed		
Number of Open Risks	3	3	9	0	2	0	0		
	High	Medium	Total	New	Increased	Reduced	Closed		
Number of Open Issues	3	4	8	5	0	0	0		

Risks

Risk No.	Owner	Description	Score Pre Mitigation	Score Post Mitigation	Trend	Comments
R1	RC	Inability to realise financial benefits detailed within the FBC	16	12		
R2	RC	Inability to deliver the scope of optimisation / transformation or qualitative benefits realisation due to competing programmes and projects/dependencies on other projects/workstreams	16	8		
R3	HV	GOSH/Supplier relationship with becomes strained	20	12		
R4	CA	Inability to adequately resource the programme through the restructure to deliver planned optimisation scope	12	16	↑	See Issue 4
R5	AT	Productivity (and consequently income) is reduced following implementation. This may be due to inefficient use of epic and/or poor adoption of new workflows	16	12		
R6	AT	Poor user adoption of system and or new processes/ inefficient use of epic	16	12		
R7	AT	Lack of staff engagement / lack of Trust resource to continue to develop the EPR.	16	8		
R8	ST	Data security is compromised	15	5		
R9	HV	Unintended system outage	15	15	↑	See Issue 5

Issues

Issue No.		Description	Priority	Trend	Comments
I1	AT	Medication stock and cost discrepancies in pharmacy	MediumHigh	↓	Action plan in place
I2	AT	Poor completion rates of Discharge Summaries and Clinic Letters	High	↓	Action plan in place
I3	HV	Blood Transfusion Laboratory Management system supplier performance	Medium	↓	Action plan in place
I4	HV	Some key members of the team have declined positions in the new structure, leaving the programme with vacancies and the loss of key knowledge at short notice.	Medium	NEW	Action plan in place
I5	ST	2 instances of unintended system downtime occurred with days through different causes	High	NEW	Action Plan in development
I6	AT	Poor clinical documentation within Epic, in particular the problem list	High	NEW	Action Plan in development
I7	AR	Staff are not using Blood Track appropriately (or to policy) when administering blood products. This has led to 'lost' units	Medium	NEW	Action Plan in place
I8	AT	Issues with build and workflow in Radiology and IR/Sedation	Medium	NEW	Action Plan in place

Notes:

2 new issues added (and coinciding risks upgraded) with action plans in place/in development as follows:

I4: Handover plans are in place with those leaving and training arrangemements being put in place where required. Work plans are being reviewed to ensure that upgrade tasks are priorotised. Discussions with HR underway to commence the recruitment process

I5: ICT are leading a route cause analysis of both incidents alongside Epic. The EPR leadership team are reviewing the comms process around unexpected downtime.

It should be noted that risks detailed in the EPR Risk Register are solely those which impact the delivery of optimisation phases, the realisation of benefits or the adoption of the system. Risks relating to patient care, or other operational themes should be added to operational risk registers.

I6-I7 Have been reviewed as watch items in this report for the last 2 months and have now been added to the log.

Full Risk and Issue log:

EPR Programme
Risk Register 2019 0

SECTION 3 –PROGRAMME MILESTONE STATUS				
Milestone ID	Date	Date Achieved	Title & Description	BRAG
01	14/06/2019	21/06/2019	Upgrade scoping complete	Complete
02	17/06/2019	17/06/2019	Upgrade build commenced	Complete
03	28/06/2019	12/07/2019	Tranche Plan finalised	Complete
04	28/06/2019	28/06/2019	25% upgrade build complete	Complete
05	12/07/019	12/07/2019	50% upgrade build complete	Complete
06	02.08.2019	05.08.2019	75% upgrade build complete	Complete
07	16.08.2019	20/08/2019	90% upgrade build complete	Complete
08	13.09.2019		Testing complete	On Track
09	07.09.2019		Training environment & materials complete	On Track
10	22.09.2019		Installation	On Track
11	30.09.2019		Post implementation training and support complete	On Track
13	01.10.2019		Commence Tranche 2	On Track
14	01.01.2020		Commence Tranche 3	On Track
15	01.04.2020		Commence Tranche 4	On Track
16			Commence Tranche 5	On Track

Notes:
07: New tasks are regularly added to which means we will only ever reach 100% of build tasks at implementation so this milestone has been reduced to 90%.

BRAG KEY

Complete	Milestone is complete	Delays	Milestone is delayed but action plan is in place and /or does not impact overall tranche delivery
On Track	Milestone is on track for delivery	Critical Delays	Milestone is delayed and no plan is in place and / or impacts on overall tranche delivery

SECTION 4– PROJECTS REPORTS

To be included from September 2019

SECTION 5 – BENEFITS REALISATION

Reference	Short Benefit description	Business case benefit value as year NPV format	Revised benefit value as year NPV format	Target Year 1 delivery (NPV)	Projected Year 1 delivery (NPV)	Exception report - July 2019
CRB 1	Software maintenance	£ 5,625,000	£ 5,571,025	£ 391k	£ 334k	Slippage on system turn-offs due to changes in clinical use
CRB 2	Transcription	£ 826,225	£ 2,674,368	£ -	£ 348k	On track
CRB 3	Data centre	£ 750,000	£ 750,000	£ 52k	£ 52k	On track
CRB 4	Pathology testing	£ 160,839	£ 188,370	£ -	£ -	No update
CRB 5	Radiology testing	£ 131,036	£ 153,465	£ -	£ -	No update
CRB 7	Coding	£ 6,250,000	£ 7,000,000	£ -	£ -	No update
CRB 8	Paper, Printing and Postage	£ 2,974,619	£ 800,000	£ -	£ -	No update
CRB 9	Medicines	£ 896,000	£ 1,864,500	£ 117k	£ -	Benefit moved to subsequent years
CRB 10	Theatres	£ 179,820	£ 179,820	£ -	£ -	No update
CRB 11	Medical records WTE	£ 2,558,667	£ 2,579,971	£ -	£ 28k	Medical records have been able to phase forward somne c a vacancy
CRB 13	LOS	£ 17,246,250	£ 17,246,250	£ -	£ -	No update
CRB 14	Outpatients	£ 2,387,313	£ 2,387,313	£ -	£ -	No update
CRB 15	IT WTE	£ 13,544,776	£ 7,000,000	£ 1,748k	£ -	Value has been slipped to year two
CRB 16	Nursing and Clinical time	£ 6,690,045	£ -	£ -	£ -	No update
CRB 17	Supply chain	£ 1,942,500	£ 1,942,500	£ -	£ -	No update
CRB 18	IPP	£ 1,875,000	£ 1,875,000	£ -	£ -	No update
CRB 19	Research	£ 5,250,000	£ 5,250,000	£ 104k	£ 104k	Incororated into the envelope for R&I directorate. R&I cur be able to over-deliver on the benefit
		£ 69,288,089	**£ 57,462,582**	£ 2,411k	£ 867k	

Notes:

Overall good progress against financial benefits is being made. Some have slipped back into next year eg CRB 15 ICT WTE reduction however others have been delivered earlier than expected eg CRB 02 Transcription cost reduction and CRB 19 Research. A Detailed Benefits Realisation Plan is in development, outlining all tasks, responsibility and timescales in realising both FBC and emergent benefits.

SECTION 6 –SUBCOMMITTEE UPDATES		
EPR Clinical & Operational Adoption Group (COAG) Chair: Andrew Taylor	The group focussed on the newly developed plan to improve the key performance metric around Discharge Summaries and Clinic Letters. Next meeting: To be scheduled	15/08/2019
EPR Transformation & Benefits Management Group Chair: Catherine Peters	The group reviewed the performance of cash releasing FBC benefits and the progress of the Benefits Realisation Plan currently in development. Next Meeting: 10/09/2019	13/08/2019
EPR Data, Reporting & Finance Group Chair: Peter Hyland	The group met on 18th July and agreed the new terms of reference. The group is focusing on the sun setting of legacy systems and the optimisation of the reporting workstream and setting the reporting strategy for the programme. Next Meeting 15/08/2019	18/07/2019

SECTION 6 –SUBCOMMITTEE UPDATES		
MyGOSH Steering Group Chair: Claire Williams	The group reviewed registration numbers (4,750) and discussed the MyGOSH sign up refresher training for CBO and Outpatient Reception staff taking place the following week. Safeguarding and MyGOSH signup was discussed; the need for more stringent sign up restrictions and checks were agreed. The new GOSH branding and its impact on MyGOSH branding was discussed. The MyGOSH Bedside pilot is on track for 6th September. The bedside tablet policy was discussed and agreed with several questions remaining surrounding PAT testing responsibilities taken away Next Meeting: 03/09/2019	06/08/2019
Nursing Advisory Group Chair: Sarah Newcombe	Several ongoing issues/examples of poor practice were discussed such as name bands attached to the bed, documenting tasks where tasks were not undertaken, reinforce the use of A-E assessment. Recent key changes affecting nursing were discussed such as FYI flags for Child Protection Plan and Court Order can now only be added/removed/edited by CSPs. The group; also discussed reports of 2-3 issues per week of monitors and vents not interfacing with EPIC and reinforced the need to call the helpdesk immediately. Next Meeting 23/08/2019	09/08/2019

SECTION 7 –FINANCES [All figures ex VAT]			
Finance RAG Status	G	Capital	Revenue
Original Programme Budget 2019/2020		£2.40m	£10.90m
Planned Spend (Full year)		£9.10m	£6.27m
Current Forecast (Full year)		£9.82m	£5.94m
Actual Spend (Month 4)		£5.08m	£2.07m

The EPR programme is moving from stabilisation into optimisation and the focus for many of the EPR team will be on developing the asset (capital activity). The EPR budgets have been updated to take this into account, resulting in a reduction in revenue impact and increase in capital costs for the programme.

Additional equipment (primarily workstation on wheels (WOWs) and speech mikes for dictation / transcription) are currently coded against the end user device and additional hardware lines in the budget. However, once new finance codes have been set up, some of these costs will move as the Charity provided additional funding for optimisation projects within EPR.

Epic is still assessing the increased costs associated with the (almost) 100% increased use than forecast and costed. This is likely to equate to c.£200k+ per annum. This cost may be offset in the current FY by underspend on other Epic lines but may become a cost pressure against the overall EPR budget in future years.

SECTION 7 –FINANCES [All figures ex VAT]

Electronic Patient Records Programme FBC Figures (excluding VAT)

EPR Lot 1 Capital Cost		01/04/2018 - 31/03/2019					
		FBC	Initial Plan	Current Plan	Plan YTD	Actual YTD	Variance
Vendor Capital	Epic Licence Fee	1,017	1,022	1,106	341	425	-84
	Epic Implementation Fees	905	2,630	2,485	1,834	1,600	235
	Epic Third Party Licence Fee	0	0	115	115	115	0
	Epic Hosting	0	88	124	124	124	0
	Vendor Capital Sub-total	**1,922**	**3,739**	**3,830**	**2,414**	**2,264**	**150**
GOSH Capital	GOSH Staff	0	3,654	4,503	1,698	2,062	-365
	Clinical Pathway Development	300	300	200	100	0	100
	GOSH Third party System	0	0	175	0	175	-175
	End User Devices	0	133	183	133	183	-50
	Additional Hardware	0	125	442	125	442	-317
	Accommodation	0	0	-3	0	-3	3
	Office costs (Contingency)	0	0	-29	0	-29	29
	EPR Travel Costs (Contingency)	0	50	-3	50	-3	53
	Integration medical devices/lab analysers	0	100	17	100	17	83
	Data conversion/migration	0	200	25	150	-25	175
	GOSH Capital Sub-total	**300**	**4,562**	**5,510**	**2,355**	**2,819**	**-464**
Capital Cost Contingency	Contingency Sub-total	**181**	**794**	**480**	**£414**	**0**	**414**
	Totals	**2,403**	**9,095**	**9,820**	**5,184**	**5,083**	**100**

EPR Lot 1 Revenue Cost		01/04/2017 - 31/03/2018					
		FBC	Initial Plan	Current Plan	Plan YTD	Actual YTD	Variance
Vendor Revenue	Epic Software Service Charge	1,414	1,376	1,376	409	174	235
	Epic subscription charges	92	87	61	26	0	26
	Epic Third Party Maintenance	194	203	158	66	21	45
	Hosting	1,547	1,458	1,402	428	371	56
	Vendor Revenue Sub-total	**3,247**	**3,124**	**2,997**	**929**	**566**	**363**
GOSH Revenue	GOSH Staff	5,514	2,094	1,425	591	624	-33
	Third Party System Costs - GOSH	766	736	510	245	10	235
	3rd Party Hardware Maintenance	102	100	67	33	0	33
	Accommodation	130	0	244	0	244	-244
	Operational Support	99	116	713	26	621	-595
	GOSH - Activity Drop in M1	398	98	90	98	0	98
	GOSH Revenue Sub-total	7,009	3,143	3,049	993	1500	-506
Revenue Cost Contingency	Contingency Sub-total	**647**	**0**	**-107**	**0**	**0**	**0**
	Totals	**10,903**	**6,267**	**5,939**	**1,922**	**2,066**	**-143**

Attachment V

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
18th September 2019

Integrated Quality & Performance Report August 2019 (Reporting on July 2019 data) **Submitted by:** Sanjiv Sharma, Medical Director Alison Robertson, Chief Nurse Andrew Taylor, Acting Chief Operating Officer	**Paper No: Attachment V**

Aims / summary

The Integrated Quality and Performance Report (IQPR) brings together a range of essential hospital metrics aligned to the CQC key lines of enquiry: Safe, Effective, Caring, Responsive and Well Led. It asks the question: are our patients receiving high quality care?

It identifies key areas for improvement in terms of quality and performance including:

- Number of incidents being closed month on month is increasing – work continues to manage the backlog
- Continued challenge around discharge summary and clinic letter performance
- 100% compliance rate with stage 1 and stage 2 duty of candour compliance in June and July 2019.
- Increase in the number of incidents, complaints and PALS contacts in IPP
- % of medication incidents which have caused harm in July 2019 exceeded the upper control limit - an review is being undertaken to understand key themes.

Action required from the meeting

Committee members to note and agree on actions where necessary

Contribution to the delivery of NHS Foundation Trust strategies and plans

The report aims to focus the organisation's attention on areas where we can improve the quality of care delivered to our patients. All the indicators within the IQPR contribute to the delivery of either regulatory or commissioner requirements, and as such are aligned to the objectives and strategy of the Trust.

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 NHS Hospital for Children NHS Foundation Trust

Integrated Quality & Performance Report August 2019

(Reporting on July 2019 data)

Sanjiv Sharma	Alison Robertson	Andrew Taylor
Medical Director	Chief Nurse	Acting Chief Operating Officer

Data correct as of: 6th September 2019

Great Ormond Street NHS Hospital for Children NHS Foundation Trust

CONTENTS

Performing well | Room for improvement | Significant improvement required | ↑ Direction of trend from previous month | Data not previously requested/available | TBC Parameter not needed/not agreed | * Potential data quality issues post EPIC. Caution to be taken in interpretation.

Always

The child first and always

Well Led Overview

Great Ormond Street NHS Hospital for Children NHS Foundation Trust

Our **Closing the Loop** Lessons Learned audit (Slide 10) this month focuses on a thematic review of safe medication management particularly in relation to controlled drugs. The audit examined whether the learning from a 2018 serious incident has been embedded. It was an in depth audit that looked at 37 best practice standards, the overall level of performance was 83.5%. An action plan to support improvement has been developed under the guidance of the Chief Nurse. A re-audit of actions relating to a red complaint relating to the death of a patient following spinal surgery was also completed and discussed at Closing the Loop. Changes have been made to the action plan following the introduction of EPIC which has changed the way that MDTs are documented. A further action to support Trust wide learning through the introduction of regular MDT self assessments has been agreed.

The **duty of candour** training campaign over the last three months appears to have contributed to a 100% compliance rate with stage 1 and stage 2 duty of candour compliance in June and July 2019. Over 1200 staff have now received face to face training, and the Education and Workforce Development Board have now signed off the training to become a key competency for staff in the hospital with the development of an electronic training package. Compliance with stage 3 (sending the completed investigation) to the patient and family still requires some work

High risk monthly review performance has improved to 72% in July 2019 (from 48% in June 2019). A review of longstanding and overdue high risks has been undertaken by the Deputy Head of Quality and Safety to ensure the accuracy of risks on the risk register and verify local processes for review and update of risks on Datix. This work is continuing with the aim that by the end of August, the risk register will be updated and all risks identified that are currently not on the risk register but held locally, will be uploaded.

We have seen a positive improvement in the numbers of **policies** which are currently in date and available to staff. 81% of all policies are now in date, with 89% of safety critical policies in date. There continues to be month on month improvement in compliance.

There is 1 open red **complaint actions** which link to one complex case. The action plan has been revised post EPIC (as planned) and presented to the July Closing the Loop meeting.

A 24% increase observed in **FOI requests** for the month of July 2019 when compared to the previous month (n=59). However, 19 of these requests did not fulfil request criteria i.e. 13 of these had section 45 applied (-no visible citation of what public authority they were seeking the information from). 5 returned with adjusted requests. To date, there have been no FOI requests escalated to the ICO in 2019. YTD there have been 3 internal reviews (IR) conducted, 2 of which have been completed but awaiting finalisation and the other has now been completed and closed.

No email SARS were released in July 2019. 60% of email SARs (3) were being processed within the 90 day limit. A detailed report of the SARS performance has been requested to provide more detail and assurance regarding the process and planned improvements.

Quality and Safety Overview

The number of **incidents being closed** month on month is increasing (in July in excess of 900 incidents were closed) whilst the percentage of incidents being closed within 45 working days remains below 50%. This is due to the number of historical and overdue incident investigation and closure which has skewed the percentage closure within 45 days. Each of the clinical directorates had produced plans and trajectory's around closure of these historical incidents. A number have successfully caught up with their backlogs. Work within the remaining directorates continues.

There were **three open SI investigations** in July. Two were submitted within deadline and currently one SI is in progress and within timescale. There are no overdue SI's. One CAS alert remains overdue. This is related to the procurement of the replacement connectors re NR-Fit. Clinical Procurement lead to attend the next Operational Board.

There are currently 8 **Trust wide risks** open on the risk register as recorded on Datix. All 8 risks have been reviewed and remain within the deadline for next review. There are a number of risks identified with risk assessments currently being drafted. Once completed, these will be presented at PSOC and Operational Board for review/approval prior to "going live" on the DATIX risk register.

Each month we track the % of **medication incidents** which cause harm (slide 9) using SPC. This month the % of medication incidents which have caused harm in July 2019 exceeded the upper control limit. An review is being undertaken to understand key themes driving the increase, and assess whether intervention is required. We will continue to keep this under monthly review.

No new Trust-wide **QI projects** have commenced in July. There are a number of mentoring projects listed. The team provides a mentoring service, offering QI support to staff who are interested in starting local projects. Mentorship provides 1:1 QI support and advice, with a time commitment between 1-6 hours per month. Currently a number of these have been paused due to a number of factors such as capacity of the project team or the appropriate timing for the department to implement change at this time.

39 areas including ward as well as speciality areas were included in the July **Quality Rounds**. All actions from the Quality Rounds undertaken in 2019 as well as actions from the 2015 & 2018 CQC reports have now been collated into 1 integrated action plan and prioritised accordingly. The operational CQC steering group meetings have been increased to weekly where work continues to ensure that changes have been embedded in light of organisational re-structure. A shared drive for all directorates and speciality leads has been created to allow for ease of access and up to date progress and completion.

The **Speaking up for Safety** training programme continues with over 50% of staff and volunteers booked onto or attended a workshop. There are a further 90 sessions booked until end of August.

Emerging trends in Patient Safety

International & Private Patient incident increases

IPP reported 71 incidents in July, up from 28 in June and 33 in May. The most commonly reported incident type was prescription errors (13), followed by dispensing issues, communication and documentation. The new SI declared this month (discussed later in this report) was an IPP SI. Early themes from the SI are around proper escalation to the responsible doctor, a theme which was also present in earlier incidents investigated in 2019. The IPP team are working hard with all involved to improve communication with responsible doctors.

Access to clinical guidelines

It was raised through several forums, including Patient Safety and Outcomes Committee, that access to clinical guidelines, policies and protocols requires improvement. Not all local guidelines are available on the intranet, and staff are not aware of the process for getting these added. In addition the search function is not very effective which can mean that it sometimes be difficult to find the most up to date guidelines when searching. This was highlighted by a recent serious incident and also a safety alert. A trust wide risk, and associated action plan, is currently being assessed.

Remote access to GOSH systems

Remote access to GOSH systems, particularly for staff working in outreach clinics, was a commonly raised theme particularly towards the beginning of July. Access to patient records as well as the internet is essential for these clinics to run, and access issues caused delays and in some cases appointments where not all areas of concern could be discussed.

Hospital Quality Performance – August 2019 (July data)

Are our patients receiving safe, harm-free care?

	Parameters	May 2019	June 2019	July 2019
Patient Safety Reporting *	R<60 A 61-70 G>70	582	546	640
Incident Closure Rate (% of incidents closed within policy)	R 0-64%A>65-75% G>76-100%	52%	43%	38%
No of incidents closed	R - <no incidents reptd G - >no incidents reptd	624	679	919
Average days to close (2018 - 2019 incidents)	R ->50, A - <50 G - <45	70	80	110
Medication Incidents (% of total PSI)	TBC	24.6%	24%	22%
WHO Checklist (overall)	R<98% G>98-100%	98.5%	99.1%	99.2%
WHO Checklist (Theatres)	R<98% G>98-100%	99.2%	99.4%	99.3%
WHO Checklist (non-theatres)	R<98% G>98-100%	97.3%	98.2%	98.8%
Near Miss reports (% of incidents reported)	R <8%, A 8-9%, G>10%	9.1%	3%	5.1%
Serious Incidents	R >1, A -1 G – 0	1	0	1
Overdue SI	R >1, A -1, G – 0	1	0	0
Safety Alerts overdue	R- >1 G - 0	2	1	1
Safeguarding Children's Reviews	New	0	0	0
	Open and ongoing	6	6	6
Safeguarding Adults Board Reviews	New	0	0	0
	Open and ongoing	1	1	1

Are we delivering effective, evidence based care?

	Target	May 19	June 19	Jul 2019
Specialty Led Clinical Audits on Track	R 0- 69%, A>60-75% G>75-100%	82%	76%	79%
Number of completed specialty led clinical audits per year	Aim =100 p.a G= YTD total at month end is on target	24	31	45
NICE guidance overdue for assessment of relevance	R=1+, G=0	0	0	0
Relevant NICE national guidance without a gap analysis	R=1+, G=0	0	0	0
Participation in mandatory relevant national audits	G=100%	100%	100%	100%

Are our patients having a good experience of care?

	Parameters	May 19	June 19	July 2019
Friends and Family Test Recommend rate (Inpatient) *	G – 95+, A- 90-94, R<90	96%	96%	97%
Friends and Family Test Recommend rate (Outpatient) *	G – 95+, A- 90-94,R<90	91%	92%	92%
Friends and Family Test - response rate (Inpatient) *	25%	22%	22%	24%
PALS (per 1000 combined pt episodes)	N/A	9.36	6.32	5.89
Complaints (per 1000 combined pt episodes)	N/A	0.48	0.25	0.3
Red Complaints (%total complaints 12 month rolling)	R>12% A- 10-12% G- <10%	9%	9%	9%
Re-opened complaints (% of total complaints 12 month rolling)	R>12% A- 10-12% G- <10%	12%	12%	14%

Are our People Ready to Deliver High Quality Care?

	Parameters	May 19	June 19	Jul 2019
Mandatory Training Compliance	R<80%,A-80-90% G>90%	92%	93%	95%
Stat/Man training – Medical & Dental Staff	R<80%,A-80-90% G>90%	82%	84%	88%
PDR	R<80%,A-80-89% G>90%	80.6%	81%	90%
Appraisal Compliance (Consultant)	R<80%,A-80-90% G>90%	84%	84%	85%
Safeguarding Children Level 3 Training compliance	R<80%,A-80-90% G>90%	77%	85%	88%
Safeguarding Adults L2 Training Compliance	R<80%,A-80-90% G>90%	91%	94%	92%
Resuscitation Training	R<80%,A-80-90% G>90%		85%	87%
Sickness Rate	R -3+% G= <3%	2.4%	2.5%	2.5%
Turnover - Voluntary	R>14% G-<14%	15.2%	15%	15.2%
Vacancy Rate – Contractual	R- >10% G- <10%	8.5%	8.5%	9%
Vacancy rate - Nursing		0.5%	6.9%	7.2%
Bank Spend		4.6%	4.6%	4.6%
Agency Spend	R>2% G<2%	0.59%	0.8%	0.7%

Great Ormond Street Hospital for Children NHS

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

Responsive Hospital Metrics		May-19	June-19	July-19
Diagnostics: patient waiting <6 weeks	R<99% G -99-100%	90.51% ↓	92.08% ↑	94.93% ↑
Cancer 31 day: referral to first treatment	R<85% G 85%-100%	No patients	No patients	No patients
Cancer 31 day: Decision to treat to First Treatment	R<96% G 96-100%	100% →	100% →	100% →
Cancer 31 day: Decision to treat to subsequent treatment - surgery	R<94% G94-100%	100% →	100% →	100% →
Cancer 31 day: decision to treat to subsequent treatment - drugs	R<98% G 98-100%	100% →	100% →	100% →
Cancer 62 day: Consultant upgrade of urgency of a referral to first treatment	-	100% →	100% →	100% →
Theatre Cancellation for non-clinical reason	-	68 ↑	41 ↓	
Last minute non-clinical hospital cancelled operations - breach of 28 day standard		16 ↓	4 ↓	
Urgent operations cancelled for a second time.	R 1+ G=0	0 →	0 →	0 →
Same day/day before hospital cancelled outpatients appointments	-	1.01% ↓	1.95% ↑	1.97% ↑
RTT Incomplete pathways (national reporting)	92%	88.25% ↓	86.0% ↓	84.47% ↓
RTT: Average Wait of All RTT Pathways		-	9.55	9.53 ↑
RTT number of incomplete pathways <18 weeks	-	6503 ↑	5769 ↓	5321 ↓
RTT number of incomplete pathways >18 weeks	-	866 ↓	939 ↑	978 ↑
RTT Incomplete pathways >52 weeks Validated	R - >0, G=0	6 ↑	10 ↑	10 →
RTT incomplete pathways >40 weeks validated	R - >0, G=0	35 ↑	50 ↑	62 ↑
Number of unknown RTT clock starts – Internal Ref	-	8	7	6
Number of unknown RTT clock starts – External Ref	-	521	467	347
RTT: Total number of incomplete pathways known/unknown - <18 weeks	-	7016 ↑	6234 ↓	5665 ↓
RTT: Total number of incomplete pathways known/unknown - >18 weeks	-	869 ↑	948 ↑	985 ↑

Effective & Productivity Hospital Metrics		May-19	June-19	July-19
Discharge summary 24 hours	R=<100% G=100%	45.27% ↓	39.26% ↓	57.38% ↑
Clinic Letter– 7 working days		56.21%% ↑	60.84% ↑	
Clinic Letter– 5 working days		45.21% ↓	51.16% ↑	
Was Not Brought (DNA) rate		8.67% ↑	10.48% ↑	8.26% ↓
Theatre Utilisation – Main Theatres	R<77% G>77%	Data under review		
Theatre Utilisation – Outside Theatres	R<77% G>77%			
Trust Beds	Bed Occupancy	Data under review		
	Beds available	392	392	396
	Avg. Ward beds closed	32	20	30 ↑
	ICU Beds Closed	4	6	5 ↓
Refused Admissions	Cardiac	2	0	1 ↑
	PICU/NICU	9	6	4 ↓
PICU Delayed Discharge	Internal 8-24 hours	2	3	1 ↓
	Internal 24h +	3	3	1 ↓
	External 8-24 hr	0	0	3 ↑
	External 24h+	3	3	1 ↓
	Total 8-24h	2	3	4 ↑
	Total 24h +	6	4	2 ↓
PICU Emergency Readmission <48h	-	1	1	2 ↑
Daycase Discharges	In Month	1,938	1,974	2,398 ↑
	YTD	4,187	6,161	8,559 ↑
Overnight Discharges	In Month	1,519	1,563	1,576 ↑
	YTD	2,529	4,092	5,668 ↑
Critical Care Beddays	In Month	1,170	1,098	2,081 ↑
	YTD	2,006	3,104	5,185 ↑
Bed Days >100 days	No of Patients	7	4	9 ↑
	No of Beddays	1,095	651	1,795 ↑
Outpatient attendances (All)	In Month	19,156	17,969	18,630 ↑
	YTD	35,965	53,934	72,564 ↑

Well Led Dashboard

Great Ormond Street NHS Hospital for Children NHS Foundation Trust

Is our culture right for delivering high quality care?

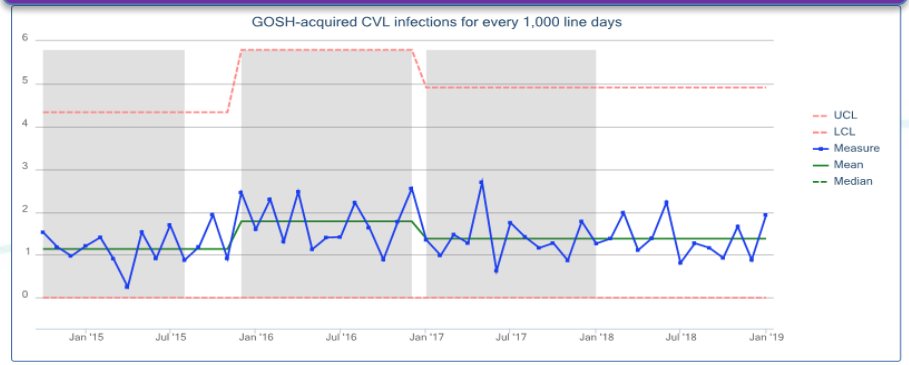
	Target	May 2019	June 2019	July 2019
High Risk Review (% reviewed within date)	R<80, A 81-90% G>90%	70%	48%	72%
Serious Incident Actions (number of actions overdue)	R- >2 A- 1-2 G- 0	TBC	TBC	TBC
Red Complaints Action Plan Completion (no of actions overdue)	R- >2 A- 1-2 G- 0	6	2	1
Duty of Candour Cases	N/A	5	4	10
Duty of Candour Conversation (Stage 1)	R<75% A 75-90% G>90%	100%	100%	100%
Duty of Candour Letter (Stage 2)	R<75% A 75-90% G>90%	80%	100%	100%
Duty of Candour – compliance with 10 days	R<75% A 75-90% G>90%	20%	50%	100%
Duty of Candour – Investigation completion	R<75% A 75-90% G>90%	60%	66%	33%
Policies (% in date)	R 0- 79%, A>80% G>90%	67%	71%	80%
Safety Critical Policies (% in date)	R 0- 79%, A>80% G>90%	66%	81%	89%
Fit and Proper Person Test Compliance (self assessment)	R - <90%A 90-99% G – 100%	100%	100%	100%
Quality Improvement Led Projects – Trust Wide	Volume monitoring	4	4	3
Quality Improvement registered Projects – Local	Volume monitoring	9	11	6
Quality Improvement Projects - Mentoring support	(new in July 2019)			5
Freedom to speak up cases	Volume monitoring	7	14	8
HR Whistleblowing - New	Volume monitoring	0	0	0
HR whistleblowing - Ongoing	12 month rolling	1	1	1
New Bullying and Harassment Cases (reported to HR)	Volume	0	0	0
	12 month rolling	9	9	9

Are we managing our data?

	Target	May 2019	June 2019	July 2019
FOI requests	Volume	49	40	59
FOI % responded to within timescale	R- <65% A – 65-80% G- >80%	90%	83%	90%
FOI - Number requiring internal review	R>1 A=1 G=0	0	0	0
FOI Number referred to ICO	G=0 R=1+	0	0	0
Information Governance Incidents	volume	13	9	19
IG incidents reported to ICO	volume	0	0	0
SARS (Medical Record) Requests		106	127	157
SARS (Medical Record) processed with 30 days	R- <65% A – 65-80% G- >80%	99%	99%	100%
New e-SARS received	volume	0	3	0
No. e-SARS in progress		2	5	5
E-SARS released		1	0	0
E-SARS released past 90 days	volume	1	0	0

Do we deliver harm free care to our patients?

CVL Infections



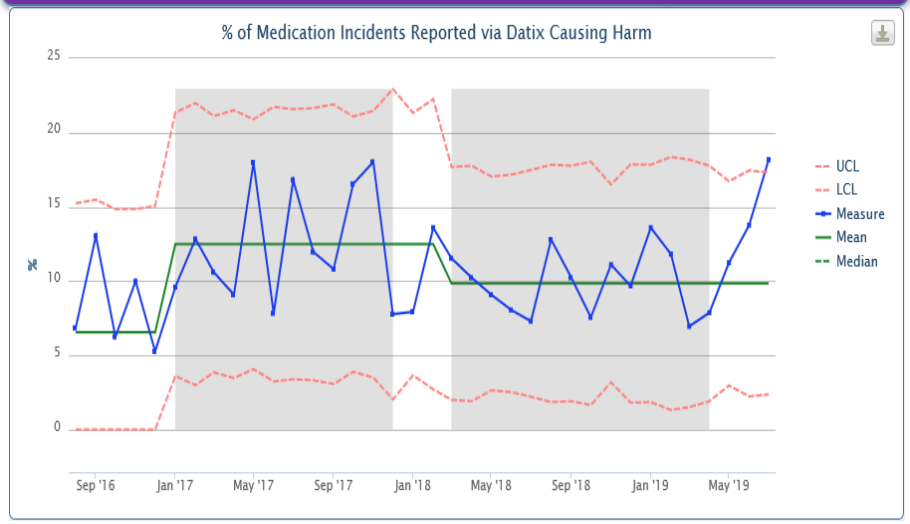
*updated chart not yet available pending rebuild of Quality Dashboards post EPIC

2019	Jan	Feb	March	April	May	Jun	Jul
Central Venous Line infections (per 1000 bed days)	2.1	2.5	3.2	0.9	2.8	0.6	1.3

Infection Control Metrics

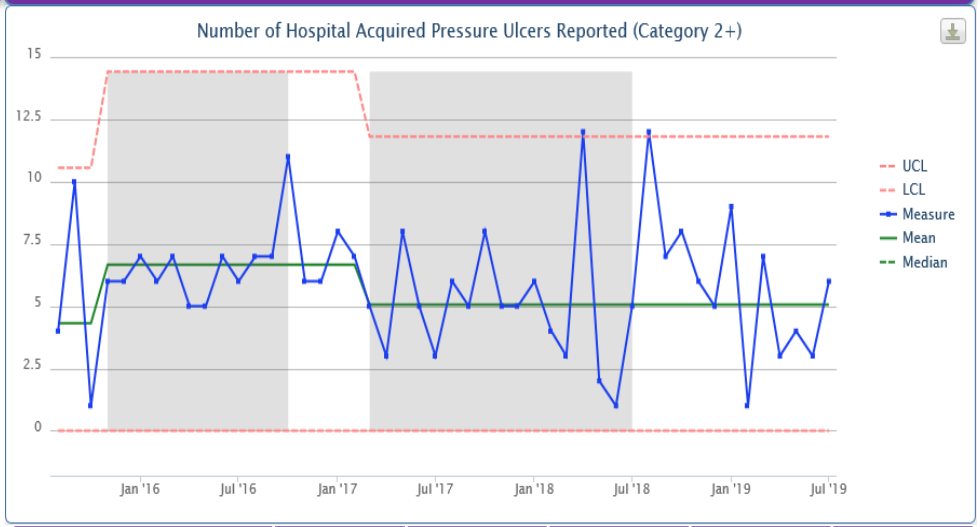
Care Outcome Metric	Parameters	May 2019	June 2019	July 2019
Bacteraemias (mandatory reporting – MRSA, MSSA, Ecoli, Pseudomas Klebsiella)	In Month	9	4	10
	YTD	13	17	27
C Difficile cases - Total	In month	1	1	1
	YTD	1	2	3
C difficile due to lapses (Considered Trust Assigned but awaiting confirmation from NHS E)	In Month	1	1	0
	YTD	1	2	2

Medication incidents causing harm



		Apr 19	May 19	Jun 19	Jul 19
% of reported medication incidents causing harm	Mean-12.5%	8%	11%	14%	18%

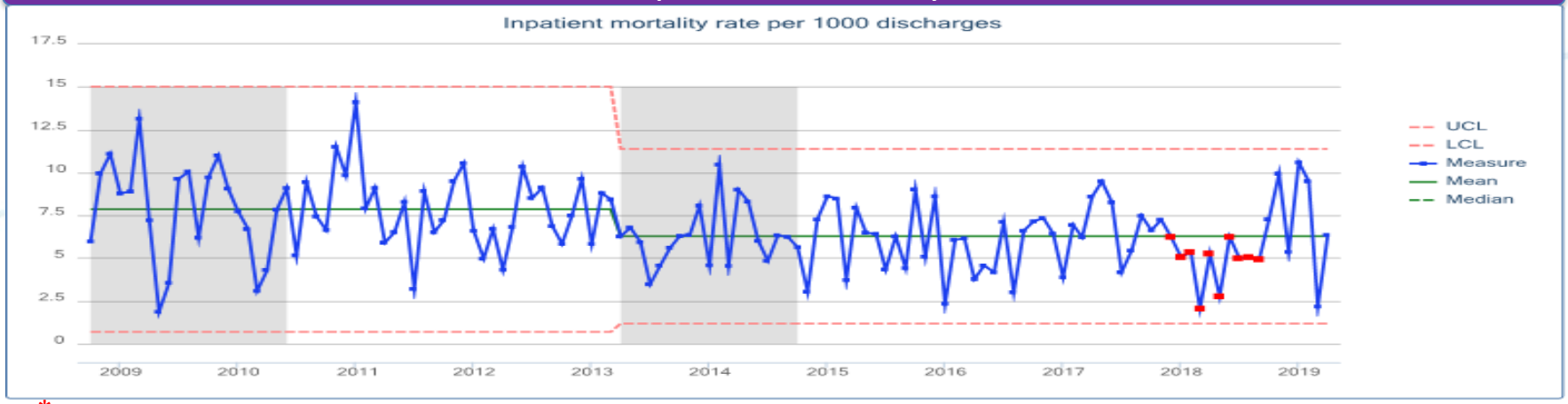
Pressure Ulcers



		April 19	May 19	Jun 19	July 19
Hospital Acquired Pressure Ulcer (2+)	R – 12+, A 6-11 G =0-5	3	4	3	6

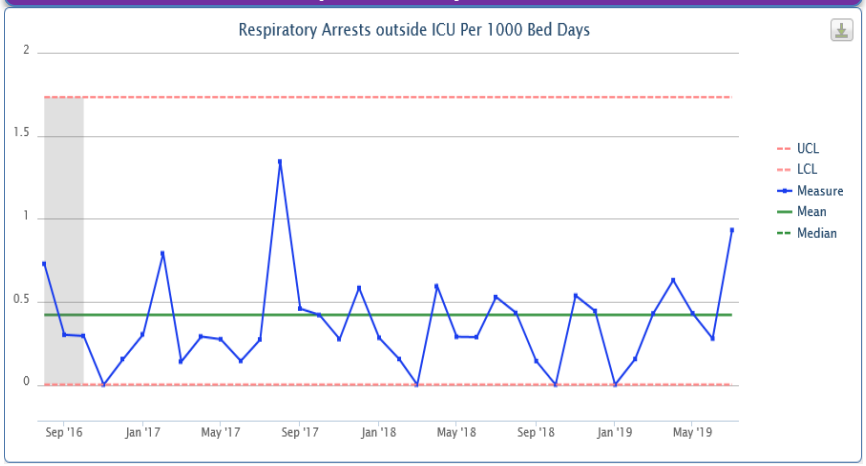
Does our care provide the best possible outcomes for patients?

Inpatient mortality

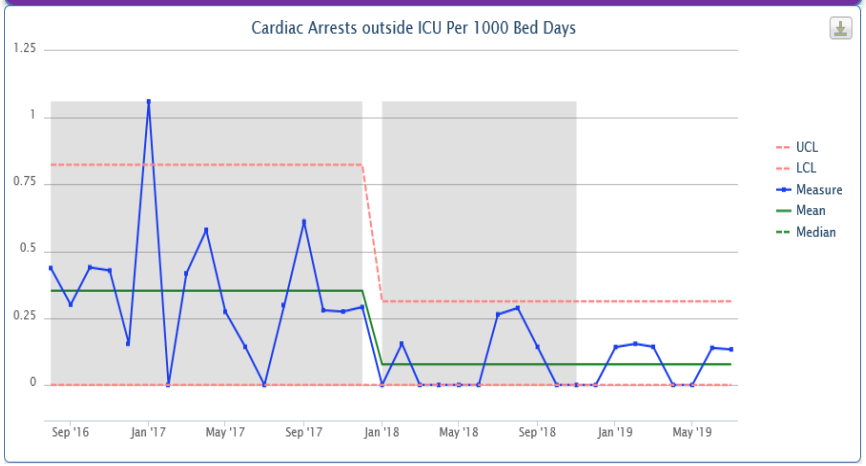


*the quality dashboards have now been re-built post EPIC and the data is currently being validated. We are aiming to include the updated run charts in the September (August data) report.

Respiratory Arrests

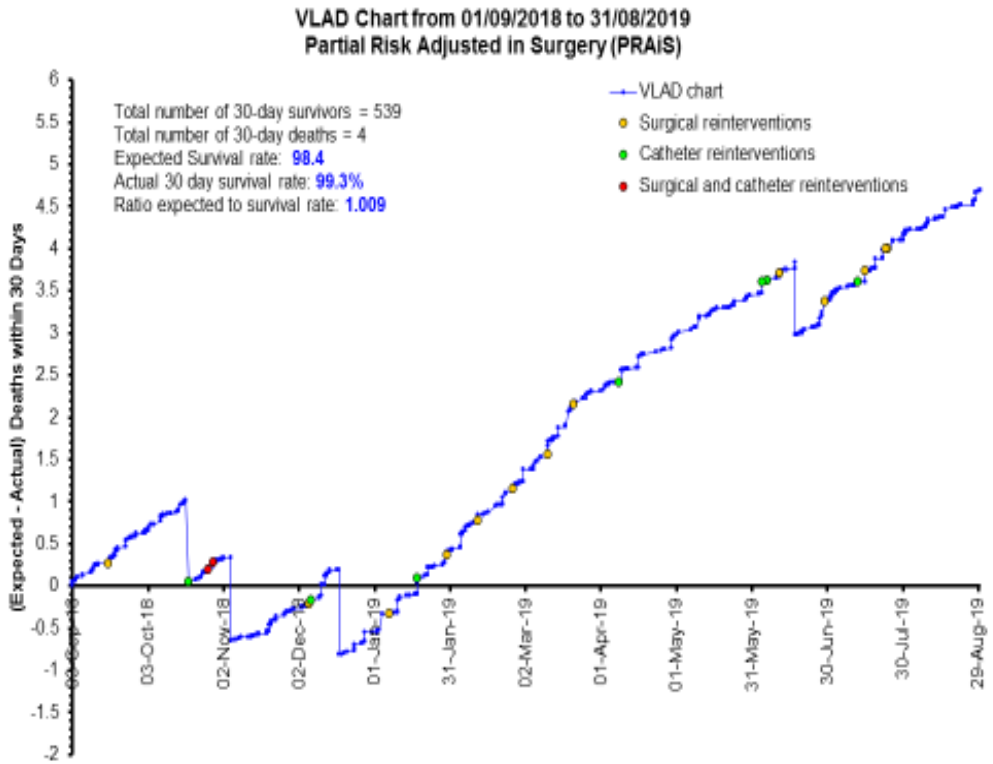


Cardiac Arrests



No concerns noted in current data trends for respiratory and cardiac arrest

Always Improving – Celebrating Successes



Variable Life Adjusted Display (VLAD)

VLAD is the running total of scores over time and represents the difference between expected and observed deaths following cardiac surgery.

This is the latest VLAD chart for the past year up to August that shows our ratio to expected survival is currently at 1.009 with an actual 30 day survival rate of 99.3% against an expected of 98.4%, which is very good especially compared to our peers and has improved since January when the ratio was at 1.004.

Closing the loop Lessons Learned Audits – July 2019

Learning from Controlled Drugs audit July 2019

A detailed audit was conducted by the Ward Pharmacists and a nurse on each inpatient ward between the 17th June and the 5th July. Learning from a Serious Incident in 2018 highlighted the importance of the documentation of controlled drugs.

How did we do?

It was an in depth audit that looked at 37 best practice standards, the overall level of performance was 83.5%.

The results do not show a significant level of non-compliance with many aspects of policy, but highlight some opportunities for improvement.
The themes for improvement across the Trust were around documentation in the CD order book and CD register.

What are we going to do to improve?

An action plan has been agreed between nursing education and pharmacy to support best practice. This includes the develop of digestible best practice guidance to be displayed in medicine storage rooms, revision of policy and education roll out to take place in September 2019

How will we know if we have made an improvement?

There will be a re-audit in December 2019.

Re-audit of implementation of actions identified from a complaint

A complaint investigation highlighted a number of learning points around the co-ordination of care for a child under the care of multiple clinical teams.

The audit reviewed the implementation of recommendations for the Spinal MDT (SMDT) meeting.

Key findings

The audit shows implementation of recommendations for the SMDT which were identified in the complaint action plan, and through an update of the action plan following the introduction of EPIC.

The audit results were reviewed at Closing the Loop and a further action has been agreed which relates to the introduction of a process for regular MDT governance self assessment. The introduction of this process will be supported by Closing the Loop and the Deputy Chiefs of Service.

Clinical Audit priorities – 2019/20 work plan

A clinical audit plan prioritises clinical audit work related to incidents, risk, complaints, and areas for improvement in quality and safety. These items are facilitated by the Clinical Audit Manager who engages with relevant staff as appropriate.

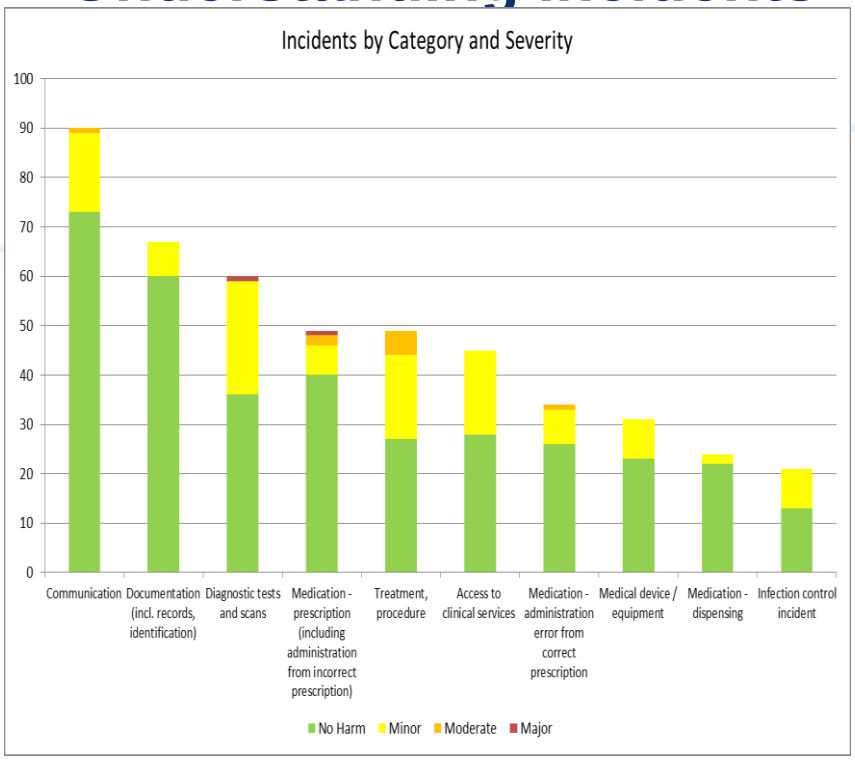
Source	Subject	Status
RCA/Red complaint	Cardiac consent re-audit	Data collection in progress , to be completed in August 2019
SI/Area where support is required	Controlled Drugs audit	Completed
Natssips	Surgical Safety Checklist audit –follow up audit to review quality of engagement and completion of the WHO checklist	Observational audit took place at the end of July 2019 in areas outside of main theatres. The results are being collated at the time of writing
NICE guidance	Mental Capacity Act	Date collection completed and recommendations being agreed in response to the audit.
Patient Safety Alert/prevention of Never Event	Reducing the risk of oxygen tubing being connected to air flowmeters	Re-audit to take place in September 2019 to assess implementation of the action plan that was agreed at the May 2019 PSOC.
Patient Safety Alert	Safe and timely management of hyperkalaemia	Audit reporting being finalised.
Patient Safety Alert	Re-audit to assess improvement in documentation post EPIC in NG Tube Testing	Data collection to take place in August 2019
Red complaint (18/056)	Review of implementation of actions agreed to improve multi -disciplinary communication , prior to , and post implementation of EPIC.	Completed

How further items for audit will be identified Further items will be established following requests made by Directorate Management, PSOC, and via SI and Complaint processes. Rapid Response Alerts which require confirmation of clinical practice, will be identified by the Patient Safety team, and audit will then be added to establish compliance .

Specific audits will be identified as requirements through Closing the Loop

Completed priority audits in the last month are on the next page of the report

Understanding incidents



Communication related incidents have risen significantly this month vs last month (increase of 60%). The vast majority of these (46) were relating to communication between teams in the hospital. Good communication is particularly important when much of our regular communication is electronic (via EPIC). It is recognised that there are times when it is best to pick up the phone and give a verbal update alongside the EPIC documentation.

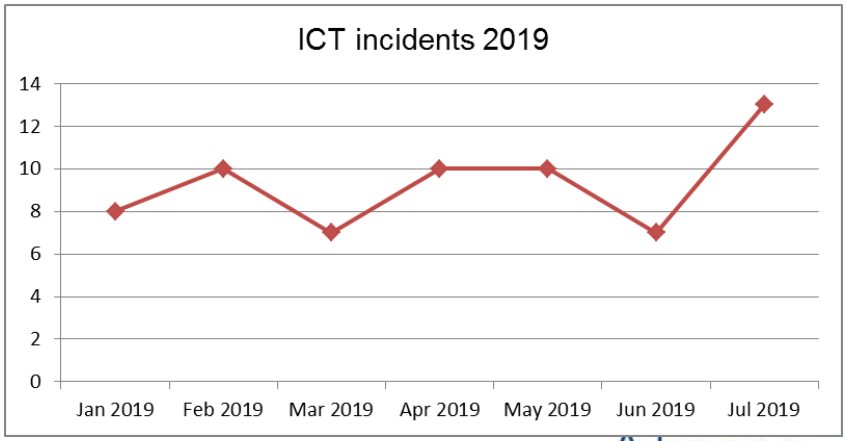
Documentation incidents have remained of major concern. This is often to do with unfamiliarity with the EPIC system and people incorrectly or failing to document.

Medication dispensing was a top 10 category this month. Concerns about late supply of medication was the main driver behind this. There were also a number of incidents around Healthcare at Home (which is non-GOSH) supplies not reaching patients, resulting in hospital admissions.

ICT Incidents

The Trust has DATIX (for reporting patient safety incidents) and Hornbill (for reporting ICT problems). There is some overlap between the two systems where ICT problems impact on patient care and we encourage staff to report on both if this is the case. This month we have been working with ICT to bring the DATIX system closer in line with Hornbill so they can better respond to DATIX incidents. This includes training more ICT staff to use the system, as well as introducing more ICT specialty and category options.

Please remember to include the hornbill reference number on any ICT Datix forms. You can report an issue on Hornbill by calling the Service Desk on 6060



Always

Welcoming Helpful Expert One Team

Patient Safety Alerts

Great Ormond Street Hospital for Children NHS Foundation Trust

New and ongoing Patient Safety Alerts

There are currently no new patient safety alerts open in the trust.
NRFit is the only PSA open (see overdue safety alert box)

Recently Closed Patient Safety Alerts

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

NHS/PSA/RE/2018/006: Resources to support safe and timely management of hyperkalaemia (Aug 2018)

NHS/PSA/RE/2019/002: Assessment and management of babies who are accidentally dropped in hospital (November 2018)

National Reporting and Learning System

The NRLS is a national scheme (linked to NHSI) for reporting patient safety incidents. Currently, NRLS advise a minimum of monthly uploads from NHS organisations. However, the standard operating procedure within the Quality & Safety team is to carry out fortnightly uploads of closed incidents. It appears that there was no an upload in February 2019, however our records demonstrate that there was an upload on the 25th January followed by an upload on the 1st, 15 and 29th March 2019.
The NRLS does not stipulate whether the incidents uploaded should be open or closed. The current Trust process is to upload closed incidents which reduce the risk of information governance breaches and incorrect harm ratings.
The Incident Management Policy is currently in the process of being updated, following National guidance and advise based on the recent publication of the NHS Patient Safety Strategy, 2019. This will be circulated for consultation and comment regarding any proposed changes to process.

Overdue Patient Safety Alerts

NHS/PSA/RE/2017/004: Resources to support safe transition from the Luer connector to NRFit for intrathecal and epidural procedures, and delivery of regional blocks. **DUE: December 2017**

Latest update: Members of the Patient Safety and Outcomes Committee (PSOC) monitor progress of this alert. The delay has been sourcing a suitable device to proceed to stage two roll out. Currently the Trust procurement lead is sourcing potential products for consideration to proceed to trial.

National Learning and updates:

The NHS Patient Safety Strategy- Safer Culture, Safer Systems, Safer Patients

This Strategy document was published by NHSE and NHSI in July 2019. It should be noted that a National Incident Response Framework will be published in September 2019.

This document is not prescriptive in its approach but is a statement of the NHS collective intent to improve safety by recognising that to make progress, we must significantly improve the way we learn, treat staff and involve patients.

There are 3 strategic aims set out in order to support the foundation of a patient safety culture and a patient safety system. These aims are related to Insight; Involvement and Improvement.
For further information please click on the link below:
*https://improvement.**nhs**.uk/resources/**patient-safety-strategy***

Patient Safety – Serious Incident Summary

Great Ormond Street Hospital for Children NHS Foundation Trust

New & Ongoing Serious Incidents				
Directorate	**Ref**	**Due**	**Headline**	**Update**
Estates and Facilities	2019/10699	08/08/2019	Staff collapsed on Trust premises.	On track to submit before deadline
Brain	2019/11025	13/08/2019	Delay in diagnosing renal failure	On track and to submit by deadline
IPP	2019/16723	23/10/2019	Oesophageal perforation	Timeline being drafted

2019/16723 – Oesophageal perforation

New SI declared on 30/07/2019.

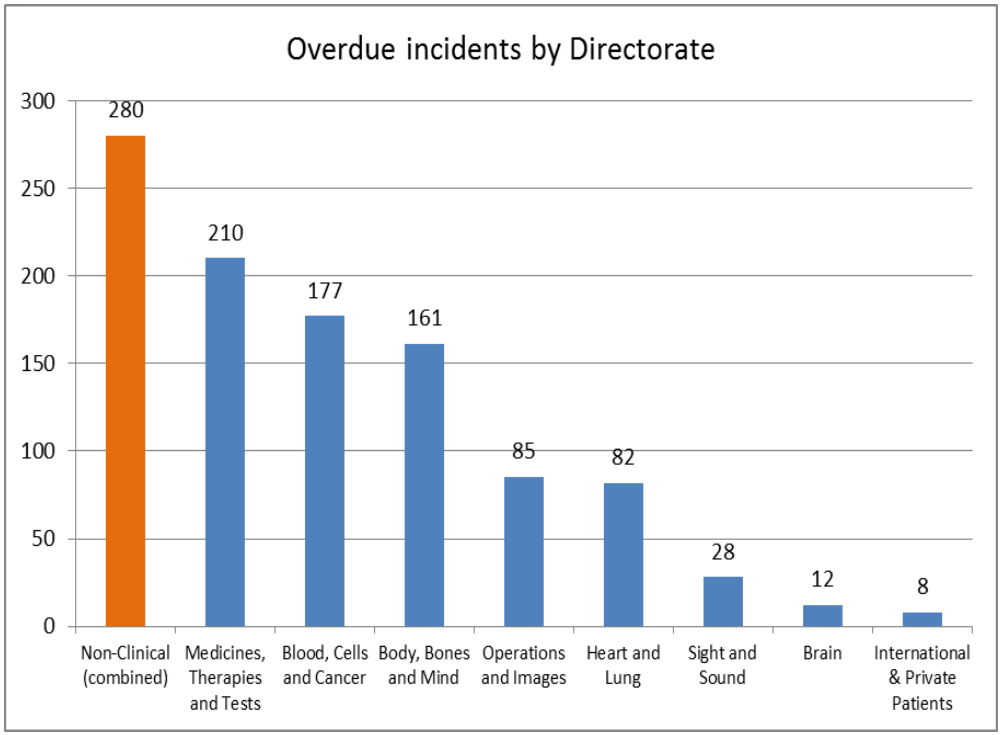
Patient admitted for Heller's Cardiomyotomy procedure via laparoscopy. The patient was instructed to be given a soft diet post operatively. When the patient deteriorated, an oesophageal perforation was identified and required urgent surgery. Following the surgical repair the patient has also incurred an acute kidney injury due which is potentially related to vancomycin.

Never Events - Lessons Learned Completed investigations sent to NHS England

2019/8273: Retained arterial line.
The learning will focus on a review of arterial line guidelines and work around the EPIC line removal page, as well as education for nurses and possible inclusion in simulation training.

2019/8826: Retained instrument.
Agreed to look at staffing numbers in theatres. Education and training to take place around counts. There was also incidental learning around a complication during the procedure- and a plan to mitigate against the risk of similar complications in future procedures of this type.

Incident Management within the Directorates



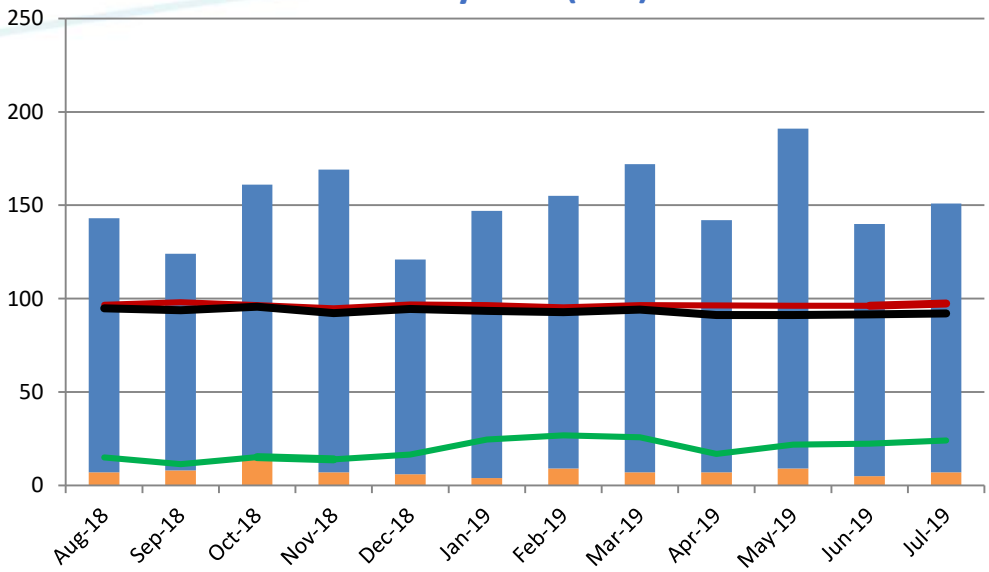
There are a large number of overdue incidents observed within the non-clinical areas such as ICT; Finance; Estates & Facilities. In order to combat the delays in reviewing and closing these incidents, a number of team members within each area have recently received DATIX/ incident management training. Also members of the Health & Safety team are attending the clinical RAG's/meetings in order to review and close the incidents once investigated jointly.

The patient safety team are also in the process of recruiting patient safety managers, who will, once in post and completed induction will be available to support and monitor non-clinical team incident management. We hope with successful recruitment, these staff members will be in post from November 2019.

Patient Experience Overview

Are we responding and improving?

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



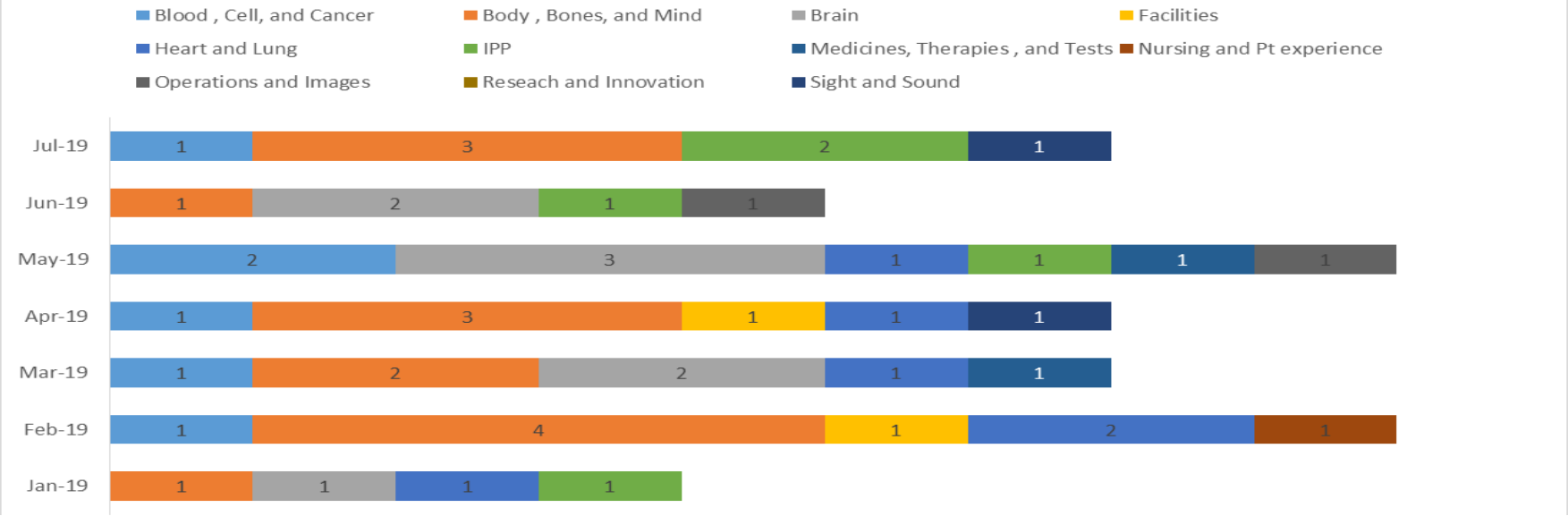
	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
PALS	136	116	146	162	115	143	146	165	135	182	135	144
Formal Complaints	7	8	15	7	6	4	9	7	7	9	5	7
FFT recommendation rate - Inpatients %	97	98	97	95	97	97	95	97	96	96	96	97
FFT recommendation rate - Outpatients %	95	94	96	92	95	94	93	94	91	91	92	92
FFT % response rate	15	11	15	14	17	25	27	26	17	22	22	24

Formal Complaints | PALS | FFT recommendation rate - Inpatients % | FFT recommendation rate - Outpatients % | FFT % response rate

There has been an increase in the number of Complaints (2) and Pals (8) concerns relating to **International and Private Patients (IPP)**. This increase has also been reflected in the number (71) of incidents reported within IPP in July and the gradual increase over the last 3 months. Complaints and Pals feedback in IPP raised concerns around post-operative care, dissatisfaction with nursing care and a lack of communication with parents. Communication was also raised as an issue in incidents, in addition to prescription and dispensing incidents and staffing levels. The percentage to recommend for FFT was 88% for IPP which is below the Trust target of 95% - see slide 22.

Complaints and Pals feedback is showing increased concerns about **delays and waiting times**. These include waits to obtain appointments, delays in accessing tests, discussing both test results and treatment plans. Poor **communication** is one cause of this and is reflected in the increase of Pals contacts regarding this and in **communication** related incidents which have risen significantly (by 60 %) – slide 12.

Complaints: Are we responding and improving?

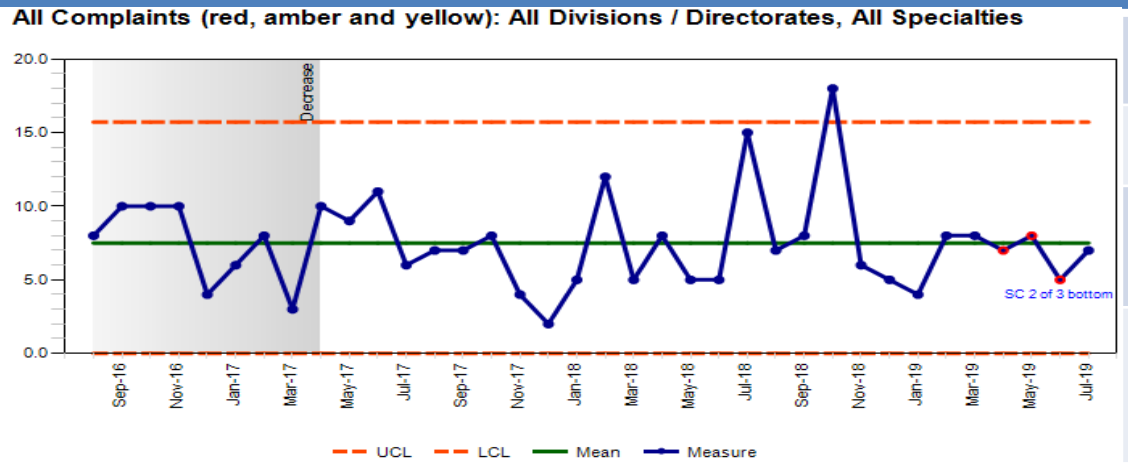


There were 7 new complaints received in July 2019 (this is just slightly below the average of 7.5 complaints per month*). Families reported concerns about:

- waiting times for a first appointment. The service wrote to the parent and stated that EPIC had caused delays to waiting times. There were a number of weeks where the amount of appointments were reduced post EPIC however the letter incorrectly implied this reduction was long standing
- poor communication and delays in delays in obtaining diagnostic tests, discussing the test results and treatment plan. The parents feel these delays have contributed to their child's ongoing health issues
- a lack of holistic and multi disciplined care following a post-op complication
- an error in the reporting of a discussion/scan at an MDT meeting to the local hospital. The parents feel this led to a change in the treatment plan
- a delay of 6 months to process a sample for genetic testing
- the behaviour of the clinician and their actions when there were potential safeguarding concerns
- post-op care and has queried if this led to infection and the break down of the wound

** Based on the last 12 months YTD.*

Red Complaints: Are we responding and improving?



No of new red complaints this financial year 2019/20:	2
New Red complaints opened in July 2019	0
No of re-opened red complaints this year 2019/20:	1
Open red complaints (new and reopened) as at 31/07/2019:	2

Red complaint

Ref	Due Date	Directorates Involved	Background	Next Steps:
19/010	09/08/19	IPP	Parents are concerned that their child was not admitted to a specialist ward and therefore didn't receive the expert and urgent care required. They feel this led to permanent brain damage	Action Plan is being finalised.

Reopened red complaint

Ref	Reopened Date	Directorates Involved	Background	Next Steps:
18/081	17/06/19	IPP	Parents are concerned that there was a delay in identifying sepsis . Investigation concluded patient's presentation was complex/ unusual and sepsis protocol was followed appropriately. Family have requested a meeting with the clinical team.	Family were unable to attend the meeting arranged in July. A new date has been agreed (September).

There are 1 overdue Red Complaint actions which relate to one complex case. The action plan from this complaint has been revised post EPIC (as planned), and was presented to the July Closing the Loop meeting. The relevant directorates are reviewing the actions and providing evidence of completion. Compliance with action plans will be monitored at the Patient and Family Experience and Engagement Committee.

PALS – Are we responding and improving?

Cases – Month	07/18	06/19	07/19
Promptly resolved (24-48 hour resolution)	124	123	111
Complex cases (multiple questions, 48 hour+ resolution)	0	8	31
Escalated to formal complaints	2	3	0
Compliments about specialities	5	1	2
*Special cases (e.g. large volume of contact following media interest)	0	0	0
Total	**131**	**135**	**144**
Themes for the top five specialties			
Lack of communication (lack of communication with family, telephone calls not returned; incorrect information sent to families)	42	43	55
Admission/Discharge /Referrals (waiting times; advice on making a NHS/ IPP referral; cancellations; waiting times to hear about admissions; lack of communication with families, accommodation)	34	9	21
Staff attitude (rude staff, poor communication with parents, not listening to parents)	14	13	2
Outpatient (cancellation; failure to arrange appointment; poor communication, franking of letters)	18	40	32
Transport (eligibility, delay in providing transport, failure to provide transport)	5	2	4
Information (GOSH information, Health information, care advice, advice NHS, access to medical records, incorrect records, missing records, support/listening)	20	26	31

There has been a small increase in Pals cases this month, and in the number of complex cases (*a case that has been open for longer than a week*). The majority of these cases relate to Sight and Sound and Body, Bones and Minds.
Pals are working with the Heads of Nursing from these directorates to promptly respond to these families and to close the cases. The main themes for these cases are a lack of communication with parents/patients and waiting times. Analysis and actions are presented at Patient and Family Engagement and Experience Committee.

Families continue to report concerns around cancelled outpatient appointments, difficulties contacting the clinical teams and obtaining information about test results/patients' care.

A review of the Pals data indicates that attempted contact made by families was primarily by telephone and not via MyGOSH. There has been 10 cases relating to MyGOSH which include concerns around: accessing the system (usernames and links to the site not working and wrong activation links sent to parent) and results not being uploaded.

2 Pals cases were received relating to EPIC around a letter lost on the EPIC system, dictated letter not proof read and then sent out to family with the wrong diagnosis .

PALS – Are we responding and improving?

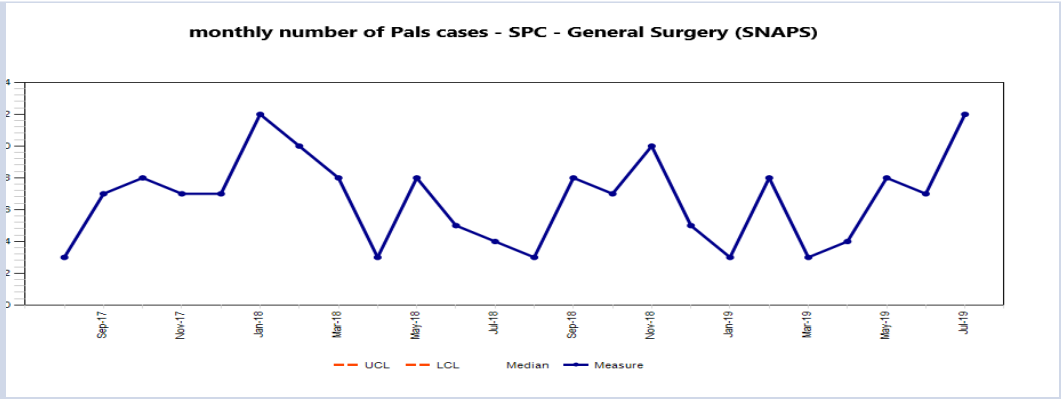
Top specialities - July	07/18	06/19	07/19
General Surgery	4	7	12
Ophthalmology	5	6	9
Cardiology	17	5	8
Urology	5	3	8
Dermatology	0	1	6

The Assistant Service Manager (ASM) for Ophthalmology has provided feedback on factors that may have contributed to their increase in Pals numbers for July.

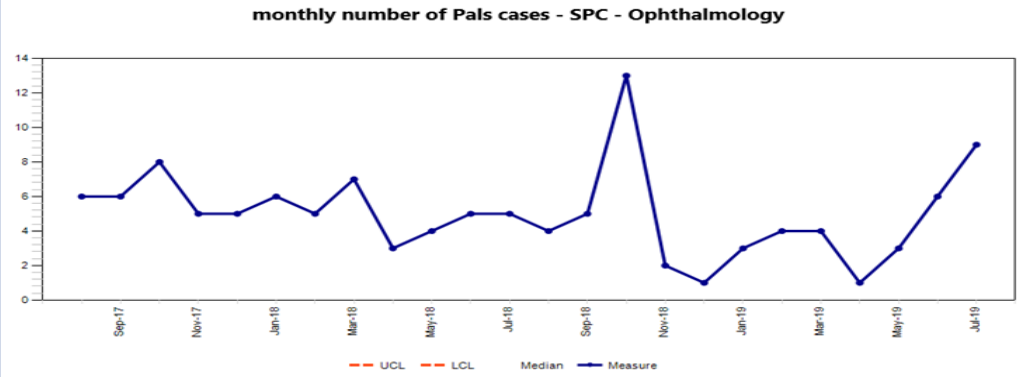
Cancellations: Many clinicians in Ophthalmology work part-time and this makes factoring in their annual leave difficult. Whilst the service tries to reduce the impact on patients, given the specialist nature of some clinics it may be unsuitable for some patients to be seen by another clinician. The service will look at how it can improve its annual leave planning and how it can reduce the impact this has on families.

Communication: The service needs to improve its communication. One aspect of this is around clinic cancellation letters and why they are not being received by parents. Whilst we do manage an element of this in house we do send a large proportion of cancellations to the Central Booking Office (CBO) for processing and they should be sending out letters to this effect. The ASM will meet with the ASM in the CBO to try and ascertain what has happened. Sign ups to my gosh should help this process and the teams are promoting this on the phone and in outpatients.

General Surgery (SNAPS) cases



Ophthalmology cases



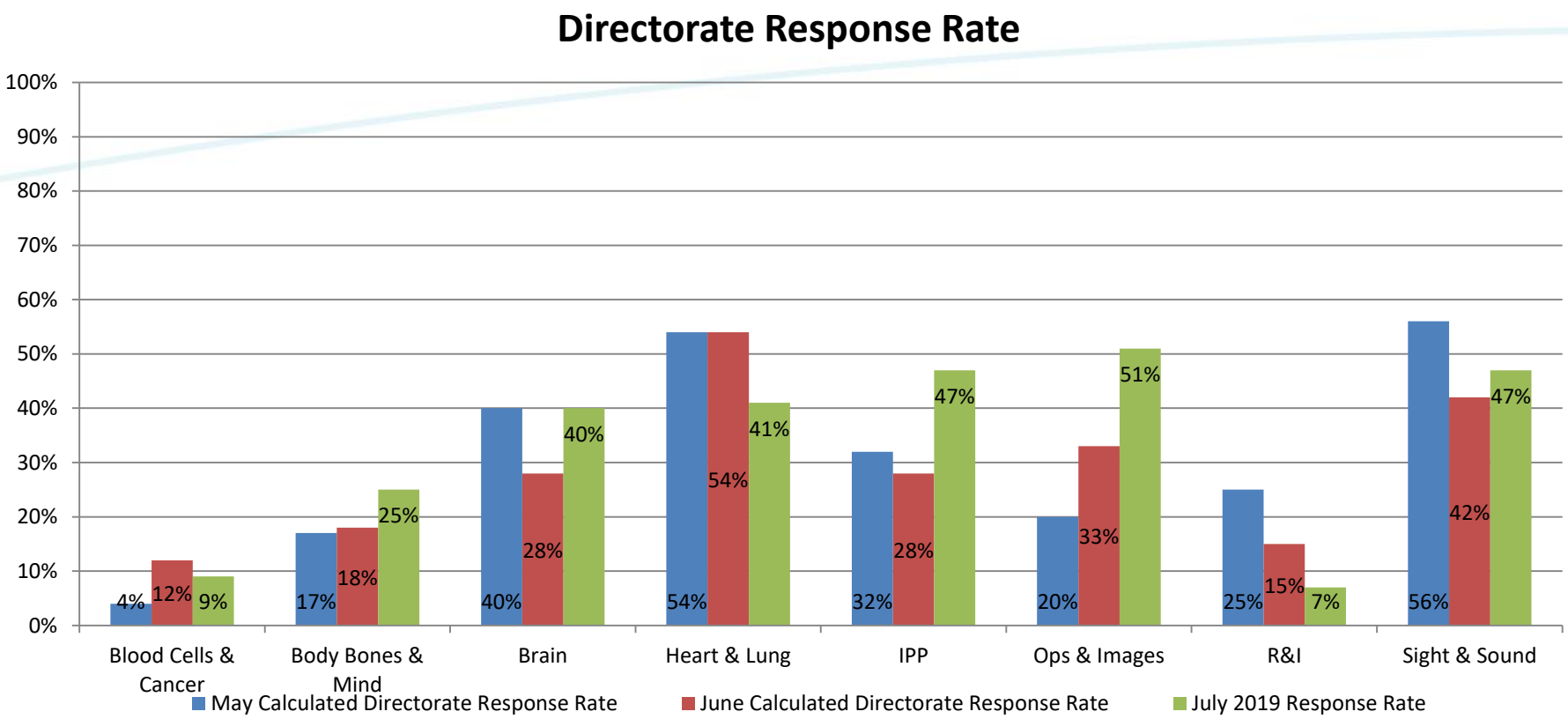
The child first and always

* Including one compliment

Always

Welcoming Helpful Expert One Team

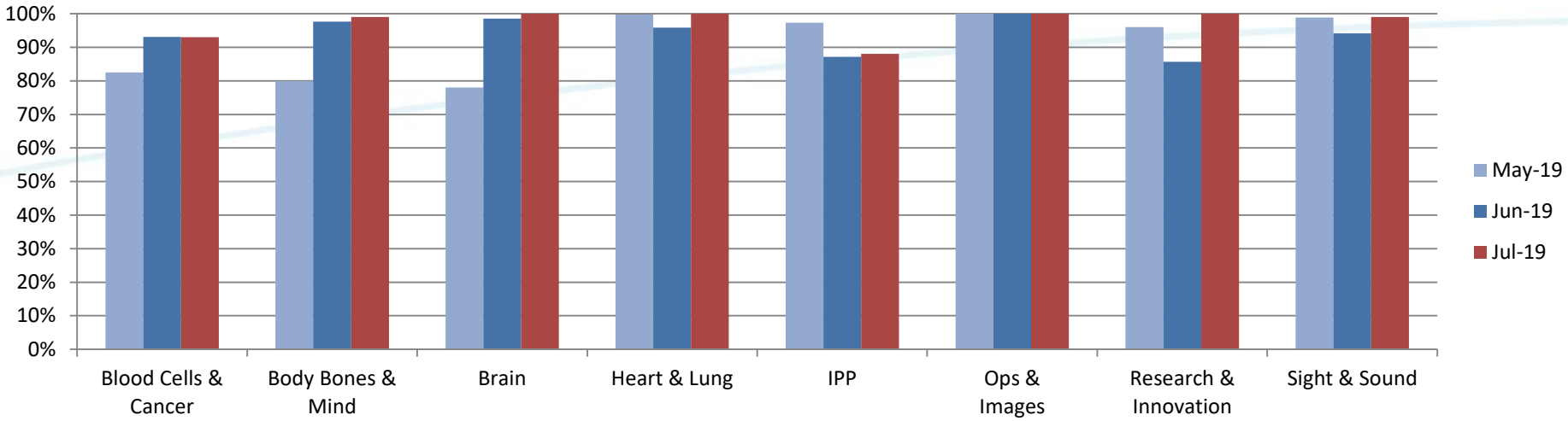
FFT: Are we responding and improving?



The overall FFT response rate has increased by 1.5% this month. Five directorates improved on last months response rate and six directorates met or exceeded the 25% target.

Blood Cells and Cancer have very high discharge rates from Safari and Pelican Ambulatory Wards which is being looked into by the EPR team and Information Services team.

FFT: Are we responding and improving?



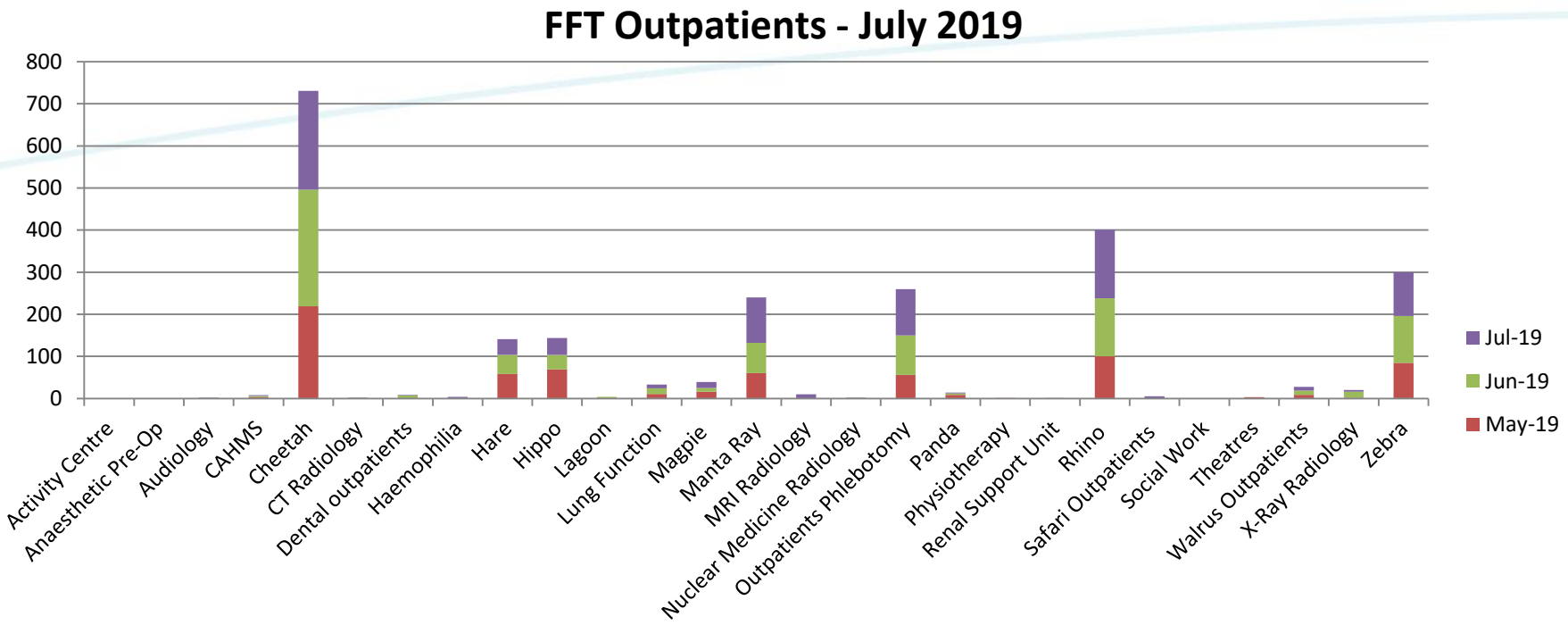
This month's percentage to recommend scores saw improvement for six directorates. Two directorates scored below the Trust target of 95%, Blood, cells and cancer scored just below the target, 93% and IPP scored 88%. The negative comments relate to catering, communication, delays on the ward. The feedback from the last 3 months will be looked into in greater detail.

	Inpatient Comments	Outpatient Comments	IPP Comments	Total Feedback	% with qualitative comments (All areas)
Mar 19	876	673	48	**1597**	**81.3%**
Apr 19	516	399	40	**955**	**85.3%**
May 19	667	701	51	**1419**	**79.4%**
June 19	714	836	40	**1590**	**80.4%**
July 19	922	865	77	**1864**	**79.1%**

FFT comments from both inpatients and outpatients increased in July 2019. The percentage of qualitative comments remains high at just below 80%.

The main theme for negative comments were Access / Admission Discharge and Transfer. These focussed on letters received for clinics which did not go ahead, difficulty contacting the relevant teams regarding appointments and long waits for pharmacy.

FFT: Are we responding and improving?



The above chart outlines the number of the FFT responses within Outpatients. There is currently no Trust or NHS target for outpatient FFT feedback. The feedback received in outpatients has increased again this month to 865. This is 3.5% increase on the previous month. The percentage to recommend score remains the same as last month at 92%. The negative comments received this month were predominantly about waiting times, letters being received but the clinic not going ahead, poor attitude of reception staff and the uncomfortable temperatures within the outpatient areas.

FFT: Are we responding and improving?
Qualitative Comments

Great Ormond Street NHS Hospital for Children NHS Foundation Trust

Positive	Negative
"Our experience over 10 years has been fantastic and the care received over this time has been excellent. Our trust and support in GOSH continues to be 100%. Thank you GOSH and the team" – Zebra Outpatients	*Feedback submitted online.* *"PLEASE HELP!! *DESPERATE* Good, thorough consultation with the doctor but 3 weeks later and no medication for my daughters migraines! I have called and left messages with his secretary, I have emailed her, i have tried using the online portal to no avail, I have called my local GP to see if they have received the prescription but they've got nothing, no letters nothing. My daughter continues to suffer with constant headaches. PLEASE HELP URGENTLY THANK YOU"*
"I love Safari Ward – all the staff as so welcoming and patient. I couldn't wish for a better place for my son to receive his treatment. Thank you for everything!" – Safari Day Care ward	
"Always understanding. Always caring and ready to help. Children and parents are put at ease and feel that children are in good, safe professional hands". – Cheetah Outpatients	
"We cannot thank everyone enough for how well you looked after our son. Communication, organisation and team work was unbelievable and all done with such sympathy and patients" – Butterfly Ward	Mother and GP were contacted the same day as the feedback was received by the Clinical Nurse Specialist. A specific email and telephone number has been set up to make it easier for families to contact the team at GOSH.

Feedback is shared with the teams concerned. All negative comments are followed up with the families (subject to contact details being available).

Quality Improvement

The QI Team support, enable and empower teams, to continuously improve the quality of care provided to patients across GOSH.

1. Mentoring QI Projects

The team provides a mentoring service, offering QI support to staff who are interested in starting projects. Mentorship provides 1:1 QI support and advice, with a time commitment between 1-6 hours per month.

Project Commenced	Area of work	Project lead:	Expected completion date	
Dec 2018	**Improve handover** quality and continuity of care for outlying patients in the cardiology service	Craig Laurence (Cardiac Fellow)	Oct 2019	
Dec 2018	To **reduce the number of unnecessary clotting samples** in SNAPS	Sonia Basson, SNAPS SpR	TBC	Project paused
Jun 2019	To reduce the number of **unnecessary blood tests**, when ordered in sets/ bundles, in Brain Division	Lucy Thomas	TBC – Pending scoping	Project paused
Jun 2019	To improve and standardise the provision of **Play in Heart & Lung** so that all C&YP receive the play support they require for their needs	Laura Walsh (Head Play Serv.)	TBC – Pending scoping	Project paused
Jun 2019	To Improve the **knowledge/ understanding for all new parents** on the precautions and restrictions on Fox/ Robin from day one of their child's admission.	Robyn Newton (Ward sister) & Anna Sillett (Ward Sister)	Aug 2019	Project closed

2. Local / Directorate QI Projects

The QI Team also provides QI support and expertise to local or divisional improvement work. The following graphics, maps where registered QI activity is taking place across the Trust:

GI Bleeds Pathway

Reduce unnecessary coagulation testing in SNAPS

ZAPPP

BMT Patient/ Family Info

Pelican ward Q&S

Mobile App Group

Datix (DRM)

Discharge Sum

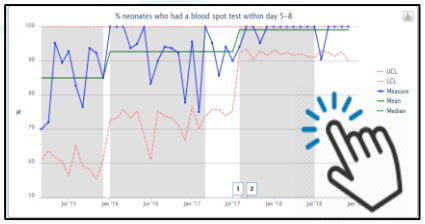
PN Administration

Project Commenced	Area of work	Project lead:	Expected completion date	
May 2019	Supporting the development of a joined up, pan-trust approach to the **management of acute gastro-intestinal haemorrhage** for inpatients	Sian Pincott (DCOS-BBM)	Aug 2019	Closing soon
Dec 2018	To improve IR theatre utilisation by implementing **ZAPPP** (zero acceptance of poor patient preparation) policy	Sam Chippington (Cons)	TBC	
Jun 2019	To implement Datix Review Rounds to **improve the culture of learning from incident reporting** in IPP	Deborah Zeitlin (Cons IPP)	Dec 2019	
May 2019	Revising the **provision of Discharge Summaries** in IPP since EPIC.	Sian Pincott (DCOS - IPP)	Dec 2019	
Jul 2018	Mobile App Development Project. Develop **a framework and process to oversee the development of Mobile Applications** in the Trust	Louis Grandjean (ID Cons) / Sue Conner (DRIVE)	Jan 2020	
Sep 2018	Supporting the implementation of Quality & Safety initiatives on **Pelican ward**	Carole Campbell (Ward Sister) & Emma Gilbert (Matron)	Jul 2019	Project closed

*Click links to open project dashboard

3. Trust wide QI Projects

Trust-wide projects are commissioned and governed by the Quality Improvement Committee, with an Executive Sponsor and a MDT steering group.



All Trust-wide project data is available on the QI dashboards page

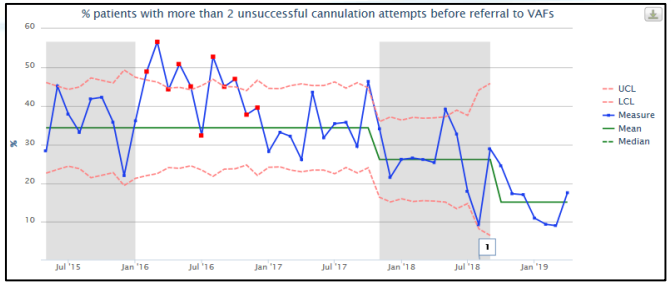
Project Commenced	Area of work	Project Lead (PL) Exec Sponsor (ES)	Expected completion date	
Feb 2019	Supporting the **medication safety work stream** of the Hospital Pharmacy Transformation Programme Board (HPTPB); PN & CD's	PL: Stephen Tomlin ES: Andrew Taylor	***TBC***	
Jun 2019	Improving safety and standardisation of **urethral catheterisation**	PL: Nicola Wilson ES: Sanjiv Sharma	Nov 2019	
Jun 2018	Reducing rejected **laboratory samples**	PL: Christine Morris ES: Sanjiv Sharma	Nov 2019	
May 2017	Reducing incidences of **extravasation harm** and repeated cannulation	PL: Emma Stockton ES: Alison Robertson	Jul 2019	**Project closed**

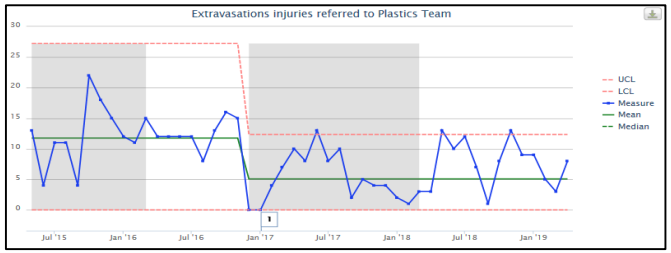
4. Closed projects

1. Reducing incidences of extravasation harm and repeated cannulation

The project has closed with statistically **sustained improvements identified** in all four outcome measures. A business-as-usual oversight plan has been developed for sustainability, placing oversight of on-going quality in the divisions.

- Average number of extravasations reported monthly on Datix **reduced from 3.85 to 2.29**
- Average number of extravasations referred monthly to the Plastics team **reduced from 11.7 to 5**
- Average percentage of patients with more than two unsuccessful cannulation attempts before referral to VAFs **decreased from 34% to 15%**
- Average number of cannulation attempts by clinicians prior to referral to Vascular Access Facilitators (VAFs) **reduced from 1.9 to 1.2**





2. Supporting the implementation of Quality & Safety initiatives on Pelican ward

QI provided advice and support to improvement work led by the Pelican Ward Sister. This includes support in gathering a baseline improvement measure through the Safety Climate survey, and baseline data for PEWS, Sepsis, Discharge summary timeliness, length of stay and ambulatory scheduling to inform further improvement work.

Quick wins in improving safety have been delivered through regular Datix incident reviews, and a Sepsis teaching package developed. An MDT improvement group has been established by the Ward Sister to continue improvements, and QI support has ceased.

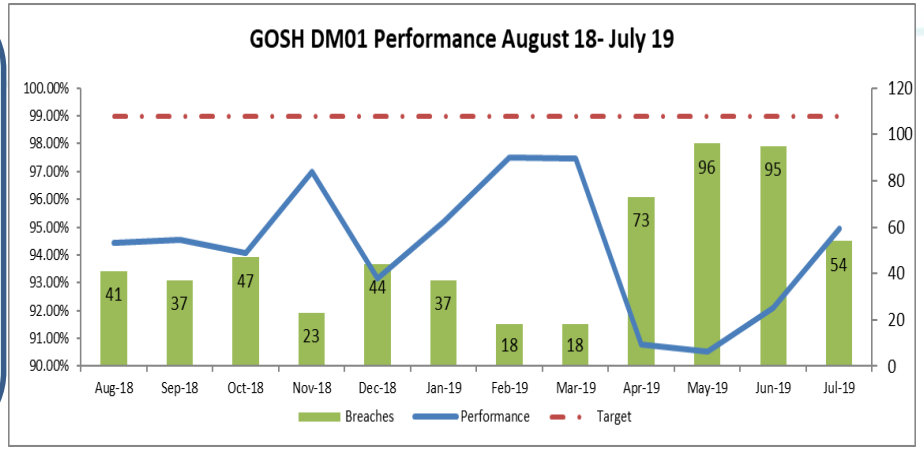
3. Improving knowledge/ understanding for new parents on the precautions and restrictions on Fox/ Robin from day one of their child's admission.

QI provided support with a parent / carer survey to identify levels of understanding and suggestions for improvement. Updates have been made to the documentation provided to families, and the ward team will be taking forward possible Epic changes in the optimisation phase.

Responsive – Diagnostic Waiting Times

July 2019 Summary

- The Trust continues to underachieve against the 99% national standard, reporting 94.93% of patients waiting within 6 weeks for the 15 diagnostic modalities
- The number of reported breaches has significantly decreased to 54 compared to May and June when we reported 96 and 95 respectively.
- The reduction in breaches has been mainly due adopting an MDT approach across clinical, administrative, operational and performance teams with focussed work encompassing capacity reviews, twice weekly PTL meetings and capturing all relevant detail on EPIC.



Of the 54 breaches, 42 are attributable to modalities within Imaging and the remaining 12 relate to Gastroscopy, Colonoscopy, ECHOs and Barium Enema.

Breaches fall in four distinct themes: 38 due to booking process issues (Booked past breach date with no reasonable offers, contact letter not sent in a timely manner, no record of accepting appointment on EPIC), 6 due to lack of capacity (Manometry lists), 4 due to Trust process issue (consultant on a/l, delay/issues in protocolling), 6 tolerance patients (cancelled due to clinically urgent patient, delay due to patient choice, too complex for list therefore requiring re-listing).

The Trust continues to monitor the diagnostic recovery plan which has been shared with NHSI. At the end of July, the Trust was behind this trajectory with a planned position of 28 breaches, a further improvement is projected for the August position. The current trajectory forecasts compliance by end of September 2019 and the Trust is working hard to meet this.

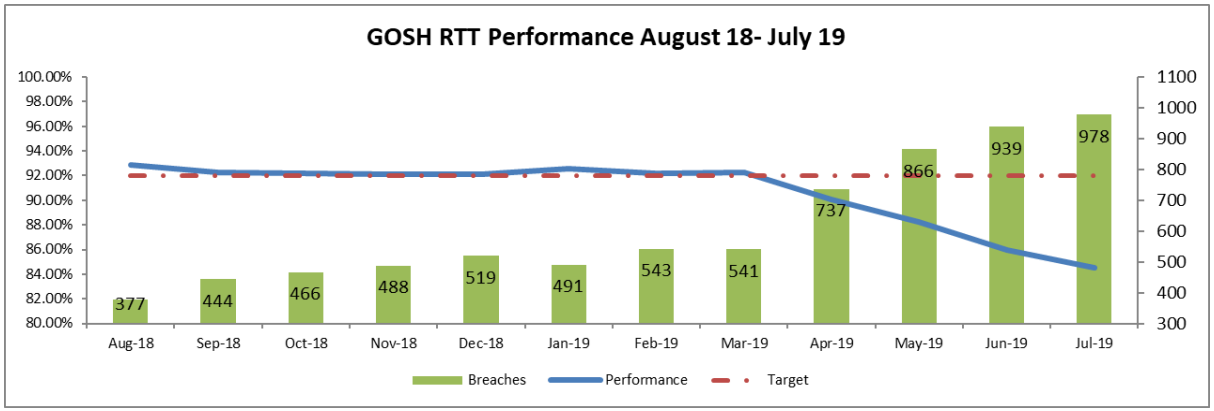
Cancer Wait Times

At the time of writing the report for the month of July 2019, no breaches against the cancer standards attributable to the Trust were reported, with performance being at 100%. Indicative performance for July projects compliance against all standards.

Responsive – Referral to Treatment

July 2019 Summary

- The Trust did not achieve the RTT 92% standard, submitting performance of 84.47%, with 978 patients waiting longer than 18 weeks. EPIC of course is a contributing factor to this position at a speciality level, with the new processes in place but there are also other specialty specific issues affecting RTT performance. At the point of the EPIC go-live a decision was taken to reduce activity across outpatient services and theatres for patient safety reasons to ensure a smooth EPIC implementation, this has impacted future capacity availability.
- Dental/Maxfax relates to the loss of two consultants (retirement and maternity leave) leaving only one consultant within the service who can complete GA work. Plastic Surgery has also experienced a loss of consultant within a highly specialised service. Cardiac Surgery have experience bed capacity issues due to the increase in volume of complex non-elective patients requiring 2:1 nursing. Orthopaedics is linked to utilisation, future loss of a consultant and specialisation.
- The Trust is currently reviewing all under achieving specialties and working with services to produce recovery plans and trajectories. Only one of the seven NHS directorates has met the 92% standard. The number of patients waiting 40 weeks+ has increased to 62 patients in July from 50 in July. Trust compliance against this standard is expected by March 2020.



National Benchmarking:

For the month of June half of the patients on the Trusts incomplete PTL were waiting less than 8 weeks (nationally 7 weeks), and 92 out of every 100 patients were waiting less than 22 weeks (nationally 22 weeks) on a PTL size of 6,615 patients.

Contextually when comparing GOSH with other Children's Trusts or other London tertiary / specialist providers, the Trust is not an outlier with differential levels of performance. Nationally out of 185 providers reporting against the standard (NHS Trusts only) 74 in June were delivering 92% or better. 10 providers reported 90-92%, 87 at 80-90% and 12 reported <80%. 1 provider did not report.

Nationally, GOSH is ranked as the 106th best performing Trust out of 184 providers. In London, GOSH is the 18th best performing Trust out of 28 Providers reporting RTT performance.

52 Week Waits:

The Trust reported 10 patients waiting over 52 weeks in the following specialties:

Dental (5)- two patients have been treated in August, two patients have requested TCIs in September, one patient still remains un booked as awaiting confirmation of treatment plan from the referring trust's surgeon who is on leave until September.

ENT (2)- one patient was treated in August and the other patient has been referred to safeguarding due to not being brought in on multiple occasions and therefore will not be discharged from the service.

Craniofacial (1) - patient was treated in August, with previous TCI in July cancelled due to surgeon being off sick.

Plastic surgery (1) - patient had a TCI on 23rd August.

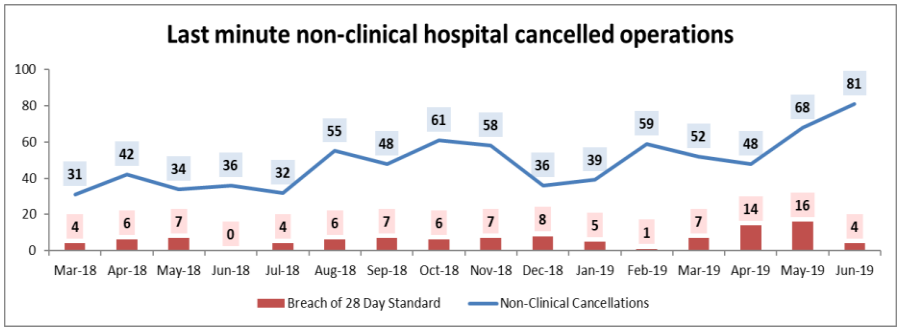
Urology (1)- difficulty in contacting parents initially to arrange a date for surgery, parents then requested for surgery to be under a specific consultant who is back from leave in Sept. Patient is booked under their first list on 18th Sept.

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

Last minute non-clinical hospital cancelled operations:

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

For Q1, the Trust reported an increase in the number of patients cancelled, with 157 patients cancelled compared to 147 in Q4 18/19. This was expected due to the system implementation and workflow challenges experienced during the early stages of go-live, and an increase in complex emergency cardiac patients impacting elective patients. The areas contributing most to the monthly position are Cardiology/Cardiac Surgery (38), ENT (17), Endocrinology (13), Surgery (12), Cardiology (10) and Radiology (4). The top three reasons recorded for the month are theatre list over run (38), ward bed unavailable (23) and ICU bed unavailable (22).



Last minute non-clinical hospital cancelled operations: Breach of 28 day standard

The Trust reported 34 last minute cancelled operations not readmitted within 28 days in Q1, (compared to 13 in Q4 18/19), again this was expected due to agreed capacity reduction: The areas contributing to the largest number of breaches are Cardiac Surgery (9), SNAPS (4), Radiology (3), Urology (2), ENT (2), Audiological medicine (2), Ophthalmology (2) and Endocrinology (2).

Urgent operations cancelled for a second time

- This indicator has been added the Dashboard for 2018/19 following agreement with NHSE the content of Schedule 4 of the NHS Contract.
- Since the start of the new financial year the Trust has reported no patient being cancelled for an urgent operation for the a second time.

Data Completeness – Mental Health Identifiers

Mental Health Identifiers: Data Completeness

The Trust is nationally required to monitor the proportion of patient accessing Mental Health Services that have a valid NHS number, date of birth, postcode, gender, GP practice and commissioner code. Within this area the Trust did not meet the 97% standard with 96.40% of patients having valid data in July. However this was an improvement from June when the trust reported 95.29%. Work is ongoing with administrative teams to improve this position and implementing a more robust process for reconciling against nationally held records.

Mental Health: Ethnicity Completion - %

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

The Trust has seen a slight increase in collating ethnicity for patients accessing mental health services, with 65.35% (+1.16%) in July having a valid ethnic code. This continues to be addressed with operational teams via weekly monitoring, refreshed training and focused Data Assurance work. Capture of this data is now completed within the EPIC system.

Patients with a valid NHS Number

% of patients with a valid NHS Number Inpatients and Outpatients

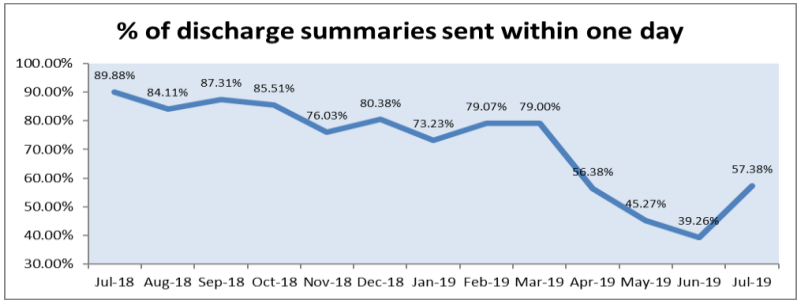
This indicator has been added the Dashboard for 2018/19 following agreement with NHSE the content of Schedule 4 of the NHS Contract.

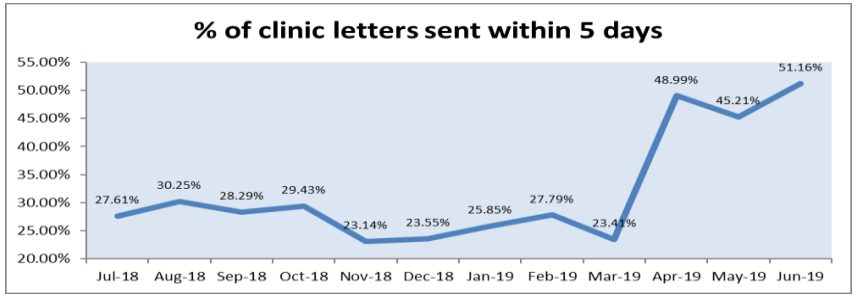
Nationally the Trust is monitored against achieving 99% of patients having a valid NHS Number across all services being accessed. As the report depicts for both Inpatients and Outpatients this is below the standard, nationally the average for both indicators is above 99%. Work is continues to improve collating our patient's NHS number.

Effective – Discharge Summaries

July 2019 Summary

- Performance within this metric continues to fluctuate and be challenging to directorates with July 2019 seeing 57.38% of discharge summaries being sent within 24 hours, which is an improvement from June performance (39.26%).
- There is a trust wide focus on improving performance for this indicator and progress against this indicator is discussed weekly at SLT and improvement targets have been set. Significant improvement has been made since July, at the point of compiling this narrative the backlog is now at 178 outstanding summaries for April – July (687 at month end).
- Working groups have been initiated to focus on specific challenges experienced by services and ensure resolutions are agreed and transacted. Training materials and courses have been reviewed and the workflow has been clearly communicated. Targeted support will be offered to individuals/services with poor metrics. The EPR team in conjunction with service managers will approach clinicians with additional training and guidance.
- Since go-live there have been 8272 discharges which required a summary and 7943 of them have been printed - 96%





Clinic Letter Turnaround Times

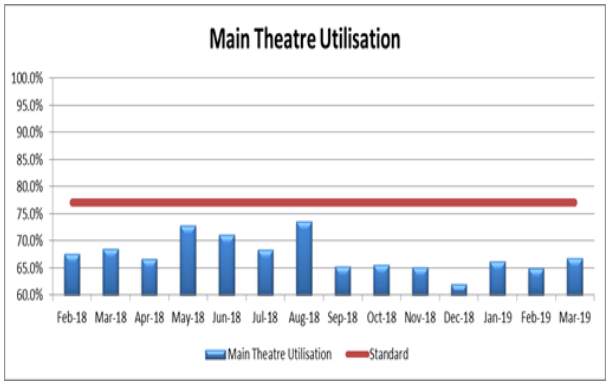
For June 2019 (as this indicator is reported a month in arrears), performance has significantly improved in relation to 5 day turnaround; 51.16% in June compared to 45.21% in May.

Actions currently in place to improve the position include additional training for Clinicians and Operational Managers around the process to ensure that everyone is aware of the process, presentation of the performance and backlog figures at the weekly at the Senior Leadership Team (SLT) meeting and targets set for improvement week on week and to be managed and flagged through the weekly PTL meetings, targeted support will be offered to individuals/services with poor metrics. The EPR team in conjunction with service managers will approach clinicians with additional training and guidance, on-going review of the exclusion criteria related to the clinic letters to ensure it is appropriate to the report and improve its quality.

Productivity – Theatre Utilisation

Theatre utilisation for the first few remains unavailable at the time of reporting. This is due to reporting the indicator data from EPIC continues to be validated and utilisation logic application understood and signed off. A reporting log has been produced detailing the metrics, definitions and issues to be resolved through work being undertaken by EPR, EPIC, operational and performance teams. Expectation is part reporting will be in place by end of September.

Work continues on targeting fully utilising lists and addressing delays with clerking and consenting of patients. However, it is expected that theatre utilisation will be impacted as EPIC stabilises and throughput returns to normal levels.



Bed Occupancy and Closures

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

Occupancy: At the time of reporting, bed occupancy was unavailable for the reporting period of July. Q1 occupancy was reported as 74.8%.

Bed closures: The average number of beds closed in July (35) was greater than the number reported in June (26). The reasons for closures are linked to staffing. This was mainly due to Sky having an average of 8 beds closed and Hedgehog having 10 beds closed. NICU/PICU have experienced an average of 5 beds closed.

Trust Activity

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

Long stay patients: This looks at any patient discharged that month with a length of stay (LOS) greater than 100 days, and the combined number of days in the hospital. For the month of July, there were nine patients whose stay in hospital was over 100 days, accumulating 1,795 bed days in total.

Productivity – PICU Metrics

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

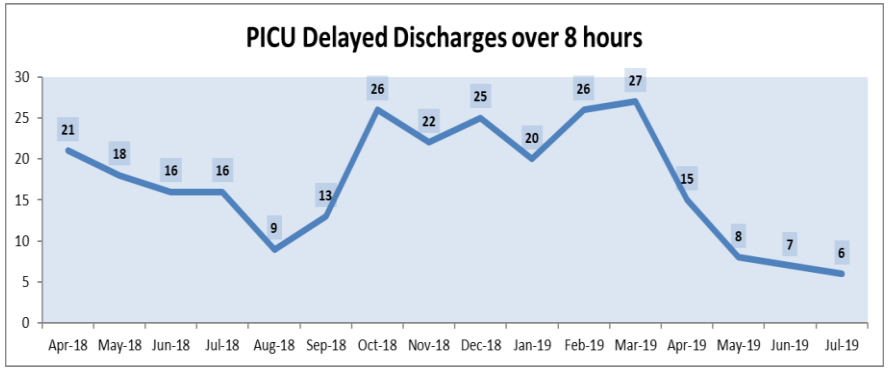
CATS PICU/NICU Refusals: The number of CATS referral refusals into PICU/NICU from other providers during July has decreased to 4 from a May position of 6.

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
Q4 18/19	63	271	23.2	10.0
Q3 18/19	79	234	33.8	16.9
Q2 18/19	45	127	35.4	8.09
Q1 18/19	27	112	24.1	6.27

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. July has seen six patients delayed over 8 hours compared to 7 in June.



PICU Emergency Readmissions:

Readmissions back into PICU within 48 hours were two patients for the month of July, compare to one in May.

Our Money

Great Ormond Street NHS Hospital for Children NHS Foundation Trust

Summary

This section of the IPR includes the position for August 2019 (Month 5). In line with the figures presented, the Trust has a Month 5 Control Total deficit of £5.4m which is £0.6m behind plan, this includes £1.1m of 2019/20 PSF funding. The Trust is generating a Month 5 net deficit of £9.1m which is £0.3m behind plan and includes an additional PSF payment relating to 2018/19 of £0.4m.

- Clinical Income (exc. International Private Patients and Pass through Income) is £0.5m lower than plan
- Non Clinical revenue is £0.8m lower than plan
- Private Patients income is £3.2m lower than plan
- Staff costs are £4.0m lower than plan
- Non-pay costs (excluding pass-through costs) is on plan

Well-Led

Great Ormond Street Hospital for Children NHS Foundation Trust

Workforce Headlines

- **Contractual staff in post**: Substantive staff in post numbers in July were 4629 FTE which is a slight decrease from June (4659 FTE), however this is higher than the same month last year.

- **Unfilled vacancy rate:** The Trust vacancy rate for July increased to 9%, which while below target is well above the long term average. This is due to an increase in the budgeted establishment as well as a change to reporting of some unidentified Better Value costs. Trust vacancy rates have been below target since July 2017. The Nurse vacancy rate for July is 7.4% which is an increase from May (6.6%)

- **Turnover** is reported as voluntary turnover. Voluntary turnover increased to 15.2%, which is above target and the same month last year. HR has established a Recruitment & Retention group, linking in with colleagues across the Trust to develop a retention plan, aligned to the existing Nursing retention collaborative work. The most common leaving reasons are Relocation and promotion. Total turnover (including Fixed Term Contracts) increased to 18% which is slightly above target and the highest since December 2017.

- **Agency usage** for July 2019 was 0.7% of total paybill, which is below the local stretch target, and is also well below the same month last year (1.1%). Human Resources Business Partners continue to work with the Directorates and corporate areas to address local pockets of agency usage. The target for 2019/20 remains 2% of total paybill. Bank % of paybill was 4.7%.

- **Statutory & Mandatory training compliance**: In July the compliance rate across the Trust increased to 95%, which is well above the target with all directorates achieving target. Across the Trust there are 8 topics below 90% including Information Governance where the target is 95%. These non-compliant topics continue to be a focus of improvement.

- **Sickness absence** remains at 2.5%, and remains below target, and below the London average figure of 2.8%. The 2019/20 target remains 3%.

- **Appraisal/PDR completion** The non-medical appraisal rate has risen to 90% in July, achieving target for the first time this financial year. 11 of the 17 Directorates have achieved target, while the remaining 6 saw improvements on their June rates. Consultant appraisal rates remain at 85% since June.

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Great Ormond Street Hospital for Children NHS Foundation Trust

Trust KPI performance July 2019

Metric	Plan	July 2019	3m average	12m average
Voluntary Turnover	14%	15.2%	15.1%	14.9%
Sickness (12m)	3%	2.5%	2.5%	2.4%
Vacancy	10%	9%	8.7%	3.6%
Agency spend	2%	0.7%	0.7%	0.9%
PDR %	90%	90%	84%	83%
Consultant Appraisal %	90%	85%	85%	84%
Statutory & Mandatory training	90%	95%	93%	92%

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

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Great Ormond Street NHS Hospital for Children NHS Foundation Trust

Directorate (Clinical) KPI performance July 2019

Metric	Plan	Trust	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Heart & Lung	Medicine, Therapies & Tests	Operations & Images	Sight & Sound	IPP
Voluntary Turnover	14%	15.2%	13.2%	15.0%	14.9%	14.9%	13.8%	12.0%	16.9%	20.6%
Sickness (12m)	3%	2.5%	2.2%	1.9%	2.1%	2.9%	1.9%	3.0%	3.5%	4.1%
Vacancy	10%	9%	-5.3%	-0.9%	1.3%	3.4%	-4.7%	2.0%	8.3%	15.1%
Agency spend	2%	0.7%	0.0%	0.1%	0.0%	0.2%	0.8%	-0.3%	0.9%	0.0%
PDR %	90%	90%	90%	89%	92%	93%	83%	90%	95%	95%
Stat/Mand Training	90%	95%	93%	95%	95%	92%	95%	95%	96%	96%

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

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Great Ormond Street NHS Hospital for Children NHS Foundation Trust

Directorate (Corporate) KPI performance July 2019

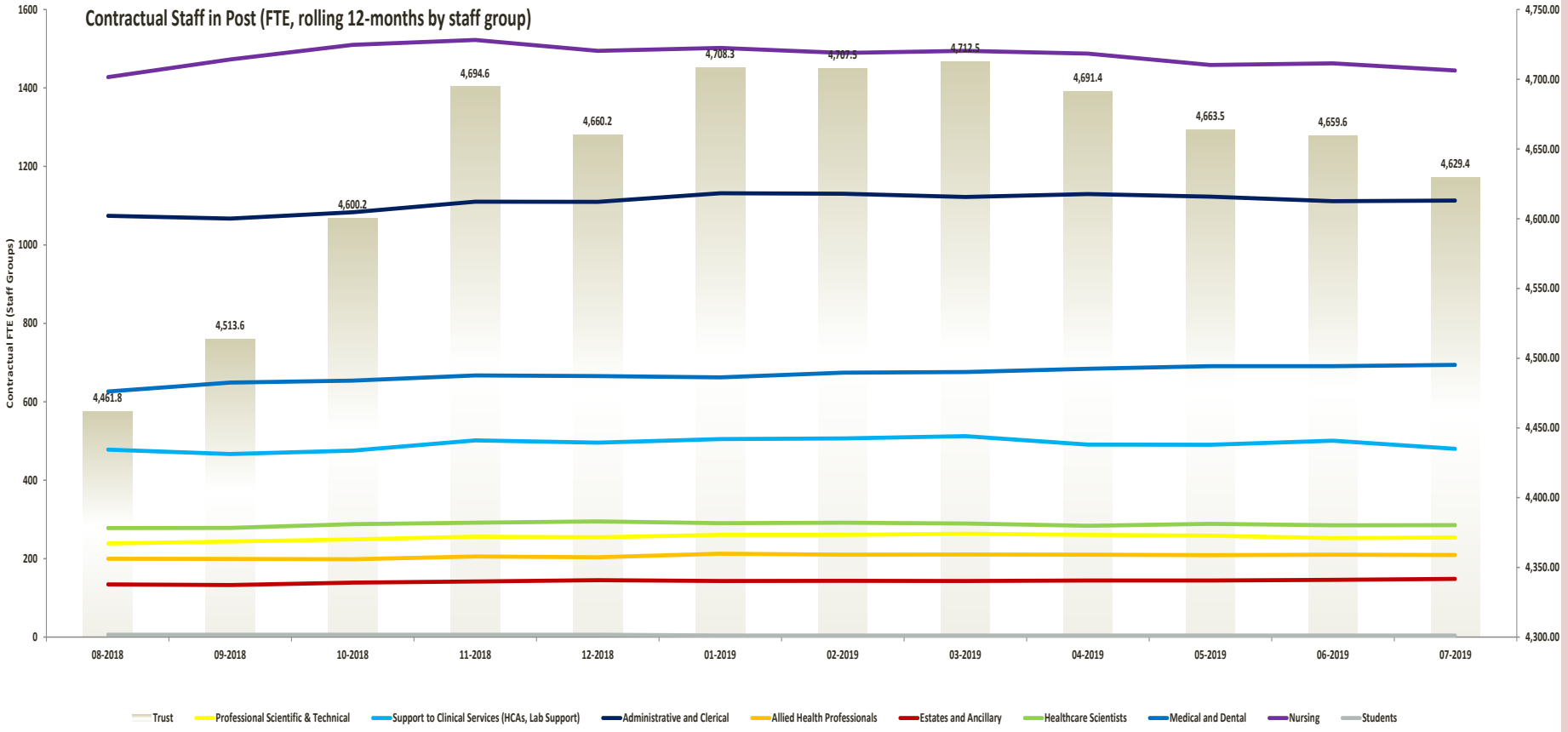
Metric	Plan	Trust	Clinical Operations	Corporate Affairs	DPS	Finance	HR&OD	Medical Director	Nursing & Patient Experience	Research & Innovation
Voluntary Turnover	14%	15.2%	15.7%	20.6%	13.7%	15.6%	20.7%	28.4%	13.6%	32.1%
Sickness (12m)	3%	2.5%	1.1%	0.0%	3.0%	1.0%	4.6%	1.4%	1.4%	1.5%
Vacancy	10%	9.0%	38.2%	3.1%	23.1%	25.7%	12.4%	25.0%	-0.2%	-115.1%
Agency spend	2%	0.7%	0.4%	0.0%	5.4%	10.8%	3.5%	0.0%	0.0%	0.0%
PDR %	90%	90%	77%	88%	91%	93%	97%	90%	89%	94%
Stat/Mand Training	90%	95%	97%	98%	97%	99%	97%	95%	98%	95%

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

Well-Led

Great Ormond Street NHS Hospital for Children NHS Foundation Trust

Substantive staff in post by staff group

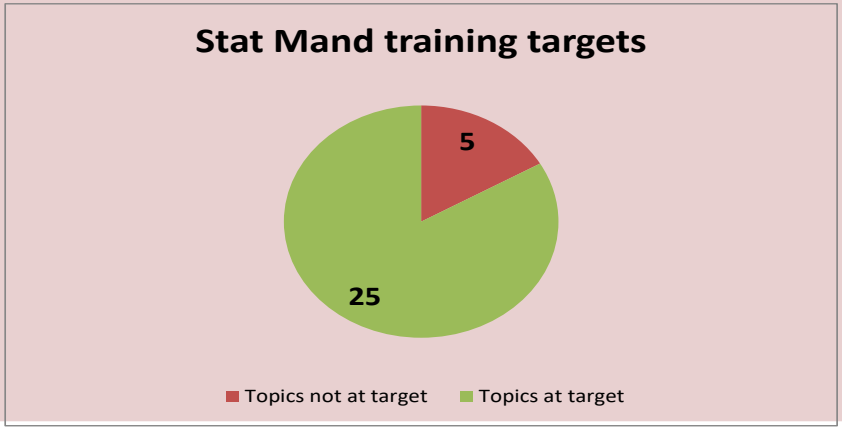


Well-Led

Great Ormond Street Hospital for Children NHS Foundation Trust

Workforce: Stat Mand Training Focus

- In the months since EPIC go live there been a sustained focus on training and development and the Trust is currently performing at one of it's higher ever rates of 95% compliance.
- Across the 30 topics, 25 (80%) are achieving target with 5 not yet achieving target although 4 of the 5 topics are within 2% of compliance.
- Only the Medical and Dental staffgroup is below 90% compliance although more recently the rate of compliance has improved towards target.



Staffgroup	StatMand Training %
Add Prof Scientific & Technical	93%
Additional Clinical Services	92%
Administrative & Clerical	95%
Allied Health Professionals	94%
Estates & Ancillary	91%
Healthcare Scientists	95%
Medical and Dental	82%
Nursing & Midwifery Registered	92%

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 18 September 2019	
Month 4 2019/20 Finance Report **Submitted by:** **Helen Jameson, Chief Finance Officer**	**Paper No: Attachment W** **Attachment Finance Report M04**

Key Points to take away

1. The Trust is required to achieve an overall control total that is agreed with NHSI annually. The Trust is £0.4m adverse to the control total YTD at Month 4; this is principally due to underperformance in private patient income being partially offset by vacancies across the organisation.

2. The Trust is behind its income target by £5.0m (excluding pass through) at Month 4. Private Patient income is behind plan by £3.0m YTD due to lower than planned levels of activity across the Trust. NHS Clinical Income that is not on block contract is behind plan by £0.3m.

3. Pay is underspent YTD by £3.1m due to the high number of vacancies across the Trust that are not being covered by equivalent Bank or Agency and reduced research costs (offset by income)

4. Non pay is £1.5m underspent year to date (excluding pass through). This predominantly relates to underspends on clinical supplies and drugs that are in part attributed to the drop in activity encountered during EPIC Go-Live. This is partially offset by non-delivery of non-pay better value schemes.

5. Cash is higher than plan by £17.7m (£57.7m against a plan of £40.0m) which includes £5.5m relating to PSF bonus and incentive for 2018/19 (this was not included in the 2019/20 plan as confirmation of these values were received after the 2019/20 plan was approved); £4.9m relating to slippage within the capital programme and higher than average receipts in relation to IPP debt.

Introduction

This paper reports the Trust's Financial Position as at the end of July 2019 (Month 4). The Trust is required to achieve an overall control total breakeven (excluding PSF) for the year which is a decrease from 2018/19. Due to reductions in income tariffs and additional costs associated with new buildings the Trust must deliver a Better Value program of £20m.

The Trust is currently £0.4m behind its YTD control total of a £4.5m deficit in M4 (excluding PSF payments). In Month 3, NHSE/I paid additional PSF monies to the Trust relating to 2018/19 (£0.3m) this was confirmed that it would not count towards the achievement of the 2019/20 control total and is therefore not included in the Trust control total position. The Trust is forecasting that the control total will be met and therefore the PSF of 3.8m will be achieved.

The Trust delivered £1.4m (£0.1m non-recurrently) YTD of the Better Value programme target of £3.8m with the remainder being covered by non-recurrent pay vacancies. Work is being undertaken to review how these non-recurrent savings can be maintained throughout the year.

Financial Position – Summary Points

NHS & other clinical revenue (excluding pass through) is adverse to plan by £0.3m YTD. The majority of services are under a block contract arrangement so the underperformance relates to those services remaining on a cost and volume contract and is due to a combination of lower levels of activity and depth of coding. The Trust is working through the impact of the coding changes brought about via the implementation of EPIC.

Private patient income is behind plan by £3.0m due to reduced activity from reduced levels of demand across the period of Ramadan and although this rose in month 4 it is offset by an increase in the income target. The Trust agreed to an increase to the IPP plan for 2019/20 for increased PICU/NICU private beds as part of the Better Value programme. While this is being implemented, demand has not emerged in line with plan.

Non-clinical income is £1.6m behind plan YTD relating to the timing of spend on approved charity funded projects and research grants. The Trust has also seen a fall in the income associated with pathology charges to other organisations since the implementation of Epic; this is currently being reviewed and is expected to improve in future months.

Pay is underspent by £3.1m YTD and £0.6m in month. The key contributors to this underspend are the number of vacancies across the organisation that not currently being backfilled by agency and bank. The Trust is currently below the NHSI agency cost ceiling that it agrees as part of its annual plan and is forecasting to be below this by year end. Some of the pay underspends relate to the delays in charitable funded projects and reduced research costs; both of these are offset by reduced income.

Non-Pay expenditure (excluding pass through) is underspent by £1.5m YTD. This is driven by lower spend on clinical supplies and drugs which is driven by lower levels of activity post EPIC go live (this is being looked into as part of the post go-live validation work). These underspends are partly offset by the under delivery of the non-pay element of the Better Value programme.

Financial Forecast – Summary Points

The Trust is currently forecasting to deliver plan.

Statement of Financial Position – Summary Points

<table>
<tr><th>Indicator</th><th>Comment</th></tr>
<tr><td>NHSI Financial Rating</td><td>The Trust overall metric score is a three which is in line with plan. Two of the five metrics are being scored as a four. The score of four is due to the deficit position at the start of the year which was planned for and planned to improve throughout the year. The annual plan is for an overall score of one.</td></tr>
<tr><td>Cash</td><td>
<table>
<tr><th>Variance/movement</th><th>Cash variance vs plan YTD (£m)</th></tr>
<tr><td>Inventories – higher than plan</td><td>(0.7)</td></tr>
<tr><td>Trade and Other Receivables – lower than plan</td><td>1.3</td></tr>
<tr><td>Trade and Other Payables - higher than plan</td><td>13.2</td></tr>
<tr><td>Other liabilities – lower than plan</td><td>(1.0)</td></tr>
<tr><td>Capital expenditure – lower than original plan</td><td>4.9</td></tr>
<tr><td>Cash variance to plan</td><td>17.7</td></tr>
</table>
</td></tr>
<tr><td>NHS Debtor Days</td><td>NHS Debtor days in month are 12 days which is in line with the plan. This is because the majority of the Trust’s NHS invoices by value relate to contractual monthly SLA payments which are settled on the 15th of each month.</td></tr>
<tr><td>IPP Debtor Days</td><td>IPP debtor days decreased from 214 to 209 days due to higher than average receipts from embassies.</td></tr>
</table>

Creditor Days	Creditor days decreased in month from 37 to 30 days as a result of the settlement of high value pharmacy invoices.
Inventory Days	Drug inventory days cannot be calculated as the value of the pharmacy inventory is not available. Non-Drug inventory days increased from 66 days to 89 days.

Action required from the meeting

- To **note** the Month 4 Financial Position

Contribution to the delivery of NHS Foundation Trust strategies and plans

The delivery of the financial plan is a key strategic objective to ensure we have sufficient funding to meet the needs of our delivery of care.

Financial implications

The Trust has not achieved its control total in month by £0.4m and although it is forecasting to receive the Q2 PSF this will not occur if the control total is not met. The PSF is back ended with increased amounts owing each Quarter. The Trust has released £0.4m of the £1.0m contingency.

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 4 2019/20

Contents

Trust Performance Summary for the 4 months ending 31 Jul 2019

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. pass-through	£43.6m	£41.4m		£160.5m	£157.0m		£484.7m	
PAY	£24.2m	£23.5m		£97.0m	£93.9m		£289.2m	
NON-PAY incl. pass-through	£17.3m	£16.1m		£68.0m	£68.0m		£199.3m	
CONTROL TOTAL excl. PSF	£2.2m	£1.8m		(£4.5m)	(£4.9m)		£0.0m	

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

AREAS OF NOTE:
As at the end of Month 4, the Trust position is adverse to the planned control total (£0.4m). The Trust Income is behind plan YTD (£3.5m) due to activity levels and some reduction in depth of coding. YTD pay costs are favourable to plan (£3.1m) due to the vacancies across the organisation not being covered by bank or agency staff. Non-pay is favourable to plan (£1.5m excl. pass-through) due to underspends relating to lower than planned activity. The Trust has received £0.4m of PSF monies relating to a 2018/19 PSF reallocation post accounts. This was not included in the annual plan and does not contribute to the control total.

INCOME BREAKDOWN RELATED TO ACTIVITY

Income breakdown Year to Date	Plan (£m)	Actual (£m)	Var (£m)	RAG
NHS & Other Clinical Revenue	£96.9m	£96.6m	(£0.3m)	
Pass Through	£20.1m	£21.6m	£1.6m	
Private Patient Revenue	£23.0m	£19.9m	(£3.0m)	
Non-Clinical Revenue	£20.6m	£19.0m	(£1.6m)	
Total Operating Revenue	£160.5m	£157.0m	(£3.4m)	

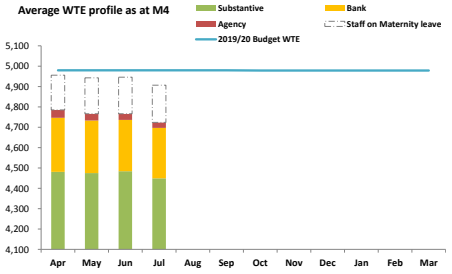
RAG: on or favourable to plan = green, 0-5% adverse to plan = amber, 5%+ adverse to plan = red

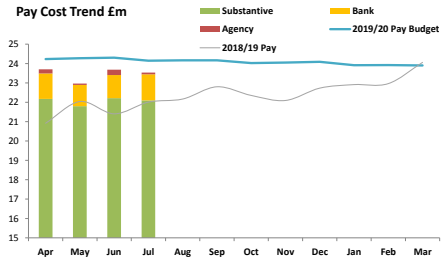
AREAS OF NOTE:
Operating revenue is adverse to plan (£5.0m excluding pass through) YTD. The Trust has entered into a block contract with NHSE and some of the CCGs for 2019/20; this is represented in the NHS income figures with an underperformance (£0.3m) arising from lower than planned levels of activity and depth of coding on those contracts that are not on block. Pass-through drugs remain on cost and volume and have over performed (£1.6m), offset by pass-through drug expenditure. Private patient income is below plan (£3.0m) due to lower levels of activity. Non-Clinical income underperformance (£1.6m) is due to timing of research studies and reduced pathology income for tests performed on behalf of other Trusts due to a change in data capture processes which have now been corrected.

PEOPLE

	M4 Plan Av. WTE	M4 Actual Av. WTE	Variance
PERMANENT	4,630.5	4,449.2	181.3
BANK	292.8	247.7	45.1
AGENCY	56.5	26.7	29.8
TOTAL	**4,979.7**	**4,723.6**	**256.1**

AREAS OF NOTE:
The pay costs in month are slightly below the average pay run rate due to reduced costs in Research, which is in part being offset by additional costs accrued for the announced medical pay uplifts for 2019/20. The WTE excludes 194.11 average contractual WTE's on maternity leave within the Trust. The in month WTE also include a one off adjustment to correct staff recharges from UCL. The actual bank and agency usage is currently below plan (and below the agency ceiling set by NHSI).



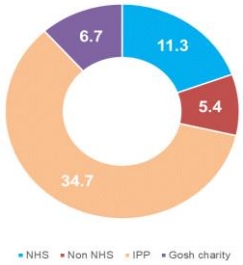


CASH, CAPITAL AND OTHER KPIs

Key metrics	Plan	Actual
Cash	£40.0m	£57.7m
IPP Debtor days	120	209
Creditor days	30	30
NHS Debtor days	30	12

Capital Programme	YTD Plan M4	YTD Actual M4	Full Year F'cst
Total Trust-funded	£5.4m	£5.4m	£17.5m
Total Donated	£16.4m	£14.0m	£44.9m
Grand Total	£21.8m	£19.4m	£62.3m

Net receivables breakdown (£m)



NHSI metrics	Plan M4	Actual M4
CAPITAL SERVICE COVER	4	4
LIQUIDITY	1	1
I&E MARGIN	4	4
VAR. FROM CONTROL TOTAL		2
AGENCY	1	1
TOTAL	3	3

AREAS OF NOTE:

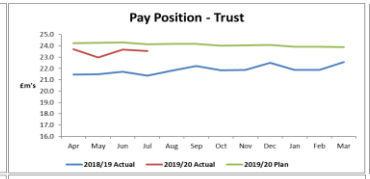
1. Cash held by the Trust is higher than plan by £17.7m of which £8.2m related to PSF for 2018/19 received in month and £6.0m received from IPP debtors in month.
2. The Trust Funded capital programme is on track against the revised plan (plan reduced by 20% as required by NHSI). The Donated Capital spend is behind plan by £2.4m at M04 due to slippage on donated Redevelopment and Medical Equipment projects.
3. IPP debtors days decreased in month from 214 days to 209 days largely as a result of higher than average receipts from Embassies, however overdue IPP debt rose by £1.2m from £30.7m to £31.9m.
4. Creditor days decreased in month from 37 to 30 days due to payments of outstanding pharmacy bills.
5. NHS debtor days increased in month from 9 to 12 days
6. NHSI metric is in line with NHSI plan with a total Trust score of a 3

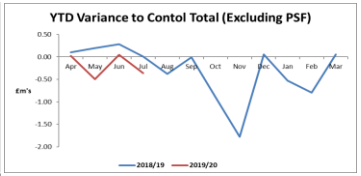
Trust Income and Expenditure Performance Summary for the 4 months ending 31 Jul 2019

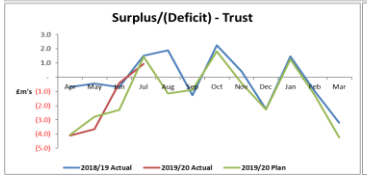
Great Ormond Street NHS Hospital for Children
NHS Foundation Trust

2019/20												2018/19	CY vs PY	
Annual Budget	Income & Expenditure	Month 4				Year to Date				Rating	Notes	YTD Actual	Variance	
		Budget	Actual	Variance		Budget	Actual	Variance						
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%	YTD Variance		(£m)	(£m)	%
296.47	NHS & Other Clinical Revenue	26.43	26.67	0.24	0.91%	96.89	96.55	(0.34)	(0.35%)	A	1	94.00	2.55	2.71%
59.94	Pass Through	5.49	5.03	(0.46)	(8.38%)	20.06	21.61	1.55	7.73%			20.50	1.11	5.41%
69.76	Private Patient Revenue	6.30	5.59	(0.71)	(11.27%)	22.95	19.91	(3.04)	(13.25%)	R	2	20.20	(0.29)	(1.44%)
62.25	Non-Clinical Revenue	5.42	4.07	(1.35)	(24.91%)	20.59	18.97	(1.62)	(7.86%)	R	3	18.70	0.27	1.43%
488.42	**Total Operating Revenue**	**43.64**	**41.36**	**(2.28)**	**(5.22%)**	**160.49**	**157.04**	**(3.45)**	**(2.15%)**	R		**153.40**	**3.64**	**2.37%**
(272.88)	Permanent Staff	(22.70)	(22.09)	0.61	2.69%	(90.62)	(88.28)	2.34	2.58%			(80.10)	(8.18)	(10.21%)
(3.48)	Agency Staff	(0.29)	(0.09)	0.20	68.97%	(1.16)	(0.63)	0.53	45.69%			(0.90)	0.27	30.00%
(12.81)	Bank Staff	(1.16)	(1.35)	(0.19)	(16.38%)	(5.17)	(4.96)	0.21	4.06%			(5.30)		0%
(289.17)	**Total Employee Expenses**	**(24.15)**	**(23.53)**	**0.62**	**2.57%**	**(96.95)**	**(93.87)**	**3.08**	**3.18%**	G	4	**(86.30)**	**(7.57)**	**(8.77%)**
(13.80)	Drugs and Blood	(1.24)	(1.40)	(0.16)	(12.90%)	(4.57)	(4.30)	0.27	5.91%	G		(4.50)	0.20	4.44%
(44.13)	Other Clinical Supplies	(3.78)	(3.67)	0.11	2.91%	(15.10)	(14.27)	0.83	5.50%	G		(13.00)	(1.27)	(9.77%)
(62.50)	Other Expenses	(5.24)	(4.37)	0.87	16.60%	(22.15)	(21.71)	0.44	1.99%	G		(20.60)	(1.11)	(5.39%)
(59.94)	Pass Through	(5.49)	(5.10)	0.39	7.10%	(20.06)	(21.66)	(1.60)	(7.98%)			(20.30)	(1.36)	(6.70%)
(180.37)	**Total Non-Pay Expenses**	**(15.75)**	**(14.54)**	**1.21**	**7.68%**	**(61.88)**	**(61.94)**	**(0.06)**	**(0.10%)**	A	5	**(58.40)**	**(3.54)**	**(6.06%)**
(469.54)	**Total Expenses**	**(39.90)**	**(38.07)**	**1.83**	**4.59%**	**(158.83)**	**(155.81)**	**3.02**	**1.90%**	G		**(144.70)**	**(11.11)**	**(7.68%)**
18.88	**EBITDA (exc Capital Donations)**	**3.74**	**3.29**	**(0.45)**	**(12%)**	**1.66**	**1.23**	**(0.43)**	**(25.80%)**	R		**8.70**	**(7.47)**	**(85.89%)**
(18.88)	Owned depreciation, Interest and PDC	(1.55)	(1.52)	0.04	2.25%	(6.14)	(6.08)	0.07	1.06%		7	(5.25)	(0.83)	(15.77%)
0.00	**Control Total (exc. PSF)**	**2.19**	**1.77**	**(0.41)**	**(18.98%)**	**(4.49)**	**(4.85)**	**(0.36)**	**(8.07%)**					
3.76	PSF	0.25	0.25	0.00	(200.00%)	0.82	0.82	0.00	(100.00%)					
3.77	**Control total**	**2.44**	**2.02**	**(0.41)**	**(17.03%)**	**(3.67)**	**(4.04)**	**(0.36)**	**(9.86%)**	R		**3.45**	**(7.49)**	**(216.96%)**
0.00	PY PSF post accounts reallocation	0.00	0.00	0.00		0.00	0.35	0.35						
(13.07)	Donated depreciation	(1.00)	(1.07)	(0.08)	(7.52%)	(4.00)	(4.04)	(0.04)	(1.13%)			(3.65)	(0.39)	(10.74%)
(9.30)	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**1.44**	**0.95**	**(0.49)**	**(34.03%)**	**(7.67)**	**(7.73)**	**(0.06)**	**(0.78%)**			**(0.20)**	**(7.88)**	**(3,938.50%)**
(5.50)	Impairments	0.00	0.00	0.00	0.00%	0.00	0.00	0.00	0.00%			0.00	0.00	0%
46.72	Capital Donations	6.34	2.76	(3.58)	(56.47%)	19.38	14.02	(5.36)	(27.66%)		6	9.70	4.32	44.54%
31.92	**Adjusted Net Result**	**7.78**	**3.71**	**(4.07)**	**(52.31%)**	**11.71**	**6.29**	**(5.42)**	**(46.29%)**			**9.50**	**(3.56)**	**(37.44%)**

DIVISIONAL CONTROL TOTALS										Rating
Plan Annual		2019/20								
		Month				Year to Date				
		Budget	Actual	Var	Var	Budget	Actual	Var	Var	
(£m)	Directorates	(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%	
(31.80)	Blood Cells & Cancer	(2.68)	(2.84)	(0.16)	(5.97%)	(10.55)	(10.49)	0.06	0.57%	G
(30.94)	Body Bones & Mind	(2.53)	(2.39)	0.14	5.53%	(10.25)	(10.00)	0.25	2.44%	G
(22.46)	Brain	(1.87)	(2.01)	(0.14)	(7.49%)	(7.45)	(7.72)	(0.27)	(3.62%)	A
(45.36)	Heart & Lung	(3.48)	(4.50)	(1.02)	(29.31%)	(15.09)	(16.62)	(1.53)	(10.14%)	R
(26.11)	Medicines Therapies & Tests	(2.16)	(2.85)	(0.69)	(31.94%)	(8.66)	(9.89)	(1.23)	(14.20%)	R
(32.84)	Operations & Images	(2.76)	(2.78)	(0.02)	(0.72%)	(10.90)	(11.22)	(0.32)	(2.94%)	A
(18.76)	Sight & Sound	(1.60)	(1.60)	0.00	0.00%	(6.28)	(6.50)	(0.22)	(3.50%)	A
24.63	International Private Patients	2.26	2.65	0.39	17.26%	8.11	7.73	(0.38)	(4.69%)	A
2.80	Research And Innovation	0.26	0.26	0.00	0.00%	0.93	0.98	0.05	5.38%	G
180.85	Corporate/Other	16.75	17.83	1.08	6.45%	55.66	58.88	3.22	5.79%	G
0.00	**Control total**	**2.19**	**1.77**	**(0.42)**	**(19.18%)**	**(4.48)**	**(4.85)**	**(0.37)**	**(8.26%)**	







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

Summary

- YTD the Trust is reporting an adverse position to the control total (£0.4m). Private patient income is below plan (£3.0m) while pay is underspent (£3.1m) and clinical activity not on a block is below plan (£0.3m).
- The Trust position includes PSF funding for months 1-4 and an additional bonus payment relating to 2018/19 (excluded from the control total); these total £1.2m.

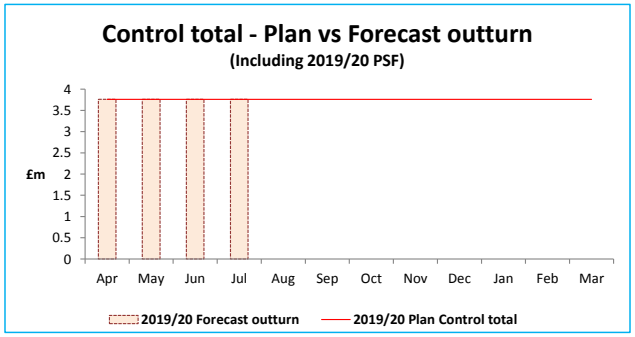
Notes

1. NHS & other clinical revenue (excluding pass through) is adverse to plan YTD (£0.3m). This is driven by lower levels of activity across the organisation on non-block NHS income.
2. Private Patient income continues to fall behind plan YTD (£3.0m) due to lower than planned activity across a number of specialties, bed closures relating to medical and nursing vacancies and lower demand.
3. Non-clinical income is adverse to plan (£1.6m) due to timing of research studies and reduced pathology testing for other organisations.
4. Pay is favourable to plan (£3.1m) due to vacancies across the Trust. The Trust has a full year plan for agency (£3.5m) and Bank (£12.8m) staffing which is also underspent at Month 4.
5. Non pay (excluding pass through) is underspent (£1.5m) YTD due to lower levels of activity across the organisation post EPIC go live and timing of research funded projects.
6. Income from capital donations is lower than plan YTD due to slippage in capital projects (£5.4m).

Trust Income and Expenditure Forecast Outturn Summary for the 4 months ending 31 Jul 2019

Great Ormond Street Hospital for Children NHS Foundation Trust

Full Year Actual 2018/19 (£m)	31 Jul 2019 Income & Expenditure	Annual Budget (£m)	Internal Forecast Full-Yr (£m)	Variance to Plan (£m)	Variance to Plan %	Rating Forecast Variance to plan	Notes
288.61	NHS & Other Clinical Revenue	296.47	293.97	(2.50)	(0.85%)	R	1
62.40	Pass Through	59.94	65.91	5.97	9.06%		
62.19	Private Patient Revenue	69.76	61.06	(8.70)	(14.25%)	R	2
74.43	Non-Clinical Revenue	62.25	60.99	(1.26)	(2.07%)	R	
487.63	**Total Operating Revenue**	**488.42**	**481.93**	**(6.49)**	**(1.35%)**		
(250.05)	Permanent Staff	(272.88)	(266.42)	6.47	(2.43%)		
(2.74)	Agency Staff	(3.48)	(1.67)	1.81	(108.38%)		
(15.84)	Bank Staff	(12.81)	(14.98)	(2.17)	14.49%		
(268.63)	**Total Employee Expenses**	**(289.17)**	**(283.07)**	**6.11**	**(2.16%)**	G	3
(11.88)	Drugs and Blood	(13.80)	(11.25)	2.56	(22.72%)	G	
(43.37)	Other Clinical Supplies	(44.13)	(41.08)	3.05	(7.42%)	G	
(66.77)	Other Expenses	(62.50)	(61.89)	0.61	(0.99%)	G	
(62.92)	Pass Through	(59.94)	(65.91)	(5.97)	9.06%		
(184.94)	**Total Non-Pay Expenses**	**(180.37)**	**(180.13)**	**0.24**	**(0.13%)**	G	4
(453.57)	**Total Expenses**	**(469.54)**	**(463.19)**	**6.35**	**(1.37%)**	G	
34.06	**EBITDA (exc Capital Donations)**	**18.88**	**18.74**	**(0.14)**	**(0.77%)**	A	
(16.69)	Owned Depreciation, Interest and PDC	(18.88)	(18.73)	0.15	(0.79%)		
17.37	**Control Total (exc. PSF)**	**0.00**	**0.01**	**0.00**	**37.50%**		
0.00	PSF	**3.76**	**3.76**	**0.00**			
17.37	**Control total**	**3.77**	**3.77**	**0.00**	**0.08%**	G	
0.00	PY PSF post accounts reallocation	0.00	0.37	0.37	100.00%		
(11.39)	Donated depreciation	(13.07)	(13.08)	(0.01)	0.11%		
5.98	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**(9.30)**	**(8.94)**	**0.36**	**(633.33%)**		
(7.90)	Impairments	(5.50)	(5.50)	0.00	0.00%		
32.78	Capital Donations	46.72	44.88	(1.84)	(4.10%)		5
30.86	**Adjusted Net Result**	**31.92**	**30.44**	**(1.48)**	**(4.86%)**		



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

Summary

- The Trust is forecasting a year end position that breaks even with the Trust control total of a £0.0m (excluding PSF).
- A block contract has been agreed with NHSE for 2019/20 and is included in the NHS Clinical income and non clinical income numbers of the forecast.

Notes

1. NHS Clinical income is forecast to be £2.5m deficit to plan which is driven by the lower than planned CCG activity and depth of coding following the implementation of EPIC.
2. Private patient income is forecast to be £8.7m adverse to the plan. This position from plan is in line with trend; this is due a forecast improvement in private patients being offset by the higher targets in the last 8 months of the year.
3. Pay is forecast to be £6.1m favourable to plan due to a number of vacancies across the organisation that are not currently being covered by temporary staffing, some of this is as of a result of lower than planned activity and some from non-recurrent vacancy management.
4. Non-pay is forecast to be £6.2m favourable at the year end excluding pass through. This is related to expected better value coming online in the later part of the year and reduced spend related to activity.
5. Capital Donations are forecast to be £1.8m below plan at the year end linked to the Trust Capital program.

2019/20 NHS Income for the 4 months ending 31 Jul 2019

Great Ormond Street Hospital for Children NHS Foundation Trust

Organisation	Contract type	Annual plan (£m)	Income plan (£m)	Income actual (£m)	Income variance (£m)	RAG YTD Variance
NHS England	Block	274.25	89.81	89.81	-	G
	Pass through drugs	51.75	17.34	18.96	1.62	G
	Cost & volume	0.80	0.17	0.18	0.01	G
Total NHS England		326.79	107.31	108.94	1.63	G
CCG contracts	Block	13.01	4.19	4.19	-	G
	Cost & volume	-	-	-	-	G
	Pass through	3.83	1.28	1.57	0.29	G
Total CCG contracts		16.84	5.47	5.75	0.29	G
CCG non contract activity	Cost & volume	6.26	2.03	1.30	(0.73)	R
	Pass through	1.22	0.41	0.25	(0.16)	A
Total NHS Clinical Income		351.10	115.23	116.25	1.03	G
Non NHS	Cost & volume	4.59	1.49	1.54	0.05	G
	Pass through	0.29	0.10	0.08	(0.02)	G
Overseas	Cost & volume	0.43	0.14	0.29	0.15	G
	Pass through	0.00	0.00	-	(0.00)	G
Private patients	Cost & volume	69.76	22.95	19.91	(3.04)	R
TOTAL CLINICAL INCOME		**426.17**	**139.90**	**138.07**	**(1.83)**	R

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

Summary

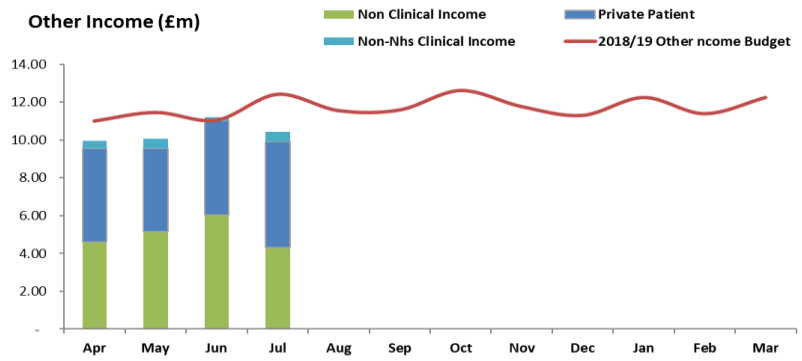
- Block contracts for activity have been agreed with NHS England for specialised commissioning and are in the process of being agreed with contracted CCGs, 86% of the CCGs have agreed their contracts this equates to £15.0m . This approach was adopted to mitigate the risk from the implementation of the new patient administration system, EPIC.
- Pass through income is being charged on a cost and volume basis for all commissioners except NHS England where drugs are on a cost and volume basis while pass through devices form part of the block contract. Due to the potential for significant variability on drugs a block was not seen as appropriate due to the potential risk.
- The key driver of the income target underperformance relates to reduced Private Patient activity (compared to plan) of £3.0m .. Work is ongoing to continue to attract new patients to bring activity back on plan.
- This adverse variance is partly offset by increased pass through drugs income for NHS England. This value is currently based on an estimate for July (whilst the new reporting system is optimised) and may be subject to change when refreshed in August.
- Due to implementation of a new EPR system there is currently a high volume of uncoded activity that is being priced at a historical average price and therefore the value for non contract and non NHS activity may increase or decrease when refreshed in August.

2019/20 Other Income for the 4 months ending 31 Jul 2019

Great Ormond Street Hospital for Children NHS Foundation Trust

Other Income Summary

		Current month			Year to date			
	Annual plan (£m)	Plan (£m)	Actual (£m)	Variance (£m)	Plan (£m)	Actual (£m)	Variance (£m)	RAG YTD Variance
Private Patient	69.76	6.30	5.59	(0.71)	22.95	19.91	(3.04)	R
Non NHS Clinical Income	4.89	0.45	0.50	0.06	1.59	1.61	0.03	G
Non-NHS Clinical Income	**74.65**	**6.75**	**6.09**	**(0.65)**	**24.53**	**21.52**	**(3.01)**	R
Education & Training	8.01	0.71	0.69	(0.02)	2.61	2.71	0.10	G
Research & Development	26.28	2.21	1.44	(0.77)	8.76	8.20	(0.56)	R
Non-Patient Services	1.00	0.09	0.17	0.08	0.33	0.29	(0.04)	G
Commercial	1.61	0.15	0.12	(0.03)	0.53	0.46	(0.07)	A
Charitable Contributions	10.72	0.94	0.89	(0.05)	3.51	3.26	(0.25)	A
Other Non-Clinical	18.40	1.58	1.01	(0.57)	5.65	5.21	(0.44)	A
Non Clinical Income	**66.01**	**5.67**	**4.32**	**(1.35)**	**21.40**	**20.13**	**(1.27)**	R



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

Summary

- Private patient income is adverse to plan due to lower than expected bed occupancy caused by referrals rates into the Trust. Month 4 income (£5.6m) is £0.6m higher than in Month 3 (£5.0m) This is £0.7m adverse to plan in month, due to the Month 4 planned increase in private patient income, and £3.0m.adverse to plan YTD.
- Research & Development income is adverse to plan (£0.8m) in month due to timing of costs confirmed relating to research studies being behind plan and therefore the offsetting income is below plan.
- Charitable contributions are £0.3m adverse to plan due to timing of spend on approved projects.
- Other Non-Clinical income is adverse to plan YTD (£0.4m) which is driven by Project DRIVE underperformance against its income target (£0.3m) and reduced levels pathology income (£0.2m) which is expected

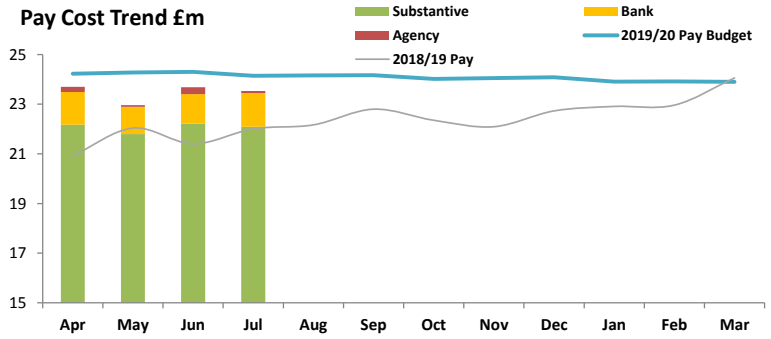
Workforce Summary for the 4 months ending 31 Jul 2019

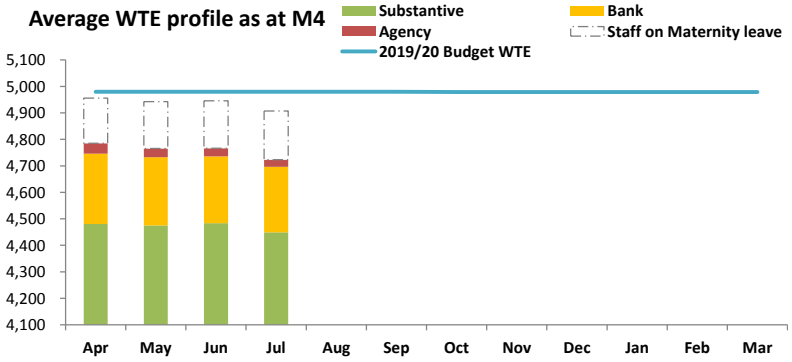
*WTE = **Worked WTE**, Worked hours of staff represented as WTE

Great Ormond Street Hospital for Children NHS Foundation Trust

£m including Perm, Bank and Agency	2019/20 plan			2019/20 actual			Variance				RAG
Staff Group	YTD (£m)	YTD Average WTE	£000 / WTE	YTD (£m)	YTD Average WTE	£000 / WTE	YTD (£m)	Average WTE Vacancies	Volume Var (£m)	Price Var (£m)	£ Variance
Admin (inc Director & Senior Managers)	19.7	1,214.2	48.6	17.0	1,126.4	45.2	2.7	87.8	1.4	1.3	G
Consultants	18.0	368.0	146.9	17.9	336.9	159.3	0.1	31.2	1.5	(1.4)	G
Estates & Ancillary Staff	1.6	146.8	33.4	1.5	130.2	33.8	0.2	16.5	0.2	(0.0)	G
Healthcare Assist & Supp	3.3	305.9	32.2	3.0	283.9	32.2	0.2	22.0	0.2	0.0	G
Junior Doctors	9.2	381.9	72.6	9.2	340.9	80.6	0.1	41.1	1.0	(0.9)	G
Nursing Staff	27.7	1,623.6	51.3	26.9	1,533.3	52.6	0.9	90.3	1.5	(0.7)	G
Other Staff	0.2	10.0	55.4	0.2	8.8	54.5	0.0	1.2	0.0	0.0	G
Scientific Therap Tech	17.0	948.4	53.7	17.3	936.5	55.4	(0.3)	11.9	0.2	(0.5)	A
Total substantive and bank staff costs	**96.8**	**4,998.8**	**58.1**	**92.9**	**4,696.9**	**59.3**	**3.9**	**301.9**	**5.8**	**(2.0)**	G
Agency	1.2	56.5	61.6	0.6	26.7	71.2	0.5	29.8	0.6	(0.1)	G
Total substantive, bank and agency cost	**97.9**	**5,055.2**	**58.1**	**93.5**	**4,723.6**	**59.4**	**4.4**	**331.6**	**6.4**	**(2.0)**	G
Reserve*	(1.0)	(75.5)	0.0	0.4	0.0	0.0	(1.3)	(75.5)	(1.4)	0.1	R
Total pay cost	**97.0**	**4,979.7**	**58.4**	**93.9**	**4,723.6**	**59.6**	**3.1**	**256.1**	**5.0**	**(1.9)**	G
Remove Maternity leave cost				(1.2)			1.2			1.2	G
Total excluding Maternity Costs	**97.0**	**4,979.7**	**58.4**	**92.7**	**4,723.6**	**58.9**	**4.3**	**256.1**	**5.0**	**(0.7)**	G

Plan reserve includes WTEs relating to the better value programme





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

Summary

- YTD pay spend is £93.9m which is £3.1m favourable to plan. The key contributor to the underspend is the number of vacancies across the organisation that are currently not being backfilled by bank or agency; this can be seen by the volume variance (£5.0m).
- A correction to the YTD WTE figure associated with Research staff charged to the Trust from other organisations has seen a reduction in the M4 WTE of circa 90, this is expected to return to the run rate next month.
- The Trust has put in a bank and agency budget alongside the permanent workforce budget in line with the NHSI reporting requirements. The agency budget has been set below the agency ceiling and is currently underspent.
- The table above does not include 194.11 average contractual WTE for staff on maternity leave which have cost £1.2m YTD. If this cost is excluded then the average cost per WTE is higher than plan by £0.5k per WTE.
- The reserve line contains the unidentified pay better value target and the plan for the apprenticeship levy which is offsetting part of the underspend within pay.
- We are not expecting to breach the agency ceiling set by NHSI and the Trust is currently below the agency ceiling.

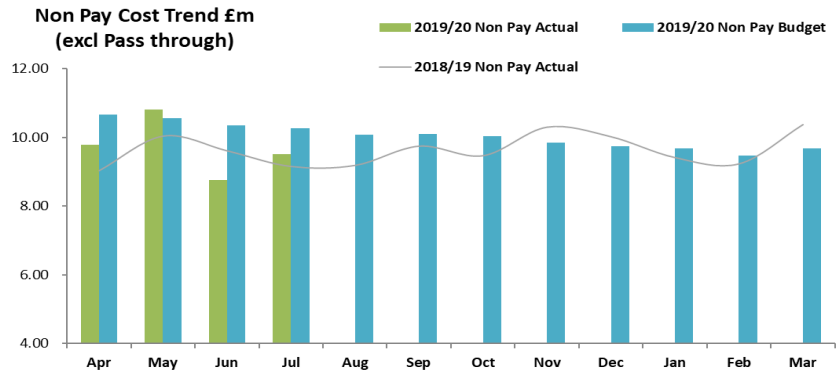
Non-Pay Summary for the 4 months ending 31 Jul 2019

Great Ormond Street NHS Hospital for Children
NHS Foundation Trust

Non-Pay Costs (excl Pass through) YTD	Budget (£m)	Actual (£m)	Variance	RAG YTD Actual variance
Drugs Costs	3.9	3.6	0.3	G
Blood Costs	0.7	0.7	(0.0)	G
Business Rates	1.4	1.4	(0.0)	G
Clinical Negligence	2.3	2.3	0.0	G
Supplies & Services - Clinical	15.1	14.3	0.8	G
Supplies & Services - General	1.8	1.5	0.3	G
Premises Costs	10.8	10.2	0.6	G
Other Non Pay	5.9	6.4	(0.4)	A
Total Non-Pay costs	**41.8**	**40.3**	**1.5**	G
Depreciation	7.6	7.6	(0.0)	G
PDC Dividend Payable	2.7	2.7	(0.0)	G
Total	**52.1**	**50.5**	**1.5**	G

Top 5 YTD Clinical* Non Pay overspends by Speciality (£m)	YTD 2019/20 Budget (£k)	YTD 2019/20 Actual (£k)	Variance (£k)	Trend
Haematology/Oncology	1,004	1,227	(223)	↑
Medical Endocrinology	340	471	(130)	↑
ENT	23	143	(120)	→
Haemophilia	102	192	(90)	→
Wards (Exc. Haem/Onc)	333	418	(85)	↑

Top 5 YTD Clinical* Non Pay underspends by Speciality (£m)	YTD 2019/20 Budget (£k)	YTD 2019/20 Actual (£k)	Variance (£k)	Trend
Cardiac Serv & H&L Central Bud	1,782	1,480	301	→
Theatre	2,769	2,574	194	↑
Nephrology	1,089	911	178	↑
PICU NICU	1,431	1,257	174	↑
Cardiac Critical Care	744	596	148	→



Clinical non-pay excludes passthrough

Summary

- YTD non-pay excluding pass through is favourable to plan (£1.5m). The key drivers behind this variance are the underspends on clinical supplies and drugs which are partially offset by higher than plan IT spend within premises costs and higher than plan transport costs, both in relation to EPIC implementation.

Top 5 clinical over/under spends

The key areas with Non-pay overspends are:

- **Haematology/Oncology** – Non Pay budget includes the Blood Cells and Cancer unidentified better value target which is the main driver for the overspend variance.
- **Medical Endocrinology -** Mainly due to the overspend on chemical pathology for recharges and drugs following EPIC go-live.
- **Audiology –** Overspend is on devices but in line with an over-performance on activity YTD.
- **Haemophilia** - Driven by increased Drug spend across the speciality.
- **Wards (Exc. Haem/Onc) -** Non pay overspend is driven by ward drugs and surgical instruments.

The key areas of Non-pay underspends are:

- **Cardiac Serv & H&L Central bud** - Driven by non pay targets that are being offset by the underperformance against private patient income.
- **Theatre -** Driven by low clinical supplies expenditure across theatres and fewer theatre sessions during go live and post-EPIC
- **Nephrology** - Outpatient drugs underspent due to lower than expected activity post-EPIC
- **PICU NICU -** Driven by low clinical supplies expenditure owing to shortfall in activity particularly for IPP
- **Cardiac Critical Care** -Linked to reduced internal pathology recharges which are forecast to be recharged in future months due improved data is retrieved from EPIC

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

Better Value summary for the 4 months ending 31 Jul 2019

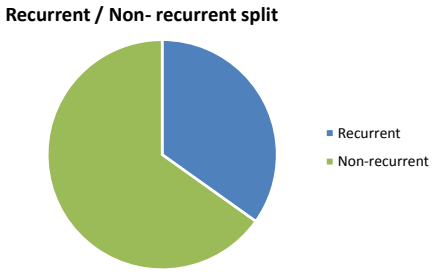
Great Ormond Street Hospital for Children NHS Foundation Trust

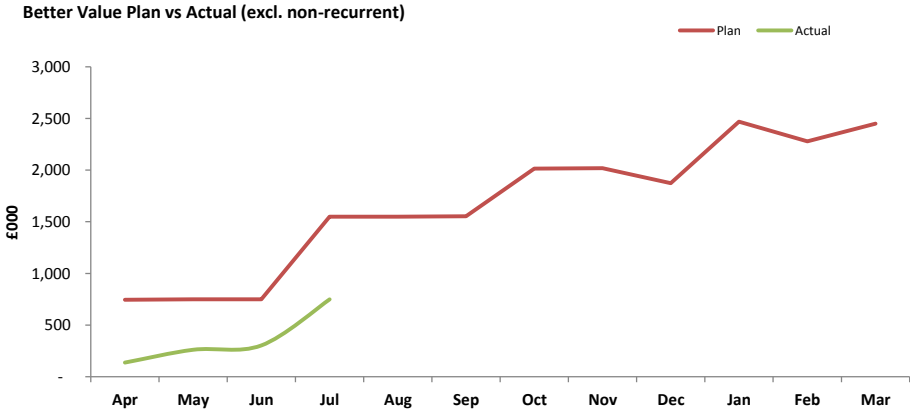
Better Value Summary						
DIRECTORATE	YTD performance £000's			Better Value Total £000's		
	Better Value target YTD	YTD delivery	YTD variance	Better Value target	Unidentified target	Schemes identified
Blood Cells & Cancer	606	51	(555)	1,817	(1,640)	172
Body Bones & Mind	635	148	(487)	1,906	(1,456)	451
Brain	459	100	(359)	1,376	(1,065)	324
Clinical & Medical Operations	98	72	(26)	295	0	264
Corporate Affairs	42	44	2	127	29	155
Finance	96	135	38	289	152	441
Genetics Laboratory Hub	147	147	0	440	0	440
Heart & Lung	1,269	221	(1,049)	3,808	538	4,347
HR	97	73	(24)	290	0	298
ICT	224	0	(224)	671	(38)	632
IPP	315	14	(301)	944	84	1,029
Medical Director	58	0	(58)	173	(173)	0
Medicines Therapies & Tests	837	69	(768)	2,511	(2,234)	264
Nursing and Patient Experience	50	2	(48)	150	(117)	49
Operations & Images	758	64	(695)	2,275	(1,763)	524
Estates and Facilities	468	59	(409)	1,405	(698)	707
Built Environment	17	0	(17)	50	0	50
Sight & Sound	342	119	(223)	1,025	(583)	443
Central	149	134	(15)	447	0	447
Better Value phasing	(2,872)	0	2,872	0	0	0
Total	**3,795**	**1,450**	**(2,344)**	**20,000**	**(8,963)**	**11,036**
Vacancies		2,344	2,344	0	0	0
Total Better Value	**3,795**	**3,794**	**(0)**	**20,000**	**(8,963)**	**11,036**

Summary

- The Better Value program is currently delivering £1.4m of the £3.8m YTD target at month 4. The rest of the delivery is being covered by Pay vacancies across the organisation. This is a £0.7m improvement on M3 partly seen through the identification and finalisation of schemes already underway.
- The Trust has identified better value savings (£11.0m) that have been removed from the Trust budgets which is a £0.4m on M3. Additional saving plans have been worked up and these require additional work to remove from the Trust plans on a recurrent basis.
- Without the Trust vacancies supporting the Trust better value program the program would be £2.3m behind target. With the staffing posts in the Trusts plans these savings can only be recognised on a non recurrent basis which will add pressure onto the 2020/21 finances of the Trust. In order to meet the Better Value program these vacancy levels will need to be maintained throughout the rest of the year.
- The Better Value program phasing can be seen in the graph below. This shows that the Better Value target increases significantly each quarter. It is therefore important that the savings across the organisation increase to cover the increased targets in later months.
- Savings across the Trust have been phased according to directorate plans and so a delivery central phasing adjustment has been made.

Recurrent / Non-recurrent	
	YTD 2019/20 Actual (£k)
Recurrent	1,322
Non-recurrent	2,472
Total Better Value	**3,794**



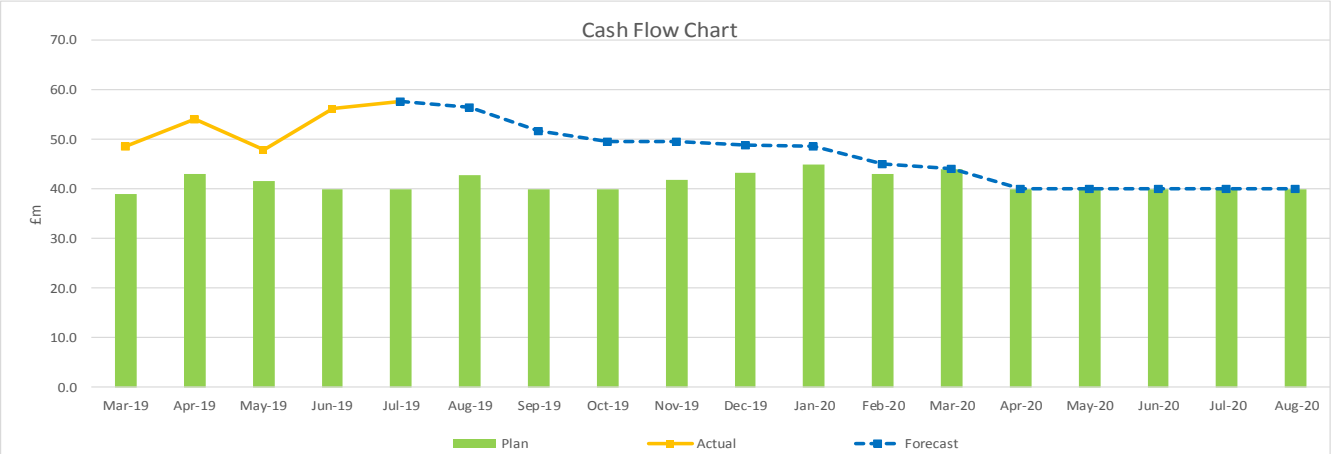


31 Mar 2019 Audited Accounts £m	Statement of Financial Position	Plan 31 Jul 2019 £m	YTD Actual 31 Jul 2019 £m	YTD Variance £m	Forecast Outturn 31 Mar 2020 £m	YTD Actual 30 Jun 2019 £m	In month Movement £m
499.04	Non-Current Assets	519.10	511.10	(8.00)	538.71	509.95	*1.15*
103.55	Current Assets (exc Cash)	86.37	97.76	11.39	88.79	100.39	*(2.63)*
48.61	Cash & Cash Equivalents	40.00	57.68	17.68	44.46	56.34	*1.34*
(74.89)	Current Liabilities	(60.72)	(84.35)	(23.63)	(66.27)	(88.11)	*3.76*
(5.01)	Non-Current Liabilities	(4.66)	(4.66)	0.00	(4.88)	(4.70)	*0.04*
571.30	**Total Assets Employed**	**580.09**	**577.53**	**(2.56)**	**600.81**	**573.87**	**3.66**

31 Mar 2019 Audited Accounts £m	Capital Expenditure	Revised Plan 31 Jul 2019 £m	YTD Actual 31 Jul 2019 £m	YTD Variance £m	Forecast Outturn 31 Mar 2020 £m	RAG YTD variance
5.81	Redevelopment - Donated	10.25	8.47	1.78	33.41	A
9.06	Medical Equipment - Donated	4.04	3.34	0.70	9.30	A
9.78	ICT - Donated	2.14	2.15	(0.01)	2.17	G
24.65	**Total Donated**	**16.43**	**13.96**	**2.47**	**44.88**	A
6.99	Redevelopment & equipment - Trust Funded	1.25	1.34	(0.13)	6.80	A
1.61	Estates & Facilities - Trust Funded	0.28	0.22	0.10	2.39	A
4.73	ICT - Trust Funded	3.84	3.83	0.01	8.27	G
0.00	Contingency	0.00	0.00	0.00	0.00	G
13.33	**Total Trust Funded**	**5.37**	**5.39**	**(0.02)**	**17.46**	G
37.98	**Total Expenditure**	**21.80**	**19.35**	**2.45**	**62.34**	A

31-Mar-19	Working Capital	30-Jun-19	31-Jul-19	RAG	KPI
20.00	NHS Debtor Days (YTD)	9.0	12.0	G	< 30.0
253.00	IPP Debtor Days	214.0	209.0	R	< 120.0
36.70	IPP Overdue Debt (£m)	30.7	31.9	R	0.0
5.00	Inventory Days - Drugs	N/A	N/A		7.0
94.00	Inventory Days - Non Drugs	66.0	89.0	R	30.0
34.00	Creditor Days	37.0	30.0	A	< 30.0
43.6%	BPPC - NHS (YTD) (number)	44.1%	43.2%	R	> 90.0%
80.3%	BPPC - NHS (YTD) (£)	81.0%	77.8%	R	> 90.0%
85.5%	BPPC - Non-NHS (YTD) (number)	85.0%	86.7%	A	> 90.0%
91.1%	BPPC - Non-NHS (YTD) (£)	90.1%	90.1%	G	> 90.0%

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



Comments:

1. The capital programme is behind the revised plan by £2.4m at M4, due to slippage on Redevelopment (Southwood Courtyard/Sight and Sound Hospital £1.7m) and equipment purchases (£0.7m). The capital plan was revised by reducing Trust-funded capital expenditure by 20% or £4.4m. The reduction was slipped to 2020/21. In addition, £1.8m was slipped to 2020/21 for donated funding of the Children's Cancer Centre. NHSI has not yet adjusted the plan in the M4 return but is expected to do so in M5.
2. Cash held by the Trust is higher than plan by £17.7m. This includes £8.2m relating to Provider Sustainability Funding received in month as well as higher than planned receipts in relation to IPP debt. The cashflow was reprofiled in the previous month and at M04 the cash held by the Trust was £2.0m higher than the revised plan profile, this is shown in the Cash Flow chart above.
3. Total Assets employed at M4 was £2.6m higher than plan as a result of the following:
   - Non current assets totalled £511.1m (£8.0m lower than plan)
   - Current assets excluding cash less Current liabilities totalled £13.4m (£12.2m lower than plan).
   - Cash held by the Trust totalled £57.7m (£17.7m higher than plan which includes £8.2m of PSF bonus and incentive relating to 2 018/19 received in month as well as £6.0m of IPP receipts in month.
4. Overdue IPP debt increased in month to £31.8m (£30.7m in M3).
5. IPP debtor days decreased from 214 days to 209 days in month.
6. The cumulative BPPC for NHS invoices (by value) decreased in month to 77.8% (81.0% in M3). This represented 43.2% of the number of invoices settled within 30 days (44.1% in M3)
7. The cumulative BPPC for Non NHS invoices (by value) remained the same as the previous month at 90.1%. This represented 86.7% of the number of invoices settled within 30 days (85.0% in M3).
8. Creditor days decreased in month from 37 days to 30 days in month, following the settlement of a high value of pharmacy invoices.
9. Non-drug inventory days increased in month to 89 days (66 in M3). Inventory days (drugs) cannot be calculated at month 4 because the value of Pharmacy inventory at 31 July 2019 is not available but plans are in place to carry out an interim count at 31 August.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 18 September 2019	
Better Value Programme **Submitted by:** Richard Collins, Director of Transformation	**Paper No: Attachment X**

Aims
This paper describes progress towards delivering the Better Value programme for 2019/20 and actions being taken to address a remaining gap against the operating plan target.

Summary position
The scoping and delivery of a full £20m Better Value programme remains a significant challenge and risk for the organisation. The programme has not delivered the full savings within the financial plan to month 4, but this has been largely offset by cost savings achieved through vacancies.

The directorate teams are continuing to meet regularly to review opportunities for further cost savings, including line by line reviews of their budgets. Schemes with a potential value of c. £20m have been identified (made up of directorate and cross cutting schemes), but as a number of these have not yet been fully worked up and signed off, they have been risk rated accordingly.

The forecast for the full financial year still indicates that there will be a c. 6m gap which will need to be mitigated through further Better Value schemes in order for the Trust to meet its control total. A meeting of the senior leadership team is scheduled for early September to collectively review options available to the Trust to close the current forecast gap.

Recommendation
The Board is asked to note the current position for the 2019/20 Better Value programme.

Contribution to the delivery of NHS / Trust strategies and plans
The Better Value Programme is a significant contributor to the Trust's overall financial strategy and plans. Delivery of the Better Value target is important in the context of the Trust's overall control total and requirement to move towards delivering a robust ongoing financial surplus.

Financial implications
Included within the overall Trust position

Legal issues
None

Who is responsible for implementing the proposals / project and anticipated timescales
Director of Transformation & project/programme leads with support of Programme Office

Who is accountable for the implementation of the proposal / project
Director of Transformation

The Better Value programme 2019/20

Year to-date delivery

- The operating plan anticipated that by M4, CIPs of £3.8m would be required in order to achieve the planned trajectory towards the £20m target by year-end.
- By M4, £1.3m was achieved recurrently, an adverse variance of £2.5m. This has continued to be mitigated through delivery of pay underspends, with some additional adjustments (e.g. savings related to the delayed opening of ZCR) also helping the Trust to achieve its YTD control total.
- The rate of Better Value delivery has increased substantially in M4. £0.6m was delivered in month, compared to £0.7m for the whole of Q1.

Schemes signed-off

- The value of schemes identified for removal from budgets has increased to **£12.6m**.
- This figure is based upon the PMO's latest information on agreed schemes (with all associated documentation signed off), adjusted also to incorporate non-recurrent pay underspends delivered in Q1, full year effects from last year's programme and some non-recurrent savings relating to the running of ZCR being lower than anticipated for this financial year.

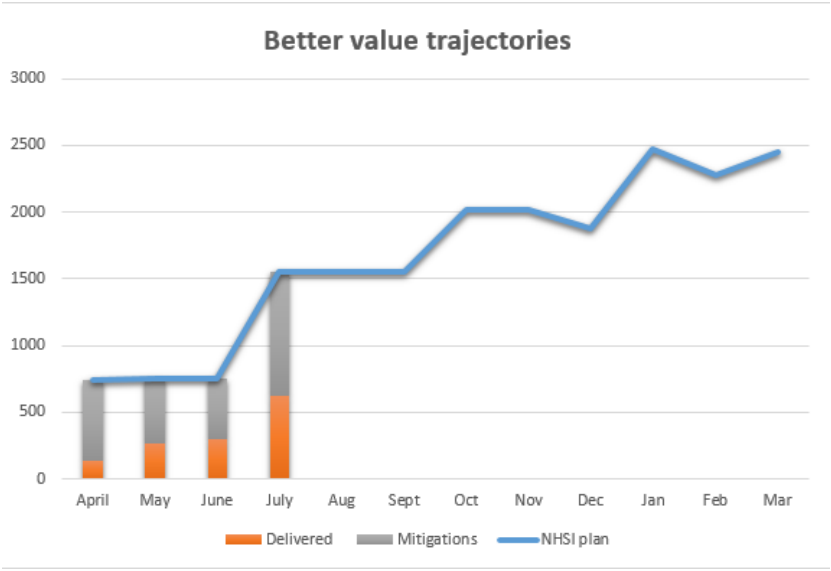
Further schemes under development

- A further £10 m of schemes are under development and not yet signed-off into budgets. The largest components relate to:
    - **Establishment control and vacancy retention** £1.5m has been delivered up to M4. However, it is forecast that a further £2m will be targeted over the remainder of the year; this assumes the level of savings delivered during Q1 will decline later in the year due to factors such as planned recruitment of new nurses.
    - **A wide range of procurement schemes** not yet signed off into budgets (potential £1m including savings from the rollout of Materials Management). This will be supported by the clinical variation work being undertaken throughout August with the clinical directorates to identify further areas where savings could be made.
    - **Reduction of debt provisions** if increased IPP payments are maintained (up to £4m saving).

- In sum, the total value of all potential identified schemes including the pipeline is **£22.6m**. However, a significant proportion (£10m) are non-recurrent, and after applying risk adjustments to the programme, the PMO currently predicts the programme would be challenged to deliver more than **£16m** in-year.

The trajectory to year-end

- The Better value requirement becomes much harder from Q2 due to the phasing of the programme in the Operating plan, as shown in the chart below:



- As noted above, the impact of risk-rating the programme means that by year-end, after building in pipeline schemes, it is currently forecast to deliver an adverse variance of c. £4m.
- Work will be taking place with the clinical directorates and finance BPs to forecast projected delivery of actuals and mitigations for the remainder of 2019/20 - To be presented at the next Transformation Portfolio Board.

Immediate actions and next steps to address the gap

- In addition further work is being undertaken to finalise the extent to which pay underspends can continue over coming months without adverse impact on quality and safety, or patient, family and staff experience. The current assumption is that, in addition to the £1.5m already delivered through pay underspends in Q1, a further £2m can be achieved over the remainder of the year.
- The Procurement Board has tasked the procurement team (GSTT) to work closer with our clinical directorates to prioritise reducing clinical variation in the products we order and a work plan is being worked up (for the procurement board on 13th September) which will highlight priority areas to go after. Furthermore, there will be more work done on identifying savings made through material management at the end of Q2 and both of these will support in delivering the full procurement target.
- IPP/PICU is subject to further work and mitigation, led by the Clinical Operations teams. The PICU scheme is currently not delivering and it is unlikely to deliver its full target by year end unless significant increase in demand occurs.
- A targeted communication and engagement programme is being developed over the summer to build on the extraordinary Big Briefing sessions, raise and maintain awareness, gain support for upcoming projects and empower staff to develop their own local initiatives.

Further actions

- The actions noted above are unlikely in themselves to provide sufficient assurance that the full £20m Better Value target can be delivered, even after including the currently identified non-recurrent mitigation schemes. Therefore, the Chief Finance Officer and Director of Transformation have scheduled a session with the senior leadership team to review other options that could be taken to further reduce costs.

Subject to the outcome of the session, schemes will worked up and PODs and QIAs completed where appropriate.

Recommendation

The Board is asked to note the current position for the 2019/20 Better Value programme.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
18th September 2019

Safe Nurse Staffing Report for June/July 2019 **Presented by: Alison Robertson, Chief Nurse.**	**Paper No: Attachment Y**

Aims / summary

This report provides the Trust Board with an overview of the nursing workforce during the months of June and July 2019 and is set out in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing published in 2016 and further supplemented in 2018.

It provides assurance that arrangements are in place to monitor nurse staffing in the inpatient wards.

Action required from the meeting

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

- Actual versus planned care hours available are within recommended parameters
- Care Hours Per Patient Per day continue to be higher than the 2018/19 average
- Work continues to improve rostering practice and to maximise the potential of the rostering system
- Agency utilisation remains very low, overall bank fill rates have increased slightly, although are reduced in the critical care areas due vacancies, skill mix issues and rises in acuity.
- There were 14 datix reports which raised concerns in relation to nurse staffing levels – appropriate escalation and actions were put in place and no harm was recorded
- A summary of the challenges in the International Private Patients Directorate around nurse staffing recruitment and retention is highlighted
- A full report outlining progress of our nurse retention plan has been presented to the People, Education and Assurance Committee
- A daily system for monitoring beds which are temporarily closed is in place. In June and July 10 beds were closed in Hedgehog and 8 on Sky ward which accounts for the majority of the bed closures
- 87 newly registered nurses commenced in September.

Contribution to the delivery of NHS Foundation Trust strategies and plans

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

Financial implications

Already incorporated into 19/20 Directorate budgets.

Who needs to be told about any decision?

Directorate Management Teams
Finance Department
Workforce Intelligence.

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

Chief Nurse; Assistant Chief Nurse, Director of Education and Heads of Nursing and Patient Experience.

Who is accountable for the implementation of the proposal / project

Chief Nurse; Directorate Management Teams.

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

1. Summary

This report on GOSH Safe Staffing contains information for the months of June & July 2019. This paper provides assurance that GOSH has processes in place to review nurse staffing levels across all in-patient ward areas and systems in place to manage the demand for nursing staff. The report also includes updates on a number of other initiatives in place to ensure safe staffing throughout the Trust and optimally utilise our nursing workforce.

2. Safer Staffing.

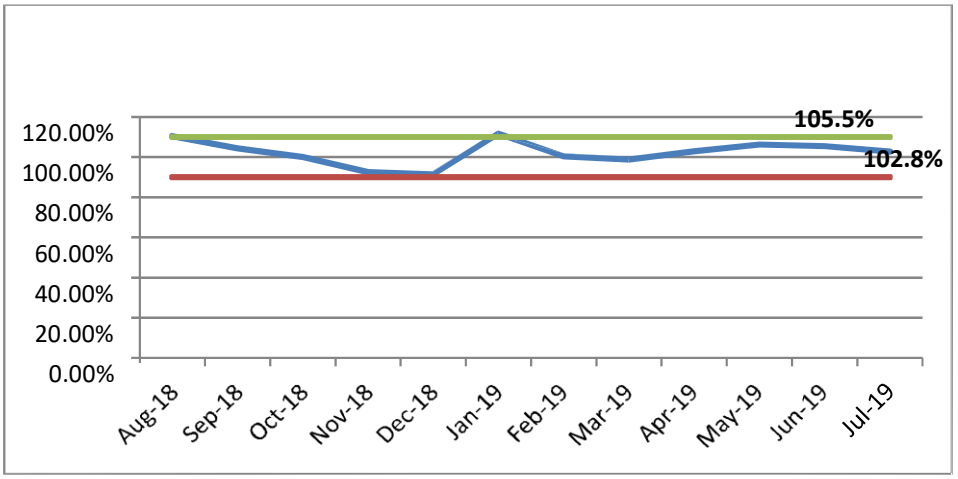
2.1 Actual vs Planned

Actual vs Planned (AvP) Hours shows the percentage of Nursing & Healthcare Assistant (HCA) staff who worked (including Bank) as a percentage of planned care hours in month. The National Quality Board recommendations are the parameters should be between 90-110%.

In June the overall fill rate of AvP was 105.5% which is within the recommended range and an improvement on the same month last year. In July the rate was 102.8%. In both months HCA fill rates at night were lower than the recommended minimum %, however Heads of Nursing and Patient Experience have verified that despite these lower rates no shifts were unsafe, and local management of available staff resolved any staffing issues.

At a Directorate level, both Heart & Lung and International & Private Patients (IPP) were outside of the recommended parameters in both months, exceeding the 110% upper range. These variances are being explored to ensure their reported plans reflect their current needs. Further information about IPP can be found in section 4.

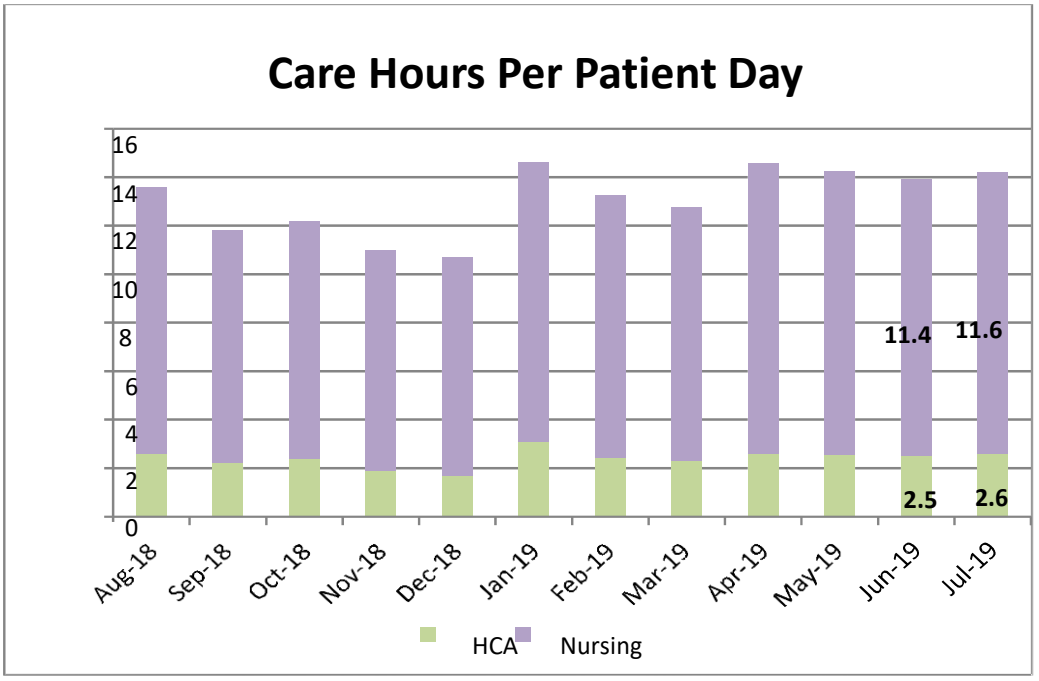
Unify Actual vs Planned Hours



2.2 Care Hours Per Patient Day (CHPPD)

CHPPD is calculated by adding the hours of registered nurses and healthcare assistants available in a 24 hour period and dividing the total by the number of patients at midnight. CHPPD is reported as a total and split by registered nurses and HCAs to provide a complete picture of care and skill mix. CHPPD data is uploaded onto the national Unify system and published on NHS Choices on a monthly basis.

When we report CHPPD we exclude the 3 ICUs to give a more representative picture across the Trust. The reported CHPPD for June 2019 was 14.6 hours, made up of 12 registered nursing hours and 2.6 HCA hours. In July, the figure was slightly lower at 14.2 hours (11.7 RN and 2.5 HCA) however both months are much higher than the 2018/19 average of 12.6 total hours.



2.3 SafeCare

Completion of PANDA assessments continued to be a focus of the Rostering Team in both June and July; inpatient wards achieved compliance rates of over 90% in both months. A working group has also been established to consider the implementation of the 'Red Flags' system within Safecare. The Red Flags process is widely used across the NHS as a way of monitoring and resolving local safety pressures, and enabling easier monitoring of trends.

3. Workforce Utilisation

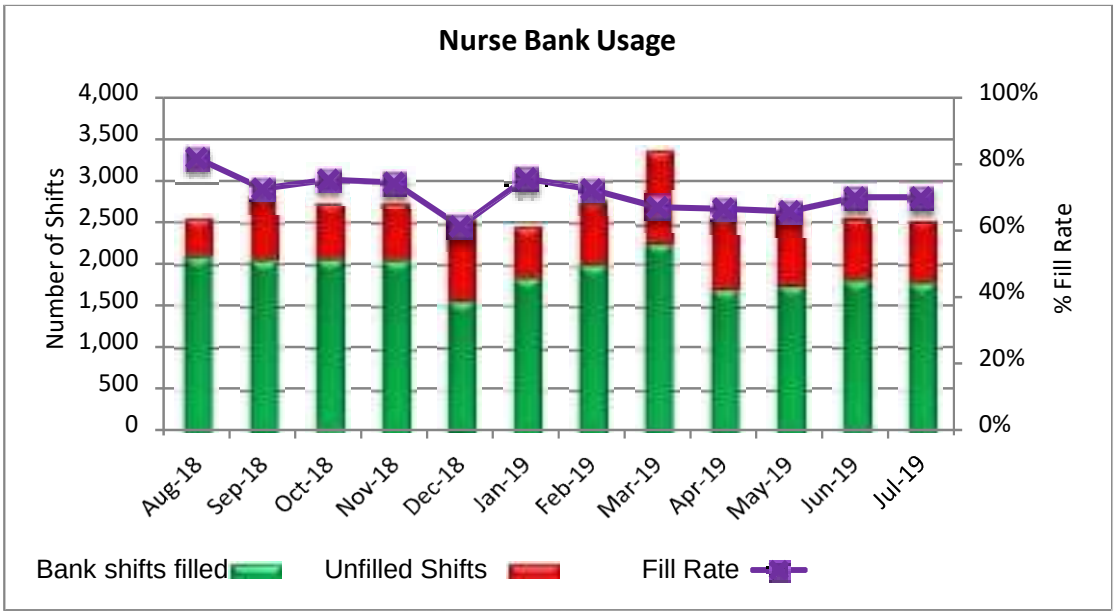
3.1 Rostering

The rostering scorecard measures are shown below. Publication of rosters in advance was a major focus for rostering managers in July and August, which is expected to show better results from September onwards. The reduction in variances between demand templates (amount of nurses to be scheduled to a shift) and the budgeted establishment continues to be addressed with the Heads of Nursing and Patient Experience and this metric continues to show improvements. The measure for

unsocial working (% of staff working at least the minimum number of unsocial shifts) is currently being reviewed.

Metric	Target	April roster	May roster	June roster	July roster
Advance Publication of a roster.	42 days +	27	29	32	29
Time Balances.(Hours per WTE)	+/- 12 hrs	7.5	8.7	8.1	8.1
% Annual Leave Unavailability	15-20%	11.2%	12.2%	11.7%	12.4%
Demand vs Budget. (WTE)	0	116	171	235	109
Additional shifts created	0	991	892	773	843
% Staff working fair proportion of night and weekend duties	50%+	46%	43%	43%	N/A
Safecare Acuity & Staffing Utilisation.	tbc	tbc	tbc	99%	100%

3.2 Temporary Staffing



Requested shifts during June (2,586 requests) and July (2,569 requests) were stable and broadly in line with the long term trend. The fill rate for both months was 70%, which is higher than the 2019/20 average of 68% although lower than the 2018/19 average of 78%. ICU requests continued to be higher than in the previous year (18%) which has an impact on their fill rate which is lower than the Trust average at 54% and 56% respectively. Recruitment has significantly improved in recent months in NICU and PICU which should have an impact on reducing bank demand once all nurses have commenced in post and achieved their competences. CICU has experienced an increase in acuity and dependency in their patient group which partly explains the rise in shift requests.

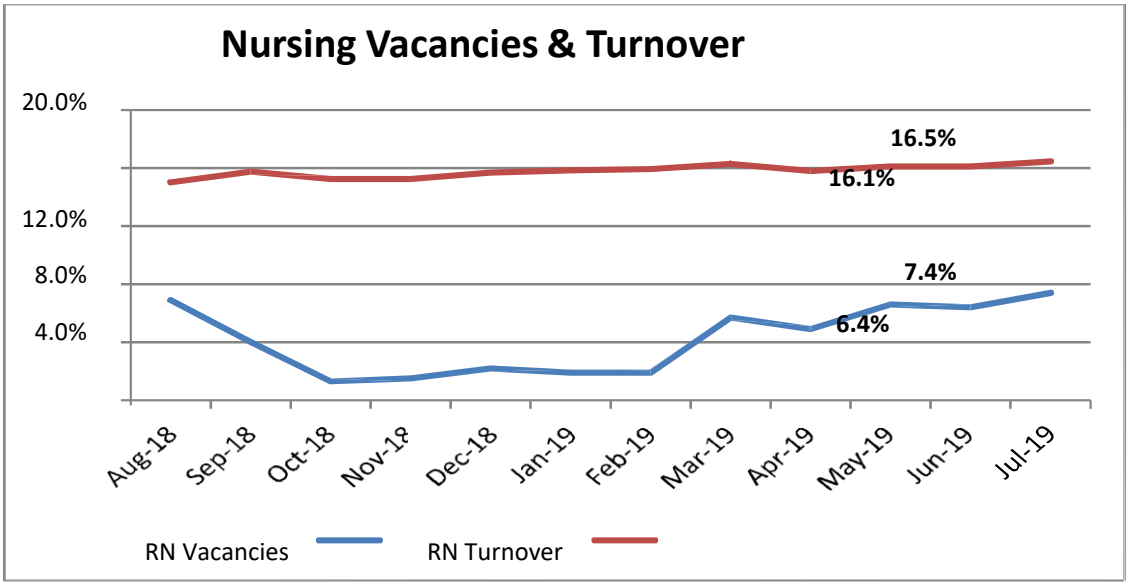
Agency nursing usage in the Trust remains well controlled. In June there was 1 shift, while in July requirements for specialist RMN care meant there were 17 shifts filled by Agency, however this was in one patient area.

3.3 Vacancies & Recruitment

The Trust nursing vacancy rate for June was 6.4% (103 WTE) and increased in July to 7.4% (108.1 WTE). This reflects a seasonal trend that sees increased vacancy rates in the summer, and was in part due to increased turnover. The highest number of vacancies was in IPP (29.9 WTE, 26.3% in July), Heart & Lung (28.03 WTE, 5.3%) and Operations & Images (20.0 WTE, 9.8%).

Band 6 Vacancies continues to be a challenge at 72.2 WTE (13.1%). One of the drivers of the Nursing Retention Pjlan is a refresh of strategies around career development which aim to support Band 5 Nurses to progress in their career at GOSH (see appendix 2).

Healthcare Assistant vacancies is improving but remains above target 33.49 (10.9%) in July. The Nursing Workforce Team will be reviewing the approach to recruiting HCAs to address the longstanding high levels of vacancies in this cadre of staff.



3.4 Retention

The Trust has joined the NHSI Retention Collaborative which provides focussed support to trusts aiming to improve retention of their nursing workforce. As part of this work, a nursing retention plan has been developed which will look at ways to improve nursing experience. The high level plan was presented to the board in March 2019 and workstreams supporting the 4 drivers have been established with nursing participation across all levels of the organisation.

The retention project has a target to reduce Band 5 and 6 combined turnover rates by 1% by March 2020. A full report on the Nurse Retention Plan was presented to the People and Education Assurance Committee in September.

4. Patient Safety

4.1 Patient Safety and DATIX

a) Unsafe Staffing Reports (DATIX)

In June there were four reported datix incidents which identified concerns around nurse staffing levels (Butterfly, Turtle, Kangaroo and Panther Urology). Three shifts were appropriately escalated to the clinical site practitioner; two of the four shifts were under staffed due to short notice sickness with bank staff also unavailable. Patient activity load was therefore prioritised and appropriate decisions were made to maintain safety.

In July there were 10 reported datix incidents in different areas across 5 directorates which identified concerns around safe nurse staffing levels. The Heads of Nursing and Patient Experience have reviewed these incidents and have confirmed that there was appropriate escalation with remedial actions put in place to manage the situation. One shift remained very tight but no harm came to patients.

b) International Private Patients (IPP)

The safe staffing reports to the Trust Board have regularly highlighted the IPP directorate as a concern in relation to their ability to staff the wards safely with RN vacancies and turnover running between 25% - 30%.

A number of safety/patient experience indicators are consistently tracked and the report attached at appendix 3 demonstrates that the IPP directorate are finding it a challenge to maintain patient safety/experience.

Action has been taken by the directorate team by merging the nursing teams from Hedgehog and Bumblebee and consolidating on one ward. Butterfly (oncology) ward has to date remained fully open, however staffing levels will be especially impacted at the end of September and some beds may also temporarily close.

The IPP leadership team have been extremely proactive for many months in terms of exploring ways in which these staffing shortfalls can be overcome. Following the last Trust Board the Chief Nurse has met with the Head of Nursing and Patient Experience and General Manager in IPP along with the HR team to review the current situation. Additional actions have been agreed:

- Deployment of the temporary use of the Trust enhanced nursing bank rate to improve fill rate

- IPP to explore international recruitment opportunities in partnership with University College Hospital, London (November)
- IPP have now successfully recruited 5 (with a further 2 interviews planned)
- Director of Nursing – Operations and the IPP Head of Nursing and Patient Experience have reviewed the IPP nurse establishments which will need to be considered in the business planning round for 2019/20
- Meetings have been held to seek additional education and staffing support from the Heart and Lung and Blood, Cells and Cancer directorates.
- The IPP team will work with colleagues in HR to explore temporary recruitment/retention premia as it is clear that all of the usual recruitment and retention approaches are not resulting in a net increase in nurses required to keep all beds open
- A number of other actions have also been put in place to strengthen the oversight and supervision of the junior medical teams.
- All actions have been pulled together in a comprehensive action plan which will be monitored at the directorate performance review

c) Closed Beds

GOSH monitors the number of beds that are closed on a daily basis due to poor staffing levels. This can be due to a number of reasons; high vacancy factor, short term sickness, increase in acuity/dependency.

In June there were between 24 – 32 beds closed on a temporary basis in July, there were between 21 – 31. It should be noted that in these two months 10 beds were closed on Hedgehog Ward (IPP) and 8 on Sky Ward (Body, Bones and Mind).

In both months between 0 – 9 beds were temporarily closed in critical care (CICU, PICU, NICU).

5. Nursing Workforce – Assurance

A two day external assessment of our current nursing workforce approach has been arranged to take place in September. Information will be sent before the site visit which will identify areas of focus.

In October a workshop has been arranged to learn about the Safer Nursing Tool for Children and Young People which will then be included in the next nursing establishment review.

6. Recruitment

In September 91 newly registered nurses (NRNs) are due to join the trust, with a further 12 deferring until January 2020.

A GOSH nursing Open Day will be held in October to begin recruitment for NRNs who will commence in March.

The critical care areas are planning to attend the Royal College of Nursing recruitment fair.

Appendix 1: June & July Workforce metrics by Directorate

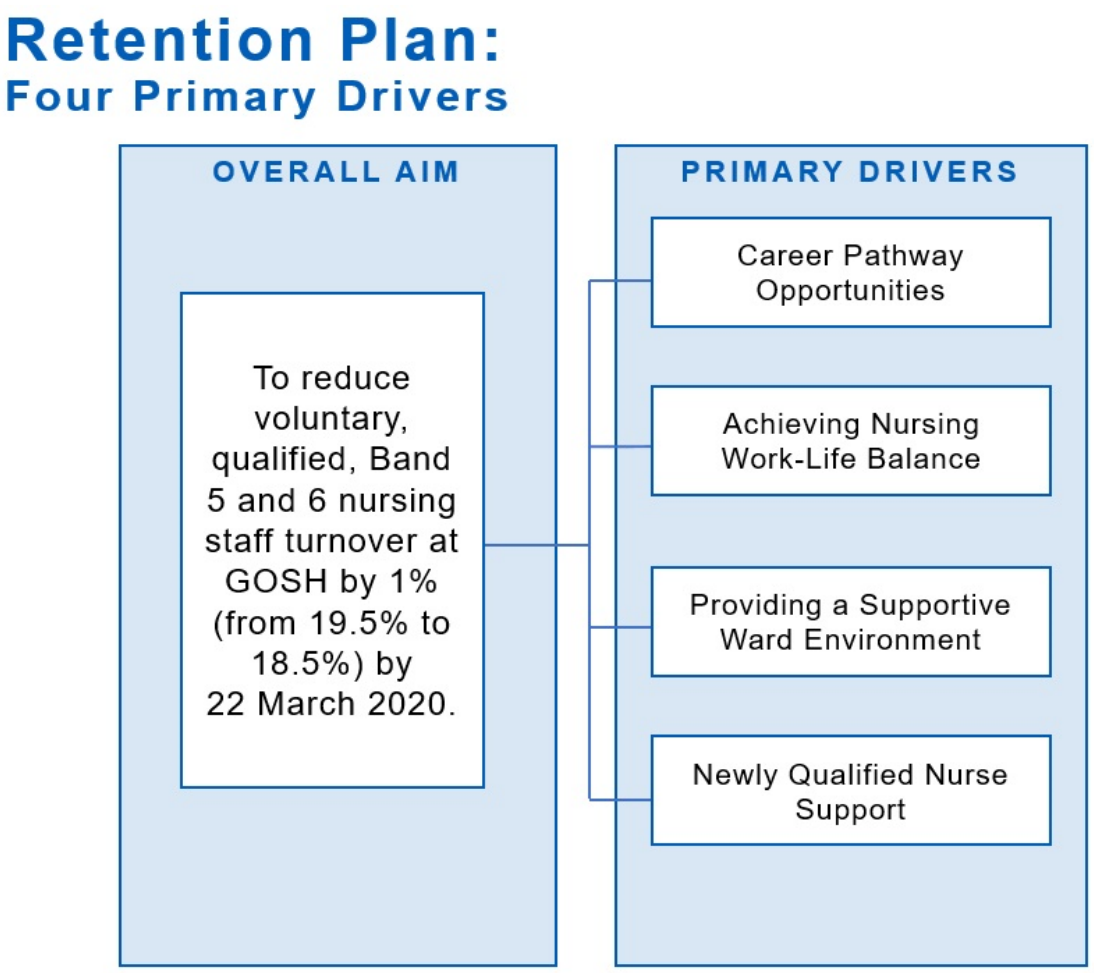
Directorate	Actual vs Planned %	CHPPD (exc ICUs)	RN Vacancies (FTE)	RN Vacancies (%)	Voluntary Turnover %	Sickness %	Maternity %
Blood, Cells & Cancer	102.9%	15.8	11.4	5.0%	13.09%	2.6%	2.3%
Body, Bones & Mind	107.7%	13.3	17.8	4.7%	13.5%	3.7%	6.3%
Brain	90.3%	12.2	-8.0	-8.2%	15.4%	2.6%	6.4%
Heart & Lung	113.3%	14.8	28.0	5.0%	17.7%	3.5%	4.3%
International & PP	119.3%	12.9	29.9	24.3%	28.3%	4.4%	6.9%
Operations & Images	-	-	20.1	9.4%	10.3%	4.6%	3.3%
Sight & Sound	91.3%	9.7	9.9	16.4%	14.0%	2.4%	5.3%
Trust	105.5%	13.9	103.5	6.4%	16.1%	3.3%	4.6%

June Nursing Workforce Performance

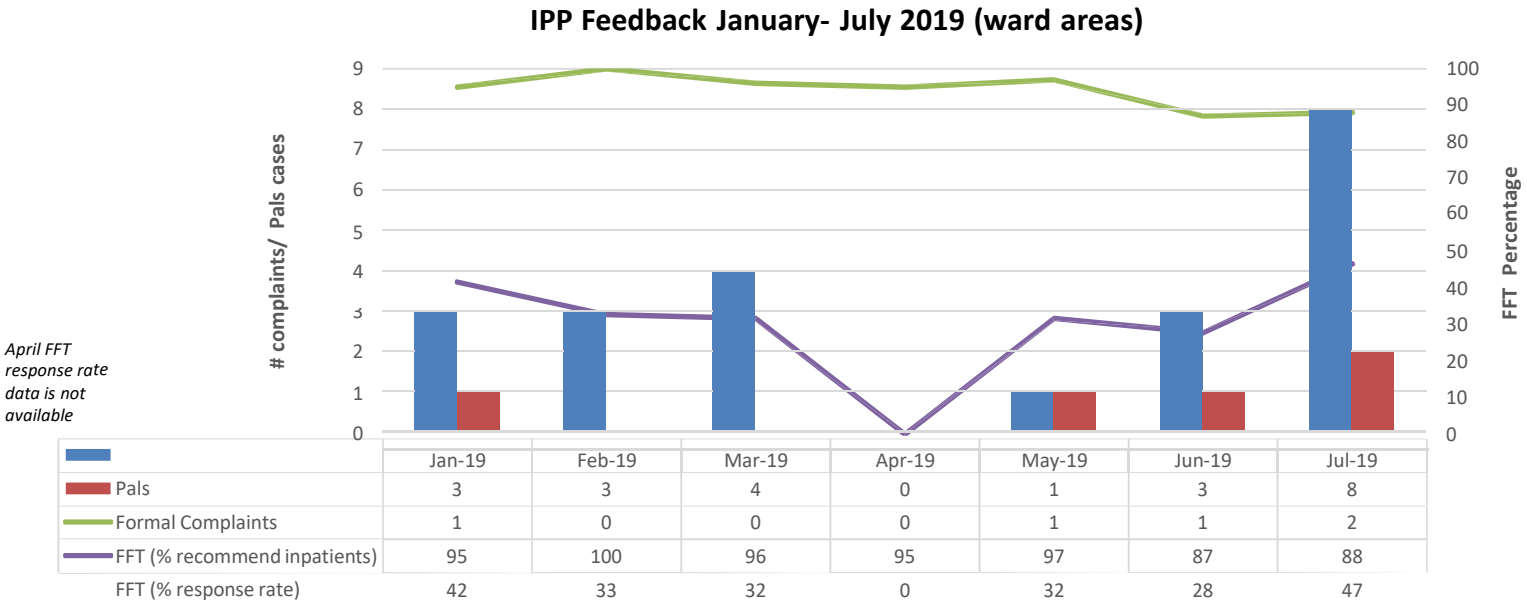
Directorate	Actual vs Planned %	CHPPD (exc ICUs)	RN Vacancies (FTE)	RN Vacancies (%)	Voluntary Turnover %	Sickness %	Maternity %
Blood, Cells & Cancer	**104.7%**	**15.3**	**11.9**	**5.1%**	**15.1%**	**2.9%**	**2.6%**
Body, Bones & Mind	**98.1%**	**12.7**	**21.4**	**8.5%**	**12.9%**	**2.6%**	**6.0%**
Brain	**98.0%**	**13.4**	**6.6**	**5.1%**	**15.4%**	**2.7%**	**5.3%**
Heart & Lung	**119.3%**	**15.3**	**24.4**	**4.6%**	**16.9%**	**3.5%**	**4.2%**
International & PP	**122.1%**	**13.9**	**31.1**	**27.3%**	**29.6%**	**4.4%**	**6.0%**
Operations & Images	**-**	**-**	**17.9**	**8.9%**	**11.0%**	**4.4%**	**2.8%**
Sight & Sound	**94.2%**	**12.2**	**6.7**	**11.9%**	**15.1%**	**3.3%**	**5.4%**
Trust	**103.0%**	**14.3**	**108.1**	**6.6%**	**16.1%**	**3.2%**	**4.4%**

July Nursing Workforce Performance

Appendix 2: Nurse Retention Plan – Drivers

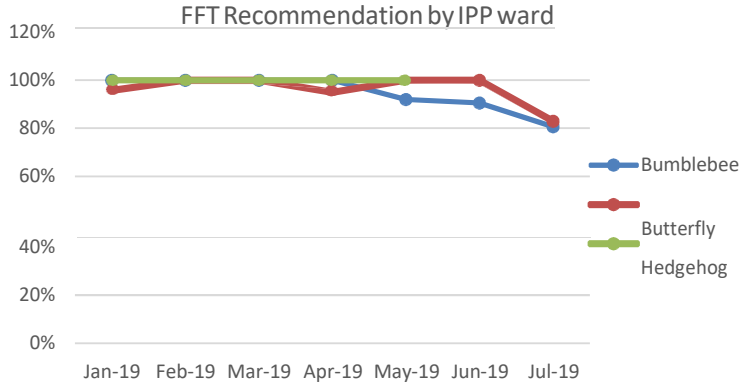


Appendix 3



April FFT response rate data is not available

	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Pals	3	3	4	0	1	3	8
Formal Complaints	1	0	0	0	1	1	2
FFT (% recommend inpatients)	95	100	96	95	97	87	88
FFT (% response rate)	42	33	32	0	32	28	47



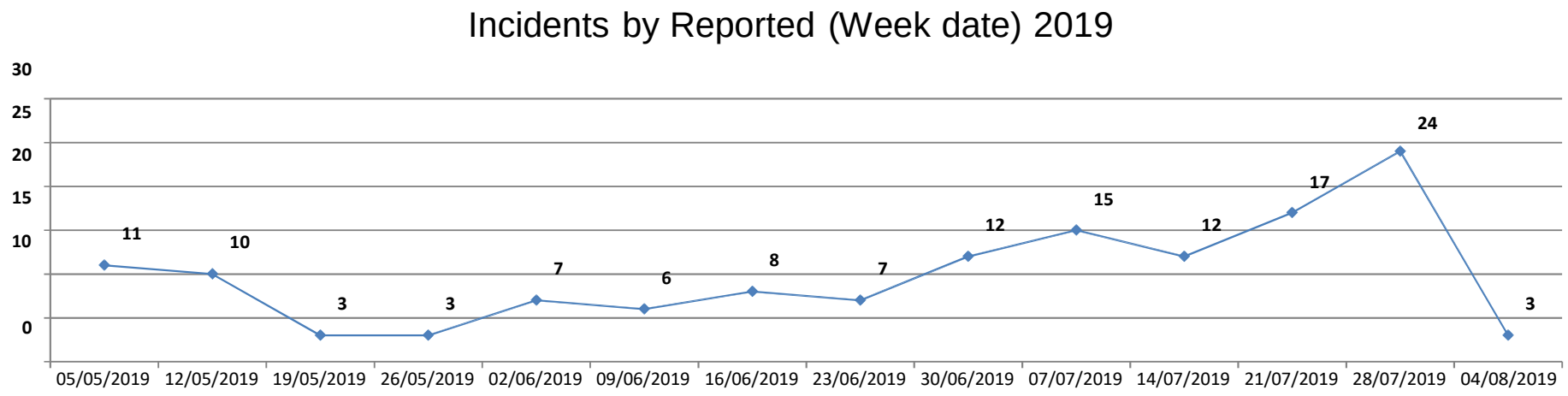
- High proportion of high risk complaints (40%) highlighting concerns about harm caused as a result of poor care.
- 22% increase in Pals cases for the same period in 2018.
- FFT recommendation rate of 95% has not achieved since June 2019.
- July recommendation rates at ward level ranged between 80.7% and 83%.

Incidents Data

There were 138 reported incidences between 5 May and 5 August compared to 174 this time last year; however Hedgehog ward was fully open in the 2018 period. There has been an increase in the severity of incidents in the 2019 three month time period compared to the same period in 2018.

	No Harm	Minor Harm	Moderate Harm	Major harm	Catastrophic	Total
2018	146	28	0	0	0	174
2019	100	34	5 - all required Duty of Candour (1x current SI)	0	0	139

The main theme in is prescribing errors which include administration from incorrect prescriptions.



Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
18 September 2019

Sustainable Development Management Plan (SDMP) 2020-2023 **Submitted by:** Nick Martin, Head of Sustainability Matthew Tulley, Director Built Environment	**Paper No: Attachment Z** - Summary of SDMP - Full SDMP document

Aims / summary

The purpose today is for the Trust Board to adopt the Sustainable Development Management Plan (SDMP).

It is a requirement of NHSI/E for Trusts' to have a Board approved SDMP. An SDMP is essential in showing how we will meet the environmental and sustainability commitments of the NHS Ten Year Plan. Public Health England view the SDMP as evidence as to how we are meeting our commitments to local public health outcomes. Adopting the SDMP shows good governance and provides the direction we wish to set in terms of our sustainability ambitions.

This is GOSH's third and significantly most ambitious SDMP. It is holistic and wide ranging in the tangible objectives it sets us across 10 key areas from 4 perspectives. We have identified four overarching goals:

- *Reducing our greenhouse gas emissions*
- *Doubling our Sustainable Development Assessment Tool score*
- *Becoming an 'excellent' rated clean air hospital*
- *Embedding the UN Sustainable Development Goals into our measurement procedures.*

The SDMP has a clear focus on health and wellbeing and how putting the 'Child first and Always' cannot be viewed in isolation from external factors - including environmental degradation and global heating – and their impacts on health. As outlined by The Lancet and UCL Institute for Global health in 2009, "Climate change is the greatest threat to health of the 21st century".

The SDMP's vision for the future is that GOSH continues to deliver high quality care and ground breaking research whilst reducing our own environmental impact. We will develop innovative models of care and increase the knowledge and confidence of our people to make change while taking a leading role globally in linking health and the environment.

It demonstrates how GOSH takes seriously our responsibility to be part of the solution so that the young people in our care - and beyond - can benefit from the opportunities that addressing these existential challenges will bring. In tandem with our ground breaking Clean Air Hospital Framework – that we are sharing across the NHS – our SDMP will involve staff, patients, commercial partners, our local community and wider collaborators in meeting this challenge and creating exciting new opportunities from it.

The SDMP is a roadmap that develops our understanding of the impacts and opportunities resulting from delivery of GOSH's core services and help us direct ourselves towards a healthier, happier, more secure and environmentally sustainable future for the children in our care and beyond. The SDMP increases our understanding of the direct link between environmental degradation, climate

change and health/wellbeing impacts on people and children and therefore the clear health benefits of addressing them.

The SDMP (and accompanying Clean Air Hospital Framework) has been developed through a broad internal & external consultation process. This has included a comprehensive review of NHS Improvement guidance, NHS Trust best practice and wide ranging stakeholder consultation sessions (staff, patients, YPF, external experts and partners). Our current baseline performance has been calculated using the NHS Sustainable Development Unit's SDAT.

The last year has brought increased success and profile in regard to GOSH leading on sustainability and air pollution. The highlights have been the launch of the GOSH Clean Air Hospital Framework and GOSH Play Street event marking National Clean Air Day.

The governance processes required to monitor delivery of the SDMP have been updated and include annual reporting to the Trust Board and EMT, quarterly meetings of the newly created SDMP Delivery Group, staff Green Champions Network, meetings with the YPF with ongoing support from both the Built Environment and Estates and Facilities Leadership teams.

Performance and impact will be identified through the annual completion of the NHS Sustainable Development Unit SDAT tool, the SDU Sustainability Reporting Portal, Trust Sustainability Report, DoH ERIC data returns and NHS PAM data returns. Beyond these annual reports a quarterly progress report will be submitted to the SDMP Delivery Group responsible for overseeing progress and an SDMP tracker will chart monthly progress.

Creating this plan has involved significant consultation with stakeholders across the Trust (including patients and the YPF) and beyond. The document begins with a message from our YPF members who have clearly expressed their views and feelings on the approach they would like to see us take.

The SDMP will act as a road map for the actions we will deliver internally and externally over the coming 3 years. The priorities highlighted will be developed into actions which inevitably will evolve during the course of the SDMP. The SDMP is a public statement of intent and symbol of collaboration with partners and our acknowledgment that climate change and environmental degradation impact on population health in general and disproportionately on the health of children and young people.

Declaring a climate emergency

The importance to young people and our staff of the environment and our responsible use of resources has become clearer during the development of this SDMP. The YPF have specifically raised that they would request that GOSH declare a climate emergency. This is an important recognition of the magnitude of the climate issue and our commitment to work with partners to act in such a way that minimises our impact on the environment. We will also commit to developing a plan to become a carbon neutral organisation.

A large number of organisations have declared a climate emergency. This includes over 100 UK Councils (including Camden) and two universities. Newcastle Upon Tyne Hospitals Foundation Trust became the first NHS Trust to declare a Climate Emergency.

Declaring a Climate Emergency means, a public acknowledgement of the climate crisis which threatens population health; a commitment to fast-tracking the

reduction of our carbon emissions, collaborative action with our civic partners to deliver a zero carbon Camden/London/UK.
Action required from the meeting - That the Board adopts this document as GOSH's SDMP for 2020-2023
Contribution to the delivery of NHS Foundation Trust strategies and plans Delivery of the SDMP contributes to resource and financial sustainability. We are legally obliged to address climate change, with a (recently strengthened) UK Government target of carbon neutrality by 2050 as set out in the UK's Climate Change Act (CCA).
Financial implications Nothing initially although 'spend to save' opportunities will be proposed to the Trust as delivery of SDMP objectives and carbon neutrality plan progresses
Who needs to be told about any decision? GOSH Green Champions YPF Staff NHSI
Who is responsible for implementing the proposals / project and anticipated timescales? Nick Martin
Who is accountable for the implementation of the proposal / project? Matthew Tulley

GOSH Sustainable Development Management Plan summary paper 2020-2023

What is the Sustainable Development Management Plan?

The Sustainable Development Management Plan (SDMP) is our roadmap that shows where the delivery of GOSH's core service has an environmental impact and presents opportunities to reduce this and bring health benefits to our patients, staff and neighbouring communities. This SDMP is our third and most ambitious. Our SDMP workflows are broken down into 10 focus areas and viewed from 4 perspectives. We have identified four overarching goals:

- Reducing our greenhouse gas emissions
- Doubling our Sustainable Development Assessment Tool score
- Becoming an 'excellent' rated clean air hospital
- Embedding the UN Sustainable Development Goals into our measurement procedures.

Detailed plans will be created to deliver the objectives below as practical implementation of the SDMP gets underway. The SDMP is also a public statement on GOSH's intentions to lead and collaborate on this important subject.

Why create an SDMP?

Climate change and global heating is considered by many to be the most pressing issue that will impact human health this century. The Lancet and the UCL Institute for Global Health said that, "Climate Change is the greatest threat to health of the 21st Century."

There are also a number of legislative imperatives that direct us towards a careful understanding of our impact on the environment. For a number of years there has been a legal commitment to reduce carbon emissions by 80% by 2050. Recently this target has been amended for the UK to be carbon neutral by 2050. At GOSH we hope that we can become carbon neutral sometime before 2050.

This SDMP is necessary for GOSH to continue delivering top quality care and ground breaking research whilst reducing our environmental impact. It will engage with our stakeholders and ensure we are mindful of how we deliver care and the wider holistic impacts on health and well-being. In order to do this the SDMP is needed to paint a picture and to involve staff, patients, commercial partners, our local community and wider collaborators. The SDMP demonstrates our commitment to being efficient in our resource consumption, identifies areas for staff to engage with and is a catalyst for change.

How we created the SDMP?

We have used NHSI guidance and UK Trust best practice in our design of this SDMP structure. The content and objectives - outlined below - have been created as part of a thorough consultation process with a broad range of stakeholders including staff and patients. They are not only ambitious but also represent the ideas and priorities communicated directly by our staff, patients and YPF.

Next steps

As soon as the SDMP has been adopted we will begin delivery of the objectives outlined below leading to achieving the above 4 goals. Our approach for doing this will involve a detailed and strategic programme of internal and external communication and engagement with appropriate stakeholders across the Trust. This will be both general and targeted and link into the creation of detailed delivery plans that will be implemented by teams across the Trust. We will work with partners and ensure the environmental impact of our activities is considered in service design, procurement and delivery. The ambition is that using our resources wisely and treading lightly on our planet becomes the natural business for everyone associated with GOSH.

In developing the SDMP a reporting and governance structure has been designed allowing for progress on delivering the SDMP objectives to be measured, tracked and reported. There will be regular consultation sessions with stakeholders (YPF, Green Champions Network etc) to ensure that direction of travel evolves and is responsive to any changing stakeholder needs.

The Ten Areas of Resource Consumption and environmental impact:

NHSI guidance suggests examining resource consumptions and environmental impact based on ten areas of focus. The ten areas are:

1) Corporate Approach
2) Asset Management & Utilities
3) Travel & Logistics
4) Climate Change Adaptation
5) Capital Projects
6) Green Space & Biodiversity
7) Sustainable Care Models
8) Our People
9) Sustainable Use of Resources
10) Carbon/Green House Gas emissions

Each area is then examined from four perspectives:

a) Reaching out: Engaging with both the local and global community
b) Self-Mastery: Embedding a culture, policies and governance in-house
c) Health: Holistic links back to health & wellbeing
d) Treading Lightly: Measuring & reducing tangible environmental impact

Being mindful of the importance of these 4 perspectives is necessary for us to make the most of every opportunity presented by each of our SDMP objectives. The full set of objectives are outlined below however to provide an example of how these 4 perspectives relate to a topic we have applied them to delivery of the Clean Air Hospital Framework below:

Our Clean Air Hospital Framework has allowed us to ***'reach out'*** in terms of leading the wider health sector conversation on air pollution (1000 downloads of the framework, media coverage & sector speaking events) and support others to act as well as making strong links in the local community with whom we have and will continue to collaborate to run a successful series of play streets. The opportunities for education through links into our clinical staff and Play Service have been powerful in terms of the ***'health & wellbeing'*** perspective and the framework's actions and scoring system and the resulting changes to our service delivery allow for a blueprint that is leading us towards ***'self-mastery'*** and increased ability to ***'tread lightly'*** through tangible reduction of the emissions we create and our ability to measure this.

The deliverable objectives contained within the 10 focus areas viewed from 4 perspectives are presented below.

Declaring a climate emergency

A number of institutions have responded to the growing awareness of the dangers of global heating by declaring a climate emergency. Over one hundred local authorities, two universities, one NHS Trust and the UK government have done so. Declaring a climate emergency is a public acknowledgement of the importance of this issue and the willingness to work in partnership to respond in a positive way to the challenges of climate change.

During the consultation process for developing this SDMP the YPF requested that GOSH consider declaring a climate emergency. This is clearly an issue that is important to our young people and also our staff. Following the adoption of the SDMP we will examine the implications of declaring a climate emergency and consider if this, along with tangible actions, is an action GOSH would wish to take.

Conclusions and recommendations

It is essential that GOSH has an ambitious approach to minimising our use of resources and working to protect and preserve our planet. This SDMP, developed in partnership with many stakeholders, sets out the challenge we have and the areas we need to focus on to deliver a sustainable service now and in the future. The SDMP will evolve over time but sets a clear roadmap of where we are and what we hope to achieve over the next few years.

The Trust Board is asked to approve the 2020-2023 SDMP

1 Corporate Approach

A. Reaching out

I. Host a hyper local ‘community sustainability working group’ to meet biannually on local issues

II. Establish a ‘sustainability innovation forum’ to facilitate collaboration projects between GOSH and national/global partners. E.g. Design and disseminate a range of health and climate change outreach material/info graphics with specialist science and industry partners

III. Play an active role in Global Green and Healthy Hospitals and other such national/international health networks

B. Self-Mastery

I. Coordinate monitoring and delivery of SDMP objectives through a cross trust delivery group—with specialist sub groups—reporting to EMT biannually

II. Create a ‘Sustainability leaders & Ambassadors’ learning programme—through the GOSH Learning Academy—for staff, leadership teams, Trust Board and patients/YPF members

III. Design a dedicated ‘SDMP communications strategy’ involving patient, staff & existing forum input

IV. Devise a ‘green dreams’ piloting process allowing road testing and refinement of patient/staff ideas before wider rollout

C. Health & Well-Being

I. Link healthcare and patient experience outcomes explicitly to sustainability

II. Collaborative with GOSH Arts and the ‘Culture Declares’ movement (aligning ourselves with other leading arts organisations such as TATE) on a further climate declaration

D. Treading Lightly

I. Review all emissions targets on ongoing basis

II. Devise a Sustainable procurement policy with particular emphasis on reducing Trust scope 3 that occur indirectly through out value chain

III. Declare publically a Climate Emergency, developing a carbon neutrality plan/target and establishing

2) Asset Management & Utilities

A. Reaching out

I. Collaborate on creating a staff home energy efficiency and indoor air quality education programme

B. Self-Mastery

I. Delivery of a thorough & consistent programme of utility consumption monitoring—both infrastructural & behavioural— to bring down use across the Trust

II. Achieve appropriate process management certification including ISO0991 and PAS99

III. Deliver a green ICT programme including sustainable search engine, auto switch off, reusable batteries, charity partnerships and material reclamation

IV. Conduct a full soft services sustainability inventory

C. Health & Well-Being

I. Install an ait quality (indoor & outdoor) monitoring network—linked to BMS where appropriate - and

D. Treading Lightly

I. Assess energy and water lifecycle costs as a key criteria in decision making when purchasing new equipment

II. Identify future carbon and revenue reduction opportunities through a 'capital investment infrastructure strategy'. E.g. Future transitioning from CHP

III. Procure 100% renewable energy with all new energy contracts

3) Travel & Logistics

A. Reaching out

I. Recognition of Great Ormond Street itself as an official 'Play Street' - delivered regularly by GOSH & local partners—by the London Borough of Camden

II. Deliver a full study of road adaptation options surrounding GOSH

B. Self-Mastery

I. Conduct a Trust-wide vehicle assessment involving measurement, engagement and implementation elements

II. Facilitate staff access to tele/video conferencing, reducing business miles to external meetings

III. Review of accessibility to GOSH for patients and staff especially those outside London

C. Health & Well-Being

I. Devise a healthy and active travel strategy— including staff cycling programme covering sate routines and full cycling infrastructure review—with associate events & investment focussed around both exercise and clean air

II. Deliver existing Green Travel Plan targets

D. Treading Lightly

I. Collaborate with main contracts to ensure 25% of GOSH associated fleet are zero tail pipe emissions and 75% on the 'Go Ultra Low' approved list

II. Increase the number of electric charging points available to staff and visitors and the proportion of

4) Climate Change Adaptation

A. Reaching out

I. Established hyper local 'community sustainability working group' has specific adaptation focus based around Board approved Climate Change Adaptation Plan and local needs

B. Self-Mastery

I. Nominate a Climate Change adaptation lead to ensure adaptation is integrated into Trust governance, risk, reporting and training processes through a Board approved 'climate change adaptation strategy'

C. Health & Well-Being

Attachment Z

I. Embed a climate impacts system—for monitoring & mitigating the impacts on staff/patient wellbeing of overheating and extreme weather events—into the Trust risk register and processes

II. Maximise the quality and ability of out estate & local green space to mitigate the effects of climate change in relation to shading, water attenuation, indoor plants and sensory experience

D. Treading Lightly

5) Capital Projects

A. Reaching out

I. Embed social value outcomes into the design and the construction specification for new build and major refurbishment projects

II. Create an inventory of fixtures, fittings and construction materials—for reuse by the Trust or local community—using a 'buildings as materials bank' methodology

III. Submit abstracts and deliver presentations at prestigious industry events including the 'Healthy Cities international design forum'

B. Self-Mastery

I. Apply a whole life cycle costing approach in the design and construction of new builds and refurbishment projects to ensure that both occupant health and sustainable development objectives are prioritised throughout the design process

II. Collaborate between a sustainability lead and the Built Environment project team to ensure the application of recognised methodologies such as BREEAM resulting in an Excellent to Outstanding rating

III. Develop a set of capital/refurbishment project sustainability guidelines that drive resource efficiency within the building through the estates strategy

C. Health & Well-Being

I. Design & deliver health & healing related research projects—linked to indoor air quality, natural light and pain/anxiety reduction—to integrate into the design and construction process

II. Educate staff on how the heating, cooling, lighting and ventilation of their building operate and how they can accurately report any performance issues

III. Embed world leading biophillia and healing environment principles in all new construction projects

D. Treading Lightly

I. Embed resource efficacy (e.g. recycled/reused/repurposed materials, low embodied carbon products, design for deconstruction principles) into the design specification for new builds and major refurbishments

II. Set clear sustainability aims and objectives that are scaled and applied to all capital and major

6) Green Space & Biodiversity

A. Reaching out

I. Establish a local community greening, biodiversity & food growing partnership to re wild GOSH/ Bloomsbury & provide fresh vegetables in coordination with local strategic plans

II. Partner with experts e.g. Royal Horticultural Society

B. Self-Mastery

I. Include a green space & biodiversity strand—including a greenery survey—within the Estate Strategy to maximise benefits from existing on site green space

II. Ensure all catering and food contracts demonstrate their sustainability credentials by exceeding government guidelines (e.g. Government Buying Standards through external accreditation such as Food for Life, red tractor, dolphin friendly, sustainable fish cities mark etc..)

III. Produce and use GOSH honey

C. Health & Well-Being

I. Develop a 'field trip safety management system' allowing staff, local community and patients the opportunity for involvement in 'open ait' educational initiatives including gardening and food growing

II. Take the Love of Nature (Biophillia) and human affinity with the natural world as a starting point for the work GOSH Arts programmes, commissions and develops

III. Create a food growing patch for YPF and School use

D. Treading Lightly

I. Research and implement the air quality impacts of barrier planting and pollution absorbing plants both indoors and out

II. Supply fresh vegetables grown on or near site for local consumption and place emphasis vegetarian and vegan options

III. Set up a process—via composting or digestion—for maximising the return of nutrients to the soil from

7) Sustainable Care Models

A. Reaching out

I. Establish a local community greening, biodiversity & food growing partnership to re wild GOSH/ Bloomsbury & provide fresh vegetables in coordination with local strategic plans

II. Partner with experts e.g. Royal Horticultural Society

B. Self-Mastery

I. Include a green space & biodiversity strand—including a greenery survey—within the Estate Strategy to maximise benefits from existing on site green space

II. Ensure all catering and food contracts demonstrate their sustainability credentials by exceeding government guidelines (e.g. Government Buying Standards through external accreditation such as Food for Life, red tractor, dolphin friendly, sustainable fish cities mark etc..)

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8) Our People

A. Reaching out

I. Establish a local volunteering & partnership network with an emphasis on sustainability

II. Provide staff training and development opportunities based around supporting an delivering the SDMP objectives

III. Invite inspirational sustainability organisations to join the YPF, Careers Festival and Big Youth Meet Up

IV. Work with pioneering organisation, Julie's Bicycle to set specific and relevant sustainability objectives for the arts

B. Self-Mastery

I. Deliver staff and visitor education campaigns with opportunities for active involvement and possible certification including through induction, online training, patient bedside displays and volunteering

II. Implement mandatory "GOLD" learning modules around both waste and energy and initially voluntary modules covering climate change, air quality and green space & biodiversity

III. Host an annual YPF/patient creative sustainability awards event (e.g. My Health & the environment) involving awards for design and film making

C. Health & Well-Being

I. Align well-being and sustainability with existing staff groups and Tryst initiatives wherever appropriate

II. Design research projects covering topics like active travel, wearable pollution monitoring and indoor quality mitigation at home

III. Trial "leave you desk active lunch", "water refill station" and "onsite smoking" studies/campaigns

D. Treading Lightly

I. Design and run a staff and department carbon foot printing campaign/competition

II. Trial innovative methods for visioning and gamifying sustainable behaviours for staff and possible visitors

9) Sustainable use of Resources

A. Reaching out

I. Expand and embed bulk item/furniture community swap and refurbishment programme

II. Explore innovative partnerships with supply chain partners around delivery consolidation sites, last mile cycle delivery and funding for electric vehicles

B. Self-Mastery

I. Ensure a sustainable procurement policy and that lead officers are in place

II. Agree a repair & refurbishment option as an obligatory part of across Trust sustainable purchasing policy

III. Adopt further waste material processing streams and further develop successful programmes including “Gloves are off”

IV. Align the GOSH Arts and sustainability Biophilia (Love of Nature) programme with Trust objectives over the use of sustainable materials, suppliers waste & processes

C. Health & Well-Being

I. Provide healthy, informed and sustainable catering choices that meet and exceed national guidelines and soil association standard for catering facilities

II. Redesign waste & recycling guidance in collaboration with staff, patients and our waste contractor

D. Treading Lightly

I. Reduce waste packaging reaching the site to near zero through innovative agreements and purchasing choices with partners and suppliers

II. Develop rainwater harvesting trials

III. Introduce a catering (Lagoon) sustainability programme including food miles, carbon impact assessment and food waste reduction initiatives

10) Carbon/GHGs

A. Reaching out

I. Identify our strategic suppliers and evidence that we are working with them to reduce the overall carbon impacts of the goods and services that they provide to GOSH & others

II. Encourage our staff and patients to reduce their carbon emissions and climate change impacts of high impact activity such as air travel, vehicle use, energy use and food supply. A positive reward system and partnerships including fully electric hire cars are in place

III. Collaboration with other local agencies including our local authority, universities and third sector organisations in order to contribute to the delivery of area wide carbon reduction strategies and plans

B. Self-Mastery

I. Measure our carbon impact annually, through the sustainability reporting portal, including core emissions such as energy, water, waste, anaesthetic gases and business travel

II. Make visible the emissions for key identified high carbon GOSH activities where patient and staff choice is available, to encourage behaviour change (e.g. choice of lease car, options for travel mode, use of dry powder rather than metered dose inhalers, data heavy IT use, turning off lights/equipment)

III. Establish a more granular Greenhouse Gas (GHG) Emissions Quantification & Reporting methodology

C. Health & Well-Being

I. Conduct post occupancy assessment of energy/carbon performance of a building while in use to ensure the parameters set in the design process have been achieved and work with the contractor to rectify any areas of poor performance

II. Encourage innovation and support new technologies that help improve our carbon performance related to energy and water usage (such as using the SDU Securing Health returns carbon curve planning tool)

D. Treading Lightly

I. Approve a further detailed carbon reduction programme, aligned to the Climate Change Act 2008 through the Trust board and gain financial support (e.g. spend to save)

II. Identify which of the products and services that we source have a big contribution to our overall carbon footprint (in use and/or embedded terms) and evidence interventions to reduce their impacts (e.g. by specifying lower carbon alternatives).

Attachment 1

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
18 September 2019

Picker - Children & Young People's Survey	**Paper No: Attachment 1**
Author: Suzanne Collin – Patient Feedback Manager, Claire Williams, Interim Head of Patient Experience and Engagement **Submitted by:** Alison Robertson, Chief Nurse	

Aims / summary

The attached report outlines the key findings (focusing on areas for improvement) from the CQC Children and Young People's Patient Experience Survey 2018. The data was collected from patients who were discharged from GOSH in November and December 2018. The survey is not open to patients 16+ years as per CQC requirements and does not include a breakdown by ward/ directorate.

The results were received at the end of July 2019 and compare GOSH to 65 other Trusts who used Picker to run the survey. The CQC will issue a report later this year including comparison against all other Trusts within England. In order to avoid delay and ensure that the data is current, this report is being presented now and will be updated following the CQC report.

Key points from the report include:

- The report is positive for GOSH with a higher than average response rate.
- Areas to prioritise and that require closer management are highlighted in slide 5.
- Actions are highlighted in slides 7 and 8.

Action required from the meeting
For information

Contribution to the delivery of NHS Foundation Trust strategies and plans

- The Health and Social Care Act 2010
- The NHS Constitution for England 2012 (last updated in October 2015)
- The NHS Operating Framework 2012/13
- The NHS Outcomes Framework 2012/13
- Trust Values and Behaviours work
- Quality Strategy

Financial implications
None

Who is responsible for implementing the proposals / project and anticipated timescales?
Claire Williams – Interim Head of Patient Experience and Engagement and Heads of Nursing and Patient Experience.

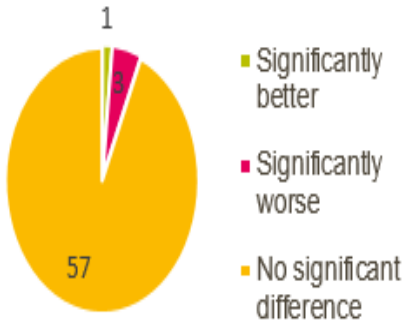
Who is accountable for the implementation of the proposal / project?
Alison Robertson - Chief Nurse.

Children and Young People's Patient Experience Survey 2018 Results

1250	1243	31%	26%	30%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (382)	Average response rate for all organisations	Your previous response rate

97%	P68. Parent felt well looked after by staff
94%	C67. Child felt well looked after in hospital
96%	P24. Staff agreed a plan with parent for their child's care

Historical comparison*



Comparison with average*

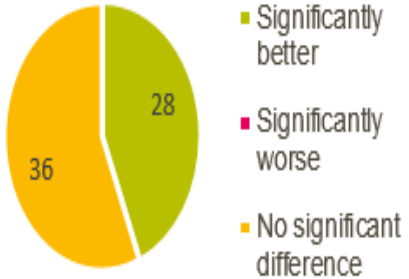


*Chart shows the number of questions that are better, worse, or show no significant difference

NB: This is compared with other Trusts who used Picker to carry out the survey

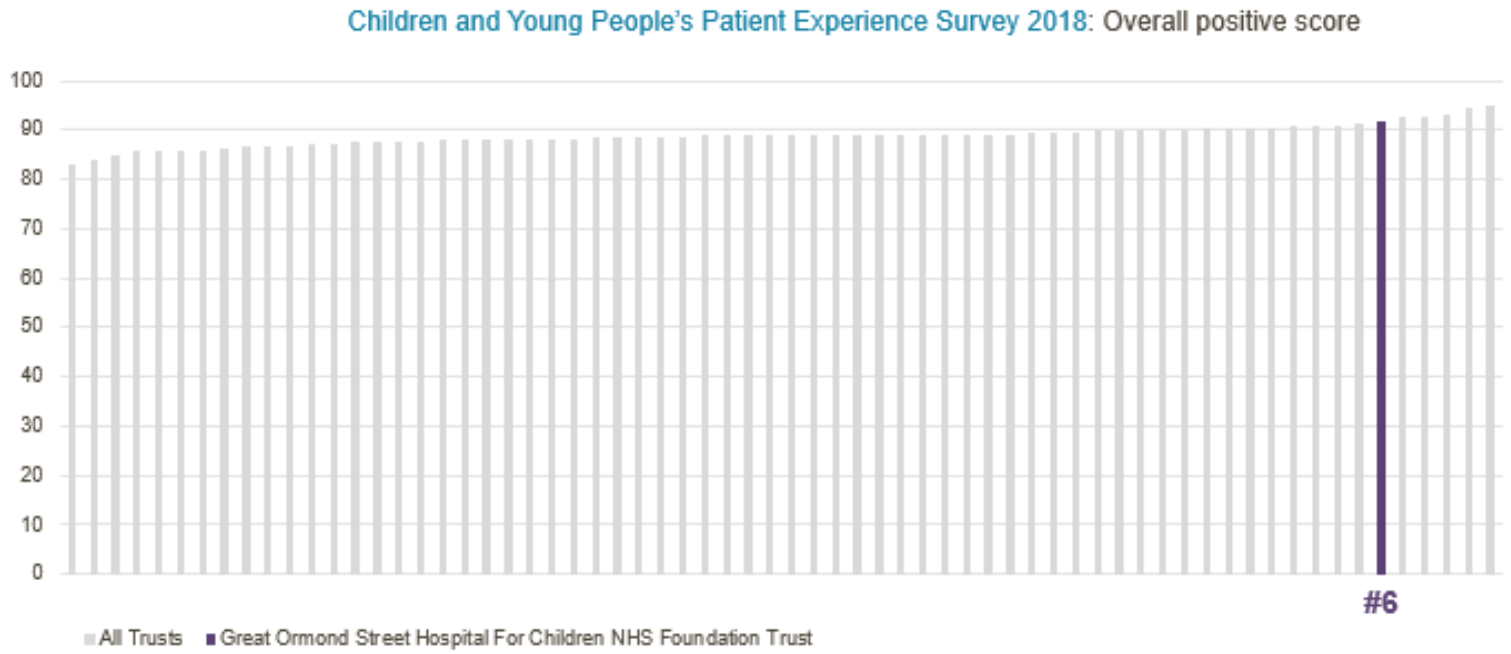
The child first and always

Always

Results

League table: overall positive score

The overall league table shows your overall positive score's ranking in comparison to the overall positive score of every other organisation that ran the Children and Young People's Patient Experience Survey with Picker this year.



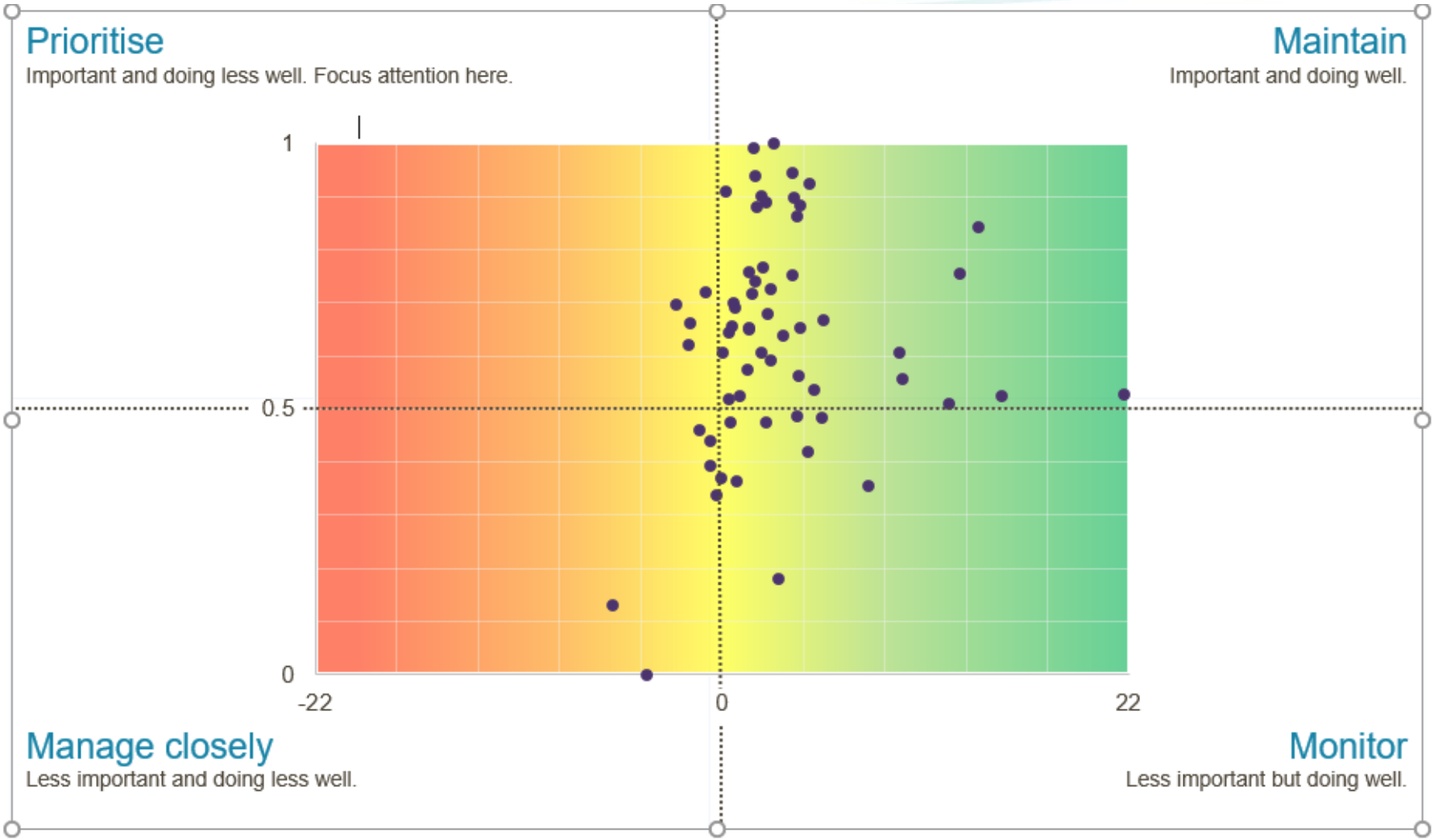
Areas of improvement

	Most improved from last survey
97% (increased from 85%)	C37. Staff spoke to child about their worries
87% (increased from 82%)	P13. Staff played with child in hospital
79% (increased from 66%)	P45. Overnight facilities for parents/ carers rated as good or very good
90% (increased from 86%)	P40. Child liked the hospital food
92% (increased from 89%)	C12. Child felt that there was enough things to do in hospital

	Least improved from last survey
48% (decreased from 65%)	C23. Child able to talk to doctor or nurse without parent or carer being there if they wanted to
95% (decreased from 98%)	P18. New members of staff introduced themselves to parent
78% (decreased from 83%)	P43. Parents were able to prepare food in the hospital if they wanted to
93% (decreased from 97%)	C55. Staff explained to child how their operation or procedure had gone
88% (decreased from 92%)	C60. Child told what would happen next with their care

*Questions asked to Parents or Carers are labelled with a **P** and questions asked to Children or Young people are labelled with a **C**.*

What matters most- Overall Improvement Map™



Areas to prioritise

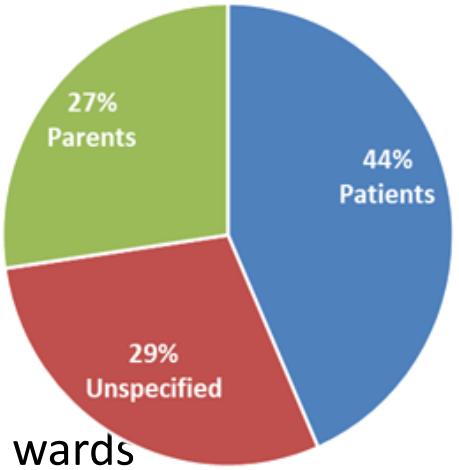
Q	Question text
P53	Staff distracted the children from operation or procedure when necessary
P56	Parent given advice about caring for child after they went home
C60	Child told what would happen next with their care
C62	Child given advice on how to look after themselves when they went home

Areas that require close management

Q	Question text
P4	Hospital did not change admission date
P18	New members of staff introduced themselves to parent
C22	Child felt staff spoke to them in a way they could understand
C23	Child able to talk to doctor or nurse without a parent or carer being there if they wanted to
C32	Child had questions answered by staff
C51	Child told what would be done during operation or procedure
C55	Staff explained to child how their operation or procedure had gone

Qualitative comments

- 66% of surveys included qualitative comments (254) indicating a strong willingness to give feedback
- 70% of comments received were positive
- Comments related to:
  - delays (treatment, appointments, medication, transport and discharge
  - inadequate communication
  - facilities, equipment and toys/ games in waiting areas and wards
  - accommodation/ beds or reclining chairs for families
  - food
  - the manner and attitude of some staff



- Many of the above issues are picked up by our Patient Stories and other feedback collected.

Summary of action taken and next steps (1/2)

Priority areas	Actions and work plan
Increased distraction from operations or procedures required	A restructure of the Play Service has been completed to increase the number of Health Play Specialists in the Trust. In addition, there is enhanced Trust-wide promotion of the Play Service and how to access it. There is ongoing review of how to meet the increased demand for Play services.
Lack of age appropriate toys/ games and activities	The Play Service are auditing areas across the Trust to ensure equity of resources (including toys and games). An appointed Senior Play Worker will lead on engagement with young people through Play. Increased activities are being developed for teenagers including the introduction of regular cinema nights. In addition, work is underway to improve the Trust Wi-Fi network and communication about restricted access to age-appropriate sites.
Food	The Trust Catering Improvement group which includes a patient representative from the Young Person's Forum has brought catering back in house and is reviewing menus, meal times and cost in response to feedback.
Accommodation and facilities for families	The Trust Accommodation working group which includes a parent representative is reviewing the provision and policies regarding accommodation for families.
Communication with families/ patients following discharge	The MyGOSH portal is intended to improve communication between families and clinical teams. To date, over 5,000 families have signed up to MyGOSH. This will form part of the optimisation programme.

Summary of action taken and next steps (2/2)

Priority areas	Actions and work plan
Privacy for patients	This issue was highlighted through the Young Person's Forum. Members created posters reminding staff to knock before entering rooms. This will be reviewed at Patient Family Experience and Engagement Committee.
Change of admission date	This is being looked at as part of EPIC optimisation alongside the change appointment function.
Enabling children/ young people to speak to a doctor or nurse on their own.	Growing Up, Gaining Independence is the Trust-wide framework for transition. The framework was launched in February 2019. Self assessment in each service across the Trust is evaluating implantation and there is a named clinician for transition in each service.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
18 September 2019

GOSH Well Led Update **Submitted by:** Matthew Shaw, Chief Executive **Co-presented by** Matthew Shaw, CEO and Anna Ferrant, Company Secretary	**Paper No: Attachment 2**

Aims / summary

To provide the Board with an update on progress with delivery of the actions and recommendations arising in the independent Well Led Governance Review conducted in October 2016 and the negative commentary presented in the April 2018 CQC Well Led Report. The Board will recall from the February 2019 update, that all outstanding actions from these two reports had been collated into one integrated Well Led action plan.
This well led action plan also included actions underway arising from a review of executive workstreams.

Appendix 1 provides a progress report on those actions recorded in the Well Led Action Plan that arose from the independent Well Led Governance Review. One action (of 36 in total from the independent report) remains in progress: A Board Development Programme is under development (to be aligned with the results of the refreshed Trust strategy) and expected for approval in Q4 2019/20.

Appendix 2 provides a progress report on those actions recorded in the Well Led Action Plan that arose from the negative commentary presented in the April 2018 CQC Well Led Report. Two actions remain in progress: A review of the GOSH internet is underway and as detailed in the draft People Strategy, a workforce plan is highlighted as an action in the plan to implement the strategy.

Appendix 3 presents a copy of the full integrated Well Led action plan. There are 12 actions that remain in progress:

- Delivery of the Trust strategy for approval in October 2019 (currently undergoing a refresh with a comprehensive consultation process)
- Approval and delivery of the People Strategy including a workforce plan and clarity about the types of roles and competencies required at GOSH for the future
- Approval and delivery of an internal communications system – this will be drafted on the back of approval of the People Strategy and the Trust strategy.
- A review of patient and family accommodation on the site in collaboration with the Charity
- Progress with refreshed job planning programme
- A review of the committee structure under the Executive Management Team and tightening of governance processes around reporting.

Action required from the meeting

To note progress with the delivery of actions cited in the integrated Well Led action plan

Contribution to the delivery of NHS Foundation Trust strategies and plans Good governance
Financial implications None
Who needs to be told about any decision? Progress with the preparation for the review will be shared with the Council of Governors. The KLOE action plan will be shared with the Senior Management Team.
Who is responsible for implementing the proposals / project and anticipated timescales? Executives
Who is accountable for the implementation of the proposal / project? Chief Executive

Attachment 2

Appendix 1 - Progress against remaining open recommendations in the independent Well Led Governance Review conducted in October 2016

Rec. No.	Recommendation from Review added to the Well Led Action Plan following February 2019 Update	Progress/ Comments
4	**Improve the communication of the Trust's recently refreshed strategy to staff and key external stakeholders.**	There are a number of communication activities that have embedded the fulfilling our potential strategy: • In May 2016 when the current clinical operations 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 exercises: - 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 The Trust conducted a review following the high profile media case in 2017. The review looked at how the Trust managed the case and supported staff with the following objectives: -To provide emotional support to staff -To listen and respond to staff affected by the event -To learn from went well and what needed improving so that we have a framework that can be employed for any future similar events -To share learning -To gather, reflect upon and implement any appropriate recommendations The Trust held an Open House week in October 2018 designed to give all staff a chance to engage and find out more about the inspiring work they are doing across the hospital. Every day of the week, a range of themed activities were held, reflecting the work underway to help our patients fulfil their potential. The week included a range of interactive activities, games, competitions, and chances to meet colleagues and find out about the role they play at GOSH. Directors actively engaged with the Open House Week, promoting the vision and values, ending in a question and answer session with the CEO and Chair. Following concerns raised by nursing staff and other professions about the
28	**Improve the internal staff communication methods to ensure that they are effective and optimal.**	

Rec. No.	Recommendation from Review added to the Well Led Action Plan following February 2019 Update	Progress/ Comments
		changes to bank rate pay, the FTSU service met with nurses and healthcare assistants to hear feedback on the following four areas: • Nursing Involvement in Service Development • Nursing staff Support • Nursing Careers • Nursing Knowledge Staff were able to give their feedback anonymously to encourage them to be either positive and/or negative in their feedback. 351 comments were received over 7 sessions. A report was submitted to the Trust Board in December 2018 with follow up at QSAC in January 2019. Following the staff consultation on the clinical operations restructure and appointment of the new roles across the directorates, an event was held off site to support the new teams getting to know one another and working together. The annual staff survey is now sent to all staff and not a random selection of staff. **September 2019 UPDATE**: The Stakeholder Engagement Strategy was approved at Board In July 2019 and the action plan is now being implemented. ACTION CLOSED AND ONGOING
10	**Commission an ongoing Board development programme. This programme should include informal time for BMs to meet together and opportunities to reflect on the Board's effectiveness and contribution towards enabling GOSH to become the leading children's hospital in the world.**	The Kings Fund (KF) has been appointed to provide support and run a development programme for the executive team. In addition, the KF provide topic based support (masterclasses) for the Board - presenting on key issues that are relevant to the role of the Board within the current NHS which will support all Board members to remain updated on key external matters affecting the Trust or influencing decisions that affect the Trust. The Advisory Board provide similar masterclasses (the Trust is a member). The opportunities provided by the KF and the Advisory Board will form part of a Board development programme, led by the new Director of HR and OD. **September 2019 UPDATE**: Work continues with the Kings Fund. Following 121 interviews with the executives and NEDs, a Board Development Programme is under development (to be aligned with the results of the refreshed Trust strategy) and expected for approval in Q4 2019/20. ACTION IN PROGRESS
11	**A follow-up review by Deloitte in the Summer of 2017 to independently verify the progress that has been made in implementing the recommendations of this report.**	**September 2019 UPDATE:** The Board has agreed that the next external independent review of the Trust governance framework will be conducted in Q1 2020/21 to allow time to take into account the findings from the forthcoming CQC Well Led Inspection in Autumn 2019. ACTION CLOSED AND ADDED TO BOARD CALENDAR A BUSINESS AS USUAL
13	**Introduce 360 degree feedback for EDs and NEDs from Board colleagues and from Councillors to improve the quality of appraisal discussions.**	**September 2019 UPDATE**: 360 degree appraisal rolled out by Kings Fund for executives and used to determine strengths and gaps in team at away day. Feedback on NEDs appraisal conducted by the SID and LG via soundings. ACTION CLOSED AND ONGOING

Attachment 2

Rec. No.	Recommendation from Review added to the Well Led Action Plan following February 2019 Update	Progress/ Comments
15	**As part of the Board development programme, ensure that sufficient time is allocated to considering why GOSH is successful, the risks to that continued success and the role of the Board in sustaining and furthering that success.**	This recommendation is being considered as part of the Trust Strategy refresh, reviewing the direction of travel for GOSH services over the next 5 – 10 years. The Board development programme will be informed by and support the delivery of the strategy (recommendation 10A above). ACTION CLOSED AND ONGOING
16	**Align the Board Code of Conduct to the Trust's 'Always' values and ensure that BM objectives include reference to the importance of role modelling these values and behaviours.**	**September 2019 UPDATE**:Council code updated, approved and rolled out to Governors. Board code updated and approved ACTION CLOSED
20	**Comprehensively explore the culture of the organisation to identify whether any changes need to be made.**	**September 2019 UPDATE**: The Director of HR and OD is leading on this. A risk has been included on the Board Assurance Framework around culture at GOSH and is actively monitored by the Board assurance committee (People and Education Assurance Committee). It includes focus on the development of an organisational development strategy/plan and statement about the Trust's intended culture. Action plans in response to the results of the 2018 staff survey have been developed and shared. A People Strategy has been developed and is subject to an initial review at Board in September 2019. The purpose of the strategy is to bring together the all of the people related issues and activities to provide visibility and to ensure they are aligned, co-ordinated and focused on delivering the priorities of the Trust alongside our commitment to our people. It will be built around the following themes: • Capacity and Workforce Planning • Education, Training and Development • Corporate and HR Infrastructure and • Culture, Engagement, Health and Wellbeing. A one year work programme has been developed. The strategy and work programme will be presented at the September Trust Board. ACTION CLOSED AND ONGOING
21	**Introduce a tool, such as a 'culture barometer', to measure and monitor aspects of GOSH's culture to provide greater Board oversight of this important area.**	

Attachment 2

Appendix 2 - Progress with actions against the remaining open negative commentary presented in the April 2018 CQC Well Led Report.

ID	Issue Highlighted in CQC 2018 Report added to the Well Led Action Plan following February 2019 Update	Update/ action
4	Some staff we spoke to were unable to describe learning implemented in relation to serious incidents. There was limited evidence of shared understanding of key learning issues throughout the trust.	**September 2019 Update:** The assurance and escalation framework has been reviewed and is subject to approval at the September 2019 Trust Board. Learning from events have been re-established. SI reports are shared at the Patient and Safety Outcomes Committee (PSOC) and information is to be cascaded to teams from PSOC representatives. SI summary reports now shared at Trust Board. The risk management strategy has been updated and approved at the July 2019 Trust Board. ACTION CLOSED
5 6 41	The trust missed opportunities for engagement with some of the local stakeholders. The trust does not demonstrate open and positive relationships with key stakeholders. It was not sharing information promptly and was often defensive when challenged on performance and safety. The trust did not proactively engage and lead on paediatric care and treatment locally. …..The trust was located within the footprint for North Central London sustainability and transformation partnerships (STP). Although the trust was fully supportive of a joined up local planning process to deliver transformational change, they felt the STP model did not directly correlate with the trust's tertiary services model which extended both across London but also throughout England. …….The trust did not take a proactive role in using their considerable expertise and resources to show leadership in working together with other regional and local providers of children and young people's care.	**September 2019 Update:** Reporting from the STP and other partners is a standing agenda item on EMT. Various examples of partnership working are documented and have been submitted to CQC (local, regional, national and international). A stakeholder engagement strategy was approved at the July Trust Board. ACTION CLOSED AND ONGOING
7 34 40	Pharmacy services did not report any key performance indicators directly to the board meaning there was a limited accountability or oversight of this service. And The chief pharmacist reported into the medical director who had board level responsibility for medicines management. Multiple changes at board level over the last few years meant information exchange both up and down the organisation was not a smooth process. Although within the pharmacy department there was a clear leadership structure in place however this was not aligned to divisional structure set up within the trust. And There was no separate medicines optimisation strategy.	**September 2019 Update:** Four areas identified for improvement via a transformation project: • Medicines safety • Medicines optimisation • Cultural (staffing) issues • Estate issues • EPIC stock reporting issues MHRA inspected in May 2019 and highlighted deficiencies in our Quality management System (QMS) and management of capacity and workflow. National emergency declared in relation to manufacture of Parenteral Nutrition. BAF risk on medicines management added in December 2019 and reviewed by QSEAC in April and July 2019 on behalf of the Board. ACTION CLOSED AND ONGOING

Attachment 2

ID	Issue Highlighted in CQC 2018 Report added to the Well Led Action Plan following February 2019 Update	Update/ action
9	Staff felt learning from high profile cases had not always been implemented or sufficiently considered by the trust leaders. High profile cases often impacted on day to day service oversight and the trust's leaders did not always fully plan for additional operational pressures nor implement prevention mechanisms to minimise this impact.	The Trust has conducted a review following the high profile media case in 2017. The review looked at how the Trust managed the case and supported staff with the following objectives: -To provide emotional support to staff -To listen and respond to staff affected by the event -To learn from went well and what needed improving so that we have a framework that can be employed for any future similar events -To share learning -To gather, reflect upon and implement any appropriate recommendations **September 2019 Update:** Actions include: -Roll out of a revised and approved Acceptable Behaviour Policy (the Trust' Conflict Resolution Policy has been refreshed and renamed as the Acceptable Behaviour Policy – plans are being put in place to roll this out. The aim of the policy is to identify inappropriate or unsafe behaviours that impact on the safe provision of care to patients; support staff and patients or careers to better understand what behaviours impact negatively on the safe provision of care to patients; end or reduce harm to staff and patients resulting from inappropriate or unsafe behaviours. The Policy embodies the Trust Always Values by drawing on the Always Welcoming commitment to provide a safe environment and the Always One Team commitment to working collaboratively to prove the best quantity care for children and young people.) - Provision of support for staff from external provides including psychologists - a Trust wide Schwartz round and facilitate a sharing experience event for those directly affected. - A technical Q and A sessions for staff to ask questions about how the case was handled and to learn for the future Work with other providers dealing with similar cases including Alder Hey (sharing experiences and supporting staff) ACTION CLOSED AND ONGOING
10	The trust was in a process of addressing findings from an independent review of their governance framework which took place in 2016. They were still to complete work required to facilitate improvements in relationships between trust's board and members' council, as well as ensure inclusivity and address potential concerns of the members council. Evidence from the well-led inspection indicated that there had not been a dynamic pace of change in the past and additional support from the board is required to achieve this. The trust's 'member's council', established to hold the board's non-executive directors to account, did not feel that the trust actively engaged them in governance. Those we were in contact with also felt the trust was not always transparent with them. Similarly, staff we spoke with did not always feel the trust assured their voices were heard and acted on. In 2016, the trust commissioned an independent review of their governance framework. The governance review report was prepared in October 2016 and noted some areas of strength including its comprehensive approach to risk management. ….However, they were still to	**September 2019 Update:** A number of actions completed: -Governors involved in review and approval of revised Trust Constitution outlining key ways governors will be kept involved -Governors worked to produce a development plan for their group development - Chair leads private meeting with Governors prior to every Council meeting -All governors allocated a NED buddy and the system has been reviewed and aligned with the feedback from governors - Governors provided with access to GOSH email, GOSH GOLD Learning Site and the Governor portal - Governors appraised of press cuttings on regular basis -Working with governors to agree implementation of new constituency boundaries and election timetable (CWG) -Governors and young people involved in the CEO and other executive recruitment stakeholder panels -Governors appointed from a shortlist the external auditors for the Trust - approved at December 2018 Council meeting -Governors invited to various events including Staff Forums when the Chair/ NEDs are in attendance; CEO leaving party etc. -Governors provided with training in the role of the Governor by NHS Providers and attending external events. BAF Risk 18 (culture) documents the controls in place to mitigate risks around the culture and the actions to be taken

Attachment 2

ID	Issue Highlighted in CQC 2018 Report added to the Well Led Action Plan following February 2019 Update	Update/ action
	facilitate improvement of relationship between trust's governing bodies (the board and members council), comprehensively explore the culture of the organisation and address some other issues raised in the report.	See actions completed above under culture. ACTION CLOSED AND ONGOING
36	The trust's policy stated that enhanced DBS checks should be repeated every three years, however, three of the fifteen files we reviewed contained DBS certificates that were more than three years old. The trust told us for remaining staff they had a log of the DBS reference numbers and all staff had relevant DBS checks in place.	**September 2019 Update:** The DBS Policy has been reviewed and approved at PAG. ACTION CLOSED
42	The trust did not have a designated recruitment or workforce strategy that set out their approach to future workforce decisions and addressed the long-term risks associated with workforce planning. ……..Nurses were unaware of workforce strategy and felt that there were no plans to retain experienced and skilled workforce but instead the trust was disproportionally focused on nurses' recruitment with little emphasis on retention.	A Workforce plan is submitted to NHSI annually **September 2019 Update:** The People Strategy included a reference to an integrated workforce plan. ACTION IN PROGRESS.
43	Nurses told us that they did not feel their contributions were always appreciated by the trust and they lacked nursing leadership at board level to ensure the nursing voice was heard within the organisation. They did not feel processes were equally applied to all staff groups and that they did not have an equal say when participating in multidisciplinary meetings.	New directorate structure strengthens nursing leadership. Restructure has created the Head of Nursing and Patient Experience role as part of the directorate leadership team Terms of reference revised for Nursing Board, Matrons meeting and Operational Sisters meeting. Following concerns raised by nursing staff and other professions about the changes to bank rate pay, the FTSU service met with nurses and healthcare assistants to hear feedback on the following four areas: • Nursing Involvement in Service Development • Nursing staff Support • Nursing Careers • Nursing Knowledge Staff were able to give their feedback anonymously to encourage them to be either positive and/or negative in their feedback. 351 comments were received over 7 sessions. A report was submitted to the Trust Board in December 2018 with follow up at QSAC in January 2019. Following the staff consultation on the clinical operations restructure and appointment of the new roles across the directorates, an event was held off site to support the new teams getting to know one another and working together. The Trust is implementing the Cognitive Institute Safety and Reliability Programme across the Trust from Board to Ward. This includes establishment of a safety champions' programme. The Programme addresses the influence and impact of organisational climate, leadership commitment, and high performance work practices on quality and safety in healthcare. The programme will provide a framework for the development of leadership competencies, a safety culture and will emphasise the importance of professional accountability. Over 65% of staff have been trained as at September 2019. ACTION CLOSED AND ONGOING.

Attachment 2

ID	Issue Highlighted in CQC 2018 Report added to the Well Led Action Plan following February 2019 Update	Update/ action
53	We noted that information provided for the public on the trust website was not always easy to find, up to date or in a user-friendly form. The director of communication was aware of the issue and said the website was being updated and patients have been involved in setting out key priories and consulted on the layout of the future website.	We have completed a review of the website architecture. A further content review is underway with the aim to improve content and navigation. ACTION IN PROGRESS.
56	We reviewed eight serious incident reports. …….there was limited evidence of shared understanding of key learning issues throughout the trust. ……some reports stated only the title of the approver rather than their full name, and some reports did not have the electronic incident reporting system reference number on (although all included the Strategic Executive Information System [STEIS] reference number). We also observed that the executive summaries did not summarise learning and recommendations from the investigation. There was no section in the SI report template to record any relevant safeguarding information. ….we noted that one action plan did not address all recommendations made in the SI report, and two action plans had no completion date or assigned accountable person for the actions listed. Action achievement status had not always been updated. ……NHS England told us that the timeliness of completion of investigations remained an area of scrutiny and whilst it was clear that the trust completed any immediate actions, the delay in completing a report and sharing it with the family was an area for improvement.	The incident management process has been reviewed with the input of the Deputy Chiefs of Service and the Heads of Nursing. All of the SI reports, the one page fliers and the Trust wide learning is shared at PSOC and feed the 'learning from….' Lunch time events. A 'Learning at GOSH' subgroup is being created so that all Trust wide learning is shared and disseminated. The SI reports have a consistent approach so that the author, approver and STEIS reference number are all clear by their titles and not individual names. All of the actions from the SI reports are listed onto Datix and are monitored electronically. These actions are audited by the Clinical Audit Manager. The hard copy reports will not be updated as once they are signed off as approved, the actions are monitored on Datix. ACTION CLOSED
57	The trust told us that patients and families were informed of the notifiable safety incident in line with the requirements of the Duty of Candour (DoC) regulations. However, there was no mention of DoC in the SI reports, such as whether the incident met the criteria for DoC or if the DoC process had been implemented. We found variable standards of engagement with parents with regards to the duty of candour.	The Trust has a Duty of Candour Policy in place outlining how staff are open and transparent when responding to incidents. Training has been rolled out to relevant staff across the hospital and reporting is now monitored at Trust Board. ACTION CLOSED AND ONGOING

Ref.	Source	Lead	Action	Deadlines	Comments	Commentary
Board skills, knowledge and experience						
W1.**A1**	Gap assess	CoSec	Declaration of Interest Policy review and roll out of revised process	Mar-19	Pending redraft of current policy and implementation of purchased IT system to record declarations	COMPLETED: Electronic version now being rolled out following paper version having been completed and ongoing
W1.**A2**	CQC report	CoSec	Mandatory training up to date for executives and NEDs. Updates to go to EMT and board	Apr-19	Acting Dir HROD has emailed an update on execs to Dep Co Sec. Report to Board members.	Check SS and AT training and appraisals
W1.**A3**	Gap assess	CoSec	Appraisal process for newer NEDs to be completed	Apr-19	Paper on Council of Governors' agenda in February 2019 and to Board in April	CLOSED: Actioned in April for JH.
W1.**A4**	Gap assess	EA (CEO)	Appraisals up to date for all exec team members	Feb-19	AF to look up on GOSH GOLD and CF to book in any outstanding PDR meetings	COMPLETED: MS appraisal to be completed
W1.**A5**	Gap assess	HROD	Update to Nom Com on the process for exec succession planning and talent management	Oct-19	Exec teams to nominate current staff that are important to develop for succession and who would step in.	There will be a talent management plan as part of the People Strategy - draft People Strategy on September 2019 Board agenda First and second successor for the executive roles developed.
W1.**A6**	CQC report	HROD	Review of performance against policy for board and SMT members: Fit and Proper Person Test (exec & NEDs) and DBS (all staff & board)	Mar-19	Look at IA for both in March 2019	CLOSED: IA conducted. Management response to be drafted against recommendations. Result is significant assurance with minor improvement potential
W1.**A7**	Deloitte	HROD	Implement 360 degree appraisal into exec development and NED appraisal process	01-Mar-19	360s for executive team to be conducted via 360 Strengthscope in advance of EMT away day 22 March. (Pilot for exec PDRs **and** NED 360s.) Board discussion needed about format for NED appraisal, noting governors' feedback on merits of a formal process	CLOSED: 360 degree appraisal rolled out by Kings Fund for executives and used to determine strengths and gaps in team at away day. Feedback on NEDs appraisal conducted by the SID and LG via soundings.

W1.**A8**	Exec work prog	CEO, SPA* (CEO)	Confirm programme for executive team development (King's Fund)	Feb-19	King's Fund preparing a programme of quarterly team sessions and individual interventions based around recommendations from Deloitte, Well Led etc. (including externally facilitated strategy sessions.)	CLOSED: 360 feedback sessions conducted for execs in Feb & March. Chair and non exec input collated during April & May for master class content. Final programme going to May board.
W1.**A9**	Exec work prog	CEO, SPA (CEO)	Confirm programme for chair and NED development (King's Fund plus other partners)	Mar-19	CEO's office working in partnership with the King's Fund to create a content-led, educational programme e.g. masterclasses. Team will obtain feedback from the NHSI's Well Led programme for board development in March – currently a phase 1 pilot for a small number of trusts. Next step is to programme an external board effectiveness review.	CLOSED: 360 feedback sessions conducted for execs in Feb & March. Chair and non exec input collated during April & May for master class content. Final programme going to May board.
W1.**A10**	Deloitte	CoSec	Update Board Code of Conduct	Feb-19	On February 2019 Board agenda	CLOSED: APPROVED and being rolled out to Directors.
W1.**A11**	CQC report	SPA (CEO), EA (CEO)	Add an update on engagement with external stakeholders into CEO's board report and schedule topic-specific updates. Ensure updates on work with partners is reported at	Jul-19	(NB this is a process to develop the board's knowledge base – stakeholder input to the strategy is covered in W.2)	COMPLETED: Stakeholder Engagement Strategy being presented at May 2019 Board (high level priniciples) and then July Board - final draft strategy
W1.**A12**	CQC report re risk	COO	Board oversight of Brexit risk	Feb-19	BAF risk being updated by small short-life steering group w/c 21 Jan. Fortnightly meetings of a working group meeting to be established. Board update in Feb	CLOSED AND ONGOING: Brexit risk populated and shared with Brexist Steering Group. Will be subject to review at RACG and Assurance Committees as normal.
W1.A12A	Deloitte	CEO	Commission an ongoing Board development programme. This programme should include informal time for BMs to meet together and opportunities to reflect on the Board's effectiveness and contribution towards enabling GOSH to become the leading children's hospital in the world.	March 220		Work continues with the Kings Fund. Following 121 interviews with the executives and NEDs, a Board Development Programme is under development (to be aligned with the results of the refreshed Trust strategy) and expected for review in Q4 2019/20
Leaders understand the challenge to quality and safety						
W1.**A13**	Exec work prog	CoSec & HROD	Establishment of a Workforce and Education Assurance Committee (permanent or task and finish – TBC at February 2019 Board)	Feb-19	(If approved at Board in February 2019) proposal for assurance committee to commence in March 2019	CLOSED: Board approved the People and Education Assurance Committee for 1 year. ToR drafted. Meetings set up and HR taking forward administratively
W1.**A14** **W7.A4**	CQC report	COO/ EA (CEO)	Establish an engagement event with the GOSH referrer community	Mar-19	Trust internal engagement/events lead drafting a proposal to come to EMT under 'stakeholder engagement' standing item EA (CEO) to agree with executives the standing item topics for EMT and relevant executive owners for regular reporting	Event date set but subject to review to enhance attanednace - revised approac now is to go to referrers and hold meetings with referral staff

W1.**A15**		HROD	Add staff to Friends and Family Test paper– process map and paper to board	Jul-19	To be built into the Board calendar	Staff FFT will be added to the IQPR going forward from July Board. Separate workforce update to PEAC from November 2019
Quality issues at GOSH						
W1.**A16**	Exec work prog	EA (CEO) & CoSec	Refresh board work plan in light of executive work plan, reporting requirements and assurance against the strategy	Apr-19	EA (CEO) to update the exec team priorities GANT chart ahead of each fifth EMT and circulate with papers so that the priorities/timescales are kept 'live'.	CLOSED: Completed and Board calendaR approved by Board
W1.**A17**	CQC report – escalation	EA (CEO)	Add Clinical Quality Review Group (CQRG) report to EMT agenda as a standing item and pull through minutes of CQRG	Feb-19	EA (CEO) to agree with executives the standing item topics for EMT and relevant executive owners for regular reporting	Added to EMT agenda
W1.**A18**		EA (CEO)	Exec team to submit headline messages to EMT administrator from key committees (via committee chairs). These will be collated as an EMT paper so that everyone is clear on issues and risks being discussed and escalated from these committees.	May-19	EA (CEO) to collate as a paper for each fifth EMT meeting	CLOSED: Relevant committees added as standing items to the EMT agenda for verbal updates by relevant executive leads
W1.**A19**		CEO/ SPA (CEO)	Produce a rolling report for board collating the findings of internal and external reviews commissioned by GOSH to provide exec and board level assurance on case-specific concerns about quality, safety, standards etc. (Corporate as well as operational.)	Apr-19	Exec team to send any significant reviews or reports to SPA (CEO). CEO's team to create a report template, allocate owners and socialise. Provide to MS for sign off. Co Sec to advise on board reporting schedule.	CLOSED: All internal/ external reviews have been circulated to the EMT or are planned to be so. Will remain on-going
W1.**A20**		All execs	Develop a process for horizon-scanning on key national reviews that are relevant to GOSH – to identify risks in the system, applicable learnings and recommendations.	Feb-19	To discuss at EMT. Quality issues stay with MD. Other execs should own theirs for now. Further consideration required at EMT in Feb.	CLOSED AND ONGOING: Horizon scanning on compliance reported to CQC Working Group
Board visibility						
W1.**A21**	Exec work prog	Dir of Comms & EA (CEO)	Create a schedule of walk-arounds for execs and NEDS. Include evenings for NEDs. Discuss the coming 6 months with the NEDs – using 'Perfect Ward' as a template.	Feb-19	Already established NED walkrounds prior to board meetings. EA to CEO is documenting existing walkrounds and it is agreed execs will walk round clinical and corporate areas once a month at least with NEDs invited to join.	CLOSED AND ONGOING: Executive walkrounds regularly in diary every week. NEDs attend walkrounds prior to Board.

W1.**A22**	CQC report - visibility	Dir of Comms & EA (CEO)	Create a schedule of board engagement activities with staff and stakeholders.	Jul-19	A schedule of meetings with the CEO and chairman with key external stakeholders will be part of the stakeholder engagement strategy. Chair dinners with different staff scheduled to Feb – these need to be extended across the year.	Dinners scheduled. Reports on meetings with stakeholders and visibility walkrounds provided at EMT.
Priority for ensuring sustainable, compassionate, inclusive and effective leadership						
W1.**A23**	Exec work prog	CN	Establish a plan to develop a leadership strategy	May-19	Paper to come to EMT by end April 2019 and then to May Board	CLOSED: Presented to Board in April 2019
W1.**A24**	Exec work prog	HROD & COO	Update EMT on implementation of the SMT coaching and mentoring programme across the new directorate leadership teams	Jun-19	Programme approved at January EMT and being rolled out - for update at EMT in May	CLOSED: A coaching and mentoring programme has been procured and is being rolled out
W1.**A25**	Exec work prog	HROD & COO	Progress update to EMT & board on the LGBT, BAME, gender and disability groups: exec ownership, actions, communications. See W3.A14	Jul-19	Board will receive WRES plan in Q1 2019 LGBT exec lead is CEO Disability: Dir Development Chairs to be appointed, set up their groups and update the board on progress and examples.	New Equality, Diversity and Inclusion Strategy is a stream of work under the People Strategy. WRES data will be discissed at the September 20-19 Board and ongoing at PEAC
W1.**A26**		HROD	Schedule an unconscious bias session with the board – content-led, information-based session e.g. best practice.	Sep-19	Factor into the board development programme	To be considered as part of a new Equality, Diversity and Inclusion Strategy. To be checked. Schedule for November 2019
W2.**A1**	Exec work prog	HoS&P*	Create a summary report on the staff and stakeholder consultation (process, audiences consulted, outcomes) used to inform the development of the operational strategy (the House).	Feb-19	The strategy was consulted on and shared widely with staff, council, CQRG and NHSE. HoS&P to confirm that appropriate updates on Open House 2019 went to Ops Board and SLT.	CLOSED: Trust Stakeholder Engagement Strategy approved at July 2019 Board.
W2.**A2**	Exec work prog	(CEO) & execs	Create clear delivery and reporting plans/processes for the 'House' – the operational strategy.	Apr-19	The 'House' implementation plan will be linked to the EMT work plan	IN PROGRESS: Workshops running with internal and external stakeholders. Will deliver final version in October 2019.
W2.**A3**	Exec work prog	Dir of Comms	Create an internal comms strategy.	Apr-19	Proposals to come to EMT	Await completion of people Strategy and organisation strategy and from this, create an Internal Comms Strategy.

			Refresh intranet content and identify other internal comms channels/fora to ensure that staff are aware of the strategy refresh and how we used their feedback.	Sep-19		Awaiting discussions on Office 365
W2.**A4**	Exec work prog	Dir of Comms, SPA (CEO)	Stakeholder audit & mapping: list and prioritise partners & networks we engage with, define relationship leads at EMT and/or GK Strategy objectives 'kick-off' session.	Apr-19	GK Strategy interviews and workshops ongoing through Feb/March. SPA (CEO) to draw together info on GOSH staff/consultants on national committees.	COMPLETED: Stakeholder Engagement Strategy being presented at July 2019 Board
W2.**A5**	Exec work prog	CEO	Identify and align other strategic initiatives, such as the Joint Research Strategy and Hospital Funding Priorities Steering Group (project managed by GOSHCC). Identify an EMT and board reporting process.	May-19	Research Strategy board is chaired by NED James Hatchley and attended by CEO & CFO.	CLOSED: Both groups will report through to Board - added to Board calendar
W2.**A6**	Exec work prog	Dir of Comms, CEO, SPA (CEO)	Develop a stakeholder engagement strategy. Nominate exec/board leads for key stakeholders. Add stakeholder engagement as a standing item to EMT agenda.	Feb-19	Stakeholder engagement strategy to be delivered by GK Strategy in a two-stage process of audit and message/strategy development. Strategy to be reviewed following development of GOSH Long Term strategy.	CLOSED: Trust Stakeholder Engagement Strategy to be presented at May 2019.
W2.**A7**	Exec work prog	CEO, SPA (CEO), COMMS	Create a list of key unresolved strategic issues. Develop a series of board-approved position statements on each (e.g. digital transformation, 10-year plan, cardiac services, paediatric services across North London, personalised medicine, commercial strategy.)	Apr-19	List to be prepared for exec strategy session 11th Feb 2019 Message development session for stakeholder engagement strategy (facilitated by GK Strategy) to be held on 4th March 2019.	COMPLETED: Board approved position statements drafted as part of the strategy development.
W2.**A8**	Exec work prog	CEO, SPA (CEO)	Design a six-month consultation process on long-term strategy – engaging with GOSH opinion formers, sounding out trusted external colleagues, presenting transformational scenarios to stimulate discussion with staff, Council, commissioners etc.	Jul-19	Output: Articulate the GOSH 5-10 year vision. Co-design GOSH-specific key principles to guide exec team and board decision-making and prioritising for big strategic decisions. Apply these criteria to long term strategy design process and broader board decision-making.	COMPLETED: Workshops established have ben run with internal and external stakeholders.
W2.**A10**	CQC report	HROD	Review and report on the organisational impact of the GOSH values	Sep-19	Staff FFT indicates staff are aware of the GOSH values but staff survey results indicate the reverse.	Reporting on staff FFT arises from People Strategy and will be reported at PEAC and results considered. peopl
W2.**A11**	Exec work prog	MD	QI Strategy – endorsing which QI process to use and the QI priorities	Mar-19	Quality priorities are being updated by Head of Quality and Safety. Will need to be presented in the annual Quality Report presented at QSAC.	CLOSED: Priorities agreed at EMT
W2.**A12**	CQC report	CN	Develop an education and training strategy	Apr-19		CLOSED: Presented at Board in 2018

W2.A13	CQC Report	CN	Nurses told us that they did not feel their contributions were always appreciated by the trust and they lacked nursing leadership at board level to ensure the nursing voice was heard within the organisation. They did not feel processes were equally applied to all staff groups and that they did not have an equal say when participating in multidisciplinary meetings.	Sep-19	New directorate structure strengthens nursing leadership. Restructure has created the Head of Nursing and Patient Experience role as part of the directorate leadership team Terms of reference revised for Nursing Board, Matrons meeting and Operational Sisters meeting. Following concerns raised by nursing staff and other professions about the changes to bank rate pay, the FTSU service met with nurses and healthcare assistants to hear feedback on the following four areas: • Nursing Involvement in Service Development • Nursing staff Support • Nursing Careers • Nursing Knowledge Staff were able to give their feedback anonymously to encourage them to be either positive and/or negative in their feedback. 351 comments were received over 7 sessions. A report was submitted to the Trust Board in December 2018 with follow up at QSAC in January 2019. Following the staff consultation on the clinical operations restructure and appointment of the new roles across the directorates, an event was held off site to support the new teams getting to know one another and working together.	CLOSED: The Trust is implementing the Cognitive Institute Safety and Reliability Programme across the Trust from Board to Ward. This includes establishment of a safety champions' programme. The Programme addresses the influence and impact of organisational climate, leadership commitment, and high performance work practices on quality and safety in healthcare. The programme will provide a framework for the development of leadership competencies, a safety culture and will emphasise the importance of professional accountability. Over 65% of staff have been trained as at September 2019.
Values and culture						
W3.**A1**	CQC report	HROD & CEO	Review staff survey results on support for staff and respect for staff including actions.	Feb-19	To be brought to Feb 2019 EMT in readiness for reporting to April Board	CLOSED: Staff survey results reported to April Trust Board. People Strategy under development and for review at September 2019 Board
W3.**A2**	Exec work prog	HROD & MD	HROD & MD to create a spreadsheet and confidential board update on recent cases of unacceptable behaviour in clinical teams.	Mar-19	Going forward, the spreadsheet will be updated quarterly and reported to EMT and board to monitor progress	CLOSED: The Board had been updated on cases and this will become a regular update every 6 months.
W3.**A3**	Exec work prog	CoSec & HROD	Possible establishment of the Workforce and Education Board assurance committee	Feb-19	(If approved) proposal for assurance committee to commence in March 2019	CLOSED: Board approved the People and Education Assurance Committee for 1 year. ToR drafted. Meetings set up and HR taking forward administratively
W3.**A4**	Exec work prog	CEO & CoSec	Consider the appointment of an associate NED on the Board with HR/OD expertise	Feb-19	Individual will be an employee (not appointee and so not appointed by Council)	CLOSED: Not approved at Board - awaiting new HR Director to start work at GOSH and then review again later in year.
Action taken to address behaviour issues						
W3.**A5**	Exec work prog	MD	Update to Board on progress with implementation of Cognitive	Apr-19	(Also note W.3.A3)	CLOSED: Actioned at April Board meeting
Openness and honesty in response to incidents						

W3.**A6**	CQC report	MD	Update the Being Open and Duty of Candour Policy.	Mar-19	Needs drafting, consultation and approval via PAG Document how the Trust manages moderate harm cases consistently.	COMPLETED: Policy dreviewed, updated and training underway across the Trust
W3.**A7**	CQC report	MD	Review of the Incident Reporting Policy taking account of negative commentary in the CQC report.	Mar-19	The SI process is being reviewed with the input of the Deputy Chiefs of Service and the Heads of Nursing.	Incidetn Reporting and Management Policy provided with an extension in preperation for new SI guidance
Induction, appraisal and career development						
W3.**A8**	CQC report	HROD, MD, COMMS	Review data and ensure appraisals and mandatory training are in place across all directorates including our own staff and honorary staff. Roll-out staff comms to raise awareness of the importance of mandatory training.	Jun-19	HROD to bring updates to EMT, OB and other forums with granular detail on which staff groups are (and are not) complying.	COMPLETED: Awareness raised at every OB, EMT and fortnightly SLT - focusing on priority groups, subjects etc.
W3.**A9**	CQC report	HROD, MD, CN	Create and socialise a list of leadership programmes for clinical and non-clinical staff	May-19	Exec team to review list and assess whether there is coherence and programmes are optimised, promote uptake as considered necessary.	CLOSED: The leadership strategy was presented at Board in April 2019 and the Learning Academy Business Case will be considered by FIC in June 2019
W3.**A10**	CQC report	MD	Implementation update on revalidation action plan	May-19	Update is annually to Board – in July. Require an update prior to this to EMT to assure actions closed	Responsible Officer reports regularly to the Board - annual report reported in July 2019
W3.**A11**	CQC report	HROD	Co-design and deliver a Workforce Transformation Strategy and plan to address cultural transformation	Sep-19		Incorporated as part of People Strategy - plan to be developed as a an action arising from the Strategy.
W3.**A12**	Exec work prog	CN	Update on Learning Academy	Jun-19	Ask Feb board to delegate authority to approve the business plan to FIC. - June FIC and July Board	COMPLETED: The Learning Academy Business Case was signed off by FIC in June 2019 and approved by Charity grants Committee
Supporting patients and staff – equality						
W3.**A13** **W7.A9**	Exec work prog	CEO	Launch staff forums on LGBT, BAME, gender and disability	Mar-19	Board will receive WRES plan in Q1 2019	WRES data and plan on September 2019 Board
W3.**A14**	Exec work prog	HROD	Update on BAME and LGBT staff fora: what changes have been proposed/ implemented? See W1.A25	Apr-19	Board will receive WRES plan in Q1 2019	CLOSED: Plan reported to April 2019 Board
Supporting our staff – well-being						
W3.**A15**	CQC report	HROD	Update on progress with implementation of Trust Recovery Programme to Trust Board	Apr-19	Present at EMT beforehand and the at Board in April	CLOSED: ongoing discussions around trust programmes related to case - via Comms and in partnership with other trusts

W3.**A16**	CQC report	HROD	Provide an update on Carefirst – effectiveness, awareness, number of staff accessing?	Sep-19	Health and Wellbeing plan to be put on intranet. CareFirst contract up for review. EAPs alone not enough – we need an internal solution – high profile case learnings. Coming to EMT. Needs to go to Operational Board. Consider how to draw together with the other staff benefits.	The People Strategy includes reference to well being and there will be a plan developed. PEAC will seek assurance of its delivery
W3.**A17**	CQC report	HROD	Commission an impact report or similar to update on progress of the multi-disciplinary health and wellbeing group and other staff wellbeing projects. Look into mental health first aiders.	Jul-19	Discussed at H and S committee and then OB for March	To be considered as part of new People Strategy - reference to well being. PEAC will seek assurance of its delivery
W3.**A18**	Exec work prog	HROD	Refresh the executive review process for GEMS	Feb-19	To EMT in May 2019	To be considered as part of new People Strategy and reporting on reward and recognition. PEAC will seek assurance of delivery
W3.**A19**	Exec work prog	CFO	Patient/family and staff accommodation review	Sep-19	Charity to be asked to lead the review on the basis of funding impact. Report to be considered by EMT in advance of board update in Sept.	In progress - review underway. Staff clinical accomodation overnight actioned (Penguin). Powis Place being extended for patient accomodation.
Supporting staff – safety						
W3.A**20**		COMMS	Comms to issue a note on the standard operating procedure for comms response when a staff member or visitor becomes ill or passes away on site or in service.	Jul-19	Response to recent staff incident	In progress
Cooperative, supportive and appreciative relationships among staff						
W3.**A21**	Exec work prog	CN	Provide update on an action plan for the roll-out of Acceptable Behaviour Policy	Mar-19	EMT update on plan	COMPLETED: Rolled out across Trust from end May 2019. Renamed as Safe and respectful Policy
Board and committee structure						
W4.**A1**	Exec work prog	CoSec	Schedule of matters reserved for the Board to be updated	Apr-19	Present at EMT beforehand and then to Board in May	On September 2019 Board agenda
W4.**A2**	Exec work prog	CoSec	Conduct external board effectiveness review	Feb-19	Request for approval of timing of next external review at Feb Board. Possibly Q1 2020/21	CLOSED: Board agreed to delay this external review noting the number of reviews already planned for Well led over the next 12 months.
Delivery of sustainable services						

W4.**A3**	Exec work prog	Dir of Redev	Sustainability Management Plan to be reviewed	Apr-19	Present at EMT beforehand and then to Board in April	On September 2019 Board agenda
W4.**A4**	Exec work prog	MD	Update on progress with job planning	Mar-19	Update to be presented at EMT	In progress. Update at SLT and about 80% completed.
W4.**A5**	Exec work prog	CEO	Redesign the Better Value Programme Board to incorporate both the existing oversight on Better Value and a 'Future Hospital' programme to oversee a 3-5 year transformation programme.	Jun-19	Exec team to work with director of programmes to develop a transformation programme based on trust strategy implementation plan and re-frame the programme board.	CLOSED: New Transformation Director role in place and evised governance structure.
Escalation and accountability						
W4.**A7**	Exec work prog	CoSec	Corporate Governance review of committees at GOSH	Dec-19	Deputy CoSec tasked with delivery	Plan in progress
W4.**A8**	Exec work prog	MD	Compliance Register being updated	Mar-19	Head of Quality and Safety tasked with delivery	COMPLETED: Reported at CQC Working Group
Internal audit						
W4.**A10**	Exec work prog	CoSec	Confirm format of internal audit monitoring at RACG	Jan-19	DepCo Sec to prepare for presentation at RACG	CLOSED: Actioned at January RACG and reporting ongoing.
Engagement with third parties and partners						
W4.**A12**	Exec work prog	CFO	PLICS review for directorates and assessment of income from partnership models (including Genomics Laboratory Hub)	Sep-19	PLICS data presented for all services based on 2018/19. Model being built to access EPIC data	The first iteration of PLICS was presented to directorates in Q2 2019/20
W4.**A13**	Exec work prog	CEO	Develop a commercial strategy as a result of feedback during the GOSH Future Strategy consultation, income review (above) and work commissioned via the Better Value/Future Hospital Transformation Board. (See W4.A5)	Jan-20	For further consideration and discussion as part of the long term strategy engagement phase. Dir Comms to explore charity partnerships' suitability for pro-bono scoping work on opportunities.	CLOSED: Research commercial matters being considered via a subcommittee of the Board. A paper is being presented at Septem,ber Board on our commercial plan, incorporating IPP, DRIVE and research
Assurance and Escalation Framework						
W4.A6 W5.**A1**	CQC Report	CoSec	Review and update the Assurance and Escalation Framework	Sep-19	Dep CoSec – see W4.A8	CLOSED: On September 2019 Board
Performance Monitoring						
W5.**A2**	Exec work prog	MD	Compliance with child death overview process – Action plan to be created	Apr-19		CLOSED: Admin support now in place and funded.

W5.**A3**	CQC Report	MD	Pharmacy – KPI reporting and medicines optimisation strategy/ medicine management annual report	Sep-19	Medicines Management risk added to BAF. Outlines timelines for a broad work programme to mitigate risk	CLOSED: Regular reporting to Board and assurance committees. Risk on BAF
W5.**A4**	Exec work plan	COO	Design a rolling internal review process of teams (Including corporate) to ensure things are regularly picked up - see W8.A5	Feb-19	Paper to Andrew has developed a template for directorates	CLOSED: Directorate reviews conduct performance and outcome assessments; Operational Board will receive deep dives from specialities within a directorate on a rolling monthly basis - looking at delivery of the GOSH strategy from the perspective of that specialty. This speciality will also present at Trust Board.
Reporting and assessment of risk						
W4.A9 W5.**A5**	CQC report	MD	Risk Management Strategy under review	Mar-19	Head of Quality and Safety tasked with delivery	CLOSED: Strategy on May Board agenda
W5.**A6**	CQC report	COO	Business case templates under review. Mechanism for reporting into board.	Jun-19	Peter Hyland/ James Scott reviewing this and ensuring fit for purpose and adequately prompts users to document all risks (finance, activity and quality) Discussions ongoing with CFO & COO	In progress. Clinical and corporate plans in place. Templates under review.
W5.**A7**	Exec work prog	CoSec	Develop a standard operating procedure for undertaking internal and external reviews of GOSH services	Sep-19	Present at EMT and discuss with Board/ QSAC	CLOSED: Drafted and to be considered at September 2019 EMT meeting
Examples of risk management at Board Level						
W5.**A8**	CQC report	COO	Review of how high profile cases are managed in the future following learning from previous cases	Jul-19	Consideration of use of business continuity planning for these cases. Report to be presented at EMT	CLOSED: At the September Board the executive team will receive an update on progres with the Trust Recovery Programme following the last high profile case
Performance monitoring						
W6.**A1**	Exec work prog	HROD	OD plan to incorporate data interpretation skills assessment, particularly for clinical leaders	Oct-19	For discussion at Operational Board	To be included in the plans of the People Strategy
W6.**A2**	Exec work prog	CEO	Board development project to incorporate an assessment of the type of information required by the board and consider their needs in terms of information/education on data	Apr-19		COMPLETED: Separate session held for NEDs on quality data and on development of IQPR and integration of quality and performance metrics

W6.**A3**	Exec work prog	CEO, COMMS	GOSH Long Term Strategy Consultation and Stakeholder Engagement review to collate information on GOSH stakeholders, which will be added to the GOSH stakeholder lists. CRM software to be purchased in late 2019 to ensure contact information is up to date and live updates on queries/feedback can be logged and shared with engagement leads.	Dec-19	Stakeholder list to be developed as part of the first phase of the stakeholder engagement strategy	CLOSED: Stakeholder engagement strategy approved at July 2019 Board
W6.**A4**	Exec work prog	MD	QI dashboards to be updated to match new directorates	Apr-19		CLOSED: Actioned and in place
Data quality						
W6.**A5**	Exec work prog	Dir P&I (COO)	Performance and planning team to provide integrated updates to EMT (including on the alignment of data quality function with major programmes such as EPR)	TBC	An action on the BAF	CLOSED: IQPR established and reported to Board. Data quality framework under review following EPIC
W6.**A6**	Exec work prog	DProg (COO)	Programme management software to be considered to provide live reports and oversight on key programmes and enable collaboration between teams	Oct-19	HoS&P, DProg & SPA (CEO) are scoping options with a view to creating a brief	CLOSED Have considered and not being progressed at current time
W6.**A7**	Exec work prog	CEO/ EA (CEO)	EMT to review information submitted for decision-making as part of the EMT work planning process	Mar-19		CLOSED: EMT workplan updated and recorded within Board calendar where relevant
W6.**A8**	Exec work prog	CEO	Appoint a Chief Clinical Information Officer to the board to advise on the organisation's progress with implementing new technologies – including live projects - EPR and clinical research information	Feb-19	Board asked to consider adding a non-voting exec post holder at February 2019 Board	CLOSED: Position as non-voting member of Board approved as invitee only for time being. Same person in role to be appointed to the position. CCIO will be appointed into this role and will be present from the April board.
W6.**A9**	CQC Report	COMMS	Ongoing reviews of GOSH Web and the internet	Dec-19		Internet Manager presented at Ops Board. Review underway. Clinical teams also updating current page content
W7.**A1**	CQC report	CN	Children and Young People's CQC Survey	Apr-19	Underway	CLOSED: On track

W7.**A2**	Exec work plan	HROD	YPF involvement in executive & NED recruitment during 2019	May-19	HROD to devise a plan	CLOSED AND ONGOING: YPF involved in all NED appointments, CEO appointment and MD appointment
W7.**A3**	Exec work plan	CN	Patient involvement and experience framework	Sep-19	Being drafted and consulted on prior to presentation at the November 2019 Trust Board	On track for November 2019 Trust Board
W7.**A5**	Exec work plan	CoSec	Team to revise the confidential agenda threshold to ensure that as many items as possible are discussed at the public board	Mar-19		CLOSED AND ONGOING: Under constant review
W8.**A1**	Exec work plan	MD	Safety and Reliability programme being piloted and subject to roll out	Apr-19	Update to Board	CLOSED AND ONGOING: Update reported to Board in April 2019
W8.**A2**	Exec work plan	Director of Transf	Flow project under review (better value programme)	Sep-19		In progress: Board established in June 2019 and work being conducted with Microsoft
W8.**A4**	Exec work plan	CEO	Digital strategy board under consideration – will oversee ICT, EPR and DRIVE	Mar-19		CLOSED: Board established.
W8.**A5**	Exec work plan	COO	Design a rolling internal review process (Including corporate) to ensure things are regularly picked up - see W5.A4	Feb-19	Paper to EMT Andrew has developed a template for directorates	CLOSED: Directorate reviews conduct performance and outcome assessments; Operational Board will receive deep dives from specialities within a directorate on a rolling monthly basis - looking at delivery of the GOSH strategy from the perspective of that specialty. This speciality will also present at Trust Board.
W8.**A6**	CQC report	CEO/ SPA (CEO)	Produce a rolling report for board collating the findings of internal and external reviews commissioned by GOSH to provide exec and board level assurance on case-specific concerns about quality, safety, standards etc. (Corporate as well as operational.)	Apr-19	Exec team to send any significant reviews or reports to SPA (CEO). CEO's team to create a report template, allocate owners and socialise. Provide to MS for sign off. Co Sec to advise on board reporting schedule.	CLOSED: Various external reporting provided to QSEAC and Board.
W8.**A7**	CQC report	All execs	Develop a process for horizon-scanning on key national reviews that are relevant to GOSH – to identify risks in the system, applicable learnings and recommendations.	Feb-19	To discuss at EMT. Quality issues stay with MD. Other execs should own theirs for now. Further consideration required at EMT.	COMPLETED: Cancer review, chair of national pathology review

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **18 September 2019**	
Workforce Race Equality Standard 2019 **Submitted by:** Caroline Anderson, Director of HR & OD	**Paper No: Attachment 3**
Aims / summary To provide Trust Board with assurance that the Trust is meeting its reporting obligations under the Workforce Race Equality Standard (WRES).	
Action required from the meeting To note the content of the report and the associated action plan	
Contribution to the delivery of NHS Foundation Trust strategies and plans Meeting the statutory duty to report publicly on this activity and meet CQC requirements.	
Financial implications None.	
Who needs to be told about any decision? N/a	
Who is responsible for implementing the proposals / project and anticipated timescales? Director of HR & OD	
Who is accountable for the implementation of the proposal / project? Director of HR & OD	

Great Ormond Street Hospital for Children NHS Foundation Trust

Workforce Race Equality Standard 2019

1. Introduction

1.1 Since 2015, NHS organisations have been required to publish data against the NHS Workforce Race Equality Standard (WRES). WRES data publication is an annual requirement and is included in the NHS standard contract for provider organisations and also features in the CQC Assessment of the 'Well Led' domain. All Trusts are also required to develop and publish an action plan based on their data, addressing any issues raised and this plan must be approved by Trust boards.

1.2 The 2019 WRES Trust data exercise has been completed and will be published with the action plan, following September Trust Board. This report has been compiled in collaboration with the GOSH BAME Staff

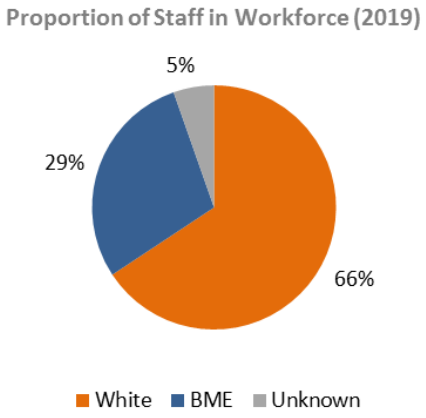
2. Main findings of the 2019 WRES

2.1 There are nine WRES indicators, four of which focus on workforce data, four from data obtained by the national NHS Staff Survey, and one indicator focusses upon Black and Minority Ethnic (BAME) representation on Trust Board. A full breakdown of Trust data is included at Appendix 1. The main points arising from the 2019 GOSH data:

Indicator 1: Proportion of BAME Staff

GOSH has an overall workforce composition of 29% BME staff. This has remained static over a prolonged period – with the proportion of BAME staff fluctuating between 27% and 29% from 2011 onwards.

When compared with London NHS staff population as a whole, GOSH is on outlier – the overall proportion of BAME NHS staff across London is 45%.



Across all professional groups, at GOSH the proportion of BAME staff is lower than the London NHS staff population. This is particularly pronounced in the Nursing workforce, with 15% of nurses BME at GOSH compared with 51% across London.

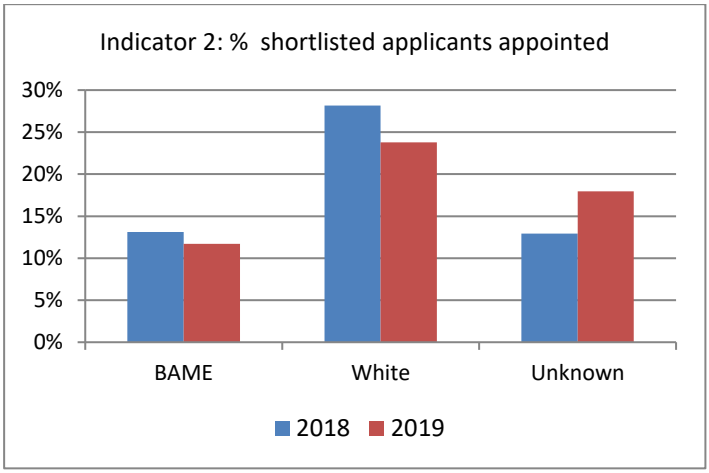
	Scientific & Technical	Add. Clinical Services	Admin. & Clerical	Allied Health Professionals	Estates & Ancillary	Healthcare Scientists	Medical & Dental	Nursing	Overall
London	39%	56%	42%	24%	51%	44%	40%	51%	**45%**
GOSH	32%	45%	39%	12%	48%	41%	30%	15%	**29%**

The highest representation of BAME staff continues to be at lower pay bands, and this trend has continued over the past 12 months. Whilst the proportion BAME staff grew overall (increase in BAME headcount of 99, compared with 114 increase in white staff headcount) this has been

clustered in lower banded posts – 70 additional BAME staff in bands 2 to 7, compared with 29 additional white staff in bands 2 to 7.

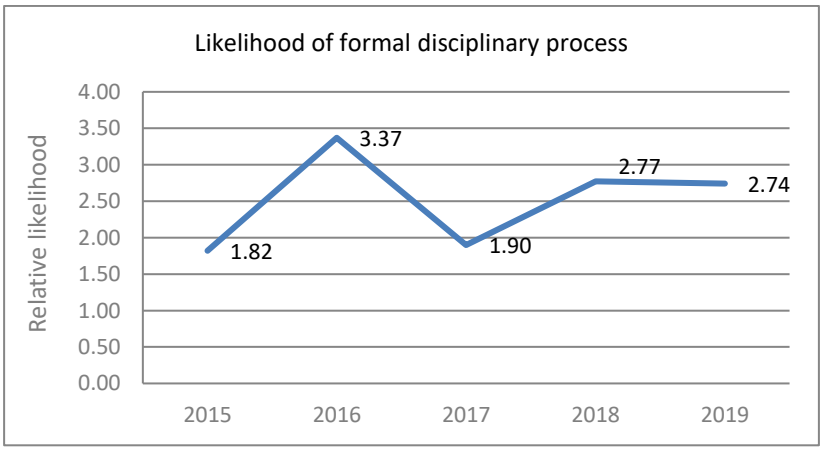
Indicator 2: Appointment of Shortlisted Applicants

In common with other public sector organisations (NHS England citing "Discrimination by Appointment" report, 2013) GOSH data continues to show that proportionately fewer BAME candidates are being appointed into jobs than white applicants. White applicants are 2.03 times more likely than BME applicants to be appointed from shortlisting. This compares to 1.45 in England and 1.63 in London (2018 WRES data).



Indicator 3: Formal Disciplinary Processes

Whilst the number of formal disciplinary cases at GOSH is relatively small overall, proportionately more staff from BME backgrounds are involved in formal disciplinary action than white staff (2.74 times more likely). This compares to 1.24 in England and 1.77 in London (2018 WRES data).



Indicator 4: Non-Mandatory Training & CPD

The uptake of non-mandatory training and CPD between BME and white staff is broadly comparable from 2018 to 2019. However, the trend over the past 5 years shows a deteriorating

picture for BME staff, with white staff now 1.28 times more likely to access non-mandatory training compared with 1.05 times more likely in 2015.

Indicator 5 and 6: Staff Experiencing Harassment, Bullying or Abuse

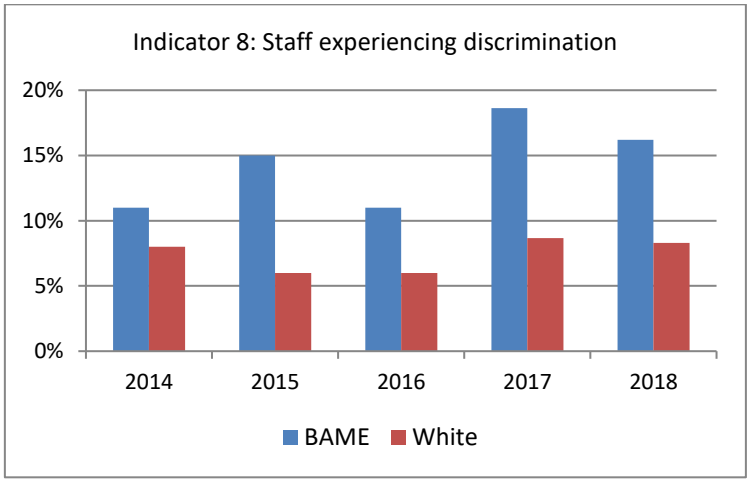
The data from the most recent NHS Staff Survey indicates that race does not appear to be a factor in whether a member of staff experiences harassment, bullying and abuse from service users (25.7% white, 16.7% BAME). This is significantly below the national figure of 28.7% and London figure of 30.4% (2018 WRES data).

There has been an improvement since 2018 in the proportion of BAME staff reporting experiencing harassment, bullying and abuse from colleagues, reducing from 35.15% of BAME respondents in 2018 to 29.00% in 2019. This is broadly similar to white staff, 30% of whom reported experiencing harassment, bullying and abuse from colleagues, and similar to the reported figure for London Trusts (29.9%, 2018 WRES Data).

Indicator 7 and 8: Staff Experiencing Discrimination

The proportion of BAME staff reporting that they believe the Trust provides equal opportunities for career progression or promotion has remained consist over the past two years – with 65.60% in 2019 compared with 65.93% in 2018.

There has been a small improvement in the proportion of BAME staff reporting they had personally experienced discrimination at work from 2018 (18.62%) to 2019 (16.20%) – however this remains significantly higher than white staff (8.30%).



Indicator 9: BME Representation at Board Level

In 2019, there has been an improvement in the proportion of BAME Board members, now 23% compared with 15% in 2018. When compared with London Trusts GOSH performs well in this matric (London 15%, National 7%). However, the GOSH Trust Board continues to have a lower representation of BAME staff than is found in the overall workforce (-5.8%).

3. Action Plan

As demonstrated within this report, GOSH performs poorly across the indicators of the WRES. As such, creation of an integrated Diversity & Inclusion (D&I) strategy is a first year priority within the 3 year GOSH People Strategy, which is due to be published in Autumn 2019.

The purpose of the D&I strategy will be to imbed D&I considerations into workplace relationships, policy and practice. Key to its creation and successful implementation will be extending the use and influence of the staff networks, including the BAME Forum.

Specific actions and initiatives currently being explored for development with the GOSH BAME forum:

- Pause in employee relations processes, prior decision to investigate – to start from November 2019
- Increased involvement of BAME staff in D&I decisions – new equality objectives, D&I Strategy development
- Integration of D&I into new management development programmes
- Review / refresh of organisational values, behaviours, culture
- Develop / train a cohort of BAME staff to participate in stakeholder panels (for key organisational job roles involving substantial management / leadership responsibility)
- Develop reverse mentoring scheme for senior leaders to enhance exposure and understanding of lived experiences of BAME staff
- Work to increase Band 8 BAME recruitment –
  - Analyse demographics of applicants for Band 8+ posts (are we getting a diverse group of applicants?)
  - Develop a process to audit recruitment decisions/records for Band 8+ posts (were there valid reasons behind selection / non selection decisions?)
  - Connect selected BAME staff (e.g. band 7 plus) to talent pool – support, develop to apply for more senior posts
  - Trained BAME stakeholder panel members
- Develop a cohort of BAME recruitment champions – to be part of stakeholder panels; to guide and help BAME staff to apply for internal roles, give advice around training opportunities, career development etc.
- Advertise management qualification apprenticeships to BAME staff – targeted advertisement through the BAME forum.
- Track quality of PDRs by including the opportunity for staff to give feedback centrally once there PDR has been completed.
- Provide supportive platform where lived experience could be shared by BAME staff.

Appendix One: **2019 WRES Indicators and Trust data**

Indicator 1
Breakdown of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) for both clinical and non-clinical workforce

Clinical Workforce	White		BME	
Band	**Headcount**	**% of workforce**	**Headcount**	**% of workforce**
Band 2	33	0.65%	43	0.85%
Band 3	118	2.32%	123	2.42%
Band 4	72	1.42%	46	0.91%
Band 5	602	11.86%	181	3.56%
Band 6	539	10.61%	175	3.45%
Band 7	520	10.24%	124	2.44%
Band 8A	188	3.70%	31	0.61%
Band 8B	79	1.56%	12	0.24%
Band 8C	32	0.63%	3	0.06%
Band 8D	6	0.12%	1	0.02%
Band 9	3	0.06%	0	0.00%
VSM	1	0.02%	0	0.00%
Consultant	259	5.10%	93	1.83%
Of which senior medical manager	7	0.14%	2	0.04%
Non-consultant career grade	7	0.14%	5	0.10%
Trainee grades	171	3.37%	111	2.19%
Other	0	0.00%	0	0.00%

Non-Clinical Workforce	White		BME	
Band	**Headcount**	**% of workforce**	**Headcount**	**% of workforce**
Band 2	58	1.14%	69	1.36%
Band 3	83	1.63%	103	2.03%
Band 4	143	2.82%	132	2.60%
Band 5	77	1.52%	77	1.52%
Band 6	96	1.89%	68	1.34%
Band 7	90	1.77%	32	0.63%
Band 8A	84	1.65%	27	0.53%
Band 8B	24	0.47%	8	0.16%
Band 8C	26	0.51%	2	0.04%
Band 8D	11	0.22%	0	0.00%
Band 9	2	0.04%	0	0.00%
VSM	12	0.24%	2	0.04%

Attachment 3

Appendix One: 2019 WRES Indicators and year on year comparison

Indicator	Descriptor	2019 GOSH	2018 All NHS Trusts	2018 London Trusts	2018 GOSH	2017 GOSH	2016 GOSH	2015 GOSH
2	Relative likelihood of white staff being appointed from shortlisting across all posts	2.03 times	1.45 times	1.63 times	2.15 times	1.73 times	2.02 times	2.57 times
3	Relative likelihood of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	2.74 times	1.24 times	1.77 times	2.77 times	1.9 times	3.37 times	1.82 times
4	Relative likelihood of white staff accessing non-mandatory training and CPD	1.28	1.15	0.98	1.20	1.19	1.07	1.05
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (From staff survey)	White: 25.70% BME: 16.70%	White: 27.7% BME: 28.7%	White: 31.8% BME: 30.4%	White: 26.3% BME: 18.31%	White: 22.9% BME: 21.62%	White: 27% BME 21%	White: 25% BME 17%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (from NHS Staff Survey)	White: 30.00% BME: 29.00%	White: 23.3% BME: 27.8%	White: 26.1% BME: 29.9%	White: 26.72% BME: 35.15%	White: 24.84% BME: 28.34%	White: 23% BME 33%	White: 24% BME 25%
7	Percentage believing that trust provides equal opportunities for career progression or promotion (From NHS Staff Survey)	White: 84.20% BME: 65.60%	White: 86.6% BME: 71.5%	White: 84.0% BME: 67.6%	White: 87.87% BME: 65.93%	White: 86.98% BME: 79.09%	White: 90% BME 78%	White: 93% BME 77%
8	In the last 12 months have you personally experienced discrimination at work from Manager /team leader or other colleagues (from NHS Staff Survey)	White: 8.30% BME: 16.20%	White: 6.6% BME: 15%	White: 7.9% BME: 16.3%	White: 8.66% BME: 18.62%	White: 6.03% BME: 11.2%	White: 6% BME 15%	White: 8% BME 11%
9	Percentage difference between the organisations' Board voting membership and its overall workforce	-5.8%			-13.5%	-11.8%	- 4.6%	-5.3%

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 18 September 2019	
Workforce Disability Equality Standard 2019 **Submitted by:** Caroline Anderson, Director of HR & OD	**Paper No: Attachment 12**
Aims / summary To provide the Board with assurance that the Trust is meeting its reporting obligations under the Workforce Disability Equality Standard (WDES).	
Action required from the meeting To note the content of the report and the associated action plan	
Contribution to the delivery of NHS Foundation Trust strategies and plans Meeting the statutory duty to report publicly on this activity and meet CQC requirements.	
Financial implications None.	
Who needs to be told about any decision? N/a	
Who is responsible for implementing the proposals / project and anticipated timescales? Director of HR & OD	
Who is accountable for the implementation of the proposal / project? Director of HR & OD	

Great Ormond Street Hospital for Children NHS Foundation Trust

Workforce Disability Equality Standard 2019

1. Introduction

1.1 Since 2019, NHS organisations have been required to publish data against the NHS Disability Equality Standard (WDES). WDES data publication is an annual requirement and is included in the NHS standard contract for provider organisations and also features in the CQC Assessment of the 'Well Led' domain. All Trusts are also required to develop and publish an action plan based on their data, addressing any issues raised and this plan must be approved by Trust boards.

1.2 The 2019 WDES Trust data exercise has been completed and will be published with the action plan, following September Trust Board.

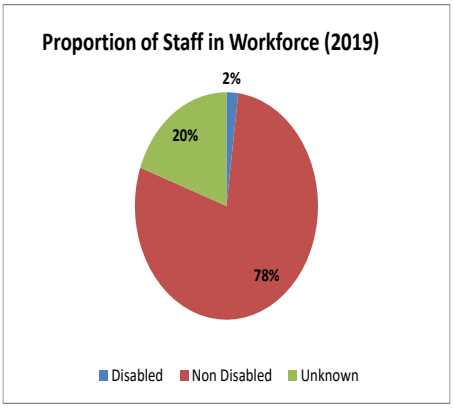
2. Main findings of the 2019 WDES

2.1 There are ten WDES indicators, three of which focus on workforce data, six from data obtained by the national NHS Staff Survey, and one indicator focusses upon Disability. A full breakdown of Trust data is included at Appendix 1. The main points arising from the 2019 GOSH data:

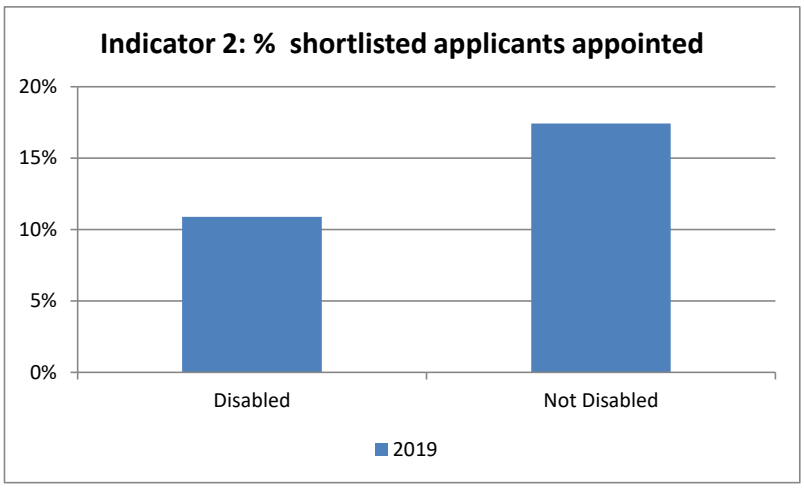
Indicator 1: Proportion of Disabled Staff

GOSH has a recorded workforce composition of 2% Disabled staff. This number is based on reported information on the Trust's Electronic Staff Record HR system.

When reviewed against the NHS Staff Survey declaration this number is low. 12.4% of respondents to the 2018 Survey question on whether the respondent had any physical or mental health conditions, disabilities or illnesses.



Indicator 2: Appointment of Shortlisted Applicants

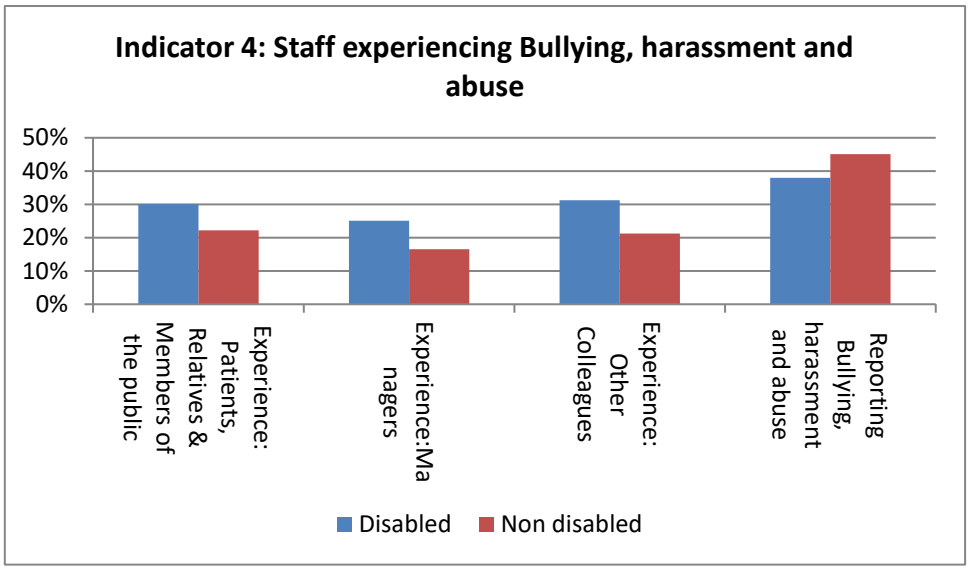


Disabled applicants were less likely to be appointed than non-disabled applicants in 2018/19, with a relative likelihood of non-disabled staff being 1.6 times more likely to be appointed.

Indicator 3: Formal Capability Processes

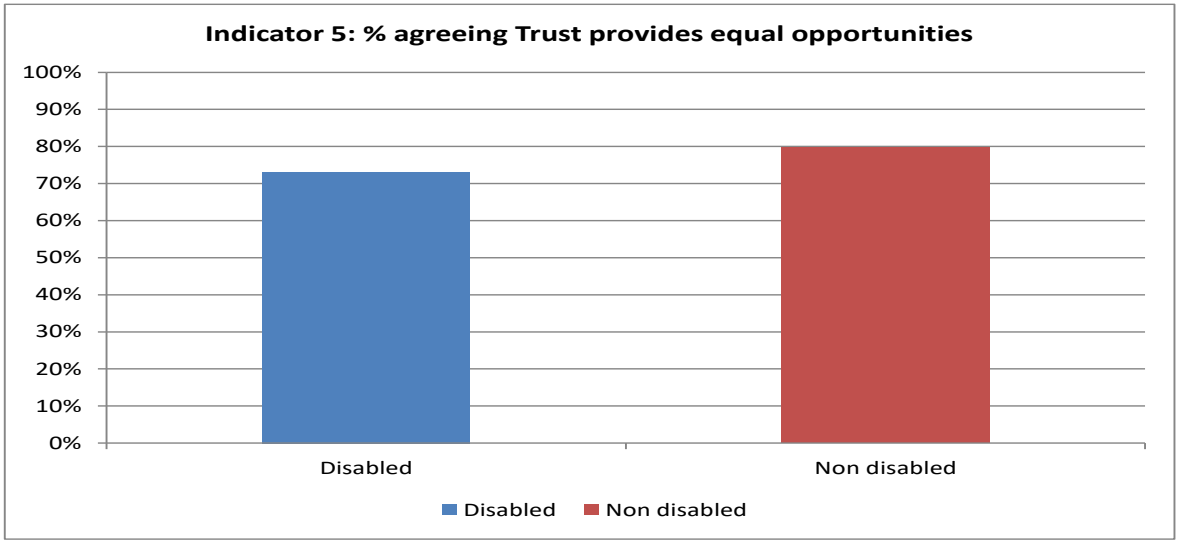
There were no formal capability cases opened in 2019 where the staff member had a recorded disability. Further work will be required to ensure the data quality of disability declarations to ensure these is not being overlooked. This measure is voluntary for the first year of reporting.

Indicator 4: Staff experience of Bullying, harassment or abuse



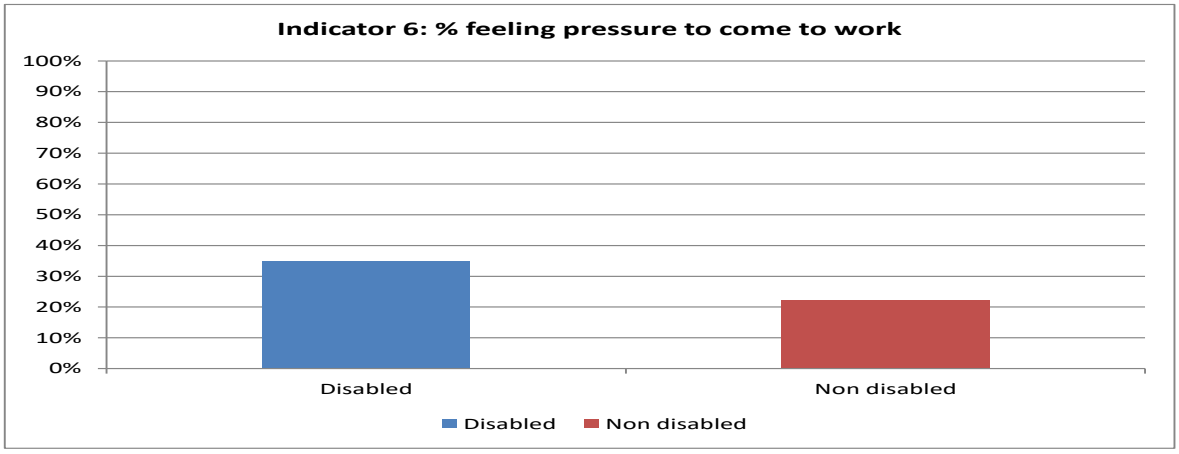
According to the 2018 Staff Survey Disabled staff were more likely to have experienced bullying, harassment or abuse at work whether the perpetrator was a member of the public, manager or other colleague than non-disabled staff and less likely to have reported that bad experience.

Indicator 5: Staff believing the Trust provides equal opportunities for career progression or promotion



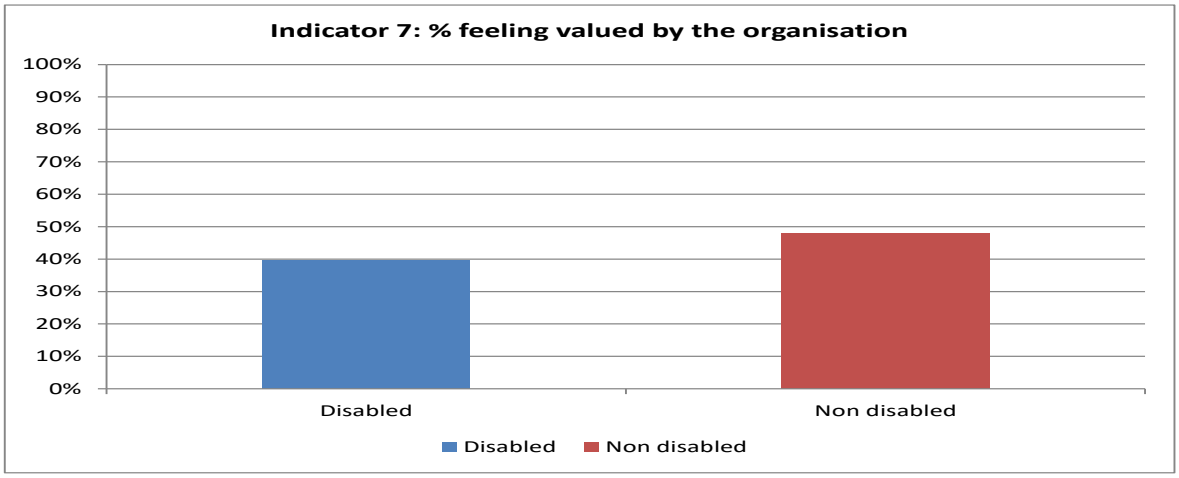
Although a majority of staff across both categories agreed the Trust provided equal opportunities disabled staff respondents in the staff survey were less likely to agree that the Trust (73%) provided equal opportunities for progression than non-disabled staff (79.8%).

Indicator 6: % of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.



34.8% of disabled respondents said that they felt pressure from their manager to attend work while being unwell, against only 22.2% of non-disabled applicants.

Indicator 7: % staff saying that they are satisfied with the extent to which their organisation values their work.



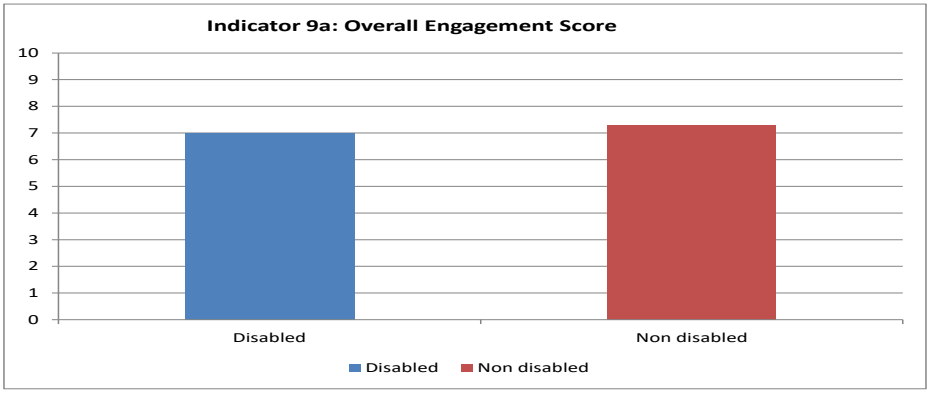
Disabled respondents were less likely to feel their work was valued by the organisation (39.6%) against 48% for non-disabled respondents.

Indicator 8: % of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

65% of disabled respondents said their employer had made reasonable adjustments to enable them to carry out their work. This question is only asked of those respondents who have identified themselves as disabled.

Indicator 9a and 9b: Engaging disabled staff

Indicator 9a looks at the Staff survey Overall engagement score for disabled and non-disabled staff on a scale of 1-10. In the 2018 Staff Survey disabled staff engagement score was lower (7) than for non-disabled staff (7.3)



Indicator 9b asks whether the Trust has taken action to facilitate the voices of Disabled staff in your organisation to be heard to which we responded yes providing the below response.

"The Trust is establishing a Disability & Long Term Health Conditions Forum, with an Executive Sponsor. The Trust is currently surveying staff to help establish the forums priorities."

Indicator 10: Disabled Representation at Board Level

There are no Board members at the Trust who have reported a disability.

3. Action Plan

As demonstrated within this report, GOSH performs poorly across the indicators of the WDES. As this is the first year of the WDES, this is the first time several of these measures have been reviewed except as part of the response to Staff Survey. As such, creation of an integrated Diversity & Inclusion (D&I) strategy is a first year priority within the 3 year GOSH People Strategy, which is due to be published in Autumn 2019.

The purpose of the D&I strategy will be to imbed D&I considerations into workplace relationships, policy and practice. Key to its creation and successful implementation will be extending the use and influence of the staff networks, including the Disability & Long term health conditions (DLTHC) Forum.

Specific actions and initiatives currently being explored for development with the GOSH DLTHC forum:

- Analyse disability / long term health conditions survey results to explore lived experience of staff and develop action plan in response to key themes
- Launch DLTHC forum

- Seek to improve data integrity - disability declaration rates on launch of self-service
- Integrated D&I Strategy development
- Review of Managing Attendance management development and Policy.
- Increased involvement of disabled staff / staff with long term health conditions in D&I decisions – new equality objectives, D&I strategy development
- Integrate D&I into new manager development programmes
- Secure Disability Confident level 2
- Enhanced engagement with all staff as part of the People Strategy
- Review / refresh of organisational values

Appendix One: **2019 WDES Indicators and Trust data**

Indicator 1

Breakdown of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) for both clinical and non-clinical workforce where disability status is recorded

Clinical Workforce	Disabled		Non-Disabled	
Band	**Headcount**	**% of workforce**	**Headcount**	**% of workforce**
Band 2	1	0.03%	68	1.80%
Band 3	6	0.16%	217	5.75%
Band 4	3	0.08%	98	2.60%
Band 5	37	0.98%	704	18.65%
Band 6	19	0.50%	597	15.81%
Band 7	11	0.29%	472	12.50%
Band 8A	4	0.11%	148	3.92%
Band 8B	1	0.03%	58	1.54%
Band 8C	0	0.00%	23	0.61%
Band 8D	0	0.00%	1	0.03%
Band 9	0	0.00%	2	0.05%
VSM	0	0.00%	1	0.03%
Consultant	0	0.00%	232	6.15%
Non-consultant career grade	0	0.00%	7	0.19%
Trainee grades	1	0.03%	288	7.63%
Other	0	0%	1	0.03%

Non-Clinical Workforce	Disabled		Non-Disabled	
Band	**Headcount**	**% of workforce**	**Headcount**	**% of workforce**
Band 2	4	0.31%	104	7.98%
Band 3	1	0.08%	174	13.35%
Band 4	3	0.23%	237	18.19%
Band 5	4	0.31%	133	10.21%
Band 6	4	0.31%	137	10.51%
Band 7	3	0.23%	106	8.14%
Band 8A	1	0.08%	93	7.14%
Band 8B	1	0.08%	28	2.15%
Band 8C	0	0.00%	28	2.15%
Band 8D	0	0.00%	10	0.77%
Band 9	1	0.08%	1	0.08%
VSM	0	0.00%	14	1.07%

Great Ormond Street Hospital for Children NHS Foundation Trust

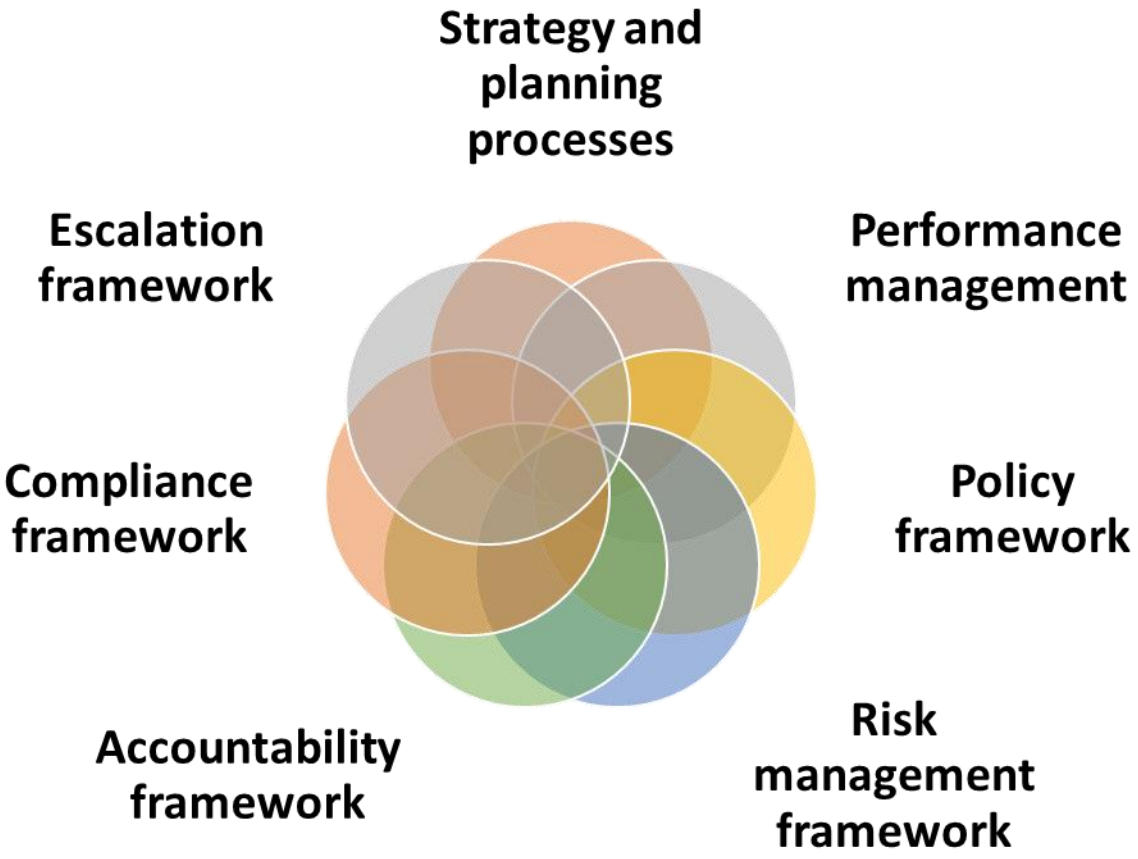
Trust Board 18 September 2019	
Revised Draft Assurance and Escalation Framework **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment 4**
Aims / summary The GOSH Assurance and Escalation Framework describes the responsibility and accountability for the Trust's governance structure and systems through which the Board receives assurance or escalated concerns and/or risks related to the quality of services, performance, targets, service delivery and achievement of strategic objectives. The purpose of the document is to provide assurance to the Trust Board, Council of Governors, patients, their families and external stakeholders that GOSH has mechanisms in place to provide safe, high quality and sustainable services. The framework has been updated to reflect current processes and governance frameworks.	
Action required from the meeting To consider and approve the update framework.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Objective 1	
Financial implications None	
Who needs to be told about any decision? Senior operational staff	
Who is responsible for implementing the proposals / project and anticipated timescales? Company Secretary	
Who is accountable for the implementation of the proposal / project? Chief Executive	

Attachment 4

Great Ormond Street Hospital for Children NHS Foundation Trust

Assurance and Escalation Framework

2019



Contents

1 Introduction

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) is an acute paediatric provider of specialised and highly specialised treatment and care for children presenting with rare and complex diseases and conditions.

Our vision, which sets our direction, is 'helping children with complex health needs fulfil their potential'. Our mission is to put 'the child first and always', which is supported by our 'Always Values' – to be always welcoming, always helpful, always expert and always one team.

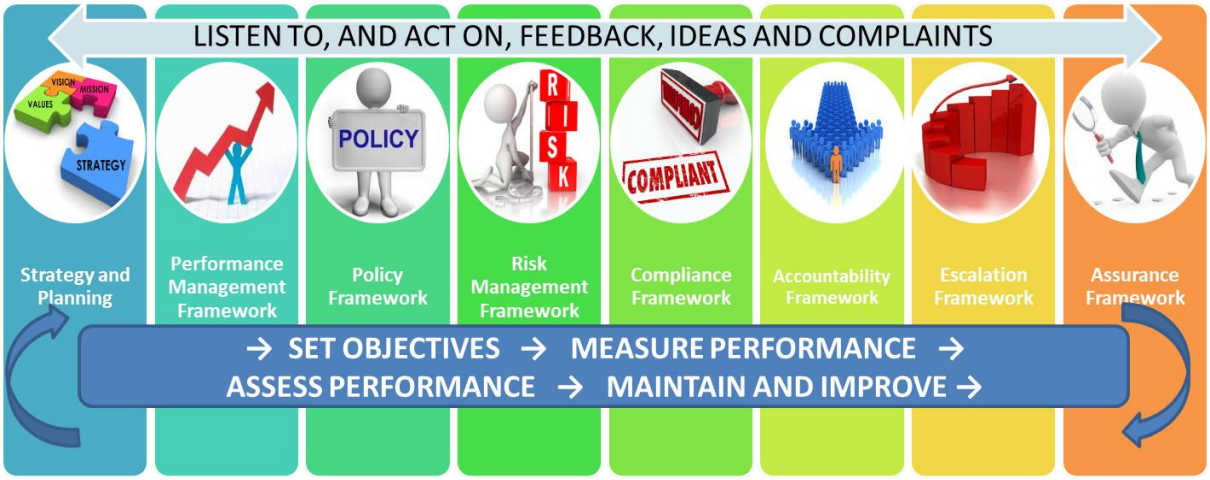
As a Foundation Trust, GOSH has a responsibility to ensure it has a governance system that supports our business. We are publicly accountable for declaring how we are assured of the quality of the services we provide.

2 What is an Assurance and Escalation Framework?

The GOSH Assurance and Escalation Framework describes the responsibility and accountability for the Trust's governance structure and systems through which the Board receives assurance or escalated concerns and/or risks related to the quality of services, performance, targets, service delivery and achievement of strategic objectives.

The purpose of the document is to provide assurance to the Trust Board, Council of Governors, patients, their families and external stakeholders that GOSH has mechanisms in place to provide safe, high quality and sustainable services.

The Assurance and Escalation Framework comprises the following elements, each of which cross-map to the purpose and aims above.



The Assurance and Escalation Framework is refreshed on a regular basis by the Risk Assurance and Compliance Group to reflect any significant changes in these eight elements.

3 How is the Assurance and Escalation Framework implemented?

The Assurance and Escalation Framework comprises the following elements:

Strategy and planning processes

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

The GOSH strategy is being refreshed between May and November 2019. In the interim, our direction continues to be guided by 'Fulfilling Our Potential' strategy.

The key points of the 'Fulfilling Our Potential' are best depicted visually in 'The House':

The **mission** describes our guiding principle: 'the child first and always'.

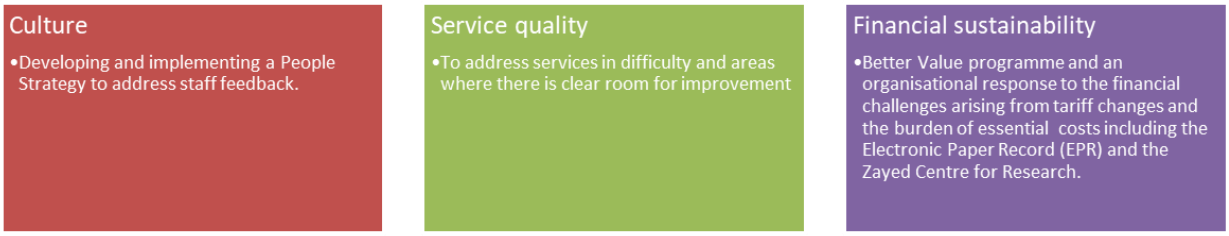
Our **vision** describes our purpose and aspiration: 'to help children with complex health needs to fulfil their potential'.

To achieve the vision we defined four core **priorities** that focus our organisation: care, people, research, and technology.

To deliver on these priorities GOSH needs to have the right capabilities and resources. The four **enablers** describe what we need to have in place in order to achieve them: a voice, (state-of-the-art) spaces, timely, reliable information and (stable and diverse) funding.

Our **values** describe the behaviours we must demonstrate in all that we do

During the transitional period between the implementation of or refreshed strategy, the Executive Team has agreed to focus on three priorities representing the Trust's most urgent challenges. These are:



These priorities will be supported by a range of other Trust Strategies that are already in place:

- Clinical strategy
- Leadership strategy
- Education and training strategy
- Stakeholder engagement strategy
- Risk management strategy
- Cyber-security strategy
- Research strategy

The following strategies are also in development:

- Digital strategy
- Transformation strategy
- People strategy
- Commercial strategy
- Quality strategy

The plan to deliver the refreshed strategy is also under review to ensure that it continues to represent the priorities of the Trust and account for the current strategic pressures and opportunities facing the organisation.

Operational Management

Performance Management

Directorate and department performance reviews take place on a monthly basis, attended by Directorate/ departmental management and Trust executives. These reviews are designed to facilitate a triangulated and risk-focused 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 Trust 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 Directorate integrated dashboard reviewed in the monthly performance reviews. Examples of metrics contained in the integrated dashboard are:

- **Caring:** Friends and family scores and number of complaints
- **Safe:** serious incidents and never events
- **Responsive:** performance against access targets
- **Well led:** sickness, turnover, appraisal rates, mandatory training compliance
- **Effective:** DNA rate
- **Productivity:** theatre utilisation, bed occupancy
- **Finances:** variance to plan

Quality improvement

Working with the Directorate management teams the aim is to continue to develop a culture of continual identification of learning from events and making changes that are effective, sustainable and improve the quality of the service and experience of our children, young people and their families.

Using the Institute for Health Improvement (IHI) model for improvement, the Quality and Safety team use data to encourage improvement activity and to demonstrate and evidence the impact of the improvement programme

The Quality and Safety team work collaboratively with the Trust's Project Management Office (PMO) to ensure the right resources are available to the right work streams at the right time. This will reduce the risk of duplication of efforts and support the transition of projects to 'business as usual' whilst providing effective support to sustain changes and monitor outcomes.

Quality Impact Assessments are required for any scheme with a potential to directly or indirectly impact quality. This includes back office and support services. The required framework considers impacts on patient safety, clinical outcomes, patient experience and staff experience.

A QIA scheme of delegation is in place as follows:

- Directorate management teams (Chief/Deputy Chiefs of Service, General Managers and Head of Nursing and Patient Experience) to review and approve all QIAs in the first instance;

- The QIA panel (co-chaired by the Medical Director and Chief Nurse) to be kept informed of the approval status of all schemes including those signed off at directorate level;
- The QIA panel to assess and sign off all QIAs for any proposal likely to have more significant potential impact (including for example those of a cross-cutting nature).

Workforce analysis and planning

The Trust Board regularly receives workforce analysis and key performance indicators, benchmarkable metrics including staffing profile, voluntary and non-voluntary turnover, sickness, agency usage (as percentage of paybill) and vacancies. Monthly Directorate performance reviews are Executive-led and consider this workforce data at a drill-down level in conjunction with finance, activity and quality data to identify themes or impact on service delivery. Nurse recruitment and retention workstreams are overseen by the Nursing Board which reports to the Executive team.

Services, specialties and directorates hold risk registers that are reviewed and updated to provide a feedback mechanism to Trust risk registers. Trust-wide strategies to mitigate workforce risks are formulated which include nurse recruitment strategies, overseas fellowship programme (for medical staff) and other actions which all form part of the Trust's developing workforce plans.

Ward establishments are reviewed on a twice yearly basis as per National Quality Board standard. Each review sees if there have been any significant changes in patient activity, acuity, case mix, professional judgement etc. requiring change in ward establishment. This is reported by the Chief Nurse to the Nursing Board, Executive Management Team and then taken to Trust Board. Removing or changes to any nursing posts has to be signed off Chief Nurse.

Individual performance plans

All staff who are employed for 12 months or longer must have a Personal Development Review appraisal. The Trust's Personal Development Review Form requires staff to link their individual duties and responsibilities with the Trust's strategic objectives and Always Values. This creates a mechanism for individual members of staff to agree with their managers how their performance relates to the delivery of the Trust's strategic objectives.

Policy Framework

It is essential that all GOSH staff are aware of, and have access to, current Trust policies, procedures and guidelines. It is also essential that these policies, procedures and guidelines are written in a standard style and format and follow the appropriate consultation and approval process.

The policy framework establishes a coordinated and consistent process for the development, approval and review of all GOSH policies. It outlines definitions of what constitutes a policy, a procedure, a guideline and an integrated care pathway. The framework standardises documentation and clarifies roles and responsibilities in policy development. It also sets an expectation for policies to be reflective of current guidance and regulatory/ legal requirements and consulted on with relevant experts and staff to ensure accuracy.

The Policy Approval Group (PAG) has delegated authority from the Risk Assurance and Compliance Group to review and approve all policies and ensure they are kept up to date and available on the Trust's online document library. The PAG is attended by a cross section of clinical and corporate staff from the Trust's directorates and departments.

The Trust maintains a policy database to assist in the management of policies. This database is used to remind policy leads when their policies are approaching the review date, and to monitor compliance with the Policy on policies, procedures, guidelines and integrated care pathways.

The Trust's Policy on policies, procedures, guidelines and integrated care pathways includes standard templates for strategies, policies, procedures and Integrated Care Pathways. These include the minimum governance considerations and requirements for these documents asa follows:

- Clear link to the Trust's Always Values
- Clear differentiation of which staff groups o the policies does and does not apply to
- Clear statements of staff roles and responsibilities
- Details of the committee/s responsible for overseeing the policy
- Details of key changes on revised and updated policies
- Relevant external compliance requirements and/or best practice standards that the policy seeks to ensure conformance with
- The indicators and mechanisms used to monitor the effectiveness of the policy
- Communication and consultation details

All Trust-wide policies must be assessed by the PAG against these requirements before being approved and uploaded to the Trust's document library.

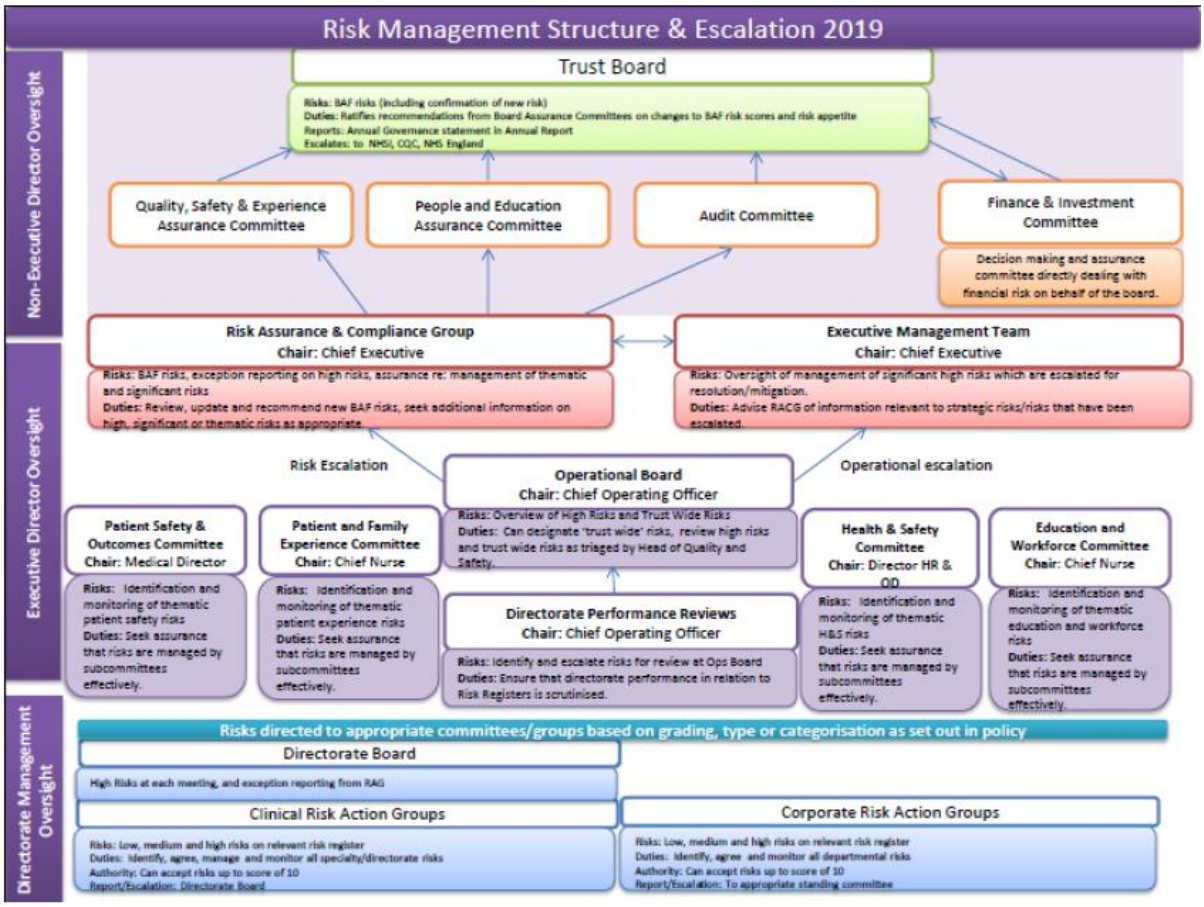
Prior to approval at the PAG, all policies must be endorsed by a relevant Committee. PAG prioritises the scrutiny of a policy's monitoring and escalation section that documents how any performance issues or risks are raised with the relevant organisational committee.

Risk Management Framework

The Trust has a comprehensive and established Risk Management Strategy that sets out the framework for GOSH to systematically manage its risks and underpins the commitment by the Trust Board to ensuring a robust risk management system is in place. 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.

Committee roles in risk management

The effective flow of risk management information in the organisation depends on an effective and functional risk management meeting structure. There are a series of operational risk committees, with delegated responsibility from the Executive Management Team. These committees are monitored by a series of assurance committees, which then report to Trust Board.



Strategic Risk Management and the Board Assurance Framework

The Trust's Board Assurance Framework provides a record of the principal strategic risks to the Trust achieving its objectives. It identifies the controls in place, the methods of assurance and gaps in both control and assurance. It is informed by the risks graded 12 or above on the Trust risk register as well as internal, external and strategic risks/ issues which may affect the Trusts business.

The Trust Board is responsible for identifying the strategic risks to the effective functioning of the Trust and the provision of managerial leadership and accountability. Its purpose is to

ensure that the Trusts systems and working practices support good corporate governance, financial probity and the management of risk to underpin safe high quality service delivery.

The Trust Board delegate responsibility for seeking assurance of the robustness of the controls and assurances cited for each BAF risk to the relevant Board assurance committee. BAF risks are reviewed by a relevant Board assurance committee on a rotational basis throughout the year to assess whether robust assurance is available to show that the controls in place are effective at mitigating the risks taking account of the risk appetite for each risk. The assurance committees then recommend to the Board any changes to BAF risk scores, removal of BAF risks, inclusion of new BAF risks (arising from horizon scanning or escalation of high graded risks or Trust wide risks) and changes to risk appetites. The Board ratifies the BAF and any changes.

The Risk, Assurance and Compliance Group (RACG) is the executive committee responsible for monitoring the effectiveness of risk management systems and the control and assurance processes in place. The RACG monitors the BAF on behalf of the Board and its assurance committees and reports directly to the Board assurance committees at every meeting.

Trust Wide Risk Register

The Trust-wide risk register contains all risks that have been identified as affecting more than one Directorate or is unable to be mitigated by an individual Directorate.

A member of the team will present the suggest Trust wide risk to the Operational Board where an appropriate Trust wide lead is allocated. The Risk Assurance and Compliance Group monitors the compliance with this strategy.

Risk Action Groups and risk registers

Each directorate and department is responsible for establishing risk action groups (RAG). The purpose of an RAG is to:

- Review reported incidents and consider any wider risks
- Undertaking risk assessments
- Systematically review risks on risk registers

Risk validation

Annually, Board members and key Trust managerial staff are asked to name their top three risks without reference to the BAF or risk registers. This process ensures that the BAF and risk registers are reflective of the most pertinent risks across the organisation.

Incident reporting and management

The Incident Reporting and Management Policy describes the process to report, record and investigate individual incidents in detail. All staff receive induction training on how to report an incident in Datix and are directed to report all actual incidents and near misses. Levels of reporting and aggregated analysis will be monitored by the Quality and Safety Team and reported through to the Patient Safety and Outcomes Committee, with feedback to the local teams.

Risk assessment and reporting

The Trust uses a 5x5 matrix to score risk – the likelihood of the risk occurring multiplied by its impact to produce a risk score and grading. For a potential risk or hazard or a ‘near miss’,

the risk is scored for its potential impact and likelihood of occurring again. The subsequent grading (**High, Medium or Low**) guides the action required**.** It also enables a baseline level of risk to be established, and re-grading to occur where appropriate, to review the effectiveness of the mitigations and controls identified to manage the risk.

Grading of risks is most effective when undertaken using a multidisciplinary approach wherever possible or as part of the Risk Action Group and determines the frequency of review, and level of oversight required in the organisation. The Trusts expectations for level and frequency of review dependent on risk score is outlined below:

Risk Grade/Nature	Score on Risk Matrix	Frequency	Responsibility for Review
Trust Wide Operational Risks	Any	In line with Risk Grade	Operational Board
Trust Wide Thematic Risks	Any	In line with Risk Grade	Appropriate Trust Committee/Sub-Committee e.g. infection control, medication safety. RACG on quarterly basis (for assurance)
Significant Risks Register	Impact of 4 or 5	Quarterly	RACG on a quarterly basis (for assurance)
Corporate Risks (often Trust Wide)	Any	In Line with Risk Grade	Corporate RAG or equivalent
High Risks	Score of 12 or above	Monthly review (6 weekly for RACG)	RACG (High Risks via triaged report) Operational Board (Directorate High Risks plus Deep Dive) Directorate Board/RAG(s) (Directorate Risks)
Medium	Score of 8 to 10	Two monthly	Directorate RAG(s)
Low	Score of 1-6	Quarterly review	Directorate RAG(s)

Accountability Framework

Scope of practice and delegations

The Trust has a clear operational structure (Appendix 1) which cascades from the Executive team structure (Appendix 2).

Teams and individual roles have been deliberately designed to deliver specific functions and services. The specific duties and responsibilities of every member of staff across the Trust is articulated in a job description. For many roles, this includes clear professional scopes of practice and rigid remits for decision making. For example, for clinical roles job scope is determined and monitored through professional registration. Another example is for some administrative roles with financial responsibilities, the Trust's standing financial instructions outline the budget thresholds each specific role is authorised to approve.

Board, Executive and Directorate Committee Structure

Similarly, the Trust's committee structure has been developed from the Trust Board down, to ensure each committee or group has a clear purpose, scope and authority. Some committees have statutory functions (for example the Trust Board, Health and Safety Committee, Infection Prevention and Control Committee), others have authority to make decisions and direct actions (for example Executive Management Team and Risk Assurance and Compliance Group) – see **Appendix 3**. Others provide advice, support and oversee specific functions (for example the Policy Approval Group).

Governance standards

To support the effective functioning of committees across the Trust, there is a Terms of Reference guideline in place. The guideline prompts committee Chairs and administrators to ensure the committee outlines and evaluates its responsibilities and performance against the following fields:

- Authority and scope
- Purpose
- Reporting arrangements
- Membership
- Meetings (frequency, arrangements for the distribution of meeting papers and minutes, secretariat responsibilities)
- Monitoring responsibilities (over the work of other committees, policies, compliance requirements)
- Committee performance evaluation.

Compliance Framework

The Trust maintains an electronic compliance register that ensures ongoing compliance with statutory and regulatory requirements.

The electronic compliance register is available via the useful links page on the Trust Intranet site. Each entry on the register is managed by a responsible lead from the compliance area and monitored centrally.

Ahead of an inspection or review, responsible leads notify the central team of the actions required, relevant evidence required and timeframes for submission for that area of compliance. This action plan is uploaded to the compliance register.

Following inspection and upon receipt of any final reports, an action plan including time scales is developed to address any recommendations as well as any monitoring processes required. The management of external assessments and submissions policy outlines the minimum requirements for action plans. Once approved by an Executive Lead, the action plan is uploaded to the electronic compliance register.

This process 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. In terms of the broader governance structure, the Compliance Framework builds on and more closely integrates other elements such as risk management, the committee structure and audit programs.

The Risk, Assurance and Compliance Group oversee the implementation of the Compliance Framework and receives regular reports.

Escalation framework

Framework for escalating concerns

The Trust encourages a climate of openness and honesty in all of its services and business dealings. There are many sources of information that are available to GOSH and are used to inform the Trust about the quality and safety of care provided and the efficient and effective use of resources. Some of these are reported internally to the Trust and others externally, as outlined below:

Internal information sources	External information sources
Risks on risk registers	Health Service Ombudsman
Incidents and debriefs after incidents	External reviews
Integrated quality and performance management reporting/ reviews	Patient surveys and staff FT
Quality Impact Assessments	Compliance bodies
Harm reviews	Royal College/ GMC feedback
Whistle blowing cases	Regulators – e.g. Care Quality Commission, NHS Improvement, Information Commissioner etc.
Safeguarding cases	LINks (Local Involvement Networks)
Line management reporting	Debriefs
Committee reporting	Meetings with commissioners
Walkaround programmes – e.g.: visible leadership programme (nursing), Executive safety walkabouts, etc	Referrer feedback
CEO Briefings	Peer reviews
Risk Action Groups	Litigation
Staff survey results	Coroner cases
PALS (Patient Advice and Liaison Service)	Local authority reporting
Complaints	Commissioners
Freedom to Speak Up cases	

Patient and Staff Friends and Family Test results	
Engagement with Governors	
Guardian of Safe Working Cases	

Staff support to raise concerns

The Trust believes that every member of staff has a duty to raise concerns about patient and staff safety and staff well-being. The Trust promotes a culture of openness and transparency and is committed to supporting staff to raise and openly discuss concerns at the earliest reasonable opportunity. A number of ways in which this can be achieved are promoted across the Trust as follows:

Speaking up for Safety

- This programme launched in partnership with the Cognitive Institute to provide training and support empowering all staff to feel equipped to speak up when faced with potential safety concerns.

Quality and Safety Team

- The Patient Safety Team is available to support staff to raise concerns or report events which relate to patient safety. Any event or near miss that could of or did cause harm to our patients, families or visitorscan be raised with them.

Guardian for Safe Working

- Oversees the safe working of the junior doctors in the Trust and is responsible for protecting the safeguards for junior doctors. Ensures action is taken, for example,around concerns about patient safety due to excess working hours and non-compliant rotas.

Staff support Bereavement Service

- Bereavement is one of the most devastating things any of us will ever go through.
- The Bereavement team supports staff experiencing loss, both in a personal and professional capacity. The service offers face-to-face sessions, telephone support, debriefs in groups or individuals.

Occupational Health

- The service supports any member of staff's health and wellbeing at work or if it impacts on their ability to undertake their job. We can provide confidential advice or sign post to where they can get further advice as appropriate.

Trade Unions at GOSH

- For any HR matters, including bullying and harassment, disciplinaries or sickness absence, trained representatives can advise, guide, support, negotiate and speak for members.

Ethics Staff Support

- Ethical dilemmas are common in professional life and particuraly at a place like GOSH. The Clinical Ethics Serviceisis there to support staff and ensure they feel prepared to make these complex and difficult decisions.

Safeguarding Team

- This team is a source of specialist advice and support, working closely with the GOSH Social Work Service on any potential safeguarding concerns. The team provide consultation and supervision, and discuss cases to determine next steps or reflect on a particular case.

Raising concerns

- The Trust's whistleblowing guidance Raising Concerns in the Workplace Policy provides the framework by which members of staff can raise concerns about safety and quality if they feel issues or concerns are not addressed via the other routes.

Equality and Diversity Groups

- The experience of our staff and volunteers is just as important as families' experience – we know that staff who feel valued work more effectively, provide safer patient care and feel able to raise concerns or suggest improvements.
- In response to the survey results, where staff reported differences in experience depending on their ethnicity, gender or sexual orientation, three staff forums were created:
  - Black, Asian and Minority Ethnic (BAME) staff forum
  - Lesbian, Gay, Bisexual and Transgender (LGBT+) and allies staff forum
  - Women's forum

Incident reporting and Duty of Candour

- The Trust has a strong culture of incident reporting, in line with the Incident Reporting and Management Policy. Under this policy, staff are required to report any incident, defined as any event or circumstance that could have or did lead to unintended or unexpected, harm, loss or damage.
- GOSH encourages, and indeed requires, staff to be as open and honest as possible at all times. In relation to clinical care, the Trust takes its duty of candour obligations seriously, as outlined in the Being Open and Duty of Candour Policy

Assurance framework

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

Internal and external audit

The Audit Committee is responsible for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical).

To provide the necessary assurance to the Audit Committee, the following internal and external audits occur across the Trust:

- Clinical audit, which is administered by the Trust's Quality and Safety Team and overseen by the Patient Safety and Outcomes Committee and Quality Safety and Experience Assurance Committee
- Internal (corporate) audit
- Fraud audit
- External audit
- Quality assurance processes on coding and data quality
- Smaller, targeted local audits to measure the effectiveness of policies and the status against compliance requirements

The outcomes and recommendations of these internal audit programs are shared at relevant committees with a view to monitor progress, but also to support the sharing of issues or opportunities for improvement across relevant areas of the Trust. The Risk Assurance and Compliance Group receives the register of open Internal Audit recommendations and supports their swift and prompt completion as far as reasonably practicable.

Learning from incidents and events

Directorate Risk Action Groups (RAGs) routinely report key learnings to the Patient Safety and Outcomes Committee (PSOC), to enable learning to be shared across clinical teams. In the PSOC, learning from complaints are considered and any themes emerging are identified.

In terms of learning from complaints, the Trust formally audits the delivery of agreed improvements/actions from complaints a year after the complaint was received, to ensure the changes we committed to make have indeed been made.

The Trust runs events series such as the Schwartz rounds and 'Learning From' events that provide forums for clinical and non-clinical staff to reflect on the practical and emotional aspects of their work. These forums provide another opportunity to identify way to improve how services are delivered and to ensure high quality care is provided at all times.

Special external reviews

Infrequently, the Trust may become aware of complex or systemic performance or quality issues that require specialist and/or additional resources to fully address. In these instances the Executive Team, as the key group responsible for the day-to-day management of the Trust may commission new projects or engage short term external expertise to mitigate performance and quality issues. The Executive briefs the Trust Board in these instances in line with their Board's Terms of Reference and the Risk Management Strategy. A Standard

Operating Procedure has been developed to ensure a consistent approach to the establishment and management of these reviews.

Board and committee appraisals evaluations

Given the critical role of committees in the Assurance and Escalation Framework, it is critical that committees are functioning effectively. To ensure this, it is a requirement that all committees (from ward level groups through to the Trust Board) review their effectiveness against their key duties and responsibilities on an annual/ two yearly basis.

Closing the Loop

The Trust has established 'Closing the Loop' - a sub-committee of the Patient Safety and Outcomes Committee – with the main purpose to deliver the Quality Priority which requires us to *'Embed a Learning Culture which supports our people to Learn and Thrive.'*

It provides a designated forum for supporting the delivery of actions associated with learning from excellence and promotes an outward looking approach to continuous quality improvement and learning

It has delegated authority to oversee the implementation of key actions required in response to learning from errors and learning from excellence. The committee is responsible for monitoring action plans from Serious Incidents and Red Complaints and for supporting the delivery of action plans to mitigate or remove systemic root causes and contributory factors based on learning from individual cases, thematic analysis and aggregated analysis.

Attachment 4

4 Monitoring of the Assurance and Escalation Framework

The table below demonstrates that there are three levels of monitoring in place for each component of the Assurance and Escalation Framework – local (individual/team level), Trust (Directorate/Executive/Board level) and external. The person responsible/group for each task listed in the table below is provided in the detail of this Framework and/or the supporting documents referenced throughout.

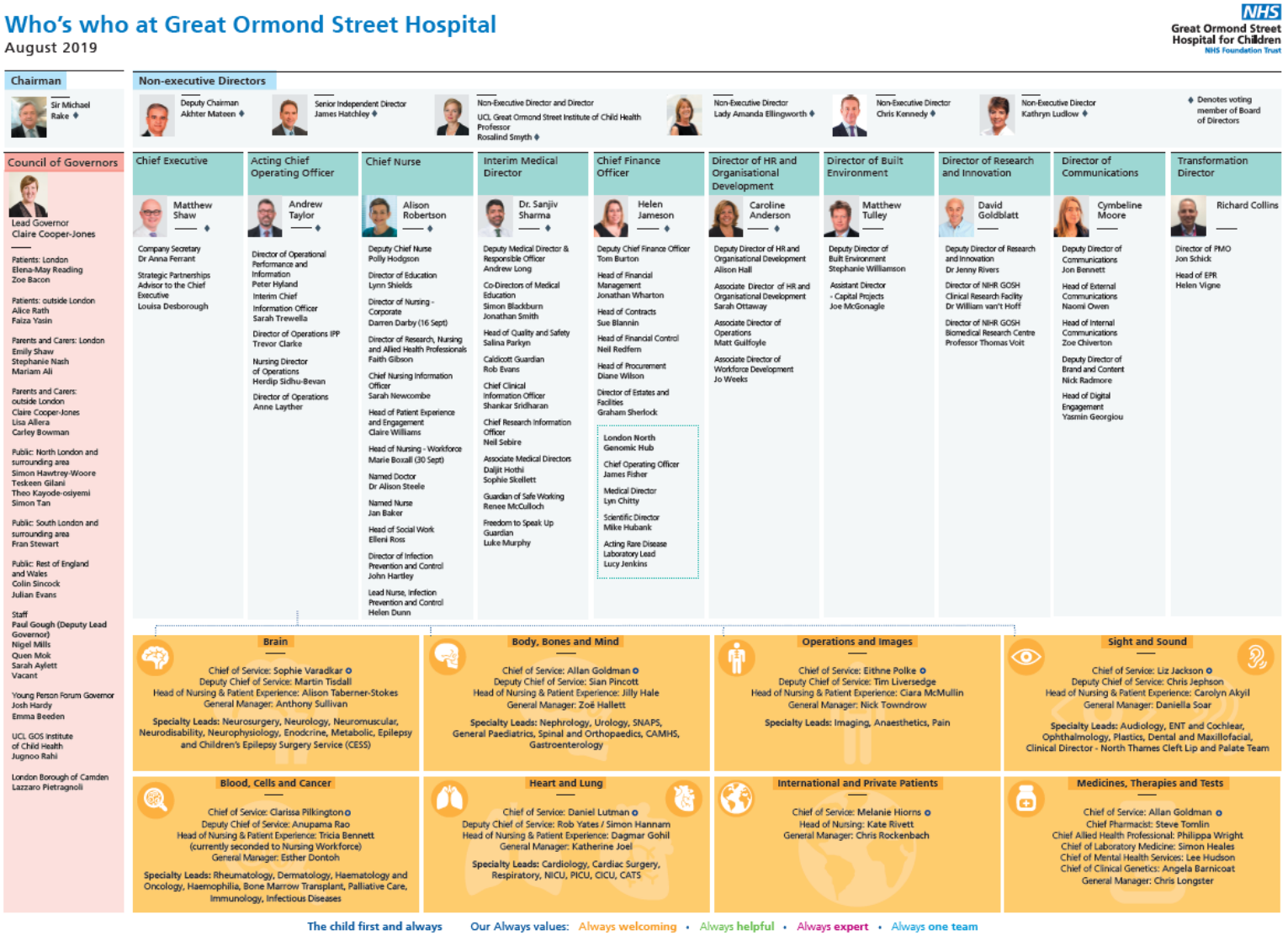
	Local	Trust	External
1. Strategy and planning	- Specialty and Directorate plans	- Specialty and Directorate plans GOSH Strategic Plan - Integrated performance reports to Trust Board (against strategic objectives)	- GOSH Strategic Plan - Annual Report
2. Performance and Quality Management	- Appraisal Process	- Directorate/ Departmental performance review meetings - Integrated performance reports to Trust Board - Internal audit	- Annual Report - External audit
3. Policy Framework	- Local monitoring of policy implementation and effectiveness (as outlined in each policy)	- Local monitoring of policy implementation and effectiveness (as outlined in each policy) - Policy compliance reports to RACG - Internal audit	- External inspections and submissions
4. Risk Management Framework	- Datix reporting - Local risk registers and Risk Action Groups	- Trust-wide risk register - Board Assurance Framework - Internal audit	- Board Assurance Framework - Horizon Scanning

	Local	Trust	External
			Framework
5. Compliance Framework	- Local (noting this may include Trust-wide) policies, procedures and audit plans - Quality Rounds	- Compliance register - Compliance update reports to RACG including thematic Quality Round reports - Internal audit	External inspections and submissions (refer to the Compliance register)
6. Accountability Framework	- Job descriptions - Professional registration - Local group/committee Terms of Reference	- Annual Board and committee evaluations - Internal audit	External inspections and submissions (e.g. Well-led assessment, CQC)
7. Opportunities for raising and escalating issues	- Reporting from various internal routes as outlined - PALS activity	- Evaluation of relevant HR policies, Speak Up for Safety and Freedom to Speak Up - Recommendations from walkaround programmes - Complaint numbers and reports - Staff, FFT and patient survey response rates - Internal audit	- Staff, FFT and patient survey response rates - Ombudsman activity - Regulator activity
8. Assurance systems and processes	- Local audits conducted - Delivery of local audit plans - Progress against local	- Completion of Board and committee appraisals - Internal/ External reviews conducted - Progress against audit plans	- External reviews conducted - External inspections and submissions

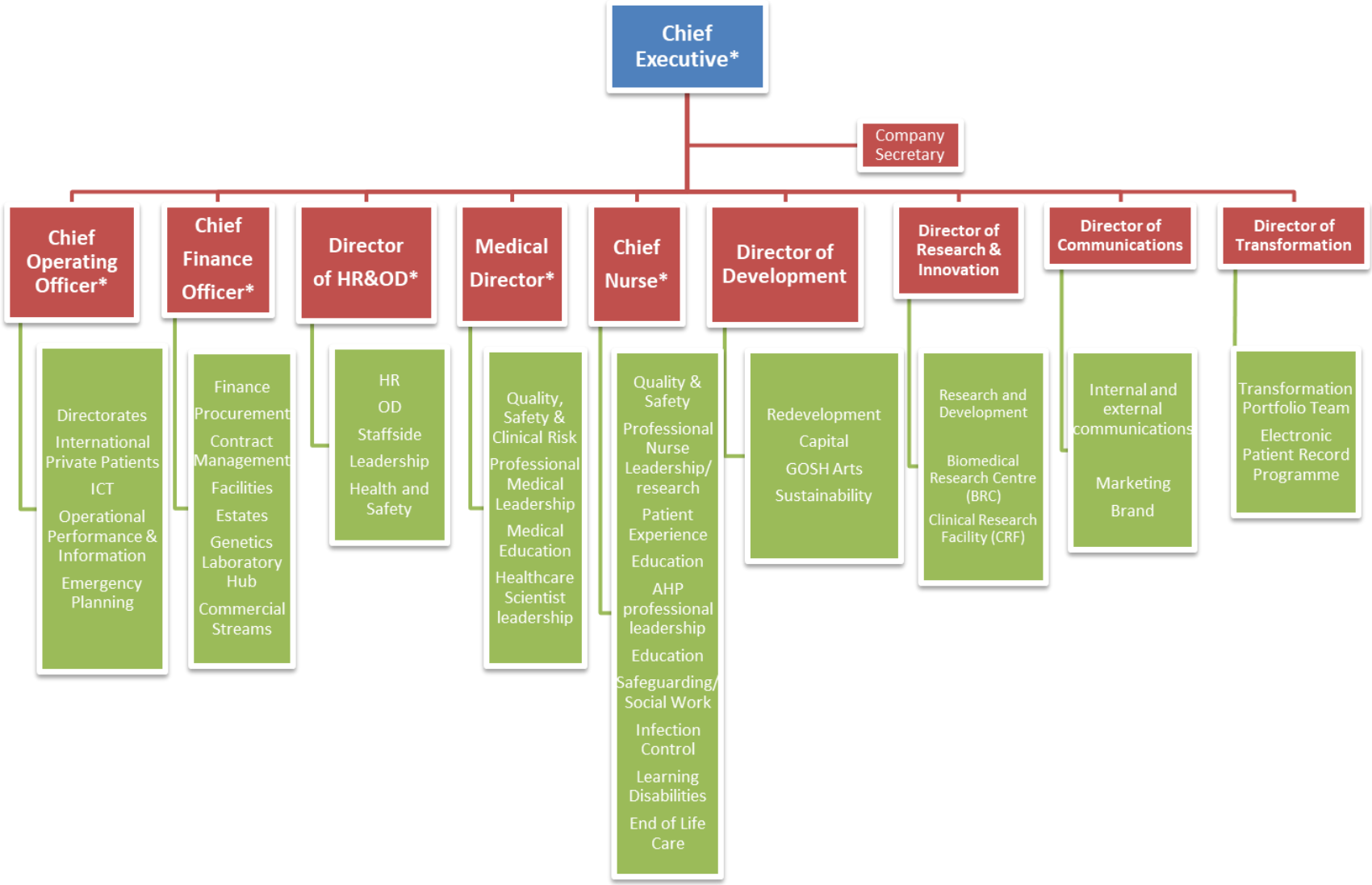
	Local	Trust	External
	audit recommendations - Completion of Board and committee appraisals	recommendations - Reporting from Closing the Loop Subcommittee	

Attachment 4

5 Appendix 1: Organisational Structure



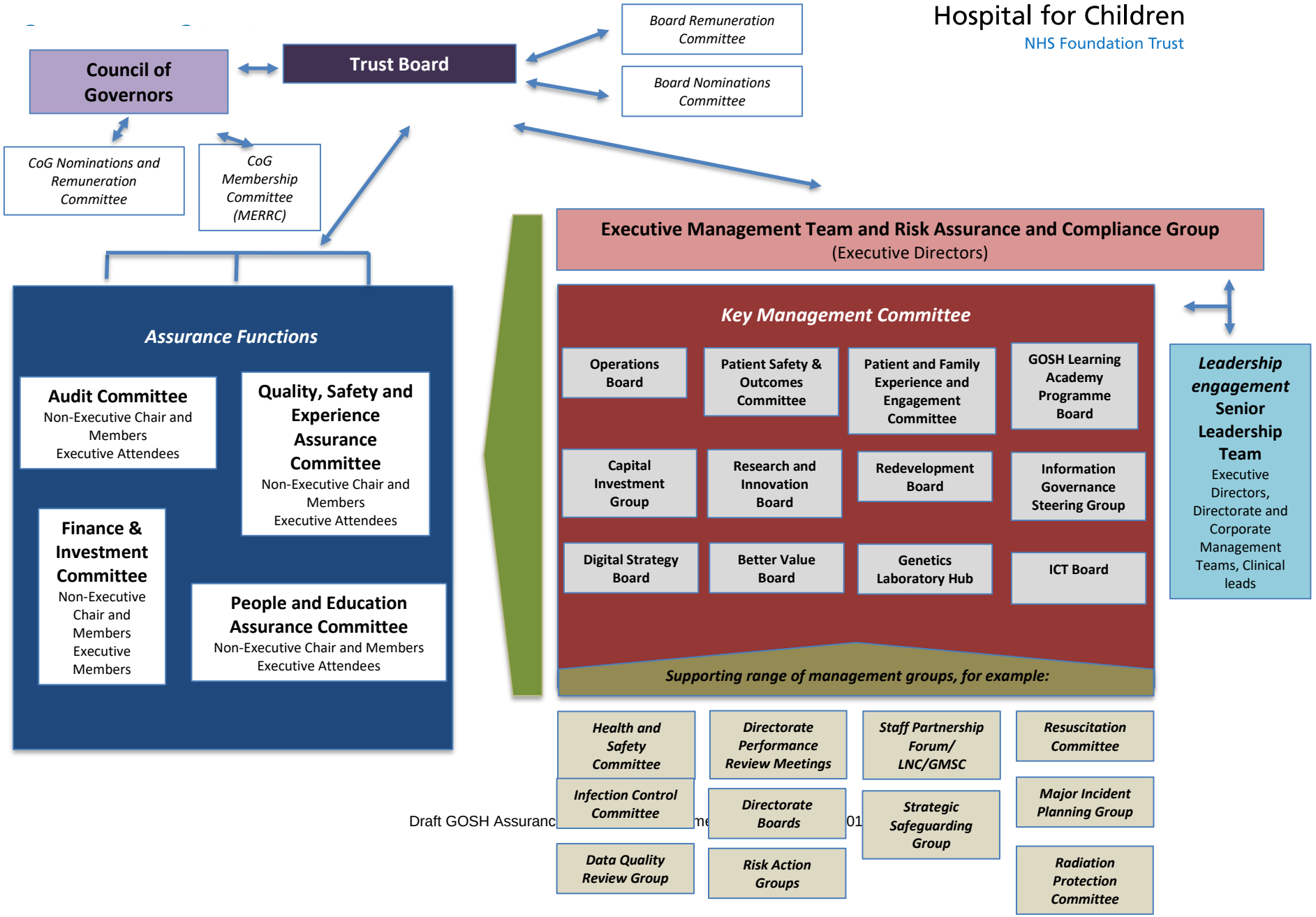
6 Appendix 2: Executive Management Team (* Voting members)



7. Appendix 3: Governance Structure

Appendix 3

Great Ormond Street Hospital for Children NHS Foundation Trust



END

ATTACHMENT 5

Attachment 5

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of the Quality, Safety and Experience Assurance Committee (QSEAC) held on 11th July 2019

Matters Arising: Update on tissue viability

A one year support role was being established to help the team meet demand. GOSH participated in ongoing education groups with NHS England to support local Trusts and this would be a key area for the Learning Academy.

Overview and emerging clinical and risk issues

A paper would be written for Board on data quality to highlight the challenges in the Trust partly as a result of the Epic go-live. Statutory and mandatory training compliance levels had dropped as had PDR completion rates and work was taking place to improve this. Staff were working at capacity as a result of Electronic Patient Record (EPR) go-live and measures were in place to support staff who were struggling.

Integrated Quality and Performance Report (May 2019)

Incident closure rates remained red rated although there had been an improvement since the previous period. Directorates had been asked to develop actions plans for improvement which were being monitored at directorate performance reviews. There had been a decrease in reported level of compliance with the WHO checklist since the introduction of Epic. Observation audits had shown that the checklist was being completed however this had not been documented on Epic. An upgrade to Epic was planned to improve recording. Clinic letter and discharge summary performance remained a challenge and work was taking place to validate data and be clear about the number of letters outstanding. It was confirmed that additional training was being provided to teams who were required to input this information. Diagnostic waits continued to be challenging and focus was being placed on improving utilisation of current lists and adding additional lists where possible.

Update on compliance with Duty of Candour

An audit had taken place to review compliance with duty of candour regulations. Following the audit, the policy had been refreshed and steps take to raise awareness amongst staff. Training had been rolled out following Epic implementation. The Trust was not currently meeting the required timescales in all cases and it was anticipated that this would improve as training rates increased.

BAF Deep Dive Risk 14: Update on plans to respond to the MHRA inspection report

A concerning inspection report had been received from the MHRA highlighting issues with controls and the environment which was not fit for purpose. A number of positive changes had been made since the report and it was highlighted that the team was working extremely hard following EPR go-live. An action plan was in place and a root cause analysis was taking place to raise lessons learnt, as a number of issues had been longstanding, with the work being monitored through CQRG.

Health and Safety Update

Improvement had been made in the safer sharps programme and three products had been reviewed by clinical staff and were going through procurement for replacement. Compliance with fire safety training continued to fluctuate but was currently at 90% and non-compliant staff were being emailed

on a monthly basis. The Trust had approached the London Fire Brigade to access potential applicants for the Fire Officer role which remained vacant after unsuccessful rounds of interviews.

Freedom to Speak Up Guardian Update

Of 26 cases which were now open, only one was not actively moving towards a conclusion. The number of reports being received was increasing, which was positive.

Update on quality impact of Better Value Schemes

The Quality Impact Assessments for all live Better Value schemes had been signed off by the panel and proposed monitoring arrangements were outlined. It was agreed that KPIs related to schemes would be reviewed quarterly and post implementation reviews would take place through the Quality Impact Assessment panel with the outcome reported to the QSEAC.

GOSH Quality Priorities 2019/20 – process of agreement

Work had been paused while the GOSH strategy was being refreshed. Following this a comprehensive Quality Strategy would be developed covering the next three to five years.

Assurance of compliance with Risk Management Strategy

In quarter one 65% of high risks had been reviewed within the required timescales and focus on corporate areas was required to ensure they were updating risks through risk action groups.

Clinical Audit Update (January – June 2019) And Clinical Audit Workplan 2019/20

Improvements had been noted in the use of consent clinics for cardiac surgery which was welcomed by the Committee. A new meeting had been established with individuals who were responsible for disseminating learning to improve this process

Palliative Care and Oncology Outreach Service

A presentation was received from the Chief of Service about the outcome of a service review and the actions which had taken place as a result of the findings. The team carried out crucial work in the community however this was not well funded by the NHS and it was vital that the importance of this work was highlighted nationally.

Update from the GOSH Bioethics Service

The Committee highlighted the importance of the sustainability of the service and it was confirmed that this was now funded by the Trust rather than the GOSH Charity. There was also potential for additional workstreams to be developed in partnership with other organisations.

Board Assurance Framework Update

The Committee agreed to increase the net risk score for the medicines management to 25 the highest possible score, as recommended by the Risk Assurance and Compliance Group.

Freedom of Information Act Annual Report 2018/19

The Committee welcomed the improvement in compliance with required timescales.

Compliance Update

The compliance register was now a live document available for update on the intranet and a programme of visits and inspections was in place the actions for which were monitored through the register.

Annual Complaints Report 2018/19

The number of complaints received in 2018/19 had increased since the previous year however it was clear that numbers were low despite the limited published complaints data from other Trusts.

Whistle blowing update - Quality related cases

No new cases had been raised since the last report. One open case had been reviewed by the Royal College of Surgeons and the report had not yet been provided however there had been no immediate patient safety concerns raised.

Internal Audit Progress Report (April 2019 – June 2019)

The Committee noted the schedule for reviews in 2019/20.

Internal and external audit recommendations update

The number of outstanding recommendations continued to reduce however it was agreed that GOSH must work towards zero overdue recommendations.

ATTACHMENT 6

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of the Finance and Investment Committee held on 25th July 2019

This report summarises the work of the Finance and Investment Committee (FIC) since its last written report to the Trust Board on Thursday 18 July 2019. The FIC held a formal meeting on 25 July 2019. Its next meeting is scheduled for Friday 27 September 2019.

Key issues for the Trust Board's attention

- The July meeting focused on the long-term financial model as the Committee's standing items for Month 3: Finance report, Productivity and efficiency (Better Value) report and Activity monitoring report, had been discussed at the Trust Board meeting on 18 July 2019.
- The Trust achieved its year to date control total in Month 3; this was principally due to the release of £0.4m of reserves in month.
- Committee members found the discussion of key developments and issues arising as the first item at the meeting valuable and requested it as a standing item for future FIC meetings.

Review of the Long Term Financial Model

The Committee undertook a full discussion on the impacts of a number of variables including bed capacity assuming various growth scenarios, tariff assumptions, staffing efficiencies, Brexit and EPIC benefits realisation.

The Non-Executive Directors requested a follow up detailed working session with the Chief Finance Officer and Deputy Chief Finance Officer to further develop the discussion.

Key developments and issues arising

Following review of the previous FIC meeting's minutes, the Chair requested updates on: discharge summaries, pharmacy improvement plans and depth of coding. The following updates were provided:

- A plan to improve performance against the 'Discharge Summaries within 24hrs' metric covering the following four to six weeks was in place.
- The Pharmacy improvement plans were a priority and would benefit from additional administrative support.
- Whilst action plans were in place to improve the depth of coding, a key risk was, that the value of next year's contract would be calculated using this year's activity.

Performance and finance standing updates

<u>Finance 2019/20 report</u>

- The Trust achieved its year to date control total in Month 3; this was due to the release of £0.4m of reserves in month.
- The Trust was behind its income target by £3.2m.
- Private Patient income was behind plan by £2.3m year to date due to lower than planned levels of activity across the Trust.
- Pay was underspent year to date by £2.5m due to the number of vacancies across the Trust.
- Non-pay was £0.7m underspent year to date (excluding pass through).

- Cash was higher than plan by £16.3m due largely to the deferral of capital expenditure.

Productivity and Efficiency (Better Value) Report

The Committee noted the ongoing challenges of meeting the Better Value target for 2019/20. There was concern about how the Trust would make further savings in 2020/21 if the Trust was finding this year's target challenging.

Work was underway to model optimum staffing levels with the aim of identifying efficiencies, different ways of working or methods for delivering additional activity.

It was noted that the new Director of Transformation was taking a fresh look at both this year's and future years' better value targets. The committee welcomed this

Activity Monitoring Report

It was noted that this item had been reviewed at the Trust Board meeting on 18 July 2019.

Integrated Performance Report

It was noted that this item had been reviewed at the Trust Board meeting on 18 July 2019.

Patient-Level Information and Costing Systems (PLICS) submission

The Committee endorsed the approach for signing off the PLICS submission by Monday 29 July.

Work was underway with other Trusts to allow the identification, assessment and comparison of healthcare costs in other organisations.

Directorate reviews

The Committee received overviews of the finances, performance, Better Value targets and key risks for the:

- Operations and Images Clinical Directorate
- Brain Clinical Directorate
- Corporate Directorates

Project Updates / Reviews

The Committee also received progress updates on: EPIC, Zayed Centre for Research, Sight and Sound Centre, IMRI and Flintoff gym.

Non recurrent Charity Projects

The Committee requested regular reporting on milestones, KPIs and benefits for the non-recurrent projects supported by the Charity..

Children's Cancer Centre (CCC)

The Committee requested that the Outline Business Case for the CCC cover:

- How GOSH's plans aligned with the national cancer direction of travel.
- A prediction of other paediatric organisations' cancer centre forward plans were.

ATTACHMENT 8

Attachment 8

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of the meeting of the Council of Governors held on 17th July 2019

GOSH Children's Cancer Centre Update

The principles for a revised proposal for the Children's Cancer Centre had been agreed by the hospital and Charity Boards which delivered similar benefits within a smaller footprint and revised funding envelope. The Outline Business Case would be considered by both Boards in September 2019. Although the Clinical Research Facility was no longer scheduled to move into the new building the required research beds throughout the Trust were being built into business planning for the Trust as a whole. A key benefit of the development would be high quality space in addition to some additional beds. A recruitment and retention plan was in place to support the work to open beds.

Chief Executive's Report

An update was provided on the following matters:

- Great Ormond Street had been closed to traffic for four hours to mark clean air day and a number of activities for patients and families took place.
- The coming months would be challenging for the Trust in terms of data and performance particularly in terms of achieving the six week diagnostic standard.
- Approximately 35% of staff had undertaken speaking up for safety training so far.

Integrated Quality and Performance Report May 2019

There had been a deterioration in discharge summary and clinical letter turnaround time following the Electronic Patient Record (EPR) go live. The number of outstanding letters was being validated and was reviewed daily. There had not been an increase in complaints or PALS contacts over the go live period.

A critical report had been received from the Medicines and Healthcare products Regulatory Agency (MHRA) on pharmacy and an action plan was in place.

Finance report (highlights)

Discussion took place around International Private Patient debt and it was noted that this had reduced in recent months and work continued to ensure that funds were paid. It was agreed that it was important to continue to lobby on the tariff for NHS services so that the Trust was less reliant on IPP activity.

Update on implementation of EPIC Electronic Patient Record

EPR had gone live as planned on 19th April 2019 and the programme remained on budget for the implementation phase and optimisation phase. The number of issues raised through the go-live period was lower than anticipated and the team had prioritised the issues which were having a greater effect on the Trust. Discussion took place around the reduction in the EPR support team and it was confirmed that additional support would be retained for challenging areas. The majority of issues which had been raised during the go live period had been closed however some were complex and required software changes which would take place in September.

Reports from Board Assurance Committees

- Quality, Safety and Experience Assurance Committee (July 2019)

The Committee received the action plan arising from the MHRA inspection and confirmed that it would remain focused on pharmacy.

Attachment 8

- Finance and Investment Committee (March and June 2019)

The Committee had discussed the challenge of achieving the 2019/20 control total and noted that Better Value schemes continued to be identified across the Trust however the target had not yet been achieved. The Learning Academy proposal had been approved for presentation to the GOSH Charity and the Committee had emphasised the importance of education.

- People and Education Assurance Committee

The first meeting of the new Committee had taken place and a number of Governors had observed.

Update from the Young People's Forum (YPF)

The YPF would be meeting with the complaints team to support work on guidance around accessible PALS contacts and complaints. The NHS Young Forum had included a session on transition the outcome of which was presented to the Chief Executive and Chief Nursing Officer of NHS England.

Update from the Constitution Working Group

The Council approve the proposed questions for the Council of Governors' effectiveness review.

GOSH Quality Report

The Council noted the report which reflected the excellent work which had taken place at the Trust over the past year.

Findings and Recommendations for the 2018/19 NHS Quality Report External Assurance Review

The Council received a report from the Trust's external audit partner on the review of the Quality Report. Two mandated indicators had been reviewed plus an additional indicator which had been chosen by Governors. The review of the 31 day cancer waits provided an unmodified opinion and an opinion was not required on the number of delayed PICU discharges. A modified opinion had been provided on 18 week RTT incomplete pathways which was a complex area with substantial human input. Some issues identified would be improved over time through the use of Epic.

Re-appointment of a Non-Executive Director on the GOSH Board

The Council approved the appointment of Mr James Hatchley for a second term of three years on the Board as recommended by the Council of Governors' Nominations and Remuneration Committee.

CQC inspection update

The Trust would be subject to an unannounced CQC inspection in late 2019 as part of a scheduled programme of inspections. Following this the CQC would return to the Trust to conduct a Well Led inspection. A focus group would take place with Governors and the CQC and it was noted that it was important to be open with the CQC and feel free to give feedback as requested.

Governance Update

The Council approved proposed changes to the buddying programme which had been recommended based on responses to a survey. The Council approved a revised membership form and the importance of completing mandatory training was reiterated.

Governors would be asked to make declarations of actual or potential conflicts of interest online following new guidance which had been published by NHS England.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
18 September 2019

Revised Trust Board Terms of Reference and Workplan **Submitted by:** Anna Ferrant, Company Secretary	**Paper no: Attachment 9** For approval

Aims / summary

The Trust Board Terms of Reference (ToR) are reviewed and updated every two years or following amendments to the Trust's Standing Orders, Reservation and Delegation of Powers.

In September 2018, the Board approved an update to the ToR in line with the Financial Reporting Council's (FRC) new UK Corporate Governance Code (January 2019), the CQC's Well Led Framework (January 2018) and the CQC's Well Led inspection report of the Trust in April 2018.

In light of the recent changes to the role title of one executive (voting), changes to other director posts who attend the Board on a non-voting capacity and establishment of a new Board assurance committee, the following amendments are proposed for approval:

- Change of role title of Deputy Chief Executive to Chief Operating Officer.
- Reference to the new Director of Transformation position (non-voting).
- Reference to the attendance of the Chief Clinical Information Officer (non-voting).
- Reference to the People and Education Assurance Committee as a committee of the Board.
- Clarification of the role of the Board in seeking assurance of the effectiveness of the collation and use of validated, accurate, timely and reliable information. It is proposed that the Audit Committee will continue to seek assurance of the controls in place to mitigate risks related to data quality and security. It is proposed that with the implementation of EPIC and DRIVE, that the board also receives an annual update on how data is being managed in the hospital in relation to access, collation, processing and analysis, storage and security within a context of operational and research data.

A revised version of the terms of reference is attached at **Appendix 1** and all amendments are shown in red text.

Board workplan

An updated version of the Trust Board workplan is attached at **Appendix 2**. The work-plan was recently approved by the Trust Board in April 2019 and presented under the eight key lines of enquiry headings of CQC's Well Led assessment.

In order to streamline reporting with the revised terms of reference, the workplan has been reviewed again and minor amendments made as follows:

- Added a review against the revised Schedule of matters reserved for the Trust Board (on the September Board agenda) and recently updated Scheme of Delegation requirements;
- Added key streams of work from the executive team annual work-plan requiring reporting at Board.
- Added an annual update on how data is being managed in the hospital in relation to

access, collation, processing and analysis, storage and security within a context of operational and research data. • Changes to reporting from management committees. This is a live document and subject to amendment throughout the year. In light of a review of assurance reporting at the Board, the workplan is expected to change again and will be brought back to Board for approval as required.
Action required from the meeting To approve the amendments to the terms of reference and the workplan.
Contribution to the delivery of NHS / Trust strategies and plans The terms of reference provide a written framework of how the Board operates.
Financial implications No direct financial implications.
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? N/A
Who needs to be told about any decision N/A
Who is responsible for implementing the proposals / project and anticipated timescales? The Trust Board and Company Secretary.
Who is accountable for the implementation of the proposal / project The Trust Board

Great Ormond Street Hospital for Children
NHS Foundation Trust

DRAFT TRUST BOARD TERMS OF REFERENCE

The Trust has Standing Orders for the practice and procedures of the Trust Board (Annex 9 of the Constitution). For the avoidance of doubt, those Standing Orders take precedence over these Terms of Reference, which do not form part of the Trust's Constitution.

1. Constitution

The Trust is governed by the NHS Act 2006 (as amended by the Health and Social Care Act 2012), it's Constitution and its Terms of Authorisation granted by the Independent Regulator (the Regulatory Framework).

2. Role

The role of the Great Ormond Street Hospital for Children NHS Foundation Trust Board is:

- To establish the Trust's purpose, vision, values and strategic direction, setting strategic objectives that are reflective of the wider health and social care economy and supported by quantifiable and measurable outcomes and performance indicators;

- To provide compassionate, inclusive and effective leadership in promoting the vision, values and standards of conduct and ethical behaviour for the Trust and its staff;

- To seek and receive assurance on the quality and sustainability of the Trust's services, promoting high standards of effectiveness, patient safety, patient experience and compassionate care;

- To ensure there are effective structures, processes, systems of accountability, validated, ~~and~~ accurate, timely and reliable information that is processed in line with legal requirements and appropriate financial and human resources in place to support the delivery of the strategy, the Trust's business plans and good quality, sustainable services.

- To ensure the Trust develops and implements appropriate risk management strategies and policies to identify, monitor and address current and future risks on the quality and financial sustainability of services and comply with regulatory and statutory requirements.

- To ensure that strategic development proposals have been informed by open and accountable consultation and engagement with staff, patients and their representatives, governors, members, the wider community and other key external stakeholders, as appropriate.

- To exercise financial stewardship, ensuring that the Trust is operating effectively, efficiently and economically and with probity in the use of resources;

- To support continuous learning and improvement ensuring the development of extensive internal and external audit, monitoring and reporting systems and seeking assurance of the effectiveness of the arrangements for staff to raise concerns in confidence and have such concerns investigated and follow up action taken where necessary.

- To encourage and promote openness, honesty and transparency about performance with, patients and their representatives, the public, staff, governors, members and other stakeholders;

- To ensure that the Trust is operating within the law and in accordance with its constitution, statutory duties and the principles of good corporate governance.

The annual work-plan documents the Board's reporting and monitoring arrangements, including reporting from the following committees:

- Audit Committee
- Quality, ~~and~~ Safety and Experience Assurance Committee
- Finance and Investment Committee
- People and Education Assurance Committee

In addition, a report of the business conducted at each of the Council of Governors' meetings shall be presented at the next ~~a~~ meeting of the Board for information.

3. Membership

The Board shall comprise 12 directors excluding the Chair.

There shall be 6 non-executive directors. The Deputy Chair may deputise for the Chair. No other person will be authorised to deputise for a non-executive director.

There shall be 6 executive directors:

- ~~the~~ Chief Executive
- ~~Deputy Chief Executive~~Chief Operating Officer
- Chief Finance Officer
- Medical Director
- Chief Nurse
- Director of Human Resources and Organisational Development.

The Non-Executive and Executive Directors listed above each hold a vote.

For executive posts, t~~T~~he Board may approve deputies with formal acting up status or interim executive director posts.

4. Attendance at meetings

The Board is committed to openness and transparency**.**

The main body of the meeting shall be held in public and representatives of the press and any other members of the public or staff shall be entitled to attend.

Members of ~~the~~ public and staff shall be excluded from the first part of the meeting due to the confidential nature of business to be transacted, or due to special reasons stated in the resolution and arising from the nature of the business of the proceedings.

In addition to Board members, the following individuals shall be entitled to remain during confidential business:

- Director of Development
- Director of Research and Innovation
- Director of International Private Patients
- Director of Communications
- Director of Transformation
- Chief Clinical Information Officer

Other senior members of staff may be requested to attend the confidential session by invitation of the Chair.

These invited individuals do not hold a vote.

5. Quorum

No business shall be transacted at a meeting unless at least five directors are present including not less than two independent non-executive directors, one of whom must be the Chair of the Trust or the Deputy Chair of the Board; and not less than two executive directors, one of whom must be the Chief Executive or another executive director nominated by the Chief Executive.

An officer in attendance for an executive director but without formal acting up/ interim director status may not count towards the quorum.

Participation in a meeting by telephone, video or computer link shall constitute presence in person at the meeting.

6. Frequency of meetings

The Board shall normally hold 6 formal Board meetings a year

In addition to the above meetings, the Board shall reserve the right to convene additional meetings as appropriate.

Executive directors and non-executive directors are expected to attend a minimum of 5 formal Board meetings per year.

7. Performance evaluation

The Board will undertake an evaluation of its own performance on an annual basis. Every third year evaluation of the Board will be led by an external facilitator.

Directors will be subject to individual performance evaluation on an annual basis:

- The Chief Executive will evaluate the performance of the executive directors;
- The Chair will evaluate the performance of the non-executive directors and the Chief Executive;
- The Senior Independent Director will evaluate the performance of the Chair.

Committees of the Board will conduct an evaluation of their effectiveness on an annual basis.

Appropriate action will be taken where recommendations are highlighted.

8. Secretariat

The Company Secretary shall act as Secretary to the Board.

The minutes of the proceedings of the Board meetings shall be drawn up for agreement and signature at the following meeting.

Signed minutes shall be maintained by the Secretariat.

Agendas and papers for the public section of all Board meetings shall be placed on the Trust website two working days prior to the meeting.

9. Review of the terms of reference

These Terms of Reference shall be reviewed bi-annually by the Board or following amendments to the Trust's Standing Orders, Reservation and Delegation of Powers.

Trust Board Work-plan 2019/ 20 (incorporating assurance committee work)

CQC Domain	Topic	Executive Director	6 February 2020	1 April 2020	18 May 2020	15 July 2020	18 September 2019	30 October 2019 (Strategy Day)	27 November 2019
Well Led	**W1: Is there the leadership capacity and capability to deliver high-quality, sustainable care?**								
	Report from Board and Council Nominations Committees and Remuneration Committee	Company Secretary		X Appraisals (NEDs and Executives) Recruitment Remuneration					X Appraisals (NEDs and Executives) Recruitment Remuneration
	Executive/ Board Development	Chief Executive			X				
	W2: Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?								
	Strategy progress update	CEO and responsible executives	Research Strategy Progress Report	Leadership Strategy Approval Clinical Strategy Approval	Overview of refreshed objectives and plans	Learning Academy Business Case Update on DRIVE Stakeholder Engagement Strategy Risk Management Strategy	Integrated People Strategy IPP Strategy and Commercial Opportunities Update	Full strategy & progress with objectives and plans 3-5 year Transformation Plan	Risk Management Strategy Compliance Patient Experience and Engagement Strategy
	Operational/ Financial Plan	Chief Operating Officer/Chief Finance Officer		Final annual plan for submission to NHSI					Draft annual plan including Capital programme
	Redevelopment of site					The case for the Children's Cancer Centre	Children's Cancer Centre Outline Business Case		Progress with Sight and Sound Hospital

CQC Domain	Topic	Executive Director	6 February 2020	1 April 2020	18 May 2020	15 July 2020	18 September 2019	30 October 2019 (Strategy Day)	27 November 2019
	Directorate Team Presentations*	Chief Operating Officer and Directorates	Brain (TBC) Heart and Lung (TBC)	Operations and Imaging – Radiology Sight and Sound (TBC)		Body, Bones and Mind -	Medicines, Therapies and Tests – Pharmacy IPP		Blood, Cells and Cancer (TBC) Medicines, Therapies and Tests - Genetics
	W3: Is there a culture of high-quality, sustainable care?								
	Report from Guardian (Q)	Guardian of Safe Working	X	X		X			X
	Report from Freedom to Speak Up Guardian	Freedom to Speak Up Guardian			Annual Report				
	Sustainability Report	Dir of Development					Sustainability Management Plan (annual)		
	Responsible Officer Report	Medical Director				Annual Report			
	Mediation and Open Employment Tribunals	Dir of HR and OD/ Medical Director		X					X
	Quality Update	Medical Director	X	X	X	X	X		X
	Business Continuity Report	Chief Operating Officer		Annual Report					
	Health and Safety Report	Dir of HR and OD			Annual Report				
	Safeguarding Report	Chief Nurse				Annual Report			
	Operational matters	Relevant		Update on					Update on

CQC Domain	Topic	Executive Director	6 February 2020	1 April 2020	18 May 2020	15 July 2020	18 September 2019	30 October 2019 (Strategy Day)	27 November 2019
		executive(s)		Cognitive pilot			Trust Recovery Plan (Media case)		Cognitive Parent/carer accommodation review
	W4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?								
	Review of compliance	Medical Director/ Company Secretary			Code of Governance/ NHSI Licence Review	CQC Progress update including well led	CQC Progress update including well led	CQC Progress update including well led	CQC Progress update including well led
	Council of Governors' Update	Company Secretary		X	X		X		X
	Board ToR/ workplan/ Matters reserved - Board and Council/SFIs	Company Secretary				SFIs/ Scheme of Delegation	Schedule of matters reserved for the Board and Council Board ToR/ Workplan		
	Register of Interests & Gifts & Hospitality & Register of seals	Company Secretary	Seals	Seals/ Gifts and Interests	Seals/ Gifts and Interest	Seals	Seals		Seals
	W5: Are there clear and effective processes for managing risks, issues and performance? **W6: Is appropriate and accurate information being effectively processed, challenged and acted on?**								
	Integrated Quality and Performance Report	COO/ Dir HR & OD/ MD/CN	X	X	X + Focus on clinical outcomes	X	X		X + Focus on clinical outcomes
	Learning from Deaths	MD	Q4		Q3	Q4			Q1
	Infection Control Report (from DIPC)	Chief Nurse/ DIPC	X			Annual Report			X
	Finance Report	Chief Finance	X	X	X	X	X		X

CQC Domain	Topic	Executive Director	6 February 2020	1 April 2020	18 May 2020	15 July 2020	18 September 2019	30 October 2019 (Strategy Day)	27 November 2019
		Officer							+ PLICS
	Board Assurance Framework Overview	Company Secretary	X (January AC and QSEAC Non-Clinical risks review)	X BAF Brexit risk	X (April AC and QSEAC Non-Clinical risks review)	X BAF Culture risk	Risk Meeting (September/ October) (AC and QSEAC Non-Clinical risks review)		X (Oct AC and QSEAC Non-Clinical risks review)
	Safe Staffing/ 6 monthly staffing review	Chief Nurse	X	X	X +6 monthly staffing review	X	X		X +6 monthly staffing review
	Update on NHS contract negotiations	Chief Finance Officer	X	X	X	X	X	X	X
	Audit Committee assurance report to Board – matters to be raised at Board	AC Chair	Whistle-blowing update/ Assurance of Risk Management processes		Annual Accounts and Annual Report assurance	Whistle-blowing update/ Assurance of Risk Management processes			Whistle-blow update/ Assurance of Risk Management processes
	QSEAC assurance report to Board – matters to be raised at Board	QSEAC Chair	Freedom to Speak Up Update/ Safeguarding			Freedom to Speak Up Update/ Safeguarding			Freedom to Speak Up Update/ Safeguarding
	Finance and Investment Committee report to Board – matters to be raised at Board	F &I Chair	TBC	TBC	TBC	TBC	TBC	TBC	TBC
	People and Education Assurance Committee report to Board - – matters to be raised at Board	PEAC Chair					x		x
	Hospital Funding	Chaired by	Incorporated into				Incorporated into		

CQC Domain	Topic	Executive Director	6 February 2020	1 April 2020	18 May 2020	15 July 2020	18 September 2019	30 October 2019 (Strategy Day)	27 November 2019
	Priorities Steering Group	James Hatchley NED	CEO Update				CEO Update		
	W7: Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?								
	Patient/ Carer Story	Chief Nurse	X	X	X	X	X		X
	Charity update	Charity			Planning for Charity B2B			X	
	Inpatient/ Outpatient/ Staff Annual Surveys	Chief Nurse/ Dir HR & OD		Staff survey results		Patient/ carer survey results			
	Annual Report & Accounts/ Quality Report/ Auditor Letters/ Annual Governance Statement	Chief Finance Officer/ Company Secretary			X				
	WRES and WDES Report and Equality Objectives	Dir of HR and OD		Equality Objectives			WRES and WDES Annual Report		
	Patient Experience and Engagement Strategy	Chief Nurse					X		
	W8: Are there robust systems and processes for learning, continuous improvement and innovation?								
	Assurance and Escalation Framework Update						X		
	Update on EPIC and DRIVE		EPIC	EPIC	EPIC	EPIC DRIVE	EPIC	EPIC	EPIC DRIVE
	Data Annual Report								x

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 18 September 2019	
Schedule of matters reserved for the Trust Board, Council of Governors and delegated committees **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment 10**
Aims / summary The Code of Governance requires that there should be a formal schedule of matters which defines those powers specifically reserved to both the Trust Board and the Council of Governors. The document has been formatted to reflect decision making powers of the Trust Board and the Council as well as monitoring responsibilities. Updates to the document are shown in red text.	
Action required from the meeting To consider and note the matters reserved to the Trust Board and Council.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Compliance with the Code of Governance and clarity about roles and responsibilities of the Board, its committees and directors and officers	
Financial implications None	
Who needs to be told about any decision? N/A	
Who is responsible for implementing the proposals / project and anticipated timescales? Company Secretary	
Who is accountable for the implementation of the proposal / project? Company Secretary	

No.	Reference	Matters reserved to the Trust Board	TB	CoG	Board Committee
		1. Strategy and Management			
1.1	Code A1c, C2 TB ToR	Responsibility for the overall leadership of the Trust within a framework of processes, procedures and controls which enable risk to be assessed and managed.	x		
1.2	Code A1d B8.a TB ToR	Responsibility for ensuring compliance with its provider licence, constitution, mandatory guidance issued by regulatory bodies, relevant statutory requirements and contractual obligations.	x		Audit Committee and Quality, Safety and Experience Assurance Committee
1.3	Code A1f TB ToR	Setting the strategic aims of the Trust (taking into consideration the views of the Council) and ensuring that the necessary financial and human resources are in place for the Trust to meet its objectives	x	In consultation with the Council of Governors	
1.4	Code A1h TB ToR	Responsibility for ensuring that the NHS foundation trust functions effectively, efficiently and economically.	x		
1.5	Code A1e Code A1i BoD ToR	Setting the Trust's vision, values and ensure its obligations to members, patients and other stakeholders as understood, clearly communicated and met	x		
1.6	Con 43 Code A1f	Approval of an annual business plan.	x	In consultation with the Council of Governors	
1.7	SFIs	The exercise of financial supervision and control by: -ensuring the financial strategy is consistent with and an integral part of the Trust's business plan -Requiring the submission and approval of budgets within approved allocations/overall income -Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money)	x		Finance and Investment Committee
1.8	Code A1 SFIs	Review of performance in the light of the Trust's strategy, objectives, business plans and budgets and ensuring that any necessary corrective action is taken	x		Finance and Investment Committee
1.9	Code A1g TB ToR	Ensuring the quality and safety of healthcare services, education, training and research delivered by the Trust and applying the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission and other relevant NHS and regulatory bodies.	x		Quality, Safety and Experience Assurance Committee

1.10	NHS Act 2006	Extension of the Trust's activities into new business or geographic areas.	x		Finance and Investment Committee
1.11	NHS Act 2006	Any decision to cease to operate all or any material part of the Trust's business.	x		Finance and Investment Committee
2. Structure and organisation					
2.1	NHS Act - Code	Major changes to the Trust's management and control structure.	x		TB Nominations Committee Audit Committee
2.2	HSCA 2012 Constitut 49	Major changes to the Trust's corporate structure, including, but not limited to, acquisitions, mergers, separations or dissolution of the Trust and significant transactions falling within the definition outlined in the Trust's Constitution.	x	x final approval to be provided by the MC	Finance and Investment Committee Audit Committee
2.3	TB SOs	The establishment of Trust Board sub-committees, their Terms of Reference and the delegation of authority to them. Monitoring reports from these committees in respect of their exercise of delegated powers.	x		
2.4	NHS Act 2006	The establishment of subsidiary companies, charities, partnerships, joint ventures or other corporate entities linked to or managed by the Trust.	x		Finance and Investment Committee Audit Committee
2.5	NHS Act 2006 Constitut 49 Code A5.15	Application for acquisitions, mergers, separations or dissolution of the Trust	x	CoG approves application (more than half of governors an approve an application for a merger, acquisition, separation or dissolution)	Finance and Investment Committee

2.6	NHS Act 2006 Constitut 49 Code A5.15	Approval of entering into a significant transaction falling within the definition agreed in the Trust's Constitution."Significant transaction" means a transaction which meets any one of the tests below: - the total asset test; or - the total income test; or - the capital test (relating to acquisitions or divestments). The total asset test is met if the assets which are the subject of the transaction exceed 25% of the total assets of the Trust; The total income test is met if, following the completion of the relevant transaction, the total income of the Trust will increase or decrease by more than 25%; The capital test 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).	x	CoG approves application (more than half of governors who vote)	Finance and Investment Committee/ Quality, Safety and Experience Assurance Committee
2.7	Con 43.7 CoG A5.15	Approval of increase (by 5% or more) of the proportion of the Trust's total income attributable to activities other than the provision of goods and services for the health service (Councillors determine together whether the trust's non-NHS work will significantly interfere with the trust's principal purpose, which is to provide goods and services for the health service in England, or its ability to perform its other functions.)	x	CoG approves application (more than half of governors who vote)	Finance and Investment Committee/ Quality and Safety Assurance Committee/ People and Education Assurance Committee
3. Financial and Governance Reporting and Controls					
3.1	Con 42	Approval of annual report and accounts.	x		Audit Committee
3.2	TB ToR	Approval of governance and other compliance declarations to NHS Improvement, the CQC and other relevant regulatory bodies, requiring board approval by statute, regulation or under contractual obligations.	x	x (in consultation with CoG where stated)	
4. Internal Controls					

4.1	CoG C2	Ensuring maintenance of a sound system of internal control and risk management including: -Receiving reports on and reviewing the effectiveness of, the Trust's risk and control processes to support its strategy and objectives -Undertaking an annual assessment of these processes -Approving an appropriate statement for inclusion in the annual report.	x		Audit Committee
5. Contracts					
5.1	SFI 8.1 SoDeleg	Major capital projects	x		Finance and Investment Committee
5.2	NHS Act 2006	Contracts which are material strategically or by reason of size, entered into by the Trust [or related subsidiary] in the ordinary course of business, for example, bank borrowings with a repayment period of over one year or acquisitions or disposals of fixed assets.	x		Finance and Investment Committee
5.3	NHS Act 2006	Contracts of the Trust [or any subsidiary] not in the ordinary course of business, for example loans with a repayment period of over one year or major acquisitions or disposals	x	x (subject to approval by the CoG where any of the significant transactions tests are met	Finance and Investment Committee
5.4	NHS Act 2006	Major investments [including the acquisition or disposal of interests or voting shares or the making of any takeover offer].	x	x (subject to approval by the CoG where any of the significant transactions tests are met	Finance and Investment Committee
5.5	High risk transactions	All investments which fall within the Regulator's definitions of High Risk transactions	x		Finance and Investment Committee
6. Communication					
6.1	TB SOs	Approval of resolutions and corresponding documentation to be put forward to governors at a general meeting.	x		
6.2	Code E1	Ensuring appropriate consultation with members, patients and the local community.	x	x	
6.3	Code E2	Ensuring that the NHS foundation trust co-operates with other NHS bodies, local authorities and other relevant organisations with an interest in the local health economy (inlcuding ensuring that processes are in place to enable cooperation and collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each)	x		
7. Board membership and other appointments					

7.1	Code A4	Appointment of the Senior Independent Director.	x	In consultation with the CoG	
7.2	TB SOs	Appointment to boards of subsidiaries.	x		
8. Remuneration					
9. Delegation of authority					
9.1	TB SOs SoM	The division of responsibilities between the Chair, Chief Executive and other executive directors.	x		
9.2	TB SOs	This schedule of matters reserved for board decisions.	x		
10. Corporate Governance matters					
10.1	CoG A1 CoG A1.8	Establishing the values and standards of conduct for the Trust and its staff and operating a code of conduct that builds on these values.	x	In consultation with the CoG	
10.2	Code A5.15	Approve a change to the constitution (more than half the members of the Board voting approve the amendment)	x	x	
10.3	CoG B.6.e	Evaluation of the Trust Board	x	Report findings to the Council	
11. Policies					
11.1	Con Annex 9	Approval of Standing Orders for the Trust Board.	x		Audit Committee
11.2	TB SO 2.4	Standing Financial Instructions, Scheme of Delegation and Matters Reserved for the Trust Board and Council of Governors.	x		Audit Committee
12. Other					
12.1	SoDeleg	Prosecution, defence or settlement of litigation [involving above £500k or being otherwise material to the interests of the Trust].	x		Audit Committee
12.2	NHS Act 2006	Any decision likely to have a material impact on the Trust from any perspective, including, but not limited to, financial, operational, strategic or reputational impact.	x		Relevant assurance committee

KEY	
NHS Act 2006	NHS Act 2006
HSCA 2012	Health and Social Care Act 2012
Constitut	GOSH Constitution (2018)
Code	Code of Governance (2014)
SoDeleg	Scheme of Delegation (2019)
SFI	Standing Financial Instructions (2019)
TB SO's	Trust Board of Directors Standing Orders (2018)
CoG Sos	Council of Governors' Standing Orders (2014)
Green highlight	Powers of the Board (decision rights)
White highlight	Recommending, monitoring and leadership responsibility of the Board

Committee column	The committees in the final column have an assurance role but do not make decisions in these matters, unless coloured in blue highlight

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
18 September 2019

Register of Seals **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment 11**

Aims / summary
Under paragraph 39 of the NHS Foundation Trust Standing Orders, the Trust is required to keep a register of the sealing of documents. The attached table details the seal affixed and authorised since 18th July 2019.

Date	Description	Signed by
30/07/2019	East Deck Chiller's Project – Stage 3 NEC Contract	HJ
27/08/2019	Design and build contract 2016 – CAT B fit out works to create new MEDU.	HJ, AF

Action required from the meeting
To endorse the application of the common seal and executive signatures.

Contribution to the delivery of NHS / Trust strategies and plans
Compliance with Standing Orders and the Constitution

Financial implications
N/A

Legal issues
Compliance with Standing Orders and the Constitution

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

Who is accountable for the implementation of the proposal / project
Anna Ferrant, Company Secretary oversees the register of seals