Great Ormond Street Hospital for Children
NHS Foundation Trust

Meeting of the Trust Board
Wednesday 16 September 2020

Dear Members

There will be a public meeting of the Trust Board on Wednesday 16 September 2020 at 1:15pm on Zoom and in Barclay House, 37 Queen Square, Great Ormond Street, London WC1N 3BH.

Company Secretary Direct Line: 020 7813 8230

AGENDA

	Agenda Item **STANDARD ITEMS**	Presented by	Author	Timing
1.	**Apologies for absence**	Chair	**Verbal**	**1:15pm**
Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.				
2	**Minutes of Meeting held on 15 July 2020**	Chair	**J**	
3.	**Matters Arising/ Action Checklist**	Chair	**K**	
4.	**Chief Executive Update**	Chief Executive	**L**	**1:20pm**
5.	**Patient Story**	Chief Nurse	**M**	**1:30pm**
	STRATEGY			
6.	**Diversity and Inclusion Strategy and Health and Wellbeing Strategy**	Director of HR and OD	**N**	**1:55pm**
7.	**Directorate Presentation: Sight and Sound Directorate**	Interim Chief Operating Officer/ Chief Finance Officer	**O - Presentation**	**2:05pm**
	RISK			
8.	**Board Assurance Framework Update**	Company Secretary	**P**	**2:25pm**
	PERFORMANCE			
9.	**Update on data quality assessment framework**	Interim Chief Operating Officer	**Q**	**2:30pm**
10.	**Integrated Quality and Performance Report – Month 4 (July) 2020 and Patient Safety Metrics**	Medical Director/ Chief Nurse/ Acting Chief Operating Officer/	**R**	**2:40pm**
11.	**Finance Report - Month 4 (July) 2020**	Chief Finance Officer	**S**	**2:50pm**
12.	**Safe Nurse Staffing Report (June and July 2020) and Six monthly staffing review**	Chief Nurse	**T** **4**	**3:00pm**
	ASSURANCE			
13.	**Update with completion of CQC recommendations**	Medical Director	**U**	**3:15pm**

14.	**Infection Control Annual Report 2019/20**	Chief Nurse	**V**	**3:25pm**
15.	**Workforce Equality** • **Workforce Race Equality Standard 2020** • **Workforce Disability Equality Standard 2020**	Director of HR and OD	**X**	**3:45pm**
16.	**Emergency Planning Annual Report 2019/20**	Interim Chief Operating Officer	**Y**	**3:55pm**
17.	**Board Assurance Committee reports** • **People and Education Assurance Committee Update –September 2020** ***Note: There have been no meetings of the Quality, Safety and Experience Assurance Committee, the Finance and Investment Committee or Audit Committee since the last Trust Board meeting.***	Chair of the People and Education Assurance Committee	**Verbal**	**4:05pm**
18.	**Council of Governors' Update – July 2020**	Chair	**Z**	**4:15pm**
	GOVERNANCE			
19.	**Trust Board Terms of Reference and Workplan**	Company Secretary	**1**	**4:20pm**
20.	**Schedule of Matters Reserved for the Board and Council of Governors**	Company Secretary	**2**	
21.	**Any Other Business** (Please note that matters to be raised under any other business should be notified to the Company Secretary before the start of the Board meeting.)			**4:30pm**
21.	**Next meeting** The next public Trust Board meeting will be held on Wednesday 25 November 2020 (location to be determined).			

Attachment S

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
16 September 2020

Month 4 2020/21 Finance Report **Submitted by:** Helen Jameson, Chief Finance Officer	**Paper No: Attachment S**

Aims / summary

This report shows the Trust's finance position against the plan set by NHSE/I for the first 4 months of the year as these reflect the assumptions made by NHSE/I on income flows and expenditure.

1. The Trust position at Month 4 is a £7.1m deficit. This has been offset by an accrual for the NHS top up payment (£7.1m) which, in line with NHS Guidance, gives the trust a breakeven position for Month 4. The total accrual for NHS top up payments for Month 4 YTD is £24.5m. NHSE have paid £15.7m of this top up. Confirmation of the M4 top up is expected mid-September. NHSE have not yet confirmed when or if they will fund the credit loss allowance (£1.9m).

2. NHSE have set the Trust a plan based on the average expenditure in M08 to M10 for 2019/20 and average Income M1-9. NHS clinical income is under a block that reflects this plan, and this includes high cost drugs and devices.

3. The key driver of the Trust deficit is the income position which is below plan. Private patient income is £10.0m below plan YTD due to reduced levels of activity associated with the Trust stopping referrals in March to facilitate Covid-19 capacity. Other non-clinical income is £11.2m below plan mainly due to research studies not linked to Covid-19 being suspended, reduced Education & Training programmes and reduced charitable donations due to projects being put on hold. The Trust has seen some increase in these in July as research studies and Trust projects restart.

4. Pay is adverse to plan YTD by £6.5m. This has been driven by staffing requirements to support the Covid-19 response including additional medical and scientific staff from other organisations and new student nurses receiving paid placements in order to support the Trust with its Covid-19 response. There have been changes to medical staff working patterns, additional staff to support mental health services and further bank cover has been required to support sickness and rotas. Many staff costs that would have been capitalised have now become part of revenue expenditure due to charity and capital projects stopping due to Covid-19.

5. Non Pay is adverse to plan YTD by £0.1m. The Trust high cost drug spend is above plan largely due to increased costs of ongoing homecare drugs costs above plan, increased Car-T treatments and new therapies for Battens disease and cystic fibrosis. The Trust has also seen an increase in costs associated with cyber security and facilitating remote access for staff and patients. The Trust saw lower levels of clinical supplies in the first months of the year related to reduced activity and this offset the high drugs spend and Covid-19 costs in prior months. In line with the Trust restoration plans the clinical supplies spend has increased in June and July and is expected to rise further as activity increases.

6. Cash held by the Trust is £109.6m which is a reduction on June of £4.3m. The Trust continued to receive block SLA payments a month in advance which contributed to the high cash balance at the end of the month.

7. Capital expenditure as at M4 YTD was £2.9m for Trust funded and £4.7m for charity funded. The Trust has also incurred £0.3m of capital spend in relation to Covid-19.

The key movements to note on the balance sheet are:

Indicator	Comment
Cash	Cash held by the Trust decreased £4.3m in July to a closing cash balance of £109.6m. This reduction was partly as a result of an increase in creditor payments in month, and partly as a result of top up payments being accrued rather than received as cash.
NHS Debtor Days	NHS Debtor days decreased from 8 to 7 days as a result of collection of NHS debt.
IPP Debtor Days	IPP debtor days increased from 279 days to 289 days due to an increase in overdue debt.
Creditor Days	Creditor days reduced from 37 days to 30 days reflecting a reduction in creditors.

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
Changes to payment methods and expenditure trends

Who needs to be told about any decision?
Chief Finance Officer

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 / Executive Management Team

Great Ormond Street Hospital for Children NHS Foundation Trust

Finance and Workforce Performance Report Month 4 2020/21

Contents

Trust Performance Summary for the 4 months ending 31 Jul 2020

KEY PERFORMANCE DASHBOARD

Great Ormond Street Hospital for Children NHS Foundation Trust

ACTUAL FINANCIAL PERFORMANCE

	In month			Year to date		
	Plan	Actual	RAG	Plan	Actual	RAG
INCOME	£43.1m	£38.7m		£172.3m	£150.4m	
PAY	(£24.1m)	(£26.0m)		(£96.2m)	(£102.7m)	
NON-PAY inc. owned depreciation and PDC	(£18.2m)	(£19.7m)		(£72.9m)	(£72.3m)	
Surplus/Deficit excl. donated depreciation	£0.8m	(£7.1m)		£3.2m	(£24.5m)	
Top up	£0.0m	£7.1m		£0.0m	£31.6m	
Surplus/Deficit excl. donated depreciation	£0.8m	£0.0m		£3.2m	£7.1m	

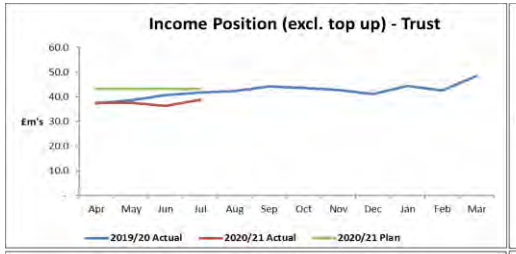
RAG: on or favourable to plan = green, 0-5% adverse to plan = amber, 5%+ adverse to plan = red

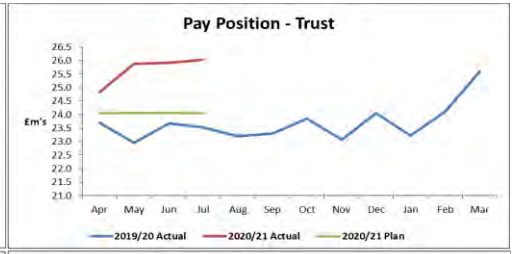
AREAS OF NOTE:

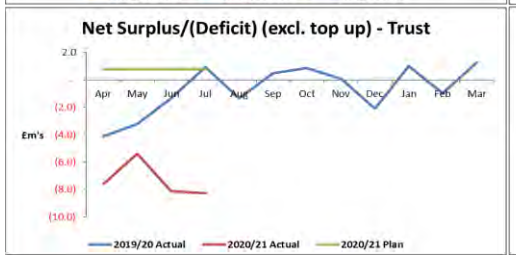
The Month 4 Trust position is a £7.1m deficit and YTD is a £24.5m deficit. An NHS top up has been accrued in line with NHS guidelines, which gives the Trust a breakeven position YTD. NHSE have validated £15.7m of the £24.5m M1 to M3 top up, the area not currently validated is the £1.9m associated with the credit loss allowance and the M4 top up. The latest information from NHSE is that the top-up arrangement will be extended to the end of September, the Trust is still awaiting clarity around future funding arrangements.

Private patient income is below the NHSE plan YTD (£10.0m). The Trust stopped referrals in March in order to expand Covid-19 capacity and therefore the income seen over the last four months has been for patients that had already been admitted. NHS prioritisation criteria are being applied to the patients in the Private Patient pipeline and so new private admittance numbers are low. The Trust has been increasing its Elective work and while income, remains unchanged due to the block, associated non-pay costs are increasing. Research and Charitable projects income is below plan (£6.0m) as projects were stopped during the pandemic, July has seen a number of research projects restart and R&D income has improved in month, additional research studies are expected to restart going forward. The Trust has received no further guidance on what is going to happen with Genetics provider to provider work which can no longer be billed and is not in the national block (£1.4m).

Pay is above plan YTD (£6.5m) due to additional staffing costs YTD to support the Covid-19 response(£5.3m) including backfill for staff shielding, backfill for increased sickness, employment of student nurses and staff to support patients from other organisations. The Trust has also seen an increase in the provisions for credit loss allowance in the month.





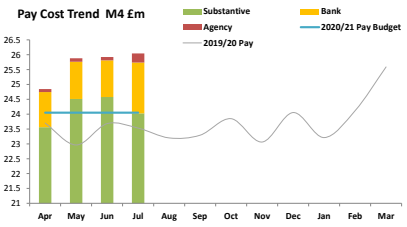


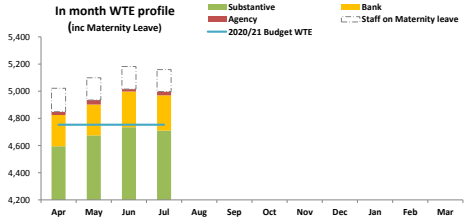
PEOPLE

	M4 Plan WTE	M4 Actual WTE	Variance
PERMANENT	4,516.9	4,710.2	(193.3)
BANK	215.3	259.9	(44.6)
AGENCY	21.2	27.6	(6.4)
TOTAL	**4,753.4**	**4,997.8**	**(244.4)**

AREAS OF NOTE:

NHSE has set a plan that is equivalent to 4,753 WTE, which shows a 244 WTE over establishment in-month (a 7% reduction in the over establishment since M3). The high level of WTE's above NHSE plan is driven by the early payment and on-boarding of year 2 and 3 student nurses, as per NHS guidance, to support the Trust Covid-19 response (107 WTE's in M4). The Trust is still providing bank cover to support sickness and rotas (112 staff at the end of July were shielding or self isolating). The Trust expects that this level of WTE's will continue to reduce as bank spend and temporary contracts continue to reduce, and capital projects restart (leading to capitalisation of staff and their WTE).



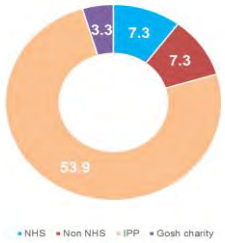


CASH, CAPITAL AND OTHER KPIs

Key metrics	*Jun-20*	*Jul-20*
Cash	£113.9m	£109.6m
IPP Debtor days	279	289
Creditor days	37	30
NHS Debtor days	8	7

Capital Programme	*YTD Plan M4*	*YTD Actual M4*	*Full Year F'cst*
Total Trust-funded	£2.9m	£2.9m	£14.5m
Total Covid	£0.3m	£0.3m	£2.9m
Total Donated	£5.3m	£4.7m	£13.8m
Grand Total	£8.5m	£7.8m	£31.2m

Net receivables breakdown (£m)



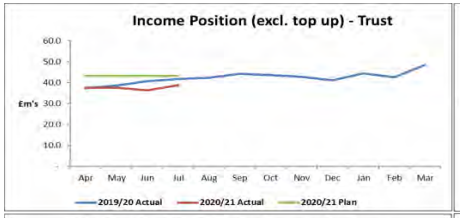
AREAS OF NOTE:

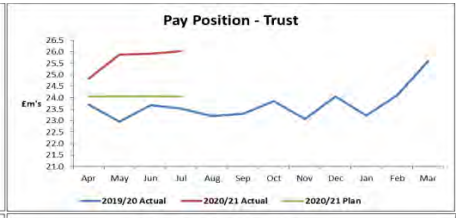
1. Cash held by the Trust decreased in month by £4.3m. The Trust continued to received SLA block payments a month in advance.
2. The capital programme for the year to date is less than plan by £0.6m: the variance is only on the the donated programme and relates to equipment purchases for which the procurement lags slightly behind the approval by the Charity.
3. IPP debtors days increased in month from 279 days to 289 days. Total IPP debt increased slightly in month to £47.7m (£47.4m in M03). Overdue debt increased in month to £44.1m (£41.9m in M03).
4. Creditor days decreased in month from 37 days to 30 days.
5. NHS debtor days decreased in month from 8 days to 7 days.

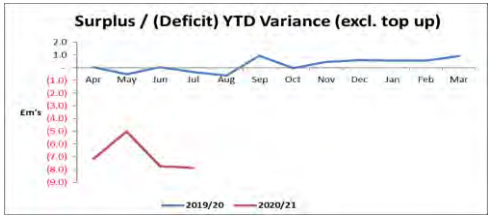
Trust Income and Expenditure Performance Summary for the 4 months ending 31 Jul 2020

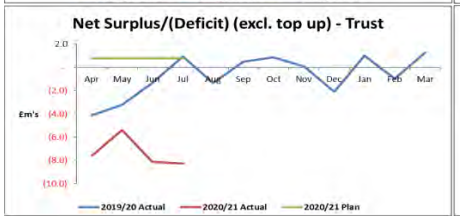
Great Ormond Street Hospital for Children NHS Foundation Trust

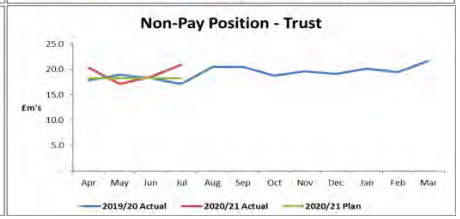
2020/21 Board Approved plan (£m)	Income & Expenditure	Month 4 NHSE Plan (£m)	Month 4 Actual (£m)	Month 4 Variance (£m)	Month 4 Variance %	Year to Date NHSE Plan (£m)	Year to Date Actual (£m)	Year to Date Variance (£m)	Year to Date Variance %	Rating YTD Variance	Notes	2019/20 Actual M4 (£m)	2020/21 NHSE Plan M4 (£m)	2020/21 Board Approved Plan M4 (£m)
414.52	NHS & Other Clinical Revenue	31.97	31.82	(0.16)	(0.49%)	127.89	127.22	(0.67)	(0.53%)	R	1	31.70	127.89	36.88
73.24	Private Patient Revenue	5.59	3.54	(2.05)	(36.69%)	22.34	12.32	(10.02)	(44.83%)	R	2	5.59	22.34	6.20
64.15	Non-Clinical Revenue	5.53	3.33	(2.20)	(39.80%)	22.10	10.90	(11.20)	(50.70%)	R	3	4.32	22.10	5.15
551.91	**Total Operating Revenue**	**43.08**	**38.68**	**(4.40)**	**(10.22%)**	**172.33**	**150.44**	**(21.89)**	**(12.70%)**	R		**41.61**	**172.33**	**48.23**
(303.12)	Permanent Staff	(22.76)	(24.03)	(1.26)	(5.55%)	(91.05)	(96.66)	(5.60)	(6.16%)			(22.07)	(91.05)	(25.28)
(0.21)	Agency Staff	(0.15)	(0.30)	(0.16)	(110.26%)	(0.58)	(0.63)	(0.05)	(8.92%)			(0.09)	(0.58)	(0.02)
(2.55)	Bank Staff	(1.14)	(1.71)	(0.57)	(49.56%)	(4.58)	(5.38)	(0.80)	(17.50%)			(1.35)	(4.58)	(0.22)
(305.88)	**Total Employee Expenses**	**(24.05)**	**(26.04)**	**(1.99)**	**(8.28%)**	**(96.21)**	**(102.67)**	**(6.46)**	**(6.71%)**	R	4	**(23.50)**	**(96.21)**	**(25.52)**
(107.60)	Drugs and Blood	(6.76)	(7.67)	(0.91)	(13.43%)	(27.06)	(29.75)	(2.69)	(9.95%)	R		(5.83)	(27.06)	(9.33)
(39.93)	Supplies and services - clinical	(3.11)	(2.83)	0.28	9.09%	(12.43)	(9.17)	3.26	26.26%	G		(2.81)	(12.43)	(3.38)
(78.79)	Other Expenses	(6.68)	(7.69)	(1.02)	(15.22%)	(26.70)	(27.39)	(0.68)	(2.56%)	R		(5.91)	(26.70)	(6.62)
(226.31)	**Total Non-Pay Expenses**	**(16.55)**	**(18.19)**	**(1.64)**	**(9.92%)**	**(66.19)**	**(66.30)**	**(0.11)**	**(0.17%)**	A	5	**(14.56)**	**(66.19)**	**(19.34)**
(532.19)	**Total Expenses**	**(40.60)**	**(44.23)**	**(3.63)**	**(8.95%)**	**(162.40)**	**(168.97)**	**(6.57)**	**(4.04%)**	R		**(38.06)**	**(162.40)**	**(44.86)**
19.72	**EBITDA (exc Capital Donations)**	**2.48**	**(5.55)**	**(8.04)**	**(324%)**	**9.93**	**(18.53)**	**(28.46)**	**(286.57%)**	R		**3.55**	**9.93**	**3.37**
(1.36)	Owned depreciation, Interest and PDC	(1.68)	(1.50)	0.18	10.57%	(6.71)	(6.01)	0.70	10.42%		7	(1.52)	(6.71)	(1.52)
18.36	**Surplus/Deficit (exc. PSF/Top up)**	**0.81**	**(7.05)**	**(7.86)**	**(975.18%)**	**3.22**	**(24.54)**	**(27.76)**	**(861%)**			**2.02**	**3.22**	**1.84**
0.00	PSF/Top up	0.00	7.05	7.05		0.00	24.54	24.54					0.00	0.00
18.36	**Surplus/Deficit (incl. PSF/Top up)**	**0.81**	**0.00**	**(0.81)**	**(99.99%)**	**3.22**	**0.00**	**(3.22)**	**(99.86%)**	R		**2.02**	**3.22**	**1.84**
0.00	PY PSF post accounts reallocation	0.00	0.00	0.00		0.00	0.00	0.00				0.00	0.00	0.00
(13.70)	Donated depreciation	0.00	(1.21)	(1.21)		0.00	(4.85)	(4.85)				(1.07)	0.00	(1.07)
4.66	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**0.81**	**(1.21)**	**(2.01)**	**(249.96%)**	**3.22**	**(4.85)**	**(8.07)**	**(250.39%)**			**0.95**	**3.22**	**0.77**
0.00	Impairments	0.00	0.00	0.00		0.00	0.00	0.00				0.00	0.00	0.00
18.36	Capital Donations	0.00	0.51	0.51		0.00	4.65	4.65			6	2.70	0.00	1.29
23.02	**Adjusted Net Result**	**0.81**	**(0.70)**	**(1.51)**	**(187.27%)**	**3.22**	**(0.20)**	**(3.42)**	**(106.21%)**			**3.65**	**3.22**	**2.07**











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

Summary

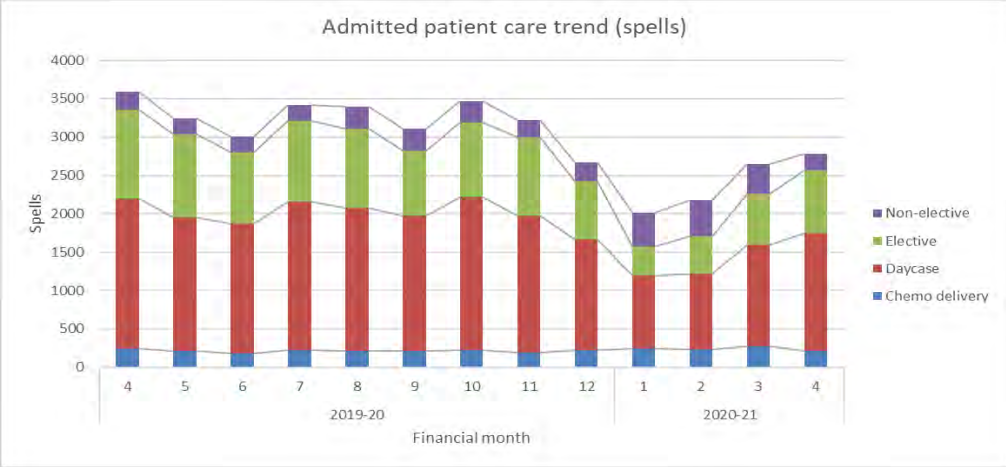
- The month 4 deficit is £7.1m, which has then been offset by the NHS retrospective top up which brings the Trust to a breakeven position.
- NHSE have validated £15.7m of the £24.5m YTD top up. They have not validated £1.9m associated with the credit loss allowance and will be reviewing the M4 £7.1m top up. This presents a risk to the Trust position.

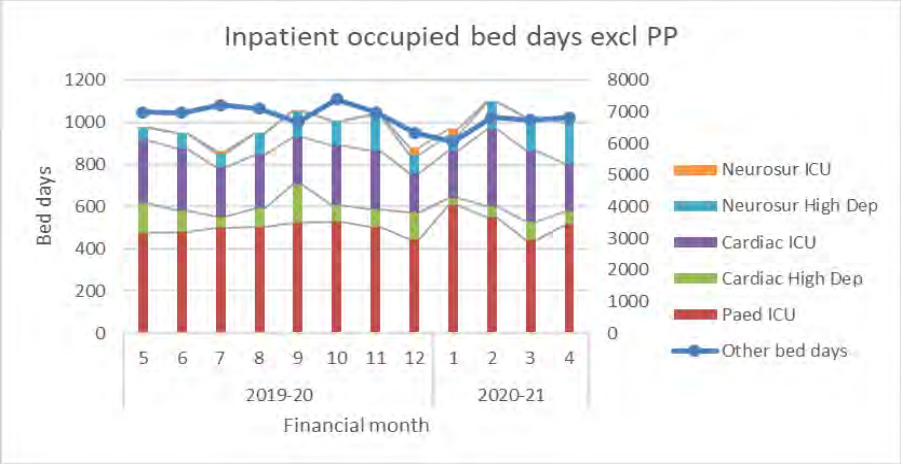
Notes

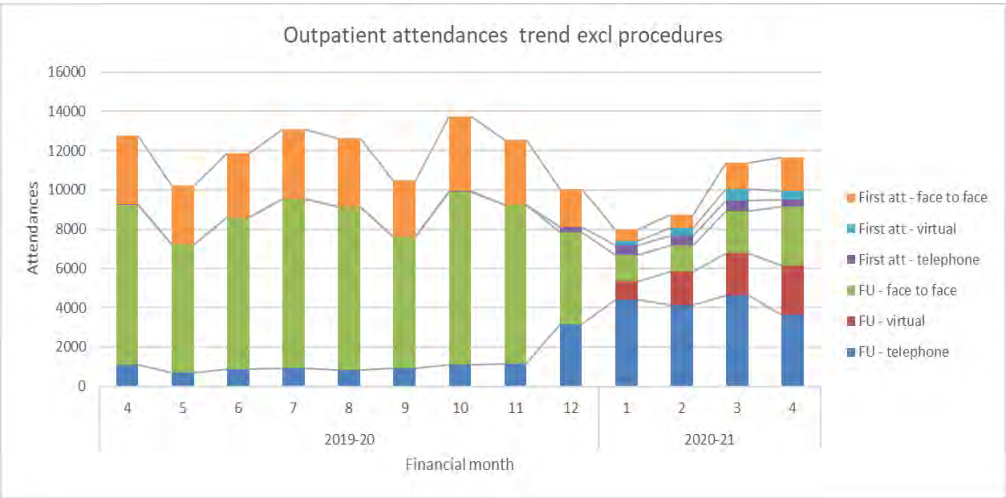
1. The NHS & other clinical revenue plan has been set centrally by NHSE for M1-4 based on the 2019/20 average income. NHS Clinical income is under a block contract for M1-6.
2. Private Patient income is £10.0m adverse YTD to the NHSE plan. The income generated is largely from long stay patients that were in the Trust before referrals were stopped in March. Following NHS prioritisation guidelines the Trust has accepted a few new referrals in July that meet the high priority criteria.
3. Non-clinical income is £2.2m adverse in month and £11.2m adverse YTD due to the stopping of research studies due to Covid-19, reduced E&T programmes, reduced charitable income and Genetics testing. NHS guidelines stops the Trust billing for Genetics tests (£1.4m) but has not built this into the NHSE contract. Research projects have started to come back online in July seeing an in month improvement (£1.3m).
4. Pay is adverse to the NHSE plan by £6.5m YTD. This has been caused by the Trust response to Covid-19 (£5.3m) due to bringing staff across from other organisations, sickness cover, cover for staff shielding, expanded Covid testing service and student nurse support in line with national guidance. The NHSE plan has been using the M8-10 staffing levels which at GOSH a low cost months resulting in a £1.1m pressure on the Trust pay bill.
5. Non pay is £1.6m adverse to plan in month and £0.1m adverse YTD. Drug costs in-month are £0.9m higher than the NHSE plan due to high cost drugs and therapies that were not part of the plan. Elective and R&D activity has increased in month and as a result, clinical supplies have increased. In-month the Trust has also seen an increase in bad debt provision.
6. The plan set by NHSE does not include a plan for capital donations.

2020/21 Overview of activity trends for the 4 months ending 31 Jul 2020

Great Ormond Street Hospital for Children NHS Foundation Trust





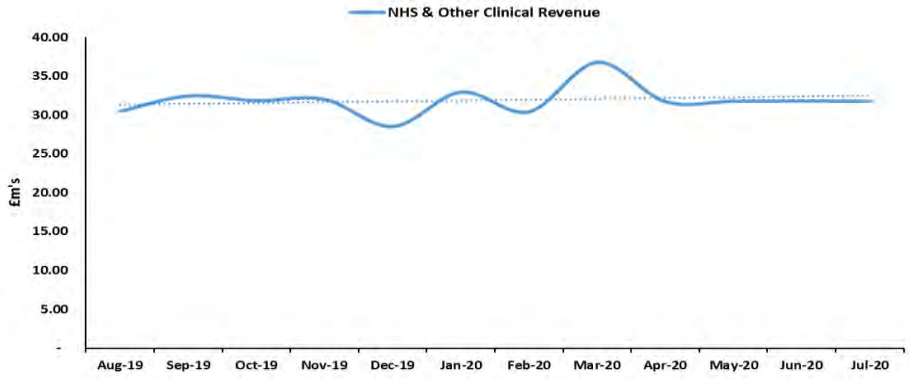


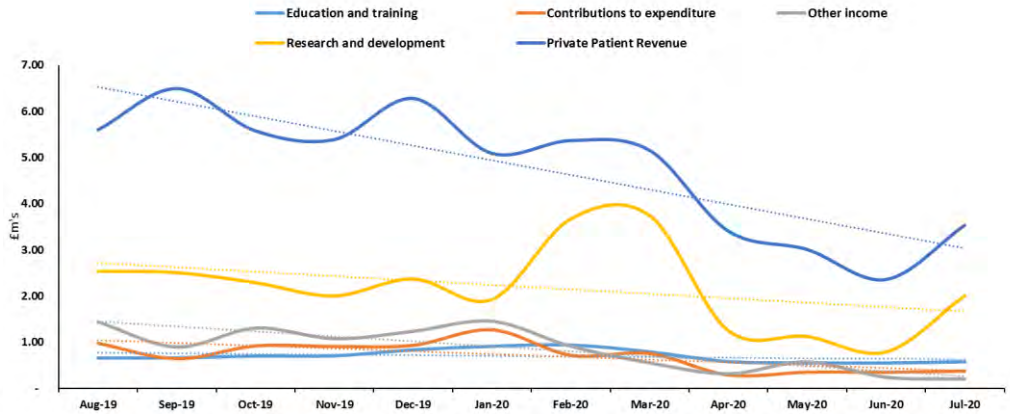
Summary

- All graphs show an overall growth in activity in July although it is at a lower level than the increase from May to June. This trend is mirrored by increased costs for clinical supplies and services with spend increasing to £2.6m versus the 2019/20 average of £2.7m per month; a rise of £0.3m versus June.
- Despite the upward trend for admitted patient care activity for all points of delivery activity levels are below the daily averages for 2019/20 with the largest shortfalls being in daycase (21%) and elective (24%).
- Outpatient attendances for July are 91% of those delivered in July 2019. Virtual and telephone attendances have reduced as a % of the total from 55.4% in April to 32.4% in July for first attendances and from 80.1% to 67.2% for follow up activity.
- Drugs spend has remained at an average of £7.4m per month when compared to June.

2020/21 Income for the 4 months ending 31 Jul 2020

Great Ormond Street Hospital for Children NHS Foundation Trust





Summary

- Operating revenue is £21.9m below plan year to date and this is being primarily driven by reductions in private patient (£10. 0m) and non-clinical income (£11.2m).
- Private Patient income is £10.0m below the NHSE plan YTD driven by ceasing acceptance of new referrals through M1 -3 due to Covid-19. The Trust has stated to increase NHS elective work based on prioritisation criteria, this includes private patients and has led to a small number of new admissions in July . The private patient referral pipeline is not expanding as countries are not sending patients for treatment.
- Research income YTD is below the NHSI plan (£3.2m). This is due to research studies having been suspended, except those on Co vid-19, in order to redeploy staff to support the Covid-19 response. A number of Research projects have restarted in July and the Trust has seen a £1.3m increase in R&D income betwe en M3 and M4.
- Other income is £3.7m below the NHSI plan. The key driver of other income is associated with the National change in the rules governing Genetics billing. The new policy states the Genetics service can no longer charge for P2P testing as the plan was to include this in the new tariff. However Genetics inc ome falls under the block contracts which has not been uplifted to cover this income (£1.4m). GOSH lab testing income is down (£1.0m) due to reduced Elective activity across other organisations an therefore reduced testing activity. It is also unclear how CEA payments will be received as guidelines suggest they are within the bock and therefore this income has reduce d compared to the NSHE plan (£0.7m)
- Charitable income is £2.8m below the NHSE plan. This is caused by the projects that were being funded having put on hold due to the Trusts response to Covid-19. With these projects stopping the Trust has seen a saving on some variable costs but many fixed staffing and non -pay costs are still being incurred by the Trust resulting in a pressure. Income is expected to increase in coming months as projects are restarted including work on the GOSH learning academy.

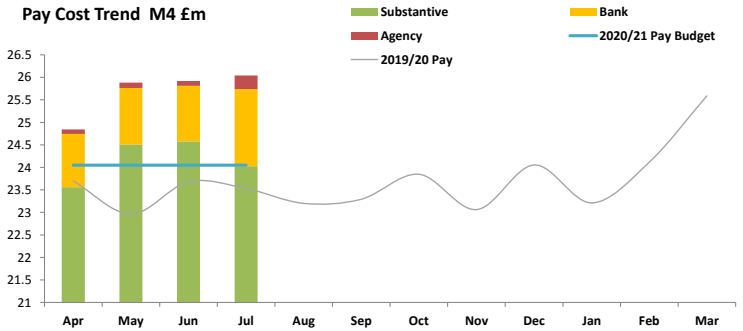
Workforce Summary for the 4 months ending 31 Jul 2020

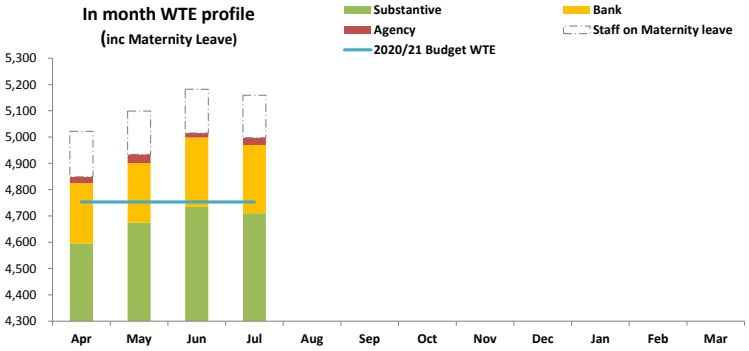
*WTE = **Worked WTE**, Worked hours of staff represented as WTE

Great Ormond Street Hospital for Children NHS Foundation Trust

£m including Perm, Bank and Agency	2019/20 actual			2020/21 actual			Variance			RAG
Staff Group	YTD (£m)	YTD Average WTE	£000 / WTE	YTD (£m)	YTD Average WTE	£000 / WTE	YTD (£m)	Volume Var (£m)	Price Var (£m)	£ Variance
Admin (inc Director & Senior Managers)	50.3	1,110.6	45.3	18.4	1,154.6	47.7	(1.6)	(0.7)	(0.9)	R
Consultants	54.5	352.1	154.7	19.4	386.5	150.6	(1.2)	(1.8)	0.5	R
Estates & Ancillary Staff	4.6	137.9	33.2	1.6	140.2	33.2	(0.0)	(0.0)	(0.0)	G
Healthcare Assist & Supp	9.1	281.7	32.2	4.0	350.5	33.9	(0.9)	(0.7)	(0.2)	R
Junior Doctors	28.4	347.1	81.9	10.0	360.1	83.5	(0.5)	(0.4)	(0.2)	R
Nursing Staff	80.7	1,526.0	52.9	28.8	1,550.7	55.8	(1.9)	(0.4)	(1.5)	R
Other Staff	0.5	9.1	53.3	0.2	10.0	55.2	(0.0)	(0.0)	(0.0)	G
Scientific Therap Tech	52.1	945.3	55.1	19.3	969.9	59.7	(1.9)	(0.5)	(1.5)	R
Total substantive and bank staff costs	**280.2**	**4,709.7**	**59.5**	**101.6**	**4,922.5**	**61.9**	**(8.2)**	**(4.2)**	**(4.0)**	R
Agency	2.0	28.8	68.8	0.6	25.6	74.1	0.0	0.1	(0.0)	G
Total substantive, bank and agency cost	**282.1**	**4,738.6**	**59.5**	**102.2**	**4,948.1**	**62.0**	**(8.2)**	**(4.1)**	**(4.0)**	R
Reserve*	2.1	0.0	0.0	0.4	1.3		0.3	0.3	0.0	G
Additional employer pension contribution by NHSE	11.6	0.0	0.0	0.0	0.0		3.9	0.0	3.9	G
Total pay cost	**295.8**	**4,738.6**	**62.4**	**102.7**	**4,949.3**	**62.2**	**(4.1)**	**(3.9)**	**(0.2)**	R
Remove maternity leave cost	(3.6)			(1.1)			(0.1)	0.0	(0.1)	A
Total excluding Maternity Costs	**292.2**	**4,738.6**	**61.7**	**101.6**	**4,949.3**	**61.6**	**(4.2)**	**(3.9)**	**(0.3)**	R

*Plan reserve includes WTEs relating to the better value programme

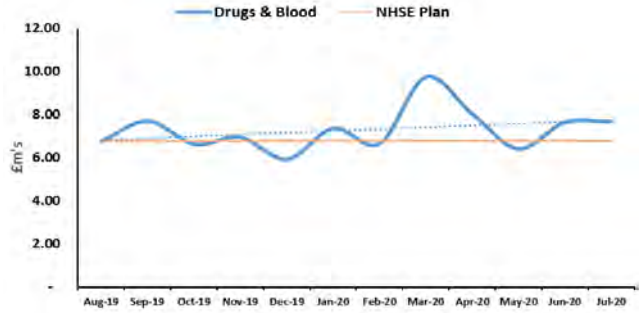


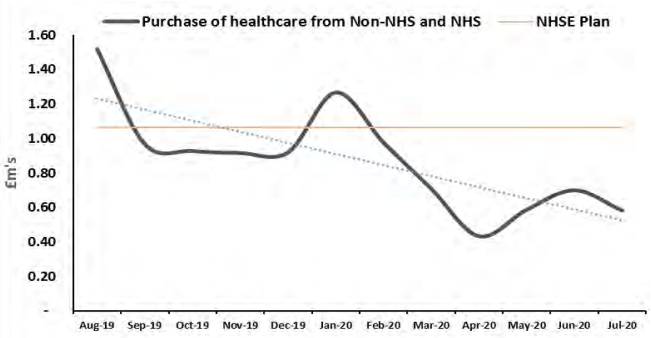


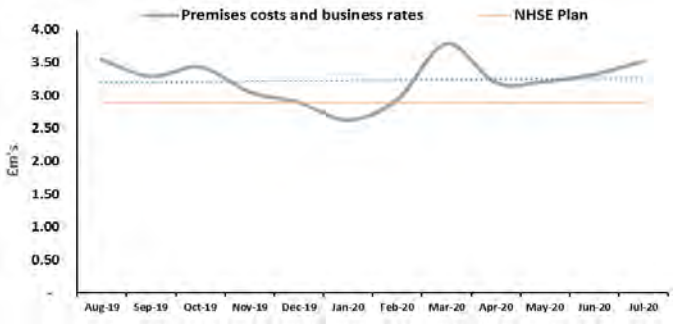
Summary

- In-month WTE's have reduced from 5,016 in M3 to 4,998 in M4. WTE numbers have reduced due staff returning to their organisations as patients returned, temporary Covid-19 support contracts ending, reduced numbers of staff shielding and partially offsetting these reductions an increase associated with additional research staff supporting the restarting of research projects.
- The Trust pay spend YTD has resulted in a £6.4m adverse variance to plan YTD. £5.3m of this is associated with additional staffing costs to deliver the Covid-19 response and is linked to backfill of staff due to sickness and shielding, student nurse placements, changes to rotas and staff from other organisations supporting new patient cohorts.. The rest of this variance is due to the M8-10 average that was used by NHSE to set the plan being a low period of spend for GOSH.
- NHSE set the Trusts Pay plan on the M8-10 2019/20 spend. Due to the nature of the work at GOSH these are typically lower activity months and therefore pay spend was low during this period. This means that compared to a wider period of comparison the Trust has a plan set c£1.1m too low.
- The Trust continues to backfill staff due to sickness cover and shielding with £2.2m of bank costs YTD attributed to Covid-19. The number of staff self-isolating has fallen to 112 at the end of July (from 141 at the end of June) and so the monthly requirement is expected to decrease in future months. At the peak of sickness and shielding in April, the Trust had over 370 staff off work.
- The Trust has seen an increase in Agency costs to support projects across the organisation including cyber security. The Trust is monitoring these increases and whether resources can be secured through the bank or fixed term contracts.

Non-Pay Summary for the 4 months ending 31 Jul 2020







Summary

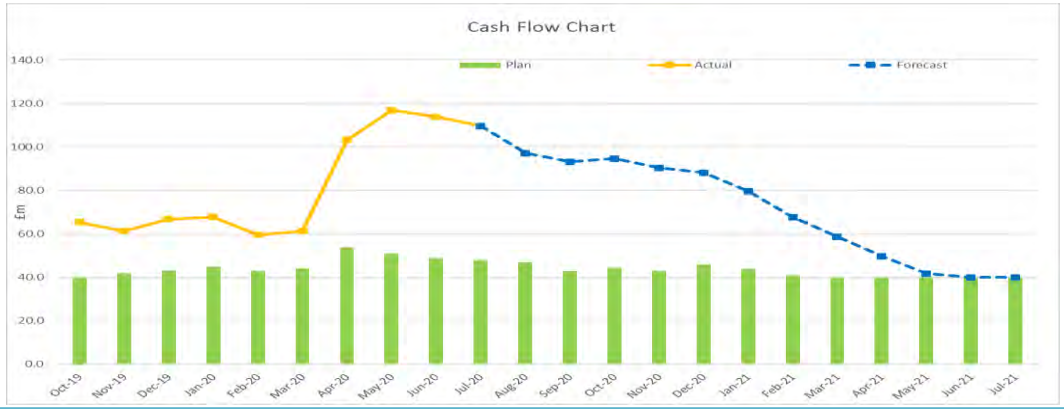
- Drugs and Blood are £2.7m higher YTD than the NHSI plan. The key drivers of spend continue to be for blood (£0.3m) and pass through drugs including homecare (£2.8m). Blood costs have as returned to 2019/20 average levels in month 4 with the return of Haematology patients to their local Trusts. Pass through overspend continues to be driven by drug therapies that were not part of the plan e.g. CF drugs, cerliponase and cannabdiol and high cost therapies e.g. CART and nusinersen.
- Supplies and services saw a significant reduction in April due to the reduction of Elective work due to the Covid-19 response. June and July saw an increase in spend on clinical supplies as Elective activity has increased inline with the Trust restoration plans. Reagent spend has increased since May as Covid testing increases and Elective activity restarts, requiring increased diagnostics. This is expected to continue to rise as more activity comes back online within the Trust
- Premises have seen an increase in costs in relation to the additional ICT expenditure involved in improving the Trust cyber security, virtual patient meetings and to facilitate remote access and working for staff. The Trust has also seen increased costs associated with segregating pathways and putting in additional social distancing measures.
- The Trust has seen a £1.9m increase YTD in the credit loss allowance due to non-payment of private patient debt. This has been calculated in line with IFRS9 and the Trust's policy.
- Depreciation is £4.1m higher than the NHSI plan as donated depreciation and capital donations were excluded from the plan.

31 Mar 2020 Audited Accounts £m	Statement of Financial Position	YTD Actual 30 Apr 2020 £m	YTD Actual 30 Jun 2020 £m	*YTD Actual 31 Jul 2020 £m*	In month Movement £m
543.87	Non-Current Assets	544.13	544.39	543.86	(0.53)
115.21	Current Assets (exc Cash)	117.03	103.22	98.35	(4.87)
61.31	Cash & Cash Equivalents	103.21	113.91	109.56	(4.35)
(102.32)	Current Liabilities	(145.60)	(143.36)	(134.29)	9.07
(6.76)	Non-Current Liabilities	(6.68)	(6.35)	(6.30)	0.05
611.31	**Total Assets Employed**	**612.09**	**611.81**	**611.18**	**(0.63)**

31 Mar 2020 Unaudited Accounts £m	Capital Expenditure	YTD plan 31 July 2020 £m	YTD Actual 31 Jul 2020 £m	YTD Variance £m	Forecast Outturn 31 Mar 2021 £m	RAG YTD variance
21.84	Redevelopment - Donated	4.02	3.85	0.17	11.21	G
7.43	Medical Equipment - Donated	1.23	0.80	0.43	2.55	A
1.95	ICT - Donated	0.00	0.00	0.00	0.00	G
31.22	**Total Donated**	**5.25**	**4.65**	**0.60**	**13.76**	A
6.78	Redevelopment & equipment - Trust Fun	0.47	0.17	0.30	6.05	R
1.90	Estates & Facilities - Trust Funded	1.29	1.05	0.24	3.46	A
11.95	ICT - Trust Funded	1.15	1.67	(0.52)	4.80	R
0.00	Contingency	0.00	0.00	0.00	0.23	G
20.63	**Total Trust Funded**	**2.91**	**2.89**	**0.02**	**14.54**	G
0.00	**Covid**	**0.29**	**0.29**	**0.00**	**2.93**	G
51.85	**Total Expenditure**	**8.45**	**7.83**	**0.62**	**31.23**	G

Working Capital	30-Jun-20	31-Jul-20	RAG	KPI
NHS Debtor Days (YTD)	8.0	7.0	G	< 30.0
IPP Debtor Days	279.0	289.0	R	< 120.0
IPP Overdue Debt (£m)	41.9	44.1	R	0.0
Inventory Days - Non Drugs	100.0	105.0	R	30.0
Creditor Days	37.0	30.0	A	< 30.0
BPPC - NHS (YTD) (number)	22.8%	34.4%	R	> 90.0%
BPPC - NHS (YTD) (£)	70.7%	61.6%	R	> 90.0%
BPPC - Non-NHS (YTD) (number)	56.8%	83.1%	R	> 90.0%
BPPC - Non-NHS (YTD) (£)	89.1%	87.6%	A	> 90.0%

RAG Criteria:
NHS Debtor and Creditor Days: Green (under 30); Amber (30-40); Red (over 40)
BPPC Number and £: Green (over 90%); Amber (90-85%); 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. Capital expenditure for the four months to 31 July is less than plan by £0.6m: the Trust-funded expenditure is on plan, and donated is less than plan by £0.6m - this relates to donated equipment procurement which lags plan slightly
2. Cash held by the Trust decreased in month by £4.3m.
3. Total Assets employed at M04 decreased by £0.6m in month as a result of the following:
   - Non current assets totalled £543.9m, a decrease of £0.5m in month
   - Current assets excluding cash totalled £98.4m, a decrease of £4.9m in month. This largely relates to the reduction in invoiced receivables for NHS debtors (£0.9m lower than M03); Non NHS debtors (£0.5m lower than M03); Capital receivables (£2.5m lower than M03) and other Charity receivables (£0.2m lower than M03). IPP invoiced receivables increased by £0.3m in month.
   - Cash held by the Trust totalled £109.6m, decreasing in month by £4.3m. This includes amounts received for invoiced debt as mentioned above as well as settlement of outstanding creditor invoices.
   - Current liabilities decreased in month by £9.1m to £134.3m which included payment to UCLH (£1m).
4. Overdue IPP debt increased in month to £44.1m (£41.9m in M03)
5. IPP debtor days increased from 279 days to 289 days in month. Total IPP debt increased slightly in month to £47.7m (£47.4m in M03).
6. The cumulative BPPC for NHS invoices (by value) decreased in month to 62% (71% in M03). This represented 34.4% of the number of invoices settled within 30 days (22.8% in M03)
7. The cumulative BPPC for Non NHS invoices (by value) decreased slightly in month to 88% (89% in M03); however BPPC for Non NHS invoices (by number) increased to 83.1% (56.8% in M03).
8. Creditor days decreased in month from 37 days to 30 days.

Attachment T

Trust Board
16 September 2020

Safe Nurse Staffing Report for reporting period June-July 2020 **Presented by:** Alison Robertson, Chief Nurse. **Prepared by:** Marie Boxall, Head of Nursing-Nursing Workforce	**Paper No: Attachment T**

Aims / summary

This report provides the Board with an overview of the Nursing workforce during the month of June and July 2020 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 safely staff the inpatient wards with the right number of nurses with the right skills and at the right time.

Action required from the meeting
To note the information in this report on safe nurse staffing which reflects actions as the trust moved from phase one into phase two of the Covid Pandemic throughout June and July and in preparation ahead of phase 3 and the re-establishment of normal activity with new ways of working.

There were no datix incidents in relation to safe staffing reported in June with two datix incidents reported in July. No patient harm occurred.

The Trust operated within nationally recommended parameters for safe staffing levels in June and July (Appendices)

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 20/21 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, Director of Nursing and Heads of Nursing

Who is accountable for the implementation of the proposal / project?
Chief Nurse; Directorate Management Teams

Attachment T
Safe Nurse Staffing Report for reporting period June - July 2020

1. Summary

This report on GOSH Safe Staffing covers the reporting period for June and July 2020. The paper provides the required assurance that GOSH had safe nurse staffing levels across all in-patient ward areas and appropriate systems in place to manage the demand for nursing staff. The report includes measures taken to ensure safe staffing throughout the Trust and during Phase 2 of the Covid 19 pandemic up to the 31st July as we work towards resuming normal activity in phase 3 (1st August 2020). The national reporting process for safe staffing was reinstated on the 3rd June 2020.

1.1 **Deployment**

All GOSH nursing staff that were deployed throughout the reporting period are now back in their home teams with departments planning for phase three and winter activity. In July there were approx. 80 nurses shielding however this number is expected to drop significantly to approx. 40 in August and further still in September as plans are in place to safely redeploy some of these nurses while others move on to maternity leave.

1.2 **Building competence and confidence**

The phase two period has enabled the upskilling of the 56 Aspirant Nurses currently employed within the trust to ensure they are ready to join workforce numbers in September, with an additional 44 supernummary Newly Qualified Nurses (NQNs) commencing the in that month. The Aspirant Nurse role was created as part of the national response to the Covid pandemic; they are nursing students in their final six months of training who were invited to opt into joining the workforce in a paid capacity to support the response earlier this year. .

1.3 **Health and Well-being (H&WB)**

In addition to encouraging staff to take annual leave to rest and recover ahead of any potential second wave and winter pressures, we are promoting the Health and Wellbeing hub and supporting and educating ward managers to apply and sustain flexible working patterns to promote H&WB.

2. Temporary Staffing

Requested shifts in June were 1854 with a slight increase to 1934 in July which remains significantly lower than the 12 month average, due to greater scrutiny and review of need across directorates. The fill rate in June was 88% and July 85% respectively, which is also an improvement on previous performance. Agency usage dropped dramatically from 224 shifts in June to 11 shifts in July following the

repatriation and discharge of mental health patients to their homes or local hospitals. Temporary staffing usage continues to remain a focus at Nursing Workforce Assurance Group (NWAG).

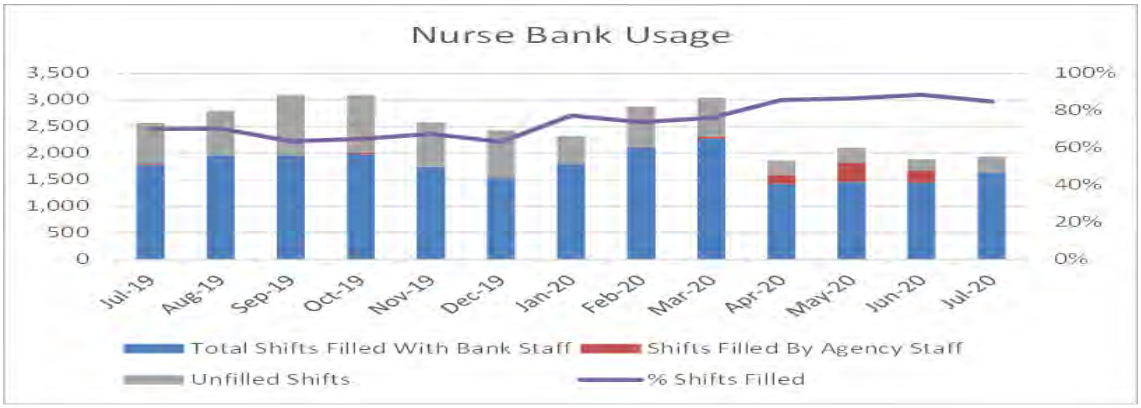


Fig. 1 *Nurse Bank Usage (12 month rolling)*

3. Incident Reporting

There were no datix incidents in relation to safe staffing reported in June with two datix incidents reported in July, 1 x Heart and Lung and 1 x Ops and Imaging.

The HoNs for each of these directorates have provided assurance that these incidents have been reviewed and closed with mitigation in place to prevent reoccurrence. No patient harm occurred.

4. Nursing Establishment Review

The biannual staffing establishment reviews which were deferred from March were undertaken in August, following completion of the Safer Nursing Care Tool scoring exercise throughout July. The Staffing Establishment Review is reported separately to the board this month.

5. Safecare

SafeCare is now fully operational in the trust and has replaced the manual bed portal system. SafeCare is automatically linked to each nursing roster and shows the utilisation of clinical staff ensuring there is the correct skill mix to deliver safe patient care. For SafeCare to work at its optimum level an accurate acuity tool needs to be embedded into the system to ensure correct triangulation of data, this would also support future safe staffing establishment reviews. Professional judgement may also be added to the system and red flags may be raised to alert senior staff if there's a concern prior to daily situation meetings. This will RAG rate the ward and may be used to make clinical staffing decisions in a more efficient way using a triangulation

of evidence based data (staffing numbers, acuity tool and clinician experience). Every inpatient ward area is now live with the Operations and Images directorate due to come on line following implementation of the rostering project in September 2020.

Appendix 1: Workforce utilisation and metrics

Actual vs Planned (AvP)

In June, the overall fill rate of AvP was 105% and in July it was 107% which is within the recommended range for both months.

Due to COVID-19, there was a national suspension of the reporting of Actual Vs planned Data to NHSI. This was re-instated in July 2020 and reported retrospectively.

Due to ward movements during the pandemic and as the directorates re-aligning to resume normal service, we were unable to source and submit increasingly accurate data. Where there were minor discrepancies, due to ward mergers and staff deployment we are able to provide narrative to explain these and mitigate against any misinformation.

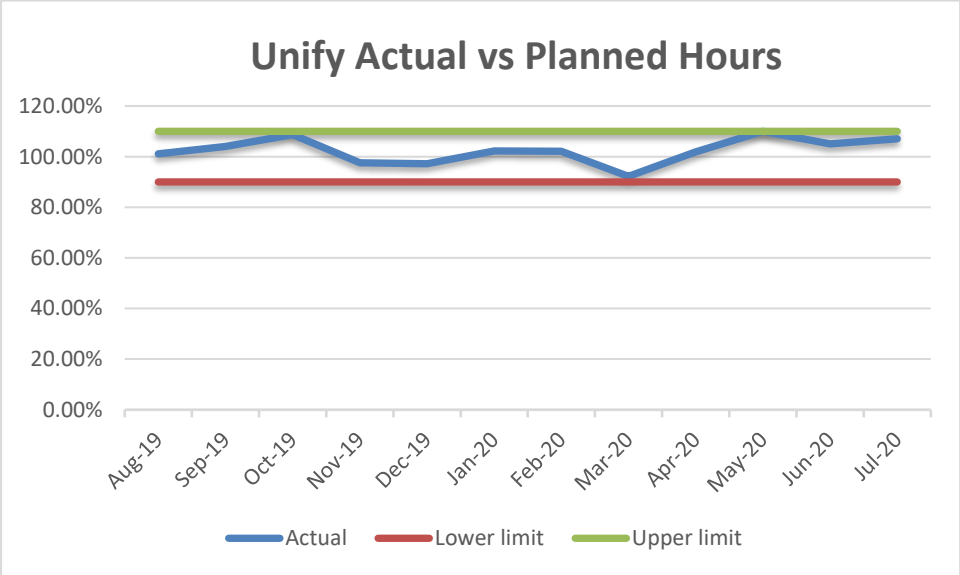


***Fig. 2** AvP Hours (12 month)*

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 July 2020 was 16.2 made up of 13.5 Registered Nurses and 2.67 HCA Hours. This is within the 12 month average CHPPD which is 13.7 hours.

Note: May and June is missing due to not having an accurate recording of midnight patient stays across the wards due to COVID merging.

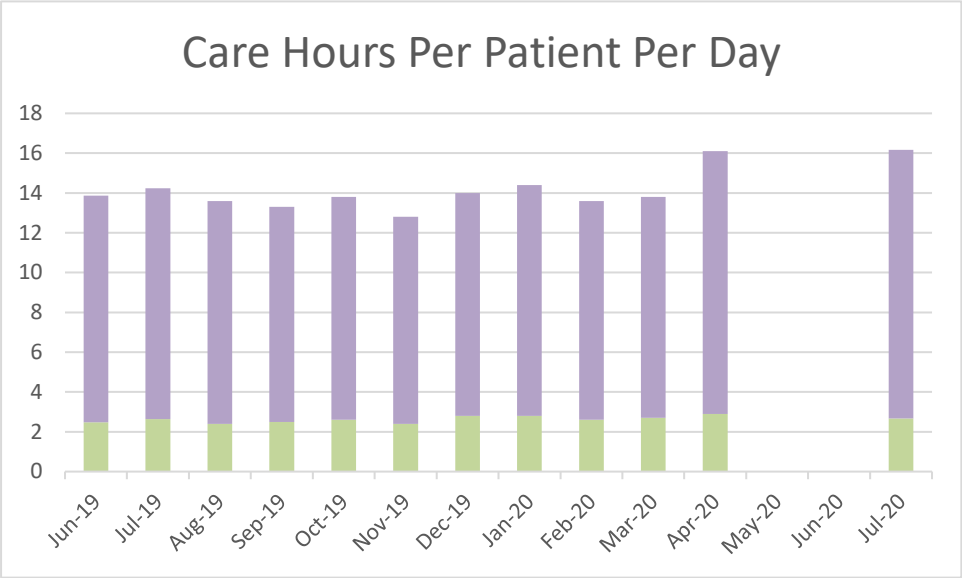


Fig. 3 *Care Hours Per Patient Day (12 month)*

Workforce metrics by Directorate

Directorate	Actual vs Planned %	CHPPD (exc ICUs)	RN Vacancies (FTE)	RN Vacancies (%)	Voluntary Turnover* %	Sickness (1 mnth) %	Maternity %
Blood, Cells & Cancer	100.1%	N/A	2.69	1.21%	11.59%	4.36%	7.95%
Body, Bones & Mind	115.1%	N/A	16.18	6.95%	17.54%	1.27%	6.78%
Brain	125.4%	N/A	14.48	11.06%	13.70%	2.55%	4.80%
Heart & Lung	101.3%	N/A	10.66	2.09%	16.45%	2.43%	5.24%
International	80.2%	N/A	7.36	7.52%	20.49%	3.60%	3.19%
Operations & Images	N/A	N/A	17.27	7.99%	15.52%	4.32%	5.05%
Sight & Sound	N/A	N/A	1.13	2.35%	12.85%	2.17%	5.77%
Trust	**102.9%**	**N/A**	**80.44**	**5.40%**	**15.13%**	**2.83%**	**5.74%**

June Nursing Workforce Performance
**Relates to all RN grade, in O&I this figure also include Operating Department Practitioners*
**Sight & Sound data not available due to merging with Panther Urology in Body, Bones and Mind*

Attachment T
Safe Nurse Staffing Report for reporting period June - July 2020

Directorate	Actual vs Planned %	CHPPD (exc ICUs)	RN Vacancies (FTE)	RN Vacancies (%)	Voluntary Turnover* %	Sickness (1 mnth) %	Maternity %
Blood, Cells & Cancer	107.7%	19.9	14.33	6.17%	11.00%	4.31%	8.37%
Body, Bones & Mind	109.5%	16.2	22.87	9.69%	16.16%	2.16%	6.90%
Brain	102.6%	11.3	14.02	10.62%	12.04%	3.01%	4.72%
Heart & Lung	111.5%	14.3	13.42	2.63%	16.01%	2.94%	4.89%
International	100.1%	21.6	7.43	7.51%	19.30%	2.70%	3.16%
Operations & Images	N/A	N/A	25.86	11.50%	14.92%	4.48%	4.59%
Sight & Sound	N/A	N/A	2.53	5.10%	12.77%	2.85%	5.77%
Trust	**107.1%**	**16.2**	**107.86**	**7.07%**	**14.43%**	**3.12%**	**5.61%**

July Nursing Workforce Performance (unvalidated at NWAG)
**Relates to all RN grades, in O&I this figure also include Operating Department Practitioners*
**Sight & Sound data not available due to merging with Panther Urology in Body, Bones and Mind*

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
16 September 2020

Safe Staffing Nursing Establishment Mid-year Review **Presented by:** Alison Robertson, Chief Nurse **Author:** Marie Boxall, Head of Nursing – Nursing Workforce	**Paper No: Attachment 4**

Aims / summary
This report provides the Board with an overview of the Mid-Year Safe Staffing Establishment which was conducted in August 2020 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 review the establishments which determine if inpatient wards are safely staffed with the right number of nurses with the right skills and at the right time.

Action required from the meeting
To note the information, recommendations and future actions planned to ensure safe staffing establishments are maintained

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
Currently incorporated into 20/21 Directorate budgets.

Legal issues
None

Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place?
Directorate Management Teams
Finance Department
Workforce Intelligence

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, Directors of Nursing and Heads of Nursing

Who is accountable for the implementation of the proposal / project?
Chief Nurse, Directors of Nursing

Attachment 4

Safe Staffing Nursing Establishment Review (2020/21)

Purpose

In June and July 2020 a nursing establishment exercise was completed to identify each of the ward requirements based on the number of established beds, acuity and activity plan for 20/21 in order to identify the nursing requirements to deliver safe high standards of care, quality care and staff and patient experience. We conduct a review of the nursing establishment at a mid-year point to provide assurance that we are maintaining safe levels and also to review progress against the implementation of recommendations since the last report. The planned March 2020 review was delayed due to the Covid 19 pandemic outbreak.

Introduction

Great Ormond Street Hospital (GOSH) has a responsibility to ensure a safe and sustainable workforce and all Trusts have to demonstrate compliance with the 'triangulated approach' to deciding staffing requirements described by the National Quality Board (NQB) guidance in the recent 'Developing Workforce Safeguards' by NHS Improvement (2018).This combines evidence based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time.

The NQB guidance states that providers:

1. must deploy sufficient suitably, competent, skilled and experienced staff to meet the care and treatment needs safely and effectively
2. to have a systematic approach to determining the number of staff and range of skills required to meet the needs of the people using the service and to keep them safe at all times
3. must use an approach that reflects current legislation and guidance where it is available

In line with NQB recommendations, a strategic annual staffing review has been conducted, the key elements of a review should be:

- obtaining feedback from children, young people and families on what is important to them and how well their needs are met
- using a systematic, evidence-based approach to determine the number and skill mix of staff required
- using a valid and reliable acuity/dependency tool
- exercising professional judgement to meet specific local needs
- benchmarking with peers
- taking account of national guidelines, bearing in mind they may be based on professional consensus.

This most recent nursing establishment review is able to demonstrate that the Trust is aligning with the outlined recommendations in order to provide assurance to the Board that the nursing workforce decisions regarding the establishments are designed to promote patient safety and quality. In addition to the above specific considerations for planning the

children and young people's workforce arising from the NQB's expert reference group's cross-check include:

- Children and young people's ward managers should use at least two methods for calculating ward workload and staffing requirements.
- Boards should ensure there is no local manipulation of the identified nursing resource from the evidence-based figures in the tool being used, as this may adversely affect the recommended establishment figures and remove the evidence base. Children and young people's acuity/dependency tools should include a weighting for parents/carers, so their impact on the ward team is reflected in ward establishments.
- Most parents or carers will stay in the hospital, making a significant contribution to their child's care and wellbeing. However, they also require support, information and often education and training to enable them to care for their child in partnership with hospital staff. Their personal circumstances and responsibilities such as other siblings, work commitments and the travelling distance to the hospital may prevent them from visiting. The child or young person will then depend more on staff for fundamental care, stimulation and emotional support.
- Time-out percentages (uplift) should be explicit in all ward staffing calculations. Managers should articulate any reasons for deviation from the 21.6% to 25.3% range emerging from the evidence review. GOSH uplift is 22%.
- Staffing multipliers (staffing resource) aligned to levels of patient acuity/dependency should be empirical and drawn only from quality assured services to avoid extrapolating from wards delivering suboptimal care.
- Adjustments should be made to workforce plans to accommodate ward geography – for example, single-room design wards.
- Two registered children's nurses should be on duty at all times in an inpatient ward.
- Allocate time within the establishment for regular events such as patient inter-hospital transfers and escort duties for patients requiring procedures and investigations if this is not already factored into the validated acuity/ dependency tool.
- Allow time for staff to respond effectively to changes in patient need and other demands for nursing time that occur often but are not necessarily predictable: for example, patient deterioration, admissions and end-of-life care. Capacity to deal with unplanned events should be built into the ward establishment using professional judgement. This is commonly referred to as 'responsiveness time'.

Methodology for Calculating Nursing Numbers

The current staffing ratios have been determined using the Royal College of Nursing (RCN 2013) and Paediatric Intensive Care Standards (PICS 2016) for guidance; these include the 22% percentage uplift that supports annual leave, sick leave, study leave etc. The ratios of nurses per patients will vary depending on the type of patient and their dependency. The ratios used by the Trust are:

Intensive Care 1:1, High Dependency 1:2, Ward 1:3

Enhanced Intensive Care - 2 Nurses: 1 Patient (this includes children requiring ECMO or renal replacement therapies).

Attachment 4

Safe Staffing Nursing Establishment Review (2020/21)

Whilst using national tools to work out establishments it is also key to note that the nursing professional judgement is also factored into the equation.

The staff establishment exercise in August 2020 included validation of the funded bed base for each ward and the type of patients nursed within those beds regarding dependency as mentioned above. Uplift was also added at 22%, also known as headroom or time-out, is a judgement about additional staff to cover time spent out of the clinical area. Essentially this covers activities such as annual leave in line with Agenda for Change or local terms and conditions, study leave, sickness absence, parenting leave, emergency or carer's leave, link meetings and improvement projects.

Since the last review a new tool, the Children's & Young People's Safer Nursing Care Tool (C&YP SNCT), has been fully implemented across the trust with testing exercises in January, March (disrupted due to pandemic) and July 2020, to assist with determining future nursing establishments. The C&YP SNCT is an adaptation of the Safer Nursing Care Tool for adult inpatient wards developed in 2006 and updated in 2013 which has been used successfully in many organisations. It has been developed to help NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing in Children's and Young People's in-patient wards. The tool, when used with Nurse Sensitive Indicators (NSIs), will also offer a reliable method against which to deliver evidence-based workforce plans.

Decision support tools, such as those for measuring acuity/dependency, help managers determine safe, sustainable staffing levels and remove reliance on subjective judgements. Professional consensus suggests no single tool meets every area's needs, so NHSI recommend combining methods.

In order to ensure a triangulated evidence based approach, data packs were shared with the HoNs and GMs ahead of the establishments reviews which outlined:

- Current budgeted staffing establishment data for 20/21
- Previous budgeted staffing establishment data for 19/20
- Bed base
- HDU bed numbers/Telemetry beds
- Royal College of Nursing (RCN) C&YP Workforce staffing ratios
- Calculations based on national guidance for that specialism i.e. Association for Perioperative Practice (AfPP), British Association for Paediatric Nephrology (BAPN), Paediatric Intensive Care Standards (PICS), RCN and Royal College of Radiologists-Guidelines for nursing care in IR (2017), Association of Anaesthetists Great Britain and Ireland (AAGBI) - Immediate post-anaesthetic recovery, AAGBI - The Anaesthesia Team (2018)
- Safer Nursing Care Tool (SNCT) calculations for guidance based on patient acuity

Attachment 4

Safe Staffing Nursing Establishment Review (2020/21)

- Registered/unregistered nursing workforce skill mix proportions
- Variance between data sets and recommended numbers

Review outcomes

Each ward staffing requirements was reviewed and cross referenced with directorates own information. It is important to note that the establishments reviewed only reflect patient facing staff, to ensure that it is transparent what the nursing requirements are to provide direct nursing care based on the number of funded beds and patient acuity. Roles such as Advanced Care Practitioners and Nurse Practitioners were not included.

The following information has been reviewed by directorate teams and confirmed by Directorate HoNs with challenge and assurance gained by Director of Nursing for Corporate and the HoN for Nursing Workforce. Due to Covid 19 pandemic and following consultation with NHSI, it has been recommended that no changes should be made to budgeted staffing establishment changes based on the SCNT scoring in 2020 as it will not provide an accurate assessment of true patient acuity during this period, and should be used for guidance only. The purpose of this review is to confirm the quality and safety of the current staffing establishment and provide assurance to the board.

Each Directorate HoN was asked the following questions:

- Do you feel that your staffing establishment is safe?
- Do you feel that your staffing establishment is correct?

Body, Bones and Mind (BBM) – The directorate HON confirmed that the current staffing establishments across the directorate are safe and correct. Mitigation is in place to address fluctuations in daily staffing levels as a result of vacancies, shielding and high levels of maternity leave through use of bank staff, ward team mergers and temporary closed beds. Professional judgement indicates the need for maintaining current staffing levels on **Squirrel Gastro** due to increased activity and adjustments to the SNCT recommendations where the bed base is less than 12, as per SNCT guidance. **Chameleon** has seen increased levels of activity and higher acuity which is demonstrated in the July SNCT scoring, staffing establishment numbers will need to be reviewed if this level of activity persists. Current **Eagle, Sky** and **Panther** establishments are higher than the RCN & BAPN or SNCT recommendations however it was felt by the Directorate HON that the scoring exercise in July did not capture the true acuity levels usually seen on these wards due to the suspension of the renal transplant programme and usual surgical activity.

Blood, Cells and Cancer (BCC) - The directorate HON confirmed that current staffing establishments across the directorate are safe and correct. **Lion, Elephant** and **Giraffe** maintain safe staffing levels across a single level through redeployment of staff where needed. Professional judgement needed to be applied to the shared staffing establishment of **Pelican inpatient** and **Pelican ambulatory (Badger)** due to working across two sites, PICB and Southwood. **Fox** and **Robin** establishments do not currently align with SNCT

recommendations however it was felt by the Directorate HON that the scoring exercise in July did not fully capture the true acuity levels usually seen on these wards as demonstrated in January. Professional judgement also needs to be applied to these wards as they have a bed base of less than 12.

Brain - The directorate HON confirmed that current staffing establishments across the directorate are safe and correct. The current staffing establishment on **Koala** aligns with national staffing recommendations including telemetry, HDU and neuro inpatient. Professional judgement supports the need for higher numbers due to the skill mix requirement, ward environment and complexity of this patient group. **RANU (Starfish)** - Due to low bed numbers and therefore low staffing establishment numbers, additional operational clinical support is required by Clinical Nurse Specialists and the Nurse in Charge (NIC) on a regular basis. Higher registered nurse ratios are also required due to low staffing levels in line with low bed base numbers. **Squirrel Endo-met** – Recent fluctuations in activity have been supported by sharing **Squirrel Gastro** staffing requirements across two units.

Heart & Lung (H&L) – The directorate HON confirmed that current establishments are safe and correct based on regular planned activity. **Leopard** SNCT scoring highlighted high patient acuity, as a result higher staffing establishment may be required if this this level of activity persists. **Kangaroo** SNCT scoring also highlighted high levels of patient acuity and professional judgement supports this finding due to challenges of ward environment and providing safe nursing care to patients all nursed in individual rooms. **Bear** ward acuity was lower in July which impacted on SNCT scoring therefore professional judgement indicates that the current establishment is required to maintain adequate quality and safety. Directorate HoN has previously benchmarked activity and acuity with peers, to review the peer benchmarking process used prior to setting of next budgeted establishment. No changes required in relation to **Walrus, Dolphin (NICU), Flamingo (CICU) or PICU**. Establishments align with national recommendations and are not determined by SNCT scoring. Discussed need to review skill mix requirements and hence registered to unregistered proportions.

Operations and Imaging (O&I) - The overall current budgeted establishment may be slightly under the national recommendations however is deemed safe by the Directorate HoN as it is mitigated through the use of own staff doing additional bank or regular bank staff known to teams. Across O&I there have been high levels of unavailability due to maternity rates, shielding, failed fit testing and long term sickness which has been managed as a result of reduced demand/activity. **Anaesthetics** – The national AfPP guidance and professional judgement indicates that this area may be marginally under establishment due to supporting roles not being included in the establishment figures. These include the coordinator role, floats required to cover breaks all day lists and across multiple areas. The anaesthetic team also support one ODP/day for the Resus team, which has not been factored into the budgeted establishment. **Scrub** – Due to the absorption of other services, activity has increased however additional staff have not accompanied the additional services. The directorate HoN has calculated that the requirement may be as much as 13.5 additional WTE. **Recovery** – Professional judgement must be applied as the local tool calculations do not factor in safe recovery of patients over multiple sites, eight in total. This has been

mitigated through the consolidation of areas and the closure of VCB and Nightingale recovery areas. A deep dive into O&I activity and review of the local tool calculations along with triangulation of the national guidance for this speciality will be conducted.

Sight and Sound (S&S) – The directorate HON confirmed that current staffing establishments across the directorate are safe and correct. National and SNCT scoring recommendations aligned exactly with current **Panther ENT** establishment. No changes or recommendations required. Panther ENT team are currently merged and supporting Panther Uro team across one unit with a plan to return to their base teams the end of September once vacancies have been filled.

International and Private Patients (IPP) – The directorate HON confirmed that current staffing establishments across the directorate are safe and correct based on the professional judgement of the directorate HoN. SNCT scoring and RCN ratios alone (which are based on NHS activity rather than private experience and expectations) indicate that IPP is over established, however professional judgement to reflect additional challenges in this area also need to be considered. The unit continues to carry a small number of vacancies however these will continue to fall as staff on board via the recruitment pipeline and is also mitigated through the reduced activity and bed closures for social distancing since the onset of the pandemic.

Recommendations implemented since the last report

1. A live document documenting all changes to the Nursing establishments is now available and maintained.
2. The implementation of the SCNT in January, March (disrupted) and July 2020.
3. Re-established the monthly Nursing Workforce Assurance Group in June 2020 which provides greater scrutiny and oversight of all workforce related activity including recruitment and retention plans, appropriate and effective use of Healthroster, use of temporary staff and associated spend and triangulation of workforce intelligence and quality metrics to ensure safe staffing and optimum skill mix.
4. Evaluation conducted and presented to Nursing Board of the role of Nursing Associate in GOSH and future plans to grow our own workforce.
5. External review of the nursing establishments conducted by Birmingham Sick Children's Hospital to ensure that GOSH is benchmarked against other similar Paediatric Hospital, with recommendations currently being worked through.

Recommendations to be implemented prior to next review

1. No changes should be made to budgeted staffing establishment on the basis of SCNT scoring conducted in 2020 due to changes in activity level and bed closures to support social distancing and the true accuracy of the calculations may not be validated.
2. To review and monitor staffing establishment requirements in H&L as triangulation indicates that it may be under establishment if activity and acuity levels remain high.
3. To review and monitor staffing establishment requirements in IPP as triangulation indicates that it may be over establishment.

Attachment 4

Safe Staffing Nursing Establishment Review (2020/21)

4. To monitor and review skill mix and reconsider proportions of registered to unregistered workforce based on need to ensure the right people with the right skills in the right place at the right time.
5. A deep dive into O&I activity and review of the local tool calculations along with triangulation of the national guidance for this specialty to be conducted.

Author: Marie Boxall - Head of Nursing (Nursing Workforce)

Date: 19/8/20

Attachment U

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
16 September 2020

Update with completion of CQC recommendations **Submitted by:** Sanjiv Sharma, Medical Director	**Paper No: Attachment U**

Aims / summary

The paper summarises the Trust's current position in relation to progress in meeting the recommendations arising from the CQC report in January 2020.

- All actions associated with Must Do recommendations are complete
- 70% of identified actions are complete
- There is one overdue action, which relates to plans to increase awareness of the Speak Up pathways through the implementation of the Quality and Safety strategies.

A meeting is planned with the CQC in September 2020 to consider recommendations relating to finances and RTT in the current context of the pandemic.

An update is provided on the Trust's meeting with the CQC in August to review the Infection, Prevention and Control Board Assurance Framework.

A summary of regulatory updates is also provided in relation to the CQC's Transitional regulatory framework, and the Memorandum of Understanding with GIRFT.

Action required from the meeting

Note the progress which has been made.
Note the changes to regulatory framework which may impact future inspections at GOSH

Contribution to the delivery of NHS Foundation Trust strategies and plans

Delivery of high quality care

Financial implications

None

Who needs to be told about any decision?

Medical Director
Head of Special Projects for Quality and Safety

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

Action owners are identified within the Always Improving Plan

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

Medical Director

Attachment U

Great Ormond Street Hospital for Children NHS Foundation Trust

CQC Update September 2020

Always Improving

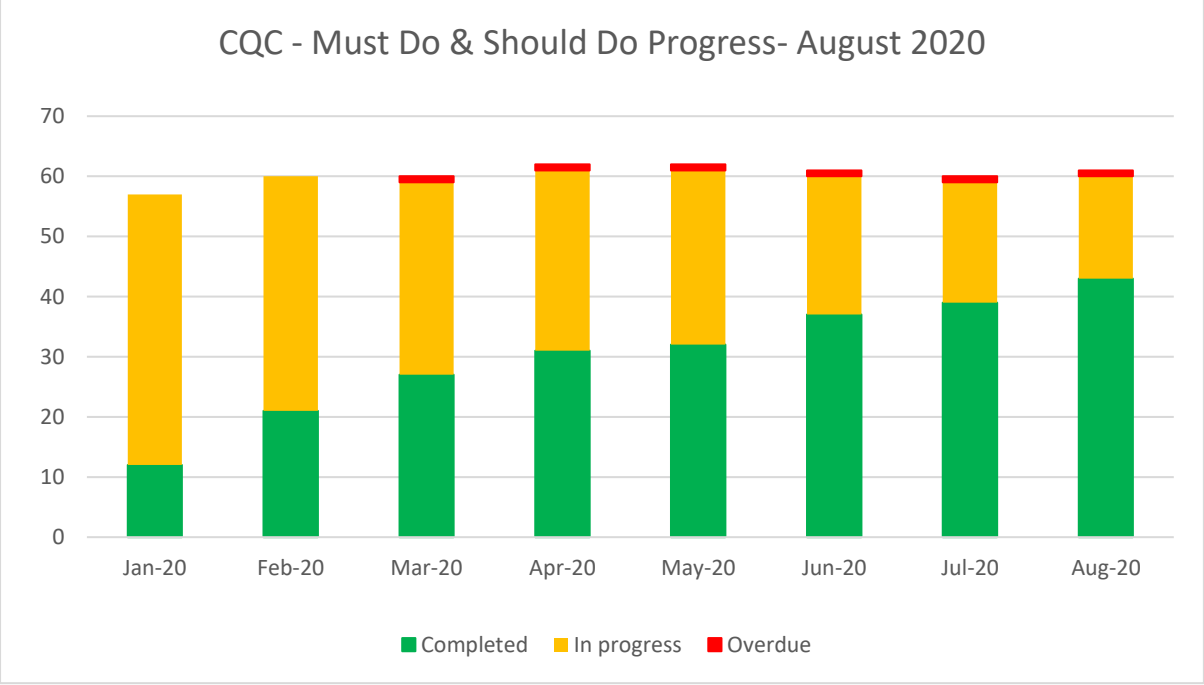
The Always Improving committee did not meet in August, although monitoring of the Always Improving Plan continued. There have been updates to the plan over the last month. The highlights are summarised below, and the full Always Improving Plan is attached to this paper.

All actions associated with Must Do recommendations and the Enforcement notice are now complete. Work continues to ensure these are embedded and that we continue to improve. For example the Controlled Drug Audit, which demonstrated good improvement, was completed in August and the Medication Must Do Audit is due to take place in September.

The following action closures are highlighted for noting:

- Quality of discharge summaries audit was completed in July 2020
- CAPA module has now been rolled out on Qpulse for Pharmacy Technical Services & QA
- Theatre equipment tracking action completed
- Key updates to Epic Mental Health records.

The overall performance is demonstrated in the chart below.



There is one action currently identified as overdue. This relates to approval of the quality and safety strategy implementation plans and how they relate to plans to improve awareness of the Speak Up programme and the accredited safety champions.

There are two actions for which deadline extensions have been requested. These relate to the Datix re-build and the associated Incident Reporting Policy update. Originally planned for completion in September, a revised date of end of December has been requested.

As previously reported there are a number of actions with 'TBC' deadlines, which are currently recorded with a status of 'in progress'. These relate predominantly to CQC report recommendations around RTT and Finance. The planned meeting with the CQC to review progress and consider next steps with these recommendations given the current national context is due to take place in September 2020.

The Quality Rounds – a series of peer supported internal assessments based on the CQC KLOEs – restarted in August 2020. It is anticipated that these will run bimonthly over the next 12 months with the focus on a different KLOE each time.

Infection Prevention & Control Board Assurance Framework

NHS England developed and published a Board Assurance Framework to support providers to self-assess compliance with Public Health England (PHE) and other COVID-19 related IPC guidance. The use of the framework is not compulsory, but is a useful source of internal assurance to support organisations to maintain quality standards at this time.

The Assurance Framework was first published on 4th May 2020, and then updated and reissued on the 22nd May 2020.

The Trust completed the IPC Board Assurance Framework (IPC BAF) in June 2020 and has been updating the document regularly. The document was reviewed and discussed at the Trust Board in July 2020. A copy of this was shared with our relationship manager at the CQC. A copy of the August update is included with this paper.

In August 2020 the Trust was contacted by our CQC relationship manager to arrange a discussion regarding the IPC BAF. We understand that all Trusts are having the same engagement meetings. This took place on the 26th August 2020 with Stella Franklin from the CQC. GOSH attendees included Alison Robertson, Chief Nurse; Helen Dunn, Director of Infection, Prevention and Control; and Roisin Mulvaney, Head of Special Projects.

The meeting included an overview presentation to the CQC regarding our successes and challenges in managing Covid-19 at GOSH, with a particular focus on the paediatric population

Following the meeting the CQC were provided with a copy of August IPC BAF, a listing of the staff incidents reported under the RIDDOR guidance, confirmation of the number of hospital acquired Covid-19 infections and a copy of the presentation.

A summary report based on their review of the BAF and the outcome of the engagement call is expected from the CQC in September. This will not be published, but will be shared with the Trust for information and action as appropriate.

Well Led Update

Planning for Outstanding – the GOSH Well Led Assessment

The Executive Team wish to agree and implement a plan of action to achieve 'Outstanding' at the next CQC Well Led Inspection (inspection expected around 2022). The Board has previously approved holding an external Well Led assessment in Q1 2021/22 (approximately half-way between the last and next CQC inspection). The external assessment will be used as an opportunity to

understand where the Trust sits in its Well Led developmental journey and seek external assurance of our understanding of our gaps and the focus of our plan.

- Work is underway to develop a plan to assess gaps in GOSH's preparation to attain 'Outstanding' for Well Led at the next CQC inspection. A gap analysis and associated plan will be drafted and will consider all of the Well Led recommendations and negative commentary presented by the CQC during its last inspection as well as any learning/ top tips available from other Trusts who have already attained 'Outstanding' for Well Led. A dashboard for monitoring progress with this plan will also be produced. This plan will be presented for discussion at the October 2020 Strategy Board. Progress with the plan will be monitored by the #Always Improving' Group and regularly reported to Trust Board.
- At the October 2020 Strategy Day, the Executive Team will use this gap analysis to recommend to the Board where they think GOSH currently sits in relation to the Well Led criteria. On the back of this, it is proposed that the Board discuss and agree the possible areas of focus for the external Well Led assessment, noting that the areas selected should be those where the most benefit can be extracted from the assessment in preparing the Trust for its next CQC inspection.

Regulatory Updates

'Less Burdensome' inspections

The CQC are due to resume inspections from September 2020, having suspended all routine inspections during phase 1 of the pandemic. Ian Trenholm, CQC CEO, indicated that they planned to make the visits 'less burdensome' and 'less of an event' for services.

It is anticipated that those who are inspected, particularly over the between September 2020 and May 2021 can expect less focus on the 'Effective' and 'Responsive' KLOEs and more of an emphasis on 'safety, access and leadership'. During what's been described as a 'transition' period, the CQC is expected to take a much more 'intelligence led' approach to regulation.

Diversity in relation to the Well Led Domain

Chair of the NHS Confederation, Victor Adebowale, has been advocating that Trusts who are underperforming on leadership diversity should not be rated 'good' or 'outstanding' by the CQC. The People Plan, published in July, also noted that the CQC will place additional emphasis on whether organisations have made 'real and measurable' progress on equality, diversity and inclusion. This will include whether they can demonstrate the positive impact of this progress on staff and patients. In response to the comments, Ted Baker, Chief Inspector of Hospitals, has noted that the Workforce Race Equality Standard indicators are already an important part of the well led inspection framework, and he would expect good or outstanding trusts to perform well on the issue

New agreement between CQC and GIRFT

In July the CQC and GIRFT published a memorandum of understanding to set out how the CQC will work with those leading the GIRFT programme to:

- Safeguard the wellbeing of people receiving health and social care in England
- Promote patient safety
- Support improvements in care

In practice this means that the GIRFT team will regularly update CQC on the findings of their reviews of individual clinical specialties. They will inform the CQC of any safety concerns identified during those reviews. They will also share a copy of their final reports and recommendations before publication. The CQC and GIRFT will liaise closely when providers are failing to implement action plans in response to GIRFT reviews.

Roisin Mulvaney
Head of Special Projects – Quality & Safety

Our Always Improving Plan

Our Ref	Report Ref	Power	KLOE	Report Recommendation		Exec Lead	Agreed Timescale	Progress update	Current Status
1	Trust Well Led	Must Do	Well Led	Ensure the Board Assurance Framework reflects all known medicine risks including the storing, administration and destroying of medicines in line with the legislation and the trust medicines management policies	2. Revise baf risk 14 (Medication Management) based on the outcome of the review of all medication risks, and the feedback from the CQC report.	Mat Shaw	3.2.2020	The BAF risk will be reviewed following reivew of Trust wide medication risks at the medicaion safety committee on the 28.1.2020. BAF risk review completed 5.2.2020.	Complete
					3. Present revised BAF risk statement and controls/assurances to RACG.		12.02.2020	BAF risk has been revised andwas presented to the Risk Assurance and Compliance Group on the 12.2.2020	Complete
					4. Revise annual plan of medication safety audits in line with risk profile		28.2.2020	Annual plan of medication audits has been devised with the support of the Clinical Audit Manager. This schedule has been approved by the Chief Pharmacist on 25.2.20. The results of each audit will be reviewed at the medication safety committee.	Complete
					5. Amend TOR for Medication Safety committee to ensure that there is regular review of all medication risks in the Trust alongside the results of the medication safety audits and that this is used to support changes to the BAF periodically.		28.1.2020	The amended TOR were reviewed on the 28.1.2020 and subject to changes agreed at the committee have been approved. New Safety Pharmacist is now receiving all incidents relating to medication safetly to analyse trends with a medication safety dashboard and identify new risks. This will be reported at the meeting on a monthly basis along side the risk register review.	Complete
					6. Deliver updated BAF with recommendations for amendments to Board on 1 April 2020		1.4.2020	Updated BAF was presented to April Trust Board.	Complete
2	Critical Care	Must Do	Safe	Ensure medicines are stored safely in line with legislation and the trusts medicines management policies	1. Review Access control to PICU clean utility room.	Sanjiv Sharma	13.2.2020	There is auditable swipecard access to the PICU medication room. This list needs to be cleansed to ensure that it is restricted to the groups agreed in the hospital's policies. A full list of all staff with access to the PICU medication room is being generated by the Security Team and the PICU Nursing team will review and identify those who can be removed. This work was completed on 13.2.2020. A further trust wide action has been identified. See Always Improving Plan Tab 2.	Complete
3	Surgery	Must Do	Safe	Ensure medicines are stored safely in line with legislation and the trusts medicines management policies	1. Ensure that IV fluids are stored securely and in line with best practice in theatres.	Sanjiv Sharma	Jan-20	1. IV fluids in theatres were moved from the corridor enclave to a swipe access controlled store room on the day of the inspection. This was completed on 5.10.2019	Complete
					2. Ensure that IV fluids are stored securely and in line with best practice in interventional radiology		Jan-20	2. IV fluids in interventional radiology were moved to a swipe access controlled store room on the day of the inspection.	complete
					3. Ensure that IV fluids are stored securely and in line with best practice in Sky ward.		Jan-20	3. The clean utility room was expanded in December 2019. Now all the IV fluids are stored in cupboards in that swipe access controlled room.	Complete
					4. Ensure that temperatures in rooms used to store medicines are monitored and recorded.		Feb-20	Jan: 1.Request submitted to estates to compile a list of all medication rooms and arrangements for temperature monitoring. 2. Trust wide risk assessment and action plan to be developed. April: Risk assessment and new SOP were reviewed at Medication Safety Committee in April 2020. Roll out anticipated in May 2020. May 2020: Estates have now developed an SOP to ensure there is temperature monitoring in each room and there is a plan for escalation of deviations. There are automatic systems for all buildings (BMS) except Frontage and Southward. A manual process for daily checks of a digital thermometer are now in place with a plan for escalation. Work continues to unify the systems to a remote monitoring process, but the risk is currently mitigated and considered closed for the purpose of this action plan. The medication safety committee will continue to oversee reports of temperature monitoring and support the action plan to unify the monitoring systems.	Complete

					5. Ensure that the service is denaturing CDs in line with policy		Feb-20	Discussed at Medication Safety Committee 28.1.2020. The key actions: 1. identify and source denaturing gel 2. confirm location for storage following review of CAS alert (should be behind a swipe card access door) 3. communicate change out to the matrons and ward sisters. Aim for full compliance by End of Feb 2020. Request was submitted to NHSSC in February, but supplies are not due to arrive until 5.3.2020. THe sachets were rolled out to all clinical areas from the 6/3/2020. **Paper outlining evidence of implementation will be reviewed at the Always Improving meeting.**	Complete
4	Children and Adolescent Mental Health Services	Must Do	Well Led	Ensure that the electronic patient record system meets the needs of the service so staff can record, update and find patient records promptly. This includes further development of, and staff adherence to, electronic patient record storage protocols.	Establish a formal Speciality Level Optimisation process to support the CAMHS service in making the necessary changes to Epic.	Richard Collins	Jul-20	Formalised process began in December 2019. There is an associated action log which tracks progress. At least 19 issues have been addressed and closed. 05.02.2020: meeting with CAMHS and Epic team, and agreed that key work to address this work was on track and would be likely to be completed by end of March 2020. April: Work has been completed, but final meeting which was due to take place in March was postponed due to Covid-19. MAy 2020: Risk Assessments are now all updated on Epic. Core meeting documentation still needs to be changed. June 2020 - CompletionDate revised to July given pressures with covid.	Complete
5	Trust Wide	Should Do	Well Led	Continue to develop and implement a formal board development programme	1. Consult on drafting a Board Development Plan	Mat Shaw	01/01/2020	AF Held meeting with Mat Shaw and Louisa Desborough to discuss framework for programme and possible external input to the development of the Board.Programme under development following comments	Complete
					2. Draft a version for consultation with EMT and update following comments		29/04/2020	April update: on track	Complete
					3. Circulate to all Board members prior to Board for consultation		12/05/2020	April update: on track	Complete
					4. Present at Board for approval		26/05/2020	April update: on track	Complete
6	Trust Wide	Should Do	Well Led	Take action to develop and assure itself about financial sustainability going forward	Deliver control target for 19/20	Helen Jameson	Jun-20	April 2020 - accounts sign off is due at the end of June, so an update on performance will be included then.	Complete
					Work collaboratively with the Children's Alliance to review and agree paediatric tarriffs	Helen Jameson	Ongoing	Ongoing. We are working with the system at an ICS, regional and national level to understand how fuunding will be allocated to specialist trusts under the new NHS financial framework to ensure the unique requirements of GOSH is understood and financial forecasts can be developed	In progress
					In light of impact of Covid-19, advice to be sought from CQC at stakeholder meetings, on how best to address this action in the current climate	Salina Parkyn	Sep-20	New action added to replace previous actions in relation to better value schemes for 2020/21 in light of Covid-19 impact. SP to invite relevant Trust staff to next CQC stakeholder meeting. Meeting with CQC likely to be in Aug/Sept, so date amended accordingly.	In progress
7	Trust Wide	Should Do	Well Led	Continue to promote the role of the FTSUG, taking proactive action to identify and address themes from staff contacts with the FTSUG	**Role promotion** 1. Survey of staff to see why they haven't used the service and analysis of results included in the annual report (April 2020) 2.Role Promotion strategy: Aligned to the change in the FTSU (after June 2020)	Sanjiv Sharma	May-20	April update: note 88 contacts with service in Feb and 10 in March. The Speak Up Service has been promoted at multiple points throughout the Covid-19 pandemic. Annual Report submitted to Trust Board and Audit Committee in May 2020.	Complete
					Proactive Action: 1. Launch Speak up for our values, and Peer Messengers roles	Sanjiv Sharma	Nov-20	The launch of this project has been paused given the current pandemic. The programme Board have agreed to being work on the PRAISE component of the project ahead of the summer, with a view to Speak Up for Values in the Autumn, but this will be conditional on the situation with Covid at that time.	In progress

					Address Themes 1. Share (anonymised) FTSUG case outcomes within the organisation to ensure staff are aware. 2. Themes from FTSUG and Speak Up to be integrated into one report to provide comprehensive insights for the Trust. 3. Actions identified through FTSU and Speak Up must be specifically followed up through PSOC	Sanjiv Sharma	May-20	April 2020- Annual report being compiled for committees in May/June 2020 June 2020- Annual Report submitted.	Complete
8	Trust Wide	Should Do	Well Led	Raise staff awareness of the safe and respectful behaviour policy and improve access to conflict resolution training	1. Seek views from staff on support needed to enact the Safe and Respectful behaviour policy specifically in relation to: - policy - training - communication	Alison Robertson	Feb-20	1. Short survey sent out with Trust Brief on 17.1.2020 and a reminder at SLT. Face to face feedback sessions have taken place. Survey due to close on 3rd February 2020. Meeting scheduled with Chief Nurse to agree plan based on feedback. 2. Safe and REspectful working group meeting took place 5.2.2020. Action plan agreed. 3. Safe and Respectful policy presentation at SLT on 20.2.2020 4. Survey completed in March 202, and feedback collated.	Complete
					2. Arrange listening events with specific areas requiring additional support.	Alison Robertson	Jan-20	5 completed in January	complete
9	Trust Wide	Should Do	Well Led	Continue to improve the quality of WRES data to enable this to be used to inform areas for development.	1. people strategy	Caroline Anderson	Jan-20	The People Strategy was launched at the Open House in November 2019	complete
					2. Consult and engage with forums and other stakeholders on the development of the D&I strategy.	Caroline Anderson	Jan-20	Completed December 2019	complete
					3. Publish strategy for consultation across the organisation	Caroline Anderson	Jun-20	Dates have been adjusted to allow for impact of COVID from April to June 2020 Consultation was launched on 25.7.20	Complete
					4. Prepare and publish the delivery plan for D&I strategy	Caroline Anderson	Sep-20	Dates have been adjusted to allow for impact of COVID from July to September 2020	In progress
10	Trust Wide	Should Do		Raise staff awareness of the role of the accredited safety champions	1. Speak Up for safety champions 2. Peer Messengers 3. Set out plans and strategy for Speak Up in the Safety Strategy Refresh.	Sanjiv Sharma	Aug-20	**July update:** Quality Strategy and Safety Strategy approved at Board in June 2020. Implementation plan for Safety strategy is being approved in August, and this will include a plan for raising staff awareness. Date amended to August to await details of plan, and then the actions will be updated accordingly to the proposed dates. **August Update:** Approval of the Safety Strategy Implementation plan is now expected to happen before the end of September.	overdue
11	Trust Wide	Should Do	Well Led	Clarify the role and expectations of governors in interview stakeholder groups, including for which roles they will be invited to participate in groups for	Clarification to be included in the Governance Update for the Council in February 2020	Mat Shaw	05/02/2020	Papert has been written and submitted to the Council outlind the roles and expectations of governors in interview stakeholder groups. Will be discussed on 5.2.2020	complete
12	Trust Wide	Should Do	Well Led	Improve the oversight of delivery of services by the pharmacy department by identifying and reporting key performance indicators via the directorate performance process to the board.	1. Introduce Qpulse to support the QMS and enable effective KPI reporting. STAGE 1: Qpulse for Deviations	Phil Walmsley	15/06/2020	The QMS has been built in Qpulse and is currently being tested. Then staff will be trained in the new system. April: The training has been provided. An SOP to support delivery was being developed, but due to issues with staffing (COVID and staff leaving) this has not yet been completed. Delays discussed at the April CQC Always Improving Meeting. It was agreed that the deadline could be extended to Mid June (from March 2020) in light of current challenges, but it was felt this was an important action which also links to the MHRA action plan.	Complete
					Qpulse Stage 2: Use of qpulse for CAPAs		31/07/2020	Workflow will be developed on Qpulse, alongside training and SOP	Complete
					Qupulse Stage 3: use of Qpulse for Change Control		31/10/2020	Workflow will be developed on Qpulse, alongside training and SOP. 1.9.20 - timescale revised to October 2020 due to vacant post in QA, 3 new starters still working through training, and some dept. sick leave.	in progress
					2. Ensure agreed KPIs are included in the monthly directorate performance pack for Medicines, Tests and Therapies.		01/01/2020	This has been in place since November 2019.	complete
					3. Monthly reporting of the KPIs through to the Always Improving Compliance group.		Feb-20	KPI dashboard has been shared with the Head of Quality and Safety. March 2020 - Compliance group TOR updated and approved.	complete

13	Trust Wide	Should Do	Safe	Take action to improve the number of incidents closed with the trust's 45 working day target	1. Weekly monitoring of open incidents- compliance with investigation timescales and closure timescales with compliance shared monthly at SLT and via IQPR	Sanjiv Sharma	ongoing	All overdue incidents from Jan 2019 - June 2019 have been closed. The vast majority of incidents from July - Dec 2019 are now also closed (1 currently still open pending QC checks) As of 3.9.20 there are 51 incidents from Jan -May 2020 which remain open.	in progress
					2. Datix Action Module refresh		Jan-20	Completed December 2019	Complete
					3. Cleanse of users from the Datix system to ensure that the right people are receiving the right incidents for investigation		Feb-20	User cleanse completed December 2019. Leaver notification reports re-instated to ensure that these are maintained. Collaboration on-going. Lists circulated to teams January 2020. March - advised that this is complete.	Complete
					4. Incident module rebuild in consultation with end users and management.		01/09/2020 Request to extend to end of December 2020	Incident module rebuild commenced Jan 2020.	in progress
					5. Investigation policy refresh in line with the new rebuild		01/09/2020 Request to extend to end of December 2020		in progress
					6. Training and education for staff in Systems Analysis (previously RCA)		TBC	**April 2020:** Due to be started in March 2020 - but postponed due to COVID-19. New date TBC Meetings taking place in April and May 2020 to assess how this can be delivered in house. **August 2020 Update:** 3 RCA training sessions have now taken place with a further one planned in early September. Dates for further sessions are currently being agreed.	in progress
14	Trust Wide	Should Do	Well Led	Improve the accuracy of the trust's information asset register	1. Develop pilot register in order to test methodology for use in the rest of the Trust.	Phil Walmsley (SIRO)	Jan-20	Pilot register has been developed.	Complete
					Launch Pilot in 2 Trust Departments	Phil Walmsley (SIRO)	Feb-20	Currently being piloted in Information team and HR with plan to report outcome of trial to IGSG on 19th February 2020. **Feb 2020:** Shared at IGSG. The update confirmed that HR and Information Services had completed their IARs. Research, Finance, ICT, IPP and CAMHS had shared their assets for update. A total of 152/556 assets had been assigned.	Complete
					Assign all known assets to initiate roll out.	Phil Walmsley (SIRO)	Mar-20	Feb 2020: It was agreed at IGSG that all 556 known assets would be assigned by the March IGSG and evidence of this produced for the DSP Toolkit. March 2020: The known assets were assigned.	Complete
					Roll out to the remaining departments across 2020.	Phil Walmsley (SIRO)	Dec-20	August update: First update of the Information Asset Register is completed. All identified Information Asset Owners are now to be trained in their role as part of the Cyber Security Remediation Plan. With this better understanding of the role and Information Assets in general each will be asked to review and confirm their areas registers. The work is currently on target for December 2020.	in progress
15	Critical Care	Should Do	Well Led	Consider developing a divisional clinical strategy for critical care areas	1. Develop 1 year strategy as part of standard business planning. 2. Develop longer term strategic vision following publication of hospital strategy refresh.	Phil Walmsley	TBC	February: 2020 business plan is in draft, and will be refreshed monthly ahead of year end. March: this will be impacted by COVID-19 response, and therefore due date will need to be revised.	In progress
16	Critical Care	Should Do	Safe	Provide consistent checks in relation to all in-use resus equipment in the critical care areas, in line with guidance from the Resus Council.	1. Remove Trolley from Flamingo as it has only been retained for training purposes. There are patient need specific resus trolleys in each of patient bays.	Sanjiv Sharma	Jan-20	Trolley has been relocated from the clinical area to the simulation suite on Alligator so that it can still be used for training	Complete
	Surgery	Should Do	Responsive	Continue to work to improve referral to treatment times	Reduce 52 week breaches to a position 32 or less by the end of March 2020	Phil Walmsley	Mar-20	Feb 2020 update: Current predicted position is 26 X 52 week breaches by end of March. April 2020: Target was reached, but noted that this will be impacted by COVID-19 and the reduction of essential activity. The ongoing work to address this will be covered as part of the Trust's Covid Recovery plan.	Complete
					Deliver a compliant diagnostic position within year.	Phil Walmsley	TBC	The RTT position has been severely affected by the Covid pandemic. All elective patients have been cancelled and	in progress

17					Work with commissioners to develop a recovery plan for RTT to improve delivery against the RTT standards as part of contracting process	Phil Walmsley	TBC	restarting elective work will be done slowly in order to protect patients and staff. The Clinical prioritisation Group is deciding on which cohorts of patients should be operated on first and this may not always be in an order to help the RTT position as the clinical necessity is the key driver. Our RTT performance has slipped from 86% to 75% between mid-March and the end of April and we expect that it will continue to deteriorate over the next 4 months. The actions listed here were developed pre-pandemic. We will liaise with CQC collegaues in our stakeholder meetings to consider how best to respond to this recommendation given current climate.	in progress
					Increase capacity for our SDR service to reduce the volume fo long waiting patients	Phil Walmsley	TBC		in progress
					develop and implement a plan to reduce long waiters in the Dental service	Phil Walmsley	TBC		in progress
					Patient Redesign in specific specialities. Flow Programme. Outpatient Transformation to improve methods and utilisation Theatre Utilisation Group Fortnightly performance meetings with GMs.	Phil Walmsley	TBC		in progress
18	Surgery	Should Do	Safe	Improve the timeliness of discharge summaries sent to the patient's GP	Reduce backlog of discharge summaries to less than 100	Phil Walmsley	Mar-20	As of 15th April, the outstanding discharge summaries was 59.	Complete
					Review the quality of discharge summaries to ensure they are meeting the needs of the GPs and referrers	Phil Walmsley	Aug-20	April 2020- extension requested in context of pandemic information returns. Extended to August 2020. Audit completed in July.	Complete
19	Surgery	Should Do	Safe	Review and improve systems for equipment maintenance in theatres so that staff are assured it is fit for use	1. Review system for tagging equipment in theatres which is managed under contract (rather than via biomed).	Sanjiv Sharma	May-20	Initial discussions between Head of Nursing for Theatres, GM for MTT and Head of BME.Meeting due to take place in 1st week of Feb. Plan and timescales to be agreed at that meeting. May 2020: work had not progressed on this, but is now being picked up between Theatres and BME. July 2020: REd stickers advising staff of steps to take in relation to checks on contracted equipment have been implemented. further work on the process to ensure kit doesn't get into theatre without these stickers is ongoing. Meeting due to take place when key staff return from leave in July.	Complete (but waiting for evidence)
			Safe		Assessment of risks/gaps associated with our equipment asset registers i.e. the 'unknown unknowns'		Sep-20	Risk assessment to be completed with support from Head/Deputy of Quality and Safety. June - ICT risk is on the risk register, but not yet for Medical Equiptment. SP liaising with CL.	In progress
20	Children and Adolescent Mental Health Services	Should Do	Responsive	Continue to take action so that staff, patients, family members and carers are not negatively affected by the lack of disabled access to the roof terrace	Access for disabled patients is not possible currently, but patients can access other outdoor gardens and spaces in the hospital. Incident forms will be raised when when patients are unable to access the roof terrace.	Phil Walmsley	Feb-20	All MCU staff have been advised to complete incident forms in the event that children are unable to access the room for any particular group activity, noting alternative arrangemetns made.	Complete
21	Children and Adolescent Mental Health Services	Should Do	Effective	Provide training and support to all relevant staff so that they are competent in their understanding and application of Gillick competence when delivering care and treatment to young people under the age of 16 years	1. Develop a new training programme based on capacity and competence	Caroline Anderson	h 2020 (and ongoi	Capacity and competence is on the teaching list for 2020 and will be annual topics. Jon Goldin did some teaching for the team on competency and consent on 29.1.2020. This will be a monthly one hour Gillick competency workshop going forward (moving to 2 monthly in due course), supported by the Practice Educator who will be keeping a log of attendance.	Complete
22	Children and Adolescent Mental Health Services	Should Do	Well Led	Provide timely administrative support for the service so audits and document scanning are not delayed.	1. Identify administrative support	Phil Walmsley	Dec-19	There is now an administrator in place, processes in place for scanning and accurate process and audit for consent forms.	Complete
					2. Develop annual audit plan for MCU.		Feb-20	Clinical Audit manager meeting with Ward Manager on 27.1.2020 to develop audit plan. 04.02.2020: Annual Audit plan now agreed.	Complete

Attachment V

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 16 September 2020	
Annual Infection Control report 2019/20 **Submitted by:** Helen Dunn Director Infection Prevention and Control	**Paper No: Attachment V**
Aims / summary: To present to the board the work undertaken in IPC over the last 12 months (19/20) and identify and risks. The executive summary is attached at Appendix 1. The full report and action plan for 2020/21 is attached for information.	
Action required from the meeting: Feedback Approval for display on public website	
Contribution to the delivery of NHS Foundation Trust strategies and plans: Prevention and control of health care associated infections prevents harm and reduces cost.	
Financial implications Failure to prevent avoidable infection leads to harm and cost.	
Who needs to be told about any decision? Each member of staff is responsible for implementing appropriate infection prevention control practice	
Who is responsible for implementing the proposals / project and anticipated timescales? Ongoing timescales displayed in workplan for 2020- 2021	
Who is accountable for the implementation of the proposal / project? Director of Infection Prevention and Control	

Attachment V

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST

INFECTION PREVENTION AND CONTROL ANNUAL REPORT

April 19 - March 20

Executive Summary Only

Compiled by: Helen Dunn- Consultant Nurse Infection Prevention Control & Director of Infection Prevention Control

(Format - Modified from the template recommended in Health and Social Care Act 2008)

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST
INFECTION PREVENTION AND CONTROL ANNUAL REPORT
April 19 - March 20

Summary

There is a fully functioning Infection Prevention and Control programme established at GOSH, with involvement of all staff.

Many of the children are susceptible to infection because of their illness or the treatment and are often already infected or colonised. We strive to protect them from their own and each other's bugs – especially respiratory and enteric viruses and antibiotic resistant organisms. The latter is a major challenge as the worldwide threat from antibiotic resistance increases.

Key achievements this year include:

- Development of ward level data dashboards
- Embedding of the IPC audit days and associated action plans
- Expansion of the gloves off work prior to covid-19
- Build and commissioning of MEDU and refurbishment of EDU
- Launch of Electronic Patient Record and subsequent optimisation
- Successful re-tender of the sterilisation services
- Response to covid-19 outbreak

Key areas of activity for 2020/2021:

- Respond to the covid-19 pandemic and provide support and infection control resource for the organisation
- Work to unify the surgical site surveillance services across to trust to provide enhanced services for all patients
- Work with estates to complete the water safety plan
- Work with facilities to re-tender the cleaning services
- Improve compliance with MRSA and stool screening on admission.
- Improve compliance with care bundles, in particular central venous lines.
- Laboratory expansion to enable appropriate testing for management of patients during covid-19 pandemic.

We strive to keep the right balance.

Helen Dunn
Consultant Nurse Infection Control & DIPC

Part A Executive summary of full report

1 Introduction

Great Ormond Street Hospital for Children NHS Trust recognises the obligation placed upon it by the Health and Social Care Act Code of Practice of the prevention and control of infections and related guidance.

2) Description of infection control arrangements
Director of Infection Prevention and Control (DIPC) and ICD- Dr John Hartley
Executive lead for IPC - Chief Nurse, Alison Robertson
Lead Nurse for Infection Prevention and Control – 1 wte, Helen Dunn
Deputy Lead Nurse in IP&C 1 wte; IPC nurse 1 wte;
Clinical Scientist in IP&C 1wte (currently 0.4 in place as scientist on NIHR fellowship 0.6; returns to wte June 2019)
Other consultant microbiologists – 4 PAs
IPC Administrative support and Data Management **–** 0.6 wte
IPC Data analyst – 2 years fixed contract commenced Mar 2018, made permanent March 2020.
Infectious Diseases CNS leads on Tuberculosis related issues;
Antimicrobial stewardship: As part of job plan for infectious disease consultant (chair of AMS committee), Antimicrobial Policy Group Chair - consultant microbiologist 1 PA (as part of IPC activity), One wte antimicrobial pharmacist

Sepsis Programme – now lead by ID Consultant 0.5 PA; supported by ID CNS

Development of IPC Team

- IPC data analyst role made permanent March 2020.
- Funding was agreed to employ a band 7 IPC nurse to support the Built Environment team. This role has been appointed to but there was a delayed start into post due to covid-19.

Data analysis - Quality Improvement team

- Dashboard development and display.
- Data analyst to develop service and transition to new integrated system (RL Solutions & Epic)

2.3 Directorate Responsibility
Each Directorate had a local group to drive local planning and implementation of IPC actions. This had faltered following the clinical service restructure but has now recommenced with 4 directorate level meetings taking place monthly and reporting to the IPCC. These meetings are:

- Medical
- Surgical
- Heart & Lung
- IPP

2.4 The Infection Prevention and Control Committee (IPCC) meets every month (except Aug & Dec). The committee reports to Patient Safety and Outcome Committee.

2.5 **Reporting lines**
The DIPC is accountable to the CEO and reports quarterly to the Board.

The DIPC and Lead nurse for IPC meet bi-weekly with Executive lead.
A report of all significant IPC issues is presented weekly to the Safety Team.
Significant IPC issues are entered on Datix, collated and passed through reporting line.
An annual plan is written and included in each annual report.

2.6 Antimicrobial stewardship and Sepsis

There is an expanded antimicrobial stewardship programme with regular committee meetings taking place and reporting to the IPCC. Whilst part of normal trust business, sepsis has met significant obstacles with extracting data from the EPR system. Work is underway to improve the recognition of sepsis and recording of appropriate interventions within EPR.

2.8 IPC advice and On-call service*.*

Continuous advice service provided by IPC Team / Consultant Microbiologists (out of hours ID consultant contribution to IPC service was withdrawn)

3.3 Outbreak Reports, Serious incidents and investigations

Contemporaneous outbreak reports are written by the IPCT and fed back to clinicians and managers and disseminated through the IPC Committee. There were no IPC SI's in 2019/20. A SI was undertaken as a result of bedbugs which was managed by the operational team and the estates team. A major outbreak group was commenced for a staff member who tested positive for COVID-19 in March 2020.

4 Budget allocation to IP&C activities

4.1 Staff

IPC Team Staff budget sits within Department of Microbiology, Virology and IPC
Directorates fund own audit and surveillance staff, including surgical site infection surveillance

4.2 Support

IT Support and hardware: is supplied within the departmental budget.
There is no separate IPC budget, but emergency outbreak funding is provided by the Trust.

5. HCAI Statistics Mandatory reporting for 2019/20

5.1 **MRSA bacteraemia** = 1 episode, not attributed to trust (2 previous year, both trust attributable)
5.2 MSSA bacteraemia = 23 episodes (26 previous year)
5.3 ***E. coli*** **bacteraemias** = 8 episodes (18 previous year)
5.4 ***Klebsiella*** **species** = 26 episodes (17 previous year)
5.5 ***Pseudomonas aeruginosa*** = 18 (16 previous year)
5.6 ***Glycopeptide resistant enterococcal bacteraemia (GRE)*** = 2 in one child (7 previous year)
5.7 Clostridium difficile **associated disease =** 7 reported, 2 trust attributable; 0 lapse in care.

Local surveillance

5.9 GOS acquired Central Venous Catheter related bacteraemia

1.3/1000 line days (72 episodes). (Rate 1.5 previous year).

5.10 Other bacteraemia episodes and antimicrobial resistance

Number of episodes - 528 clinical episodes. A rise from 432 last year.
Rate of primary gram negative resistance in blood culture episodes – this year has seen a reduction in gentamicin resistance but a 10% rise in resistance to piptazo is still noted justifying the use of piptazo and amikacin as a first line for gram negative sepsis.

5:12 Surgical Site Infection Surveillance and Prevention
SSI surveillance was limited across the organisation this year. This is due to the EPR implementation and additional work required to bring data out of Epic into the new reporting and recording system for SSI (RL Datix).

5.13 Surgical specialties
We remain an outlier for spinal surgery but have seen a decrease in the reported rate of infection; variation explained by the complex case mix. A specific programme to improve the surgical pathway has assisted with this decrease in rates which has resulted in a lower rate.

5.12 Cardiothoracic specialities
The Cardiothoracic SSI group has met regularly throughout the year with good involvement from the MDT. Due to staffing issues surveillance was not completed every month. Organ space infection was rare.

5.13 Neurosurgery
Continuous surveillance is undertaken as part of weekly audit programme, with dash boards for permanent shunts.

It is difficult for the Divisions to maintain surveillance, especially due to staff turnover, and alternative structure may be needed in the long term, for which a proposal will be developed as part of the IPC work plan for 2020/21.

5:16 Viral infections detected while at hospital

A decrease in enteric virus testing is noted. There has been an increase in both HAI & CAI respiratory viruses, the most likely cause is an increase in viral testing for new pathogens as standard in-house. Failure to identify and isolate symptomatic children is continues to be a problem but is improving with more patients being placed in isolation when symptoms develop.

Respiratory viral infections detected:	Total	Community onset	Hospital onset
Total in 2017/18	509	354	155
Total in 2018/19	810	555	255
Total in 2019/20	920	625	295
Enteric viral infections detected:			
Total in 2017/18	498	272	226
Total in 2018/19	595	307	288
Total in 2019/20	339	184	155

5:18 MRSA Admission Screening and colonisation/carriage
We continue with a universal admission screening policy, the average compliance with this was 50%.

There was a decrease in acquired MRSA from 22 in 2018/19 to 16 in 2019/20. Many cases were isolated and extensive investigation found no point source. However one outbreak in cardiac was related and a potential sources identified.

5:19 Multiple resistant 'gram negative' (MDRGN) organisms screening and rates
Universal admission faecal screening is advocated and compliance is around 12%. Detection of MDR-GN carriage / colonisation remains steady. There was an increase of acquired across both standard gram negative and highly resistant, carbapenemase producing organisms.

5.20 Vancomycin resistant enterococci

Cases detected both in hospital and out of hospital continued to decline.

5.21 Serious Untoward incidents and complaints involving Infection, major outbreaks and threats
No SI's were declared.
There were 2 major outbreaks; cardiac MRSA and SARS-CoV2 in a staff member also within cardiac. There was also an adenovirus outbreak of sustained transmission in Robin and Fox ward.

6. Hand Hygiene and CVC on going care guidelines
Appropriate guidelines are in place and audited quarterly. Care bundle audits have been updated to reflect newly updated national guidance.

7. Facilities
Cleaning- No report received. Improvement plan completed and maintenance of cleaning standards achieved. SI regarding VHP occurred- action plan completed.

Decontamination- A new sterile services provider has been tendered and appointed. The new build of a Medical Equipment Decontamination Unit (MEDU) was complete and the Endoscopy Decontamination Unit (EDU) was refurbished.

8. Estates-
Ventilation: The trust specialist ventilation programme continues. Work was undertaken to verify 6 additional source isolation rooms on Pelican and prepare Hedgehog as the COVID-19 cohort ward.
Water: The Water Safety Management Group continues to develop and manage risk associated with water. Risk from heater cooler units has been controlled. Sampling was suspended in some areas due to the COVID-19 pandemic.
Redevelopment / projects – IPC continue to work with redevelopment. The development of the IPC post within redevelopment was approved and the post appointed to.

9. Trust wide audit
A Trust annual IPC audit programme is followed with results available on the trust intranet and Nursing Care Quality Dashboards.

Trust IPC audit days are held quarterly to complete hand hygiene and point prevalence audits as well as associated action plans.

'Bare-below-the-elbows' component of hand hygiene remains continues to be excellent with compliance over 90%, hand hygiene compliance remains lower than previous years but areas for improvement remain the focus of the audit rather than demonstrating compliance.

Central venous line care bundle audit remains lower than acceptable. Most areas for improvement remain around documentation. Work was undertaken with EPR to make this easier which was slow to implement but is now completed.

9:5 Antimicrobial stewardship and Sepsis

Antimicrobial Stewardship – the CQUINS is now discontinued and the reduction in antimicrobials is part of the standard contract. A fully functioning AMS team is now embedded.

9.6 Sepsis report

Sepsis is led by an ID consultant. The programme is now part of normal business for the organisation. Work is underway to improve the identification and management of sepsis within EPR.

10. Occupational Health

OH continues to provide 'new entrants' screening ,"Exposure Prone Procedures" clearance, staff immunisation (including influenza, final uptake 59% (61% previous year) and blood borne virus exposure follow up (57 events, compared to 65 in previous year).

11 Targets and Outcomes	Target	Outcome
MRSA bacteraemia –	0	0
Clostridium difficile infection (lapses in care)	<5	2 (0 lapse in care)
Rate of GOS acquired line infection /1000 days	< 1.3	1.3
Analysis for S. aureus bacteraemias	100%	100%
MRSA colonisation acquisition	0	16
Hand hygiene audits	95%	78%,
CVL care bundle audits	90%	47%
For substantive staff:		
IPC level 1 induction	95%	96%
IPC level 2 update	95%	89%

12. Training activities

Basic IPC training and update is provided for all staff through either e-learning, face to face teaching from the IPC team or both. Update is now only through e-learning, including assessment questions. Attendance is monitored.

New training modules:

The online level 2 update training package is due to be updated.

IPC training days: A popular training day programme continues.

Hand hygiene training for staff on wards is provided locally, and by the IPC team for staff without a ward. All episodes should be recorded by the training department.

IV and aseptic non-touch technique training an update is provided for nursing staff locally but currently there is no assurance that this is provided to all medical staff.

Attachment X

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board **16th September 2020**	
Workforce Race Equality Standard 2020 and **Workforce Disability Equality Standard 2020** **Submitted by: Caroline Anderson. Director of HR&OD**	**Paper No: Attachment X**
Aims / summary To provide Trust Board with assurance that the Trust is meeting its reporting obligations under the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) and update on how the Trust will respond to its findings.	
Action required from the meeting To note the content of the report and the launch of the GOSH Diversity & Inclusion Strategy which embeds WRES and WDES indicators into the GOSH People Strategy.	
Contribution to the delivery of NHS / Trust strategies and plans Meeting the statutory duty to report publicly on this activity and meet CQC requirements.	
Financial implications None.	
Legal issues None.	
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	

Workforce Race Equality Standard 2020

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 During the height of the COVID pandemic the requirement to complete the WRES submission was initially withdrawn to allow Trusts to focus on operational priorities, however there was an internal decision to continue with gathering the relevant data to allow for an internal WRES report. Subsequently the central decision to pause reporting was reversed and the initial publication schedule resumed. The 2020 WRES Trust data exercise has been completed and submitted ahead of the 31st August deadline and this paper will be published online as required, following September Trust Board.

1.3 In September 2020, the Trust will launch a Diversity & Inclusion Strategy.

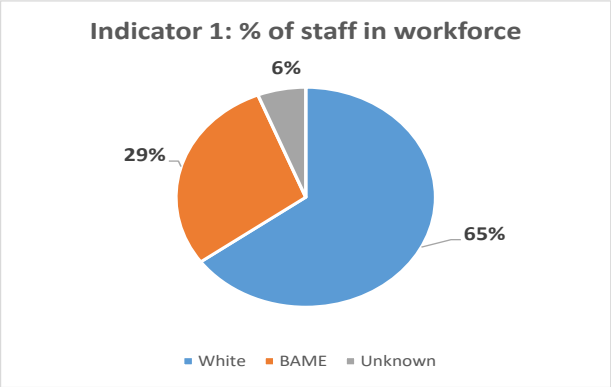
2. Main findings of the 2020 WRES

2.1 There are nine WRES indicators, four of which focus on HR&OD 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. This year, the Trust is not required to submit its Staff Survey data as this is publicly available. The main points arising from the 2020 GOSH data:

Indicator 1: Proportion of BAME Staff

GOSH has an overall workforce composition of 29% BAME 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 closer to 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 16% of nurses BAME at GOSH compared with 51% across London.

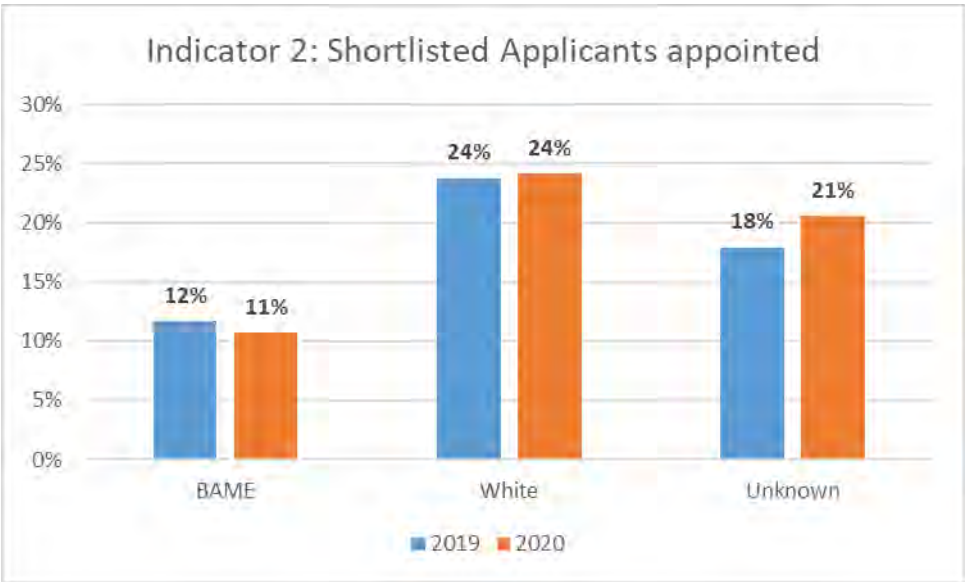
	Scientific & Technical	Add. Clinical Services	Admin. & Clerical	Allied Health Professionals	Estates & Ancillary	Healthcare Scientists	Medical & Dental	Nursing	Overall
London *	39%	56%	42%	24%	51%	44%	40%	51%	**45%**
GOSH	30%	43%	39%	12%	49%	39%	32%	16%	**29%**

*Source 2019 NHS Digital report

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 of BAME staff remained at 29% there was a small increase in BAME headcount (increase in BAME headcount of 34, compared with 22 increase in white staff headcount). Within the Medical workforce there was a 2% increase in BAME representation driven by a 5% increase in Trainee grade Drs to 37% of the total workforce.

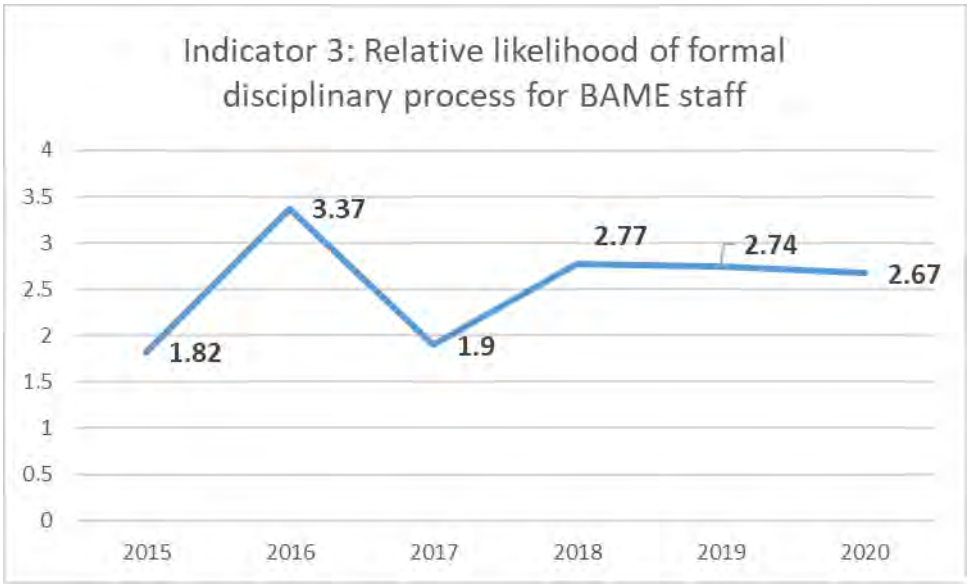
Indicator 2: Appointment of Shortlisted Applicants

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 2.25 times more likely than BAME applicants to be appointed from shortlisting. This represents a worsening picture from the 2019 report (2.03 times) as well as being higher than the London average (1.60 for London trusts: 2019 WRES data).



Indicator 3: Formal Disciplinary Processes

Whilst the number of formal disciplinary cases at GOSH is relatively small overall, proportionately more staff from BAME backgrounds are involved in formal disciplinary action than white staff (2.67 times more likely). This compares to 1.22 in England and 1.67 in London (2019 WRES data). This overrepresentation has been reported since the start of the WRES dataset in 2015.



Indicator 4: Non-Mandatory Training & CPD

The uptake of non-mandatory training and CPD between BAME and white staff is broadly comparable from 2019 to 2020. However, the trend over the past 6 years shows a deteriorating picture for BAME staff, with white staff now 1.18 times more likely to access non-mandatory training compared with 1.05 times more likely in 2015.

Indicator 5 to 8: NHS Staff Survey data

The data for these indicators is no longer included in our submission to the Dept of Health but will continue to be monitored as part of the national WRES dataset. On 3 of the 4 indicators, the results for BAME respondents indicate a worse experience than for white respondents

Staff Survey Indicator	White	BAME
Indicator 5: % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	25.2%	16.9%
Indicator 6: % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	29.4%	36.2%
Indicator 7: % of staff believing that the trust provides equal opportunities for career progression or promotion	84.0%	57.9%
Indicator 8: % of staff personally experiencing discrimination from managers or other colleagues	6.9%	18.0%

Indicator 9: BAME Representation at Board Level

In 2020, BAME board representation was 21% compared to 15% in 2018. When compared with London Trusts GOSH performs well in this matric (London 17%, National 8%). However, the GOSH Trust Board continues to have a lower representation of BAME staff than is found in the overall workforce (-8.3%).

3. Diversity & Inclusion Strategy

As demonstrated within this report, GOSH performs poorly across many of 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 was 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.

The D& I Strategy ***Seen and Heard*** will be presented to the September Trust Board and launched Trust wide in late September 2020. Although the strategy does not focus exclusively on race, driving improvements to the WRES indicators form a key strand of the 4 pillars of the Strategy.

Workforce Disability Equality Standard 2020

1. Introduction

1.1 Since 2019, NHS organisations have been required to publish data against the NHS Workforce 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 During the height of the COVID pandemic the requirement to complete the WDES submission was initially withdrawn to allow Trusts to focus on operational priorities, however there was an internal decision to continue with gathering the relevant data to allow for an internal WDES report. Subsequently the central decision to pause reporting was reversed and the initial publication schedule resumed. The 2020 WDES Trust data exercise has been completed and submitted ahead of the 31st August deadline and this paper will be published online as required, following September Trust Board.

1.3 In September 2020, the Trust will launch a Diversity & Inclusion Strategy.

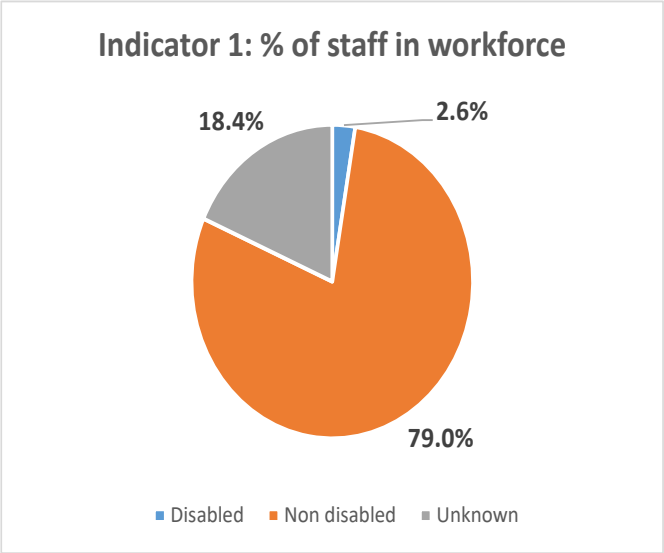
2. Main findings of the 2020 WDES

2.1 There are eleven WDES indicators, three of which focus on HR&OD data, six from data obtained by the national NHS Staff Survey, one a practical example of how the trust facilitates the voice of disabled staff and one indicator focusses upon Disabled representation on Trust Board. The main points arising from the 2020 GOSH data are set out below:

Indicator 1: Proportion of Disabled Staff

GOSH has a recorded workforce composition of 2.6% 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% of respondents to the 2019 Survey question on whether the respondent had any physical or mental health conditions, disabilities or illnesses



The Trust D&I strategy will have as a measure of success improvements to the declaration rates of disabled staff to address the reported gap between HR data and the Staff Survey. By improving the quality of the datasets, the validity of the WDES submission will be enhanced, and actions arising to improve the experience of disabled staff will be more based in the experience of those staff.

Indicator 2: Appointment of Shortlisted Applicants

Disabled applicants were less likely to be appointed than non-disabled applicants in 2019/20, with a relative likelihood of non-disabled staff being 1.3 times more likely to be appointed. This was an improvement from the previous WDES submission which was 1.6 times more likely.

Indicator 3: Formal Capability Processes

There were no formal capability cases opened in 2019/20 where the staff member had a recorded disability. However with a significant gap between ESR data and self-reported status, it is possible that capability cases involving disabled staff have not been recorded as such. This indicates the importance of improving declaration rates amongst staff.

Indicator 4 to 9a: NHS Staff Survey data

The data for these indicators is no longer included in our submission to the Dept of Health but will continue to be monitored as part of the national WDES dataset. On 7

of the 8 indicators, the results for disabled respondents indicate a worse experience than for non-disabled respondents

Staff Survey Indicator	Disabled	Non-disabled
Indicator 4: % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	30.8%	21.5%
Indicator 4: % of staff experiencing harassment, bullying or abuse from managers in the last 12 months	29.4%	14.8%
Indicator 4: % of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	36.9%	22.6%
Indicator 5: % of staff believing that the trust provides equal opportunities for career progression or promotion	67.1%	78.1%
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.	29.0%	20.5%
Indicator 7: % staff saying that they are satisfied with the extent to which their organisation values their work.	39.8%	51.1%
Indicator 8: % of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	64.2%	-
Indicator 9a: % Overall Staff Engagement score *(1-10 where 10 is a better score)*	7.0	7.4

Indicator 9b: Facilitating Disabled Voices

As part of the submission we are required to provide a practical example of how the Trust is facilitating disabled voices. We listed the launch of the Disabled & Long term Health Conditions (DLTHC) forum in December 2019.

Indicator 10: Disabled representation at Board Level

There are no Board members at the Trust who have reported a disability. The Chief Finance Officer is the Executive Lead for the Trust Disabled & Long term Health Conditions Forum

3. Diversity & Inclusion Strategy

As demonstrated within this report, GOSH performs poorly some of the indicators of the WDES, while the ongoing challenge of poor declaration rates for this characteristic make it harder to address challenges that disabled staff face. In order to address these challenges and ensure the culture at GOSH is welcoming and supportive to all our staff, the development of a Diversity & Inclusion Strategy was identified as a first year priority of the GOSH People Strategy that was launched in November 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 DLTHC Forum.

The D& I Strategy ***Seen and Heard*** will be presented to the September Trust Board and launched Trust wide in late September 2020. Although the strategy does not focus exclusively on any single protected characteristic, driving improvements to the WDES indicators form a key strand of the 4 pillars of the Strategy.

Attachment Y

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 16 September 2020	
Emergency Preparedness, Resilience & Response (EPRR) Annual Report 2019/20 **Submitted by:** Camilla McBrearty – Emergency Planning Officer Phil Walmsley – Accountable Emergency Officer (Interim COO)	**Paper No: Attachment Y**
Aims / summary To provide a summary of the work undertaken across the Trust regarding EPRR for the year 2019/20, including assurance of full compliance across all NHS England & Improvement core standards for EPRR	
Action required from the meeting Approval of the report	
Contribution to the delivery of NHS Foundation Trust strategies and plans Emergency preparedness and incident management	
Financial implications None	
Who needs to be told about any decision? Emergency Planning Group Executive Team Operational Board	
Who is responsible for implementing the proposals / project and anticipated timescales? Emergency Planning Office Accountable Emergency Officer	
Who is accountable for the implementation of the proposal / project? Emergency Planning Office Accountable Emergency Officer	

Attachment Y

Great Ormond Street Hospital NHS Foundation Trust
Emergency Preparedness, Resilience & Response Annual Report 2019/20

1. Executive Summary

The Trust is committed to developing and maintaining policies and procedures by taking a proactive approach to emergency preparedness, resilience and response (EPRR). The purpose of this report is to provide information relating to business continuity and emergency preparedness across the Trust in 2019/20. It details incidents, compliance with NHS England & NHS Improvement (NHS E&I) core standards, completed training exercises, and continuing plans to take forward and improve the management of emergency planning and business continuity in the Trust.

2. Introduction

This report summarises the work of the emergency planning team, key aspects of the organisations emergency preparedness over the past year and how the trust maintains its readiness to prepare, respond and recover from both emergencies and disruptive challenges. Throughout the year a continuous process of exercising, testing, training and assurance has taken place. The Trust continues to work with external agencies such as NHS E&I and other trusts to ensure maximum preparedness and business continuity following any adverse major incidents.

3. EPRR Assurance

The Emergency Planning Officer (EPO) completed a RAG rated self-assessment against the NHS Core standards for EPRR in September 2019. The overall response showed an increase in compliance against the previous year with four ‘ambers’ self-identified, all of which were fulfilled between this time and the review meeting on 15th October 2019. NHSE&I, the Trust’s Accountable Executive Officer (Chief Operating Officer) and EPO took part in the meeting, where it was verified that all of the core standards had been achieved and therefore, a fully compliant score has been recorded for the Trust. This is the first time that this level has been achieved for the Trust.

There were several recommendations from NHSE&I relating to the work that had been done in the previous year, and the EPO developed an action plan to address the gaps. This document is attached for reference. The Critical and Major Incident Plan was amended and signed off at Operations Board in December 2019.

Action Plan post assurance 2019 updat

At Trust level, The Major Incident Planning Group (MIPG) continues to meet on a quarterly basis to review the progress of the yearly work plan and the training & exercise programme. Plans and policies are reviewed and discussed here before being taken to Policy Approval Group or Operational Board for agreement and sign off.

4. Business Continuity Plans and Polices

The Trust Business Continuity Plan was reviewed and amended to incorporate Assurance 2018 recommendations, namely to strengthen enhanced our Business Impact Assessment and RAG (red/amber/green) service criticality ratings, and was approved by Ops Board July 2019 in readiness for the 2019 assessment.

5. Training and Exercises 2019/20

Training type	Audience/role	Content
Monthly Duty Manager refreshers *Monthly*	General Managers and Heads of Nursing on the Duty Manager rota with on call function	• Incident response • Setting up incident control centre • Scenario training • Lessons identified through minor incidents
Strategic Leadership in Crisis training *27 September 2019*	Executive Management team and Directors fulfilling the Gold rota with on call function	• Civil Contingencies Act responsibilities • Defensive decision making • Legal considerations and logging
Business Continuity management (BCM) *Targeted sessions February & March 2020, plus annual review training*	Senior Leadership Team General Managers Chiefs of Service	• BCM awareness and responsibilities • BCM plan content and reviews • Contingencies for contractors and stakeholders • Table top scenario exercises • Individual annual review sessions
Incident Loggists *3 sessions between September 2019 and February 2020*	Volunteers from across the Trust fulfil the loggist role (14 in total)	• Emergency management overview • Methods of logging • Legal background and reasoning • Practical assessment
EU Exit 'no deal' scenario planning *Throughout weekly planning meetings*	Directors and Senior Managers with responsibility for Business Continuity	• Scenario planning based on short, medium and long term planning. • supply of medicines and vaccines; • supply of medical devices and clinical consumables; • supply of non-clinical consumables, goods and services; • workforce; • reciprocal healthcare; • research and clinical trials and • data sharing, processing and access

The ***Duty Managers*** who carry out the Trusts tactical on-call function (Silver rota) continue to ***receive refresher training on a monthly basis*** in managing the response to emergencies, with an expectation that they attend at least one session per year. This regular training incorporates learning from real incidents which have occurred both in the Trust and across the London region, and includes setting up the incident control room and running through their roles.

An external trainer from NHSE&I supported the EPO to deliver ***Strategic Leadership in Crisis training to the Executive team*** in September 2019 to consolidate the in-house training they receive as part of the Gold rota requirements. Additional senior management training sessions have also been arranged on an ad hoc basis when new members have joined the Gold rota. There have also been online learning modules sent to the Gold and Silver on call on topics such as 'Working with your Loggist' to ensure the smooth running on incidents. There are further Strategic leadership sessions planned by NHSE&I for mid-2020 which will be offered to all members on the Gold rota.

As part of the focus on **Business Continuity** across the Trust for 2020, ***training is being offered to all senior managers with responsibility for business continuity management, with the first sessions taking place in February and March 2020***. This will now be continued on an annual basis in line with the required scheduled reviews for preparedness plans and has been continued through the COVID-19 response where all contingency plans were reviewed and strengthened as needed. A table top exercise is incorporated into each session, where managers use their current plans to enable us to validate and review them as a collective and make amendments as necessary. A ***business continuity management presentation was due to be delivered to the Senior Leaders*** of the Trust on 1st December 2019, but this was unfortunately re-scheduled to February and then further delayed due to the suspension of these meetings during our COVID-19 response. This session is now scheduled for 7th May 2020.

Exercise Flambé is an interactive table-top exercise which explores staff roles during a full ward evacuation as a result of a fire. The session identifies 'best practice' for their specific area and learning from the 'Live' evacuation exercises. These sessions are done on a rolling basis and the EPO has had input into the content of the training and has attended 6 of these in the current year.

14 new ***Incident Loggists*** were trained between October and January to Public Health England (PHE) standard, who are ready to deploy to provide GOLD support in the event of a major incident. This training proved to be a timely investment, as 2 loggists per day were required to support both the Silver and Gold command structures for 12 weeks during our COVID-19 response.

A number of exercises devised by NHSE&I were successfully delivered through all levels of the organisation re: ***EU Exit*** to test business continuity in the event of a no deal scenario, just prior to this reporting period. The focus was on the seven tests as prescribed by Government and included the supply of medicines, vaccines, medical devices, clinical consumables non-clinical consumables, and workforce. This work has been held from the Government update/decision in October 2019, and as of this report being produced, has not yet been reactivated due to the Coronavirus response.

The EPO had planned to run a ***multi-department Pandemic Flu exercise*** in March 2020, as well as develop and deliver a Trust wide live play exercise in 2020 (as is required every 3 years) to incorporate both the 'Live Play' and 'Command Post' requirements, but, as per NHS E&I guidance, where a real incident negates the need for a similar exercise[1], these did not take place due to the extensive work and elements completed in the Trusts COVID-19 response. The full report from this,

[1] "If an organisation activates their ICC in response to a live incident this replaces the need to run an exercise, providing lessons are identified and logged and an action plan developed." (NHS England Emergency Preparedness Resilience and Response Framework 2015, sec 10.4)

as well as debriefing and action plan for lessons identified will be produced after the initial response phase is stood down – date and timeframe unknown at this time.

The learning from all training and exercises is shared with the major incident planning group and supports the review process of the relevant emergency plans and training programmes.

6. Incidents

Trust wide ICT downtime – July 2019

July 2019 saw an unscheduled ICT event across the Trust, which included the inability to access Epic, therefore invoking downtime procedures. All areas followed the downtime procedures, with no adverse effects. The lessons identified from this were as follows:

- A review and enhancement of the Epic Downtime guide available on wards/service areas
- Additional awareness training carried out in real time immediately post event, including testing all dedicated contingency laptops
- After the event, the EPO worked with the Electronic Patient Records (EPR) team on enhancing business continuity arrangements awareness by:
- Negotiating the addition of Business Continuity Awareness (BCA) information into the Trust induction
- Additional BCA information, plus a knowledge check, being added to the local induction
- A plan to provide extra learning opportunities on GOLD learning portal (2020)

The 'un-booked attenders' incident 15th September 2019.

At 02.00hrs on 15th September 2019, two adult males presented to main reception stating they had been stabbed and needed medical attention. Security let the men enter and contacted the on duty supervisor, who attended main reception and took them to a side room while requesting the urgent assistance of the Clinical Site Practitioners (CSP's). The London Ambulance Service (LAS) and Metropolitan Police (Met) had been called via 999 by security staff. The condition of both men deteriorated and the in house emergency team were called. Life-saving treatment commenced, including having the major haemorrhage protocol activated. Multiple LAS and Met units attended, including Helicopter Emergency Medics who took over leadership and management of the situation. Both men were transported to Royal London Hospital at 02:32hrs.

The associated "Un-booked Attenders Policy" was reviewed following lessons learned from this overnight incident. They included:

- Review of security control of the main entrance (intercom) after hours and actions to take should a similar situation present
- Greater personal security awareness and dynamic risk assessment for CSP's or other first responders during incidents where violence may have occurred

This policy was finalised and proposed for Policy Agreement Group in February, but was delayed to the next meeting. Update to follow.

Internal Flooding in Octav Botnar Wing and Camelia Botnar Labs

This incident occurred on 24th September 2019, when heavy rainfall overwhelmed the guttering and associated infrastructure, leading to water entering two hospital buildings. This was dealt with and rectified within four hours, by relocating four patients (due to concerns over one of two lifts in the

building being out of order and the possible associated implications/risk over only one further lift being available in the area in case of emergency or fire), and by Estates staff rectifying the physical issue of blocked guttering. The cause was found to be a service failure in the outsourced gutter cleaning regime, as the responsible party had not undertaken any of the required work in some time, causing the build-up of debris in a number of locations which meant the system was overwhelmed and water entered the buildings.
Post incident, a contractor was engaged to undertake the cleaning of the full roof drainage systems for all Trust buildings. This included small repairs being carried out, and all areas that had been water damaged being re-painted, and flooring replaced. The cost of these works was to be recovered from the original provider under the terms of the contract, and they were given 2 months to provide action plans to continue to provide the services under their contract arrangements. Once these had been produced, the original contractor continued to check and clean the gutters under the terms of the contract, however the Trust Estates management also put in place a Planned Preventative Maintenance schedule until March 2020 to check the work. This has been satisfactory since.

COVID-19 January 2019 – present (ongoing incident management).
Since mid-January 2019, the Trust has been involved an unprecedented situation, with levels of incident management response never seen before in the history of the NHS due to the worldwide pandemic of COVID-19. As this reporting period falls in the centre of the response, this report will be unable to provide a summary, but as soon as a full report has been completed, it will be made available to the Board.

7. Next steps

The EPO supported by the MIPG will continue to progress with emergency preparedness across the Trust with emphasis on training and exercises for all senior managers and decision makers. There continues to be a focus on business continuity across the Trust, which has only been further highlighted due to the COVID-19 response, and the lessons learned from this will be reviewed, debriefed and used to shape ongoing policy management.

Attachment Z

Summary of the Council of Governors' Meeting
Held on 14th September 2020

Update on Speak Up for Safety Programme
A presentation was received on progress that had been made with the Speak Up programme. Almost 80% of staff had received training with good feedback having been received. Training had been included in induction to ensure it continued to be embedded in the Trust. The next phase of the programme had been scheduled for launch in June 2020 and 27 peer messengers had been trained however this had been paused to the COVID-19 pandemic. GOSH was in the top 10 Trusts with most improved use of the Freedom to Speak Up Service.

Chief Executive Report
Focus was being placed on safely increasing activity to begin the treat the backlog of patients as a result of the impact of COVID-19. A clinical prioritisation group had been established to guide the prioritisation of patients. A national risk assessment tool had been developed to review the health needs of staff and this had been rolled out to managers and completed for approximately 90% of staff. New signage and one way systems had been introduced in the hospital and spaces were being assessed to ascertain the number of people who could work in the space.

Activity was currently taking place at approximately 60% of capacity which benchmarked well compared to other organisations and approximately 50% of the waiting list had been prioritised which was substantial progress. Harm reviews were taking place where patients could not be treated in the timeframe set out by the Clinical Prioritisation Group.

Integrated Quality and Performance Report May 2020
Key areas receiving focus were Duty of Candour stage 2 and 3, compliance with the WHO checklist and the incident closure rate. Discussion took place around the options available for staff whose offices and workspaces had been deemed safe for a reduced number of staff and the importance of changing practice where possible was noted. Governors expressed some concern about patient appointment cancellations that had occurred due to the requirement to receive COVID-19 test results for patients in advance of procedures. The challenges of current processes were acknowledged and it was confirmed that the Board would be reviewing alternative options. As a result of the pandemic and further work required around imaging for the hospital as a whole, there would some delay to the Children's Cancer Centre development and the decant work would also become increasingly complex as a result of the requirements of distancing.

Finance report (highlights) May 2020
At month 2 the Trust's position was £4.2million deficit offset by an NHS top up payment of £4.2million in order to cover costs associated with the COVID-19 pandemic resulting in a breakeven position. A block contract was now in place and the deficit, driven by considerably reduced research and development and IPP activity, was covered by a top up payment. Discussion took place around losses and special payments and it was confirmed that comparison took place year on year and regular reviews took place at Audit Committee in order to reduce this amount as far as possible.

Reports from Board Assurance Committees

- Quality, Safety and Experience Assurance Committee (April and July 2020)

It was confirmed that the newly appointed Non-Executive Director had joined the Committee which now had three members.

- Finance and Investment Committee (March, May and July 2020)

The Committee had reviewed the change in commissioning throughout the pandemic and the outturn of the accounts. Consideration was being given to working towards business as usual and on the continuing development projects. There had been an increase in cyber security threats which had been discussed by the Finance and Investment Committee, the Audit Committee and the Board.

- People and Education Assurance Committee (February and June 2020)

Focus was being placed on updating the People Strategy to bring it in line with the changes in the workforce such as a substantial increase in staff working from home. Focus was also being placed on ensuring that staff felt safe and supported. It was agreed that data around the impact of Brexit on the workforce would be considered at the next meeting.

Update from the Young People's Forum (YPF)

Discussion had taken place with the ethics team about young people's experience of lockdown. Concern had been expressed about the potential social crisis having negative health impact and the impact of unequal access to technology and a rise in screen time. Focus was being placed on sustainability particularly during development projects and work was taking place with the European Children's Hospitals Organisation (ECHO) on which the YPF had provided feedback.

GOSH Quality Report

The report had been recommended to the Board for approval by the Quality, Safety and Experience Assurance Committee. Due to the pandemic the 2020/21 report had not required inclusion in the Annual Report and would not be reviewed by the external auditors.

Always Improving Action Plan (Response to CQC recommendations)

All 'must do' actions arising from the CQC inspection in January 2020 had been completed. Of the associated actions around 60% were complete. The importance of embedding the work into business as usual was emphasised.

Governance Update

- Non-Executive Director Appraisals

Appraisals for three Non-Executive Directors were approved by the Council. They had been recommended for approval by the Council of Governors' Nominations and Remuneration Committee.

- Update from the Constitution Working Group

The Council approved the following updates to the constitution as recommended by the Constitution Working Group:

  - Amendments to annexes 1, 3 and 4 in order align the allocation of members to classes in line with current electoral boundaries.
  - Inclusion of annex 11 to allow a temporary phasing of elections for one election only.
  - Amendment to annex 10 to allow the Trust to hold a virtual AGM and AMM and virtual voting at this event
  - A reduction in the minimum members for the constituency 'Patient – Rest of England and Wales'

- Update from the MERRC

It had been agreed that the AGM theme would be 'Celebrating our People'. Planning was taking place for the 2020/21 elections and a communications plan had been developed with a theme for each month.

- Council of Governors' Effectiveness Review Survey

The Council agreed a change to the approach to buddying whereby NEDs host a zoom session focusing on specific Trust Board or assurance committee paper. It was agreed that this would be kept under review.

- Update to the Lead Governor and deputy Lead Governor Job Description and appointment of a Deputy Lead Governor

The Council approved an amendment to the Lead and Deputy Lead Governor role description to be clear about the importance of visible leadership through involvement.

Attachment 1

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 16 September 2020	
Revised Trust Board Terms of Reference and Workplan **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment 1** **For approval**

Purpose of report

To present the revised Trust Board Terms of Reference and Workplan and seek approval of the proposed amendments.

Summary of report

Trust Board Terms of Reference (ToR)

The Trust Board Terms of Reference (ToR) are usually reviewed and updated every two years or following amendments to the Trust's Standing Orders, Reservation and Delegation of Powers. In September 2019, the Board approved amendments to the ToR in light of the changes to the role titles of members, changes to attending the Board on a non-voting capacity and establishment of a new Board assurance committee.

In light of the imminent launch of the Trust Strategy 'Above and Beyond' as well as the Diversity and Inclusion and Health and Well Being Strategies, the ToR have been updated to include reference to the role of the Board in embracing diversity and supporting and empowering staff. All suggested amendments are in red text.

Trust Board workplan

An updated version of the Trust Board workplan is attached at **Appendix 2**. This includes a proposed rota for directorate presentations at Board and progress reporting against the separate strategies. All revisions are in red text.

Action required from the meeting

The Board is asked to review the proposed amendments and approve the revised terms of reference and workplan.

Contribution to the delivery of NHS Foundation Trust priorities	**Contribution to compliance with the Well Led criteria**
☐ **Enhanced corporate governance**	☐ **Leadership, capacity and capability**

Strategic risk implications

Relevant to all BAF risks.

Financial implications

Not Applicable

Implications for legal/ regulatory compliance

The ToR sets out the purpose, scope, authority of the Board as well as the membership and reporting, in line with the principles under the Code of Governance.

Consultation carried out with individuals/ groups/ committees The Executive Management Team have commented on and recommended for approval the attached ToR and workplan.
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
Which management committee will have oversight of the matters covered in this report? Trust Board

Attachment 1

Board Assurance Framework Risk Statements

Risk
1. **Financial Sustainability**
2. **Recruitment and Retention**
3. **Operational Performance**
4. **GOSH Strategic Position**
5. **Unreliable Data**
6. **Research Infrastructure**
7. **Cyber Security**
8. **Electronic Patient Records**
9. **Business Continuity**
10. **Redevelopment and estate**
11. **Information Governance**
12. **Medicines Management**
13. **Consistent delivery of quality services**
14. **Political Instability**
15. **Service Innovation**
16. **Culture**

Attachment 1

Great Ormond Street Hospital for Children NHS Foundation Trust

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;

- 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;

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

- Establish a work environment where diversity is embraced and the skills, capacity and morale of our staff are prioritised. Ensure that staff feel well led, valued, developed, supported and empowered to be and do their best.

- Ensure there are effective structures, processes, systems of accountability, validated, 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.

- 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.

- Ensure that strategic development proposals ~~have been~~are 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.

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

- 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.

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

- 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, 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 meeting of the Board for information.

3. Membership

The Board shall comprise 13 directors excluding the Chair.

There shall be 7 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:

- 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, the Board may approve deputies with formal acting up status or in 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 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~~Estates and Facilities and the Built Environment
- 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.

All of t~~T~~hese 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, the 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.

~~Approved~~ Draft: September ~~2019~~2020

Attachment 1

Trust Board Work-plan 2020/ 21 (purple shaded = Confidential agenda)

CQC Domain	Topic	Executive Director	3 February 2021	20 March 2021	26 May 2021	7 July 2021	16 September 2020	14 October 2020 (Strategy Day)	26 November 2020
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 plan/ Effectiveness Review	Chief Executive/ Company Secretary	Board Development Session: TBA Procurement of external Well Led Facilitator	Board Development Session: TBA External Well Led Assessment commences in April 2020	Board Development Session: TBA	Board Development Session:	Board Development Session: ? September Unconscious Bias Executive Development session: 11 August Update on Well Led Assessment	Executive Development session: ? October Well Led Self-Assessment Challenge Session	Board Development Session: ? November Ocado and innovation
	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 (Under review)	CEO and responsible executives	Integrated People Strategy Progress Report Quality Strategy Progress Report Safety Strategy Progress Report	GOSH Learning Academy Strategy Progress Report Stakeholder Engagement Strategy Progress Report	DRIVE Strategy Progress Report	IPP Strategy and Commercial Opportunities Progress Report	Trust Strategy Launch: 22 September Diversity and Inclusion Strategy Health and Well-being Strategy	Full strategy & progress with objectives and plans Revised Risk Management Strategy	Research Strategy Progress Report Patient Experience and Engagement Framework Progress Report

Attachment 1

CQC Domain	Topic	Executive Director	3 February 2021	20 March 2021	26 May 2021	7 July 2021	16 September 2020	14 October 2020 (Strategy Day)	26 November 2020
	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	Update on Children's Cancer Centre		Progress with Sight and Sound Hospital
	Directorate Team Presentations* (Under Review)	Chief Operating Officer and Directorates	Operations and Imaging IPP	Heart and Lung	Medicines Therapies and Tests	Body, Bones and Mind Brain	Sight and Sound		Blood, Cells and Cancer
	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 (Hotspots paper)	Medical Director	X	X	X	X	X		X
	Business Continuity Report	Chief Operating Officer		Annual Report					

Attachment 1

CQC Domain	Topic	Executive Director	3 February 2021	20 March 2021	26 May 2021	7 July 2021	16 September 2020	14 October 2020 (Strategy Day)	26 November 2020
	Health and Safety Report	Dir of HR and OD			Annual Report				
	Safeguarding Report	Chief Nurse				Annual Report			
	Operational matters	Relevant executive(s)		Update on Cognitive pilot					Update on Cognitive Parent/carer accommodation review
	Gender Pay Gap Report				X				
	W4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?								
	Review of compliance	Medical Director/ Company Secretary		CQC Progress update including well led	Code of Governance/ NHSI Licence Review		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					Schedule of matters reserved for the Board and Council Board ToR/ Workplan		SFIs/ Scheme of Delegation
	Register of Interests & Gifts & Hospitality & Register of seals	Company Secretary	Seals	Seals/ Gifts and Interests	Seals/ Gifts and Interest	Seals	Seals		Seals

Attachment 1

CQC Domain	Topic	Executive Director	3 February 2021	20 March 2021	26 May 2021	7 July 2021	16 September 2020	14 October 2020 (Strategy Day)	26 November 2020
	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	X + Focus on clinical outcomes	X		X + Focus on clinical outcomes
	Learning from Deaths	MD		Q2	Q3	Q4			Q1
	Infection Control Report (from DIPC)	Chief Nurse/ DIPC		X			Annual Report		X
	Finance Report	Chief Finance Officer	X	X	X	X	X		X + PLICS
	Board Assurance Framework Overview	Company Secretary		X Review of risks against new strategy + (January AC and QSEAC Non-Clinical risks review)	X	X	X		X
	Safe Staffing/ 6 monthly staffing review	Chief Nurse	X	X +6 monthly staffing review	X	X	X +6 monthly staffing review		X
	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

Attachment 1

CQC Domain	Topic	Executive Director	3 February 2021	20 March 2021	26 May 2021	7 July 2021	16 September 2020	14 October 2020 (Strategy Day)	26 November 2020
	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	X	X	X	X	X	X	X
	People and Education Assurance Committee report to Board - – matters to be raised at Board	PEAC Chair		X		X	X		X
	Hospital Funding Priorities Steering Group	Chaired by James Hatchley NED	Incorporated into CEO Update				Incorporated into 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	Chief Finance Officer/ Company Secretary			X				

Attachment 1

CQC Domain	Topic	Executive Director	3 February 2021	20 March 2021	26 May 2021	7 July 2021	16 September 2020	14 October 2020 (Strategy Day)	26 November 2020
	Statement								
	WRES and WDES Report and Equality Objectives	Dir of HR and OD		Workforce Equality Objectives Update YEAR Equality, Diversity & Inclusion: Update against service delivery Equality Objectives			WRES and WDES Annual Report		
	W8: Are there robust systems and processes for learning, continuous improvement and innovation?								
	Assurance and Escalation Framework Update						X		
	Data Annual Report			x					

Attachment 2

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 16 September 2020	
Schedule of matters reserved for the Trust Board and Council of Governors **Submitted by: Anna Ferrant, Company Secretary**	**Paper No: Attachment 2** **□ For approval**
Purpose of report To note the matters reserved to the Trust Board and Council and approve the document, including the amendments proposed.	
Summary of report The NHS 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 note and approve the Schedule of matters reserved for the Trust Board and Council of Governors	
Contribution to the delivery of NHS Foundation Trust priorities **□ Effective quality/ corporate/ financial governance**	**Contribution to compliance with the Well Led criteria** **□ Leadership, capacity and capability**
Strategic risk implications Not applicable	
Financial implications Not applicable	
Implications for legal/ regulatory compliance The NHS 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.	
Consultation carried out with individuals/ groups/ committees Guidance and legislation reviewed for the purposes of drafting the document are outlined on the Schedule.	
Who is responsible for implementing the proposals / project and anticipated timescales? Company Secretary	
Who is accountable for the implementation of the proposal / project? Chair	
Which management committee will have oversight of the matters covered in this report? Not applicable	

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		Finance and Investment Committee
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	Finance and Investment Committee
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/ People and Education 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 CoG	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/ Audit 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/ Audit 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

No.	Reference	Matters reserved to Board Committees	Committee	Reporting to TB	Informing/ approval of CoG
		1. Strategy and Management			
		2. Structure and organisation			
		3. Financial and Governance Reporting and Controls			
3.3	SOs	Approval of any significant changes in accounting policies or practices.	Finance and Investment Committee	x	
3.4	SOs SFI 4.1	Approval of treasury management policies, including external funding (borrowing arrangements), banking arrangements and operating cash management policy.	Finance and Investment Committee	x	
		4. Internal Controls			
		5. Contracts			
		6. Communication			
		7. Board membership and other appointments			
7.3	NHS Act 2006 Con 23	Changes to the structure, size and composition of the Trust Board.	TB Nominations Committee	x	Approval where the changes impact on the number of NED appointments
7.4	NHS Act 2006 Con 29	Appointment and removal of the Chief Executive.	TB Nominations Committee	x	Approval of the appointment
7.5	NHS Act 2006 Con 29	Appointment and removal of Executive Directors to the Trust Board	TB Nominations Committee	x	Informing
7.6	BoD SO 20.8	Appointment of Acting Executive Directors.	TB Nominations Committee	x	Informing
7. 7	NHS Act 2006 Con 31	Continuation in office of any director at any time, including the review of suspensions, termination of service of an executive director as an employee of the Trust, subject to the law and their service contract.	TB Nominations Committee	x	
		8. Remuneration			
8.1	NHS Act 2006 Con 35	Determining the remuneration policy for the executive directors, Company Secretary and other senior executives and managers.	TB Remuneration Committee	x	
8.2	NHS Act 2006 Con 35 CoG D1	The introduction of any performance related remuneration or bonus scheme for executive directors or staff.	TB Remuneration Committee	x	
		9. Delegation of authority			
		10. Corporate Governance matters			
8.2	Audit Code	Approval of a policy delegating authority by the Council to the CEO and Audit Committee for commissioning additional services from the external auditor	Audit Committee	x	Approval
		11. Policies			
		12. Other			
12. 3	CoG C3	Review and approve arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.	Audit Committee	x	
12.4	Cons 47	Approval of the overall levels of insurance for the Trust including Directors' and Officers' liability insurance [and indemnification of directors].	Finance and Investment Committee	x	

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 Standing Orders (2018)

CoG Sos	Council of Governors' Standing Orders (2018)
Audit Code	Monitor (NHSI) Audit Code
Blue highlight	Powers of the Committees (decision rights) - these committees report these decisions to the Board

No.	Reference	Matters reserved to the Council of Governors	CoG	TB	Committee
1. Strategy and Management					
1.1	Code A1f TB ToR	Providing input to the strategic aims of the Trust as recommended by the Board	x	Board approves strategy	
1.2	Con 43 Code A1f	Providing input to the annual business plan as recommended by the Board.	x	Board approves plan	
2. Structure and organisation					
2.1	NHS Act 2006 Constitut 49 Code A5.15	Approves application for acquisitions, mergers, separations or dissolution of the Trust	x (more than half of governors approve an application)	Board approves application	Finance and Investment Committee
2.2	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 (more than half of governors voting)	Board approves application	Finance and Investment Committee/ Quality, Safety and Experience Assurance Committee/ People and Education Assurance Committee
2.3	Con 43.7 Code 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 (more than half of governors who vote) Governors to 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 (more than half of governors voting)	Board approves increase	Finance and Investment Committee/ Quality, Safety and Experience Assurance Committee/ People and Education Assurance Committee
3. Financial and Governance Reporting and Controls					

3.1	Con 44	Receiving the annual report and accounts, auditor reports and annual reports at a general meeting.	x		
4. Internal Controls					
5. Contracts					
6. Communication					
6.1	CoG E1 Con 16.1.2	Represent the interests of the members of the Trust as a whole and the interests of the public	x		Membership Engagement and Recruitment and Representation Committee
7. Board membership and other appointments					
7.1	NHS Act 2006 Con 23	Changes to the structure, size and composition of the Board.	x (approve changes to NEDs)		CoG Nominations Committee
7.2	NHS Act 2006 Con 12	Changes to the structure, size and composition of the Council and membership.	x (and requires membership approval)		Constitution Working Group
7.3	NHS Act 2006 Con 26	Appointment and removal of the Chair of the Board and Council.	x		CoG Nominations and Remuneration Committee
7.4	NHS Act 2006 Con 29.2	Approval of the appointment of the Chief Executive	x	x (NEDs appoint and remove CEO but recommend the appointment to the Council)	
7.5	NHS Act 2006 Con 26	Approval of the process for appointment and the appointment and re-appointment of the Chair and Non-Executive Directors.	x	x (COG consults with the Board)	CoG Nominations and Remuneration Committee
8. Remuneration					
8.1	NHS Act 2006 Con 35	Setting the remuneration and term of office of the non-executive directors (and market testing every three years using external professional advisers).	x		CoG Nominations and Remuneration Committee
9. Delegation of authority					
10. Corporate Governance matters					
10.1	NHS Act 2006 Con 40.2	Appointment, reappointment or removal of the external auditor.	x		Audit Committee

10.2	HSCA 2012 Con 2	Holding the Non-Executive Directors to account for the performance of the Board, including ensuring the Board acts so that the Trust does not breach the conditions of its licence.	x	x (in consultation with the Board)	
10.3	Code B.6.d	Assess collective performance of the Council and impact on the Foundation Trust	x (and report to membership)	x (in consultation with the Board)	Constitution Working Group
10.4	CoG SOs	Establishing the visions, values and standards of conduct for the governors and members and operating a code of conduct that builds on these values.	x	x (in consultation with the Board)	Constitution Working Group
10.5	Code B6.6	Approval and implementation of policy for removal of governors who consistently and unjustifiably fails to attend the meetings of the council; has an actual or potential conflict of interest which prevents the proper exercise of their duties; or, where behaviours or actions of a governor or group of governors may be incompatible with the values and behaviours of the NHS foundation trust.	x (majority of those voting whether there is a case to be answered/ to uphold the statement of case/ to impose sanctions as deemed appropriate)		
10.6	Code A5.15	Approve a change to the Constitution (more than half the members of the Council voting approve the amendment)	x	x	
		11. Policies			
11.1	Con Annex 8	Standing Orders for the Council of Governors.	x	x	
		12. Other			
12.1	CoG B.6.e	Evaluation of the Council of Governors	x	Report findings to the Board	Constitution Working Group

KEY	
NHS Act 2006	NHS Act 2006
HSCA 2012	Health and Social Care Act 2012
Blue highlight	GOSH Constitution (2018)
SoDeleg	Scheme of Delegation (2019)
SFI	Standing Financial Instructions (2019)
TB SO's	Trust Board Standing Orders (2018)
CoG Sos	Council of Governors' Standing Orders (2018)
Yellow highlight	Powers of the Council (decision rights)
White highlight	General duties and monitoring role of the Council
Green highlight	**Council is consulted (advisory role)**
Committee column	The committees in the final column have an advisory role