NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

**GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST**
**VIRTUAL MEETING OF THE COUNCIL OF GOVERNORS**
**Wednesday 22 April 2020**
**3:00pm – 4:00pm**
**Zoom Connection (Governors and Board Members Only)**

| NO. | ITEM | ATTACHMENT | PRESENTER | TIME |
|---|---|---|---|---|
| 1. | **Welcome and introductions** | | Michael Rake, Chair | 3:00pm |
| 2. | **Apologies for absence** | | Michael Rake, Chair | |
| 3. | **Declarations of interest Register for Governors 2020** | **A** | Michael Rake, Chair | |
| 4. | **Minutes of the meeting held on 5 February 2020** | **B** | Michael Rake, Chair | |
| 5. | **Matters Arising and action log** | **C** | Anna Ferrant, Company Secretary | |
| | **PERFORMANCE and ASSURANCE** | | | |
| 6. | **Update on planning for COVID -19: Question and Answer Session** | **Verbal** | Matthew Shaw, Chief Executive | 3:10pm |
| | **GOVERNANCE** | | | |
| 7. | **Update on Lead Governor Appointment** | **Verbal** | Michael Rake, Chair | 3:35pm |
| 8. | **Update from Council of Governors' Nominations and Remuneration Committee**<br>• **Appointment of the UCL nominated NED on the GOSH Board**<br>• **Nominations for members of the Committee** | <br>**D**<br>**Verbal** | <br>Anna Ferrant, Company Secretary<br>Anna Ferrant, Company Secretary | 3:40pm |
| 9. | **Compliance with the NHS provider licence – self assessment** | **E** | Anna Ferrant, Company Secretary | 3:50pm |
| 10. | **Any Other Business** | **Verbal** | Michael Rake, Chair | 4:00pm |

Attachment A

## Council of Governors

## 22 April 2020

# Council of Governors' Declarations of interest 2020

### Summary & reason for item

The purpose of this paper is to present the Council of Governors' Register of Interests 2020 and remind Governors of their responsibilities to declare their interests on DECLARE, the Trust's online declaration of interest portal.

### Governor action required

- To note the content of the Governors' register of interests.
- To declare any additional interests on DECLARE that arise or any changes in circumstance affecting the Council of Governors' register of interests.

### Report prepared by

Paul Balson, Deputy Company Secretary, paul.balson@gosh.nhs.uk

### Report presented by

Anna Ferrant, Company Secretary

Attachment A

# Declarations of interest - Council of Governors 2020

**Background**

Under the Trust's Declarations of Interest, Gifts and Hospitality Policy (which is compliant with the NHS England model policy) Governors, Executive and Non-Executive Directors, Senior Leadership Team Members and all consultants (including honorary consultants) are designated **decision-making staff**. That is: staff more likely than others to have a decision-making influence on the use of taxpayers' money because of the requirements of their role. Appendix 1 provides an overview of the types of interests to be declared.

Also under the policy, decision-making staff are expected to make an annual mandatory declaration of interest, gifts and hospitality.

To assist the Corporate Affairs Team in managing the large numbers of declarations from decision making staff, the Trust purchased DECLARE - an online solution for the management of declarations of interest, gifts, hospitality and sponsorships.

During the first phase of DECLARE roll out in November 2019, the Governor declarations held on file were uploaded by the Corporate Affairs Team. Governors were then asked to check the uploaded declarations before they were made publicly available on the Trust website.

**Action required**

The register of interests is available here: https://gosh.mydeclarations.co.uk/home. The 2020 Governor Register of Interests is attached at **Appendix 2.**

Governors are asked to note the Governors' register of interests and where they require updating or new interests need to be added, to login to https://gosh.mydeclarations.co.uk/home and make any changes or new declarations as required. Login support is available from the Corporate Affairs Team if required.

Governors are asked to:

1. Note the Governor Register of Interests.
2. Login to https://gosh.mydeclarations.co.uk/home and make any changes or new declarations as required. Login support is available from the Corporate Affairs Team if required.
3. Ensure the Governor register of interests is kept up to date throughout a tenure as a GOSH Governor.

Attachment A

**Appendix 1: Declarations of Interest FAQ**

<u>What is an interest?</u>

A 'conflict of interest' is:

*"A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."*

A conflict of interest may be:

- Actual - there is a material conflict between one or more interests
- Potential – there is the possibility of a material conflict between one or more interests in the future

Governors may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived conflict.

There are four types of interest (further information is available from the Corporate Affairs Team):

- **Financial interest** - Where an individual may get direct financial benefit from the consequences of a decision they are involved in making.
- **Non-financial professional interest** - Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career
- **Non-financial personal interest** - Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career
- **Indirect interest** - Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making

Appendix 2

**NHS**
**Great Ormond Street Hospital for Children**
**NHS Foundation Trust**

## Great Ormond Street Hospital for Children NHS Foundation Trust

## Council of Governors' Register of Interests 2020

| Constituency | Name | Declared Interests |
|---|---|---|
| **Patient and Carer Governors** | | |
| Patients from outside London | Faiza Yasin | None |
| | Alice Rath | None |
| Patient from London | Elena-May Reading | None |
| | Zoe Bacon | None |
| Parents and carers from London | Mariam Ali | None |
| | Stephanie Nash | None |
| | Emily Shaw | The Little Jimmy Brighter Future Fund - a fund within GOSHCC<br>Since December 2016 my husband and I have managed a fund within GOSHCC, The Little Jimmy Brighter Future Fund fundraises for the charity to buy GOSH life-support equipment in memory of our son. We are not employed by the Charity and all time and endeavours by us and our supporters is given freely on a voluntary basis and without remuneration.<br>We select life-support equipment to purchase for the Hospital from a procurement list agreed between the Hospital and Charity. To date we and our supporters have fundraised over £325,000 and we have recently committed to continue our fundraising with new targets. |
| Parents and carers from outside London | Lisa Allera | GOSH Patient Experience Committee<br>GOSH (PALS) Volunteer<br>GOSH Research Parent Advisory Group<br>Steering Committee – Cardiac Post-Surgical Morbidity Study |

Appendix 2

| Constituency | Name | Declared Interests |
|---|---|---|
| | | Husband – member of Corporate Partnerships Board for GOSH Charity |
| | Carley Bowman | None |
| | Claire Cooper-Jones and Lead Governor | None |
| **Public Governors** | | |
| North London and surrounding area | Simon Hawtrey-Woore | None |
| | Theo Kayode-Osiyemi | None |
| | Simon Tan | TBC |
| | Teskeen Gilani | None |
| South London and surrounding area | Fran Stewart | Esher Sixth Form College<br>Trustee of the College. Sit on College Trust Board and relevant Sub Committees; Audit Sub Cttee and also Finance & Estates Sub Cttee. Role is unpaid.<br>Declared now and not previously as confirmation from Companies House regarding recognition of Esher Sixth Form College as an entity only recently received. |
| The rest of England and Wales | Colin Sincock | None |
| | Julian Evans | None |
| **Staff Governors** | | |
| | Sarah Aylett | Children's Trust, Tadworth, Surrey<br>Medical Advisor to the Children's Trust, Tadworth, Surrey<br>Advisor to the Clinical Governance and Safeguarding committee- attend 4 meetings (10 hours total) per year<br><br>Children's Trust, Tadworth<br>Visiting Consultant Paediatric Neurologist to the Children's Trust, Tadworth.<br>Visiting epilepsy clinic x3/year (total 21 hours) and non-urgent advice (8 hours/year) |
| | Margaret Bugyei-Kyei | None |
| | Nigel Mills | None |

Appendix 2

| Constituency | Name | Declared Interests |
|---|---|---|
| | Paul Gough | None |
| | Quen Mok | HCA Healthcare<br>I am on the clinical rota with a group of 8 paediatric intensivists covering the PICU in the Harley Street Clinic. I ensure that this does not clash with the clinical rota at Great Ormond Street Hospital.<br>1 in 8 weeks, when not on clinical duty for GOSH<br><br>Tushinskaya Trust<br>Appointed as Trustee for Tushinskaya Trust. This is a UK registered charity set up in 1988 by the previous Medical Advisor to the British Embassy in Moscow. The aim of the charity is to improve the health and welfare of sick Russian children in hospitals. Young Russian doctors or nurses are selected for The Diana, Princess of Wales memorial scholarships to spend 12 weeks in Great Ormond Street Hospital as clinical observers. I have been on the selection panel since 2005 and was appointed as Trustee in 2011. |
| **Appointed Governors** | | |
| London Borough of Camden | Lazarro Pietragnoli | Declaration not received |
| University College London,<br>Institute of Child Health | Jugnoo Rahi | The Royal College of Ophthalmologists - Member of the Paediatric Subcommittee<br>Purpose – to formulate and provide RCOpht's position and advice regarding clinical practice, services and policies in paediatric ophthalmology<br><br>The Royal College of Ophthalmologists - Member of the Academic Committee |

Appendix 2

| Constituency | Name | Declared Interests |
|---|---|---|
| | | Purpose/aims<br>1. Safeguarding – protecting academic ophthalmology and ensuring all ophthalmologists are equipped with skills to undertake, assess and apply research by promoting academic education and research including through contributions to RCOphth Council and relevant College Committees<br>2. Influencing and advocating – for research training and funding and support for academic communities and research networks<br>3. Profiling academic ophthalmology – by maintaining good working relationships with other academic institutions and funding bodies including the Medical Research Council, the Wellcome Trust, NIHR, the Academy of Medical Sciences, and the Academy of Medical Royal Colleges.<br>4. Enabling – supporting the development of and access to opportunities for academic ophthalmology training and signposting to useful resources<br>5. Promoting equal opportunities for all ophthalmologists in academic ophthalmology. |
| Young People's Forum | Josh Hardy | None |
| Young People's Forum | Emma Beeden (stepped down as of 13/02/2020) | London South Bank University - LSBU People's Academy<br>Working with the LSBU nursing lecturers to improve the course and insure that their trainee nurses are equipped with the skills to effectively communicate with, treat and support young people. This is a part time paid role |

Appendix 2

| Constituency | Name | Declared Interests |
|---|---|---|
| | | Royal College of Paediatrics and Child Health<br>I first took part in MRCPCH exams in 2017 however I am unable to take part in them as I am over 18.<br>I started volunteering with RCPCH&US directly in 2019. In this role I have taken part in projects to help paediatricians have the right skills to speak to young people, judged for the PAFTAs (Paediatric Awards for Training Achievements) and helped them to interview for new staff.<br>I get my travel reimbursed for this but I do not get paid.<br><br>Nation Institute for Health and Care Excellence (NICE)<br>I am a Lay Member on the Babies, Children and Young People's Experiences of Healthcare Guideline committee.<br>I bring my lived experience to the guideline to ensure the voices of young people are heard throughout the whole process.<br>For this role I get my travel reimbursed and I also receive a lay member fee of £150 per session<br><br>NHS Youth Forum (NHSYF)<br>The NHSYF is a group of 25 young people who all have experience of the NHS.<br>We work with policy makers within the NHS to try and make services more youth friendly. I have been involved in projects to help young people feel comfortable sharing the story and transition. More notably, I and the rest of the forum were one of the groups asked for their opinion on what should be included in the long term plan.<br>I get my travel reimbursed for this but it is not paid. |

Great Ormond Street Hospital for Children
NHS Foundation Trust

**DRAFT MINUTES OF THE COUNCIL OF GOVERNORS' MEETING**
**5th February 2020**
**Charles West Boardroom**

| Name | Role |
|---|---|
| Sir Michael Rake | Chair |
| Alice Rath | Patient and Carer Governor: Patients outside London |
| Faiza Yasin | |
| Zoe Bacon** | Patient and Carer Governor: Patients from London |
| Dr Emily Shaw | Patient and Carer Governor: Parents and Carers from London |
| Mariam Ali | |
| Lisa Allera | Patient and Carer Governor: Parents and Carers from outside London |
| Dr Claire Cooper-Jones | |
| Simon Hawtrey-Woore | Public Governor: North London and surrounding area |
| Theo Kayode-Osiyemi** | |
| Colin Sincock | Public Governors: The rest of England and Wales |
| Julian Evans | |
| Fran Stewart | Public Governors: South London and Surrounding Area |
| Margaret Bugyei-Kyei | Staff Governors |
| Dr Quen Mok | |
| Paul Gough | |
| Dr Sarah Aylett | |
| Josh Hardy | Appointed Governor: Young People's Forum |
| Emma Beeden | Appointed Governor: Young People's Forum |

**In attendance:**

| Name | Role |
|---|---|
| Akhter Mateen | Non-Executive Director |
| Lady Amanda Ellingworth | Non-Executive Director |
| Kathryn Ludlow | Non-Executive Director |
| James Hatchley** | Non-Executive Director |
| Helen Jameson | Chief Finance Officer |
| Dr Sanjiv Sharma | Medical Director |
| Dr Anna Ferrant | Company Secretary |
| Paul Balson | Deputy Company Secretary |
| Peter Hyland* | Director of Operational Performance and Information |
| Caroline Anderson | Director of HR and OD |
| Roisin Mulvney* | Head of Special Projects – Quality and Safety |
| Victoria Goddard | Trust Board Administrator (minutes) |

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

***Denotes a person who was present by telephone*

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| **46** | **Apologies for absence** |
| 46.1 | Apologies for absence were received from: Elena-May Reading, Patient and Carer Governor; Stephanie Nash, Patient and Carer Governor; Carley Bowman, Patient and Carer Governor; Mr Simon Yu Tan, Public Governor; Teskeen Gilani, Public Governor; Nigel Mills, Staff Governor; Lazzaro Pietragnoli, Appointed Governor and Jugnoo Rahi, Appointed Governor. Apologies were also received from Matthew Shaw, Chief Executive. |
| **47** | **Declarations of Interest** |
| 47.1 | No declarations of interest were received. |
| **48** | **Minutes of the meeting held on 26 November 2019** |
| 48.1 | The Council of Governors **approved** the minutes of the previous meeting. |
| **49** | **Matters Arising and action log** |
| 49.1<br><br>49.2<br><br>49.3 | The actions taken since the previous meeting were noted.<br><br><u>Selection of indicator for audit (for Quality Report)</u><br><br>Peter Hyland, Director of Operational Performance and Information said that Governors had selected 'Last Minute Non-Clinical Hospital Cancelled Operations'. The Trust's External Auditors would begin testing in the coming weeks. |
| **50** | **GOSH Strategy – final** |
| 50<br><br>50.1<br><br>50.2 | Caroline Anderson, Director of HR and OD presented the Trust's new strategic framework 'above and beyond; our five year strategy to advance care for children and young people with complex health needs'. Stakeholder events had taken place with staff and partners throughout summer 2019 and as a result six key principles had been developed which would act as reference points for planning and decision making going forward. Six priorities had also been identified which would be the focus of work up to 2025. The learning academy was a key part of the strategy as was the commitment to opening the Children's Cancer Centre.<br><br>During the consultation, respondents had appreciated the sense of journey and purpose depicted through the use of the rocket and space theme.<br><br>Colin Sincock, Public Governor said that it was vital to ensure that a plan was in place to deliver the strategy and Caroline Anderson said that the Trust Board would consider the strategy for approval on 6th February and the same meeting would also consider the transformation strategy which was key to the delivery of the overall strategy. |

| 51 | **GOSH CQC Inspection Report 2019** |
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| 51.1 | Sir Michael Rake, Chair said that the CQC report had been discussed during the Chair and Governors' private meeting and Governors had been clear that the report emphasised the need to continue to focus in particular areas such as pharmacy. Dr Sanjiv Sharma, Medical Director agreed that although the report was indicative of good progress in many areas, there was still work required. |
| 51.2 | Roisin Mulvaney, Head of Special Projects – Quality and Safety confirmed that the Trust had been given a rating of 'good' overall and all services had now been rated either 'good' or 'outstanding' which was an improvement on the previous report. She added that the Trust had been disappointed with the rating of 'requires improvement' for the safe key line of enquiry. Three areas had been inspected: surgery, critical care and CAMHS which had not previously been reviewed as a standalone service. The rating for Well Led in CAMHS had deteriorated as a result of a lack of responsiveness to the challenges of Epic in the service. Well led overall had moved from 'requires improvement' to 'good' which was a key achievement. |
| 51.3 | The excellent work of the Young People's Forum had been highlighted in the CQC report along with research at GOSH and work on patient experience. |
| 51.4 | Roisin Mulvaney said that work was taking place to review access to PICU medication rooms and to ensure that all IV fluids were appropriately stored. An Always Improving Plan had been developed which combined all related action plans and would be monitored through the Executive led Always Improving Group. She said that overall GOSH benchmarked well throughout the report notwithstanding the ambition to move to a rating of 'outstanding' in all areas. |
| 51.5 | Dr Sarah Aylett, Staff Governor welcomed the positives in the report. She highlighted the concerns raised around infection control which came as a result of lack of basic practice along with a concern raised around equipment. She queried the action that was being taken to improve storage in pharmacy. Roisin Mulvaney said that it was vital to support staff to follow correct practice and to enable staff to speak up where they saw that this was not the case. Work was taking place with the Infection Control team about one area where there would be specific focus and there was a plan in place for this. Comments in the report around equipment related to a specific piece of equipment in theatres which was being used by a contractor and discussion would take place about the way in which contractor equipment could be tagged as safe. |
| 51.6 | Dr Sanjiv Sharma, Medical Director said that issues in pharmacy were not limited to storage and it was important to ensure that the correct team structure was in place with the correct roles and work on this was progressing with Epic. A safety manager was now in place in the team and the newly appointed Deputy Medical Director was overseeing the programme of work. Dr Sharma said that work had begun on the safety strategy which would be presented at the Quality, Safety and Experience Assurance Committee (QSEAC) meeting in April. He added that the Trust must be an exemplar for safety. |
| 51.7 | Dr Quen Mok, Staff Governor asked whether the CQC had visited the urology team as actions related to the service were not included in any of the 'must do' action. Roisin Mulvaney confirmed that all areas had been visited and meetings |

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| | had taken place with all directorate management teams. Dr Sharma said that GOSH had been open with the CQC who were aware of the review by the Royal College and had been in attendance at the QSEAC meeting when the report had been shared. |
| 51.8 | Lisa Allera, Patient and Carer Governor asked whether there were required timeframes related to the enforcement notice and Roisin Mulvaney said that the action plan was being submitted to CQC in the week beginning 10th February and it was anticipated that 'reasonable' timeframes would be in place and all actions were scheduled for completion in 2020 with the exception of the rebuild of the Mildred Creak Unit. Lisa Allera asked how communication was taking place with patients and families and Roisin Mulvaney said that following discussion at Trust Board consideration would be given to the information which would be provided on the website showing when actions were completed. |
| 51.9 | Sir Michael said that whilst the report was a considerable improvement on previous CQC inspections there was still work to do. He added that some issues had been on-going for a long time and this was unacceptable and must not be the case going forward. |
| 51.10 | Simon Hawtrey-Woore, Public Governor noted that CAMHS had been rated 'requires improvement' for well led and requested further information about the rating. Dr Sharma confirmed that the issue was specifically related to the use of Epic. |
| 51.11 | Discussion took place around the way in which risk was managed throughout the organisation and whether risk management throughout the levels of the Trust required additional oversite from Non-Executive Directors. Akhter Mateen, Chair of the Audit Committee said that Non-Executive Director scrutiny was provided at Audit Committee which would take recommendations from the Risk Assurance and Compliance Group and either accept or challenge those recommendations. Fran Stewart, Public Governor asked whether a review of the 'safe' key line of enquiry would take place at the Audit Committee and Akhter Mateen said that this fell under the remit of the QSEAC which would review the action plan arising from the CQC along with Internal Audit which would provide assurance that the recommendations had been implemented. Oversight of this would then be provided at the Audit Committee through QSEAC updates. |
| **52** | **Operational Plan 2020/21 Update** |
| 52.1 | Peter Hyland, Director of Operational Performance and Information said that nationally there were challenges around finances and workforce. GOSH also had challenges and opportunities in terms of being clear about its place in the system both regionally and nationally, changes in specialist services and commissioning, the continued implementation of Epic and the refreshed strategy. |
| 52.2 | Planning guidance had recently been issued by NHS England and Improvement which was in line with the previous year and final plans were due to be submitted by the Trust in April 2020. The Trust's internal planning process had been strengthened and three iterations of plans had been received for each clinical and corporate area with emerging areas of focus. |

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| 52.3 | Peter Hyland said that improvement was required in terms of RTT performance particularly for long waiting patients and it was vital to ensure that, despite the challenges around funding in specialised and highly specialised commissioning, the Trust was appropriately funded for the activity that would be required to meet these targets. The Trust would also be required to make efficiency savings and to ensure that this did not impact on the quality and safety of services. |
| 52.4 | Colin Sincock, Public Governor asked whether there were other Trusts in London achieving a surplus whose business planning GOSH could learn from? Peter Hyland said that control totals were adjusted based on each Trust's financial circumstances so whilst it wasn't possible to learn from their particular outturn, GOSH's clinical directorates had been clear that external collaboration was key both in terms of working with a variety individual partners and within networks. |
| 52.5 | Dr Claire Cooper-Jones, Patient and Carer Governor asked whether Non-Executive Directors agreed with the key challenges. Akhter Mateen highlighted workforce as a key area of focus. He said that year-on-year it had been challenging to reach the agreed outturn and there had been significant risks to doing so, however the Trust had always met the control total in the past. He added that as challenges continued, focus must be placed on recruitment and retention and making savings. Chris Kennedy, Non-Executive Director said that as changes were made to tariff these often resulted in unintended consequences for GOSH and it was important to continue to raise these issues within the system. Amanda Ellingworth, Non-Executive Director said that it was vital that the Trust was able to make efficiencies through transformation rather than a large number of annual schemes. Sir Michael agreed and said that the North Central London STP also faced major financial challenges which would impact on GOSH. |
| 52.6 | **Action:** The Council requested that papers included fewer acronyms in future and that where these were required an explanation was provided. |
| **53** | **Chief Executive Report** |
| 53.1 | Integrated Quality Report December 2019 data (highlights) |
| 53.2 | Dr Sanjiv Sharma, Medical Director said that in March 2019 the Trust had asked the Royal College of Surgeons to undertake a review of the Urology Service as the College provided a service review programme with robust governance arrangements. The report had been received in May 2019 and had been shared with the Board and QSEAC, had provided recommendations which continued to be worked through with the team. There had been good engagement from the team and good improvements had been made in the time since the review. The team had taken part in facilitated away days and good functional discussions were taking place as well as clinical data being collected to share and benchmark with other organisations. Dr Sharma said that it was important to continue to support the team and this would be done for six months to ensure new processes were embedded. He said that the group had world class expertise and therefore it was vital that they were supported to work together effectively. |

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| 53.3<br><br><br><br><br><br>53.4<br><br>53.5 | An action plan had been developed in response to the preventing future deaths report issued by the coroner and a focus was being placed on improving cross organisational and multidisciplinary team (MDT) working. Good progress was being made and Terms of Reference for MDTs would be presented to Operational Board on 12th February. The aim was to run pre-operative assessment clinics and it was vital that teams were resourced to do this.<br><br>Performance dashboard December 2019 data<br><br>The Trust's performance against the 52 week wait metric was challenging as a result of the reduction in consultants in dental who undertook general anaesthetic work. The service had been paused to external referrals following discussion with NHS England in September 2019 which had led to issues in the London network with the capacity of other London centres being challenged. GOSH had attempted to recruit a locum consultant but had not been successful. Interviews were taking place for a substantive appointment. A trajectory had been submitted to set out how 52 weeks waits would be reduced by year end. |
| 53.6 | Radiology was experiencing challenges particularly around MRI capacity as a result of increase in referrals and planned referrals. Discharge summary and clinic letter performance continued to plateau however there were no outstanding summaries dating to before November 2019. Issues were primarily around summaries and letters at the weekend as administrative support was required to complete the letters. |
| **54** | **Reports from Board Assurance Committees** |
| 54.1 | Quality, Safety and Experience Assurance Committee (January 2020) |
| 54.2 | Lady Amanda Ellingworth, Chair of the QSEAC said that an Associate Medical Director for Safety was now in post and would be leading on the development of a Safety Strategy which would be presented to the QSEAC. Following Professor Rosalind Smyth's departure from the Board there were now only two Non-Executive members of the Committee and Lady Ellingworth emphasised the importance of ensuring this was rectified in a timely fashion. |
| 54.3 | Finance and Investment Committee (December 2019) |
| 54.4 | James Hatchley, Chair of the Finance and Investment Committee said that the primary focus had been around the delivery of the Control Total for 2019/20 which was a risk. Members of the Committee had been taking part in additional telephone calls to receive updates on the financial position following ongoing reforecasting with directorates and to ensure that continuing to report that the Control Total would be met was appropriate. |
| 54.5 | The Committee had been comfortable that the Better Value programme would achieve £18.5milion against a £20million target. Some posts had not been filled as quickly as anticipated and the committee had sought assurance around the progress with Referral to treatment (RTT) as a result. James Hatchley reiterated that financial challenges in 2020/21 would increase. |
| 54.6 | |

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| | Focus continued to be placed on the Electronic Patient Record (EPR) and reviewing the benefits to ensure that the benefits that the financial case was built on would materialise. |
| **55** | **Finance report December 2019 data (highlights)** |
| 55.1<br><br>55.2<br><br>55.3 | Helen Jameson, Chief Finance Officer said that the Trust was still working towards meeting the Control Total and she was receiving daily updates on the budget setting position. She said that it remained likely that the outturn would be met however it would continue to be challenging.<br><br>Akhter Mateen said that Directorate presentations were received at each meeting and most recently this had been from Heart and Lung and Medicines, Therapies and Tests. Both had commented that they felt the revised Directorate structure was working well and a positive Internal Audit report had confirmed this.<br><br>Colin Sincock noted the Trust's increased cash balance and queried how the cash would be used. Helen Jameson confirmed that cash was held in specific bank accounts as required by the NHS. |
| **56** | **Reports from Board Assurance Committees** |
| 56.1<br><br>56.2<br><br>56.3<br><br>56.4 | People and Education Assurance Committee (December 2019)<br><br>Kathryn Ludlow, Chair of the PEAC confirmed that the approved Terms of Reference and workplan for the committee were now in place and the committee had requested summaries of exit interviews. The Committee had received the first staff story which had been inspiring and had illustrated the importance of staff feeling supported to progress in their career. Discussion had taken place around the Learning Academy and the Committee had emphasised the importance of planning beyond the three year funding that had so far been allocated.<br><br>Focus had been placed on honorary contracts which had been reviewed and approximately 50% terminated for reasons such as individuals no longer undertaking the role or failure to complete mandatory training.<br><br>Colin Sincock said that he had observed the meeting and welcomed the presentation from a healthcare scientist. He suggested that similar presentations continued to take place and it was confirmed that they would be a standing item on the agenda. |
| **57** | **Update from the Young People's Forum (YPF)** |
| 57.1<br><br>57.2 | Emma Beeden, Member of the YPF said that the forum had been working closely with the development team since the inception of the Children's Cancer Centre and recently the group had been considering names for new wards in the building. Emma Beeden had spoken at the GOSH Conference about her experience at the Trust particularly related to transition.<br><br>Josh Hardy, Member of the YPF said that the forum had emphasised the importance of nature and sustainability in the Children's Cancer Centre |

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| | development. They had suggested that outside areas for relaxation would set GOSH apart as a children's hospital and improve outcomes and patient experience. |
| 57.3 | GOSH Children's Charity had spoken with the YPF around the areas that were charity funded and the impact that Charity had on the hospital particularly in terms of patient experience, which had been extremely valuable. |
| **58** | **Process for appointment of a Lead Governor and Deputy Lead Governor at GOSH** |
| 58.1 | Paul Balson, Deputy Company Secretary said that the Lead Governor and Deputy Lead Governor roles were appointed for a period of 12 months in April each year. He outlined the nomination and election process for the appointment which would take place in advance of the April Council of Governor meeting and confirmed that nominations would be sought between 10th February and 16th March. The Council **approved** the process. |
| 58.2 | It was confirmed that no changes had been made to the content of the role description which was **approved** by Governors. |
| 58.3 | It was noted that training for the Lead Governor and Deputy Lead Governor would be based on individual needs and would be provided by the Trust in combination with external training and information sessions such as those provided by NHS Providers. |
| **59** | **Governance Update** |
| 59.1 | Paul Balson said that a summary had been provided in the paper around the feedback Governors had given about the group's training and development needs. |
| 59.2 | The Membership Engagement Recruitment and Representation Committee (MERRC) had considered ways of recruiting members in underrepresented constituencies and had particularly focused on the use of MyGOSH. A meeting would take place with the EPR team to review this further. |
| 59.3 | The Trust had received 42 applications for the stakeholder engagement manager post and six candidates had been shortlisted. Interviews would take place in the week beginning 10th February and the Chair of MERRC would sit on the interview panel. |
| 59.4 | An action arising from the CQC inspection related to the Council of Governors was around clarifying the role and expectations of governors in interview stakeholder groups. Governors confirmed they were satisfied with the clarifications set out. |
| 59.5 | Council effectiveness survey action plan update |
| 59.6 | The Council noted the update. |

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| 59.7 | <u>Refreshed NED appraisal process</u> |
| 59.8 | Anna Ferrant said that NHS Improvement and England had published new guidance in November 2019 around the Chair's appraisal process. It had been agreed at the Governors' meeting in November 2019 that the GOSH framework would be updated in line with this guidance for both the Chair and Non-Executive Directors. |
| 59.9 | The process for appraising the Chair involved ensuring that stakeholder feedback was considered and the paper set out the proposed stakeholders. The Senior Independent Director would appraise the chair under this framework. The same process would be used to appraise Non-Executive Directors however there would be no requirement to seek additional stakeholders' views. |
| 59.10 | The Council **approved** the processes for the Chair and NED appraisals. |
| 59.11 | <u>Refreshed Chair and NED terms and conditions</u> |
| 59.12 | Anna Ferrant said that the terms and conditions had been updated in light of GDPR and following legal advice. They would be in place for the new Non-Executive Director from UCL. |
| 59.13 | The Council **approved** the refreshed terms and conditions. |
| **60** | **Any other business** |
| 60.1 | There were no items of other business. |

Attachment C

# COUNCIL OF GOVERNORS ACTION CHECKLIST
## February 2020

### Checklist of outstanding actions from previous meetings

| Paragraph Number | Date of Meeting | Issue | Assigned To | Required By | Action Taken |
|---|---|---|---|---|---|
| 52.6 | 05/02/20 | The Council requested that papers included fewer acronyms in future and that where these were required an explanation was provided. | **All paper authors** | **On-going** | Noted and for action in all Council reports |

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Great Ormond Street Hospital for Children NHS Foundation Trust

## Council of Governors

## 22 April 2020

**Appointment of a University College of London nominated Non-Executive Director on the GOSH Trust Board**

**Summary & reason for item:**

To consider the recommendation from University College of London to appoint Professor Russell Viner, Professor of Adolescent Health at the UCL Institute of Child Health for a three year term as a Non-Executive Director on the Great Ormond Street Hospital for Children Foundation Trust Board.

The Council of Governors' Nominations and Remuneration Committee has considered the nomination by email and recommend this nominee for approval to join the GOSH Board for a three year term as a Non-Executive Director (subject to appointment checks).

**Governor action required:**

To consider and approve the appointment of Professor Russell Viner as a Non-Executive Director on the Great Ormond Street Hospital Trust Board.

**Report prepared by:**

Dr Anna Ferrant, Company Secretary

**Item presented by:**

Dr Anna Ferrant, Company Secretary

The Trust Constitution provides for one Non-Executive Director on the Great Ormond Street Hospital for Children Foundation Trust Board to be appointed by the University College of London (UCL). The Committee should note that the Constitution does not stipulate who the representative from the University must be, so long as this person exercises functions for the purposes of the University.

Professor Rosalind Smyth, Director of the Institute of Child Health previously held this role and stepped down on 31 December 2019.

Professor David Lomas, UCL Provost conducted an appointment process within UCL. An advert was circulated within UCL and one application was received. An interview for the candidate was conducted in February 2020 by Professor Lomas and Mr James Hatchley, GOSH Senior Independent Director. Professor Russell Viner was successful at interview and UCL formally nominated him as the UCL appointed Non-Executive Director on the GOSH Trust Board.

For information, a copy of the person specification for the role is attached, along with a short biography below:

*Russell Viner is currently President of the Royal College of Paediatrics & Child Health (RCPCH), the leading voice for children and young people's health in the UK. He is also Professor of Adolescent Health at the UCL Institute of Child Health in London, a paediatrician who sees young people with diabetes each week at University College Hospital and he directs the Department of Health Obesity Policy Research Unit.*

*Russell has a long history of leadership in national health policy, from involvement in the 2005 National Service Framework to helping ensure children and young people were central to the 2019 NHS Long Term Plan. He is currently Vice-Chair of the NHS England Children and Young People's Transformation Board, responsible for strategic oversight of children's health in England, and Chair of the Stakeholder Council for the Children's Transformation Board. He also has significant 'hands-on' experience within the NHS, having been Clinical Director in a busy teaching hospital and clinical director for children and young people for the NHS across London, responsible for leading healthcare strategy for London's 2 million children and young people.*

*Russell Viner was one of the founders of Adolescent Health in the UK. He set up the first Adolescent Medicine service in the UK and went on to become the UK's first professor of Adolescent Health, helping lead a new focus on adolescent healthcare in the UK and Europe. He was a founder of the UK Association for Young People's Health (AYPH) and now serves as Patron. He has been Vice-President of the International Association for Adolescent Health. He has acted as an advisor on adolescent health and obesity for the Departments of Health and for Education in England and for the World Health Organisation and Unicef internationally. He is an Executive Committee member for the International Paediatric Association and will be President of the 2021 International Paediatric Congress.*

*His research focuses on population health, policy and health services for children and young people. Academically, he has published over 200 peer reviewed papers and is currently named on >£20 million in current research grants.*

The Council Nominations and Remuneration Committee reviewed Professor Viner's application letter and CV and noted that Professor Viner has a strong clinical (paediatric) and research background and works at a strategic level both within UCL, nationally and internationally.

The Council will be aware that under the Trust Constitution, non-executive directors can hold office for six consecutive years on the Foundation Trust Board (two x three year appointments).

**Governor action required**

The Council is asked to consider the UCL nomination, and, taking into account Professor Viner's skills and experience, approve the recommendation from the Nominations Committee for his appointment to the Trust Board as a Non-Executive Director from 1 May 2020 (subject to employment checks, including the Fit and Proper Person's Check).

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

## Great Ormond Street Hospital for Children NHS Foundation Trust

## Non-Executive Director (nominated by University College London (UCL)

## Person Specification

The candidate should have a strong focus on strategic development and implementation and a grasp of the three cornerstones of GOSH's strategy:

- safe, effective patient care, experience and outcomes;
- world leading research; and
- an excellent place to work and learn.

We are looking for a candidate who will champion effective, safe services and an excellent patient and family experience. You will be personally influential and demonstrate intellectual ability with the capacity to analyse and master complex information and handle differing views in a flexible way.

Essential criteria

- Experience (clinical background or strong interest) in healthcare and healthcare related research.
- Knowledge of university related commercial matters.
- Demonstrate a strong commitment to excellent healthcare, the principles of the NHS and the Trust's Always Values.
- Ability to contribute to the hospital's strategic development and challenge constructively across all areas of the business
- The diplomacy and empathy to engage, promote and sustain relationships with internal stakeholders (Board members, Governors and staff).
- Excellent communication skills, a collaborative working style and awareness of the sensitivity of the services GOSH provides.
- Uphold the highest standards of conduct, displaying the principles of selflessness, integrity, objectivity, accountability, openness, honesty, and leadership.
- Qualified to be a member of the NHS Foundation Trust with a home within one of its public constituency boundaries.

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

# Council of Governors

## 22 April 2020

**Compliance with the NHS provider licence – request for governor views on the Trust self-assessment**

**Summary & reason for item:** To request governors' views on the annual Trust self-assessment of compliance with NHS Improvement ("NHSI") license conditions for providers of NHS services

**Governor action required:** To review the attached self-assessment, request clarification and provide comments on the Trust stated position against the relevant Licence conditions.

**Report prepared by:** Anna Ferrant, Company Secretary

**Item presented by:** Anna Ferrant, Company Secretary

**Compliance with the NHS provider licence – request for governor views on the Trust self-assessment**

The NHS provider licence is NHS Improvement's (NHSI) main tool for regulating providers of NHS services. The licence sets out important conditions that providers must meet to help ensure that the health system works for the benefit of NHS patients. These conditions give NHSI (the regulator) the power to:

- set prices for NHS funded care in partnership with the NHS England and require information from providers to help them in this process;
- enable integrated care across the NHS system;
- safeguard choice and prevent anti-competitive behaviour which is against the interests of patients;
- support commissioners to protect essential health services for patients if a provider gets into financial difficulties; and
- oversee the way that NHS foundation trusts are governed.

A Foundation Trust (FT) Board is required by NHS Improvement to annually declare compliance or otherwise with a small number of FT licence conditions plus a requirement under the Health and Social Care Act. The declaration is published on the GOSH website.

The Council is asked to note that the requirements for this declaration in 2020 under current Covid planning circumstances have not been released by NHSI. In the meantime, based on the assumption that the review is still required, GOSH has prepared the attached evidence base and will update the Council about submission dates (or postponement) as soon as this known.

**Overview of usual requirements for reporting compliance with FT Licence**

| Licence condition | Deadline and comment |
|---|---|
| **Condition G6(3):** Providers must certify that their board has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution. | The deadline for this declaration is **xx May 2020 (TBC).** The G6 self-certification also needs to be published within one month of sign off by the Board. |
| **Condition CoS7(3):** Providers providing commissioner requested services (CRS) must certify that they have a reasonable expectation that the required resources will be available to deliver the designated service. | The deadline for this declaration is **xx May 2020 (TBC).** |
| **Condition FT4(8)**: Providers must certify compliance with required governance standards and objectives | The deadline for this declaration is **xx June 2020 (TBC).** Board is required to identify risks to achieving the governance standards and any mitigating actions taken to avoid those risks. |
| NHS Improvement require the Board to state whether it is satisfied that during the financial year most recently ended the Trust has provided the necessary training to Governors, as required in s.151(5) of the Health and Social Care Act to ensure that they are equipped with the skills and knowledge they need to undertake their role. | The deadline for this declaration is **xx June 2020 (TBC)**. |

NHSI require that an FT Board must take into account the views of governors when considering whether the Trust confirms compliance with the above declarations.

**Action required**

**Appendix 1** documents self-assessed evidence against the four conditions. The Executive Team at GOSH has reviewed the evidence and recommends 'Confirm' for Conditions G6(3), CoS7(3) and FT4(8). The Council of Governors is asked for their views on the attached conditions and evidence cited. Governor and Executive comments will be reported to the Board in May 2020.

Great Ormond Street Hospital for Children NHS Foundation Trust

**Appendix 1: FT Licence self-certification – four requirements that must be signed off by the Board**

*The board must sign off on self-certification for the following licence conditions and H&SCA requirement, taking into account the views of governors.*

| Licence condition | Description | Confirmation: Confirmed or Not Confirmed | Assurance |
|---|---|---|---|
| **G6 – Systems for compliance with licence conditions and related obligations** **(scope = past financial year 2019/20)** | The Licensee shall take all reasonable precautions against the risk of failure to comply with the Conditions of this Licence, any requirements imposed on it under the NHS Acts, and the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.<br><br>The steps that the Licensee must take ….shall include:<br>(a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and<br>(b) regular review of whether those processes and systems have been implemented and of their effectiveness.<br><br>A statement shall be provided for Monitor to certify compliance with this condition no later than 2 months from the end of the | The Executive Team have considered the evidence cited and recommend 'Confirmed'.<br><br>Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors | The Trust has systems and processes to monitor risks of failure through lack of compliance or adverse variances in performance:<br><br>There is clear accountability at Board level for safety and clinical quality objectives and structured reporting of performance against these objectives. (see Annual Governance Statement in annual report)<br><br>The Trust's Assurance and Escalation framework sets out how the organisation identifies, monitors, escalates and manages concerns and risks in a timely fashion and at an appropriate level. This covers the following key areas:<br>• Risk Management<br>• Compliance<br>• Performance<br>• Information Governance<br>• Safeguarding<br>• Health and Safety<br><br>Risk Management<br>The Trust's risk management strategy, which sets out how risk is systematically managed, extends across the organisation from the front-line service through to the Board, to promote the reduction of clinical and non-clinical risks associated with healthcare and research, and to ensure the business continuity of the Trust. The strategy identifies the organisational risk management structure, the roles and responsibilities of committees and groups that have some responsibility for risk, and the duties and authority of key individuals and managers with regard to risk management activities. It describes the process to provide assurance for the Trust Board review |

| Licence condition | Description | Confirmation: Confirmed or Not Confirmed | Assurance |
|---|---|---|---|
| | financial year. | | of the strategic organisational risks, and the local structures to manage risk in support of this policy.<br><br>**Assurance**: The GOSH CQC report (2020) stated: *Staff at all levels were clear about their roles, areas of responsibility and accountability. This included delegation of responsibility to committees. The trust had an assurance and escalation framework with groups and committees providing the board with assurance or escalating concerns and/or risks relating to the quality of services, performance, targets, service delivery and achievement of strategic objectives.*<br><br>*The GOSH Board Assurance Framework includes a strategic risk of failing to maintain compliance with the Trust Licence (BAF Risk 5). This is monitored by the Risk Assurance and Compliance Group and assurance sought of the robustness of the controls cited at the Audit Committee (see below).*<br><br>On managing and learning from incidents, the CQC report stated: "*There was a clear system for categorising, reporting, investigating and learning from serious incidents, supported by the incident reporting and learning policy and duty of candour policy. Themes from serious incidents were used to inform targeted improvement work or organisational learning, for example the changes to handover and provision of revised duty of candour training*."<br><br>The Board receives a regular, high level summary of significant quality related issues currently being managed by the executive team at GOSH. It includes summaries and learning from internal and external reviews of services as well as concerns identified through concerns raised by our staff and our patients and their families; and through the aggregation of data regarding quality performance.<br><br>**Assurance**: The GOSH CQC report (2020) stated:<br>*"The trust had systems and processes for identifying risks, planning to eliminate or reduce these, and coping with both the expected and unexpected. The risks recorded on the corporate risks register reflected those that leaders stated were the top risks and there was evidence that these* |

| Licence condition | Description | Confirmation: Confirmed or Not Confirmed | Assurance |
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| | | | *were regularly reviewed."*<br><br>*"Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care."*<br><br>The CQC stated (Surgery service): *Staff recognised and reported incidents and near misses.* Critical care service: *The last four governance committee minutes included discussions about complaints, incidents, key performance indicators (KPIs), training, risk register, learning, issues from other health and safety committees, and other clinical issues and audits. Actions to address concerns or outstanding issues were identified and monitored through the monthly critical care governance meetings. The meetings were minuted for dissemination to other staff who were not able to attend.*<br><br>The Trust's Board Assurance Framework is used to provide the Board with assurance that there is a sound system of internal control in place to manage the key risks to the Trust of not achieving its strategic objectives. The BAF records the controls in place to manage the key risks, and highlights how the control is operating. The BAF includes cross-references to assurance obtained from internal and external audits, and self-assessments of compliance with other regulatory standards. It has been monitored by the Board assurance committees and updated throughout the year. In April 2020 the Board is reviewing an updated BAF which has been aligned with the refreshed 5 year Trust strategy.<br><br>The Risk Assurance and Compliance Group monitors progress with the BAF. This includes a 'stress test' of BAF risks to check (using key performance indicators and external assurance information) whether the controls and assurances cited are working and appropriate.<br><br>**Assurance:** The GOSH CQC report recommended (must do): "*Ensure the board assurance framework reflects all known medicine risks, including the storing, administration and destroying* |

Attachment E

| Licence condition | Description | Confirmation: Confirmed or Not Confirmed | Assurance |
|---|---|---|---|
| | | | *of medicines in line with legislation and the trust medicines management policies."* This recommendation has been acted upon and the relevant BAF updated to reflect the different stages of managing medicines safely.<br><br>Compliance<br>The foundation trust is fully compliant with the registration requirements of the Care Quality Commission. The Trust has identified an executive director and a manager who are respectively accountable and responsible for ensuring compliance with the CQC registration standards. It is the responsibility of these staff to collate evidence of compliance with the standards. The evidence is reviewed periodically by compliance staff.<br><br>In December 2019, the CQC conducted a scheduled unannounced inspection of three services (critical care, surgery and CAMHS) and an announced inspection against the well-led criteria. The report was published in January 2020. The Trust retained a rating of 'Good' overall.<br>The CQC issued 2 enforcement notices:<br>• Regulation 12: Safe Care and Treatment: This recommendation relates to the robustness of access control measures in PICU medication room; the safe storage of IV fluids in theatres, interventional radiology and on one of the surgical wards; the process for denaturing controlled drugs on wards; and the temperature monitoring arrangements for medication rooms.<br><br>**Assurance**: Work has been conducted to review and secure storage of IV fluids across theatres and radiology and update access control in PICU. Progress with denaturing of controlled drugs and temperature monitoring arrangements are underway.<br><br>• Regulation 17: Good Governance: This recommendation relates to the articulation of the breadth of the medicines risk on the board assurance framework; and the need to ensure that the EPR system fully meets the needs of the staff in the CAMHS service to deliver safe care.<br><br>**Assurance**: Medicines risk: The medicines BAF has been updated and is subject to regular review by the Risk Assurance and Compliance Group. |

| Licence condition | Description | Confirmation: Confirmed or Not Confirmed | Assurance |
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| | | | **Assurance**: EPR and CAMHS service: Following the inspection in October 2019, work began immediately between the EPR and CAMHS team to identify and address problems. This included instigating a formal Speciality Level Optimisation process. There is an associated action log which tracks progress, and all actions which had been classified as high risk were completed in March 2020.<br><br>In total the hospital was advised of 4 'Must Do' actions which were required to bring services in line with legal requirements. The Trust was also been advised of 18 'Should Do' actions (10 Trust wide, 2 Critical Care, 3 Surgery and 3 Mental Health) which were required to comply with minor breaches that did not justify regulatory action and to prevent the service from failing to comply with legal requirements in future, or to improve services.<br><br>**Assurance**: The Trust ran a programme of work to ensure CQC readiness and to maintain compliance for the Trust with a view to ensuring that compliance and governance are interlinked with quality, safety and experience and embedded in day to day working within the Trust.<br><br>A CQC action plan has been developed to address all actions. An executive led committee, Always Improving, has been established and meets monthly to review progress against this action plan, whilst supporting the ongoing work with the Trust's CQC compliance. This committee reports into the Risk, Assurance and Compliance meeting with regular reports to Board and the Council of Governors. The Trust will continue to conduct mock inspection framework (CQC Quality Rounds) in clinical directorates and review potential areas/sources of learning for example reviews of themes from other CQC reports and evaluation of CQC Insight reports.<br><br>The Quality, Safety and Experience Assurance Committee receives updates on CQC compliance and all other compliance areas on a regular basis. A database supports monitoring of ongoing inspections, audits and self -assessments. |

| Licence condition | Description | Confirmation: Confirmed or Not Confirmed | Assurance |
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| | | | <u>Information Governance</u><br>The Information Governance Steering Group monitors information governance risks and compliance with GDPR. The Trust has been compiling its submission for the Data Security and Protection Toolkit (DSPT). This annual submission demonstrates GOSH's position against the legal requirements providing assurance that we are practicing good data security and our personal information is handled correctly. While GOSH is already compliant with the majority of mandatory requirements, some areas of improvement have been identified for which action plans have been produced. These include fully implementing the compliance with the national data opt-out and training levels for staff.<br><br>This year there have been three serious information governance incidents (classified at a reportable level using the Incident Reporting Tool within the DSPT) involving sensitive information. Details are as follows:<br>• Over 60 cases were identified of staff having sent emails containing patient data non-securely to personal emails.<br>• Monitoring information of 10 new members of staff was erroneously sent to their new managers.<br>• A letter containing sensitive safeguarding information was sent to an incorrect address local to a patient.<br><br>Each of these cases have been reported to the Information Commissioner's Office (ICO) and NHS England as Serious Reportable Incidents with an internal root cause analysis completed and shared. The learning from these has been implemented back into Trust practice to ensure similar incidents do not occur. The ICO considered the information provided via reporting and investigating and in each case decided that no further action was necessary given the Trust's response and approach.<br><br>The Trust's internal auditors conducted an audit of compliance with elements for GDPR and provided a rating of 'partial assurance with improvements required'. Whilst the report found that *"Effective governance structures have been established to oversee the delivery of the Trust's* |

| Licence condition | Description | Confirmation: Confirmed or Not Confirmed | Assurance |
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| | | | *information governance and data privacy requirements", the Trust's information asset register did not document all requirements and additional physical controls for limiting access to the Trust IT systems were recommended.* The CQC also stated that the Trust should *"Improve the accuracy of the trust's information asset register".* An action plan is in place – the port control programme has been rolled out and the information asset register is in the process of being completed across the Trust.<br><br>*The CQC report stated: "The board were sighted on information governance issues including some issues with data quality which could impact on its ability to accurately report performance internal and externally. While data quality was improving, and action was taken when specific data issues were identified, more work was required to ensure accurate data was available to inform discussions and provide assurance."*<br><br>In the CQC evidence base document: *"Information breaches were taken seriously, and action taken to mitigate the risks associated with the breach and reduce the risk of re-occurrence. It was recorded on the BAF that personal and sensitive data was not always effectively collected, stored, shared or made accessible in line with statutory and regulatory requirements. There had been several breaches of regulatory requirements in the last 12 months which could be attributed to staff not following trust policies or human error. All these breaches had been investigated and none to date had been 'upheld' by the ICO. To facilitate learning the trust had held a learning event which considered internal breaches. To widen this learning the trust was collating learning from external breaches and issues which would be shared with staff."*<br><br>Infection Control<br>The Infection Prevention and Control Committee (IPCC) meets monthly and reports to Patient Safety and Outcome Committee. A continuous advice service is provided by IPC Team / Consultant Microbiologists. The Director of Infection Prevention and Control meets bi-weekly with the Chief Nurse.<br><br>*The CQC reported that "Some services did not always control infection risk well. Staff used* |

| Licence condition | Description | Confirmation: Confirmed or Not Confirmed | Assurance |
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| | | | *equipment and control measures inconsistently, they did not always use hand sanitisers when entering or leaving the wards, or when moving between patient bays". In other services, the CQC stated (surgery): "controlled infection risk well. Staff used equipment and control measures to protect patients, their families and themselves from infection. They kept equipment and the premises visibly clean".* An action plan is in place to respond to these matters and ensure a consistent approach to infection control across the Trust.<br><br>Health and Safety<br>The Trust is committed to effectively minimising risks, controlling hazards and preventing harm to all. This is done through a proactive programme of risk assessment and audit. There are clear processes for incident reporting and we encourage a culture in which staff report incidents. The Trust's governance structure ensures statutory compliance is undertaken within legislative requirements. Assurance via the Health and Safety Committee has been provided on a range of subjects such as violence against staff, sharps compliance, Control of Substances Hazardous to Health and fire safety.<br><br>The Trust's internal auditors conducted an audit into estates health and safety and provided a rating of 'partial assurance with improvements required'. The audit recommended improvements to planning of quarterly visual inspections and annual inspections of ventilation equipment and monitoring of findings/ actions to close gaps; development of an action plan to respond to the self-assessment against estates health and safety requirements; and, development and management of derogations for the Trust's sites where ventilation is not fully compliant with recommended practice, such as Health Technical Memoranda. A plan is in place to implement the necessary actions.<br><br>Safeguarding<br>The Strategic Safeguarding Committee, chaired by the Chief Nurse, oversees all safeguarding matters across the Trust and reports into the Patient Safety and Outcomes Committee (PSOC).<br><br>The CQC stated (CAMHS): *"Staff understood how to protect patients from abuse and the service* |

| Licence condition | Description | Confirmation: Confirmed or Not Confirmed | Assurance |
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| | | | *worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the unit had a safeguarding lead."*<br><br>In the CQC evidence base document*: "We saw safeguarding information displayed in waiting areas, offering advice and guidance to staff and patients on how to recognise and report abuse. Staff knew how to access safeguarding policies and procedures on the trust intranet. The trust had recently updated its safe and respectful behaviour policy, which provided the steps for staff to follow when faced with an aggressive parent. The update to the policy protected staff as they could now escalate the incident quickly, using a warning card system."*<br><br>*"Staff used an electronic flagging system, held on the patient's electronic record, to identify children at risk or on a child protection plan. Staff could also see if a safeguarding referral had been made. A safeguarding referral is a request made to the local authority or police to intervene, support or protect a child or vulnerable adult from abuse. From June 2018 to May 2019, there were 107 child safeguarding referrals made by staff within surgery."*<br>The CQC report cited a number of areas that the Trust should focus on following the inspection and a plan is in place to act upon these matters, monitored at the Always Improving Group:<br><br>*Raise staff awareness of the safe and respectful behaviour policy and improve access to conflict resolution training.* A survey has been conducted with staff and feedback used to raise awareness of the policy.<br><br>Performance monitoring<br>Directorate performance reviews take place on a monthly basis, attended by directorate management and Trust executives. These reviews are designed to facilitate a triangulated and risk-focused discussion across a number of key domains: Caring, Safe, Responsive, Well-Led (people, management and culture), Effective, Finance, Productivity. The information presented at the performance reviews include an integrated dashboard which provides a one page summary of key metrics across the domains, allowing rapid identification of linked risks and |

| Licence condition | Description | Confirmation: Confirmed or Not Confirmed | Assurance |
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| | | | issues. An integrated performance report is then scrutinised at each Trust Board meeting. This provides a summary of the key issues in each domain and actions planned to resolve, as well as an integrated dashboard – this provides trust level data using the same format as the directorate integrated dashboard reviewed in the monthly performance reviews.<br><br>**Assurance**: The internal auditors conducted an audit into the Trust's directorate governance framework and provided an assurance rating of 'Significant assurance with minor improvement potential' (October 2019).<br><br>**Assurance**: The CQC report stated: *"There were clear reporting lines from ward to board and from board to wards, to manage performance and identify, potential issues or failure to meet local and national standards. These were informed by the integrated quality and performance report which included both safety and financial information and discussed at the monthly directorate performance review meetings, attended by the directorate management team and representatives from the trust executives".*<br><br>However, the CQC stated that the Trust should: "*Improve the oversight of delivery of services by the pharmacy department, including identifying and reporting key performance indicators via the directorate performance process to the board*." A number of actions have been delivered in response to improve reporting through to the Trust Board.<br><br><u>Escalation</u><br>The Trust has systems and processes in place to support staff and patients in escalating concerns in provision of care or management of systems. These include the complaints process, PALS, Freedom to Speak Up Guardian, Guardian of Safe Working, Raising Concerns Policy, Counterfraud service etc. The Trust is one of the first UK hospitals to partner with the Cognitive Institute in their Safety and Reliability Improvement Programme. Signing up to this partnership recognises our commitment to achieving zero preventable harm and delivering the best possible outcomes through providing the safest, most effective and efficient care. Safety Champions from across the hospital have been appointed. |

| Licence condition | Description | Confirmation: Confirmed or Not Confirmed | Assurance |
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| | | | **Assurance**: CQC stated (2020): "*Staff at all levels were clear about their roles, areas of responsibility and accountability. This included delegation of responsibility to committees. The trust had an assurance and escalation framework with groups and committees providing the board with assurance or escalating concerns and/or risks relating to the quality of services, performance, targets, service delivery and achievement of strategic objectives."*<br><br>*Managers at all levels in the trust had the skills, knowledge and experience to run a service providing high-quality sustainable care. Leadership had been strengthened since the last inspection with several changes of both executives and non-executives. The executives were described as an inclusive, dynamic team who were open and transparent.*<br><br>*Leaders were knowledgeable about the challenges to quality and sustainability the trust faced including those arising from the current NHS financing model for specialised services; and its dependence on continuing to be able to attract international private patients. Leaders were proactive in addressing these through a range of initiatives including exploring alternative international markets and research activity.*<br><br>*The trust had a vision and strategy that was currently being refreshed in consultation with staff, children, families and stakeholders. Staff understood the trust's vision, values and strategy and were supportive of these. Several strategies to support the trust strategy were either in place or currently being developed. These aligned and supported the trust's vision.*<br><br>*The hospital had a culture in which staff could speak openly about safety concerns allowing these to be effectively managed and safe high-quality care delivered. Leaders at all levels across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.*<br><br>*Leaders did not tolerate behaviour that was not in line with the trust's values, regardless of seniority. In some directorates staff continued to report issues with bullying and harassment, low morale and lack of staff engagement. Several initiatives had been implemented to address these* |

| Licence condition | Description | Confirmation: Confirmed or Not Confirmed | Assurance |
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| | | | *including a 'stand up for our values', program to tackle those behaviours that were not in line with the trust's values and promoting the Dignity at work policy. At the time of our inspection the impact of these initiatives had not yet been measured but will be measured through the next NHS staff survey and staff engagement.*<br><br>*"Children, young people and their families were aware of how to raise a complaint. Complaints and concerns were taken seriously and responded to in a timely manner. Improvements were made to the quality of care as a result of complaints and concerns being raised."*<br><br>The CQC report cited a number of areas that the Trust should focus on following the inspection and a plan is in place to act upon these matters, monitored at the Always Improving Group:<br><br>• *Continue to promote the role of the Freedom to Speak Up Guardian (FTSUG), taking proactive action to identify and address themes from staff contacts with the FTSUG.* Work is underway but delayed due to Covid-19 planning.<br>• *Raise staff awareness of the role of the accredited safety champions.* Work is underway and due for delivery in June 2020.<br>• *Take action to improve the number of incidents closed within the trust's 45 working day target.* Some actions have been delivered and some remain underway and delayed due to Covid-19 planning.<br><br>The internal auditors conducted an Incident Reporting audit looking at the processes in place for the recording and management of operational risks. The report allocated a rating of 'Partial assurance with improvement required'. The audit report identified a large number of open incident reports, exceeding the Trust 45 day target. Recommendations were made related to the management of incident reporting and a plan is in place to implement the necessary actions.<br><br>In 2019, the NAO public sector award for excellence in public sector reporting was won by Great Ormond Street Hospital. The award recognises good corporate reporting that builds trust and transparency. |

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| | | | The Trust assesses compliance with the FT licence annually. |
| **CoS7 – Availability of resources** **(scope = next financial year 2020/21)** | The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.<br><br>The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.<br><br>The Licensee, not later than two months from the end of each Financial Year, shall submit to Monitor a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:<br><br>(a) “After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after | The Executive Team have considered the evidence cited and recommend “Confirmed” for (a) “After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.”<br><br>Response to be considered by the | The Trust sets its budget on an annual basis and actively manages and monitors its financial position and resource levels on a regular basis throughout the year through routine performance reporting to the Board and its Committees. The Executive Team actively monitors the finance position at every meeting to ensure that the mitigations in place are effective and appropriate.<br><br>As the national NHS operational planning process has been suspended for 2020/21 the Trust has still approved a budget for the year based on the planning process prior to COVID19. To date, it has received confirmation from DHSC that all expenditure would be funded until at least the end July 2020 after which time the system is expected to return to a block contracting system. Discussions remain ongoing with NHSE/I about how any loss of commercial income will be rectified after exiting from the COVID19 crisis recognising there will be a lead time to build the business back up.<br><br>No material agreements which might create a material risk have been entered into.<br><br>The Trust Audit Committee and Board will review for approval the 2019/20 annual report and accounts (26 May 2020), on a going concern basis, confirming that the Directors have a reasonable expectation that the organisation has the required resources available for the next 12 month licence (a).<br><br>The Trust is implementing a robust savings plan for 2020/21. The Trust is holding discussions with other NHS trusts on managing implications of tariff changes.<br><br>Assurance: Both External and Internal Audit services provide assurance that reporting is accurate and there is no material mis-statement.<br><br>The CQC stated: “The trust had developed a long-term financial model that was subject to |

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| | taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."<br>OR<br><br>(b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services".<br><br>OR<br>(c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources | board in light of assurance provided here and taking into account the views of the governors | regular in-depth scrutiny by the board through its finance and investment committee. The trust had concluded that, under current NHS financial assumptions, it was likely to face significant financial challenge over the next two years." …The Trust should: "Take action to develop and assure itself about financial sustainability going forward .".<br><br>"Leaders were knowledgeable about the challenges to quality and sustainability the trust faced including those arising from the current NHS financing model for specialised services; and its dependence on continuing to be able to attract international private patients. Leaders were proactive in addressing these through a range of initiatives including exploring alternative international markets and research activity."<br><br>The internal auditors conducted an audit into the Better Value programme and provided an assurance rating of 'Significant assurance with minor improvement potential' (October 2019).<br><br>The internal auditors conducted an audit into the Trust's financial controls and provided an assurance rating of 'Significant assurance with minor improvement potential' (October 2019). |

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| | available to it for the period of 12 months referred to in this certificate". | | |
| **FT4- NHS foundation trust governance arrangements** **(scope = next financial year 2020/21)**<br><br>**PLEASE NOTE – all four parts need to be confirmed for an overall 'confirmation'** | The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. | The Executive Team have considered the evidence cited and recommend "Confirmed".<br><br>Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors | The Trust has a range of governance and assurance structures and systems in place including a Trust wide strategy, scheme of delegation, risk management framework, accountability framework, compliance framework, escalation framework, policy framework and assurance framework and a financial management framework (see controls and assurances above).<br><br>Directors and governors are asked to sign a code of conduct (both documents were refreshed in 2018) and declare any interest for publication on a Register of Interests.<br><br>**Assurance**: A new Declarations of Interest and Gifts and Hospitality Policy has been launched, updated in line with NHS England's policy and identifying key decision makers. The Trust has also implemented a new electronic declaration portal for staff to update declarations immediately and to ensure timely reporting publicly.<br><br>The Trust's Local Counter Fraud Service is in the process of collating evidence toward the Trust's NHS Counter Fraud Authority Self-Review Tool and informed the Trust Audit Committee in April 2020 that they are proposing an overall green (compliant) return.<br><br>Directors complete a self-assessment for the Fit and Proper Person Test (and are reviewed against the criteria annually) and are required to declare any interests annually. Governors sign an eligibility form which includes reference to the Fit and Proper Person's Process.<br><br>**Assurance**: The CQC stated: "*The trust had a process and a recently updated and approved fit and proper persons (FPP) policy to assess that staff with director level responsibilities, including the NEDs, were compliant with FPP in accordance with Regulation 5 of the Health and Social Care Act (2014). Overall responsibility for FPP was held by the chairperson, who delegated this responsibility to the company secretary.* |

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| | | | *FPP checks were completed on appointment and annual reviews were the responsibility of a member of the human resources team, supported by the company secretary. We saw evidence that checks were carried out and that an electronic spreadsheet of compliance was maintained. This spreadsheet was a live document and used as a tool to identify any checks i.e. Disclosure and Barring Service (DBS) checks which were due for renewal. The trust also required all directors, NEDs, budget holders and councillors to complete an electronic annual conflict of interest and hospitality declaration. This approach facilitated on-going compliance with Regulation 5 of the Health and Social Care Act (2014).”*<br><br>A self-assessment is prepared annually against the Monitor code of Governance and will be reported to the Board in May 2020. The Trust Board considers that from 1 April 2019 to 31 March 2020 it was compliant with the provisions of The NHS foundation trust Code of Governance and proposes to explain its compliance (on a comply or explain basis) for the following criteria in the annual report – to be approved by the Board in May 2020:<br>• To be determined following review.<br><br>Further information about corporate governance systems and standards at GOSH is detailed below. |
| | The Licensee shall:<br>(a) have regard to such guidance on good corporate governance as may be issued by Monitor from time to time;<br>(b) comply with the following paragraphs of this Condition. | The Executive Team have considered the evidence cited and recommend ‘Confirmed’.<br><br>Response to be considered by the Board in light of assurance provided here and taking | The Trust has regard to guidance on good corporate governance as issued by NHS Improvement. |

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| | | into account the views of the governors | |
| | The Licensee shall establish and implement:<br>(a) effective board and committee structures;<br>(b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and<br>(c) clear reporting lines and accountabilities throughout its organisation. | The Executive Team have considered the evidence cited and recommend 'Confirmed'.<br><br>Response to be considered by the Board in light of assurance provided here and taking into account the views of the governors | The Board has a formal schedule of matters reserved for its decision, and delegates certain matters to committees.<br><br>The Board has a work programme, which includes all matters the Board is required to consider by statutory, regulatory and other forms of guidance. It also has a range of strategic and operational performance information, which enables it to scrutinise the effectiveness of the Trust's operations, and deliver focused strategic leadership through its decisions and actions. The Board maintains its commitment that discussion of patient safety will always be high on its agenda.<br><br>There are three Board assurance committees - the Audit Committee, the Quality, Safety and Experience Assurance Committee and the People and Education Assurance Committee. These committees assess the assurance available to the Board in relation to risk management, review the Trust's non-clinical and clinical and quality risk management processes and review the structures and processes in place to deliver the Trust's vision for a supported and innovative workforce, an excellent learning environment and a culture that aligns with the Trust's strategy and always values. All three committees raise issues that require the attention of the Board at every Board meeting.<br><br>In addition to the three assurance committees, the Finance and Investment Committee considers financial performance, productivity and use of resources. The chairs of these committees report to the Board following every committee meeting. Each committee is charged with reviewing its effectiveness annually. |

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| | | | The Trust has terms of reference and work plans in place for the Board, Council and assurance committees. The Board committees conduct annual effectiveness reviews (surveys) on the delivery of their terms of reference and running of the committees. Findings are reviewed and where appropriate, changes to the terms of reference and workplans of the committees are made.<br><br>The assurance committees receive minutes from other assurance committees to prevent matters falling between them. Summaries of assurance committee meetings are reported at the Board and the Council. At the Council, the chairs of the assurance committees present the summary reports and are held directly to account by the governors at the Council meeting. Governors are also invited to attend assurance committees and Board meetings throughout the year.<br>The Trust's Assurance and Escalation Framework presents a single, comprehensive picture of the governance and assurance structures and systems through which the Trust Board and other stakeholders receive assurance. The Trust routinely reviews and reports this assurance through the following key governance processes and frameworks including:<br>• Performance Management: The Trust has a range of frameworks and policies in place that outline how the Trust's performance objectives and standards will be met, reviewed and managed.<br>• The Trust's Risk Management Strategy (see above) sets out how the organisation identifies, monitors, escalates and manages risks in a timely fashion and at an appropriate level.<br>• The Trust has in place a comprehensive and integrated Compliance Framework that seeks to ensure on-going compliance with statutory and regulatory requirements through integrated, rigorous and proactive structures, policies and practices. It ensures appropriate controls are in place to maintain compliance with statutory and regulatory requirements and that external guidance and alerts are considered in a fulsome and responsive way.<br>• Policy Framework: This provides for clear and accessible policies, procedures and guidelines which support staff in undertaking their duties in a safe and effective way that takes account of all relevant legislation, regulation and guidance. The Trust's policy |

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| | | | framework is administered by the Policy Approval Group (PAG) and reported through to the Risk Assurance and Compliance Group.<br>• Committee structure: The Trust's committee structure, developed from the Trust Board down, is currently under review to ensure each committee or group has a clear purpose, scope and authority. Some committees have statutory functions, others have authority to make decisions and direct actions, and others provide advice, support and oversee specific functions. The review is being conducted via the Risk Assurance and Compliance Group.<br>• The Risk Assurance and Compliance Group monitors progress with the strategic risks on the Board Assurance Framework (see above).<br><br>There are eight directorates, each with a Chief of Service, Deputy Chief of Service, Head of Nursing and General Manager. The Senior Leadership Team meets weekly (around 100 senior managers from across the clinical and corporate areas of the Trust). An Operations Board made up of senior operational managers from across the Trust meets fortnightly. The purpose of the Operational Board is to bring together clinical and corporate senior leadership members to ensure the robust, effective and efficient operational management of the Trust.<br><br>The Trust's risk management strategy sets out how risk is systematically managed. This extends across the organisation, from the front-line service through to the Board, to promote the reduction of clinical and non-clinical risks associated with healthcare and research, and to ensure the business continuity of the Trust.<br><br>**Assurance**: The CQC reported stated: "*Staff at all levels were clear about their roles, areas of responsibility and accountability. This included delegation of responsibility to committees. The trust had an assurance and escalation framework with groups and committees providing the board with assurance or escalating concerns and/or risks relating to the quality of services, performance, targets, service delivery and achievement of strategic objectives*."<br><br>The CQC evidence base document stated: "*The trust board had the appropriate range of skills,* |

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| | | | *knowledge and experience to perform its role. Executives and non-executive directors (NEDs) had a mix of skills and attributes which were complimentary to each other and their backgrounds ensured there was cover across clinical and operational activity."*<br><br>*"All those we spoke with said leadership had been strengthened since the last inspection and that the CEO was very visible and open. Some staff reported that the CEO had visited their departments and explored how staff were feeling. This made them feel he was genuinely interested in the work they were doing and their wellbeing. The executives were described as an inclusive, dynamic team who were open and transparent.*<br><br>*We observed that the board worked effectively together. At the board meeting we attended, all board members were prepared for the meeting, constructively challenged each other. Those NEDs not present had sent in comments on papers which were shared at the meeting by the chair. Board members were knowledgeable not only about their own portfolios but also about those of other board members, this provided support if the portfolio lead was not available."*<br>The internal auditors conducted an audit into the Trust's directorate governance framework and provided an assurance rating of 'Significant assurance with minor improvement potential' (October 2019).<br><br>See assurances cited on risk management above. |
| | The Licensee shall establish and effectively implement systems and/or processes:<br>(a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;<br>(b) for timely and effective scrutiny and oversight by the Board of the | The Executive Team have considered the evidence cited and recommend 'Confirmed'.<br><br>Response to be considered by the | The Board has agreed standing orders and standing financial instructions, which provide the framework for ensuring appropriate authorisation of expenditure commitments in the Trust. The Board's processes for managing its resources include approval of annual budgets for both revenue and capital, reviewing financial performance against these budgets, and assessing the results of the Trust's cost improvement programme on a monthly basis. In addition, the Trust has a prescribed process for the development of business cases for both capital and revenue expenditure and, where significant, these are reviewed by the Trust Board.<br><br>Each specialty and clinical directorate has an internal monitoring structure so teams regularly |

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| | Licensee's operations;<br>(c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; | Board in light of assurance provided here and taking into account the views of the governors | review their progress and identify areas where improvements may be required. Each directorate's performance is considered at monthly performance review meetings (see above). The Finance and Investment committee reviews the operational, productivity and financial performance and use of resources both at Trust and divisional level.<br><br>The Board has a work programme (aligned with the Well Led Assessment Key Lines of Enquiry), which includes all matters the Board is required to consider by statutory, regulatory and other forms of guidance. It also has a range of strategic and operational performance information, which enables it to scrutinise the effectiveness of the Trust's operations, and deliver focused strategic leadership through its decisions and actions. The Board maintains its commitment that discussion of patient safety will always be high on its agenda. A Board development programme is under review.<br><br>The Board assurance committees scrutinise the strategic risks facing the trust on a rotational basis every year, with committee members reviewing the effectiveness of controls and seeking assurances that any gaps in controls will be closed in a timely manner.<br>Key performance indicators are presented on a monthly basis to the Trust Board. The report, which has recently been refreshed and integrates quality and performance data includes progress against external targets, internal safety measures, operational efficiency/process measures, well-led and other clinical quality measures such as complaints, incidents and reports from specific quality functions within the Trust such as the Patient Advice and Liaison Service (PALS). It also includes the external indicators assessed and reported monthly by the CQC. The report is aligned to the CQC key lines of enquiry: Safe, Effective, Caring, Responsive and Well Led. It asks the question: are our patients receiving high quality care?<br><br>Assurance: The external auditors envisage issuing an XXXXX audit opinion for 2019/20 TBC<br><br>In December 2019, the Trust was inspected by the CQC and achieved an overall rating of GOOD for its clinical services and GOOD for the assessment of Well Led. An action plan was developed and rolled out across the Trust (see above for monitoring framework). |

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| | | | **Assurance**: See statements from the CQC above on senior management, performance management and internal audit reports. |

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| **s.151(5) of the Health and Social Care Act (not a licence condition)** **(scope = past financial year 2019/20)** | NHS Improvement require the Board to state whether it is satisfied that during the financial year most recently ended the Trust has provided the necessary training to Governors, to ensure that they are equipped with the skills and knowledge they need to undertake their role. | The Executive Team have considered the evidence cited and recommend 'Confirmed'.<br><br>Response to be considered by the board in light of assurance provided here and taking into account the views of the governors | **Governor Induction and training and development:**<br>During 2019/20, governors received mandatory Trust training and were provided with access to the Trust's internal on line training portal (GOLD) to update their training during their tenure. This is actively monitored by the Deputy Company Secretary and governors reminded and supported to complete the training during the year.<br><br>Prior to each Council of Governors' meeting, the Chair meets with all governors in a private session. This gives the Governors an opportunity to discuss any issues directly with the Chair and to gather information about the Trust and its activities and processes.<br><br>The Trust has established a buddying programme between Non-Executive Directors (NEDs) and governors. The buddying programme provides governors with direct contact with a NED to support their role and share information on matters of interest or concern. The programme has been evaluated and revised during the year.<br><br>Governor Development sessions have been developed in partnership with Governors to provide them with the skills and knowledge needed to deliver their key duties over their tenure.<br><br>Several Governors attended external training and events throughout the year and provided reports back to the Trust. These included:<br>• Governor Focus conference, to help Governors explore how they can be best equipped to support their Trusts in delivering quality healthcare.<br>• GOVSEC's Government IT Security Conference, which explored how public sector organisations and professionals could make sense of securing their IT functions in a rapidly changing environment.<br>• GovernWell: Member and public engagement, which aimed to help Governors explore what 'Representation' meant.<br><br>Governors have access to an online library of resources. This provides governors with 24/7 access to key documents and information.<br><br>Governors receive a monthly newsletter from the Corporate Affairs team containing key dates, developments and training and development opportunities. |