Great Ormond Street Hospital for Children
NHS Foundation Trust

Meeting of the Trust Board
Wednesday 26 May 2021

Dear Members

There will be a public meeting of the Trust Board on Wednesday 26 May 2021 at 2:00pm by video conferencing.

Company Secretary Direct Line: 020 7813 8230

AGENDA

	Agenda Item STANDARD ITEMS	Presented by	Attachment	Timing
1.	**Apologies for absence**	Chair	**Verbal**	**2:00pm**
Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.				
2.	**Minutes of Meeting held on 30 March 2021**	Chair	**G**	
3.	**Matters Arising/ Action Checklist** **Action 216.4:** multiyear trends for metrics such as speaking up, serious incidents and their closure	Chair	**H** **9**	**2:05pm**
4.	**Patient Story**	Chief Nurse	**I**	**2:10pm**
5.	**Directorate presentation: Medicines, Therapies and Tests Directorate**	Chief Operating Officer/ Senior Leadership Team for Directorate	**J**	**2:25pm**
6.	**Chief Executive Update**	Chief Executive	**K**	**2:40pm**
	ANNUAL REPORT AND ACCOUNTS			
7.	**GOSH Foundation Trust Annual Financial Accounts 2020/21 and Annual Report 2020/21 Including:** ○ **the Annual Governance Statement** ○ **the assurance committee annual reports** ○ **Draft Head of Internal Audit Opinion** ○ **Draft Representation Letter** **Draft Representation Letter**	Chief Finance Officer Company Secretary Audit Committee Chair	**L (Accounts)** **10 (Annual Report)** **11 to follow**	**2:50pm**
8.	**Compliance with the Code of Governance 2020/21**	Company Secretary	**M**	**3:00pm**
9.	**Compliance with the NHS provider licence – self assessment 2020/21**	Company Secretary	**N**	**3:05pm**
	STRATEGY and RISK			
10.	**GOSH 2021/22 Budget**	Chief Finance Officer	**O**	**3:10pm**
11.	**Trust Risk Appetite Statement**	Company Secretary	**P**	**3:20pm**

12.	**Board Assurance Framework Update**	Company Secretary	**Q**	**3:25pm**
	PERFORMANCE			
13.	**Integrated Quality and Performance Report – Month 1 2021/22**	Medical Director/ Chief Nurse/ Chief Operating Officer Interim Chief Operating Officer	**R**	**3:30pm**
14.	**Month 1 2021/22 Finance Report**	Chief Finance Officer	**S**	**3:40pm**
15.	**Learning from Deaths Mortality Review Group - Report of deaths in Q3 2020/2021**	Medical Director	**T**	**3:50pm**
16.	**Safe Nurse Staffing Report (February - March 2021)** **Nursing Establishment Review**	Chief Nurse	**U** **8**	**4:00pm**
	ASSURANCE			
17.	**Infection Control Update**	Chief Nurse/ Director of Infection, Prevention and Control (DIPC)	**W**	**4:20pm**
18.	**Annual Reports** • **Annual Freedom to Speak Up Report 2020/21** • **Annual Health and Safety and Fire Report 2020/21** • **Gender Pay Gap Report 2020/21** • **Guardian of Safe Working Report Q4 2020/21 and Annual Report 2020/21**	 Freedom to Speak Up Guardian Director of Estates, Facilities and the Built Environment Director of HR and OD Guardian of Safe Working (Renee McCulloch)	 **X** **Y** **Z** **1**	**4:30pm**
	GOVERNANCE			
19.	**Board Assurance Committee reports** • **Audit Committee update – April 2021 meeting and May 2021 (verbal)** • **Quality, Safety and Experience Assurance Committee update – April 2021 meeting** • **Finance and Investment Committee: Revised Terms of Reference** *There has been no meeting of the People and Education Assurance Committee and the Finance and Investment Committee since the last Trust Board in March 2021*	 Chair of the Audit Committee Chair of the Quality and Safety Assurance Committee Chair of the Finance and Investment Committee	 **2** **3** **4**	**4:45pm**

20.	**Council of Governors' Update – April 2021**	Chair/ Company Secretary	**5**	**4:55pm**
21.	**Declaration of Interest Register (Directors and Staff)**	Company Secretary	**6**	**5:05pm**
22.	**Director and Governor Code of Conduct**	Company Secretary	**7**	**5:10pm**
23.	**Any Other Business** (Please note that matters to be raised under any other business should be notified to the Company Secretary before the start of the Board meeting.)			**5:15pm**
24.	**Next meeting** The next confidential Trust Board meeting will be held on Wednesday 7 July 2021 in the Charles West Room, Barclay House, Great Ormond Street, London, WC1N 3BH.			

Attachment S

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
26 May 2021

Month 1 2021/22 Finance Report **Submitted by:** Helen Jameson, Chief Finance Officer **Presented by:** Helen Jameson, Chief Finance Officer	**Paper No: Attachment S**

Aims / summary

The month 1 financial position is a deficit of £2.9m which is £1.4m adverse to plan. The latest Trust plan agreed with NHSE for the year totals to a target deficit for the end of the year of £8.2m.

NHSE has issued updated income figures for the first half of the financial year (the planning approach will now split the year into two halves) and the plan has been updated for these as agreed. This has resulted in £16.6m of additional NHS income for H1, inclusive of £8.8m relating to prospective Covid-19 funding (costs must be demonstrates to realise this) and £5.8m of Non-NHS income top-up (again losses must be demonstrated to secure this). No adjustments have been made for H2 NHS income as this is not expected to be released until September. This leads to the current Trust plan showing a £5.5m deficit for H1 and £2.7m deficit for H2; the improved position in H2 being driven by expected recovery of private patient income and delivery of additional better value. Key points about the M1 position are as follows:

1. The month 1 financial position is a deficit of £2.9m which is £1.4m adverse to plan. The key drivers of the Trust adverse variance relate to income. The Trust has seen private patient income £1.1m adverse to plan, along with £0.7m below plan NHS clinical income due to lower than plan cost and volume activity and lower than expected Covid costs for which the Trust is receiving income. International private patient sponsors are also only currently sending their most complex patients abroad due to continued travel restrictions due to Covid-19.
2. Pay is £0.3m adverse to plan; staff turnover levels have remained low as a result of the pandemic and high staff levels have been retained across the board. The Trust continues to look to reduce the impact on staffing numbers of Covid-19 with appropriate challenge around proposed new posts and reviews of temporary staffing spend.
3. Non-Pay is £1.8m favourable to plan. Key drivers of this are impairment of receivables relating to IPP (£0.4m favourable to plan) due to continued debt payments couple with reduced new activity coming into the hospital, which in turn has reduced the aged debt profile. In addition, lower than plan utility and maintenance payments (£0.7m) have arisen due to lower than plan Covid costs (with an offsetting lower than plan income relating to Covid cost funding).
4. Cash held by the Trust is £131.5m which is £5.3m higher than M12 largely driven by the Trust receiving £16.1m from NHSE in month.
5. Capital expenditure as at M1 is £0.8m, which is less than plan by £0.2m, all on the Trust-funded programme.

The key movements to note on the balance sheet are:

Indicator	Comment
Cash	Cash held by the Trust increased in month by £5.3m, from £126.2m to £131.5m.
NHS Debtor Days	NHS debtor days decreased in month from 5 days to 3 days, falling within the target of 30 days for the Trust.
IPP Debtor Days	IPP debtor days decreased in month from 288 days to 281 days.
Creditor Days	Creditor days increased in month from 31 days to 34 days.

Action required by the meeting]

To **note** the Month 1 Financial Position

Contribution to the delivery of NHS / Trust strategies and plans

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

Financial implications

Changes to payment methods and expenditure trends

Legal issues

N/A

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

Chief Finance Officer / Executive Management Team

Who is accountable for the implementation of the proposal / project

Chief Finance Officer / Executive Management Team

Finance and Workforce Performance Report Month 1 2021/22

Contents

Trust Performance Summary for the 1 months ending 30 Apr 2021

KEY PERFORMANCE DASHBOARD

ACTUAL FINANCIAL PERFORMANCE

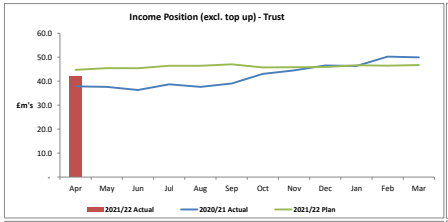
	In month			Year to date		
	Plan	Actual	RAG	Plan	Actual	RAG
INCOME	**£44.7m**	**£42.0m**		**£44.7m**	**£42.0m**	
PAY	**(£26.5m)**	**(£26.7m)**		**(£26.5m)**	**(£26.7m)**	
NON-PAY **inc.** owned depreciation and PDC	**(£19.8m)**	**(£18.2m)**		**(£19.8m)**	**(£18.2m)**	
Surplus/Deficit excl. donated depreciation	**(£1.6m)**	**(£2.9m)**		**(£1.6m)**	**(£2.9m)**	
Top up	**£0.0m**	**£0.0m**		**£0.0m**	**£0.0m**	
Surplus/Deficit excl. donated depreciation	**(£1.6m)**	**(£2.9m)**		**(£1.6m)**	**(£2.9m)**	

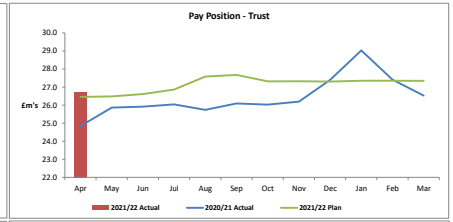
RAG: on or favourable to plan = green, 0-5% adverse to plan = amber, 5%+ adverse to plan = red

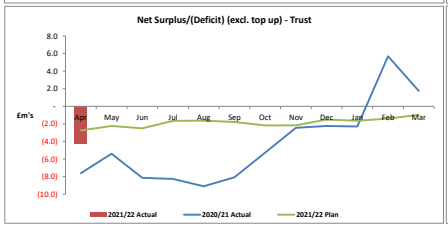
AREAS OF NOTE:

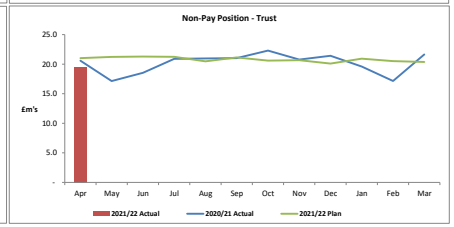
The month 1 financial position is a deficit of £2.9m which is £1.4m adverse to plan. The latest Trust plan agreed with NHSE for the year totals to a target deficit for the end of the year of £8.2m. NHSE has issued updated income figures for the first half of the financial year (the planning approach will now split the year into two halves) and the plan has been updated for these as agreed. This has resulted in £16.6m of additional NHS income for H1, inclusive of £8.8m relating to prospective Covid-19 funding (costs must be demonstrates to realise this) and £5.8m of Non-NHS income top-up (again losses must be demonstrated to secure this). No adjustments have been made for H2 NHS income as this is not expected to be released until September. This leads to the currnet plan showing a £5.5m deficit for H1 and £2.7m deficit for H2; the improved position in H2 being driven by expected recovery of private patient income and delivery of additional better value.

NHS clinical income is £0.7m below plan due to lower than plan cost and volume activity, whilst private patient revenue is also £1.1m adverse to plan. International private patient sponsors are also only currently sending their most complex patients abroad due to continued travel restrictions due to Covid-19. Impairment of receivables relating to IPP is also £0.4m favourable to plan due to continued debt payments and reduced new activity coming into the hospital, which in turn has reduced the aged debt profile. Pay is £0.3m adverse to plan; staff turnover levels have reduced as a result of the pandemic and high staff levels have been retained across the board. The Trust continues to look to reduce the impact on staffing numbers of Covid-19 with appropriate challenge around proposed new posts and reviews of temporary staffing spend. Non-Pay is £1.8m favourable to plan due to the aforementioned impairment of receivables (£0.4m) and lower than plan utility and maintenance payments (£0.7m) due to lower than plan Covid costs (with an offsetting lower than plan income relating to Covid cost funding).







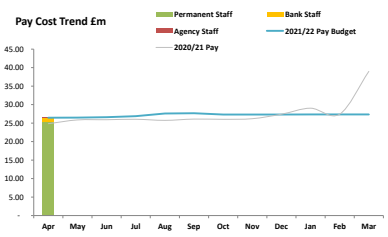


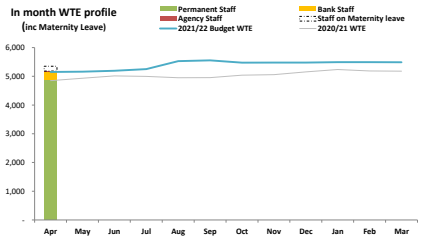
PEOPLE

	M1 Plan WTE	M1 Actual WTE	Variance
Permanent Staff	5,107.9	4,897.3	210.6
Bank Staff	43.7	256.1	(212.5)
Agency Staff	-	28.3	(28.3)
TOTAL	**5,151.6**	**5,181.7**	**(30.1)**

AREAS OF NOTE:

Month 1 WTE's have remained in line with M12 levels (M1 - 5,182 vs M12 - 5,178), but are slightly above plan for M1. The Trust is continually working to reduce the impact of Covid-19 on staffing requirements, especially given staff turnover has signifcantly reduced. The Trust currently monitors any new proposed posts at a vacancy panel where directorates are challenged prior to being approved for hire. This month has also seen lower nursing bank usage across the Trust than in the last few months (c.£0.4m lower than M12 2019/20) due to lower activity and further controls that have been implemented by operational teams to monitor bank usage requests and changes by ward to keep this spend controlled. High levels of admin agency staff continues due to additional senior assistance for the ICT directorate. Agency spend in the Trust is monitored and consideration is given as to whether resources can be secured through the bank or fixed term contracts in order to reduce this cost.



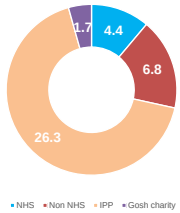


CASH, CAPITAL AND OTHER KPIs

Key metrics	Mar-21	Apr-21
Cash	**£126.2m**	**£131.5m**
IPP debtor days	**288**	**0**
Creditor days	**31**	**34**
NHS Debtor days	**5**	**3**

Capital Programme	YTD Plan M1	YTD Actual M1	Full Year F'cst
Total Trust-funded	**£0.5m**	**£0.3m**	**£18.0m**
Total Donated	**£0.6m**	**£0.5m**	**£16.0m**
Total Grant-funded	**£0.0m**	**£0.0m**	**£0.5m**
Grand Total	**£1.0m**	**£0.8m**	**£34.4m**

Net receivables breakdown (£m)



AREAS OF NOTE:

1. Cash held by the Trust increased in month by £5.3m.

2.The capital programme for the year to date is less than plan by £0.2m of which is all on the Trust-funded programme.

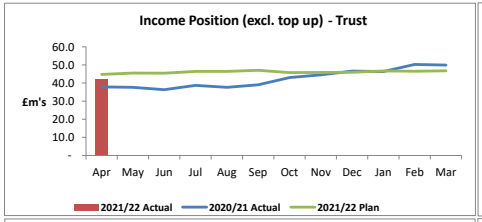
3.IPP debtors days decreased in month from 288 days to 281 days. Total IPP debt decreased in month to £26.3m (£28.9m in M12). Overdue debt decreased in month to £26.1m (£27.1m in M12).

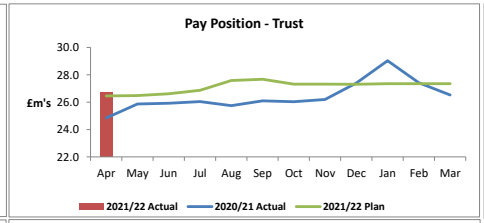
4. Creditor days increased in month from 31 days to 34 days.

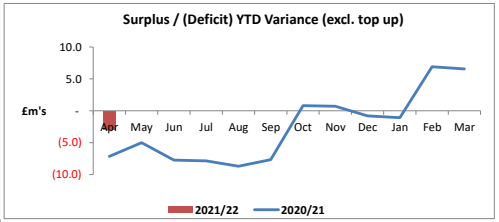
5. NHS debtor days decreased in month from 5 days to 3 days.

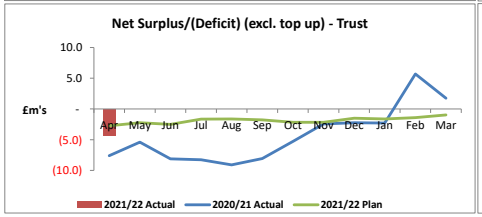
Trust Income and Expenditure Performance Summary for the 1 months ending 30 Apr 2021

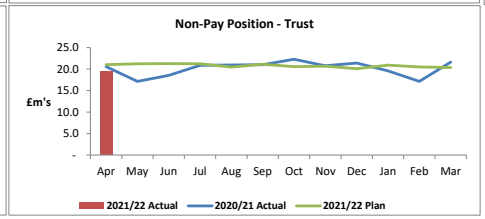
2021/22											Notes	2020/21	2021/22	2021/22
Full year	Income & Expenditure	Month 1				Year to Date				Rating		Actual	Plan YTD	Plan In-month
plan		Plan	Actual	Variance		Plan	Actual	Variance		YTD Variance		M1		M1
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%			(£m)	(£m)	(£m)
436.56	NHS & Other Clinical Revenue	37.10	36.35	(0.74)	(2.01%)	37.10	36.35	(0.74)	(2.01%)	R	1	31.75	37.10	37.10
54.52	Private Patient Revenue	2.62	1.52	(1.10)	(41.99%)	2.62	1.52	(1.10)	(41.99%)	R	2	3.41	2.62	2.62
61.75	Non-Clinical Revenue	5.02	4.12	(0.90)	(18.01%)	5.02	4.12	(0.90)	(18.01%)	R	3	2.66	5.02	5.02
552.83	**Total Operating Revenue**	**44.74**	**41.99**	**(2.75)**	**(6.15%)**	**44.74**	**41.99**	**(2.75)**	**(6.15%)**	R		**37.82**	**44.74**	**44.74**
(322.87)	Permanent Staff	(26.20)	(25.21)	1.00	3.81%	(26.20)	(25.21)	1.00	3.81%	G		(23.56)	(26.20)	(26.20)
0.00	Agency Staff	0.00	(0.21)	(0.21)		0.00	(0.21)	(0.21)				(0.10)	0.00	0.00
(2.79)	Bank Staff	(0.25)	(1.33)	(1.08)	(430.63%)	(0.25)	(1.33)	(1.08)	(430.63%)	R		(1.18)	(0.25)	(0.25)
(325.66)	**Total Employee Expenses**	**(26.45)**	**(26.75)**	**(0.29)**	**(1.10%)**	**(26.45)**	**(26.75)**	**(0.29)**	**(1.10%)**	A	4	**(24.84)**	**(26.45)**	**(26.45)**
(104.16)	Drugs and Blood	(8.66)	(7.80)	0.87	10.01%	(8.66)	(7.80)	0.87	10.01%	G		(8.03)	(8.66)	(8.66)
(34.65)	Supplies and services - clinical	(2.73)	(3.28)	(0.55)	(20.05%)	(2.73)	(3.28)	(0.55)	(20.05%)	R		(1.68)	(2.73)	(2.73)
(77.87)	Other Expenses	(6.87)	(5.50)	1.36	19.87%	(6.87)	(5.50)	1.36	19.87%	G		(8.14)	(6.87)	(6.87)
(216.68)	**Total Non-Pay Expenses**	**(18.26)**	**(16.58)**	**1.68**	**9.22%**	**(18.26)**	**(16.58)**	**1.68**	**9.22%**	G	5	**(17.84)**	**(18.26)**	**(18.26)**
(542.34)	**Total Expenses**	**(44.72)**	**(43.33)**	**1.39**	**3.12%**	**(44.72)**	**(43.33)**	**1.39**	**3.12%**	G		**(42.68)**	**(44.72)**	**(44.72)**
10.49	**EBITDA (exc Capital Donations)**	**0.02**	**(1.34)**	**(1.36)**	**(6,521.10%)**	**0.02**	**(1.34)**	**(1.36)**	**(6,521.10%)**	R		**(4.86)**	**0.02**	**0.02**
(18.70)	Owned depreciation, Interest and PDC	(1.58)	(1.59)	(0.02)	(1.14%)	(1.58)	(1.59)	(0.02)	(1.14%)		7	(1.50)	(1.58)	(1.58)
(8.21)	**Surplus/Deficit (exc. PSF/Top up)**	**(1.56)**	**(2.93)**	**(1.37)**	**(88%)**	**(1.56)**	**(2.93)**	**(1.37)**	**(88%)**			**(6.36)**	**(1.56)**	**(1.56)**
0.00	PSF/Top up	0.00	0.00	0.00		0.00	0.00	0.00				6.36	0.00	0.00
(8.21)	**Surplus/Deficit (incl. PSF/Top up)**	**(1.56)**	**(2.93)**	**(1.37)**	**(88.31%)**	**(1.56)**	**(2.93)**	**(1.37)**	**(88.31%)**	R		**(0.00)**	**(1.56)**	**(1.56)**
0.00	PY PSF post accounts reallocation	0.00	0.00	0.00		0.00	0.00	0.00				0.00	0.00	0.00
(14.20)	Donated depreciation	(1.18)	(1.33)	(0.15)		(1.18)	(1.33)	(0.15)				(1.25)	(1.18)	(1.18)
(22.41)	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**(2.74)**	**(4.26)**	**(1.52)**	**(55.63%)**	**(2.74)**	**(4.26)**	**(1.52)**	**(55.63%)**			**(1.25)**	**(2.74)**	**(2.74)**
0.00	Impairments & Unwinding Of Discount	0.00	0.00	0.00		0.00	0.00	0.00				0.00	0.00	0.00
15.98	Capital Donations	0.55	0.50	(0.05)		0.55	0.50	(0.05)			6	2.02	0.55	0.55
(6.43)	**Adjusted Net Result**	**(2.19)**	**(3.76)**	**(1.57)**	**(71.75%)**	**(2.19)**	**(3.76)**	**(1.57)**	**(71.75%)**			**0.77**	**(2.19)**	**(2.19)**











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

Summary

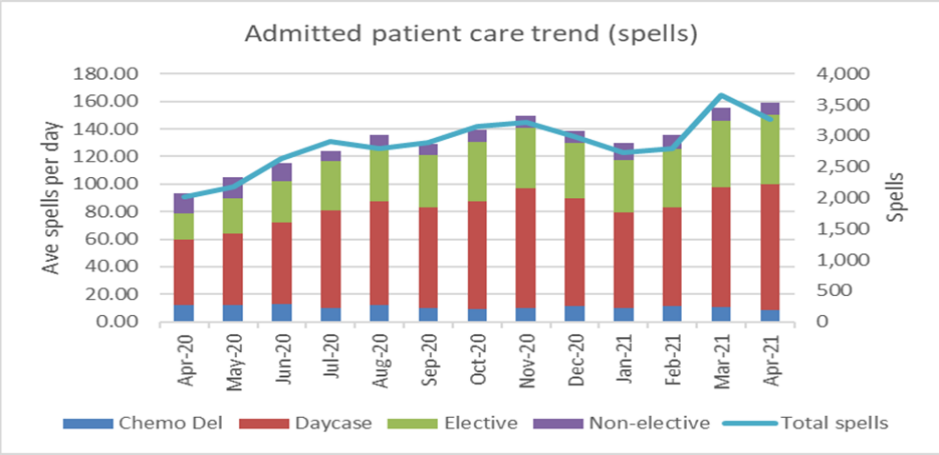
- The month 1 financial position is a deficit of £2.9m which is £1.3m adverse to plan.
- The latest Trust plan agrees with NHSE for the year totals to a target deficit for the end of the year of £8.2m.

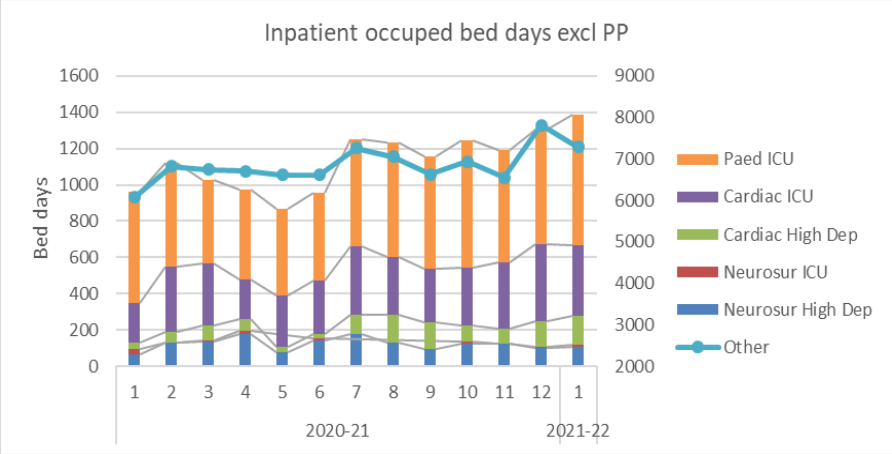
Notes

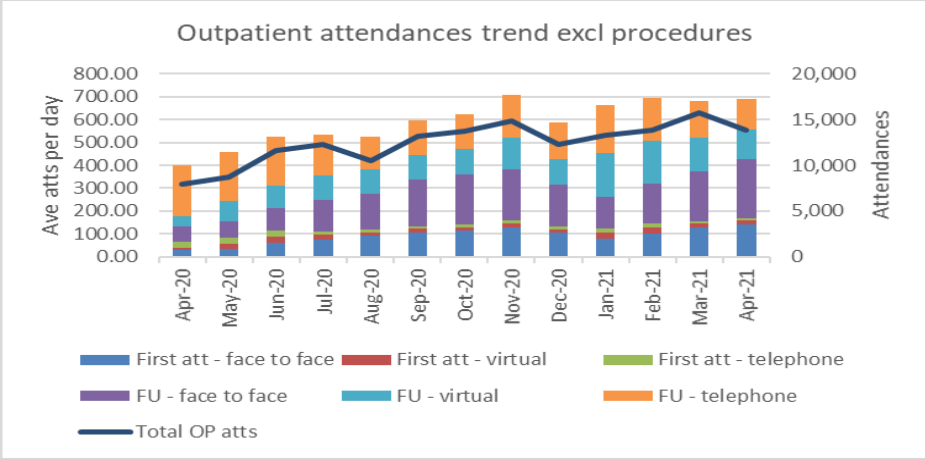
1. NHS Clinical income is £0.7m adverse plan in month 1 owing to cost and volume activity and associated drugs costs being lower than plan, and reduced income relating to COVID-19 as a result of lower than anticipated cost levels.
2. Private Patient income was £1.1m adverse to plan in-month due to travel remaining suppressed due to Covid-19; international sponsors are only sending the most complex patients overseas. With continuing travel restrictions, it is likely this income stream will continue to be affected until such time as travelling is deemed to be safer for patients. The private patient income target grows throughout the year given expectation of an uplift in activity as the year progresses.
3. Non-clinical income is £0.9m adverse to plan in-month. This is driven by lower than plan charity and research income due to the continued impact of delay from Covid on project progression and timing differences to the plan.
4. Pay is adverse in-month to the plan by £0.3m. Turnover levels within the staffing groups has reduced as a result of the pandemic and high staff levels have been retained across the board. The Trust continues to look at managing down the impact of Covid-19 on staffing and proposed new posts are carefully reviewed. Nursing bank has been significantly lower in-month (c.£0.4m) than across the prior year with activity being low across the Trust.
5. Non pay is £1.8m favourable to the plan in-month. This is driven by impairment of receivables being £0.4m favourable to plan given continued payments and reduced new activity, and premises costs being £0.7m favourable to plan due to lower than plan utility and maintenance payments, partially driven by lower than plan Covid costs, for which there is a corresponding lower than plan income for Covid cost funding.

2021/22 Overview of activity trends for month ending 30 April 2021

Great Ormond Street Hospital for Children NHS Foundation Trust





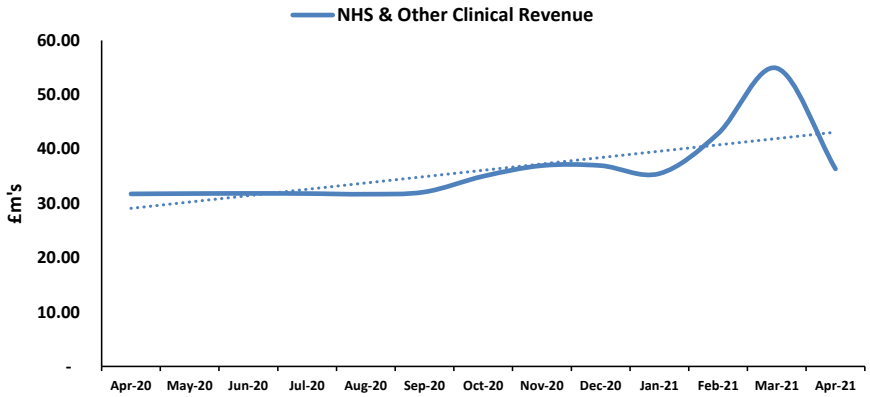


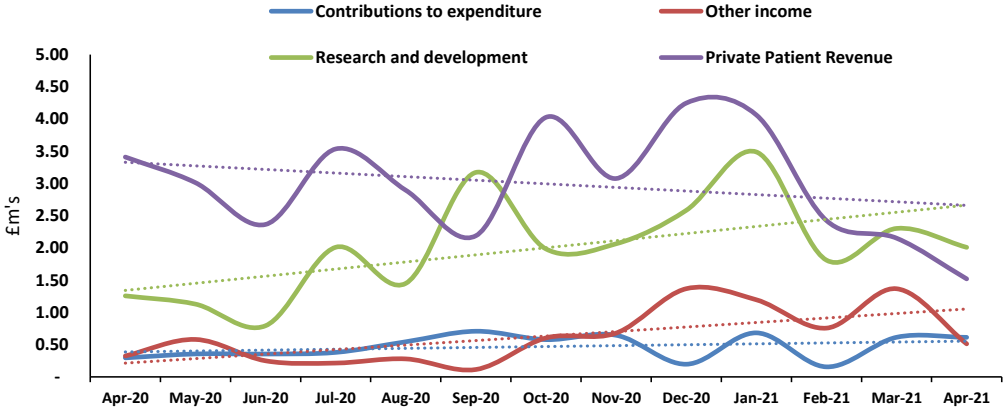
NB: All activity accounts are based on those used for income reporting

Summary

- Daycase spells have increased 4.9% and elective spells 4.7% per working day versus March. Non-elective activity continues to decrease with it being 13% below March levels.
- In line with the increase in daycase and elective spells, critical care occupied bed days are higher than March and other bed days whilst not as high as March are above the levels of April 2020-February 2021.
- Outpatient attendances are at a similar level to March and are showing a sustained increase over the last 3 months versus the second lockdwon period. Non-face to face attendances as a % of the total have dropped further to 42% when compared to March (50) owing to the decline in COVID cases allowing more face-to-face activity.
- The upward trends in activity are reflected in increased costs of clinical supplies & services (£2.9m v £2.7m in March 2021 excluding donated stock).
- Performance against the national elective recovery framework targets will be reported one month in arrears owing to the high volumes of uncoded activity at working day 1 impacting on the robustness of the calculation. The threshold at system level is 70% of April 2019 activity adjusted for working days rising in 5% intervals to 85% by July.

2020/21 Income for the 1 months ending 30 Apr 2021





Summary

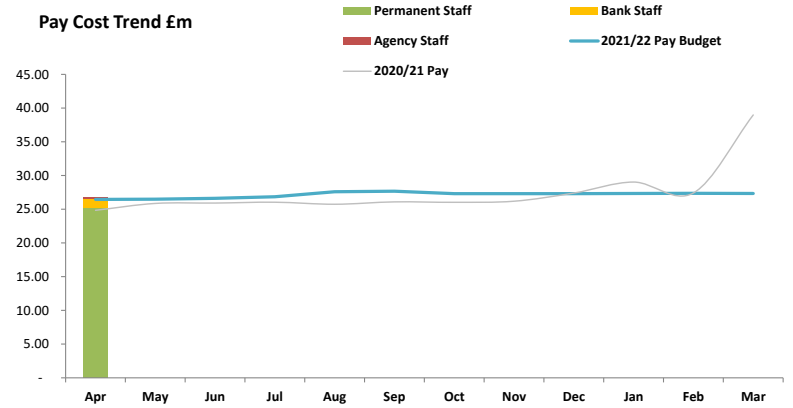
- NHS Clinical income is £0.7m adverse plan in month 1 owing to cost and volume activity and associated drugs costs being lower than plan and reduced income related to COVID-19 income as a result of lower than anticipated costs.
- Private Patient income is £1.1m adverse to plan in month. Given the continued travel restrictions both domestically and globally, sponsors are only sending their most complex patients abroad, resulting in significantly lower income levels for the Trust. The reduced level of referrals is expected to continue until after restrictions are lifted. The private patient income target grows throughout this year with the expectation that activity will begin to return as the year goes on; this is all dependent upon these restrictions lifting and continued success in limiting further waves of variants of Covid-19.
- Research income is adverse to plan by £0.2m due to lower than plan commercial income. Last year research income was significantly reduced due to research studies having been suspended, except those on COVID-19, in order to redeploy staff to support the Covid-19 response. Although the effect of COVID-19 on research studies is reducing it is expected to continue over the coming weeks. However, it is hoped that as the impact of Covid reduces, research will return more towards levels seen in 2019/20 instead of the much reduced activity in 2020/21. Research contracts continue to be recognised in line with contract milestones and project delivery.
- Other income is £0.4m adverse to plan. This is due to lower than plan laboratory activity (both NHS and non-NHS).
- Charitable income is £0.4m adverse to plan due to timing differences to the plan. Last year many charity projects were delayed as a result of Covid-19 and many of these will be coming online this year.

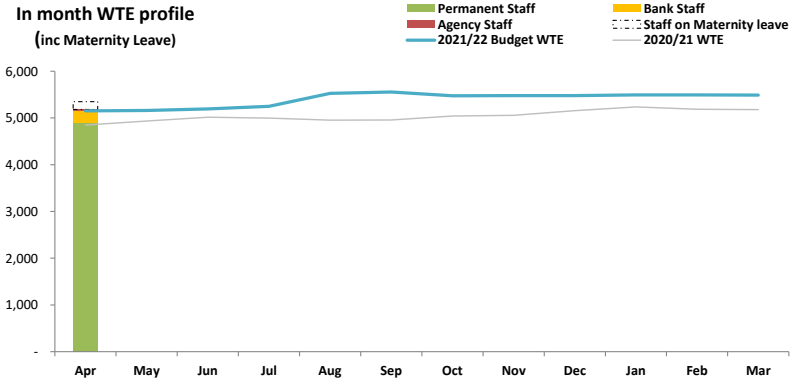
Workforce Summary for the 1 months ending 30 Apr 2021

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

£m including Perm, Bank and Agency	2020/21 actual full year			2021/22 actual			Variance			RAG
Staff Group	YTD (£m)	YTD Average WTE	£000 / WTE	YTD (£m)	YTD Average WTE	£000 / WTE	YTD (£m)	Volume Var (£m)	Price Var (£m)	£ Variance
Admin (inc Director & Senior Managers)	56.5	1,193.8	47.4	5.1	1,264.2	48.0	(0.3)	(0.3)	(0.1)	A
Consultants	60.3	387.7	155.5	5.0	408.1	147.6	0.0	(0.3)	0.3	G
Estates & Ancillary Staff	4.7	138.7	33.7	0.4	134.7	34.0	0.0	0.0	(0.0)	G
Healthcare Assist & Supp	11.3	325.9	34.7	0.9	312.4	34.3	0.1	0.0	0.0	G
Junior Doctors	31.4	377.0	83.2	2.7	396.4	82.4	(0.1)	(0.1)	0.0	A
Nursing Staff	89.8	1,600.9	56.1	7.5	1,614.5	56.1	(0.1)	(0.1)	0.0	A
Other Staff	0.7	12.3	53.8	0.1	14.6	52.4	(0.0)	(0.0)	0.0	G
Scientific Therap Tech	56.9	981.8	58.0	4.8	1,008.5	56.7	(0.0)	(0.1)	0.1	G
Total substantive and bank staff costs	**311.6**	**5,018.1**	**62.1**	**26.4**	**5,153.4**	**61.6**	**(0.5)**	**(0.7)**	**0.2**	A
Agency	3.7	28.3	129.4	0.2	28.3	87.4	0.1	0.0	0.1	G
Total substantive, bank and agency cost	**315.2**	**5,046.4**	**62.5**	**26.7**	**5,181.7**	**61.7**	**(0.4)**	**(0.7)**	**0.3**	A
Reserve*	1.9	0.3		0.1	0.0		0.1	0.1	0.0	G
Additional employer pension contribution by NHSE	12.4	0.0		0.0	0.0		1.0	0.0	1.0	G
Total pay cost	**329.6**	**5,046.6**	**65.3**	**26.7**	**5,181.7**	**61.9**	**0.7**	**(0.6)**	**1.3**	G
Remove maternity leave cost	(3.1)			(0.3)			0.0	0.0	0.0	G
Total excluding Maternity Costs	**326.4**	**5,046.6**	**64.7**	**26.5**	**5,181.7**	**61.3**	**0.7**	**(0.6)**	**1.4**	G

Plan reserve includes WTEs relating to the better value programme

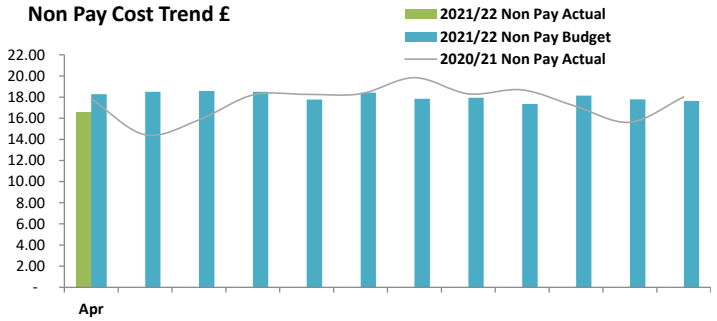


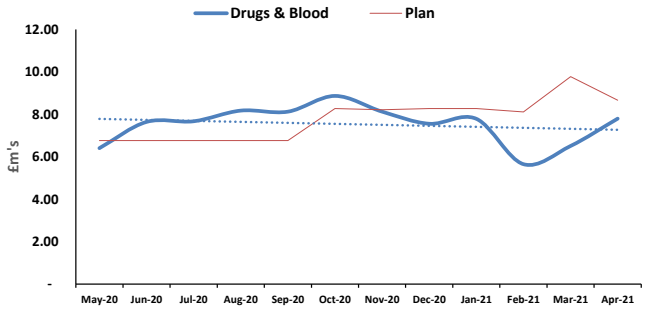


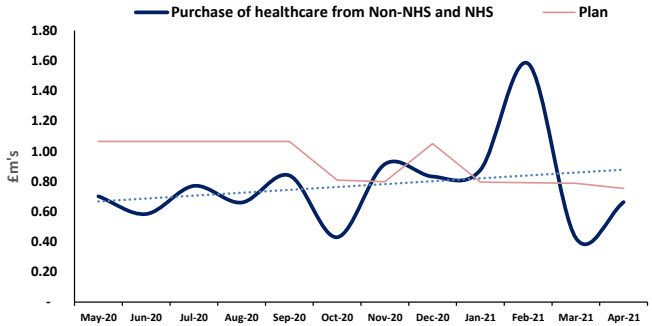
Summary

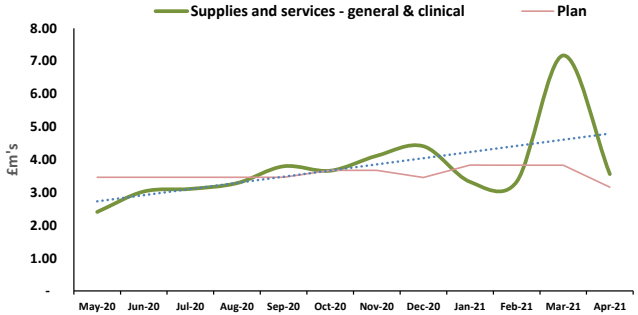
- Pay costs and WTE's are slightly above plan (£0.3m, 30 WTE's) due to continued high levels of staffing as a result of Covid which has resulted in low levels of staff turnover. The Trust is receiving reimbursement for costs relating to Covid and as a result there will be corresponding income for those pay costs identified.
- M1 WTE's are significantly higher than the average for last year due to several changes in the WTE profile in the final half of last year, most notably no longer being able to capitalise EPR staff leading to their inclusion in the revenue position and WTE profile. These posts are now included in the budget for 2021/22.
- This month has seen significantly lower nursing bank usage across the Trust (c.£0.4m lower than M12 2019/20) due to lower activity across the Trust. Further controls have been implemented by the operational teams to monitor bank usage requests and changes by each ward in order to keep this spend controlled.
- High levels of admin agency staff continues due to additional senior assistance for the ICT directorate. Agency spend in the Trust is monitored and consideration is given as to whether resources can be secured through the bank or fixed term contracts in order to reduce this cost.
- Pay costs may continue to rise during parts of the year given current plans in development to begin accelerated activity in order to reduce patient waiting times as a result of delays due to Covid-19.

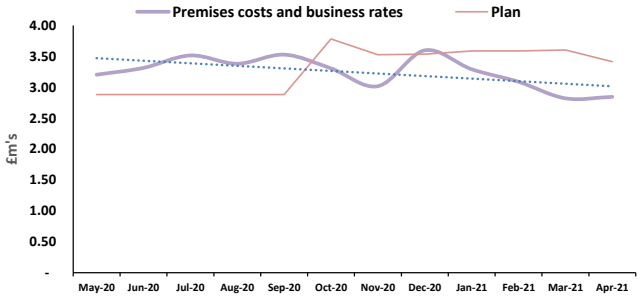
Non-Pay Summary for the 1 months ending 30 Apr 2021











Summary

- Non-pay costs are below plan by £1.7m. This is driven largely by impairment of receivables being £0.4m favourable to plan and premises costs being £0.7m favourable to plan.
- Impairment of receivables (£0.4m favourable to plan) is due to continued payments of debt coupled with reduced new activity, meaning overall aged debt is decreasing. This has been calculated in line with IFRS9 and the Trust's policy.
- Premises is lower than plan by £0.7m; this is driven by lower than plan utility costs and lower than plan maintenance costs due to lower than anticipated Covid costs. This is offset by a corresponding reduction in income for covid cost funding. It is expected that non-pay costs will rise upon the opening of the Sight & Sound building and when further EPR optimisation work increases later in the year.
- Purchase of Healthcare from NHS and non-NHS & supplies and services in M1 have remained broadly on trend comparable to prior year. Additional activity is likely to be completed in order to reduce patient backlogs and therefore it is expected that these costs will rise in the coming months (including for improved IPP activity levels).

Cash, Capital and Statement of Financial Position Summary for the 1 months ending 30 Apr 2021

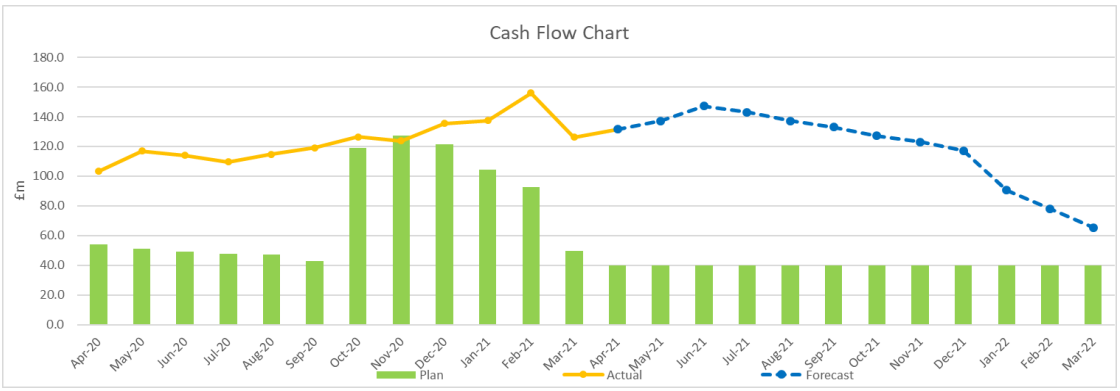
31 Mar 2021 Unaudited Accounts £m	Statement of Financial Position	YTD Actual 31 Mar 21 £m	*YTD Actual 30 Apr 21 £m*	In month Movement £m
532.75	Non-Current Assets	532.75	531.13	(1.62)
64.56	Current Assets (exc Cash)	64.56	62.52	(2.04)
126.19	Cash & Cash Equivalents	126.19	131.46	5.27
(102.80)	Current Liabilities	(102.80)	(108.39)	(5.59)
(6.45)	Non-Current Liabilities	(6.45)	(6.28)	0.17
614.25	**Total Assets Employed**	**614.25**	**610.44**	**(3.81)**

31 Mar 2021 Unaudited Accounts £m	Capital Expenditure	YTD plan 30 Apr 21 £m	YTD Actual 30 Apr 2021 £m	YTD Variance £m	Forecast Outturn 31 Mar 2022 £m	RAG YTD variance
6.50	Redevelopment - Donated	0.55	0.48	0.07	13.70	A
2.56	Medical Equipment - Donated	0.00	0.02	(0.02)	2.28	R
0.00	ICT - Donated	0.00	0.00	0.00	0.00	G
9.06	**Total Donated**	**0.55**	**0.50**	**0.05**	**15.98**	G
0.00	Total Grant funded	0.00	0.00	0.00	0.46	G
5.09	Redevelopment & equipment - Trust Funde	0.30	0.24	0.06	7.26	A
1.10	Estates & Facilities - Trust Funded	0.13	0.04	0.09	6.53	R
2.67	ICT - Trust Funded	0.02	0.01	0.01	3.82	R
0.00	Contingency	0.00	0.00	0.00	0.39	G
8.86	**Total Trust Funded**	**0.45**	**0.29**	**0.16**	**18.00**	A
2.56	**PDC**	**0.00**	**0.00**	**0.00**	**0.00**	G
20.48	**Total Expenditure**	**1.00**	**0.79**	**0.21**	**34.44**	A

Working Capital	31-Mar-21	30-Apr-21	RAG	KPI
NHS Debtor Days (YTD)	5.0	3.0	G	< 30.0
IPP Debtor Days	288.0		R	< 120.0
IPP Overdue Debt (£m)	27.1	26.1	R	0.0
Inventory Days - Non Drugs	95.0	82.0	R	30.0
Creditor Days	31.0	34.0	A	< 30.0
BPPC - NHS (YTD) (number)	41.6%	67.4%	R	> 90.0%
BPPC - NHS (YTD) (£)	70.6%	75.7%	R	> 90.0%
BPPC - Non-NHS (YTD) (number)	83.4%	66.4%	R	> 90.0%
BPPC - Non-NHS (YTD) (£)	88.9%	93.1%	G	> 90.0%

Salary overpayments (£000)	98.6	80.1
Salary overpayments identified (Number)	30	9

RAG Criteria:
NHS Debtor and Creditor Days: Green (under 30); Amber (30-40); Red (over 40)
BPPC Number and £: Green (over 90%); Amber (90-85%); Red (under 90%)
IPP debtor days: Green (under 120 days); Amber (120-150 days); Red (over 150 days)
Inventory days: Green (under 21 days); Amber (22-30 days); Red (over 30 days)



Comments:

1. Capital expenditure for the month to 30 April was less than plan by £0.2m: Trust-funded expenditure was less than plan by £0.2m; donated was on plan
2. Cash held by the Trust increased in month by £5.3m.
3. Total Assets employed at M1 decreased by £3.8m in month as a result of the following:
   - Non current assets totalled £531.1m, a decrease of £1.6m in month
   - Current assets excluding cash totalled £62.5m, a decrease of £2.04m in month. This largely relates to the following: Contract receivables including IPP which have been invoiced (£2.8m lower in month); accrued income (£1.1m higher in month); capital receivables (£0.6m higher in month) and Other non NHS receivables (£0.6m lower in month).
   - Other non NHS receivables includes Charity debt (£1.0m lower in month); Prepayments (£0.3m higher in month) and VAT receivable (£0.3m higher in month).
   - Cash held by the Trust totalled £131.5m, increasing in month by £5.3m.
   - Current liabilities increased in month by £5.5m to £108.4m. This largely includes the increase in deferred Income (£3.4m higher in month) and expenditure accruals (£2.6m higher in month). Other payables also increased by £1.9m in month and this includes PDC and other taxes (£0.8m higher); IPP deposits (£0.3m higher). Capital creditors decreased by £2.4m in month.
4. IPP debtors days decreased in month from 288 days to 281 days. Total IPP debt decreased in month to £26.3m (£27.1m in M12). O verdue debt decreased in month to £26.1m (£27.1m in M12
5. The cumulative BPPC for NHS invoices (by value) increased in month to 76% (71% in M12). This represented 67% of the number of invoices settled within 30 days (42% in M12)
6. The cumulative BPPC for Non NHS invoices (by value) increased in month to 93% (89% in M12). This represented 66% of invoices settled within 30 days (83% in M12)
7. Creditor days increased in month from 31 days to 34 days.
8. There were 9 overpayments in month which total £80k. These overpayments are largely as a result of incorrect pay rates being paid to members of staff and will be recouped through future wages or via invoice if staff have left the Trust. The largest overpayments identified in the month were £31k relating to the period Apr 20- Mar 21 and £32k for a 15 month period to Mar 21. The Finance team will be reviewing the historic overpayment log to identify departments and reasons where the largest number and value of overpayments occur. This information will be shared with HR for discussion with departmental leads and where required, changes will be put in place which will ensure that overpayments are identified and st opped at the earliest opportunity and recurrence is minimised.

Attachment T

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
26 May 2021

Learning from Deaths Report – Learning from Deaths in Q3 2020/21 **Submitted by:** Dr Sanjiv Sharma , Medical Director	**Paper No: Attachment T** For information and noting

Purpose of report

To provide Trust Board with oversight of
1. Learning from deaths identified through mortality reviews, this includes positive practice, but also where there were modifiable factors.
2. Progress with the implementation of the Child Death Review Meetings (CDRM).

This scope of this report is GOSH inpatient deaths that occurred between 1st October 2020 and 31st December 2020. Twenty six children died at GOSH in this period. We have been able to maintain resilience with our mortality reviews throughout the Covid 19 pandemic.

Summary of report

- This report was presented to the Patient Safety and Outcomes Committee (PSOC) on the 12th May. It highlights learning points from mortality reviews and actions that are being taken in response to them .There are no overall themes highlighted in the report which require further Trust wide action and consideration by PSOC or Closing the Loop.
- There were no deaths in this period which met the criteria for requiring an SI investigation.
- There were no cases reviewed that had modifiable factors in the child's care at GOSH that may have contributed to vulnerability, ill health or death.
- The review process highlighted particular positive aspects of care the co-ordination of care, and communication in eighteen deaths.
- There are no outliers which require investigation noted in real time PICU/NICU risk adjusted mortality. Crude mortality is within normal variation. The gold standard for measuring paediatric mortality is through benchmarking by the Paediatric Intensive Care Audit Network (PICANET) .The most recent PICANET report was published on the 11th February 2021 and covers the calendar years 2017-2019. The report shows GOSH PICU/NICU and CICU risk adjusted mortality as within expected range.
- The reviews highlight the support and sensitivity offered from members of the child's clinical teams and those involved in wider holistic care including, psychology, family liaison nurses, play team, chaplaincy, as well as multi-disciplinary working between different clinical teams involved in the child's care. Examples of this are indicated in the report.

- In six cases the impact of the COVID 19 pandemic was noted explicitly on the experience of the family, around managing visitation and childcare. It should be noted that GOSH has been following necessary national policy on COVID 19 visitation restrictions and paid close attention to them, as they changed ,and their impact throughout the Covid 19 pandemic. GOSH guidelines on visiting have been frequently reviewed and amended when changes to national policy have allowed.

Attachment T

<table>
<tr><td colspan="2">Action required from the meeting
There are no recommendations or actions for the Board to consider</td></tr>
<tr><td>Contribution to the delivery of NHS Foundation Trust priorities
Quality/ corporate/ financial governance</td><td>Contribution to compliance with the Well Led criteria
Culture of high quality sustainable care
Effective processes, managing risk and performance
Accurate data/ information
Robust systems for learning, continuous improvement and innovation</td></tr>
<tr><td colspan="2">Strategic risk implications
BAF Risk 12: Inconsistent delivery of safe care</td></tr>
<tr><td colspan="2">Financial implications
Not Applicable</td></tr>
<tr><td colspan="2">Implications for legal/ regulatory compliance
Meets the requirement of the National Quality Board to report learning from deaths to a public board meeting. Child Death Review Meetings (CDRM) are statutory following the publication of the Child Death Review Statutory guidance which applies for all child deaths after 29th September 2019.</td></tr>
<tr><td colspan="2">Consultation carried out with individuals/ groups/ committees
This report has been reviewed and approved by the Patient Safety and Outcomes Committee (May 2021)</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales?
Dr Pascale du Pré, Consultant in Paediatric Intensive Care, Medical Lead for Child Death Reviews
Andrew Pearson, Clinical Audit Manager</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project?
Medical Director</td></tr>
<tr><td colspan="2">Which management committee will have oversight of the matters covered in this report?
Patient Safety and Outcomes Committee</td></tr>
</table>

Attachment T

Great Ormond Street Hospital for Children NHS Foundation Trust

Learning from Deaths: Report of deaths in Q3 2020/21

Aim of report

Highlight learning from deaths identified through mortality reviews, this includes positive practice, but also where there were modifiable factors. Modifiable factors are defined as factors, which by means of nationally or locally achievable interventions could be modified to reduce the risk of future child deaths.

This scope of this report is GOSH inpatient deaths that occurred between 1st October 2020 and 31st December 2020.

Background

Mortality reviews take place through two processes at GOSH:

1. **Mortality Review Group (MRG**). This was established in 2012 to provide a Trust level overview of all deaths to identify learning points, themes and risks and take action as appropriate to address any risks. This process is linked with local case reviews undertaken by specialty teams and provides an additional oversight of inpatient deaths in the Trust. This group continues to review deaths to ensure a thorough level of review and challenge can be provided before reviews are finalised at a Child Death Review Meeting (CDRM), as well as identifying learning points and making referrals to other safety investigation processes at the earliest opportunity.
2. **Child Death Review Meetings (CDRM)** These are now in place at GOSH following the publication of the Child Death Review Statutory guidance which applies for all child deaths after 29th September 2019.Child Death Review Meetings are "a multi-professional meeting where all matters relating to a child's death are discussed by the professionals directly involved in the care of that child during life and their investigation after death." They include clinicians or professionals from external providers. CDRM meeting should be held within 12 weeks of the child's death, following the completion of all necessary investigations and reviews.

Completion of mortality reviews

Twenty six children died at GOSH between 1st October 2020 and 31st December 2020.

- Reviews (i.e. an MRG or a CDRM) have been completed for all cases.
- Twenty one CDRMs have taken place. Five cannot take place until the completion of necessary coroner investigations and reviews. This in line with the Child Death Review Statutory Guidance.

We have been able to maintain resilience with our mortality reviews throughout the coronavirus (COVID-19) pandemic.

This report highlights learning at the time of writing, and it is important to note that additional learning could be identified at a later stage through the coroners /CDRM / SI processes.

The table below shows the summary of the deaths that occurred during the quarter using NHS England reporting guidance.

Total number of inpatient deaths at GOSH between 1st October 2020 and 31st December 2020.	26
Number of those deaths subject to case record review (either by the MRG, or at a CDRM)	26
Number of those deaths declared as serious incidents	0
Number of deaths where a modifiable factor was identified at GOSH that may have contributed to vulnerability, ill health or death.	0

Number of deaths of people with learning disabilities	2
Number of deaths of people with learning disabilities that have been reviewed	2
Number of deaths of people with learning disabilities where a modifiable factor was identified at GOSH that may have contributed to vulnerability, ill health or death.	0

Of the twenty six deaths in the period:

Modifiable factors at GOSH (0)
There were no cases reviewed that had modifiable factors in the child's care at GOSH that may have contributed to vulnerability, ill health or death.

Deaths that are subject to an SI investigation (0)
There were no deaths in this period which met the criteria for requiring an SI investigation.

Positive practice (18)
The review process highlighted particular positive aspects of care, the co-ordination of care, and communication in eighteen deaths. This does not mean that exemplary care and communication was not practiced more widely than in those cases, but that the review process highlighted particular examples of excellence in those cases.

The reviews highlight the support and sensitivity offered from members of the child's clinical teams and those involved in wider holistic care including; psychology, family liaison nurses, play team, chaplaincy, as well as multi-disciplinary working between different clinical teams involved in the child's care. Positive practices highlighted are summarised below.

Family members were able to stay with the child in her final hours. Child was adequately sedated and not in pain in the final hours.
Both parents received support from GOSH psychology team and PICU family liaison nurses.
Excellent MDT working with NICU, Dermatology, Palliative care, Plastics, Microbiology, Ophthalmology
Swift transfer from a London hospital to GOSH with known AVM, MDT working with surgery/neuro/IR
Very good team work. Good symptom care and peaceful death.
Given the devastating prognosis and rapid progression of the tumour. The end of life was well planned and the patient died peacefully.
Excellent multidisciplinary approach to treatment. Despite the potentially poor prognosis the use of ECMO was an attempt to allow treatment therapies to have chance to work. The family were made aware of the very guarded prognosis at all times and at all decision points. The rheumatology team consulted widely, including north American centres and no further suggestions were forthcoming. After this child's death the mother returned to CICU to visit the bedspace which she greatly appreciated.
The family liaison team and play specialists on CICU worked with the family to facilitate a "good death" at such a tragic time
Relative had rapid transit through an airport on arrival. Mortuary staff at GOSH were very kind and supported daily viewings.
Mother presented to a London hospital in preterm labour (having booked at another hospital) which meant she delivered in the appropriate place (extreme prematurity). Transferred within five hours of referral to surgical team at GOSH. Excellent MDT team working between NICU, SNAPS, Renal CF team, Genetics, Family Liaison and Chaplain. Good communication with both parents.
This family had extreme emotional reactions and this was very challenging for the ward and nursing teams to manage - the Lion team were commended for their sensitivity towards the child in these challenging circumstances and at balancing active treatment alongside palliative care.
Excellent coordination for the provision of emergency laparatomy in NICU with very clearly defined criteria - notable that still able to coordinate this so effectively despite hospital pressures during current pandemic. Excellent communication between Surgical team and

NICU in coordinating this especially on Alligator Ward (temporary relocation of NICU during COVID-19
Nurse and parent-led end of life care for withdrawal of treatment was the best that it could be given the difficult circumstances.
Rapid and efficient transfer to GOSH post delivery. NICU registrar was able to provide interpretation to help communication with family which was greatly appreciated by the medical team and the family (has been fed back to the individual). Chaplain attended during cardiopulmonary resuscitation.
Bed and transfer to GOSH from local quickly arranged via CATS. NICU team credited for continuing to raise the question of cytopenia which led to diagnosis. Excellent team working with Haematology and Cardiology. Family Support Worker supported the family and linked the mother with Citizens Advice and mother fed back that this was really helpful. Baby was picked up by Palliative Care team at the Haematology Meeting due to new diagnosis who offered support to medical team who welcomed palliative care involvement but baby sadly died before first meet scheduled.
Prompt recognition and treatment and referral. Investigations for intestinal atresia were conducted in the most non-invasive way possible without causing unnecessary suffering/pain for the child. The multiple and early MDTs were highly commended as well as clear communication with the family throughout. The Pain team and Palliative care teams were thanked for their input with symptoms control for this baby. The family were extremely grateful for the care provided and offered to donate organs and skin for research which given the circumstances was an incredible gesture and a reflection on the good relationship and communication between the teams and the family.
Parents were extremely grateful to the A&E Consultant at the local Hospital. *Outstanding communication local hospital-CATS-GOSH* *• BIMDG guidelines followed during patient admission* *• Resus UK guidelines followed thoroughly during cardiac arrest event*
Large MDT discussion to decide whether or not to intervene surgically with regards to the heart lesion. Considerable time and care was taken to discuss in detail the pros and cons in this very difficult situation.

Additional learning points identified (13)

These were not deaths where modifiable factors were identified, but where learning points were identified around best practice which could improve quality, the co-ordination of care, or patient and family experience.

This section highlights learning points and actions that are being taken in response to them. There are no overall themes highlighted in the report which requires further Trust wide action and consideration by PSOC or Closing the Loop.

Location of learning	Learning	Actions from learning
GOSH	In the future it would be important take into account the co-morbidities of Noonan's syndrome before considering lung transplant.	No additional actions were identified through this review, the learning points have been identified with the clinical teams involved in the case.
Community care	This child had been taken to the GP several times (over an 18 month period) because of non- identified rashes, muscle weakness and losing weight. The primary care teams referred appropriately but the child presented with acute respiratory deterioration before being seen by the tertiary centre. It should be noted that the presentation was not typical and the diagnosis was rare and difficult to make, but potentially treatable. This case	Paediatric Consultant with interest in Rheumatology at another London hospital where the child was seen will present this case at the M&M and as part of wider teaching to local GPs

	demonstrated the importance of following the NICE guideline in when to refer children for specialist review for example when the rash distribution is unusual, associated with systemic factors or does not respond to conventional treatment.	
Learning when establishing networks	Congenital Heart Network issues - although the baby's outpatient care is linked to GOSH along a clear pathway, the obstetric care goes via local hospital 1 and therefore antenatal planning via local hospital 2. It is GOSH preference to be able to meet with the family antenatally, so that plans are consistent. It didn't become an issue on this occasion, but does set a path of communication difficulties and should be considered when planning network and pathway plans going forward.	The fetal team have identified the need to improve communication regarding pending cases between the local and GOSH teams and this has been actioned with regular weekly meetings where upcoming cases are discussed.
Local hospital	Baby was induced and delivered at night. The night team were not familiar with the expected course.	The local team have identified and actioned the better availability of antenatal scan reports so that teams can access these at all times.
GOSH and local teams	The presence of persistent pneumatosis after 48 hours as a strong indicator of the presence of necrotic bowel and the need for surgical intervention was highlighted as a learning point demonstrating the value of repeat Xrays at 24 and 48 hours to help guide intervention and to guide timely discussion and referral to surgical teams to ensure timely, necessary intervention (surgery) at the right time. This has been highlighted in the deaths of two children in this period.	No additional actions were identified through this review, the learning points have been identified with the clinical teams involved in the case
Local hospital	Review of the case at the local hospital identified the need to expedite the scanning of notes into the Evolve system to ensure better availability of notes in Mortality cases.	This has already been actioned.
Tertiary centre and paediatric oncology shared care unit(POSCU)	Communication issues were highlighted between tertiary centre (and the POSCU on discharge. The discharge summary was not sent and did not represent the complexity of the treatment course. The POSCU and Community nursing teams were not included in discharge planning meetings. A virtual meeting did take place with the GOSH palliative care CNS and an interpreter signposting mother how to seek advice if child became unwell however there were challenges with interpretation (Covid- and Community teams.	UCLH Oncology Consultant will alert the UCLH POSCU Lead to these issues in order to improve communication at discharge with POSCU and Community teams.

	It was identified that the Family misunderstood the role of the hospice in funeral arrangements.	Palliative Care working on a project liaising with hospices about written communication about what services are available and provided to families.
GOSH	The local teams fed back that improved communication from GOSH regarding the circumstances of death (early copy of discharge summary and a record of the bereavement follow up discussions and PM report) would be helpful in facilitating their ongoing communication and consistency of information with families after death	This has been fed back to PICU and discussions on how to improve communication with local teams for long term patients of children with a new significant diagnosis are ongoing. The difficulties in identifying the local Consultant and getting through to them due to long delays with switchboard at GOSH and locals have been highlighted as barriers.
GOSH	Earlier consideration of parallel planning and limitations to escalation of treatment in a baby with multiple comorbidities would have prevented prolonged cardiopulmonary resuscitation. Suggestion that more visible links on Epic (IT systems) would facilitate better coordination of joint care between NICU and CICU teams in the future. Baby delivered at local even though care had been transferred to tertiary centre (multiple antenatal abnormalities) Transfer of antenatal care policy between local and tertiary centre being reviewed as an action.	There is now a NICU consultant who is the link between NICU and CICU and more work will be done to improve communication and collaboration between both teams, including a link on Epic. Transfer of antenatal care policy between local and tertiary centre being reviewed as an action. Weekly MDT held between Fetal/Paediatrics/Obstetrics and Midwife teams to make plans for care and place of delivery in place already as an action following this case.
Local team and GOSH	Mother was not made aware that she could stay with baby at GOSH (sent home from local hospital and did not accompany baby with CATS transfer) Spent 3 days commuting from home without accommodation provided at GOSH. Mother called NICU and received an update (reassuring) about another baby. This was very distressing for mother who reported she might have returned to the hospital sooner. There was difficulty getting the sibling and auntie in for a visit due to COVID 19 restrictions despite recommendation from Head of Nursing that restrictions do not apply in end of life care/events which caused mother distress. This is being fed back to the Patient Experience team.	Fed back to local team at CDRM and fed back to family liaison team and practice educators to ensure bedside nurses know to offer accommodation to parents. An action from the CDRM was for the NICU Lead to write to the family to apologise. Difficulties around visitation were fed back to the Patient Experience team.
GOSH	Venous and arterial access were difficult on arrival at GOSH. Some time was spent tried to source a size 5F vascath. Delay did not have any effect on outcome. Size 6.5F vascath appropriate for this size infant.	The CVC guideline has been updated

GOSH	Importance of early and documented MDT discussions for children with Infective Endocarditis who may require cardiothoracic surgery.	No additional actions were identified through this review, the learning points have been identified with the clinical teams involved in the case
Local hospital	Importance of appropriate triage of paediatric patients in primary care : did coronavirus impact access to GP review	This is a wider issue – fed back at national level via CDOP.

Impact of COVID 19 pandemic on deaths at GOSH in Q3
We amended our mortality review process at the start of the COVID 19 pandemic to ensure we indicate where there has been impact of the pandemic on a death occurring at GOSH, and the experience of patients and families.

There were two deaths at GOSH in this period where it was possible to conclude that the COVID 19 pandemic had an impact on the death occurring at GOSH.

1. The cause of death was Covid pneumonitis (with other comorbidities). This patient had long term conditions and COVID 19 was community acquired.
2. A delay in going to theatre due to a parent being COVID positive may have contributed to the baseline condition at the time of surgery.

In two cases, whilst it is not possible to definitively conclude, it was felt that there may have been an impact of the pandemic on the death occurring at GOSH

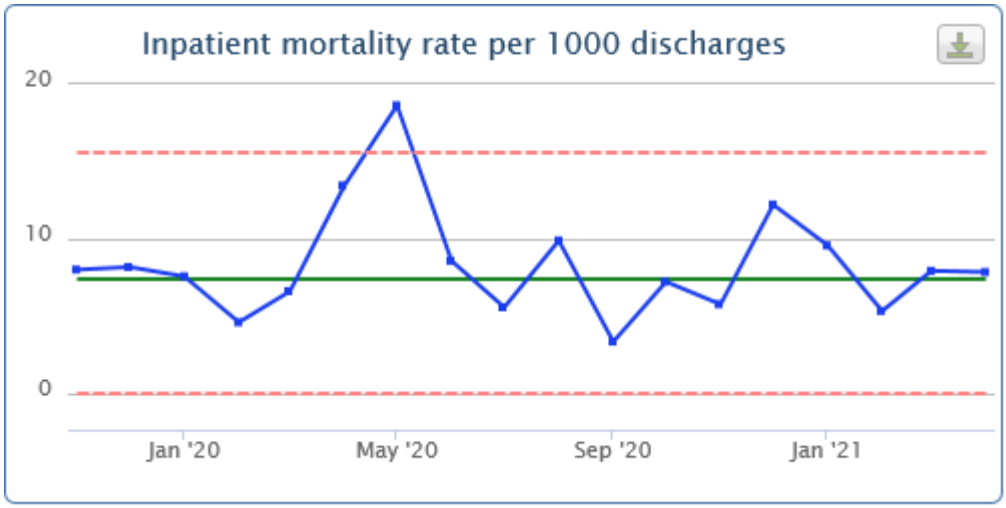
1. Diagnosis of hand, foot and mouth made in telephone discussion between paramedics in the home and GP on telephone. Infective endocarditis is not common but lesions look very different to those typical of hand, foot and mouth. Unable to comment on what lesions looked like at this stage as no one present who saw them. Unsure if a diagnosis at this stage would have been made or if the outcome would have been different. It is possible that pre-coronavirus pandemic the patient was more likely to have been seen by GP.
2. Impacted on continuity of care from NICU Consultants (while one NICU Consultant was waiting for results of testing) which meant each consultant covered 24 hrs as opposed to having one consultant on all week. Buccal swab to confirm diagnosis was not processed by lab due to COVID pressures.

In six cases the impact of the pandemic was noted explicitly on the experience of the family. It should be noted that GOSH has been following necessary national policy on COVID 19 visitation restrictions and paid close attention to them, as they changed ,and their impact throughout the Covid 19 pandemic. GOSH guidelines on visiting have been frequently reviewed and amended when changes to national policy have allowed.

1. Mother was positive for COVID. Father considered as primary contact only able to see their baby at birth and then met in GOSH after 14 days of isolation.
2. Family would have appreciated grandparents support which was not possible due to COVID visiting restrictions
3. Parents from outside of UK and with no support network in UK. Grandmother likely to have found it very difficult to enter UK from South America
4. Restrictions were placed on the number of visitors which may have caused distress to the family. The security team challenged the family when visiting restriction were lifted at end of life and this caused additional distress. There were challenges with interpretation (COVID related). Recurrent problems with securing interpreter services (COVID -related: no availability of face to face interpreters during pandemic). Use of doctors to interpret does not always carry the same impartiality that an independent interpreter can provide.
5. Due to COVID the parents had nobody to look after their other children and had to rush back home for school pick up although they were able to return to GOSH for end of life events. In normal circumstances other relatives may have been able to look after their other children.
6. When the patient was deteriorating rapidly in the evening there was difficulty getting relative in for a visit due to COVID restrictions despite recommendation from Head of Nursing that restrictions do not apply in end of life care/events.

Mortality rate

The crude mortality rate is within normal variation. There have been no outliers detected in our real time risk adjusted monitoring of PICU/NICU deaths.This is important as the majority of patient deaths at GOSH are in intensive care areas. Risk adjusted mortality is monitored weekly at the PICU/NICU Morbidity and Mortality meeting.



The gold standard for measuring paediatric mortality is through benchmarking by the Paediatric Intensive Care Audit Network (PICANET) .The most recent PICANET report was published on the 11th February 2021 and covers the calendar years 2017-2019. The report shows GOSH PICU/NICU and CICU risk adjusted mortality as within expected range

---

17h May 2021
Dr Pascale du Pré, Consultant in Paediatric Intensive Care, Medical Lead for Child Death Reviews
Andrew Pearson, Clinical Audit Manager

Attachment U

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
26 May 2021

Safe Nurse Staffing Report for reporting period Feb 21 - March 21 **Submitted by: Alison Robertson, Chief Nurse.** **Prepared by: Marie Boxall, Head of Nursing - Nursing Workforce**	**Paper No: Attachment U** **□ For information and noting**

Purpose of report

To provide the Board with an overview of the nursing workforce during the months of February and March 2021 and in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing (2016) and further supplemented in 2018. It provides assurance that arrangements are in place to safely staff the inpatient wards with the right number of nurses with the right skills and at the right time.

Summary of report

- All external North Central London (NCL) deployments ended in March, with debriefing sessions and evaluations currently being undertaken to inform future response plans.
- The Trust Registered Nursing (RN) vacancy rate was 4.69 in February and reduced to 4.68% in March. In February the RN turnover was 12.40% and in March 12.48% and remains within the trust target.
- There were no Datix incidents in February and two in March, both in relation to safe staffing levels with no patient harm.
- The reported Care Hours Per Patient Day (CHPPD) was 13.97 in Feb and 13.25 in March.
- Actual vs Planned CHPPD has not been reported again this month, which is a statutory and regulatory requirement. Reasons behind this have been outlined in the report.

Action required from the meeting

To note the information in this report on safe nurse staffing which reflects actions as the trust experiences the second surge in the pandemic while maintaining care for priority patients and supporting general paediatric activity.

Contribution to the delivery of NHS Foundation Trust priorities	**Contribution to compliance with the Well Led criteria**
□ PRIORITY 1: Make GOSH a great place to work by investing in the wellbeing and development of our people **□ Quality/ corporate/ financial governance** Safe levels of nurse staffing are essential to the delivery of safe patient care and experience.	**□ Leadership, capacity and capability** **□ Vision and strategy** **□ Culture of high quality sustainable care** **□ Responsibilities, roles and accountability** **□ Effective processes, managing risk and performance** **□ Accurate data/ information** **□ Engagement of public, staff, external partners** **□ Robust systems for learning, continuous improvement and innovation**

Strategic risk implications BAF Risk 12: Inconsistent delivery of safe care
Financial implications Already incorporated into 20/21 Directorate budgets.
Implications for legal/ regulatory compliance Safe Staffing
Consultation carried out with individuals/ groups/ committees Nursing Board, Nursing Workforce Assurance Group
Who is responsible for implementing the proposals / project and anticipated timescales? Chief Nurse, Director of Nursing and Heads of Nursing
Who is accountable for the implementation of the proposal / project? Chief Nurse; Directorate Management Teams
Which management committee will have oversight of the matters covered in this report? People and Education Assurance Committee

Attachment U

Safer Staffing Trust Report May 2021

1. Purpose

This paper provides the required assurance that GOSH had safe nurse staffing levels across all in-patient ward areas and appropriate systems in place to manage patient demand and capacity. This report covers the reporting period for February – March 2021 and includes measures to ensure the health and well-being of staff following the pandemic surge during this period. It also updates on the strategic support provided to the wider system for our North Central London (NCL) partner organisations; the North Middlesex, Royal Free, Whittington and University College Hospitals.

2. Covid 19 Pandemic - Second Surge Response

As in the second surge of the pandemic, GOSH nursing staff were required to work in new ways and across different wards, departments and organisations, cover during this reporting period. At times, it has also required nursing staff to work in environments and with patient groups that may be unfamiliar. We followed NHSE/I principles and Nursing and Midwifery Council (NMC) regulatory guidance to support our response and maintain safe staffing measures which were outlined in previous reports. We are now working towards recovery and restoration of staff and services.

2.1 Deployment

All external deployments ended in March. We are currently conducting debriefing sessions and evaluations to inform 'lessons learnt' and ensure improved processes are in place if we are required to respond again in the future. We will specifically be looking at whether:

- additional training and maintenance of skills are needed
- there are preferred means of communication with staff while on deployment
- additional support is required by line mangers
- additional support is required of the wider organisation
- there are any additional Health and Well Being considerations

3. Recruitment

We continue to maintain a number of recruitment pipelines to ensure the resilience and sustainability of our nursing workforce, especially as restrictions lift. The Philippines has recently been added to Red List countries which has posed additional challenges, however we are working to safely support the arrival of Cohort 3 and future cohorts who may be affected.

3.1 International Nurses (GOSH 50) –

- Cohort 1: (11 Candidates) All passed their examinations at first attempt and are now working as registered nurses on their wards.
- Cohort 2: (12 candidates) Arrived and working towards exams which are due on 22nd June 2021, joining the registered workforce numbers in July.
- Cohort 3: (10 candidates) Planned to arrive on Friday 21st May 2021
- Cohort 4: (8 candidates) Preliminary Arrival Date: Friday 16th July 2021
- Cohort 5: (9 candidates) Preliminary Arrival Date: Friday 17th September 2021

3.2 Newly Qualified Nurses (NQNs) –

The recruitment of our next cohort of NQNs for September is currently underway. In April we held a successful virtual open day with approx. 100 attendees interested in this opportunity. We have been advised by the education team that this cohort may be smaller than previous years due to disruptions in studies as a result of the

pandemic. We plan to mitigate the lower numbers by having an additional intake in November 2021 and/or January 2022.

3.3 Experienced Nurses - Targeted Recruitment Campaign

Following the success of the targeted Operations and Imaging (O&I) recruitment campaign earlier this year, the Nursing Workforce Team will be undertaking another focused campaign for the Heart and Lung (H&L) directorate in particular CICU. This will be in addition to the recruitment of international nurses to address vacancies in this speciality.

4. Vacancy and Turnover Rates

The Trust Nursing Vacancy rate has remained relatively stable over the last 6 months fluctuating between 4.5% and 4.9% with the exception of a brief spike of 5.70% in December 2020. The trust is currently at the second lowest vacancy rate (4.68%) since the start of the financial year. The vacant RN WTE during this period fell slightly by 0.2 FTE from 73.9 in Feb 21 to 73.7, continuing the trusts positive trajectory.

In terms of recruitment there were 12 (12 WTE) new starters in February and 20 (19.60 WTE) in March, offset by 21 (18.20 WTE) Leavers in February, 10 (7.65 WTE) in March.

Voluntary turnover has also remained relatively stable between 13% and 12.5%, for more than 6 months. In February the RN turnover was 12.40% and in March 12.48% and remains within the trust target.

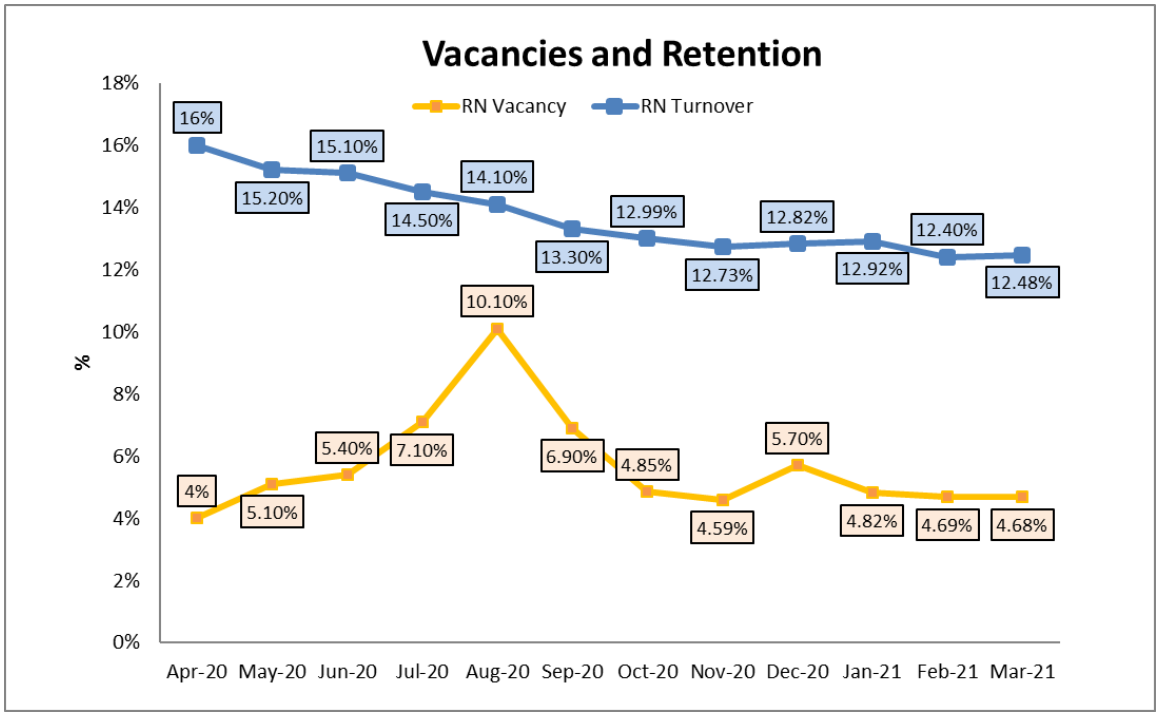


Fig.1 Registered Nurse vacancy and voluntary turnover rate (12 month view)

5. Temporary Staffing

The total shifts requested excluding shifts requested then subsequently cancelled has increased with 2687 in February and 3040 in March. Of these 83% were filled which is a decrease of 4% on the previous month. Agency usage remained at 0%. Bank usage

remained high during this period for a number of reasons including back fill to support NCL deployments, staff vaccination clinic, high patient acuity, staff self-isolation, high maternity rates and staff sickness. As we resume normal activity and with the end of deployments we anticipate the number of bank shifts will decrease, however we also need to consider the additional annual leave which was carried over into the new financial year and the impact that this may have.

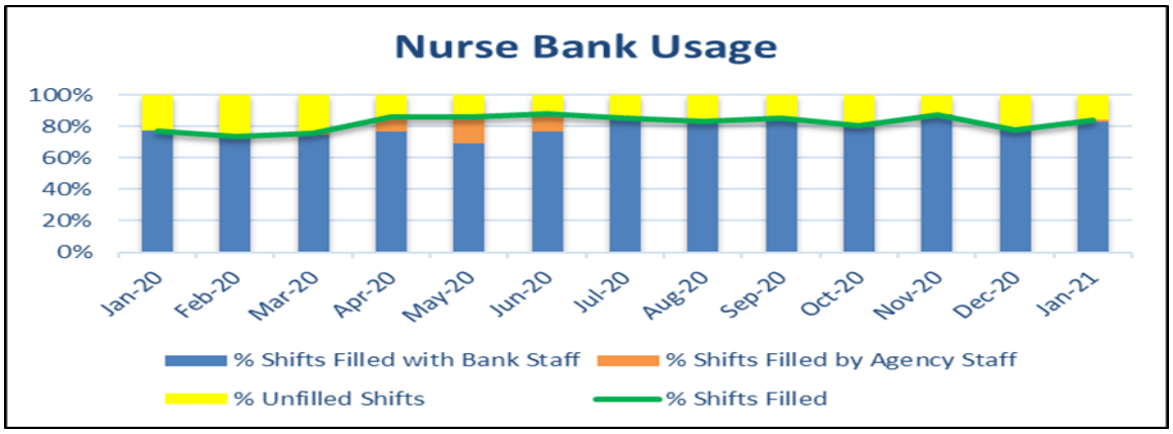


Fig.2 Nurse Bank Usage (13 month view)

6. Incident Reporting

There were no reported safe staffing incidents for nursing in February, with two in March. One in Brain directorate and one in the O&I directorate. Both have been investigated and closed with no patient harm, and assurance from Heads of Nursing that appropriate mitigation had been put in place.

7. Care Hours Per Patient Day (CHPPD)

CHPPD is calculated by adding the hours of Registered Nurses (RNs) and Healthcare Assistants (HCAs) available in a 24 hour period and dividing the total by the number of patients at midnight. CHPPD is reported to provide a complete picture of care and skill mix. CHPPD data is uploaded onto the national Unify system and published on NHS Model Hospital on a monthly basis.

CHPPD includes total staff time spent on direct patient care but also on activities such as preparing medicines, updating patient records and sharing care information with other staff and departments. It covers both temporary and permanent care staff but excludes nursing students and staff working across more than one ward. CHPPD relates only to hospital wards where patients stay overnight. When we report CHPPD we exclude the 3 ICUs to give a more representative picture across the Trust.
The reported CHPPD for Feb 2021 was 13.97 made up of 11.41 Registered Nurses and 2.56 HCA Hours. This decreased slightly in March 2021 to 13.25, 10.88 Registered Nurses and 2.36 HCA Hours

Actual vs Planned CHPPD has not been reported again this month for two reasons. Firstly, due to budgeted establishment templates not being updated during this financial year which would lead to misleading information. We have been advised by finance that these will be complete by the end of April and then shared with the rostering team to upload.

Secondly, Clinical Operations team, Electronic Patient Records (EPR) team and the Workforce Information team continue to work on an electronic solution, with the Epic team leading on providing a 'beds staffed' functionality to allow for more accurate reporting. This will be taken into account when calculating Actual vs Planned CHPPD and the refinement in the reporting methodology. Reporting of accurate Actual vs Planned CHPPD on a monthly basis is a regulatory requirement.

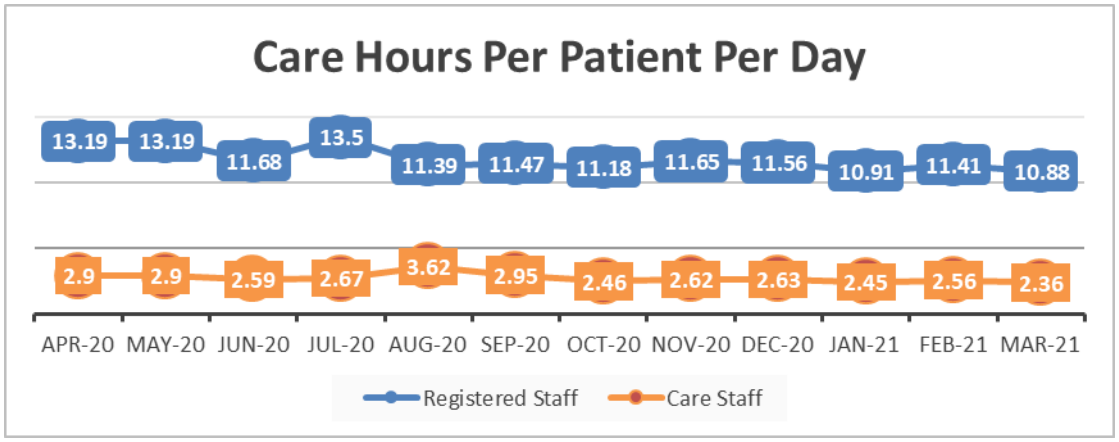


Fig. 3 Care Hours per Day – Breakdown (12 month view)

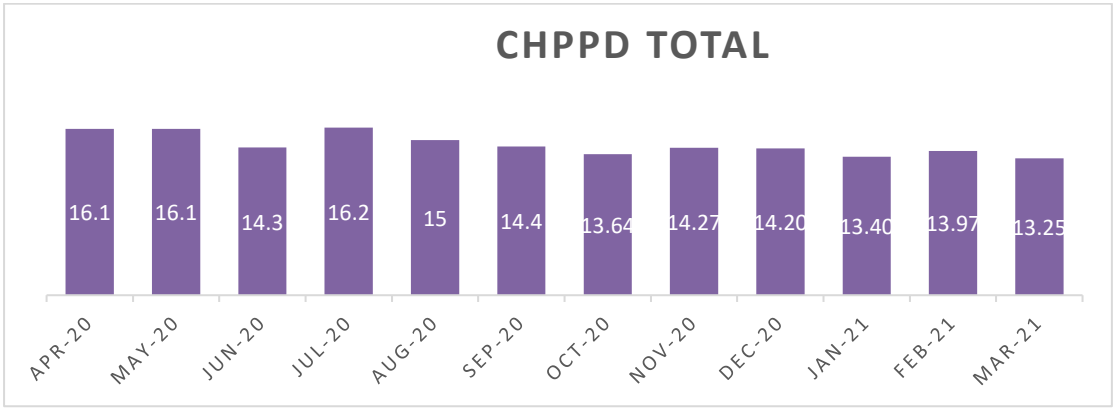


Fig. 4 Care Hours per Day - Total (12 month view)

8. Updates

8.1 Safe Staffing Establishment Review

The Safe Staffing establishment review was completed in April with the report presented to Trust Board in May 2021.

8.2 Safe Staffing for Nursing Policy

The Safe Staffing Policy for Nursing has been rewritten to fully align with NHSEI Developing Workforce Safeguards Guidance (NHSEI 2018) and will be presented to Policy Advisory Group (PAG) for approval in June.

Appendix 1: February & March 2021 Workforce metrics by Directorate

Feb-21					
Directorate	**CHPPD (exc ICUs)**	**RN Vacancies (FTE)**	**RN Vacancies (%)**	**Voluntary Turnover* %**	**Sickness (1 mnth) %**
Blood, Cells & Cancer	14.5	4.88	2.1%	7.1%	3.0%
Body, Bones & Mind	13.6	9.68	4.9%	15.6%	3.4%
Brain	12.5	5.83	4.2%	9.5%	2.2%
Heart & Lung	14.1	26.27	4.6%	15.3%	3.9%
International	16.4	21.60	19.7%	10.3%	3.8%
Operations & Images	N/A	14.41	5.0%	17.2%	4.7%
Sight & Sound	12.9	6.04	7.6%	12.4%	3.0%
Research & Innovation	N/A	8.35	14.2%	10.5%	4.4%
Trust	14.0	79.07	4.8%	12.9%	3.5%

February nursing workforce performance relates to all RN grades. Trust totals may include nursing posts from some other directorates not listed above.
NB. The high vacancy rate in IPP does not impact on patient care. Due to the closure of Hedgehog Ward, the staff have been deployed to Bumblebee Ward therefore high nursing/patient ratios are maintained. Research vacancy rates are determined by research activity.

Mar-21					
Directorate	**CHPPD (exc ICUs)**	**RN Vacancies (FTE)**	**RN Vacancies (%)**	**Voluntary Turnover* %**	**Sickness (1 mth) %**
Blood, Cells & Cancer	13.03	9.68	4.1%	6.8%	3.3%
Body, Bones & Mind	12.34	9.23	4.6%	15.4%	2.8%
Brain	13.96	5.74	4.1%	8.7%	3.1%
Heart & Lung	13.47	27.28	5.0%	15.2%	3.5%
International	15.97	20.86	19.0%	10.8%	2.9%
Operations & Images	N/A	8.05	3.3%	16.5%	2.5%
Sight & Sound	11.66	7.02	8.9%	11%	1.7%
Research & Innovation	N/A	8.35	14.2%	8.2%	3.4%
Trust	N/A	73.73	4.7%	12.5%	3.0%

March nursing workforce performance relates to all RN grades. Trust totals may include nursing posts from some other directorates not listed above.
NB. The high vacancy rate in IPP does not impact on patient care. Due to the closure of Hedgehog Ward, the staff have been deployed to Bumblebee Ward therefore high nursing/patient ratios are maintained. Research vacancy rates are determined by research activity.

Attachment 8

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
26 May 2021

Safe Nursing Establishment March 21 **Submitted by: Alison Robertson, Chief Nurse.** **Prepared by: Marie Boxall, Head of Nursing - Nursing Workforce**	**Paper No: Attachment 8** **□ For information and noting**

Purpose of report
To provide assurance to the Trust Board that arrangements are in place to review the establishments on a biannual basis, to determine if inpatient wards are safely staffed with the right number of nurses with the right skills and at the right time. This is in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing published in 2016 and further supplemented in 2018. It also incorporates NHSE/I's Developing Workforce Safeguards (2018).

Summary of report

- This report provides the Board with the findings from the Biannual Safe Nursing Establishment review which was conducted in March 2021, having been postponed from January due to second surge.
- The review found that the current nursing establishments are safe.
- A further review will be required in areas with increased acuity or change in service provision following the pandemic.
- The assurance process continues to evolve and strengthen in line with Developing Workforce Safeguards guidance (NHSE/I 2018)

Action required from the meeting
To note the information in this report on safe nurse staffing establishments

Contribution to the delivery of NHS Foundation Trust priorities	**Contribution to compliance with the Well Led criteria**
□ PRIORITY 1: Make GOSH a great place to work by investing in the wellbeing and development of our people **□ Quality/ corporate/ financial governance** Safe levels of nurse staffing are essential to the delivery of safe patient care and experience.	**□ Leadership, capacity and capability** **□ Vision and strategy** **□ Culture of high quality sustainable care** **□ Responsibilities, roles and accountability** **□ Effective processes, managing risk and performance** **□ Accurate data/ information** **□ Engagement of public, staff, external partners** **□ Robust systems for learning, continuous improvement and innovation**

Strategic risk implications
BAF Risk 12: Inconsistent delivery of safe care

Financial implications
Already incorporated into 20/21 Directorate budgets.

Attachment 8

Implications for legal/ regulatory compliance Safe Staffing
Consultation carried out with individuals/ groups/ committees Nursing Board, Nursing Workforce Assurance Group
Who is responsible for implementing the proposals / project and anticipated timescales? Chief Nurse, Director of Nursing and Heads of Nursing
Who is accountable for the implementation of the proposal / project? Chief Nurse; Directorate Management Teams
Which management committee will have oversight of the matters covered in this report? People and Education Assurance Committee

Great Ormond Street Hospital for Children NHS Foundation Trust

Purpose

The purpose of this review is to confirm the safety of the current staffing establishment and provide assurance to the board. In February and March 2021 a nursing establishment exercise was completed to identify each of the ward requirements based on the number of established beds, acuity and activity plan for 21/22 in order to identify the nursing requirements to deliver safe high standards of care, quality care and staff and patient experience. There is a biannually review to provide assurance that we are maintaining safe levels and also to review progress against the implementation of recommendations since the last report. The review was slightly delayed due to the second Covid 19 pandemic surge. Budgeted staffing establishments for 21/22 have not been confirmed at time of review.

Introduction

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

The NQB guidance states that providers:

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

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

Requirement	Compliance status
Using a systematic, evidence-based approach to determine the number and skill mix of staff required	
Using a valid and reliable acuity/dependency tool	
Exercising professional judgement to meet specific local needs	
Benchmarking with peers	
Taking account of national guidelines, bearing in mind they may be based on professional consensus.	
Obtaining feedback from children, young people and families on what is important to them and how well their needs are met	Working on how we improve we capture this in relation to safe staffing

In addition to the above, the NQB's expert reference group's cross-check includes:

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

Methodology for Calculating Nursing Numbers

Since the last review, the Children's & Young People's Safer Nursing Care Tool (C&YP SNCT), has been fully implemented across all inpatient services within the trust with the most recent collection of data taken over a 4 week period in February/March following postponement of the January collection as a result of the second pandemic surge. The C&YP SNCT is an adaptation of the Safer Nursing Care Tool for adult inpatient wards developed in 2006 and updated in 2013 which has been used successfully in many organisations. It has been developed to help NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing in Children's and Young People's in-patient wards. The tool, when used with Nurse Sensitive Indicators (NSIs), is a reliable method against which to deliver evidence-based workforce plans. The day case tool was also piloted on this occasion, however further work needs to be conducted to ensure the validity of the results.

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

In order to ensure a triangulated evidence based approach, data packs were shared with the Directorate Heads of Nursing and Patient Experience (HoNs), and members of the review panel: Head of Nursing (Nursing Workforce), Director of Nursing, Clinical Site Director, Associate Director of Finance, and the Deputy Director of Human Resources and Organisational Development, ahead of the establishments' reviews. The packs contained:

- Data on the existing budgeted staffing establishment
- Data on previous budgeted staffing establishments
- Bed base
- HDU bed numbers/Telemetry beds
- Safer Nursing Care Tool (SNCT) calculations for guidance based on patient acuity
- Royal College of Nursing (RCN) C&YP Workforce staffing ratios
- Calculations based on national guidance for that specialism i.e. Association for Perioperative Practice (AfPP), British Association for Paediatric Nephrology (BAPN), Paediatric Intensive Care Standards (PICS), RCN and Royal College of Radiologists-Guidelines for nursing care in IR (2017), Association of Anaesthetists Great Britain and Ireland (AAGBI) - Immediate post-anaesthetic recovery, AAGBI - The Anaesthesia Team (2018)
- Registered/unregistered nursing workforce skill mix proportions
- Variance between data sets and recommended numbers
- Nurse Bank spend on temporary staffing
- Overview of datix incidents reported since the last review, to identify any themes, trends or areas for concern.

Staffing Establishments

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

The following information was shared with directorate teams and confirmed by Directorate HoNs, with challenge and assurance gained by the review panel members (as listed above). Due to the Covid 19 pandemic and following consultation with NHSI, it has been recommended that no changes should be made to reduce budgeted staffing establishments based on the SCNT scoring performed in 20/21 as it will not provide an accurate assessment of true patient acuity during this period, and should be used for guidance only. Each Directorate HoN was asked a number of questions which aligned with the NHSI Workforce Safeguards (2019) and Care Quality Commission (CQC) Key Lines of Enquiry.

The overarching assurance required is -

- That directorate staffing establishments are safe
- That directorate staffing establishment are correct

Review outcomes

The review confirmed that the current nursing establishment is safe. Individual directorates are outlined as follows:

Body, Bones and Mind (BBM) – The directorate HON confirmed that the current staffing establishments across the directorate are safe and correct. Mitigation is in place to address fluctuations in daily staffing levels as a result of vacancies, shielding and high levels of maternity leave through use of bank staff, ward team mergers and temporary closed beds. Professional judgement indicates the need to maintain current staffing levels on **Squirrel Gastro** due to higher bed base numbers, anticipated acuity increase as normal activity resumes and adjustments to the SNCT recommendations where the bed base is less than 12 (as per SNCT guidance). **Chameleon** has seen increased levels of activity with a requirement to open additional beds at weekends. It is anticipated that the increase in the planned budgeted establishment for 21/22 will reflect the SNCT scoring as previously recommended. Current **Eagle** and **Sky** establishments are in line with SNCT recommendations. Eagle Ward are planning to review their workforce to consider incorporating the use of an unregistered technical support role, specifically around the provision of haemodialysis, to meet the recruitment challenges of being based in central London and to promote a more sustainable workforce in the future. They are working with their network colleagues to benchmark and explore this option. **Mildred Creek Unit (MCU)** staffing establishment was deemed safe although the current establishment will need to be reviewed once the unit has relocated. The change in physical environment will need to be considered in maintaining patient safety and safe staffing levels. A specific mental health SNCT is under development which will be applied once available.

Blood, Cells and Cancer (BCC) - The directorate HON confirmed that current staffing establishments across the directorate are safe and correct. An options proposal is currently being considered to merge **Lion** (currently showing as slightly over establishment based on existing activity which does not reflect true pre-pandemic acuity) and **Giraffe** (which is showing as under establishment based on existing activity which appears higher than pre-pandemic). Such a merger will address any imbalance in the establishments, and we will continue to monitor and triangulate with quality metrics. Both wards maintain safe staffing levels across a single level through redeployment of staff where needed. **Elephant** No changes required. Professional judgement needed to be applied to the shared staffing establishment of **Pelican (inpatient)** and **Pelican (ambulatory - Badger)** due to working across two sites, PICB and Southwood. Most recent activity and acuity is also higher than previous reviews and therefore current establishments may not be sustainable in the longer term. This will be reviewed in June when activity levels return to normal. **Fox** and **Robin** establishments are currently higher than SNCT recommendations however with fluctuating acuity levels over the past 12 months and also the need to apply professional judgement as bed bases are less than 12, these establishments will need to be reviewed prior to any changes being made. **Safari** As a day

case unit the Directorate HoN confirmed that staffing levels were safe however due to the complexity and high throughput on the unit a review of the skill mix would be undertaken.

Brain - The Directorate HON confirmed that current staffing establishments across the directorate are safe and correct. The current staffing establishment on **Koala** aligns with national staffing recommendations including telemetry, HDU and the SNCT score. Professional judgement supports the need for the current numbers due to the skill mix requirement, ward environment and complexity of this patient group. **RANU (Alligator)** – no changes required. **Squirrel Endo-met** – No changes required to establishment. Recent fluctuations in activity have been supported by sharing **Squirrel Gastro** nursing support across both units. **Kingfisher** – staffing establishment is deemed safe with a number of beds currently closed due to social distancing measures. Extended hours of service is planned in 21/22 and the establishment will need to be reviewed, with SNCT also applied to be applied to future day case activity. **Possum** Ward was not open during the SNCT scoring activity but will be included in future reviews.

Heart & Lung (H&L) – The directorate HON confirmed that current establishments are safe and correct based on regular planned activity. **Leopard** No changes required. **Kangaroo** Due to a drop in activity levels during the scoring period, SNCT measures were lower than previously observed. It is anticipated that once normal activity has fully resumed the SNCT scoring will align to the budgeted establishment numbers, therefore no changes are recommended. **Bear** Patient acuity was slightly higher than usual during the scoring period and has been reflected in the SNCT data. As a result it was deemed that staffing levels were safe during this period but will need to be closely monitored and triangulated with quality and patient outcome metrics, and reviewed again if the increased activity and higher acuity persists. No changes required in relation to **NICU, Flamingo (CICU) or PICU**. Establishments align with national critical care guidance and are not determined by SNCT scoring.

Operations and Imaging (O&I) - The current budgeted establishment is deemed safe and correct by the Directorate HoN. Following a deep dive as recommended in the previous report, a centralised targeted recruitment campaign was undertaken with a large proportion of vacancies now been filled. This campaign will continue to address some specific needs such as Cardiac Scrub and to mitigate any future turnover as a result of restrictions lifting. **Anaesthetics** – The current establishment is in line with national AfPP guidance and professional judgement. **Scrub** – One area of concern has been staffing levels in cardiac scrub however capacity has been reduced by 25% to mitigate this and to maintain safety. As recruitment and upskilling continues, it is anticipated that full capacity will be achieved by August 2021.**Recovery** – No changes needed.

Sight and Sound (S&S) – Panther ENT and Panther Urology (previously in the BBM directorate) were merged for approximately 3 months and during the SNCT scoring exercise. The directorate HON confirmed that current staffing establishment was safe although it's lower than the recommended SNCT score, activity was reduced at the weekends to mitigate the existing numbers and skill mix. The wards have now demerged and it is anticipated that the budgeted establishment for **Panther Urology** will be increased in 21/22 to reflect professional judgement in light of the junior skill mix and increasing levels of activity.

International and Private Care (I&PC) – The directorate HoN confirmed that current staffing establishments across the directorate are safe and correct based on the professional judgement of the directorate HoN. SNCT scoring and RCN ratios alone (which are based on NHS activity rather than private experience and expectations) indicate that I&PC is over established, however professional judgement to reflect additional challenges in this area such as cultural differences, language barriers and service user expectations also need to be considered. **Butterfly** The unit continues to carry a small number of vacancies however these will continue to fall as staff on board via the recruitment pipeline and are also mitigated through the reduced activity. **Bumblebee** True activity not reflected in scoring due to reduced activity as a result of temporary bed closures due to social distancing measures and lack of international business. **Hedgehog** Ward is currently closed with no definitive opening date, staff are currently working on Bumblebee ward.

Recommendations from the previous report

1. No changes should be made against budgeted staffing establishment on the basis of SCNT scoring conducted in 20/21, due to changes in activity level and bed closures to support social distancing. The true accuracy of the calculations may not be validated. – **Actioned.**
2. To review and monitor staffing establishment requirements in H&L as triangulation indicates that it may be slightly under establishment on Bear Ward if activity and acuity levels remain high. **– To be actioned by next review once normal activity fully resumes.**
3. To review and monitor staffing establishment requirements in I&PC as triangulation indicates that it may be over establishment. **– Currently being undertaken and will be fully completed by next review.**
4. To monitor and review skill mix and reconsider proportions of registered to unregistered workforce based on need to ensure the right people with the right skills in the right place at the right time. - **To be actioned by next review once normal activity fully resumes.**
5. A deep dive into O&I activity and review of the local tool calculations along with triangulation of the national guidance for this specialty to be conducted – **Nursing establishment review completed with a targeted recruitment campaign undertaken to address the staffing gap.**

Additional recommendations to be implemented prior to next review

1. Improve the way we capture feedback from children and their families and how we apply this to the establishment reviews.
2. Improve the way we incorporate patient outcomes to improve triangulation and increased assurance into the review process.
3. To follow the formal process outlined in the new Safe Staffing Policy (To be approved) ahead of the next biannual review to improve assurance and transparency.
4. Gain confirmation of the number of commissioned High Dependency Beds (HDU) across the trust.
5. To achieve improved the triangulation methodology of Nurse Sensitive Indicators with the implementation of the Ward Accreditation scheme.

Conclusion

The review found that the current nursing establishments are safe. The assurance process continues to evolve and strengthen in line with Developing Workforce Safeguards guidance (NHSE/I 2018), with the next review planned in September, to be reported to board in November.

Attachment W

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
26th May2021

Regular report on Infection Prevention and Control **Submitted by**: **Helen Dunn, Director of Infection Prevention Control**	**Paper No: Attachment W** **□ For information and noting**

Purpose of report
To provide the Board with assurance around infection prevention control activities within the Trust, whilst highlighting any areas of concern.

Summary of report
This reports focuses on IPC activity over the last year. Mandatory and non-mandatory reporting infections and colonisation data is provided with comparison to previous years to assure the board that IPC programmes in place remain to deliver safe care. Data on hand hygiene compliance and mandatory training is also provided. Work is underway as part of the IPC programme to improve screening compliance on admission for both MRSA and stool screening and a working group has been brought together to look at intravenous line care and standardising practice.

Key achievements and risks are detailed at the beginning of the document. All key risks have identified action plans in place but nevertheless remain a risk until work to complete them or bring them up to the required standard is completed. These include assurance from estates and facilities around water and ventilation, an active sepsis programme reporting to the trust DIPC and bringing the domestic service in-house.

Action required from the meeting
Approval of report and noting of any risk areas identified

Contribution to the delivery of NHS Foundation Trust priorities	**Contribution to compliance with the Well Led criteria**
□ PRIORITY 4: Improve and speed up access to urgent care and virtual services	**□ Culture of high quality sustainable care** **□ Robust systems for learning, continuous improvement and innovation**

Strategic risk implications
BAF Risk 12: Inconsistent delivery of safe care

Financial implications
Not Applicable

Implications for legal/ regulatory compliance
Health & Social Care Act
Risk:

- Improvement notice from CQC if not able to provide evidence of compliance or not complying

Consultation carried out with individuals/ groups/ committees
N/A

Who is responsible for implementing the proposals / project and anticipated timescales? Various- depending on any actions identified
Who is accountable for the implementation of the proposal / project? DIPC
Which management committee will have oversight of the matters covered in this report? Infection Prevention Control Committee Patient Safety Outcomes Committee

Attachment W

Great Ormond Street Hospital for Children
NHS Foundation Trust

Regular DIPC Infection Prevention & Control Report to Trust Board
2020-2021 Update at 04/05/21

Three top achievements since last report:

1. Response to COVID- management of positive staff (risk assessments) and patients and creation of COVID-19 management pathways.
2. Fully established IPC team with DIPC in post, Infection Control Doctor (ICD) in post and additional posts of Lead Practice Educator in place.
3. Data feed to start surgical site surveillance in place and system live on EPR (RL).

Three significant ongoing risks

1. Lack of assurance from estates and facilities around water and ventilation. Further detail on this is below in the E&F section with mitigations included.
2. Sepsis programme was not fully implemented. It's is now included as part of the Deteriorating Child Group with IPC representation.
3. Bringing the domestic services in-house. This poses a significant risk to the IPC team as a large amount of work is required during the mobilisation phase on an already stretched IPC team.

Report

1. Infection Prevention and Control (IPC) team

- Team is now fully staffed, awaiting start date for new band 6 on a fixed term contract for 1 year.

2. Health care associated infection (HCAI) statistics

HCAI Mandatory national reporting:

	2020/21		**Last financial year 2019/20**	
	Developed while in hospital	**Admitted with**	**Developed while in hospital**	**Admitted with**
MRSA bacteraemia	**2**	**0**	**0**	**1**
MSSA bacteraemia	**7**	**11**	**13**	**10**
E. coli bacteraemia	**12**	**5**	**6**	**2**
P. aeruginosa bact	**9**	**5**	**8**	**10**
Klebsiella sp. bact	**8**	**4**	**15**	**11**
C. difficile infection	**10**	**3**	**2**	**4**

HCAI non-mandatory internal reporting – infection and significant colonisation:

	2020/21		**Last financial year 2019/20**	
Infection:				
GOS acquired CVC related bacteraemia	**1.2/1000 line days (63 infections)**		**1.3/1000 line days (73 infections)**	
	Developed in hospital	**Admitted with**	**Developed in hospital**	**Admitted with**
Respiratory viral infection	**88**	**383**	**295**	**625**
Enteric viral infection	**60**	**71**	**155**	**184**

Colonisation:				
MRSA colonisation	**12**	**153**	**19**	**202**
MDR GN (non CPO) colonisation	**93**	**120**	**85**	**142**
Carbapenemase producing (CPO) GN*	**17**	**2**	**21**	**3**
Vancomycin resistant enterococci	**5**	**10**	**5**	**22**
MDR GN = Multi antibiotic resistant gram negative 'alert' organism ; CPO = carbapenemase producing organism				

*this data is from 2019 and 2020 respectively

Issue: Increase in gram negative colonisation acquired whilst in hospital
Control activity: investigation into acquired colonisations
Risk: there may a significant amount of unknown children colonised with resistant gram negative organisms we are unaware of as stool screening is less than 20% compliant.
Assurance: monthly monitoring at IPCC. Directorates to each put action plans in place to improve compliance.

3. Major outbreaks or preventable high risk exposure events.

Date	Organism and issue	Ward/ Department	Outcome
April 2020	Staph capitis Patient cluster	NICU	London wide group met and discussed if an issue across NICUs in London. Isolates sent for sequencing. Wider issue across UK- PHE now leading a UK incident.
Sep 2020	COVID- 19 Staff outbreak	Ventilation Technician Department (Heart & Lung)	Reported externally
Sep 2020	COVID- 19 Staff outbreak	MRI sedation service (Operations & Images)	Reported externally
Oct 2020	COVID- 19 Staff outbreak	Blood Cells and Cancer services	Reported externally
Oct 2020	COVID- 19 Staff outbreak	Recovery (Operations & Images)	Reported externally
Jan 2021	COVID- 19 Staff outbreak	Estates department	Reported externally

4. Infection prevention and control regular audits and data display

- Hand hygiene data remains stable at between 75-85% compliance and good compliance with bare below the elbows (>95%).
- Care bundle data demonstrates the need to improve documentation on EPR with regard to invasive devices.
- MRSA and stool screening compliance is low. Stool screening <20% and MRSA between 60-70% compliant.

5. Estate and facilities – issues

- Specialist ventilation schedule is behind plan. This is due to staffing issues and assurances processes in place in previous years. Action plan in place to ensure all areas are verified and plated as appropriate. Weekly meetings in place to bring testing of all areas up to date as rapidly as possible.
- Standard ventilation- work currently underway to verify airflows across the trust in standard bedrooms. Managed as a special working group.

- Lack of resource in estates and facilities in the past has meant there has been a lack of assurance regarding any water risks related to legionella. Recruitment underway for additional technicians for water and ventilation.

6. IPC Training - 05/05/2021

Trust compliance with level 1 training	94%
Trust compliance with level 2 training	91%
COVID training	57%

Actions: Monitor and increase training in for COVID training.

7. Infection Prevention and Control Committee – Other items of discussion and developments from recent meetings

1. *Burkholderia contaminans*- PHE have notified trusts of an increase in this organism. There is laboratory testing advice that has come out for any organisms identified. Whilst no point source has been identified there is an association with ultrasound gel and best practice guidance on its use has been issued.

Helen Dunn
Consultant Nurse IPC and DIPC

14/05/2021

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
26th May 2021

Annual Freedom to Speak Up report **Submitted by: Dan Sumpton, Freedom To Speak Up Guardian**	**Paper No: Attachment X** **For discussion**

Purpose of report

- To provide the committee with an overview of the numbers of cases being raised, themes and support offered by the Guardian/Ambassadors in 2020/21.
- To provide an update on the Freedom to Speak Up service and wider speaking up programmes.
- To highlight any concerns related to our FTSU provision and culture of speaking up

Summary of report

A new full-time Guardian came into post in December 2020. During 2020/21 there have been 4 different people undertaking the role of Guardian for varying periods of time. Alongside this, a number of other related personnel changes have impacted on the continuity, provision and promotion of the service at times.

In 2020/21 the service dealt with 115 recorded cases. This compares to 183 recorded contacts in 2019/20 and 84 recorded cases in 2018/19. Two special themes related to petitions accounted for 84 recorded cases in 2019/20. In 2020/21 Staff highlighted bullying, harassment and difficult relationships with peers and managers as priority concerns. Patient safety and quality of care was the second highest concern raised and all matters have been, or are being, managed by the appropriate service leads. Allied Health Professionals raised the greatest number of concerns with administration, clerical and ancillary being the second highest group of workers raising concerns.

There were a number of developments during 2020/21 including the launch of the Trust Speak Up for our Values programme, further speak up training on GOLD, improved data collection and reporting and an ongoing review of our the speaking up programmes alignment.

The Annual NHS staff survey highlighted some overall improvements in the culture within the Trust. However, in relation to speaking up specific questions it highlighted the ongoing work that needs to be done to improve the culture of speaking up in the Trust and make this a great place to work.

The FTSU service continues to develop new ideas and work in partnership with other key stakeholders to make sure we are improving and providing a high level of service to those needing to speak up, improve access and opportunity to speaking up and support the Trust to improve the culture of speaking up.

Great Ormond Street Hospital for Children NHS Foundation Trust

Action required from the meeting To note the report and consider whether the current FTSU service is providing the appropriate level of support for those needing to speak up and that we are contributing to improving the culture of speaking up in the Trust.	
Contribution to the delivery of NHS Foundation Trust priorities □ **PRIORITY 1: Make GOSH a great place to work by investing in the wellbeing and development of our people** □ **Quality/ corporate/ financial governance**	**Contribution to compliance with the Well Led criteria □ Leadership, capacity and capability** □ **Vision and strategy** □ **Culture of high quality sustainable care** □ **Responsibilities, roles and accountability** □ **Effective processes, managing risk and performance** □ **Accurate data/ information** □ **Engagement of public, staff, external partners** □ **Robust systems for learning, continuous improvement and innovation**
Strategic risk implications All BAF Risks	
Financial implications Not applicable	
Implications for legal/ regulatory compliance The Trust Speaking Up culture is assessed as part of a key line of enquiry related to the "well led" question in CQC inspections. A poor culture of speaking up impacts on this key line of enquiry and therefore CQC rating.	
Consultation carried out with individuals/ groups/ committees N/A	
Who is responsible for implementing the proposals / project and anticipated timescales? Dan Sumpton FTSU Guardian	
Who is accountable for the implementation of the proposal / project? Sanjiv Sharma Medical Director	
Which management committee will have oversight of the matters covered in this report? QSEAC and PEAC	

Freedom to Speak Up Guardian's Report: 12/05/2020

Introduction

The Freedom to Speak Up (FTSU) service is part of wider programme of speaking up within the Trust which includes Speak Up for Safety and Speak Up For Values. The service offers independent and confidential support to people so they can speak up and be heard when they feel unable to do so by other routes. People can raise any concerns they may have about the quality and safety of the care we provide or about anything that gets in the way of them doing their job.

Service Provision, Resource and Governance

The FTSU service is provided by a full-time FTSU Guardian and a small group of FTSU ambassadors. The Guardian works in partnership with the Speak Up programme manager and Associate Medical Director responsible for speaking up.

The Guardian reports directly to the Medical Director and meets regularly with the Chief Executive and other senior leaders to provide updates, escalate concerns and provide an overview on thematic concerns. The Guardian also meets with the non-executive director (NED) who is responsible for FTSU and for Whistleblowing. The FTSU Guardian provides quarterly data to the National Guardians Office (NGO) and reports quarterly to the Quality, Safety & Experience Assurance Committee and the People & Education Assurance Committee.

The role of the Guardian

The Guardian provides confidential and independent advice and support to our staff to raise concerns when they are unable to do so through other routes available to them or when they feel these have not been successful. Support and regular contact is provided throughout the process of speaking up. Feedback has highlighted the importance of this function for the wellbeing and empowerment of staff to speak up in future.

The Guardian and Ambassadors promote awareness of FTSU pathways and promote a culture of speaking up. An important part of the Guardian role is also to support managers and leaders in the Trust to listen, act as required, and then feedback to those raising concerns. The Guardian currently sits on the Health & Wellbeing Steering Group and the Diversity & Inclusion Steering Group and attends the Staff partnership Forum to support the strategic development of a positive speaking up culture.

Developments in 2020/21

A new full-time Guardian came into post in December 2020. During 2020/21 there have been 4 different people undertaking the role of Guardian for varying periods of time. Alongside this, a number of other related personnel changes have impacted on the continuity, provision and promotion of the service at times. The Trust is also currently reviewing the Speak Up programmes to make sure that they are aligned with both our Diversity and Inclusion

framework, and our Health and Wellbeing framework, to ensure that we are able to deliver our statutory and national obligations as well as our local priorities to the highest standard.

In June, the Trust launched Praise as part of the Speak Up for Values programme. Praise continues to be well used in the Trust and is a positive way of acknowledging the good work of colleagues. Since June, 1951 people have been praised by 815 colleagues with a total of 3059 praises being submitted.

The i-speak up platform was launched in October 2020 and allows people to provide feedback about a colleague's perceived unprofessional behaviour. The platform has received 8 messages which were triaged by a team of senior staff members. Only 1 of those messages was passed to a peer messenger to deliver the feedback. The reasons for the low level of use of the platform is currently being reviewed and considered.

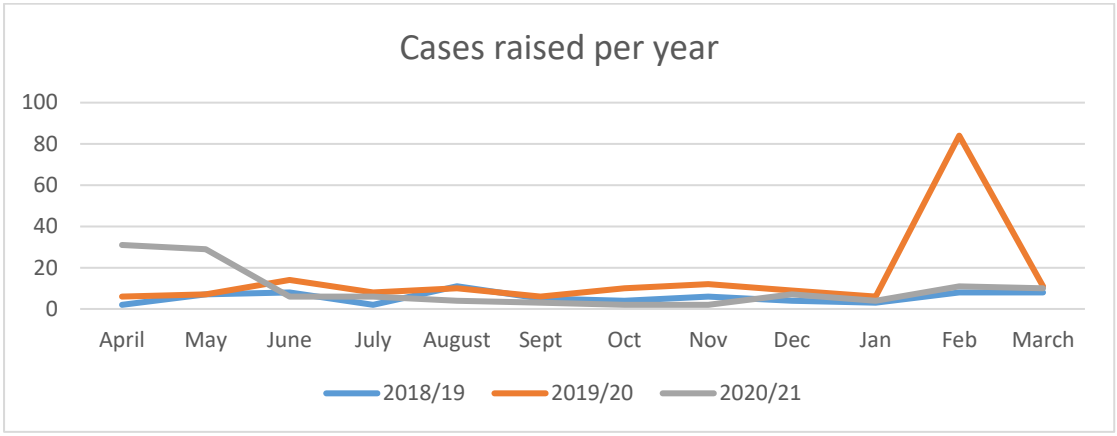
Due to Covid 19, the Speak Up for Safety training became an online only module via GOLD and continues to be part of induction for all new staff. The current compliance rate for people undertaking the Speak Up for Safety training is 85%.

In April 2021, the NGO national online training modules for workers and managers were embedded into the Trust training portfolio. The NGO "speaking up" training now sits alongside the Trust "speak up for safety" training to provide an informative and robust understanding of speaking up for all new starters in the Trust. The NGO "listening up" training for line managers which supports them to support staff raising concerns is now part of the management development programme on GOLD. This is an important step forward in meeting the national and local training needs of our staff.

We have introduced a more robust data collection and storage process for data and information collected from those raising concerns. This follows the NGO guidance on recording and providing data.

The Guardian recently chaired the first of a new Paediatric FTSU Guardian network with colleagues from Sheffield Children's hospital and Alder Hey Children's hospital. Whilst in its early stages, this provides us the opportunity to support and learn from other colleagues and peers. The Guardian is involved in some upcoming joint workshop, coaching sessions and listening events to support a culture of speaking up and support staff to feel more empowered to speak up.

FTSU Contacts April 2020 – March 2021



In 2020/21 the service dealt with 115 recorded cases. This compares to 183 recorded contacts in 2019/20 and 84 recorded cases in 2018/19. As was reported in last year's report, two special themes related to petitions brought by OCS staff accounted for 84 recorded cases in 2019/20 which accounts for the unusual increased number of concerns raised. This makes a year on year comparison difficult, but taking this number into account, it appears that there continues to be an increase in people accessing the service since 2018/19.

Themes of concerns raised

(Note that the data for Q1 is missing detail on themes and professional backgrounds so this summary relates to Q2-Q4 only)

Theme (Q2-4 only)	**%**
Bullying and Harassment	48
Patient safety/quality of care	33
Staff safety/wellbeing	9
Other	9

Background (Q2-4 only)	**%**
Allied Health Professional	34
Admin/Clerical/Ancillary	26
Medical	13
Nurse	13
Other	19

Staff highlighted bullying, harassment and difficult relationships with peers and managers as priority concerns. These tended to be complex and multi-faceted and on a number of occasions involved HR processes and investigations that were already in process. Some of the concerns raised suggest long standing problems in some departments with people experiencing unprofessional and rude behaviour from colleagues. Patient safety and quality of care was the second highest concern raised and all matters have been, or are being, managed by the appropriate service leads. Some of the patient safety/quality of care issues were also related to the primary concern of bullying and harassment.

Allied Health Professionals (AHP) made the most contacts. However, a number of the concerns raised were about the same issue which may account for the higher number of contacts from this professional group. Admin/Clerical/Ancillary colleagues were the second largest group raising concerns.

A discussion with the previous FTSU Guardian highlighted that the increased number of people raising concerns in April and May 2020 (Q1 of 2020/21) related to the impact of CV19 such as working from home, differences in workload at home and on site, and perceived differences within teams about how some staff are treated.

Eight cases were raised anonymously in 2020/21. 4 cases were raised by a senior colleague on behalf of a group of workers who approached them. Their concern was investigated by the service manager, a plan put into place and feedback provided. Being able to raise concerns anonymously is an important way for people to speak up when they may not normally feel able to do so.

Two people who raised concerns highlighted that they had experienced detriment as a result of speaking up. These were both in relation to feeling ostracised and victimised by their managers.

Feedback

19 people responded to our request for feedback with 13 noted that they would speak up again, 3 said they would not and 3 reported "don't know". The six respondents who reported "no" or "don't know" related to Quarter 2 of 2020/21 and we do not have any further information. All the people who responded in Quarter 3 and 4 of 2020/21 reported that they would speak up again.

Staff survey results and Freedom to Speak Up index

The NGO will publish the Freedom to Speak Up index later this year. This allows us to benchmark the organisation against our peers based on 4 questions in the 2020 NHS staff survey. Last year we were in the top ten Trusts for greatest overall increase in the index score which is testament to the work that has gone on within the Trust around speaking up.

This year's staff survey results:

- 72.6% would feel secure raising concerns about unsafe clinical practice (**-1.7%** v LY. National average 75.6%).
- 66.8% feel they would be fairly treated if involved in error, near miss or incident (**+1.9%** v LY. National average 65.9%)
- 89.5% feel the organisation encourages them to report error, near miss or incident (**-0.2%** v LY. National average 89.8%)
- 94.4% know how to report unsafe clinical practice (**-0.8%** v LY. National average 95.4%)
- 68% would feel safe to speak up about concerns. (National average 69.3%). A recent pulse survey in Feb 2021 highlighted that only 58% of the 1053 people asked said they would feel able to speak up about anything that concerned them.

Future plans: We will be working with other key stakeholders to continue to improve visibility and access to the FTSU service for everyone working at GOSH. We will also be working hard to support and promote a culture of speaking up with the immediate focus being on the staff survey results and to identify groups of staff that may require more support in speaking up. Once we have clearer direction on the alignment of the speaking up programmes we will be

able to move ahead with a plan for future improvements, innovations and a clearer communications strategy.

Dan Sumpton, Freedom to Speak Up Guardian: 12/05/2021

Attachment Y

Trust Board **26th May 2021**	
Fire Health and Safety Annual report **Submitted by:** Chris Ingram, Fire, Health and Safety Manager	**Paper No: Attachment Y**
Aims / summary To inform the Trust Board of the on-going work streams, themes and priorities faced by the Trust and the progress and problems in relation to fire, health and safety.	
Action required from the meeting None	
Contribution to the delivery of NHS Foundation Trust strategies and plans Zero Harm	
Financial implications A serious incident could result in very large fines if we were found to be at fault.	
Who needs to be told about any decision? Not Applicable	
Who is responsible for implementing the proposals / project and anticipated timescales? Fire, Health and Safety Manager	
Who is accountable for the implementation of the proposal / project? Fire, Health and Safety Manager	

Fire, Health and Safety Annual Report 2020 - 2021

The Fire, Health and Safety team support the Trust management and employees to meet their statutory duties in relation to controlling the risks and precluding the chance of harm to patients, visitors and staff.

The table below highlights work that has been completed by the team during the year:

Description of work	Progress and lead	Timescale	Original RAG rating	Current RAG rating
The Trust reports Health and Safety and Fire Safety incidents on Datix. The team also administer and approve all Security incidents.	1078 (828 last year) health and safety incidents were reported from 1/4/20 – 31/3/21. This included 110 patient safety accidents. The increase can be attributed to COVID 19 particularly the reaction to the vaccine. **Fire, Health and Safety Team**	The team aims to reply to each H&S incident within 1 working day.		
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) - Any incident that involves a staff member being away from the Trust for more than 7 days, results in a serious injury or has occupational exposure to a named disease must be reported under RIDDOR.	14 incidents were reported under RIDDOR. This is an increase from 8 in the previous year. This can be attributed to reporting some incidents following exposure to COVID 19. **Fire, Health and Safety Team**	Incidents must be reported under RIDDOR within 15 days		
Train 90% of staff in Health and Safety and Fire Safety. Health and Safety training is completed through E-Learning and has not been affected by COVID 19. An E-Learning module has also been introduced for Fire Safety training but staff are encouraged to still complete this course face to face to allow trainers to answer any queries staff might have.	On the 1st April 2021 compliance with Health and Safety training was 98% (93% in 2020) Fire Safety training compliance was 90% (91%) for annual training and 89% (92%) for bi-annual training. A live exercises has been completed in IMRI and another one is planned for 3.6.21 in the Sight and Sound Centre. **Fire, Health and Safety Team**	Monitored monthly. Email sent out to all those who are not compliant on the 1st of each month by the training Department.		
Safer Sharps - The Trust is required to comply with the Health and Safety (Sharps Instruments in Healthcare)	A working group has met over the reporting period to discuss and implement	Monitored at the Health and Safety Committee		

Regulations 2013 (the regulation), which is monitored by the Health and Safety Executive (HSE).	actions relating to safer sharps. Extra resource was asked for and granted for the Clinical Procurement Team. Currently this role has not been filled. Safety products introduced into the Trust include: • Butterfly Needles • Insulin Pens • Stitch Cutter All standard products have a risk assessment completed for them. These have been sent to the Ward Managers. **Procurement and Health and Safety Team**	(Bi-monthly)		
Risk Impact Assessments are undertaken when a project is ready to begin. The Fire, H&S team will review them. Local staff will receive training prior to taking over the area.	Projects that have been completed this year include: • The Physiotherapy Gym • IMRI • Cath Labs/ MR4 • MEDU • Sight and Sound Centre Work has started on: • Children's Cancer Centre • Decant for the Children's Cancer Centre **Redevelopment Team and Fire, Health and Safety Team**	As and when required		
All Control of Substances Hazardous to Health (COSHH) information has been updated across the clinical and areas. All relevant non-clinical areas such as Estates have also been completed.	Audit completed and presented to the Health and Safety Committee in December 2020. **Department Managers and Health and Safety Team**	Assessments are updated and audited on an annual basis.		
Fire Risk Assessments - A new more comprehensive assessment tool is now being used. This has been agreed with the London Fire Brigade. (LFB)	100% of fire risk assessments have been completed in clinical areas. 91% of fire risk assessments have been completed in non clinical areas as of 1/4/21.	Monitored monthly at the Estates Performance Meeting. Monitored at the H&S		

	Improving to 100% compliance is a priority for the team. Extra resource has been recruited to help with this. **Fire, Health and Safety Team**	Committee bi-monthly		
Incidents and Unwanted fire signals. The London Fire Brigade (LFB) were called out to the Trust 1 time over the reporting period.	WEB74496 – Contractor completed smoke test which resulted in smoke spreading throughout the Southwood Building. **Fire, Health and Safety Team**	Monitored at the Health and Safety Committee (Bi-monthly)		
Scheduled and familiarisation visits from London Fire Brigade.	Due to COVID 19 the LFB are only attending the Trust if they are called to an emergency. They have been invited to attend and review all of our new buildings. They are attending the Sight and Sound Centre in June. **Fire, Health and Safety Team**	LFB are invited into the Trust whenever a new building is commissioned. They are also free to attend at any time to inspect.		

Impact of COVID 19

- Fire Safety Training is now being completed over Zoom. This does not allow training in actual departments removing a chance for staff to become familiar in their area.
- The team was part of the Returning to Work Safely Group to ensure staff return to working on-site in a safe manner. The team was also a part of the Home Working Task and Finish Group to explore opportunities to increase working at home.
- The team is now part of the Workspace Strategy Group to ensure we use our available space in a safe and efficient manner.
- Increased reporting under RIDDOR.
- Increased musco-skeletal injuries due to a lack of ergonomic facilities available when staff are working from home.

Main aims for 2021/2022

- The team will play a vital role in ensuring that the Trust adapts safely to working under conditions imposed by COVID 19. This will include staff returning to site in a safe and controlled manner.
- Maintain Health and Safety training and fire safety compliance above 90%.
- Respond to all Health and Safety incidents within 1 working day.
- Ensure that our new buildings meet high safety standards and are safe for our staff and patients to move into before they are used.
- Ensure 100% compliance in regard to fire risk assessments.

Attachment Z

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board **26 May 2021**	
Gender Pay Gap Report **Submitted by:** Sarah Ottaway, Acting Deputy Director of HR&OD	**Paper No: Attachment Z**
Aims / summary To provide the committee with information on the 2020 Gender Pay Gap reporting, analysis of the pay gap and year on year trend.	
Action required from the meeting For information and comment	
Contribution to the delivery of NHS / Trust strategies and plans Ensuring the trust has consistent and transparent processes for determination of pay contributes to making GOSH a great place to work for all staff.	
Financial implications None	
Legal issues No legal issues	
Who is responsible for implementing the proposals / project and anticipated timescales Director of HR & OD	
Who is accountable for the implementation of the proposal / project Director of HR & OD	

Attachment Z

Gender Pay Gap Report 2020

1.0 Introduction

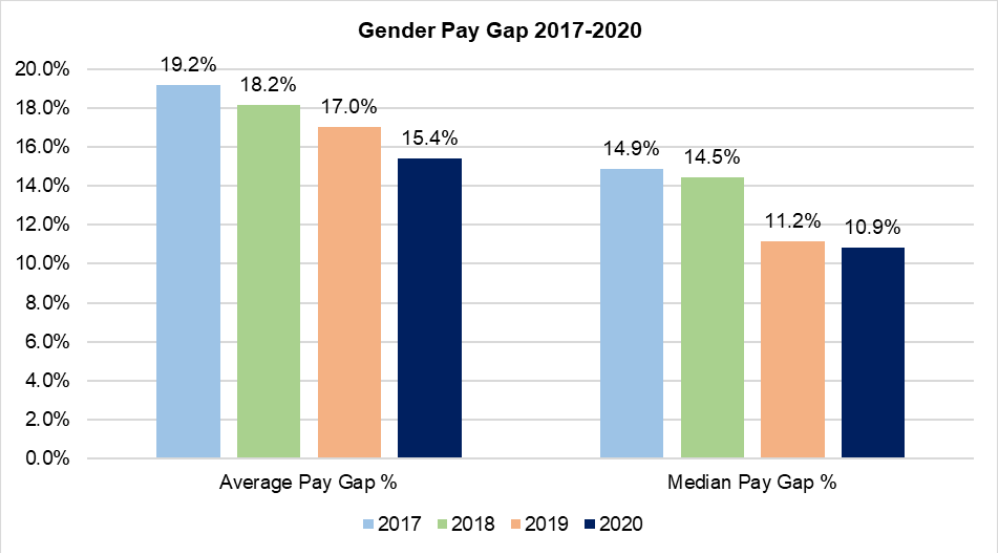
1.1 All other employers with more than 250 staff are required to report data relating to the Gender Pay Gap. The data reported in this paper shows the pay gap as at 31st March 2020, as required by the Regulations. Although the statutory reporting requirement was suspended in 2020 due to the onset of COVID, the Trust submitted its 2019 data ahead of that suspension. The deadline for the 2020 submission has been extended to October 2021.

1.2 Whilst both equal pay and the gender gap deal with the disparity of pay women receive in the workplace, they are two different issues:

- Equal pay means that men and women in the same employment performing equal work must receive equal pay, as set out in the Equality Act 2010.
- The gender pay gap is a measure of the difference between men's and women's average earnings across an organisation. It is expressed as a percentage of earnings and represents the difference between the mean hourly rate of ordinary pay of male and female employees, and the difference between the median hourly rate of ordinary pay of male and female employees

2.0 Gender Pay Gap

2.1 In common with many NHS Trusts GOSH has a gender pay gap. In 2020 the average pay for a male employee was £4.06 per hour (15.4%) higher than the average female hourly rate. The median hourly rate gap was lower at £2.37 per hour (10.9%). Both % and £ value are slightly lower than the previous year, and represent a continuation of the trend of a decreasing gender pay gap.

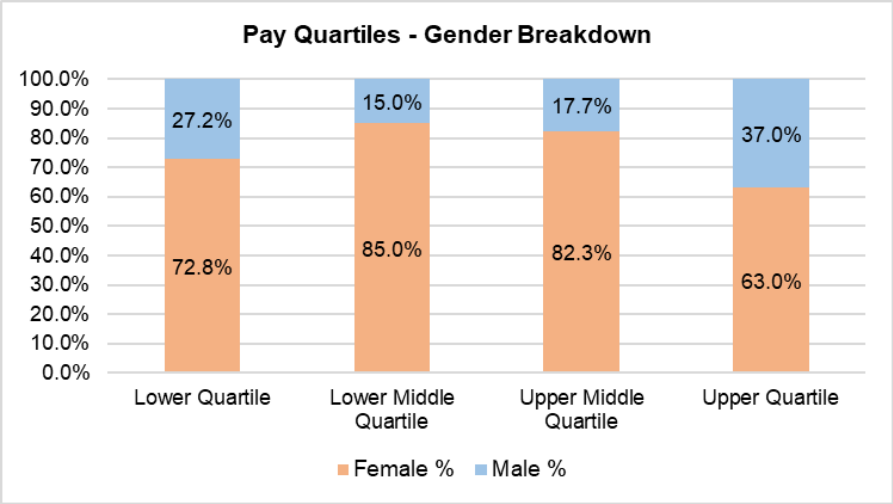


2.2 Reasons for the pay gap are complex and driven by the traditional demographics of the healthcare workforce. For example the Nursing and Administrative & Clerical professions are predominately female, and women make up 77% of the overall Trust workforce.

	Female Headcount	Male Headcount	Total Headcount	Female %	Male %
Add Prof Scientific & Technic	259	70	329	79%	21%
Additional Clinical Services	430	93	523	82%	18%
Administrative & Clerical	758	373	1131	67%	33%
Allied Health Professionals	259	25	284	91%	9%

Estates and Ancillary	67	100	167	40%	60%
Healthcare Scientists	224	82	306	73%	27%
Medical and Dental	426	343	769	55%	45%
Nursing	1509	87	1596	95%	5%
Total	**3932**	**1173**	**5105**	**77%**	**23%**

2.3 Whilst the GOSH pay quartile data shows that the highest percentage of staff across all pay quartiles are females, the highest proportion (relatively) of male staff are to be found in the highest pay quartile:



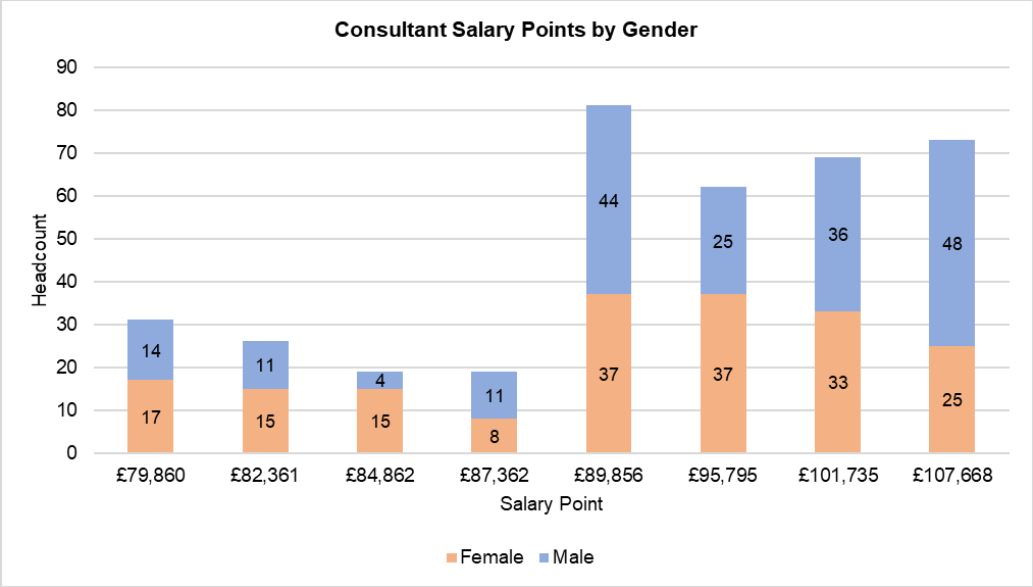
3.0 Medical vs. Non-Medical Gender Pay Gap

3.1 When considering the data at a more granular level it is clear one of the main drivers for the gap at GOSH is the difference our consultant workforce makes on pay levels across the organisation.

3.2 Whilst we have a fairly equal number of men and women consultants (51% and 49% respectively), female consultants form part of a much larger population of women when looking at the gap at the organisational level (as the Trust is 77% female). Consequently their effect on female average pay is less than male consultant pay is on male average pay:

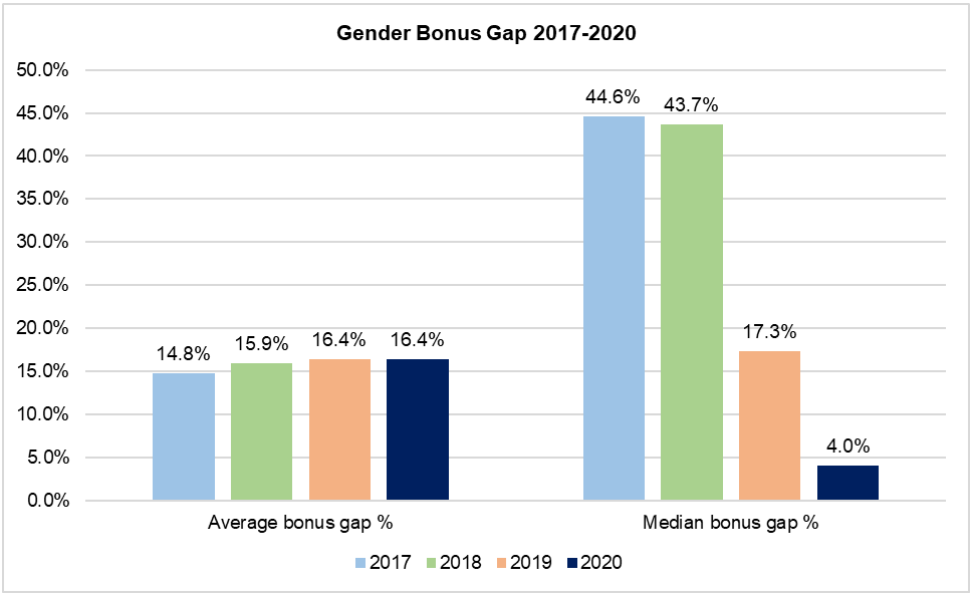
Gender pay gap (non-medical)		Gender pay gap (medical/dental)	
Mean	**Median**	**Mean**	**Median**
Women on a mean average earn 3p per hour more than men.	Women on a median average earn 14p per hour more than men.	Men on a mean average earn £2.93 per hour more than women.	Men on a median average earn £5.76 per hour more than women.
-0.14%	-0.75%	7.07%	13.45%

3.3 Within the consultant workforce the distribution of men and women along the consultant payscale broadly represents the traditional demographic of the medical workforce (i.e. predominately male). Over time, as the demographic shift within the trainee medical workforce filters through to the consultant workforce, and female consultants' progress up the payscale, the ratio of female consultants at higher points of scale will increase and contribute to a reduction in gender pay gap at GOSH.



4.0 Bonus Gender Pay Gap

4.1 Earnings in the calculation for bonus payments relate to consultant Clinical Excellence Awards (CEAs). The average gender bones gap currently stands at £2,279 per annum (16.4%), and the median £252 per annum (4.0%). It should be noted that while there has been a small increase in the average bonus payment, the median gap has reduced significantly since 2018.



4.2 The proportion of staff receiving bonus pay was 7.25% (male) and 1.53% (female) – based on the total workforce at GOSH. It should be noted only Consultant medical staff are eligible to receive CEAs – 40% of the consultant workforce hold a CEA. This breaks down to 33% of female consultants and 47% of male consultants holding a CEA.

	Consultant Headcount	Award Holders	%
Female	187	62	33%
Male	193	90	47%
Total	**380**	**152**	**40%**

4.2 Local clinical excellence awards are decided by a GOSH panel which consists of a diverse range of participants, representing the diversity the consultant workforce at GOSH including ethnicities,

gender and specialities. Applications and allocation of awards are monitored against a range of protected characteristics including Gender.

5.0 Addressing the Gender Pay Gap

1.3 The GOSH People Strategy had the creation of an integrated Diversity and Inclusion (D&I) Framework as a key output in the first year of delivery. The D&I framework "Seen and Heard" was launched in September 2020 and includes commitments to deliver activity built around the four themes below, which will support addressing the issues which contribute to the existence of a Gender Pay Gap:

- Opening-up external recruitment – promoting GOSH as a creative, diverse and inclusive employer of choice
- Creating internal career paths and opportunities for progression and ensure fair and transparent access to jobs, training and education
- Creating a more inclusive work culture for all to build understanding and connectivity and support value-based people management practice
- Creating channels and safe spaces which amplify the employee voice, ensuring that we listen, hear and take action as a consequence.

Attachment 1

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 26 May 2021	
Guardian of Safe Working report Q4 2020/21 **Submitted by:** Dr Renée McCulloch, Guardian of Safe Working	**Paper No: Attachment 1**
Aims / summary This report is the fourth quarter report of 2020/21 to the Board regarding Junior Doctor working practice at GOSH. This report covers the period 1st January to 31st March 2021 inclusive.	
Action required from the meeting Requirement for permanent solution to rest facilities – improvement plan in place. Successful medical workforce management of second COVID surge with minimum disruption and patient safety maintained	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Guardian of Safe Working (GOSW) supports and enables a safe and positive working and learning environment for junior doctors. This contributes to the Trusts strategic objective relating to providing safe patient care and an excellent place to work and learn.	
Financial implications Fifth nodal salary point has been applied for 2020/21 Cost savings from Medical Workforce Leads supporting rota management	
Who needs to be told about any decision? n/a	
Who is responsible for implementing the proposals / project and anticipated timescales? Dr Renee McCulloch, Guardian of Safe Working, Associate Medical Director: Workforce Mr Simon Blackman Deputy Medical Director for Medical & Dental Education	
Who is accountable for the implementation of the proposal / project? Dr Sanjiv Sharma, Medical Director	

Attachment 1

Guardian of Safe Working
Fourth Quarter: 1st January 2021 – 31st March 2021

1 Purpose

To inform the board on issues arising relating to the junior doctors working at GOSH and the work of the Guardian of Safe Working (GOSW). The GOSW is directly accountable to the trust board.

2 Background See Appendix 1

3 Medical Workforce Response to Second COVID Surge

Planning

3.1 Post first COVID surge the medical director's office recruited medical workforce leads (MWLs) to improve out of hour's infrastructure and to enable GOSH to deliver a flexible, responsive and clinically capable medical workforce to meet rapid change in demand due to COVID in a sustainable way.

3.2 Established clear Standard Operating Procedure and guidance including a staged resurgence plan 9 to:

- Maintain safety of patients and clinical workforce
- Maintain urgent and elective work
- Keep junior doctors within specialties or allied specialties
- Continue training and education infrastructure within specialties
- Flex capacity into additional or new areas of work as demanded by the sector

3.3 Granular capability assessed through an education and skills workforce assessment (change in medical staff since first surge) and establishing specialty minimal numbers.

Response during Dec 2020 to March 2021 COVID surge

3.4 Escalation level 2/3 required

3.5 Bronze medical workforce group met daily with MWLs managing daily situational assessment and rotas in response to absence and requirement

3.6 Strategy to maintain critical OOH staffing required by moving doctors from day to night shifts

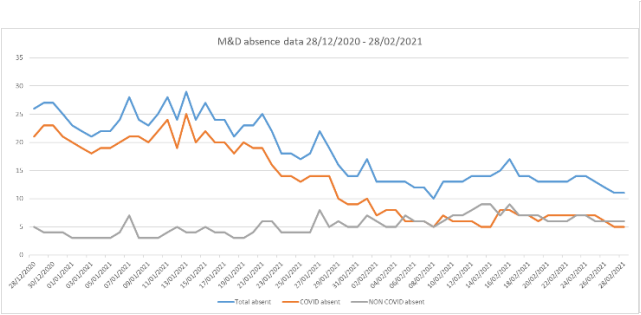
3.7 PICU rota development staffed two areas ('hot and cold')

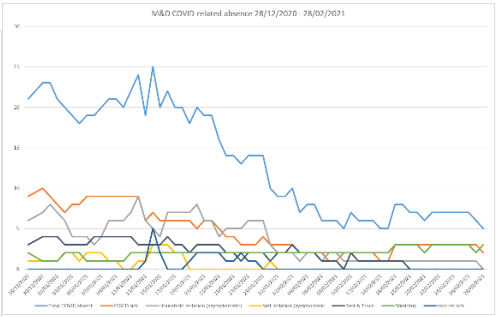
3.8 General Paediatric and PIMS TS wards opened: two rotas stood up using existing resource; additional resource from NCL: three North Middlesex registrars only

3.9 Incremental workforce plans using 'shadow rotas' established in anticipation of various scenarios –

3.10 fantastic, supportive response from medical workforce.

3.11 Monitoring of COVID related absence with 'check in' support –peak absence at 9%; some cluster absence.

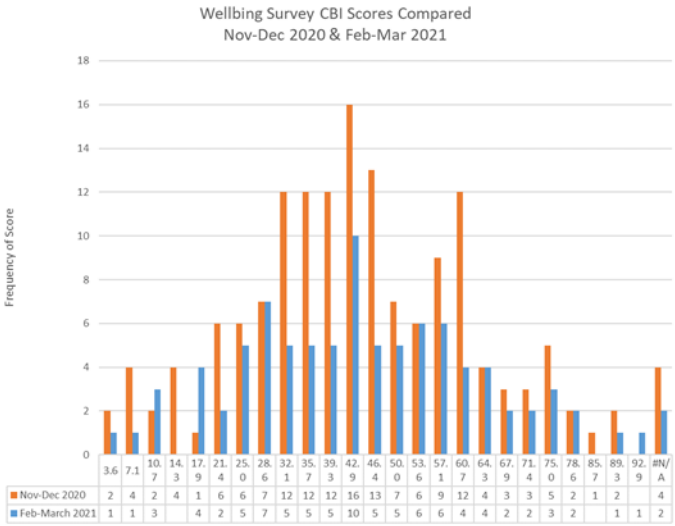


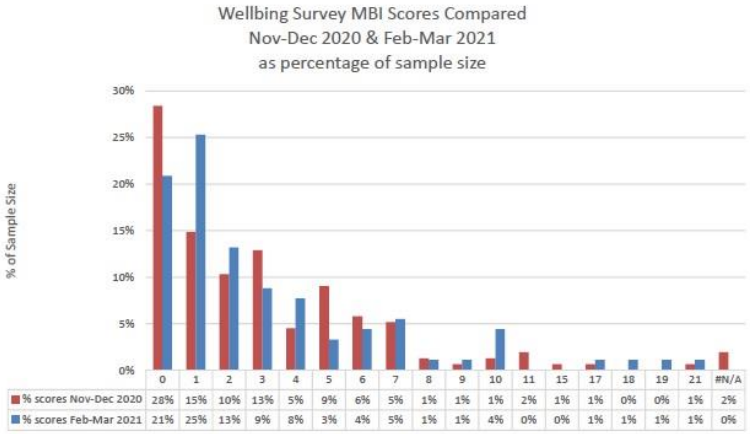


3.12 Supported consultant redeployment; non-consultant grade doctors were not redeployed.

3.13 All rotas and working hours remained compliant through second surge

4 Measurement of wellbeing and burnout in two serial surveys.





Categorization: Depersonalization, Human Services Form	
	Frequency
High	13 or over
Moderate	7-12
Low	0-6

above from: MBI-HSS Interpretation scoring key.

Total scores registering as High are 3 in the Nov-Dec 2020 survey and 4 in Feb-March 2021.

Again, results are comparable (Pearsons correlation, 0.859, significant to 0.01) when using percentages to correct for the difference in sample sizes.

4.1 Methodology was based on validated questions from the NHS staff survey and burnout questions from the Copenhagen Burnout Inventory. The survey was run in two cycles, Nov-Dec 2020 and Feb-Mar 2021, at the onset and end of the “second wave” of the Covid-19 pandemic, with the aim to capture junior doctors twice within the September-February rotation (as followed by HEE Paediatric trainees).

4.2 The distribution of results from the first and second cycles are demonstrated above; 246 responses were received. Similar findings shown in both survey runs, with a normal distribution of scores and very few “red -flag” results suggesting high burnout. It was encouraging not to see a rise in burnout scores between the first and second runs (within the limitations of this broad, survey-based approach).

4.3 High rates of burnout were seen in 3 (Nov survey) and 4 (Feb survey) – all respondents were referred to the GOSH wellbeing resources at the time of the survey.

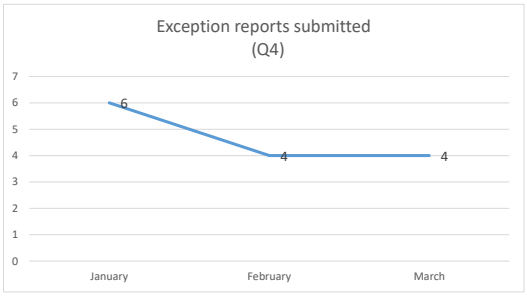
4.4 In conclusion, these responses are evidence of a resilient junior doctor workforce at GOSH who have coped well with the demands of the pandemic alongside the support put in place. We note that the

Attachment 1

5 Exception Reporting: High Level Data

5.1 Number of exception reports (ER) at GOSH remain low reflecting cohort a) senior trainees b) non UK Trust doctors c) poor engagement with ER system

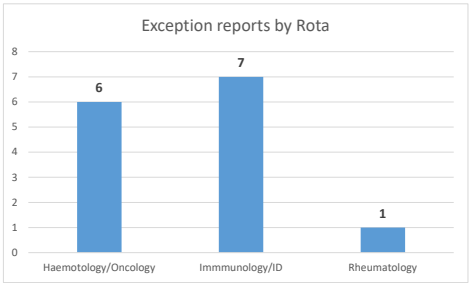
5.2 Numbers of doctors submitting reports reduced this quarter following a small increase in Quarter 3.



5.3 14 ERs submitted in this quarter all related to extra hours worked.

5.4 6 doctors submitted the reports (5 SPR, 1 SHO)

5.5 ER reports across 3 rotas HaemOnc and ImmID have had high vacancy rates

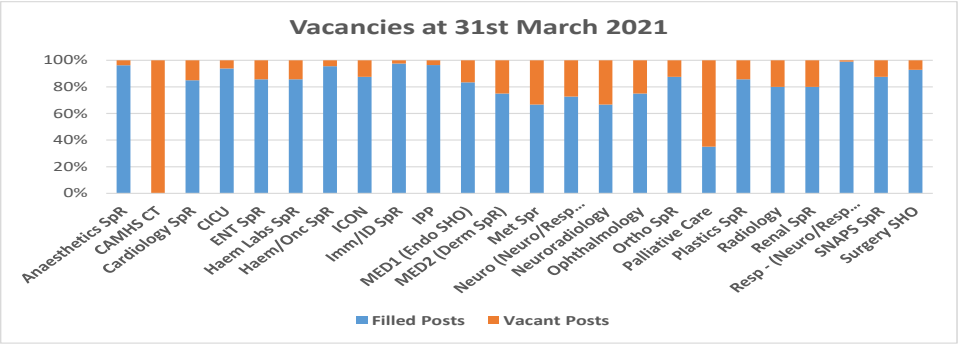


5.6 Exception Report Outcomes:

Outcome ERs January to March	
TOIL	2
Compensation	11

6 Vacancy Rates

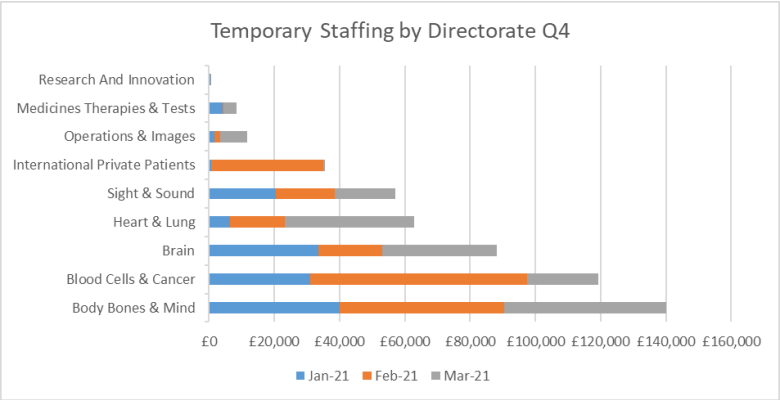
6.1 The overall vacancy rate across junior doctor rotas as of 31/03/2021 is 8.6% with 28 FTE vacant out of a total of 326 rota slots.



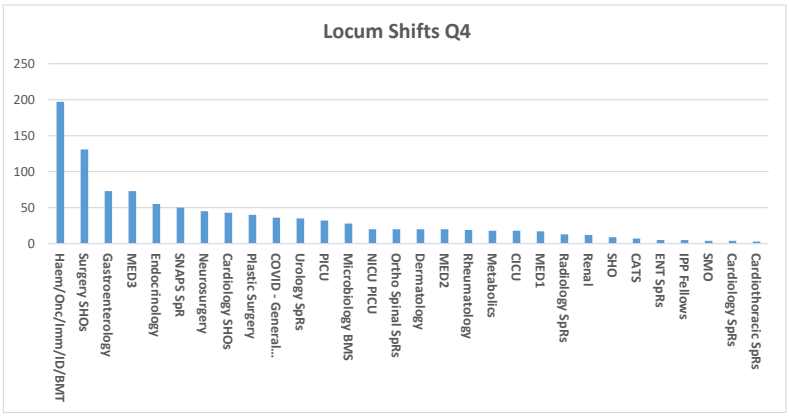
7 Bank and Agency data

7.1 The Trust spent £351,723 on Junior Dr temporary staffing in Q4 which equates to 4.4% of the quarter's total pay bill. Of this £344,910 (98%) was Bank spend while £6,813 (2% was Agency)

Attachment 1



7.2 The Haem/Onc/Imm/ID/BMT rota was the most frequent rota using temporary bank shifts with 197 shifts filled (18.7% of the total), followed by Surgery SHOs (12.4%).



8 Rest Facilities

8.1 Implementation of the New Amendments October 2019 – August 2020: new changes to safety and rest limits attract GOSW fines if they are reported. No reports to date despite likely breaches due to limitations on rest facilities.
8.2 Restricted on site space for rest, alongside an increase in requirement (COVID distancing; people unable to stay with friends/ colleagues closer to work) overloaded the limited rooms and 'feet up space' available.
8.3 Bed chairs have been purchased for additional feet up space.
8.4 A new booking system for those who must contractually access a bedroom is in place.
8.5 Plans to renovate and improve the quality of the rest space is currently being undertaken.

9 Compliance Issues

9.1 **PICU/ CATs rotas are now compliant for weekend frequency following an increase in establishment**
9.2 Child and Adolescent Mental Health Rota – This rota remains under review. It is a shared rota with five other Trusts and is therefore complex. It is currently a non-resident on call rota and may require changing to meet compliance. Trainees are currently auditing activity.
9.3 The implementation of the '5th nodal salary point' will result in a cost pressure at GOSH due to the seniority of many of our junior doctors.
9.4 Junior Doctors Forum: remains active with directorate representatives and leadership roles within the Trust.

10 Summary

10.1 Careful planning and implementation of learning from the first COVID surge addressed a requirement to scale up rapidly, mitigate unexpected absence and ensure a flexible team approach.

10.2 Ongoing monitoring and improvement work to out of hours working is being implemented by the medical workforce leads.

10.3 ER process remains weak and used by few. Systems enabling regulation of response completion and payment time scales are being implemented by GOSW and medical HR.

10.4 Rest facilities have been a considerable issue but the situation is now improving.

10.5 Junior doctors are well engaged and the JDF invites the Board members to continue to attend its meetings.

Appendix 1 Background Information for Trust Board

In 2nd October 2017 all junior doctors in training transferred to the new contract with 2016 Terms & Conditions (TCS).

The 2016 TCS clearly indicate the importance of appropriate working hours and attendance at training and education for junior doctors. Both issues have a direct effect on the quality and safety of patient care.

The statutory role of 'Guardian of Safe Working' (GOSW) was introduced in the 2016 and includes;

- overseeing the safeguards outlined in the 2016 contract
- ensuring that issues of compliance with safe working hours are addressed by the doctors and/or the employer
- facilitating the reporting structures
- overseeing the wellbeing of the junior doctors
- a requirement to provide quarterly reports to Trust board.

Exception reporting is the contractually mandated mechanism used by doctors to inform the Trust when their day-to-day work varies significantly and/or regularly from the agreed work schedule of their post. The purpose of exception reports is to ensure prompt resolution and / or remedial action to ensure that safe working hours are maintained.

Exception reports are submitted electronically by doctors to their educational supervisor. Upon receipt of an exception report, the educational supervisor will discuss with the doctor what action is necessary to address the reported variation or concern. The outcome of an exception report may be compensation, in the form of time off in lieu or payment for additional hours worked, or an adjustment to the work schedule of the post.

Whilst exception reporting is a mechanism of the 2016 contract for doctors in training, GOSH has elected to extend the use of the system to doctors employed under local (non-training) TCS, in order to encourage safe working practices for all doctors, provide equity and obtain a more comprehensive view of junior doctors working hours across the Trust.

The 2016 contract requires that a Junior Doctors Forum (JDF) is established in every Trust. The JDF primarily represent trainees and offers a forum for addressing concerns pertaining to working hours and conditions and education and training. This is in place and meets every month.

There are 45 different rota patterns currently in place within the Trust.

Attachment 1

The Trust uses 'Allocate' software for rota design and exception reporting. There have been issues with navigation of software and consistency of use (wide range of inputs for the same exception reports). There are no automated ways to identifying breaches. This must be done manually.

Allocate have improvement updates due in 2019 to include:

- Ability to close exception when trainee fails to respond (Jan 2020)
- Guardian quarterly board data report (not yet available)
- Simplify the adding of overtime hours
- Process for tracking time of in lieu and overtime payments
- Allow supervisor and Guardian role for the same user
- Standardised themes for breach types.

Publication of Amendments 2016 TCS September 2019:
Context for 2018 contract review

The new junior doctor contract was introduced in England without the BMA's agreement in 2016. The intention of the negotiations on this new contract was to introduce for doctors in training new, improved safe working arrangements, more support for their education and a new modernised pay system. The BMA and NHS Employers agreed during negotiations on this contract to jointly commission in August 2018 a review of its efficacy, to identify any areas for improvement to the contract terms. In 2019 a new referendum of the BMA Junior Doctor membership accepted the 2016 contract, including the amendments that have been negotiated.

TCS contract includes but is not limited the following amendments:

a. Weekend frequency allowance maximum 1:3
b. Too tired to drive home provision
c. Accommodation for non-resident on call
d. Changes to safety and rest limits that will attract GoSW fines.
e. Breaches attracting a financial penalty broadened to include:
    1) Minimum Non Resident overnight continuous rest of 5 hours between 2200-0700
    2) Minimum total rest of 8 hours per 24 hour NROC shift
    3) Maximum 13 hour shift length
    4) Minimum 11 hours rest between shifts
f. Exception Reporting
    1) Response time for Educational Supervisors - must respond within 7 days. GoSW will also have the authority to action any ER not responded to
    2) Payment must be made within 1 month of agreement or on next available payroll. No extra admin burden should occur
    3) Conversion to pay - 4 week window from outcome agreed to identify a shift before the end of the placement for TOIL to be taken. If this doesn't happen, payment should automatically be given. At the end of a placement, any untaken TOIL should be paid
g. Time commitment and administrative support for GOSW.

Implementation of New Amendments 2016 TCS
The 'refresh' requirements for the 2016 contract is in progress at GOSH –a staggered timeline is in place for implementation to be completed between October 2019 and August 2020.

Attachment 1

Executive Summary

- This paper summarises progress to the year end 31 March 2021 in providing assurance that non-consultant (junior) doctors at Great Ormond St Hospital (GOSH) are safely rostered and enabled to work hours that are safe and compliant, with opportunity to access training and education.

- Robust medical workforce management during the COVID pandemic provided a safe and effective response.

- An ongoing medical workforce improvement programme has continued to ensure GOSH is safely staffed. Improved data intelligence has enabled the Trust to fully understand the dependencies and requirements of the junior medical workforce and deliver financial efficiencies

- Compliance with 2016 TCS: Implementation of the New Amendments October 2019
  - Critical care rotas achieved compliance in the fourth quarter 2020-21
  - Rest facilities continue to require improvement.
  - CAMHs rota remains under review
  - The implementation of the 5th nodal salary point' has resulted in a significant cost pressure at GOSH due to the seniority of many of our junior doctors in 2020

- Exception reporting (ER) requires more integration and is a risk for monitoring assurance and compliance with 2016 contractual obligations of the Trust as doctors continue to struggle with many aspects of the reporting process. Integration into medical culture and systems enabling process regulation continue to be addressed. Exception reporting (ER) experience, rota gaps and vacancies for junior doctors across the Trust are described with actions taken to address them are described.

- GOSH vacancy rates has varied between 6.8 and 12.1% over 2020/21 and continue to be below the national average

- One fine has been levied with current ERs to date. Fines would only apply for doctors on the 2016 TCS on formal training programs (35% of GOSH junior medical workforce). All doctors at GOSH can ER.

1. Purpose

This paper provides assurance to the Board on progress being made to ensure that doctors working hours are safe for the year ending March 2021.

The Board is asked to report information on rota gaps and the plan for improvement in the Trust's Quality Account and publish the details of Guardian fines in the Trust's annual accounts.

COVID related response for the medical workforce in first and second surges is also reported for assurance purposes.

2. Introduction

2.1. The 2016 Terms and Conditions of Service (TCS) highlight the importance of appropriate working hours and attendance at training and education opportunities for junior doctors. Both issues have a direct effect on the quality and safety of patient care with increasing recognition on the negative effect of rota gaps on junior doctor training and wellbeing.

2.2. The 2016 TCS set firm limits to the number of hours trainee doctors can spend on duty and provided a process for:

- reporting safety concerns in the workplace which reach senior management level
- trainees to record if they worked beyond their scheduled hours
- fining departments directly for the most serious breaches of working hours
- providing work schedules to doctors before starting a job and in more detail than previously
- trainees to inform if they are not able to attend education and training opportunities
- the establishment of a junior doctors forum (JDF) to discusses work and training issues

2.3. Contractually every Trust has a Guardian of Safe Working (GoSW), a senior appointment who ensures that issues of compliance with safe working hours are addressed and provides assurance to the Board of the employing organisation that doctors' working hours are safe.

3. COVID-19 Medical Workforce

3.1. **COVID Rotas March 23rd – June 22nd 2020 (Appendix 1)**

As part of the Major Incident Planning the Medical Director's Office structured a bronze medical workforce group to establish key processes and infrastructure to ensure a medically and surgically competent workforce 24/7. A rapidly responsive decision arm with medical oversight built and co-ordinated a rota system that provided a flexible, timely approach to safe staffing based on patient need. A novel senior leadership network was created from the Medical Director's Office to nominated Medical Workforce Leads with clear lines of accountability and responsibility on clinically led decisions about the allocation of junior doctor resource.

3.1.1. Medical and surgical expertise was distributed equitably across the organisation based on need, eradicating the artificially created silos that had previously formed based on clinical units, directorates and locations, resulting in a networked system of care at value delivering a full service without additional staff. By continually reviewing the numbers of doctors, the skill set of the team and the clinical workload, the hospital was kept safe and well-staffed throughout the pandemic

3.1.2. COVID rotas supported a 'stand by system' for absence cover for 30% predicted reduction in junior doctor workforce. All COVID rotas were compliant with TCS 2016 with 12.5 hour shift patterns; banded 1a

3.2. **Return to Specialty based Rotas June 22nd – Changes to out of hours (OOH) rotas post COVID (Appendix 2)**

3.2.1. GOSH stepped on to new, fully compliant rotas on June 22nd. These rotas have effectively utilised the junior medical workforce to its full capacity and created the opportunity to have improved safety and a higher quality of patient care alongside a flexible team approach to 'step up' out of hours and potentially reduce bank spend.

3.2.2. The COVID 19 pandemic exposed additional risks relating to the lack of reliable data intelligence and a poor operational infrastructure to adequately address the OOH demands at GOSH. As part of the COVID recovery plan Medical Workforce Leads were appointed to continue to develop and improve out of hours working.

3.3. **Second Surge COVID December 2020 to March 2021**

3.3.1. The pandemic exposed significant workforce risk of a nature not seen before – high levels of unexpected absence and a changing patient demographic, with the requirement to continue clinical activity and upscale rapidly required a flexible, responsive and clinically capable medical workforce to meet the necessity for rapid change.

3.3.2. **Medical Workforce Leads (MWLs) appointed in November 2020 (Appendix 3)**, supported by the AMD workforce (GOSW) managed both COVID response and the need for improved infrastructure to create the resilience to match demand in a sustainable way. This included:

- Upscale and redesign of rotas – all tested for individual rota compliance
  - ICUs
  - General Paediatrics
  - PIMs TS
  - 'Shadow' rota development to rapidly expand service cover
- Daily situational awareness briefing and anticipatory plan
- Medical workforce redeployment management
- Wellbeing surveys pre and post second surge
- Wellbeing – 'check ins'
- Daily absence monitoring

3.4. **Medical Workforce Improvement Programme commenced November 2020: positive change and key areas of focus by the Medical Workforce Team include**

- Escalation level planning for the medical workforce pandemic response
- Cross directorate medical leadership OOH
- Active Rota Management
  - Situational decision making
  - Flexible Workforce – skills survey
  - Cost effective, managed bank spend
  - Daily clinician input throughout Covid-19
- Junior Doctor mentoring and leadership development
- Governance and risk infrastructure
- Hospital at Night: process, teamwork and leadership development
- Dashboard development: data reconciliation and capture
- Wellbeing assessment, pathways and integration

4. Implementation of 2019 New Amendments to 2016 TCS: Headlines

4.1. A referendum of the BMA Junior Doctor membership (August 2019) accepted the 2016 contract, including negotiated amendments. Implementation of the contract refresh have been fully implemented at GOSH in line with the required time line (completion August 2020).

4.1.1. Every rota has been line checked and updated for compliance with new amendments

4.1.2. PICU/NICU/CATS rotas were initially non-compliant for weekend frequency until November 2020 when the establishment was increased

4.1.3. Child and Adolescent Mental Health (CAHMs) rota remains under review with respect to safety and compliance. Shared with five other Trusts, it is currently a non-resident on call rota and may require changing to meet compliance for continuous rest. Trainees are currently auditing activity post COVID.

4.1.4. Access to appropriate rest facilities are inadequate for social distancing and numbers of clinicians requiring on site facilities. A more permanent solution is required; some improvement work is underway and more chair-beds for feet up rest are now ordered. Safety and rest limits now attract GOSW fines.

4.1.5. The implementation of the '5th nodal salary point' resulted in an unplanned cost pressure (approximately £0.6M) due to the seniority our junior doctors cohort.

4.2. The GoSW now has the authority to action any exception reports that have not been responded to. This is frequently required due to issues with understanding the software and the need to meet deadlines .

5. Patient Safety

5.1. During 2019/20 there have been no actual and immediate safety concerns reported directly through the exception reporting ER system (several have been created in error).

5.2. It is known that basic administrative and clinical tasks can negatively affect patient safety and quality of experience by detracting from time available for tasks that specifically require doctors. Implementation of an electronic patient record 'Epic' introduced in April 2019 may have improved some of the burden of administrative tasks undertaken by Junior Doctors although the impact of Epic on Junior Doctor working is yet to be fully evaluated.

5.3. **Rest provision** contributes to safe patient care by ensuring staff are making safe effective decisions. The 2016 TCS mandates the provision of adequate rest facilitates or alternative arrangements for safe travel home and includes provision of accommodation for non–resident on call and those 'too tired to drive home'. GOSH has increased bed availability on site from 12 to 21 beds. Rest facilities are currently housed on an unused ward. The facilities have received some upgrading supported by the 2019 Department of Health facilities fund (£60k) to support the BMA/ NHS 'Fatigue and Facilities Charter'. Current rest facilities provide adequate accommodation although costings and logistics to develop permanent rest facilities for junior doctors are required.

6. Work Schedules

6.1. NHS employers mandate that doctors in training should receive schedules of work that are safe for patients and safe for doctors and should be finalised and available 8 weeks prior to commencement of the new post. Working patterns of doctors in training are significantly influenced by rota gaps and changes in service requirements which in turn effects access to training and educational opportunities.

6.2. Due to the second COVID surge, rotational posts were deferred by Health Education England from February to March 2021. This impacted on work schedule deadlines.

6.3. Delayed international medical graduate recruitment due to COVID has caused rota gaps in haematology and oncology with trainees reporting additional duty hours through the exception reporting system.

7. High level Data* as of 31st March 2021

Number of trust doctors	223.6

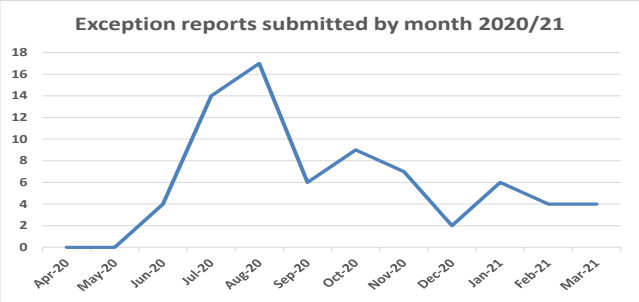
Number of training doctors	118.3
Number of vacant unfiled posts	18.7 out of a total of 307 rota slots (6%)

*Numbers indicate full time equivalent posts

8. Exception Reporting

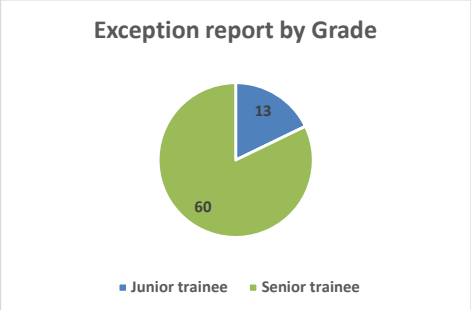
8.1. Exception reporting (ER) is the mechanism by which doctors are able to report safety concerns in the workplace and as such GOSH enables both Health Education England (HEE) trainees and non-training (trust) grade doctors to exception report at GOSH. All GOSH junior doctors can receive either financial compensation or time off in lieu for additional work performed if either preauthorised or when validated by a clinical manager.

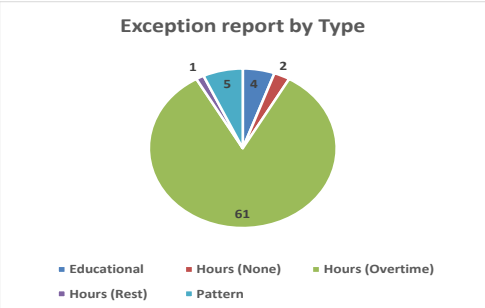
8.2. In 2020/21 GOSH received 73 exception reports submitted by a total of 24 individual doctors. There were no ERs from March until May 2020, and few December 2020 to March 2021, likely due to COVID pandemic disruption. There is an overall reduction from 149 reports submitted by 31 doctors in 2019/20.



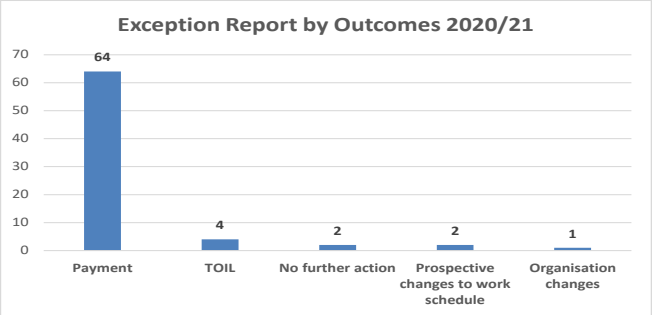
8.3. Presented monthly less than 1% of the junior doctor workforce are submitting ERs. This is a very small proportion of doctors but aligns with the national knowledge and our local ER survey in January 2020.

8.4. The majority of ERs are related to additional hours work and submitted by senior Trust grade (non-training) doctors.

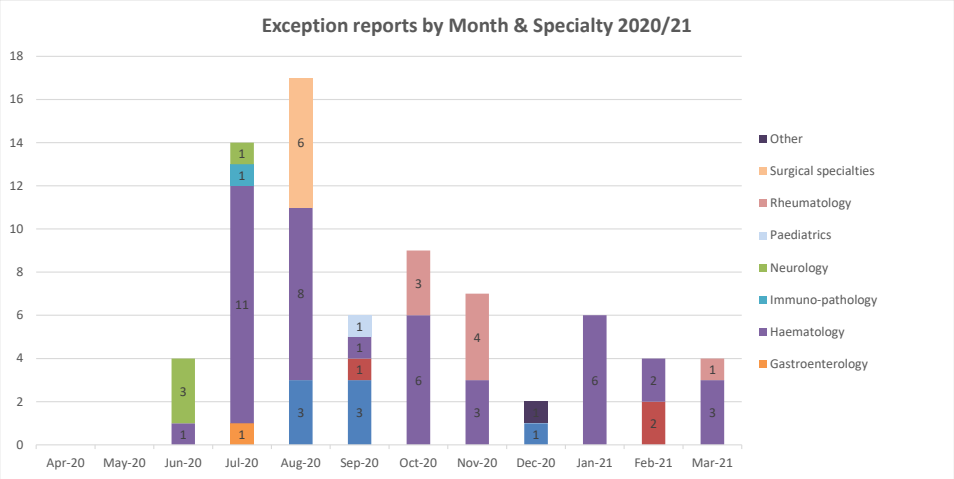




8.5. Most ERs resulted in financial compensation. One doctor has an outstanding work schedule review

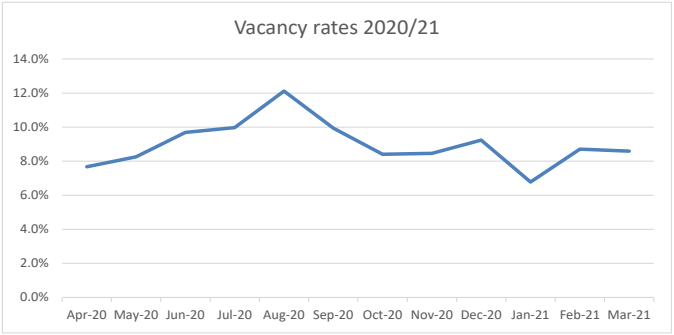


8.6. ERs have been presented by multiple specialties. Variation in reporting patterns are seen through the year. Incidence of reporting can be seen in some specialities that have experienced vacancies with subsequent high volume work flow resulting in additional hours as seen by a 30-40% reduction in baseline establishment in haematology/oncology which is reflected in ER numbers.



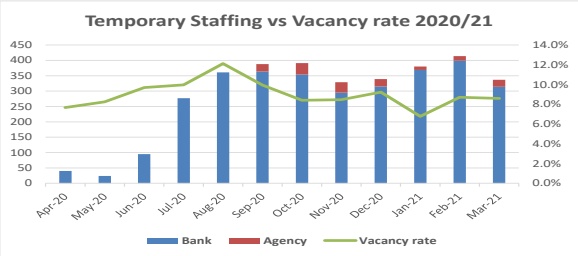
9. Rota Gaps and Vacancy Rates

9.1. GOSH vacancy rate has varied between 6.8% and 12.1% over 2020/21 (broadly similar to the previous year; range 6.8-12.8%) but continues to sit below the national average.



9.2. Vacancy rates and rota gaps reflect the end point of multiple workforce issues including:

- short term unplanned absence
- delays in recruitment process, particularly timeframes for on boarding international medical graduates
- long term structural rota problems and complex interdependencies
- variations in numbers of trainees sent to the Trust by the deanery
- national reduction in the medical paediatric workforce.



9.3. Rota gaps have been highlighted as an organisational pressure. Measures are being taken to mitigate the situation at GOSH include:

- appointing Medical Workforce Leads to closely support rota management
- increasing the number of doctors who are able to provide out of hours support applying equitable out of hours working principles to the medical workforce,
- establishing minimal numbers of doctors required to safely staff speciality areas
- devising new rotas that factor in minimum doctor numbers and hours for annual and study leave
- implementation of a standard operation procedure for rota gaps in medical specialities
- allocating managerial oversight providing cross organisation rota coordination and support

10. Fines

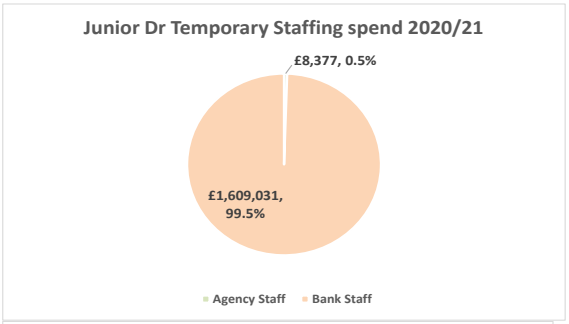
10.1. One fine has been levied with current ERs to date. This was associated with unintended additional bank duties for a surgical SHO. Fines only apply for the doctors on the 2016 TCS.

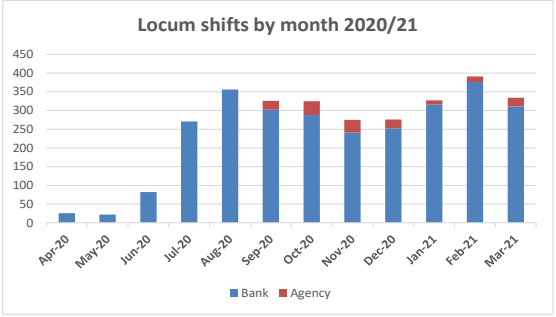
10.2. Current ER system does not automatically identify breaches as the system is dependent on the doctors to report breaches which they are often reluctant to do.

11. Bank Hours

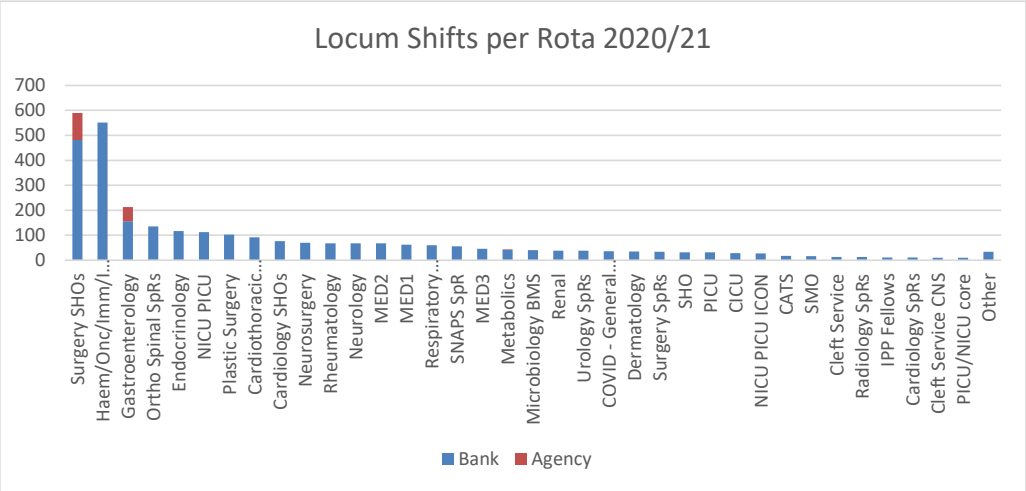
11.1. Bank shifts are filled 'in house' as opposed to locum agencies. There is significant reliance on internal 'bank' locums to cover both short and long term gaps in junior medical staff rotas across the Trust.

11.2. Year to Date spend is £1.61 million (of which Agency spend was £8,377 (0.5%). **This is £1.36 million lower than the previous year**.





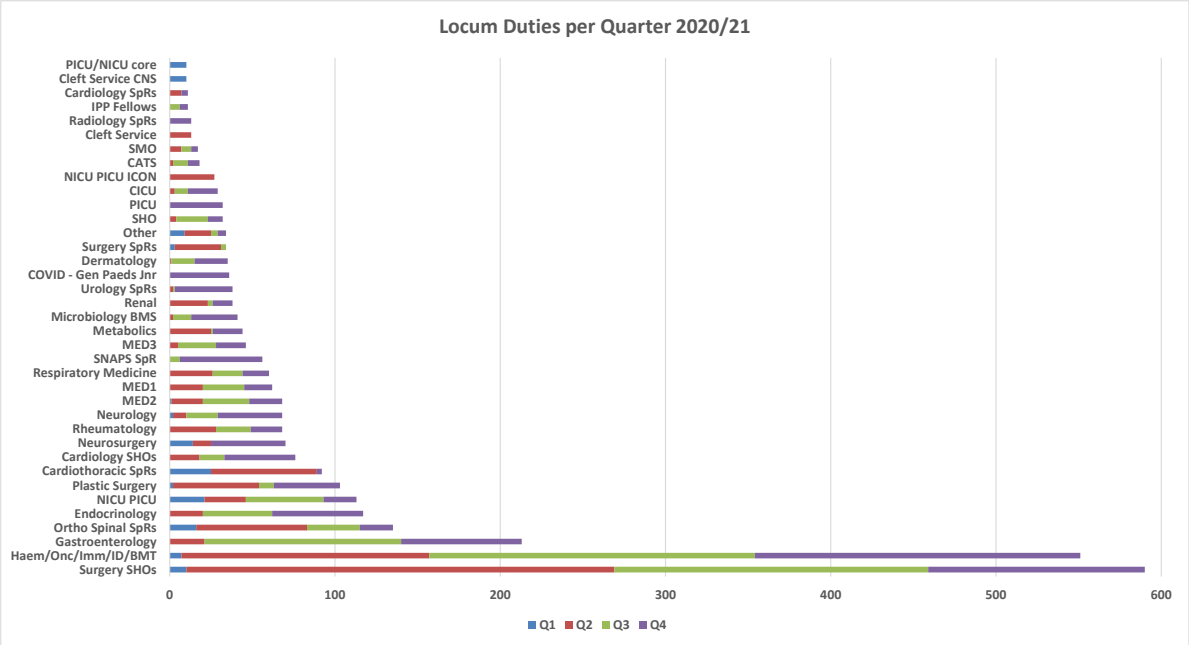
11.3. If non-consultant grade doctors wish to do work additional to their work schedule they must be aware of breaching safe working hours. Doctors themselves have a responsibility and duty of care for regulating their own hours of working, in addition to the organisation. Some organisational oversight is achieved through the rota coordinators. However, more robust systems and guidance are required.



11.4. Whilst Finance data reports spend against cost centres rather than rotas, when looking at shifts booked across the rotas, the Surgery SHO rota accounted for the largest number (19.6% of the total) followed by Haem/Onc/Imm/ID/BMT at (18.3%).

11.5. Vacancy was given as the most common reason (68%) of bookings followed by Short term staff sickness (6.5%) and COVID-19 (3.9%). Locum cost data must be triangulated with unfilled hours due to vacant posts and salary cost saving.

11.6. Detailed analysis of speciality areas requiring locum shifts is being undertaken monthly by the AMD workforce and MWLs. Clarification of dependencies and consideration for ways to provide clinical support is being considered.



12. Junior Doctors Forum (JDF)

12.1. The JDF was first established in spring 2017. On line meetings commenced in March 2020 and continue to run monthly with good attendance. Junior medical staff are represented as 'JDF Reps' in each directorate attending management meetings. Access to extended leadership training is currently being considered.

12.2. General engagement with the junior doctors across the organisation is good. Improvement in new messaging platforms, such as the new Rungway platform is likely to reach more junior medical staff.

13. Matters for the Board:

13.1. Significant achievements managing a safe and effective medical workforce during COVID pandemic.

13.2. Development of the Medical Workforce Lead role has provided excellent infrastructure and improvement to OOH working.

13.2.1. Clinical input to rota management and analysis of junior medical workforce bank costings has resulted in a significant saving to the Trust.

13.2.2. Risk related to poor compliance assurance offered by the exception reporting system should continue to be acknowledged. Most assurance is determined by good clinical leadership and infrastructure management by the MWLs and rota coordinators.

13.3. Awareness of requirement for better data intelligence to support clinical workforce planning

13.4. Consideration of a Junior Doctor representation at Executive and Board level.

Appendix 1:

COVID – 19 Medical Rota Proposal March 2020

GUIDING PRINCIPLES
• **Maintain safety of patients and staff**
• **Collaborative working across departments**
• **Wider situational awareness for risk assessment allowing informed and timely decisions**
• **Prioritisation of patient need**
• **Prioritisation of 24/7 clinical cover – pan Trust oversight**
• **Deployment based on clinical capability rather than current role**

The underlying approach to the COVID 19 clinical workforce planning has included:

- Planning must accommodate an unknown patient and staff demographic; we must be responsive and adaptable with structures in place to support rapid change
- Staff wellbeing is paramount – all rotas will have contingency staffing factored in to provide 30-50% back up on days and nights should someone call in sick/ be unable to work. Rotas will also have rest days that will be respected.
- All rotas will run 12.5 hour day and night shifts
- Depth and breadth of clinical workforce will need to be activated to ensure sharing of responsibilities
- Education and training will be delivered in parallel with upskilling /refreshing of staff skills and as an ongoing programme.
- We are ready to review, change and refine these plans as needed

In order to safely staff the trust in the face of potential staff shortages Workforce Bronze proposes the following structure.

Classification of Medical Staff

Doctors in the trust will be classified into the following categories:

Tier 3: Expert Clinical Decision Makers	Clinicians who have overall responsibility for patient care: consultants as well senior registrars / fellows who can 'act –up'
Tier 2: Senior Clinical Decision Makers	Medical & surgical registrars/CSPs/ ACPs: clinicians who are capable of making a prompt clinical diagnosis and deciding the need for specific investigations and treatments

Tier 1: Competent Clinical Decision Makers	Clinicians who are capable of making an assessment of the patient: includes SHOs (ST1-3); ANPs; CNS; ACPs*; redeployed clinicians

Note that these categories are context specific; so surgical registrar may, for example, be able to work at Tier 2 in their own specialty but at Tier 1 whilst covering medical patients. Following a review of ACP competencies in the trust by the Education Team, we have concluded that ANPs not currently on medical rotas will not be able to act above Tier 1. Some CNSs may be able to work at Tier 1 in their clinical areas, but this must be balanced against the potential need for them to support the nursing workforce.

The trust will have 5 rotas to maintain critical services and provide emergency provision

1. Specialist Medicine
2. Acute Surgery
3. Haematology, Oncology and BMT
4. Critical Care
5. Pelican (COVID-19), whilst these patients remain cohorted

All junior doctors on these rotas will be asked to work 12.5 hour shifts. We have used a survey to identify those doctors with critical care skills who could be offered training to move into critical care roles. The junior doctor workforce will then be classified into the following categories:

- Tier 2 Medical
- Critical care competent or competent following training
- Haem/Onc/BMT with EPIC Beacon training
- Tier 2 Acute Surgery
- High dependency Competent
- Tier 1

The individual rotas will be run as follows

Medicine

This rota will provide staffing for critical inpatient work which needs to continue despite restrictions to elective activity, for example critical inpatient infusions. Please note that we think this work will continue to delineate a weekday vs. weekend day differentiation which has been accommodated. Most of the inpatient specialist medicine work will be provided by specialty consultants with support from the tier 2/1 pool.

This rota will provide:

Weekday	12 x Tier 2
	12 x Tier 1
Weekend day	8 x Tier 2
	8 x Tier 1

Nights	4 x Tier 2
	4 x Tier 1

This rota is designed with 4 x doctors on backup days and 2 x doctor on backup nights, which provides 50% contingency at night and 30% during the day. This rota will require 42 doctors to run from our current establishment of 48.7 at Tier 2, leaving us some contingency and the opportunity to redeploy some doctors to other areas.

Acute Surgery

The emergency surgery service will be staffed by Tier 2 Acute Surgery doctors, who will principally be those with general paediatric surgery experience, on the basis that reduced elective activity will significantly reduce patient numbers, in plastics, orthopaedics, urology and ENT.

The rota will provide:

Daytime	2 x Tier 2 Acute surgery
	2 x Tier 1
Nights	2 x Tier 2 Acute surgery
	1 x Tier 1

Additional cover will be required to run any elective lists which will be operating during this period. It is recommended that any elective lists are staffed by two surgical consultants

Specialty cover will be provided at Tier 3 by the Consultants.

Neurosurgery and Cardiothoracic Surgery represent critical urgent care services and their rotas will remain as they currently run. Contingency arrangements will need to be made to allow for potential staff sickness on these rotas.

Haematology, Oncology, Immunology, ID & BMT (Blood Cells Cancer rota) – Clinical Lead Lynne Riley

An increase in demand for these services is anticipated. Current staffing numbers are low. In order to meet the demand of this rota given the reduction in staff due to sickness, doctors from the Tier 2 pool will be redeployed and trained to deliver services via EPIC Beacon. These doctors will be offered additional induction and training during the week beginning 16th March.

This rota will provide:

Weekday

Haem	2 x Tier 2, 1 x Tier 1

Onc	2 x Tier 2, 1 x Tier 1
BMT	4 x Tier 2. 1 x Tier 1
Safari	2 x Tier 2, 3 x Tier 1

Weekend day	3 x Tier 2, 3 x Tier 1
Nights	2 x Tier 2
	2 x Tier 1

Pelican (COVID – 19)

This rota will be supported by the BCC rota and offered whilst patients with COVID-19 continue to be cohorted on Pelican. This rota will require

Day	1 x Tier 2 1 x Tier 1
Night	1 x Tier 21 x Tier 1

Critical Care

Staffing to allow 70 critical care beds to be achieved according to PICC standards can be delivered from existing staffing without allowing for sickness. This rota will be supported by provision from anaesthesia, with middle grade staff released by a decrease in elective activity. This workforce will be supplemented by other doctors with critical care experience who can act at Tier 2 with additional training.

The cardiology registrars will remain on their current rota with the cardiology fellows who are not on the current rota being drafted onto a 12.5 hour rota pattern.

Education Needed

ITU induction & training for doctors new to the system.

EPIC training for anaesthetic doctors rotating to ITU

EPIC Beacon training for those doctors joining Haem/Onc BMT

Staffing Hub

A staffing hub is being established by HR. This will need significant oversight by the clinical teams within each area. Success depends on knowledge of the skill set of the clinicians and a clear administration and communication process.

We suggest that the hub convenes on a daily at the end of the working day in order to confirm plans for the following 24 hours

Staff Wellbeing

The wellbeing of the clinical staff is paramount to the delivery of sustainable, quality care. We want to develop and deliver a wellbeing strategy which includes: a process that checks in on our staff who are self-isolating or are unwell; those who are far away from home and those who are feeling most vulnerable. This is the first time our generation have been faced with a work related mortality risk and we need to listen and respond to their fears and concerns.

Appendix 2:

H@N June 2020 – Stepping off COVID rotas- Medical Workforce Preparedness Bronze Workforce Group

COVID rotas were devised on the following principles:

- Maintain safety of patients and staff
- Collaborative working across departments
- Wider situational awareness allowing informed, timely decisions
- Prioritisation of patient need
- Prioritisation of 24/7 clinical cover – pan Trust oversight
- Deployment based on clinical capability rather than role

Underlying approach included:

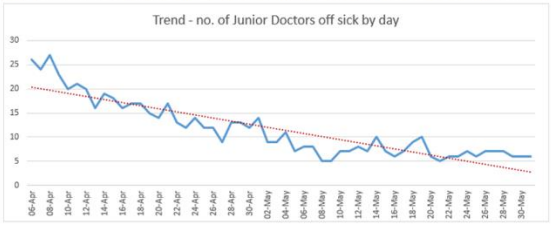
- Planning for unknown needs; rapid change needed
- Staff wellbeing paramount
- Clinical workforce activated to share responsibility
- Survey of ANPs/ CNS support for T1 rota – **unable to demonstrate medical level capability**

During April and May 2020

- COVID Absence rates 7 to 27% (non COVID baseline vacancy rate 7-16%)
- No gaps in COVID rotas –shifts internally covered with standby system:
- April 446 shifts; May: 197 shifts

Sickness absences (all rotas)

Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Total for week	Daily average
w/c 06/04/2020	26	24	27	23	20	21	20	161	23.0
w/c 13/04/2020	16	19	18	16	17	17	15	118	16.9
w/c 20/04/2020	14	17	13	12	14	12	12	94	13.4
w/c 27/04/2020	9	13	13	12	14	9	9	79	11.3
w/c 04/05/2020	11	7	8	8	5	5	7	51	7.3
w/c 11/05/2020	7	8	7	10	7	6	7	52	7.4
w/c 18/05/2020	9	10	6	5	6	6	7	49	7.0
w/c 25/05/2020	6	7	7	7	6	6	6	45	
Total	98	105	99	93	89	82	83	649	



COVID rotas – what has worked well?

- Rapid on - boarding, induction and training
- Cross specialty working: willingness for one team working from most
- System and process development:
- Centralised rota coordination 7 day service 07:30-21:00
- Establishing safecare system for doctors (sickness and absence tracking)
- Wellbeing support pathways (phone backs)
  Remote consultants checking 'real time' situational assessment and feeding back to workforce leads
- Engagement by team of consultants who have had operational oversight New work committed to handover process

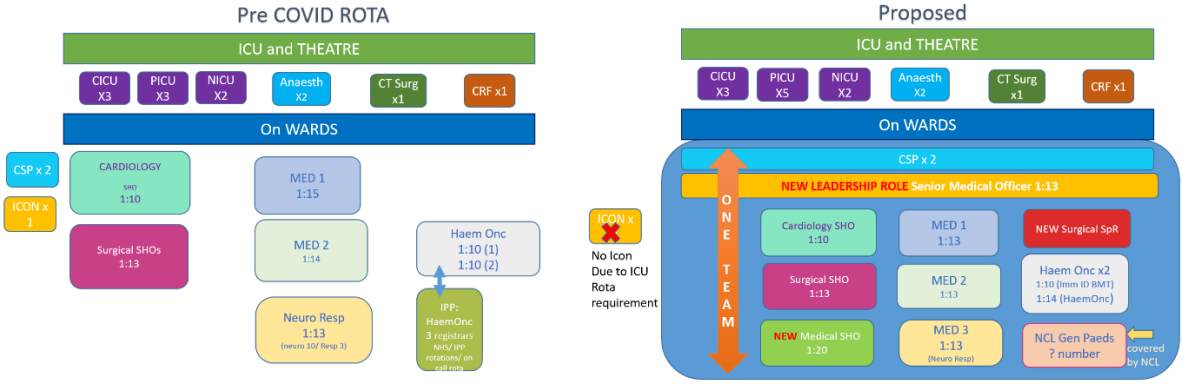
COVID rotas – what has been challenging?

- Establishing a safe and effective handover – space and logistics
- Old operational infrastructure to H@N
  - No managerial support

- No formalised lines of responsibility
- Lack of coordination from NCL for workforce numbers – need to constantly flex
- Frequent changes in dates and timeframes by NCL creates lack of trust
- Turning on other activity either by default or in a planned way but without medical workforce in place.
- No opportunity for consideration of wider individual doctor needs/ resilience at start
- Communication via email to JDs who prefer other platforms
    - Managing many with little resource – fuelled by commitment and good will

Approach to next step

- 24/7 Patient safety is paramount and must be everybody's business
- COVID rotas are not optimal for surgical and specialty restoration – they were devised for emergency short term cover and minimal regular activity
- Service needs to be resilient for second COVID wave and offer a 'step up' or flexible approach
- Preference to keep people in their base specialities
- Aim for safe H@N with increased absence and system for 'rota gap' management

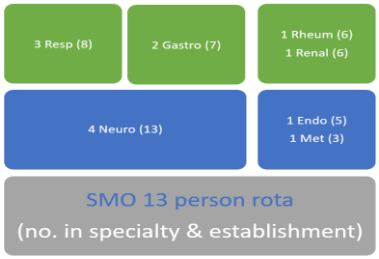


New Rotas development plan:

- Four 13 person medical rotas
- New leadership role Senior Medical Officer
- IPP Fellows join MED1 MED2
- Neuro Resp becomes MED 3
- 5 respiratory and 3 neurology fellows not doing nights go onto rota
- Medical SHO tier produces capability to 'act up'
- SNAPS & UROLOGY combine for resident surgeon

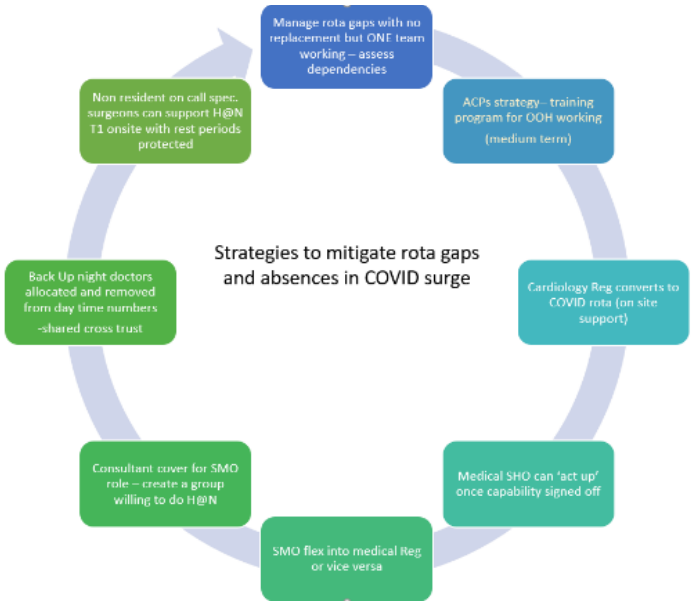
The Senior Medical Role:

- ST 7/8 or POST CCT fellows/ SPIN (APLS providers)
- Overnight leadership of entire medical team in conjunction with CSPs
- Supporting collaborative task based working
- Education & Training: Medical SHO capability development assessment and sign off
- Daytime/weekend cover remains within specialty
- Funded leadership & management program at GOSH
- Departmental identification of "step-up/transition" to consultant working in a supported way.
- Fits Shape of Training Model for 2021 – post CCT speciality training



Benefit: Improved Gap Management and Potential COVID Surge Capacity

- Meets requirement to step up for absence cover but maintain speciality cover
- Flexible and effective team accommodate rota gaps across specialities - broadens scope of gap cover (i.e MED3 neuroresp covered by any registrar as the team are working as ONE)
- Consultant on call is expert; Registrar is skilled
- Minimum number of H@N doctors to be established - need data for flow, acuity and capacity once new rota set up
- Intention for team to flex +/- 1 registrar; SHO post will not be backfilled. Intention is for this to create a pool of able doctors who can act up under supervision of SMO



Risks

Reduced day time medical capacity

- Every set of 7 nights takes 8 daytime service days away; this totals 16 day service days in 26 weeks – so 3 weeks and 1 day for 14 nights.
  - Neurology and respiratory 1:13 precovid rota; MED 1 and MED 2 were 1:14/15 precovid so negligible day time impact on MED1 and MED2

Areas affected:

1. Respiratory
   a. 5 out of 8 fellows now doing nights = 15 weeks and 5 day per 26 weeks
   b. 1 SHO doing 10 nights per 26 weeks = 12 days per 26 weeks
   c. Lung transplant fellow works alongside 0.8 consultant. No cross cover offered from respiratory or cardiology. Leaves service vulnerable

Action: Monday 1st June SS and DL agreed 9th fellow post to offset day time service loss. Lung transplant fellow will start on 8th rota line and when new fellow appointed will step off to long day and weekends only

2. Neurology
    a. 3 out of 10 additional fellows doing nights = 9 weeks and 3 days per 26 weeks.
    b. 4 SHOs doing nights (1 in 20) = 7 weeks per 26 weeks

    Action: Consider maintaining COVID arrangements for neurosurgical cover with ANP and Gen Paeds support neuro as third line back up
    Flow project to consider different approach (Advanced Clinical Practice/ Physicians Associates)

Appendix 3:

Medical Workforce Leads Duties and Responsibilities

- Work as a team alongside the AMD workforce, medical HR; rota coordinating team; OOH general manager, CSPs and service lead to shape clinical workforce leadership and management out of hours
- Remit to deliver further infrastructure improvement, of OOH working with an equitable cross Directorate approach with the focus of patient safety, junior medical workforce experience, training and education and the evolving GOSH response to an ongoing COIVD 19 threat.
- Support the medical pastoral and mentorship programme with a focus on OOH team working and support
- Promote learning excellence through focus on active learning from OOH experience, developing capability framework for SHOs and leadership programme for SMOs
- Integrate OOH performance into local faculty group review and educational supervision framework

Individual Areas of Responsibility

With the AMD as project lead, each medical workforce lead will have individual areas of responsibility that will contribute to:

1. **Safer Patient Care**

    - Active management of real time clinical decision making with situational knowledge of complex patient requirement in relation to workforce dependencies to ensure out of house cover is safe
    - Daily review of rota gaps and absence; risk assessing team capability in line with patient dependency; redeploying junior doctor workforce with equity into suitable roles
    - Ensure governance and safety issues have appropriate cross Directorate responses with clear lines of responsibility, reflection and learning from events out of hours
    - Active management of Datix linked to OOH working
    - Establish a monthly OOH clinical risk group

2. **Improved System Management**

    - Establish effective clinical communication strategies optimising existing resource and considering innovative systems

    - Development and application of EPIC based systems to support OOH working (specifically medical handover and clinical documentation)

- Medical Handover process improvement – training, oversight and evaluation
- Surgical handover process improvement – training and oversight and evaluation
- Develop trust wide SOP outlining general process for escalation pathways for unsafe staffing and expectations

- Work with departments to agree escalation pathway based on overall principles of safety and value

3. Accurate Data Information Systems

- Dashboard development to ensure key data is captured to support planning
- Facilitate and enable internal recruitment and retention including establishing development of career pathways within GOSH- monthly review

4. Improved Experience

- SMO weekly support and development meetings
- Establish feedback systems and work to improve the reputational issues that currently exist at GOSH related to OOH working

5. Focus on Education and Training

- Deliver systems intelligence development programme delivered to Senior Medical Offices- weekly
- SHO OOH clinical competency framework- assess baseline capability and delivery of weekly training
- Implement a training programme to induct current fellows/ registrars into out of hours working
- Feedback into local Faculty groups to ensure OOH performance is connected to junior doctor review

Attachment 2

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of the Audit Committee meeting held on 14th April 2021

Matters arising: Cladding used in the Trust

It was noted that a professional review had provided assurance that cladding used in the Trust was safe and a written summary had been provided. The Committee emphasised the importance of obtaining a full, formal report.

Matters arising: Information Governance Dashboard

Discussion took place around Subject Access Requests, a number of which were overdue against the 60 day timeframe. Updates were provided to requestors on an approximately fortnightly basis and partial releases of information were made where possible. Discussion took place around resources in the team and it was agreed that consideration would take place to assess whether this was sufficient. It was noted that it was vital to support key corporate services to manage relevant Subject Access Requests.

The Trust was confident that it would implement the new National Opt Out requirements and the new Caldicott Guardian principle by their respective deadlines.

The Committee noted updates from the following Board Assurance Committee meetings:

- Quality, Safety and Experience Assurance Committee –April 2021
- Finance and Investment Committee – January and March 2021
- People and Education Assurance Committee – February 2021

Board Assurance Framework (BAF) Update and revised GOSH Risk Appetite Statement

- Risk 1: Financial Sustainability

The Risk Assurance and Compliance Group (RACG) recommended that the International and Private Care (I&PC) risk should not be separated from the financial sustainability risk in lieu of non-NHS income that was being provided by NHS England which currently mitigated the risk. The committee agreed this and requested that this was reviewed in three months and that feedback continued to be provided to NHS England about the impact of reduced I&PC income.

- Risk 7: Cyber Security

In response to enhance governance around IT and cyber security, it had been agreed that the IT Board would be dissolved and replaced with an IT Recovery Board with more senior decision makers. Discussion took place around seeking an additional advice for the Board to focus on Cyber Security and this was agreed. The Committee agreed that once an action plan was in place, Audit Committee members would hold a focused meeting on Cyber Security between Audit Committee meetings.

- Risk 10: Redevelopment / estates

It was agreed that an estates risk would be added to the BAF.

- Medicines Management

The risk had been discussed at QSEAC and it had agreed to hold an extraordinary meeting focused on delivery of the plan and assurance of its timescales.

- Risk 14: Political Instability

It was agreed that the political instability risk and strategic position risk would be merged and the wording would refer to 'optimisation' of the Trust's Strategy.

- Risk appetite

It was agreed that the paper would be refined and considered again by the committee.

The Committee requested that the RACG review the gross and net scores of the BAF risks and whether they were red rated (notwithstanding the net risk score).

Board Assurance Framework Deep Dives:

- Risk 6: The risk that the Trust is unable to accelerate and grow research and innovation to achieve its full Research Hospital vision due to not having the necessary research infrastructure.

GOSH had registered 130 trials related to COVID-19 and enrolled 3,500 staff and patients into studies. The Biomedical Research Centre and Clinical Research Facility had both substantially increased the number of studies taking place within the most recent funding cycle. The research governance team ensured that a robust research governance framework was in place to enable clinicians to undertake a variety of research projects involving the Trust's unique patient group. The Zayed Centre for Research had been instrumental in the Trust's ambition to fulfil its research ambitions.

Year End Update 2020-21

It was noted that stock counts were particularly complex for 2020/21 due to the stock controlled by NHS England being counted as donated stock therefore considerably benefitting the bottom line. Discussion took place around the risk of the Trust continuing to have access to stock that had been recognised in the accounts but was not on Trust premises and it was agreed that whilst other Trusts had a much greater share of this stock, minimising GOSH's risk, it was important to control this.

Update on IFRS 9

The Committee had agreed outside the meeting that some overseas visitor payments would be provided for at 100%. The calculated provision percentage for I&PC had fallen from 85% in January to 55% as the result of receipts in the final quarter of the year and it was agreed that the provision percentage would be capped at 50% as the risk was not felt to be higher than this.

Internal Audit Progress Report

The Committee noted the outcome of four reviews. Actions arising from the Cyber Security Action Plan review would be monitored by the Committee to ensure progress was being made as a large number of actions had a deadline of August 2021. Discussion took place around the outcome of the EPR benefits realisation review and the committee expressed some concern about the lack of focus in the review on the critical role that the EPR had played in GOSH's ability to react at pace to the pandemic and to begin recovery at pace. The Committee requested that the executive summary of the review and summary in the Head of Internal Audit Opinion were reviewed by the Auditors. The Committee noted the Head of Internal Audit Opinion which was one of significant assurance with minor improvement opportunities.

Internal and external audit recommendations – update on progress

There had been good movement in overdue recommendations between January and April 2021.

Attachment 2

Draft Internal Audit Strategic and Operational Plan: 2021-22
It was agreed that the review of incident management would be removed from the 2021/22 plan as GOSH was in the process of commissioning a similar external review. It was agreed that the replacement review would be confirmed later in the year to allow capacity for an appropriate review at that time.

External Audit: Interim update report to the Audit Committee for the year ended 31 March 2021
The Trust was on course for submission in the required timeframe and the auditors were preparing to begin their work. A key change had been made to Value for Money reporting and a self-assessment was required which was a substantial undertaking.

Local Counter Fraud Specialist (LCFS) Progress Report
One investigation had been closed and two new cases received. The NHS Counter Fraud Authority (NHSCFA) had published its guidance and based on this information GOSH had some areas of non-compliance. Feedback had been provided to the NHSCFA about the challenges of applying guidance retrospectively.

Local Counter Fraud Specialist (LCFS) Workplan 2021/22
The Committee approved the workplace for 2021/22.

Draft Annual Governance Statement 2020-21
The Committee approved the statement of internal controls and provided feedback about further areas for inclusion in the statement.

Results from the Audit Committee Survey 2020-21
Work had taken place to highlight the focus of different committees where residual overlap remained and the structure the committee agenda to ensure the key items were at the beginning of the agenda.

Draft Audit Committee Annual report 2020-21
It was noted that this would be circulated to committee members outside the meeting.

Raising Concerns in the Workplace Update
No new cases had been raised since the last report.

Write offs
Discussion took place around the size of the drugs write-off which had significantly increased. A governance process was being implemented in pharmacy to enable better stock management and oversight. The Committee discussed the implications of potential refrigeration outage for drugs and an update on this matter was referred to the QSEAC.

Update on Procurement Waivers
There had not been an increase in the number of waivers during the pandemic showing that the Trust had adhered to its usual systems and processes throughout this time.

Attachment G

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of the Quality, Safety and Experience Assurance Committee held on 8th April 2021

QSEAC Effectiveness Review Survey results

A positive response was achieved which was indicative of the progress the committee was making to ensuring that information received was assurance based rather than operational. Three recommendations had been made in order to improve the level of assurance received and to increase the focus placed on patient experience as part of each paper. It was noted that an assurance committee chairs' meeting would be held and overall effectiveness of the assurance committees would be discussed.

QSEAC Annual report 2020/21

The Committee noted the draft annual report and agreed to provide comments to the Company Secretary outside the meeting.

Overview and Emerging clinical and risk issues covering (BAF Risk 13: Inconsistent delivery of safe care)

Over 90% of patients had been prioritised for treatment based on clinical need which was an excellent achievement; this would be ongoing as patients were referred and harm reviews were taking place at the point at which patients were seen. GOSH had the highest number of priority two patients across North Central London. The committee noted the risk which was currently being held by the organisation and acknowledged that it was unlikely that there would be zero physical or psychological harm to patients given the considerable change in time to treat. In order to clear the backlog, GOSH was working at over 100% of activity levels when compared to 2019/20 for both elective care and outpatients.

Updates were provided on cases for which external support was being sought. Following the review by NHS England of a red complaint, a serious incident had been declared and GOSH had been keen for an external investigation to take place to identify learnings. Terms of Reference had been developed and GOSH was currently commenting on these with a view to ensuring they were as broad as possible to identify all relevant learning. The committee noted the updates on other cases.

Quality focused external reviews

- Update on medicines management at GOSH

Improvements had been made in the use of Epic in the pharmacy service and further work was required to improve readiness for the follow-up inspection from the Medicine and Healthcare products Regulatory Agency (MHRA). A positive internal audit report had been received however it was noted that this had a narrow remit and had been focused on progress with the MHRA action plan. Discussion took place around the estate and it was confirmed that a good solution for pharmacy would be in place before implementation of plans for the Children's Cancer Centre development. The Committee requested a route map showing how the specific issues in pharmacy would be addressed and efficient timelines for doing so and agreed to follow this up between meetings.

Quality and Performance in the IQPR (February data)

There had been an increase in the number of incidents closed in the month and focus was being placed on reducing the backlog of open incidents. There had been a reduction in the compliance of high risk reviews in line with the risk management strategy and additional resource in the patient safety team would support improvement in this area in the future. A thematic analysis of red complaints was being undertaken following a substantial increase in the number received. The complaints policy had been updated in order to improve engagement with families.

GOSH Learning Disability Strategy 2020-2025

The Strategy had been approved by the Patient and Family Experience and Engagement Committee and would be monitored by the Family Equality Group. A year one action plan had been developed. The Committee welcomed the development of the strategy and emphasised the importance of involving families, noting their expertise in this area. The importance of working with other organisations to share practice and the development of SMART objectives was also highlighted. The Committee requested that work to support parents and family members with a learning disability or autism was also included.

Update from the Risk Assurance and Compliance Group (RACG) on the Board Assurance Framework and Always Policy Update

The RACG reviewed the medicines management risk and concluded that the net risk score should remain the same due to the additional work required in the area. The Committee had asked the medical director to review the risk around inconsistent delivery of safe care in the context of medicines management. A proposal would be taken to the Audit Committee to add a separate estates risk to the BAF. A plan was in place ensure that 100% of the Trust's Always Policies were in date.

Compliance Update with Always Improving Plan

Must-do actions arising from the CQC inspection were complete and timelines had changed for should do actions as a result of the Pandemic. Discussion took place around duty of candour and the committee emphasised the importance of Trust-wide staff understanding of the reporting process when issues arose.

Internal Audit Progress Report (Quality focused reports) and draft annual plan 2021/2022

The Committee noted the review of pharmacy which had provided a rating of 'significant assurance with minor improvement potential'. The committee agreed that the incident management review would be replaced in the 2021/22 calendar due to the external review of the incident management process which was already planned and this would be discussed by the Audit Committee.

Internal audit recommendations update

One recommendation was currently overdue an extension and this had been agreed by the RACG.

Internal Audit Annual Report including Head of Internal Audit Opinion

The Committee noted the Head of Internal Audit Opinion rating of 'significant assurance with minor improvement potential' for the Trust and that the opinion would be considered by the Audit Committee in April 2021.

Safeguarding Report Q3 2020/21

Safeguarding activity had increased in line with a national increase. Discussion took place around supervision and its importance in giving staff confidence to address issues as they arose. The Committee discussed the perplexing presentation team and noted that its expertise had initially been used to support work on known cases in the Trust and would now be advertised more widely in the Trust. A refresh of the safeguarding strategy was taking place now that the new Named Nurse for Safeguarding was in post.

Health and Safety Update Q4 2020/21

Discussion took place around the Trust's vaccination programme. It was confirmed that the staff vaccination rate was approximately 75%. The most recent audit of hands, face, space, place showed over 95% compliance. The committee discussed the serious nature of near misses in terms of fire safety. It was confirmed that each near miss was followed up with learning disseminated to department heads.

Freedom to Speak Up Guardian Update (January – March 2021) – Quality related

The number of cases was increasing following a recent reduction and was now more in line with previous quarters. Work would take place to identify areas which had reported difficulty in speaking up from the staff survey.

Update on whistle blowing cases (January – March 2021) – Quality related
There had been no new cases reported in the period.

The committee noted updates from the following assurance committees:

- People and Education Assurance Committee (February 2021)
- Audit Committee (January 2021)

Matters to be raised at Trust Board

- The outcome of the QSEAC effectiveness survey
- Progress with medicines management and the route map to improvement requested by the QSEAC
- The Learning Disability Strategy
- Integrated Quality and Performance Report
- Refresh of the Safeguarding Strategy
- Positive progress in Freedom To Speak Up.

QUALITY, SAFETY AND EXPERIENCE ASSURANCE COMMITTEE
Thursday 8th April 2021 at 12:30pm – 3:30pm by video conference
AGENDA

	Agenda Item	Presented by	Attachment	Time
1.	**Apologies for absence**	Chair		**12.30pm**
2.	**Minutes of the meeting held on 21 January 2021**	Chair	**A**	**12:35pm**
3.	**Matters arising/ Action point checklist** **Verbal update on progress with the Clinical Prioritisation Process (Risk 3 Operational Performance)**	Chair Chief Operating Officer/ Medical Director	**B** **Verbal**	**12:40pm**
4.	**QSEAC Effectiveness Review Survey results** **QSEAC Annual report 2020/21**	Company Secretary	**C** **K**	**12:45pm**
	LEARNING FROM DATA ANALYSIS, INVESTIGATIONS, REVIEWS, AUDIT AND SURVEYS			
5.	**Overview and Emerging clinical and risk issues covering (BAF Risk 13: Inconsistent delivery of safe care):**	Medical Director/ Chief Nurse/ Chief Operating Officer	**D**	**12:55pm**
6.	**Quality focused external reviews (national reviews and local reviews of other organisations)** • Update on medicines management at GOSH	Medical Director/ Stephen Tomlin, Chief Pharmacist	**E**	**1:10pm**
7.	**Quality and Performance in the IQPR (February data)** Including: • the work of the Patient Safety and Outcomes Committee • the work of the Patient and Family Experience and Engagement Committee	Medical Director/ Chief Nurse/ Chief Operating Officer	**F**	**1:25pm**
8.	**GOSH Learning Disability Strategy 2020-2025**	Chief Nurse	**G**	**1:35pm**
	RISK AND GOVERNANCE			
9.	**Update from the Risk Assurance and Compliance Group on the Board Assurance Framework and Always Policy Update**	Company Secretary	**H**	**1:45pm**
10.	**Compliance Update with Always Improving Plan**	Medical Director	**J**	**2:00pm**
	ASSURANCE OF SYSTEMS AND PROCESSES			
11.	**Internal Audit Progress Report (Quality focused reports) and draft annual plan 2021/2022**	KPMG	**M**	**2:10pm**
12.	**Internal audit recommendations update**	KPMG	**N**	**2:20pm**
13.	**Internal Audit Annual Report including Head of Internal Audit Opinion**	KPMG	**U**	**2:25pm**

14.	**Safeguarding Report Q3 2020/21**	Chief Nurse	**O**	**2:30pm**
15.	**Health and Safety Update Q4 2020/21**	Director of Redevelopment, Estates and Facilities	**P**	**2:40pm**
16.	**Freedom to Speak Up Guardian Update (January – March 2021) – Quality related**	Freedom to Speak up Guardian	**Q**	**2:50pm**
17.	**Update on whistle blowing cases (January – March 2021) – Quality related**	Director of HR and OD	**R**	**3:00pm**
	FOR INFORMATION			
18.	**Update from the :** • **People and Education Assurance Committee (February 2021)** • **Audit Committee (January 2021)**	Kathryn Ludlow, Chair of PEAC Chief Executive	**S** **T**	**3:05pm**
19.	**Matters to be raised at Trust Board**	Chair	**Verbal**	
20.	**Any Other Business**	Chair	**Verbal**	
21.	**Next meeting**	**Thursday 1st July 2021 12:30pm – 3:30pm**		
	Terms of Reference **Acronyms**	**1** **NHS Confederation Acronym Buster available at:** https://www.nhsconfed.org/acronym-buster		

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
26 May 2021

Finance and Investment Committee Terms of Reference **Submitted and presented by:** James Hatchley, NED and FIC Chair Helen Jameson, Chief Finance Officer	**Paper No: Attachment 4** 2021/22 Terms of reference for Finance and Investment Committee

Aims / summary

The Finance and Investment Committee's terms of reference (ToR) and workplan were reviewed in March 2021.

It is good governance practice to periodically review the ToR and workplans of the Assurance Committees to ensure that they are fit for purpose, support the aims of Committee and allocate adequate time to the pertinent issues.

Terms of reference

The Committee agreed the following changes to the terms of reference.

Change	Rationale
Updating of job titles throughout	New role titles of members and attendees added.
Inclusion of reference to the confidential meetings of the FIC in section 3. Meeting	The terms of reference needed to mention that there are confidential meetings of the Committee.
Updated section 6. Reporting	This section was updated to reflect the reporting arrangements in place.

The Committee agreed that although there has been a slight pause in the traditional financial systems due to COVID-19 and a system wide focus on coping with the virus, the Committee's terms of reference should not be amended to reference COVID-19. This is because COVID has become business as usual and the responsibilities noted in the TOR are flexible enough to cover any additional reporting arrangements.

Workplan

The Committee work plan was also revised by the Chair, Chief Finance Officer and Head of Corporate Governance. The review took into consideration:

- The previous three years' work plans
- External submission deadlines
- Requests for content from Committee members.

Action required from the meeting

To approve the FIC Terms of Reference.

Contribution to the delivery of NHS / Trust strategies and plans Compliance with the Constitution and best practice guidance.
Financial implications None.
Legal issues None.
Who is responsible for implementing the proposals / project and anticipated timescales Chair of the Finance and Investment Committee.

FINANCE AND INVESTMENT COMMITTEE

TERMS OF REFERENCE

1 Authority and Scope

The Committee will operate as a sub-committee of the Trust Board and is chaired by a Non-Executive Director.

The Committee has delegated authority from the Trust Board to oversee financial strategy and planning, financial policy, investment and treasury matters and reviewing and recommending for approval major financial transactions. The Committee will also maintain an oversight of the Trust's financial position, and relevant activity data and productivity metrics.

2 Membership

2.1 Chair

The Board will nominate a Non-Executive Director to act as Chair of the Committee. In their absence, the Chair will nominate one of the other Non-Executive Directors to act as Chair.

2.2 Regular members

- Three Non-Executive Directors [one of whom shall be the Chair]
- Chief Executive
- Chief Operating Officer
- Chief Finance Officer

2.3 In attendance

- Director of Estates, Facilities and Built Environment
- Director of Transformation
- Chief Data Officer
- Associate Director of Financial Management

Committee members may ask any other executive director, senior manager or external advisers to attend and address meetings of the committee, regularly or by invitation.

Invitees have no right of regular attendance.

2.4 Quorum

For a quorum, there must be the Chair (or nominated deputy NED) plus one other NED (if not acting in the capacity of nominated deputy) and two Executive Directors (one of which must be the Chief Finance Officer, or if absent, the Associate Director of Financial Management).

3 Meeting

3.1 Frequency of Meetings

The Committee will meet not less than four times a year. Meetings will be scheduled to take into account external and internal financial submission deadlines.

Meetings can be held virtually when required.

Some attendees may be excluded from part of the meeting due to the confidential nature of business to be transacted. Those excluded (and other relevant staff) may attend on the basis of invite only for the purposes of providing relevant information to the members.

3.2 Work plan and conduct

The Committee will develop an annual work plan. The plan will be reviewed on a regular basis to ensure that it supports the aims of Committee as specified above.

The effectiveness of the Committee will be assessed annually.

The agendas, papers and minutes will be distributed not less than three working days prior to meetings.

Papers can be tabled in exceptional circumstances.

Any other business to be notified to the Chair of the meeting in advance.

3.3 Secretariat

Secretarial support shall be provided to the Committee by the Corporate Affairs Team who will take minutes of the meeting and give appropriate support to the Chair and Committee members.

4 Purpose of Committee

4.1 Financial

Review the annual and medium term financial plans for revenue and capital, and make recommendations to the Board.

Review progress against key financial and operational targets, including monthly and year end finance and activity reports (including cash flow and balance sheet information) and financial performance ratings (e.g. NHSI metrics).

Review trends in workforce numbers and costs including temporary staffing costs, in order to ensure resource levels remain within the levels prescribed by the financial plan.

Review capacity utilisation, productivity and efficiency measures and progress in delivery of the Trust's targets.

Receive reports on the annual commissioner contracting arrangements and review overall performance on contracts.

Review progress on Service Line Reporting, Patient Level Costing and the Trust's Reference Costs.

Oversee the Trust's Treasury management strategy and borrowings arrangements.

All other matters included in the Trust's scheme of delegation. These include changes in the Trust's corporate structures, investments or acquisitions including significant transactions, material contracts in the ordinary course of business, other contracts not in the ordinary course of business, and transactions which would lead to an increase in the Trust's non NHS income by more than 5%.

4.2 Capital and revenue investments and service developments

Oversight on the financial implications of all major investments and business developments including the Redevelopment programme.

Advise the Board on all proposals/business cases for major capital expenditure in line with the Scheme of Delegation

Review the Estates and IT strategies and delivery of those strategies.

Review the Trust's Procurement policies and processes

5 Information requirements

The Committee will receive reports as outlined in the committee work plan.

The Committee will receive regular reports on financial performance, workforce and staff costs, delivery of P&E targets, capital investment, relevant productivity metrics and cyber security.

6 Reporting

The Chair of the Committee will present a summary of business conducted at each meeting and a copy of the agenda to the Trust Board and the Council of Governors.

The Committee will share a summary report with the Audit Committee, Quality Safety and Experience Assurance Committee and the People and Education Assurance Committee.

The Committee will prepare and submit an annual report on its activities and its effectiveness and key achievements to the Trust Board and as part of the Trust Annual Report document.

7 Monitoring

7.1 Monitoring of policies

The Committee is responsible for reviewing and approving the Treasury Management Policy.

7.2 Review of effectiveness and terms of reference

The Committee will review its Terms of Reference in March on an annual basis.

The Committee shall review its effectiveness in March on an annual basis.

DATE AMENDED : 24 March 2021

NEXT REVIEW : March 2022

Attachment 5

Summary of the Council of Governors' Meeting held on 20th April 2021

Matters arising

Governors had discussed the ways in which they could fulfil their roles and represent their constituencies during the pre-meet. It was agreed that meeting agendas would be discussed between the Chair, Lead Governor and Company Secretary to ensure that a balance could be achieved between statutory requirements of the Council and Governors' areas of interest.

Declaring a Climate Emergency

GOSH had declared a climate and health emergency on 22nd February 2021 and committed to ambitious targets around carbon emissions. The Council noted the importance of the necessary changes being embedded in the organisation as a whole. Work was taking place with the design partner of the Children's Cancer Centre development to create a framework showing where the greatest impact on CO_2 could be made. The Council emphasised the importance of considering accessibility alongside emissions which was a key issue for many of the Trust's patients and families. As a key component of the Trust's Above and Beyond Strategy was sustainability and monitoring of progress would take place as part of the portfolio management process.

Patient and Family Experience Framework

The Trust was in the process of outlining its ambitions for the way in which it would work to enhance patient experience. Work was taking place to learn from peers both nationally and internationally and the focus was being placed on listening to children, young people and families through surveys and focus groups and analysing PALS, Friends and Family Test and Complaints data. Following previous feedback from the Young People Forum a programme or work had been developed to support siblings.

Chief Executive Report

Focus was being placed on treating the backlog of patients as the Trust moved out of the second surge of the pandemic and a number of short term priorities had been set for the Executive Team focusing on the fundamental areas of operation. Diversity and inclusion was also a key priority. An audit had taken place around hands, face, space, place precautions and this had shown over 95% compliance in all areas. Discussion took place around the plans for open plans offices. The importance of using space as efficiently as possible was highlighted particularly given the impact of social distancing and it was felt that this could be best achieved in many cases through the use of open plan spaces.

Finance report February 2021

The month 12 position had been submitted showing a £13million surplus as a result of funding being received for services which had not initially been included in the block contract along with a top up in lieu of non-NHS income. GOSH had been able to complete 50% of its capital programme in the financial year and focus had been placed on critical infrastructure matters. The Council discussed the implication of the new NHS White Paper for GOSH given that only a very small proportion of patients were referred from the local area. This was being escalated to a national level and would be monitored by the Finance and Investment Committee.

Update from the Young People's Forum (YPF)

The YPF had been working with the anaesthetic team on a project around making greener choices in healthcare and had collaborated with the Redevelopment Team and the GOSH Children's Charity on an art installation in the Sight and Sound Building. Discussion took place about engagement between youth forums nationally and it was noted that GOSH had hosted the first national youth forums meet up in 2017 and it was anticipated that this would resume following the pandemic.

Attachment 5

Reports from Board Assurance Committees

- Quality, Safety and Experience Assurance Committee (April 2021)

The Committee was focusing on the governance of the patient prioritisation process and improvement action being taken in pharmacy. QSEAC had requested a routemap for completion of outstanding actions arising from a regulatory inspection. A new Named Nurse for Safeguarding had started in post and would be refreshing the Safeguarding Strategy and new Freedom To Speak Up Guardian would be taking a strategic approach to the routes in place for staff to speak up across the Trust.

- Audit Committee (April 2021)

The committee requested a formal report to confirm the positive findings of a review of the cladding used on the Trust's estate following the Grenfell tragedy. Emphasis continued to be placed on cyber security which was key particularly in the context of GOSH's EPR and research platform. The draft Head of Internal Audit Opinion had provided a rating of significant assurance with minor improvement opportunities and the committee reviewed four reports. Discussion took place around the review of EPR benefits realisation and noted the importance of EPR throughout the pandemic.

- People and Education Assurance Committee (February 2021)

A presentation had been received from Occupational Health who were doing considerable work to support staff during the pandemic. The Committee continued to monitor the impact of the pandemic on staff turnover and were increasingly focusing on the TUPE transfer of staff from the formerly outsourced cleaning service.

- Finance and Investment Committee (March 2021)

A confidential session had taken place to discuss commercial arrangements which would be vital to support the Trust going forward. The Committee was clear about the importance of prioritising the backlog of patients.

Council of Governors' Election evaluation

The election had gone ahead in line with the timetable that had initially been set out and had used images and videos for the first time to engage voters.

Process for electing the Lead Governor and Deputy Lead Governor

The Council approved the process for electing the Lead Governor and Deputy Lead Governor.

Appraisal process for the Chair and Non-Executive Directors and the role of Governors

The Council approved the proposal to delay the Chair and Non-Executive Directors' appraisals noting the challenge of Governors giving meaningful feedback on performance when new in role.

Draft Council of Governors' section in GOSH Annual Report 2020/21

The report outlined the composition of the membership and future plans for engagement as well as providing an overview of the Council of Governors.

Compliance with the NHS provider licence – self assessment

An annual self-assessment was completed by the Trust to declare compliance or otherwise with a small number of Foundation Trust licence conditions. The Council agreed the proposal to declare compliance with each condition.

Membership of Council committees

Governors were asked to express their interest for seats on each of the following Council committees:

- Council of Governors' Nominations and Remuneration Committee
- Constitution Working Group
- Membership, Engagement, Recruitment and Representation Committee (MERRC)

Attachment 6

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
26th May 2021

Declarations of Interests (Directors and Staff) **Submitted by: Anna Ferrant, Company Secretary**	**Paper No: Attachment 6** **For information and noting**

Purpose of report
This paper provides the annual summary of the management of declarations of interests, gifts, hospitality and sponsorship at GOSH and compliance with the policy in 2020. The Directors' Register of Interests is attached. A link is provided to the public register to access all staff and director declarations here: https://gosh.mydeclarations.co.uk/declarations

Summary of report
As part of the guidance issued by NHS England on staff and directors declaring interests and gifts and hospitality, Trusts are required to define 'Decision Making Staff'. These are individuals who have been determined to "*have influence in spending tax-payers' money*" and are required to make a positive or nil declaration about their interests at least annually. In 2018 GOSH's Declaration of Interests, Gifts, Hospitality and Sponsorship Policy was updated in line with this guidance.

As at 31st December 2020 76% of Decision Making Staff had made a positive or nil declaration in the calendar year 2020.

In May 2021 it was agreed at EMT that the definition of Decision Making Staff would be widened in recognition of the importance of accurately capturing individuals within the definition of Decision Making Staff. A communication programme is underway with staff defined as Decision Makers to remind them to declare in 2021.

Action required from the meeting
The Board is asked to note:

- the action taken to comply with the declaration of interests, gifts, hospitality and sponsorship and
- the proportion of Decision Making Staff who made a declaration in 2020
- the register of directors' interests
- the public register available on DECLARE showing staff interests.

Contribution to the delivery of NHS Foundation Trust priorities	**Contribution to compliance with the Well Led criteria**
Quality/ corporate/ financial governance	**Effective processes, managing risk and performance** **Accurate data/ information** **Engagement of public, staff, external partners**

Strategic risk implications

Staff must ensure they are not placed in a position that compromises their role, or may give the appearance that their role has been compromised, or that compromises the position of the Trust with regard to its statutory duties.

Financial implications Under the Bribery Act 2010 unlimited fines can be levied against the Trust.
Implications for legal/ regulatory compliance The Bribery Act 2010 came into effect on 1 July 2011. The Act makes it a criminal offence to give, promise or offer a bribe, and to request, agree to receive or accept a bribe. The maximum penalty for bribery will be 10 years imprisonment for individuals engaging in bribery and an unlimited fine for the hospital.
Consultation carried out with individuals/ groups/ committees Revised definition for Decision Making Staff approved at EMT Presentations given to SLT Emails sent to all Decision Makers
Who is responsible for implementing the proposals / project and anticipated timescales? Victoria Goddard
Who is accountable for the implementation of the proposal / project? Anna Ferrant
Which management committee will have oversight of the matters covered in this report? Executive Management Team

Attachment 6

Great Ormond Street Hospital for Children NHS Foundation Trust

Compliance with the Declaration of Interests, Gifts, Hospitality and Sponsorship Policy 2020/21

Background

In 2017 NHS England issued guidance for NHS Trusts, CCGs and NHS Foundation Trusts on staff and directors declaring interests and gifts and hospitality. Whilst this has the status of 'guidance', NHS England recently emphasised has Trusts are required to adopt the guidance and this requirement is included in the NHS contract; NHS England issued a template policy.

The Trust's Declaration of Interest and Gifts, Hospitality and Sponsorship Policy was updated in 2018 in line with this guidance which included the requirement to define 'Decision Making Staff' - those staff who "*have influence in spending tax-payers' money*". These individuals are required to make a declaration about their interests at least annually (or where there are no interests, to make a nil return). In June 2018 EMT agreed that the following groups of staff would constitute 'Decision Making Staff':

- Executive and Non-Executive Directors
- Members of the Senior Leadership Team
- Consultants and honorary consultants
- Governors on the GOSH Council of Governors.

Compliance with the policy in 2020

The Trust adopted an online system called DECLARE in 2019 which enables all staff to declare and manage their own declarations. New starters who are Decision Making Staff receive an initial email from DECLARE and the system sends weekly reminders to all Decision Makers who have not made a positive or nil declaration in the calendar year. In December 2020 Executive Directors sent emails to Decision Making Staff in their areas reminding them to declare by the end of the calendar year. As at 31st December 2020 there were 660 Decision Making Staff on DECLARE comprised of the above groups of which 76% had made at least one positive or nil declaration in the calendar year. Declarations were made as set out in the table below.

Decision Maker Declarations 2020

Interest type	Number of Declarations
Nil declaration	352
Charitable money donations	9
Clinical private practice	78
Gifts and donations of equipment	1
Hospitality	6
Loyalty interests	28
No change to existing declaration	39

Outside employment	110
Patents	1
Shareholding and other ownership interests	8
Sponsorship events	24
Sponsored posts	1
Sponsored research	24
Total	681

In September 2020 the Trust's Counter Fraud Specialist undertook a review of compliance with the declarations of interests, gifts, hospitality and sponsorship policy. As part of this review sample testing was undertaken on 32 members of staff and a small number of undeclared interests were identified. The procurement team confirmed that the Trust did not contract with the relevant companies and members of staff were contacted and asked to make their relevant declarations. Whilst the Trust's Counter Fraud Specialist has confirmed that the robustness of GOSH's processes benchmark well against other organisations, the NHS Counter Fraud Authority requires 100% compliance for Decision Making Staff declarations.

The Scope of Decision Making Staff

In March 2021 EMT approved a recommendation to widen the definition of Decision Making Staff. This recognised the importance of more accurately capturing staff who do have *influence in spending tax-payers' money* and was rolled out in May 2021 with the following groups constituting Decision Making Staff:

- All staff at band 8c and above
- All doctors at any grade including honorary positions
- All budget holders at any band
- Governors on the GOSH Council of Governors
- Executive and Non-Executive Directors

*Includes Bank and contracted staff in any of the above categories

The new definition has led to a substantial increase in the number of Decision Making Staff and now sits at 1,507. This change was presented at the Senior Leadership Team meeting and all Decision Making Staff have received an email from the Company Secretary confirming this status and what is required of them, and an email from the DECLARE system including the relevant information to access the system. A new approach is also being taken to scheduled reminders with quarterly emails from the system being sent to Decision Making Staff to support real engagement in the process.

Register of Directors' Interests

The Register of Directors' Interests is attached at appendix 1.

Register of staff interests

The public register is available at the following link https://gosh.mydeclarations.co.uk/declarations

Attachment 6

Register of Interests 2020-21
Great Ormond Street Hospital for Children NHS Foundation Trust
Directors
Non – Executive Directors (Voting)

Name	Declared Interests
Sir Michael Rake	Chairman Newday Ltd Vice President, Royal National Institute of Blind People Chairman, Majid Al Futtaim Holdings (UAE) Senior Advisor, Chatham House Member of International Business and Diplomatic Exchange Advisory Board Chairman of the Advisory Board, Engie Ltd Chairman, Phoenix Global Resources Chairman of the International Chamber of Commerce UK Director, (owner) MDVR Services Ltd Director, University College London Partners (UCLP) Chairman, Wireless Logic Limited Director, Trust Payments Limited Chairman, Ola UK Limited Citigroup, Adviser
Mr Akhter Mateen	Non-Executive Director CABI (Centre for Agriculture and Biosciences International) Trustee, Developments in Literacy (DIL) UK Non-Executive Director, Kings College Hospital NHS Foundation Trust Trustee – Malala Fund UK
Mr James Hatchley	Group Strategy Director 3i Group Plc Member of the 3i Group plc Investment Committee Board member of Scandlines Infrastructure ApS, a Danish Ferry business of which 3i own 35%.
Lady Amanda Ellingworth	Director, Plan International Inc Trustee, Plan International UK Deputy Chair, Sir Ernest Cassel Education Trust
Mr Chris Kennedy	Chief Financial Officer ITV Plc Non-Executive Director, Whitbread PLC Non-Executive Director, The EMI Archive Trust Ltd
Ms Kathryn Ludlow	Consultant, Linklaters LLP Special Advisor to G3, the Good Governance Group Trustee of the International Rescue Committee Employee, Centreview Partners LLP Trustee of The Hall for Cornwall
Prof Russell Viner	President and Trustee, Royal College of Paediatrics and Child Health (until 15 May 2021) Consultant (Honorary), UCL Hospitals NHS Foundation Trust Professor, University College London Member of Sage – Government Office for Science, and of subgroups Spi-B (behavioural science) and SPI-Children, In each of these I advise Government on COVID-19 re children and young people.

Attachment 6

Register of Interests 2020-21
Great Ormond Street Hospital for Children NHS Foundation Trust
Directors
Executive Directors (Voting)

Name	Declared Interests
Mr Matthew Shaw, Chief Executive	Director, UCLP Director, Apollo Studios Residents' Association Executive Director, NCL Provider Alliance Partner – Consultant Anaesthetist at GOSH
John Quinn, Chief Operating Officer (from 4th January 2021)	None
Caroline Anderson, Director of HR and OD	None
Prof Alison Robertson, Chief Nurse	None
Dr Sanjiv Sharma, Medical Director	Member, Board of Governors, Haverstock School Board member, University of Stirling Management School Business Advisory Board Director, Greenberry House. Apartment block with 9 flats, each with a share of freehold.
Helen Jameson, Chief Finance Officer	None
Phillip Walmsley, Chief Operating Officer (until 3rd January 2021)	None

Other Directors (Non-Voting)

Zoe Asensio-Sanchez, Director of Estates, Facilities and the Built Environment	None
Professor David Goldblatt	None
Cymbeline Moore	None
Richard Collins	Director, Integris Solutions Limited Integris Solutions Limited, 50% share of limited company (ordinary shares)

Attachment 7

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
26 May 2021

Code of Conduct for Governors and Code of Conduct for Directors **Submitted by:** Anna Ferrant – Company Secretary	**Paper No: Attachment 7** **For approval**

Purpose of report

The Code of Conduct sets out the standards of conduct the Trust expects of its Directors and Governors. These documents are presented to the Trust Board for approval.

The codes cover the expectations of the Principles of Public Life, the core principles of the NHS as defined in the NHS Constitution, the Trust's Always Values and other relevant key Trust policies.

The 2021/22 Code of Conduct for Directors has been updated to reference the Bribery Act 2010 and has had its format improved. There have been no other material changes.

The 2021/22 Code of Conduct for Governors has been updated to reference the Bribery Act 2010 and has also had its format improved. There have been no other material changes.

Summary of report

The Codes of Conduct reflect current good governance and best practice and are clear about the responsibilities for both Directors and Governors and when the codes apply.

All Directors and Governors are required to sign and adhere to their relevant Code of Conduct.

Both 2021/22 Codes of Conduct were enhanced with references to the Bribery Act 2010 as a result of a recommendation arising from the Local Counter Fraud Specialists' (LCFS) review of Trust procedures against The Bribery Act 2010.

Next steps

Once approved by the Trust Board the Code of Conduct for Directors will be circulated to all Trust Board Directors to sign and return to the Corporate Affairs Team.

The Code of Conduct for Governors will be presented to the Council of Governors on 6 July 2021 for approval. Once approved, it will be circulated to all Governors to sign and return to the Corporate Affairs Team.

Action required from the meeting

The Trust Board is asked to approve the Code of Conduct for Directors and the Code of Conduct for Governors.

Contribution to the delivery of NHS Foundation Trust priorities	**Contribution to compliance with the Well Led criteria**
□ PRIORITY 1: Make GOSH a great place to work by investing in the wellbeing and development of our people **□ Quality/ corporate/ financial governance**	**□ Effective processes, managing risk and performance**

Attachment 7

Strategic risk implications Not applicable.
Financial implications Not applicable.
Implications for legal/ regulatory compliance Not Applicable.
Consultation carried out with individuals/ groups/ committees Not applicable.
Who is responsible for implementing the proposals / project and anticipated timescales? All Governors and Directors will be expected to sign and return their relevant Code of Conduct by Friday 30 July 2021. The Company Secretary and Corporate Affairs Team will support completion of this. The Corporate Affairs Team will support the Chair in ensuring Governors and Directors adhere to their Codes of Conduct throughout 2021/22.
Who is accountable for the implementation of the proposal / project? Company Secretary.

Attachment 7

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST

CODE OF CONDUCT FOR DIRECTORS

1 Introduction

1.1 It is important that Great Ormond Street Hospital for Children NHS Foundation Trust (the "**Trust**") enjoys the confidence of its stakeholders so it is essential that each person involved in the governance of the Trust adopts the highest standards of conduct.

1.2 This document is the Code of Conduct for the Trust's Directors (the "**Code**") who are appointed in accordance with the Constitution. The Trust is governed by the National Health Service Act 2006, the Health and Social Care Act 2012 and its Constitution (together the "**Governance Framework**"). All Directors are required to act in accordance with the provisions of the Governance Framework and this Code.

1.3 This Code should be read in conjunction with Governance Framework of the Trust and the documents listed in Appendix A. If there is any discrepancy between this Code and the Constitution or any document defined in Appendix A, those documents shall prevail.

2 Application of this Code

2.1 This Code applies to Directors when they are acting in the capacity of a Trust Director and outlines the behaviour expected of persons holding such office within the Trust.

2.2 This Code also applies to Directors when acting in other capacities (including a personal capacity) in the event that there are concerns about a Director's conduct when they are acting in such other capacity and those concerns are relevant to the person's role as a Director. The Trust will act proportionately and reasonably when applying this Code in any such circumstances.

3 Values and Principles

3.1 As holders of office in the Trust, a public authority, Directors are required to adopt the seven Principles of Public Life (also known as the Nolan Principles)[1] which are as follows:

3.1.1 Selflessness: Holders of public office should act solely in terms of the public interest.

3.1.2 Integrity: Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3.1.3 Objectivity: Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

3.1.4 Accountability: Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

3.1.5 Openness: Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

[1] The Principles of Public Life are defined here.

3.1.6 Honesty: Holders of public office should be truthful.

3.1.7 Leadership: Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

3.2 Directors are also expected to support the core principles of the NHS as defined in the NHS Constitution and summarised below:

3.2.1 The NHS provides a comprehensive service, available to all.

3.2.2 Access to NHS services is based on clinical need, not an individual's ability to pay.

3.2.3 The NHS aspires to the highest standards of excellence and professionalism.

3.2.4 The NHS aspires to put patients at the heart of everything it does.

3.2.5 The NHS works across organisational boundaries and in partnership with other organisations in the interests of patients, local communities and the wider population.

3.2.6 The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.

3.2.7 The NHS is accountable to the public, communities and patients that it serves.

3.3 Directors are also required to adopt the Trust's values (the "**Always Values**"), which, with the associated behavioural standards, are as follows:

3.3.1 Always Welcoming: respect, smiles, friendly.

3.3.2 Always Helpful: understanding, helps others, patient, reliable.

3.3.3 Always Expert: professional, safe, excellence, improving.

3.3.4 Always One Team: listen, communicate, involve, open.

3.4 Each value is underpinned by behavioural standards which Directors are expected to display at all times. A full description of the Always Values and the associated behaviours will be given to Directors by the Company Secretary.

3.5 Directors are also expected to adopt and comply with any codes of conduct or policies of the Trust which describe standards of behaviour that are relevant to employees and other individuals involved in the governance or operation of the Trust. The relevant policies are listed at Appendix B and a copy of each will be given to each Director at the time of their induction.

4 The role and conduct of Directors

4.1 The role of each Director and of the Trust Board is defined in the Trust's Constitution and in relevant terms of reference and role descriptions. Directors are required to comply with these documents (and others defined in Appendix A) and any relevant policies and procedures issued to them. Any Director who is non-compliant with any of these requirements, or is aware of non-compliance by others, must notify the Company Secretary immediately.

4.2 In order to discharge their roles effectively, Directors are expected to adopt high standards of conduct. Therefore, in addition to adopting the values and principles set out above, Directors are expected to:

4.2.1 Demonstrate commitment to the Trust as a whole and act in its best interests at all times, including in relation to any other interests which Directors may have

(in which respect refer to section 8 below);

4.2.2 Conduct themselves in a manner that reflects positively on the Trust and in accordance with the Trust's Always Values as outlined above and not in any way that would reasonably be regarded as bringing their office or the Trust into disrepute;

4.2.3 Recognise that the Trust is fully committed to the protection of children and as such all Directors are required to participate in appropriate assessments relevant to child protection.

4.2.4 Understand the role and authority of the Trust Board and the governance of the Trust;

4.2.5 Contribute to the development of and support the Trust's mission, vision, and strategy;

4.2.6 Give thorough consideration to information and advice provided in the course of the business of the Trust such that no Director should adopt a position without fully considering (and if necessary challenging) all of the information available, while always acting in the best interests of the Trust;

4.2.7 Focus on the key issues for the Trust and not give undue attention to any single issue, or act in support of or advocate for any member, group of members, campaign (or similar);

4.2.8 Obtain and have regard to advice from the Chair, the Chief Executive (including in his/her capacity as Accounting Officer) or the Company Secretary, particularly in respect of matters of conduct, responsibilities and compliance with the Constitution and other relevant governance requirements;

4.2.9 Participate in training and development provided by or through the Trust, whether for individual Directors or for the Trust Board as a whole;

4.2.10 Commit the necessary time to the role, including attendance at meetings of the Trust Board and seminars (where practicable), and training and development events.

4.2.11 Acknowledge the responsibility of the Council of Governors to hold the non-executive directors individually and collectively to account for the performance of the Trust Board, (including representing the interests of the Trust's members and partner organisations in the governance and performance of the Trust), and to have regard to the views of the Council of Governors.

5 Fit and proper person

5.1 It is a condition of the Trust's NHS Provider Licence that each Director serving on the Trust Board is a 'fit and proper person' (as defined in the Trust's NHS Provider Licence). Directors must certify on appointment, and each year, that they are/remain a fit and proper person. The provisions of the Constitution apply in respect of determining whether or not a person is fit and proper (and, if they are not, in respect of disqualification from office).

6 Accountability of Directors

6.1 Each Director is accountable to the Trust Board for his/her performance and conduct.

6.2 The Directors collectively are accountable for the effectiveness of the Trust Board, the exercise of its powers and the performance of the Trust.

7 Confidentiality, Data Protection and Freedom of Information

Confidentiality

7.1 Directors may receive information which is not publically available, including information relating to individuals (including patients or employees of the Trust) and sensitive commercial information relating to the Trust's business.

7.2 Directors are required to observe and follow the requirements set out by information governance rules, policies, standards and procedures. Directors must ensure that they are aware of the handling requirements, take personal responsibility for the quality of data recorded and protect information at all times. Directors must not attempt to breach information security in any way. Further information can be obtained from the Trust's Information Governance department or Caldicott Guardian.

7.3 The Trust Board must work openly and transparently. The majority of its business is conducted in public, including through the publication of meeting papers, but in specific circumstances it may be necessary for briefings to be provided in confidence or for confidential matters to be considered.

Data Protection

7.4 Directors recognise that any disclosure of confidential information (unless required by law) puts at risk the Trust's compliance with its duties of confidentiality and, where such data is personal data, the General Data Protection Regulation and the Data Protection Act 2018 (or any future data protection legislation) and other relevant law (the "**Data Protection Legislation**"). Such a disclosure may also undermine the Trust's ability to function effectively and/or its reputation and may therefore be contrary to the requirements of this Code.

7.5 Directors must comply, at all times, with the Data Protection Legislation.

Freedom of Information

7.6 Directors acknowledge that the Trust is subject to the Freedom of Information Act 2000 ("**FOIA**"), and shall comply with the Trust's policy relating to freedom of information requests at all times. If a director receives a request for information under FOIA he or she must not reply to such a request and must instead follow Trust procedure.

General

7.7 Information may be received by Directors pursuant to the Trust's whistleblowing policy. The Trust openly encourages all members of staff to raise any concerns they may have about patient care openly and honestly. There are clear processes for raising concerns in this regard and it is vital that where a Director is involved with a complaint received under the Trust's whistleblowing policy such information is dealt with strictly in accordance with the aforementioned policy.

7.8 In accordance with the Constitution, the Trust will investigate any breaches of confidentiality on the part of Directors and will take appropriate action.

7.9 No provision of this Code shall preclude any Directors from making a protected disclosure within the meaning of the Public Disclosure Act 1998 but where a Director is considering making any such disclosure, they should seek advice from the Company Secretary.

8 Directors' Interests and Gifts and Hospitality

8.1 Directors must at all times be impartial, honest and beyond suspicion in the conduct of Trust business and adhere to the Trust's Countering Fraud, Bribery and Corruption

Policy. It is an offence under the Bribery Act 2010 to give, promise or offer a bribe, and to request, agree to receive or accept a bribe.

8.2 Directors must at all times adhere to the Trust's Declarations of Interest and Gifts, Hospitality and Sponsorship Policy. Directors must ensure they are not placed in a position that compromises their role, or may give the appearance that their role has been compromised, or that compromises the position of the Trust with regard to its statutory duties.

Director's Interests

8.3 Directors of the Trust have a duty under the Governance Framework to "avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests" of the Trust.

8.4 The Trust recognises that some Directors hold roles in other organisations or have other interests and welcomes the experience this can bring to the Trust, provided any potential conflicts are recorded and avoided.

8.5 It is important that all decision-making in the Trust is robust and based upon openness and transparency. The Trust therefore has in place arrangements to ensure that relevant interests are declared by Directors, and to address any conflicts between such interests and those of the Trust. Directors are required to comply with these arrangements, as defined in the Constitution, and relevant policies and procedures (which are provided to Directors).

8.6 Where there is any doubt as to the relevance of an interest for any Directors, or the process through which an interest should be addressed, advice must be sought from the Company Secretary before the relevant Director is involved in taking a decision or participating in a discussion.

8.7 Directors must not seek to use their position improperly to confer any advantage or disadvantage on any person.

Gifts and Hospitality

8.8 No Director should, or should appear, to secure gifts or hospitality by virtue of their role at the Trust. There may be serious consequences for Directors and the Trust if gifts or hospitality are accepted in certain situations. If any Director has any doubt as to whether or not a gift may be accepted it should be refused or advice should be sought from the Company Secretary before the gift and/or hospitality is accepted.

9 Equality

9.1 Directors are expected to understand and promote the policies of the Trust which relate to equality and diversity.

9.2 The Trust has a duty under the Equality Act 2010 ("EA 2010") to:

9.2.1 eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the EA 2010;

9.2.2 advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and

9.2.3 foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

10 Representing the Trust

10.1 The Trust has in place policies and arrangements to manage its relations with the media

and other stakeholders to ensure that its reputation is protected and to enable the organisation to function effectively.

10.2 Where the work of the Trust Board is relevant to a matter that is the subject of reporting in the media, or discussions with stakeholders, the Chair or another nominated Director, supported by the Trust's Communications Department, will speak on behalf of the Directors.

10.3 To protect Directors and to ensure a co-ordinated and managed approach to media and stakeholder relations, no Director may approach the media or any other stakeholder, or respond to requests for comment, or otherwise seek to represent the Trust. Any Director receiving a request for comment must, without responding, refer it immediately for action by the Trust's Company Secretary.

10.4 Any Director who is approached in a personal capacity by the media or any other stakeholder may respond but must make it clear that he/she is doing so in that capacity, not as a representative of the Trust, and must have regard to this Code and in particular to the reputation of the Trust when doing so. Before making such comments Directors should seek advice from the Trust's Company Secretary.

10.5 Directors must also take care when expressing views on social media or other platforms which may compromise their position at the Trust or the interests of the Trust.

11 Training & development

11.1 The Trust is committed to providing appropriate induction, training and development opportunities for Directors to enable them to carry out their role effectively. This ensures compliance with the statutory duty which states that the Trust has to take steps to ensure that the Directors are equipped with the skills and knowledge they require. Each Director is, therefore, required to participate in training and development opportunities that have been identified as appropriate for him/her.

12 Interpretation of this Code, and compliance

12.1 Any Director who requires advice on the provisions or application of this Code should obtain it from the Company Secretary.

12.2 All Directors are required to comply with this Code. Each Director must confirm this within 7 days of his or her appointment by signing and returning to the Company Secretary a copy of this Code.

12.3 Any suspected or actual non-compliance with this Code will be addressed in accordance with the Constitution.

13 Approval and review of this Code

13.1 This Code was approved by the Trust Board on 26 May 2021 - TBC

13.2 This Code will be subject to review, led by the Chair and Company Secretary, not more than two years from its date of approval.

14 Declaration

I Click or tap here to enter text. have read, understood and agree to comply with this Code of Conduct for the Trust Board of Great Ormond Street Hospital for Children NHS Foundation Trust.

Signature Click or tap here to enter text. Date Click or tap to enter a date.

APPENDIX A: GOVERNANCE DOCUMENTS

1. GOSH Constitution, including its appendices
2. Standing Orders
3. Standing Financial Instructions
4. Any terms of reference for the Trust Board or any committees established by it
5. Schedule of matters Reserved to the Trust Board and Council of Governors
6. Foundation Trust Code of Governance
7. Provider Licence of the Trust
8. Any role descriptions or similar for Directors

APPENDIX B: POLICIES AND PROCEDURES

1. Declarations of Interest and Gifts and Hospitality Policy
2. Confidentiality Policy
3. Disclosure and Barring Service Policy
4. Fire Policy
5. Health and Safety Policy
6. Media Policy
7. Safeguarding Children and Young People Policy

Attachment 7

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST

CODE OF CONDUCT FOR GOVERNORS

1 Introduction

1.1 It is important that Great Ormond Street Hospital for Children NHS Foundation Trust (the Trust) enjoys the confidence of its stakeholders so it is essential that each person involved in the governance of the Trust adopts the highest standards of conduct.

1.2 This document is the Code of Conduct for the Trust's Governors (the Code), the members of the Council of Governors (the COG) which is part of the Trust's governance structure as defined in its Constitution. The Code sets out the standards of conduct which the Trust expects of its Governors.

1.3 This Code should be read in conjunction with the Constitution and other documents relevant to the governance of the Trust, as defined in Appendix A, as well as the Foundation Trust Code of Governance[1]. If there is any discrepancy between this Code and the Constitution or any document defined in Appendix A, those documents shall prevail.

2 Application of this Code

2.1 This Code applies to Governors when they are acting in that capacity.

2.2 Whilst this is the case, the Trust recognises that the Governor role is part-time and unpaid so the Trust will act proportionately and reasonably when applying the expectations set out in this Code while also maintaining standards of conduct that are commensurate with the important role which Governors have in the governance of the Trust.

2.3 This Code applies to Governors when acting in any another capacity only in the event that there are concerns about a Governor's conduct when they are acting in such other capacity and those concerns are relevant to the person's role as a Governor. The Trust will act proportionately and reasonably when applying this Code in any such circumstances.

3 Values and Principles

3.1 As holders of office in the Trust, a public authority, Governors are required to adopt the Principles of Public Life[2] which are as follows:

3.1.1 Selflessness: Holders of public office should act solely in terms of the public interest.

3.1.2 Integrity: Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3.1.3 Objectivity: Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

3.1.4 Accountability: Holders of public office are accountable to the public for their

[1] The Foundation Trust Code of Governance is available here.
[2] The Principles of Public Life are defined here.

decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

3.1.5 Openness: Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

3.1.6 Honesty: Holders of public office should be truthful.

3.1.7 Leadership: Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

3.2 Governors are also expected to support the core principles of the NHS as defined in the NHS Constitution[3] and summarised below:

3.2.1 The NHS provides a comprehensive service, available to all.

3.2.2 Access to NHS services is based on clinical need, not an individual's ability to pay.

3.2.3 The NHS aspires to the highest standards of excellence and professionalism.

3.2.4 The NHS aspires to put patients at the heart of everything it does.

3.2.5 The NHS works across organisational boundaries and in partnership with other organisations in the interests of patients, local communities and the wider population.

3.2.6 The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.

3.2.7 The NHS is accountable to the public, communities and patients that it serves.

3.3 Governors are also required to adopt the Trust's values (the Always Values), which, with the associated behavioural standards, are as follows:

3.3.1 Always Welcoming: respect, smiles, friendly

3.3.2 Always Helpful: understanding, helps others, patient, reliable

3.3.3 Always Expert: professional, safe, excellence, improving

3.3.4 Always One Team: listen, communicate, involve, open

3.4 Each value is underpinned by behavioural standards which Governors are expected to display at all times. A full description of the Always Values and the associated behaviours will be given to Governors by the Company Secretary.

3.5 Governors are also expected to adopt and comply with any codes of conduct or policies of the Trust which describe standards of behaviour that are relevant to employees and other individuals involved in the governance or operation of the Trust. The relevant policies are listed at Appendix B and a copy of each will be given to each Governor at the time of their induction and made available on the Governor portal.

4 The role and conduct of Governors

4.1 The role of each Governor and of the Council of Governors is defined in the Trust's Constitution and in relevant terms of reference and role descriptions. Governors are required to comply with these documents (and others defined in Appendix A) and any relevant policies and procedures issued to them. Any Governor who is non-compliant

[3] The NHS Constitution is available here.

with any of these requirements, or is aware of non-compliance by others, must notify the Company Secretary immediately.

4.2 The Governors recognise that the Council of Governors is an important part of the Trust's governance structure and as such it must work constructively and collaboratively with the Board of Directors (the Board), which, as required by the Trust's Constitution and NHS Provider Licence[4], is responsible for the governance of the Trust. Governors therefore commit to developing (with the Board) and adopting arrangements to facilitate such a relationship between the Council of Governors and the Board, and with relevant members of staff.

4.3 In order to discharge their roles effectively, Governors are expected to adopt good standards of conduct. Therefore, in addition to adopting the values and principles set out above, Governors are expected to:

4.3.1 Demonstrate commitment to the Trust as a whole and act in its best interests at all times, including in relation to any other interests which Governors may have (in which respect refer to section 8 below);

4.3.2 Conduct themselves in a manner that reflects positively on the Trust and in accordance with the Trust's Always Values as outlined above and not in any way that would reasonably be regarded as bringing their office or the Trust into disrepute;

4.3.3 Recognise that the Trust is fully committed to the protection of children and as such all Governors are required to participate in appropriate assessments relevant to child protection.

4.3.4 Understand the role and authority of the Council of Governors and the governance of the Trust;

4.3.5 Recognise that the Council of Governors acts collectively and corporately such that each Governor must adopt and support its decisions;

4.3.6 Accept that no Governor has any individual responsibilities or authority and must not seek to act other than through the Council of Governors;

4.3.7 Contribute to the development of and support the Trust's mission, vision, and strategy;

4.3.8 Give thorough consideration to information and advice provided in the course of the business of the Council of Governors such that no Governor should adopt a position that is unreasonably contrary to such advice or to recommendations, or unreasonably withhold approval on any matter;

4.3.9 Focus on the key issues for the Trust and not give undue attention to any single issue, or act in support of or advocate for any member, group of members, campaign (or similar);

4.3.10 Obtain and have regard to advice from the Chair, the Chief Executive (including in his capacity as Accounting Officer) or the Company Secretary, particularly in respect of matters of conduct, responsibilities and compliance with the Constitution and other relevant governance requirements;

4.3.11 Participate in training and development provided by or through the Trust, whether for individual Governors or for the Council of Governors as a whole;

4.3.12 Commit the necessary time to the role, including attendance at general

[4] The Trust's NHS Provider Licence is available here.

meetings of the Council of Governors, seminars, and training and development events.[5]

5 Fit and proper person

5.1 It is a condition of the Trust's NHS Provider Licence that each Governor serving on the Council of Governors is a 'fit and proper person' (as defined in the Trust's NHS Provider Licence). Governors must certify on appointment, and each year, that they are/remain a fit and proper person. The provisions of the Constitution apply in respect of determining whether or not a person is fit and proper (and, if they are not, in respect of disqualification from office).

6 Accountability of Governors

6.1 Each Governor is accountable to the Council of Governors and, through arrangements put into place by the Trust, to the members who elected them, or the organisation that appointed them, for his/her performance and conduct.

6.2 The Governors collectively are accountable for the effectiveness of the Council of Governors as an important part of the Trust's governance, for which the Board is responsible.

6.3 In connection with this, Governors accept the role of the Chair as the leader of the Council of Governors as defined in the Constitution and other governance documents (at Appendix A).

7 Confidentiality

7.1 The Council of Governors must work openly and transparently. The majority of its business is conducted in public, including through the publication of meeting papers, but in specific circumstances it may be necessary for briefings to be provided in confidence or for confidential matters to be considered.

7.2 Governors must comply with the Trust's policies and procedures in respect of confidentiality, as provided to them. Therefore, Governors must not disclose information which is stated as being confidential, other than when it is lawful to do so.

7.3 Governors recognise that any disclosure of confidential information puts at risk the Trust's compliance with its duties of confidentiality and, where such data is personal data, the General Data Protection Regulation (Regulation (EU) 2016/679), Data Protection Act 2018 (or any future data protection legislation) and other relevant law. Such a disclosure may also undermine the Trust's ability to function effectively and/or its reputation and may therefore be contrary to the requirements of this Code.

7.4 In accordance with the Constitution the Trust will investigate any breaches of confidentiality on the part of Governors and will take appropriate action.

7.5 No provision of this Code shall preclude any Governors from making a protected disclosure within the meaning of the Public Disclosure Act 1998 but where a governor is considering making any such disclosure, they should seek advice should from the Company Secretary.

8 Governors' interests

8.1 The Trust recognises that some Governors hold roles in other organisations or have

[5] During elections the Trust will communicate to members the time commitment associated with the Governor role so that members who nominate themselves as candidates understand the Trust's expectations. The Trust will make clear that a Governor may be removed from office if he/she fails to comply with requirements in the constitution with respect to attendance at meetings. The Trust expects that staff who are elected as Staff Governors will be allowed appropriate time to fulfil their duties in that role (and will not be required to use annual leave for this purpose).

other interests; it values these where they enable Governors to make an informed contribution to the governance of the Trust.

8.2 It is important that all decision-making in the Trust is robust and based upon openness and transparency. Governors must at all times be impartial, honest and beyond suspicion in the conduct of their Trust business. Governors must not seek to use their position improperly to confer any advantage or disadvantage on any person. .It is an offence under the Bribery Act 2010 to give, promise or offer a bribe, and to request, agree to receive or accept a bribe.

8.3 The Trust has in place arrangements to ensure that relevant interests are declared by Governors (and others), and to address any conflicts between such interests and those of the Trust. Governors are required to comply with these arrangements as defined in the Constitution and relevant policies and procedures (which are provided to Governors).

8.4 Where there is any doubt as to the relevance of an interest for any Governor, or the process through which an interest should be addressed, advice must be sought from the Company Secretary.

9 Representing the Trust

Media

9.1 The Trust has in place policies and arrangements to manage its relations with the media and other stakeholders to ensure that its reputation is protected and to enable the organisation to function effectively.

9.2 Where the work of the Council of Governors is relevant to a matter that is the subject of reporting in the media, or discussions with stakeholders, the Chair, supported by the Trust's Communications Department, will speak on behalf of the Governors. In doing so the Chair may consult with the Lead Governor or other Governors as appropriate.

9.3 To protect Governors and to ensure a co-ordinated and managed approach to media and stakeholder relations, no Governor may approach the media or any other stakeholder, or respond to requests for comment, or otherwise seek to represent the Trust. Any Governor receiving a request for comment must, without responding, refer it immediately for action by the Trust's Company Secretary.

9.4 Any Governor who is approached in a personal capacity by the media or any other stakeholder may respond but must make it clear that he/she is doing so in that capacity, not as a representative of the Trust, and must have regard to this Code and in particular to the reputation of the Trust when doing so. Before making such comments Governors should seek advice from the Trust's Company Secretary but where no such advice is sought Governors should notify the department after making comment.

Visits to premises of the Trust or other organisations

9.5 In connection with the work of the Council of Governors the Trust may from time to time invite Governors to visit the Trust's services or facilities, including premises which are not open to members of the public, or premises operated by other organisations. Governors must comply with any arrangements put into place by the Trust (or the other organisation concerned) for such visits, including requirements in respect of infection control and dress.

9.6 In order to ensure the privacy of patients and so that the Trust's services function effectively, Governors may not otherwise visit any of the Trust's premises in their capacity as Governors. Governors may not in that capacity visit the premises of any

other organisation without the permission of the Trust and the other organisation concerned.

9.7 The above provisions do not prevent any Governor from visiting the Trust in a personal or other capacity, including as a patient, a carer of a patient, or as a volunteer.

10 Training & development

10.1 The Trust is committed to providing appropriate induction, training and development opportunities for Governors to enable them to carry out their role effectively. This ensures compliance with the statutory duty which the Trust has to take steps to ensure that the Governors are equipped with the skills and knowledge they require.

10.2 Each Governor is, therefore, required to participate in training and development opportunities that have been identified as appropriate for him/her (except with reasonable cause in the opinion of the Chair, Company Secretary and Lead Governor).

11 Interpretation of this Code, and compliance

11.1 Any Governor who requires advice on the provisions or application of this Code should obtain it from the Company Secretary.

11.2 All Governors are required to comply with this Code. Each Governor must confirm this within 28 days of his election or appointment by signing and returning to the Company Secretary a copy of this Code.

11.3 Any suspected or actual non-compliance with this Code will be addressed in accordance with the Constitution.

12 Approval and review of this Code

12.1 This Code was approved by the:

12.1.1 Trust Board on 26 May 2021 - TBC

12.1.2 Council of Governors on 6 July 2021 - TBC

12.2 This Code will be subject to review, led by the Chair and Company Secretary, not more than one year from its date of approval.

13 Declaration

I Click or tap here to enter text. have read, understood and agree to comply with this Code of Conduct for the Council of Governors of Great Ormond Street Hospital for Children NHS Foundation Trust.

Signature Click or tap here to enter text. **Date** Click or tap to enter a date.

APPENDIX A: GOVERNANCE DOCUMENTS

1 **Constitution, including its appendices**

2 **Standing Orders**

14 Standing Financial Instructions

15 Any terms of reference for the Council of Governors or any committees established by it

16 Schedule of matters Reserved to the Board and Council of Governors

17 Foundation Trust Code of Governance

18 Code of Conduct for Governors

19 Standard Operating Procedure on Electronic Communications

20 Any role descriptions or similar for Governors

APPENDIX B: POLICIES AND PROCEDURES

1 **Declarations of Interest, Gifts, Hospitality and Sponsorship Policy**
2 **Countering Fraud, Bribery and Corruption Policy**
3 **Confidentiality Policy**
4 **Disclosure and Barring Service Policy**
5 **Fire Policy**
6 **Health and Safety Policy**
7 **Media Policy**
8 **Safeguarding Children and Young people Policy**