Meeting of the Trust Board
Wednesday 2 February 2022

Dear Members

There will be a public meeting of the Trust Board on Wednesday 2 February 2022 at 2:15pm held on Zoom

Company Secretary Direct Line: 020 7813 8230

AGENDA

	Agenda Item STANDARD ITEMS	Presented by	Attachment	Page number	Timing
1.	**Apologies for absence**	Chair	**Verbal**		**2:15pm**
Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.					
2	**Minutes of meeting held on 24 November 2021**	Chair	**A**	**3**	
3.	**Matters Arising/ Action Checklist**	Chair	**B**	**13**	
4.	**Chief Executive Update**	Chief Executive	**C**	**15**	**2:25pm**
5.	**Patient Story**	Chief Nurse/ Head of Patient Experience	**D**	**20**	**2:35pm**
6.	**Directorate presentation: Sight and Sound**	Chief Operating Officer/ Senior Leadership Team for Directorate	**E**	**28**	**2:50pm**
7.	**CQC Inpatient Survey results presentation**	Chief Nurse	**F**	**45**	**3:05pm**
	RISK				
8.	**Infection Control Assurance Framework**	Chief Nurse/ Director of Infection, Prevention and Control	**G**	**64**	**3:20pm**
	PERFORMANCE				
9.	**Integrated Quality and Performance Report (Month 9) December 2021**	Medical Director/ Chief Nurse/ Chief Operating Officer	**I**	**103**	**3:30pm**
10.	**Finance Report - Month 9 (December) 2021**	Chief Finance Officer	**J**	**155**	**3:45pm**
11.	**Safe Nurse Staffing Report (October – December 2021)**	Chief Nurse	**K**	**166**	**3:55pm**
	ASSURANCE				
12.	**Guardian of Safe Working Report Q3 2021/22**	Guardian of Safe Working – Renee McCulloch	**L**	**175**	**4:05pm**

13.	**Board Assurance Committee reports** • **Quality, Safety and Experience Assurance Committee update – January 2022 meeting**	Chair of the Quality, Safety and Experience Assurance Committee	**M**	**182**	**4:15pm**
	• **Finance and Investment Committee Update – November 2021**	Chair of the Finance and Investment Committee	**P**	**185**	
	• **Audit Committee Assurance Committee Update – January 2022 meeting (including Board Assurance Framework Update)**	Chair of Audit Committee	**Q**	**187**	
	• **People and Education Assurance Committee Update – December 2021 meeting**	Chair of the People and Education Assurance Committee	**R**	**194**	
14.	**Council of Governors' Update – November 2021 meeting**	Chair	**S**	**196**	**4:30pm**
	GOVERNANCE				
15.	**Standing Financial Instructions and Scheme of Delegation**	Chief Finance Officer	**T**	**199**	**4:35pm**
16.	**Well Led Update**	Company Secretary	**N**	**281**	**4:40pm**
17.	**Register of Seals**	Company Secretary	**U**	**283**	**4:45pm**
18.	**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.)				
19.	**Next meeting** The next public Trust Board meeting will be held on Wednesday 27 April 2022 in the Charles West Room, Barclay House, Great Ormond Street, London, WC1N 3BH.				

Attachment A

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT Minutes of the meeting of Trust Board on 24th November 2021

Present

Sir Michael Rake	Chair
James Hatchley	Non-Executive Director
Chris Kennedy	Non-Executive Director
Amanda Ellingworth	Non-Executive Director
Kathryn Ludlow	Non-Executive Director
Akhter Mateen	Non-Executive Director
Professor Russell Viner	Non-Executive Director
Matthew Shaw	Chief Executive
Darren Darby	Acting Chief Nurse
John Quinn	Chief Operating Officer
Sanjiv Sharma	Medical Director
Helen Jameson	Chief Finance Officer
Caroline Anderson	Director of HR and OD

In attendance

Cymbeline Moore	Director of Communications
Zoe Asensio Sanchez	Director of Estates, Facilities and the Built Environment
Anna Ferrant	Company Secretary
Victoria Goddard	Trust Board Administrator (minutes)
Claire Williams*	Head of Patient Experience
Aimee*	Parent of a GOSH patient
Carly Vassar*	Head of Nursing for Body, Bones and Mind
Sian Pincott*	Chief of Service, Body, Bones and Mind
Jeremy Nobes*	General Manager, Body, Bones and Mind
Nick Martin*	Head of Sustainability and Environmental Management
Renee McCulloch*	Associate Medical Director and Guardian for Safe Working
Alaettin Carikci*	Diversity and Inclusion Organisational Development Partner
Julian Evans	Governor (observer)
2 members of staff	

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

116	**Apologies for absence**
116.1	No apologies for absence were received.
117	**Declarations of Interest**
117.1	Sir Michael Rake, Chair declared that he was Vice President of the RNIB.
118	**Minutes of Meeting held on 29th September 2021**

118.1	The Board **approved** the minutes of the previous meeting.
119	**Matters Arising/ Action Checklist**
119.1	The actions taken since the last meeting were noted.
120	**Chief Executive Update**
120.1	Matthew Shaw, Chief Executive thanked staff for their hard work to ensure that activity remained high in order to reduce the backlog of waiting patients.
120.2	It had been announced that staff working in health and social care settings must be fully vaccinated by 1st April 2022 and Matthew Shaw said this would be an emotive subject and no clear guidance had been published yet. He added that just over 10% of GOSH staff were unvaccinated.
120.3	**Action:** Russell Viner, Non-Executive Director asked what proportion of GOSH patients aged 12 and over had been vaccinated and asked whether this would be part of clinical assessment going forward. It was agreed that an update would be provided at the next meeting.
120.4	James Hatchley, Non-Executive Director asked whether 100% of GOSH's workforce would require vaccination and Matthew Shaw said that this was not yet clear as the requirement was for 'frontline' staff but no guidance had been published to define this.
121	**Patient Story**
121.1	The Board received a patient story via video conference from Aimee, mother of Anoosha, a patient at GOSH since she was four months old.
121.2	Aimee said that Anoosha had received successful cardiac surgery at GOSH but had developed intestinal failure as she grew older which had led to her spending 5 years at GOSH under a large number of specialties. Aimee said that she received good support from staff and had valued the hospital school. The team had supported Anoosha to experience the things that she would have had access to if she had been at home such as trips to the park. She added that she felt clinical teams had always prioritised Anoohsa's care and knew her well.
121.3	Aimee said that the key challenge had been communication and this was the case whether it was between teams, within teams or between doctors and nurses. She said that she had been required to speak up to ensure that she was seen as a partner in her child's care. Aimee said that it had been challenging when there had been a rotation of staff such as doctors in training as it was important that clinical staff knew each patient. She welcomed the introduction of MyGOSH which provided a useful method of communicating with staff and also gave appointment reminders.
121.4	Aimee said that there was considerable expense involved in long hospital stays as costs were duplicated with part of the family remaining at home. Amanda Ellingworth, Non-Executive Director asked if there was more that the hospital could do to support families who were living separately and Aimee said that as a result of the pandemic, siblings had not been able to visit the hospital and this had been challenging. There had also been considerable expense involved with

	traveling home weekly. She highlighted that it was possible for outpatients to claim travel expenses back under some circumstances and added that consideration should be given to a scheme such as this for long term patients.
121.5	**Action:** Claire Williams said that there had been issues around catering vouchers which could be given to families and work was taking place to identify the cause of these issues. An update would be provided to the QSEAC.
121.6	Sir Michael Rake, Chair asked whether doctors in training were given feedback on their interactions with families and Sanjiv Sharma, Medical Director said that it was vital that they were aware of the importance of families in patients' treatment and said that this feedback would be provided through the education team.
122	**Directorate Presentation: Body, Bones and Mind**
122.1	Carly Vassar, Head of Nursing and Patient Experience for Body, Bones and Mind said there had been key successes for the directorate through surges of the pandemic such as working collaboratively across North Central London to develop a CAMHS solution. The directorate had also worked well on Super Saturday and continued to take part in the Paediatric Accelerator to reduce the backlog of patients which was a key challenge. Currently dialysis was at full capacity and there were national concerns around the retention of dialysis nurses.
122.2	Jeremy Nobes, General Manager said that the directorate had delivered a high proportion of planned activity throughout the pandemic. He said that the current challenge in terms of the backlog of patients was related to theatre capacity and as a result of social distancing there had been a reduction in the number of available beds. The directorate had a significant number of long waiting patients and harm reviews were taking place as waits breached specific thresholds. Consideration was also being given to how the Trust was supporting the region if pressure were to increase in adult intensive care settings.
122.3	Sian Pincott, Chief of Service said that pandemic continued to have a significant impact on teams and staff had worked well to be redeployed both internally and externally and take on additional services. Listening events would be introduced for teams and work was taking place to improve communications within the directorate. An early warning system for the health of teams was also being introduced.
122.4	Russell Viner highlighted that safety initiatives and the closure of serious incidents were a key priority for the Trust and noted the complexity of the incidents in which the directorate were involved. He asked whether this contributed to the delayed timeframes for incident closures and Sian Pincott said that it did and added that alongside complex clinical issues there were often also complex issues being managed with families. She said that it would be important for the directorate to improve ongoing communications with families.
122.5	James Hatchley noted that the clinical outcomes for the renal team had last been updated in 2018 and asked if there were challenges to publish more recent data. Sian Pincott said that the team had continued to work during the pandemic and the published outcomes would be updated.

123	**Annual planning and budget setting 2022/23**
123.1	Helen Jameson, Chief Finance Officer said that the Trust's original annual plan for 2021/22 projected an £8.2million deficit. Further guidance had now been issued for the second half of the year including around the elective recovery fund (ERF) and this had moved the plan to £1.1million deficit. James Hatchley said that the plan had been reviewed in detail at the Finance and Investment Committee and it was clear that significant progress had been made including overperformance against planned activity.
123.2	The Board **approved** the proposed plan for the second half of the year.
124	**Sustainability Reset**
124.1	Zoe Asensio Sanchez, Director of Estates, Facilities and the Built Environment said that the team was working to address the gaps identified by the internal audit and ensure that a robust governance structure was in place. She said that the implications of declaring a climate emergency were broad and resource would be required to implement the requirements. Workstream leads would develop plans for each area which would encourage cooperation throughout the Trust.
124.2	Akhter Mateen, Non-Executive Director asked how the work was connect with the Integrated Care System (ICS) and whether there were initiatives which could be jointly run across North Central London (NCL). Nick Martin, Head of Sustainability and Environmental Management said that the NCL Greener Governance Board had met in November and was discussing the ways in which Trusts could work together, particularly around the public realm. Work was also taking place with the Local Health Authority to develop a Camden healthy streets alliance and a positive meeting had taken place.
124.3	Chris Kennedy, Non-Executive Director asked what criteria GOSH would use to identify an offset partner and asked if NCL would use one organisation. Nick Martin said that discussions on this were currently taking place.
125	**Integrated Quality and Performance Report – Month 7 (October) 2021**
125.1	Sanjiv Sharma, Medical Director said that from January 2022 the report would move to a balanced scorecard format which would support the presentation of assurance to the Board and Committees.
125.2	There was currently poor performance in some metrics including Duty of Candour and significant investment had been made in the patient safety team and nine newly appointed members of staff had been appointed. These staff would be joining the Trust between January and March 2022 and the current Service Review Manager would become Interim Head of Patient Safety from 29th November 2021. Her would focus on the recovery of performance against the key metrics and Sanjiv Sharma confirmed that this improvement would be monitored through QSEAC. Russell Viner highlighted that the Trust was waiting for the external review on the GOSH serious incident process and also the starting in post of a large number of staff. He said that it was important to take action in these key areas in the interim.

125.3	Darren Darby, Chief Nurse said that the Trust continued to meet the Friends and Family Test response rate and patient satisfaction remained above 97%. He said that although the response rate was being met overall, one Directorate continued to have a trend of not meeting the response rate and Heads of Nursing had been asked to develop an action plan which would be monitored through the Patient Engagement and Experience Committee (PFEEC).
125.4	PALs contacts related to communications had continued to fall however there was a theme of contacts around staff behaviour and this would continue to be monitored given the pressure under which staff had been working for a prolonged period of time.
125.5	There had been an increase in pressure ulcers with a theme around medical devices. A deep dive would be reviewed at Nursing Board and would also be presented to QSEAC with an action plan.
125.6	John Quinn, Chief Operating Officer said that benchmarking activity showed that GOSH was performing second in terms of recovery of elective activity in North Central London and first in terms of outpatients. Overall activity was above plan for the year however some areas were below plan and this was being monitored. RTT continued to improve in line with the trajectory and 104 week waits were also reducing. It was anticipated that there would be one patient who had waited 104 weeks by 1 January 2022. The Trust continued to meet the targets for cancer waits.
126	**Finance Report – Month 7 (October) 2021**
126.1	Helen Jameson, Chief Finance Officer said that the Trust's financial position had deteriorated in month 7 as a result of the change to the Elective Recovery Fund (ERF) scheme. An in-month deficit of £3.2million had been reported which was £2.3million adverse to plan however the year to date position remained above plan as a result of ERF activity in prior months. Cash remained strong and work was taking place to continue to reduce debtors with further movement being received from the Trust's largest debtor.
127	**Safe Nurse Staffing Report (August - October 2021)**
127.1	Darren Darby said that there was currently a 1.5% nursing vacancy rate which was extremely positive. A 'GOSH 50' international recruitment campaign had ended which had recruited 5 cohorts of nurses and all the those who had been appointed would have joined the Trust by the end of January 2022. The final cohort would all take up roles in CICU.
127.2	The number of nurses who were on maternity or sick leave continued to be a challenge and maternity leave was increasing. Benchmarking was taking place with other paediatric hospitals which tended to have a younger workforce and learning would be discussed with other Trusts.
127.3	Thirteen Datix reports had been raised related to safe staffing. All cases had been reviewed and it was confirmed that no patient harm had occurred. Plans to mitigate challenges related to the pandemic continued to be under review.
127.4	Sir Michael Rake said that pressure on staff turnover had been anticipated but had not yet materialised. He asked for a view over the next 12 months and

	Darren Darby said that staff were likely to reflect on work/life balance as restrictions were lifted. He added that mandatory vaccines were also likely to be a challenge as was potential industrial action around the pay award. He said that he was confident that a robust pipeline of staff was in place and there was less of a reliance of traditional recruitment practices.
127.5	Caroline Anderson, Director of HR and OD said that the approach to recruitment had changed over the last year and was now focused on more local recruitment which had helped to improve retention.
127.6	**Action:** Matthew Shaw said that the last time benchmarking had taken place GOSH had a maternity rate which was twice that of other Trusts. It was agreed that maternity and sickness rates would be separated in future safe staff nursing reports.
127.7	Discussion took place around the approach to recruitment in terms of the mandatory vaccination requirements and the ability of members of staff to continue to be employed at GOSH after 1st April 2022. Caroline Anderson said that newly appointed staff were asked about their vaccination status in order to support planning but added this was not yet mandated. Sir Michael Rake said that it was important to consider the approach to recruitment in this context.
127.8	James Hatchley noted that there had been 24% unfilled bank shifts and said that this was likely to have an impact on substantive staff. He asked if this was a result of staff fatigue. Darren Darby said that the Trust was heavily reliant on substantive nurses for the staff bank, therefore as sickness and isolation requirements increased, the fill rate decreased. He added that it was important to focus on removing bank shifts which were not required in a timely manner to ensure that numbers were not skewed and to widen the group of staff who comprised the staff bank.
128	**Update on Board Assurance Framework**
128.1	Anna Ferrant, Company Secretary said that two new risks had been recommended for approval by the Audit Committee: GOSH Learning Academy and the Children's Cancer Centre. The risk description had been approved by the Audit Committee with minor amendments.
128.2	The Board **approved** the recommended new BAF risks.
129	**Board Assurance Committee reports**
129.1	<u>Audit Committee (October 2021)</u>
129.2	Akhter Mateen, Chair of the Audit Committee said that the Committee had reviewed the financial sustainability, data quality and strategic direction risks and noted the positive result of an internal audit on data quality. The Trust's external auditors had reported that the Value for Money Audit for 2020/21 had been completed without the identification of significant concerns or weaknesses.
129.3	<u>Quality, Safety and Experience Assurance Committee (October 2021)</u>
129.4	Amanda Ellingworth, Chair of the QSEAC said that the committee had discussed quality and safety including some indicators which continued to require

	improvement. Focus had also been placed on patient experience and a delivery plan for the patient experience programme would be review by the committee at its next meeting.
129.5	People and Education Assurance Committee Update –September 2021
129.6	Kathryn Ludlow, Chair of the PEAC said that the team was moving into year two of the people strategy and was continuing to focus on staff wellbeing. There continued to be a positive increase in the number of staff who were speaking up using the freedom to speak up service and the committee noted the work that was taking place to ensure the routes for speaking up were clear.
129.7	Finance and Investment Committee Update (September 2021 and November 2021)
129.8	James Hatchley, Chair of the Finance and Investment Committee said that focus was being placed on understanding the impact of Integrated Care Systems on commissioning and the position of International and Private Care (I&PC) was critical in this context. The Committee continued to review the financials related to the Children's Cancer Centre and particularly the risk associated with the contingency and inflation.
129.9	Russell Viner said that he had attended an NHS England webinar on audit and risk and expressed some concern about the move to ICS commissioning. It was confirmed that this would be discussed further at the Trust Board Strategy Day in December. Chris Kennedy said it was clear that significant uncertainties about the practical operation of the system remained.
130	**Guardian of Safe Working Update**
130.1	Renee McCulloch, Associate Medical Director and Guardian for Safe Working said that work was taking place to understand the financial spend for non-consultant grade doctors and the forecast costings. She said that consideration was being given to ensuring there was junior doctor representation on committees and groups across the Trust and reverse mentoring.
130.2	Matthew Shaw said that it was important that there was parity with other professional groups in the Trust in terms of involvement and it was important to consider where value would be added. John Quinn said the transformation programme was being reconfigured into five programmes within which there would be opportunities for wider stakeholder engagement. He agreed that it was important to identify and include talent in the wider organisation.
130.3	**Action:** It was agreed that consideration would be given to reverse mentoring by junior doctors to members of the Board.
130.4	Akhter Mateen asked whether Health Education England (HEE) had provided any feedback on the quality of training experience provided to doctors in training by GOSH. Renee McCulloch said that GMC reviews of training took place however this only encompassed half of GOSH's junior doctors as half were non-HEE trainees and consideration was being given to rolling out surveys to groups who were not usually included in this kind of feedback. She added that the Health Service Journal (HSJ) had rated GOSH in the top 5 Trusts for experience which was a significant improvement from its previous position close to the bottom of the group and reflected the good work that had taken place.

130.5	Russell Viner said that he had experienced substantial benefits from engaging doctors in training on committees and the new perspective this provided. He asked if GOSH had a chief registrar role and Renee McCulloch said that it didn't but some senior doctors in training had been elevated through the Junior Doctor Forum and ensuring they were represented at the directorate management level. A Senior Medical Officer role had also been developed which was an out of hours leadership role with a leadership programme and this had been positive.
130.6	Discussion took place around the proportion of doctors in training in London in comparison to elsewhere nationally and Helen Jameson said that this was being reviewed in line with the implementation of ICSs. Renee McCulloch said that GOSH offered training opportunities which were not available elsewhere and clinicians would also seek post consultant specialist training which the Trust was well positioned to provide in future. She said that it was important to view clinical education as a competitive market and a route to recruitment of high-quality individuals.
131	**Learning from Deaths Mortality Review Group - Report of deaths in Q1 2021/2022**
131.1	Sanjiv Sharma said that had been 25 inpatient deaths during the reporting period and of those deaths review, one had been identified as having modifiable factors. A serious incident had been declared in this case, which was currently being investigated.
131.2	Good examples of patient care had been identified but also additional learning in 10 patients. There had also been 11 patients for whom patient experience had been impacted as a result of pandemic related restrictions.
131.3	Russell Viner said that a report by the national child database highlighted deprivation as a key issue for children. He asked how much the Trust was aware of the impact of a patient's socioeconomic circumstances on their pathway to GOSH. Matthew Shaw said that an externally written report should be considered by the Board which highlighted the association between socioeconomic group and likelihood of mortality.
131.4	**Action:** Matthew Shaw said that it was important to accelerate the Trust's work on health inequalities and it was noted that this would be discussed at the Trust Board Strategy Day. It was agreed that a further update would be discussed at the February 2022 Trust Board meeting. Sanjiv Sharma said that he was presenting at an education event on data around access to paediatric services broken down by elements such as gender, race and socioeconomic background. It was agreed that this would also be considered by the Board.
131.5	James Hatchley noted that five mortality reviews had not taken place as a result of consultant capacity and sought assurance that this was a key priority for consultants. He said that it was possible that there could be further national restrictions as a result of the pandemic and said that it was vital to act with compassion for families during end of life care. Sanjiv Sharma said that the importance of engaging in the process had been reiterated to consultants. He added that the Trust's COVID precautions did allow for local clinical judgement in key areas.

132	**Seen and Heard annual report 2021**
132.1	Caroline Anderson said that this was the first Seen and Heart annual report which sought to present staff data broken down by protected characteristics and would also enable the Trust to meet its Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES).
132.2	Key changes in the year included an increase in the proportion of Black, Asian and Minority Ethnic (BAME) staff employed at GOSH which had been driven by local nurse recruitment. There had also been an increase in BAME representation in senior managers. Improvements had been made across nine WRES metrics which was extremely positive and in all WDES metrics. Caroline Anderson said that although the report highlighted the progress that had been made it also identified areas for future focus.
132.3	Sir Michael Rake said that it was clear that in the general population people with visual impairments were not being given sufficient opportunities to work with technology and asked whether GOSH was doing enough in this regard. Caroline Anderson said that more work was required in this area and added that only a small number of individuals had self-declared either a disability or long-term illness. Alaettin Carikci, Diversity and Inclusion Organisational Development Partner said that action around visual impairment was an issue across the NHS and added that NHS England were launching a visibility toolkit which aimed to tackle outdated notions of what it meant to live with a disability.
132.4	**Action:** Amanda Ellingworth welcomed the appointment of a Diversity and Inclusion Organisational Development Partner and said that reverse mentorship was key in this area. Chris Kennedy agreed and said that his experience at other organisations had shown the importance of receiving feedback from colleagues from diverse background on their experience of working for an organisation. It was noted that the PEAC committee welcomed staff stories at each meeting and it was agreed that this would be considered at Board or PEAC to provided staff feedback on diversity and inclusion.
133	**Council of Governors' Update – November 2021**
133.1	<u>Constitution and Governance Working Group Terms of Reference and GOSH Constitution Amendment</u>
133.2	Anna Ferrant said that a minor amendment to the GOSH constitution around attendance at Council meetings by Governors and revised terms of reference for the Constitution and Governance Working Group had been approved by the Council of Governors at its November 2021 meeting. Approval was also sought from the Board
133.3	The Board **approved** the Constitution and Governance Working Group Terms of Reference and GOSH Constitution Amendment.
133.4	<u>Succession Planning for Non-Executive Directors</u>
133.5	Anna Ferrant said that following discussion at the Council of Governors' Nominations and Remuneration Committee and the Council of Governors' meeting the Council had approved the succession plan for Non-Executive Directors. This involved the recruitment of two NEDs from a wider pool of diverse

	candidates who would initially join the Trust as Associate NEDs and would move into the substantive role without the need for further recruitment, subject to satisfactory performance.
133.6	The Council had also approved the proposal to extend Akhter Mateen's tenure for a further 3 months in order to ensure that there was continuity in the Audit Committee Chair role throughout the annual accounts process for 2021/22.
133.7	The Board welcomed the approvals by the Council of Governors.
134	**Any other business**
134.1	**Action:** It was agreed that one member of each group from the NED walkrounds would send a bullet point summary of the visit to the Chief Executive.

Attachment B

TRUST BOARD – PUBLIC ACTION CHECKLIST
February 2022

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
92.10	29/09/21	Amanda Ellingworth asked how the Board could improve the Trust's approach to transformation and Eithne Polke said it was important to empower teams to make radical decisions and make significant change. She said that Board support to implement 6-4-2 theatre scheduling was important as the approach would significantly reduce waste. Matthew Shaw agreed that this would have a considerable change in the way the hospital worked and it was agreed that an update would be provided on progress with implementing this would be provided at a future meeting.	JQ	February 2022	Verbal Update
120.3	24/11/21	Russell Viner, Non-Executive Director asked what proportion of GOSH patients aged 12 and over had been vaccinated and asked whether this would be part of clinical assessment going forward. It was agreed that an update would be provided at the next meeting.	JQ	February 2022	Verbal Update
121.5	24/11/21	Claire Williams said that there had been issues around catering vouchers which could be given to families and work was taking place to identify the cause of these issues. An update would be provided to the QSEAC.	DD	January 2022	Passed to QSEAC in January 2022
127.6	24/11/21	It was agreed that maternity and sickness rates would be separated in future safe nurse staff reports.	DD	February 2022	Actioned and on-going
130.3	24/11/21	It was agreed that consideration would be given to reverse mentoring by junior doctors to members of the Board.	SS	February 2022	This is being incorporated into the 'Embark, Advance and Transition' programme which is looking at the recruitment, onboarding and on-going development / support of the

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
					medical workforce in the Trust an will be fed back via QSEAC / PEAC.
131.4	24/11/21	Matthew Shaw said that it was important to accelerate the Trust's work on health inequalities and it was noted that this would be discussed at the Trust Board Strategy Day. It was agreed that a further update would be discussed at the February 2022 Trust Board meeting. Sanjiv Sharma said that he was presenting at an education event on data around access to paediatric services broken down by elements such as gender, race and socioeconomic background. It was agreed that this would also be considered by the Board.	DD	April 2022	Postponed to April 2022 Board agenda – verbal update
132.4	24/11/21	Chris Kennedy agreed and said that his experience at other organisations had shown the importance of receiving feedback from colleagues from diverse background on their experience of working for an organisation. It was noted that the PEAC committee welcomed staff stories at each meeting and it was agreed that this would be considered at Board or PEAC to provided staff feedback on diversity and inclusion.	CA	February 2022	Passed to PEAC to consider in February 2022

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 2 February 2022	
Chief Executive's Report **Submitted by: Matthew Shaw, Chief Executive**	**Paper No: Attachment C** **☐ For information and noting**
Purpose of report Update on key operational and strategic issues.	
Summary of report An overview of key developments relating to: • Covid-19 response • Key people, finance and service issues • Trust strategy and partnerships	
Action required from the meeting None	
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** **☐ PRIORITY 2: Deliver a Future Hospital Programme to transform outdated pathways and processes** **☐ PRIORITY 3: Develop the GOSH Learning Academy as the first-choice provider of outstanding paediatric training** **☐ PRIORITY 4: Improve and speed up access to urgent care and virtual services** **☐ PRIORITY 5: Accelerate translational research and innovation to save and improve lives** **☐ PRIORITY 6: Create a Children's Cancer Centre to offer holistic, personalised and co-ordinated care** **☐ 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 **Not Applicable**	**Consultation carried out with individuals/ groups/ committees** **Not Applicable**

Who is responsible for implementing the proposals / project and anticipated timescales? Executive team	Who is accountable for the implementation of the proposal / project? CEO
Which management committee will have oversight of the matters covered in this report? Executive team	

Part 1: Hospital activity update

The latter part of 2021 was extremely challenging, with high rates of staff absence related to the Omicron surge. Sickness rates were the highest ever for GOSH at 9% average for December, which included daily rates of over 12% with similar rates of self-isolation as seen during the earlier 2021 peak.

To offer a rapid response to changing circumstances and avoid the situation escalating to the point where an incident was declared, the Trust re-established the incident management structure to run alongside BAU structures. We prioritised P1 and P2 patients, and those over 52 weeks, and conducted rapid reviews to ensure that no patient came to harm through the delays in P3 and P4 treatments. A number of wards across the Trust were merged to ensure that the correct staffing ratios could be maintained.

I want to say a huge thank you to our frontline staff, operational teams and corporate support teams for their heroic efforts to help us stay open and stay safe in these exceptionally difficult circumstances. Their work ensured we were able to deliver safe care and ensure the majority of staff were able to continue to take much needed annual leave.

In terms of elective activity, the Omicron surge impacted on our performance for elective and outpatient activity. We have gone from achieving 96 per cent volume against baseline for electives in my last report to 86 per cent last week. For outpatients, we have dropped from 113 per cent to 105 per cent last week. (4 week rolling totals reported 21st January 2022.)

However, with sickness rates improving things are now more stable and we are already starting to see a return to our previous performance trajectory.

Covid cases in London peaked at around 20 December 2021 and we gather that London will be back in the pre-Omicron daily case range within 1-2 weeks, with NCL following slightly after this. It is likely to be 4-5 weeks before Covid occupied beds in the adult sector are back at the pre-Omicron levels (150~). Across NCL, 24% of beds remain occupied by Covid (compared to the peak of 29%) and there has been a shift in the age of Covid admissions with 65+yrs patients now accounting for approximately 50% of the admissions (previously 30%).

Update on the Paediatric Accelerator

We are currently planning for the next ‘Super Saturday’ initiative, which is a shared endeavour across the paediatric accelerator trusts to drive recovery and transformation in children’s hospitals. Teams are planning to run additional theatre lists, diagnostics and outpatients and running educational sessions including theatre and laboratory tours to involve and engage our young patients and their families.

The £20m national recovery investment in the paediatrics for the Accelerator, shared across the 10 trusts within the Children's Hospitals Alliance, has had a transformational effect in a number of services.

As a group, NHSE has recognised us as one of the top performing Accelerators. Collectively member trusts have:

- Delivered over 100% of 2019/20[1] inpatients and outpatients activity every month except September, making the paediatric accelerator programme one of the highest performing nationally[2];
- Invested £1m in an innovative project to use Artificial Intelligence to identify children at risk of not being brought for appointments;
- Delivered a programme of work around healthcare inequalities, including going live this month with two pilots in Sheffield and Birmingham to provide free transport for children, helping support deprived families to attend their appointments;
- Delivered high quality benchmarking and paediatric-specific data, which has been used by NHSE colleagues.

We are in discussions with colleagues within NHSE/I to explore how the Children's Hospitals Alliance partners can support investment in recovery for 2022/23. I am hopeful that this programme, which has proven its ability to deliver, will be supported to continue this important work.

Part 2: Look-ahead for the new year

In the latter part of last year, we described our recovery strategy to our senior management team as the 'GOSH quadruple aim', namely:

1. Driving up activity
2. Improving quality, rigour and consistency to deliver the basics
3. Maximising our resources
4. Looking after our people

Looking ahead, this will be an important year for complex children's services, with significant challenges including locally mandated structures and funding flows, the ongoing requirement to drive activity, support staff through the ongoing uncertainty, high workloads and the risk of burnout and navigating mandatory vaccinations.

On 24th December 2021, NHSE published the operational planning guidance for 2022/23, which indicated the requirement for increased activity including:

- 10% more than pre-pandemic elective activity in 2022/23
- 30% more than pre-pandemic elective activity by 2024/25.

It also required that trusts respond to the aspiration to reduce in-hospital activity, particularly on follow-up appointments. There is an expectation (subject to Covid infections continuing to decline) that Trusts will develop their virtual care offer through virtual wards, reconfiguring care across pathways, new models for diagnostics and improved strategies for Patient Initiated Follow-Up. It also signals financial support to develop these initiatives, as well as support for children affected by autism and learning difficulties.

We are working with GOSH colleagues and our partners across the children's hospital sector to identify new ways to offer enhanced virtual support children and young people, while continuing to deliver safe, effective and efficient on-site care.

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[2] See: https://www.hsj.co.uk/quality-and-performance/icss-given-160m-to-accelerate-electives-fail-to-hit-pre-covid-activity/7031379.article for statistics from other accelerator programmes.

Part 3: People

Special thanks are due this month to our HR team for their support to facilitate our new obligations on mandatory vaccinations. We continue to have conversations with the small numbers of staff who are concerned about getting vaccinated and are not currently flagging this as a major risk for service continuity. Our Director of HR & OD Caroline Anderson will be able to provide a more detailed verbal update at the meeting.

We await the national staff survey results carried out in late 2021, which will give us important insights into staff wellbeing and experience and these will feature in later reports.

We are delighted to welcome our new Chief Nurse Tracy Luckett to her first board meeting and warmly thank our Acting Chief Nurse, Darren Darby, for his support over the past four months.

Part 4: Quality & safety

Gastroenterology reviews

In October 2021, the CQC requested further information regarding the Gastroenterology service and the subsequent external reviews commissioned. Following a review of the information available, the Trust provided a detailed breakdown of the steps and assurance taken and relevant discussions with families concerned. CQC have confirmed they have no further questions and thanked the Trust for the way in which the information was documented and presented. The team reported that the review of information and actions taken since the first RCPCH review was helpful, and the rationale provided identifying to respective cohorts and the inclusion criteria addressed their concerns.

Dental

As part of a pilot inspection programme, the CQC undertook an inspection of our Dental services in December 2021 as one of nine Trusts in London. This inspection was carried out virtually, with two CQC inspectors and a Specialist Dental Advisor. The CQC have confirmed that they were happy with the assurance provided and that there would be no further requirements from the Trust.

The CQC confirmed they will not be undertaking any onsite inspections, except in the cases of Dental Services or if significant concerns / risks had been identified. All current meetings and interactions are to be held virtually until further notice.

Part 5: Partnerships

NCL Start Well consultation update

As previously reported to the Board, a review of paediatric services across the ICS, the NCL ICS ‘Start Well’ programme has commenced involving all providers including Children’s Acute Transport Service (CATS) and the North Thames Paediatric Network (NTPN). GOSH is represented on the programme board by our Medical Director, Sanjiv Sharma and represented by clinical and operational leaders on all three workstreams in relation to planned care, emergency access and neonatal care. Initial workshops and discussions are planned prior to April 2022, with the work re-starting in May 2022 following the pre-election period, with the expectation of going to public consultation in summer.

Change in national and regional leadership for NHSE

We congratulate Sir David Sloman, our previous regional director for London, for his appointment as Chief Operating Officer for NHSE and Andrew Ridley, who will lead the London regional office on an interim basis while recruitment for a substantive post holder gets underway.

Sir David replaces Mark Cubbon, who has been interim chief operating officer since Amanda Pritchard's appointment as CEO last summer and is now Chief Delivery Officer for the Long Term Plan and leading on the merger of NHS England and NHS Improvement with Health Education England, NHS Digital and NHSX.

Mr Ridley has been chief executive of Central London Community Healthcare Trust, for 5 years and has previously held national roles, working as NHS England regional director for the south of England from 2014 to 2016, and in senior roles including CEO at Tower Hamlets Primary Care Trust between 2005 and 2011. We look forward to working with him over the coming months.

NHSE has also announced that Sir Jim Mackey will now lead on national elective recovery, following his appointment as an adviser on recovery in September.

Ends

Attachment D

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
2 February 2022

Patient Story: An example of what GOSH does best **Submitted by** Darren Darby, Acting Chief Nurse **Prepared by** Dr Jack Bartram, Consultant Paediatric Haematologist	**Paper No: Attachment D** □ **For information and noting**

Purpose of report
The Great Ormond Street Hospital Patient Experience Team works in partnership with ward and service managers, clinical teams, the Patient Advice and Liaison Service (PALS), and the Complaints and Patient Safety Teams to identify, prepare and present suitable patient stories for the Trust Board. The stories ensure that experiences of patients and families are heard, good practice is shared and where appropriate, actions are taken to improve and enhance patient experience.

Summary of report
This story differs from previous patient stories in that it is presented by the Haematology team. It sets out the events around an 11 year old girl with an abdominal mass being admitted to GOSH on a Saturday morning. The story outlines the collaboration between multiple teams to assess and treat the patient within a day preventing death or severe disability. The story embodies the Trust values at their best leading to a positive outcome for this patient.

Action required from the meeting
For information

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** □ **Culture of high quality sustainable care** □ **Engagement of public, staff, external partners** □ **Robust systems for learning, continuous improvement and innovation**

Strategic risk implications
BAF Risk 3: Operational Performance

Financial implications
Not Applicable

Implications for legal/ regulatory compliance

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

Consultation carried out with individuals/ groups/ committees N/a
Who is responsible for implementing the proposals / project and anticipated timescales? Head of Patient Experience and Engagement
Who is accountable for the implementation of the proposal / project? Acting Chief Nurse
Which management committee will have oversight of the matters covered in this report? Patient and Family Experience and Engagement Committee

An example of what Great Ormond Street Hospital does best

Friday evening referral of an 11 year old girl with an abdominal mass

Dr Jack Bartram, Consultant Paediatric Haematologist

11 year old girl with an abdominal mass

PRESENTATION AT LOCAL HOSPITAL

1 month unwell - fever, lethargy, neck swelling and abdominal pain.

Appeared well. Masses in neck and abdomen, otherwise normal examination.

Normal blood tests.

Ultrasound abdomen shows large mass in lower abdomen.

INITIAL PLAN

Urgent CT scan with images to GOSH (not done)

Arrange for transfer to GOSH by Saturday 9am

ARRIVAL AT GOSH Saturday 10.30 am

Clerking by fellow - additional issues noted:

Headaches, constipation

Marked deterioration in the past 48 hours.

Severe back pain and some difficulty in walking.

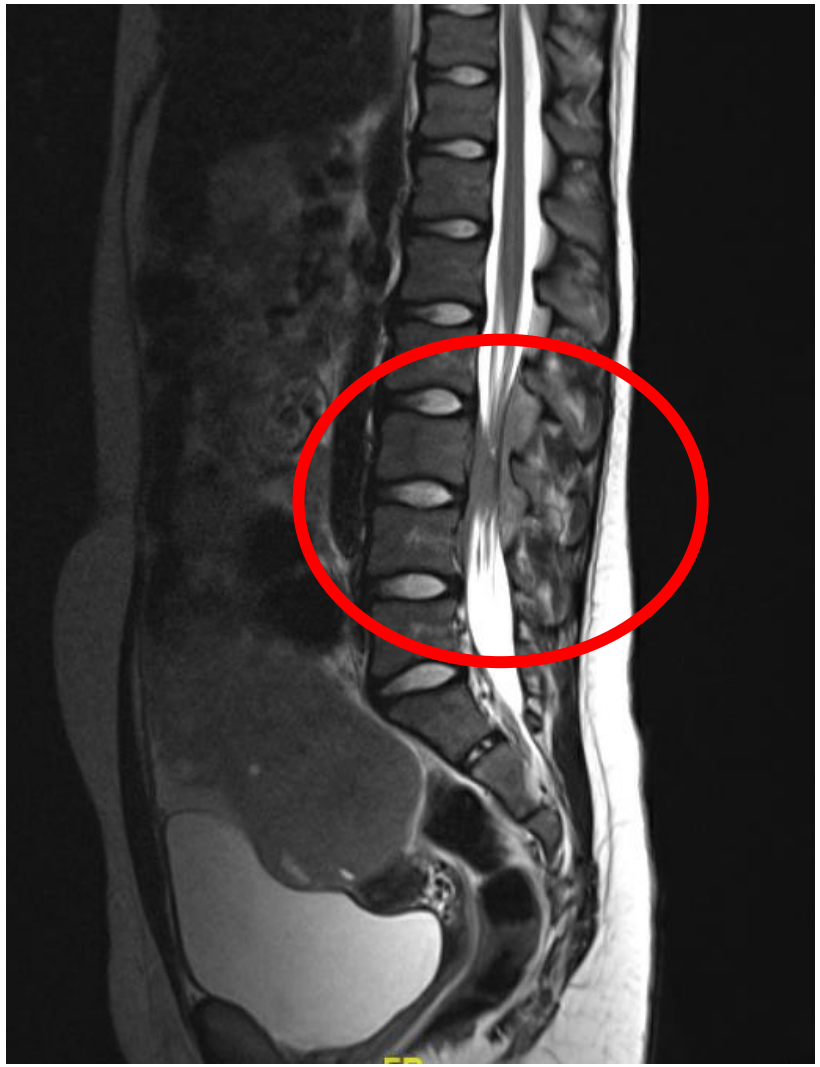
On examination:

– large hard masses in neck and abdomen.

– Neurological exam – power 4/5 of left leg

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

Recognition of Time-sensitive Medical Emergency



<u>Spinal Cord Compression in context of aggressive malignancy</u>

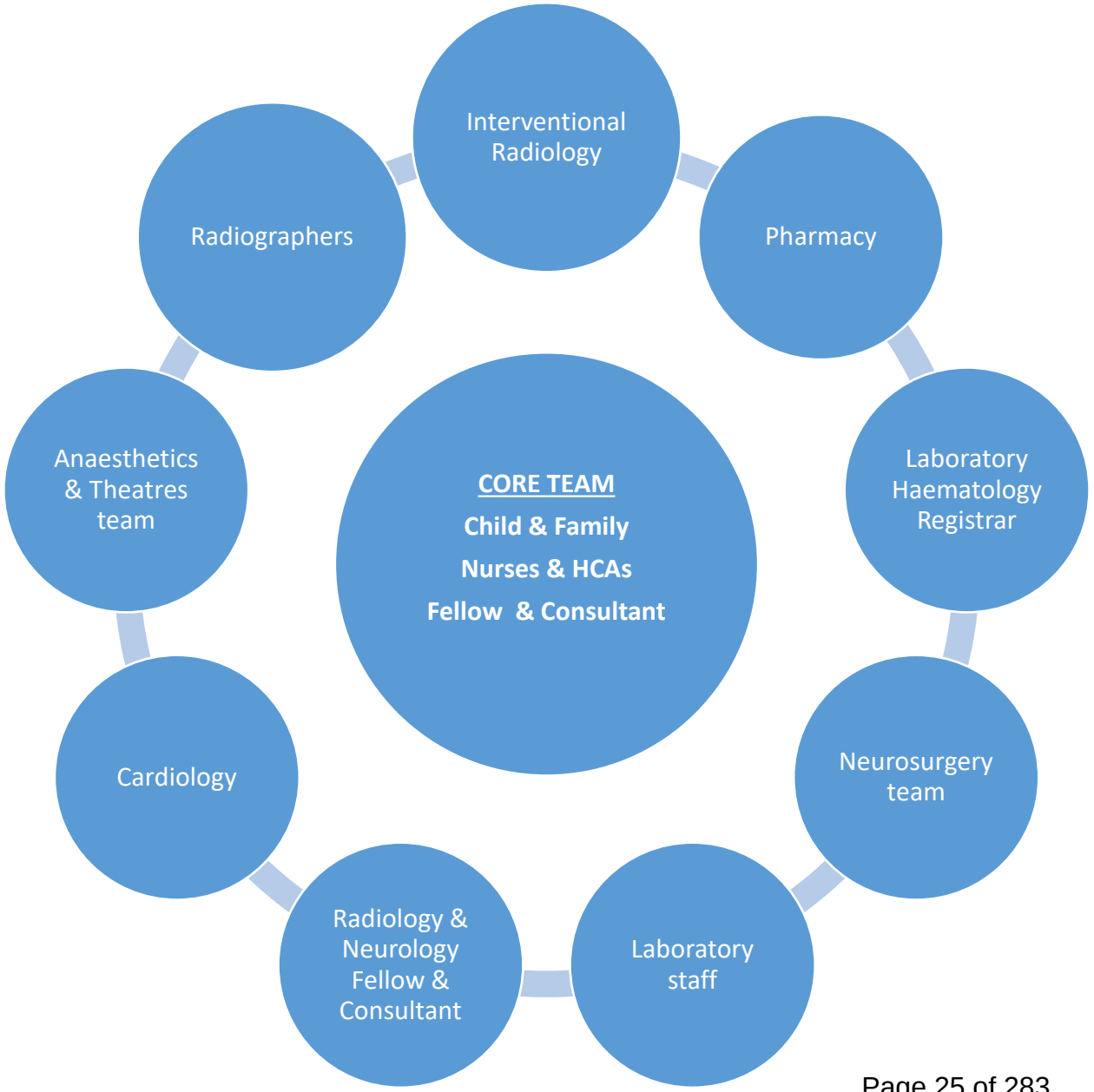
Delay could lead to:

Irreversible damage of spinal cord
Compression of other vital structure
Tumour Lysis syndrome

-> Death or severe disability

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

One Team



Timeline

10:40 : Admitted

12:40 : CT
Discussion + report 15:00

MRI head + spine finished 18:25 – report 18:45.

Neurosurgery review

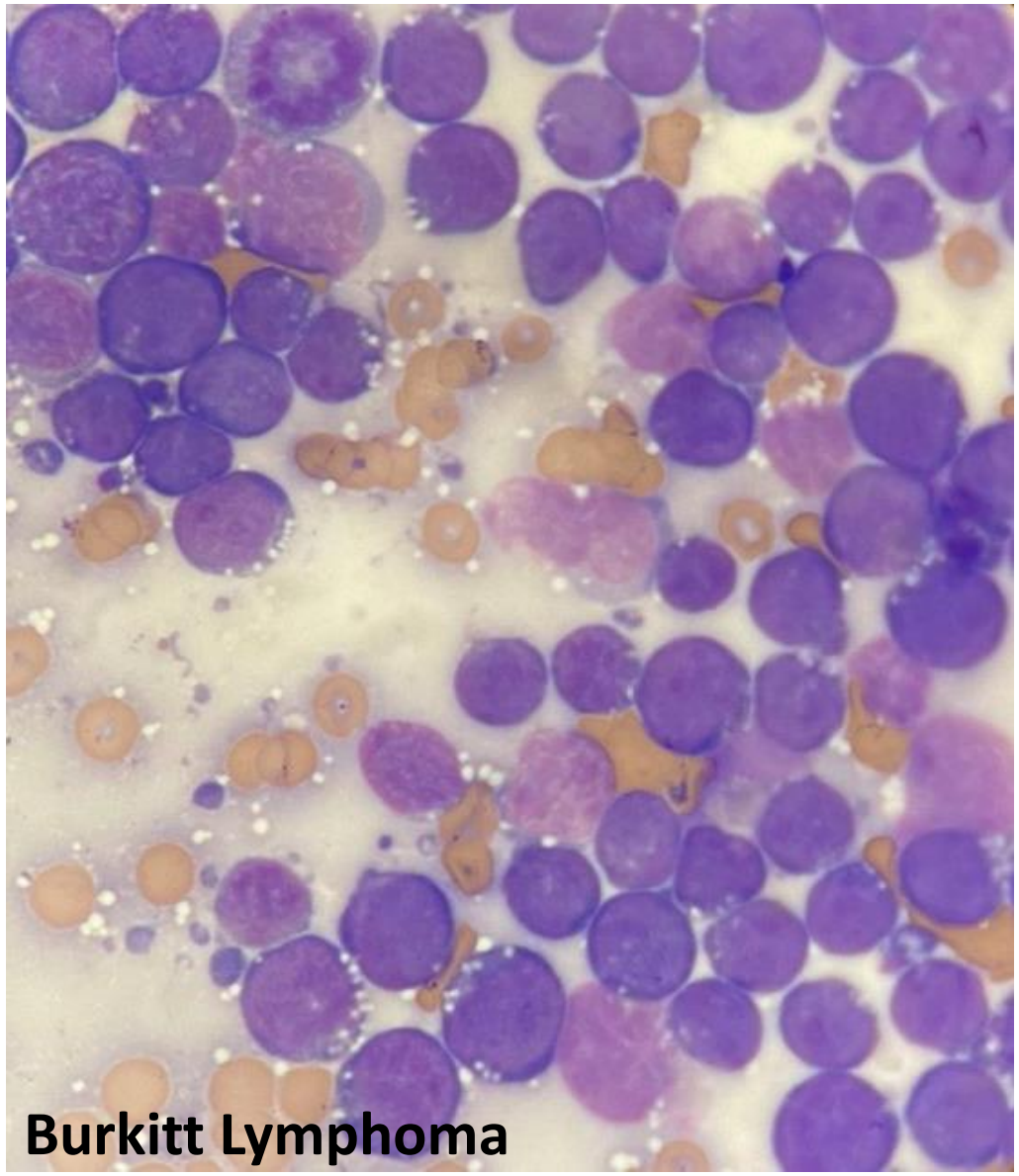
Cardiology review

20:30 : Line insertion, Biopsy, bone marrow

21:30 : Sample analysis

23:00 : Started steroids and chemotherapy

Clinical outcome



Burkitt Lymphoma

-By evening unable to walk

<u>- Coming through the door to treatment → 12 hours</u>

- By next day fully mobile
- Now responding well to chemotherapy, no neurological deficit
- Extremely good chance of long term cure

Learning from excellence

Always Welcoming

Family and child central – constant updates

Always Helpful

When necessary out of hours care = weekday care

Always Expert

Consultant-to-consultant discussion can help expedite good care

Focusing on time-sensitive aspects to deliver emergency care

Always One Team

With outstanding communication

Attachment E

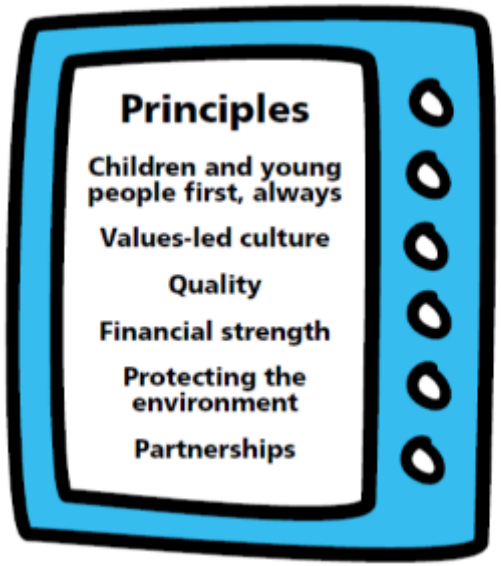
Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board 2nd February 2022	
Directorate presentation: Sight and Sound **Submitted by: John Quinn, Chief Operating Officer**	**Paper No: Attachment E** **□ For information and noting**
Purpose of report To present an annual overview of the Sight and Sound Directorate's activities, achievements and challenges.	
Summary of report The last year has seen the opening of the Sight and Sound Outpatient facility, the successful transfer of the medical illustration team in house and restructuring of the medical records team which has included increased support for MyGOSH. The ophthalmology and ENT departments have introduced new treatments including ocular gene therapy. We continue to have challenges in terms of waiting times across all specialities and the recruitment of paediatric dentists. Waiting times for our patient groups have been particularly impacted by Covid. Our top priority going forward continues to be the reduction of waiting times which will require increased theatre and ward capacity	
Action required from the meeting For information	
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** **□ PRIORITY 2: Deliver a Future Hospital Programme to transform outdated pathways and processes** **□ PRIORITY 4: Improve and speed up access to urgent care and virtual services** **□ PRIORITY 5: Accelerate translational research and innovation to save and improve lives** **□ 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 BAF Risk 3: Operational Performance and BAF Risk 12: Inconsistent delivery of safe care	
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? Not applicable
Who is accountable for the implementation of the proposal / project? Not applicable
Which management committee will have oversight of the matters covered in this report? EMT

SIGHT AND SOUND

SIGHT & SOUND (S&S) DIRECTORATE REVIEW



Trust Board
February 2022

Liz Jackson Chief of Service

Chris Jephson Deputy Chief of Service

Donna Richardson General Manager (Interim)

Carolyn Akyil Head of Nursing

S&S Leadership Team

Chief of Service

Liz Jackson

General Manager (Interim)

Donna Richardson

Head of Nursing and Patient Experience

Carolyn Akyil

Deputy Chief of Service

Chris Jephson

SIGHT AND SOUND

Directorate Profile

SIGHT AND SOUND

Our Budget

- Annual Budget 21/22: £25.7 million

Our Clinical Spaces

- **Panther**– Acute ENT, Plastics and all other S&S other than Uro (14 beds)
- **Panther Urology** (11 beds)
- **Sight & Sound Centre** – Outpatient area for children with Sight and Hearing loss
- **Falcon** – (ZCR) Outpatient area hosting specialist clinics (Cardiology, inherited Cardiology, Respiratory, Infectious Diseases and many more)
- **Hippo, Hare and Zebra** – (RLHIM) Outpatient areas hosting specialist clinics (Renal, Rheumatology, Dermatology and many more)
- **Cheetah** – Outpatient area hosting spinal and orthopaedic clinics
- **Manta Ray** – Outpatient area hosting a variety of clinics but mainly Neurodisability
- **Hedgehog** – Urodynamics and Urology pre-admission
- **Magpie** – Plastics day attenders

Our Staff

Staff Group	WTE
Additional Clinical Services	58.7
Add Prof Scientific and Technic	30.6
Administrative and Clerical	139
Allied Health Professionals	5.9
Estates and Ancillary	3
Healthcare Scientists	15.7
Medical and Dental	82.4
Nursing and Midwifery Registered	81.4
Grand Total	**416.5**

Our services

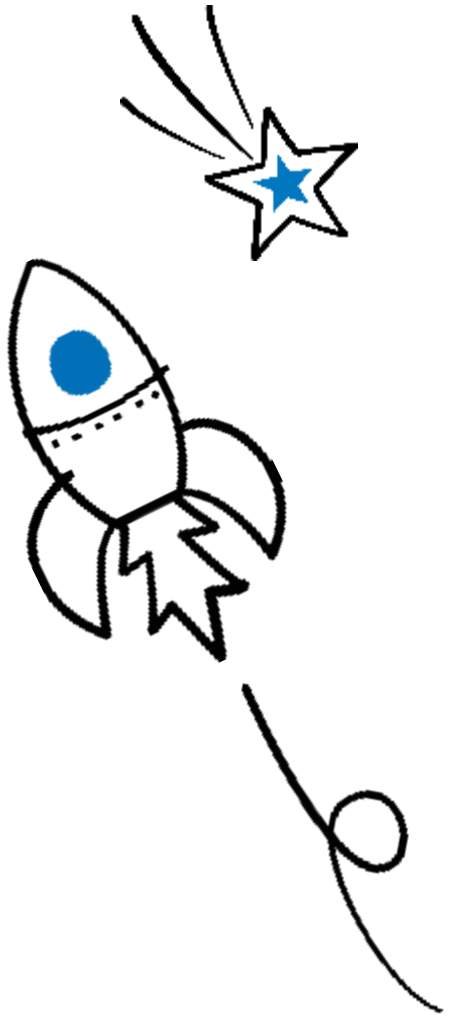
SIGHT AND SOUND

Clinical Specialties

- Audiology
- Cochlear Implant (CI)
- ENT
- Cleft
- Craniofacial
- Dental
- Maxillofacial
- Ophthalmology
- Plastics
- Urology

Support Services

- Outpatients
- Central booking office
- Ward admin. teams
- Digital records
- Medical illustration
- Main reception
- Travel reimbursement



Top three successes and challenges in the last year

SIGHT AND SOUND

Top three successes

- Opening of Sight and Sound Building
- Successful TUPE of Medical Illustration and restructure of Digital Services
- Clinical innovation and commitment to research

Top three challenges

- Long Waiters (hindered by Covid)
- Bed Capacity
- Dental Recruitment

Top three priorities

- Reduce waiting times and waiting list backlogs
- Embedding learning and change from specialty action plans
- Relocation of Urodynamics from Hedgehog and Outpatients from Frontage

Successes

SIGHT AND SOUND

Sight and Sound Building
June 2021

'The Big Tea' at Buckingham Palace
July 2021

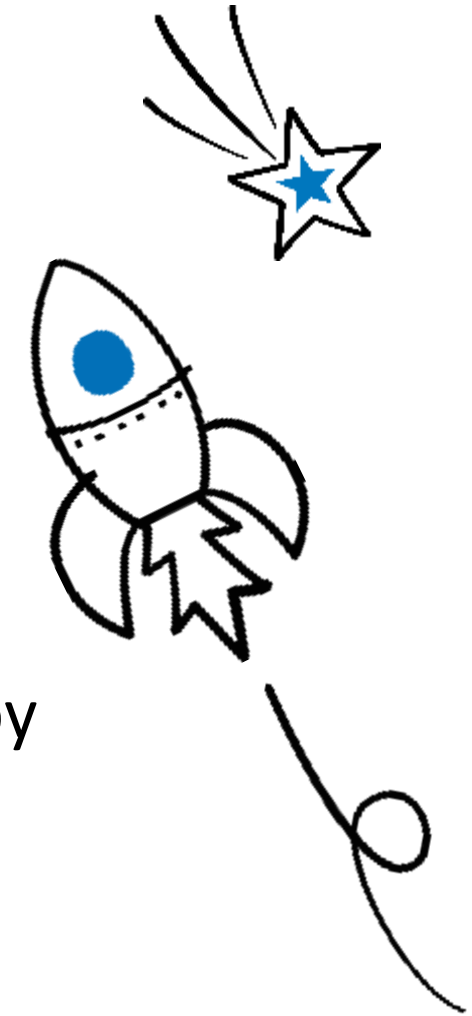
HSJ Value Award
September 2021

Research and Innovation - Eyes

SIGHT AND SOUND

Established as a centre for intraocular gene therapy

- Voretigene Neparvovec RPE65 gene therapy – treated youngest patient in the world – 10 patients in total – transformative treatment.
- Approved site for RegenX Bio CLN2 gene therapy programme.
- In negotiation with Neurogene for CLN5 gene therapy
- Axovia collaboration ahead of BBS1 and 10 gene therapy programmes



Research and Innovation - Eyes

SIGHT AND SOUND

Children with rare genetic disease get world-first treatment to save sight

10 Jan 2022, 10 a.m.

Clinicians at Great Ormond Street Hospital (GOSH) and UCL GOS Institute of Child Health (ICH) are the first in the world to test a treatment that could prevent blindness in children with the rare and fatal genetic disorder, CLN2 type Batten disease. 8 patients treated Discussions with NHSE about taking programme forward with more patients once 18 months of funding has expired.

Research and Innovation - ENT

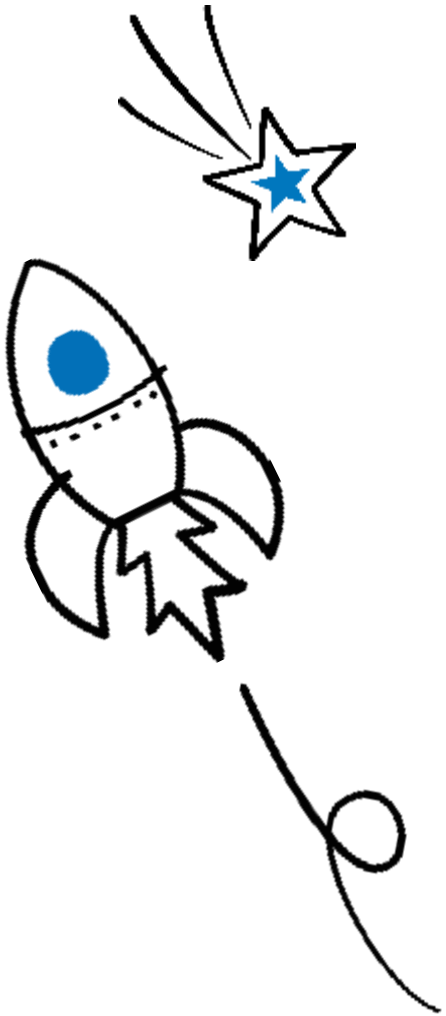
SIGHT AND SOUND

Middle ear implants

Introduction of middle ear implants for microtia – 2 patients operated on in November with support from a German surgeon

Laryngeal reinnervation

First patient has completed surgery with 5 further patients being assessed



Restoring elective activity and clinical prioritisation

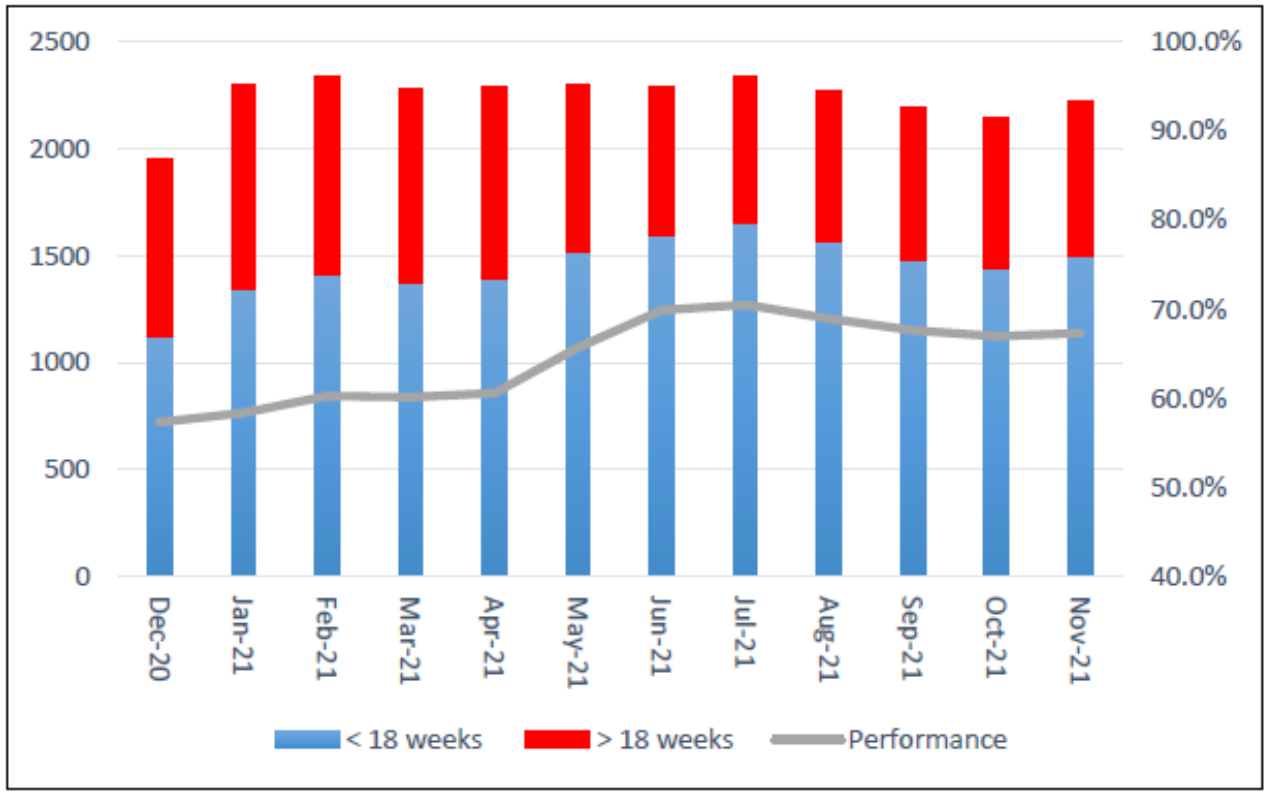
Situation:

- RTT remains a challenge
- 104 week waits improved (4 pts over 104 weeks, 89 pts over 52 weeks)
- Patients prioritised
- WLI/accelerator lists where possible inc. locum hand surgeon

Challenges:

- Theatre capacity
- Bed availability
- Patient cancellations – some due to Covid, some due to parent reluctance to come in during current times.

RTT incomplete pathways: % of patients waiting <18 weeks	Period	Target	Actual
	Nov-21	92.0%	67.3%



May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
65.7%	69.9%	70.5%	69.0%	67.7%	67.0%	67.3%

Principle 2: A values-led culture

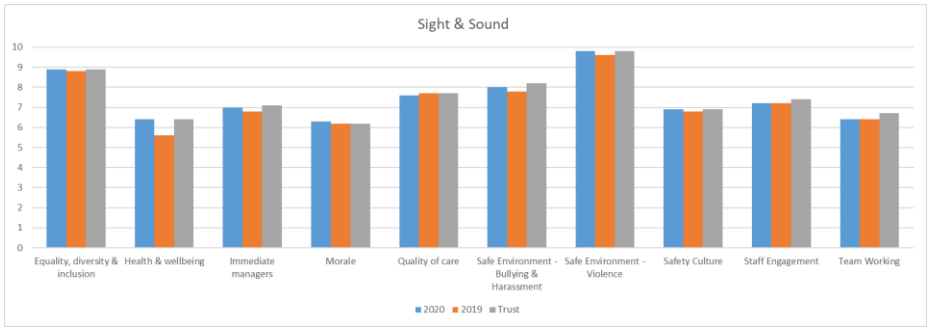
SIGHT AND SOUND

What are the top three issues for workforce?

- Specialist Staff Recruitment (esp. Dental Consultants and Urology Ward nurses [25% vacancy])
- Health and Wellbeing including culture and moral in some areas
- VCOD

Staff Survey – Meaningful changes to date

- Career progression conversations with individuals & plan
- Transparent discussions regarding Discrimination & Bullying (and what it looks and feels like)
- Equal access to job opportunities within services
- Employee recognition scheme (treat Friday, employee of the month, Birthday celebration)
- Encouragement to use 'Freedom to Speak Up Guardian'



Health and Wellbeing Ambassadors?

Volunteers who are focused on promoting the health and wellbeing agenda at a local level across the Directorate, by championing, supporting & raising awareness of the range of positive initiatives rolled out by the Trust.

Principle 3: Quality

SIGHT AND SOUND

Quality & Safety Improvements:

- Friends and Family Test, have achieved target response rate consistently over last year with recommended rate averaging 95%
- Reduction in overdue Datixes
- Outpatient transformation programme: Clinic Utilisation, Clinic Templates, Clinic Room Booking and Outpatient Reporting
- Increase in virtual clinics and space identified for them as pilot project, relaunch of admin improvement programme

Complaints Annual Summary

13 formal complaints in last 12 months (82,387 patient activity spells)

Predominant theme through all is communication

PALS encounters

570 out of a total of 2408 pan Trust. Includes compliments and 88 requests for historical information from medical records.

CQC Visit

Dental – Pilot project however no concerns were raised and no further action/inspection is required

Principle 4: Financial strength

Income | Capital (AC L3)	Annual Budget (£)	In Month Budget (£)	In Month Actual (£)	In Month Variance (£)	YTD Budget (£)	YTD Actual (£)	YTD Variance (£)	Current vs. Previous year Actual (£)
Non Clinical Income	358,752	29,896	5,872	(24,024)	269,064	139,609	(129,455)	93,898
Non Pay Costs	(4,050,100)	(329,704)	(375,841)	(46,137)	(3,060,986)	(3,805,438)	(744,452)	(1,069,643)
Non-Nhs Clinical Income	1,389,859	136,381	22,714	(113,667)	937,941	671,915	(266,026)	75,157
Pay	(23,399,635)	(1,985,202)	(1,950,271)	34,931	(17,444,028)	(17,672,544)	(228,516)	(1,501,468)
Grand Total	**(25,701,125)**	**(2,148,630)**	**(2,297,526)**	**(148,896)**	**(19,298,009)**	**(20,666,457)**	**(1,368,448)**	**(2,402,055)**

Efficiency & Savings-Better Value 21/22

£66k saving due to medical illustration coming in house

2021/22 Position

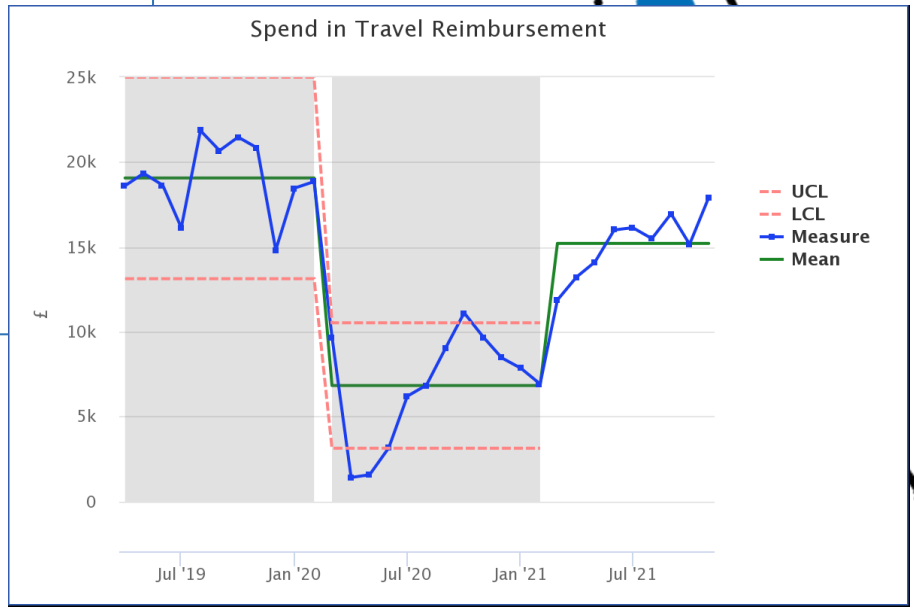
- **Private Income –** Negative YTD £0.3m, but have achieved over 70% of IPP target
- **Pay Budget-** Negative YTD £0.5m – Junior Doctor spend on bank/locum staff to cover long term absences and shift patterns
- **Non-Pay –** Negative YTD £0.7m – spend on clinical supplies across Audiology and CI as well as helmeting treatment costs for Craniofacial patients

Principle 5: Protecting the Environment

SIGHT AND SOUND

Commitment to Sustainability:

- Reduction in miles travelled by patients (graph shows reduction in Travel Reimbursement)
- Increased outpatient consultation space – to enable higher number of 'virtual consultations' to take place
- Working from home - reduction in miles travelled and carbon emissions
- DocMan – reduction in paper and printing and postage
- MyGosh – reduction in paper and printing



Principle 6: Partnerships

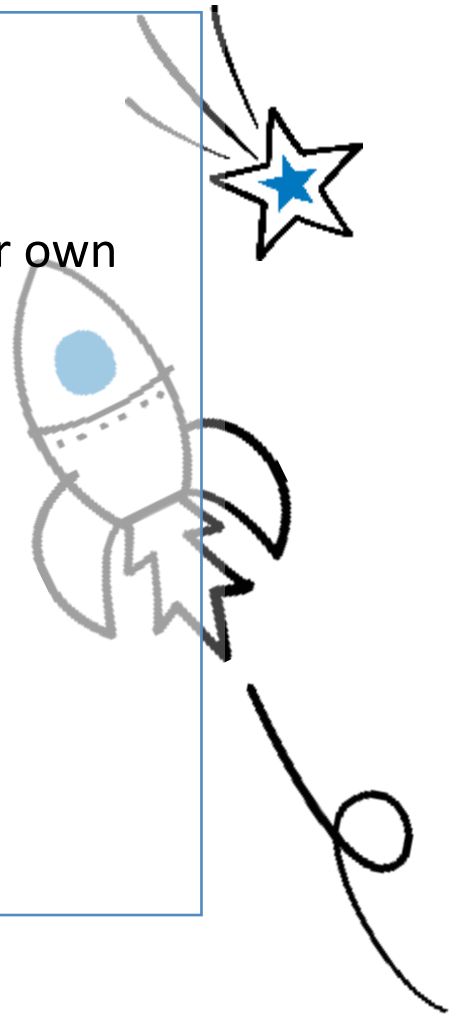
SIGHT AND SOUND

System Working

- Support for Covid related capacity issues
  - Urology (torsion) North Central London (NCL)
  - ENT inc. cochlear implants NCL
  - Cleft for Mid and South Essex NHS FT
- Collaboration across NCL to improve dental referral pathways
- Leading peer reviews for Auditory Brainstem Response (ABR) and hearing aid fitting for network

Charity

- Funding for the first cohort of apprentice nurses – growing our own workforce



Attachment F

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
2 February 2022

CQC Children & Young People Patient Experience Survey Results **Submitted by** Darren Darby, Acting Chief Nurse **Prepared by** Suzanne Collin, Patient Feedback Manager	**Paper No: Attachment F** ☐ **For information and noting**

Purpose of report
The attached slides summarise the key findings of the CQC Children and Young People's Patient Experience Survey 2020. They set out the feedback on key aspects of patient experience in the hospital and areas for improvement.

Summary of report
This national survey was sent to patients aged 0-15 years old who were discharged from GOSH between November 2020 and January 2021. The survey is not open to patients 16+ years and does not include a breakdown by ward/ directorate. The CQC issued its full Benchmark Report (attached) in December 2021 which includes details of performance in comparison to other Trusts in England.

Key points of the survey results are:

- GOSH is an outlier for providing better experiences than expected for patients 0-15 years
- GOSH scored in the top 20% of Trusts on 45 questions with responses on 33 questions much better or better when compared with all other Trusts.
- Top scores (compared with the national average) relate to CYP responses on activities and involvement in decision about care and parent / carer responses on wi-fi and facilities to prepare food.
- There is some variance between responses from patients and their families.

Initial actions in response to the issues highlighted by the survey around food, wi-fi and communication. are set out in slide 17.

RP4_Great Ormond Street Hospital for C

Action required from the meeting
For information

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** ☐ **Culture of high quality sustainable care** ☐ **Engagement of public, staff, external partners** ☐ **Robust systems for learning, continuous improvement and innovation**

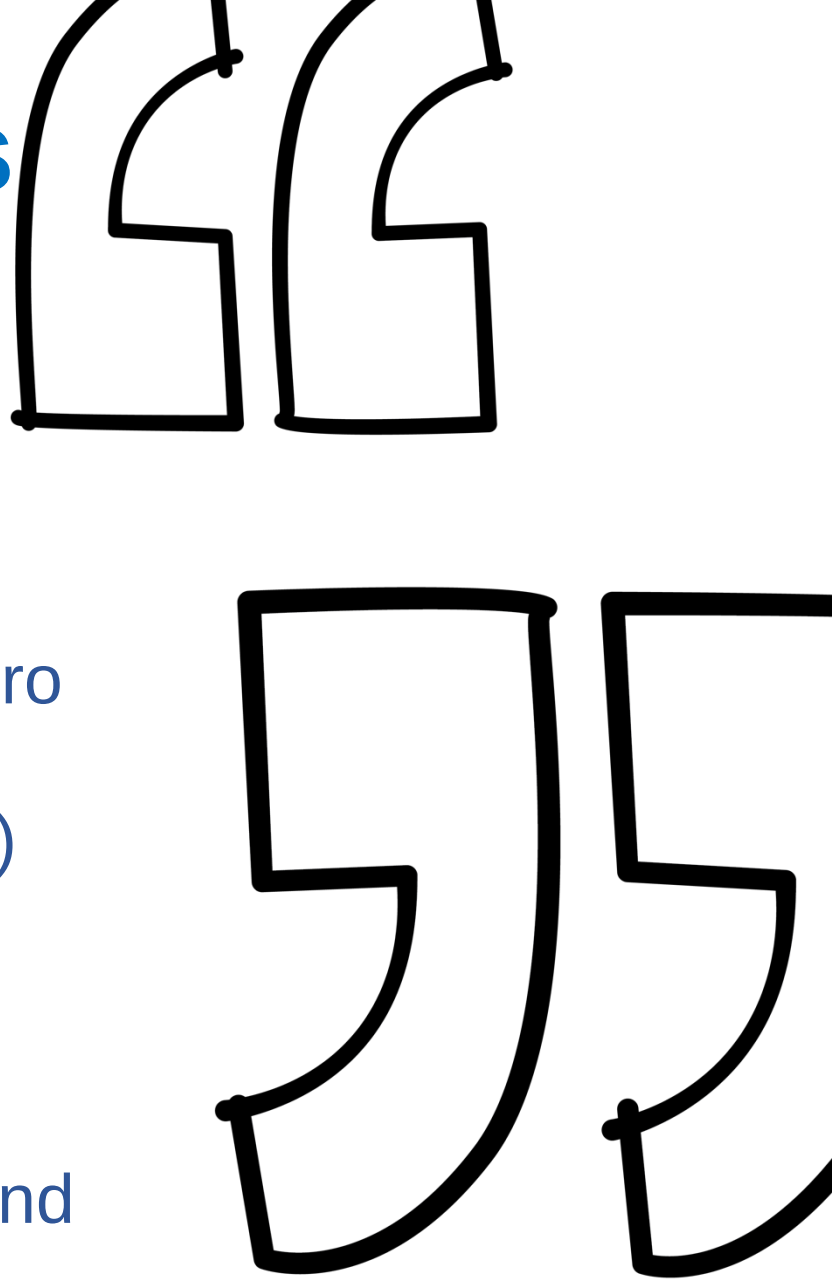
Strategic risk implications All BAF risks
Financial implications Not Applicable
Implications for legal/ regulatory compliance • The Health and Social Care Act 2010 • The NHS Constitution for England 2012 (last updated in October 2015) • The NHS Operating Framework 2012/13 • The NHS Outcomes Framework 2012/13
Consultation carried out with individuals/ groups/ committees N/a
Who is responsible for implementing the proposals / project and anticipated timescales? Head of Patient Experience and Engagement
Who is accountable for the implementation of the proposal / project? Acting Chief Nurse
Which management committee will have oversight of the matters covered in this report? Patient and Family Experience and Engagement Committee

Children and Young People's Patient Experience Survey 2020/21
CQC results – Published December 2021

Suzanne Collin

Headlines: excellent results

- Commended by the CQC for being an outlier for providing **better** experiences than expected for patients 0-15 years
- GOSH scored in the top 20% of Trusts on 45 questions.
- GOSH scored in the bottom 20% of Trusts on zero questions.
- Top scores (compared with the national average) relate to CYP responses on activities and involvement in decision about care and parent / carer responses on wi-fi and facilities to prepare food.
- Some variance between responses of patients and parents/ carers.



Survey Details

- Mandatory biennial survey with three age appropriate versions, 0-7, 8-11 and 12-15 years.
- In 2021 a new provider ***Patient Perspective*** carried out the survey on behalf of GOSH.
- Paper survey sent to 1,250 patients who were discharged from GOSH between November 2020 and January 2021.
- Scoring of questions is predominantly *'Yes / No / Sort of / Don't know'* and contain a small free text section.
- 125 trusts took part and the national response rate was 24.2% (n=27,374 responses).
- GOSH Response rate (28%) was slightly reduced compared with 2018 (31%).

Who took part in the survey?

1250 invited to take part

351 completed

43 urgent/emergency admission

308 planned admission

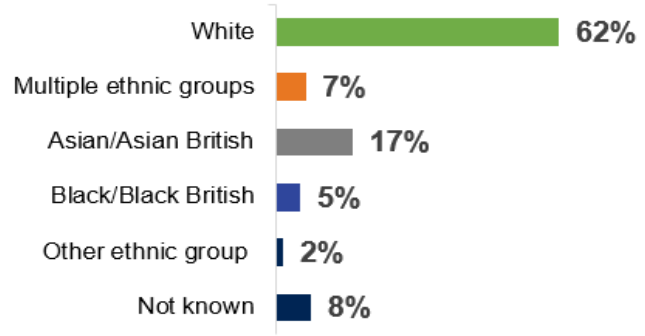
28% response rate

24% average response rate for all trusts

31% response rate for your trust last year

AGE OF PATIENTS

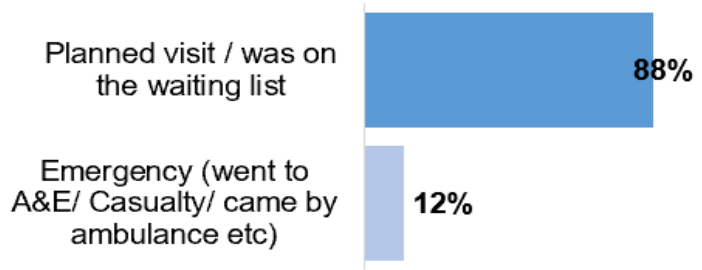
ETHNICITY



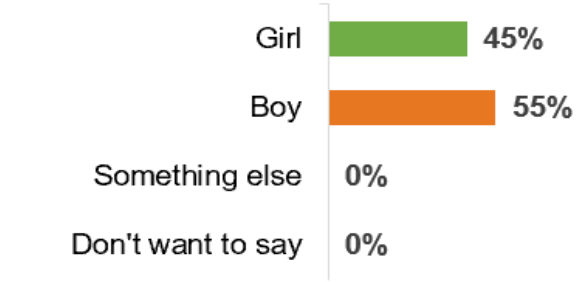
LONG-TERM CONDITIONS

of participants have **physical or mental health conditions, disabilities or illnesses** that have lasted or are expected to last 12 months or more.

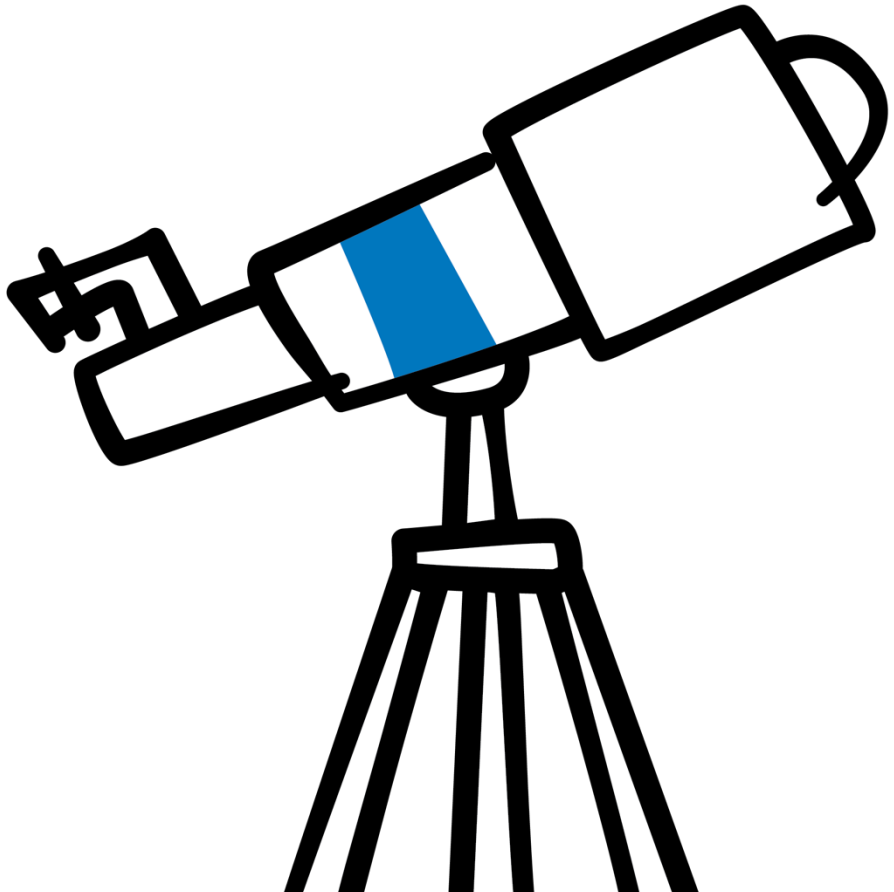
ROUTE OF ADMISSION



GENDER



Results 2021- Banding



Better

GOSH results were **much better than expected** when compared with all other Trusts for 13 questions.
GOSH results were **better** when compared to all other Trusts for 20 questions.
GOSH results were **somewhat better** when compared to all other Trusts for 3 questions.

Worse

GOSH results were **much worse** when compared to all other Trusts for 0 questions.
GOSH results were **worse** when compared to all other Trusts for 0 questions.
GOSH results were **somewhat worse** when compared to all other Trusts for 0 questions.

Same

GOSH's results were **about the same** as other trusts for 32 questions.

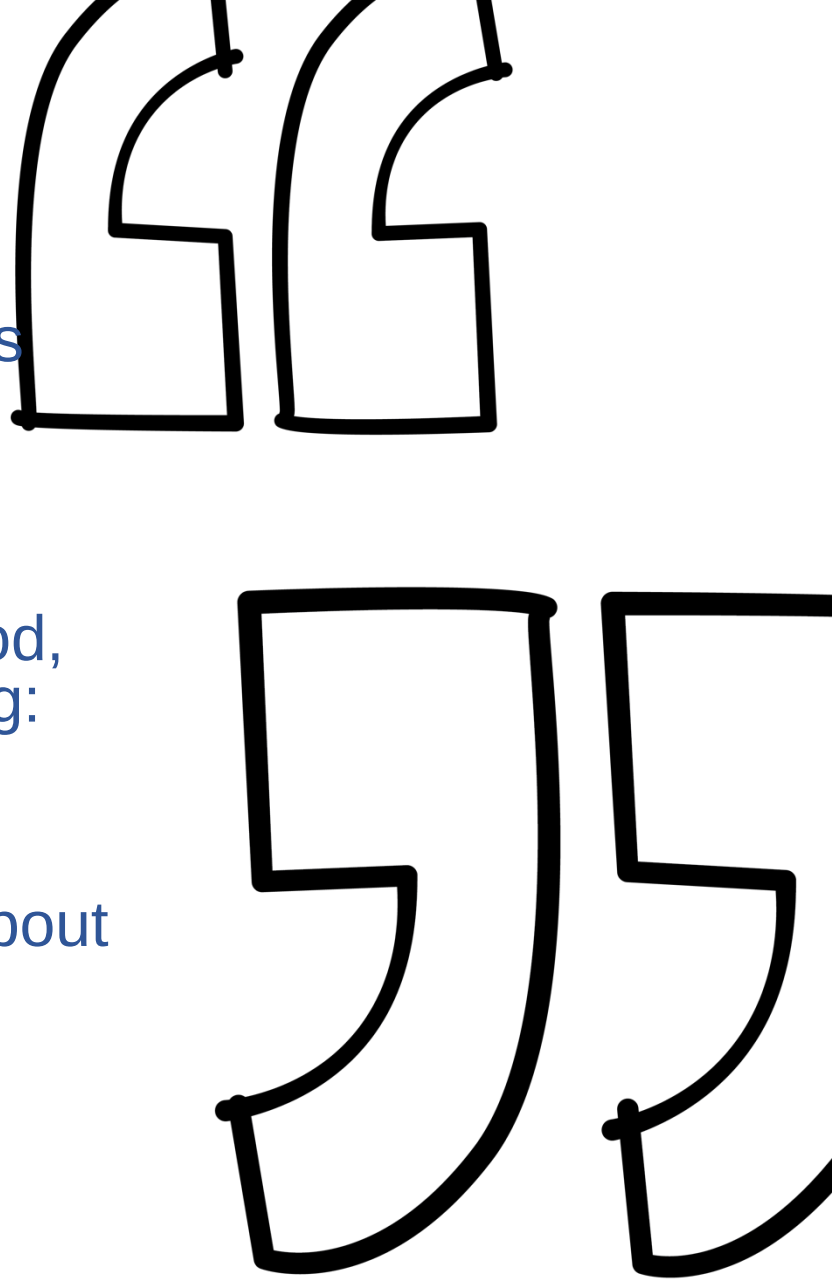
Result Summary

- GOSH response rate (28%) was slightly reduced compared with 2018 (31%).
- GOSH response rate was higher than the average from other Trusts who used Patient Perspective.
- Scores remained constant compared to 2018 survey.
- No questions improved more than 10% compared to 2018, however the scores were consistently high.
- One question had a reduction of more than 10% compared with 2018.
  - Were there enough things for your child to do in the hospital? Score changed from 84% in 2018 to 63% in 2021.

Responses from Children & Young People

- GOSH scored in the top 20% of Trusts for 12 questions (the remaining 11 questions were in the middle 60%) and predominantly above the national average.

- Key themes from the middle tiered questions, were food, Wi-Fi, friendliness of staff and communication including:
  - Did staff speak to you in a way you understood?
  - Did the hospital staff answer your questions?
  - If you had any worries, did the staff speak to you about them?
  - Could you speak to staff without your parent being there if you wanted?
  - Did you have a contact for staff if you had any concerns when you got home.



Qualitative Comments from CYP

"We would like the hospital to reduce use of single use plastic in their catering. Polystyrene needs to go! Thank you so much for such wonderful care"

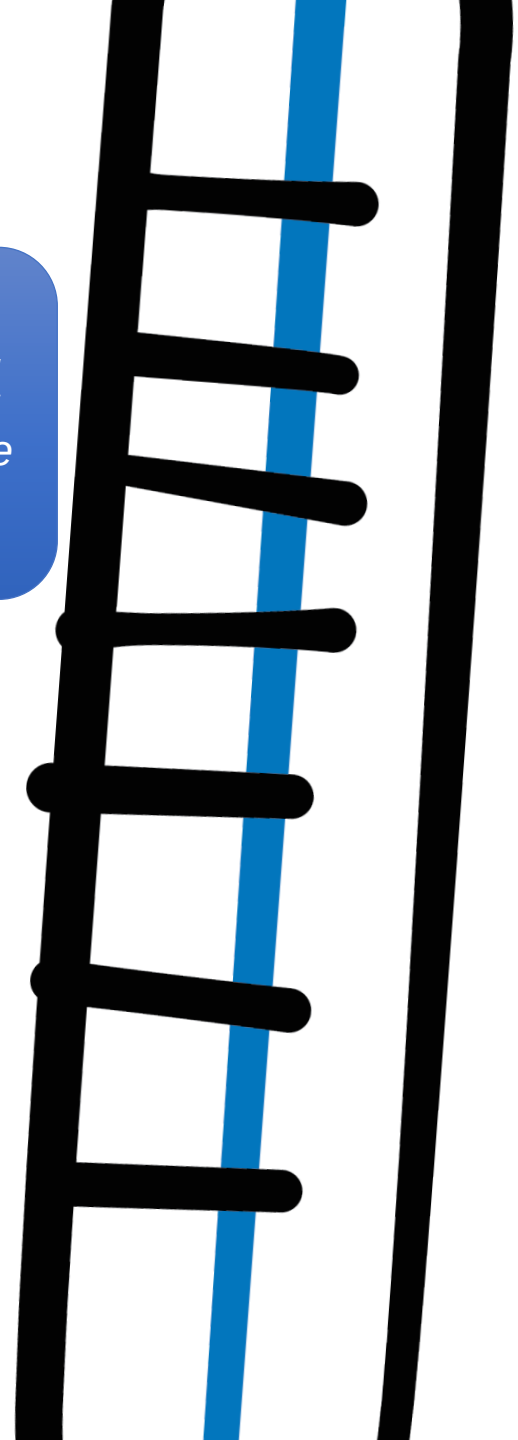
"I really enjoyed my time whenever I was at GOSH. Whilst admitted, whenever or how much pain I was in, the vibes were mostly calming and along with the staff it felt like home and calmed my anxiety"

"Waited 4 hrs in corridor prior to procedure. Xbox did not work. Had a room to myself but I didn't like the bed. The food was good, the best of all the hospitals I've been in"

"I wanted to say thank you to all the staff, doctors, physios and nurses for helping me to get better and for entertaining me. You really made me feel better when I was really sad. Thank you NHS!"

"My time in hospital was good and all the doctors and nurses were always supportive and kind. The doctors will always make you feel comfortable and safe"

"The play workers were lovely and got me lots of things to do to pass the time"



Responses from Parents

Middle tiered questions included;

- Did the hospital change your child's admission date?
- Before operations or procedures, did staff answer your questions in a way you could understand?
- During any operations or procedures, did staff play with your child or do anything to distract them?
- Did you have a contact for staff if you had any concerns when you got home.

Qualitative Comments - Parents

"The staff at GOSH are exceptional! We are regulars so it is important to be greeted by a friendly and caring team. Thank you so much for your hard work to make it as good as it can be for our children"

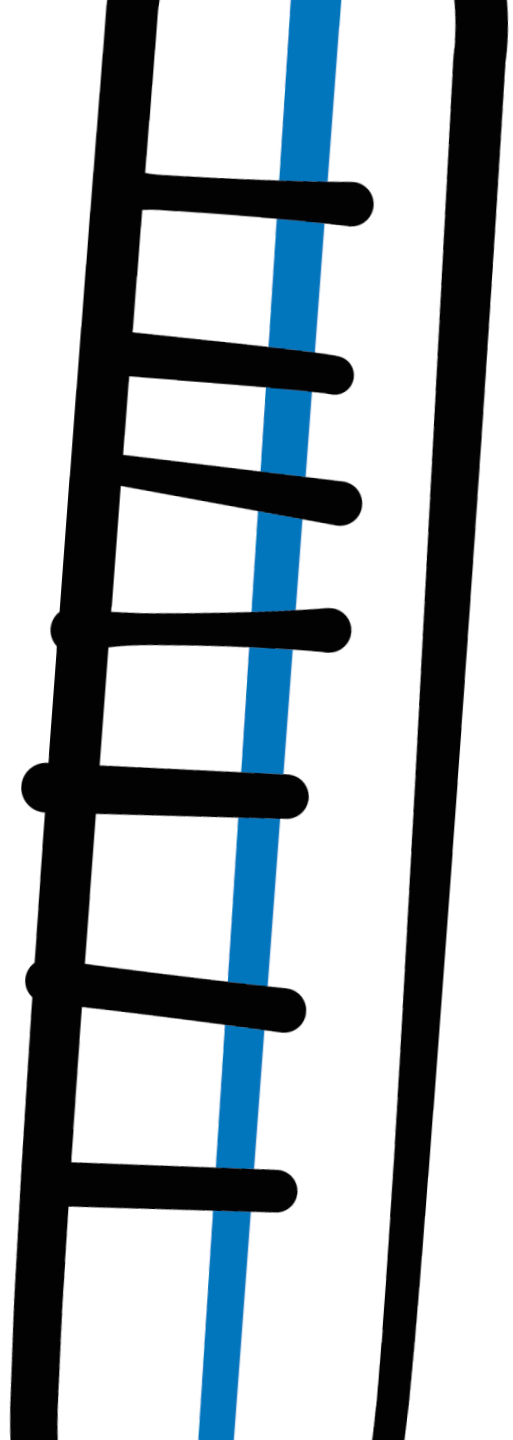
"Amazing experience, you saved my son's life!"

"I would have liked more support as a new Mum"

"My son is very well looked after at GOSH. The pandemic made the whole situation very difficult, but everyone dealt with it very well"

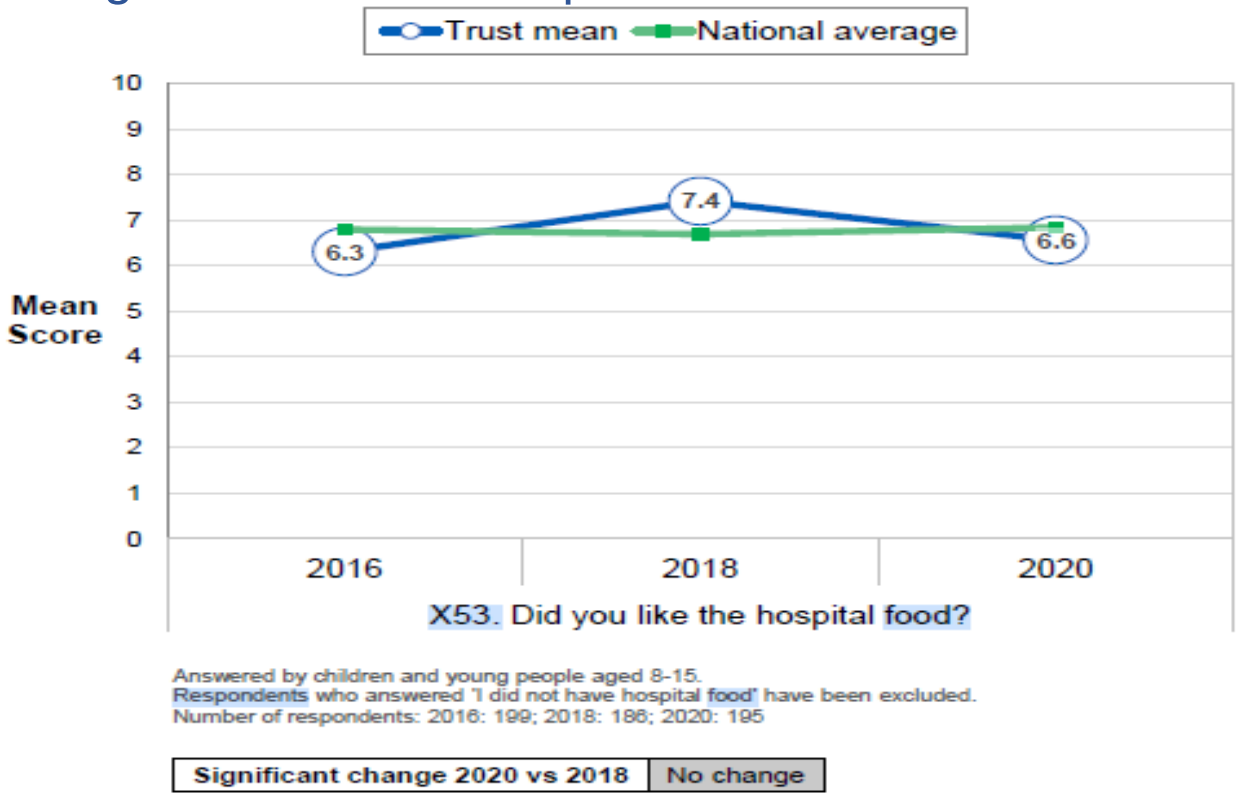
"Staff at the hospital were great, everything was explained clearly. I was involved in decisions and the play staff were great with my son"

It was challenging to feed myself without leaving my son alone due to being unable to share care with my wife. I would have been happy to pay to eat the hospital meals with my son.



Feedback on food

- CYP and parent carer response very slightly below national average
- Mixed qualitive comments - parent / carer comments related to vegetarian options, lack of meals offered to families, inadequate assurance regarding allergens and a general need for improvement.

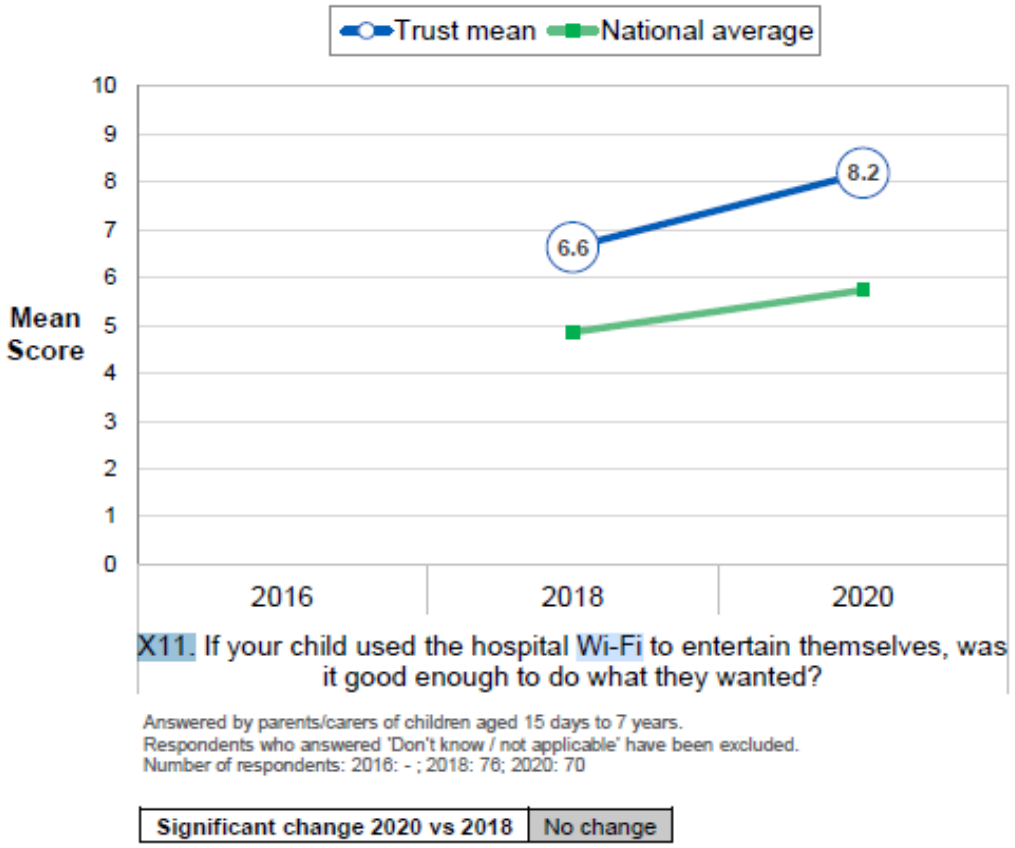


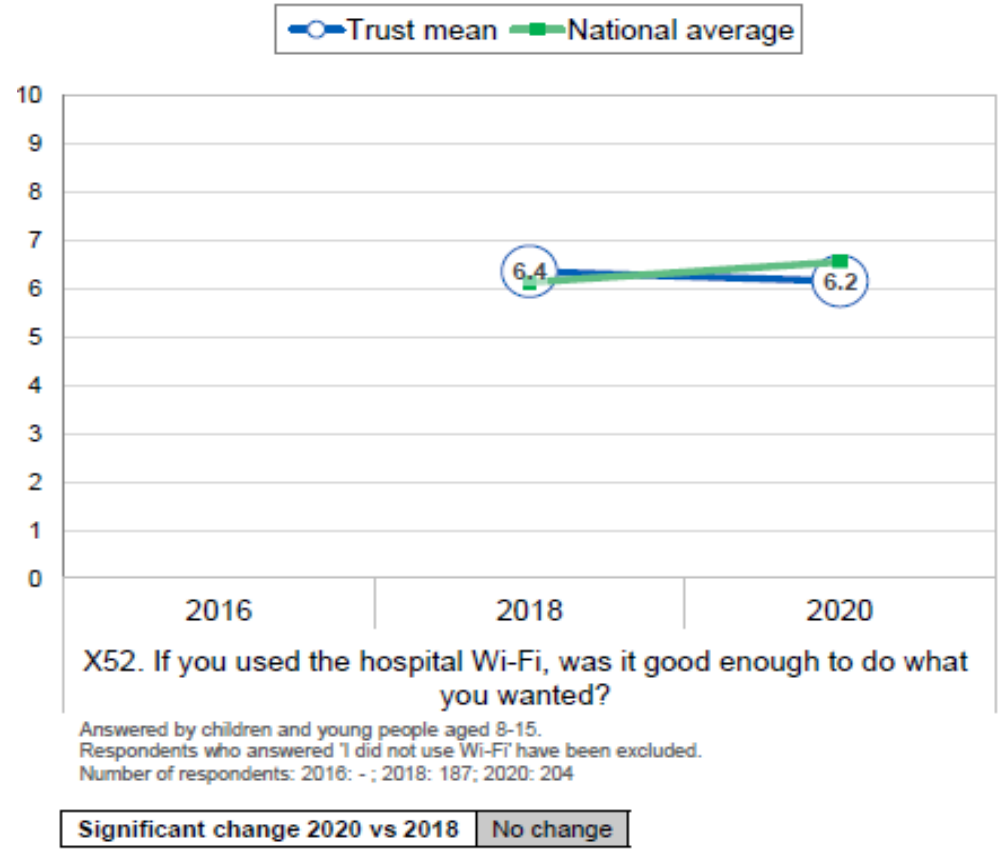
CYP qualitative comments
The food could have been better cooked.
The food was nice too and since staying in hospital I started to drink juice.
I liked the hospital because they gave me very good food and the staff are kind and don't make people sad.
Good- the food was really nice.
Food was good but always suited to children.
Food could be a lot better.
Unfortunately, there are not many vegetarian food options except a plain cheese sandwich which I don't like.
Hospital staff are always so nice, however food isn't as nice.
Food - I need smooth blended food - no tomatoes etc., was not given a menu and was told only Halal chicken available and given always the same, then discovered there was a blended menu.
The toppings of the food could be better by offering things such as olive oil and a better variety of gluten and diary free food.
Lagoon café should improve the variety of food.
I liked the hospital's food and entertainment.
I didn't like them giving sandwiches for lunch. I would prefer 2 hot meals.

Feedback on Wi-Fi

- CYP response reduced marginally from 2018 results and is slightly lower than the national average
- Parent/carer response increased significantly and is above the national average.

Qualitative comments
CYP: *Their wi-fi was very poor*
Parent/ Carer: *Please improve the Wi-Fi for the guests and also change the hospital food.*

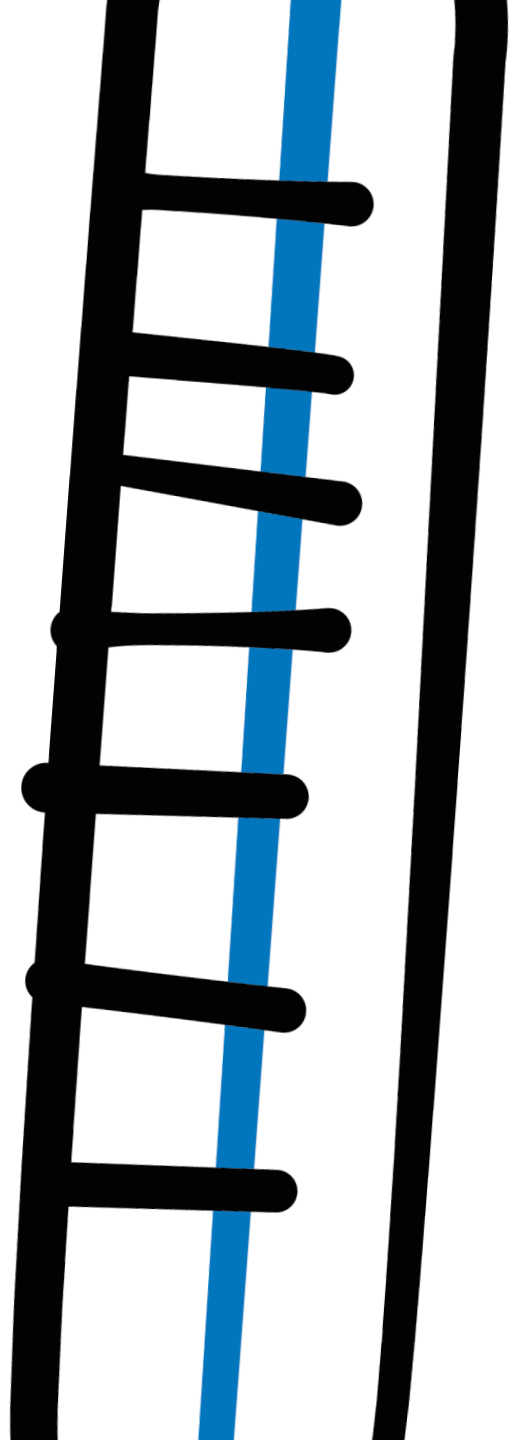




Patient Experience during Covid-19

Covid-19 had an widespread effect on so many aspects of the patient journey and experience at Great Ormond Street. Many of the qualitative comments from parents referenced the impact of being in hospital during a pandemic and the effects of restrictions reflecting national guidance.

Staying in hospital with a child with a condition as a first time mum during COVID-19 has been truly awful. The national one parent only policy resulted in me being alone to care for my baby, mostly by myself without support. As parents are not offered food I needed to provide this for myself which was often incredibly difficult as I wasn't able to leave baby. If he was awake I did not feel supported by staff in this way (lack of offer to watch baby while I sterilised/made a drink/prepared food for myself). I felt a hospital such as GOSH could have used their resources creatively to help new parents such as myself. Plenty of volunteers stood at the entrance guiding visitors - they would surely come in handy making a tea for an exhausted, exceptionally stressed parent. Help was not offered unless I asked or made it clear I was struggling.



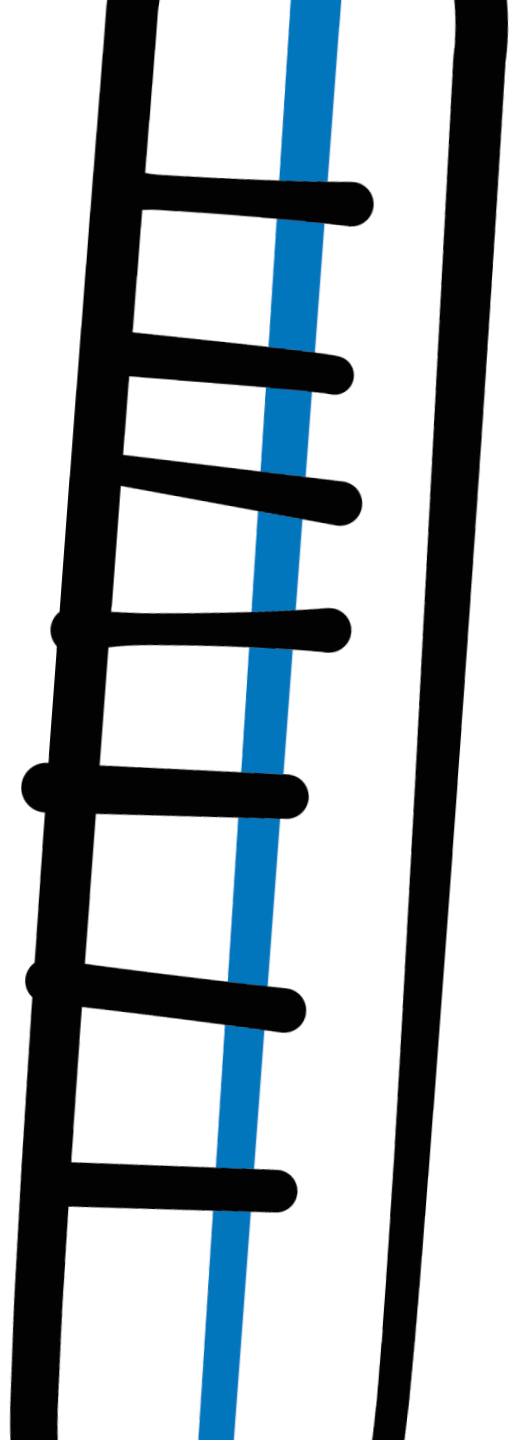
Patient Experience during Covid-19

"We visited during COVID so there were more limitations than there would have been otherwise, but the staff were all great. I was particularly impressed with the speed of our appointment. The consultant listened to my concerns and we were able to reach a good solution to eliminate a certain condition".

"It was difficult to get the appointment during pandemic. It felt like patients without COVID did not matter"

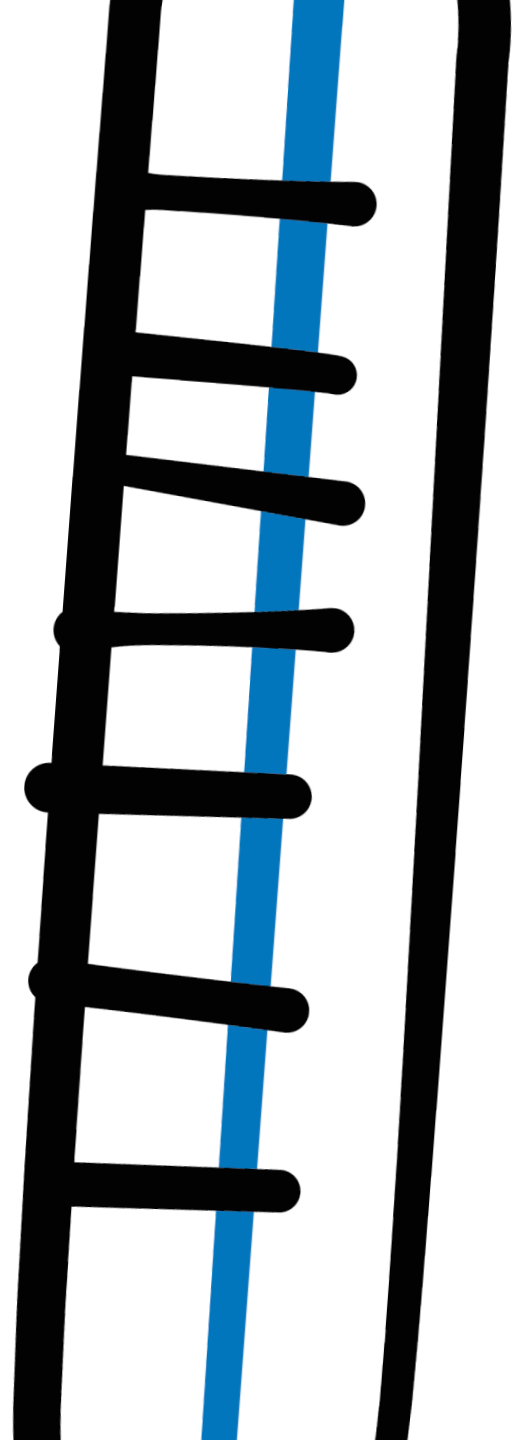
"Due to COVID the playrooms were shut so she had to play in her cot on the ward which was tricky but no-one's fault"

We received incredible care for our child. In challenging COVID times and when we had not been heard by local hospitals the GOSH team are a breath of fresh air. Incredibly professional, friendly and a safe pair of hands for our most precious thing - our daughter. I cannot praise the team any more highly. As this is an ongoing condition I feel lucky to have such a good team caring for my daughter.



Limitations of the data

- The questionnaires are not sent to patients who are 16 and above, as required by the CQC.
- Questionnaires were limited to patients who were inpatients in November 2020 – January 2021.
- The survey is sent to day case and inpatients so some patients would not have experienced staying overnight.
- Survey was carried out when Covid-19 restrictions were in place within the hospital.
- Breakdown by ward / directorate not available.
- Two new questions were added, so there is no historical data for comparison.
- Data collected during Covid-19 which impacted visitors to the Trust and the activities available to patients.



Next steps

- Disseminate results at relevant committees such as PFEEC.
- Share results with all staff via communications such as Headlines & Roundabout.
- Review actions resulting from the survey and identify any existing work streams where the actions can be incorporated.
- Develop an action plan for all other areas not covered by existing work streams.

Actions underway to date

Issue	Actions
Wi-Fi	Working with ICT, changes have been made to improve Wi-Fi (including guest access) across the Trust. Patient and family information about the Wi-Fi access and restrictions of this is being updated.
Food	Following extensive changes within the Catering Team, the Catering Working Group has resumed with action plans being drawn up in response to patient and family feedback (including this survey) to address issues including the range, choice, quality and timing of meals, food vouchers and the Lagoon.
Communication	Communication issues highlighted by this survey are being incorporated into a review of actions in response to the NICE guidance *'Babies, children and young people's experience of healthcare'* with work underway looking at how we listen, record and act on the voice of the child, Me First and We Can Talk training, and improve information provided to patients and families. Work is to be commenced regarding how we enable patients to speak to staff without their parents/ carers.

Attachment G

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
2 February 2022

Infection Control Assurance Framework **Submitted by:** Helen Dunn, Director of Infection Prevention and Control (DIPC)	**Paper No: Attachment G** ☐ **For approval**

Purpose of report
The purpose of this report is to provide assurance that Infection Prevention and Control (IPC) Measures have been reviewed in light of changes in national guidance to support management of COVID-19. The report provides assurance that the Trust meets the required standards as set out in the Assurance Framework published by NHS England on the 22nd May 2020. The framework has been updated several times since then, with the most recent update issued in December 2021 and that where there are gaps in performance, assurance or mitigation there is a clear plan to manage this.

Summary of report
As described above the BAF has been in place for a number of years now around COVID-19 and has been presented to trust board several times.

- A significant update to the board assurance framework was published on 24th December 2021 (highlights in yellow within document). An acute inpatient assessment toolkit was also published to be completed.
- We are largely compliant with the framework (any areas for repeated assurance or actions are in blue within the document) and any areas identified for improvement in the risk assessment toolkit are underway.

Areas identified for improvement:

- Risk assessment, BAF and any guidance at GOSH which differs from the national guidance has not been presented to the ICS.
- Create a local induction checklist on our key COVID procedures for external contractors, agency etc to ensure compliance.
- Safe working group info and hub needs updated to ensure Hands, Face, Place and Space guidance clear in clinical areas.
- Level 2 cleans not completed when patients are stepped down from isolation precautions.
- Some re-audits of best practice such as screening for covid (including laboratory TAT), use of PPE would provide further more up to date assurance
- Routine lateral flow testing compliance could be improved.
- PGD's to be updated for bacterial infections so dispensing can take place following an exposure.
- Currently no OH record held following line manager discussion with staff who fail fit testing.
- Main area within risk assessment that is currently being working on is around standard ventilation. Work currently underway by estates team to verify and rectify areas with mechanical ventilation.

Action required from the meeting
Note the assurances offered, including the plans to undertake more detailed audits over the following months to help identify additional areas for improvement.

Contribution to the delivery of NHS Foundation Trust priorities **□ Quality/ corporate/ financial governance**	**Contribution to compliance with the Well Led criteria** **□ Leadership, capacity and capability** **□ Culture of high quality sustainable care** **□ Responsibilities, roles and accountability** **□ Effective processes, managing risk and performance**
Strategic risk implications BAF Risk 12: Inconsistent delivery of safe care	
Financial implications None	
Implications for legal/ regulatory compliance Part of the Health & Social Care Acy (2015). Compliance with BAF overseen by CQC and commissioners. Fit testing also sits within Health & Safety Law • Risks of non-compliance include improvement notices and other regulatory mandates.	
Consultation carried out with individuals/ groups/ committees Discussed with members of Silver, presented to IPCC and EMT and individuals as appropriate.	
Who is responsible for implementing the proposals / project and anticipated timescales? Director of Infection Prevention and Control	
Who is accountable for the implementation of the proposal / project? Director of Infection Prevention and Control Chief Nurse	
Which management committee will have oversight of the matters covered in this report? IPCC	

Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key Lines of enquiry	*Evidence*	*Gaps in Assurance*	*Mitigating Actions*
Systems and processes are in place to ensure that: • A respiratory season/winter plan is in place: • That includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services • To enable appropriate segregation of cases depending on the pathogen • Plan for and manage increasing numbers where they occur • A multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.	Laboratory has a wide range of assays and testing streams to support clinical areas including symptomatic and asymptomatic testing. Red, amber and green pathways renamed to be called viral respiratory pathways. Majority of hospital single rooms so isolation achieved, except ICU and HDU bays	ICU would struggle to manage patients appropriately if a surge in COVID-19 patients occurred. COVID ICU shut and works means no space to decant easily and not enough medical staff and nursing staff to easily open a cohort area.	Local plans in place to use more cubicles on ICU and prioritise screening for this area to keep flow moving.
Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	FRSM continue to be worn throughout the organisation by all staff unless eating and drinking or working alone in an office. Parents and carers advised to wear masks when not in a cubicle alone with their child.	Staff compliance is not always 100%. This is monitored through Hands, space and face audits.	Regular updates given at SLT etc and big brief on the importance of mask wearing and adherence to guidance.

Organisational employers risk assessments in the context of managing seasonal respiratory infectious agents are: - Based on the measures as prioritised in the hierarchy of controls, including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area - Applied in order and include elimination; substitution, engineering, administration and PPE/RPE. - Communicated to staff.	Risk assessment for organisation completed and shared with silver and gold. See risk assessment for further information.	See risk assessment for further information.	See risk assessment for further information.
Safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example integrated care systems.	Risk assessment shared with silver and gold.	Not currently shared with ICS.	Will discuss with DIPC for ICS and share as necessary
If the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example integrated care systems.	Stepdown procedures for patients who have tested positive for COVID-19 are different from that within the national guidance. These have been approved by silver and gold.	These have not been formally presented to the ICS as there was no mechanism to undertake this.	Will discuss with DIPC for ICS and share as necessary
Risk assessments are carried out in all areas by a competent person with the skills, knowledge and experience to be able to recognise the hazards associated with respiratory infectious agents	Risk assessment completed by the DIPC and ICD for the trust following discussion with the emergency planning officer and H&S lead, shared with IPC team and Silver for comments and amendments.		

If an unacceptable risk of transmission remains following the risk assessment, the extended use of respiratory protective equipment (RPE) for patient care in specific situations should be considered	Currently RPE in use for all AGP. This is not because of failing within risk assessment but because a small number of patients became symptomatic and tested positive within 48hrs of admission exposing staff who were wearing FRSM on a green pathway. Decision made by silver to move to FFP for all AGP to reduce risk to staff and preserve staffing.	Regularly reviewed at covid meetings and any changes would be discussed with ICU areas, theatres and heads of nursing.	
Ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	Red, Amber, Green Pathways in place and available on the GOSH Web Covid Hub. IPC team available advice on risks associated with patient movement. Patient pathways document contains information about how positive/suspected cases should be managed including decisions on movement-approved by Silver and Gold command. Incident reporting in place to highlight any issues with compliance, so that these can be investigated and learned from. Cleaning Guidelines in Place and regularly audited.	that on occasions when it is necessary to cohort COVID-19 or non-COVID-19 patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per national guidance;	
The Trust Chief Executive the Medical Director and Chief Nurse has oversight of the daily sitrep in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases	Process is in place with DIPC and Chief Nurse involved in SitRep sign off to ensure data quality.		

There are check and challenge opportunities by the executive/senior leadership teams of IPC practices in both clinical and non-clinical areas	Senior leaders taking part in the Hands, Face, Space, Place Audits. Ad Hoc Visible leadership walkrounds by the Executive team Discussion of results of audits through the SLT meeting and Big Brief.		
Resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors)	Regular HH audits Isolation audits and action plans as part of quarterly audit days. All staff included in audit	Do external contractors have training or top 10 tips for IPC they need to know about when visiting GOSH	should be covered in local induction but could be standardised for consitency
The application of IPC practices within this guidance is monitored e.g. - Hand hygiene - PPE donning and doffing training - Cleaning and decontamination	Regular HH audits Isolation audits and action plans as part of quarterly audit days. All staff included in audit Cleaning and decontamination is monitored by the appropriate committees and concerns escalated as needed.		
The IPC board assurance framework is reviewed, and evidence of assessments are made available and discussed at Trust board	IPC BAF will be reviewed as part of the agreed reporting to Trust Board. Specific updates on outbreaks and safety related issues are also included in the monthly Integrated Quality and Performance Report.		
The trust board has oversight of ongoing outbreaks and action plans	Regular updates from DIPC. Overview of outbreaks and their management included in Trust Board updates as part of the integrated quality and performance report.		
The trust is not reliant on a particular masks type and ensure that a range of predominately	The trust has a wide range of FFP3 masks. One is ordered externally to		

UK made FFP3 masks are available to users as required	meet the NPSA alert on valves and others are supplied via push stock.		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key Lines of enquiry	*Evidence*	*Gaps in Assurance*	*Mitigating Actions*
the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.	A working group has been set up by the facilities team to implement this.		
the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	This would be managed by the Space committee.		
cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	This is monitored at a local level by the facilities team and monitored at the performance meeting and also the IPCC.		
increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.	The majority of our clinical areas are specified to very high risk and therefore we provide over and above usual expectations and in line with national expectations. SLA's and KPI presented at soft facilities performance meeting Confirmation received of change of cleaning frequencies in trust to reflect covid advice.		
Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a	All areas of the hospital are cleaned with chlorclean or an approved alternative if it is unavaliable. This is specified within the contract, and		

combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.	audited. Chlorine is used in all cleans.		
if an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.	An alternative solution is not used. Chlorine as recommended is used throughout the trust.		
manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	They are trained with standard infection control prevention. Using level 2 clean which is inline with national guidance. Q&A sessions provided. Evidence provided by cleaning team on training given to staff		
a minimum of twice daily cleaning of: ○ patient isolation rooms. ○ cohort areas. ○ Donning & doffing areas ○ 'Frequently touched' surfaces eg, door/toilet handles, patient call bells, over bed tables and bed rails. ○ where there may be higher environmental contamination rates, including: ▪ toilets/commodes particularly if patients have diarrhoea.	Work has been undertaken with the facilities team to ensure that high touch areas in communal areas are cleaned as specified. Cleaning guidance for office areas has been developed. Safe working hub- video and documentation for staff to inform them Risk assessment for hand dryers completed- taken to Ops board Aug 2020 evidence received from OCS that cleaning is enhanced in areas as requested (e.g uplift of OPD etc) Covid mandatory training in place.	Safe working group and hub needs information updated as also used for offices within clinical areas.	

○ A terminal/deep clean of impatient rooms is carried out: ○ Following resolutions of symptoms and removal of precautions ○ When vacated following discharge or transfer (this includes removal and disposal/or laundering of curtains and bed screens) ○ Following an AGP **if room vacated** (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	Rooms are always level 2 cleaned following discharge of a patient who has had an infection alert triggered whilst in there. Signs are available to ensure last AGP is documented in rooms on the GOSH web and guidance is also available on fallow times in different rooms on the GOSH web.	Currently a level 2 clean is not carried out on step down of patients from isolation precautions	Rooms will always be cleaned daily (in most cases twice as VHR) and disposable equipment used
reusable non-invasive care equipment is decontaminated: ○ between each use. ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing, or repair equipment.	Cleaned in line with the patient associated ward equipment cleaning matrix available on the gosh web. This is also monitored as part of the cleaning audits and fed back locally and through the IPCC		
Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	This is monitored at a local level by the facilities team and monitored at	Also plans to be included in the ward safety level project Accredit.	

	the performance meeting and also the IPCC.		
As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities.	Ventilation system requirements are laid out in the Specialist ventilation policy held on the Gosh Web. This also specifies the Trust standard for standard single bedrooms '6 air change slightly negative'. The implementation of this policy is overseen by the IPCC and the ventilation safety committee.		
the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer.	Estates, IPC and an external AE sit on the ventilation safety committee. Data on ventilation is reviewed by the estates, IPC and the AE as appropriate.		
a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	This has taken place and a risk assessment is held by estates. Info on air changes included in covid training for staff, Fallow times available for clinical staff on the GoshWeb.		
where possible air is diluted by natural ventilation by opening windows and doors where appropriate	Most clinical areas have mechanical ventilation but where windows can be opened in office areas this is encouraged.		
where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative	This has been considered but no air changes are so low in clinical areas it has been employed.		

technologies are considered with Estates/ventilation group.	In clinical areas where air changes are below standard fallow time currently extended.		
when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	Screens are only used on reception areas on in speech and language rooms where masks cannot be used. They are included in the cleaning for that area.		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key Lines of enquiry	*Evidence*	*Gaps in Assurance*	*Mitigating Actions*
Systems and process are in place to ensure that:			
arrangements for antimicrobial stewardship are maintained	Antimicrobial rounds are taking place virtually to maintain social distancing and minimise contact whilst preserving arrangements for antimicrobial stewardship.		
previous antimicrobial history is considered	Each patient where there are previous positive microbiological samples will have a antibiogram which details the history of their historical micro samples, these are referred to in all decision making in conjunction with their clinical presentation concomitant therapy and allergy status.		
the use of antimicrobials is managed and monitored: ○ to reduce inappropriate prescribing.	As well as directed AMS ward rounds our prescribing system Epic collates lists of patients on the following agents; meropenem, piperacillin/tazobactam, aminoglycosides, antifungals and		

○ to ensure patients with infections are treated promptly with correct antibiotic.	restricted antimicrobials, such as those that are not in empiric guidelines or are associated with broad spectrum activity or high rates of adverse effects, eg colistin. This list is also monitored routinely for potential inappropriate antimicrobial prescribing. There is an antimicrobial policy group which convenes monthly to review empiric Trust guideline, antimicrobial formulary and practice at the Trust and an antimicrobial stewardship committee who meet quarterly to discuss AMS agendas, strategy, Trust practice and audit and service improvement.'		
mandatory reporting requirements are adhered to, and boards continue to maintain oversight.	Mandatory reporting up to date and maintained. Quarterly report to Board from Infection Control, with monthly IPC monitoring data through the IQPR		
risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	Risk assessments are carried out for CPE and patients with other resistant microorganisms are managed in the correct transmission-based precautions. The AMS and IPC team liase closely.		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.			
Key Lines of enquiry	*Evidence*	*Gaps in Assurance*	*Mitigating Actions*
Systems and process are in place to ensure that:			

visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors	COVID clinical guideline which incorporates national guidance on intranet GOSH website covid FAQs are updated regularly in line with changes to advice. Hospital switchboard message is also updated in line with this guidance. Additional security presence at entrances to buildings to help communicate this message, with escalation to PALS in event of disagreement. There are arrangements in place to enable patient/family specific exemptions in exceptional circumstances with authorisation from the relevant Head of Nursing. The visiting guidance is kept under close review in light of feedback from families and is regularly considered through Silver.		
national guidance on visiting patients in a care setting is implemented.	Visitors guideline which incorporates national guidance on intranet		
restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	This is included within the visiting guidance and would be assessed for each outbreak and communicated to EMT and the Trust.		
there is clearly displayed, written information available to prompt patients' visitors and staff to comply with	Otto the octupus campaign includes posters on hands, face and space. Video running at outpatients. Video for children and written information		

handwashing, wearing of facemask/face covering and physical distancing.	on the website. Video is also running in main reception. Regularly updated FAQ on the website - which are signposted through in text reminders when attending for admissions or outpatients. Information is translated into top languages.		
if visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	All visitors are requested to wear a FRSM on entry to the hospital.		
Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (e.g. parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible	Visitors and resident carers have a daily symptom check as standard. Anyone identified with symptoms is offered a PCR test and asked to leave if possible. If this is not possible they are provided with FRSM to limit exposure to their child and others and managed in the child's bedroom.		
visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment eg, carer/parent/guardian.	Where possible visitors would be asked to leave whilst an AGP is performed. Any parents/carers who needed to stay would be offered PPE.		
Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been adopted C1116- supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	This has been considered for implemenation but GOSH already has its own behaviours which covers all points within the		

	'hands, face, space and place' guidance		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key Lines of enquiry	*Evidence*	*Gaps in Assurance*	*Mitigating Actions*
Systems and process are in place to ensure that:			
signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Signage about what to when you enter the hospital is available at the main entrance. No emergency department so the aim is all families are screened prior to arrival.		
Infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred.	Infection status would be included on discharge summaries and also verbally handed over.		
staff are aware of agreed template for screening questions to ask.	Defined template for questions on Epic to support staff.		
screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment.	Over the phone screening is in place for all OPD and admissions attending the Trust.	Not all patients are captured or answer the phone for telephone screening.	The questions are re checked on arrival to the hospital.
front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and	There is no ED but CATS treat all patients as possible or confirmed COVID-19 and all patients are screened on admission to ICU or		

segregation of cases to minimise the risk of cross-infection as per national guidance.	wards if transferred from another trust.		
triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	Telephone screening triage is not always undertaken by clinical staff. However the process requires escalation of all 'no' answers to a clinical member of staff.	Not always undertaken by clinical staff, but any 'no' responses are escalated to clinical staff.	
there is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved.	Trust guidance on covid testing. Audit of compliance in high risk areas (ICU) carried out in 2021.	Audit should be carried out to demonstrate compliance	
patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.	There is an individual risk assessment based on the child's age. Masks are offered to children from 11+.	This is not monitored specifically in the paediatric population.	
patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result.	No emergency department but all patients admitted to ICU and ward areas are managed as amber until their admission test is returned.		
patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.	>75% of beds are isolation rooms so this is achieved.		
patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered.	All children who suffer from severe immune defiencies or require protective isolation are managed in appropriate rooms. COVID is only known to currently cause disease and complications in a very small sub-set of children. Children with COVID are not looked after on Leopard (where		

	children with CF and other long term respiratory conditions are managed)		
where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	Treatment for patients who are covid positive is delayed for between 4-6 weeks in line with guidance from our team in O&I. this is for all respiratory viruses, not just covid.		
face masks/coverings are worn by staff and patients in all health and care facilities.	FRSM are worn by all staff and parents/carers in line with our hands, face, space and place guidance.	Patients are not routinely asked to wear masks.	
where infectious respiratory patients are cared for physical distancing remains at 2 metres distance.	Use of floor markings and bed spaces have been assessed in all clinical areas.		
patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff.	We maintain a 2m social distance throughout all clinical areas (except dialysis where an individual risk assessment is in place) as children can have a variety of respiratory infections.		
patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly.	Pre-Screening Calls prior to appointment. Screening on arrival. If non urgent- asked to go home as per PHE guidance and rearrange when well. COVID 19 guideline sets out the process for dealing with clinically unwell patients who need to be seen.		

	IPC would be called and able to provide advice. If risk identified would be recorded as an incident.		
isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative.	Daily assessment of patients, and prompt testing. contact tracing for all positive patients.		
patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	Pre-Screening Calls prior to appointment. Screening on arrival. If non urgent- asked to go home as per PHE guidance and rearrange when well. COVID 19 guideline sets out the process for dealing with clinically unwell patients who need to be seen. IPC would be called and able to provide advice. If risk identifed would be recorded as an incident.		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of discharge their responsibiliti es in the process of preventing and controlling infection			
Key Lines of enquiry	*Evidence*	*Gaps in Assurance*	*Mitigating Actions*
Systems and process are in place to ensure that:			
appropriate infection prevention education is provided for staff, patients, and visitors.	Otto the octopus Information on internet page for patients Covid information leaflets IPC training programme for staff Signs at entrance to hospital with clear instructions.		

training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.	In addition to standard IPC training on induction and update training, there has been additional Ad hoc education through the practice education team during the pandemic.This includes videos showing best practice for donning and doffing. Addidional guidance and support has been delivered via the Big Briefings and All Staff Comms. An infection control covid-19 hub was quickly established on the GOSH web.		
all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;	COVID clinical guideline on GOSHWeb. Videos to support donning and doffing have been produced and are available on the Infection Control Hub on GOSHweb. Fit testing SOP in place May 2020 audit showed high levels of compliance with donning and doffing practice.	Re-audit of PPE planned for assurance	
adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	Infection Control Audit schedule		
gloves are worn when exposure to blood and/or other body fluids, non- intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	Gloves off project Gloves included where necessary as part of transmission based precautions.		
the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable	Within clinical areas there are no hand towels in use. Risk assessment for hand dryers in	Monitoring for any staff or patient transmissions. Will review	

paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance.	public and staff areas has been undertaken and is being reviewed for approval at Operational Board in August 2020.	policy if there is an increase in these transmissions.	
staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	Hands, Face, Place Space audits. Infection Control Audit Schedule includes quarterly hand hygience audits. Posters, including instructional posters, floor marking in place. One way systems in place - with a Covid Secure assessment process in place. Communications to staff regarding travelling to work via daily Covid-comms. Support from volunteers services in addition to posters and visual advice on the reception screens regarding masks in main reception.		
staff understand the requirements for uniform laundering where this is not provided for onsite.	Staff Uniform Policy All staff comms Staff awareness of uniform policy and laundering requirements included in audit and as part of IPC audit day		
all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance.	Information on symptoms regularly included in comms for the trust and also included in covid refresher training.		

to monitor compliance and reporting for asymptomatic staff testing	This is monitored by the covid group or silver when in place.	Testing fatigue, also lower rates as a lot of staff have tested positive in the last 90 days and guidance not to test unless a contact.	
there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	This is reviewed by the covid group and silver. Hospital acquired cases are followed up by the IPC team.		
positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	Infection control management, and weekly updates are included in the weekly safety report. Silver meeting receives updates. All User comms identiy the number of patients and staff who have symptoms. Outbreak protocol in place. Risk assessments undertaken by IPC (rather than OH). There have been 5 staff outbreaks since March 2020, including 1 in 2021.		
7. Provide or secure adequate isolation facilities			
Key Lines of enquiry	*Evidence*	*Gaps in Assurance*	*Mitigating Actions*
Systems and process are in place to ensure that:			
that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	Children under the age of 11+ are exempt from facemasks. They are offered to children over this age but not enforced. All parents and carers are aware of the need to wear FRSM when not alone in the cubicle with their child and when in communal areas.		

separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients.	In OPD all patients who are exposed or have respiratory symptoms are deferred or seen in an isolation room. They would go straight to this room and not wait in the main wait. See safari and OPD isolation guides.		
patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.	These patients would be managed in a single cubicle on the RED pathway. See covid clinical guidleline.		
patients are appropriately placed ie, infectious patients in isolation or cohorts.	On wards patients would be nursed in cubicles or virtual cubicles with >2 m in HDU bays and ICU areas,		
ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).	This is regularly assessed by the ward teams and reviewed by silver and the covid group when necessary. Currently decision made to maintain >2m social distancing in all clinical areas until easter 2022		
standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result	These patients would be managed in SICP on the green pathway.		
the principles of SICPs and TBPs continued to be applied when caring for the deceased	All patients who are deceased are managed as per the mortuary guidance and in standard precautions as a minimum.		
8. Secure adequate access to laboratory support as appropriate			

Key Lines of enquiry	*Evidence*	*Gaps in Assurance*	*Mitigating Actions*
Systems and process are in place to ensure that:			
testing is undertaken by competent and trained individuals.	Specimen collection guideline updated in May 2020. UKAS accreditation up to date for the labs- SOPs for sampling procedures in lab held on Qpulse with appropriate training record		
patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance;	Patients are tested promptly with a rapid test available if clinically required. Realtime audit available on Epic dashboard. Bronze microbiology meeting monitors overall TAT and escalates concerns accordingly Dashboard showing screening rates within 24 hours of admission.	The TAT aren't always within 24 hours.	However there is a business plan being progressed to make lab 24 hours.
Staff testing protocols are in place	Staff testing is available on site and via courier. See staff clinic testing SOP for more info	Currently only tested for Sars-CoV2- plan to expand for all respiratory viruses.	
there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available.	Microbiology Bronze meeting.		
there is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data).	Microbiology Bronze meeting.		

screening for other potential infections takes place.	Full standard infection control service running. Diagnostic samples available for full respiratory viruses within lab for both standard and rapid tests.		
that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.	Covid guidance set out on GOSHweb.		
that those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise.	Covid guidance set out on GOSHweb. Daily symptom check and confirmation of current pathway carried out by nursing staff on each shift.		
that all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission.	Covid guidance set out on GOSHweb.	GOSH does retest at day 3, but not at day 5 and 7. this is in line with good practice for paediatrics, wherease the identified standard in this document applies to the adult population.	Currently the ICU retest every 72hrs as isolation cubicles are limited.
that sites with high nosocomial rates should consider testing COVID-19 negative patients daily.	GOSH has had 28 incidence (probable + definitive) of nosocomial infection in a year, so this would not be considered a sufficiently high nosocomial rate. All instances have been risk-assessed and investigated/actioned appropriately, including external notification as required.		
that those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous	GOSH patients are not typically transferred to care homes, but may be transferred to hospice or nursing home. Testing takes place as		

90 days), and result is communicated to receiving organisation prior to discharge.	necessary and infection control results are communicated in discharge summaries.		
those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	GOSH patients are not typically transferred to care homes, but may be transferred to hospice or nursing home. Testing takes place as necessary and infection control results are communicated in discharge summaries.		
there is an assessment of the need for a negative PCR and 3 days self- isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	GOSH follows the RCPCH guidance on elective testing of paediatric patients.	Following RCPCH guidance rather than NHS E guidance which is primarily directed at the adult population.	
9. Have and adhere to policies designed for the individuals care and provider organisations that will help to prevent and control infections.			
Key Lines of enquiry	*Evidence*	*Gaps in Assurance*	*Mitigating Actions*
Systems and process are in place to ensure that:			
the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all the staff (permanent, agency and external contractors).	Hands, face, space and place audits. IPC audit schedule.	There is evidence that not all contractors/agency on site are familiar with the COVID-19 guidance on-site.	work to be completed to have a quick guide for contractors on-site or agency staff attending with key covid-19 mitigations they need to

			undertake whilst here at GOSH
staff are supported in adhering to all IPC policies, including those for other alert organisms.	Policy in place and available on the infection control webpage on GOSH. Udpates are included regularly as guidance changes.		
safe spaces for staff break areas/changing facilities are provided.	This is managed by the safe space group and through silver.	Can be challenging to find enough areas as hospital not designed for staff to take breaks socially distanced or alone if under an exemption.	
robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	Outbreak policy. These would be documented as a datix and also by the IPC team as an incident in their internal reporting. It would also be reported to NCL in line with local guidance.		
all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance.	Category B waste guidance is followed for all suspected infections. And Categaory 3 in the Lab. Waste Audit.		
PPE stock is appropriately stored and accessible to staff who require it.	Stock levels are reviewed and circulated daily. Incident reporting and escalation pathways for staff who cannot access when they need it.		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key Lines of enquiry	*Evidence*	*Gaps in Assurance*	*Mitigating Actions*
Systems and process are in place to ensure that:			
staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	OH is open and available for appointments. IPCT can also be contacted for queries on COVID as can the consultant on call or the CSP out of hours.		
bank, agency, and locum staff follow the same deployment advice as permanent staff.	All staff are encouraged to raise any concerns about where they are placed with their line manager.		
staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self- isolate (see Staff isolation: approach following updated government guidance)	Exemption process in place approved by GOLD and SILVER and monitored by IPC and clinical operations to allow staff to return safely to work.		
staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	COVID clinical guideline on GOSHWeb. Videos to support donning and doffing have been produced and are available on the Infection Control Hub on GOSHweb. Fit testing SOP in place May 2020 audit showed high levels of compliance with donning and doffing practice.	Re-audit of PPE planned for assurance	
a fit testing programme is in place for those who may need to wear respiratory protection.	Fit testing service with up to date training records held on a central dashboards. Fit testing is now a		

	funded service within IPC with permanent staff		
where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: - lead on the implementation of systems to monitor for illness and absence - facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce - lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenzas and COVID-19 - Encourage staff vaccine uptake	These are reported as incidents and followed up by the IPC team, OH and local clinical team as needed. Incident created and datix logged and followed up by IPC. Also reported at weekly safety meeting and IPCC for any trends etc to be identified. Vaccination programme in place and lead by OH for all vaccinations. HR oversee sickness and absence reporting trends into the daily sitrep.	PGDs for other bacterial infections need updating so can be dispensed	
staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	All staff are expected to follow IPC policies and procedures regardless of vaccination status (including the use of PPE). This is audited in the IPC audit days.		

a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. • A discussion is had with employees who are in the at-risk groups including those who are pregnant and specific ethnic minority group; • That advice is available to all health and social care staff, including specific advice to those at risk from complications • Bank, agency and locum staff who fall into these categories should follow the same deployment advice as permanent staff • A risk assessment is required for health and social care staff at high risk of complications,	Managerial discussions. Facilitation of staff to work from home. Occupational Health support. Risk Assessment for vulnerable staff. Well being hub. Demographic Risk Assessments. Safe Working Risk Assessments. Cerfification of Covid Secure areas. The position at the end of July was 94% of all staff had completed the risk assessment, with 95% of BAME staff risk assessments completed. Amazon business account set up for Staff to order homeworking equipment directly. Pregnancy risk assessments are also completed for staff who are pregnant.		

including pregnant staff			
vaccination and testing policies are in place as advised by occupational health/public health.	Vaccination/antibody testing is a condition of employment as is overseen by OH. Mandatory vaccination work being led by HR.		
Staff required to wear FFP3 resuable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records	Fit testing service with up to date training records held on a central dashboards. Fit testing is now a funded service within IPC with permanent staff		
staff who carry out fit test training are trained and competent to do so.	Competency checklist in place.		
All staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used	Fit testing database. SOP/guideline for fit testing.		
All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	This is encouraged and most staff are fit tested to more than one model.	Staff do not wish to attend fit testing for multiple appointments.	
a record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	Fit testing database.		
those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated	Fit testing database.		

testing on alternative respirators and hoods.			
That where fit testing fail, suitable alternative equipment is provided. Resuable respirators can be used by individuals if they comply with HSE recommendation and should be decontaminated according to the manufacturers instructions	Reusable respirators are available in a variety of areas and info is held on the GoshWeb. Following use they are decontaminated according to manufacturers instruction in MEDU.		
members of staff who fail to be adequately fit tested a discussion should had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.	Fit testing database. Health Roster HR Redeployment plan OH Hoods.		
a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	Fit testing record available. Staff members are advised to speak with their line manager re roles.	This is currently not held in the occupational health record	
boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff	Fit testing database. Incident reporting.		

safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.			
consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance.	Health Roster.. Operational Hub. Daily Head of Nursing Huddle.		
health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	Staying Safe @ GOSH guidance Safe working hub Hands, Face, Place Space.		
staff absence and well-being are monitored and staff who are self -isolating are supported and able to access testing.	Daily monitoring of staff sickness and those who are self isolating/quarantining. The number and % of the workforce affected is included in the daily comms email to ensure good levels of visibility. Phone call service for staff who are self-isolating including peer support for medical staff who are unwell.		

	Onsite testing is available including serology testing for all staff who want it.		
staff who test positive have adequate information and support to aid their recovery and return to work.	Occupational Health Service/Line manager screening prior to return to work. Safe return to site working group. Safe working checklists and risk assessments.Managerial support. Well Being Hub which includes access to psychological support.		

Criteria for completing a local risk assessment

Acute inpatient areas

24 December 2021, Version 1

Purpose:

To support organisations and employers to undertake a local risk assessment in the context of managing seasonal respiratory viral infections focussing on influenza, SARS- CoV-2 and respiratory syncytial virus (RSV) based on the measures as prioritised in the hierarchy of controls.

This includes:

- A set of risk mitigation measures prioritised in the order: elimination, substitution, engineering, administrative controls, and PPE (including respiratory protective equipment [RPE]).
- Risk assessments must be carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents: this can be the employer, or a person specifically appointed to complete the risk assessment. Communication should take place with employees during this process and on completion of the risk assessment.
- The completed risk assessment can be used to populate local risk management systems.

Trust/organisation name	Date of initial assessment	Assessor's name	Date of review

What are the hazards?	Who might be harmed and how?	Standard required	What further action do you need to take to control risks?

Contracting or spreading SARs-CoV-2 and other seasonal respiratory viral infections:
Influenza
RSV
	• Patients
	• Staff
	• Contractors
	• Visitors
		Monitor:
		• community prevalence of infections
		• new variants of concern (VOC)
		• number of hospital admissions
		• number of outbreaks.
		Monitor:
		• Organisational operational capacity, for example:
		  ○ emergency department (ED) pressure
		  ○ trolley waits
		  ○ bed capacity.
			This standard is met. Data is available at trust, directorate and ward level about all types of respiratory infections on the dashboard accessible to all. Info all shared and reviewed at IPCC.
			
			In addition data on RSV, flu and covid is included in the daily sitrep. *Although this only covers inpatients- so work is underway to include daycase's as this can have an impact on flow.*

Contracting or spreading SARs-CoV-2 and other seasonal respiratory viral infections: **Influenza** **RSV**	• Patients • Staff • Contractors	**Elimination** (physically remove the hazard) **Redesign the activity such that the risk is removed or eliminated** **Key mitigations** – check systems are in place to ensure: • where treatment is not urgent, consider delaying this until resolution of symptoms – providing this does not impact negatively on patient outcomes. • patients who are known or suspected to be positive with a respiratory pathogen, including SARs-CoV-2, and whose treatment cannot be deferred should receive care from services who are able to operate in a way which minimises the risk of spread of the virus to other patients. **Patients:** Screening, triaging and testing is in place for SARs-CoV-2 and other respiratory agents relevant to the setting, eg RSV/influenza. This must be undertaken to enable early recognition and to clinically assess patients prior to face to face attendance/procedures to identify whether: • patient is fully vaccinated • patient has no respiratory symptoms linked to clinical case definition for SARs-CoV-2 • patient must be tested prior to admission, as advised by the clinician. For SARs-CoV-2 there may still be a requirement to self-isolate prior to surgery, and this will be determined on an individual risk basis. • patients admitted as an emergency should undergo triaging and testing as soon as this is practical, based on clinical need.	Screening and testing is carried out and described in the COVID clinical guideline and SOP for the covid screening clinic. All patients who are asymptomatic are screened 3 days prior to admission/AGP or less or on admission. Asymptomatic patients have a SARS-CoV2 test only and symptomatic patients have a full resp panel. All patients are reviewed daily and placed on RED, AMBER, GREEN pathways as appropriate. ICUs rescreen every 72hrs. Children arriving from overseas are managed on an amber pathway for 10 days. Parents managed as per government guidance. Exemption process in place. *LFT testing compliance reviewed daily*. *Standard twice weekly LFT is difficult to maintain due to testing fatigue.* *Work going on led by HR around mandatory vaccination.*

What are the hazards?	Who might be harmed and how?	Standard required	What further action do you need to take to control risks?

		Staff:
		Check systems are in place to ensure that:
		• fully vaccinated staff and students who are identified as a contact of a positive COVID-19 case will no longer be expected to isolate and will be expected to return to work.
		  ○ See updated UKHSA guidance on NHS staff and student self-isolation and return to work.
		  ○ Follow appropriate variant of concern (VOC)-specific guidance for self-isolation and testing
		• twice-weekly Lateral Flow Device testing should be carried out for all staff
		• ensure staff working in all clinical areas:
		  ○ are fully vaccinated against respiratory infections (including COVID-19) as advised by public health/occupational health
		  ○ are asymptomatic.	

Contracting or spreading SARs-CoV-2 and other seasonal respiratory viral infections: **Influenza** **RSV**	• Patients • Staff • Contractors	**Substitution** (replace the hazard) **Replace the hazard with one that reduces the risk** **Key mitigations:** This is not possible for healthcare to achieve as treatment needs to be carried out, so emphasis needs to be on the mitigating risks on other controls. However, some services may still consider the use of implementing virtual consultations (telephone or video) and offering these where appropriate to patients with a suspected or confirmed respiratory infection.	Wherever possible patients who have been exposed or positive identified by screening are deferred or offered virtual appointments if appropriate. O&I team review when patients appropriate for anesthetic following resp infection.

What are the hazards?	Who might be harmed and how?	Standard required	What further action do you need to take to control risks?
Contracting or spreading SARs-CoV-2 and other seasonal respiratory viral infections: **Influenza** **RSV**	• Patients • Staff • Contractors	**Engineering** (Control, mitigate or isolate people from the hazard) **Design measures that help control or mitigate risks, such as ventilation, barriers, and screens.** **Priority should be given to measures that provide collective protection rather than those that just protect individuals or a small group of people.** **Key mitigations:** • Ensure adequate ventilation systems are in place, ie mechanical/or natural national recommendations for minimum air changes are met as defined for the care area. This should be carried out in conjunction with organisational estates teams/specialist advice from ventilation group and/or authorised engineer on how best to achieve the recommended number of air changes as appropriate. See HTM 03-01 Specialised ventilation for healthcare buildings. • Identify areas (clinical and non-clinical) which are poorly ventilated or where existing ventilation systems are inadequate. • Maximise mechanical ventilation in collaboration with Organisation Ventilation Group COVID-19 SOP Room Ventilation, available on FutureNHS Collaboration Platform. • Dilute air with natural ventilation by opening windows and doors where appropriate. • If considering screens/partitions in reception/waiting areas to ensure air flow is not affected and cleaning schedules are in place, consult with appropriate facilities teams. • Assess whether room provision (negative, neutral and positive ventilation) is and would continue to be sufficient were there to be an increase in patients requiring isolation for respiratory infection. Work in a multidisciplinary team with hospital leadership, engineering and clinical staff to plan for creation of adequate isolation rooms/units. • Assess the function of the care area and ensure overcrowding is not an issue – particularly if patients with known or suspected respiratory infections are being cared for. **Patients with respiratory infections should not be cared for in poorly ventilated/overcrowded areas**. Where a clinical space has very low air changes and it is not practical to increase dilution effectively then consider alternative technologies with the Estates/ventilation group. See Adult inpatient facilities: planning and design (HBN 04-01)	*Standard agreed as 6 a/c slightly negative for all standard bedrooms. Work ongoing to ensure all bedrooms at this air change. Current mitigation in place of extended fallow times post AGP to two hrs.* Specialist ventilated areas in spec and reviewed in monthly ventilation monitoring group. Wherever possible covid patients are looked after in PPVL cubicles. *IPC team rolling out ward manuals so staff know what cubicles are in their areas- delayed due to covid demands.* *Safe working group not currently in place- Estates can you write the plan in here.*

What are the hazards?	Who might be harmed and how?	Standard required	What further action do you need to take to control risks?

Contracting or spreading SARs-CoV-2 and other seasonal respiratory viral infections:
Influenza
RSV
	• Patients
	• Staff
	• Contractors
		Administrative controls (change the way people work)
		Administrative controls are implemented at an organisational level (eg the design and use of appropriate processes, systems and engineering controls, and provision and use of suitable work equipment and material) to help prevent the introduction of infection; and to control and limit the transmission of infection in healthcare.
		
		Key mitigations – check systems in place to ensure that:
		• screening, triaging and testing is undertaken to enable early recognition of SARs-CoV-2 and other infectious agents (eg influenza, RSA)
		• separation is maintained in space and/or time between patients with or without suspected respiratory infection, by appropriate:
		  ○ appointment and clinic scheduling
		  ○ patient placement for infectious patients in isolation or cohorting.
		  ○ regular assessments of physical distancing and bed spacing, taking into account potential increases in staff-to-patient ratios and equipment needs (dependent on clinical care requirements).
		  ○ Consider lowering occupancy thresholds to reduce the density in shared areas, to enable physical distancing and improve ventilation.
		• for patients who are known or suspected to be positive with a respiratory pathogen, including SARs-CoV-2, and treatment cannot be deferred, care should be provided via services that can operate in a way that minimises the risk of spread of the virus to other patients/individuals
		• there is provision of appropriate infection control education for staff, patients and visitors
		• the provision of additional hand hygiene stations (alcohol-based hand rub) and signage, to ensure good hygiene practices in staff, patients and visitors
		• safe spaces are provided for staff break areas/changing facilities
		• regular cleaning regimes are followed and compliance monitored, including shared equipment
		• staff and patients comply with current public health measures, including masks/face coverings, physical distancing measures, limiting the number of visitors, as appropriate.
			Screening and triage in place at admission and pre-admission for all patients.
			Red, amber, green pathways in place. Majority of wards and hospital have cubicles so within the exception of ICU and HDU bays on wards and closure of playrooms bays rarely needed to be closed.
			
			ICU have admission screening bays. 2M social distancing maintained in most areas (dialysis excluded) to reduce risk.
			
			Step down procedures in place for respiratory viruses for normal immunity and immunosuppressed children.
			
			Space for staff to have breaks has been challenging. Sign in sign out sheets up. Can be difficult for staff on exemptions to take breaks alone.
			
			No issues identified with cleaning but recent change to inhouse cleaning so has been some challenge in monitoring cleaning in all areas

What are the hazards?	Who might be harmed and how?	Standard required	What further action do you need to take to control risks?
Contracting or spreading SARs-CoV-2 and other seasonal respiratory viral infections: **Influenza** **RSV**	• Patients • Staff • Contractors	**Person protective equipment (PPE)/respiratory protective equipment (RPE)** (Protect the worker with personal protective clothing) **Employers are under a legal obligation – under the control of COSHH regulations, to adequately control the risk of exposure to hazardous substances where exposure cannot be prevented.** **PPE must** be worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or **in line with SICP and TBPs**. **PPE is considered to be the least effective measure of the hierarchy of controls. PPE should be considered in addition to all previous mitigation measures higher up in the hierarchy of controls.** **Key mitigations** – check systems in place to ensure: • there is adequate supply and availability of PPE – including RPE – to protect staff, patients and visitors. • all staff required to wear an FFP3 mask have been fit-tested (this is a legal requirement). • face masks/coverings should be worn by staff and patients in all healthcare facilities as per government guidelines. • all staff (clinical and non-clinical) are trained in putting on, removing and disposing of PPE. • visual reminders are displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance.	Fit test service established and available for staff. Daily monitoring of stock levels of masks and PPE provided by materials management team. PPE audited on IPC audit days and feedback to ward staff with action plans if needed. *Hands, face, space audits take place. Compliance varies but is monitored and discussed at SLT, Ops board and Big brief.*
If transmission remains following this risk assessment, it may be necessary to consider the extended use of RPE (FFP3) for patient care in specific situations			

- Reference: https://www.england.nhs.uk/coronavirus/publication/infection-prevention-and-control-supporting-documentation/
- **Compendium of guidance and resources: COVID-19**. This contains the key COVID-19 documents relevant for England, including the documents linked within this tool. This resource is updated quarterly with settings-specific guidance highlighted within relevant sections of the document.
- A full suite of COVID-19 infection prevention and control guidance for healthcare settings can be access here: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

Attachment I

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
2nd February 2022

January IQPR (December 2021 Data) **Submitted by:** Dr Sanjiv Sharma, MD Darren Darby, Acting Chief Nurse John Quinn, COO Caroline Anderson, Director of HR & OD	**Paper No: Attachment I** □ **For approval** √ **For discussion** □ **For information and noting**

Purpose of report

Sept IQPR

To present the IQPR data and narrative to the Board to show the monthly performance on the key indicators and to provide the Board with assurance that the indicators on patient safety, patient experience and performance are monitored regularly.

Proposal for IQPR revisions

To set out for discussion a proposal for revision of the IQPR to provide improved assurance for the Board.

Summary of IQPR report

- The December report shows that the incident reporting rate has reduced slightly inline with reduction in activity levels and seasonal period. The percentage of incident closure rate has increased to 53%, with average days to close increasing from 53 to 57. This is related to resource capacity within the Patient Safety Team. Improvement should be seen in February.
- The Trust has 6 open serious incidents, but none are overdue for December.
- The position with high risk reviews has dipped slightly, and overdue actions have increased from the previous month. Focus continues in improving the performance in liaison with the directorates. With weekly reporting is being monitored and milestones in place.
- The Friends and Family Test response rate in December was 27% and is above the target of 25%. Targets for ratings of experience for inpatients (97%) and Outpatients (95%) was achieved. Feedback from patients and families is consistent with previous months.
- There were 5 formal complaints received in December 2021. At the time of reporting there are 9 open complaints. No new red graded complaints were received, and overdue red complaint actions are at 1.
- PALS contacts fell by 24% (to 132) reflection of the Omicron wave impact and reduced activity. Despite lower staffing levels 82% of PALs contacts were resolved with 48 hours. Complex contacts have decreased in December. Concerns regarding transport increased, thematic analysis is underway.
- WHO checklist GA procedures in main theatre reduced marginally to 97%.
- Cardiac Arrests outside of ICU has seen a statistically significant increase. A review of RECALLS and clinical documentation has taken place. Themes have been identified and shared with Deteriorating Patient Improvement.
- Sickness Absence increased significantly to 5.9%, nearly 40% of absences related to Covid. Self-isolation rapidly increased to an average of 129 episodes per day.
- RTT – Decrease in performance of 1.1% to 75.3% and 9% below trajectory. 52 Week waits decrease of 8 patients to 194 at end of December. Omicron wave had a significant impact on performance and capacity across all services.

- DM01 – Decrease in the reported position for December 2021 at 87.6%, 1.7% decrease from November and 1.7% above trajectory. 6 Week breaches increased by 35 to 159.

Action required from the meeting
The Board are asked to note the report.

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 **□ PRIORITY 2: Deliver a Future Hospital Programme to transform outdated pathways and processes** **□ PRIORITY 3: Develop the GOSH Learning Academy as the first-choice provider of outstanding paediatric training** **□ PRIORITY 4: Improve and speed up access to urgent care and virtual services** **□ PRIORITY 5: Accelerate translational research and innovation to save and improve lives** **□ PRIORITY 6: Create a Children's Cancer Centre to offer holistic, personalised and co-ordinated care** **□ Quality/ corporate/ financial governance**	**□ 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 3: Operational Performance and other BAF risks relevant to the data reported.

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?
The MD supported by the AMDs

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

Which management committee will have oversight of the matters covered in this report?
RACG, QSEAC, FIC, Closing the Loop and PFEEC.

Great Ormond Street Hospital for Children
NHS Foundation Trust

Integrated Quality & Performance Report January 2022 (December 2021 data)

Sanjiv Sharma	Darren Darby	John Quinn	Caroline Anderson
Medical Director	Acting Chief Nurse	Chief Operating Officer	Director of HR & OD

Hospital Quality Performance – January 2022 (December data)

Are our patients receiving safe, harm-free care?

	Parameters	October 2021	November 2021	December 2021
Incidents reports (per 1000 bed days)	R<60 A 61-70 G>70	88 (n= 651)	88 N=638	75 N=497
Incident investigations completed in month		513	704	426
No of incidents closed	R - <no incidents reptd G - >no incidents reptd	475	416	332
Incident Closure Rate (% of incidents closed within policy)	R 0-64%A>65-75% G>76-100%	40%	54%	53%
Average days to close	R ->50, A - <50 G - <45	56.5	53	57.3
Medication Incidents (% of total PSI)	TBC	22.1%	20.3%	23.8%
WHO Checklist (Main Theatres GA only)	R<98% G>98-100%	99%	98%	97%
Near Miss reports (% of incidents reported)	R <8%, A 8-9%, G>10%	5.9%	4.4%	3.2%
New Serious Incidents		1	3	0
Overdue Serious incidents	R >1, A -1, G – 0	0	0	0
Safety Alerts overdue	R- >1 G - 0	0	0	0
Serious Children's Reviews Safeguarding children learning reviews (local)	New	0	0	0
	Open and ongoing	10	8	8
Safeguarding Adults Board Reviews	New	0	0	0
	Open and ongoing	2	2	2

Are we delivering effective, evidence based care?

	Target	Oct 21	Nov 21	Dec 21
Specialty Led Clinical Audits on Track	R 0- 60%, A>60-75% G>75-100%	77%	77%	80%
Number of completed specialty led clinical audits per year	Aim =100 p.a G= YTD total at month end is on target	64	77	86
NICE guidance overdue for assessment of relevance	R=1+, G=0	0	0	0
Relevant NICE national guidance without a gap analysis	R=1+, G=0	0	0	0
Participation in mandatory relevant national audits	G=100%	100%	100%	100%

Are our patients having a good experience of care?

	Parameters	October 2021	Novemb er 2021	December 2021
Friends and Family Test Experience rating (Inpatient)	G – 95+, A- 90-94, R<90	97%	97%	97%
Friends and Family Test experience rating (Outpatient)	G – 95+, A-90-94,R<90	94%	95%	95%
Friends and Family Test - response rate (Inpatient)	25%	26%	32%	27%
PALS (per 1000 combined pt episodes)	N/A	8.45	6.47	6.32
Complaints (per 1000 combined pt episodes)	N/A	0.42	0.26	0.24
Red Complaints (%total complaints 12 month rolling)	R>12% A- 10-12% G- <10%	10%	10%	9%
Re-opened complaints (% of total complaints since April 2020)	R>12% A- 10-12% G- <10%	4%	3%	5%

Are our People Ready to Deliver High Quality Care?

	Parameters	October 2021	Novemb er 2021	December 2021
Mandatory Training Compliance	R<80%,A-80-90% G>90%	91%	91%	92%
Stat/Man training – Medical & Dental Staff	R<80%,A-80-90% G>90%	84%	85%	87%
PDR	R<80%,A-80-89% G>90%	86%	87%	88%
Appraisal Compliance (Consultant)	R<80%,A-80-90% G>90%	95%	89%	91%
Honorary contract training compliance	R<80%,A-80-90% G>90%	75%	74%	78%
Safeguarding Children Level 3 Training compliance	R<80%,A-80-90% G>90%	87%	86%	89%
Safeguarding Adults L2 Training Compliance	R<80%,A-80-90% G>90%	90%	91%	92%
Resuscitation Training	R<80%,A-80-90% G>90%	83%	83%	83%
Sickness Rate	R -3+% G= <3%	4.3%	4.2%	5.9%
Turnover - Voluntary	R>14% G-<14%	11.5%	11.3%	11.7%
Vacancy Rate – Contractual	R- >10% G- <10%	5.6%	5.2%	5.7%
Vacancy Rate - Nursing		1.01%	1.20%	2.99%
Bank Spend		5.0%	5.1%	5.2%
Agency Spend	R>2% G<2%	1.2%	1.2%	1.2%

Hospital Quality Performance – January 2022 (December data)

Is our culture right for delivering high quality care?

	Target	October 2021	November 2021	December 2021
High Risk Review (% reviewed within date)	R<80, A 81-90% G>90%	75.3%	73%	69.4%
Serious Incident Actions (number of actions overdue)	R- >2 A- 1-2 G- 0	60	60	63
Red Complaints Action Plan Completion (no of actions overdue)	R- >2 A- 1-2 G- 0	2	1	1
Duty of Candour Cases	N/A	11	5	9
Duty of Candour Conversation (Stage 1)	R<75% A 75-90% G>90%	100%	100%	100%
Duty of Candour Letter (Stage 2) Has a letter been sent?	R<75% A 75-90% G>90%	33%	80%	60%
Duty of Candour – compliance with 10 days	R<75% A 75-90% G>90%	33%	40%	60%
Duty of Candour - Stage 3 Total sent out in month	Volume	5	4	1
Duty of Candour – Stage 3 Total (%) sent out in month on time	R<50%, A 50-70%, G>70%	40%	75%	0%
Duty of Candour – Stage 3 Total overdue (cumulative)	G=0 R=1+	2	3	5
Policies (% in date)	R 0- 79%, A>80% G>90%	89%	88%	86%
Safety Critical Policies (% in date)	R 0- 79%, A>80% G>90%	90%	90%	87%
Fit and Proper Person Test Compliance (self assessment)	R - <90%A 90-99% G – 100%	100%	100%	100%
Inquests currently open	Volume monitoring	19	15	15
New Freedom to speak up cases	Volume monitoring	21	12	5
HR Whistleblowing - New	Volume monitoring	0	0	0
HR whistleblowing - Ongoing	12 month rolling	0	0	1
New Bullying and Harassment Cases (reported to HR)	Volume	0	0	1
	12 month rolling	3	3	4

Are we managing our data?

	Target	October 2021	November 2021	December 2021
FOI requests	Volume	34	49	36
FOI Closures: % of FOIs closed within agreed timescale	R- <65% A – 65-80% G- >80%	79%	89%	78%
No. of FOI overdue (Cumulative)		1	1	1
FOI - Number requiring internal review	R>1 A=1 G=0	0	0	1
FOI Number referred to ICO	G=0 R=1+	0	0	0
Information Governance Incidents	volume	17	11	7
IG incidents reported to ICO	R=1+, G=0	1	0	0
SARS (Medical Record) Requests	volume	130	149	93
SARS (Medical Record) processed within 30 days	R- <65% A – 65-80% G- >80%	98%	99%	100%
New e-SARS received	volume	1	0	0
No. e-SARS in progress	volume	3	3	3
E-SARS released	volume	2	0	1
E-SARS partial releases		0	0	1
E-SARS released past 90 days	volume	0	0	0

Description	Target	Oct 2021	Nov 2021	Dec 2021
52 week + breaches reported (ticking at month end)	Volume	194	202	194
52 week + harm reviews to be completed (for treatment completed or seen in month)		107	98	87
Clinical Harm Reviews Returned at point of reporting		33	21	15
Clinical Harm Identified at point of reporting		0	0	0

Do we deliver harm free care to our patients?

Central Venous Line Infections

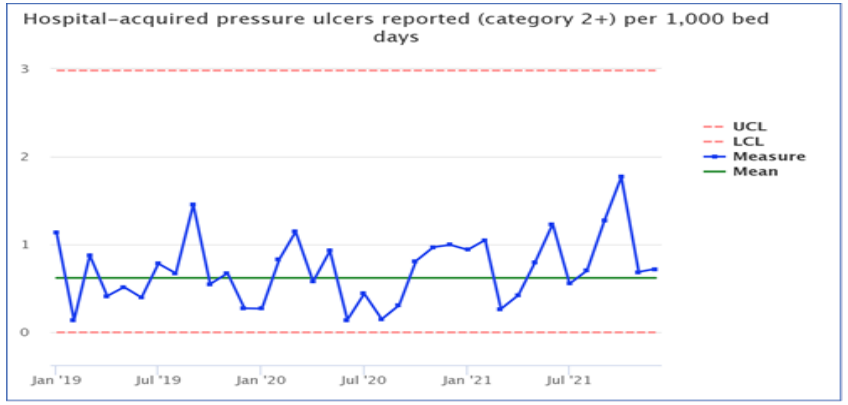
GOSACVCRB (GOS acquired CVC related bacteraemias ('Line infections')*

Period	GOSACVCRB_No	DaysRecorded	Rate	Rate_YtD
Year 18/19	82	52972	1.5	1.5
Year 19/20	73	56333	1.3	1.3
Year 20/21	63	54195	1.2	1.2
Apr-21	4	4388	0.9	0.9
May-21	7	4492	1.6	1.2
Jun-21	3	4571	0.7	1
Jul-21	6	4376	1.4	1.1
Aug-21	8	4392	1.8	1.3
Sep-21	6	4444	1.4	1.3
Oct-21	3	4471	0.7	1.2
Nov-21	6	4411	1.4	1.2
Dec-21	4	4315	0.9	1.2

Infection Control Metrics

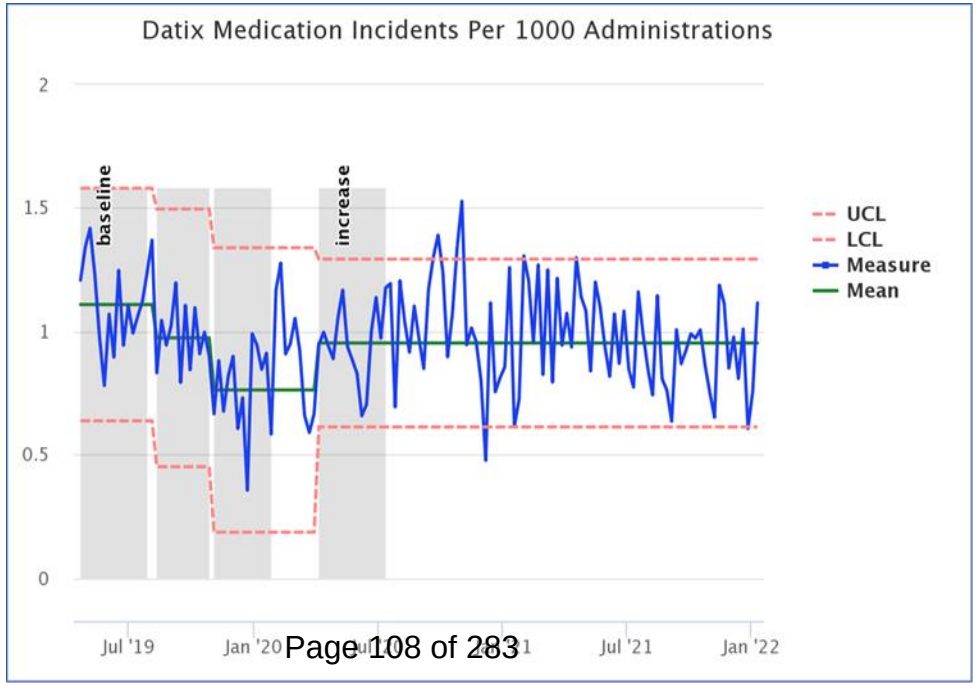
Care Outcome Metric	Parameters	Sept 2021	Oct 2021	Nov 2021	Dec 2021
Bacteraemias (mandatory reporting – MRSA, MSSA, Ecoli, Pseudomas Klebsiella)	In Month	10	2	6	3
	YTD (financial year)	30	32	38	41
C Difficile cases - Total	In month	1	0	1	0
	YTD (financial year)	6	6	7	7
C difficile due to lapses (Considered Trust Assigned but awaiting confirmation from NHS E)	In Month	0	0	0	0
	YTD	5	5	5	5

Pressure Ulcers



		Sept 21	Oct 21	Nov 21	Dec 21
Volume	R – 12+, A 6-11 G <=5	9	13	5	9
Rate	R=>3 G=<=3	0.59	0.59	0.59	0.59

Medication Incidents



105 medication-related incidents were reported in December 2021.

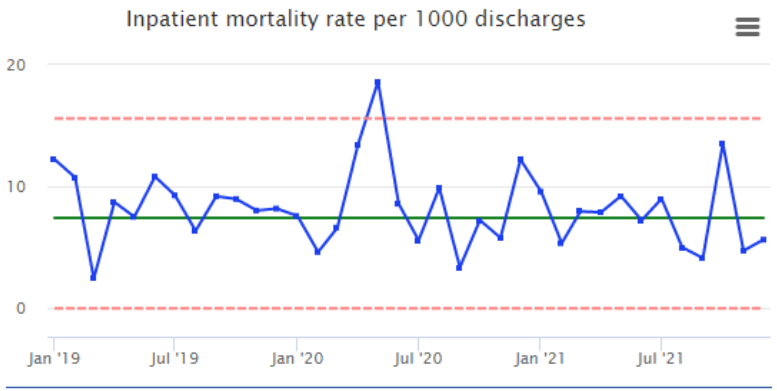
24% (↓) of these reported incidents were related to drug administration errors from correct prescriptions and 19% (↓)were related to medication dispensing. The biggest increase was in medication storage incidents which were 25% of incidents.

48 medication incident investigations were completed and closed in December.

There was 1 incident reported as moderate harm,17 causing minor harm and 87 causing no harm

Does our care provide the best possible outcomes for patients?

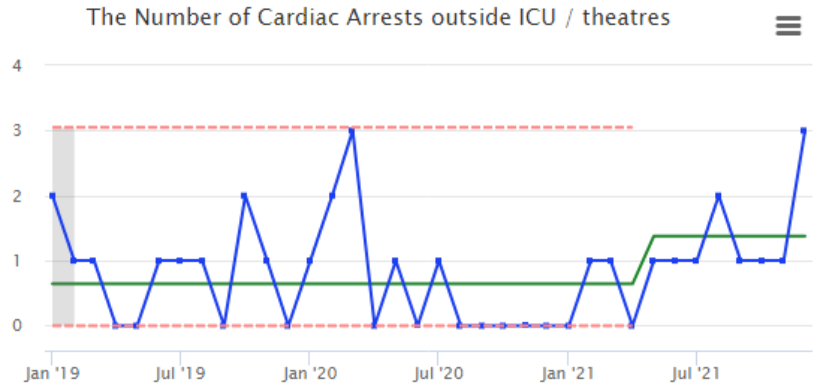
Inpatient mortality



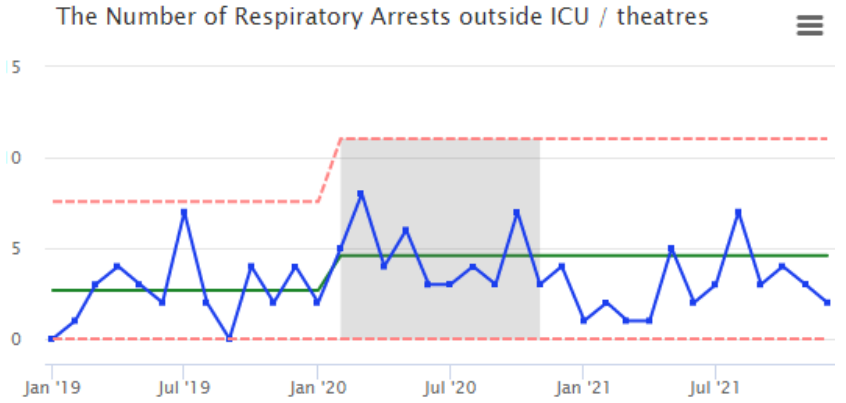
The crude mortality rate is within normal variation.
There have been no outliers detected in our real time risk adjusted monitoring of PICU/NICU deaths. This is important as the majority of patient deaths at GOSH are in intensive care areas. Risk adjusted mortality is monitored weekly at the PICU/NICU 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 13th January 2022 and covers the calendar years 2018-2020. The report shows GOSH PICU/NICU and CICU risk adjusted mortality as within expected range

There has been a statistically significant increase in the number of **cardiac arrest**s outside of ICU since May 2021 (from .64 to 1.14 a month). In December 2021 the Head of Resuscitation Services reviewed the the RECALLS and clinical documentation for each cardiac arrest between May 2021 and December 2021. This has highlighted themes around the completion of observations, and prompt escalation of the deteriorating patient prior to arrests, and are being brought to the attention of the Deteriorating Patient improvement work.

Cardiac Arrests



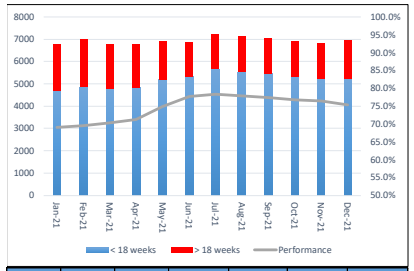
Respiratory Arrests



Do our processes and systems support patient access?

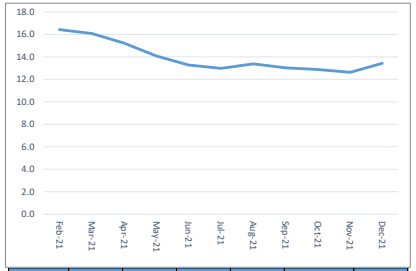
Patient Access

RTT incomplete pathways: % of patients waiting <18 weeks	Period	Target	Actual
	Dec-21	92.0%	75.34%



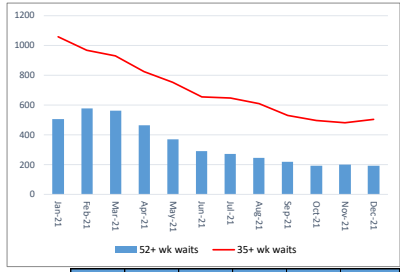
	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
	77.67%	78.31%	77.82%	77.42%	76.70%	76.45%	75.34%

RTT: Average waits for open pathways	Period	Target	Actual
	Dec-21	8.1	13.4



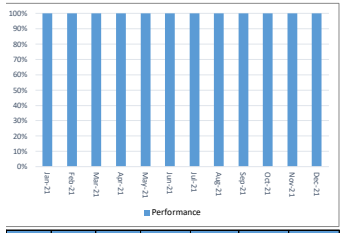
	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
-1.11%	13.3	13.0	13.4	13.0	12.9	12.6	13.4

RTT: Incomplete pathways 52 weeks or more	Period	Target	Actual
	Dec-21	0	194



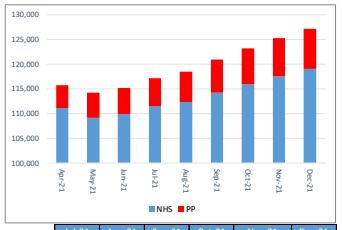
	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
52 wks+	272	247	219	194	202	194
35 wks+	647	609	530	495	480	505

Cancer: 62 day consultant upgrade	Period	Actual
	Dec-21	*100.0%*



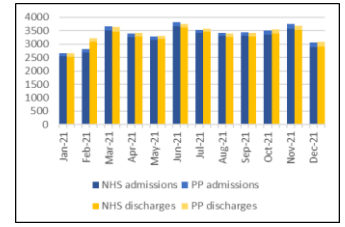
	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	*100.0%*

Open referrals at month end (NHS & PP)	Period	Actual
	Dec-21	127,163



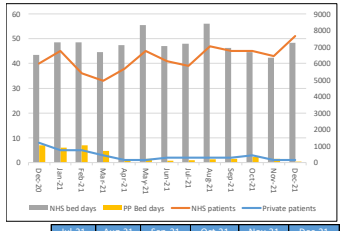
	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
NHS	111,516	112,426	114,251	115,972	117,556	119,080
PP	5,662	6,089	6,728	7,265	7,779	8,083

	Period	Actual
Admissions (NHS & PP)	Dec-21	3060
Discharges (NHS & PP)	Dec-21	3079



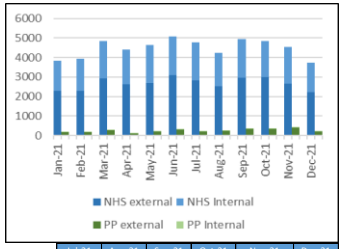
	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Admissions	3524	3424	3444	3502	3747	3060
Discharges	3581	3385	3419	3550	3692	3079

Patients not yet discharged with LOS >50 days	Period	Actual
Bed days	Dec-21	52
	Dec-21	7,317



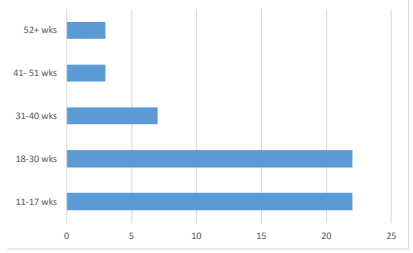
	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Patients	41	49	47	48	44	52
Bed days	7345	8619	7192	7036	6576	7317

External Referrals (NHS & PP)	Period	Actual
	Dec-21	2434
Internal Referrals (NHS & PP)	Dec-21	1531



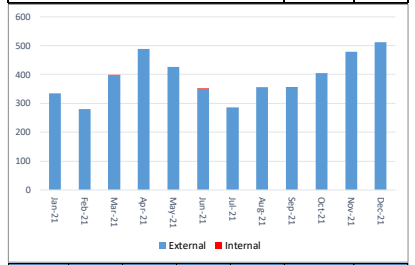
	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
External	3032	2769	3277	3325	3063	2434
Internal	1952	1701	2012	1882	1908	1531

RTT: Weeks wait of 18 week RTT pathways received from external Trusts as at Dec 2021



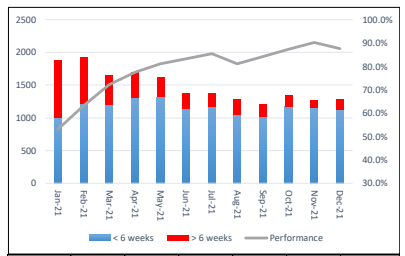
	0-10 wks	11-17 wks	18-30 wks	31-40 wks	41- 51 wks	52+ wks
Total	4603	22	22	7	3	3

RTT: Total unknown clock starts	Period	Actual
	Dec-21	512



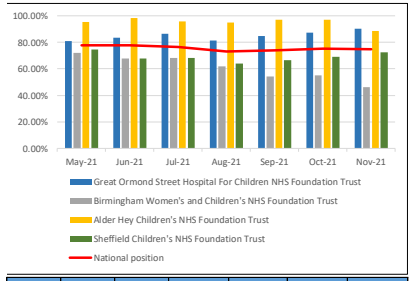
	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
	351	287	357	356	405	479	512

Diagnostics: % of patients waiting less than 6 weeks for a diagnostic test	Period	Target	Actual
	Dec-21	99.0%	87.67%



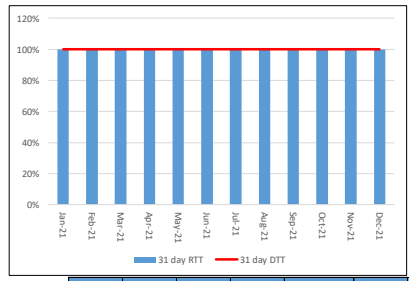
	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
	83.28%	85.36%	81.06%	84.33%	87.38%	90.24%	87.67%

Diagnostics: National % patients waiting less than 6 weeks for a test	Period	Target	Actual
	Nov-21	99.0%	74.98%



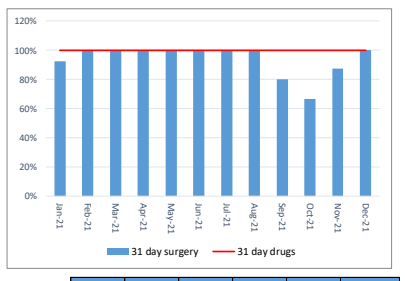
	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
	77.70%	77.62%	76.49%	72.88%	73.91%	75.02%	74.98%

	Period	Target	Actual
Cancer: 31 day referral to treatment	Dec-21	85.0%	*100%*
Cancer: 31 day decision to treat	Dec-21	96.0%	*100%*



	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
31 day RTT	100%	100%	100%	100%	100%	*100%*
31 day DTT	100%	100%	100%	100%	100%	*100%*

	Period	Target	Actual
Cancer: 31 day subsequent treatment (Surgery)	Dec-21	94.0%	*100%*
Cancer: 31 day subsequent treatment (Drugs)	Dec-21	98.0%	*100%*

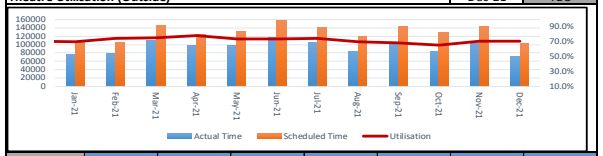


	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Surgery	100%	100%	80%	67%	88%	*100%*
Drugs	100%	100%	100%	100%	100%	*100%*

Are we productive and efficient?

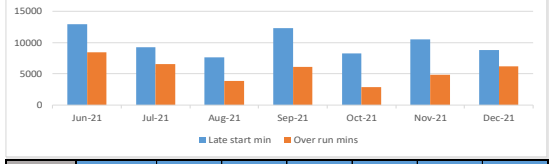
Productivity & Efficiency

	Period	Actual
Theatre Utilisation (Main)	Dec-21	70.62%
Theatre Utilisation (Outside)	Dec-21	TBC



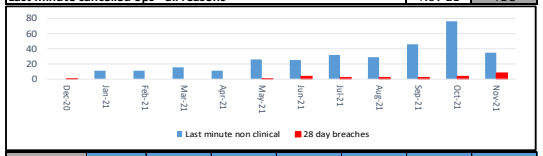
Month	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Main	74.17%	74.26%	70.42%	68.86%	65.27%	70.91%	70.62%
Outside	TBC	TBC	TBC	TBC	TBC	TBC	TBC

	Period	Actual
Late starts in Main theatres (minutes lost)	Dec-21	8841
Overruns in Main theatres (minutes lost)	Dec-21	6170



Month	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
-0.29% Late starts	12941	9298	7679	12330	8278	10516	8841
Overruns	8446	6539	3858	6109	2830	4889	6170

	Period	Actual
Last minute hospital cancelled ops for non clinical reasons	Nov-21	35
Last minute hospital cancelled ops - breaches of 28 day standard	Nov-21	8
Last minute cancelled ops - all reasons	Nov-21	TBC



Month	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
-1675 Non clinical	26	25	32	29	46	76	35
1281 Breaches	1	4	2	2	2	4	8

	Period	Actual
Average length of stay	Dec-21	TBC

Under construction

Month	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Main	TBC	TBC	TBC	TBC	TBC	TBC	TBC

	Period	Actual
Bed Occupancy	Dec-21	79.87%

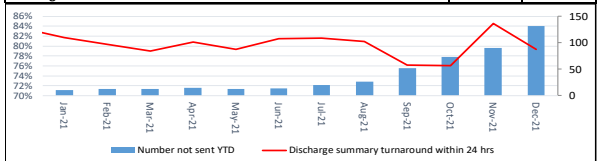
Month	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Main	74.11%	72.50%	71.32%	73.07%	75.19%	79.62%	79.87%

	Period	Actual
Average monthly ward bed closures (excluding weekends)		

Under Construction

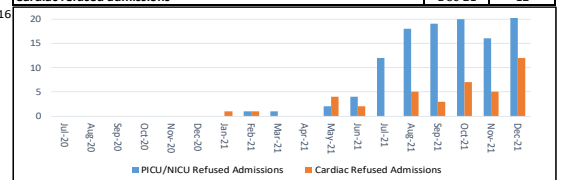
Month	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
-0.25% Rate							

	Period	Actual
Discharge summary turnaround within 24 hours	Dec-21	79.34%
Discharge summaries - number not sent in month	Dec-21	41
Discharge summaries - number not sent YTD	Dec-21	132



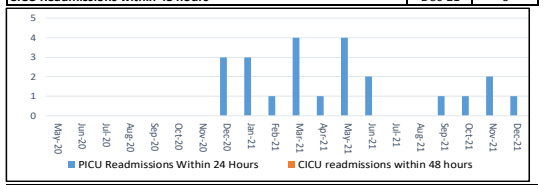
Month	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Performance	81.53%	81.56%	80.94%	76.18%	76.03%	84.54%	79.34%
Not sent	1	7	9	26	22	19	41

	Period	Actual
PICU/NICU CATS refused admissions	Dec-21	29
Cardiac refused admissions	Dec-21	12



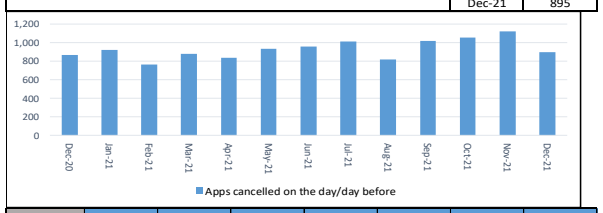
Month	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
-5.20% PICU/NICU	4	12	18	19	20	16	29
Cardiac	2	0	5	3	27	5	12

	Period	Actual
PICU Readmissions within 24 hours	Dec-21	1
CICU Readmissions within 48 hours	Dec-21	0



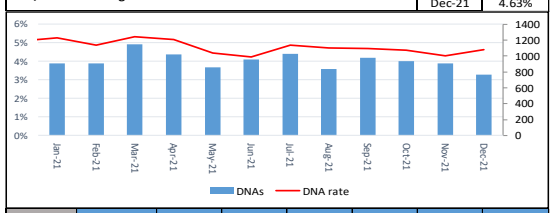
Month	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
13 PICU	2	0	0	1	1	2	1
7 CICU	0	0	0	0	0	0	0

	Period	Actual
Outpatient appointments cancelled on the day/day before	Dec-21	895



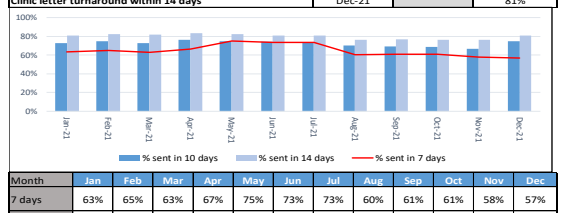
Month	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Cancellations	955	1014	818	1015	1052	1117	895
Attendances	20121	18868	16295	18793	18267	20377	15715

	Period	Actual
DNA/Was Not Brought rate	Dec-21	4.63%



Month	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Rate	4.25%	4.87%	4.71%	4.70%	4.61%	4.30%	4.63%
DNAs	958	1024	840	977	934	910	1016

	Period	Target	Actual
Clinic letter turnaround within 7 days	Dec-21	100%	56.56%
Clinic letter turnaround within 10 days	Dec-21		75%
Clinic letter turnaround within 14 days	Dec-21		81%



Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
7 days	63%	65%	63%	67%	75%	73%	73%	60%	61%	61%	58%	57%
10 days	72%	75%	72%	76%	75%	74%	73%	70%	69%	69%	66%	75%
14 days	80%	82%	82%	83%	82%	81%	81%	76%	77%	76%	76%	81%

Are we Safe?

There were 6 open serious incident investigations in December 2021.

A number of reports have been reviewed by NHSE and queries have been forward to the Trust for response. Some of these are overdue for further response as awaiting information from both the patient safety team and the lead directorates. A closure plan is now in place following discussions with NHSE . The final draft of the revised SI processes/Policy is undergoing final amendments was presented to the Operational Board and other relevant committees following feedback received and amendments made.

The incident reporting rate has decreased from 638 in November to 497 in December. This decrease is attributed to the festive period and is comparable to the rates reported in the same period in 2020. Increased staffing pressure may also have had an impact on reporting in some areas. There was also a decrease in the numbers of incident investigations completed by the directorate or speciality teams in this period, from 704 in November to 426 incident investigations completed in December. There was a decrease in the closure rate of completed incident investigations with 416 closed in November and 332 closed in December . This delay in closure of completed investigations is related to the reduced staffing numbers with in the patient safety team. These staffing numbers are to be increased by the beginning of February 2022 with the start of new staff members and further recruitment is in progress.

Compliance continues to be monitored and summary reports and milestone documents are circulated to the Executive team, directorate/departmental leads as well as individual handlers.

There are no CAS alerts that are currently overdue for completion. One alert is due for closure in January 2022.

WHO checklist: Performance for GA procedures (all departments) is at 96% for all areas including main theatres.

In Main theatres performance has dropped slightly since last month.

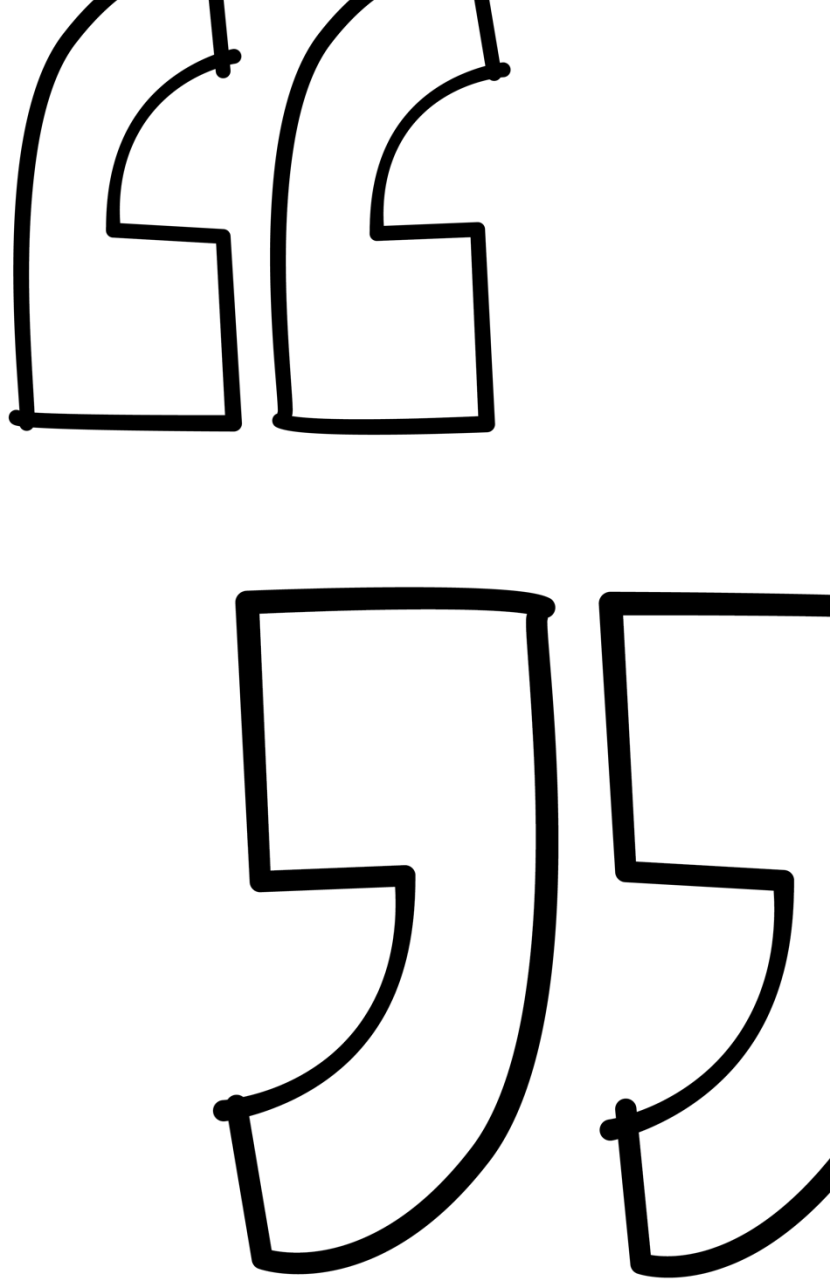
Row Labels	Incomplete	Complete	%
ANAESTHETICS		1	100%
CATH AND EP LAB		26	100%
CT	4	5	56%
GASTRO INVESTIGATIONS UNIT		40	100%
INTERVENTIONAL RADIOLOGY	10	261	96%
MAIN THEATRES	14	543	97%
MRI	11	124	92%
NUCLEAR MEDICINE		6	100%
Grand Total	**39**	**1006**	96%

Are we Caring?

Pals contacts (n=132) reduced significantly in December to the lowest number since October 2020. There was an increase in concerns raised about patient transport with families reporting concerns about the reliability of the service and the drivers. A new transport provider has been selected and there will also be a new trust appointed transport manager. The Pals team are liaising with Patient and Family Site Services to identify any interim actions to improve patient experience until the new provider is in place. Pals have received their lowest number of Cardiology contacts since March 2019 following concerted efforts by the Cardiology team and a comprehensive action plan to address consistently high numbers of cases. In the context of a particularly challenging month within the hospital, the sustained prompt response rate for Pals contacts (82% of contacts within 48 hours) across all directorates is particularly positive.

Complaints decreased this month (n=5) in comparison to last month, but this reflects the lower number of complaints received in December last year (n=4). Complaints relate to a variety of issues including breakdown in relationships with staff, a potential mis-diagnosis, delays in follow up care and referrals to other services and teams. The Health Service Ombudsman is proposing to investigate a historic complaint and confirmation of their decision is expected in late January 2021. Following a sustained reduction, the metric for the percentage of high risk complaints (n=3) is now green at 9%. This is significantly lower than the same period last year when there were 8 high risk complaints.

The **Friends and Family Test** response rate was 27% for December, a slight reduction compared with November. At Trust level, targets for FFT response rates and ratings of experience for inpatients (97%) and outpatients (95%) were achieved. Six directorates achieved the target response rate with the exception of Blood Cells and Cancer and the Clinical Research Facility. Six directorates achieved a rating of experience above 95%. Feedback was consistent with previous months with a common theme of admission and discharge issues, environmental and catering issues. Comments related to catering have been featured on the FFT focus slide (slide 16).



Are we Effective?

Clinical Audit

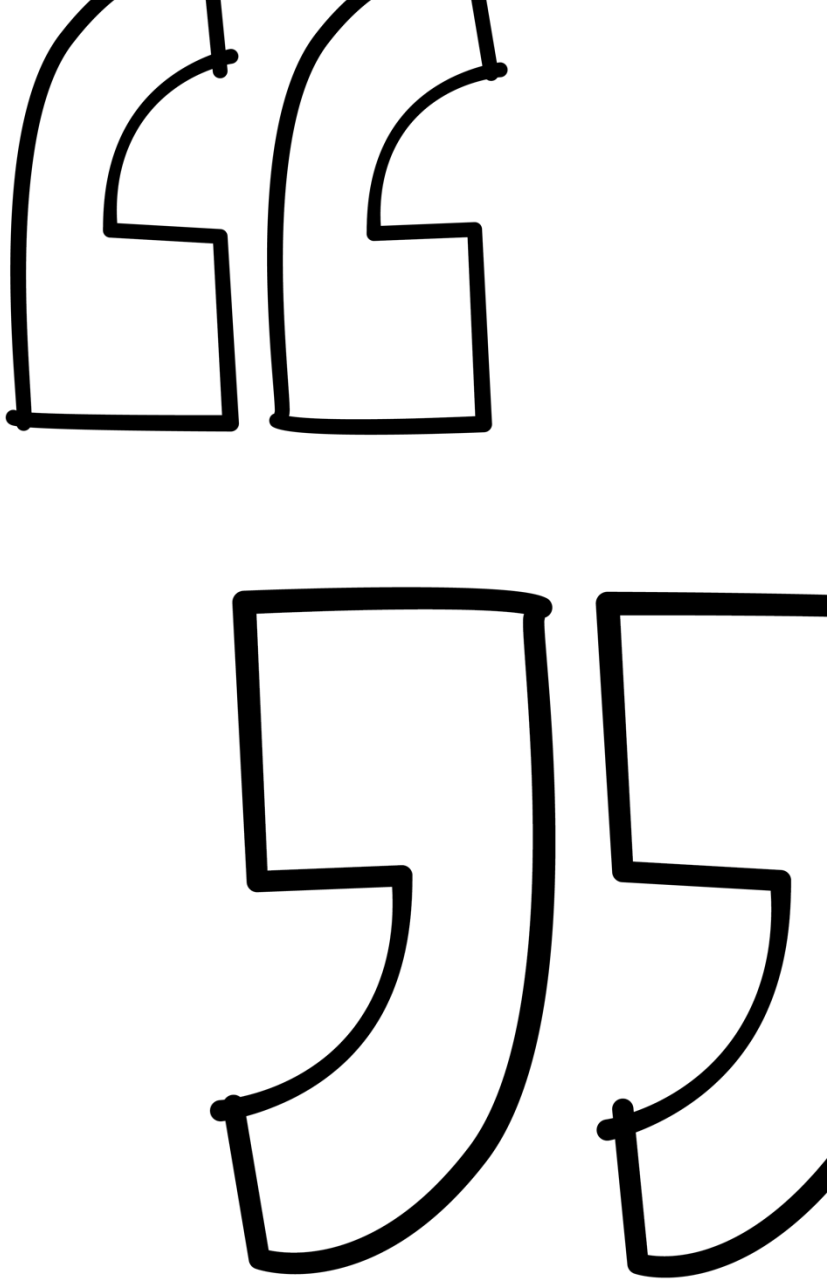
We have a priority clinical audit plan to support learning from incidents, patient complaints, and to investigate areas for improvement in safety and quality

Priority audits completed in the last month include

- Medicine Administration audit
- Hands Face Space Audits

We are on track for meeting our target for completed specialty led audit so far for 2021/22 (77) audits completed YTD) .This measure is useful as it gives an indication of engagement in clinical audit.

We continue to monitor NICE guidance published each month and note that there is no NICE guidance overdue for review.



Are we Responsive?

We are currently at 87.6% of patients waiting less than 6 weeks for the **15 diagnostic modalities (DM01).** This is a slight decline from last month's position when we reported 90.2%. The number of breaches reported in December (159) compared to the number of breaches reported in November (124) has increased. The Trust is currently 1.7% below trajectory for returning to meeting the 99% standard by March 2022. Routine requests are being categorised to an additional level to ensure patients are not adversely waiting longer than clinically safe, with patients waiting beyond the must be seen by date clinically reviewed.

The national diagnostic position for November performance stood at 74.9%, GOSH was tracking 15% above this. Nationally 364,058 patients were waiting 6 weeks and over for a diagnostic test at the end of November.

Comparative children's providers have seen similar movements. Sheffield Children and Birmingham Women's and Children's reported performance of around 46-72% for October 2021 whilst Alder Hey was higher at 88.7%.

November **Cancer Waiting Times** data has now been submitted nationally and the Trust achieved 100% against four out of the five standards. For December, the Trust is forecasting all five standards to be met.

The Trust did not achieve the **RTT** 92% standard, submitting a performance of 75.3%, with 1711 patients waiting longer than 18 weeks, this is slight decrease in performance from the previous month's 76.4%. The Trust is below the predicted trajectory by 9% for the month of December. This has resulted from bed pressures and staff/patient illness and isolation. The current PTL consists of 10% of patients being categorised as P2 patients and 70% as P3/P4 patients. As at the end of December, the Trust reported a total of 194 patients waiting 52 weeks or more; this is a decrease of 8 patients (4%) from the previous month. 68% of patients waiting over 52 weeks have a future contact booked.

Nationally, at the end of November, 59.7% of patients waiting to start treatment (incomplete pathways) were waiting up to 18 weeks, thus not meeting the 92% standard. The national position for November 2021 indicates a decrease of patients waiting over 52 weeks with 295,262 patients compared to 367,142 in April 2021 (19% reduction).

RTT Performance for comparative children's providers is Sheffield Children (69.3%) and Birmingham Women's and Children's (77.9%) and Alder Hey (63.4%). On average 470 52-week breaches were reported in October for these providers.

Are we Well Led?

There were 9 Moderate Harm incidents reported potentially requiring **duty of candour** in December 2021. Being Open/Duty of Candour stage 1 conversations took place in 100% of incidents. Of the letters from incidents due to be completed in December 60% were sent within the 10 day timeframe. 1 stage 3 duty of candour was shared in December, this was not achieved on time. Duty of Candour data is circulated as part of the weekly safety report for review and action by directorates.

Risk Register: High risk monthly review performance was recorded as 69%, a slight reduction on last month. Risk compliance is now also discussed and reviewed at the monthly Performance reviews and at weekly meetings between the executive team and directorate leads. All high risks and Trust-wide risks are discussed monthly at the Operational Board meeting. A deeper dive review is due to be undertaken and presented at RACG to understand the areas and barriers for timely review of these risks.

The Trust received **36** FOI requests in November 2021, 15 requests were returned requesting clarification (section 45) 3 were not re-submitted within the deadline for the applicant to respond so were closed and 9 were subsequently received with new deadlines for response – (for January 2022). 7 of these requests have now been fully completed with the final responses issued and 3 requests are still awaiting re-submission by the applicants to respond by the deadlines of 20 January 2022, 26 January 2022 and 28 January 2022. 3 requests were returned requesting clarification of the requested information, 2 were not responded to within the deadline for the applicant to respond so were closed and 1 remains open pending a response from the applicant by the deadline of 3 February 2022. Of the 36 FOI requests received in December 2022, 77% were responded to within the legislated timescale(n28). The remaining 4 requests received in December have January deadlines with 1 request pending partial information from the department so the draft response can be completed and 1 request awaits information from the department, 1 awaiting MDO Business Manager approval, 1 request pending clarification from the department(Heart & Lung) in respect of the information provided to the FOI Team. 1 request for Internal Review was received and is currently being reviewed.

There are currently 79 open **Serious Incident actions** in December 2021, 63 of which are over their initial completion date. A small number of actions have been completed with evidence uploaded in December 2021. The Patient Safety Team continue to work with the directorates to ensure completion and closure of SI actions. Closing the Loop meetings occur monthly which review the overdue actions to understand and address any barriers to completion of the action and embedding of the learning, there is a plan to highlight the total number of actions in this forum too. Actions owners are contacted directly to ensure actions are completed and evidence provided. Where there are delays in completing the action but there is a defined later date for completion/approval/closure, the action deadlines are extended to reflect the reasons for delay. SI actions by directorate/department are also reviewed at the monthly Performance meetings

Covid–19 at GOSH

We have changed the way that we work at GOSH in March in order to ensure that we play our part in supporting the NHS to respond effectively to Covid-19. This slide brings together a number of key metrics to help understand the overall picture.

There were 32 COVID-19 related incidents reported in December 2021, 8 of which were graded as minor harm and 24 as no harm. The largest portion of these incidents (6) were related to staffing. Over the Christmas period, staff absence related to COVID-19, either through sickness or self-isolation, was among the highest in the London area.

No COVID-19 outbreaks were recorded in December 2021

Workforce Headlines: December 2021

Contractual staff in post: Substantive staff in post numbers in December were 5307.7 FTE, a decrease of 32.4 FTE since November 2021. Headcount was 5727 (an increase of 32 on the previous month).

Unfilled vacancy rate: Vacancy rates for the Trust increased to 5.8% in December from 5.2% the previous month but is lower than the same month last year (7.6%). The vacancy rate remains below the 10% target and it is lower than the 12 month average of 6%. Vacancy rates in the clinical directorates remained below target in December.

Turnover: is reported as voluntary turnover. Voluntary turnover increased to 11.7% in December from 11.3% in November but it remains below the Trust target (14%). Total turnover (including Fixed Term Contracts) increased to 14.2% in December.

Agency usage: Agency staff as a percentage of paybill in December remained at 1.2%, and remained well below the local stretch target (2%). Agency use is almost exclusively taking place within Corporate Non-Clinical Directorates and amongst some Allied Health Professional disciplines. Bank % of paybill increased to 5.2% in December.

Statutory & Mandatory training compliance: The December training rate for the Trust increased to 92% which is above target with all bar 2 directorates achieving target (Property Services & ICT). The Directorate Management and Learning teams are working to address gaps in compliance. The medical and dental staffgroup are the only staffgroup below the 90% target, at 87% for December. Across the Trust there are now 11 topics below the 90% target (including Information Governance where the target is 95%). Safeguarding Children Level 3 compliance for substantive staff is just below the 90% target (89%). Honorary Contractors compliance remains a focus and work to improve compliance is ongoing.

Appraisal/PDR completion: The non-medical appraisal rate increased to 88% in December although it remains below target with only 8 Directorates achieving target. Individual Directorates are being liaised with to improve compliance. Consultant appraisal rates increased in December to 91%. reduced to just below the 90% target at 89%.

Sickness absence: Sickness rates have increased significantly in the last few months. December sickness was 5.9%,almost double the 3% target, and above the target for the 6th month in a row. 14 of the 19 Directorates exceeded the 3% target. COVID for nearly 40% of sickness absence in December, up from 9.7% in November. Self Isolation rapidly increased in early December with an average of 129 episodes per day in December (up from a November average of 23 per day). The Trust saw indicative sickness and absence rates of over 12% during the runup to Christmas as the impact of COVID increased. It should be noted that despite recent increases, GOSH sickness rates remain below the most recent NHS average (5.1% July 2021)

Trust Workforce KPIs: December 2021

Great Ormond Street Hospital for Children
NHS Foundation Trust

Metric	Plan	December 2021	3m average	12m average
Voluntary Turnover	14%	11.7%	11.5%	11.2%
Sickness (1m)	3%	5.9%	4.8%	3.6%
Vacancy	10%	5.8%	5.5%	5.9%
Agency spend	2%	1.2%	1.2%	1.1%
PDR %	90%	88%	87%	88%
Consultant Appraisal %	90%	91%	92%	92%
Statutory & Mandatory training	90%	92%	91%	93%

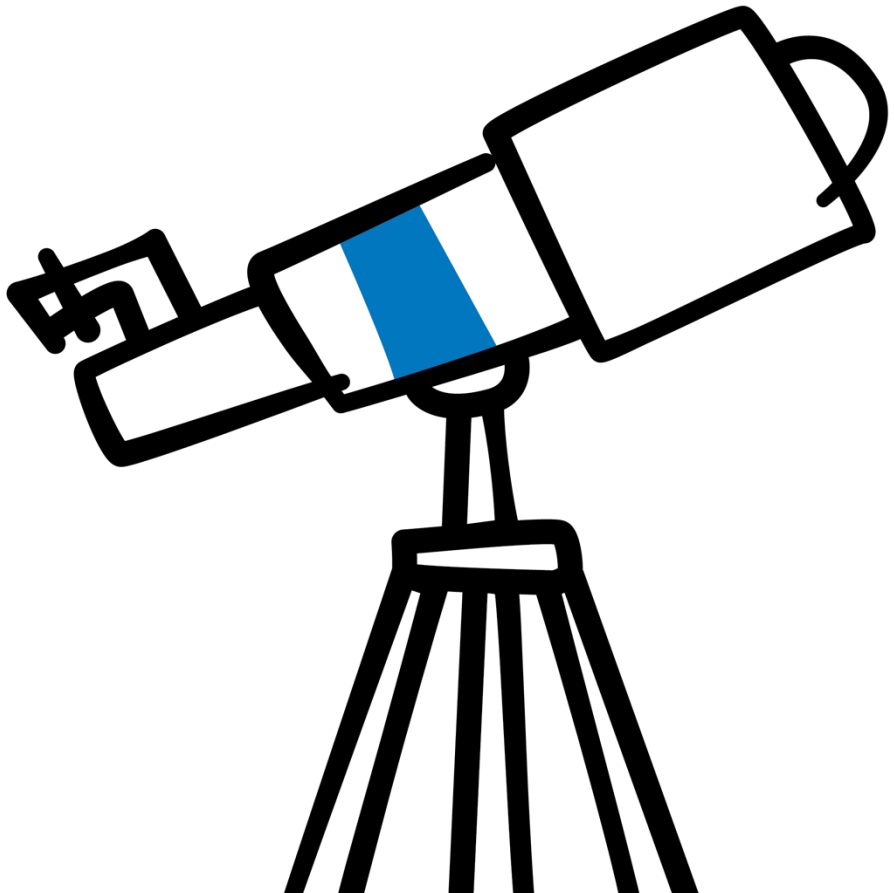
Key: Achieving Plan Within 10% of Plan Not achieving Plan

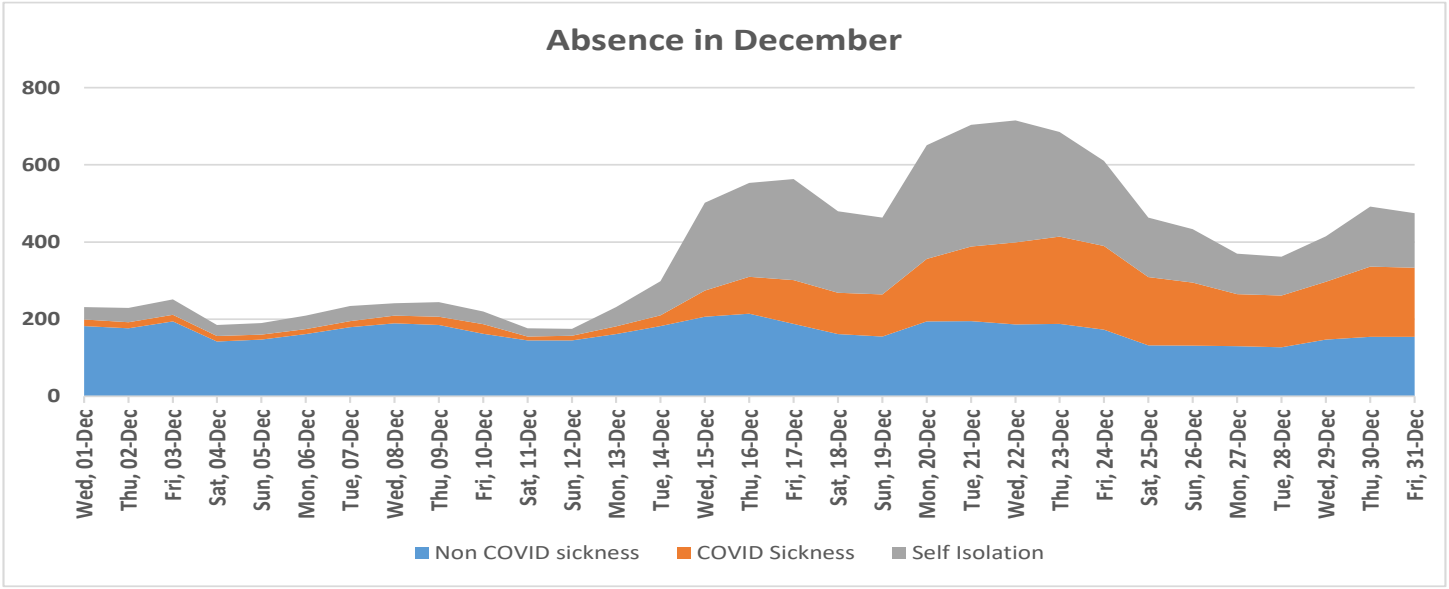
Directorate KPI performance December 2021

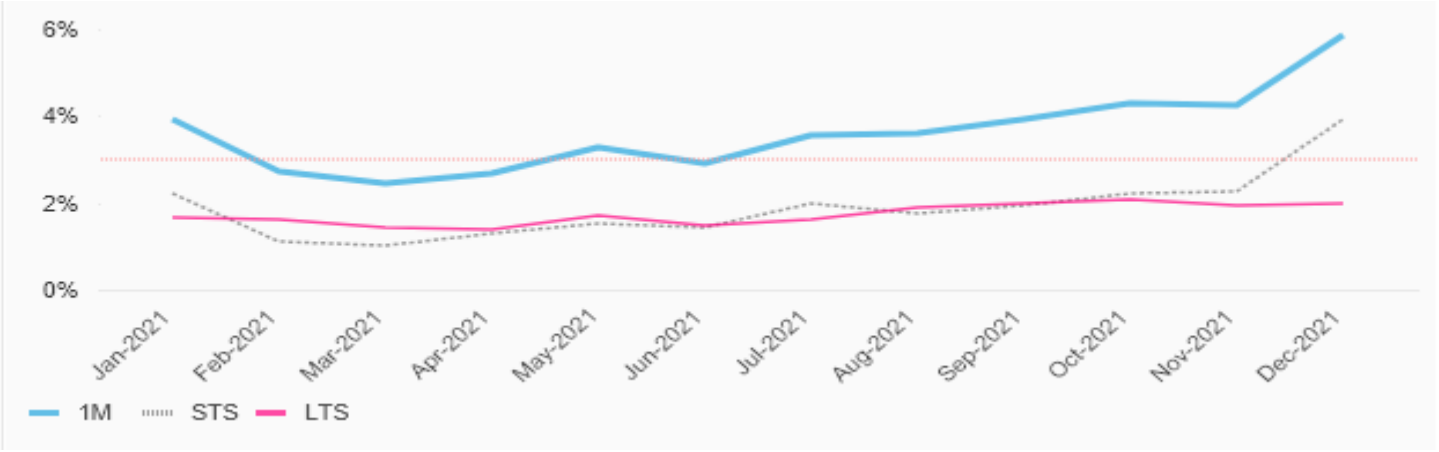
Metric	Plan	Trust	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Heart & Lung	Medicine, Therapies & Tests	Operations & Images	Sight & Sound	IPP	Genetics	Clinical Operations	Corporate Affairs	ICT	Property Services	Finance	HR&OD	Medical Director	Nursing & Patient Experience	Research & Innovation	Transformation
Voluntary Turnover	14%	11.7%	11.6%	11.9%	10.4%	12.6%	12.6%	11.9%	9.7%	14.1%	6.6%	13.4%	12.1%	11.1%	6.7%	7.7%	14.1%	10.8%	8.3%	13.9%	32%
Sickness (1m)	3%	5.9%	4.7%	5.6%	5.1%	6.9%	6.0%	8.0%	4.4%	6.5%	4.7%	6.5%	0.0%	4.4%	8.9%	2.7%	2.9%	2.5%	3.7%	6.6%	0.6%
Vacancy	10%	5.8%	2.0%	-7.8%	4.5%	0.7%	-0.8%	2.5%	7.1%	9.5%	-7.4%	6.1%	9.6%	15.7%	10.0%	18.5%	7.7%	27.2%	1.8%	11.2%	14.1%
Agency spend	2%	1.2%	-0.1%	0.1%	0.1%	0.3%	1.2%	1.5%	0.1%	0.9%	0.0%	0.2%	5.8%	20.9%	2.7%	9.4%	5.0%	6.3%	1.4%	0.0%	0.0%
PDR %	90%	88%	89%	88%	87%	89%	91%	86%	95%	88%	88%	78%	92%	65%	95%	92%	92%	59%	84%	86%	66%
Stat/Mand Training	90%	92%	93%	92%	93%	90%	95%	92%	98%	97%	98%	96%	94%	89%	66%	98%	95%	96%	97%	98%	97%

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

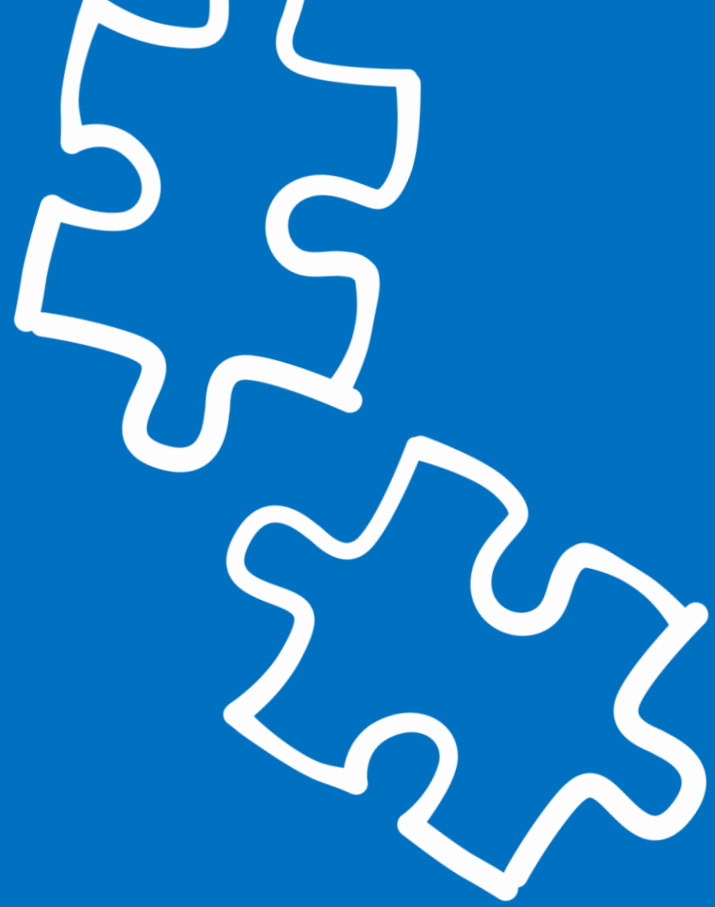
Absences in December







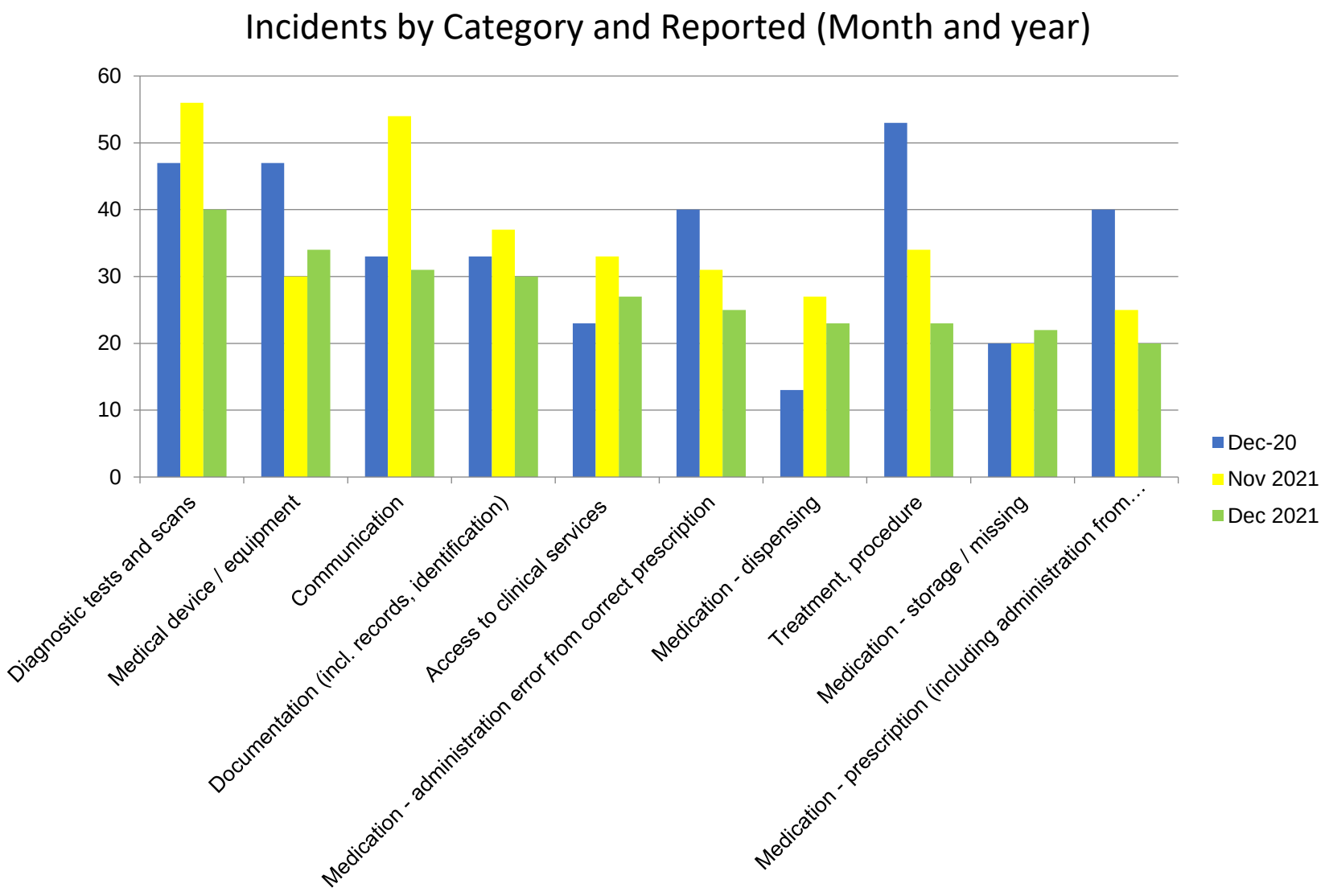
Quality and Safety



This section includes:

- Analysis of the month’s patient safety incidents
- Lessons learned from a recent serious incident
- Summary of Serious Incidents
- Overview of Safety Alerts
- Progress update on speciality led clinical audits
- Update on priority audits
- Summary of Hands, Face, Space & Place audit findings
- Overview of WHO Safer Surgery Checklist performance
- Overview of Quality Improvement work

Understanding our Patient Safety incidents



During December there was a reduction in patient activity which makes a like-for-like comparison with November 2021 problematic. A comparison with December 2020 shows a reduction in incidents related to medication administration, prescription and storage though an increase in dispensary related incidents in the pharmacy. There was also a drop in treatment related incidents.

Patient Safety
Serious Incident Summary

New & Ongoing Serious Incidents

Directorate	Ref	Due	Headline	Update
Brain H&L	2021/19865	10/01/2022	Potential missed diagnosis of blocked VP shunt	04/01/2022: Report with lead investigator (DCOS) for review before being shared with other centres. Difficult to expedite due to AL from key people.
MTT (Pharmacy) Research BC&C	2021/20487	15/01/2021	Critical breach in the manufacture of a trial medication	20/12/2021: report shared with panel for review
BBM	2021/22235	27/01/2022	Delays in identifying misplacement of spinal metalwork.	20/12/2021: Draft report to be amended and recirculated to the panel following feedback
Brain (some input from H&L)	2021/23436	11/02/2022	IG breach- patient's biological parent sent clinic letter which included foster carer's address	20/12/2021: information gathering continues and panel meeting date to be confirmed

2021/22218 - Data breach of secure address

What happened?

On 19 October 2021, the patient and her father came to the hospital together for investigation of symptoms with a possible inherited/genetic cause. They arrived together at main reception to be checked in. At check-in, the patient was asked to confirm her address. They gave an address, which did not match the one on record. The receptionist then read out the address on the system, which the patient confirmed was their address. Following this the receptionist confirmed the phone number on record back to the patient and her father. The father therefore heard both the patient's home address and the mother's telephone number.

Key recommendations:

- A new system for securing addresses will be implemented into the Trust's electronic patient record system
- As the EPR system has changed, there have been administrative changes to the way addresses are secured. A new process should be described clearly and appended into the Safeguarding Children Policy.
- Training should be provided to all administrative staff on how to manage administration of electronic patient records where addresses are secured. Guidance should also be provided to clinical staff to outline the changes in process.
- A SOP should be drafted for outpatients staff outlining the process for confirming patient identity and updating their medical record.

Patient Safety Alerts/ MHRA alerts

NatPSA/2021/005/MHRA

Philips Ventilator, Cpap And Bipap Devices: Potential For Patient Harm Due To Inhalation Of Particles And Volatile Organic Compounds

Issued: 23/12/2021

Due: 22/02/2022

NatPSA/2021/010/UKHSA

The safe use of ultrasound gel to reduce infection risk

Issued: 11/11/2021

Due 31/01/2022

CH/2021/002

Changes To Mhra Drug Alert Titles And Classifications

No due date (actions relevant to ongoing 'Alerts' Policy)

SDA/2021/014

Tocilizumab (RoActemra®) 162mg/0.9ml solution for injection pre-filled syringes and pre-filled pens – Non Covid-19 indications

Issued: 25/10/2021

Due: N/A

SDA/2021/04

Discontinuation of Morphine sulphate (MST CONTINUS®) 20mg, 30mg, 60mg,

100mg and 200mg prolonged release granules for oral suspension

Issued: 26/02/2021

Due Date: N/A

SDA/2021/013

Supply Disruption Alert- Diazepam RecTubes® 2.5mg Rectal Solution

Issued: 11/10/2021

Due: N/A

NatPSA/2021/008/NHSPS

Elimination of bottles of liquefied phenol 80%

Issued: 25/08/2021

Due: 25/02/2022

Clinical Audit

A central clinical audit plan describes the areas of priority for clinical audit work that will ultimately provide a consistent and systematic method to investigate areas for improvement in quality and safety whilst supporting the organisation's learning from incidents, risks and complaints

Completed priority audits in 2020/21 YTD

- GOSH/I+PC response to Patterson Inquiry

- Enabling Optiflow outside of ICU
- Learning from an incident 2020/23369. Appropriate scanning of consent forms.
- Learning from an incident -Respiratory arrest following residual anaesthetic agent in patient cannula following a general anaesthetic (2020/20297)
- Hands, Face, Space, Place audits
- Review of frequency of I+PC Consultant ward round presence
- Medicine Storage Audit
- Spinal MDT meeting -how well is it working?
- Review of frequency of IPP Consultant ward round presence
- Controlled Drug Audit
- Medicine Administration Audit
- Learning from complaint (18/093) PICU documenting updates given to families
- Audit of compliance with peri-operative wearing of appropriate FFP masks
- Clinical Audit - PICU ward round and medical plans documentation, and documentation of PICU nursing observations

Current priority audits in progress

Audit	Why do this audit?	Status
Patient Safety alert – Eliminating the risk of inadvertent connection to medical air via a flowmeter.	To check each area has air outlets capped off and that air flowmeters have been removed in line with the requirements of the Patient Safety Alert.	Audit underway and to be completed in January 2022.
Quality of clinical documentation I+PC	To support the directorate to deliver high quality clinical documentation that supports care and communication.	A re-audit to assess changes made in response to the first cycle of the audit was completed in December 2021.The findings are being reviewed with the team involved in the audit.
Learning from SI – 2021/11391 - Faulty batch of Histoacryl glue potentially impacting patient treatment outcomes	To review whether lot numbers are being recorded where implants, particularly products which are not obviously implants (such as glue), are used for IR embolisations.	Prospective audit underway and will be completed in February 2022.

Specialty led clinical audit

In addition to our priority clinical audit plan, we support and enable clinical teams to engage in clinical audit as a way of reviewing and assessing the quality of care provided and to identify where improvements should be made

We are on track for meeting our target so far for 2021/22 completed audits (86 audits completed YTD) This measure is useful as gives an indication of the capacity of teams to engage in reviews of the quality of care provided.

Quality Improvement - support the QI framework outlined in the Trust Quality Strategy ("doing things better")

1. Priority improvement programmes (December 2021)

Programme of work	Priority projects	Executive Sponsor (ES)
Highly reliable clinical systems	➢ Identification and responsiveness to the deteriorating patient	Sanjiv Sharma
	➢ Increasing safety and reliability of TPN prescription and delivery	Polly Hodgson
	➢ Co-designing the SI framework	Sanjiv Sharma
	➢ Establishing a Tri-parallel process for SIs, Red Complaints and High Profile cases	Sanjiv Sharma
Wellness at Work	➢ Design, development and testing of wellbeing indicator ➢ Establishing 'team self care': local team-level wellbeing initiatives	Dal Hothi
Caring for the complex patient	➢ Safe management of patients with high BMI	Sanjiv Sharma
Continuously finding better ways to work	➢ Introduction of a Ward Accreditation Programme to increase clinical quality and oversight of quality metrics from Board to Ward	Darren Darby
	➢ Reducing pre-analytical laboratory sample rejections/ building laboratory capability for improvement	Dal Hothi
Building capacity and capability for improvement	➢ QI Education Programmes ➢ Project Coaching	Dal Hothi
The QI team is also supporting the Clinical Pathway Redesign Programme, and associated projects in partnership with the Transformation team.		

2. Directorate-level/ Responsive QI Work-

Directorate projects

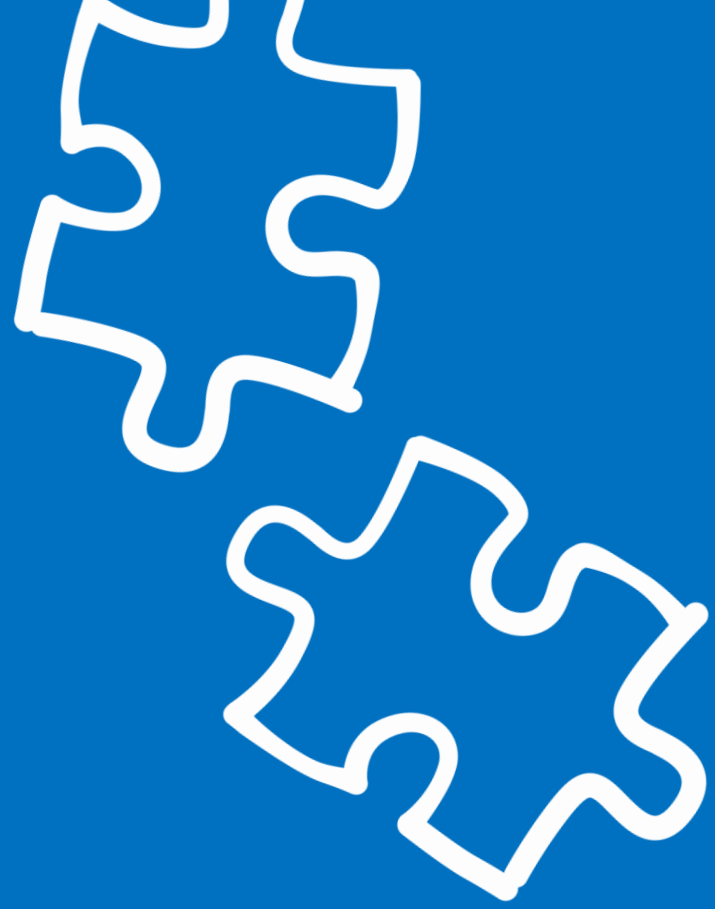
Project Commenced	Area of work	Project lead:	Expected completion date
May 2020	Increase opportunities to empower and enable children and young people to register their complaints	Claire Williams (Head of Patient Experience)	December 2021
Oct 2020 (support paused)	Increase communication skills training across all Allied Health Professionals placement pathways at GOSH	Ali Toft (AHP Information Officer) and Vicki Smith (AHPs Education Lead)	April 2022
Oct 2020	Improve adherence with tracheostomy safety box equipment and bed space signage	Michaela Kenny (Chief Nurse Junior Fellow)	June 2022
Jan 2021 (Restart)	Reduce waste in the process, standardise activities and enable a process driven pathway to the Orthopaedic CNS activity	Claire Waller (Matron)	January 2022
February 2021 (support paused)	Improve effectiveness of pre-chemotherapy/procedure bloods process on Safari Unit	Dave Burley (Assistant Service Manager)/ Safari Improvement Group	September 2021
March 2021	To produce an educational pathway aimed at transitioning undergraduate nurses to registered nurses, with 100% of host students meeting their core competencies and passing their six month probation	Hannah Fletcher, Clare Paul and Natalie Fitz-Costa (Practice Educators)	March 2024
March 2021 **(Paused)**	Improve nurse satisfaction of the nursing handover process on Chameleon ward	Sarah Murphy	June 2021
March 2021 (support paused)	Improve communication experiences for hospitalised children and adolescents with learning disabilities and/or Autism.	Ruth Garcia-Rodriguez (Consultant Child and Adolescent Psychiatrist)	September 2021

The QI team has held 2 QI project surgeries during the month of December

Patient Experience

This section includes:

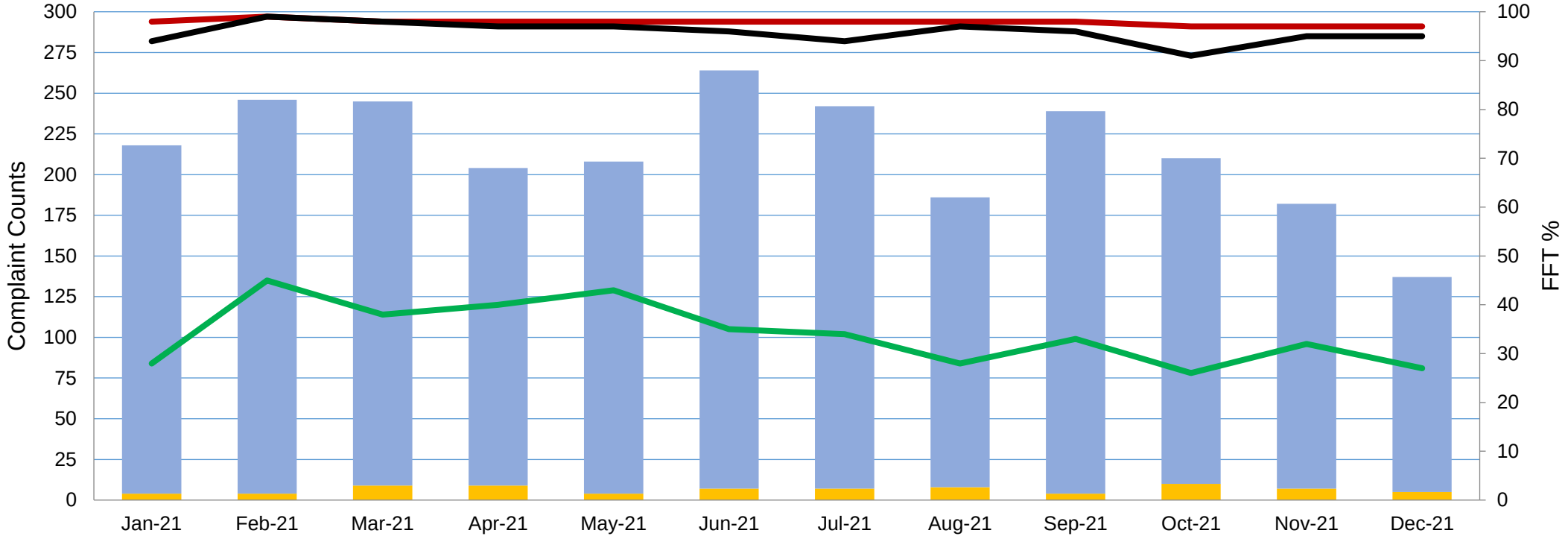
- Integrated overview of patient feedback
- Monthly assessment of trends and themes in complaints
- Overview of Red Complaints
- Pals themes and trends
- Learning and improvements from Pals contacts
- Friends and Family Test feedback trends and themes



Patient Experience Overview

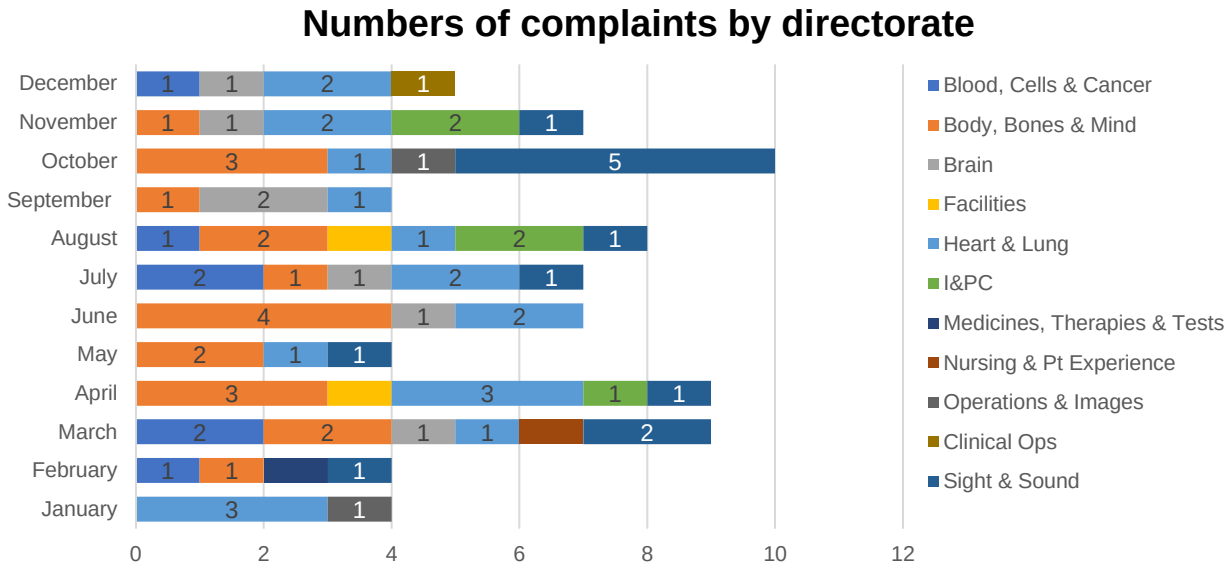
Are we responding and improving?

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



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Pals contacts	214	242	236	195	204	257	235	178	235	200	175	132
Formal Complaints	4	4	9	9	4	7	7	8	4	10	7	5
FFT rating of experience - Inpatients %	98	99	98	98	98	98	98	98	98	97	97	97
FFT rating of experience - Outpatients %	94	99	98	97	97	96	94	97	96	91	95	95
FFT % response rate	28	45	38	40	43	35	34	28	33	26	32	27

Complaints: Are we responding and improving?



There were 5 new formal complaints received in December 2021, which is an increase in the number of complaints received compared to last December (n=4). However, this is lower than the average amount of complaints received over the past 12 months (n=6.67).

This month families reported concerns about:

- The care received and delayed referrals to other teams and services.
- Clinical care and a breakdown in relationships with the team. The family requested that a new lead clinician be assigned to address this.
- Historical care and whether there was a mis-diagnosis which led to a delay in receiving appropriate care and treatment.
- Whether their child was transferred and admitted to the correct award, received appropriate care including whether the ward team responded promptly to their child's deterioration.
- The way in which they were treated by a member of staff when visiting their child at GOSH and also for the lack of response received when they raised the issue informally.

The Trust rate of complaints by combined patient activity this month (0.24 complaints per 1,000 CPE) slightly decreased from last month (0.26) and is reflective of the decrease in complaint numbers. Four directorates received complaints this complaint:

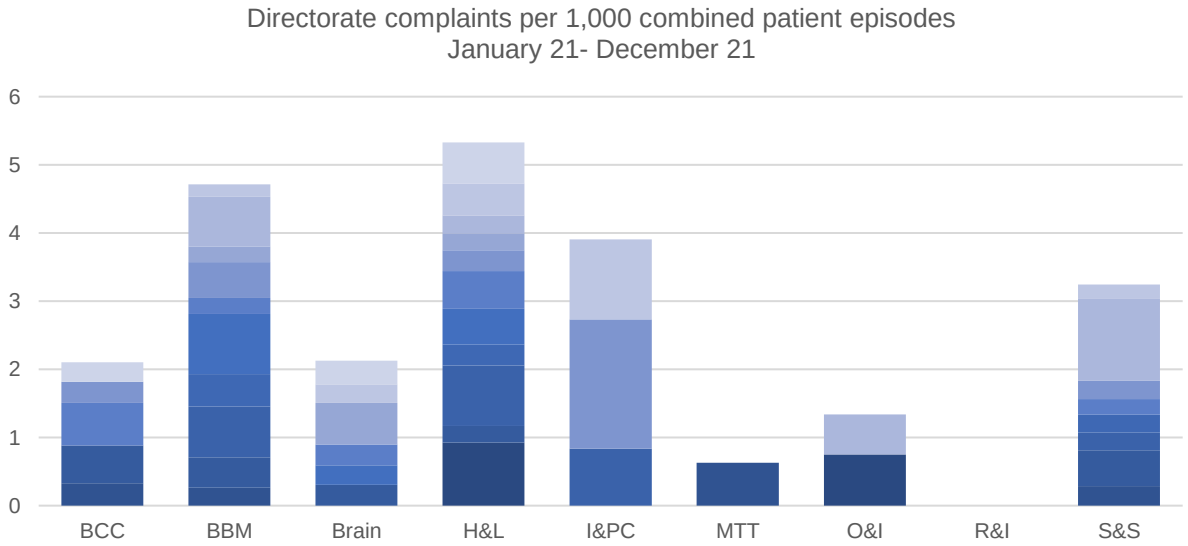
Heart and Lung received 2 complaints this month and saw an increase in its complaint rate (0.64) compared to last month (0.48).

Brain also saw an increase in its rate this month (0.37) compared to last month (0.29).

Blood, Cells and Cancer's rate this month (0.31) remained stable compared to when they last received a complaint in August (0.31).

Clinical operations received one complaint this month but we are unable to analysis patient activity data as there are no comparable outpatient or inpatient episodes for the service.

At the time of writing (18/01/22), there are 9 open/ active complaints.
Of 65 complaints received since 1 April 2021, 56 have been closed (37 within the original timeframe agreed and 19 with extended timeframes).



Red/ High Risk complaints: Are we responding and improving?

NEW red complaints opened in **December 2021**	**NEW** red complaints **since APRIL 2021***	**REOPENED** red complaints **since APRIL 2021**	**ACTIVE** red complaints (new & reopened)	**OVERDUE** red complaint actions
0	3	0	1	1

Active Red Complaint

Ref	Directorate	Description of Complaint	EIRM Outcome:	Update:
21-042	Sight and Sound	Parent has raised a number of concerns around her child's urology surgery and follow up care.	EIRM took place on 15th November 2021 and concluded that an independent clinical opinion should be sought	Complaint has been graded red and an EIRM has taken place, which concluded that an independent clinical opinion should be sought. Terms of Reference (TOR) are being updated and will incorporate any comments from the family who have indicated they wish to contribute to the TOR. An external clinician to conduct the review is being confirmed.

Closed Red Complaint since October 2021

Ref	Directorate	Description of Complaint	EIRM Outcome:	Update:
21-014	Body Bones & Mind (Spinal)	Mother raised concerns about incorrect placement of spinal screws instruments and the delayed identification of this.	EIRM took place on 24/06/21 and complaint **was not** declared an SI. Further EIRM convened and SI **was** declared	In line with the commitment at the first EIRM to reconsider if an SI should be declared if significant information comes to light during the investigation, a further EIRM was convened and a SI was declared. The EIRM decided that the complaint response would be sent to the family in the meantime to avoid delay. The complaint investigation concluded that there was a failure to carry out a CT scan earlier and that this is likely to have resulted in an earlier intervention. The SI report will be shared with the family once completed and will outline the learning from their experience.

** Includes one historic complaint regraded in April 2021*

PALS – Are we responding and improving?

Cases – Month	12 month trend	12/20	11/21	12/21
Promptly resolved (24-48 hour resolution)		132	133	106
Complex cases (multiple questions, 48 hour+ resolution)		32	39	23
Escalated to formal complaints		2	1	1
Compliments about specialities		0	2	2
Total:		**166**	**175**	**132**
Top Six Themes				
Lack of communication (lack of communication with family, telephone calls not returned; incorrect information sent to families).		64	22	14
Admission/Discharge /Referrals (Waiting times; Advice on making a NHS referral; advice on making an IPP referral, cancellation).		1	10	3
Staff behaviour (Rude staff, poor attitude, inadequate communication with parents, lack of professionalism).		0	13	16
Outpatient (Cancellation; Failure to arrange appointment).		21	62	34
Transport Bookings (Eligibility, delay in providing transport, failure to provide transport)		13	2	13
Information (Access to medical records, incorrect records, missing records, GOSH information, Health information, care advice, advice, support/listening)*		67	66	52

December sees a 24% decrease in the number of contacts received in comparison to the preceding month. Despite reduced staffing within the hospital, the number of promptly resolved contacts remains consistently high with 82% of these being responded to and resolved by the relevant speciality teams within 48 hours or less.

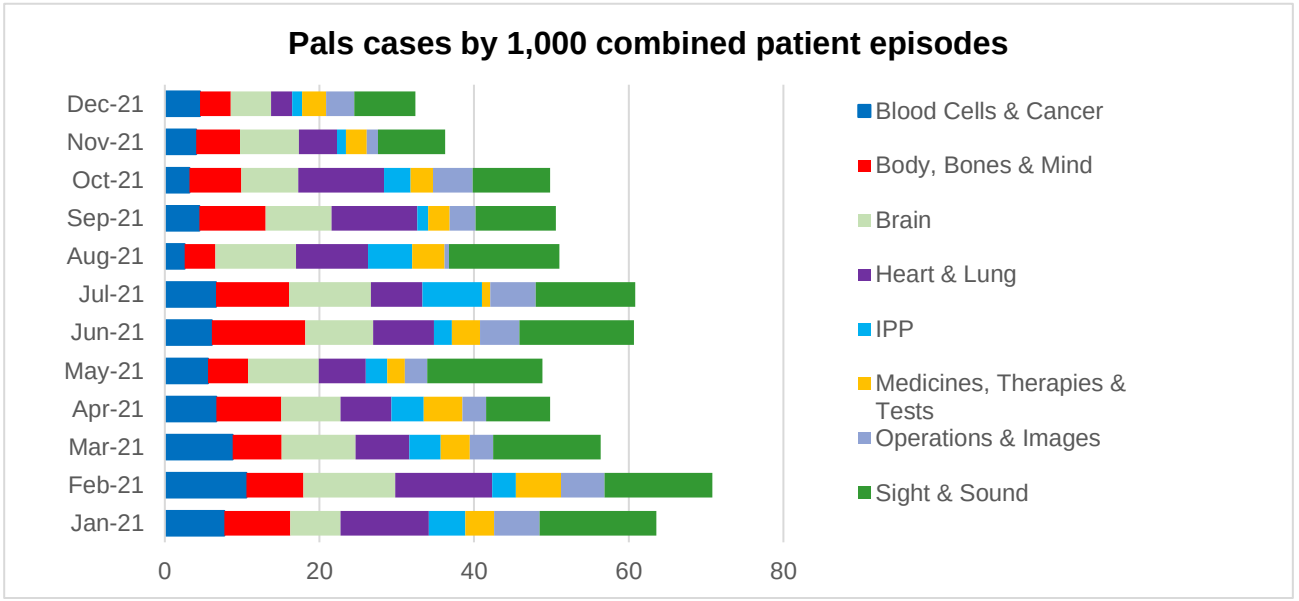
Pals have noted an influx in Transport related contacts resulting in the 13 received in December which represents an approximate 6-fold increase compared to November. Contacts typically involve parents/carers providing feedback on various aspects of their transport experience with a particular focus on booking errors, vehicle availability, delays, and driver conduct.. A new transport provider will be in place in March and the Trust has also appointed a new transport manager. In the meantime, Pals are currently working alongside senior management to create a thematic analysis of transport contacts to identify actions to address this in the interim.

There were reductions of 45% and 36% in Outpatient and Information related contacts respectively. Despite this, both remain prominent themes in December, with an emphasis being placed on parents/carers sharing requests for additional guidance on managing patient symptoms and the impact that hospital initiated cancellations would have on these. Examples include a mother expressing her dissatisfaction with the delay to her child's annual review and a patient seeking advice on how best to manage a re-emergence of their condition. Pals continue to work alongside the speciality teams ensuring that concerns are promptly shared, and parents/carers are also routinely kept updated and reassured of their status of their requests.

Pals received a heart- warming compliment from a patient wishing to praise the Radiology team for the '*brilliant and compassionate care*' provided to her during a recent MRI admission. The patient explains that she was feeling extremely anxious about this procedure and that her fears *'intensified upon viewing the scanner'*. She explains that the team were *'extremely reassuring and patient*' and even made accommodations for her sore shoulder whilst completing the scan. The patient describes being left feeling 'relieved and comforted' and mentions that she *would 'definitely recommend the GOSH MRI team to anyone of her age requiring a similar treatment*'.

PALS cases by directorate

For the second consecutive month the Heart & Lung directorate has recorded its lowest volume of Pals contacts since January 2021 (2.71 per 1,000 CPE). This can largely be attributed to a significant decline in the volume of Cardiology contacts which, compared to November, recorded a 64% decrease.



	BC&C	BB&M	Brain	H&L	IPC	MT&T	O&I	R&I	S&S
Jan-21	26	33	20	38	4	6	8	0	52
Feb-21	36	29	37	44	3	10	9	0	50
Mar-21	36	30	32	30	5	7	9	1	55
Apr-21	24	38	25	23	5	6	6	0	33
May-21	19	23	29	21	3	4	5	0	60
Jun-21	23	59	32	31	3	7	10	0	64
Jul-21	23	43	36	25	9	2	11	0	58
Aug-21	9	16	28	32	6	7	1	0	55
Sep-21	18	40	28	45	2	5	6	0	45
Oct-21	13	30	24	44	5	5	9	0	43
Nov-21	17	31	28	21	2	6	3	0	43
Dec-21	16	16	15	9	2	5	6	0	30
YTD	**260**	**388**	**334**	**363**	**49**	**70**	**83**	**1**	**588**

PALS – Are we responding and improving?

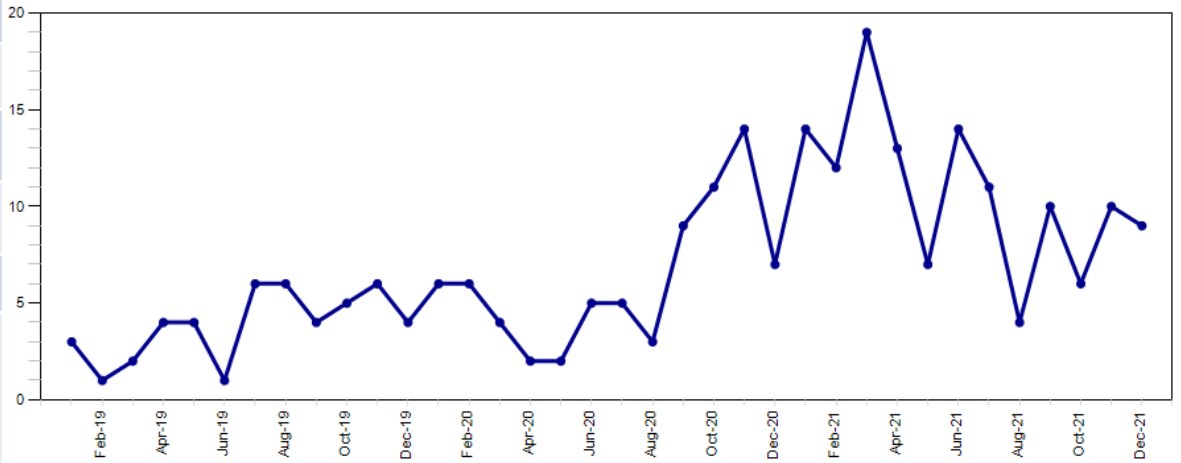
Top specialities – Month	12/20	11/21	12/21
Dermatology	7	10	9
Gastroenterology	9	7	7
General Surgery (SNAPS)	3	11	7
Cardiology	18	17	6
Medical Records	3	8	6

Dermatology- Pals have received 9 Dermatology contacts in December with a primary focus centring around parents/carers expressing difficulties when attempting to contact the administrative teams in order to cancel or postpone upcoming inpatient and outpatient stays often due to potential Covid- like symptoms.
Pals continue to work closely with the Dermatology admissions and administrative teams ensuring that queries are not only promptly escalated and addressed but that families are also provided with up to date contact information should this be required in the future.

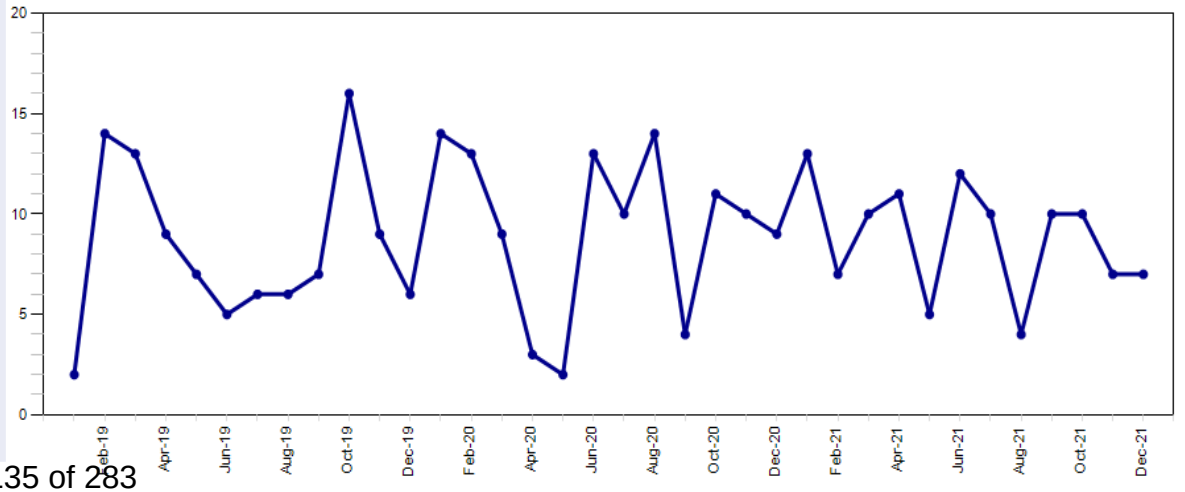
Gastroenterology- Pals have recorded 7 Gastroenterology contacts in December. Common themes for December's contacts involve parent/carers seeking guidance from the clinical team regarding various aspects of patient-specific care plans. Pals continue to share all contacts received with the both the clinical and administrative team who remain extremely responsive and proactive in their approach, something which can be evidenced by 85% of December's contacts being resolved by the service in under 48 hours.

Cardiology- Pals would like to draw attention to the Cardiology team who in December recorded their lowest volume of contacts since March 2019 (n=6). It is acknowledged that Cardiology have implemented a comprehensive action plan to address consistently high contacts and the reduction in contacts is testament to the ongoing work being undertaken by both clinical and administrative teams within the speciality.

Dermatology contacts by patient activity- (total cases excluding formal complaints)



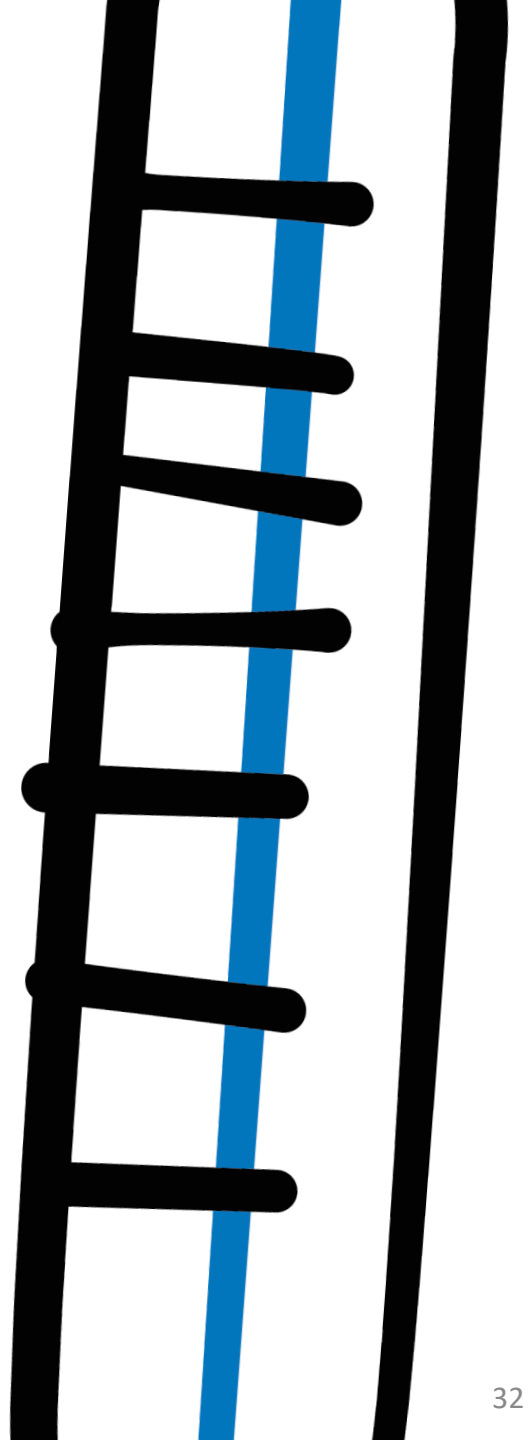
Gastroenterology contacts by patient activity- (total cases excluding formal complaints)



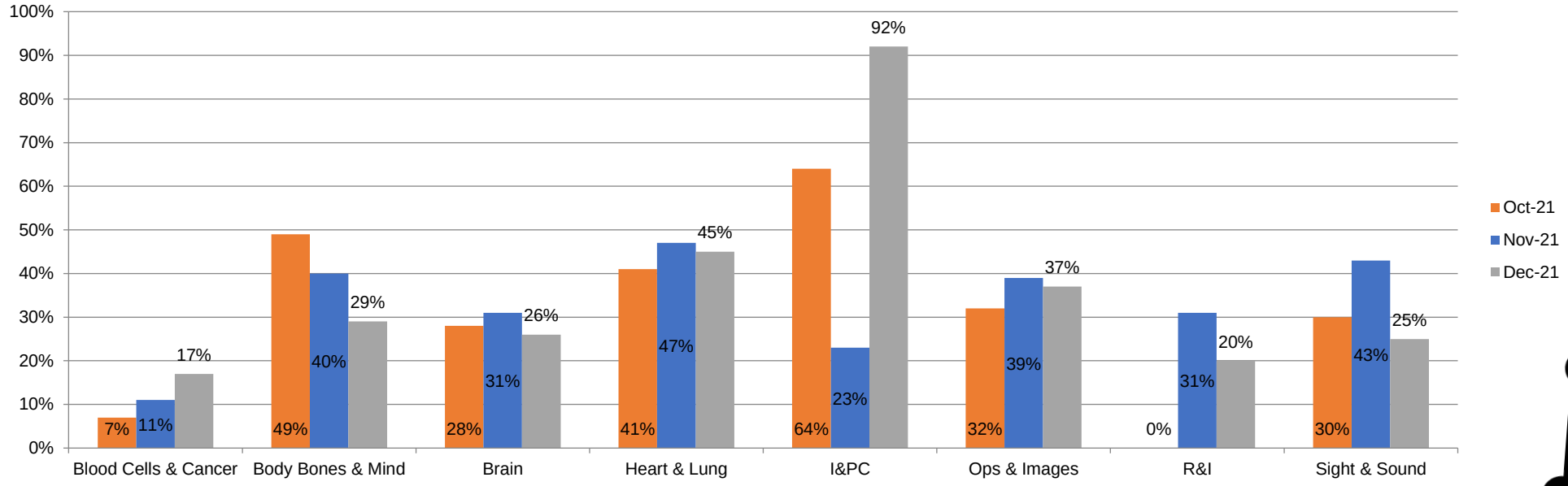
Learning from PALS

Pals were contacted by a father wishing to provide feedback on the feelings of stress and anxiety experienced while awaiting a response from his child's speciality team regarding previously shared concerns. Father explained that while he was grateful that the team were investigating and addressing these, he felt that a lack of regular updates in the interim led to him experiencing feelings of 'helplessness and of being lost'.

As a result of this, the Pals service have begun work on revaluating the way in which we support families, particularly those sharing complex or emotionally challenging concerns. Pals understand that speciality teams are often extremely busy and so are not able to always provide families with regular, routine updates and so, through a combination of both daily and weekly audits and a new standard operating procedure, Pals believe we are now better placed to support both speciality teams and patients by providing regular updates on the status of raised concerns and queries, something which we feel will go a long way in providing families with an extra layer of reassurance in what can often be a stressful and emotional time.



FFT: Are we responding and improving?



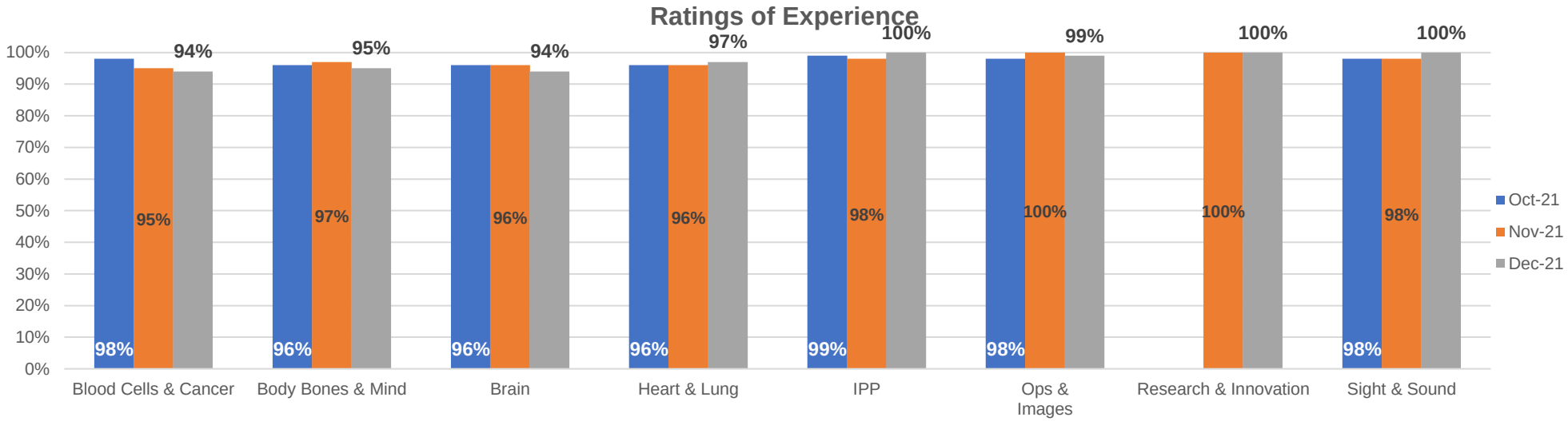
The Trust response rate has decreased slightly to 27%, however this is still above the Trust target.

At directorate level, Blood Cells and Cancer and the Clinical Research Facility on R&I were marginally below the Trust Target for response rate.

Consistent with previous months, negative comments related predominantly to Access, Admission and Discharge, followed by hospital Environment & Infrastructure and Catering. Negative comments about food related to the timing of the meals and the presentation of the food. There were also comments about the cost of the food in the Lagoon and how it would be really useful for families to be able to order and pay for food without leaving their child on the ward.

There were so many positive comments about staff professionalism and expertise. Staff were also praised for being efficient, sharing their knowledge and for being kind. The cleanliness of the hospital was also praised. There were also comments from patients thanking the hospital for their Christmas gifts.

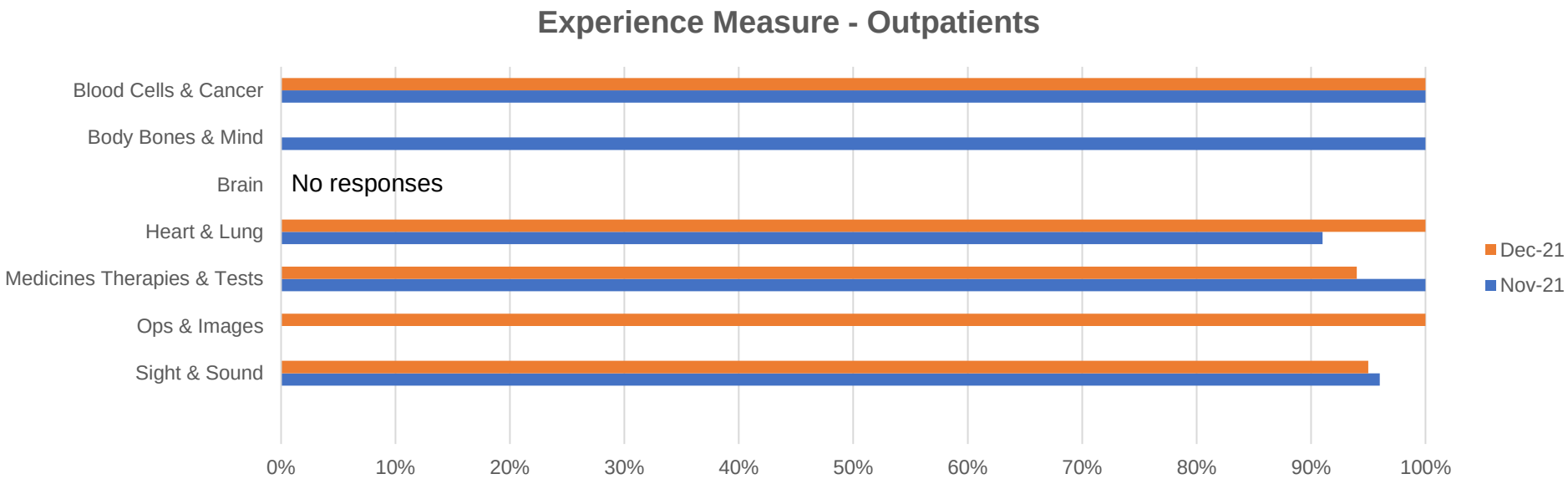
FFT: Are we responding and improving?



	Inpatient Comments	Outpatient Comments	IPP Comments	Total Feedback	% of FFT comments from CYP	% with qualitative comments (All areas)
May 21	980	432	163	**1575**	**14%**	**90%**
Jun 21	951	409	190	**1550**	**17%**	**92%**
Jul 21	879	304	147	**1330**	**17%**	**92%**
Aug 21	691	481	145	**1317**	**13%**	**93%**
Sept 21	816	640	155	**1611**	**13%**	**93%**
Oct 21	662	682	147	**1491**	**15%**	**93%**
Nov 21	850	555	65	**1470**	**16%**	**89%**
Dec 21	577	314	216	**1107**	**17%**	**91%**

- Inpatient response rate – **27%**
- Experience measure for inpatients – **97%**
- Experience measure for outpatients – **95%**
- **17%** of FFT comments are from patients.
- Outpatient comments decreased compared with the previous month. There was a reduction in on site appointments.
- **(n=314).**
- Inpatient comments decreased compared with the previous month, common for December **(n=577).**
- Consistently high number of qualitative comments – **91%**

FFT: Are we responding and improving? – Experience Measure - Outpatients



The volume of FFT feedback for December decreased which is comparable with December 2020. However, the measure of experience has increased to 95% and has met the Trust target.

Negative comments predominantly referred to late notice cancellation of appointments and confusing communication about appointment times and dates. There were also comments that suggested that not all families were aware of the tests / procedures that their child was due to have at an appointment. Families felt that it would be helpful to know about these in advance of the appointments, so they could prepare their child. There were also some comments about environmental issues, such as the problematic lifts in the RHLIM Building and the confusing signage in the Sight and Sound Centre.

There were many positive comments about staff and their expertise. Comments referenced how patients were made to feel at ease by the staff who were friendly, accommodating and always really helpful.

FFT Focus - Catering

"Food in canteen not equipped for food allergies"

"The food was really flavourless so I was unable to eat it as it was very plain and lacked flavour."

"The food timings are off, eating at 4.30pm is too early!"

"An in hospital food catering service for parents we would be happy to pay for the food, it just makes things easy for us some don't have family at home to get food or not able to go out to get food"

"A way ordering food for mums and dads without having to leave there ward".

All of the above comments have been shared with the relevant service areas.

FFT Comments

From beginning to end of the treatment every single member of her team has been incredible. The organisation even under the pressure of COVID has been excellent and we are very grateful for the care she received. ***– Robin Ward***

All the doctors & nurses have been amazing. They could not have been more helpful with any questions that we had during our stay while she was having treatment. – **Elephant Ward**

It's been such a positive experience for us. All the staff are so knowledgeable, friendly and helpful. They were so warm and friendly towards our son by signing, talking and blowing bubbles for him – they had lots of patience when answering questions. Thank you all.
Nightingale Ward

All kept to time. Able to request an appointment later in the day to enable us to travel in from Brighton. Excellent explanations of prognosis and options so my 11 year old could understand too –
Hippo Outpatients

All of the above comments have been shared with the relevant service areas.

Great Ormond Street Hospital for Children
NHS Foundation Trust

IQPR Trust Performance Update January 2022

Reporting December 2021 data

John Quinn, Chief Operating Officer

Overview

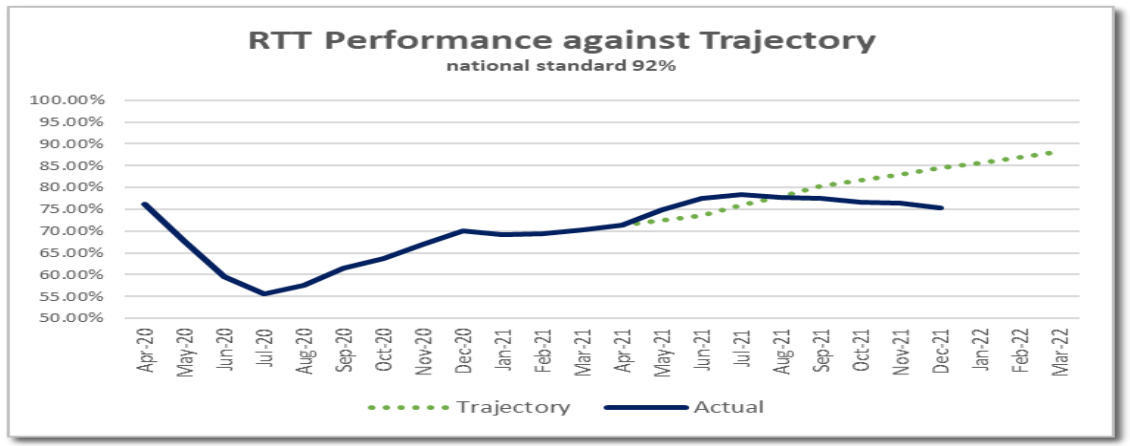
Standard	Target	Current Performance	Trend (Change since last month)	Forecast Compliance
Referral to Treatment (RTT)	92% in 18 wks	75.3%	↓ 1.1%	September 2022
No. over 18 Week waits	-	1711	↑ 94	-
52 Week waits	0	194	↓8	June 2022
104 Week Waits	0	5	↓2	December 2021
Diagnostics	99% in 6 wks	87.6%	↓2.5%	March 2022
31 Day: Decision to treat to 1st Treatment	96%	*100%*	⟷	
31 Day: Subsequent treatment – surgery	94%	*100%*	↑ 12%	
31 Day: Subsequent treatment - drugs	98%	*100%*	⟷	
62 Day: Consultant Upgrade	No national target	*100%*	⟷	

RTT

Performance

Forecast – 84.4%

Actual v Trajectory



75.3%
People waiting less than 18 weeks for treatment from referral.

Target 92% ↓ -1.1%

194
Patient wait over 52 weeks

↓ 8

5
Patients waiting over 104 weeks

↓ 2

Directorate Performance

Blood, Cells and Cancer – 88.8%
Brain – 82.3%
Body, Bones and Mind – 64.9%
Heart and Lung – 78.1%
Medicines, Therapies & Tests – 92.0%
Operations & Images – 85.1%
Sight and Sound – 65.8%

Bottlenecks

- Omicron wave impact;
  - Priority on P1, P2 and long wait patients through theatres in December
  - Staff and patient illness and isolation resulting in cancellations, and patients deferring booked appointments.
  - Significant reduction in bed availability due to staff illness and isolation
- Insufficient theatre capacity remains in Craniofacial, Plastic, Orthopaedics and Spinal to reduce long waits
- Specialist surgeon activity particularly for joint cases and complex patients
- Dental consultant availability
- Community/local physiotherapy capacity for the SDR pathway

Actions

- Waiting lists initiatives in place for January and February
- March 2022 'Super Saturday' planning for additional activity
- Bed closures being signed off by Senior Directorate Team
- Weekly operational meeting with service leads and theatre team to ensure capacity is used appropriately
- Weekly PTL challenge sessions with directorates
- Continued focus on reduction of long wait patients with plan to eliminate 104 week waits by April 2022.

RTT - continued

Performance

Challenged Directorates

Directorates – below 80% performance December 2021

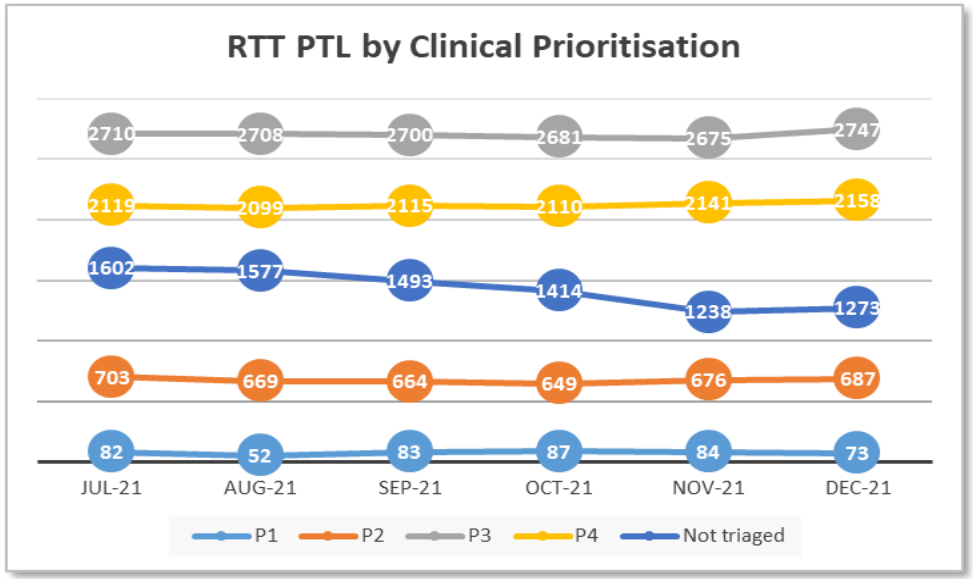
Body, Bones and Mind – 64.9%
Heart and Lung – 78.1%
Sight and Sound – 65.8%

Key Specialties

- Orthopaedic breaches have increased this month (+7) and remain significant at 189. Long waits continue relating to complex patients, staff absence and capacity constraints
- SNAPS breaches increased in December but remain lower than the first 8 months of the calendar year
- Spinal Surgery breaches increased slightly in December. Challenges in capacity constraints
- Cardiac Surgery breaches have increased by 10 breaches to 18 in December 2021. Beds capacity and urgent patients has impacted reducing waits
- Dental breaches have increased by 16 breaches to 84 in December 2021.
- ENT breaches have increased by 10 breaches to 140 in December 2021
- Plastic Surgery breaches have decreased sightly (-2) at the end of December 2021 and remains a significant challenge at 185.

	Projected Date (not signed off/validated)	Sep-21	Oct-21	Nov-21	Dec-21	% change	Dec 2021 No. of >18 Weeks	Breaches
Body, Bones & Mind								
CAMHS	N/A - continue to meet	84.4%	77.7%	71.7%	70.8%	-0.88%	33	
Gastroenterology	Mar-22	72.8%	71.2%	69.0%	70.5%	1.44%	44	
General Paediatrics	Feb-22	75.0%	63.0%	59.3%	58.3%	-0.93%	15	
Nephrology	N/A - continue to meet	88.5%	88.0%	87.7%	92.4%	4.72%	7	
Orthopaedics	Does not meet 92%	52.3%	50.3%	53.0%	48.1%	-4.89%	189	
SNAPS	Jan-23	79.0%	78.7%	79.9%	75.3%	-4.60%	72	
Spinal Surgery	Does not meet 92%	58.1%	61.1%	61.7%	59.5%	-2.17%	79	
Directorate Total	Nov-22	**68.2%**	**66.3%**	**66.7%**	**64.9%**	**-1.81%**	**452**	
Heart & Lung								
Cardiac Surgery	Feb-22	77.2%	76.6%	86.2%	74.3%	-11.92%	18	
Cardiology	Mar-22	78.1%	80.4%	77.9%	78.3%	0.33%	163	
Pulmonary Hypertensio	Sep-21	100.0%	66.7%	60.0%	100.0%	40.00%	0	
Respiratory Medicine	Dec-21	87.8%	78.2%	83.0%	76.6%	-6.42%	11	
Directorate Total	Mar-22	**78.8%**	**79.9%**	**78.7%**	**78.1%**	**-0.59%**	**193**	
Sight & Sound								
Audiological Medicine	Mar-22	68.1%	70.2%	76.3%	76.6%	0.38%	32	
Cleft	Mar-22	73.3%	75.8%	73.5%	72.0%	-1.47%	14	
Cochlear Implant	Mar-22	72.2%	83.3%	93.8%	88.9%	-4.86%	2	
Craniofacial	Does not meet 92%	54.8%	52.6%	52.3%	50.6%	-1.70%	82	
Dental	Does not meet 92%	66.1%	64.2%	59.5%	51.2%	-8.36%	84	
Ear Nose and Throat	Dec-21	74.2%	74.3%	74.4%	73.3%	-1.03%	140	
Maxillofacial	Mar-22	69.2%	64.1%	62.5%	63.4%	0.94%	34	
Ophthalmology	Oct-22	74.3%	70.8%	71.0%	73.2%	2.25%	90	
Orthodontics	Dec-22	57.1%	53.1%	61.5%	55.2%	-6.37%	13	
Plastic Surgery	Does not meet 92%	51.0%	51.9%	52.1%	53.0%	0.99%	185	
Urology	Dec-22	78.8%	79.2%	79.4%	72.7%	-6.69%	85	
Directorate Total	Mar-23	**67.7%**	**67.0%**	**67.3%**	**65.9%**	**-1.42%**	**761**	

RTT PTL - Clinical Prioritisation



P2	P3	P4	Not Prioritised
687 ↑ 11	2747 ↑ 72	2158 ↑ 17	1273 ↑ 35

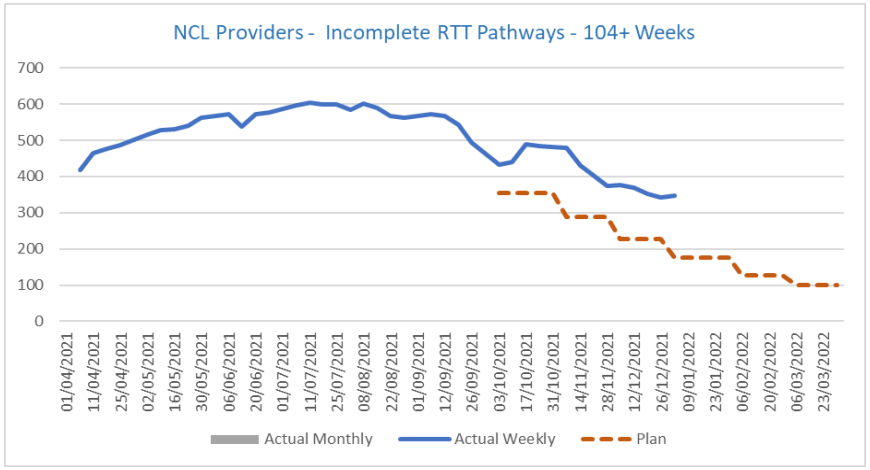
Clinical Prioritisation – past must be seen by date

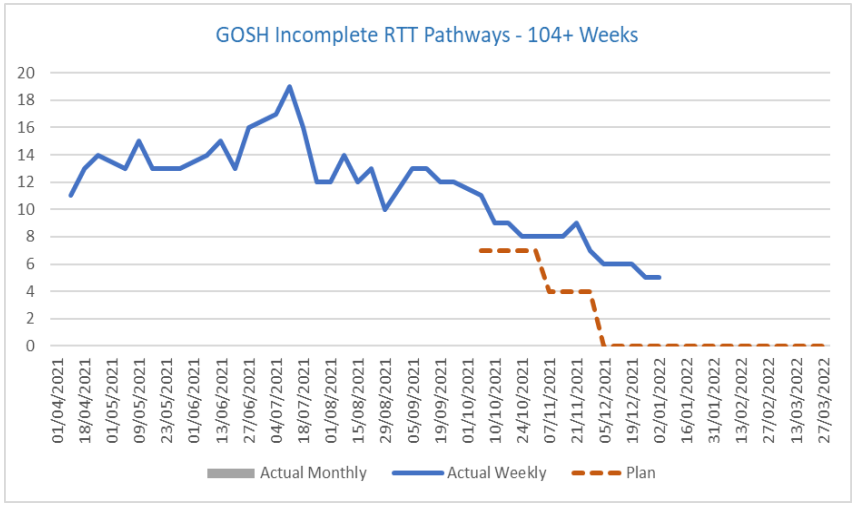
P2	P3	P4
187 ↑ 24	508 ↑ 38	276 ↑ 19

- The current RTT PTL is 6938 patients, 1273 require clinically prioritising with 997 being under 18 week waits. The remaining patients on the PTL are cohorted as follows: P1a/P1b – 73 patients (1.0%), P2 – 687 (9.9%), P3 – 2675 (39%) and P4 – 2158 (31%).
- It is recognised some sub-speciality areas including Plastic Surgery, Orthopaedics, Spinal and SDR have significant backlogs with many of these patients being within the clinical priority groups of 3 and 4.
- The number of P2 patients waiting beyond their must be seen by date has increased to 187. Of these 119 (63%) are admitted and 68 (36%) are non-admitted.
- The largest volume of P2 breaching patients are within SNAPs (24), Cardiology (16), Cardiac Surgery (16), Clinical Genetics (14), Dental (13), Gastroenterology (11) and Orthopaedics (10). These make up 55% of the breached P2.
- The Trust receives a high volume of patients on inherited RTT pathways. As at the end of December 2021, 67% of patients on the Trust's RTT ticking waiting list were referred from other Trusts, and some of these patients (35) had been waiting more than 18 weeks at their referring Trust. Three of these patients were waiting 52 weeks or more when they were referred to us.

NCL RTT Long Waits Position @ 2nd January

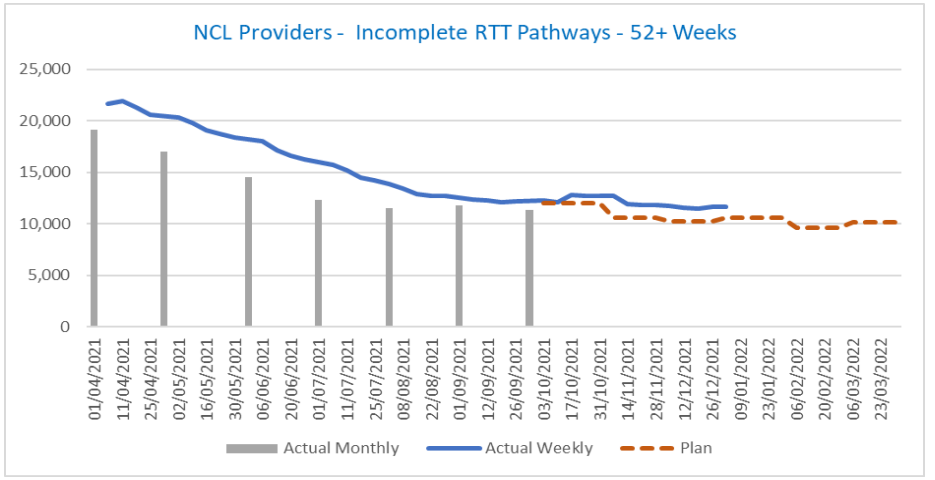
104+ Weeks - 347

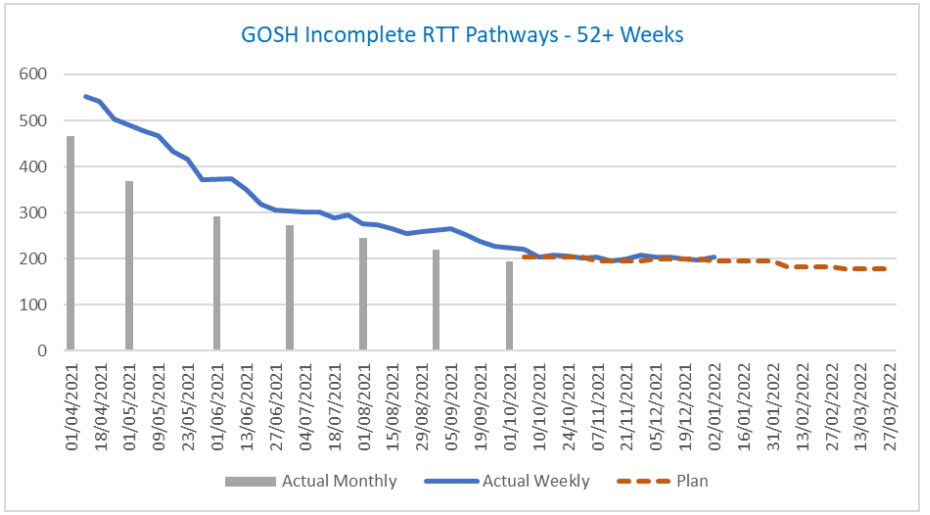




- Overall for NCL the 104 week wait position is above projected plan by 171. Mainly driven by RFH and UCLH numbers. GOSH is above trajectory by 5 patients.
- The 52 week wait performance for NCL is 1,117 above plan. This mainly due to Royal Free and RNOH being above plan. GOSH is below the agreed 52 week trajectory submission. A revised trajectory has been submitted part of the H2 planning round.

52+ Weeks - 11,711





Diagnostics - DM01

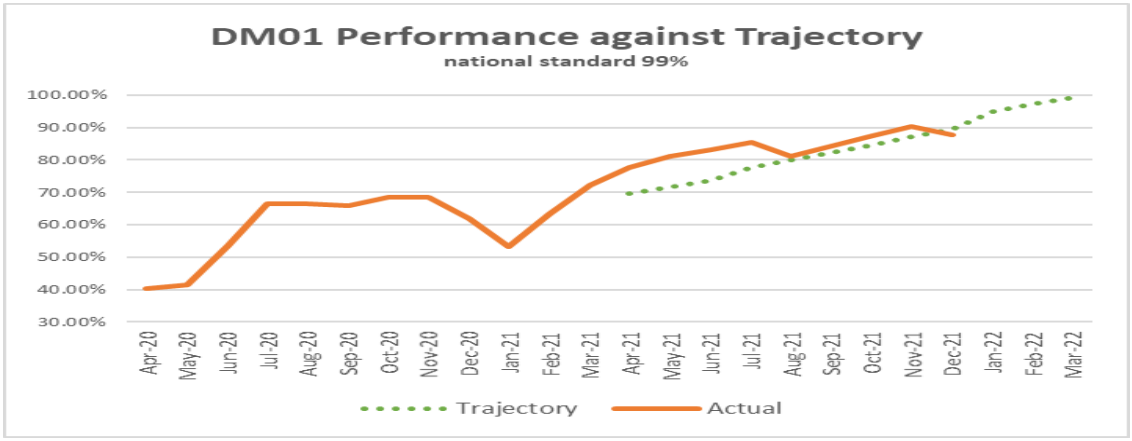
Performance

Forecast – 89.3%

87.6%
People waiting less than 6 weeks
Target 99% ↓ 1.7%

159
Number of Breaches
↑ 35

Actual v Forecast



Modality Focus

Of the 159 breaches, 63 are attributable to modalities within Imaging (48 of which are MRI), 17 in ECHO, 33 in Sleep Studies, 7 in Gastroscopy, 4 in Audiology, 16 in Colonoscopy, 1 in Cystoscopy, 16 in Neurophysiology and 2 in Urodynamics.

Both Operations and Imaging and Sight & Sound as directorates have achieved above 90% of patient waiting under 6 weeks for a diagnostic test.

At the end of December 2021, 12 patients were reported to be waiting 13 weeks and over for their diagnostic test, a decrease of one patient from November. The majority are booked in January.

Bottlenecks

- Omicron wave impact; staff and patient illness and isolation resulting in cancellations, and patients deferring booked appointments.
- Reduced capacity over Christmas and New Year period
- MRI sedation capacity remains challenging and current demand exceeds available capacity
- Echo compliance has improved but capacity remains limited for stress and sedated Echo
- Respiratory staff long term absence impacting sleep study activity
- Capacity constraints in Neurophysiology

Actions

- Weekly scheduling meetings for challenged areas to review utilisation, clinical prioritisation and long waits
- Discussion with services on waiting list initiatives to reduce the backlog
- Revisit diagnostic capacity and demand modelling for Neurophysiology

Cancer Waiting Times

Performance

Forecast – 100%

November Actual

100%
31 Day Referral to First Treatment
Target 96%

88%
31 Day: Subsequent Treatment – Surgery
Target: 94%

100%
31 Day: Subsequent Treatment – Drugs
Target:98%

100%
62 Day Consultant Upgrade.
No Target

December Forecast

100%
31 Day Referral to First Treatment
Target 96%

100%
31 Day: Subsequent Treatment – Surgery
Target: 94%

100%
31 Day: Subsequent Treatment – Drugs
Target:98%

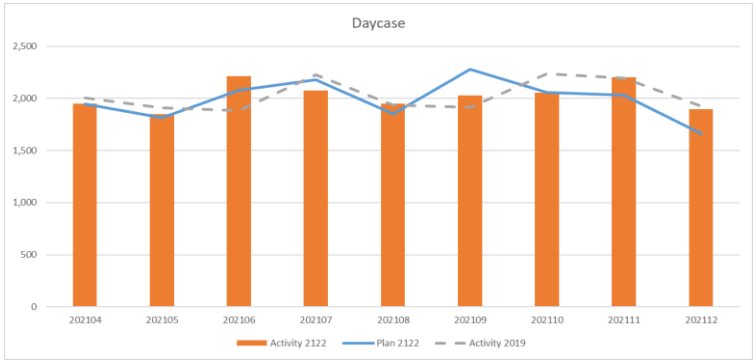
100%
62 Day Consultant Upgrade.
No Target

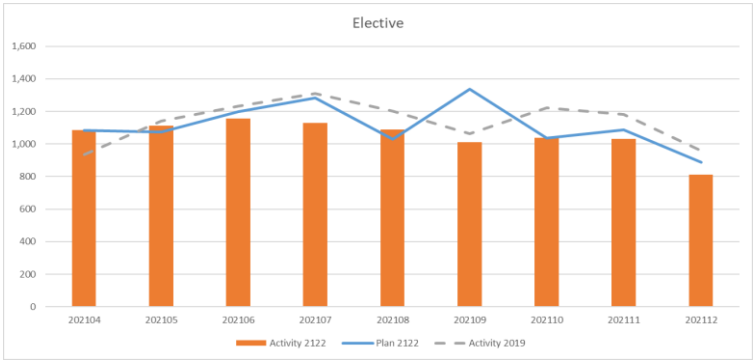
Bottlenecks

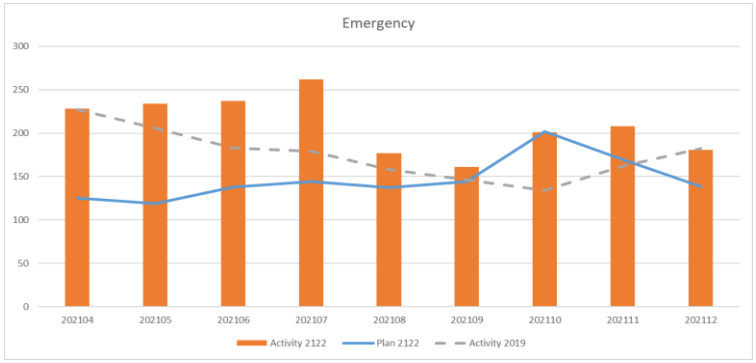
- October Breach in 31 day subsequent treatment due to patient choice- choosing to have surgery after the breach date.
- November breach was also due to patient choosing to delay their surgery
- December- we are forecasting 100% compliance across all five indicators. However, we know of three patients who are past their 31 day subsequent surgery breach date which will be reported in January. Two of the three breaches are due to the patients being too unwell to have surgery before their breach date and one breach is due to family requesting to delay surgery.

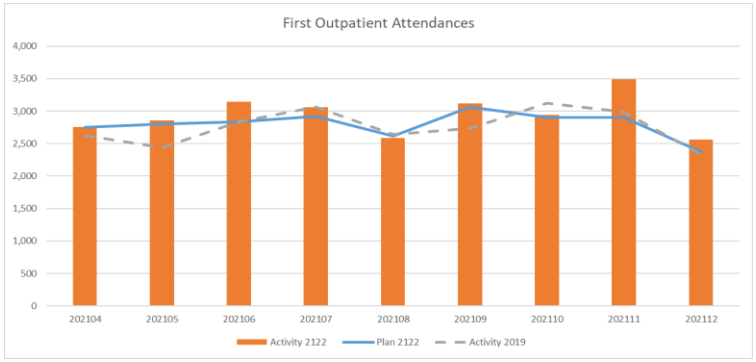
Activity Monitoring

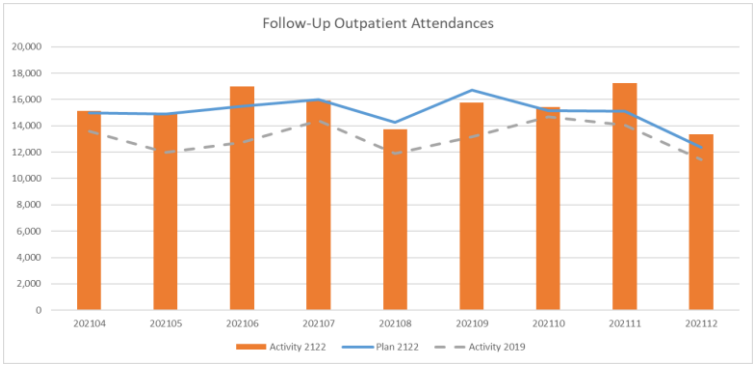
Activity Monitoring by Month











Point of Delivery	Plan 21/22	Activity 21/22	Activity 20/19	% of 20/19
Day-case	17,905	18,216	18,235	99.9%
Elective	10,013	9,458	10,248	92.3%
Emergency	1,317	1,889	1,577	119.8%
First Outpatients	25,162	26,529	24,782	107.0%
Follow-up Outpatients	134,915	138,543	117,986	117.4%

Appendix

Productivity and Efficiency

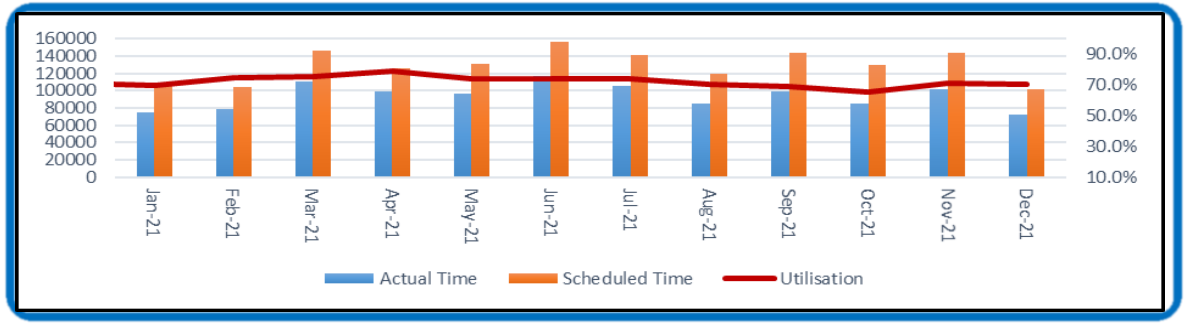
Theatre Utilisation

Performance

70.62%
of scheduled sessions in main theatres were utilised
↓ 0.29%

8841
Late start minutes
↓ 1675 minutes

6170
Overrun minutes
↑ 1281 minutes



Bottlenecks

- December utilisation has been impacted by the Omicron wave; patient and staff illness/isolation
- Potential reduction in throughput due to enhanced cleaning turnaround times. Level 2 cleans have significantly impacted theatres

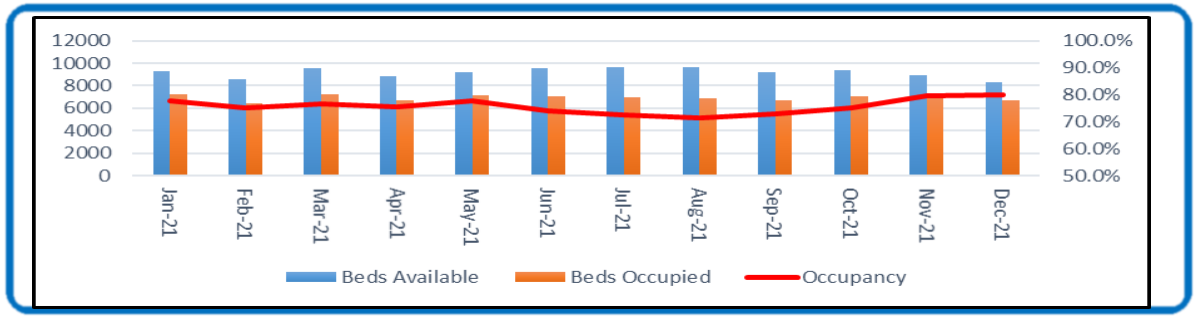
Bed Occupancy

Performance

79.8%
of inpatient beds (including ICU and I&PC) were occupied
↑ 0.25%

80.6%
Of NHS inpatient beds (including ICU were occupied)

Bed Closures



Bottlenecks

- Bed closures due to social distancing requirements and staffing
- Increased patient acuity on Cardiac wards impacting cancelled operations
- ICU areas experienced significant increases in occupancy
- Potential additional demand pressure through anticipated RSV surge

Productivity and Efficiency

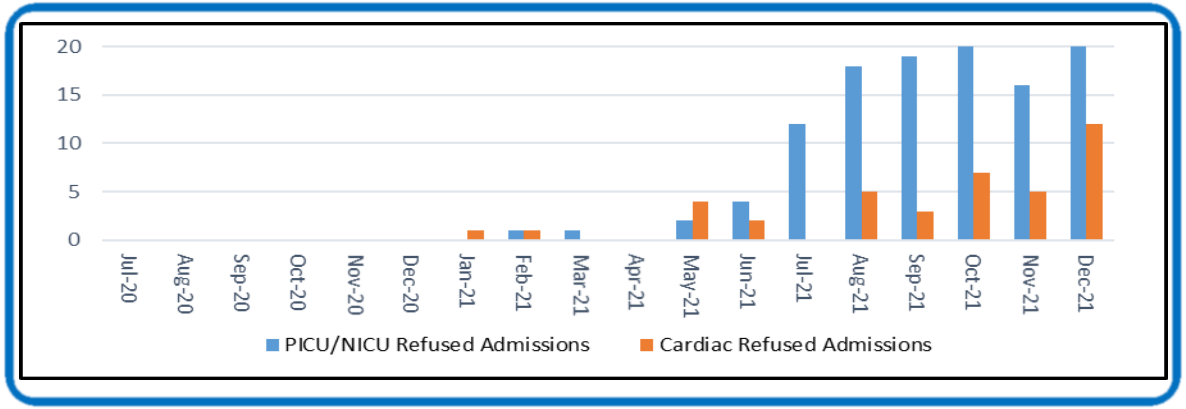
PICU/CICU

Performance

29
PICU/NICU refused admissions
13

12
Cardiac CATS refused admissions
7

1
PICU readmissions within 24 hours
1



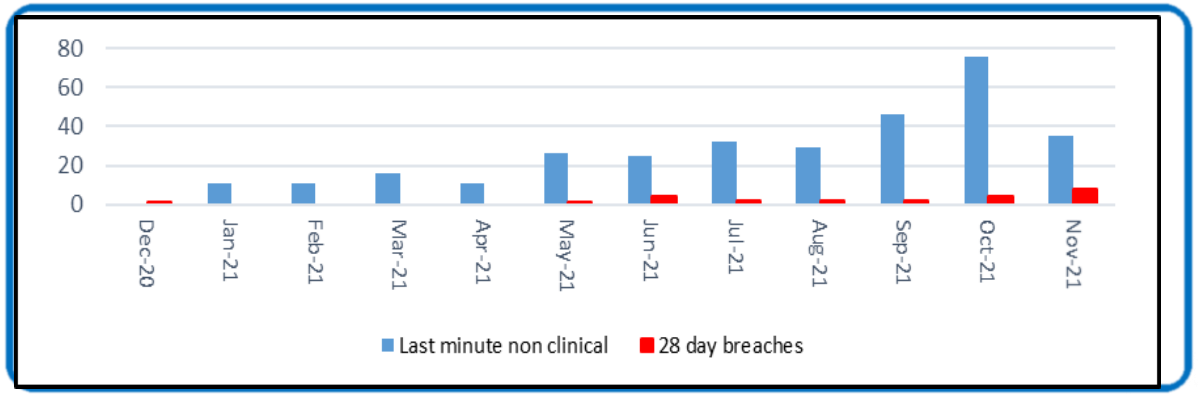
Bottlenecks:
- Number of available PICU and CICU beds

Cancelled Operations

Performance

35
Last minute cancelled operations for non clinical reasons
41

8
28 day breaches- last minute cancelled operations
4



Bottlenecks
- List overrun, ICU and ward bed unavailability and urgent patients taking priority.
- 28 day breaches due to urgent patients taking priority, MRI scanner broken down and major incident led to delay in rescheduling patients within breach date due to capacity.

Patient Communication

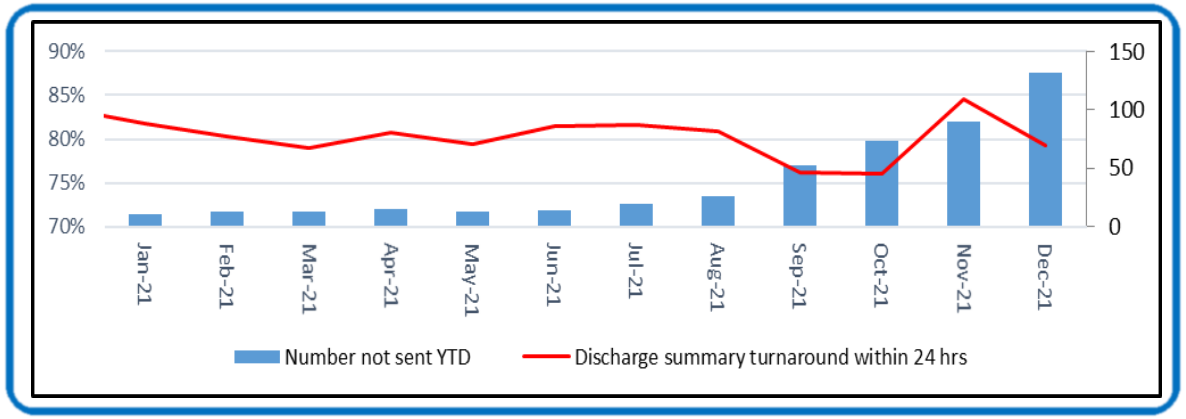
Discharge Summaries

Performance

79.34%
of patients who were discharged from GOSH had a letter sent to their referrer or received within 24 hours
Contractual target: 100%
5.20%

90.1%
of letters were sent within 2 days of discharge
1.26%

132
Number of letters not sent ytd
7



Actions

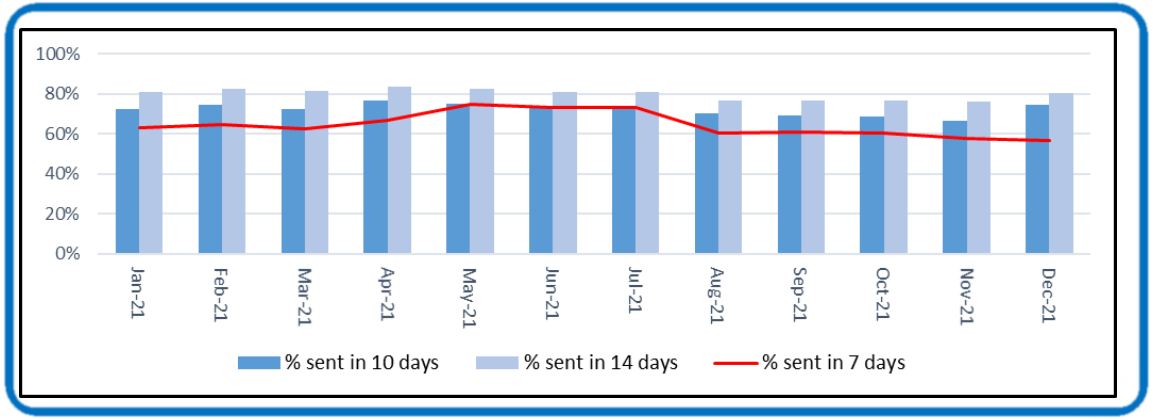
- Focus at consultant meetings
- Directorates working with clinical teams on real time completion including weekends

Clinic letters

Performance

56.5%
of outpatient clinic letters were sent within 7 days
Contractual target: 100%
1%

2,940
Number of letters not sent (rolling 12 months)
290



Actions

- Focus at consultant meetings and directorate board
- Bespoke training provided to refresh teams of Epic workflow
- Action plans in place to initially meet 10 day turnaround and then reduce to 7 day

Attachment J

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
2nd February 2022

Month 9 2021/22 Finance Report **Submitted by:** Helen Jameson, Chief Finance Officer	**Paper No: Attachment J**

Aims / summary

The Trust financial position is a deficit of £3.4m YTD which is £1.8m adverse to the newly approved H2 NHSEI plan. The Trust YTD deficit position is driven by lower than plan ERF income due to reduced scope to earn this in H2, a continued reduction in Private Patient income and high levels of bank and agency staff due to Covid-19 sickness and isolation. The emergence of the Omicron variant has created uncertainty around H2, particularly around what this may mean for Trusts and how it may affect or change funding arrangements.

Key points to note within the financial position are as follows:

1. Income overall YTD is £2.8m adverse to plan for the Trust driven by ERF activity being below plan and reduced scope to earn ERF (£1.5m). In addition the Trust continues to see lower than plan private patient income (£1.3m) due to Covid-19 and the continued travel restrictions.
2. Pay is adverse YTD to the plan by £1.4m. High levels of bank and agency staffing have continued in order to backfill staff isolation and sickness. The Trust continues to recruit to permanent vacancies where possible and has seen some new starters in the last three months. High temporary staffing costs (bank and agency) are expected to continue reflecting the ongoing impact of Covid-19
3. Non-Pay is £2.6m favourable YTD. Key drivers of this are lower than planned usage of high cost drugs and devices and a reduction in in impairment of receivables due to the Trust continuing to receive regular payment of private patient aged invoices
4. Cash held by the Trust in Month 9 is £0.3m higher than last month and is £125.2m. Capital expenditure is currently below plan by £4.0m, with the Trust funded programme below plan by £5.6m and the donated programme £1.6m above plan.

The key movements to note on the balance sheet are:

Indicator	Comment
Cash	Cash held by the Trust is £125.2m which is £0.3m higher than M8.
NHS Debtor Days	NHS debtor days increased from 3 days in Month 8 to 4 days in Month 9, falling within the target of 30 days for the Trust.
IPP Debtor Days	IPP debtor days increased from 74 days in Month 8 to 80 days in Month 9.
Creditor Days	Creditor days has increased from 20 days to 22 days.

Action required by the meeting
To note the Month 9 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 9 2021/22

Contents

Trust Performance Summary for the 9 months ending 31 Dec 2021

KEY PERFORMANCE DASHBOARD

ACTUAL FINANCIAL PERFORMANCE

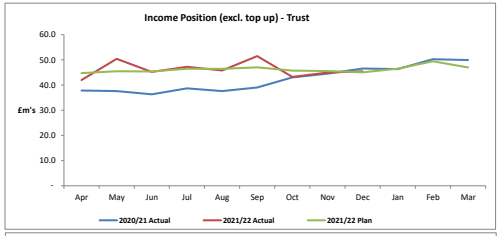
	In month			Year to date		
	Plan	Actual	RAG	Plan	Actual	RAG
INCOME	£45.1m	£45.4m		£418.5m	£415.7m	
PAY	(£28.3m)	(£28.9m)		(£249.0m)	(£250.4m)	
NON-PAY inc. owned depreciation and PDC	(£18.1m)	(£18.2m)		(£171.0m)	(£168.7m)	
Surplus/Deficit excl. donated depreciation	(£1.4m)	(£1.7m)		(£1.5m)	(£3.4m)	

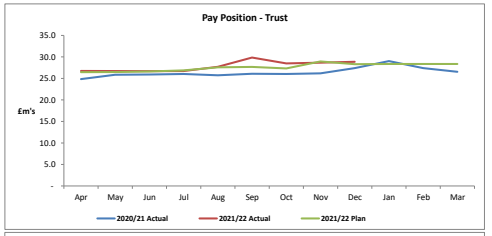
RAG: on or favourable to plan = green, 0-5% adverse to plan = amber, 5%+ adverse to plan = red
YTD Plan is comprised of H1 Actual and H2 plan

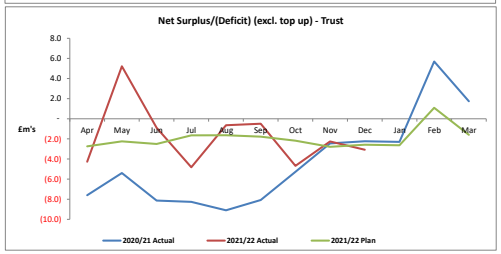
AREAS OF NOTE:

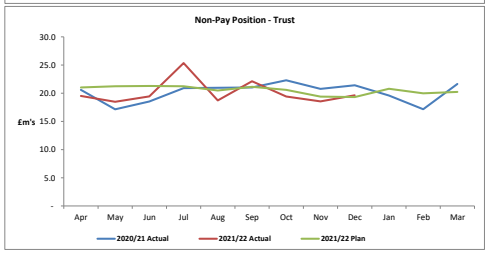
The in month Trust financial position at Month 9 is a deficit of £1.7m which is £0.3m adverse to the (revised) plan. The YTD financial position is a deficit of £3.4m which is £1.8m adverse to plan.

Income is £2.8m adverse to plan YTD due to reduced scope to earn ERF linked to the change in ERF methodology (£1.5m) and reduced levels of private pateint income (£1.3m) adverse to plan YTD which has been caused by reduced levels of activity from the continued impact of Covid-19. Pay is £1.4m adverse to plan YTD due to high levels of bank and agency staffing covering staff absence from sickness and isolation relating to Covid. Non pay is £2.6m favourable to the plan YTD. This is largely driven by lower than planned usage of high cost pass through drugs and devices along with continued reduction in the impairment of receivables from the payment of private patient invoices.







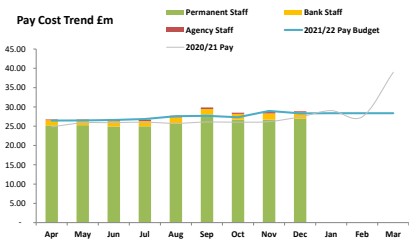


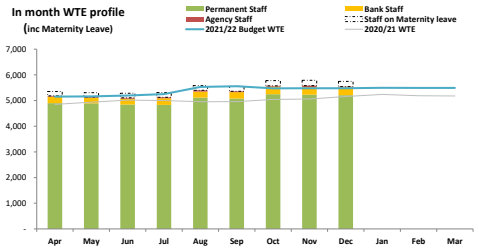
PEOPLE

	M9 Plan WTE	M9 Actual WTE	Variance
Permanent Staff	5,437.9	5,204.5	233.4
Bank Staff	39.7	312.2	(272.5)
Agency Staff	-	26.5	(26.5)
TOTAL	**5,477.5**	**5,543.2**	**(65.7)**

AREAS OF NOTE:

Month 9 WTE's decreased slightly from last month but are higher than plan due to continued high levels of temporary staff usage in relation to Covid isolation and sickness backfill. The 31st December absence rate due to Covid was 8% of the total Trust workforce. In Month 9 agency staffing reduced to 27 (from 53 in M8) but are still required to provide additional senior assistance for the ICT, IPP & Finance directorates; who are in the process of recruiting permanently to these roles.



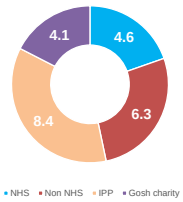


CASH, CAPITAL AND OTHER KPIs

Key metrics	*Nov-21*	*Dec-21*
Cash	**£124.8m**	**£125.2m**
IPP debtor days	**74**	**80**
Creditor days	**20**	**22**
NHS Debtor days	**3**	**4**
BPPC (£)	**90%**	**90%**

Capital Programme	*YTD Plan M9*	*YTD Actual M9*	*Full Year F'cst*
Total Trust-funded	**£11.6m**	**£5.9m**	**£17.7m**
Total PDC	**£0.0m**	**£0.0m**	**£1.4m**
Total Donated	**£6.6m**	**£8.3m**	**£11.9m**
Total Grant-funded	**£0.2m**	**£0.0m**	**£0.4m**
Grand Total	**£18.3m**	**£14.3m**	**£31.3m**

Net receivables breakdown (£m)

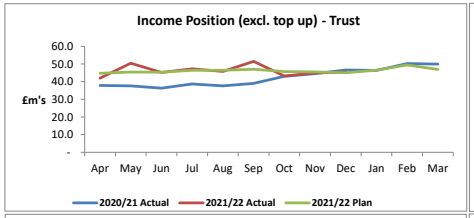


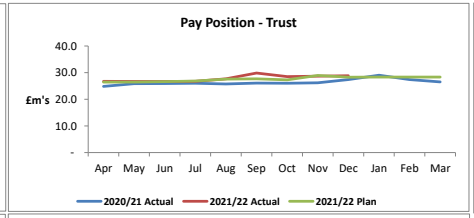
AREAS OF NOTE:

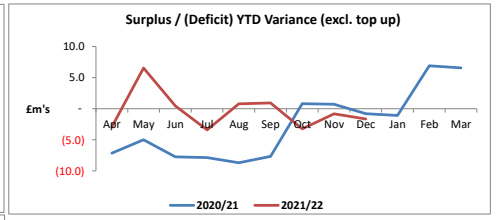
1. Cash held by the Trust increased in month from £124.8m to £125.2m.
2. Capital expenditure for the year to date was £4.0 less than plan. The Trust-funded programme was £5.6m less than plan, donated was £1.8m more than plan, and grant-funded £0.2 less than plan. The forecast outturn is now £0.3m less than plan assuming additional equipment projects are approved. PDC has been allocated to the Trust for a further £1.4m.
3. IPP debtors days increased in month from 74 to 80. Total IPP debt (net of cash deposits held) increased in month to £8.4m (£7.7m in M08) as a result of increased billing in December. Overdue debt decreased in month to £10.1m (£12.1m in M08) due high levels of payment from embassies.
4. Creditor days increased in month from 20 days to 22 days.
5. NHS debtor days increased in month from 3 days to 4 days.
6. In M09, 90% of the total value of creditor invoices were settled within 30 days of receipt; this represented 82% of the total number of creditor invoices paid in month. This remains below the NHSE target of settling at least 95% of invoices within 30 days.

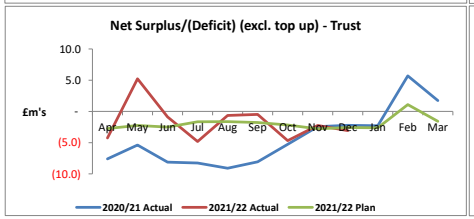
Trust Income and Expenditure Performance Summary for the 9 months ending 31 Dec 2021

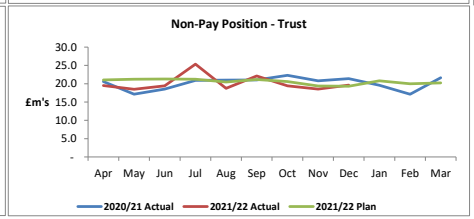
2021/22										Notes	2020/21	2021/22	2021/22
Annual Plan (H1 Act + H2 Plan)	Income & Expenditure	Month 9				Year to Date				Rating		Plan YTD	Plan In-month
		Plan	Actual	Variance		Plan (H1 Act + H2 Plan)	Actual	Variance		YTD Variance	Actual M9		M9
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%		(£m)	(£m)	(£m)
475.16	NHS & Other Clinical Revenue	37.39	38.23	0.85	2.26%	356.92	355.18	(1.74)	(0.49%)	R	1	36.96	356.92	37.39
29.13	Private Patient Revenue	2.71	1.82	(0.88)	(32.61%)	19.49	18.20	(1.29)	(6.64%)	R	2	4.25	19.49	2.71
57.13	Non-Clinical Revenue	4.96	5.36	0.40	8.07%	42.09	42.37	0.28	0.66%	G	3	5.36	42.09	4.96
561.42	**Total Operating Revenue**	**45.05**	**45.41**	**0.36**	**0.81%**	**418.50**	**415.75**	**(2.75)**	**(0.66%)**	R		**46.57**	**418.50**	**45.05**
(312.37)	Permanent Staff	(26.41)	(26.92)	(0.50)	(1.91%)	(233.00)	(234.42)	(1.42)	(0.61%)	R		(24.97)	(233.00)	(26.41)
(4.84)	Agency Staff	(0.46)	(0.31)	0.15		(3.46)	(3.04)	0.42		G		(0.28)	(3.46)	(0.46)
(16.87)	Bank Staff	(1.44)	(1.64)	(0.20)	(13.87%)	(12.55)	(12.98)	(0.43)	(3.40%)	A		(2.16)	(12.55)	(1.44)
(334.08)	**Total Employee Expenses**	**(28.31)**	**(28.86)**	**(0.55)**	**(1.94%)**	**(249.01)**	**(250.44)**	**(1.43)**	**(0.57%)**	R	4	**(27.40)**	**(249.01)**	**(28.31)**
(98.64)	Drugs and Blood	(8.00)	(7.34)	0.66	8.29%	(73.12)	(70.56)	2.56	3.50%	G		(7.56)	(73.12)	(8.00)
(39.70)	Supplies and services - clinical	(2.93)	(3.41)	(0.48)	(16.41%)	(29.71)	(30.25)	(0.53)	(1.80%)	R		(4.11)	(29.71)	(2.93)
(72.56)	Other Expenses	(5.84)	(6.02)	(0.18)	(3.13%)	(54.74)	(54.19)	0.55	1.00%	G		(7.01)	(54.74)	(5.84)
(210.90)	**Total Non-Pay Expenses**	**(16.77)**	**(16.77)**	**0.00**	**0.00%**	**(157.57)**	**(155.00)**	**2.57**	**1.63%**	G	5	**(18.68)**	**(157.57)**	**(16.77)**
(544.97)	**Total Expenses**	**(45.09)**	**(45.64)**	**(0.55)**	**(1.22%)**	**(406.58)**	**(405.44)**	**1.14**	**0.28%**	G		**(46.08)**	**(406.58)**	**(45.09)**
16.45	**EBITDA (exc Capital Donations)**	**(0.04)**	**(0.22)**	**(0.19)**	**(518.52%)**	**11.92**	**10.31**	**(1.61)**	**(13.49%)**	R		**0.49**	**11.92**	**(0.04)**
(17.62)	Owned depreciation, Interest and PDC	(1.34)	(1.44)	(0.11)	(7.99%)	(13.47)	(13.68)	(0.21)	(1.58%)			(1.28)	(13.47)	(1.34)
(1.17)	**Surplus/Deficit (exc. PSF/Top up)**	**(1.37)**	**(1.66)**	**(0.29)**	**(21%)**	**(1.55)**	**(3.37)**	**(1.82)**	**(118%)**			**(0.79)**	**(1.55)**	**(1.37)**
0.00	PSF/Top up	0.00	0.00	0.00		0.00	0.00	0.00				0.00	0.00	0.00
(1.17)	**Surplus/Deficit (incl. PSF/Top up)**	**(1.37)**	**(1.66)**	**(0.29)**	**(21.35%)**	**(1.55)**	**(3.37)**	**(1.82)**	**(117.74%)**	R		**(0.79)**	**(1.55)**	**(1.37)**
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
(15.41)	Donated depreciation	(1.21)	(1.42)	(0.21)		(11.89)	(12.53)	(0.64)				(1.45)	(11.89)	(1.21)
(16.58)	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**(2.58)**	**(3.08)**	**(0.50)**	**(19.30%)**	**(13.43)**	**(15.90)**	**(2.46)**	**(18.34%)**			**(2.24)**	**(13.43)**	**(2.58)**
0.00	Impairments & Unwinding Of Discount	0.00	0.00	0.00		0.00	0.00	0.00				0.00	0.00	0.00
9.30	Capital Donations	0.60	0.66	0.06		7.50	8.34	0.84				0.42	7.50	0.60
(7.28)	**Adjusted Net Result**	**(1.98)**	**(2.42)**	**(0.44)**	**(22.26%)**	**(5.94)**	**(7.56)**	**(1.63)**	**(27.41%)**			**(1.82)**	**(5.94)**	**(1.98)**











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

Summary

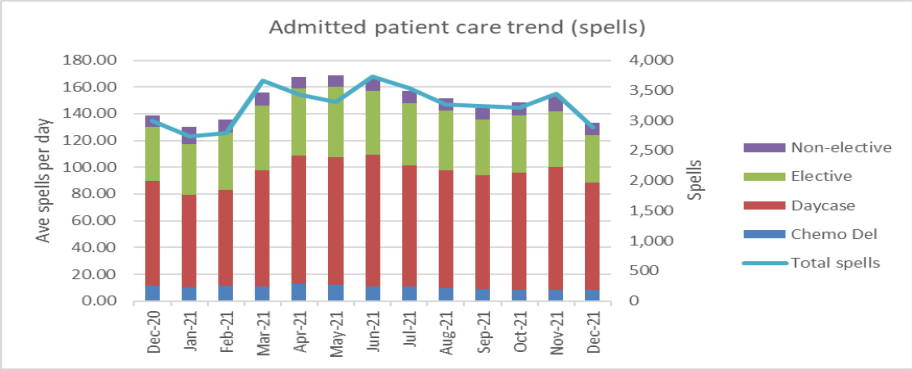
- The in month Trust financial position at Month 9 is a deficit of £1.7m which is £0.3m adverse to the revised plan. As a consequence the YTD financial position is a deficit of £3.4m which is £1.8m adverse to the revised plan.

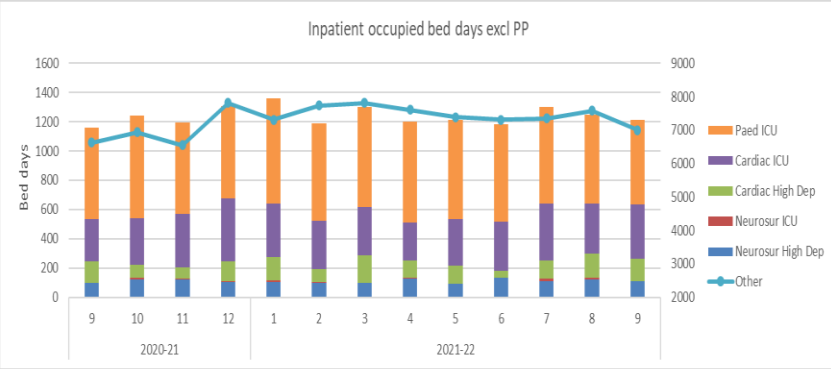
Notes

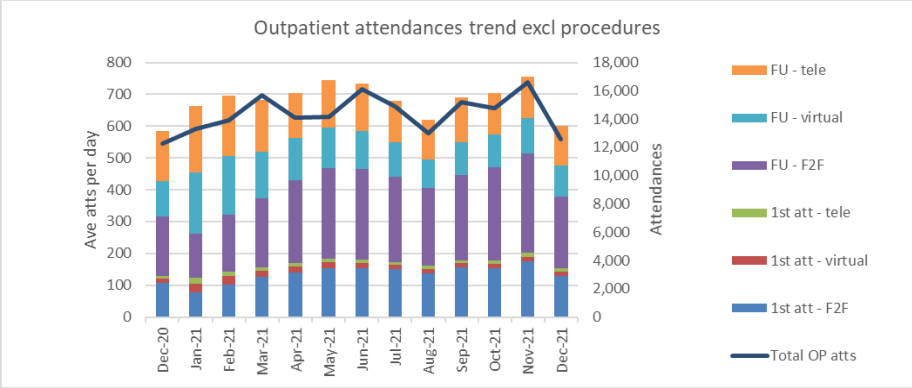
1. The scope for the Trust to earn ERF has significantly reduced in H2. As a result NHS and Other Clinical income is £1.7m adverse to plan YTD.
2. Private Patient income is £0.9m adverse to plan in month and £1.3m adverse to plan YTD. This is due to Covid-19 and the associated suppression of travel. The Trust expects to see private patient income continue to be affected by Covid-19 pandemic.
3. Non-clinical income is £0.4m favourable to plan in month and £0.3m favourable to plan YTD due to higher levels of commercial income recognition accross the Trust.
4. Pay is adverse YTD to the plan by £1.4m, due to high levels of bank and agency staffing have continued with sickness and isolation backfill relating to Covid.
5. Non pay is £2.6m favourable to the plan YTD. This is driven by lower than planned usage of high cost pass through drugs and devices due to reduced levels of activity and a reduction in impairment of receivables linked to the payment of invoices previously provided for.

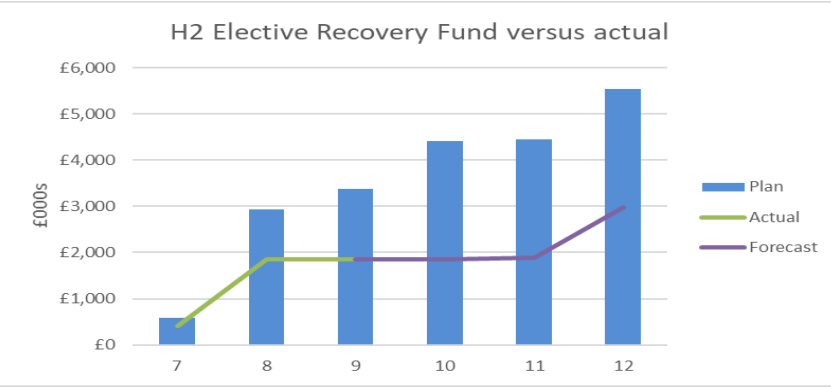
2021/22 Overview of activity trends for month ending 31 December 2021

Great Ormond Street Hospital for Children NHS Foundation Trust







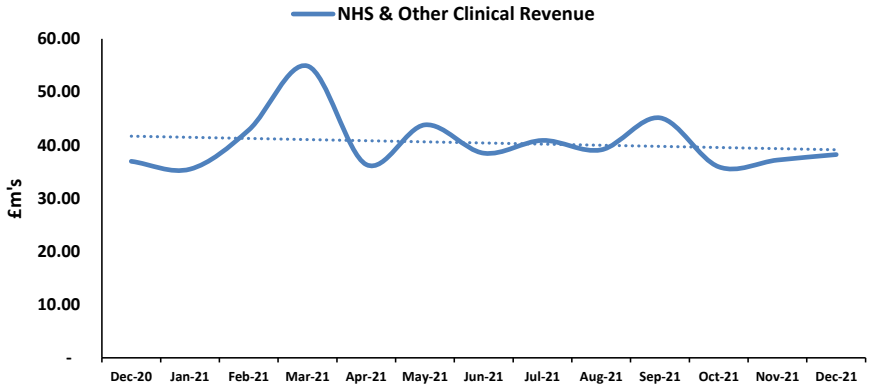


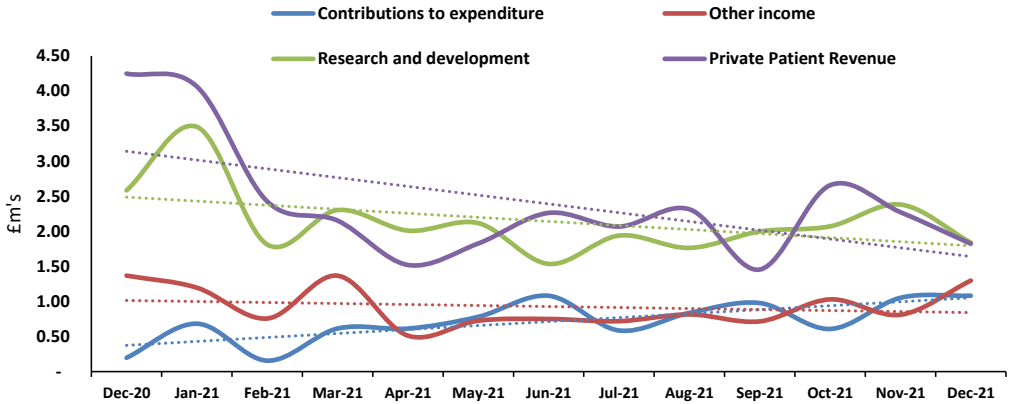
Summary

- Overall activity in December has significantly decreased per working day for all points of delivery and this is reflected in lower bed days . This level of reduction is larger than was seen in Christmas 2019 (pre-Covid)for all points of delivery suggesting that the impact of Omicron on staffing levels further decreased activity over and above the normal level of the seasonal impact of Christmas (e.g. a further 2% reduction for OP attendances).
- The largest reductions for admitted patient care per working day is for elective and non-elective spells at 15.3% and 15.7% respectively. Outpatient attendances have decreased 20.5% per working day versus November with face to face first and follow up activity showing the largest reductions (26.7% and 27.8%). Non-face to face attendances as a % of the total have increased from 36% to 41% when compared to November reflecting the need to reduce face to face appointments as a result of Omicron.
- Clinical supplies and services have decreased in line with activity reductions from November (£3.2m to £2.9m).
- A revised national elective recovery scheme has been implemented in H2 where funding is received when the number of clock stops are above 89% of 2019/20 levels at a system level. The % above the threshold is applied to the 2019/20 income values by month to derive the payment due. GOSH has estimated income under the scheme of £5.5m to March however the system performance means that no national funding will be received. The system has agreed to fund ERF from their allocations to encourage increased activity. The estimated value for October-December is £1.86m versus a plan of £3.4m, an under-performance of £1.5m. The majority of this shortfall is in November (£0.9m) and December (£0.4m) however there may be an increase as clock stops are finalised for December. It is expected that zero ERF will be generated for December and January owing to Covid however it is assumed the February and March plan will be delivered giving a forecast total of £3.0m versus a plan of £5.5m (an adverse variance of £2.5m).

NB: activity counts for spells and attendances are based on those used for income reporting

2020/21 Income for the 9 months ending 31 Dec 2021





Summary

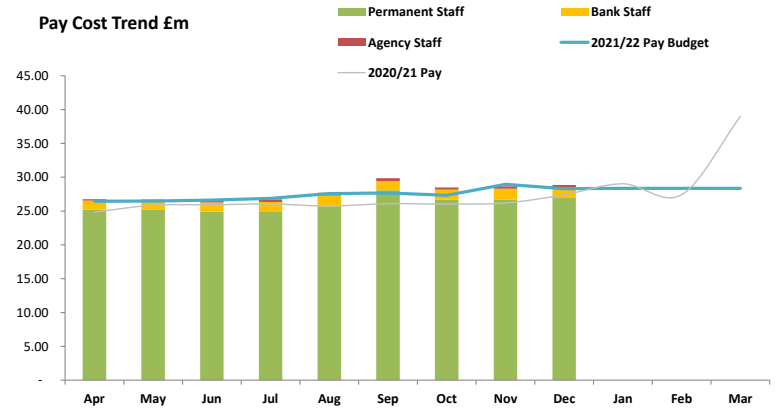
- Trust total income YTD is £2.8m adverse to plan, driven by lower than plan ERF income in H2 (£1.5m) and underperformance in relation to private patient income (£1.3m).
- Private Patient income is £1.3m adverse to plan YTD. Given the slow return to global travel, sponsors are only sending their most complex patients abroad, resulting in significantly lower income levels for the Trust. The reduced level of referrals is expected to continue and creates an ongoing challenge for the Trust.
- Research and development income has gradually increased over the past few months due to additional commercial income and this is forecast to continue.

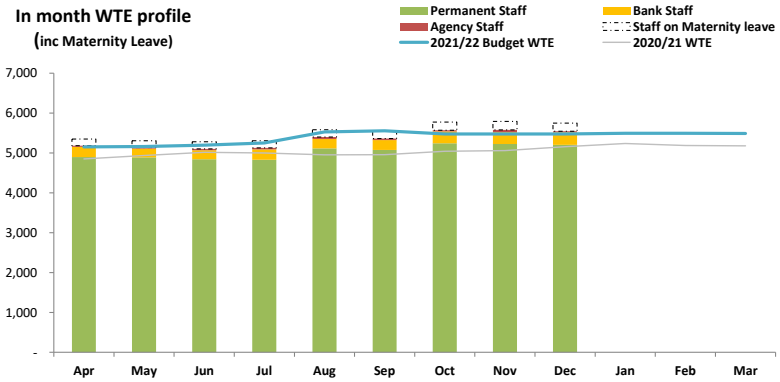
Workforce Summary for the 9 months ending 31 Dec 2021

*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	FY (£m)	FY 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	45.4	1,247.2	48.6	(3.0)	(1.9)	(1.1)	R
Consultants	60.3	387.7	155.5	47.1	394.8	159.1	(1.9)	(0.8)	(1.1)	R
Estates & Ancillary Staff	4.7	138.7	33.7	6.9	287.2	32.3	(3.4)	(3.8)	0.3	R
Healthcare Assist & Supp	11.3	325.9	34.7	8.5	323.8	35.0	(0.0)	0.1	(0.1)	G
Junior Doctors	31.4	377.0	83.2	23.7	383.4	82.5	(0.2)	(0.4)	0.2	A
Nursing Staff	89.8	1,600.9	56.1	69.6	1,616.0	57.5	(2.3)	(0.6)	(1.6)	R
Other Staff	0.7	12.3	53.8	0.6	15.4	54.8	(0.1)	(0.1)	(0.0)	A
Scientific Therap Tech	56.9	981.8	58.0	44.6	1,028.8	57.8	(1.9)	(2.0)	0.1	R
Total substantive and bank staff costs	**311.6**	**5,018.1**	**62.1**	**246.6**	**5,296.7**	**62.1**	**(12.9)**	**(13.0)**	**0.1**	R
Agency	3.7	28.3	129.4	3.0	35.9	113.0	(0.3)	(0.7)	0.4	A
Total substantive, bank and agency cost	**315.2**	**5,046.4**	**62.5**	**249.6**	**5,332.6**	**62.4**	**(13.2)**	**(13.7)**	**0.5**	R
Reserve*	1.9	0.3		0.8	0.2		0.6	0.6	0.0	G
Additional employer pension contribution by NHSE	12.4	0.0		0.0	0.0		9.3	0.0	9.3	G
Total pay cost	**329.6**	**5,046.6**	**65.3**	**250.4**	**5,332.8**	**62.6**	**(3.3)**	**(13.1)**	**9.8**	R
Remove maternity leave cost	(3.1)			(3.2)			0.9	0.0	0.9	G
Total excluding Maternity Costs	**326.4**	**5,046.6**	**64.7**	**247.2**	**5,332.8**	**61.8**	**(2.4)**	**(13.1)**	**10.7**	R

*Plan reserve includes WTEs relating to the better value programme

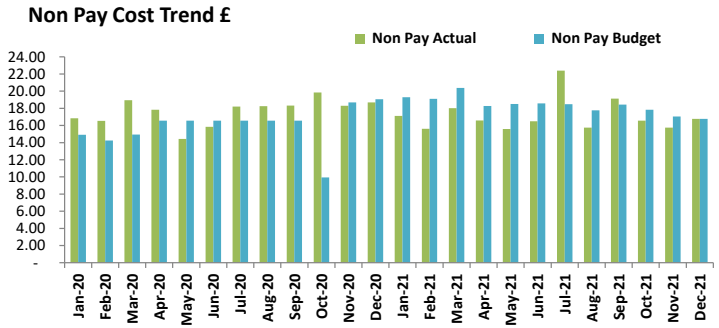


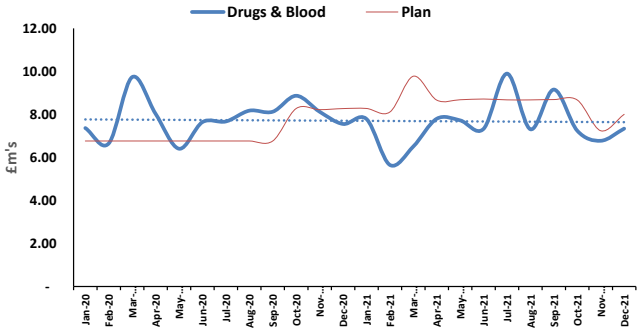


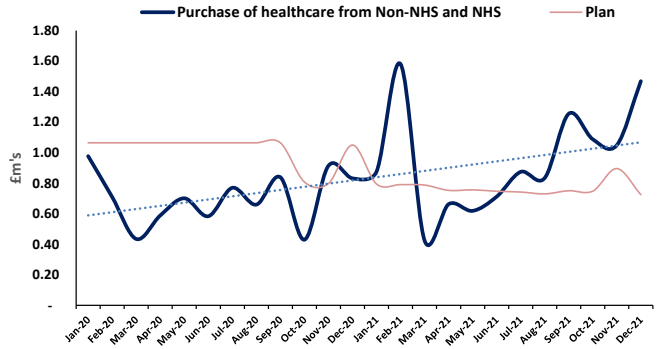
Summary

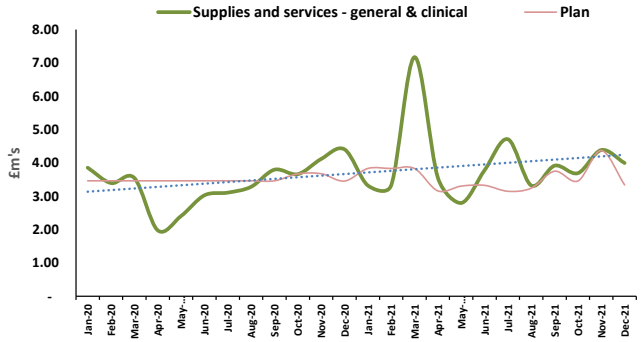
- Pay costs are adverse to plan YTD (£1.4m). Staffing levels overall remain high due to Covid driving down staff turnover and impacting staff in relation to isolation and sickness. As of 31st December, the percentage of staff absent with Covid was 8% of the Trust workforce.
- As a result of the levels of staff absence Nursing bank costs have seen a significant increase but are still lower than last year. The Trust is starting to seeing staff absence falling but it is expected to continue to impact into January.
- When comparing 2020/21 to 2021/22 the largest volume variance increases are in Estates and ancilliary which is due to the movement of domestic staff in house. The next largest is in Scientific and Theraputic staff. This is driven by increased activity accross the Genetics labs and the additional costs associated with testing staff, patients and visitors linked with policies around Covid-19.
- The price variance has remained mainly the same a reduction in Estates & Facilities with the Trust bringing in house the domestic staffing.
- The Trust has seen an increase in materinty leave with current costs equalling the full year costs in 2020/21. This results in an increase in temporary staffing costs.

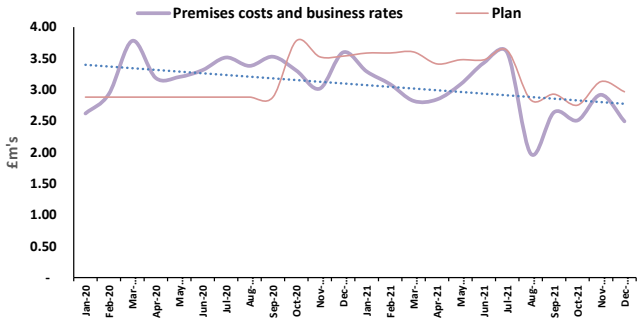
Non-Pay Summary for the 9 months ending 31 Dec 2021





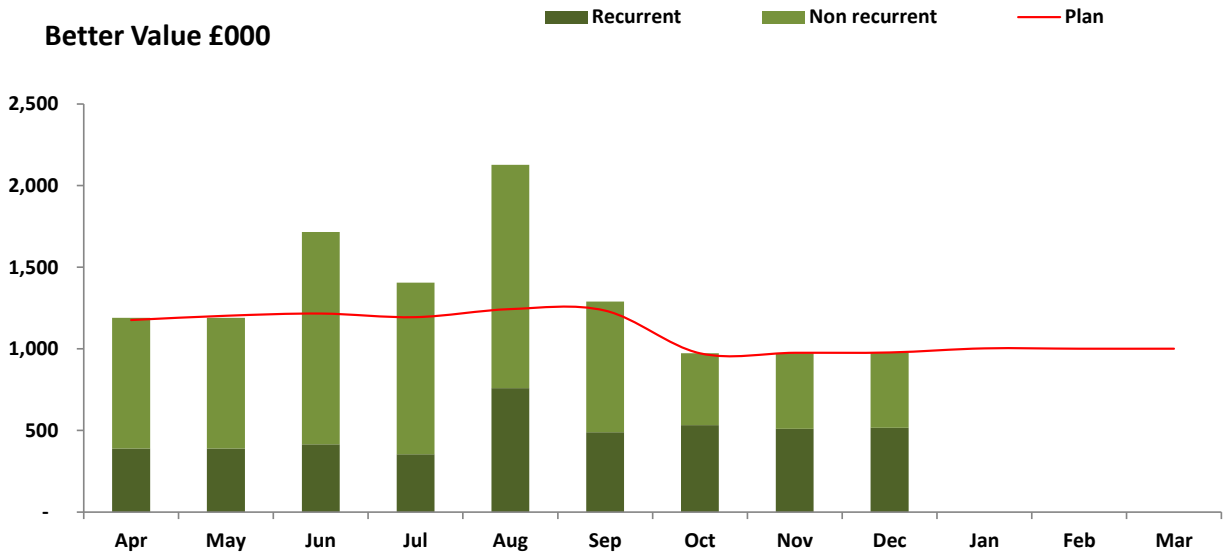


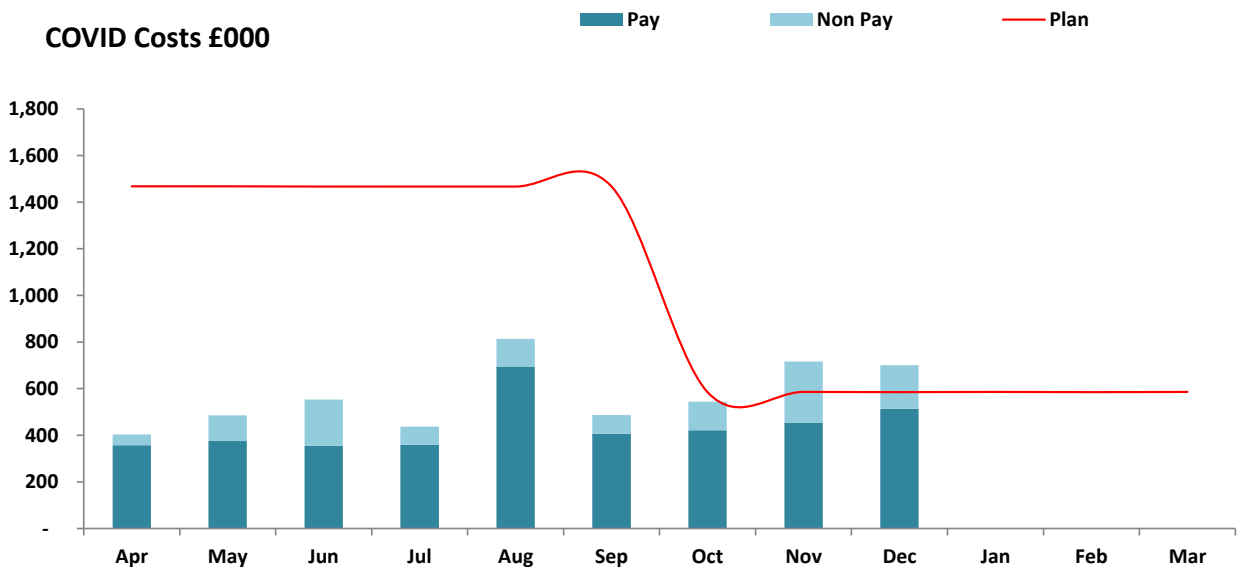




Summary

- Non pay is on plan in-month and £2.6m favourable YTD. The year to date large favourable variance is largely due to drug expenditure being lower than plan linked to lower patient volumes requiring high cost drugs in month.
- The Trust has seen continued payment of private patient aged invoices that have seen a further reduction in impairment of rec eivables in month. The Trust continues to work to collect payment for these invoices and continue to reduce the debt.
- Healthcare from Non NHS bodies was high in M9 due to additional costs associated with external lab testing costs and higher a ctivity for the Anthony Nolan tissue typing. These costs have offset the underspends above.





Better Value and Covid-19 costs

- The Trust has a better value programme plan for H2 of £5.9m as per the new H2 plan submission. The Trust has achieved £11.9m of better value savings YTD largely through controlled spend both recurrently and non-recurrently. The Trust continues to work on better value schemes despite the reported numbers reflecting a reduced plan from that in H1.

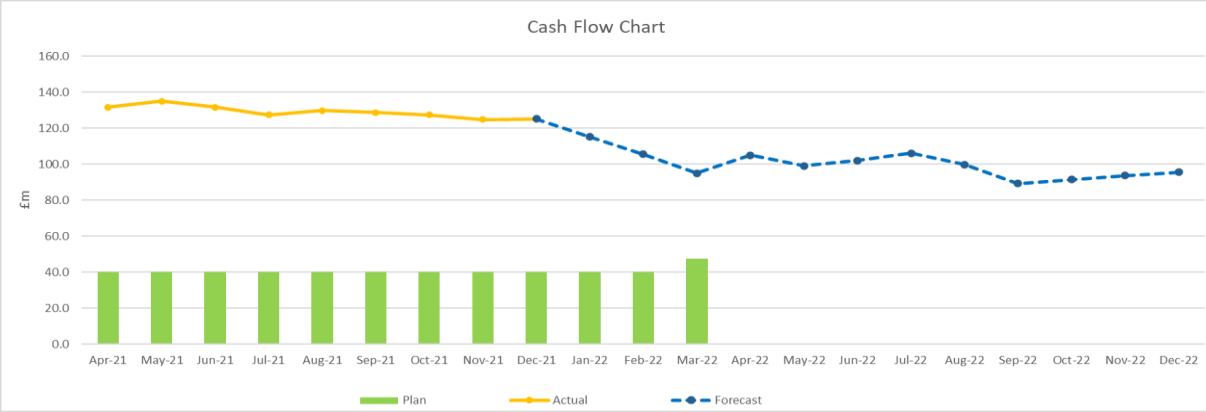
- Covid costs YTD have totalled £5.1m largely for additional staffing needs to meet the covid response and a variety of non-pay spends including decontamination, lab and consumables spend. These costs have risen with the Omicron variant and the additional costs incurred by the Trust to maintain services.

31 Mar 2021 Audited Accounts £m	Statement of Financial Position	YTD Actual 30 Nov 21 £m	*YTD Actual 31 Dec 21 £m*	In month Movement £m
532.75	Non-Current Assets	525.37	525.25	(0.12)
64.56	Current Assets (exc Cash)	70.20	73.40	3.20
126.19	Cash & Cash Equivalents	124.84	125.16	0.32
(102.80)	Current Liabilities	(105.32)	(111.18)	(5.86)
(6.45)	Non-Current Liabilities	(5.98)	(5.94)	0.04
614.25	**Total Assets Employed**	**616.18**	**606.69**	**(2.42)**

31 Mar 2021 Audited Accounts £m	Capital Expenditure	YTD plan 31 December 2021 £m	YTD Actual 31 December 2021 £m	YTD Variance £m	Forecast Outturn 31 Mar 2022 £m	RAG YTD variance
6.50	Redevelopment - Donated	5.80	7.32	(1.52)	9.19	A
2.56	Medical Equipment - Donated	0.75	1.00	(0.25)	2.67	A
0.00	ICT - Donated	0.00	0.02	(0.02)	0.02	G
9.06	**Total Donated**	**6.55**	**8.34**	**(1.79)**	**11.88**	A
0.00	**Total Grant funded**	**0.20**	**0.00**	**0.20**	**0.37**	R
5.09	Redevelopment & equipment - Trust Fund	5.88	3.79	2.09	10.89	A
1.10	Estates & Facilities - Trust Funded	4.62	0.59	4.03	1.58	R
2.67	ICT - Trust Funded	1.05	1.39	(0.34)	4.00	A
0.00	Sensyne	0.00	0.00	0.00	1.23	G
0.00	Contingency	0.00	0.00	0.00	0.00	G
0.00	Disposals	0.00	0.00	0.00	(0.22)	G
0.00	Accelerator programme (Trust funded)	0.00	0.15	(0.15)	0.19	G
8.86	**Total Trust Funded**	11.55	5.92	5.63	17.67	R
2.56	**PDC**	**0.00**	**0.00**	**0.00**	**1.40**	G
20.48	**Total Expenditure**	**18.30**	**14.26**	**4.04**	**31.32**	A

31-Mar-21	Working Capital	30-Nov-21	31-Dec-21	RAG	KPI
5.0	NHS Debtor Days (YTD)	3.0	4.0	G	< 30.0
288.0	IPP Debtor Days	74.0	80.0	G	< 120.0
27.1	IPP Overdue Debt (£m)	12.1	10.1	R	0.0
95.0	Inventory Days - Non Drugs	89.0	94.0	R	30.0
31.0	Creditor Days	20.0	22.0	G	< 30.0
41.6%	BPPC - NHS (YTD) (number)	40.4%	41.9%	R	> 95.0%
70.6%	BPPC - NHS (YTD) (£)	70.4%	72.3%	R	> 95.0%
83.4%	BPPC - Non-NHS (YTD) (number)	84.1%	84.0%	R	> 95.0%
88.9%	BPPC - Non-NHS (YTD) (£)	91.8%	92.2%	A	> 95.0%
81.7%	BPPC - Total (YTD) (number)	82.0%	82.1%	R	> 95.0%
87.4%	BPPC - Total (YTD) (£)	89.8%	90.4%	G	> 95.0%

RAG Criteria:
NHS Debtor and Creditor Days: Green (under 30); Amber (30-40); Red (over 40)
BPPC Number and £: Green (over 95%); Amber (90-95%); 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 year to 31 December was £4.0 less than plan; Trust-funded expenditure was £5.6m less than plan; donated was £1.8m more than plan; grant-funded £0.2m less than plan. Priority projects have been identified for approval at EMT to achieve a forecast Trust funded outturn of £0.3m less than plan. The Trust-funded programme now includes the Accelerator Programme for which additional CDEL will not be allocated. £1.4m of PDC has been allocated to the Trust for Targeted Investment Fund projects and NCL programmes.
2. Cash held by the Trust increased by £0.3m to £125.2m.
3. Total Assets employed at M09 decreased by £2.4m in month as a result of the following:
   - Non current assets decreased by £0.1m to £525.3m.
   - Current assets excluding cash totalled £73.4m, increasing by £3.2m in month. This largely relates to the following: Contract receivables including IPP which have been invoiced (£1.3m higher in month); accrued income (£0.8m higher in month); other receivables (£0.5m higher in month; capital receivables was £0.2m higher in month and inventories was £0.4m higher in month.
   - Cash held by the Trust totalled £125.2m, increasing in month by £0.3m.
   - Current liabilities increased in month by £5.8m to £111.2m. This includes Capital creditors (£1.2m higher in month); expenditure accruals (£1.3m higher in month); and deferred income (£2.6m higher in month) and NHS payables (£1.3m higher in month). This is offset against the decrease in Other payables (£0.6m lower in month).
4. IPP debtors days increased in month from 74 to 80. Total IPP debt (net of cash deposits held) increased in month to £8.4m (£7.7m in M08) as a result of increased billing in December. Overdue debt decreased in month to £10.1m (£12.1m in M08) due high levels of payment from embassies.
5. In M09, 82% of the total number of creditor invoices were settled within 30 days of receipt; this represented 90% of the total value of creditor invoices paid in month. This was below the NHSE target of settling at least 95% of invoices within 30 days.
6. By supplier category, the cumulative BPPC for Non NHS invoices (by number) remained the same as the previous month at 84%. This represented 92% of the total value of invoices settled within 30 days (92% in M08). The cumulative BPPC for NHS invoices (by number) was 42% (40% in M08). This represented 72% of the value of invoices settled within 30 days (70% in M08). These scores by supplier category are also both below the NHSE target of settling 95% of invoices within 30 days.
7. Creditor days increased in month from 20 days to 22 days.

Attachment K

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
2nd February 2021

Safe Nurse Staffing Report for reporting period Oct & Nov 21 **Submitted by: Darren Darby, Acting Chief Nurse.** **Prepared by: Marie Boxall, Head of Nursing - Nursing Workforce**	**Paper No: Attachment K** **□ For information and noting**

Purpose of report

To provide the Board with an overview of the nursing workforce during the months of Oct & Nov 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

- 57 international nurses have joined the Trust to date
- 16 Newly Registered Practitioners (nurses) joined the Trust in January with a further 19 scheduled to join the trust in April 22.
- The Trust nursing vacancy rate decreased to 1.01% in Oct and rose to 1.2% in Nov. with voluntary turnover rates remaining stable and below Trust target at 12.75% in Oct and 12.76% in Nov.
- Despite low vacancy rates and stable turnover rates, staffing levels remain challenged by high sickness (4.9% Nov) and increasing maternity/parenting rates (5.5% Nov).
- There were 13 safe staffing incidents over the reporting period 10 (Oct) and 3 (Nov) with no reported patient harm. This was predominantly driven by short term sickness and Covid self-isolation requirements.
- The reported Care Hours Per Patient Day (CHPPD) was 16.22 in Oct. and 15.61 in Nov.
- The biannual Safe Staffing Establishment review process has commenced in January and will be reported to board in April.

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 21/22 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

1. Purpose

The purpose of this report is to provide 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 October and November 2021.

2. Staffing Assurance Framework for Winter 2021/22 preparedness guidance

Throughout the pandemic GOSH nursing staff have been required to work in new ways and in different wards, departments and organisations. At times, it has also required nursing staff to work in environments and with patient groups that may be unfamiliar. We follow NHSE/I principles and Nursing and Midwifery Council (NMC) regulatory guidance to support our response and maintain safe staffing measures as outlined in the previous reports, and the Staffing Assurance framework for Winter 2021/22 preparedness guidance which was published in November 2021.

3. Recruitment

We continue to maintain several centralised recruitment pipelines to ensure the resilience and sustainability of our nursing workforce, especially as restrictions lift. This is in addition to local recruitment led by clinical teams for specific roles.

Recruitment Pipelines

- 16 Newly Registered Nurses (NRNs) commenced employment in January, with a further 19 NRNs planned to commence in April. Planning and recruitment are currently underway for the next intake in Oct 2022.
- 10 Health Care Support Worker Apprenticeships commenced employment end of January 2022
- 57 internationally recruited (IR) nurses have joined the trust to date:
  Cohort 5: Seven nurses arrived in October 2021 and have completed their OCSE exam in December. They are ready to commence work in their clinical areas as Band 5 RNs in January 2022.
  Cohort 6: 11 nurses arrived in January 2022. OSCE tests are booked for beginning of March 2022 and expected to be working as Band 5 RNs in their clinical areas at the end of March 2022.
- New IR nurse campaign commencing with Capital Nurse Consortium with an aim of 20 nurses per intake three times per year, every January, May and Sept, commencing May 2022.

4. Vacancy and Turnover Rates

The Trust nursing vacancy rate decreased in Oct 2021 to 1.01% but then increased slightly to 1.20% in Nov. Voluntary turnover has remained stable and below the trust target, at 12.75% (Oct) and 12.76% (Nov).

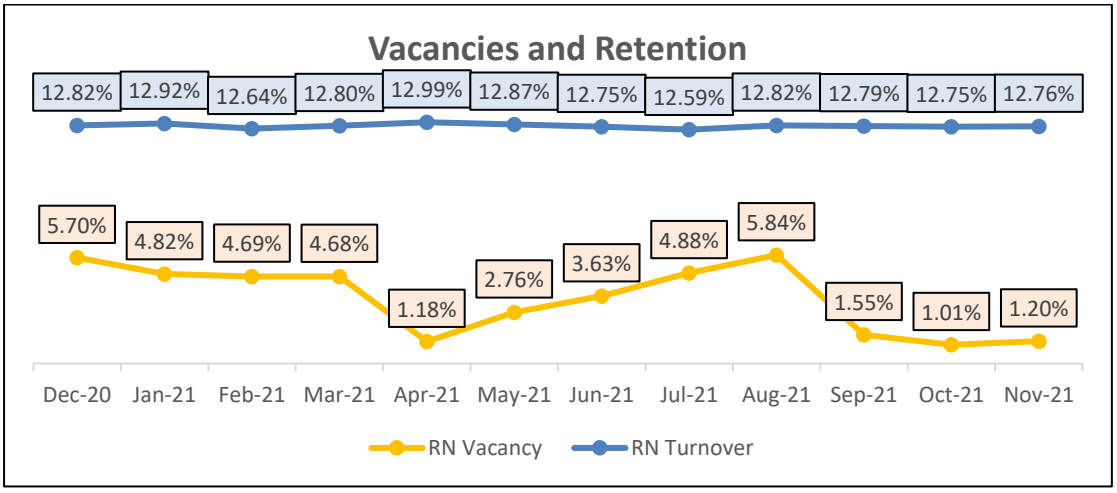
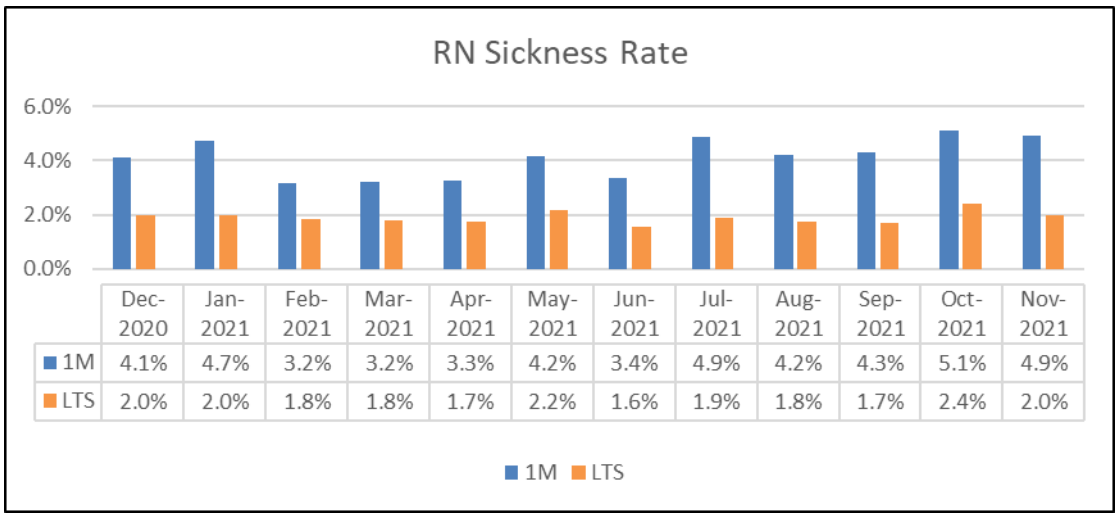


Fig.1 Registered Nurse vacancy and voluntary turnover rate (12-month view)

5. Unavailability

As reported previously, despite low vacancy rates and stable turnover rates, staffing levels remain challenged by high sickness (4.9% Nov) and increasing maternity/parenting rates (5.5% Nov). Clinical teams responded effectively to maintain safe staffing levels through deployment, working additional bank shifts and ward/team mergers. Active recruitment continues and teams are being encouraged to explore innovative ways to address absences including internal transfers, secondments and development opportunities rather than relying wholly on temporary staffing. Heads of Nursing are also advised to review their unavailability ahead of roster 'sign off' to ensure headroom is being maintained.



	Dec-2020	Jan-2021	Feb-2021	Mar-2021	Apr-2021	May-2021	Jun-2021	Jul-2021	Aug-2021	Sep-2021	Oct-2021	Nov-2021
1M	4.1%	4.7%	3.2%	3.2%	3.3%	4.2%	3.4%	4.9%	4.2%	4.3%	5.1%	4.9%
LTS	2.0%	2.0%	1.8%	1.8%	1.7%	2.2%	1.6%	1.9%	1.8%	1.7%	2.4%	2.0%

Fig.2 Short term (1m) and Long-Term Sickness (LTS) 12 month rolling trend.

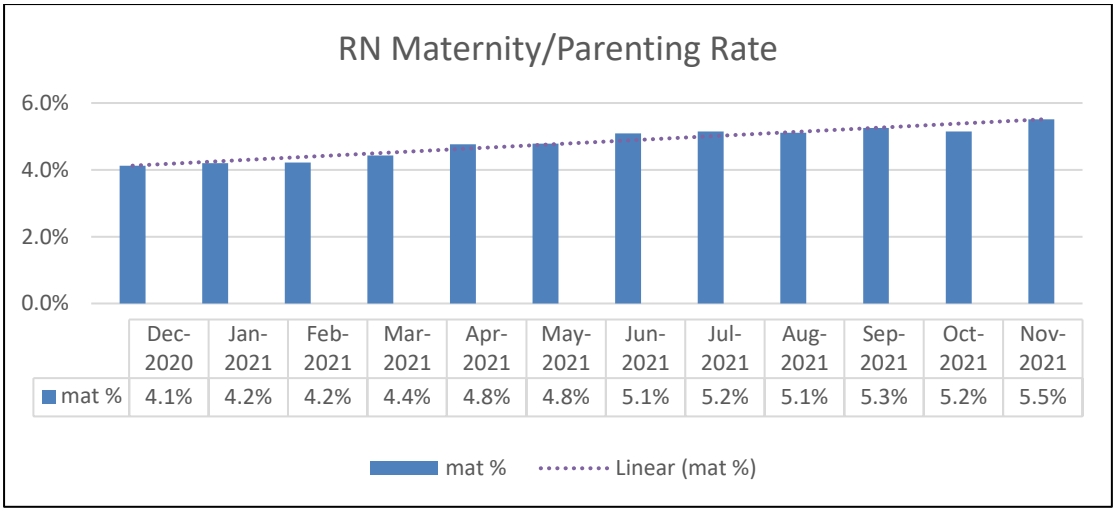


Fig.3 Maternity/parenting rates (12 month rolling trend)

6. Temporary Staffing

The total number of shifts requested, excluding those requested then subsequently cancelled, decreased in November to 2033 from the previous month which was 2288 (October). Temporary staff usage is monitored and scrutinised at the monthly Nursing Workforce Assurance Group (NWAG) with over a 20% reduction in the number of requests compared to the same period in the previous year. Shifts filled by bank have increased by 2% from 83% (October) to 85% (November) in this period.

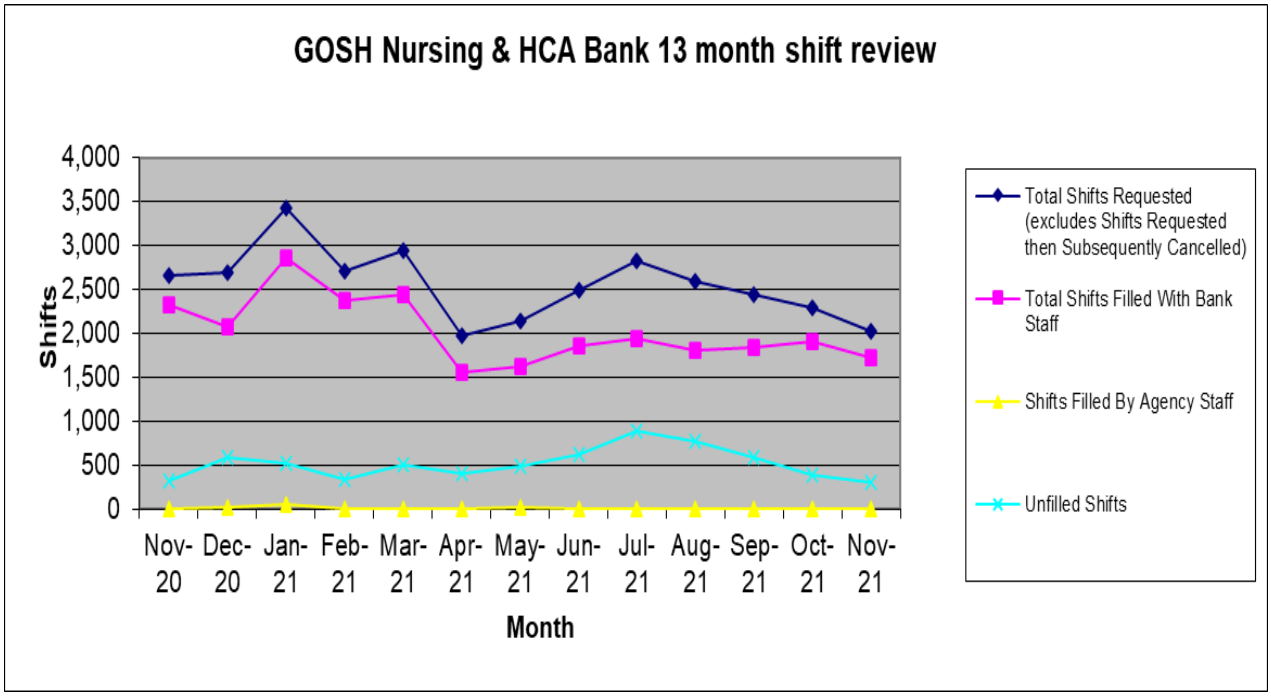


Fig.4 Temporary nursing staff bank shift requests

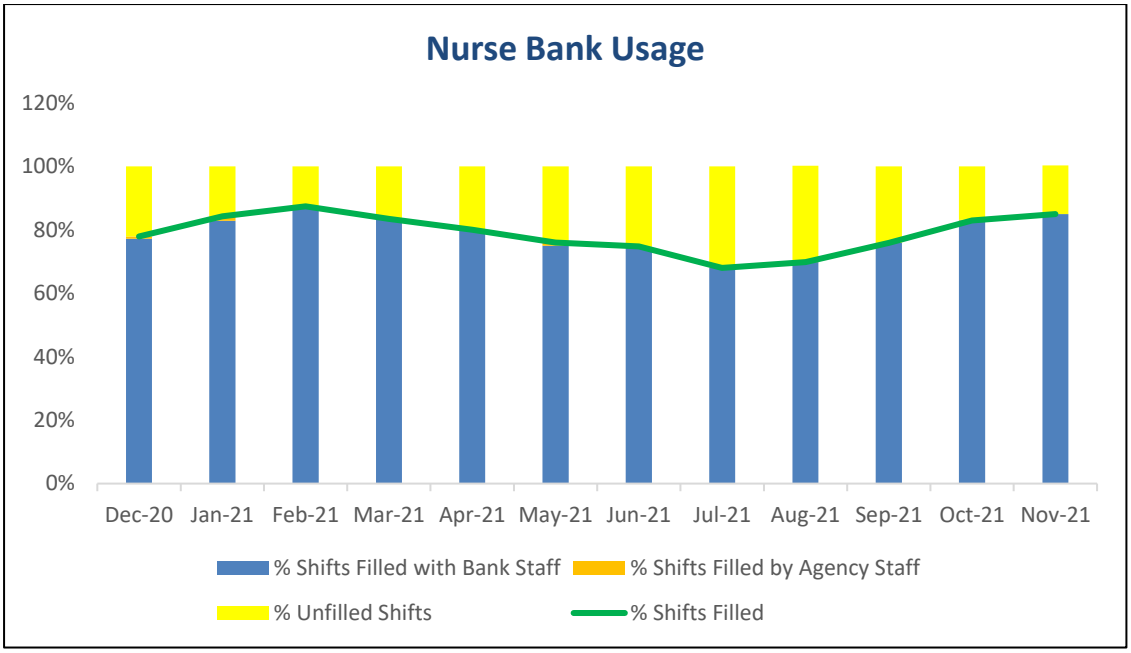


Fig.3 Nurse Bank Usage (12 month view)

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/units including the ICUs, where patients stay overnight. CHPPD included ICUs as of April 2021 hence the noticeable increase.

The reported CHPPD for October 2021 was 16.22 made up of 14.06 Registered Nurses and 2.16 HCA Hours. In November 2021 the figure was 15.61 in total, 13.71 Registered Nurses and 1.90 HCA Hours.

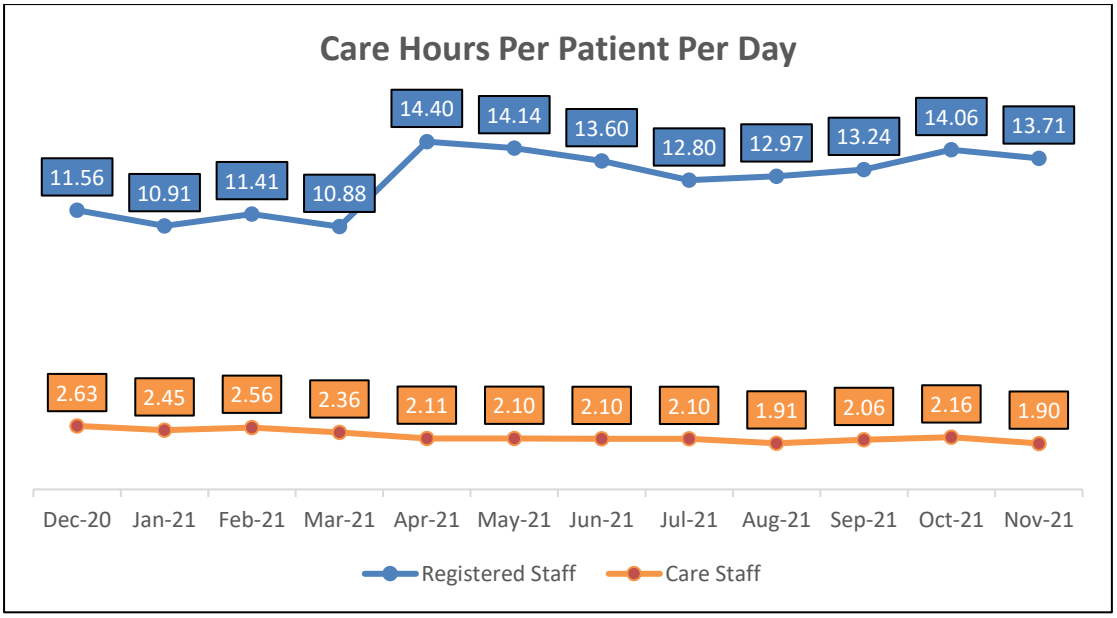


Fig. 4 Care Hours per Day – Breakdown (12 month view)

8. Safe Staffing Incident Reporting

There were 10 Datix reports in relation to staffing levels in October; 2 O&I, 3 H&L, 3 BCC, 1 Brain, and 1 BBM. In November there were 3 Datix incidents; 1 O&I, 1 BCC and 1 H&L. There were no datix reports from IPC and S&S.

Assurance has been provided by the HoNs that no patient harm occurred and plans to mitigate the ever-changing challenges as a result of the pandemic are under constant review. The incidents were predominantly driven by short term sickness, high maternity rates, Covid isolation requirements and planned annual leave.

9. Safe Staffing Establishment Reviews

The Safe Staffing Establishment review process will commence this month with the Safer Nursing Care Scoring exercise being undertaken on the wards over the coming weeks. The outcome of the review will be reported to Trust Board in April 2022.

Appendix 1 – Oct and Nov 2021 Workforce metrics by Directorate

Oct-21						
Directorate	**CHPPD (Inc ICUs)**	**Actual vs Planned**	**RN Vacancies (FTE)***	**RN Vacancies (%)***	**Voluntary Turnover* %**	**Sickness (1 mo) %**
Blood, Cells & Cancer	12.6	70.9%	0.7	0.3%	10.9%	7.8%
Body, Bones & Mind	14.2	84.5%	-3.1	-1.6%	9.7%	4.7%
Brain	13.0	75.4%	-2.5	-1.9%	11.5%	2.6%
Heart & Lung	21.6	82.7%	-5.8	-1.1%	14.9%	3.8%
International	16.2	63.0%	-3.3	-4.1%	14.9%	4.6%
Operations & Images	N/A	N/A	6.0	2.4%	12.2%	7.3%
Sight & Sound	12.3	88.2%	7.3	9.0%	16.4%	1.6%
Research & Innovation	N/A	N/A	14.7	24.9%	15.6%	4.4%
Trust	16.2	78.2%	13.2	1.0%	12.7%	5.1%

**Relates to all RN grades. Trust totals within the narrative may include nursing posts from some other directorates not listed in the above tables. High vacancy rates in R&I are due to reduced activity as staff are recruited on the basis of funded activity as needed.*

Nov-21						
Directorate	**CHPPD (Inc ICUs)**	**Actual vs Planned**	**RN Vacancies (FTE)**	**RN Vacancies (%)**	**Voluntary Turnover* %**	**Sickness (1 mth) %**
Blood, Cells & Cancer	12.7	71.3%	2.6	1.1%	11.7%	6.7%
Body, Bones & Mind	12.9	87.3%	-5.1	-2.6%	8.6%	4.9%
Brain	12.8	78.8%	-1.1	-0.8%	13.0%	4.4%
Heart & Lung	20.4	86.1%	-6.8	-1.3%	14.6%	4.9%
International	17.0	63.7%	-3.8	-4.7%	15.0%	3.1%
Operations & Images	N/A	N/A	7.3	2.9%	12.6%	5.7%
Sight & Sound	12.5	94.2%	6.5	8.0%	15.1%	2.0%
Research & Innovation	N/A	N/A	14.7	24.9%	15.7%	7.1%
Trust	15.6	80.6%	16.4	1.2%	12.8%	4.9%

**Relates to all RN grades. Trust totals within the narrative may include nursing posts from some other directorates not listed in the above tables. High vacancy rates in R&I are due to reduced activity as staff are recruited on the basis of funded activity as needed.*

Attachment L

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 2nd February 2022	
Guardian of Safe Working report **Submitted by:** Dr Renée McCulloch, Guardian of Safe Working	**Paper No: Attachment L**
Aims / summary This report is the combined Q2 and Q3 report of 2021/22 to the Board regarding Junior Doctor working practice at GOSH. This report covers the period 1st July to 31st December 2021 inclusive.	
Action required from the meeting • Note requirement for ongoing data cleansing and finance review of junior doctor budgets • Requirement for administrative support for the GOSWH	
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 • COVID response is ongoing. Costings related to the junior doctor workforce are monitored. • Continuing payment for overtime hours is documented through the exception reporting practice	
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 Blackburn Deputy Medical Director for Medical & Dental Education	
Who is accountable for the implementation of the proposal / project? Dr Sanjiv Sharma, Medical Director	

Attachment L

Guardian of Safe Working
Q2 and Q3: 1st July 2021 – 31st December 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.

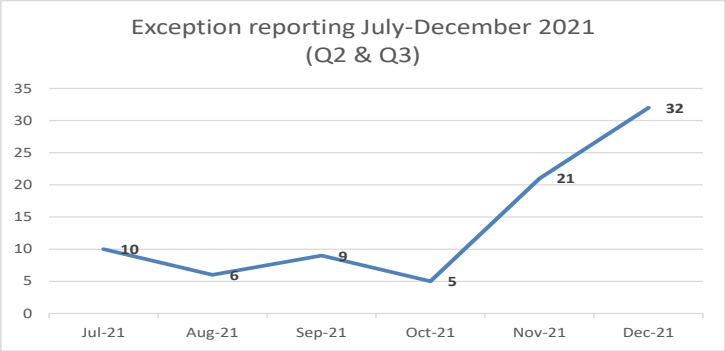
2 Background

See Appendix 1

3 Exception Reporting (ER): High Level Data

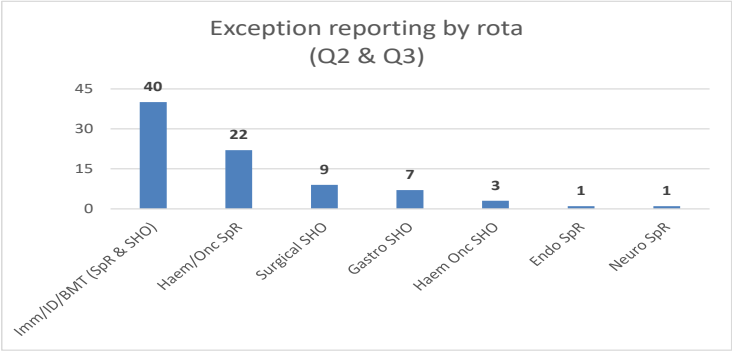
3.1 Number of exception reports (ER) at GOSH remain low reflecting cohort a) senior trainees b) non-UK Trust doctors c) poor engagement with ER system

3.2 Average exceptions per month increased from Q1 (8 per month to 13.8 per month)



3.3 83 ERs submitted in the period July to December (quarterly average 41.5)..

- 73 ER: extra hours worked.
- 8 Service Support
- 1 Educational access
- 1 Pattern of work
- 22 doctors submitted the reports (15 SPR, 7 SHO)
- 3 doctors reported more than 10 times each in the period
- 1 doctor submitting 17 ERs on one day (retrospective reporting)
- ER reports across 7 rotas – majority BMT/ Immunology. Active intention to report in BMT, Immunology and Infectious Disease to support evidence for establishment expansion



3.4 **Q2 & 3 ER Quotes**

- *Had to work longer hours as insufficient support on BMT rota today*

- *No time to document during long day (many queries, two sick patients, needed to sort medication and finalised discharge summary for a patient) needed to stay an hour later to finalise documentation from shift.*
- *Early start to consent and clerk patient for procedure arranged by CNS.*
- *There was a protected teaching session which we attended, so I needed to stay back to compensate and finish my notes and some jobs …not fair to leave for the long day person who was busy answering external calls since the moment the handover finished*
- *Once again, bone marrow transplant is an area with complex patients that need liaison between several teams, organising things and an evolving plan during the day, which sometimes makes it hard to get everything done in time.*

3.5 **Exception Report Outcomes:**

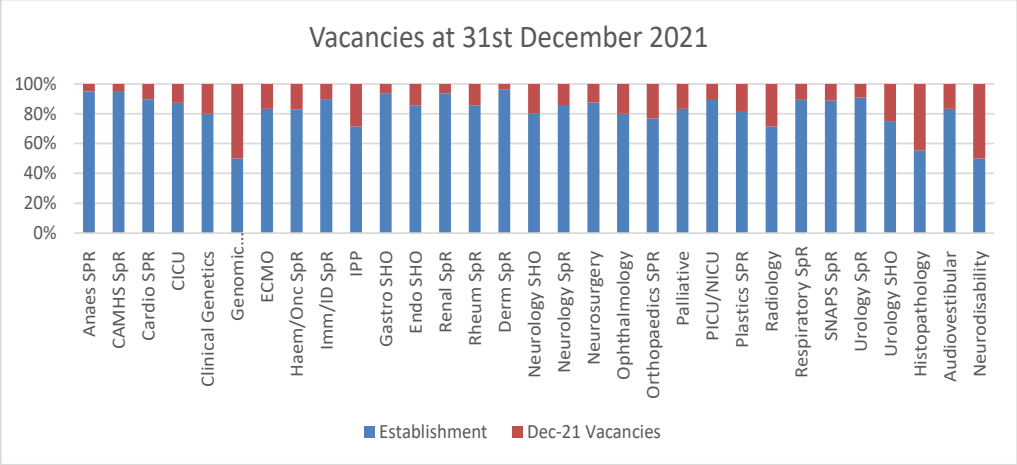
Outcome	Outcome
Initial decision upheld	9
No further action	4
Organisation changes, Payment	1
Payment	39
Prospective changes to work schedule	1
TOIL	8
Organisation changes, Payment, TOIL	2
Prospective changes to work schedule, Payment	4
Payment and unresolved (but closed)	15
Grand Total	83

3.6 **Action:**

3.6.1 Immunology and Bone Marrow Transplant – increased to establishment of 9 doctor in progress from March 2022.

4 Vacancy Rates

4.1 The overall vacancy rate across junior doctor rotas as of 31st December is 11% with 41.9 FTE vacant out of a total of 369 FTE establishment. This is an increase of 1.9% since September 2021 (9.4%)



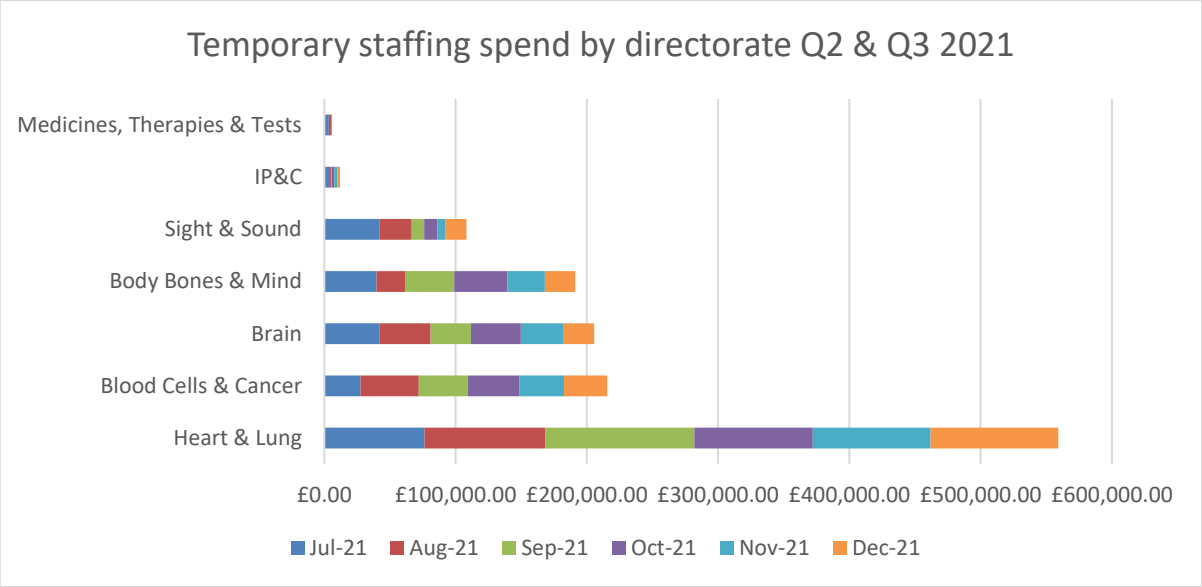
5 Finance, Bank and Agency data

5.1 The Trust spent £1,309,936.65 on Junior Dr temporary staffing in Q2 & 3. This was an increase from Quarter 1 (5.9%). Of this £1,249,956.26 (95.5%) was Bank spend while £59,980.39 (4.5%) was Agency.

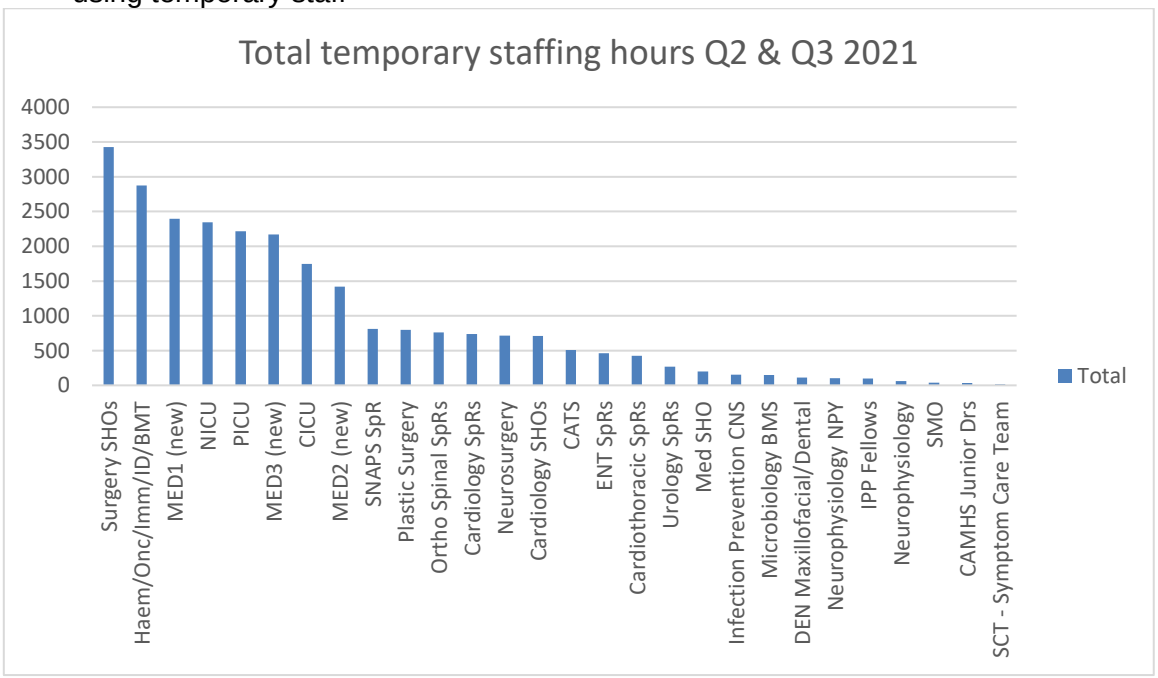
5.2 Salary savings from vacancy are not offset in these figures.

5.3 COVID related absence resulted in a £107,743.16 (8.25%) bank spend; highest in Q3

5.4 Heart and Lung have the highest directorate spend but include ICUs, CATs, cardiac service.



5.5 When looking at shifts booked in the period, Surgical SHO rota was the most frequent rota using temporary staff



5.5.1 The surgical SHO rota is under review by the medical workforce team and surgical specialities - minimum numbers are inadequate for specialty cross cover and use of bank and agency has been required. Currently modelling new rota solutions.

5.5.2 Immunology/ Infectious Disease had 43% vacancy in September/ October. Out of hours bank work was covered internally.

5.5.3 ICU specialties have had some staffing issues in part caused by delays in doctors on boarding.

5.5.4 Flexibility and safe medical cover afforded by the 'medical' team out of hours during COVID is reflected in the MED1 MED 2 MED 3 SMO bank spend. Note any gaps were proactively filled in December in anticipation of short notice, unexpected COVID absence.

6 Ongoing Compliance Issues with 2016 TCS: Implementation of the New Amendments October 2019 – August 2020:

6.1 Rotas are compliant but there are 'pressure points' as seen in Surgical SHO and Imm / ID rotas.

6.2 The GOSWH continues to have no formal administrative support. Raised with medical HR who are currently reviewing their service.

7 Junior Doctors Forum (JDF)

7.1 We have a new JDF President Cara Morgan (Pulmonary Hypertension Fellow)

7.2 JDF have a proposal for new bank rates – still awaiting discussion

8 Summary

8.1 All GOSH rotas are compliant – challenges continue with respect to vacancy management and unexpected gap from vacancy and sickness related issues.

8.2 The medical workforce, consultants and junior doctors, escalated a rapid, unified and organised response to COVID related absence for the precipitous Omicron surge. Complete data set will be in Q4 report.

8.3 Workforce data cleansing, monitoring and improvement work is ongoing.

8.4 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.

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.

Attachment M

Great Ormond Street Hospital for Children
NHS Foundation Trust

Summary of the Quality, Safety and Experience Committee meeting held on 20th January 2022

Quality and Safety at GOSH

Discussion took place about the way in which the committee could support the Trust's aim to improve the fundamental areas of operation and how an overview of areas such as complaints, incidents and PALS contacts would move towards this goal, rather than reviewing cases individually. It was noted that there had been a very high staff absence rate during the most recent surge of the COVID19 pandemic and it was confirmed that the Trust had been able to revert to the plans that had been in place during the initial surges of the pandemic. Planned activity had already been reduced in order to support staff to take annual leave over the Christmas holidays. Positive patient and family feedback had also been received.

The Committee discussed a potential amendment to the Health and Social Care Bill as a result of 'Charlie's Law' and highlighted that work was taking place to publish the Trust's experience of best interest court applications.

A substantial piece of work would take place to consider the safest way in which paediatric HDU services should be provided. This would be managed by the transformation team and would involve significant stakeholder engagement.

Emerging Significant Risks

The Committee discussed the work that was taking place around Duty of Candour and whether this would move the Trust to the required position. The progress so far was noted and the committee requested that future papers set out the timeline for improvement which could be monitored to identify whether actions were having the required impact. Early indications of results from the staff survey showed that metrics which were used as a proxy for the safety of an organisation had increased by 5% which was positive.

Medicines Management Update (BAF Risk 11: Medicines Management)

A shadow Chief Pharmacist was in post and would take up the substantive role on 1st February 2022. The MHRA had removed the GOSH's critical finding however the Inspection Action Groups (IAG) had written to the Trust asking that an assessment of the improvement plan was undertaken by an independent third party and this was in progress.

Patient Safety Delivery Plan

A large number of workstreams were in place with metrics linked to each and a patient safety implementation board was being developed which would include representation from NHS England and the Integrated Care System (ICS). A board development session later in the year would focus on this work. The Committee noted the considerable work involved in the programme and emphasised the importance of monitoring progress.

Learning Disabilities and Autism Update

Key challenges related to ensuring that staff had the confidence and capability to meet the needs of children and young people with learning disabilities or autism. The Committee expressed some concern about the work around Deprivation of Liberty (DoL) Assessments being handed over from the safeguarding team to the learning disabilities team and the impact on capacity of that team but it was confirmed that the safeguarding team would continue to lead on this work.

Update on Actions from Patient and Family Feedback including Update from the Patient Family Experience and Engagement Committee (PFEEC)

The CQC patient survey had found GOSH to be an outlier in providing a better experience than expected. Improvements were also noted in feedback being received from patients and families and PALS contacts related to communication were reducing. A new Transition Manager had joined the Trust and the committee emphasised the importance of this area of work.

Update on work of the Patient Safety and Outcomes Committee (PSOC)

Discussion took place around the number of deaths which had increased in recent reporting periods. It was confirmed that deaths were reviewed both locally and nationally and deaths in ICU were monitored by PICANET which developed a standardised mortality rate. GOSH was within nationally accepted levels and no commonalities had been identified from local reviews.

Tissue Damage Injuries

There had been an increase noted in tissue damage injuries in October 2021. No themes had been identified and incidents had since reduced. Some learning had been identified which had been shared with Head of Nursing and Tissue Viability Nurses. No concerns had been identified around staffing at the time of the incidents.

Safeguarding Update

The safeguarding training programme was being reviewed to ensure that it was wide-ranging and innovative and the programme for doctors in training was being reviewed to ensure it was appropriate. Focus was being placed on delivering standardised supervision to ensure that staff felt confident to manage these cases. An external review of the safeguarding service was being put out to tender and it was anticipated that it would begin in April 2022.

Update from the Ethics Committee

A draft terms of reference was under review for an external review of the Committee. Financial support was being discussed with the Director of Grants and Impact at the GOSH Children's Charity with a view to implementing a three-year improvement programme.

Internal Audit Progress Report (Quality focused reports)

It had been agreed that the reporting of the review of IT Data Security and Protection Toolkit would be delayed to early 2022/23. There were no overdue actions related to reviews within the QSEAC's remit.

Clinical Audit Update

The Trust continued to be compliant against all mandatory national audits and the team was on target to complete 100 clinical audits in 2021/22 which was excellent progress.

Update from the Risk Assurance and Compliance Group on the Board Assurance Framework

An internal audit on the management of strategic risks and the BAF had provided a rating of 'significant assurance' which was an excellent outcome.

- Update on compliance with policies

Currently 88% of policies were in date and discussion was taking place with policy authors to appropriately reduce the number of policies.

QSEAC Annual Effectiveness Survey Questions

Questions were in line with those of the previous year in order to compare results. The Committee agreed the questions to be used.

Whistleblowing update

Two cases had been raised under the whistleblowing policy. They had been investigated and it had been found that neither involved patient safety concerns.

Freedom to Speak Up Guardian Update

Individuals using the service had expressed concern about alleged detriment being caused to them as a result of speaking up. The importance of acting on concerns raised and being consistent over time was emphasised in order to give staff confidence.

Health and Safety Update

Additional resource in procurement to support safer sharps was being recruited which was positive. Risk assessments were in place in the interim however it was vital to ensure that safer sharps products could be procured as quickly as possible.

The Committee noted the update of the December meeting of the People and Education Assurance Committee.

Governor feedback

Governors discussed the importance of patient and carer feedback and experiences when considering delivery of learning disability services and the importance of the work underway with transition.

Finance and Investment Committee Update

The Finance and Investment Committee (FIC) held a regular scheduled meeting on Monday 22 November 2021.

Key issues

Finance report month 7

At Month 7, the Trust's performance showed a deficit of £3.2m in-month. This was £2.3m adverse to the approved plan.

The Committee discussed how variances in Elective Recovery Fund (ERF) and COVID spend could affect the Trust's year end position.

The Chair noted that a key challenge moving forward was prioritising the costs of sustainability given the activity and income uncertainty.

The Chief Finance Officer presented key updates on NHS system changes (the White Paper).

Integrated Performance Report Month 8

The Trust continued to perform broadly in line with planned activity levels following the COVID-19 activity reductions. Work was ongoing to clear the backlog of patients.

2021/22 Annual Plan update

The Committee received an update on the business planning process for 2022/23, including budget setting and the progress made to date.

Sustainability reset paper

The Committee received an oversight of the sustainability programme structure, highlights and priorities.

Potential Increases in Energy Costs

Based on several factors, Trust electricity and gas costs would increase from £4.9m per year to between £8.0m and £8.3m.

The Committee agreed that reducing energy should be part of the Trusts green and sustainability plans.

Capital Prioritisation Approach

The Trust's capital programme for 2021/22 addressed the Trust's risks; and, given the limited resource to address these risks, was effective.

Performance review of the in-house cleaning and Security contract

Work was underway with the in-house cleaning team to develop them and create a service that delivered service a tailored to the Trust needs.

The Trust was happy with the new security provider.

CCC and Major Project Update Reports

The Committee received updates on the CCC from the Children's Cancer Centre Delivery Director.

For post implementation reviews, the Committee requested that members of staff are invited to present the item.

Feedback from Governors

The Chair sought feedback from Governors in observance.

End of report

Summary of the Audit Committee meeting held on 21st January 2022

Matters arising

The Committee discussed the improvements which were being made in ICT and the informal support which was being received from an external ICT director. It was noted that good progress had been made which in some areas had exceeded the improvement trajectory and the Committee agreed that the external ICT Director would attend the next Audit Committee meeting to provide feedback in advance of an decision being taken as to whether the service should no longer be considered a service in recovery.

Vaccination as a Condition of Deployment (VCOD)

There were 300 staff at GOSH whose vaccination status was not clear and discussions were taking place with these individuals. It had been agreed that business continuity discussions would take place once the number of impacted staff could be confirmed. It was likely that the impact at GOSH would be substantially less than at other Trusts. Work was taking place to review the impact on contractors.

Trust Board assurance committee updates

Committee noted updates from the following assurance committees:

- Quality, Safety and Experience Assurance Committee –October 2021 and 20 January 2022
- Finance and Investment Committee – November 2021
- People and Education Assurance Committee - December 2021

Board Assurance Framework Update

The Committee discussed recommendations which had been made by the Risk Assurance and Compliance Group (RACG) around consideration as to whether BAF risks continued to represent risks to the GOSH strategy.

- BAF Risk 8: Business Continuity and BAF Risk 9: Estates Compliance

The Committee agreed that the risk would remain on the BAF with and the description would be reworded to acknowledge the ongoing risk to the way in which health services are managed.

- BAF Risk 7: Cyber Security

Discussion took place around whether the work to improve cyber security would result in a reduction to the likelihood of a successful attack or the consequences of an attack. The committee agreed to reduce the risk score to 3L x 5C and noted that the risk remained red rated.

GOSH Learning Academy and Children's Cancer Centre BAF risks

The Committee approved the wording and risk score of the new GOSH Learning Academy (BAF risk 16) and agreed that the Children's Cancer Centre BAF risk (Risk 15) would be reviewed and updated in order to give sight to the different elements of the risk.

- BAF Risk 9: Estates Compliance

The Committee agreed with the recommendation from the RACG that the net score for this BAF risk is moved from 4L x 4L to 5L x 4C on the basis of new information gathered since the last review of the risk.

A copy of the updated BAF is attached at **Appendix 1** for information.

Board Assurance Framework Deep Dives

- BAF Risk 3: Operational Performance

Work would be required on demand and capacity in each specialty and the implications of this for waiting list recovery. Work had begun on collaborations with other organisations in some areas but it was likely that acceleration of this work would be required. It was confirmed that much of the prioritisation work had been built into Epic and this was supporting efforts to focus on high priority patients.

- BAF risk 10: Information Governance

Additional resource in the Information Governance team had led to an improvement in the capacity of the team and the amount of work taking place. It was noted that although staff training levels were high, two incidents had occurred. Further training was required around how information governance was used in practice when interacting with patients and families. The Committee emphasised the importance of taking a realistic view of the service and the work required and requested a dashboard showing the trends in compliance with the different areas of information governance.

BAF Risk 9: Estates Compliance

The Committee welcomed the transparency of the external review of compliance and emphasised the importance of having robust discussions with suppliers and contractors and escalating to the Committee if issues arose in recruiting to gaps in the estates and facilities team. The Committee agreed with the recommendation from the RACG that the net score for this BAF risk is moved from 4L x 4L to 5L x 4C for the current time.

Annual update on emergency planning; fire and business continuity

The Trust was not required to complete any live exercises in 2021/22 as a result of the COVID19 pandemic which was considered a live exercise however training and live exercises had continued to be undertaken. Learning had been identified in terms of a lack of trained loggists in the Trust and a virtual system had been introduced to increase availability and training for additional individuals would be taking place.

Data Quality Update (BAF Risk 5: Unreliable data) – kite-marking focus

New metrics were being developed for the updated Integrated Quality and Performance Report and once this was complete a kitemarking exercise would take place. A data quality score would also be introduced.

Write offs

There had been a substantial increase in write offs of blood and expired drugs from the same period in the previous year as a result of work taking place on the process to identify expired stock in the Robot which was currently manual. The project would be complete by March 2022 following which drugs nearing their expiry date could be identified and used on a more timely basis.

External Audit 21/22 Progress update

Monthly meetings would be taking place with the finance team going forward to address key issues. The interim audit was planned for March 2022 and consideration was being given to whether any matters could be brought forward.

Internal Audit Progress Report (November 2021 – January 2022) and Technical Update including recommendations update

Two final reports were received: Core Financial Controls which provided a rating of 'significant assurance with minor improvement opportunities'; and Strategic Risk Management: BAF which provided a rating of 'significant assurance'. The Committee asked the RACG to consider timelines for completing internal audit recommendations and ensure they were realistic.

Counterfraud Update
A local assignment on secondary employment and working while sick would be taking place and the draft plan for 2022/23 would be presented at the next meeting.

Year-End Update
There had been no material changes to accounting policies.

Updated SFIs and Scheme of Delegation
Updates had been made to reflect changes in key procurement rules.

Credit Note Provision (IFRS 9)
Proposed percentages for debt provisioning had been revised to consider the movement in trading over the last 12 months. The Committee approved the proposed provisioning policy and welcomed the continued reduction in overdue debt. They noted that as the debt reduced is was likely to be increasingly challenging to recoup.

Raising Concerns in the Workplace Update
The Committee noted the current cases. Further work was required to ensure there was clarity around the ways in which staff could raise concerns.

Audit Committee Effectiveness Survey – review of questions
The Committee agreed the questions to be used in the Audit Committee Effectiveness Survey.

Updated Assurance and Escalation Framework
The Committee approved the updated framework.

Procurement Waivers
The list of waivers was noted.

Any other business
The Internal Audit, External Audit and Counter Fraud contracts had been awarded for a period of 3 years with the option to extend for a further 2 years. It was agreed that an internal and external audit effectiveness review would be undertaken over the next few weeks.

Governor feedback
Discussion took place around staff access to the GOSH network and emails once they had left the Trust in light of staff whose contracts may be terminated as a result of VCOD. It was agreed that this would be considered further outside the meeting.

Great Ormond Street Hospital for Children NHS Foundation Trust: Board Assurance Framework (January 2022)

No.	Short Title	Trust Principle	Trust Priority	Risk type and description	Gross Risk		Net Risk		Risk Appetite	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee	Last Reviewed by Assurance Committee
					L x C	T	L x C	T							
1	Financial Sustainability	**Principle 4: Financial Strength**		Failure to continue to be financially sustainable	5 x 5	**25**	4 x 5	**20**	**Cautious**	1-2 years	Chief Finance Officer	**Helen Jameson, Chief Finance Officer**	05/11/2021	Audit Committee	April 2021 Oct 2021
2	Recruitment and Retention	**Principle 3: Safety and quality**	**Priority 1: Make GOSH a great place to work/ Priority 3: Develop the GOSH Learning Academy**	The risk that the organisation will be unable to recruit and retain sufficient highly skilled staff	4 x 5	**20**	2 x 5	**10**	**Cautious**	1-2 years	Director of HR and OD	**Sarah Ottaway, Associate Director of HR and OD/ Caroline Anderson Director of HR and OD**	11/11/2021	People and Education Assurance Committee	February 2021 March 2021 (TB on GLA) For Feb 2022
3	Operational Performance	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme / Priority 3: Improve and speed up access to urgent care and virtual services**	Failure of our systems and processes to deliver efficient and effective care that meets patient/carer expectations and supports retention of NHS statutory requirements and the FT licence.	4 x 5	**20**	3 x 5	**15**	**Minimal**	1 year	Chief Operating Officer	**Sue Chapman, John Quinn, Rebecca Stevens/ Richard Brown**	15/11/2021	Audit Committee/ QSEAC	January 2021 Audit Committee and QSEAC January 2022
4	GOSH Strategic Position	**All Strategy Principles**	**All priorities**	Failure to optimise the Trust strategy under current and future NHS, financial, political and social frameworks.	**4 x 4**	**16**	**3 x 4**	**12**	**Cautious**	5-10 years	Chief Executive	**Matthew Shaw/ Ella Vallins**	18/11/2021	Audit Committee	Oct 2021
5	Unreliable Data	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme**	Failure to establish an effective data management framework:	4 x 4	**16**	4 x 3	**12**	**Minimal**	1-2 years	Chief Operating Officer	**Richard Brown, Chief Data Officer**	16/11/2021	Audit Committee	January 2021 Oct 2021
6	Research infrastructure	**Principle 3: Safety and quality/ Principle 4: Financial Strength**	**Priority 5: Accelerate translational research and innovation to save an improve lives**	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.	3 x 5	**15**	3 x 4	**12**	**Minimal**	1-2 years	Director, Research & Innovation	**Jenny Rivers, Dep Dir, R&I**	10/11/2021	Audit Committee	April 2021
7	Cyber Security	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme**	The risk that the technical infrastructure at the Trust (devices, services, networks etc.) is compromised via electronic means.	5 x 5	**25**	3 x 5	**15**	**Averse**	1-2 years	Chief Operating Officer	**Mark Coker, Director of ICT/ John Quinn, COO**	9/11/2021	Audit Committee	January 2021 May 2021 Oct 2021
8	Business Continuity	**Principle 3: Safety and quality/ Principle 5: Protecting the Environment**	**Priority 2: Deliver a Future Hospital Programme**	The trust is unable to deliver normal services and critical functions during periods of significant disruption. Due to: Gaps in planning, logistical challenges or unexpected events causing difficulties for staff and patients. Impact: An adverse effect on the trust's operational performance	4 x 5	**20**	4 x 3	**12**	**Averse**	1 year	Chief Operating Officer	**Rachel Millen, Emergency Planning Officer/ John Quinn, Chief Operating Officer**	02/11/2021	Audit Committee	January 2021
9	Estates Compliance	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme**	Inadequate maintenance of the estate affects the safety of the environment in which care is delivered by staff to patients and carers.	**5 x 4**	**20**	**5 x 4**	**20**	**Averse**	1 year	Director of Estates, Facilities and Built Environment	**Zoe Asensio-Sanchez, Director of Estates, Facilities and Built Environment/ Bryony Freeman**	10/11/2021	Audit Committee	October 2021

No.	Short Title	Trust Principle	Trust Priority	Risk type and description	Gross Risk		Net Risk		Risk Appetite	Mitigation time horizon	Executive Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee	Last Reviewed by Assurance Committee
					L x C	T	L x C	T							
10	Information Governance	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme**	Personal and sensitive personal data is not effectively collected, stored, appropriately shared or made accessible in line with statutory and regulatory requirements.	4 x 5	**20**	3 x 5	**15**	**Averse**	1 year	Chief Operating Officer	**John Quinn, Chief Operating Officer / Julian Marku, Head of Information Governance**	07/01/2022	Audit Committee	January 2021 April 2021 (SARS) Oct 2021 January 2022
11	Medicines Management	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme**	Medicines are not managed in line with statutory and regulatory guidance (procuring, storing, prescribing, manufacturing and giving of medicines (including self-administration)) and that processes are not appropriately documented or monitored.	5 x 5	**25**	4 x 5	**20**	**Averse**	1-2 years	Chief Operating Officer	**Steve Tomlin, Chief Pharmacist/ Nick Towndrow, GM/ John Quinn, Chief Operating Officer**	16/11/2021	Quality, Safety and Experience Assurance Committee	May 2020 (TB) January 2021 (QSEAC) October 2021
12	Inconsistent delivery of safe care	**Principle 3: Safety and quality**	**Priority 2: Deliver a Future Hospital Programme**	Patients are not consistently cared for within a comprehensive safety system which ensures they are protected from avoidable harm and focuses on openness, transparency and learning when things go wrong.	4 x 4	**16**	3 x 4	**12**	**Averse**	1-2 years	Medical Director	**Sanjiv Sharma, Medical Director/ Hussein Khatib/ Nikki Fountain**	16/11/2021	Quality, Safety and Experience Assurance Committee	Reports on quality of services at every Board and QSEAC
13	Service Transformation	**Principle 1: Children and young people first and always**	**Priority 2: Deliver a Future Hospital Programme**	Failure to embrace service transformation and deliver innovative, patient centred and efficient services.	4 x 4	**16**	3 x 4	**12**	**Open**	1-5 years	Chief Operating Officer	**John Quinn, Chief Operating Officer/ Anthony Sullivan, Transformation Programme Manager**	16/11/2021	People and Education Assurance Committee	December 2020 September 2021
14	Culture	**Principle 2: Values led culture**	**Priority 1: Make GOSH a great place to work**	There is a risk that GOSH fails to develop its culture and levels of staff engagement and motivation in alignment with its strategy and values,	4 x 4	**16**	3 x 4	**12**	**Averse**	1-5 years	Chief Executive	**Caroline Anderson Director of HR and OD**	11/11/2021	Trust Board/ People and Education Assurance Committee	February 2021 March 2021 (TB) December 2021
15	Cancer Centre Under further review -risk statement and mitigations	**All Strategy Principles**	**Priority 6: Create a Children's Cancer Centre to offer holistic, personalised and coordinated care**	The risk that inadequate planning of the Children's Cancer Centre and the impact of the external economic and political environment on these plans may result in a failure to deliver the expected patient and business benefit and a failure to deliver against the approved budget and deliver value for money.						1-5 years	Director of Estates, Facilities and Built Environment	**Zoe Asensio-Sanchez, Director of Estates, Facilities and Built Environment/ Gary Beacham, Children's Cancer Centre Delivery Director**		Audit Committee	
16	GOSH Learning Academy	**Principle 2: Values led culture / Principle 3: Safety and quality**	**Priority 1: Make GOSH a great place to work/ Priority 3: Develop the GOSH Learning Academy**	Risk of the GOSH Learning Academy not establishing a financially sustainable framework, impacting on its ability to deliver the outstanding education, training and development required to enhance recruitment and retention at GOSH and drive improvements in paediatric healthcare.	**4 x 3**	**12**	**3 x 3**	**9**	**Minimal**	1-2 years	Chief Nurse	**Darren Darby, Acting Chief Nurse/ Lynn Shields, Director of Education**	16/12/2021	People and Education Assurance Committee	July 2022

GOSH BAF Risks – Gross Scores January 2022

Likelihood		Consequences				
		1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
	5 Almost Certain					7. Cyber Security; 1. Financial Sustainability; 12. Medicines Management
	4 Likely				5. Unreliable data; 14: Culture; 12. Inconsistent delivery of safe care; 5. GOSH Strategic Position; 13. Service Innovation; 9. Estates Compliance	2. Recruitment & Retention; 8. Business Continuity; 10. Information Governance; 3. Operational Performance
	3. Possible					6. Research Infrastructure and resourcing
	2. Unlikely					
	1.Rare					

GOSH BAF Risks – Net Scores January 2022

Likelihood		Consequences				
		1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
	5 Almost Certain				9. Estates Compliance	
	4 Likely			5. Unreliable data; 8. Business Continuity		12. Medicines Management; 1. Financial Sustainability
	3. Possible				14: Culture; 5. GOSH Strategic Position; 6. Research Infrastructure and resourcing; 13. Service Innovation; 12. Inconsistent delivery of safe	10. Information Governance; 3. Operational Performance; 7. Cyber Security
	2. Unlikely					2. Recruitment & Retention
	1.Rare					

QSEAC & Audit Committee | QSEAC | Audit Committee | Trust Board | People and Education Assurance Committee

Attachment R

Great Ormond Street Hospital for Children
NHS Foundation Trust

Summary of the People and Education Assurance Committee meeting held on 8th December 2021

The Committee noted summaries of the following assurance committees:

- Quality, Safety and Experience Assurance Committee (October 2021)
- Audit Committee (October 2021)

People Strategy – Frameworks update and People Strategy Update

An impact tracker had been developed to assess whether the work taking place was having an impact that would be recognised by staff. The Committee said it was vital to escalate any delays to the implementation of the strategy as a result of lack of resource in the HR team. Discussion took place around the reach of the women's network and the importance of support being provided by HR to increase the maturity of staff forums in order to enable them to support staff across the organisation.

Nursing Workforce update

It was noted that the Trust's nurse vacancy rate in October had been 1% which was positive however the availability of nurses when considering maternity and sick leave was lower. The Committee requested data to show areas in which a lack of availability of nurses had the potential to interrupt patient flow. The Committee discussed the potential implications of for staff in health and social care settings to be vaccinated by 1st April 2022 and noted that the Trust was awaiting further national guidance and legal opinion.

Apprenticeship staff story

More than 50% of apprentices at GOSH identified at black, Asian or minority ethnic which supported GOSH in its ambition to become a more diverse employer. Apprentices with no previous healthcare experience had been recruited and over three years there had been a retention rate of more than 95%. Staff stories were received from two GOSH apprentices and welcomed the impact of apprenticeship programmes at the Trust. The Committee highlighted the importance of maintaining sustainable funding for the GOSH Learning Academy going forward and asked that this was discussed by the Board at a future meeting.

Review of Speak Up Programme

Focus placed on the Speak Up programme overall had highlighted the importance of raising concerns and it was important to ensure that there was focus on organisational listening and learning. The committee discussed the Speak Up for Safety Programme and it was agreed that although this had not been as successful as initially anticipated it was vital that consideration was given to the aspects of the programme which should be taken forward.

Update on Staff focused Freedom to Speak Up cases

There continued to be challenges, including with culture, in the estates team and senior colleagues were working hard in this area. The importance of identifying the key benefits to staff of speaking up was emphasised with the aim of replicating this within teams to help issues to be identified and staff supported before concerns developed.

Update on the Board Assurance Framework

The Risk Assurance and Compliance Group had discussed a number of BAF risks to ascertain whether they continued to represent risks to the Trust's strategy. This included the Recruitment and Retention Risk. It had been agreed that this risk would remain on the BAF - whilst positive work had taken place to develop a robust pipeline of staff, there continued to be issues in some areas and uncertainty about staff turnover as a result of the pandemic.

Update on 2021 Staff Survey response

The highest number of surveys ever had been completed and national results would be published in February 2022. Discussion took place around the importance of using the directorate leadership structure to cascade communications such as the importance of completing the staff survey. It was noted that it was important to act on results to ensure that the benefit of completing the survey was clear to staff.

Annual report on relations with staff partners and union representatives and consultation processes

The Committee welcomed the work that had taken place to develop positive and constructive partnership working with unions which had supportive activity such as insourcing of cleaning colleagues.

Workforce Metrics Update (December 2021)

The Committee requested that consideration was given to the action that could be taken to reduce vacancies and ensure succession plans were in place in ICT, finance and property services. It was noted that 14.6% of staff sickness was related to anxiety, stress and depression and it was reported that a collaborative model of providing occupational health services was being explored which would bring economies of scale and offer the provision of psychological support on a wider basis.

PEAC Evaluation 2022 – Draft Questions

Work would take place to reduce the number of questions and the survey would be sent to participants in January 2022.

Deep dive of BAF Risk 14: Culture

Discussion took place around the measures that were in place to ensure that HR policies were applied fairly throughout the organisations at all levels. It was highlighted that it was challenging to gain real insight into issues such as silo working. The pandemic had supported the reduction in silo working as a result of the cross cover and inter team working required and the committee agreed that it was important that this progress was not lost and agreed to invite a group of nurses or doctors in training to join the next PEAC meeting to take part in a discussion about the people strategy.

Attachment S

Great Ormond Street Hospital for Children
NHS Foundation Trust

Summary of the Council of Governors' meeting held on 23rd November 2021

Chair's update

During the pre-meet between Governors and the Chair, Governors had been keen to understand ways in which they could represent the interests of their constituents and it was agreed that this would be reviewed at the Membership Engagement, Recruitment and Representation Committee. Governors raised concern about ongoing funding from the GOSH Children's Charity for patient experience and it was confirmed that existing funding levels had recently been approved by the GOSHCC Grants Committee.

GOSH Well Led Review Report

The review had highlighted the good work which was taking place and progress that had been made but identified further work which was still required. Focus was particularly required around the autonomy of directorates and strengthening of the Senior Leadership Team to ensure that individuals and teams were empowered to make decisions at the appropriate levels. Discussion took place around the implications of this and it was confirmed that training was taking place for divisional leaders many of whom were new in post.

GOSH operating in the new NHS Landscape – Integrated Care Systems

There would be 42 ICSs nationally once they became statutory and GOSH treated patients from 41 of these. GOSH was based in North Central London and these patients comprised only 5% of the Trust's activity. It was not clear how funding, which was being calculated to reflect the needs of a local population, would at a specialist Trust such as GOSH. There were potential strategic risks around the introduction of ICSs such as the disruption of funding flows, workforce and equality of access and GOSH was working with the Federation of Specialist Hospitals to influence and to ensure that unintended consequences of system changes were minimised.

Annual Business Planning 2022/23

Work continued to increase activity whilst adhering to infection control guidance. It was anticipated that the Elective Recovery Fund (ERF) would continue to be based on activity in 2019/20. As GOSH was in a financially challenged system it would be required to meet a higher savings target. It was noted that planning was challenging as a result of the uncertainty around commissioning and the draft plans would be reviewed by the Council of Governors.

Chief Executive Report

Significant changes were taking place at directorate leadership level which was challenging. Activity had been reduced as a result of feedback from staff that there was considerable fatigue in the workforce. Intensive care had often been red rated in terms of availability, in line with London as a whole. Discussion took place around the time taken for actions arising from complaints and incidents to be fed back to clinical and staff governors expressed some concern about the length of time taken to review incidents and highlight learning. It was noted that the Trust had commissioned an external review of the serious incident process.

- Finance report (highlights) October 2021

There had been changes made to the Elective Recovery Fund for the second half of the year. This would now be based on clock stops which was a risk for GOSH. Focus was being placed on increasing income from International and Private Care (I&PC) in order to close this gap as much as possible.

Selection by Governors of a Local Quality Indicator for external data testing and inclusion in the Quality Report 21/22
The Council agreed to continue with the selection which had been made in 2021, but had not been tested due to the pandemic: '*last minute non clinical hospital cancellations'*.

Update from the Young People's Forum (YPF)
The YPF continued to work with the Children's Cancer Centre architects to provide feedback on social spaces and patient bedrooms and design updates had been made in response. A new Transition Manager had joined GOSH and would be reviewing the Growing Up and Gaining Independence (GUGI) guidance as requested by the Forum.

Reports from Board Assurance Committees
The Council noted reports from the following assurance committees:

- Quality, Safety and Experience Assurance Committee (October 2021)
- Audit Committee (October 2021)
- Finance and Investment Committee (September and November 2021)
- People and Education Assurance Committee (September 2021)

Succession Planning – Non-Executive Directors
The Council approved a proposal to recruit two Non-Executive Directors at the same time from a group of candidates with a wider skill set. Successful candidates would initially be appointed to associate NED roles with the expectation that the individuals would move into NED roles without a further recruitment process subject to satisfactory performance. The Council also approved the revised appointment timetable.

Appraisal and extension of the tenure of the Deputy Chair
The Council approved the outcome of the appraisal of the Deputy Chair. They also approved a proposal to extend the tenure of the Deputy Chair for a further three months to 30 June 2022 to ensure there was continuity in the Audit Committee Chair role throughout the annual accounting process 2021/22.

Governance Update
The Council approved the following:

- Revised Constitution and Governance Working Group Terms of Reference
- Attendance at Council of Governor meetings Standard Operating Procedure (SOP)
- Amendments to the GOSH Constitution

- <u>Questions for Council self-assessment of effectiveness survey 2022</u>

Discussion took place around the number of proposed questions and it was noted that some questions had been asked in the previous year to allow direct comparison of results and additional questions had been requested by the Constitution and Governance Working Group. It was agreed that consideration would be given to including fewer questions in the next year's survey.

- <u>Establishing the Induction Working Group</u>

A group was being established and a request for members would be sent by email.

- <u>Update from the NHS Providers Governors' Advisory Committee</u>

Guidance was being developed on the role of Governors under the Integrated Care Systems model.

Update from the Membership Engagement Recruitment and Retention Committee
There had been an increase in the number of members joining the Trust however GOSH's membership was

under-represented in terms of men and members from black, Asian and minority ethnic backgrounds. Polls were being carried out to identify barriers to joining the membership.

- Elections 2021 Update

Video voter resources had been developed and would be published on the Trust's online platforms.

- Update on development of revised GOSH Membership Strategy

Key themes would be around knowledge, inclusivity and sustainability and would be underpinned by the theme of connectivity.

Any other business

Two Governors would be stepping down from the Council as a result of moving out of their constituencies.

Chair and NED Appraisal process

The Council approved the outcome of the appraisals of the Chair and the NEDs.

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
2 February 2022

Updated SFIs and Scheme of Delegation **Submitted by: Helen Jameson, Chief Finance Officer**	**Paper No: Attachment T** **□ For approval**

Purpose of report
To present proposed updates to the Trust's Standing Financial Instructions and Scheme of Delegation.

Summary of report

- The Trust's SFIs and Scheme of Delegation were last updated in July 2019 and are due to be reviewed. The suggested updates to the documents have been endorsed by the Trust's Executive Management Team and Audit Committee.
- Since July 2019, the most significant change has been as a result of the UK leaving the European Union. This has affected the rules around Procurement. In addition, changes have been made to reflect current structures.
- The Scheme of Delegation has been simplified where possible, including the merging of approvals for revenue and capital business cases to improve clarity.
- Suggested changes are summarised below and the attached documents show track changes so that the Committee can see where changes have been suggested.

Action required from the meeting
The Board is asked to approve the suggested changes

Contribution to the delivery of NHS Foundation Trust priorities **□ Quality/ corporate/ financial governance**	**Contribution to compliance with the Well Led criteria** **□ Responsibilities, roles and accountability** **□ Effective processes, managing risk and performance**

Strategic risk implications
BAF Risk 1: Financial Sustainability

Financial implications
Both documents describe how finance processes and authorisations have been designed

Implications for legal/ regulatory compliance
The Standing Financial Instructions and Scheme of Delegation form part of the Trust's governance arrangements.

Consultation carried out with individuals/ groups/ committees The suggested changes have been endorsed by the Executive Management Team
Who is responsible for implementing the proposals / project and anticipated timescales? Chief Finance Officer
Who is accountable for the implementation of the proposal / project? Chief Finance Officer
Which management committee will have oversight of the matters covered in this report? N/A

Introduction

The Trust's Standing Financial Instructions (SFIs) and Scheme of Delegation were last updated in July 2019. Ideally, these documents should be updated on an annual basis; this did not happen in 2020 as a result of the pressures created by the pandemic. The most significant suggested change in the revised documents relates to procurement rules now that the UK has left the European Union. Other changes have been suggested to reflect the changes in the Trust's structures and to improve clarity.

The Trust's SFIs and Scheme of Delegation have been reviewed on a detailed basis, and a number of changes have been suggested as a result. The appendix to this paper highlights all of those suggested changes which the meeting is requested to review and endorse the suggested changes.

Suggested Amendments

The key suggested amendments are outlined below:

- Since the UK exited the European Union, the Trust is no longer required to observe the OJEU limit or to advertise contracts above this limit in OJEU. In addition, as of 16 August 2021, NHS Foundation Trusts are now classified as central government bodies for the purposes of the Public Contracts Regulations 2015 (PCR). This will mean that the threshold for application of compulsory procurement for supplies and services contracts will be reduced from £189,330 to £122,976. A number of amendments are suggested, following consultation with Procurement, as required under the Regulations.
- To recognise the recent changes in the Trust's structures as well as the latest NHS nomenclature to ensure that the references to internal and external postholders and bodies are up to date.
- To reflect the fact that the Trust's Capital limit (CDEL) is set externally and cannot be exceeded.
- To update the Vacancy Approval Process section of the Scheme of Delegation following consultation with Human Resources.
- To update the Counter-Fraud section of the SFIs following consultation with the Trust's Local Counter-Fraud Specialist to ensure that they are compliant with Government standards.
- To simplify the Scheme of Delegation and improve its clarity for readers; for example streamlining the sections on business case approvals which are currently split between revenue and capital. The majority of business cases involve both capital and revenue expenditure and it therefore makes more sense not to split cases between the two.

The Standing Financial Instructions and Scheme of Delegation will be reviewed regularly and where amendments are identified, these will be recommended to EMT for discussion before going to the Audit Committee, and then the Trust Board for approval.

Appendix 1

Chapter	Amendments
1. Audit and Counter-Fraud	Explicit mention of bribery. An update reflecting the change from NHS Protect to the NHS Counter-Fraud Authority. Security management procedures are no longer governed by the NHS Counter-Fraud Authority; this is now done by NHSE/I. Removal of references to the Area Anti-Fraud Specialist which no longer exists. Explicit mention of Government Functional Standard 013: Counter-Fraud.
2. Business Planning, Budgets, Budgetary Control and Monitoring	No changes.
3. Annual Report and Accounts	References to Councillors amended to Governors.
4. Bank Accounts, External Borrowing and Investment of cash	Inclusion of PayPal account. References to DH amended to DHSC.
5. Income, Fees and Charges and Security of Cash Cheques and Other Negotiable Instruments	References to Research and Development updated to refer to Research and Innovation. References to DH amended to DHSC.
6. NHS Contracts or Service Agreements for the Provision of Services	References to Councillors amended to Governors.
7. Terms of Service and Payment of Directors and Employees	Removal of section relating to the annual review of Consultant Discretionary Points. References to Councillors amended to Governors.
8. Non-Pay Expenditure	No changes.
9. Fixed Asset Register and Security of Assets	No changes.
10. Capital Investment and Private Financing	No changes.
11. Stock Control and Receipt of Goods	References included to off-site locations.
12. Disposals and Condemnations, Losses and Special Payments	An update reflecting the change from NHS Protect to the NHS Counter-Fraud Authority.
13. Computerised Systems	References to the Chief Information Officer updated to Chief Data Officer and/or Director of ICT.
14. Risk Management and Insurance	References to Director of Estates updated. References to DH amended to DHSC.
15. Tendering and Contracting Procedure	References to EU legislation amended to UK.

16. Retention of Records	References to DH amended to DHSC.
17. Research and Innovation	References to Research and Development updated to refer to Research and Innovation.
18. Acceptance of Gifts by staff and other standards of business conduct	No changes.
Scheme of Delegation	References to Standing Orders updated. Updates to Finance Department staff job titles as a result of changes in the structure. Updates to reflect the changes in the Vacancy Approval process. Approvals for ICT capital schemes under £500k to be approved by CIG rather than the IMT Board following the disbanding of the IMT Board. Tender limits reduced from £181,302 to £122,976 as a result of the reclassification of NHS Foundations Trusts to fall within 'central government bodies'. References to OJEU changed to PCR (Public Contract Regulations). Business Case approvals for revenue and capital have been merged for simplicity Control and management of stock updated to cover all stock locations. Updates to capital expenditure limits to reflect the Trust's external capital limit.

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST ("the Trust")

Standing Financial Instructions

Contents

These Standing Financial Instructions were approved by the Trust Board on ~~18 July 2019~~xx 2021

1 Audit and Counter Fraud

1.1 Audit Committee

1.1.1 In accordance with Standing Orders, the Trust Board shall establish an Audit Committee, with clearly defined terms of reference and membership consistent with relevant guidance issued by Regulators or the Department of Health and Social Care. The role of the Audit Committee is to provide assurance to the Trust Board by obtaining an independent and objective view of the Trust's financial systems, financial information, and compliance with relevant laws and guidance.

1.1.2 The Committee will:

a. Ensure that the reporting systems for Audit shall be consistent with any guidance on reporting issued by, or endorsed by, the Regulator (e.g. the NHS Audit Committee Handbook) and approved by the Audit Committee.

b. Ensure there is an effective audit function and oversee Internal and External Audit services. The Audit Committee shall be involved in the selection process when there is a proposal to review the provision of internal and external audit services.

c. Review the adequacy and effectiveness of:

i. the system of integrated governance, risk management and internal control, across the whole of the Trust's activities, (but excluding clinical governance and clinical risk management systems whilst there exists a separate committee of the Trust ~~b~~Board with equivalent responsibilities for clinical governance), that supports the achievement of the organisation's objectives;

ii. financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgements;

iii. the information prepared to support the assurance framework prepared on behalf of the Trust Board and advise the Trust Board accordingly; and

iv. policies and procedures for all work related to fraud, bribery and corruption ~~and security management and~~ as required by the NHS Counter-Fraud Authority~~Protect~~.

~~iv.~~v. policies and procedures for security management as required by NHSE/I

d. Ensure compliance with:

i. relevant codes of governance issued by Regulators and the Department of Health and Social Care; and

ii. the Trust's Standing Orders and Standing Financial Instructions.

e. Review schedules of:

i. Debt write offs for approval

~~i.~~ii. losses and special payments~~compensations and make recommendations to the Board; and~~

~~ii.~~iii. ~~debtors/creditors balances over 6 months old and £50,000 and explanations/action plans~~working capital.

f. Review the Annual Report and Accounts and all risk and control related disclosure documents (in particular the Annual Governance Statement) together with any appropriate independent assurances prior to endorsement by the Trust Board.

1.1.3 Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the chair of the Audit Committee should raise the matter at a full

meeting of the Trust Board. Exceptionally, the matter may need to be referred to Regulators.

1.1.4 The terms of reference of the Audit Committee, including its role and the authority delegated to it by the Trust Board and by the Council of Governors, should be made publically available.

1.2 Role of Internal Audit

1.2.1 Internal audit will review, appraise and report upon:

a. The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

b. The adequacy and application of financial and other related management controls;

c. The suitability and quality of financial and other related management data;

d. The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

I. Fraud and other offences,
II. Waste, extravagance, inefficient administration,
III. Poor value for money or other causes.

1.2.2 The Head of Internal Audit shall be accountable to the Chief Finance Officer. Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation of the objectivity of the audit, the Head of Internal Audit shall seek advice from the Trust Board Chair~~man~~ or Chair~~man~~ of the Audit Committee. This reporting system shall be reviewed at least every three years.

1.2.3 The Chief Finance Officer will refer audit reports to the appropriate officers designated by the Chief Executive. The Head of Internal Audit will agree timescales for implementing audit recommendations with designated officers. Failure to adhere to these timescales shall be reported to the Audit Committee who shall take necessary action to ensure compliance with such recommendations.

1.2.4 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee Members, the Chair and Chief Executive of the Trust. The Head of Internal Audit will issue an annual opinion to the Audit Committee and the Trust Board in accordance with the requirements of Regulators and the Department of Health and Social Care.

1.2.5 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

1.2.6 The Chief Finance Officer is responsible for:

a. Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control which include the establishment of an internal audit

function;

b. Ensuring that the internal audit is adequate and meets, as a minimum, the NHS mandatory audit standards and is in compliance with Regulator's Audit Codes; and

c. Ensuring that the Audit Committee receive an annual report from the Internal Auditors and an assessment of their effectiveness.

1.2.7 The Chief Finance Officer and designated internal auditors are entitled without necessarily giving prior notice to require and receive:

a. Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b. Access at all reasonable times to any land, premises or members of the Trust Board and Executive Management Team or employee of the Trust;

c. The production of any Trust cash, stores or other property of the Trust under a member of the Trust Board and an employee's control; and

d. Explanations concerning any matter under investigation.

1.3 External Audit

1.3.1 The external auditor is appointed by the Council of Governors. The Audit Committee must ensure a cost-efficient service.

1.3.2 The Auditor shall be required by the Trust to comply with the Audit Code for NHS Foundation Trusts.

1.3.3 In the event of the auditor issuing a public interest report the Trust shall forward a report to the regulator within 30 days (or shorter period if specified by the Regulator). The report shall include details of the Trust's responses to the issues raised within the public interest report.

1.4 Security Management

1.4.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on NHS security management and will nominate a Director, the Security Management Director (SMD) to be responsible to the Trust Board for NHS Security Management.

1.4.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified ~~by the NHS Protect Standard Contract and~~ NHSE/I Standards for Providers.

1.4.3 The SMD will ensure the appointment of a LSMS who will provide a written report, at least annually, to the Audit Committee.

1.5 Fraud, Bribery and Corruption

1.5.1 In line with their responsibilities, the Chief Executive and Chief Finance Officer shall monitor and ensure compliance with relevant directions and guidance on countering fraud, bribery and corruption within the NHS including the *Bribery Act 2010*.

1.5.2 The *Bribery Act 2010* replaces the "*Prevention of Corruption Acts 1889 - 1916*" with new corporate and individual offences as defined within these Standing Financial Instructions. All staff and contractors should be made aware of the Act to ensure compliance. Any breach of the Act may result in criminal proceedings being commenced.

1.5.3 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the NHS Counter Fraud and Corruption Manual, ~~and~~ relevant directions and guidance, including Government Functional Standard 013: Counter Fraud~~.~~

1.5.4 The Chief Finance Officer should also prepare a "Counter Fraud Policy and Response Plan", in line with the Trust's Fraud and Bribery Policy, that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it~~.~~

1.5.5 The LCFS shall report to the Chief Finance Officer and shall work with staff in the NHS ~~Protect~~Counter-Fraud Authority ~~and the Area Anti-Fraud Specialist (AAFS)~~ in accordance with the NHS Counter Fraud and Corruption Manual and Government Functional Standard 013: Counter Fraud.~~.~~

1.5.6 The LCFS will provide a written report, at least annually, to the Audit Committee.

1.5.7 It is the responsibility of the Chief Finance Officer to decide at what stage to involve the police in cases of misappropriation, and other irregularities other than fraud, bribery and corruption after taking advice from the LCFS and/or LSMS.

2 Business Planning, Budgets, Budgetary Control and Monitoring

2.1 Preparation and Approval of Annual Plans and Budgets

2.1.1 The Chief Executive will compile and submit to the Trust Board an annual business plan, which takes into account financial targets and forecast limits of available resources. The annual plan will comply with the Regulator's requirements, set at authorisation and annually, and contain:

a. A statement of the significant assumptions on which the plan is based; and

b. Details of major changes in workload, delivery of services or resources required to achieve the plan including finances and workforce

c. Details of CIP requirements and plans for delivery and in year monitoring

2.1.2 A~~t the start~~ part of the ~~of~~ business planning process the Chief Operating Officer will, on behalf of the Chief Executive, prepare and submit a business plan for the approval of the Trust Board. The Business plan

a. A detailed description of the activity plans for the Trust services taking into consideration commissioner intentions and national guidance.

b. The impact of the Trust's business cases and site development

c. Expected changes to workforce and plans of meeting the Trusts requirements

d. Identify risks

e. Demonstrate compliance with any regulatory requirements.

2.1.3 At the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Trust Board. Such budgets will:

a. Be in accordance with the aims and objectives set out in the Trust's annual business plan;

b. Accord with workload and manpower plans

c. Be produced following discussion with appropriate budget holders;

d. Take account of any limits of expected income arising, or expected to arise, from contracts with funders;

e. Identify potential risks; and

f. Demonstrate compliance, if practicable, with the minimum requirements of the Regulator.

2.1.4 The Chief Finance Officer shall compile the Budgets in line with the Business Plan produced by the Chief Operating Officer and the Workforce plans produced by the Director of HR and OD.

2.1.5 All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be set and monitored, as a consequence the Chief Finance Officer will have right of access to all budget holders on budgetary matters.

2.1.6 All budgets holders will sign up to their allocated budgets at the commencement of each financial year. Any non-compliance will be escalated to the relevant Director who will take responsibility or detail non-compliance to the Chief Executive.

2.1.7 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to facilitate successful budget management.

2.2 Budgetary Delegation

2.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. Delegation must be to specific post holders and in writing. The notice of delegation will include:

a. The budget holder;

b. The amount of the budget;

c. The purpose(s) of each budget heading;

d. Individual and group responsibilities;

e. Authority to exercise virement (transfer of funds between budgets);

f. Achievement of planned levels of service; and

g. The provision of regular reports.

2.2.2 This Chief Executive may also delegate elements of budgets that cross the organisation which can include:

a. Trust CIP responsibility

b. Cross Cutting business cases or individual schemes.

2.2.3 The Chief Executive and delegated budget holders must not exceed the budgetary total or budget transfer (virement) limits set by the Trust Board, except as specified below:

a. The Chief Executive is permitted to authorise expenditure over the budget up to an amount specified in the financial limits.

b. A budget may be varied on the basis of a business case for revenue or capital investment provided it has been approved by the EMT, FIC or Trust Board (as determined by the financial limits) and does not result in a material adverse change to the financial position reflected in the current year's budget or medium term financial plan.

c. Where total expenditure is forecast to exceed the Trust's expenditure budget but this excess is substantially offset by additional unbudgeted income and as a result it is reasonable to believe, based on forecast information reported to the Trust Board, that there is no material adverse change to the financial position of the Trust reflected in the current year's budget or medium term financial plan. This needs to take into account a review and risk assessment to the payment of the additional unbudgeted Income.

2.2.4 Any budgeted funds not required for their designated purpose revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

2.2.5 Non-recurring budgets must not be used to finance recurring expenditure without the written authority of the Chief Executive.

2.2.6 Commitment to overspend against the budget to year end or to raise expenditure against unfunded initiatives arising in year will need written authorization from the Chief Executive.

2.3 Budgetary Control and Reporting

2.3.1 The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:

a. Monthly financial reports to the Trust Board in a form approved by the Trust Board containing:

i. Income and expenditure to date showing trends and forecast year-end position;

ii. Movements in working capital;

iii. Other Statement of Financial Position changes where these are material;

iv. Explanations of any material variances from plan;

v. Details of any corrective action, proposed or taken, where necessary along with the Chief Executive's and/or the Chief Finance Officer's view of whether such actions are sufficient to correct the situation; and

vi. Monthly reports on capital project spend and projected outturn against plan.

b. The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c. Investigation and reporting of variances from financial, workload and manpower budgets;

d. Systems to ensure adequate pre-authorisation of all pay and non-pay expenditure, including authorised signatory arrangements.

e. Monitoring of management action to correct variances; and

f. Arrangements for the authorisation of budget transfers.

2.3.2 Each budget holder is responsible for ensuring that:

a. Any likely overspending or shortfall in income which cannot be addressed by virement is not incurred without the prior consent of the Chief Executive;

b. The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

c. No permanent employees are appointed without the approval of the Chief Executive other than those provided for in the budgeted establishment as approved by the Trust Board;

d. Identifying and implementing cost improvements, cost savings and income generation initiatives to achieve a balanced budget; and

e. Effective systems exist within the directorate to ensure that all expenditure is authorised in advance of commitment (e.g. operation of authorised signatory systems) and that the individuals incurring expenditure fully understand their budgetary control responsibilities.

2.3.3 The Chief Executive is responsible for authorising the implementation of cost improvements, cost savings and income generation initiatives in accordance with the requirements of the Annual Business Plan.

2.3.4 The Chief Finance Officer shall monitor financial performance against budget and annual plan, periodically review them, and report to the Trust Board.

2.4 Capital Expenditure

2.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI - 9).

2.5 NHS ~~NHSE/I~~ Returns

2.5.1 The Chief Executive is responsible for ensuring that any required NHS~~E/I~~ returns are submitted to the appropriate regulatory organisations.

3 Annual Accounts and Reports

3.1 Annual Accounts and Reports

3.1.1 The Chief Finance Officer, on behalf of the Trust will:

a. Prepare and submit financial returns in accordance with the Trust's accounting policies, guidance applicable to NHS and public bodies and relevant financial reporting standards; and

b. Prepare annual accounts in such form as the Regulator may, with the approval of Treasury, direct.

3.1.2 The Trust's annual accounts must be audited by an independent external auditor appointed by the Council of Governors. The Trust's audited Annual Accounts must be presented to the Trust Board for approval and received by the ~~Council~~Governors at a public meeting and made available to the public.

3.1.3 The Trust will publish an Annual Report, including a Quality Report, in accordance with guidelines from the Regulator and in compliance with any other relevant guidance for NHS Foundation Trusts and shall also take account of good practice from the public and private sector.

3.1.4 The report will give:

a. Information on any steps taken by the Trust to secure that the actual membership of its public constituency and the patients' constituency is representative of those eligible for membership and any information the regulator requires; and

b. Any other information the regulator requires.

4 Bank Accounts, External Borrowing and Investment of cash

4.1 General

4.1.1 The Trust Board, through the Finance and Investment Committee, shall approve the treasury and cash management policy~~strategy~~ and all banking arrangements.

4.1.2 The Chief Finance Officer is responsible for managing the Trust's banking arrangements, ensuring compliance with relevant regulatory guidance, directions and legislation and for advising the Trust Board on the provision of banking services and operation of accounts, borrowing and investment requirements. The Chief Finance Officer shall seek the approval of the Trust Board prior to engagement of any bank or financial institution.

4.2 Bank Accounts

4.2.1 The Chief Finance Officer is responsible for:

a. Authorising the opening or closing of bank accounts and Government Banking Service (GBS) accounts in the name of the Trust;

b. Operating all bank accounts and GBS accounts;

c. Reporting to the Trust Board all arrangements made with the Trust's bankers for accounts to be overdrawn and ensuring payments made from the bank account and GBS account do not exceed the amount credited to the account except where arrangements have been made; and

d. Monitoring compliance with relevant guidance from the Regulator or the Department of Health and Social Care on the level of cleared funds and amounts overdrawn.

4.3 Banking and Investment Procedures

4.3.1 The Chief Finance Officer will prepare detailed instructions on the operation of bank accounts; including the Trust's PayPal account and GBS accounts, which must include:

a. The conditions under which each account is to be operated;

b. The limit to be applied to any overdraft; and

c. Those authorised to sign cheques or other orders drawn on the Trust's accounts.

4.3.2 A Treasury Management Policy that sets out arrangements for investment of surplus funds and associated risk management. This policy will be approved by the Finance and Investment Committee.

4.3.3 The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

4.4 Tendering and Review

4.4.1 The Chief Finance Officer should monitor performance of banking services providers to ensure that the levels of service are in accordance with the agreed contract, reflect best practice and represent best value for money.

4.4.2 Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Trust Board. This review is not necessary for accounts held through the GBS.

4.5 Signatories

4.5.1 The Chief Finance Officer will advise the bankers in writing of the officers authorised to release money from or draw cheques on each bank account and GBS account of the Trust. Cancellation of authorisation will be notified promptly to the bankers.

4.6 Charitable Donations/ Special Trustees

4.6.1 Charitable funds associated with the Trust are administered by the Great Ormond Street Hospital Children's' Charity. Any charitable donations received by the Trust should be paid over to the Charity for administration.

4.7 External Borrowing

4.7.1 The Trust must ensure compliance with any relevant guidance issued by the Regulator before undertaking any borrowing arrangement.

a. The Trust may borrow money from any commercial source for the purposes of or in connection with its operations.

b. Any application for a loan or overdraft must be approved by the Chief Finance Officer or by an employee so delegated by him/her.

c. All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Chief Finance Officer.

d. The Chief Finance Officer must establish a monitoring system to ensure that any covenants within credit agreements are adhered to.

4.7.2 The Chief Finance Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

4.7.3 All long term borrowing must be consistent with the plans outlined in the current annual business plan.

4.7.4 The Chief Finance Officer will include key information relating to the Statement of Financial Position in each monitoring report prepared for the Trust Board. This will include changes to long term debt, Public Dividend Capital and other borrowings. Taken together with the revenue account report it will show the planned and projected position on interest and capital.

4.8 Investments

4.8.1 ~~Temporary~~Any cash ~~surpluses~~holding in excess of the Trust's short-term requirements must be held only in such public or private sector investments as approved through the Treasury Management Policy and should be consistent with relevant guidance from the Regulator.

4.8.2 The Chief Finance Officer is responsible for reporting periodically to the Finance and Investment Committee concerning the performance of investments held.

4.8.3 The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

4.9 Public Dividend Capital

4.9.1 On authorisation as a foundation trust the Public Dividend Capital (PDC) held immediately prior to authorisation must continue to be held on the same conditions as applied prior to authorisation.

4.9.2 Draw down of PDC, if made available by the Secretary of State, will be authorised in accordance with the mandate determined with the Department of Health and Social Care.

4.9.3 The Trust shall pay a dividend on its PDC calculated according to the method determined from time to time by the Department of Health and Social Care or the Regulator.

5 Income, Fees and Charges and Security of Cash Cheques and Other Negotiable Instruments

5.1 Income Systems

5.1.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due, including NHS, commercial and Research and Innovation~~Development~~ (R&I~~D~~) income.

5.1.2 The Chief Finance Officer is also responsible for the prompt banking of all monies received. All cash must be banked directly with the Cashiers Department by the payer unless specific authority from the Chief Finance Officer has been received and suitable procedures are in place to ensure the security of funds.

5.2 Fees and Charges (other than in relation to provision of NHS services for patient care – refer to SFI 6)

5.2.1 The Chief Finance Officer is responsible for regularly reviewing and approving the level of all fees and charges other than those determined by the Department of Health and Social Care or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered relevant guidance on ethical standards in the NHS shall be followed.

5.2.2 It is the responsibility of all employees to inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all NHS Contracts and Service Agreements, commercial agreements and contracts (including Research and Innovation~~Development~~), leases, tenancy agreements, private patient undertakings and other transactions.

5.2.3 The Trust must comply with the rules around non-NHS income as required under NHSE/I's Risk Assessment Framework and any Department of Health and Social Care guidance.

5.3 Debt Recovery

5.3.1 The Chief Finance Officer is responsible for ensuring that:

a. Appropriate recovery action is taken on all outstanding debts;

b. Income not received and deemed irrecoverable is dealt with in accordance with losses procedures, and reported to the Trust's Audit Committee;

c. No officer, without prior express authority from the Chief Finance Officer is allowed to agree with any third party, to the cancellation or reduction of a legitimate debt owed to the Trust; and

d. Overpayments should be detected (or preferably prevented) and recovery initiated.

5.4 Security of Cash, Cheques and Other Negotiable Instruments

5.4.1 The Chief Finance Officer is responsible for:

a. Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b. Ordering and securely controlling any such stationery (or approving delegated arrangements where this is considered appropriate);

c. The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d. Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

e. Reporting, recording and safekeeping of cash, cheques and negotiable instruments.

5.4.2 Official money shall not under any circumstances be used for the encashment of personal cheques or IOUs.

5.4.3 All cheques, postal orders and cash, shall be banked intact on a timely basis. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

5.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

6 NHS Contracts or Service Agreements for the Provision of Services

6.1 Contracts for NHS Services

6.1.1 The Trust Board shall maintain the capacity and capability of the Trust to provide commissioner requested services and shall regularly review compliance.

6.1.2 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable contracts with service commissioners for the provision of NHS services.

6.1.3 All contracts shall be legally binding and should include terms and conditions consistent with good commercial practice within the NHS and should have effective risk management clauses in so far as is reasonably achievable.

6.1.4 The Chief Executive, as the Accounting Officer, will ensure that regular reports are provided to the Audit Committee, the Finance and Investment Committee and the Trust Board detailing amounts contracted for, actual and forecast income from contracts.

6.1.5 In respect of contracts for the provision of NHS patient services no officer, except within the boundaries of any delegated authority, is allowed to confirm or agree with a third party the reduction or waiver to the Trust's normal charges, without the prior express authority of the Chief Finance Officer.

6.1.6 Where the Trust enters into a relationship with another organisation for the supply or purchase of any other services, clinical or non-clinical, the responsible officer should ensure that an appropriate contract is concluded and authorised by both parties.

6.2 Non-NHS Income

6.2.1 Any planned increase of five per cent or more of the proportion of total income from non-NHS sources must be supported by a majority of Governors~~councillors~~ in a vote.

7 Terms of Service and Payment of Directors and Employees

7.1 Remuneration and Terms of Service

7.1.1 The Governors ~~Councillors~~ are responsible for setting the remuneration of non-executive directors including the Chair of the Trust Board. The ~~Council~~Governors should seek advice from external professional advisers to market test remuneration levels as appropriate but not less frequently than every five years or if they intend to make a material change to remuneration of any non-executive director.

7.1.2 The Trust Board should establish and determine the terms of reference of a Remuneration Committee, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

7.1.3 The Remuneration Committee will:

a. In respect of the Chief Executive, Executive Directors, notify the Trust Board about appropriate remuneration and terms of service, including:

i. all aspects of salary (including any performance-related elements/bonuses);

ii. provisions for other benefits, including pensions and cars; and

iii. arrangements for termination of employment and other contractual terms.

b. report decisions to the Trust Board on the remuneration and terms of service to ensure they are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff as appropriate;

c. monitor and evaluate the performance of individual executive directors; and

d. advise on and oversee appropriate contractual arrangements including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

7.1.4 The Committee shall report in writing to the Trust Board the bases for its decisions. The Trust Board remains accountable for taking decisions on the remuneration and terms of service of executive directors. Minutes of the Trust Board's meetings should record such decisions.

7.1.5 In respect of lay members and employees other than Executive Directors, the Remuneration Committee will receive and consider proposals for setting remuneration and conditions of service, and make recommendations to the Trust Board.

7.1.6 The Remuneration Committee will receive reports detailing all Trust employees who have been made redundant or taken early retirement. These reports will include the cost to the Trust of the redundancy or early retirement.

~~7.2 Consultant Discretionary Points~~

~~7.2.1 Annually the Medical Director will make recommendations to the Trust Board regarding the award and funding (having taken advice from the Chief Finance Officer) of Consultant Discretionary Points.~~

~~7.3~~7.2 Funded Establishment

~~7.3.1~~7.2.1 The workforce~~manpower~~ plans incorporated within the annual budget will form the funded establishment (see also SFI 2). The funded establishment of any department may ~~not be varied without the approval of the Chief Executive (or as delegated under the Scheme of Delegation).~~only be amended in line with the Trust's Scheme of Delegation.

~~7.4~~7.3 Staff Appointments and Redundancies

~~7.4.1~~7.3.1 No director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary basis, or hire agency staff, or agree to changes in any aspect of remuneration:

a. Unless it is within the approved budget and funded establishment and the Director or employee has appropriate delegated responsibility; and

b. The proposal conforms to any establishment control procedure that may be in place at the time.

~~7.4.2~~7.3.2 No director or employee may commit the Trust to any redundancy, early retirement or negotiated employment termination settlement without the approval in advance of the Chief Finance Officer and the Director of Human Resources and Organisational Development.

~~7.5~~7.4 Processing of Payroll

~~7.5.1~~7.4.1 The Chief Finance Officer is responsible for:

a. specifying timetables for submission of properly authorised time records and other notifications;

b. ensuring that the final determination of pay and allowances have been calculated in accordance with national agreements where relevant or otherwise Trust-determined agreements;

c. making payment on agreed dates; and

d. agreeing method of payment.

~~7.5.2~~7.4.2 The Chief Finance Officer will issue and maintain procedures regarding:

a. Verification and documentation of data;

b. The timetable for receipt and preparation of payroll data and the payment of employees;

c. Maintenance of subsidiary records for superannuation, income tax, national insurance contributions and other authorised deductions from pay;

d. Security and confidentiality of payroll information;

e. Checks to be applied to completed payroll before and after payment;

f. Authority to release payroll data under the provisions of the Data Protection Act;

g. Methods of payment available to various categories of employee;

h. Procedures for payment by cheque or bank credit, to employees and officers;

i. Procedures for the recall of cheques and bank credits;

j. Pay advances and recovery thereof;

k. Maintenance of regular and independent reconciliation of pay control accounts;

l. Ensuring the principle of separation of duties is applied in the preparation of records;

m. A system to ensure the recovery, from persons leaving the employment of the Trust, of sums of money and property owed by them to the Trust;

n. That payroll records are retained in accordance with statutory and other requirements; and

o. Systems exist to detect and recover overpayments.

~~7.5.3~~7.4.3 The Director of HR& OD will issue guidance and procedures to managers who have delegated responsibility for:

a. Submitting termination forms, time records, and other notifications in accordance with agreed timetables and procedures;

b. Completing time records and other notifications in accordance with instructions and in the form prescribed;

c. Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination, or retirement.

~~7.5.4~~7.4.4 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

~~7.6~~7.5 Contract of Employment

~~7.6.1~~7.5.1 The Trust Board shall delegate responsibility to the Director of Human Resources and Organisational Development:

a. Ensuring that all employees are issued with a Contract of Employment in a form approved by the Trust Board and which complies with employment legislation; and

b. Dealing with variations to, or termination of, contacts of employment.

~~7.7~~7.6 Managers' Responsibility

~~7.7.1~~7.6.1 Managers are responsible for:

a. Following the procedures and guidance relating to the completion and submission of payroll documentation. It is particularly important that termination forms are submitted promptly upon becoming aware of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, Human Resources department must be notified immediately.

b. Ensuring there are appropriate systems of internal check and control in place within their directorate or department to ensure that time records and expense claims are capable of meaningful certification.

8 Non-Pay Expenditure

8.1 Delegation of Authority

8.1.1 The Trust Board will approve the level of non-pay expenditure within the budget on an annual basis and the Chief Executive will determine the level of delegation to budget managers, in line with NHS best practice and following guidance from boards and committees as appropriate. The Trust's **Scheme of Delegation** (attached at Appendix A) sets this out and delegated limits can be varied in-year only with the approval of the Chief Executive.

8.1.2 The Chief Finance Officer will set out:

a) A list of requisitioners authorised to requisition goods and services

b) The maximum level of each requisition and the system for authorisation above that level.

8.1.3 The Chief Finance Officer will establish and maintain procedures on the seeking of professional advice regarding the supply of goods and services and will ensure that all requisitioners authorised to place requisitions are aware of the procedures. This will include maintaining guidance on ***Tendering Procedures for Goods and Services (see also SFI 15)***.

8.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

8.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust and ensure that he/she has no conflict of interest or contravene the requirements of *The Bribery Act 2010*. In so doing, the advice of the Trust's procurement department shall be sought.

8.2.2 The Chief Finance Officer will:

a. advise the Trust Board regarding the setting of thresholds above which quotations, competitive or otherwise, or formal tenders must be obtained (having regard to legislation and directives regarding public sector procurement); and, ensure the thresholds are reflected in the Scheme of Delegation and financial limits referenced to these SFIs and regularly reviewed;

b. issue and maintain procedural instructions on obtaining goods, works and services. (Refer to SFI 15 "***Tendering for Goods and Services Procedures***");

c. Design and maintain systems to ensure that there are controls over the commitment of funds; and

d. Design and maintain systems for the verification and certification of the receipt of goods and services to ensure that only valid invoices are paid and minimise the opportunity for overpayment. The system shall provide for:

i. A list of directors/employees (including specimens of their signatures) authorised to approve invoices;

ii. Certification that:

e. Goods have been duly received, examined and are in accordance with specification and the prices are correct

f. Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

g. In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the appropriate rates, the materials have been checked as regards quantity, quality and price and the charges for the use of vehicles, plant and machinery have been examined;

h. Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

i. The account is arithmetically correct; and

j. The account is in order for payment.

k. be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms unless there is a valid dispute, or otherwise, in accordance with the NHS Better Payment Practice Code. Provision shall be made so that advantage can be taken of accounts subject to cash discounts.

l. design and maintain systems for:

   a. ensuring that payment for goods and services is only made once the goods and services are received (except as for 8.2.4 below)

   b. the use and control of purchasing cards.

8.2.3 Prepayments are only permitted where exceptional circumstances apply. In such instances:

a. Prepayments are only permitted where the financial advantages outweigh the disadvantages;

b. The appropriate director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

c. The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the Public Contracts Regulations 2015 where the contract is above a stipulated financial threshold); and

d. The budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

8.2.4 The Chief Executive and the Chief Finance Officer shall ensure that the arrangements for financial control and the financial audit of building and engineering contracts and property transactions comply with all applicable guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

8.3 Responsibilities of All Employees

8.3.1 All employees must follow the Trust's procedures when obtaining goods, works and services (also refer to ***SFI 15 Tendering for Goods and Services Procedure***) and obtain best value for money.

a. Ensuring that all contracts (other than for purchases permitted within the scheme of delegation), leases tenancy agreements and other commitments which may result in a liability must be approved by the Chief Finance Officer in advance of any commitment being made (refer to SFI 9.2);

b. Ensuring that the Public Contracts Regulations 2015 for advertising and awarding contracts are followed;

c. Ensuring that adequate budgetary provision exists against the budget code they are using, or they have made appropriate arrangements for virement or reporting the expected over commitment;

d. Ensuring that all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract, purchases from petty cash or with approved purchasing cards;

e. Follow the Trust's procedures on certifying receipt of goods, works and services to enable invoices to be paid (relevant management procedures); and in particular note and comply with the following points:

   i. All non-stock orders must be placed via requisitions on the Trust's purchasing system (except where the employee has been issued specifically with a Trust-authorised purchasing card);

   ii. Ensure that stock items are used wherever possible;

   iii. Take goods on trial or loan where this commits the Trust to a future purchase;

   iv. Split requisitions to avoid financial thresholds;

   v. Enter contracts, including rental and leasing agreements, that are for items of a capital nature without the express approval of the Chief Executive and Chief Finance Officer (see SFI 9); - add more detail to SFI9 re leasing policies

   vi. restrict purchases from petty cash or through the employee expense reimbursement system to items of very low value unless exceptionally authorised.

8.3.2 Employees should also be aware of the restrictions in relation to accepting gifts, inducements or other personal advantage which could be considered to be bribes under *The Bribery Act 2010*.

a. This includes ensuring that no order shall be issued to an organisation which has made an offer of gifts, reward or benefit to directors or employees other than:

   i. Isolated gifts of a trivial character or value; or

   ii. Conventional hospitality, such as lunches in the course of working visits.

b. No visits, at supplier's expense should be made without the prior written approval of a director.

8.4 Procurement

8.4.1 The procurement function will:

a. Only process fully authorised requisitions and ensure that competition is (or has been) appropriately taken in accordance with the Trust's Tendering for Goods and Services Procedure;

b. Liaise with the Chief Finance Officer on issues regarding the systems for ordering, receipt and payment;

c. Place sequentially numbered Purchase Orders incorporating the Trust's terms and conditions of trade.

8.5 Petty Cash

8.5.1 Purchases that will be reimbursed from petty cash are restricted in type and value and must be supported by receipt(s) and certified by an authorised signatory

8.5.2 The Chief Finance Officer will determine record-keeping and other instructions relating to petty cash.

9 Fixed Asset Register and Security of Assets

9.1 Asset Registers

9.1.1 The Chief Finance Officer is responsible for the maintenance of registers of assets, and arranging for a periodic physical check of assets against the asset register.

9.1.2 The Trust shall maintain a computerised asset register recording fixed assets which should include the minimum data specified by the Regulator.

9.1.3 Additions to the fixed asset register must be clearly identified to an appropriate manager and be validated by reference to:

a. Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchase from third parties;

b. Stores, requisitions and wage records for own materials and labour including appropriate overheads; and

c. Lease agreements in respect of assets held under a ~~finance~~ lease and capitalised under the Trust's accounting policies.~~.~~

9.1.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). The Trust may not dispose of any protected property without the approval of the regulator. This includes the disposal of a part of such property or the granting of an interest in or over it.

9.1.5 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

9.1.6 The value of each asset shall be revalued at current values in accordance with appropriate methods for NHS Foundation Trusts.

9.1.7 The value of each asset shall be depreciated using methods and rates in accordance with guidance issued by the Regulator.

9.2 Security of Assets

9.2.1 The overall control of fixed assets is the responsibility of the Chief Executive.

9.2.2 Asset control procedures for fixed assets, including donated assets, must be approved by the Chief Finance Officer. This procedure shall make provision for:

a. Recording managerial responsibility for each asset;

b. Identification of additions and disposals;

c. Identification of all repairs and maintenance expenses;

d. Physical security of assets

e. Periodic verification of the existence of, condition of, and title to, assets recorded;

f. Identification and reporting of all costs associated with the retention of an asset.

9.2.3 Any discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the Chief Finance Officer.

9.2.4 Whilst each employee has responsibility for the security of property and assets of the Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Trust Board. Any breach of agreed security practices must be reported in accordance with Trust Guidance

9.2.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported initially to the Director responsible for Estates and the Chief Finance Officer by directors and employees in accordance with the procedure for reporting losses.

9.2.6 In line with Trust guidance, managers should ensure that where practical, assets should be marked as Trust property.

9.2.7 Equipment and other assets may be loaned to the Trust. Employees and managers must ensure that the Trust management procedure is followed; in particular that conditions attaching to the loan are documented and the asset identified. Loaned assets must not be entered in the Trust's asset register.

10 Capital Investment~~,~~ Private Financing and Leasing

10.1 Capital Investment

10.1.1 The Trust Board shall approve financial limits for the Trust's annual programme of capital investment as part of the budget process. The approval of a capital programme shall not constitute approval for expenditure on any scheme within the programme.

10.1.2 The Chief Executive shall ensure that:

a. there is an adequate appraisal and approval process (including proposed changes to projects after their initial approval) in place for determining capital expenditure priorities and the effect of each proposal upon annual plans;

b. there are processes in place for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

c. capital investment in new facilities or major redevelopments is not undertaken without confirmation of commissioner's(s) support and the availability of resources to finance all revenue consequences, including capital charges; and

d. all processes and procedures are consistent with relevant guidance and regulatory requirements.

10.1.3 The Trust's scheme of delegation will include limits for capital investment management which must be reviewed and approved on a regular basis.

10.1.4 For every significant capital expenditure proposal the Chief Executive shall ensure that:

a. a business case (in line with Department of Health and Social Care or the Regulator's guidance) is produced and approved prior to the commitment of expenditure setting out:

i. An option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to cost

ii. Appropriate project management and control arrangements

iii. The involvement of appropriate Trust personnel and external agencies

b. the Chief Finance Officer has validated the costs and revenue consequences detailed in the business case.

10.1.5 For capital schemes where the contracts stipulate stage payments, the responsible Director, as relevant, will issue procedures for their management, incorporating any relevant external regulations or guidance

10.1.6 The Chief Finance Officer shall assess on annual regular basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HM Revenue and Customs guidance.

10.1.7 The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

10.1.8 The Chief Executive shall ensure that there are procedures in place to identify managers' responsible for each scheme and specify:

a. levels of authority to commit expenditure;

b. authority to proceed to tender;

c. approval to accept a successful tender.

10.1.9 The Chief Finance Officer shall issue procedures governing the financial management, (including variations to contract), of capital investment projects and valuation for accounting purposes.

10.2 Leasing

~~10.2.1~~ Any finance or operating leases must be agreed and signed by the Chief Finance Officer in line with the Trust's Scheme of Delegation.~~.~~

11 Stock Control and Receipt of Goods

11.1 General position

11.1.1 Stock should be:

a. Kept to optimum levels;

b. Subjected to at least two stock takes per year;

c. At the lower of cost and net realisable value

11.2 Control of Stock, Stocktaking, condemnations and disposal

11.2.1 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stock locations shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and / or the Supply Chain employees, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated Estates Manager.

11.2.2 The responsibility for security arrangements and the custody of keys for any stock locations, including off-site locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer.

11.2.3 The Chief Finance Officer shall set out procedures and systems to regulate the stock locations including records for receipt of goods, issues, returns to suppliers, and losses.

11.2.4 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in stock at least twice a year.

11.2.5 Where a complete system of stock control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

11.2.6 The designated Manager/Head of Pharmacy shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also ***SFI 12 Disposals and Condemnations, Losses and Special Payments***). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

12 Disposals and Condemnations, Losses and Special Payments

12.1 Disposals and Condemnations

12.1.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers. The Trust may not dispose of any protected property without the Regulator's consent.

12.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate and ensuring the disposal process is structured so as to achieve best value for the asset.

12.1.3 Unserviceable articles:

a. can only be condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer;

b. disposals must be recorded by the Condemning Officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of, and all entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer; and

c. the Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

12.2 Losses and Special Payments

12.2.1 The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments.

12.2.2 Any employee discovering or suspecting a loss of any kind must immediately inform the Chief Finance Officer or inform an officer charged with responsibility for responding to concerns involving loss or fraud confidentially. This officer will then appropriately inform the Chief Finance Officer and/or Chief Executive. Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police, following advice from the LSMS, if theft or arson is involved.

12.2.3 In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Finance Officer must inform the LCFS and any other relevant organisations in accordance with DH guidance or direction.

12.2.4 The Chief Finance Officer must notify the NHS ~~Protect~~Counter-Fraud Authority and the External Auditor of all frauds and consider whether any other organisations should also be so notified.

12.2.5 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify:

a. the Trust Board;

b. the LSMS;

c. the Audit Committee; and

d. the External Auditor.

12.3 Authorisation and Reporting of Losses and Special Payments

12.3.1 The writing off of losses shall be approved by the Chief Finance Officer where the loss is under £10,000 and approved by the Chief Executive where the loss is over £10,000. All losses written off shall be reported to the Audit Committee in line with guidance within the HM Treasury manual, Managing Public Money.

12.3.2 For any loss, the Chief Finance Officer should consider whether any claim can be made against insurers.

12.3.3 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

12.3.4 The Trust Board shall approve a scheme of delegation for the approval and authorisation of losses and special payments within the limits of delegation granted to the Trust by the Regulator. Authorising officers must undertake fuller reviews of systems to reduce the risk of similar losses occurring in the future and seek advice where they believe a particular case raises issues of principle.

12.3.5 Payments in excess of delegated limits must be referred for approval by the Regulator; payments cannot be made without prior approval.

12.3.6 The Chief Finance Officer will compile a quarterly schedule of all losses and special payments. These will be reviewed and reported to the Trust's Audit Committee.

12.4 Bankruptcies, Liquidations and Receiverships

12.4.1 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

13 Computerised Systems

13.1 Responsibilities

13.1.1 The Chief Finance Officer, with the Chief Data~~Information~~ Officer and the Director of ICT, is responsible for the accuracy and security of the computerised financial data of the Trust. In consultation with other officers as appropriate, he/she shall ensure the adequacy of:

a. procedures to protect the Trust's data, programmes and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for Data Protection legislation and information governance requirements.

b. controls over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy completeness and timeliness of the data, as well as the efficient and effective operation of the system.

c. controls which ensure that the computer operation is separated from development, maintenance and amendment.

d. the audit trail through the computerised systems and that such computer audit reviews as he/she may consider necessary are being carried out.

13.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

13.2.1 In the case of other computer systems which are generally used with the Trust, the Chief Executive will ensure that there is a nominated director responsible for the accuracy and security of each critical information system in the Trust. The responsibilities of each director will be equivalent to those set out in 13.1.1 above for financial systems.

13.2.2 In addition the Senior Information Risk Owner (SIRO) will ensure that there is a nominated Information Risk owner at a senior level and the responsible directors /employees will send to the SIRO:

a. Details of all information flows into and out of the system;

b. Details of the access controls and procedures used to protect confidential information;

c. Risk registers detailing any significant information risks as defined within the Trust's information governance policies;

d. Processes put in place to ensure best practice standards in maintaining data quality; and

e. Controls over usage of the internet.

13.3 Contracts for Computer Services with other health bodies or outside agencies

13.3.1 The ~~Chief Information Officer~~ Director of ICT shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

13.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

13.4 Risk Assessment

13.4.1 The ~~Chief Information Officer~~Director of ICT shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

13.4.2 Privacy Impact assessments should also be undertaken on all relevant systems and updated in the event of major changes to systems.

13.5 Requirements for Computer Systems which have an impact on corporate financial systems

13.5.1 Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall need to be satisfied that:

a. Systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

b. Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c. Chief Finance Officer staff have access to such data; and

d. Such computer audit reviews as are considered necessary are being carried out.

13.6 Requirements for Computer Systems which have an impact on processes involved in patient care

13.6.1 The Chief Executive will ensure that a lead clinician at Trust Board Level is appointed as the Clinical Safety Lead - Clinical Systems to be responsible for ensuring clinical risk arising from the use of IT systems / health software and implementation of changes in such systems or new systems is managed effectively.

14 Risk Management and Insurance

14.1 Risk

14.1.1 The Chief Executive shall ensure that the Trust has a risk management strategy and a programme of risk management, equivalent to the Department of Health and Social Care assurance framework requirements, which must be approved and monitored by the Trust Board.

14.1.2 The programme of risk management shall include:

a. A process for identifying and quantifying risks and potential liabilities;

b. Engendering among all levels of staff a positive attitude towards the control of risk;

c. Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d. Contingency plans to offset the impact of adverse events;

e. Audit arrangements including; internal audit, clinical audit, health and safety review;

f. A clear indication of which risks shall be insured; and

g. Arrangements to review the risk management programme.

14.1.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on Internal Control within the Annual Report and Accounts.

14.2 Insurance

14.2.1 The Chief Executive in consultation with the Chief Finance Officer will be responsible for ensuring adequate insurance cover is effected in line with the ~~r~~Risk M~~m~~anagement P~~p~~olicy approved by the Trust Board. This will include insuring through the risk pooling schemes administered by NHS Resolution, self-insuring for some or all of the risks covered by the risk pooling schemes and purchasing insurance from an external company. If the Trust Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

14.2.2 Where the Trust Board decides to use the risk pooling schemes administered by NHS Resolution or external insurance the designated officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The designated officer shall ensure that documented procedures cover these arrangements.

14.2.3 Where the Trust Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the designated officer shall ensure that the Trust Board is informed of the nature and extent of the risks that are self-insured as a result of this decision.

14.2.4 The Chief Finance Officer should ensure documented procedures also cover the management of claims.

14.2.5 The value of all assets insured shall be reviewed annually by the designated officer.

14.2.6 The Director of ~~Develo~~pment~~Estates~~ Estates, Facilities and the Built Environment shall ensure that all engineering plant under the Trust's control is inspected by the relevant insurance companies within the periods prescribed by legislation.

14.2.7 Each officer of the Trust shall promptly notify the designated officer of all new risks or property which may require to be insured and alterations affecting existing risks or insurances.

14.2.8 The Trust may purchase and maintain insurance for risks involving liability by the Trust for the Trust's benefit, and for the benefit of members of the Council of Governors, the Trust Board and the Secretary.

15 Tendering and Contracting Procedure

15.1 Duty to comply with Standing Orders and Standing Financial Instructions

15.1.1 The procedures for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 42 Suspension of Standing Orders is applied).

15.1.2 The *Bribery Act 2010* replaces the fragmented and complex offences at common law and in the *Prevention of Corruption Acts 1889 -1916*. This broadly defines the two sections below:

- Two general offences of bribery – 1) Offering or giving a bribe to induce someone to behave, or to reward someone for behaving, improperly and 2) requesting or accepting a bribe either in exchange for acting improperly, or where the request or acceptance is itself improper;

- The corporate offence of negligently failing by a company or limited liability partnership to prevent bribery being given or offered by an employee or agent on behalf of that organisation.

15.1.3 All personnel involved in tendering and contracting activities must be aware of the *Bribery Act 2010* and must ensure that all dealings with other organisations and their staff do not bring them in breach of the Act that could leave them open to criminal proceedings being commenced.

15.2 Legislation~~EU Directives~~ Governing Public Procurement

15.2.1 The Public Contracts Regulations 2015~~ and such EU procurement directives as have effect in English law~~, which prescribe procedures for awarding all forms of contracts by a public sector body shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

15.3 Regulator Guidance for capital investments

15.3.1 The Trust shall comply with the requirements of the Regulator's Annual Reporting Manual and any other guidance in respect of the procurement of capital investment, estate and property transactions. In addition the Trust shall comply with the guidance issued in respect of *The Bribery Act 2010*.

15.4 Reverse eAuctions

15.4.1 The Trust should have policies and procedures in place for the control of all tendering activity carried out through Reverse eAuctions.

15.5 Formal Competitive Tendering

15.5.1 General Applicability
Subject to clause 16.5.3, The Trust shall ensure that competitive tenders are invited for:

a. the supply of goods, materials and manufactured articles;
b. the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSC);
c. the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

15.5.2 Health Care Services

Where the Trust wishes to procure the supply of Social and Other Specific Services as detailed in Schedule 3 of the Public Contracts Regulations 2015 (whether by sub contract or otherwise), the Trust must consider its duties in law and whether such services requirements must be advertised. Where the circumstances require it to advertise these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 8 and 9.

15.5.3 Exceptions and instances where formal tendering need not be applied

Formal tendering procedures need not be applied where:

a. the estimated expenditure or income does not, or is not reasonably expected to, exceed **£50,000 excluding VAT or other such amount approved within the financial limits,** although it is still required to seek a minimum of three quotations, where practicable, where the estimated expenditure is above £20,000 or other such amount approved within the financial limits;

b. where the supply is proposed under special arrangements negotiated by the DHSC or another NHS/public body which includes ProCure22 and framework agreements in which event the said special arrangements must be complied with;

c. regarding disposals as set out in Standing Financial Instructions SFI 12;

d. where the requirement is covered by an existing contract;

e. where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members which includes the Trust.

Formal tendering procedures **may be waived** by the Chief Finance Officer together with one other executive director (that is, Single Tender Action or "**Use of the negotiated procedure without prior publication of a contract notice"**, in respect of procurements which would otherwise be subject to advertisement under the Public Contracts Regulations 2015, in the circumstances set out in Regulation 32 and in respect of all other procurements in the following circumstances:

a. when, for reasons of extreme urgency brought about by events unforeseen by the Trust, the goods or services could not be obtained in time under competitive tendering, e.g. where remedial works are required following a disaster, but failure to plan the work properly would not be regarded as a justification for a single tender;

b. —when the goods or services can be supplied only by one source and there is no reasonable alternative or substitute;

c. —when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

d. there is a clear benefit to be gained from maintaining continuity with an earlier project, however in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

e. where the requirement is for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Chief Finance Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work; or

f. where there is an exceptional clinical emergency.

The waiving of competitive tendering procedures should not be used to avoid competition or the lack of planning or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

15.5.4 Fair, transparent and Adequate Competition

Where the requirement to carry out a competitive tender does apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

The only exception to this rule would be in the case that Competitive dialogue tendering procedures are to be used. In this case, the minimum number of economic operators invited to dialogue shall be no less than three, in the case that the total value of the contract is above the ~~OJEU~~ limit set in the Public Contracts Regulations 2015. However, at the post dialogue phase this can be reduced to a minimum of two tenders, unless exceptional circumstances exist where this isn't possible, and with the approval of the Project Team on behalf of the Chief Finance Officer. If the Trust considers it appropriate to continue with less than three bidders, it must ensure there is transparent competition and all evidence is documented. Public sector procurement guidelines must be followed in all instances.

Where a purchase exceeds the ~~OJEU~~ limit set in the Public Contracts Regulations 2015, but only a single provider is identified having advertised our requirements, approval must be sought from the Chief Finance Officer together with one other executive prior to award of the contract.

15.5.5 Building and Engineering Construction Works

Competitive Tendering cannot be waived for building and engineering construction works and maintenance without Regulator approval.

15.5.6 Items which subsequently breach thresholds after original approval

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

15.6 Instances where formal competitive tendering or competitive quotation is not required

15.6.1 Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

a. Where tenders or quotations are not required, because expenditure is below £20,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Finance Officer.

b. where the supply is proposed under special arrangements negotiated by the DHSC or a framework agreement (for example, Crown Commercial Service, NHS London Procurement Partnership, PPC, NHS Supply Chain) in which event the said special arrangements must be complied with.

15.7 Private Finance for capital procurement (overlap with SFI No. 9)

15.7.1 The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Trust Board proposes, or is required, to use finance provided by the private sector the following should apply:

a. The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

b. Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health and Social Care for approval or treated as per current guidelines.

c. The proposal must be specifically agreed by the Board of the Trust.

d. The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

15.8 Compliance requirements for all contracts

15.8.1 The Trust Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

a. The Trust's Standing Orders and Standing Financial Instructions;

b. ~~Relevant EU Directives,~~ The Public Contracts Regulations 2015 and other statutory provisions;

c. Any relevant directions including the Capital Investment Manual, Estate code and guidance on the Procurement and Management of Consultants;

d. Such of the NHS Standard Contract Terms and Conditions as are applicable;

e. Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;

f. Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited;

g. In all contracts made by the Trust, the Trust Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust. All contracts shall be recorded in the Trust's system for contract management.

15.9 Personnel and Agency or Temporary Staff Contracts

15.9.1 The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

15.10 Healthcare Contracts and Services Agreements (see overlap with SFI No. 6)

15.10.1 Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the relevant NHS service provision contract and administered by the Trust. A contract with a Foundation Trust, being a Public Benefit Corporation (PBC), is a legal document and is enforceable in law.

15.10.2 The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Trust Board.

15.11 Disposals (See overlap with SFI No. 12)

15.11.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

a. any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

b. obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

c. items to be disposed of with an estimated sale value of less than £50,000, this figure to be reviewed on a periodic basis;

d. items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

e. land or buildings concerning which DHSC guidance has been issued but subject to compliance with such guidance.

15.12 In-House Services

15.12.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

15.12.2 In all cases where the Trust Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

a. Specification group, comprising the Chief Executive or nominated officer/s and specialist.

b. In-house tender group, comprising a nominee of the Chief Executive and technical support.

c. Evaluation team, comprising normally a specialist officer, a supplies officer and a Chief Finance Officer representative.

d. For services having a likely annual expenditure exceeding £500,000, a non-officer member should be a member of the evaluation team.

15.12.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

15.12.4 The evaluation team shall make recommendations to the Trust Board.

15.12.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

15.13 Applicability of SFIs on Tendering and Contracting to assets purchased from grants or donations

15.13.1 These Instructions shall not only apply to expenditure from Exchequer funds.

15.13.2 They also apply to the procurement of works, services and goods purchased from funds donated by a charity, a grant giver or any other organisation which provides funds to the Trust to enable it to purchase a specified item.

15.14 Use of e Procurement and eTendering

15.14.1 The Chief Finance Officer will approve use of electronic systems for procurement.

15.14.2 Electronic Tendering - All invitations to tender using the Trust's or its agent's E-Tendering Portal will be on a formal competitive basis. Issue of all tender documentation will be undertaken through a secure website with controlled access. All tenders will be received into a secure electronic vault so that they cannot be accessed until an agreed opening time. The details of persons opening the documents will be recorded in the audit trail together with the time and date of opening.

16 Retention of Records

16.1.1 The Chief Executive shall be responsible for maintaining archives for all records, including electronic records, required to be retained in accordance with Department of Health and Social Care guidelines.

16.1.2 All records held in archives shall be capable of retrieval by authorised persons.

16.1.3 Records held in accordance with latest Department of Health and Social Care guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

17 Research and Innovation~~Development~~

17.1.1 All research and innovation~~development~~ activities within the Trust shall be notified to the Director of Research and Innovation through the Research and Innovation Office.

17.1.2 The Director of Research and Innovation shall ensure that there are appropriate governance procedures in place to ensure any research is conducted in accordance with relevant regulations and that there are processes in place to assess and approve contractual commitments relating to the execution of research.

17.1.3 The Chief Finance Officer shall ensure that procedures are implemented and monitored which ensure that all such activities are properly accounted for and that all funding is used as directed by the grantor / funder.

18 Acceptance of Gifts by staff and other standards of business conduct

The Chief Executive will ensure that all staff are aware of the Declarations of Interests and Gifts and Hospitality policy. The policy requires that all staff members and Trust ~~b~~Board members with private or personal interests which might affect their role within the Trust, declare these interests on joining the organisation, on a regular basis and whenever the potential for conflict arises. It covers financial interests, non-financial professional interests, non-financial personal interests and indirect interests.

The policy also provides guidance to staff and Trust ~~b~~Board members on the procedure to be followed in the event of any gift, hospitality or sponsorship being offered. It outlines restrictions in relation to accepting gifts, inducements, benefits in kind or other personal advantage which could be considered to be bribes under *The Bribery Act 2010.*

Great Ormond Street Hospital for Children NHS Foundation Trust

Scheme of Delegation

Version 5.0 – to be approved

Date: November 2021

Document Control Page

This Scheme of Financial Delegations Manual has been created as a subset of the Standing Financial Instructions of Great Ormond Street Hospital NHS Foundation Trust.

Sign-Offs

Version	Role	Position	Date
5.0	To be endorsed by	Executive Management Team	06/10/2021
	To be recommended for approval by	Audit Committee	January /2022
	Approval	Trust Board	TBC

Contents

Section 1 Introduction and Purpose

Introduction

This document constitutes the Scheme of Delegation as required to be prepared in accordance with the *Great Ormond Street Hospital for Children NHS Foundation Trust Constitution (Constitution), Annex 9, Clause 20.2*.

The Chief Executive shall prepare a scheme of delegation identifying his or her proposals, which shall be considered and approved by the Trust Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendments to the scheme of delegation that shall also be considered and approved by the Trust Board, as it see fit. The Constitution also outlines the definition of a significant transaction and the process for approval of any transaction that falls into this category. This should be read in addition to this *Scheme of Delegation* document. Refer to the extracts from the relevant extracts from the Constitution in Section below.

Purpose

The purpose of this Manual is to document and consolidate the guiding principles, functions, level and restrictions or conditions of delegated authority for executives and staff within the Trust.

Section 2 Hierarchy of Delegation and Sub-Delegation

Application of Delegation

Level 1 Board	***Clause 4 Powers*** *4.1 The powers of the Trust are set out in the 2006 Act.* *4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.* *4.3 Any of these powers may be delegated to a committee of directors or to an executive director.*
Level 2 Chief Executive	***Annex 9 - Clause 1.~~2~~1*** *Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of standing orders, the schedule of reservation and* ***delegation of powers and/or the standing financial instructions*** *(on which he or she should be advised by the Chief Executive.)*
Level 3-11	Refer to ***Schedule 1 for Sub-Delegations to Positions*** in the organisation approved by the Chief Executive and Chair.

Levels of Sub-Delegation

The Delegation financial limits are also linked to the position/role of the staff member, if not specifically mentioned in Section 1. If these limits apply refer to Schedule 1 to determine the level of financial delegations that applies.

The Levels outlined in Schedule 1 will be those set on the financial system.

Types of Delegation Authority

The types of financial delegation outlined in this document include:

- Expenditure approval delegations
- Invoices and credit note requests
- Business case approval delegations
- Procurement delegations
- Contracts signing delegations
- Other non-financial delegations.

Section 3 Principles

General Delegation Principles

Delegates Must:

1) Act within your authority by ensuring you hold the relevant delegation
1) Understand your authority by referring to relevant guidance, limitations and directions
2) Act with the Trust's values in mind
3) Avoid conflicts of interest
4) Consider the Trust's business needs
5) Seek expert advice when making a decision
6) Make decisions objectively, reasonably and fairly.

Delegates Must Not:

1) Exercise delegations in respect of someone outside of your immediate line of control
2) Exercise powers in respect of a position higher than your own
3) Exercise a delegation in respect of yourself (i.e. confer a personal benefit)
4) Exercise a delegation on behalf of an absent employee unless it is within the scope of your delegated authority or you are officially acting in the position.

Compliance

i. All delegates are required to comply with manuals and directives issued by the Trust, including their own unit's manuals and directives.
ii. Delegated authority is subject to internal controls and to any overriding National laws, e.g. purchase or dispensing of dangerous drugs.

Responsibility

i. Delegations are made to positions, not to persons, and are specific to the position's work unit and/or role. Ultimate responsibility for performance of the functions or exercise of the authority or power rests with the authority holder.
ii. Where an authority holder delegates an authority to an individual position, the person occupying that position becomes personally accountable for the delivery of that authority.
iii. The delegation to a position is unique and is not transferable by the delegate.
iv. Delegations extend to the officer substantively appointed to that position and any person acting in that position for a specified period unless otherwise excluded in the terms of the temporary appointment. Delegations do not extend to volunteers or councillors.
v. Where the Scheme of Delegation specifies a delegate, the position to which the delegate reports is also deemed to have the delegated authority except where otherwise determined by legislation, policy or a Chief Executive instruction.
vi. Where the permanent officer takes leave, it is their responsibility to instruct the relieving officer of the level of delegation that is attached to the position and the responsibilities associated with the delegation.

Application

i. Delegates are expected to exercise their powers, authorities, duties or functions delegated to them in a responsible, efficient, consistent and cost-effective manner.

ii. Discretion is to be utilised by the delegate in determining whether to exercise a delegation or refer the matter to a higher authority.
iii. When an officer is exercising their financial delegation, they are required to clearly provide their name, position and date when signing.

Financial Delegation Principles

Delegates Must:

1) Only approve expenditure in cost centres under the delegate's authority
2) Only approve expenditure where there is sufficient budget to cover the cost
3) Only approve expenditure on goods and services related to official work and business use
4) Only approve expenditure where all relevant Trust's procedures and policies have been followed
5) Only approve expenditure to the financial limit of the delegation
6) Only approve expenditure where evidence exists that goods have been received and/or services have been performed in accordance with and at the rate/s of an agreed contract or arrangement
7) Employees are to note that an expenditure approval is to be given prior to any commitment being made, contract signed or purchase order raised.

Delegates Must Not:

1) approve a gift or settlement of any legal claim unless specifically delegated this authority
2) transfer the financial delegation granted by the Trust Chief Executive to another employee
3) break one purchase down into several smaller items to avoid breaching the financial limit of the delegation
4) approve expenditure on capital works, contracts or special payments unless specifically delegated this authority
5) exceed their delegation limits even if automated systems permit this to occur
6) Approve any expenditure incurred by the delegate on travel, meals, conferences and other similar expenditure
7) Assume the financial delegation of an absent delegate if you are not authorised to do so.

Suspension, Revocations and Reductions in Financial Delegations

- The terms of any financial delegation cannot be exceeded under any circumstances.
- Financial delegations cannot be sub-delegated once granted by the Trust Chief Executive.
- Improper performance of responsibilities may result in disciplinary action being taken against the employee concerned.
- The power to revoke, suspend or reduce financial delegations granted to positions within the Trust rests with the Chief Executive in respect of delegations made.
- If circumstances arise which warrant the suspension, revocation or reduction of a financial delegation, full details must be forwarded to the Trust's Chief Finance Officer. The Trust's Chief Finance Officer will submit an appropriate recommendation to the Chief Executive for consideration.
- If the recommendation is approved, the delegation will be amended to reflect that reduction, suspension or revocation.

- The amended Expenditure Approval Financial Delegation Register or Procurement Delegation Register or Contracts Signing Delegation Register will be published on the intranet.

Reviewing and Maintaining the Scheme of Delegations

This Scheme of Delegation~~s Manual~~ may be amended from time to time to reflect changes in legislation, Trust policy or operational requirements.

The Trust will coordinate regular~~annual~~ reviews of financial, procurement and contracts signing financial delegations for positions and limits. A revised version is submitted to ~~Trust Chief Finance Officer for~~ the Executive Management Team and Audit Committee for endorsement before submitting it to ~~Chief Executive and~~and the Trust Board for approval.

~~Requests for changes outside the annual reviews can occur on the basis of urgency should there be a change in organisational structure or new position titles created. The requests should first be approved by the relevant Trust Executive and forwarded to the Chief Finance Officer for processing and coordination of approval by the Chief Executive.~~

Section 4 Relevant Legislation – GOSH Constitution

The following paragraphs from the GOSH Constitution outlines the powers of delegation and the requirement for standing orders for the Trust.

Powers of Delegation

Clause 4 Powers

4.1 The powers of the Trust are set out in the National Health Service Act 2006~~,~~. ~~as amended by the Health and Social Care Act 2012.~~

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

Standing Orders Practice and Procedure

ANNEX 9 Standing Orders for the Practice and Procedure of the Trust Board

Clause 1 Interpretation and definitions

~~*1.1*~~

1.~~1~~2 Save as otherwise permitted by law, the Chair of the Trust shall be the final authority on the interpretation of these paragraphs and the Standing Orders (on which they should be advised by the Chief Executive or Company Secretary).

Clause 20 Delegation to Officers

20.1 Those functions of the Trust which have not been retained as reserved by the Trust Board or delegated to a committee or sub-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Trust Board.

20.2 The Chief Executive shall prepare a scheme of delegation identifying his or her proposals, which shall be considered and approved by the Trust Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendments to the scheme of delegation that shall also be considered and approved by the Trust Board, as it see fit.

20.3 Nothing in the scheme of delegation shall impair the discharge of the direct accountability to the Trust Board of the director responsible for finance to provide information and advise the Trust Board in accordance with statutory or regulatory requirements. Outside these statutory or regulatory requirements, the role of the director responsible for finance shall be accountable to the Chief Executive for operational matters.

Clause 26~~.~~ Standards of Business Conduct

26.1 Directors of the Trust shall comply with standing financial instructions prepared by the director of finance (Chief Finance Officer) and approved by the Trust Board for the guidance of all staff employed by the Trust.

Clause 32. Schedule of Matters Reserved to the Trust and Scheme of Delegation of powers

32.1 The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect (as adopted from time to time) as if incorporated in these Standing Orders.

Significant Transaction Definition

Clause 47. Mergers etc. and significant transactions

47.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

47.2 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

47.3 In paragraph 47.2, the following words have the following meanings:

47.3.1 "Significant transaction" means a transaction which meets any one of the tests below:

47.3.1.1 the total asset test; or

47.3.1.2 the total income test; or

47.3.1.3 the capital test (relating to acquisitions or divestments).

47.3.2 The total asset test is met if the assets which are the subject of the transaction exceed 25% of the total assets of the Trust;

47.3.3 The total income test is met if, following the completion of the relevant transaction, the total income of the Trust will increase or decrease by more than 25%;

47.3.4 The capital test is met if the gross capital of the company or business being acquired or divested represents more than 25% of the capital of the trust following completion (where "gross capital" is the market value of the relevant company or business's shares and debt securities, plus the excess of current liabilities over current assets, and the Trust's total taxpayers' equity).

47.3.5 For the purposes of calculating the tests in this paragraph 47.3 figures used for the Trust assets, total income and taxpayers' equity must be the figures shown in the latest published audited consolidated accounts.

47.4 A transaction:

47.4.1 excludes a transaction in the ordinary course of business (including the renewal, extension or entering into an agreement in respect of healthcare services carried out by the Trust;

47.4.2 excludes any agreement or changes to healthcare services carried out by the Trust following a reconfiguration of services led by the commissioners of such services;

47.4.3 excludes any grant of public dividend capital or the entering into of a working capital facility or other loan, which does not involve the acquisition or disposal of any fixed asset of the Trust

NB The definitions of significant transactions as described above have been prescribed by the NHS~~E/I Improvement.~~

Section 5 Summary of Expenditure Approval Financial Delegations

This section will summarise the delegated responsibilities and the associated delegated officer, linked to the Standing Financial Instructions.

This table also refers Schedule 1 where applicable.

5.1 Management of budgets and approval to spend revenue funds (non-pay)

The Trust's annual Budget Plan is approved by the Trust Board at the commencement of the financial year following a review by the Finance & Investment Committee.

This delegation has application in respect of the management and approval to spend revenue funds for non-pay expenditure included within the annual approved Trust budget plan (for example, approval of purchase orders and sign-off of invoices).

Note – delegations relating to the approval of a business case, procurement or the signing of a contract are outlined separately *(refer Delegations 6.1, 7.2 and 7.3, and Sections 6 and 7).*

The detailed instructions are outlined in ***SFI 2 Business Planning, Budgets, Budgetary Control and Monitoring***.

#	Delegated Responsibilities	Delegated Officer or Group
1.1	**Authority to approve non-pay expenditure within individual budgets if included within the Trust's annual Budget Plan excluding:** • **Business rates and NHS Resolution *(refer Delegation 1.2)*** • **Factor 8 blood and high cost drugs *(refer Delegation 1.3)*** • ~~**Development *(refer Delegation 1.4)***~~ • **Situations where a business case is required *(refer Section 4)***	
1.1.1	Management of individual budgets if included within the Trust's annual Budget Plan	***Refer Schedule 1***
1.1.2~~3~~	**Virements~~:~~** Less than £100,000 (this relates only to expenditure virements which do not cross directorates)	**General Manager** OR **Chief of Service** (or delegations as agreed with the Chief Finance Officer) AND

#	Delegated Responsibilities	Delegated Officer or Group
	Above £100,000	**Chief Finance Officer** ~~OR **Chief Operating Officer** OR **relevant Executive Director)** (or delegations as agreed with the Chief Executive)~~ **General Manager** OR **Chief of Service** (or delegations as agreed with the Chief Finance Officer) AND Chief Finance Officer OR Chief Operating Officer OR Chief Executive The virement must be signed by both the budget holder *from* whom the budget is transferring and the budget holder *to* whom the budget is transferring
1.2	**Authority to approve business rates and NHS Resolution non-pay expenditure within budget**	
1.2.1	Less than £5,000,000	**Chief Executive** OR **Chief Operating Officer** OR **Chief Finance Officer**
1.2.2	Over £5,000,000	**Trust Board**
1.3	**Authority to approve home delivery of Factor 8 or high cost drugs non-pay expenditure within budget**	
1.3.1	Less than £10,000,000	**Chief Executive** OR **Chief Operating Officer** OR **Chief Finance Officer**
1.3.2	Over £10,000,000	**Trust Board**
1.4	**Authority to approve capital~~non-pay~~ expenditure included within the approved plan within individual project budget ~~(Development)~~**	
1.4.1	Less than £1,000,000	~~**Deputy Director of Development**~~ Director of Estates, Facilities and the Built Environment
1.4.2	Over £1,000,000 up to £5,000,000	**Chief Executive** OR **Chief Operating Officer** OR **Chief Finance Officer** OR **Director of ~~Development~~Estates, Facilities and the Built Environment**
1.4.3	Over £5,000,000	Two of **Chief Executive** OR **Chief Operating Officer** OR **Chief Finance Officer** OR **Director of Estates, Facilities and the Built Environment~~Development~~**
1.~~4~~5	**Authority to approve non-pay expenditure in excess of budget excluding ~~excluding~~:** ~~• **Development *(refer Delegation 1.6)***~~ • **Situations where a business case is required *(refer Section 4)*** **(note: this applies to business-as-usual overspends per Directorate per month)**	
1.~~4~~5.1	Less than £500,000	~~**Chief Executive** OR **Chief Operating Officer** OR **Chief Finance Officer** OR~~ Responsible **Executive Director**

#	Delegated Responsibilities	Delegated Officer or Group
1.5.2	Over £500,000 up to £4.500,000	**Chief Executive** OR **Chief Operating Officer** OR **Chief Finance Officer** *Approval noted by:* ~~Audit~~Finance and Investment Committee
1.~~5~~6	**Authority to approve capital expenditure in excess of individual project budget ~~(Development)~~ NB the total Trust capital budget cannot be exceeded**	
1.~~5~~6.1	Approval of any increase to the individual capital ~~expenditure~~scheme budgets as against the approved annual capital programme to a maximum of £100,000*(refer Section 5)*	*:* Capital Investment Group
1.~~5~~6.2	Approval of any increase to the individual capital ~~expenditure~~scheme budgets as against the approved annual capital programme over £100,000 ~~**where the revised budget is below £2,500,000**~~*(refer Section 5)*	**Executive Management Team** *Prior endorsement required by:* Capital Investment Group
~~*1.6.3*~~	~~Approval of any increase to the individual capital expenditure budgets as against the approved annual capital programme over £100,000 **where the revised budget is between £2,500,000 and £4,500,000***~~(refer Section 5)~~	~~**Finance & Investment Committee**~~ ~~*Prior endorsement required by:*~~ ~~Executive Management Team AND~~ ~~Capital Investment Group~~
~~*1.6.4*~~	~~Approval of any increase to the individual capital expenditure budgets as against the approved annual capital programme over £100,000 **where the revised budget is in excess of £4,500,000***~~(refer Section 5)~~	~~**Trust Board**~~ ~~*Prior endorsement required by:*~~ ~~Finance & Investment Committee AND~~ ~~Executive Management Team AND~~ ~~Capital Investment Group~~
1.~~6~~7	**Authority to approve capital expenditure in excess of the total capital budget**	
1.~~7~~6.1	Approval of any increase in the total capital budget above the value signed off by Trust Board would breach CDEL and is **not permitted**	~~**Finance & Investment Committee**~~ ~~*Prior endorsement required by:*~~ ~~Capital Investment Group~~
1.~~7~~8	**Authority to approve non-pay expenditure relating to non-audit based professional services to be provided by the Trust's external auditor**	
1.~~7~~8.1	Approval of any proposed non-audit based professional services to be delivered by the Trust's external auditor	**Chief Finance Officer AND the Chair of the Audit Committee** *Prior endorsement required by:* Executive Management Team Approval noted by the Audit Committee

5.2 Special Purpose Funds

This delegation has application when Special Purpose Funds ("SPF") are donated to the Trust by the GOSH Children's Charity ("GOSHCC"). SPFs arise when funds are donated for a specific usage within the GOSHCC's objects, with the restriction being placed upon use by

the donor. This may be for use by a specific department/ward or for a particular type of research.

Day-to-day administration of an SPF is delegated to relevant, senior Trust employees or individuals with joint contracts of employment with the Trust and ICH (known as "Fundholders"). Fundholders are named individuals rather than linked to position levels.

The detailed instructions are outlined in the ***GOSHCC SPF Induction Pack***.

#	Delegated Responsibilities	Delegated Officer or Group
2.1	**Authority to approve expenditure relating to an SPF**	
2.1.1	Approval of expenditure relating to an SPF where the expenditure is in accordance with the charitable objectives of the GOSHCC and the restricted purpose of the SPF	**SPF Fundholder** AND co-signed by **General Manager / Operational Lead**

5.3 Invoice requests

This delegation has application in respect of the raising of an invoice requesting payment from an external organisation.

All invoices for NHS commissioning services must go via the Commissioning Contracts team within the Finance Directorate.

All invoices for International and Private Care (I&PC)~~Patients~~ must be ~~approved via the IPP IPC~~Accounts Receivable team and raised in accordance with the approved I&PC~~P~~ tariff rates.

#	Delegated Responsibilities	Delegated Officer or Group
3.1	**Authority to approve the raising of an invoice request (except I&PC) to an external organisation**	
3.1.1	Less than £100,000	**Budget holder AND Management Accountant** OR **Senior Management Accountant**
3.1.2	Over £100,000 up to £500,000	**Budget holder AND Finance Manager**
3.1.3	Over £500,000 up to £1,000,000	**Budget Holder AND Finance Business Partner**
3.1.4	Over £1,000,000	**Budget Holder AND Associate Director of Finance (~~Head of~~ Contracts, Costing & Income)** OR **Associate Director of Finance (~~Head of~~ Financial Management)**
3.2	**Authority to approve the raising of an I&PC invoice**	
3.2.1	**All invoices to be approved by the Deputy Director of I&PC in line with the agreed tariffs**	
3.~~3~~2	**Authority to approve a credit note relating to reimbursement of income previously invoiced**	
3.~~3~~2.1	Less than £25,000	**Associate Director of Finance (Financial Control)~~ler~~** OR **~~Deputy Financial Controller~~**

#	Delegated Responsibilities	Delegated Officer or Group
~~3.2.2~~	~~Over £25,000 up to £100,000~~	~~**Deputy Chief Finance Officer**~~
3.~~3~~2.~~3~~2	Over £~~100~~25,000	**Chief Finance Officer**
NB For all invoice requests other than Clinical Income from NHS England and NHS Improvement, the budget holder remains the responsible person for confirming the validity of the charge to be raised to the external body.		

5.4 Expense claims

This delegation has application in situations where an employee is claiming reimbursement for an expense they have incurred personally. The Trust's detailed policy covering expense claims is outlined in the ***Staff Expenses Policy***.

#	Delegated Responsibilities	Delegated Officer or Group
4.1	**Authority to approve expense claims**	
4.1.1	Approval of expense claim within assigned delegation limit *(refer Schedule 1)* and claim is allowable per the Staff Expenses Policy	**Employee's line manager**
4.1.2	Approval of expense claim above assigned delegation limit *(refer Schedule 1)* and claim is allowable per the Staff Expenses Policy in line with their delegated limit	**General Manager / Chief of Service / Deputy Director** OR **Executive Director**

5.5 Management of budgets and approval to spend revenue funds (pay)

This delegation has application in respect of the management and approval to spend revenue funds for pay expenditure included within the annual approved Trust budget plan – in other words, this delegation applies to recruitment to fully funded staff posts that are included within the existing HR establishment. Note, any proposed increases to the HR establishment or new posts will require a business case to be approved *(refer Delegation 6.1)*.

The detailed process to be followed when seeking to appoint temporary or permanent staff is outlined in the ***Vacancy Approval Process***, including the role and membership of the Vacancy Review Panel, and the requirement for the relevant Recruitment Form to be signed off and approved.

#	Delegated Responsibilities	Delegated Officer or Group
5.1	**Authority to approve staff appointments if within budget ~~AND within existing HR establishment (e.g. recruitment to vacancies within the establishment)~~**	
5.1.1	Staff appointment (where the post is included within existing establishment)~~ up to and including Band 78b posts and Junior Doctors~~	**Approval from ~~appropriate~~local Trust vacancy panel in line with the Vacancy Approval Process** **Pre-approval by Chief of Service, General Manager or Head of Nursing**

#	Delegated Responsibilities	Delegated Officer or Group
		Corporate Directorates (including Research and Innovation) require authorisation from Director, Deputy Director or Assistant Director *Prior endorsement required by:* **Finance and HR**
5.1.2	Staff appointment (Band 7 or junior where the post is not included within existing establishment)	**Approval from Trust-wide vacancy panel in line with the Vacancy Approval Process (following approval by the local Trust vacancy panel)** **Pre-approval by Chief of Service, General Manager or Head of Nursing Corporate Directorates (including Research and Innovation) require authorisation from Director, Deputy Director or Assistant Director** *Prior endorsement required by:* **Finance and HR**
5.1.3~~2~~	Staff appointment (where the post is not included within existing establishment) (Band 8A and above)~~–~~ ~~Bands 8a, 8b, 8c, 8d, 9 and Very Senior Manager~~	**Executive Management Team** **Prior approval will be given at the appropriate Trust vacancy panel as per the Vacancy Approval Process** *Prior endorsement required by:* **Finance and HR**
5.1.4~~3~~	Staff appointment – existing Medical Consultant Posts	**Executive Management Team** **Prior approval will be given at the appropriate Trust vacancy panel and the Chief of Service meeting as per the Vacancy Approval Process** *Prior endorsement required by:* **Finance and HR**
5.1.5~~4~~	Staff appointment – Executive Directors and other Directors referenced on the Trust Board	**Chief Executive** AND **Relevant Executive Director** AND **Director Human Resources & Organisational Development** (for the purpose of confirming appropriate level of appointment / remuneration)
5.2	**Authority to approve remuneration arrangements for staff**	
5.2.1	Approval of remunerations arrangements (including additional allowances above basic salary) – all staff levels excluding Executive Directors and Directors referenced on the Trust Board	**Director Human Resources & Organisational Development** AND **Relevant Executive Director** AND **Chief Executive Officer**
5.2.2	Approval of remuneration arrangements – Executive Directors and other Directors referenced on the Trust Board	**Remuneration Committee**
5.3	**Authority to approve pay expenditure relating to staff timesheets (including overtime)**	
5.3.1	Approval of staff time sheets for both substantive and temporary staff	**Relevant Executive Director** OR **Director** OR **General Manager** OR **Chief**

#	Delegated Responsibilities	Delegated Officer or Group
		of Service OR **Deputy Director** OR **Service Manager** OR equivalent

5.6 Approval of business cases requesting ~~revenue~~ funding

A business case (also known as an investment proposal) is a document that provides the rationale for why the Trust should agree to fund a particular project.

This delegation has application when a business case requesting ~~revenue~~ funding ~~(i.e. excluding capital)~~ is required to be prepared and approved. Note, delegations relating to procurement or the signing of a contract are outlined separately *(refer Sections 6 and 7)*.

A business case is required in the following situations:

- When ~~revenue~~ funding is requested in excess of allocated budget OR
- A change to the model of service delivery or model of care is proposed OR
- A change to the HR establishment is proposed OR
- An existing contracted service is required to be re-tendered.

~~Operational Delivery and Planning~~The Business Case Review Group is required to scrutinise ~~and endorse~~ all ~~revenue~~ business cases requesting new budget from the contingency prior to the case going to the Trust's Operational Board and the Capital Investment Group (where relevant) for endorsement, and then EMT, FIC or Trust Board (dependent on the financial value) for final approval.

The detailed instructions are outlined in ***SFI 2 Business Planning, Budgets, Budgetary Control and Monitoring***.

Determining the appropriate approval process

The appropriate approval process for a business case is determined by the value of the business case. The following principles should be applied to calculate the value of the business case:

- For non-pay or capital expenditure business cases, the value of the business case should be calculated on the basis of the total cost over 5 years
- For pay expenditure business cases, the value of the business case should be calculated based on the yearly cost, and
- For business cases combining non-pay, capital and pay expenditure, the value of the business case should be calculated on the basis of the total cost over 5 years.
- New revenue budgets can only be funded from the Chief Executive's contingency; additional capital budgets can only be funded from within the approved capital plan or from an additional allocation of PDC to the Trust~~.~~

Escalating the business case approval process

There will be situations where a business case is relatively low value but of strategic importance to the Trust. Accordingly, any Executive Director has the right to override these delegations to escalate approval up the approval process. Example situations include:

- Politically or commercially sensitive, novel or contentious
- Outsourcing of a service with implications on staffing
- Deemed of strategic importance and intrinsically linked to the Trust's strategic direction and priorities, or
- Where the Directorate is not meeting its budget control total.

An Executive Director cannot override these delegations to de-escalate approval down the approval process.

#	Delegated Responsibilities	Delegated Officer or Group
	Authority to approve business cases requesting ~~revenue~~ funding	
6.1.1	Up to £2,500,000	**Executive Management Team** *Prior endorsement required by:* Operational Board Capital Investment Group (where relevant)
6.1.2	Over £2,500,000 up to £4,500,000	**Finance & Investment Committee** *Prior endorsement required by:* Operational Board Capital Investment Group (where relevant) Executive Management Team
6.1.3	Over £4,500,000 Outline Business Case	**Trust Board** *Prior endorsement required by:* Operational Board Capital Investment Group (where relevant) Executive Management Team AND Finance & Investment Committee
	Full Business Case	**Trust Board** *Prior endorsement required by:* Operational Board Capital Investment Group (where relevant) Executive Management Team AND Finance & Investment Committee

5.7 Approval of business cases requesting capital funding

The annual Capital Programme is approved by the Trust Board annually following a review by the Finance & Investment Committee. All capital schemes should form part of this outline programme, but approval of the programme does not constitute approval for expenditure for an individual capital scheme within the programme. A business case is required to be prepared and approved for these individual capital schemes.

A business case (also known as an investment proposal) is a document that provides the rationale for why the Trust should agree to fund a particular project. It must also include the revenue consequences.

This delegation has application when a business case requesting capital funding is required to be prepared and approved. Note, delegations relating to procurement or the signing of a contract are outlined separately *(refer Sections 6 and 7)*. The detailed instructions are outlined in ***SFI 9 Capital Investment, Private Financing and Leasing***.

#	Delegated Responsibilities	Delegated Officer or Group
7.1	**Authority to approve the annual Capital Programme**	
7.1.1	Approval of the annual Capital Programme and the overall capital expenditure budget	**Trust Board** *Prior endorsement required by:* Finance & Investment Committee
7.1.2	Approval of any increase to the overall capital expenditure budget as against the approved annual capital programme	**Finance & Investment Committee** *Prior endorsement required by:* Capital Investment Group NB The total capital budget cannot exceed the Trust's annual CDEL limit
7.2	**Authority to approve business cases requesting capital expenditure (excluding ICT)**	
7.2.1	Less than £500,000 (if there are revenue consequences EMT, Finance and Investment Committee or Trust Board must approve as appropriate)	**Capital Investment Group** *Approval noted by:* Executive Management Team **NB the Procurement of Equipment Group manage the prioritisation of spend on medical equipment+ but the responsibility for authorising expenditure remains with CIG**
7.2.2	Over £500,000 up to £2,500,000	**Executive Management Team** *Prior endorsement required by:* Capital Investment Group *Approval noted by:* Finance & Investment Committee
7.2.3	Over £2,500,000 up to £4,500,000	**Finance & Investment Committee** *Prior endorsement required by:* Capital Investment Group AND Executive Management Team
7.2.4	Over £4,500,000 OR major redevelopment works	

#	Delegated Responsibilities	Delegated Officer or Group
	Outline Business Case	**Trust Board** *Prior endorsement required by:* Capital Investment Group AND Executive Management Team AND Finance & Investment Committee
	Full Business Case	**Trust Board** *Prior endorsement required by:* Capital Investment Group AND Executive Management Team AND Finance & Investment Committee
7.3	**Authority to approve business cases requesting capital expenditure (ICT)**	
7.3.1	Less than £500,000	**Information Management & Technology Board** *Approval noted by:* Executive Management Team AND Capital Investment Group
7.3.2	Over £500,000 up to £2,500,000	**Executive Management Team** *Prior endorsement required by:* Information Management & Technology Board *Approval noted by:* Capital Investment Group Finance & Investment Committee
7.3.3	Over £2,500,000 up to £4,500,000	**Finance & Investment Committee** *Prior endorsement required by:* Information Management & Technology Board AND Executive Management Team *Approval noted by:* Capital Investment Group
7.3.4	Over £4,500,000 Outline Business Case	**Trust Board** *Prior endorsement required by:* Information Management & Technology Board AND Executive Management Team AND Finance & Investment Committee *Approval noted by:* Capital Investment Group
	Full Business Case	**Trust Board** *Prior endorsement required by:* Information Management & Technology Board AND Executive Management Team AND Finance & Investment Committee *Approval noted by:* Capital Investment Group

Recording, monitoring and approval of payments under the losses and special payments regulations

This delegation has application in respect of the recording, monitoring and approval of payments under the losses and special payments regulations. The detailed instructions are outlined in ***SFI12 Disposals and Condemnations***. The Chief Finance Officer is responsible for ensuring Losses and Special Payment Register is maintained.

#	Delegated Responsibilities	Delegated Officer or Group
8.1	**Cash losses and bad debts**	
	Note: these write-offs, once agreed, will impact on individual budgets – there is no central provision. A bad debt write-off for these purposes is the writing off of any income due to the Trust, whether or not invoiced – it does not include adjustments relating to invoices raised in error.	
8.1.1	All losses ~~Less than £10,000~~	**Chief Finance Officer**
8.1.2	All bad debt write offs~~Over £10,000~~	~~**Chief Executive** OR **Chief Operating Officer** OR **Chief Finance Officer**~~**Audit Committee**
8.2	**Authority to approve losses of equipment and property**	
8.2.1	Less than £100,000	**Chief Operating Officer** OR **Chief Finance Officer**
8.2.2	Over £100,000 up to £500,000	**Chief Executive** *Approval noted by:* Audit Committee
8.2.3	Over £500,000	**Audit Committee** OR **Trust Board**
8.3	**Authority to approve claims net of recovery from NHS Resolution**	
8.3.1	Up to £100,000	Two of **Chief Executive** OR **Chief Operating Officer** OR **Chief Finance Officer** OR **Executive Director**
8.3.2	£100,000 to £500,000	**Executive Management Team**
8.3.3	Over £500,000	**Audit Committee** OR **Trust Board**
8.4	**Authority to approve losses of stock**	
8.4.1	All losses of stock	**Chief Finance Officer** *Approval noted by:* Audit Committee
8.5	**Authority to approve settlements relating to ~~staff grievance and~~ patient complaints**	
~~*8.5.1*~~	Staff grievance settlements other than in response to a formal process	**Chief Finance Officer** ~~**Executive**~~ AND **Director of Human Resources & Organisation Development**
8.5.1~~2~~	Ex-gratia payments in respect of ~~C~~complaints	~~**Chief Nurse** AND~~ **Chief Finance Officer** Approval noted by the Audit Committee
8.6	***Losses of patient or staff property or cash***	

#	Delegated Responsibilities	Delegated Officer or Group
8.6.1	All losses of patient or staff property or cash	**Chief Finance Officer** ***Approval noted by:*** **Audit Committee**

~~5.8~~5.7 Management of patients' property

The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

This delegation has application with respect to the management of patients' property, including the disposal of deceased patients' property. The detailed instructions are outlined in ***SFI 14 Patients' Property.***

#	Delegated Responsibilities	Delegated Officer or Group
9.1	**Authority to approve the release of property belonging to a deceased patient**	
9.1.1	Property valued up to £5,000	~~**Deputy**~~ **Chief Finance Officer** *Indemnity form must be signed prior to release*
9.1.2	Property valued over £5,000	**Chief Finance Officer** *Probate or Letters of Administration must be provided prior to release*

Section 6 Summary of Procurement Delegations

All UK Public Sector organisations are subject to *Public Procurement Regulations 2015* which stipulate how goods and services should be purchased fairly and transparently with evidence of good value for money.

The detailed instructions for tendering and contracting by or on behalf of the Trust are outlined in ***SFI 16 Tendering and Contracting Procedure***. SFI 16 states the requirement for formal competitive tendering and the limits for quotations and tenders (summarised in the table below). It also states the exceptions and instances where formal competitive tendering is not required.

Total Contract Value[1]	Procedure
Less than £20,000	Obtain alternate process/quotes where practicable
£20,000 to £50,000	Seek a minimum of three (3) written quotes (see below for instances where three written quotes cannot be obtained)
Goods and Services between £50,000 and £122,976~~181,302~~ Light Touch Regime services (see below) £50,000 to £615,278 Works Contracts £50,000 £4,551,413	Advertise through the Trust e-Tendering Portal AND Either undertake mini-competition through an approved multi-supplier framework agreement where **all approved suppliers capable of providing the relevant requirements** must be invited to bid OR undertake a tender exercise where a minimum of five (5) should be invited to bid for the contract
Good, supplies and services above £ 122,976~~181,302~~ Light Touch Regime services (see below) above £615,278 Works Contracts above £4,551,413	Advertise through the Trust e-Tendering Portal AND Either undertake mini-competition through an approved multi-supplier framework agreement where **all approved suppliers capable of providing the relevant requirements** must be invited to bid and the value is within the framework limit OR conduct a full tender process compliant with the Public Contracts Regulations 2015 for which advice must be sought from the Procurement team

Notes:

- Works are defined as 'Activities constituting works' as per Schedule 2 of the Public Sector Procurement Regulations 2015 and fall under Common Procurement Vocabulary code 450000. If not specified under this schedule the threshold for goods and services apply.
- A single supplier (direct call off) from an approved multi-supplier framework is only permitted under the framework rules i.e. the supplier selected must be the top ranked as per the process set out in the framework who are capable of providing the relevant requirements
- Mini-competitions undertaken form multi-supplier frameworks MUST invite all suppliers under the relevant lot and only the suppliers listed on the framework
- All suppliers invited to bid for Trust contracts must have been verified that they have the technical capability to supply the goods, services or works required.
- On award of contract, the service specification should not be significantly different from that assessed as part of the tender process otherwise this will render the process invalid.

[1] 'Total Contract Value' is exclusive of VAT and relates to the whole of life cost of the contract.

Total Contract Value[1]	Procedure
• Award of contracts should be based on the most economically advantageous offer. Where quality/price evaluation is planned, the criteria must be pre-determined and set out in the Request for Quotation or tender to ensure fair competition	
The Public Procurement thresholds ~~for the period January 2018~~16 August 2016 ~~to December 2019~~ are as follows:- • Supply and Service Contracts - £~~181~~122,976~~,302~~ • Social and other specific services covered by the 'Light Touch Regime' as set out in Schedule 3 of the Public Contracts Regulation 2015 - £615,278 • Works contracts - £4,551,413	

6.1 Waiving of formal competitive tendering

Formal competitive tendering can be waived only in limited circumstances, and these are outlined in SFI 16. In instances where formal competitive tendering is to be waived, an 'SFI Waiver Form' must be completed and approved by those with delegated authority.

This delegation has application when:

- The total contract value is over £20,000 and up to £50,000, and a minimum of three (3) quotations have not been received, OR
- The total contract value is over £50,000 and up to the ~~OJEU~~ limit set out in the Public Contracts Regulations 2015 (PCR), and a minimum of three (3) formal competitive tenders have not been received, OR
- The total contract value is either over the ~~OJEU~~ limit set out in the Public Contracts Regulations 2015, ~~an OJEU~~a compliant ~~-~~tender process has not been conducted OR a minimum of three (3) formal competitive tenders have not been received.

~~Formal competitive tendering can be waived only in limited circumstances, and these are outlined in SFI 16. In instances where formal competitive tendering is to be waived, an 'SFI Waiver Form' must be completed and approved by those with delegated authority.~~

#	Delegated Responsibilities	Delegated Officer or Group
10.1	**Authority to approve waiving of formal competitive tendering**	
10.1.1	Supply of goods, services and design contracts up to ~~OJEU~~ PCR limit	**Chief Finance Officer** AND one other **Executive Director** *Approval noted by:* Executive Management Team AND Audit Committee
10.1.2	Works contracts up to ~~OJEU~~ PCR limit	**Chief Finance Officer** AND **Chief Executive Officer** *Approval noted by:* Executive Management Team AND Audit Committee~~Trust Board~~
10.1.3	Contracts above the ~~OJEU~~ PCR limit (in the case of sole suppliers)	~~**Chief Executive Officer**~~**Trust Board**

#	Delegated Responsibilities	Delegated Officer or Group
		Approval noted by: Executive Management Team AND Audit Committee ~~*Approval noted by:*~~ ~~Executive Management Team AND~~ ~~Trust Board~~

6.2 Selection of preferred tenderer(s) for contract award

This delegation has application when a formal competitive tender process is conducted.

At the conclusion of the tender evaluation stage, the evaluation team will make a decision on the award of contracts and will prepare a recommendation report that recommends the preferred tenderer(s). The report will detail the factors (including price, quality, and timing) that define the tender that provides the best overall value for money, and provide a comparison with the details of the nearest competing bids, where appropriate, with reasons for their rejection.

The Delegated Officers have authority to approve the recommendation report. Following approval award, post-tender negotiations can be initiated with the successful tenderer to improve the successful offer, where appropriate, and the formal contract should be prepared.

Where a purchase exceeds the limit set in the Public Contracts Regulations 2015, but only a single provider is identified having advertised our requirements, approval must be sought from the Chief Finance Officer together with one other executive prior to award of the contract.

#	Delegated Responsibilities	Delegated Officer or Group
11.1	**Authority to approve selection of preferred tenderer(s) for contract award**	
11.1.1	Capital	**Chief Finance Officer**
11.1.2	Non-capital	
	Less than £50,000	**Executive Director** OR **Chief of Service** OR **General Manager**
	Over £50,000	**Chief Executive** OR **Chief Operating Officer** OR **Chief Finance Officer**

6.3 Acceptance of late tenders

This delegation has application when a formal competitive tender process is conducted.

The Invitation to Tender documentation will specify the date and time by which tenderers must submit a tender response. Late tenders should not be accepted unless in exceptional and genuine circumstances – including, issues outside of the tenderer's control such as ICT difficulties uploading to the tendering portal, or where acceptance of the tender would ensure adequate competition.

#	Delegated Responsibilities	Delegated Officer or Group
12.1	**Authority to approve acceptance of late tenders**	

#	Delegated Responsibilities	Delegated Officer or Group
12.1.1	Tender received within two (2) hours after the specified tender closing time	**Executive Director** OR **Chief of Service** OR **General Manager**
12.1.2	Tender received more than two (2) hours after the specified tender closing time	**Chief Finance Officer**

Section 7 Summary of Contracts Signing Delegations

A contract is an agreement between two or more parties under which each party assumes an obligation (for example, to provide a service) which they intend will be legally binding (that is, it can be enforced by a court). A contract can be reflected in a formal document or can be formed by an exchange of correspondence or even verbal communication.

GOSH is a body corporate established under the *Health Services Act 2006* according to the laws of England and Wales on 1 March 2012, and may sue and be sued in its corporate name. The legal entity by which GOSH contracts with external organisations is the "Great Ormond Street Hospital for Children NHS Foundation Trust", with its principal place of business at Great Ormond Street, London WC1N 3JH.

There are **no values or limits** assigned to the Contracts Signing Delegations.

7.1 Signing healthcare funding contracts and service agreements

This delegation has application when the Trust is entering into a legally binding contractual agreement with a third party organisation for the provision of NHS healthcare services. The detailed instructions are outlined in ***SFI 6 Funding Contracts***.

#	Delegated Responsibilities	Delegated Officer or Group
13.1	**Authority to sign funding contracts and service agreements**	
13.1.1	All contracts and service agreements with a third party organisation for the provision of NHS healthcare services	**Chief Finance Officer** OR **Chief Operating Officer** OR **Chief Executive**

7.2 Signing commercial contracts

This delegation has application when the Trust is entering into a legally binding contractual agreement with one or more other parties under which each party assumes an obligation. A commercial contract could relate to one of the following:

- the supply of goods (including equipment, consumables and consignment stock), services, maintenance or design services
- provision of "works" (as defined in the *Public Contracts Regulations 2015*)[2]
- research
- commercial intellectual property.

A commercial contract could take the form of a deed, contract, agreement, release, discharge, indemnity, guarantee, consent, instrument, and any other documents which binds the Trust legally to another party by imposing an obligation on each party.

The detailed instructions for tendering and contracting by or on behalf of the Trust are outlined in ***SFI 15 Tendering and Contracting Procedure***.

[2] Activities constituting "works" are defined in Schedule 2 of the *Public Contracts Regulations 2015* to include: construction of new buildings and works, restoring and common repairs; site preparation; building of complete constructions or parts thereof; building installation; building completion; renting of construction or demolition equipment.

#	Delegated Responsibilities	Delegated Officer or Group
14.1	**Authority to sign commercial contracts**	
14.1.1	Less than £~~4~~2,500,000	**Chief Executive** OR **Chief Operating Officer** OR **Chief Finance Officer**
~~*14.1.2*~~	~~Less than £2,500,000 (Works)~~	~~**Director of Development & Property Services AND Chief Executive** OR **Chief Operating Officer** OR **Chief Finance Officer**~~
14.1.~~2~~3	Over £2,500,000 up to £4,500,000	**Chief Executive** **OR Chief Finance Officer** *Prior approval required by:* Finance & Investment Committee
14.1.~~3~~4	Over £4,500,000	**Trust Board Chair** OR **Chief Executive** **OR Chief Finance Officer** *Prior approval required by:* Finance & Investment Committee AND Trust Board ~~(Delegation to the Chief Executive can occur following approval by the Trust Board; delegation to be evidenced in the minutes)~~

Before exercising this delegation, the Delegated Officer must ensure that the essential prerequisites have been completed – these include:

- **General Manager** OR **Head of Department** OR **Service Manager** has reviewed the contract specification to confirm it contains the correct scope, reflects any subsequent agreements or negotiations with the supplier, and that specific input has been obtained throughout the drafting process from relevant areas within the Trust (e.g. ICT, information governance and security, clinical service delivery, facilities, data protection including application of the Data Protection Act 2018/~~*EU*~~ *UK General Data Protection Regulation*)
- **Senior Finance Manager** OR ~~**Deputy Chief Finance Officer**~~**Associate Director of Finance (Financial Management)** has reviewed the commercial and pricing schedule to confirm the pricing and budgetary aspects are appropriate.
- Where the contract relates to specific goods and/or services obtained through a tender process conducted by the Trust or it's~~s~~ external procurement partner (Guy's and St Thomas's (GSTT)), ~~the **GSTT Business Partner** has~~have been reviewed ~~the contract~~ to confirm ~~it complies with~~ all applicable procurement rules have been complied with and that the terms and conditions are appropriate.
- **GOSH Procurement** ~~**& Commercial Contracts**~~ **team** has reviewed the terms and conditions to confirm that they are appropriate and seek further input from specific areas in the Trust and / or legal review from external legal providers, where appropriate.

This contract review and approval process is outlined in the ***Contract Approval Form***, which must be completed prior to contract signature and execution.

7.3 Custody of Seal

The following extract from the Trust Constitution outlines the use of the Sealing of Documents.

~~37~~28 *Custody of Seal*

~~37~~28.1 *The common seal of the Trust shall be the responsibility of the Trust Secretary and kept in a secure place.*

~~38~~29 *Sealing of Documents*

~~38~~29.1 *Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two executive directors duly authorised by the Chief Executive, and shall be attested by them.*

~~38~~29.2 *Before any building, engineering, property or capital document is sealed it must be approved and signed by the Chief Finance Officer~~, or an officer nominated by him or her~~ and authorised and countersigned by the Chief Executive, or an officer nominated by him or her who shall not be within the originating directorate.*

~~38~~29.3 *All deeds entered into by the Trust and all documents conveying an interest in land must be executed by the application of the Trust's seal.*

3~~0~~9 *Register of Sealing*

3~~0~~9.1 *An entry of every sealing shall be made and numbered consecutively in a ~~book~~record provided for that purpose, and shall be signed by the persons who shall have approved and authorized the document and those who attested the seal. A report of all sealing shall be made to the Trust Board at the next meeting of the Trust Board~~least quarterly. The report shall contain details of the seal number, the description of the document and the date of sealing.~~*

7.4 Signing non-legally binding administrative arrangements

This delegation has application when the Trust is entering into non-legally binding administrative arrangement with one or more other parties. The non-legally binding administrative arrangements could relate to one of the following:

- Memoranda of Understanding (either intra-Trust, with other NHS organisations, or with a commercial third party)
- Service level agreements (intra-Trust)
- Operating level agreements (intra-Trust).

#	Delegated Responsibilities	Delegated Officer or Group
16.1	**Authority to sign non-legally binding administrative arrangements**	
16.1.1	All non-legally binding administrative arrangements	**Chief Executive** OR **Chief Operating Officer** OR **Chief Finance Officer**

Section 8 Summary of Non-financial Delegations

8.1 Risk management and insurance

This delegation has application in respect of the management of risk across the Trust. The detailed instructions for risk management and insurance are outlined in ***SFI 15 Risk Management and Insurance***.

#	Delegated Responsibilities	Delegated Officer or Group
17.1	**Management of risk and insurance**	
17.1.1	Ensuing the Trust has a risk management strategy in place and a programme of risk management	**Chief Executive**
17.1.2	Ensuring the Trust has arrangements in place for the provision of adequate insurance cover for the Trust that are not indemnified through the NHS Resolution	**Chief Executive** AND **Chief Finance Officer**
17.1.3	Approval of an agent to act on behalf of the Trust for providing the above cover via third party organisation	**Chief Finance Officer**

8.2 Management and control of stock

This delegation has application in respect of all stock held by the Trust, including medical and surgical consumables, pharmaceuticals, diesel fuel, catering supplies, and GOSH CC shop stock items. The detailed instructions for the management and control of stock are outlined in ***SFI 11 Stock Control and Receipt of Goods***.

#	Delegated Responsibilities	Delegated Officer or Group
18.1	**Management and control of stock**	
18.1.1	*Medical and surgical consumables stock*	
	• Approving stock portfolio (including re-order levels and frequency)	**Designated Area Manager** (e.g. Ward Sister, Matron, Lead Nurse, Lab Manager)
	• Replenishing stock to approved maximum levels	**Head of Materials Management**
	• Ensuring stock is held in registered stock locations	**Head of Materials Management**
	• Conducting stock takes	**Head of Materials Management**
	• Signing off stock takes and obsolete stock	**Head of Materials Management** AND **Designated Area Manager** (e.g. Ward Sister, Matron, Lead Nurse, Lab Manager)
18.1.2	*Pharmaceutical stock* (including approving stock portfolio, stock replenishment, ensuring stock is held in	**Chief Pharmacist**

#	Delegated Responsibilities	Delegated Officer or Group
	registered locations, conducting stock takes, and signing off stock takes and obsolete stock)	
18.1.3	*Diesel fuel, catering supplies, cleaning supplies and GOSH CC shop stock* (including approving stock portfolio, stock replenishment, ensuring stock is held in registered locations, conducting stock takes, and signing off stock takes and obsolete stock)	**Director of ~~Development~~Estates & Facilities Estates, Facilities and the Built Environment**

Schedule 1 – Delegated Expenditure Approval and Invoice Request Limits

The following levels are created for the purposes of linking a position level to a level of authorisation in the electronic financial system for the Trust.

Where a significant contract is approved by the Trust Board, the Chief Finance Officer will have the delegation to raise any purchase orders required related to the approved contract. Evidence of Board approval must be provided with the requisition.

e-Delegation Level	Position	Purchase Order and Invoice Approval (excluding ~~Development and~~ Business Cases)	Credit Note Approval
Level 1	Trust Board	>£4,500,000	
Level 2	Chief Executive	£4,500,000	
Level 3	Chief Operating Officer	£2,500,000	
Level 4	Chief Finance Officer	£2,500,000	No limit
Level 5	Other Executive management Team members	£500,000	
~~Level 6~~	~~Deputy Chief Finance Officer~~	~~£100,000~~	~~£100,000~~
Level 6~~7~~	Direct reports to the Executive Management Team	£100,000	
Level 6	Associate Director of Finance (Financial Control)	~~£5~~100,000	£25,000
Level 7~~8~~	Direct reports of level 5~~7~~ including Chiefs of Service, Head of Nursing & Patient Experience and General Managers	£50,000	
~~Level 9~~	~~Financial Controller~~	~~£50,000~~	~~£25,000~~
Level ~~10~~8	Budget Holders	£25,000	
Level ~~11~~9	Budget Administrators	£2,000	

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
2 February 2022

Well Led Review Report Action Plan **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment N** ☐ **For approval**

Purpose of report
To present an update to the action plan developed to deliver against the recommendations outlined in the externally led Well Led Review Report (July 2021).

Summary of report
Following a public procurement process, BDO LLP in partnership with Arden & GEM were commissioned to carry out an independent developmental Well Led review of the Trust's leadership and governance (a mandatory requirement for FTs). Reviewers applied CQC's Well Led framework and associated lines of enquiry.

The spreadsheet attached for information outlines the action plan in response to the recommendations and provides assurance that progress has been made with delivery of the plan with the remaining actions on track to close by end April 2022.

In summary, the majority of recommendations have been actioned. Those in progress for delivery by the stated timelines are:

- A review of the governance and administration of the Operational Board, aligning escalation and reporting between directorates and departments and improving monitoring of operational performance.
- Continued work in refining the Integrated Quality Performance Report (IQPR) to Board and delivery of assurance reporting to the Board and assurance committees.
- Consultation with Governors on establishment and delivery of a new Council development programme.
- Consideration of the review into management of complaints, claims and incidents.
- Continuation of work to consolidate, manage and communicate the Speak Up process going forward.
- Review of the governance framework for the Children's Cancer Centre.
- Work to update the Board Development Programme.

Action required from the meeting
The Board is asked to note the progress with the action plan.

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**	☐ **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 Board Assurance Framework risks	
Financial implications None.	
Implications for legal/ regulatory compliance The report findings will be shared with CQC at the next inspection or beforehand.	
Consultation carried out with individuals/ groups/ committees The report is being cascaded across the Trust and discussed with key groups.	
Who is responsible for implementing the proposals / project and anticipated timescales? Chief Executive and Executive Directors	
Who is accountable for the implementation of the proposal / project? Chair	
Which management committee will have oversight of the matters covered in this report? EMT and Trust Board	

NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board
2 February 2022

Register of Seals **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment U**

Aims / summary
Under paragraph 39 of the NHS Foundation Trust Standing Orders, the Trust is required to keep a register of the sealing of documents. The attached table details the seal affixed and authorised.

Date	Description	Signed by
16/12/2021	Lease: Ground floor premises for 26 and 27 Boswell Street	HJ, MS
16/12/2021	Main Nurses Home: Level 8 smart offices and level 9 on call rooms	HJ, MS

Action required from the meeting
To endorse the application of the common seal and executive signatures.

Contribution to the delivery of NHS / Trust strategies and plans
Compliance with Standing Orders and the Constitution

Financial implications
N/A

Legal issues
Compliance with Standing Orders and the Constitution

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

Who is accountable for the implementation of the proposal / project
Anna Ferrant, Company Secretary oversees the register of seals