Great Ormond Street Hospital for Children NHS Foundation Trust

Meeting of the Trust Board
Thursday 27th July 2017

Dear Members

There will be a public meeting of the Trust Board on Thursday 27th July 2017 at 1:30pm in the Charles west Boardroom, Great Ormond Street, London, WC1N 3JH.

Company Secretary
Direct Line: 020 7813 8230
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AGENDA

	Agenda Item STANDARD ITEMS	Presented by	Attachment
1.	**Apologies for absence**	Chairman	**Verbal**
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 25 May 2017**	Chairman	**A**
3.	**Matters Arising/ Action Checklist**	Chairman	**B**
4.	**Chief Executive Update**	Chief Executive	**Verbal**
5.	**Audit Committee Update – May 2017**	Chairman of the Audit Committee	**D**
6.	**Quality and Safety Assurance Committee update – July 2017 meeting**	Chairman of the Quality and Safety Assurance Committee	**Verbal**
7.	**Finance and Investment Committee Update – June 2017**	Chairman of the Finance and Investment Committee	**E**
8.	**Members' Council Update – June 2017**	Interim Chairman of the Members' Council	**F**
	STRATEGY		
9.	**Refurbishment of the Italian Hospital Building to develop a "Sight and Sound Hospital"**	Director of Development	**Y**
	PERFORMANCE		

10.	**Integrated Quality Report – 31 May 2017** **Including:** • **Annual Complaints Report 2016/17** • **Annual PALS Report 2016/17**	Interim Medical Director/ Chief Nurse	**G**
11.	**Integrated Performance Report (May and June 2017)** **Including:** • **Finance Update (June 2017)**	Deputy Chief Executive Chief Finance Officer	**H** **J**
12.	**Better Value 2017/18 Summary**	Programme Director	**K**
	ASSURANCE		
13.	**Medical Revalidation Annual Board Report and Statement of Compliance**	Associate Medical Director	**L**
14.	**Safe Nurse Staffing Report (May and June 2017)**	Chief Nurse	**M**
15.	**Feedback from Staff Listening Events**	Director of HR and OD	**N**
16.	**CQC Action Plan Update**	Company Secretary	**O**

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.)

Next meeting
The next Trust Board meeting will be held on 27 September 2017 in the Charles West Room, Great Ormond Street, London, WC1N 3JH.

ATTACHMENT A

Attachment A

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT Minutes of the meeting of Trust Board on 25th May 2017

Present

Ms Mary MacLeod	Interim Chairman
Dr Peter Steer	Chief Executive
Mr David Lomas	Non-Executive Director
Mr Akhter Mateen	Non-Executive Director
Mr James Hatchley	Non-Executive Director
Professor Stephen Smith	Non-Executive Director
Professor Rosalind Smyth	Non-Executive Director
Ms Nicola Grinstead	Deputy Chief Executive
Mr Ali Mohammed	Director of Human Resources and OD
Ms Loretta Seamer	Chief Finance Officer

In attendance

Mr Matthew Tulley	Director of Development
Ms Janet Williss	Deputy Chief Nurse
Dr Anna Ferrant	Company Secretary
Ms Victoria Goddard	Trust Board Administrator (minutes)
Mrs Herdip Sidhu-Bevan*	Assistant Chief Nurse – Patient Experience and Quality
Miss Emma James*	Patient Involvement and Experience Officer
Mr Matthew Norris	Members' Council (observer)

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

6	**Apologies for absence**
6.1	Apologies for absence were received from Dr David Hicks, Interim Medical Director, Ms Cymbeline Moore, Director of Communications and Ms Juliette Greenwood, Chief Nurse. Ms Janet Williss, Deputy Chief Nurse was in attendance in Ms Greenwood's stead.
7	**Declarations of interest**
7.1	There were no declarations of interest.
8	**Minutes of the meeting held on 29th March 2017**
8.1	It was noted that Jim Mackey's name had been misspelt.
8.2	Minute 197.5: An addition to the paragraph to be made to ensure it is clear that the Board wishes to undertake risk horizon scanning.
8.3	Subject to the above amendments, the minutes were **approved.**
8.4	<u>Amendment to December 2017 Trust Board Minutes</u>
8.5	The Board discussed and **approved** the amendment to the discussion which had

	taken place around the finance update at the December meeting to make it clear that historically the majority of actual P&E improvements had been delivered through incremental income rather than cost initiatives.
9	**Matters Arising/ Action Checklist**
9.1	It was confirmed that an update on the number of outpatient cancellations would be considered by the committee as part of a full report.
10	**Chief Executive Update**
10.1	Dr Peter Steer, Chief Executive gave an update on the following matters: • Global cyber security attack: The GOSH ICT team had worked extremely hard to ensure the Trust remained unaffected by the attack and this had been acknowledged by NHS England and NHS Improvement. Clinicians had also worked well to manage significant inconvenience. • The Court of Appeal judges would be would be reaching a decision on the Trust's high profile PICU patient. • Chairman recruitment: The Executive Team were extremely positive about the recommendation that had been made and advice was being received about announcing the appointment during purdah.
10.2	<u>Safety and Reliability Improvement Partner Programme</u>
10.3	**Action:** Dr Steer presented a paper which was a proposal to appoint the Cognitive Institute to introduce a safety and reliability improvement programme. He said that he had worked with the organisation previously in conjunction with a large number of hospitals, however at this point GOSH would be one of 10 Trusts working with the company. He said that there was no other organisation which could provide the package of work which was required and work would take place to ensure this was the case for procurement purposes.
10.4	Ms Mary MacLeod, Interim Chairman noted that there was a Board development programme which could potentially be used and added suggested that this could be helpful as part of the wider Board development work.
10.5	The Board **supported** the proposal.
11	**Patient Story**
11.1	Ms Emma James, Patient Involvement and Experience Officer presented the patient story of two young people who had taken part in the takeover day, and their parents. The story highlighted the positive impact of the experience on the patients.
11.2	The following recommendations were made by the parents which would be discussed and taken forward as appropriate: • Conversations between doctors and children and young people should be discussed with parents in the first instance as they would be able to direct doctors on the level at which discussion should be pitched. • An area to be provided for patients who struggled with tolerating loud or continuous noise.

11.3	It was noted that notwithstanding the recommendation made around discussion between Doctors and children and young people, it was very important that clinicians were able to hear the voice of the patient. It was reported that many of the benefits of the takeover day had been around meeting other young people. Ms Mary MacLeod, Interim Chairman suggested that work could take place through the YPF to look at support to patients who felt isolated in hospital and it was noted that a teen café had begun to be run by the Chair of the YPF.
11.4	Discussion took place around communication as it continued to be a theme of patient stories and other feedback provided to the Trust. It was confirmed that an update would be provided at the next meeting of the Patient and Family Experience and Engagement Committee (PFEEC) because it was also an area that had been raised during the Listening Event.
11.5	**Action:** It was confirmed that Ms MacLeod would write to the two patients involved in the story.
12	**Audit Committee update – April 2017 meeting and revised Audit Committee Terms of Reference and workplan**
12.1	Mr Akhter Mateen, Chairman of the Audit Committee noted that further to the April meeting for which a written update had been provided, the May meeting had taken place immediately before the Trust Board. He said that the committee had ratified its Terms of Reference and workplan, and had reviewed the Trust's response to the global cyber security breach; the committee had commended the IT team for their work.
12.2	The Committee had discussed the annual report and accounts and recommended them to the Trust Board for approval.
13	**Quality and Safety Assurance Committee update – April 2017 meeting**
13.1	Ms Mary MacLeod, Interim Chairman said that as had been reported to the Members' Council in April, she would be handing over Chairmanship of the Committee to Professor Stephen Smith, Non-Executive Director and a handover meeting would be taking place in the coming weeks.
13.2	Professor Rosalind Smyth, Non-Executive Director highlighted that there continued to be discussions about the key risk of nurse recruitment and retention and said that the committee had received the results of leaver surveys which had highlighted the attitude of managers and colleagues and opportunities for progressions and contributory factors in individuals' decisions to leave GOSH.
13.3	**Action:** Mr Akhter Mateen, Non-Executive Director said that he had attended the staff listening events and requested the raw data collected from this session. It was agreed that an update would be provided to the Board on the key issues arising from the staff listening event including proposals to take forward solutions.
14	**Finance and Investment Committee Update – March and May 2017**
14.1	Mr David Lomas, Chairman of the Finance and Investment Committee said that the Committee noted that the Trust had met its contracted activity target for 2016/17 and had reviewed the committee effectiveness and the feedback received from the effectiveness survey.

14.2	**Action:** The Committee had reviewed the Trust's property estate and Mr Lomas recommended that this was also reviewed by the Board. It was agreed that this would be incorporated into an update on facilities. The Committee had emphasised the importance of learning from the development of the Centre for Research in Rare Disease in Children before the Trust progressed phase 4.
14.3	Professor Stephen Smith, Non-Executive Director noted the significant Better Value target and asked to what extent the Trust was confident that they would be able to achieve this. Ms Loretta Seamer, Chief Finance Officer said that in 2016/17 there had been a number of savings which had been non-recurrent and work was taking place with the Programme Management Office (PMO) to identify schemes for 2017/18. She added that there was currently a reasonable level of confidence that the target would be achieved.
15	**Members' Council Update – April 2017**
15.1	Ms Mary MacLeod, Interim Chairman said that a date of 29th June 2017 had been confirmed for the Board and Members' Council facilitation session and a follow up session would be planned for the Autumn.
16	**GOSH Foundation Trust annual financial accounts and annual report 2016/17 including the Annual Governance Statement, the Audit Committee Annual Report and the draft Head of Internal Audit Opinion**
16.1	Mr Akhter Mateen, Chair of the Audit Committee confirmed that the Audit Committee had recommended the documents to the Board for approval.
16.2	The Trust was reporting a significant reduction in deficit as a result of having achieved the control total and therefore receiving a sustainability and transformation fund (STF) payment and an additional bonus. A reduction in the value of land and buildings was noted as a result of engaging a valuer with a robust valuation method in line with the recommendation from the Trust's external auditor.
16.3	It was noted that the Head of Internal Audit Opinion had provided a rating of significant assurance with minor improvement potential and eight of ten reviews had also provided this rating. It was confirmed that all recommendations from the internal audit of the implementation of the electronic patient record, which had providing a rating of no assurance, had been implemented. The external auditors had provided an unqualified opinion and had no significant findings in terms of the risks reviewed. As anticipated a qualified opinion had been returned on the review of RTT as GOSH had not returned to reporting for a full year.
16.4	Ms Mary MacLeod, Interim Chairman asked for additional information around Deloitte's findings in their review of cancelled operations. Mr Mateen reported that there had not been a strong audit trail of documentation and the auditor had reported that had the data been extrapolated to a full year, a qualified opinion may have been provided.
16.5	Ms MacLeod asked if this issue required further discussion at the Quality and Safety Assurance Committee and Ms Grinstead confirmed that it would be considered as part of the programme of work around cancelled operations. She added that the queried pathways had already been highlighted by the data quality

	process and would have been validated as part of the standard process.
16.6	**Action:** It was agreed that in future years an annual report from the Finance and Investment Committee would also be included in overall annual report.
16.7	The Board **approved** the following documents: • annual financial accounts and annual report 2016/17 • Annual Governance Statement • Audit Committee Annual Report • draft Head of Internal Audit Opinion
17	**Compliance with the NHS provider licence – self assessment**
17.1	Dr Anna Ferrant, Company Secretary presented the self-assessment and said that the Trust was currently compliant with all relevant aspects of the license conditions, although risks associated with one condition of the license, around systems for compliance with licence conditions and related obligations had been highlighted through use of an amber RAG rating.
17.2	The Board **noted** the self-assessment and **approved** the declaration.
18	**Compliance with the Code of Governance**
18.1	Dr Ferrant presented the paper and highlighted the areas which GOSH were required to undertake on a 'comply or explain' basis.
18.2	The Board **agreed** the Trust's compliance.
19	**Integrated Performance Report (30th April 2017)**
19.1	Ms Nicola Grinstead, Deputy Chief Executive presented the report which was in a new style to enable additional flexibility to include trend analysis.
19.2	**Action:** Professor Rosalind Smyth, Non-Executive Director asked when there was likely to be an improvement in cancellations as a result of the focused work that was taking place in this area. Ms Grinstead said that currently work was taking place to consider the protocol that was in place to cancel operations. She said that GOSH was applying the full definition for the cancellations and it was clear than many organisations did not do this. It was agreed that a deep dive would be presented at the next meeting of the Quality and Safety Assurance Committee.
19.3	**Action:** Mr David Lomas, Non-Executive Director commended the improvements made to the layout of the report. He suggested the inclusion of the attrition rates of nurses after one and two years at GOSH and the ratio of nurse vacancies to the number of offers made. It was agreed that this would be considered outside the meeting. Further consideration would also be given to including research information in future performance reports.
19.4	The Committee discussed the nurse vacancy rate. Ms Janet Williss, Deputy Chief Nurse said that there had been a large number of newly qualified nurses employed by the Trust scheduled to commence at the end of Seprember 2017 and there were more new starters than in previous years. Dr Peter Steer, Chief Executive emphasised that there was no risk to the Trust when the nurse vacancy rate was below 10% as there was an effective bank service available comprising

	primarily GOSH nurses. Having the ability to work additional shifts through the bank team was often a significant draw to the Trust for nurses.
19.5	Workforce Metrics & Exception Report (30th April 2017)
19.6	Mr Ali Mohammed, Director of HR and OD presented the report and said that PDR and mandatory training rates were now at target levels. Mr Akhter Mateen, Non-Executive Director welcomed the increase in green RAG rated metrics.
19.7	Finance Update (30th April 2017)
19.8	Ms Loretta Seamer, Chief Finance Officer said that the Trust was reporting its planned deficit for month 1 as result of both costs and income being down on plan. Debtor days had risen however a new supervisor for IPP debt manager had been recruited.
20	**Staff Friends and Family Test results – Quarter 4 2016/17**
20.1	Mr Ali Mohammed, Director of HR and OD said that the results continued to be positive and in line with previous years.
20.2	**Action:** Discussion took place around being clear on the Trust's vision and it was noted that only 42% of staff were clear what this was. It was agreed that consideration would be given to updating the wording to be clear about what staff were required to understand.
21	**Annual Safeguarding Report 2016/17**
21.1	Ms Janet Williss, Deputy Chief Nurse presented the annual report and confirmed that a substantive named Doctor for safeguarding had been appointed with increased time allocated to this part of their work. It was reported that there had been a significant increase in workload in line with national levels.
21.2	Mr David Lomas, Non-Executive Director queried the drivers of the increase in caseload which had almost doubled over the year. Ms MacLeod said that this was likely to be a result of increases in awareness and increased identification of risk by local authorities and confirmed that this increase had been experienced throughout the country and by CAFCASS (the children and family court advisory service).
21.3	**Action:** It was agreed that a deep dive would take place at QSAC on the relationship between the social work and safeguarding teams.
21.4	**Action:** It was agreed that the QSAC statement in the report should be amended to be clear that safeguarding issues were escalated by the Committee to the Board.
21.5	It was confirmed that the named doctor for safeguarding would attend QSAC.
22	**Safe Nurse Staffing Report (March and April 2017)**
22.1	The Board welcomed the improved reporting and noted that there had been no unsafe shifts reported since the last meeting.

22.2	**Action:** It was agreed that the definition for the standard nursing ratios by patient age and ward would be included in the next safe nurse staffing report along with a glossary of terms.
23	**Board Assurance Framework Update**
23.1	Dr Anna Ferrant, Company Secretary presented the year end BAF position and said that work would now take place to update risks for 2017/18. It was confirmed that the Audit Committee had agreed to reduce move the likelihood score for the productivity risk following the focused work that had taken place and the definition of risk 7 would be reviewed.
23.2	**Action:** A presentation which had been provided to the General Medical Staffing Committee on nurse recruitment and retention would be provided to the Board.
23.3	**Action:** It was agreed that the definition of risk 9 would be amended to be less negative.
24	**Quality Report 2016-17**
24.1	**Action:** The following amendments to the Quality Report were agreed: • Add in mention of the Trust's excellent cardiac outcomes • Make the paragraph on journal presentations more prominent
24.2	The Board **approved** the Quality Report.
25	**Integrated Quality Report – 30th April 2017**
25.1	Professor Stephen Smith, Non-Executive Director said that it was vital to reduce the time between an incident occurring and the report being completed. He noted a longer than expected time frame for some incident reports to be completed.
25.2	**Action:** Dr Peter Steer, Chief Executive confirmed that learning was disseminated quickly and it was agreed that consideration would be given to including dates in the report that these actions had been completed.
25.3	<u>National guidance on learning from deaths</u>
25.4	**Action:** It was agreed that QSAC would consider the process that was currently in place around the national guidance on learning from deaths.
26	**Any other business**
26.1	There were no items of other business.

ATTACHMENT B

Attachment B

TRUST BOARD – PUBLIC ACTION CHECKLIST
July 2017

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
54.3 152.1	20/07/16 01/02/17	It was agreed that work would take place to investigate the status of the tier 4 mental health services tender and to give consideration to highlighting the gap in services. It was agreed that an update and recommendation on these matters would be provided at the next meeting. Baroness Blackstone, Chairman asked whether the national tender for tier 4 mental health services had been published. Dr Peter Steer, Chief Executive said that it was expected to be received in the near future and GOSH had already begun to engage with other London organisations around the mental health landscape.	NG	TBC	Not yet due. An update will be provided to the Board once the national tender for the service has been published
158.8	01/02/17	It was agreed that the next research and innovation report would include focus on non-grant based direct funding such as enterprise. The report would also include the impact that the Zayed Centre for Research into Rare Disease in Children would have once on line to research as a whole and to the Trust's income.	DG	January 2017 (as part of strategy reporting to Board)	Not yet due
192.5	29/03/17	A report on theatre utilisation would be provided at the next meeting.	NG	July 2017	On agenda as an appendix to the Integrated Performance Report
197.5	29/03/17	It was agreed that feedback from the GOSH Children's Charity and UCL GOS Institute of Child Health would be provided at Trust Board seminar sessions in rotation.	AF	May 2017	To be built in to the Board Development Programme

Attachment B

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
198.1	29/03/17	It was agreed that Dr Ferrant would circulate the newly updated NHS England guidance on declarations of interests and declarations and declarations of gifts and hospitality.	AF	May 2017	In progress
10.3	25/05/17	Discussion took place about a proposal to work with the Cognitive Institute. It was suggested that there was no other organisation which could provide the package of work which was required and work would take place to ensure this was the case for procurement purposes.	DH	June 2017	Actioned
11.5	25/05/17	It was agreed that the Interim Chairman would write to the patients and families involved in the patient story to thank them and provide them with an update on actions.	MM	July 2017	In progress
13.3	25/05/17	It was agreed that comments from a staff listening even would be circulated and a report would be provided to the Board giving feedback on key issues and solutions which the Trust could take forward.	AM	July 2017	On agenda: Item 15
14.2	25/05/17	It was reported that the committee had reviewed the Trust's property portfolio and recommended that this also be considered by the Trust Board. It was agreed that the update would also be an update on facilities.	MT	September 2017	Not yet due
16.6	25/05/17	It was agreed that the annual report 2017/18 would include a Finance and Investment Committee annual report in light of the Committee's work around key areas such as EPR.	AF/DL	May 2018	Noted

Attachment B

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
18.1	25/05/17	It was agreed that typographical errors in the code of governance paper would be sent to the Company Secretary outside the meeting.	MM	May 2017	Actioned
19.2	25/05/17	It was agreed that a deep dive on cancellations would be received at QSAC	NG	July 2017	On July 2017 QSAC agenda
19.3	25/05/17	It was agreed that consideration would be given to including in future performance reports would include the attrition rate of nurses after one and two years and the number of nursing vacancies in comparison to the number of offers made. Further consideration would also be given to including research information in future performance reports.	NG/JG	September 2017	Not yet due
20.2	25/05/17	Further consideration would be given to the wording of the questions in the staff friends and family test.	AM	September 2017	Not yet due
21.3	25/05/17	It was agreed that a deep dive on the relationship between the social work and safeguarding teams would be considered at QSAC.	JG	July 2017	Added to QSAC action checklist
21.4	25/05/17	It was agreed that the definition for the standard nursing ratios by patient age and ward would be included in the next safe nurse staffing report along with a glossary of terms.	JG	July 2017	On agenda under safe staffing report
22.2	25/05/17	It was agreed that the definition of risk 9 would be changed to be less negative.	NG	July 2017	All BAF are for review at the July Risk Management Meeting

Attachment B

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
23.2	25/05/17	A presentation which had been provided to the General Medical Staffing Committee on nurse recruitment and retention would be provided to the Board.	JG	TBC	Date to be confirmed
24.1	25/05/17	The following amendments to the Quality Report were agreed: • Add in mention of the Trust's excellent cardiac outcomes • Make the paragraph on journal presentations more prominent	DH	May 2017	Actioned
25.2	25/05/17	Consideration to be given to adding in dates that the required actions arising from incidents were completed such as training and dissemination of learning.	JG/DH	July 2017	On agenda under Integrated Quality Report
25.4	25/05/17	QSAC to consider the process that was in place at GOSH around the national guidance on learning from deaths	DH	July 2017	Added to QSAC action checklist

ATTACHMENT D

Attachment D

Update from the Audit Committee meeting held on 25 May 2017

Chief Financial Officer's review of the Annual Financial Accounts 2016/17, including the Going Concern assessment

The Committee noted the change in the valuation of fixed assets as a result of engaging a valuer with a more robust methodology in line with Deloitte's recommendation. It was noted that income had increased by 7.9% and operating costs before impairment of fixed assets had increased by 6.1% including the costs that had been incurred as a result of RTT. Income from charitable donations remained in line with the previous year.

It was confirmed that the accounts had been prepared on an going concern basis.

Annual Financial Accounts 2016/17 and GOSH Draft Annual Report 2016/17 including Annual Governance Statement Annual Audit Committee Report

The Committee discussed the number of off payroll engagements which had been in place over the year. Given the Trust's focus on moving staff onto permanent contracts, discussion took place as to whether to provide further information on the progress that had been made since the end of the reporting period. It was agreed that this would be done if the change was considered to be material.

Discussion took place around including a potential additional disclosure around aged debt and it was noted that a significant proportion was overdue by 6 – 12 months the proportion aged over 12 months was minimal. It was agreed that as both GOSH and Deloitte believed that sufficient provisions had been made and the risk of default was not regarded as high, this additional disclosure was not required.

Quality Report 2016/17

The Committee welcomed the Quality Report and noted that feedback had already been incorporated into the document from a variety of areas including members of the Board and Members' Council.

Discussion took place about the programme of Kitemarking that was being undertaken for performance metrics and it was noted that it was important to prioritise the areas where Kitemarking was required due to the resource intensive nature of the process.

Internal Audit Annual Report 2016/17 including Head of Internal Audit Opinion 2016/17

It was confirmed that the Head of Internal Audit Opinion remained unchanged as 'significant assurance with minor improvement potential'. The Committee discussed this outcome in the context of the audit that had been undertaken on the implementation of the EPR programme which had provided a rating of 'no assurance'. The Committee noted that the recommendations of that audit had all been implemented and KPMG were satisfied with the work that had taken place since the review.

Final Report on the financial statement audit for the 12 month period ended 31 March 2017 and 2016/17 Quality Report Quality Assurance Review

The Trust's external auditors confirmed their intention to issue an unmodified opinion on GOSH's true and fair statement and also on the value for money statement. They had no concerns regarding any inconsistencies in the Annual Report. Nothing of concern had been noted in the management override of controls.

It was confirmed that an unmodified opinion would be issued on 31 day cancer waits. A qualified opinion would be issued on 18 weeks RTT as the Trust had not reported for the full year however the significant improvements made in this area was noted.

Discussion took place around cancelled operations and it was noted the Deloitte had identified a number of pathways where they had not been able to trace the Trust's reported data to supporting evidence in patients' notes. It was confirmed that an increased focus on this indicator continued at the Quality and Safety Assurance Committee and a deep dive would take place at its next meeting.

Board Assurance Framework at 31 March 2017

The Committee discussed Risk 2: Productivity on the BAF and agreed that sufficient work had been done to enable the likelihood score to be reduced. It was noted that further work was required for risk 4: recruitment and retention and therefore it was recommended that the net risk score remained unchanged.

The Committee received an update on the following high level risks:

- Risk 9: Unreliable data

The most recent internal audit had provided significant assurance with minor improvement potential. The net risk score had moved from 16 to 9 and the aim was to reduce the score to 6 or below.

- Risk 13: Business Continuity

GOSH benchmarked highly in terms of national performance, particularly in terms of incident preparedness and business continuity. The net risk score was felt to be reflective of the current situation. Discussion took place about the likelihood score and it was agreed that if the Trust felt that the likelihood score could not be positively changed by the programme of work taking place, the risk appetite score should be reconsidered.

Risks identified at/or since the last meeting:

- IR35 Compliance

It was noted that of 66 individuals who were affected by the change in regulations issues and only two remained outstanding.

- Cyber security incident

It was confirmed that GOSH was unaffected by the global cyber-attack as a result of disconnecting access to external emails and internet. No patient appointments had been cancelled, however some delays were experienced.

Review of non-audit work conducted by the external auditors

The committee noted that Deloitte had carried out two pieces of non-audit work: the Well Led Governance Review and provision of business rates advice. Appropriate assurances had been sought of their independent and necessary sign off of the work undertaken.

Assurance of compliance with the Bribery Act 2011

The Committee approved the statement to be published on the GOSH website.

Update on raising concerns

There had been one whistleblowing incident since the last meeting which was being managed in the appropriate way. It was noted that the national freedom to speak up guardian had visited the Trust to raise the profile of raising concerns.

Matters to be raised at Trust Board

- Annual accounts, annual report and annual statements
- External auditors review of year end documents
- Head of Internal Audit Opinion
- Board Assurance Framework
- Cyber Security
- Whistleblowing.

ATTACHMENT E

Attachment E

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of the Finance and Investment Committee held on 21st June 2017

Productivity and Efficiency Review 2017/18 Plan

The Committee noted that the Better Value programme remained on plan at month two and discussed the likelihood of the target being achieved given a number of schemes were unlikely to achieve their annualised projections as a result of the timing of projects. It was confirmed that there was a high level of confidence around a number of schemes. The Committee received an update on the Better Value work that was taking place in theatres.

International Private Patients Capacity Growth Business Case – Post Implementation Review

A post implementation review was conducted for the new IPP ward opened in 2016. It was noted that the development had been completed with an overspend and discussion took place around the process and parameters of seeking further approval for business cases where there was a substantial overspend. The Committee asked that further work take place to consider this process. It was noted that notwithstanding some delays to the project, which had delayed the opening of the ward, IPP had achieved its targets for 2016/17.

Phase 4 – Health Service Plan

The Committee received a presentation on the clinical service modelling completed in order to inform the phase 4 business case. Discussion took place about likely activity in the medium term given that previous years had seen broadly flat activity levels.

Finance Report 2017/18 Month 2

The Committee discussed IPP debtor days and noted that they had increased. It was agreed that work would take place to look at the 90 day target and consider whether this was appropriate. Discussion took place around provisioning for IPP debt and whether the appropriate provisions were in place. It was confirmed that the percentage model continued to be used to consider the risk. It was agreed that further work would take place to look at different methods of IPP reporting.

Whole time equivalent profile and deep dive into profile of administrative staff

It was agreed that work would take place through the Children's Hospitals Alliance to benchmark which groups of staff were included in the 'administrative' bracket for reporting purposes. It was noted that over 2016/17 the number of whole time equivalents (WTEs) increased by 65, related to RTT improvement work and ICT and EDM where formerly outsourced services had become internal. Discussion took place around the growth of workforce in support activities in the context of activity levels and the proportion of staff as a whole who fell into the administration bracket and whether this was value for money.

Review of aged debt profile over 181 days

It was noted that some aged debt related to other Trusts and CCGs and further follow up was to be undertaken before any decision made to determine next actions.

Initial approach and agreement of bench marking to other paediatric Trusts

The Committee discussed the data which the aim of understanding how GOSH compared to other paediatric Trusts in terms of value for money and noted that from NHS activity GOSH was generating a significantly larger loss than other paediatric Trusts. It was suggested that this work should also consider the way the Trust's income profile would change following the completion of phase 4 when the Trust was able to undertake additional NHS activity.

NHS Contract Update 2017/18

The committee noted the recent correspondence from NHS England around the possibility of Trusts entering into block contracts, however contracts continued to be payment by results or local prices in the majority of cases. The Trust had confirmed with NHS England that the Trust had capacity to open additional PICU beds and GOSH was awaiting the outcome of the NHSE PICU review.

Procurement Update including dashboard

It was noted that the Better Value target for procurement of £2million was against an addressable spend of approximately £44million which was a greater proportion than the average target across the Trust. It was confirmed that focused work was taking place around the improvement of inventory management and the improvement of the P2P platform as well as pricing for major contracts of supplies.

Capital Programme Update

The Committee agreed that prior to the approval of the phase 4 business case it would be important to consider the Trust's last four large development projects and the lessons learnt from these.

Patient/Reference Cost Annual Submission

The Committee noted that GOSH was an early adopter of the new patient level costing system (PLICS) that as part of the national Costing Transformation Programme

The Committee agreed to raise the following matters to the Trust Board:

- Clarity around redevelopment
- Ensuring estates was appropriately high profile at Board level
- Phase 4 timelines.

ATTACHMENT F

Attachment F

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of the Members' Council meeting on 28th June 2017

Quality Report 2015/16 including External Auditor Report 2015/16

The Council received the completed version of the Quality Report and the helpful feedback received by Councillors on earlier versions was welcomed. It was confirmed that that the Trust's external auditors had given positive comments about the quality of the report. A qualified opinion had been provided for RTT as the Trust had not reported a full year of data. Follow up on recommendations was taking place at the Board Assurance Committees.

Audit Committee May 2017

The Trust's Head of Internal Audit Opinion had been provided to the Trust as 'significant assurance with minor improvement potential' and an update was received on outstanding recommendations from audits. The external auditors had given an unmodified opinion on the Trust's accounts and had nothing significant to report. No risks had been identified in terms of value for money. It was confirmed that the Trust had achieved its control total for 2016/17. IPP debtors had improved but increased prior to year-end; the matter continued to be under Audit Committee scrutiny.

The Members' Council discussed the External Audit contract which had been previously approved by the Council for three years with the option to extend for a further two years. The Council discussed the length of time that Deloitte had been engaged as GOSHs auditors and any implication for independence. It was reported that the external auditors had confirmed their continued independence at the Audit Committee meeting and a new partner would now be working with the Trust. The Council approved the extension.

Process for appointment of two NEDs

The Council received the update and agreed with the recommendation from the Members' Council Nominations and Remuneration Committee that two NEDs should be sought at the same time but to begin their tenures following the respective departures of Ms Mary MacLeod and Mr David Lomas. The Council approved the use of Harvey Nash to support the search. It was agreed that experience in family law would be added as a desirable characteristic to the 'advocacy NED' person specification and an addition would be made to ensure that the individual had an understanding of the patient experience. Discussion took place around the timeframe for the recruitment and the it was agreed to take advice from Harvey Nash on the matter.

MC Nominations and Remuneration Committee terms of Reference and nominations to sit on the Committee

The Council approved the nominations of three Councillors to sit on the Committee and it was agreed that staff Councillors would be approached outside the meeting.

Update on implementation of the Always Values

A presentation was received on the progress with implementing the Always Values. Discussion took place around the work to embed a 'one team' culture as it was agreed that when this did not work well, issues were often raised for families, and it was noted that the Trust's Electronic Patient Record (EPR) EPR would be a significant support for this work. The Council noted that the Trust was working

to implement real time patient experience and this system would provide opportunities to highlight the Always Values to patients and families.

Updates from the Membership Engagement, Recruitment and Representation Committee (MERRC)
It was reported that membership numbers continued to rise steadily. Discussion took place about the AGM and the importance of this event for potential new councillors who would be able to meet the Council. It was reported that discussion had taken place at the meeting with Councillors, the Interim Chairman and the Senior Independent Director (SID) about the importance of being clear about the time commitment that was required for Councillors and of having a robust induction programme.

Update from the Young People's Forum (YPF)
The Council noted the YPF's annual report and the work that had taken place to introduce a team café in the hospital to support young people who may feel isolated in the hospital environment.

Update from the Patient and Family Experience and Engagement Committee
It was reported that hospital walkrounds with members of MERRC had been formalised and the Trust had won a bid to host the first national YPF meeting.

Councillor activities
The following activities were reported:

- Attendance at the Councillor, Chairman and SID meeting
- Observing at Trust Board and assurance committee meetings which was noted to be very worthwhile for Councillors.

Quality and Safety Assurance Committee (April 2017)
The Council noted the report. It was confirmed that Chairmanship of the meeting had moved to Professor Stephen Smith, Non-Executive Director.

Finance and Investment Committee Summary Report
The Committee had considered GOSH's financial position in comparison with other paediatric hospitals and noted the substantial support that IPP made at GOSH, however the risk of IPP debtors and the concentration of activity with a small number of customers was noted. Discussion took place about IPP debt and it was reported that it was vital to ensure that good relationships were in place with embassies.

GOSH Fire Risk Assessment
It was confirmed that the Trust had a high degree of assurance about the fire safety of the estate and this was supported by work conducted with the London Fire Brigade who had not raised any concerns and the Trust's own fire safety officer. The importance of being able to securely compartmentalise buildings was emphasised.

Well Led Review
The Council noted that 23 recommendations out of 36 had been completed and this information had been presented to NHS Improvement and the CQC who were satisfied with the progress made.

Chief Executive Update

An update was provided on the Freedom to Speak Up event that had taken place at the hospital which had been attended by the National Guardian and a range of speaker from across the NHS. Discussion took place around Referral to Treatment and the challenge of clock starts was noted particularly in a tertiary organisation such as GOSH.

The Council reviewed and noted the quality and safety, workforce and finance reports.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27th July 2017

Outline Business Case to refurbish the Italian Hospital to develop a "Sight and Sound" Hospital **Submitted by:** Matthew Tulley, Development Director/ Loretta Seamer, Chief Finance Officer	**Paper No: Attachment Y**

Aims / summary

The business case identifies and explains the rationale for bringing the Italian Hospital, a significant asset on the GOSH precinct site, back into clinical use. A detailed options appraisal process identified both the opportunity (and optimum level of construction intervention) presented by the Italian Hospital and the need to provide enhanced clinical facilities for our large number of ophthalmology and audiology patients. The bespoke needs of this patient group readily lends itself to a specialised patient environment and the intention is to provide an exemplar scheme that puts GOSH at the leading edge of thinking how we provide a high quality experience for this patient group.

The business case is structured using the HM Treasury five case model.

1) Strategic Case: This section describes the rationale for the investment case. It explains the joint work undertaken by GOSH and GOSHCC to review the existing and future use of property assets the purpose being to identify whether they are being used appropriately to support the GOSH strategy and the GOSHCC mission and objectives. This section demonstrates how the "Sight and Sound Hospital" not only supports the need to provide a better quality patient experience for a significant proportion of our patient population it also supports the longer term redevelopment programme.

2) Economic Case: This section describes the options that were examined to meet the expressed need. The options covered three aspects a) the potential opportunities afforded by a redevelopment of the Italian Hospital; b) the clinical services that could potentially have occupied the space; c) the options to reprovide space for audiology and ophthalmology services. The detail shows that a relatively limited intervention is considered the best treatment for the Italian Hospital and limiting the services to either outpatient or daycare services. In terms of the provision for audiology and ophthalmology services the alternative to the Italian Hospital scheme is a double decant involving a move to Southwood Building and a subsequent move to either VCB or the Phase 4 facility. In terms of service quality and value for money a single move of these services is the best option.

3) Commercial Case: This describes how the scheme will be delivered. The project is perfectly suited to the NHS P22 framework and we will be working with our P22 framework partner Kier to develop and deliver the scheme. There is a realistic but challenging programme.

4) Financial Case: The financial case identifies the capital and revenue consequences of the scheme. The capital cost is estimated at £21.6m. This has been reviewed by the GOSH quantity surveyor and has been subject to an initial cost estimate from Kier who state the scheme can be delivered within the declared budget. The costs will

become fixed during the design development process and be part of the FBC submission. The GOSH Charity has reviewed the investment case and confirmed their commitment to provide the capital funding of £21.6m subject to Trust Board approval. The income and expenditure section shows that the investment is currently predicted to create a cost pressure of around £350k pa. This is a conservative estimate. No additional income from potential NHS growth has been factored into the case and no IPP income. The revenue costs are currently estimates including a contingency. The period between OBC approval and FBC submission will be used to finalise the revenue costs and identify income generating opportunities.

5) Management Case: This section describes how the project will be delivered, the resources in place, the programme and risks. Planning is a key risk. There has been a number of pre-application meetings with the London Borough of Camden and we have responded to Officer's comments.

The OBC is clear on how the scheme will be delivered, the benefits to patients and staff and the contribution of the investment to supporting the Trust's objectives.

Action required from the meeting
The Trust Board is asked to approve the OBC, recognise the further detailed development work required to complete the FBC and the timescale for presenting the FBC to the Trust Board.

Contribution to the delivery of NHS Foundation Trust strategies and plans
The project supports our clinical strategy and provides enhanced opportunities for research. The project supports our commitment to provide inspiring places to work and to be sustainable.

Financial implications
The OBC identifies the capital and revenue consequences of the investment.

Who needs to be told about any decision?
Redevelopment project board
GOSHCC
Clinical teams
Residents Liaison Group

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

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

Great Ormond Street Hospital for Children
NHS Foundation Trust

Outline Business Case

Refurbishment of the Italian Hospital Building to develop a "Sight and Sound Hospital"

Great Ormond Street Hospital for Children NHS Foundation Trust

Version: 0.6

19 July 2017

Version Control

Trust	Great Ormond Street Hospital for Children NHS Foundation Trust
Document Title	Outline Business Case for Refurbishment of the Italian Hospital Building to develop a "Sight and Sound Hospital"
Version	V 0.5
Status	Draft
SRO	Matthew Tulley
Contact	Bryony Freeman

Version	Date of Revision	Key Changes	Status
0.1	07/07/2017	Draft	Draft
0.2	10/07/2017	Draft	Draft
0.3	10/07/2017	Draft	Draft
0.4	11/07/2017	Draft with revised financials for review by EMT	Draft
0.5	13/07/17	Draft responding to feedback from EMT	Draft
0.6	19/07/2017	Draft supplemented following presentation to Trustees	Draft

GOSH Stakeholders Consulted

The following stakeholders have been consulted in the development of design and / or the draft business case.

Name	Role	Division	Version Reviewed	Date of Review
Sarah Metson	General Manager	Barrie	V0.1	31/03/2017
Andrew Smith	Finance Manager	Finance	V0.1	31/03/2017
Aaron Shah	Finance manager	Finance	V0.1	31/03/2017
Tom Burton	Deputy Director, Finance	Finance	V0.3	31/03/2017
Keith Norris	Head of Facilities	DPS	V0.3	31/03/2017
Jeff Legge	Head of Estates	DPS	V0.2	31/03/2017
Linda Martin	Director of Estates & Facilities	DPS	V0.2	31/03/2017
Crispin Walking-Lee	Head of Healthcare Planning	DPS	v0.3	10/07/2017
Loretta Seamer	Chief Finance Officer	Finance	V0.4	11/07/2017
Matt Tulley	Director of Development	DPS	V0.4	11/07/2017
Stephanie Williamson	Deputy Director of Development (and Chair of the Project Steering Group)	DPS	V0.4	11/07/2017
Kiki Syrad	Deputy Director, Grants & Information	GOSHCC		
Paul Mills	Director of Property & Redevelopment	GOSHCC		
Project Groups				
Sarah Metson	JM Barrie General Manager (Deputy Chair)	JM Barrie		
Emma Hau	Healthcare Planner	DPS		
Helen Dunn	Lead Nurse, Infection Prevention & Control	Charles West		
Catie Stuart	Matron: Outpatients	Charles West		
Fiona Duncan	Lead Audiologist	JM Barrie		
Bronwen Walters	Orthoptist	JM Barrie		
Ben Hartley	Consultant (ENT)	JM Barrie		
Margaret Hollis	Head of Decontamination	DPS		
Aidan Holmes	Head of Health & Safety	DPS		
Sam Williams	Fire Officer	DPS		
Catherine Browholme	Scientist	JM Barrie		
Brindha Anandanadarajah	Audiologist	JM Barrie		
Barbara Brekle	Deputy Lead Nurse	Charles West		
Elaine Cloutram Green	Scientist	Charles West		

Contents

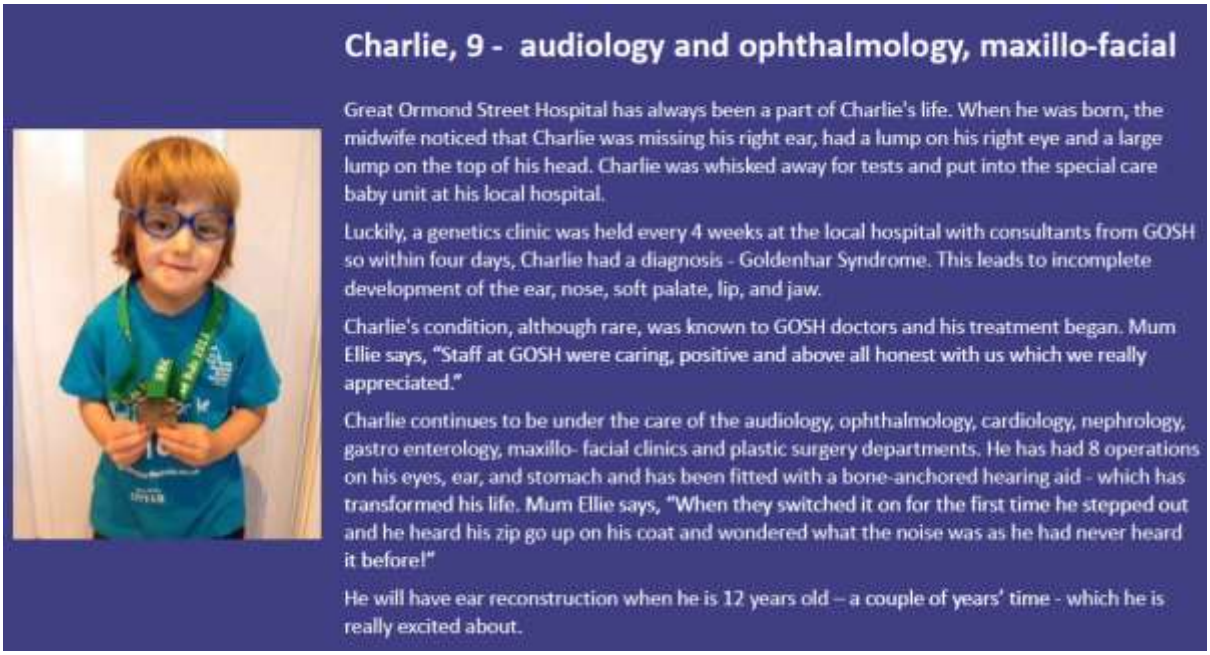
1 Executive Summary

Background

The Italian Hospital opened in 1890; was rebuilt in 1898 and extended in 1940. The Hospital served the population of 'Little Italy' in Clerkenwell. It operated as a private hospital with 48 beds until the early1980's. It was then purchased by the Charity and has been put to various uses including clinical use, providing accommodation for the GOSH Charity and currently non-clinical use as the GOSH staff nursery, parent accommodation and offices. The building is listed and sits within a conservation area. Of particular interest are the façade on Queen Square; the central staircase and the chapel.

In 2015 GOSH and the Charity agreed to undertake a review of the use of all GOSHCC property to examine that use was in line with GOSH and Charity objectives. As the Italian Hospital is a significant asset it was agreed this would be the first property to be reviewed. In late 2016 an architectural feasibility study was commissioned and an option appraisal and concluded that this building would suit an ambulatory service of which. Ophthalmology, Audiology and ENT were identified as the most appropriate services to occupy the space.

The vision that developed was the establishment of a **'Sight and Sound Hospital at GOSH'** with existing services in the building to be rehoused as part of the refurbishment and decant plan. Therefore this business case outlines an opportunity to redevelop the Italian Hospital within the Great Ormond Street Hospital precinct into an outpatient clinical building, to provide a 'sight and sound' model of care for ophthalmology, audiology, cochlear implant, ENT, SLT, craniofacial and cleft palate outpatient services.



Options

The redevelopment of the Great Ormond Street Frontage Building, referred to as Phase 4 in the Precinct redevelopment Masterplan, will require the outpatient services on Level 1 and 2 to be decanted and then relocated back into the new facility.

The review of use of the Italian Building has provided the opportunity for these services to move only once into an appropriate facility that will also enhance the model of care and increase the capacity for service growth in the future and eliminate the need for a second decant.

Benefits

The redevelopment of this building will deliver the following benefits to patients and staff and improved model of care for the 'Sight and Sound' Outpatient Services:

- Provide a new arrival experience for patients and families attending clinics in these specialties;
- Re-provision of space and provides capacity growth of audiology and ENT sound booths on the lower ground floor (8 sound booths, plus a vestibular lab and caloric treatment);
- Consulting and treatment space for ophthalmology; audiology and ENT patients;
- Anaesthetic preoperative assessment will be provided on the ground floor (1 room) to avoid the need for families to visit the main site as well as this building;
- All patients will have their height and weight measured (which is an improvement on current practice – due to space restrictions);
- EPR will be launched as part of the building installation and setup which would also include self-check-in;
- Eye drop rooms will be set up on each floor (with a healthcare assistant);
- A calling/ queuing system will direct patients to their clinic.

Other Benefits:

- Any spare capacity would be suitable for other speciality outpatients
- Potential to house secretarial teams in the building, providing closer working opportunities with clinical teams and for admissions team to support scheduling directly with parents/ patients
- Consistent capacity expectations with potential growth opportunities.

Trust Demand and Capacity Requirements

The Trust demand & capacity modelling system for the NHS specialties outlined shows:

Specialty	2016	2019/20	2023/24	2038/39
Audiological Medicine	4.2	4.4	4.5	4.7
Cleft Surgery	1.0	1.0	1.1	1.1
Cochlear Implant	2.5	2.6	2.7	2.8
Craniofacial Surgery	1.0	1.5	1.6	1.7
Ear Nose & Throat	2.4	2.4	2.5	2.6
Ophthalmology	11.2	12.3	12.7	13.3
Speech & Language Therapy	2.7	2.8	3.0	3.1
TOTAL	25.0	27.2	28.1	29.4

The increased capacity will enable us to meet the expected growth in these services of 6000 patients annually by 2024. The Trust also sees approx. 2,500 IPP patients a year for these specialties. The capacity model for IPP assumes a 10% growth per annum.

Financial

The two options for location of these services require different levels of capital investment. The capital costs for the original Phase 4 option is estimated at £30.6million and the Italian Building option (including the purchase of the new property to accommodate the staff crèche is £24.6

million. The funding for the refurbishment of the Italian Hospital has been requested from the Charity and there are initial indications that there is significant donation available to support this project.

Therefore on the basis of the assumptions outlined in this case, the capital investment required for the preferred option would provide value for money for capital investment and also would avoid two decants for this service as per the original Phase 4 option planning. The refurbishment also provides additional capacity in the Italian building for either NHS or IPP outpatient services and makes best use of current building stock. The use of the available space in the Phase 4 programme that would otherwise be utilised by the outpatient services would be assigned for other use. This will be assessed as part of the separate business case.

The more detailed income and expenditure impact will be evaluated as part of the full business case but this initial assessment assumes that any service growth is accounted for in the current two year financial plan or future plan baseline demographic growth built into contracts with any demand over and above these baseline assumptions would form part of specific negotiations for additional growth with commissioners. The cost assessment assumes that the service will move with no change in service volumes but has included an additional administration position to manage the central reception. An assessment of the Italian Building operational costs compared to the Frontage Building space has been based on cost per m2. Overall this initial assessment indicates a cost increase of £350k pa to operate in the new building.

Process for moving from OBC to FBC

Once the OBC is approved, the project team will progress towards FBC and the relevant approvals process. The FBC will outline items required prior to financial closure and contract award and will provide additional information required to commit funding/ award a contract. This will include:

- Any developments or material changes since the OBC
- Update on town planning and listed building consent.
- Finalise the detailed cost programme from the Trust P22 partner (Kier)
- Full timetable for any contract negotiations and award of contract
- Final review of the strategic discussion, options appraisal, return on investment, affordability and achievability of the project
- Monitoring plans, evaluation and benefits realisation
- Full proposals outlining models of care for the services planned to move into the building, including an evaluation of potential IPP opportunities
- Further review and potential revision of income or expenditure costs for the building
- Finalising the design: it is expected that user group meetings and detailed designs will be completed by the end of July. An exercise to re-test the design will take place in August and this could include a reconsideration of a telemedicine suite and alternative uses of space. The design option review would take place in August and September with a strategic group of stakeholders.

2 Introduction

2.1 Background

The Italian Hospital opened in 1890; was rebuilt in 1898 and extended in 1940. The Hospital served the population of 'Little Italy' in Clerkenwell. It operated as a private hospital with 48 beds until the early 1980's. It was then purchased by the Charity and has been put to various uses including clinical use, providing accommodation for the GOSH Charity and currently non-clinical use as the GOSH staff nursery, parent accommodation and offices. The building is listed and sits within a conservation area. Of particular interest are the façade on Queen Square; the central staircase and the chapel.

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The redevelopment of the Great Ormond Street Frontage Building, referred to as Phase 4 in the redevelopment Masterplan, will require the outpatient services on Level 1 and 2 to be decanted and then relocated back into the new facility. The review of use of the Italian Building has provided the opportunity for these services to move only once into an appropriate facility that will also enhance the model of care and increase the capacity for service growth in the future and eliminate the need for a second decant.

2.2 Purpose of this Business Case

This outline business case has been prepared to support the investment decision by EMT and the Trust Board. This outline business case sets out the overall best offer for the Trust, documents the proposed contractual arrangements, confirms funding and affordability and sets out the detailed management arrangements and plans for successful delivery and post implementation evaluation.

As per the NHS Improvements' guidance relating to transactions for NHS Foundation Trusts, GOSH is required to report transactions that meet specific criteria to NHS Improvement, however the investment in the Refurbishment of the Italian Hospital does not trigger NHS Improvement reporting requirements (as outlined in the supplementary document '*Reporting Guidance'*). This has not been formally confirmed by NHS Improvement.

The full business case will update the cost review conducted at the outline business case stage to confirm the preferred option.

2.3 Structure of Business Case

HMT Green Book guidance recommends that NHS and Public Sector organisations follow the 'Five Case Model' for the preparation of business cases. This business case has therefore been prepared in line with this recommended approach and comprises the following key components:

- **The Strategic Case** – This sets out the strategic context and the case for change, which together provide the supporting rationale for investment in the Programme;
- **The Economic Case** – This demonstrates that the organisation has selected the choice for investment which best meets the existing and future needs of the service and optimises value for money;
- **The Commercial Case** – This outlines the content and structure of the proposed deal;
- **The Financial Case** – This confirms funding arrangements and affordability and explains any impact on the balance sheet of the organisation; and
- **The Management Case** – This demonstrates that the scheme is achievable and can be delivered successfully to cost, time and quality.

3 Strategic Case

GOSH's mission is to help children with complex health needs fulfil their potential. To achieve this mission we must maximise our site's potential to meet current and future healthcare needs, ensure our models of care, systems and processes support our exemplary clinical care. GOSH must continue to improve the quality of its care, the patient and staff experience and the efficient use of resources.

3.1 Strategic Alignment

3.1.1 Supporting Trust strategic objectives

Objective	Connection to Italian Hospital
6.1 Be recognised as the most environmentally sustainable healthcare provider in the UK with all staff recognising their stewardship role	Opportunity to maximise the building to provide care for outpatient services currently housed in the Frontage Building. Improved environment will allow innovation in waste management, lighting and patient flows
6.2 Maximise our site's potential to meet current and future healthcare needs	Significant improvements to environment and patient experience offered for hearing and visually impaired children and other related services such as SLT, Cleft palate and ENT.
6.3 Provide our clinical teams with the equipment they need to deliver cutting-edge care to our patients	Tailor-made facilities will allow clinical teams, in conjunction with the development team and architects, to design according to the needs of these patient groups This project has the aspiration to be an exemplar sight and sound environment.

3.2 Scope Services

There are three key aspects to the case for change, summarised below.

3.2.1 Review of GOSHCC property assets.

In 2015 GOSH and the Charity agreed to undertake a strategic review of the GOSHCC property portfolio to examine if the assets are being used effectively to support the strategic aims of the hospital as well as maximising the benefit of these assets in the delivery of the Charity's objectives. As the most significant individual asset it was agreed the Italian Hospital should be reviewed first to consider if the building could be put to better, possibly clinical use. In 2016 GOSH commissioned Sonnemann Toon Architects to undertake a feasibility study to explore potential for outpatient; day case and inpatient use. The subsequent report recommended limiting the construction interventions due to the listing and the clinical activity to outpatient care due to patient safety.

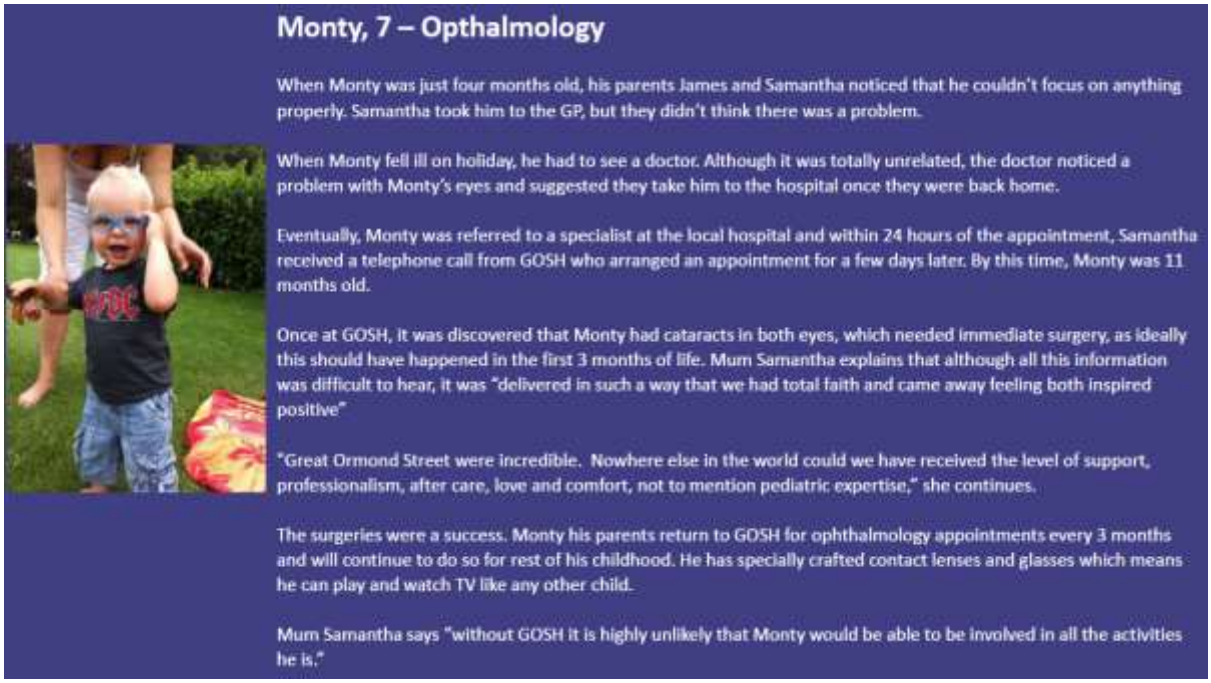
3.2.2 Current outpatient space quality for audiology and ophthalmology

The specialties currently intended for the Italian Hospital are housed in generic outpatient rooms, designed for flexible use across multiple specialties. The space is viewed by the clinical, management and redevelopment teams as unsuitable accommodation.

These specialties would benefit from tailored-designed rooms which could incorporate blackout blinds/ specialised lighting for ophthalmology and support changing models of care. These patients check in at main reception, then at Cheetah reception and again at Rhino reception. An exemplar, dedicated 'sight and sound' building would allow specific design for this patient cohort, including

signage and lighting solutions to support those with visual or auditory impairments. It would also provide new opportunities for co-location of these services as many patients and families are seen on the same day in multiple clinic appointments. Furthermore, the layout of the building and the single point of entry and exit represent an opportunity to introduce a new arrival experience for patients and families.

Patients would check in on the ground floor using an electronic system that would then direct them to the appropriate department elsewhere in the building. This significantly eases wayfinding, as patient information and appointment letters do not need to include detailed information about the location of the clinic, only the address of the building. It also allows flexibility as to where the clinic is held and allows the space to be used to its maximum capacity.



3.2.3 Phase 4 decant requirements

In order to facilitate Phase 4 of the Trust's redevelopment master plan (Frontage and Paul O'Gorman site), an extensive programme of enabling works and decants is required to empty these buildings to allow construction to start. Most of the departments re-locating from Frontage are outpatient functions. In the original decant plan, the outpatient clinics from the Frontage Building were planned to relocate to the Southwood Building including expensive construction on audiology booths. It subsequently became apparent this would only work at L8 and would impact Safari. Southwood was also under additional space pressure to accommodate MCU and Panda with the impact of the probability of increasing the amount of off-site commercial office space we would need to deliver the decant plan.

A second issue, along with finding the appropriate space for the initial decant, is that this would itself be a temporary home and thus require further investment at a later date, probably as part of Phase 4, to create the permanent location for these services. To a certain extent the specialist nature of the clinical spaces required for audiology and ophthalmology services would compromise the strategy of creating generic and highly flexible spaces in the Phase 4 development.

3.3 Clinical Infrastructure Capacity

3.3.1 Change in Outpatient Infrastructure Capacity

The table below outlines the current capacity and the new capacity that will be available after the redevelopment. Some of the additional rooms allow for an improved model of care and others for future expansion of outpatient services.

The additional outpatient services on Level 3 will initially be for new growth in services related to either NHS or IPP. This has not yet been determined.

In particular this will provide 13 additional consulting rooms; 2 additional booths; 2 additional sound treated rooms; 4 additional counselling rooms; 1 additional procedure room; dedicated eye drop rooms; larger ophthalmic imaging room.

Space has also been allocated in the design for a dispensing optician. This could become a tendered service with a private provider. In addition the Outpatient Model of Care Group will be set up and launched in August, with a view to:

- Research and appraise emerging models of outpatient care and their applicability in the context of children's healthcare
- Identify clinical champions to test new ways of working
- Explore innovative models of care for the outpatient setting

Description	Current allocation (from floor plans and room assessment)	Italian Hospital allocation (from floor plans)
Consulting rooms/ exam rooms (+ 13 rooms)	**Total: 26** 26 consulting rooms	**Total: 39** 39 consulting rooms/ exam rooms
Audiology booths (+2 Booths and +2 Sound Treated Rooms)	**Total: 6** 6 soundproof booths	**Total: 10** 8 booths & 2 sound treated rooms
Offices (-1 with introduction of agile working)	**Total: 21 desks**	**Total: 20 desks**
Counselling rooms (+ 4)	**Total: 0**	**Total: 4**
Other (no change)	1 vestibular chair and 1 caloric room ENT treatment room: 1	1 vestibular chair and 1 caloric room ENT treatment room: 1
EDT Lab; eye movement lab (+1)	**Total: 3**	**Total: 4**
Eye drop room (+2)	**Total: 0 (currently administered in ad hoc available rooms)**	**Total: 2**
Contact lens fitting room (+1)	**Total: 0**	**Total: 1**

3.3.2 NHS Activity

The table below gives the NHS activity by service for 2016/17 and modelled requirements going forward based only on demographic and epidemiological growth:

	Outpatient attendances		
Service	2016/17 Actual	2024 Modelled	2038 Modelled
Ophthalmology	25,961	29,513	30,656
Audiology	3,544	3,832	3,985
Cochlear Implant	1,720	1,867	1,952
ENT	5,459	5,852	6,079
SLT	2,671	2,867	3,007
Cleft	1,990	2,112	2,179
Craniofacial	2,133	3,097	3,207
TOTAL	**43,342**	**49,140**	**51,065**

In addition the IPP Division saw 2,504 patients in those specialties in 2016/17.

3.3.3 NHS Demand

The Trust demand & capacity modelling for the specialties in scope indicated that additional rooms will be required as outlined previously.

Capacity by Type	Baseline 2016/17	2019/20	2023/24	2038/39
Total	25.0	27.2	28.1	29.4

3.4 Benefits Summary

The Benefits Realisation Plan (BRP) describes the objectives and benefits associated with the project and how these benefits will be delivered. It ensures that the project is designed and managed in the right way to deliver quality and value benefits to patients, staff and local communities. The BRP will also define how and when outcomes and benefits are measured.

The potential benefits of the Italian Hospital development include:

Benefit	Current state	Future state
Improved capacity management	Inappropriate use of consulting rooms for activity such as eye drops and imaging Services constrained by current capacity and quality of facilities	Increased provision of specialist treatment and diagnostic rooms New accommodation offers greater flexibility for room allocation and growth beyond activity model if required (Level 3 can become further clinic space for ophthalmology / audiology if required)
Improved quality and suitability of facilities	Current facilities designed as generic outpatients and adapted for use by these patient groups offering a poorer experience	Design will respond to needs of specific patient groups particularly in relation to lighting; acoustics; wayfinding; seating; colour.
Enhanced sustainability of Trust	Feasibility study showed current usage of IH as poor. Do minimum decant planning results in a poorer patient experience and significant capital costs	Maximises use of property within close precinct for clinical use Enables a more sustainable use of Phase 4 for generic outpatients and expansion of services such as pharmacy Opportunity for a new model of care resulting in improved experience and efficiencies Opportunity for IPP work
Improved working environment for staff	Current accommodation makes new models of care difficult to implement and unrewarding for staff working in	Creates a clear identity for this group pf services enhancing the experience for staff. Improved

Benefit	Current state	Future state
	cramped and modified facilities.	access to natural light; improved staff facilities
Enhanced reputation	Current facilities do not enhance the reputation of the clinical services operating from them	Opportunity for an exemplar environment for VIP and HIP children
Donor engagement	Decant solution unattractive to donors for funding.	Very attractive project for donors, targeting specific patient groups; strong case for need and strong branding opportunity.

3.5 Strategic Risks

The table below summarises some of the key strategic risks associated with the Programme.

Table 6: Key Risks and Mitigations

Key Risks	Mitigations
The site is designated as a heritage asset and therefore, town planning may be difficult to achieve without potential compromise to the design and therefore functionality of the building	• Early engagement with London Borough of Camden through the pre-application process resulting in level of agreement • Early engagement with neighbours and community • Commitment to engage with external stakeholders throughout the construction management planning process
The site is constrained and so construction planning may be difficult	• Careful engagement by Kier in the construction management process • Careful co-ordination with other projects both at GOSH and NHNN • Effective working with Camden Transport Team
It is possible that due to the impact on neighbouring buildings during planned construction there may be party wall disputes (e.g., with the Mary Ward Centre)	• Engagement with neighbours commenced with on-site presentation and meeting • Communication routes outlined • Party Wall advisor appointed
Section 106 negotiations may be protracted, leading to a delay starting construction on site	• Section 106 lawyer appointed • Key S106 matters to be identified quickly • Appropriate resource applied to resolution
There may be limited opportunities to maximise physical connections to the wider Trust site for heating and cooling (which will impact the BREAAM scores)	• Design team to undertake feasibility study • Camden asked to support any future town planning implications • Alternative solution for standalone approach fully

Key Risks	Mitigations
	developed.
Delay to nursery project programme may impact start on site for both IH Project and Phase 4	• Procurement route selection under review – traditional route may be quicker • Design works commenced early

4 Economic Case

This section outlines the options analysis that was conducted. This analysis confirms the preferred option that will meet the Trust's scope and service requirements, and deliver the expected benefits identified in the strategic case.

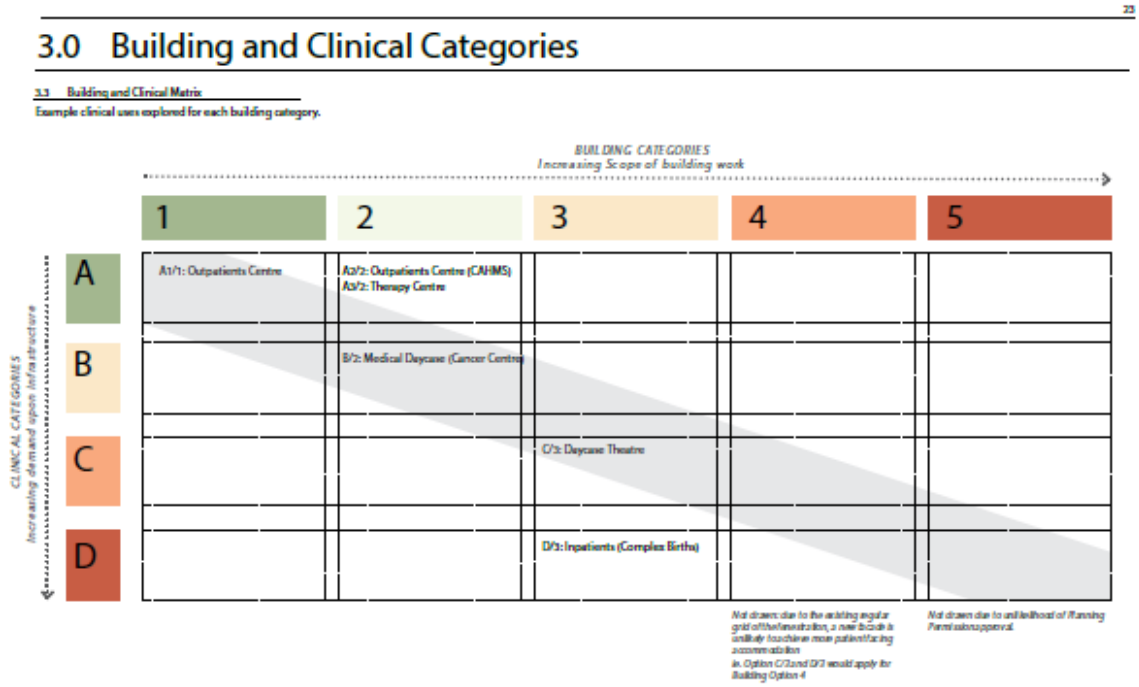
4.1 Options Development

There are two key elements to the economic case:

- Italian Hospital potential redevelopment options
- Options relating to the clinical specialties selected for this building (see options appraisal)

4.1.1 Italian Hospital redevelopment Options

Sonnemann Toon architects completed a feasibility study in 2016 for redeveloping the Italian Hospital into clinical use. The study considered possible uses based on two criteria: 1: clinical complexity/ acuity and 2: scope of building intervention. The key output was a two dimensional matrix which considered the clinical complexity/acuity on one axis and scope of building intervention on the other. The matrix is shown below.



The outcome of the feasibility study was that building intervention should be restricted to protect the historic fabric and heritage asset and clinical activity should be restricted to ambulatory care for patient safety reasons. This meant the future use would be restricted to AB/1/2 categories identified in the evaluation matrix.

4.1.2 Options Appraisal Clinical Specialty Location

In developing the next stage of detail a number of potential uses have been considered. These options were presented to the Development Board which approved the recommendation for the sight and sound hospital (project scope document attached).

Table 7: Options Appraisal

Option	Benefits	Limitations
Safari ward relocation from the Southwood Building	• Redevelop Italian Hospital into a 'cancer day care centre'	• Engineering infrastructure requirements are considered too high • Plans to co-locate cancer day-care and inpatients in Phase 4 (poor return on investment if moves to the IH)
Kingfisher ward relocation from Octav Botnar Wing	• Opportunity to move to a new location	• Activity covers day-care and overnight stays with frequent investigations – requirement to build an inpatient environment is not suitable • Co-location with Gastroenterology Investigation Suite would be lost
Somers Clinical Research Facility relocation from the Frontage Building	• Opportunity to move to a new location	• CRF covers overnight stays and so IH is not a suitable location
Outpatient space	• Avoids audiology booths double decant (moving into Southwood and then to Phase 4) which is costly • Opportunity to create a dedicated environment, tailor made for this group of specialties 'sight and sound hospital'	• None highlighted
Caterpillar Outpatients relocation from Octav Botnar Wing	• Allows expansion of IPP inpatient service • Quality of environment could be created in the IH	• Separation from the IPP inpatient unit which would impact on the service efficiency

4.2 Shortlisted Options

The 'do nothing' option was not considered as the teams currently deliver services in an unsuitable environment, with a significant impact on patients experience and limiting the ability to grow services in future.

Based on the analysis the following two options were identified.

Option	Advantages	Disadvantages
A) Southwood decant for P4 and final reprovision on island site. **(masterplan 2015 plan)**	• No decant of Italian Building required	• Audiology soundproof booths to be relocated to Level 9 Southwood building and then re-provided in Phase 4 • This is costly due to the complex engineering required and also impacts Safari service delivery • Outpatient clinics would move into Southwood areas vacated when PICB opens (which would require significant investment) • The double decant is disruptive to service and costly.
B) Redevelop Italian Hospital into a 'sight and sound' hospital	• Enables audiology soundproof booths to have a long-term relocation, single decant. • Overall Phase 4 benefits as space on Levels 2 and 3 would be freed up, allowing integration of therapies/ pharmacy/ imaging into the building	• Requires town planning approval • Capital investment of c£21m • • Revenue impact of c£350k

4.3 Options Value Review

The following is an estimate of the cost to refurbish the Southwood Building to enable the decant of the Outpatient services from the Frontage Building when Phase 4 commences and the estimated cost of the replacement building capacity included in Phase 4.

The refurbishment of the Italian building option will:

- avoid incurring the Southwood refurbishment costs;
- allow the 2,617m2 of space allocated in Phase 4 to be repurposed to more generic and flexible space.

Refurbished Italian Hospital - cost transfer breakdown	Sq m	£ per sq m	Total	Source
Ophthalmology, Audiology and Cochlear implant to Southwood L6	2,617	£ 1,480	£4,531,597	2017 minor works rate (excluding DPS fees, non-works costs, gosh arts, contingency) but including 17.% FF&E
Ophthalmology, Audiology and Cochlear implant to new build Phase 4 final location	2,617	£10,000	£26,170,000	Phase 4 estimated costs per m2

Option A – Total Capital Costs £30.6 million

a) The option requires the decant of the services included in the scope of this business case to Southwood to enable the Phase 4 redevelopment with the service returning to the Frontage Building. Therefore capital costs comprises:

   — refitting the Southwood Building £4.4 million; and

   — cost of the Frontage building in Phase 4 £26.2 million.

Option B – Total Capital Cost £24.6 million

a) Total programme costs of Italian Building Refurbishment £21.6 million.

b) The property to house the staff nursery has been purchased by the Charity at a cost of £3million.

4.4 Preferred Option

Following several reviews at the Development Programme Board and the Executive Management Team the option to create a "Sight and Sound Hospital" for ophthalmology and audiology has been determined as the best fit. This option supports the development of a purpose built unit for services that see some of our more complex outpatients and require bespoke spatial design. The development supports the delivery of Phase 4 but is not dependent upon it.

4.5 Decant Strategy for Italian Hospital

The current occupants of the building can be broken into three types:

- Staff nursery – run as cost neutral to the Trust supported by a Charity grant and fees
- Parent accommodation
- Offices for volunteers and psycho-social

The Charity has acquired a property in Long Yard for refurbishment as a staff nursery and has indicated this will continue to be fully supported by grant. The refurbishment project plan indicates the move can take place in May 2018.

The current provision of parent accommodation is 71 rooms which rises in September 2017 to 86 rooms with the addition of the newly acquired Sandwich Street accommodation. When the Italian building closes in May 2018 there will be a loss of 34 rooms reducing the total provision to 52 rooms. 15 of the rooms lost with redevelopment of the Italian Building will be re-provided in Sandwich Street. Options are being worked up to meet the estimated demand which, based on the Trust's policy has been calculated at around 70 rooms.

The offices will be decanted into other Trust accommodation and the planning is underway.

5 Commercial Case

5.1 Procurement Approach

Great Ormond Street Hospital for a number of years has used the NHS ProCure frameworks to work alongside a construction partner to develop and deliver major capital schemes. ProCure22 (P22) is the latest iteration of this Construction Procurement Framework administrated by the Department of Health (DH) for the development and delivery of NHS and Social Care capital schemes in England. It is consistent with the requirements of Government Policy including the Productivity and Efficiency agenda; the Government Construction Strategy; the Public Contracts Regulations 2015; the National Audit Office guidance on use of centralised frameworks; and the Cabinet Office Common Minimum Standards for procurement of the Built Environment in the Public Sector.

P22 represents the third iteration of the DH Framework providing Design and Construction Services for use by the NHS and Social Care organisations for a range of works and services. P22 continues to build on the principles of its predecessors to streamline the procurement process and create an environment in which Clients, Principal Supply Chain Partners (PSCPs) and their supply chains develop stronger partnerships to drive increased efficiency and productivity whilst supporting enhanced clinical outputs for patients and improved environments for staff and visitors.

Following a competitive process supported by the Department of Health P22 team GOSH appointed Kier Construction as our P22 PSCP in March 2017. Kier are now working with GOSH in the design development of the Italian Hospital scheme and managing the design and cost teams to deliver the project within budget. Following completion of the design Kier will tender the sub-contractor works packages on an open book basis to establish an agreed Guaranteed Maximum Price (GMP). Once agreed Kier are responsible for and manage the risk of outturn costs being higher than the agreed GMP. Savings below the GMP (i.e. where anticipated risks do not materialise) are shared between GOSH and the PSCP.

The GOSH projects team will manage the performance of Kier in delivering the contracted works. A dedicated project manager is responsible for overseeing works on-site and working with Kier to deliver the project to cost and programme. Project progress is reported to the Capital Investment Group and Development Programme Board.

5.2 Agreed Services

5.2.1 Design and Construction Team

The GOSH redevelopment team have significant experience in leading design, commissioning and construction for new buildings. The commercial strategy includes:

- the appointment of Sonnemann Toon as experts in healthcare facilities within Grade II listed buildings
- the appointment of Kier as the P22 providers and therefore main contractor

This project will be led by the Redevelopment capital projects team and will be included in the overall capital programme.

5.2.2 Design Principles

The design principles for this project are as follows:

Area	Design Principles
Architectural Excellence	Sonneman Toon Architects will work with the GOSH clinical teams to maximise the potential of the building and aim to provide as much clinical outpatient space as possible in a high quality and uplifting environment.
Interior Design	The interior design employed in the Italian Hospital will be of great importance to the feel and experience of the building for patients and their families.
Fixtures, Fittings, Equipment, Furnishings	The Trust has developed a comprehensive schedule of principles to be followed in the selection of internal fixtures and fittings.
GOSH Arts	Sonnemann Toon have highlighted areas in which GOSH Arts can create a unique patient experience and potentially integrate art installations into the fabric and design philosophy of the building.
Sustainability: materials	Materials used should meet requirements of the NHS Sustainability Agenda where it is appropriate to do so. The project will achieve BREEAM 'Very Good'.

The Draft plans are provided as Appendix 1.

5.3 Contract Management

Within the P22 suite of documents there are standard form of contracts to be used on all Major and Minor construction projects.

The Italian Hospital project will use the following contract;

MAJOR WORKS NEC3 Engineering and construction contract Option C Target contract with activity schedule; a pro forma Project Letter of Instruction to be issued to a PSCP by the GOSH to initiate a Major Works Project (P22 NEC3 Option C Templates A and B).

A draft version of the contract has been prepared by Kier and GOSH has procured the services of Gardiner & Theobald to review the contract documentation and advice on issues such as liquidated damages and the specific Z clauses etc.

Ongoing during the works the contract will be administrated by the P22 Cost Adviser, (currently being selected via a competitive tender process)

5.4 Implementation Timescales

Completed Tasks to date:

- The design team was appointed in January 2017 and the P22 construction partner (Kier) was selected in March 2017.
- The pre application meeting with Camden was held in April 2017 and the GMP will be received in November 2017.

The project Timetable is set up below:

Task	Month
Business case approval EMT and Trust Board	Jul 2017
Charity Grant funding Approval	Jul 2017
Town planning application Submitted	Jul 2017
GMP received	Nov 2017
Update Business Case with final GMP for Board Update and Approval	Dec 2017
Decant current occupants	May 2018
Construction Commences on site	Jun 2018
Construction completion	Aug 2019
Occupation	Oct 2019

6 Financial Case

6.1 Overview

On the basis of that assumptions outlined below, the capital investment required for the preferred options provides value for money as this avoids two decants for this service under the original Phase 4 option planning. The refurbishment also provides some additional capacity in the Italian building for either NHS or IPP outpatient services and makes best use of current building stock.

The costs to operate the Italian Hospital are more than the current space, but this includes additional capacity for growth for which no additional margin for growth in income has been included in this initial assessment. At this stage of assessment there will be an increase in costs of £350k pa before applying any increase in income.

The capital option indicates value for money but there will be a cost pressure to relocate the services pending a full review of the costs to operate the services in the new facility. This will need to be completed for the Full Business Case.

6.1.1 Income and Expenditure Assumptions

The financial case is based on a number of elements:

1 Services

a) The new facility will be a relocation of outpatient services from the Frontage Building

b) In this initial review, there are no assumptions for growth in NHS activity over and above any growth assumptions included in the current NHSI two year Trust Financial Plan, i.e. the services will not increase at a rate greater than the current demographic growth.

c) There is capacity to enable future demand to be managed with some additional capacity in the facility.

d) No assumptions have yet been included for the use of available outpatient capacity for IPP outpatient services and therefore any income or costs related to this change.

2 Facility cost implications for running the Italian Hospital.

a) Some of the Hard and Soft FM costs from running the Frontage building clinics will transfer (based on Frontage level 1 and level 2 GIA).

b) The financial table estimates the new FM costs offset by reduction in costs post transfer.

c) The cost model indicates there will be a cost pressure for an increase in Hard and Soft FM costs (£61k).

3 Building Rent/Rates Costs

a) The building is owned by the Charity and therefore as per the policy no rent is charged to the Trust for clinical areas leased from the Charity.

b) Therefore no rental charges are included in the model.

c) Council rates is now included as previously covered by the funded family accommodation and nursery services (£150k).

4 Operational Costs

a) The assumption is that the current services will relocate and transfer existing workforce, with minimal requirement for change in operational costs of the clinics, except for the following:

- New Reception Administration Staff (1WTE) (£28k).
- Additional Security/Porter/MatMan support as this is a separate clinical building (1WTE) (£50k).
- ICT costs – includes annual cost of fibre optic link (£6k).
- Contingency expenditure estimate of 10% has been included.

Any increase to the existing workforce would need to be supported by a separate business case, justifying the demand and service growth

6.2 Capital Costs

The estimated cost of the project is £21.613million. This includes construction, equipment, ICT, professional fees, contingency and VAT. The estimate was provided by Mesh. The table below summarises the estimated cost of the project and phasing of costs over the 2 financial years.

Category	£ Total	2017/18	2018/19
Construction costs	12,600,000		12,600,00
Inflation to Q3 2018	759,000		759,000
Equipment & IT	2,500,000		2,500,000
Professional Fees	2,000,000	1,700,000	300,000
Contribution to public art (as per Trust policy)	154,000		154,000
VAT	3,600,000		3,600,000
Total Construction Cost	**21,613,000**	**1,700,000**	**19,913,000**

6.3 Charity Capital Funding Support

The Charity have indicated support for this project and proposed that the July 2017 meeting of the Trustees will be asked to provide support within a cap of £23m with confirmation of the final grant to the hospital after the GMP has been received in November 2017. This will be contingent on Trust Board approval.

A corporate partner has already expressed interest in the naming rights for this project for £10m. A kick off workshop for the Charity Fundraising team took place on 21st June. The case for need and key messaging framework are already under development. The breakdown for fundraising is drafted and a new strategy for donor recognition will be agreed. The application for the capital funding support from the charity for the project will be confirmed in July 2017. The draft OBC was submitted for review to the July meeting of the GOSHCC Trustees. The Trustees agreed, subject to Trust Board approval of the business case, to commit £21.6m to support the Italian Hospital redevelopment.

6.4 Summary Financial Impact/Affordability

The following table summarises the expected cost pressure of £350k to operate the new facility assuming the level of services is the same as currently provided. Impact on PDC has not yet been included.

The cost assessment includes:

- an additional administration post to manage the central reception;
- additional FM support for security, porter and material management as this is now managed in separate facility;
- Hard and Soft FM services based on rate per m2 offset by reduction in this cost from the Frontage Building;
- rates for the building (previously paid for by the charity;
- ICT recurrent expenditure;
- contingency pending the final review for the Full Business case.

Expenditure	Base Year Nominal Costs 2017	
Expenditure		
Italian Building:		
- Receptionist	£ 28,000	a
- Security/Porter/MatMan	£ 50,000	
- Hard FM costs	£ 180,502	
- Soft FM costs	£ 130,680	
- Rates	£ 150,000	
- ICT	£ 6,000	
- Contingency	£ 54,518	
	£ 599,700	
Frontage Reduction Costs:		
- Hard FM costs	-£ 144,700	
- Soft FM costs	-£ 104,760	
	-£ 249,460	
Net Expenditure Cost	**£ 350,240**	

7 Management Case

7.1 Introduction

The Management Case details the specific arrangements that will be put in place to manage successful delivery of the Programme. It describes the following:

- Programme structure and governance;
- Main roles and responsibilities;
- Project implementation milestones; and
- Change management, benefits realisation, risk management and project review arrangements.

7.2 Programme Management Arrangements

GOSH has a strong track record of delivering major capital schemes, from the Phase 1 development which became operational in 2006 to the new Centre for Research into Rare Diseases in Children which is due to open in 2018. The Trust evaluates its projects and refines its management approaches accordingly; the "lessons learned" from Phases 1, 2 and the early lessons from Phase 3 will be applied to the Italian Hospital Project to ensure best practice in delivering major healthcare capital projects is achieved.

The Phase 2A lessons learned summary document is attached as Appendix 2 to this document. Key lessons include:

- Communication with teams and departments (but also the wider Trust) being affected by relocation, including move dates and orientation sessions well in advance of decant, is key to ensuring cohesiveness of the overall project. Floor Managers will play a key role in this redistribution of information, including any mandatory training that is required for staff in the new areas.
- Early involvement of clinical teams helped with strategic planning, space planning and commissioning of rooms and floors. Clinical leads also a strong supporting role with developing staffing strategies from a workforce planning perspective and should be continued in ongoing projects.
- All stakeholders including parental representation were welcomed and helpful elements to the floor groups but there was no representation from volunteers, leading to them being felt isolated and unwelcome. All stakeholders should feel included and represented as all parties are part of the overall operation of the space.
- Consistent standardised documentation was a useful tool throughout, from action and meeting logs through to operational policy development and project planning. This should be continued and implemented wherever possible to ensure the clear flow of information continues throughout the operational commissioning process.
- Staff identified the emotional attachments staff, patients and families have to the areas that they are currently occupying. This should be acknowledged and a strategy to mark the occasion and the transition between these should be in keeping with the level of emotion and ownership these parties feel, both in the area they are leaving and in the introduction to the new spaces.

7.3 Project Management Arrangements

The Trust has put in place robust project management arrangements to ensure that the project will:

- Be integrated into the Trust's ongoing programme of clinical change
- Be managed to minimise its impact on the continued operation of GOSH as the UK's largest tertiary children's hospital
- Be delivered on time and to budget
- Represent an effective, value for money investment for the Trust

The project organisational structures and roles are summarised below

7.4 Project Management Roles

The following key project roles will be maintained throughout the project:

Investment Decision-Maker: the Trust Board will maintain an overview of the project, receiving regular reports on progress and retaining accountability for the delivery of all aspects of the project

Project Owner: the Chief Executive of the Trust, as Accountable Officer, will retain personal accountability for project delivery. The Project Owner chairs the Redevelopment Programme Board and receives monthly updates.

Project Director: is the key point in the Trust for providing leadership and direction of the scheme for internal and external stakeholders. This role is currently undertaken by Matthew Tulley, who is an experienced NHS Project Director.

Design Lead: is responsible for establishing the vision and the development of the design brief from inception through to completion of the project. The Deputy Director of Development will fulfil this role.

This structure will be reviewed to ensure that it provides the appropriate levels of governance and engagement during the development of the brief, design and construction. The project team will be supported by professional advisors appointed specifically for the development.

7.5 Risk Management Plan

Risk management is an essential part of the development of any project. The objective of the risk management process is to establish and maintain a "risk aware" culture that encourages on-going, proactive identification and assessment of project risks.

The risk management strategy will incorporate the following activities:

- Risk identification and reporting
- Evaluation of proximity, probability and impact of the risk occurring
- Allocation of risk owner
- Development of risk mitigation responses including prevention, reduction, transference, acceptance of reduction
- Identification of escalation procedures
- Planning and resourcing of responses to risks
- Monitoring and reporting of risk status

- The risk register will be reviewed and updated on a regular basis

A full construction risk register has been drawn up by the architects on the scheme.

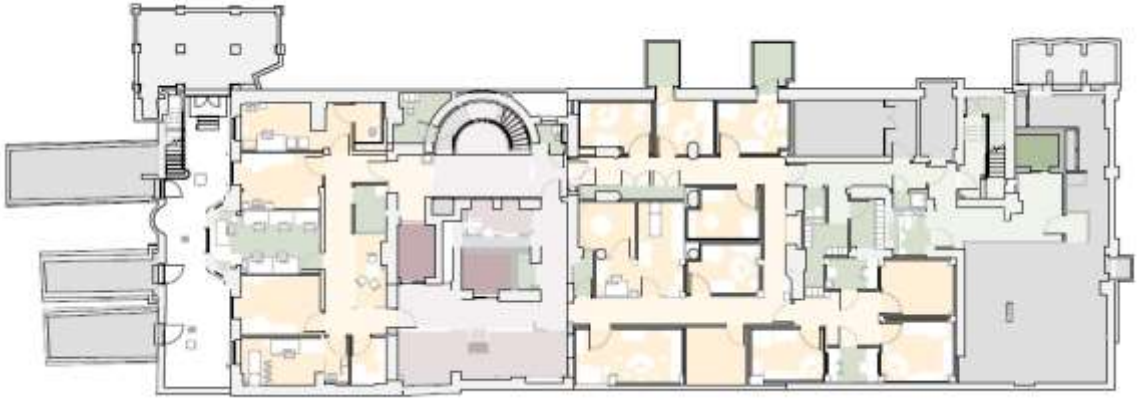
7.6 Stakeholder Engagement and Communication Plan

GOSH is committed to engaging fully with internal and external stakeholders throughout the planning and design of major capital projects.

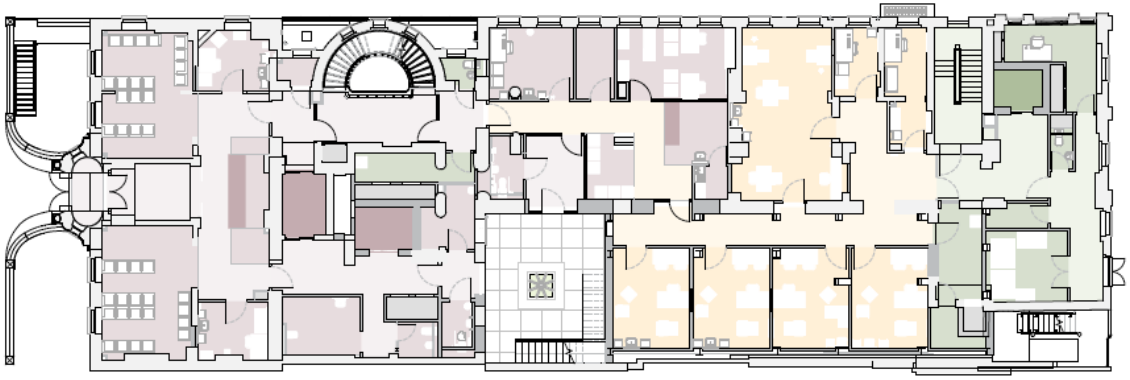
In keeping with its motto 'The Child First and Always', the Trust also includes children and their families in this process. It is important to gain their perspective on what they feel does not currently work well at GOSH and what the future of the hospital looks like for them. The Trust uses a number of different methods for workshops including a web based interactive board, and CYP workshops.

The Stakeholder Involvement and Communications strategies will align with the Trust's overall corporate communications and public relations strategies. The Trust's approach will dovetail with the GOSH Children's Charity's Major Donor Strategy to ensure consistent and seamless marketing of the Redevelopment. It provides a framework for project-specific Communications Plans for the various elements of the programme.

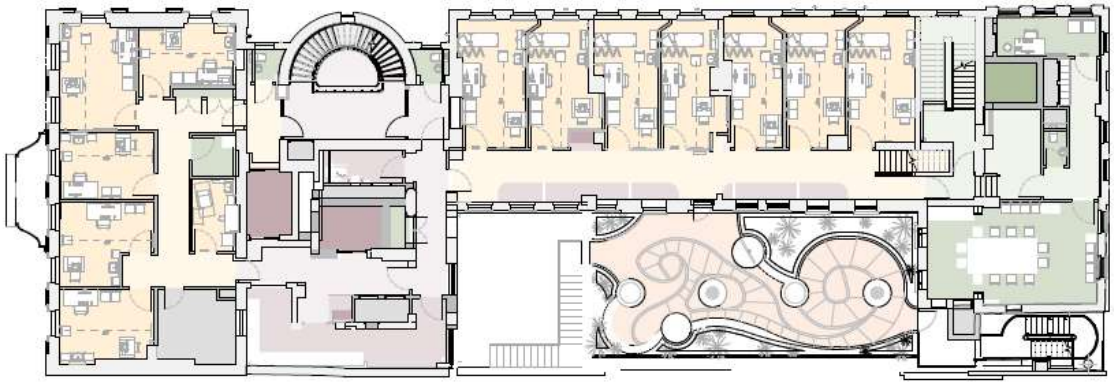
Appendix 1 Draft plans



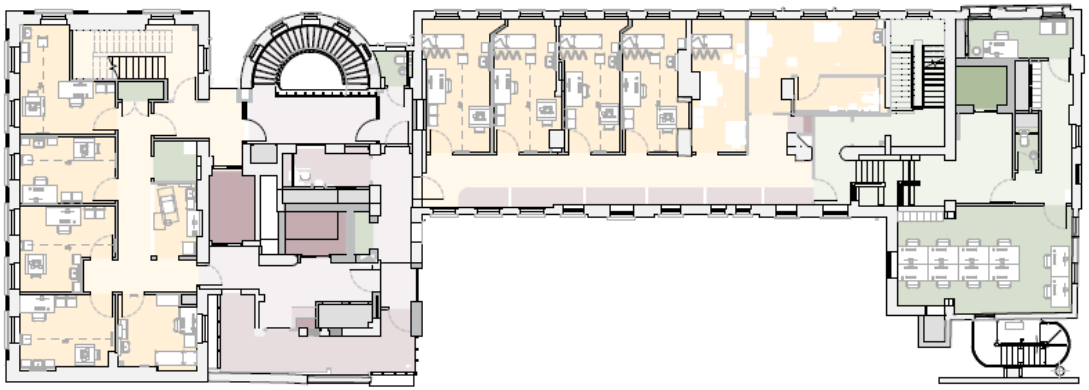
Basement



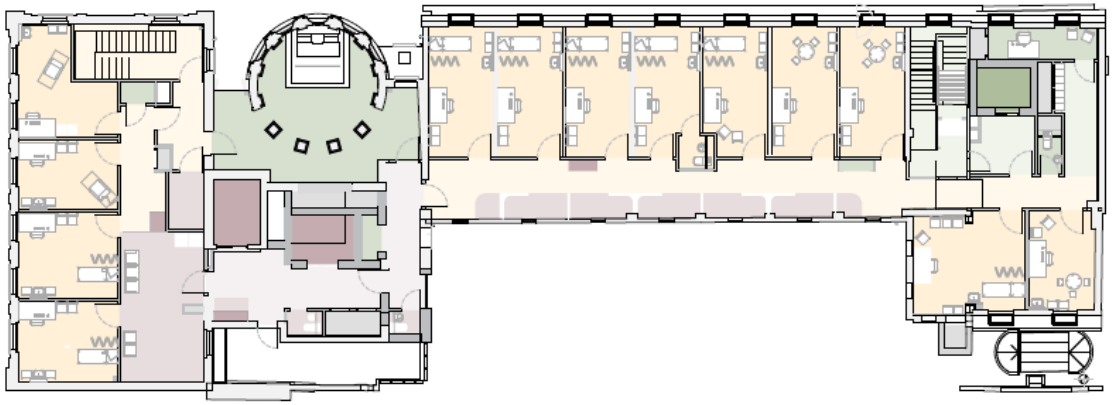
Ground Floor



First Floor



Second Floor



Third Floor

Attachment G

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27th July 2017

Integrated Quality Report	**Paper No: Attachment G**
Submitted by: Dr David Hicks, Medical Director Juliette Greenwood, Chief Nurse	

Aims / summary

The Quality and Safety report has been revised and combined in to an Integrated Quality Report to provide information on:

- whether patient care has been safe in the past and safe in the present time
- how the Organisation is hearing and responding to the feedback and experience of our children and young people and parents
- what the Organisation is doing to ensure that we are implementing and monitoring the learning from our data sources e.g. (PALS, FFT, Complaints and external reports as appropriate)
- data quality kite-marking has now been added to the report as per the Board's request

Action update:

- **Consideration to be given to adding in dates that the required actions arising from incidents were completed such as training and dissemination of learning.**

Progress updates for the actions for closed or de-escalated SIs has been added to the report. The Board should note that as these SIs are recently closed or de-escalated, the actions may be in progress or on-going due to the timeframes for completion. Actions are allocated individual timescales for completion based on the complexity of the actions and the resource allocation for completion.

Action required from the meeting

To note the style of the report, providing any feedback or requested changes to the Medical Director and Chief Nurse to note the on-going work supporting any suggested changes to work streams.

Contribution to the delivery of NHS Foundation Trust strategies and plans

The work presented in this report contributes to the Trust's objectives.

Financial implications

No additional resource requirements identified

Who needs to be told about any decision?

Quality and Safety team, Patient Experience team, Divisional Management teams

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

Divisional Management teams with support where needed, Quality and Safety team, Patient Experience team

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

Medical Director and Chief Nurse

Integrated Quality Report

Dr David Hicks, Interim Medical Director
Juliette Greenwood, Chief Nurse

June 2017 (covering March – May 2017)

Index

Great Ormond Street Hospital for Children NHS Foundation Trust

Safety

Care/ Experience

Outcomes/ Effectiveness

Improvement

Has patient care been safe in the past?

Measures where we have no concerns

Great Ormond Street Hospital for Children NHS Foundation Trust

This slide contains an overview of some of the key measures monitored within the Trust; these will be considered by exception. Where there are measures/trends of concern, a slide containing a deep dive of that information will be included in the report.

Measures for self reporting systems do not always have a direct correlation between the data and safety; e.g. an increase in reporting may not always be a result of an unsafe environment but instead as a result of a good reporting culture which in turn can improve safety via learning.

Please see appendix 1 for the methodology used for the measures below.

Data Quality Kite-mark	Measure	Comment
	**Non-2222 patients transferred to ICU by CSPs**** ** patients should be transferred to ICU before they have an arrest where possible which would indicate the early identification of a deterioration prior to an arrest.	There remains an average of 8 non-2222 patients transferred to ICU by CSPs per month; the process continues in normal variation.
	**Cardiac and respiratory arrests**** **The figures within the Integrated Quality Report includes arrests within all areas outside of ICUs (including day case Wards, day units, outpatient areas and non-clinical areas e.g. main reception) whilst the Safe Staffing Report arrest data only refers to arrests on in-patient Wards . The data will therefore differ between the two reports as the Integrated Quality Report includes additional areas.	Overall, the data remains stable for both measures at 2 cardiac arrests per month and 2.7 respiratory arrests per month; the process is in normal variation at GOSH and is not statistically significant.
	Cardiac arrests outside of ICU	**Respiratory Arrests outside of ICU**
March 2017	**3** (Badger x2, Walrus)	**1** (Giraffe)
April 2017	**4** (Badger x3, Robin)	**2** (Squirrel (SNAPS), Koala)
May 2017	**2** (Badger, Rainforest)	**2** (Badger)
	**Mortality**	The data remains stable at 6.3 deaths per 1000 discharges; the process is in normal variation and is not statistically significant.

Has patient care been safe in the past?

Measures where we have no concerns

Great Ormond Street Hospital for Children NHS Foundation Trust

This slide contains an overview of some of the key measures monitored within the Trust; these will be considered by exception. Where there are measures/trends of concern, a slide containing a deep dive of that information will be included in the report.

Measures for self reporting systems do not always have a direct correlation between the data and safety; e.g. an increase in reporting may not always be a result of an unsafe environment but instead as a result of a good reporting culture which in turn can improve safety via learning.

Please see appendix 1 for the methodology used for the measures below.

Data Quality Kite-Mark	Measure	Comment
	**Never Events**	The last Never Event was in May 2017 (which was 332 days after the previous Never Event). The Never Event declared in May 2017 is for a retained object while the previous Never Event was due to medication given via a misplaced NG tube.
	**Serious Incidents**** ****by date of incident not declaration of SI**	The data has shown a reduction in serious incidents reported per month from 1.2 to 0.7 however the most recent 2 months performance indicate that this reduction has **not** been sustained. There have been 2 SIs reported in April 2017 and 2 SIs reported in May 2017. More data is needed before a decision can be made.
	**Hospital acquired pressure ulcers reported (grades 2+)**	Performance remains within normal variation at 6.7 per month.
		March 2017 / **April 2017** / **May 2017**
	Grade 2 hospital acquired pressure ulcers	**5** (3 are device related) / **3** (3 are device related) / **4** (2 are device related)
	Grade 3 hospital acquired pressure ulcers	**0** / **0** / **0**
	Grade 4 hospital acquired pressure ulcers	**0** / **0** / **0**
	**GOSH-acquired CVL infections**	The data remains stable at 1.8 CVL infections per 1000 line days.* **The Quality and Safety team use Statistical Process Control (SPC) for measuring performance. This enables us to analyse the variation in a process and differentiate between 'common cause' and 'special cause' variation. This allows us to determine with some statistical rigour when there are improvements in processes. The methodology used in the 'Integrated Performance Report' is different where the trend is determined by comparing the performance of the 2 previous months.* *SPC also enables us to calculate average performance for a process which is the figure we quote. The 'Integrated Performance Report' gives the performance figures for the 3 most recent months only.*

Has patient care been safe in the past?

Serious Incidents and Never Events

Great Ormond Street Hospital for Children NHS Foundation Trust

Serious Incidents and Never Events March- May 2017

No of new SIs declared in March-May 2017:	**3**	No of new Never Events declared in March-May 2017:	1
No of closed SIs/ Never Events in March-May 2017:	**1**	No of de-escalated SIs/Never Events in March- May 2017:	1

New SIs/Never Events declared in March-May (4)

STEIS Ref	Incident Date	Date Report Due	Description of Incident	Divisions Involved	Senior Responsible Officer (SRO)	Patient Safety Manager	Executive Sign Off	Divisional Contact
SI 2017/ 9747	06.04.17	10/07/17	Preventable aspiration cardiac arrest secondary to ventilator operation	JM Barrie	Associate Medical Director- Quality, Safety and Patient Experience	Lead Patient Safety Manager	Interim Medical Director	Divisional Chair, JM Barrie
SI 2017/ 10146	Identified on 07/04/17	13/07/17	Human tissue sent to incorrect location	Charles West	Deputy Medical Director/ Caldicott Guardian	Patient Safety Manager	Interim Medical Director	Divisional Co-Chair, Charles West
SI 2017/ 10169	13/03/17	13/07/17	Migrated needle during cardiac procedure	JM Barrie and Charles West	Associate Medical Director- Quality, Safety and Patient Experience	Lead Patient Safety Manager	Chief Nurse	Divisional Assistant Chief Nurse, JM Barrie
2017/ 13562	04/05/17	18/08/17	(Never Event)- Retained object	JM Barrie	Deputy Medical Director	Patient Safety Manager	Interim Medical Director	Matron-Theatres

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Great Ormond Street Hospital for Children NHS Foundation Trust

Learning from closed/de-escalated SIs in March-May 2017 (2):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
SI 2016/31065 (de-escalated 17/03/17)	The patient was referred to this centre for shared care management of an aortic coarctation with the local hospital in Cambridge, Addenbrookes. The patient underwent a series of screening investigations and subsequent multidisciplinary reviews where the consensus opinion was to proceed to surgical repair. The patient was admitted to theatre but the procedure was not completed as the surgeon with the support of a senior cardiology colleague felt the degree of aortic narrowing evident on macroscopic inspection was not sufficiently severe to justify surgical repair. Although the repair was not carried out, the patient underwent surgery and required post-operative management on cardiac intensive care and then the cardiac ward for three days ahead of discharge. It is possible that a coarctation repair may still be required in the future.	The findings from the pre operative serial echocardiograms and MRI were not supported by the intraoperative clinical findings and it was thus felt there was potentially more risk associated with proceeding with a modified surgical procedure than would be gained by not undertaking a modified repair.	• Divisional Director to discuss with consultant body, who chair the JCC, to ensure that a summary of all the discussion is outlined to the designated recorder and not just the outcome of the discussion. **Action complete- March 2017** • Senior divisional management team to propose and plan the consent clinic with the appropriate support, resources and membership. **Action on-going- consent programme currently being critically appraised. Dedicated consent clinic is currently under consideration to include specific consent taken by operating surgeon and considering use of technology such as skype to obtain consent.** • Complete the consent audit on the cardiac day care unit and collate the data. **Action complete- audit presented 7th July 2017 to Cardiac M&M meeting.** • Present the data to the cardiac services in appropriate forums e.g.: Cardiac Board, consultants meeting, M&M **Action complete (see above)** • Review the information provided to families ahead of admission for elective procedures, how it is presented to them and when it is presented to them. **Action on-going; this links in with the work regarding the dedicated consent clinic and is under review.**	Staff should ensure that there is consistent recording of any discussions, not just outcomes, held at multi-disciplinary meetings to ensure that the decision process and rationale is clear to all.
SI 2016/33178 (closed 19/04/2017)	Information Governance Breach- information was sent to the birth parents of a patient where a court order was in place restricting information from being shared with them.	The PIMS record with contact details for the patient's birth parents was not amended once the Trust became aware that ongoing information should not be shared with them.	• PIMS alert for care orders to ensure that potential issues are flagged to all staff reviewing the patient record a) Create PIMS alert which would signify there is a relevant care order **Action is currently in progress.** b) Create process for ensuring these are regularly reviewed (ongoing process) **Action is currently in progress and links in with the action above.** c) The member receiving information about a change in care details should be directly responsible for checking that PIMS information is updated accordingly. **Action is in progress.** • Review all the records of all patients with a 'secure address' on PIMS for the last 2 years, to ensure that there are no other patients for whom we hold contact details on PIMS of parties who should no longer receive information about the child a) Collate list of those with secure address from Information Services **Action complete: initial report run on 09/06/2017; this will be updated and reviewed.** b) Review information held on PIMS alongside information held by social work team **Action is currently in progress.** • A new tab has been created on EDM (Electronic Document Management System for care orders to be uploaded and stored in. **Action complete 13/06/17**	If a patient has a secure address staff should be more vigilant. Demographic details to be checked at each visit and please ask for help from a manager if unsure

Are we responding and Improving?

Patient and Family Feedback: Red Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

Red Complaints in March-May 2017

No of new red complaints declared in March- May 2017:	1	No of re-opened red complaints in March- May 2017:	0
No of closed red complaints in March-May 2017:	2		

Open red complaints- March-May 2017 (4)

Ref	Opened Date	Report Due	Description of Complaint	Divisions Involved	Exec Lead	Division Lead
17/ 002	10/04/17	13/07/17	Patient attended GOSH for open heart surgery during which a surgical needle was retained. The missing needle was noticed by the surgical team at the surgical count and the patient was subsequently x-rayed and re-opened to retrieve the needle before being transferred to recovery. The complainant has raised concerns regarding the additional procedure time, additional x-ray imaging and also the additional bypass support required to retrieve the needle.	JM Barrie	Chief Nurse	Divisional Assistant Chief Nurse- JM Barrie
17/011	05/05/17	31/07/17	Patient has raised concerns regarding a procedure that took place in 2004 following receipt of new information which prompted the patient to complain. Complaint received on 05/05/2017; logged as a red complaint on 10 May 2017 after additional information was reviewed.	JM Barrie	Interim Medical Director	Head of Clinical Service
17/018	19/05/17	30/08/17	Patient attended the Cardiac Catheter Lab for a procedure, during the procedure there were complications. During manipulation and injection of contrast the patient had a cardiac arrest and required CPR. Emergency sternotomy was carried out and the guide wire was removed and the patient was transferred to the Ward.	Charles West	Interim Medical Director	Divisional Director, West Division

Are we responding and Improving?

Patient and Family Feedback: Learning from Red Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

Learning from closed red complaints in March-May 2017 (2):

Ref:	Summary of complaint:	Outcomes/Learning:
16/075	The complainant raised concerns regarding the decision making regarding the need for a surgical repair for aortic narrowing and the consent process. The complainant also raised concerns that the patient received an unnecessary procedure as the surgical repair was not undertaken as it was found to be not clinically needed during the procedure and therefore not undertaken.	This complaint was linked with a serious incident investigation (SI 2016/ 31065 de-escalated 17/03/17); the complaint was answered via the serious incident root cause analysis report. The learning from the SI can be found on slide 5.
16/079	The complainant raised concerns that there were complications post procedure including septic shock and heart failure. Concerns were raised regarding the procedure undertaken, consent and post operative care provided.	A full investigation was undertaken and a report was shared with the family on completion. The report provided a detailed explanation for the care and management provided and the rationale for the clinical decisions made.

Are we responding and improving?

Learning from Friends and Family Test- Inpatient Data

Great Ormond Street Hospital for Children NHS Foundation Trust

Data Quality Kite-Mark

Inpatient Results April 2017

April 2017

Overall FFT Response Rate = 27.2%

Overall % to Recommend = 97.7%

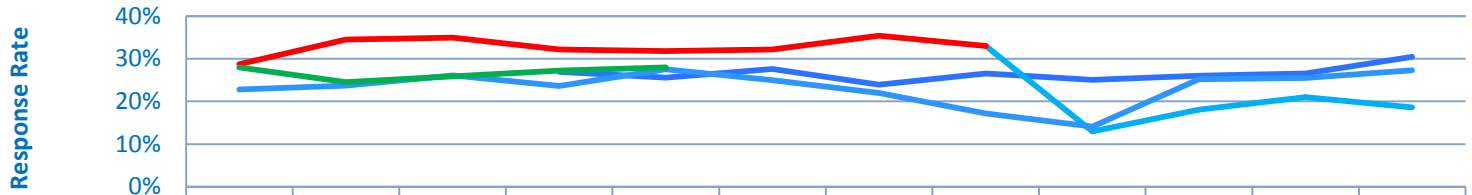
Inpatient Results May 2017

May 2017

Overall FFT Response Rate = 28.4%

Overall % to Recommend = 97.7%

FFT Responses over time



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2014				27%	26%	28%	24%	27%	25%	26%	27%	30%
2015	29%	34%	35%	32%	32%	32%	35%	33%	13%	18%	21%	19%
2016 revised	23%	24%	26%	24%	28%	25%	22%	17%	14%	25%	25.50%	27.3%
2017 revised	28%	25%	26%	27%	28%							

Q4 2016/17 Top 3 Themes

Positive Themes:	No +ve comments	Total comments
Always Helpful (Understanding, Helps Others, Patient, Reliable)	771	779
Always Welcoming (Respect, Smiles, Friendly, Reduce Waiting)	537	555
Always Expert	648	700

Negative Themes:	No -ve comments	Total comments
Access / Admission / Transfer / Discharge	50	76
Staffing levels	13	26
Environment & Infrastructure	117	393

May 2017 Top 3 Themes

Positive Themes:	No +ve comments	Total comments
Always Helpful (Understanding, Helps Others, Patient, Reliable)	281	284
Always Expert	234	245
Always Welcoming (Respect, Smiles, Friendly, Reduce Waiting)	135	139

Negative Themes:	No -ve comments	Total comments
Staffing Levels	4	5
Access / Admission / Transfer / Discharge	20	27
Catering	20	33

Are we responding and improving?

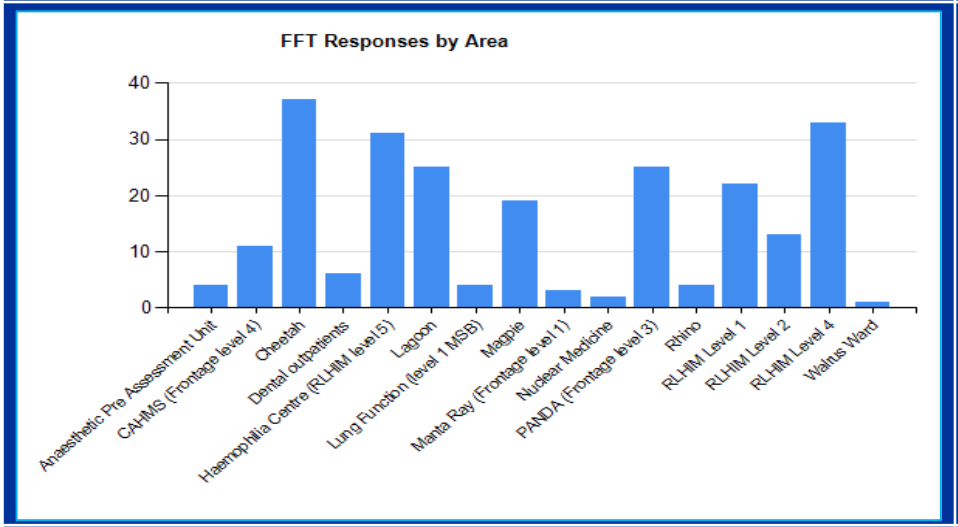
Learning from Friends and Family Test- Outpatient Data

Great Ormond Street Hospital for Children NHS Foundation Trust

Data Quality Kite-Mark

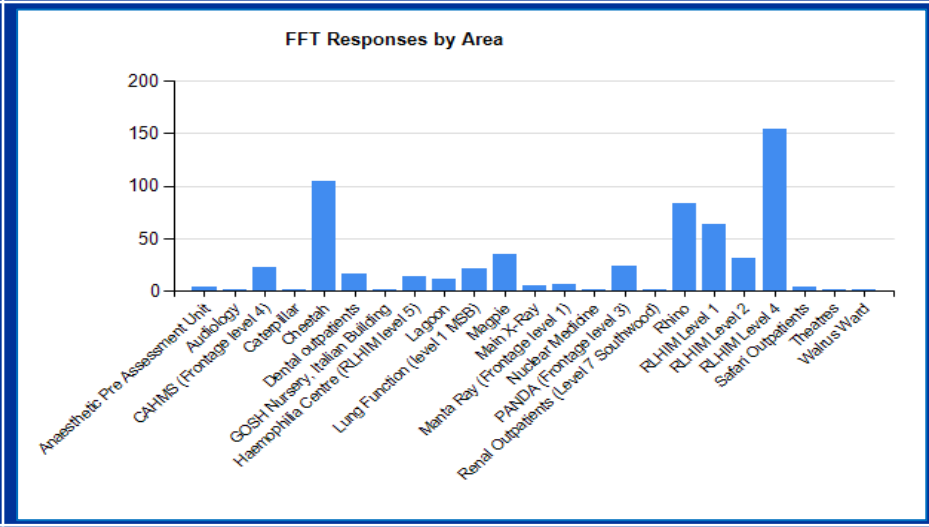
Outpatient Results April 2017

April 2017
Overall % to Recommend = 89.9%



Outpatient Results May 2017

May 2017
Overall % to Recommend = 93.6%



The average percentage to recommend for Outpatients in May 2017 has increased to 93.6%
The number of responses dropped significantly in April 2017, however the responses increased to normal levels in May 2017.

Are we responding and improving?

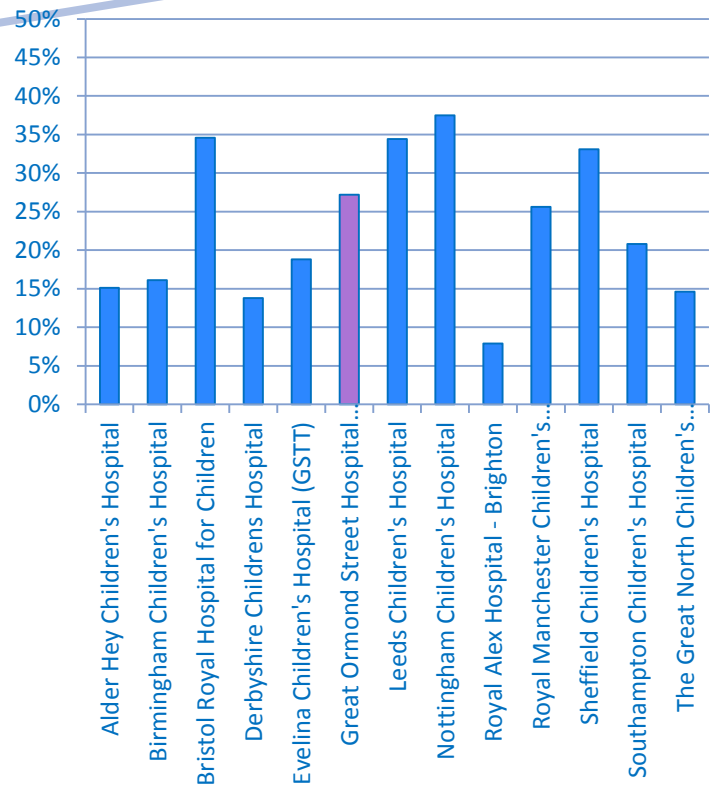
FFT Updates / Benchmarking

Great Ormond Street Hospital for Children NHS Foundation Trust

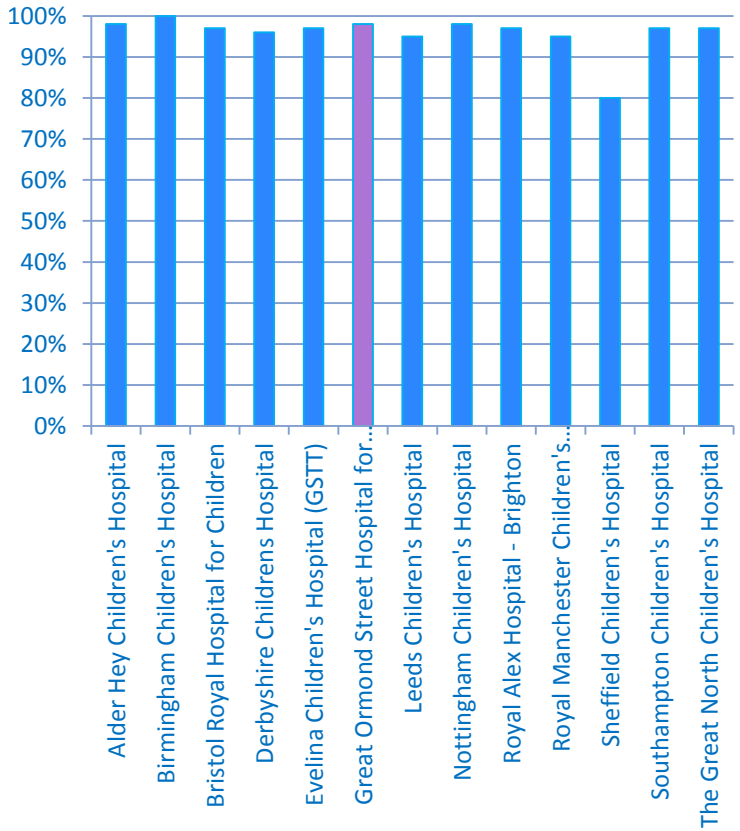
- FFT comments feature in roundabout each month.
- Real Time Feedback supplier has been chosen.

*Based on NHS Choices Data – April 2017 (this is the most current data available at report production)

Response Rates



Percentage to Recommend



Are we responding and improving?

Learning from Friends and Family Test- Positive Feedback

Great Ormond Street Hospital for Children NHS Foundation Trust

Below is a snapshot of some of the positive received via FFT during the reporting period. Positive feedback is shared with the relevant teams for dissemination.

Patient Feedback

Everything was so incredibly nice. The staff was so helpful and brilliant.

I think the good thing was all the nurses and doctors were helping and taking care of me, Thank you!

Play specialist is fab!

Everything was so incredibly nice. The staff was so helpful and brilliant.

Nurses are super kind and gentle.

Parent/Carer Feedback

The staff were outstanding from the moment my daughter arrived to the time she went home. The nurses, doctors and support staff were incredible throughout our stay. The care my daughter received was fantastic. I couldn't say anything negative, everyone was so helpful, understanding, patient, considerate and willing to help - This is a fabulous hospital.

GOSH is world class. The surgeons, doctors, nurses, sisters, dietitian are all very knowledgeable, and very thorough, hard-working and extremely kind. The surgeons were quick to make a diagnosis and operating appropriately to fix a problem which should have been fixed 6 weeks ago at my local hospital! Thank you so much GOSH!

Are we responding and improving?

Learning from Friends and Family Test- 'You Said, We Did' Feedback

Great Ormond Street Hospital for Children NHS Foundation Trust

Below is a snapshot of some of the negative feedback received via FFT during the reporting period and the subsequent actions taken. There is a process in place for the management of negative feedback to ensure that this is acted upon appropriately.

'You Said'

We did

"The family accommodation system is terrible. They have no space for families to stay unless it is booked through ways that are not available to us. We have been here many months and could never once get a day for my family to stay for a visit. Another family that came through PICU (and lives in London) had accommodation for their entire BMT!

The Parent Accommodation policy sets out criteria defining who is eligible for this support. The family who raised this concern would only be entitled to off-site parent accommodation if their child was in in an intensive care or high dependency bed. Once the patient moves off intensive care then the parents are no longer entitled to accommodation and will be asked to vacate. One parent only will be accommodated at the bedside on the ward.

There is an exception to this rule which relates to accommodation owned and managed by the Sick Children's Trust (SCT). The SCT operate a different policy to GOSH in that they allow parents to stay in their accommodation irrespective of whether their child is in Intensive care or in a High Dependency bed. This does create problems and it may be what this family is referring to. We are currently undertaking an estate strategy review of all patient and parent accommodation and one of the things that we wish to address is the difference between SCT and Trust policies.

The treatment area is the waiting area - It is hugely overcrowded, Dirty. Patient treatment chair/beds are not cleaned before or after patients are treated in them. Patient's relatives and other patients are crowded around giving no privacy to patients being treated. Supplies of medical equipment are out of stock (sticky plasters removing gel) Staff opened a window while wearing examinations gloves and then proceeded to examine/treat my daughter without changing them. Chairs are broken - it is awful to be a patient on this ward - truly terrible.

The e-mail has been received by the Ward Sister and the matter is being reviewed as a matter of urgency.
Regarding the overcrowded infusion room, this has been ongoing issue but staff on the Ward always try to ensure the privacy policy is adhered to . Examination of patients are always carried out in the cubicles. In the treatment room, there are 3 recliner chairs which enables staff to administer infusions to 3 patients at a time.
Regarding the staff not following infection control guidance with regards to use of gloves, this will be discussed will all of the clinical team on the Ward to remind them the importance of following guidelines for infection control.
This particular shift was busy due to staff sickness; we are sorry that this had an impact on patient experience.

Arrived at Bear Ward this morning to be admitted for theatre on the AM list. Bear Ward sent us to Walrus, where Walrus weren't expecting us then sent back to Bear Ward to be told we weren't going to be admitted as someone made a MISTAKE yet again after a hour Walrus kindly took us in and looked after us well, but now it is 11:50am and still waiting to go to theatre. I think this is disgusting as my son's anaesthetic notes can't be found and wasting more time this has happened on a few occasions. Not pleased, notes should be checked the night before.

Parent has been contacted via telephone. Ward sister apologised for the confusion and lack of communication. The Ward Sister (Bear Ward) is reviewing the procedures in order to prevent this reoccurring in the future and will share findings with the family. The family were asked if they would like a written letter however they have declined at this stage. Contact details have been shared if the family have anything they would like to discuss in the future.

Are we responding and improving?

Featured Project: eDIARY Tool

Great Ormond Street Hospital for Children NHS Foundation Trust

Project Aim:

- To introduce a self-reflective tool across all wards by June 2017 in order to encourage organisational and individual learning from incidents and near misses.

Background:

- The Trust has ad existing Drug Error Analysis Toolkit (DAT): developed for medication errors however on review it was found to be viewed by staff as punitive rather than supportive
- Recommendation in November 2016 via Patient Safety and Outcome Committee to replace the DAT with a more comprehensive and non-punitive tool
    - 'Culture of safety surveys repeatedly indicate that a sense of safety and confidence is not widespread in healthcare.' (Kabcenell et al 2016)

What is eDIARY?

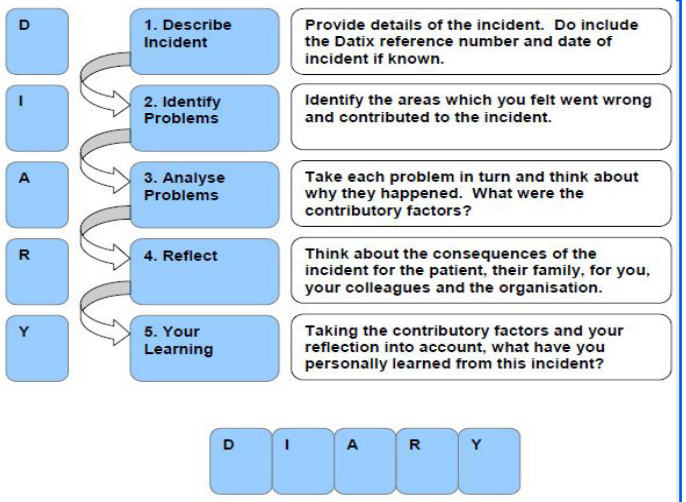
- The DIARY is an online multidisciplinary, non-punitive tool to facilitate reflective practice in the event of incidents and near misses.

Why is it being used?

- Research shows individual and organisational learning is best supported when staff have the resources and support to learn from events and apply that knowledge to improve future practice.
- GOSH's Patient Safety Outcomes Committee has recommended using the tool across the Trust

What does it do exactly?

- The tool provides staff involved in incidents the opportunity to identify and analyse what went wrong, reflect on the event, and identify individual and organisational learning points.
- As such incidents can be difficult for patients and staff, eDIARY aims to help alleviate this by means of supportive review for second victims, positive learning, and mapping out a course for future action.



Progress to date:

- eDIARY tool launched Trust-wide
- Training sessions held throughout all areas as requested to ensure sustainability
- E-Learning training developed for all staff unable to attend in-person training (to be made available on intranet page)
- eDIARY Intranet page live, containing eDIARY information, training, key contacts and additional resources on reflective practice
- Tool embedded in Safety Toolkit for medical starters; DATIX system and communications; and GOSHweb (Quick Links, Useful Links, Clinical Governance and Safety)
- First round of comms complete

Next Steps:

- Comms Team to publish internal communications in line with updated communications and engagement plan
- Embed eDIARY in Quick Links and Useful Links on GOSH Intranet
- Continue to monitor and incorporate feedback around usability and effectiveness of the tool from users post-launch
- Embed in new starter training (August)
- Roundabout article (July)

Are we responding and improving?

Quality Improvement Project Status Update (with Executive sponsorship)

Great Ormond Street Hospital for Children NHS Foundation Trust

Project	Project Aims	Project Leads	Project Timescales and Progress
Nursing Quality Measures	To demonstrate Ward Nursing Quality Measures	Executive Sponsor- **Chief Nurse** Clinical Lead- **Assistant Chief Nurse**	Progress to date: • The NCQM Dashboard went live in early April 2017 • Initial verbal feedback is very positive with some minor additions being added to the dashboard including learning from audit. All additional changes to be made by the end of May 2017. • A formal feedback questionnaire is being created and will be circulated to staff in May/June. • Parent and patient surveys are being carried out to establish what information they would like to see displayed on the wards.
Neonates	To improve the quality and safety of care within inpatient neonates/small infant* at GOSH by October 2017 [*<28 days or 4kg]. The three areas of focus are to: • Reduce the number of avoidable bloodspot test repeats • Increase the recognition and management of neonatal jaundice • Improve documentation and delivery of IV fluid management	Executive Sponsor- **Chief Nurse** Nursing Lead- **Neonatal Nurse Advisor** Medical Lead- **Head of Clinical Service**	October 2017 Progress to date: • Neonatal Intranet page live – all resources to be collated for staff in central location online • E-learning for bloodspots, jaundice and fluids developed – blood spot module complete • Neonatal fluid management guideline complete • Ward materials for staff updated into neonatal folder • Developed new pathway for neonatal admissions for ward admins • Neonatal education package in development PDSAs: • Continue testing admin pathway, including access to NHS Spine for Ward Admins to identify and complete missing NHS numbers on PiMS • Testing Neonatal Admission and Assessment form, to replace birth History form • Testing neonatal information folders on NICU, Koala, Squirrel • Trialling new born blood spot e-learning with PEs, link nurses and project group
PEWS	To replace the Children's Early Warning System (CEWS) with the Paediatric Early Warning System (PEWS) for wards across GOSH by September 2017	Executive Sponsor- **Chief Nurse** Medical Lead- **Consultant Intensivist** Nursing Lead- **Clinical Site Practitioner**	Progress: • Second Steering group meeting occurred – 5th June 2017 • CEWS vs PEWS Nervecentre data comparison reports developed. • Continued difficulty in sourcing identical CareVue data. • Clinical review meetings took place with Cardiac and Renal specialties to discuss their EWS concerns. • Birmingham Children's Hospital visit set for the 5th July to establish how their PEWS system is used operationally e.g. in specific patient populations & managing escalation. • Nursing Training and Education package currently being development – Train the Trainer approach.

Are we responding and improving?

Quality Improvement Project Status Update (with Executive sponsorship)

Great Ormond Street Hospital for Children NHS Foundation Trust

Project	Project Aims	Project Leads	Project Timescales and Progress
Transition	Specialties are working on the short-term requirements of the Transition CQUIN and work is on-going on longer-term improvement strategies with specialties to ensure the Trust meets the recommendations of the NICE Transition Guidelines.	Executive Sponsor- Chief Nurse	On-going project Progress to date: • Q4 CQUIN submitted (target achieved but will need confirmation from Commissioners) • 6 young people have now joined Steering Group • Minimum standards for a Transition Plan being agreed • Project underway with UCLH and Barts to improve transition for YP with an LD or additional needs- 1st draft of joint information leaflet • Pilot underway of dedicated Transition tab on PIMS showing which YP have a Transition Plan in place • Pilot of Consultant alert list showing date of next appointment and frequency of appointments for YP over 16 Next steps: • Finalise minimum standards that must be met in any specialty-specific Transition Plans • Revision of Trust Transition Policy
Extravasation	To reduce the incidence of extravasation injury at GOSH	Executive Sponsor- **Chief Nurse** Clinical Lead- **Consultant Anaesthetist**	Progress to date: • Six work streams underway • VHP Framework & Tool – Koala, Eagle, Bumblebee. Bear and Walrus have completed training , to commence tool in June 2017 respectively. Hedgehog ward commencing in Jul 2017. Peter Pan are in discussion. • VHP Tool – Feedback survey underway for Staff and Families completed. Report due in June 2017. • Communication group – agreed format, awaiting final roll out decision. • Training video – Script and staff ready – funding has now been withdrawn. Unable to progress until new funding is secured. • Long lines - Early discussions underway with Neonatal Consultant & Bear ward, potentially pilot to commence in Sep 2017.

Appendix 1

Methodology for key Trust measures

Great Ormond Street Hospital for Children NHS Foundation Trust

Measure	Methodology	
Never Events	Never events are defined here - https://www.england.nhs.uk/ourwork/patientsafety/never-events/	
Non-2222 patients transferred to ICU by CSPs	Unplanned non-2222 patient transfers to ICU, admitted as deteriorating patients from ward areas by the CSP team.	
Cardiac and respiratory arrests	**Cardiac arrests outside of ICU:** The monthly number of cardiac arrests outside of ICU wards (recorded from calls made to the 2222 Clinical Emergency Team). Cardiac arrests are defined by any patient requiring cardiac compressions and/or defibrillation. Cardiorespiratory arrests count towards the cardiac arrests total, not the respiratory arrests total.	**Respiratory arrests outside of ICU:** The monthly number of respiratory arrests outside of ICU wards (recorded from calls made to the 2222 Clinical Emergency Team). Respiratory arrest is defined by any patient requiring bag mask ventilation. (Previous to May 2013 this was defined as any patient requiring T-piece and/or Bag Valve Mask.) Cardiorespiratory arrests count towards the cardiac arrests total, not the respiratory arrests total.
Mortality	The inpatient mortality rate per 1000 discharges. The numerator is the number of patients who die whilst inpatients at GOSH. The denominator is the number of inpatients who are discharged each month. Day case admissions (as specified by a patient classification of 2 or 3) are excluded from the denominator. CATS patients who are not admitted to GOSH are excluded from this measure.	
Serious Incidents	This is the monthly count of serious incidents (SIs), by date of incident (as opposed to date incident was reported). A serious incident is defined as an incident that occurred in relation to care resulting in one of the following: • Unexpected or avoidable death of one or more patients, staff visitors or members of the public. • Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm • Allegations of abuse • One of the core sets of 'Never Events' http://www.england.nhs.uk/ourwork/patientsafety/serious-incident/	
GOSH-acquired CVL infections per 1000 line days	The definition for this measure is complex and can be found here: http://goshweb.pangosh.nhs.uk/clinical_and_research/qi/Infection%20Prevention%20and%20Control/CVL%20Infection/Pages/default.aspx	

Appendix 1

Methodology for key Trust measures

Great Ormond Street Hospital for Children NHS Foundation Trust

Measures for self reporting systems do not always have a direct correlation between the data and safety; e.g. an increase in reporting may not always be a result of an unsafe environment but instead as a result of a good reporting culture which in turn can improve safety via learning.

Measure	Methodology
All complaints	All complaints added together (red, amber and yellow).
Red complaints	A count of all red complaints per month. Red complaints are defined as severe harm to patient or family or reputation threat to the Trust.
Amber complaints	A count of all amber complaints per month. Amber complaints - lesser than severe but still poor service, communication or quality evident.
Yellow complaints	A count of all yellow complaints per month. Yellow complaints - issues or difference of opinion rather than deficient service.
Number of PALS cases	A simple count - the number of PALS cases.

Attachment G

Appendix 2: SPC Frequently Asked Questions

Contents

Attachment G

What is a Dashboard?

A dashboard is a way of organising and presenting data in an easy to understand way. In the same way that a car dashboard lets you check your speed, revs, temperature and petrol with one quick glance, an improvement dashboard lets you check quickly whether your area is improving. Unlike a car dashboard, our dashboards let you see what is happening over a period of time, in the form of a graph. At GOSH, most dashboards are a collection of graphs, mainly in the form of statistical process control (SPC) charts.

Where are the Quality Improvement dashboards?

You can find the Quality Improvement improvement dashboards by following the links in the Quality Improvement intranet homepage. (double click the Quality Improvement logo, or find via GOS Web under 'Commonly Used Links'. Alternatively, click here to take you to the Quality Improvement Dashboards and Data Collection contents page.

What is SPC?

Statistical Process Control (SPC) charts were first developed by an industrial engineer called Walter Shewhart while he was working for Bell Telephones in the 1920s. He was concerned with eliminating the two most common problems in manufacturing:

- Type 1 error – "false positive" – Over-reacting to natural variation
- Type 2 error – "false negative" – Under-reacting to an actual problem

Shewhart wanted a way of distinguishing *natural cause* variation from *special cause* variation. Nearly all processes exhibit some level of natural variability - for example your commute to work will take a different length of time each day, in fact you would consider it strange if it didn't. Special causes occur because of a significant change in the in the underlying process - in the case of your commute, this might be a tube strike, or because the bus has started taking a longer route.

Process control charts were developed to allow easy differentiation between common and special cause variation. In the case of Bell Telephones, this would be to prevent engineers being called out to look at some equipment that was actually just varying as normal, and on the other hand to know when something was genuinely malfunctioning and required attention. In the case of a hospital it might be to tell if your theatre utilisation had improved, or if DNA rates had dropped.

SPC charts:

- are an excellent way of **measuring for improvement**
- Use the pattern of events in the past to predict with some degree of certainty where future events should fall.
- distinguish between the natural/common cause variation and special cause variation
- enable you to look for problems when they are there, not when they are not
- can motivate staff to improve practice thereby reducing adverse events and minimising variation

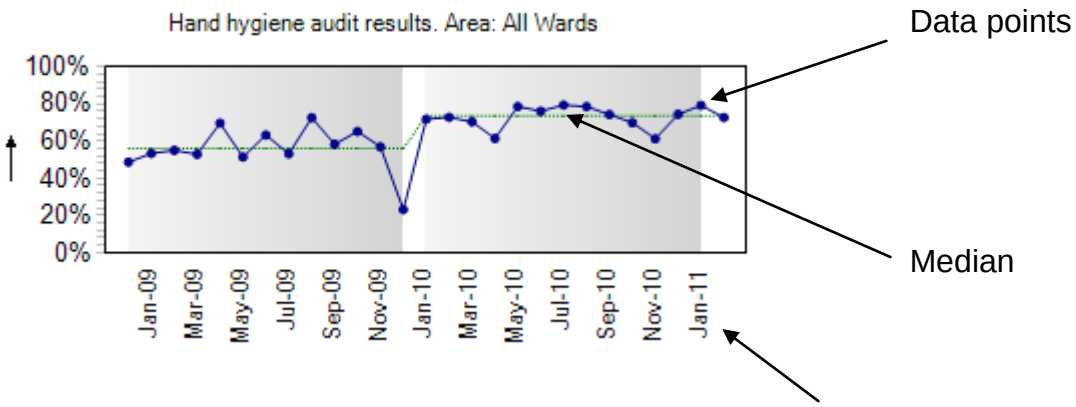
Attachment G

There are two types of SPC charts: run charts and control charts.

What is a Run Chart?

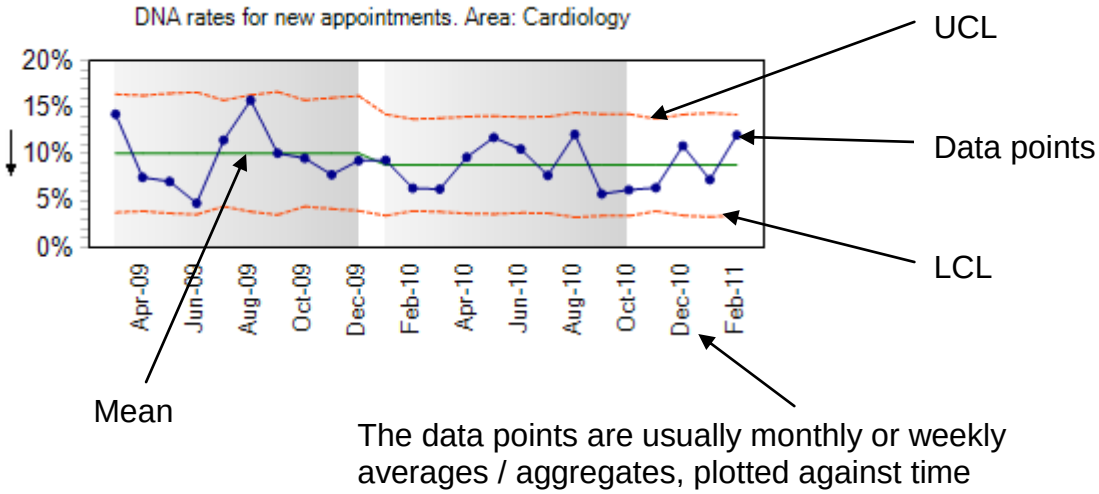
A run chart is used when analysing more than one process, when the data is summed (or aggregated). For instance, if we want to analyse medication errors Trust wide, we would use a run chart - there is more than one process because there are multiple wards in a the Trust with each ward having its own medication process.

Run charts consist of your data points plotted against time, plus the median of your data points within a specified time period (within a single process). The mean can sometimes be used instead of the median, but at GOSH we usually plot the median, as it will be less affected by system-wide outliers.



What is a Control Chart?

A control chart is used when analysing a single process. They consist of your data points plotted against time, alongside the mean (or average) of your data, plus the upper control limit (UCL) and lower control limit (LCL).



Attachment G

The purpose of control charts is to allow simple detection of events that are indicative of actual process change. This simple decision can be difficult where the process characteristic is continuously varying; the control chart provides statistically objective criteria of change. When change is detected and considered positive its cause should be identified and possibly become the new way of working, where the change is negative then its cause should be identified and eliminated.

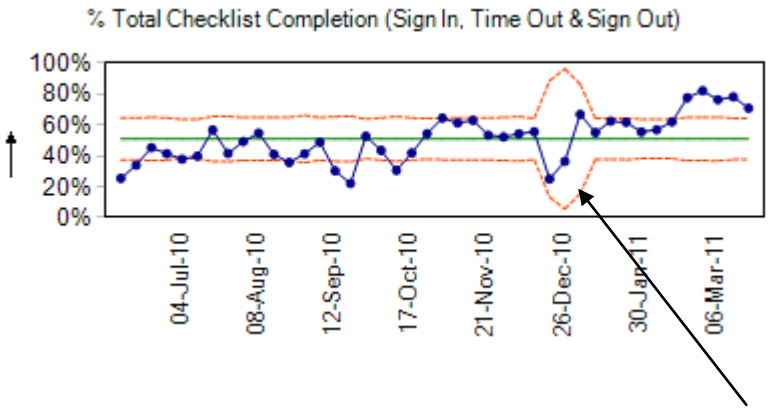
What are the Upper and Lower Control Limits?

The upper and lower control limits help you to analyse and interpret the chart. The limits are calculated based on the data, and the formulas used to calculate them depend on the measure used.

The control limits are set three standard deviations away from the mean (although this is often an approximation, depending on the type of control chart used) so that at least 99% of the data should fall within the limits.

Why are the control limits sometimes wiggly?

Wiggly control limits are used on U-charts and P-charts only. They wiggle because they are calculated using the sample size which can vary from period to period. For example, the number of patients seen in a clinic will change from week to week.



The control limits are wider here which tells us that there was a smaller sample size for this period

What are the 9 different types of control charts?

1. **XMR chart.** Used for individual measurements with only 1 subgroup. (Example of a subgroup is a theatres, clinic or ward.) Example: How many medication orders do we process each week?

2. **X-bar and R chart.** This monitors the average value over time where your variables dataset is made of multiple subgroups of less than 10 observations per subgroup. Example: For a daily sample of five medication orders, what is the turnaround time?

3. **X-bar and S chart.** Similar to an 'X-bar and R' chart but its used when you have lots of measurements in each sample (over 10) Example: For a daily sample of 25 medication orders, what is the turnaround time?

4. **C-chart.** This is used when you count the number of incidents when there is an equal opportunity for the incident to occur. Example: For a sample of 100 medication orders each week, how many errors were observed?

5. **U-chart.** Similar to a C-chart but where your sample size is not the same. This makes the control limits wiggly! Example: For all medication orders each week, how many errors were observed?

6. **P-chart:** Used to represent the fraction or percentage of the samples that are unacceptable where the sample size varies from period to period (making the control limits wiggly) Example: For all medication orders each week, what percentage have one or more errors?

7. **nP-chart:** Like a P-chart but the sample size is always the same. So rather than the percentage of units, you measure the number of units. Example: For a sample of 100 medication errors each week, how many have one or more errors?

8. **G-chart:** Is used when the occurrences are rare. Example: To measure the number of surgeries between SSI infections.

9. **T-Chart:** Is used when your measure is time between rare occurrences. Example: The time between serious incidents.

XMR and P charts are the most commonly used SPC charts for improvement at GOSH.

What is Common Cause Variation?

Common (or natural) cause variation is where the data points are between the upper and lower control limits, evenly spaced around the mean. Common cause variation does not mean either “bad variation” or “good variation”. Common cause variation merely means that the process is stable and predictable.

What is Special Cause Variation?

Special cause variation can be spotted using three simple rules:

a. **Runs**. A run is defined as seven consecutive points above or below the mean/median.

b. **Trends**. A trend is defined as seven consecutive points all increasing or decreasing.

c. **Outliers**. An outlier is a data point which is outside of the control limits.

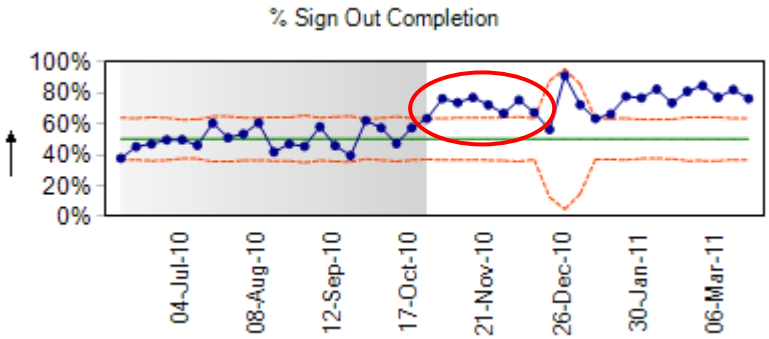
Special cause variation should not be viewed as either “bad variation” or “good variation”. You could have a special cause that represents a very good result which you would want to emulate, or a very bad result which you would want to avoid.

All special causes should be investigated to see whether they are an indication of process change and / or improvement.

What is a Run?

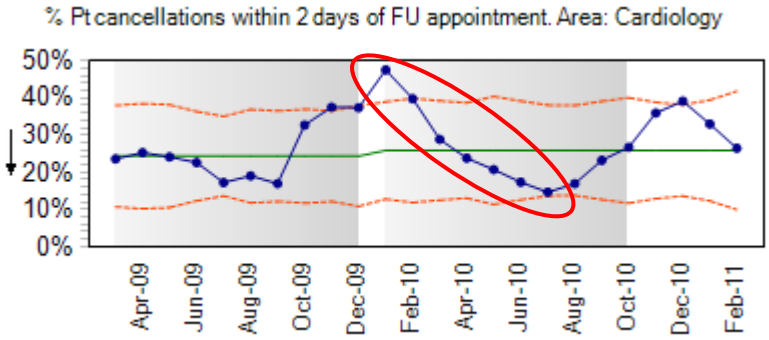
A run is defined as seven consecutive points above or below the mean/median. Here’s an example:

Attachment G



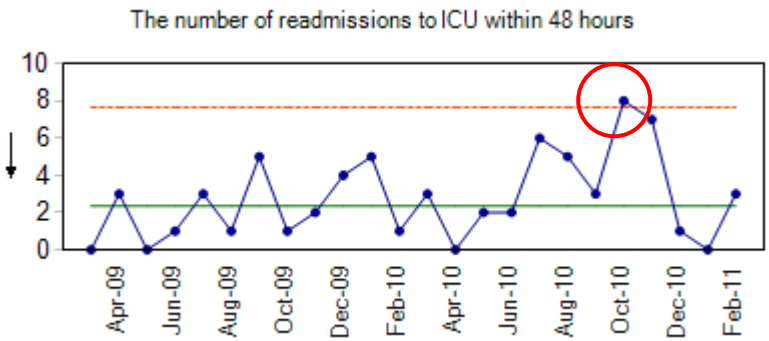
What is a Trend?

A trend is defined as seven consecutive points all increasing or decreasing. Here's an example:



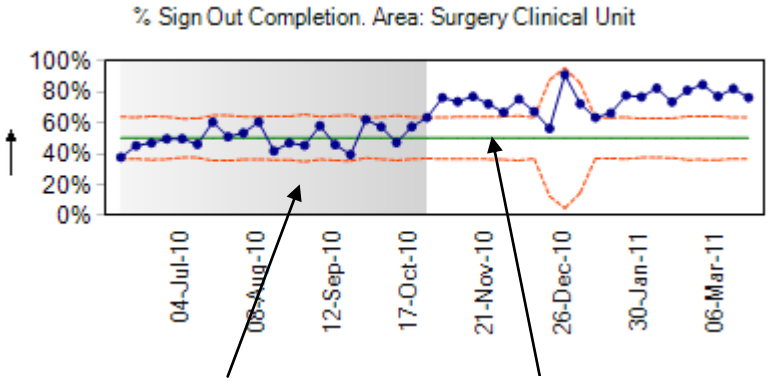
What is an Outlier?

An outlier is a data point which is outside of the control limits. Here's an example:



What is a Baseline?

When measuring for improvement on an SPC chart, you should aim to collect at least 21 points worth of data as a baseline (although this is not always possible – e.g. for monthly data this might take too long). Calculate the mean and control limits for this baseline data, and use this baseline mean and control limit lines to measure future data against:



baseline period

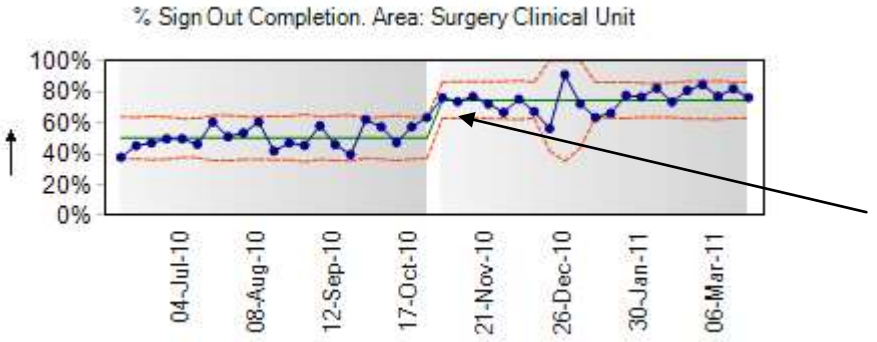
mean and control limits continued from baseline

What happens when you have a Special Cause?

Step / Process Changes: When you have spotted a run or a trend for a measure, you can be statistically sure that the process has changed.

The control limits can be re-calculated from the date the run or trend started (or from when a process change was implemented, after further investigation of the measure).

For example, with the Sign Out Completion measure above (where there has actually been a run of 16 consecutive points above the mean after the baseline, we can recalculate the mean and limits as below, so we have an improved process with common cause variation about the mean again:



mean and control limits recalculated

Outliers: If you spot an outlier, it must be investigated. It indicates that something either very good or very bad has happened and action needs to be taken either to correct the problem so that it doesn't happen again, or to learn from the good practice so that it can be applied in future.

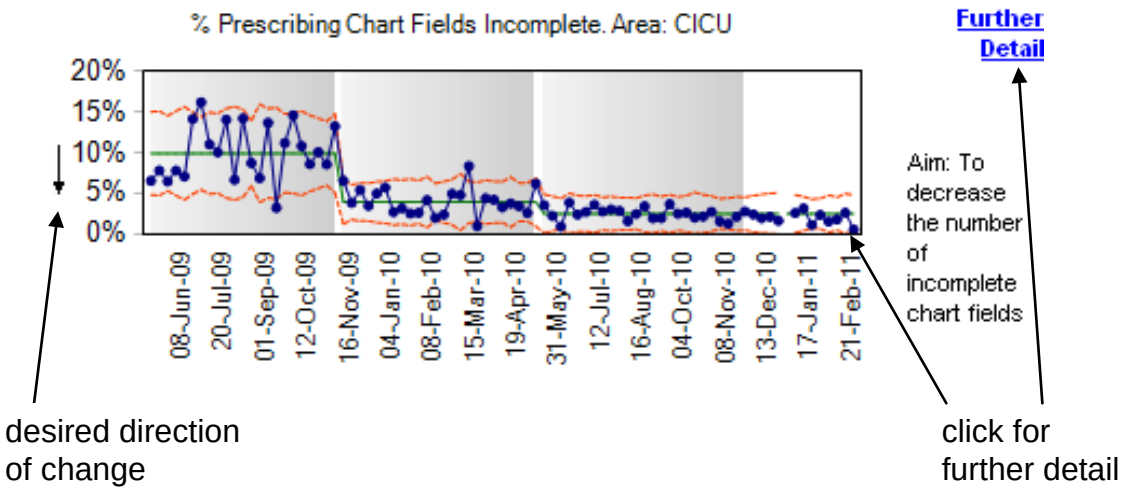
If you spot a special cause on an SPC chart, alert your clinical unit improvement coordinator/manager or one of the Quality Improvement analysts, who can recalculate the mean and control limits and add annotations to the charts.

Any other tips for interpreting SPC at GOSH?

The **arrow** to the left of each chart represents the desired direction of change.

To access **Further Detail and Definitions** for a particular measure on one of the improvement dashboards, either click on a data point or the 'Further Detail' link next to the dashboard charts

Attachment G

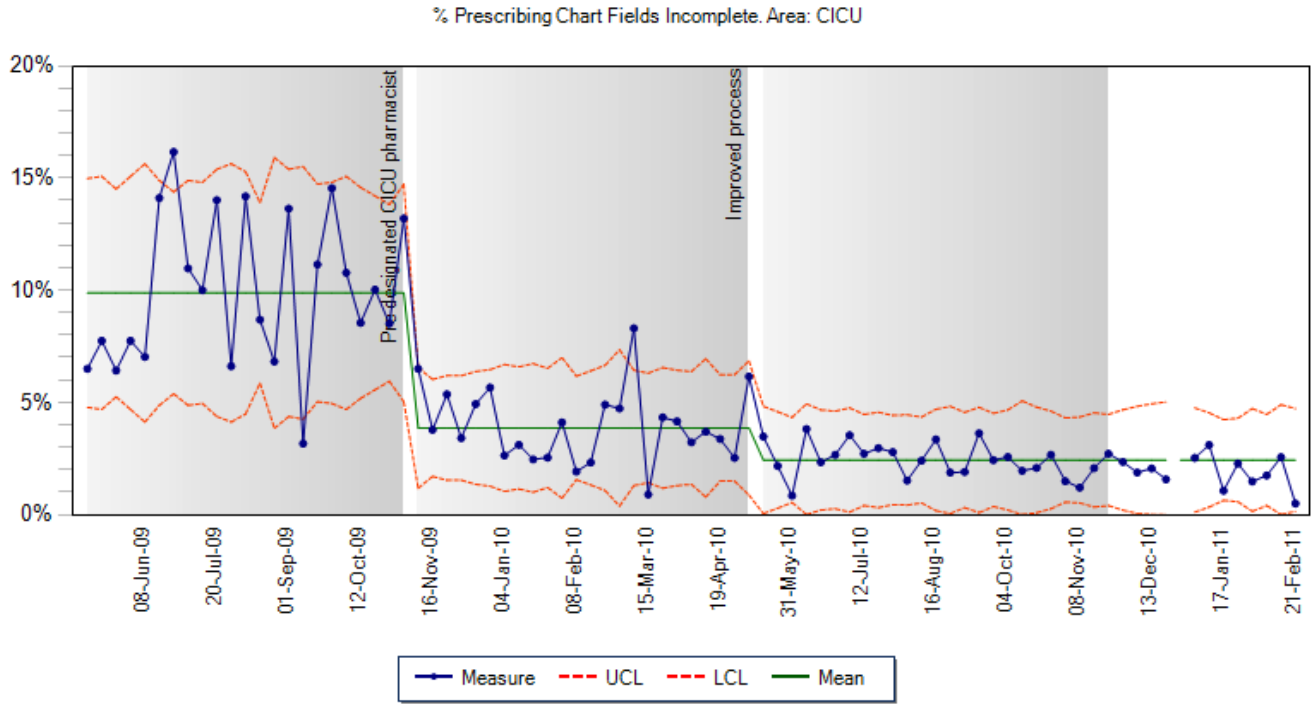


Here you can view a page with a larger version of the SPC chart (see below), plus the following:

- Measure definition, definition source and data source
- Labelled baselines / processes and annotations
- A table containing the figures that make up the measure; including date, data, UCL, LCL, mean (or median if it's a run chart), numerator and denominator (where applicable)

Back to dashboard <<

Desired Direction of Change



Definition: The percentage of front of prescribing chart (5s and 6s) fields not completed. There are 11 fields on each prescribing chart. Data is collected Monday to Friday, excluding weekends and bank holidays.

Definition Source: CICU team

Data Source: CICU Prescribing

Week Start Date	% Prescribing Chart Fields Incomplete	Upper Control Limit	Lower Control Limit	Mean	Incomplete 5s and 6s fields	Total chart fields
21-Feb-11	0%	5%	0%	2%	2	407
14-Feb-11	3%	5%	0%	2%	9	352
07-Feb-11	2%	4%	0%	2%	9	517

Attachment G

Why is it so important that we measure things?

Improvement is not about measurement, but without measurement, how do we know if a change has led to an improvement? SPC is an excellent method of showing that a process change has led to a statistically significant improvement, and that you should therefore carry on working in this new improved way.

How can you find out more?

For more further (and more in-depth information), here are two useful guides to SPC charts and how we measure for improvement:

- Measuring for Improvement (NHS Institute for Innovation and Improvement)
- Basics of Statistical Process Control (David Howard, Management-NewStyle)

Alternatively, contact the Quality Improvement analysts or your clinical unit's improvement coordinator/manager.

Complaints Annual Report

2016/2017

Donna Robinson – Patient Safety and Complaints Manager

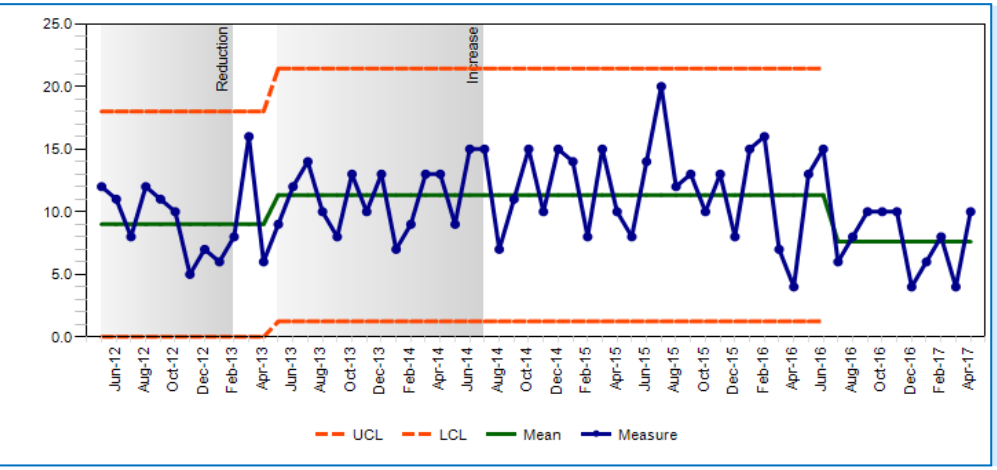
Complaints Summary

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of Key Points:

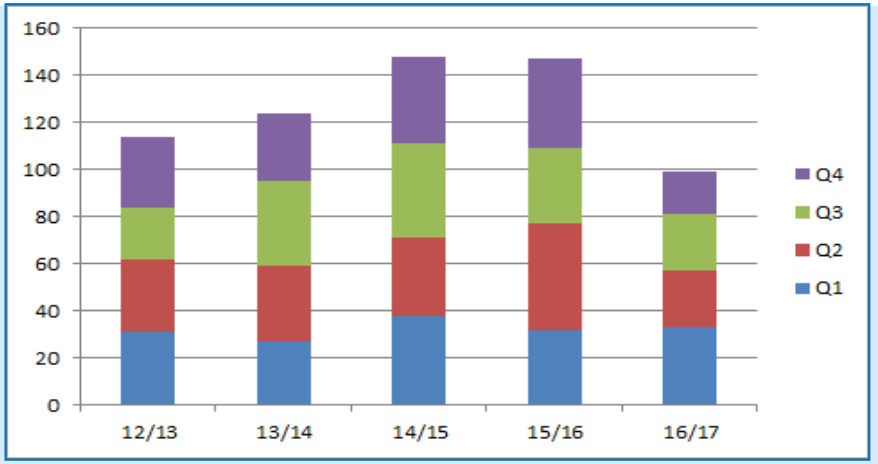
- The Trust received 103 formal complaints and 99* of these were investigated in line with the NHS Complaint Regulations. This is a 32% reduction on the previous year.
- 5 complaints were graded as red compared to 12 red complaints last year (2015/16).
- 72% of closed complaint responses were sent out within the agreed timescale and 48% of draft responses were received by the Complaints Team on time from the lead investigator.
- Themes raised within complaints include delays in treatment, the gastroenterology service, concerns with written communication and a lack of communication with families.
- 1 complaint was referred to the Parliamentary and Health Service Ombudsman during the year. 2 complaints were closed this year, 1 was not upheld and the other was partially upheld.

Number of formal complaints received by the Trust:



Trends for the number of formal complaints received since April 2012

Commentary: *The Trust received 103 formal complaints in 2016/17 and 99 of these were investigated in line with the NHS Complaint Regulations (4 were withdrawn or related to care a number of years ago). This compares to 151 last year and represents a 32% decrease in the number of complaints received. The complaints team also received 64 contacts where concerns were raised informally and therefore not managed as a formal complaint (in agreement with the families concerned).



Complaints per quarter per financial year

Commentary:

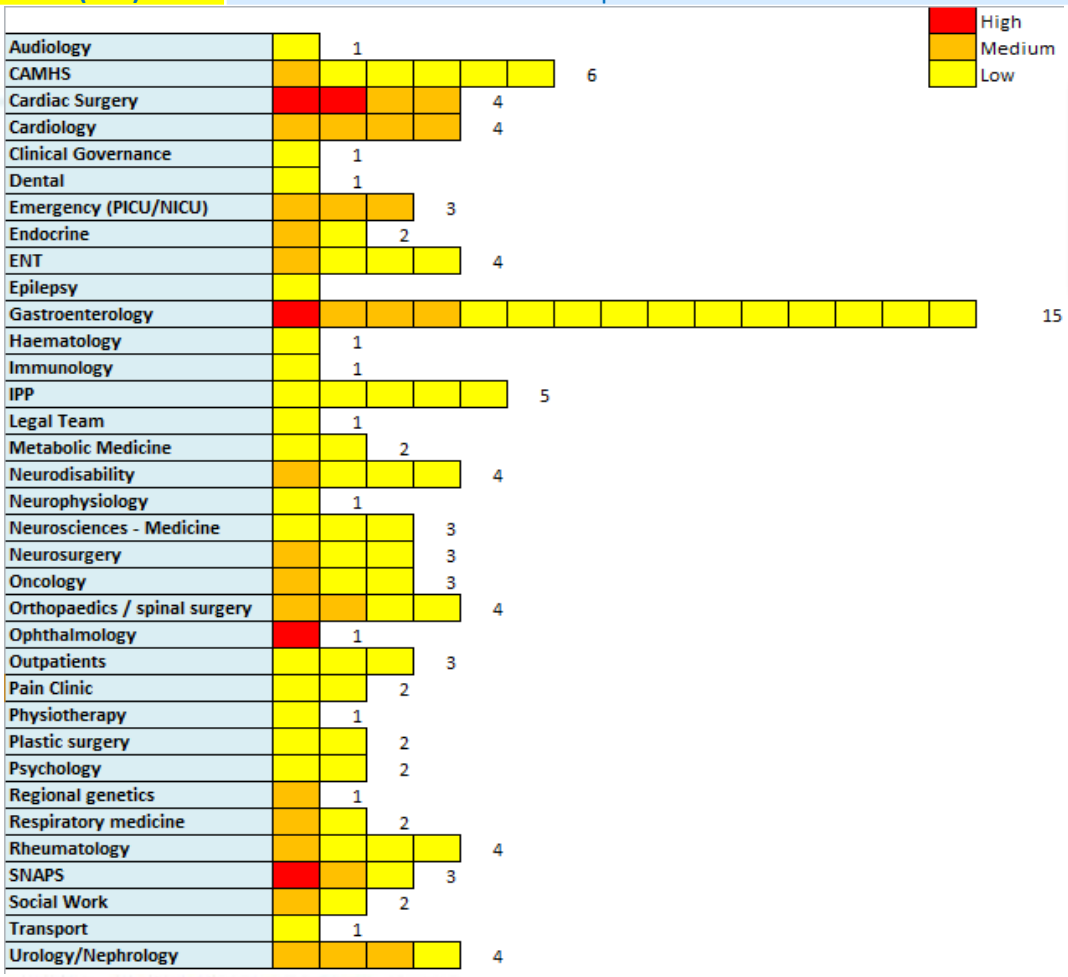
18 new formal complaints were received in quarter four 2016/17. This is the least amount of complaints received in one quarter throughout the year. In addition, it is the least amount of complaints received in one quarter over the last 5 years.

Complaints by Grading & Speciality

Great Ormond Street Hospital for Children NHS Foundation Trust

Complaint grading definitions:

Red (high)	severe harm to patient or family or reputation threat to the Trust.
Amber (medium)	lesser than severe but still (a reported) poor service, communication or quality evident.
Yellow (low)	minor issues or difference of opinion rather than deficient service.



Commentary:

Analysis of the 2016/17 complaint data at speciality level identified a theme in the number of gastroenterology complaints received. This has been detailed further on the Complaints Trend Analysis slide (slide 9).

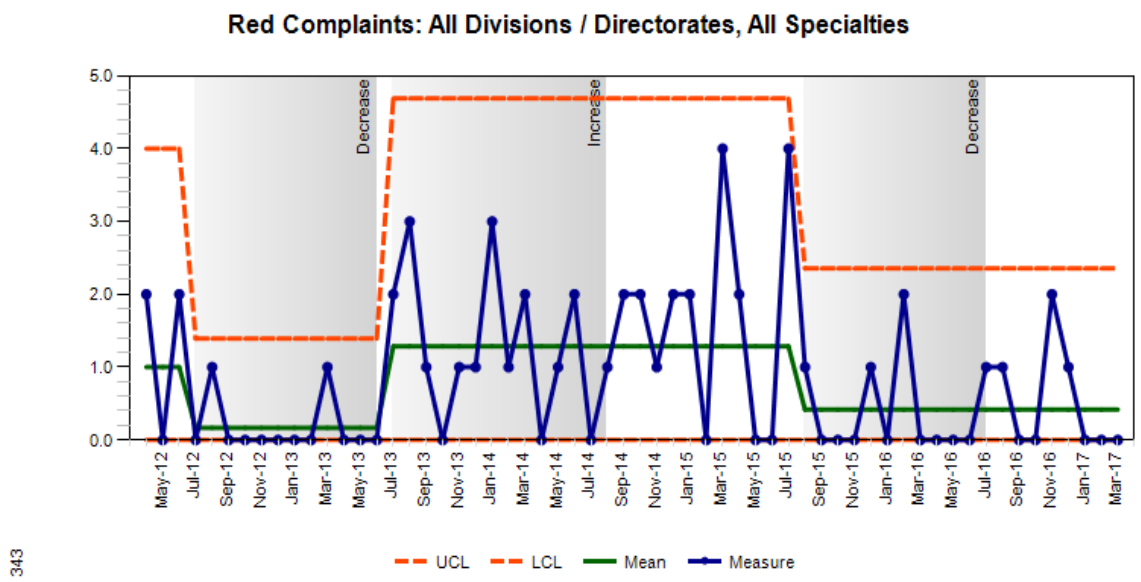
Comparison of complaints grading by year

	2016		2015	
	Number of complaints	% of complaints	Number of complaints	% of complaints
Red	5	5%	12	8%
Amber	28	28%	36	24%
Yellow	66	67%	103	68%
TOTAL	**99**	**100%**	**151**	**100%**

Red Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

Red Complaints



No of new red complaints in 2016/17:	5
No of re-opened red complaints in 2016/17:	1
Total no of open red complaints at the end of the reporting period (31/03/2017):	1 reopen
No of closed red complaints in 2016/17:	7

Number of new red complaints per quarter (16/17):

Q1	Q2	Q3	Q4
0	2	3	0

Subject themes from red complaints (16/17)

There were no reoccurring themes from the 12 red complaints.

Appropriate action plans have been devised and are being monitored (please see point 8 for examples). Any identified risks have been added to the Trust wide risk register and been appointed an executive lead. A one page learning from red complaints is also completed and shared to ensure Trust wide learning.

Complaints by Patient Activity

Great Ormond Street Hospital for Children NHS Foundation Trust

"Combined Patient Activity" is a very simple measure of all patient activity at Great Ormond Street Hospital. It combines inpatient (finished consultant episodes) and outpatient (attended appointments and ward attenders) activity so that it can be used as a denominator for comparable measures across the Trust such as complaints, harm and incident rates. It is useful for measures with numerators (such as the number of formal complaints etc.) that are applicable across multiple patient groupings (e.g. not only inpatients).

combined patient activity = outpatient attendances + inpatient episodes

This combined activity measure has advantages over other such measures of overall patient activity in that it is simple to understand and calculate, is easy to combine or separate NHS and private activity and it can be applied across a number of hospitals. It also produces patient numbers that are realistic, without applying complex weightings to different patient groupings.

Percentage of complaints received compared to patient activity for each Division:

Directorate	Total number of Complaints	Adjusted patient activity	Amount of Complaints per 1000 Adjusted Patient Days	% of Complaints per 1000 Adjusted Patient Days
Charles West	22	127311	0.173	20.8%
JM Barrie	69	165722	0.416	50.1%
IPP	5	20634	0.242	29.1%
Totals:	96	313667	0.306	100%

Percentage of complaints received compared to patient activity for the specialties with the highest amount of complaints:

Specialty	Total number of Complaints	Adjusted patient activity	Amount of Complaints per 1000 Adjusted Patient Days	% of Complaints per 1000 Adjusted Patient Days
Gastroenterology	15	5317	2.82	33.66%
Cardiac Surgery	4	2053	1.95	23.24%
Neurodisability	4	3715	1.08	12.84%
CAMHS	6	6357	0.94	11.26%
ENT	4	7291	0.55	6.54%
Orthopaedics/Spinal Surgery	4	9741	0.41	4.90%
Rheumatology	4	11161	0.36	4.28%
Urology/Nephrology	4	20385	0.20	2.34%
Cardiology	4	50908	0.08	0.94%
Totals:	49	116928	0.42	100%

Complaints Timescale

Great Ormond Street Hospital for Children NHS Foundation Trust

Complaints closed within the agreed timescales:

Total number of complaints investigated in the year:	**99**	**Total number of complaints closed in the year:**	**112**
Percentage of draft reports received from investigation staff on time:	**48%**	**Percentage of responses completed and sent to complainant within the agreed timescale:**	**72%**

Yearly comparison of complaints closed within the agreed timescales:

48% of draft reports were received from the investigating staff on time last year (15/16). This has not changed this year and remains at 48%.

The percentage of responses completed and sent to complainant within the agreed timescale has increased this year to 72% from 60% last year.

Complaints timescale monitoring

Since April 2016, the timescales for all new complaints (which have since been closed) are being monitored at each stage of the process in order to further understand the delays and therefore what additional support may be required.

	JM Barrie	Charles West	IPP	Corporate Departments
Number of complaints	77	27	5	3
% of drafts received on time	46%	46%	60%	66%
% of responses sent on time	72%	71%	80%	66%

Stage of the formal Complaints sign off process	Average number of days
Average working days for the complaints team to review draft	4
Average working days for the division to finalise the report following the draft review	19
Average working days for Chief Nurse sign-off	2
Average working days for CEO sign-off	2

Disability and Ethnicity Data

Great Ormond Street Hospital for Children NHS Foundation Trust

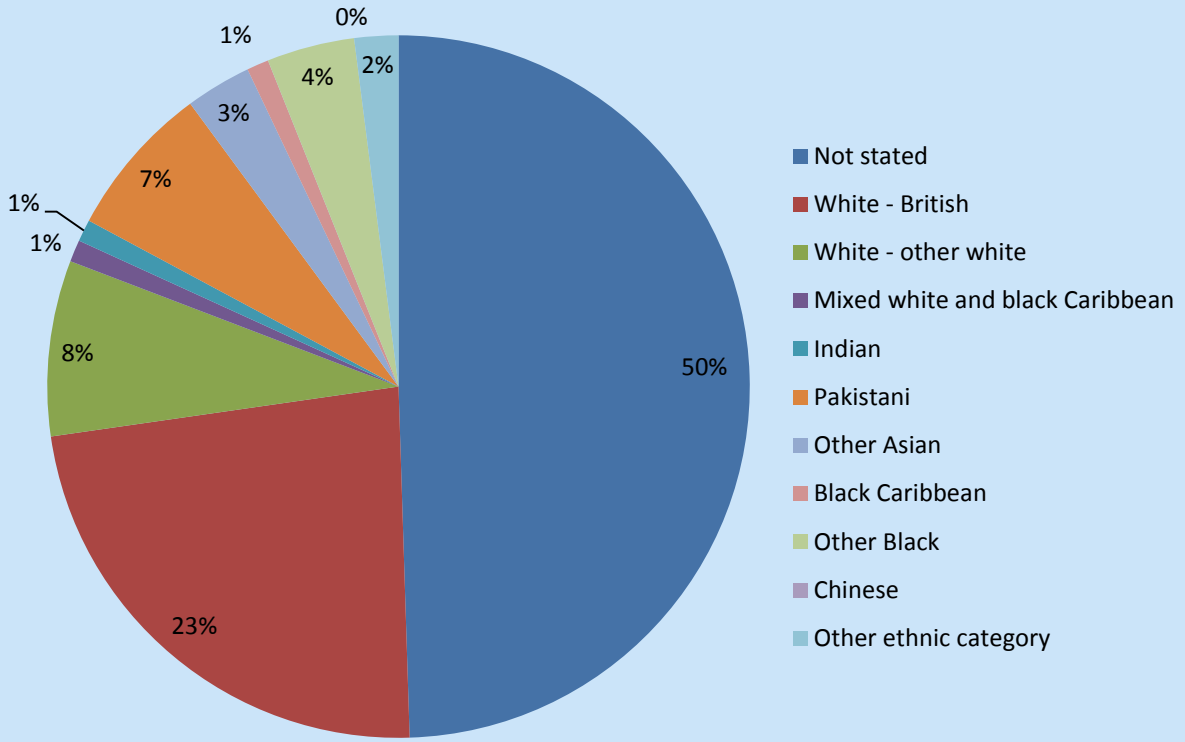
Disability data:

8.1% of complaints received during the 2016/17 financial year concerned a patient recorded as having a disability; this is an increase in comparison with 15/16 which was 6.7%.

Over the upcoming year the complaints team will continue to make improvements to its service by making it more accessible. This will include adding information regarding making a complaint in British Sign Language (BSL) onto our website.

Complaint Ethnicity Data (16/17)

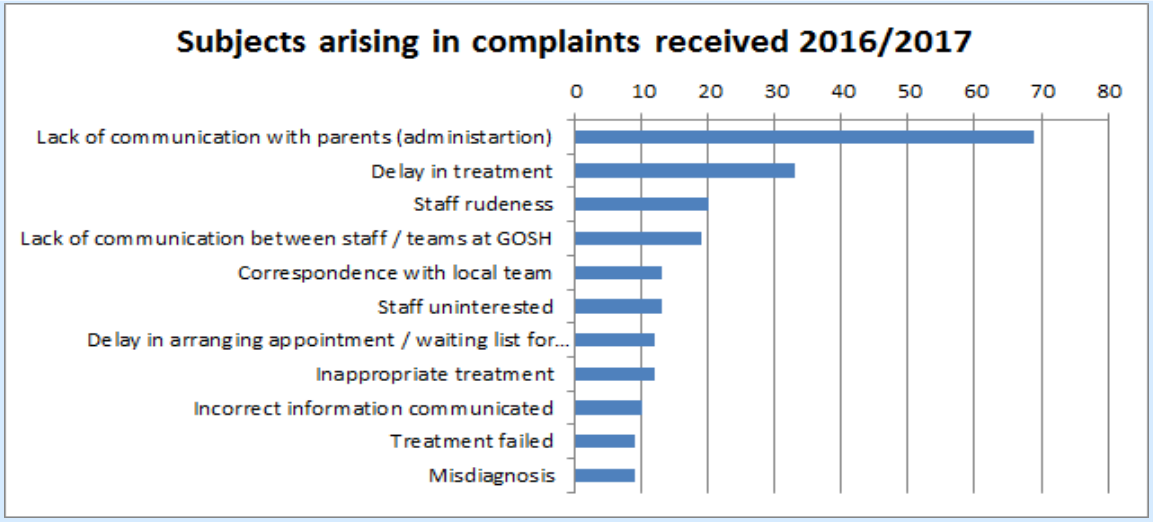
In order to understand who is and is not accessing the complaints service, the Trust records the ethnicity of the patient when complaints are received. This is done using either the Patient Information Management System (PIMS) or information within the complaint. In 50% of cases the complaints team were unable to log this information as the information was not recorded on PIMS.



Complaint Trend Analysis

Great Ormond Street Hospital for Children NHS Foundation Trust

Subjects arising in complaints received 2016/17



Some complaints raise multiple issues regarding a number of services and specialities. This chart shows the 10 most common issues raised in complaints received this financial year.

Communication

- Communication continued to be a theme raised within complaints this year and included both **written communication** and a **lack of communication with parents/families** as detailed below:
- **A lack of communication with parents/families** continues to be highlighted as a theme and remains as the top issue in complaints this year . This concern was raised in 68 complaints and represented 66% of all complaints received this year, this is an increase on last year (57%). These complaints raised concerns around the following areas: telephone calls and voicemail messages not being responded to, clinicians not responding to email messages, families not being fully informed on their child's care plan, families not being kept updated on the reasons for delays in going to theatre and then not being fully informed of the reasons for cancelled surgery.
- Concerns with **written communication** was also identified as a theme within complaints. Families raised concerns that medical reports and clinic letters communicated wrong or misleading information and confidential letters were sent to the wrong people or addresses (constituting an information governance breach) . Five families raised concerns about the amount of time it took GOSH to communicate that a referral had been declined, these families raised concerns that decision letters were either not sent at all or received weeks later which delayed the care and treatment for their child.

Complaint Trend Analysis

Great Ormond Street Hospital for Children NHS Foundation Trust

Gastroenterology

- Analysis of the 2016/17 complaint data at speciality level identified a theme in the number of gastroenterology complaints being raised. Throughout the year 15 complaints were raised and investigated which represented 15% of all the Trust complaints (same percentage as last year).
  The concerns raised within these complaints differed to themes seen previously and included:
  - declined referrals,
  - differing clinical opinions
  - and transition of care.

- As detailed within last years annual report, the Trust invited a review from the Royal College of Paediatric and Child Health of our Gastroenterology service. It is good practice to invite a review of services by other specialists in the same clinical area from other parts of the UK or internationally to help drive forward improvements and ensure best care. Following the findings of the Royal College of Paediatric and Child Health, and taking the learning from the themes of the complaints received, a gastroenterology review group was created and an action plan was devised to continue to improve the service. The majority of the actions were completed during the summer and autumn of 2016 and since this time the number of complaints received concerning the Gastroenterology service has decreased - please see the table below:

	Quarter 1 2016/17	Quarter 2 2016/17	Quarter 3 2016/17	Quarter 4 2016/17
Number of Gastro complaints received	6	5	4	0

Delay in Treatment

Delay in treatment was raised in 33 complaints this year. The causes highlighted by families included:

- **On the day cancelled procedures** due to no available beds and the theatre list over running; and prioritisation of clinically urgent patients.

- Long **waits** for appointments and to undergo tests that need to be undertaken internally and external to the Trust .

- **Poor follow up** of actions identified in clinic. These concerns included referrals to other services not taking place, bloods not being requested appropriately and therefore delays in them being carried out, follow up appointments not being booked and letters to external agencies not being written (i.e. the school).
- As detailed above, five families reported delays in treatment as a consequence of not being promptly informed of **declined referrals.**

Complaint Trend Analysis

Great Ormond Street Hospital for Children NHS Foundation Trust

31% of the subjects raised this financial year were linked to the 'One Team- Communicate' value. A further breakdown of complaints in relation to the Trust Always values and themes from these can be found below:

Complaints and the Trust Always Values 2016/2017:

Always Welcoming- Respect	5	Always Welcoming- Friendly	27	Always Helpful- Understanding	2	Always Helpful- Help others	3
Always Welcoming- Smiles	0	Always Welcoming-Reduce Waits	54	Always Helpful- Patient	1	Always Helpful- Reliable	11
Always Expert- Professional	2	Always Expert- Excellence	42	One Team- Listen	31	One Team- Involve	1
Always Expert- Safe	29	Always Expert- Improving	0	One Team- Communicate	94	One Team- Open	1

Themes

- **Reduce Waits**: several complaints have raised concerns regarding long waiting lists to be seen within a service and one family reported having to wait a year to be seen under the pain team.
- **Waits** have also resulted in delays to treatment and this is detailed further on the slide above.
- **Friendly and Respect**: 32 complaints raised concerns that staff were not friendly or respectful and staff rudeness was raised in 33 complaints received this year.

- **Understanding: F**amily specifically raise concerns that they did not understand the care plan and treatment decision. Closely linked to this are the concerns raised by families that they were not communicated with regarding care plans and treatment – detailed in the section below.
- **Reliable:** concerns were raised regarding cancelled appointments, surgery and admissions (also linking into the delayed treatment theme identified on the above slide).
- Reliable: families also raised concerns that they arrived to clinic to find out that the clinic had been cancelled and they had not been informed.

- **Excellence:** Several complaints queried the care plan or diagnosis of the patient and there was a theme identified that raised concerns about the differing clinical opinions within a service.
- **Safe:** Complaints have raised concerns that patients were discharged too soon and in three examples, the patients were either readmitted after a number of days/weeks and in one case the patient was admitted to PICU prior to being discharged.

- **Communication**: 66% of complaints received this year indicated a lack of communication with the parent/carer.
- **Listen and Communication**: concerns were raised regarding a lack of parental input to decision making / communication with parents concerning care plans and treatment decisions.
- One family raised concerns that a multi disciplinary team (MDT) meeting had not taken place prior to their child's surgery and have queried if this could have prevented the serious incident that occurred following surgery.

Learning from Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

Examples of learning from Complaints:

Details of complaint:	What we said we would do/Action taken:
A variation in a patient's DNA has been incorrectly transcribed onto a report. This single variation altered the interpretation of the result.	Improve the process of checking DNA variants forms, by changing the protocol to include an additional level of review by an independent reviewer.
A patient was discharged without blood tests being reviewed and subsequently deteriorated.	Improve the process of requesting urgent blood tests and improve the recording of the correct contact details on the blood test request form on one inpatient ward.
Parents raised concerns that their child's transition to adult care was poorly organised and managed and no formal transition clinic was booked.	The speciality have changed the way they monitor and book their transition clinics. This is being monitored by the speciality wide improve project and has also fed into the Trust wide transition project.

We carried out an audit to assess the implementation and effectiveness of learning from the complaint

What did the audit tell us?
In 98% (98/100) of cases variant forms were independently reviewed. 98% of cases (98/100) were correctly transcribed onto the report. Actions have been taken to reinforce the process of independent reviews, and to implement an automated report to reduce human error.

We carried out an audit assess the implementation and effectiveness of learning from the complaint

What did the audit tell us?
100% of standards to minimise the risk of this event from reoccurring had been implemented. The ward had introduced a number of measures to prevent this incident from reoccurring.

Quality Improvement Trust Wide Project: The learning from this complaint has been fed into the Trust wide transition project which aims to improve the transition process.

Learning from Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

Learning from Complaints:	
Details of complaint:	**What we said we would do/Action taken:**
A complaint highlighted the importance of appropriate management following suprapubic line insertion ahead of a urodynamic study.	New suprapubic line pathway introduced, which included an escalation process when complications occur.
A family attended an Ophthalmology outpatient appointment. The areas were overcrowded and their appointment was delayed.	A new system was introduce whereby families can wait anywhere in the hospital and be contacted by a buzzer system when they are able to be seen
Family raise concerns that planned surgery was cancelled. The patient was being cared for under the oncology and cardiothoracic teams and had been discussed at an oncology MDT with someone from cardiothoracic present. However the process within the team carrying out the surgery required the patient to be discussed at the thoracic MDT before they could be listed for surgery.	The clinical teams and the divisional director's have remove the risk of having to wait for discussion at the local MDT; and develop a process for ensuring patients were added directly to a waiting list for surgery from the oncology MDT. A working group has been established with input from the Service Managers, the MDT co-ordinator, Admissions Co-ordinator and surgical team. The aim of the working group is to establish a more efficient method of ensuring oncology patients are booked appropriately into a cardiothoracic surgical list.

We carried out an audit assess the implementation and effectiveness of learning from the complaint

What did the audit tell us?
The audit provides a level of reassurance that escalation occurs appropriately when complications occur.

We carried out an audit to assess the implementation and effectiveness of learning from the complaint.

What did the audit tell us?
An analysis of Friends and Family Test data does not suggest that concerns raised in the complaint, are a wider theme within Ophthalmology outpatients. The small observational audit of the use of the buzzers suggested that they have had a positive impact upon the experience of waiting.

We are planning to undertake an audit.
As there have not been any referrals made through this new process to date, the audit will be planned to commence in August 2017, to ensure sufficient numbers for the sample.

Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

Re-opened Complaints: (10) –		
Ref	**Reason for dissatisfaction:**	**Action taken:**
15/145	Complainant felt that part of the report was incorrect.	A further investigation took place and information provided was provided to evidence the information detailed within the report
15/126	Complainant has requested clarification on points within the investigation report.	A response was provided to provide further clarification.
15/121	Complainant felt that part of the report was incorrect and asked for further information on the action plan.	Further investigation has taken place and information provided regarding the action plan.
16/009	Complainant had questions on the information provided within the report.	A further written response was provided.
16/021	Complainant wished to take up an offer of meeting to discuss the complaint and complaint response	Meeting took place to discuss the complaint and response
15/007	Complainant requested clarification on points within the investigation report.	A further written response was provided.
16/051	Complainant requested clarification on points within the investigation report.	A further written response was provided.
16/022	Complainant wished to share her disappointment with the conclusion concerning the clinical decision not to perform surgery.	A telephone meeting took place to hear and discuss the outstanding concerns.
15/112	Complainant felt that part of the report was incorrect and was dissatisfied with the investigation and conclusions.	An independent opinion was sought and a complaint resolution meeting is being arranged.
16/058	Complainant raised a further question based on the information within the initial complaint response	A further written response was provided.

Parliamentary and Health Service Ombudsman (PHSO) activity:		
Ref	**Case Details:**	**Current status:**
New cases received in 16/17:		
15/051	This complaint relates to care in 2014 . Parent raised concerns that the team did not follow the correct treatment protocol and therefore delayed appropriate treatment	Partly upheld
Existing cases carried over to 16/17:		
14/110	Family raised concerns regarding the treatment that the patient received in 2014 on NICU and queried if/how this impacted on their child's death.	Not upheld

Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

Clinical Records Audit

Complaints and complaint responses are confidential, and are always kept separate from patients' clinical notes. Compliance
with this is monitored in a yearly audit of 10 clinical records selected at random. The audit found that there were that no complaint correspondence in any of the records checked.

Patient experience and satisfaction surveys regarding the complaints service:

"The complaint put in follow up actions to mitigate risks if a similar complaint being raised"

"The response was delayed but I was kept informed. Good communication which at GOSH means a lot"

"The complaints team telephoned me to discuss the situation offered to arrange appointments and provided contact details"

'Well Founded' Complaints:

In accordance with the NHS Complaints Regulations 2009, the Trust is required to comment on the complaints it considers to be "well-founded". This Trust feels that every complaint received is of value and is an opportunity to learn. Any family who have felt the need to raise concerns with us has experienced what they have perceived to be an unsatisfactory service. A complaint investigation may conclude that the care and treatment provided to a child has been appropriate, however this often highlights failures in communication which have led the family to have concerns.

PALS Report

Annual 2016/17 and Q4 2016/17

Luke Murphy
Pals Manager

PALS Summary

Great Ormond Street Hospital for Children NHS

Summary of Key Points:

The key points identified for this report are:

1. Annual data
2. Quarterly data
3. Annual and Q4 data by top 5 specialities
4. Annual and Q4 top 5 themes
5. Annual and Q4 Always values and Initiatives
6. Social Media and other feedback

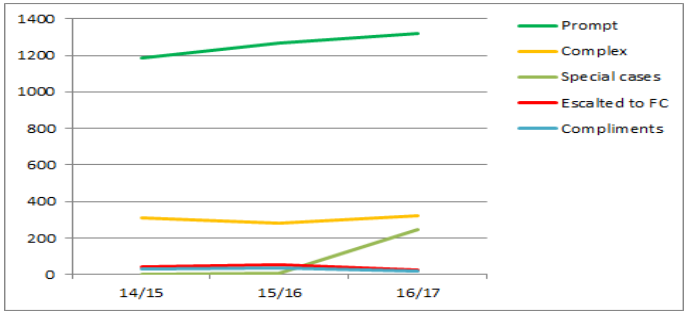
Comparison of PALS cases received by the Trust during financial year 2016/17

PALS grading definitions:

Escalated to Formal complaint	Families who want a formal escalation to their concerns
Complex Cases (multiple issues and 48h+)	These cases involve multiple questions and take teams longer than 48 hours to resolve
Promptly Resolved (24-48h)	These cases are resolved promptly (24-48hr)

Cases	14/15	15/16	16/17
Promptly resolved cases (-48h)	1188	1269	1323
Complex Cases (48h+)	311	279	320
Escalated to Formal Complaints	43	53	25
Compliments about specialities	30	37	21
Special cases*	0	5	247
Total activity	1572	1643	1936

Graph showing Pals cases by category during financial years 2014-2017



Commentary:

The promptly resolved cases have been gradually increasing since 2014 to the present financial year. The number of complex cases has also increased.
The number of cases that families want escalated to formal complaints has decreased.
The number of compliments shared with Pals have decreased as well since the previous two financial years.

*Special Cases: These are cases that have generated work not related to the normal Pals caseload but are supported by the Pals team.
There have been three episodes of special cases-

1. Q1 16/17 a petition/letter writing campaign relating to a patient needing a bed to have a BMT. There were 70 contacts and each was responded to, these were not recorded individually on the system.
2. Q116/17 and Q3 and Q4 16/17 the second stage gastroenterology review took place . There were 43 contacts.
3. Q3 16/17 there was 208 contacts following an episode of Question time, this was associated with the Speech and Language therapy Team. Each respondent received a verbal or written response.

PALS Cases for Q4 2016/17

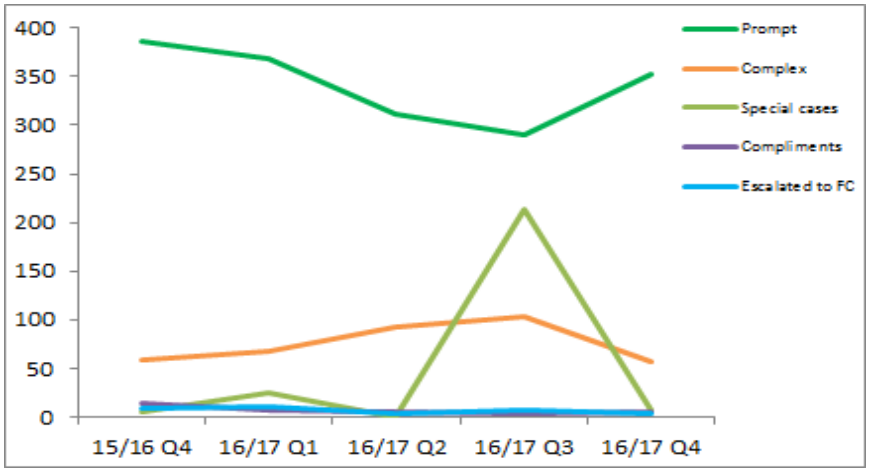
Great Ormond Street Hospital for Children NHS Foundation Trust

Comparison of PALS cases received by the Trust during Q4 16/17

Table showing Pals cases by grading comparing Q4 in 2016/17 in comparison to previous quarters.

Cases	Q4 15/16	Q3 16/17	Q4 16/17
Promptly resolved	386	290	354
Complex cases	59	104	57
Escalated to formal complaints	9	7	3
Compliments about specialities	14	4	5
*Special cases	5	214	8
Total	473	619	427

Graph showing Pals cases by category comparing Q4 16/17 to previous quarters



Commentary

There has been a decrease in total Pals cases from Q4 15/16 and Q3 16/17 when compared to Q4 16/17.

However in Q4 16/17 there has been an increase in promptly resolved cases, when compared to Q3 16/17.

The increase in Q3 16/17 is attributed by the special cases

PALS Cases by Speciality 2016/17

Great Ormond Street Hospital for Children NHS Foundation Trust

Annual 16/17 comparison of the top 5 specialities

Specialty	14/15	15/16	16/17
Gastroenterology	152	211	219
SALT	1	3	214
Orthopaedic/Spinal	133	79	96
Neurosciences	64	85	93
General Surgery	89	67	83

Thematic analysis – Top three themes contributing to speciality in 16/17

Gastroenterology- Poor communication – decrease in queries
Care advice –there has been a gradual decrease with families needing support
Failure to arrange an appointment-there has been an increase in queries between 14/15 & 16/17 (16/17 43 cases were related to the Gastro Review).
SALT- 208 cases related to staff members comments on the BBC's "Question Time".
Orthopaedic and Spinal- Poor communication – increase in queries
Cancellation - theme has seen an increase in cases compared to previous years
Failure to arrange appointment - increase in queries
Neurosciences-Poor Communication – increase in queries
Transport –there was an increase in queries
Cancellation of appointments/admissions - there has been a decrease in queries
General surgery- Poor communication- there has been a decrease in queries
Cancellation-there has been an increase
Failure to arrange appointments- There has been an increase in queries

IPP

Year	14/15	15/16	16/17
IPP	17	20	24

Thematic analysis – Top three themes contributing to IPP in 16/17

The number of IPP Pals cases has increased in 2016/17.
The cases were related to: poor communication between families and the team
concerns about discharge from the hospital to home country
advice about IPP processes.

Estates & Facilities

Year	14/15	15/16	16/17
Accommodation & Transport	45	32	35
Building Repairs	9	10	7
Security	6	6	6
Reception staff	0	0	5
Laundrette	1	1	4

Thematic analysis – Top three themes contributing to Estates and Facilities in 16/17

Accommodation there has been an increase in queries relating to families needing accommodation
Transport- there has been an increase since 15/16 in families concerns with transport arrangements/bookings.
Staff attitude- there has been an increase (3) in families reporting attitude of staff when booking into hospital accommodation.
Laundrette related to families from BMT wards not being able to wash clothes when the machines had been broken.

PALS Cases by Speciality Q4 16/17

Great Ormond Street Hospital for Children NHS Foundation Trust

The top 5 specialities comparing Q4 16/17 to previous quarter

Specialty	Q4 15/16	Q3 16/17	Q4 16/17
Gastroenterology	81	42	36
Neurosciences	28	20	26
General surgery	13	19	23
Cardiac Surgery	8	20	20
Orthopaedic/Spinal Surgery	22	24	17

Thematic analysis – Top three themes contributing to speciality in Q4

Gastroenterology- Poor communication; Care advice; Failure to arrange appointment,

Neurosciences- Poor communication; Outpatient appointment transport concerns; Cancellations

General surgery has increased across the quarters. Themes Communication/Letters; Cancellation; Failure to arrange an appointment

Cardiac surgery cases remain the same as the previous quarter they are increasing from Q4 15/16. Themes are Cancellation; Communication/Letters; Accommodation

Orthopaedic and Spinal Poor communication; Cancellation of procedures; Transport.

IPP

Quarter	Q4 15/16	Q3 16/17	Q4 16/17
IPP	5	6	7

Thematic analysis- top three themes contributing to cases in IPP in Q4

The top three themes for IPP queries to Pals were:

Inappropriate discharge- families came to Pals as they were concerned about discharge plans made and needed additional support.
Lack of communication with families- Queries related to concerns families had about treatment plan changes during the admission
Advice about referral process- families at other private hospitals attended seeking reports/opinions

Estates and Facilities

Quarter	Q4 15/16	Q3 16/17	Q4 16/17
Accommodation	5	6	7
Post room	0	1	3
Reception staff	0	2	3
Patient Bedside Entertainment	0	0	2
Catering Kitchen	2	1	1

Thematic analysis- top three themes contributing to cases in Q4

Accommodation- Additional accommodation needed; Communication regarding accommodation;
Transport following discharge
Post room- families received letters without being franked and had incurred charges
Reception staff- families have concerns
Patient bedside entertainment- families had concerns about blocked websites including youtube ;
Catering kitchen- these cases were linked to the attitude of staff and quality of pureed food for inpatients

PALS Thematic Analysis

Great Ormond Street Hospital for Children NHS Foundation Trust

Top 5 themes arising in PALS cases received in 2016/17

Theme	14/15	15/16	16/17
Communication	555	538	481
Cancellations	151	212	216
Staff attitude	5	4	214
Care advice	219	204	149
Waiting times	68	82	80

Communication- Gastroenterology is the speciality with the highest concerns from families about poor communication. The other specialities are Neurosciences, Orthopaedics/Spinal, Rheumatology and General Surgery.

Cancellation - Cardiac Surgery; Orthopaedic /Spinal Surgery; General Surgery and Urology. Each speciality has seen an increase in this theme.

Staff attitude- The queries in this category related to an episode of Question Time.

Care Advice- is when parents are trying to get advice from their clinical teams as distinct to other forms of communication problems. Gastroenterology, Immunology, General surgery and PICU. Immunology queries have increased.

Waiting times for a plan following an OPA - Gastroenterology, Cardiology, General surgery and ENT. There has been an increase in the queries relating to waiting times from 14/15 to the present day

PALS Trend Analysis

Great Ormond Street Hospital for Children NHS Foundation Trust

Top 5 themes arising in PALS cases received Q4 16/17

Theme	Q15/16	Q3 16/17	Q4 16/17
Communication	142	135	152
Cancellation	53	53	49
Care advice	57	22	39
Failure to arrange appointment	24	6	13
Accommodation	14	17	12

Communication- The top 5 specialities are Gastroenterology; Orthopaedics/Spinal, Neuroscience, Urology and Cardiology. Highest number of concerns are related to lack of communication relating to being an outpatient

Cancellation- Cardiac surgery, Cardiology, Dental, ENT and Maxio-facial. The cancellations are predominantly after families attend the Trust, with no prior notice and are for both inpatients who admissions are cancelled and outpatients whose appointments were cancelled with no prior notice

Care advice-Top 5 specialities whose patients have concerns about the lack of information about care advice are General Surgery, Renal, ENT, Gastro and Neurology.

Accommodation These contacts include both longer term accommodation support for families whose need change over the admission and for those more complex families with support needs.

Failure to arrange Ophthalmology, Orthopaedic/Spinal, SALT, MRI and Endocrine. Theyse3 cases are related to multiple appointments needing to be arranged or when cancellations have occurred and a new appointment has not been arranged.

Always values, Initiatives and Special cases

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Always year*: 2016/17

Value	15/16	16/17	Value	15/16	16/17	Value	15/16	16/17	Value	15/16	16/17
Always Welcoming- Respect	5	10	Always Welcoming- Friendly	16	19	Always Helpful- Understanding	127	197	Always Helpful- Help others	105	163
Always Welcoming- Smiles	3	3	Always Welcoming- Reduce Waits	34	41	Always Helpful- Patient	37	145	Always Helpful- Reliable	230	396
Always Expert- Professional	121	181	Always Expert- Excellence	22	28	One Team- Listen	25	226	One Team- Involve	17	11
Always Expert- Safe	61	120	Always Expert- Improving	55	28	One Team- Communicate	165	345	One Team- Open	42	23

*Trust values were recorded from Q2 15/16

Thematic analysis- top three themes

Welcoming- this category has the lowest number of queries compared to the other three.

Themes:

Families not feeling respected by their experience at the hospital, either due to interaction with staff or with the process they encountered.

Cancellations for admissions and appointments; poor communication and failure to arrange appointments

Families requiring additional support to help reduce their stressful experience when coming to the hospital including parking; encounters with staff

Information about admissions; poor communication; information regarding transport

Helpful-this category has the highest number of Pals queries.

Themes:

The majority of cases are related to lack of reliability and poor communication and this is mirrored with our annual and quarterly themes.

Poor communication; transport arrangements; cancellations

Cancellations; poor communication; accommodation concerns

Cancellations of admissions/appointments; poor communication and lack of transport

Poor communication; accommodation concerns and cancellations

Expert

Themes:

Poor communication; support with having clinical questions responded to following cancellations and cancellations

Lack of communication; Care advice; Delays in treatment

Poor communication; transport delays; access of medical records

Questions relating to patients health; poor communication; concerns relating to treatment pathway

One Team- one team listening is the highest category

Themes:

Poor communication; cancellations; delays in arranging treatment

Poor communication; Accommodation for siblings; support with questions about health

Poor communication; Cancellations of appointments/admissions and administrative errors

Clarity about treatment plans from teams; Cancellations of appointments and poor

Always values, Initiatives and Special cases Q4

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Always year*: Quarter comparison

Value	Q4 15/16	Q3 16/17	Q4 16/17	Value	Q4 15/16	Q3 16/17	Q4 16/17	Value	Q4 15/16	Q3 16/17	Q4 16/17	Value	Q4 15/16	Q3 16/17	Q4 16/17
Always Welcoming- Respect	2	2	4	Always Welcoming- Friendly	6	4	5	Always Helpful- Understanding	69	40	38	Always Helpful- Help others	29	28	39
Always Welcoming- Smiles	2	0	1	Always Welcoming- Reduce Waits	5	9	13	Always Helpful- Patient	14	37	63	Always Helpful- Reliable	83	115	71
Always Expert- Professional	57	47	36	Always Expert- Excellence	12	10	7	One Team- Listen	14	212	3	One Team- Involve	12	0	1
Always Expert- Safe	39	30	21	Always Expert- Improving	20	8	3	One Team- Communicate	91	72	122	One Team- Open	18	5	0

*Trust values were recorded from Q2 15/16

Thematic analysis- top three themes

Welcoming- this category has the lowest number of queries compared to the other three for both annual and quarter cases.
Information about facilities in the hospital; financial concerns and delays in arranging admission
Professionalism of staff; accommodation for additional family members
Failure to arrange appointments; support regarding care plan and advice regarding care process
Support with parking fines and praise for staff care

Helpful-This category has the highest number of Pals queries.
Poor communication; advice about a care plans; accommodation during admissions
Poor communication; cancellations of appointments after arrival; transport not being arranged
Cancellations; lack of communication; concerns with care plans
Poor communication; cancellations and concerns with accommodation

Expert
Poor communication; failure to arrange appointments and cancellations
Poor communication; Cancellations and delays in arranging treatment
Poor communication; cancellations and catering
Concerns about treatment; advice about diagnosis; accommodation

One Team- One team listening is the highest category
Care plan support; failure to arrange appointments and concerns with accommodation
Poor communication with family
Poor communication

Key Initiatives 2016/17

Pals Outreach Project (Popping)

Commentary: POP stands for Patient Outreach Project

This program focuses on six inpatient wards in the Trust at a time which may be selected based on the number of Pals queries in a particular division if deemed appropriate. The Pals team visit the wards with the aim of sharing information, hearing concerns and improving patient experiences. The focus is always on assisting parents who struggle to leave their children on the ward to come to Pals. Pals are trialing this ward based additional support service to these families.

Promoting Patient and Family Information

Commentary: During 2016/12017 Pals reviewed the types of informal queries we had and then started providing information leaflets in the main reception of the hospital to support families with these queries. Each trolley has a different focus/theme and we are constantly monitoring the uptake and updating leaflets with new information we gather. One trolley is reserved for the financial advice sheets from "Contact a Family". This is used to promote their service and direct families to the support provided by that charity. The most popular leaflets that have been provided are: local map, local parking, travelling to GOSH, Learning disabilities "Hospital Passport". In Q4 2016/17 over a thousand leaflets had been provided.

Social Media & Other Feedback

Great Ormond Street Hospital for Children NHS Foundation Trust

Social Media and NHS Choices:

Postings on Social Media and on NHS Choices are shared with the clinical team that the posting relates to. NHS Choices has a public reply posted from the Pals Team encouraging direct contact with us to help support the concerns raised by the family. The postings are however anonymous and each of the postings this quarter had to be shared with the relevant teams without patient details to act upon.

Hi-my seven week old is being treated for a cancerous tumour. The staff have been amazing and I can't thank them enough. I just wondered if you ever had a choir sing in the hospital? I'm in a choir and I am certain they would like to sing for the patients, staff and parents if the opportunity ever rose. Please do let me know

We will be forever grateful to this incredible hospital . Our son was just 24 hours old when he was admitted to Flamingo Ward at GOSH. It was a total whirlwind situation but every single membe of staff were fantastic. He was taken straight into theatre as soon as we arrived . The surgeons and nurses were amazing . We were put up in parent accommodation and that was a huge relief as we knew we were so close by. If it wasn't for GOSH our amazing little boy wouldn't be with us now. We will be forever grateful for everything you did for us. Xxx

Sky Ward- Every person we have met through our stays in sky ward have expressed how wonderful the staff at Great Ormond Street Hospital are. There is not just one but many from a great many departments coming together and providing the premier hospital care expected from the world's number one children hospital thank- you.

my nephew is a long term patient. Your staff have lost his blanket which comforts him during operations

They need an initiative to sort that department out. Absolutely sick of #Gastro

Compliments:

Grandmother sent compliment for team on acute and Eagle for care for grandson.	Renal / Nephrology
Mother describing a staff nurse member as: "kind and helpful" she was and how "experienced and knowledgeable" so that over the years of working with her they had always felt "they were in the hands of someone who really cared".	Rheumatology
Mother wanted to give her thanks to the male staff member on main reception whom she says "Has the most important job to welcome nervous families when they are coming in and he does it really well".	Reception
PALS received a telephone call from Patient's mum, who wanted to compliment the play specialist who spent time with Child. Unfortunately Mum cannot remember the name of the play specialist but it was at the appointment for Spinal Cons.. Parent said that they had a lovely manner and engaged with Child very well. Mum was very happy with the process. Parent noted in particular that it was a "good experience" and was particularly happy with the separate room used to meet the specialist.	Orthopaedics
Mother wanted to thank the catering team for the availability of food and drinks as well as the decorations.	Catering Kitchen
Family would like to pass on their thanks to the consultant and the nursing team on ICU who recently operated on their grandchild.	Cardiothoracic
Mother came to pals to thanks the staff on the ward for treating her son as in previous experiences he has been scared at times.	Neurodisability

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27th July 2017

Integrated Performance Report: May & June 2017 (Month 2 & 3 2017/18) **Submitted by:** Nicola Grinstead, Deputy Chief Executive/ Peter Hyland, Director of Planning and Information	**Paper No: Attachment H**

Aims / summary

The Integrated Performance Report (IPR) is focused on the key areas/ domains in line with the CQC, in order to be assured that the Trust's services are delivering to the level our patients and families, Trust Board and our commissioners and regulators expect.

The indicators included are those that have been recommended by the Trust Board, Clinical Divisions and other relevant parties. It is expected that these will evolve and iterate overtime.

The narrative provides provide more detail / analysis from the IPR of those indicators not meeting the required standards or where they warrant further mention.

This report also provides an update on the following:

- Outputs of the Kite Marking for the Integrated Performance Report
- Update on Theatre Utilisation and work to support improvement

Action required from the meeting

Board members to note the content to the report, including a deep-dive update on theatre utilisation.

Contribution to the delivery of NHS Foundation Trust strategies and plans

All the indicators within the IPR contribute to the delivery of either regulatory or commissioner requirements, and as such are aligned to the objectives and strategy of the Trust

Financial implications

For indicators that have a contractual consequence there could be financial implications for under-delivery

Who needs to be told about any decision?

Where appropriate and applicable: Internal stakeholders, NHS Improvement and NHS England Special Services Commissioners

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

Each Domain / Section has a nominated Executive Lead

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

As above

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

Integrated Performance Report

Nicola Grinstead, Deputy CEO
July 2017
(Month 2 & 3 2017/18)

The child first and always

Index

Great Ormond Street Hospital for Children NHS Foundation Trust

Executive Summary

Great Ormond Street Hospital for Children NHS Foundation Trust

May / June 2017 (MONTH 2 & 3 2017/18)

The Trust Integrated Performance Report (IPR) is designed to focus on the key areas/ domains below, in order to be assured that our services are delivering to the level our patients & families, Trust Board and our commissioners & regulators expect.

The domains are consistent with the Care Quality Commission and cover:

- Caring
- Safe
- Responsive
- Well-led
- Effective

The IPR additionally includes further indicators and metrics with regard to Our Money (Finance) and Productivity. These indicators are those that have been recommended by the Trust Board, Clinical Divisions and other relevant parties. The IPR is attached as an appendix to this supporting narrative. The narrative is continuing to be revised. This month the Well-led section has been expanded to integrate the HR & OD report into the overarching narrative. As per previously for other elements his report and narrative should continue to be looked at in conjunction with the Quality and Safety Report and Finance Report.

At the time of writing the Trust Board report, not all Month 3 (June 2017) data is available, as this falls prior to a number of key national submissions or the data has not been reviewed in time for inclusion.

Caring

(to be reviewed alongside the Integrated Quality and Safety Report)

Great Ormond Street Hospital for Children NHS Foundation Trust

Friends & Family Test (FFT)

Headlines via the Performance Report for these measures are:

- Continued very positive recommendation responses for those undertaking the Inpatient FFT (97.72% for May 2017)
- The rate (%) of those responding (for Inpatients) is showing signs of continued improvement over the last few months, which is very encouraging. As at May 2017., this was up to 28.42% (an increase on the prior month). The IPP Division in particular in May reported response rate levels of 48.02% (above the Trust target), and both NHS Divisions nearing 30% at +28% each.

A comprehensive over-view and assessment of the Inpatient FFT delivery is provided in the Integrated Quality and Safety Report, tracking response rates over time and also in comparison to other organisations. This is reviewed and assessed in the relevant Trust Committees, and Divisional Nursing leads provide regular updates at their monthly Divisional Performance meetings.

Access to Healthcare for people with Learning Disabilities

The Trust continues to report compliance with this requirement against the measure outlined in the supporting appendix which provides an over-view of the definitions for each indicator.

Safe

(to be reviewed alongside the Integrated Quality and Safety Report)

Great Ormond Street Hospital for Children NHS Foundation Trust

Serious Incidents and Never Events

As confirmed in the Performance Dashboard and in the Quality & Safety Report, the number of reported incidents for May 2017 are:

- Serious Incidents = 1 (YTD = 3)
- Never Events = 1 in May 2017 - This is with regard to a retained object and the usual process / investigations are being followed

These are further detailed in the Quality and Safety Report

Healthcare Associated Infections (HCAIs)

Incidents of C. Difficile

Following the 3 incidents reported in April, the Trust reported 0 for May 2017 (having only have 4 for 2016/17 in total). These cases continue to be investigated as to whether they resulted from a lapse of care (the Trust last year reported no lapses of care following review with Commissioners).

Incidents of MRSA

The Trust continues to report no incidents into May 2017 (which is a continuation of the trend from the last few months, and where only 3 cases were reported in 2016/17)

CV Line Infections

Following a deterioration in May to 2.7 (per 1000 line days), June has reported very low levels at 0.63. All incidents have been investigated by the lead nursing staff with involvement from the Infection Control team. As per the Q&S report, the ongoing trend / position over time is within expected levels shoiwng no sustained outlying behaviour.

WHO Surgical Checklist Completion (> 98%)

The Trust has seen a significant improvement in this area this over the last couple of month, reporting for the first time Trust-wide delivery of the 98% standard with 98.77%. In May and further improvement in June with 99.63% As reported previously, in main theatres, the drive has been to ensure there is a sustained level of completion rates, following the NatSIPPs programme, which has resulted in May only having 12 not being completed (compared to 34 in April). Outside of main theatres, the focus have been on Dermatology where significant improvements continue to be seen (with the recent review of process and updating the checklist to be more fit for purpose).

Responsive

Great Ormond Street Hospital for Children NHS Foundation Trust

Diagnostics (99% < 6 weeks)

The Trust continues to report improvements in this area, with May 2017 reporting 97.49% against the 99% standard for accessing the 15 diagnostic modalities with 6 weeks of referral / request. This is a marginal improvement on April reporting 97.44%

As reported previously due to the volumes reportable for GOSH (in a typical month) any more than approximately 6 patients waiting longer than 6 weeks, means the Trust is outside the 99% requirement. In May the Trust reported 18 > 6 weeks, distributed across the modalities on the table opposite.

As reportedly previously, in Audiology (which had been accounting for the majority of patients waiting in excess of 6 weeks), the service has increased physical capacity along with other actions, This has now resulted positively in reducing the numbers waiting for Audiology diagnostics services in excess of 6 weeks. As at May the service was 97.4%, reporting only 2 patients waiting longer than 6 weeks (these were due to patient choice).

The remaining 16 were for a range of issues – the largest component relating to process issues that are being addressed, such as more timely requesting of the scan / etc, and vetting procedures (largely associated with imaging); others due to the complexity of some of the patients (which either requires multiple clinicians / teams involvement or further clinical information prior to test) and patient choice (which continues to present a challenge to the Trust for this standard). To note the gastroscopy performance is distorted because of the low volume of patients reportable for the month (17) and of which 3 were waiting longer than 6 weeks (due to patient complexity etc.).

DM01 May 2017: Modality	% < 6 weeks
Cardiology - Echocardiography	100.00%
Sleep Study	100.00%
Magnetic Resonance Imaging	97.52%
Computed Tomography	98.21%
Non-obstetric ultrasound	93.44%
Barium Enema	100.00%
DEXA Scan	100.00%
Audiology - Audiology Assessments	97.40%
Neurophysiology - peripheral neurophysiology	100.00%
Urodynamics - pressures & flows	100.00%
Colonoscopy	100.00%
Cystoscopy	100.00%
Gastroscopy	82.35%
Trust Total	**97.49%**

Cancer Wait Times

For the reporting period up to May 2017, there have been no patient pathway breaches reported against the Cancer Wait time standards applicable to the Trust.

Responsive

Great Ormond Street Hospital for Children NHS Foundation Trust

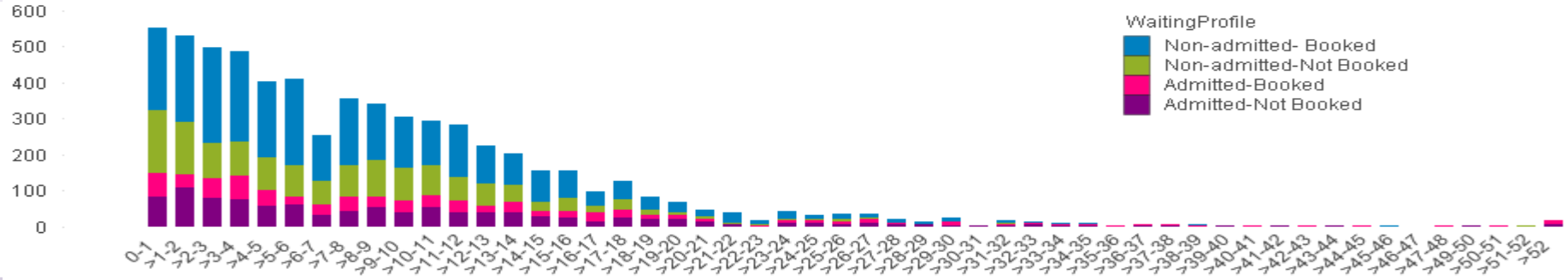
Referral to Treatment Time (incomplete standard > 92%)

Whilst the Trust remains below the RTT incomplete standard of > 92% (of pathways waiting no longer than 18 weeks), it continues to be above its improvement trajectory. At May 2017 performance was 90.36%, with the trajectory at 88.2%

As stated previously those areas contributing most to the non-delivery of the standard are those previously highlighted pressure specialties (Orthopaedics, Spines, Plastics, Urology and SNAPs). Plans are in place and being revisited to ensure clarity remains on when these services are expected to become compliant. Much of the delivery are associated with change projects across the Trust and with PICB opening.

Benchmarking data available nationally (for April) comparing Trust RTT performance has GOSH at 97 (out of 152 Trusts). The other children's hospitals (Alder Hay, BHC and Sheffield) are delivering the standard, however there is variability across specialist and tertiary centres, and throughout London.

The pace of improvement has slowed over the last couple of months. This has largely been associated with operational issues within the Rheumatology and Genetics service. In Rheumatology this has been due to a waiting list not having been captured on PIMS and with regard to Genetics this is due to an increase in the volume of pathways waiting for treatment due to the management of outpatient clinic templates. Action plans are in place within the services to return to delivery (expected August and September respectively). The graph below provides an overview of the distribution of the Trust's RTT wait times (for those with known clock start pathways). As shown when compared to previously, a number of longer waiting pathways are present (see 52 week section)



52 week waits:

As is evident from the above and the appended dashboard, the number of pathways waiting over 52 weeks has increased over the last 2 months. As at May this was 16. 12 of which are associated with Rheumatology, the others are as a consequence of patient choice, capacity constraints in challenging areas.

Since reporting 4 pathways had clock stop activities in June, 8 have TCIs through July and August. The remainder have subsequently declined treatment or have had other treatment / management.

Unknown clocks starts:

The number of pathways with an unknown clock start (i.e. referred to the Trust without confirming the start date of the pathway) in May was 17%. This is a reduction on previous months (following the recent improvements on historic levels). Key referrers are being targeted where this information is missing.

Responsive

Great Ormond Street Hospital for Children NHS Foundation Trust

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

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

As previously reported the Trust submitted 180 last minute non-clinical hospital cancelled operations for Quarter 4 of 2016/17. For the first 2 months of 2017/18 to contribute to Q1, the Trust has had 37 (April) and 55 (May), so it is fully expected for this to be a significant improvement on the prior quarter (and of Q1 last year, where 197 were reported).

Focused work remains on-going within key areas to continue to build on these improvements. Operational teams continue to balance between urgent / emergency cases versus elective with bed capacity remaining a challenge. Certain specialties are additionally being reviewed (e.g. Radiology), and further escalation steps are being put in place with operational senior management teams – some new actions took effect in May, and it will be encouraging to see the impact of these.

Very positively for the Trust is the significant improvement in rebooking last minute cancelled operations within 28 days of the cancellation. In May the Trust only had 2 instances of this (having had 7 instances in March, and 4 in April). All potential 28 days breaches are being escalated and reviewed by the Divisional Operational Directors.

Well-Led

Great Ormond Street Hospital for Children NHS Foundation Trust

Workforce Headlines

- **Contractual staff in post:** GOSH increased its contractual FTE (full-time equivalent) figure by 18 in June to 4123 compared to April 2017 (4105).
- **Unfilled vacancy rate:** The Trust's unfilled vacancy rate is currently 11.51%
- **Turnover** is reported as voluntary turnover in addition to the standard total turnover. Voluntary turnover currently stands at 15.8%; this reported value excludes non-voluntary forms of leavers. Total (voluntary and non-voluntary) turnover has increased to 19% in June 2017
- **Agency usage** for 2017/18 (year to date) stands at 2.2% of total paybill. The Trust has established a Better Value Scheme scrutinising all agency spend. Significant progress has already been made in converting agency staff to either permanent contracts or bank. All RTT validators have now been converted and the Trust has extensive recruitment campaigns underway for specific target staff groups in order to reduce agency further. NHS Improvement (NHSI) have set an agency spend ceiling for all Trusts (3% for GOSH, £6.525 million) and the Better Value Scheme aims to achieve overall savings of £250K.
- **Statutory & Mandatory training compliance:** In June the compliance across the Trust remained at 91%. Currently, all but one of the directorates/divisions are meeting the in-year 90% compliance requirement.
- **Sickness absence** has remained at 2.2% and is below the London average figure of 2.8%. Short-term sickness (STS) (episodes of sickness up to 4-weeks) has decreased to 1.01% across the Trust whilst long-term sickness has also decreased to 0.89%.
- **PDR completion rates** The Trust overall appraisal rate stands at 88% - a decrease of 2% since April 2017. Areas meeting the in-year target of 90% are IPP, Human Resources & OD and Development & Property Services.

Please refer to the analysis on the next 4 pages which provides a breakdown of the above in more detail

Well-Led

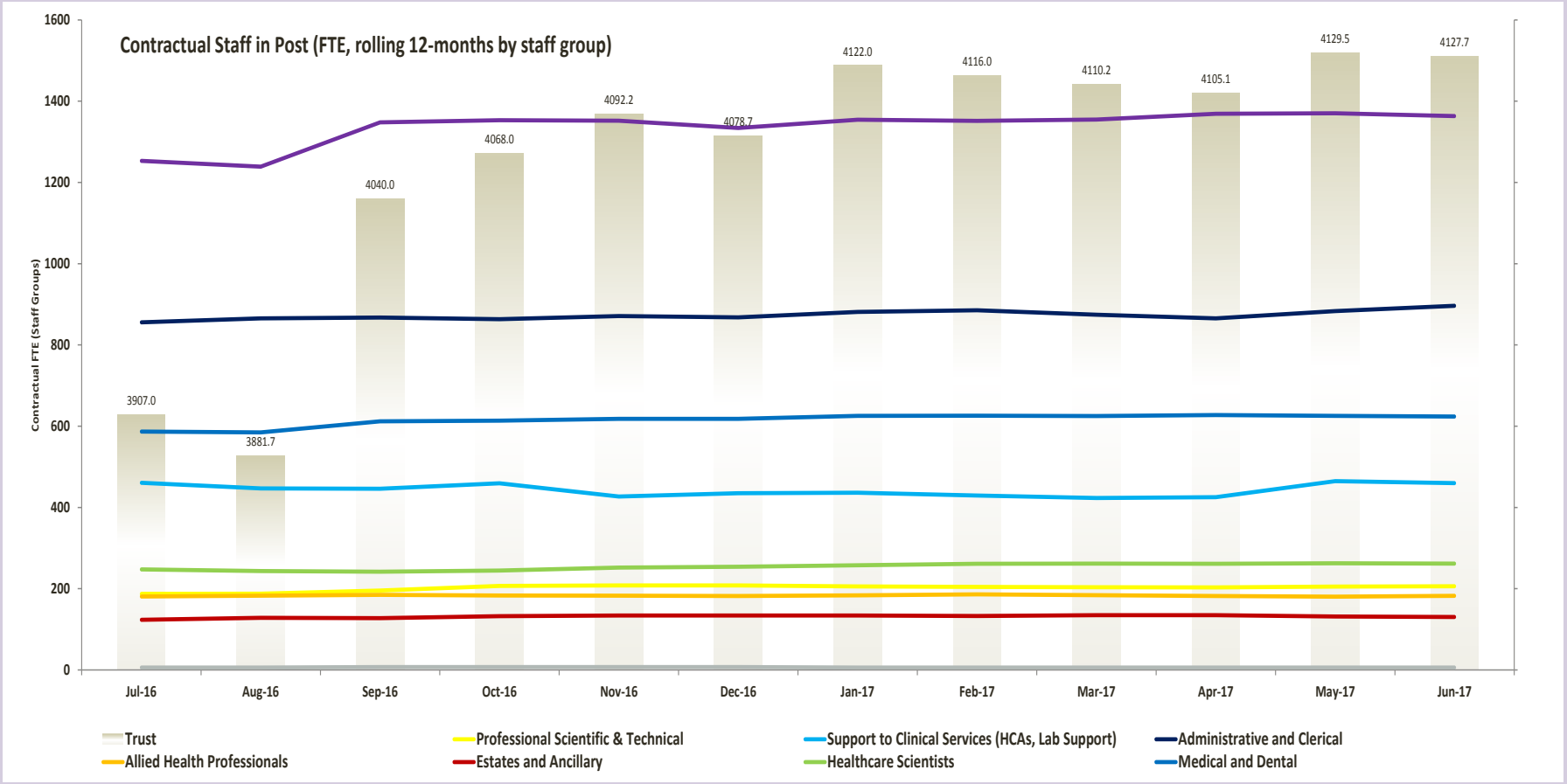
Great Ormond Street Hospital for Children NHS Foundation Trust

Trust KPI performance June 2017

Metric	Plan	Jun-17	3m average	12m average
Voluntary Turnover	14%	15.8%	15.7%	16.5%
Total Turnover	18%	18.9%	18.8%	19.0%
Sickness (12m)	3%	2.2%	2.2%	2.3%
Vacancy	10%	11.5%	11.9%	8.6%
Agency spend	2%	2.2%	2.3%	3.4%
PDR %	90%	88%	90%	83%
Statutory & Mandatory training	90%	91%	91%	87%

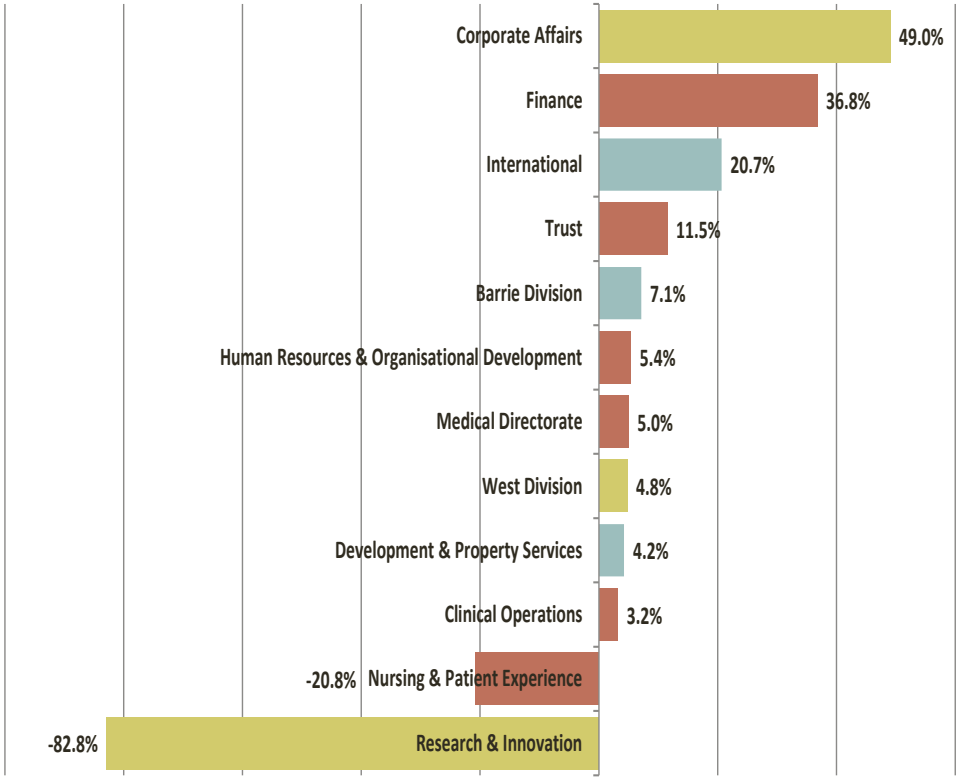
Key:
Achieving Plan **Within 10% of Plan** **Not achieving Plan**

Substantive staff in post by staff group

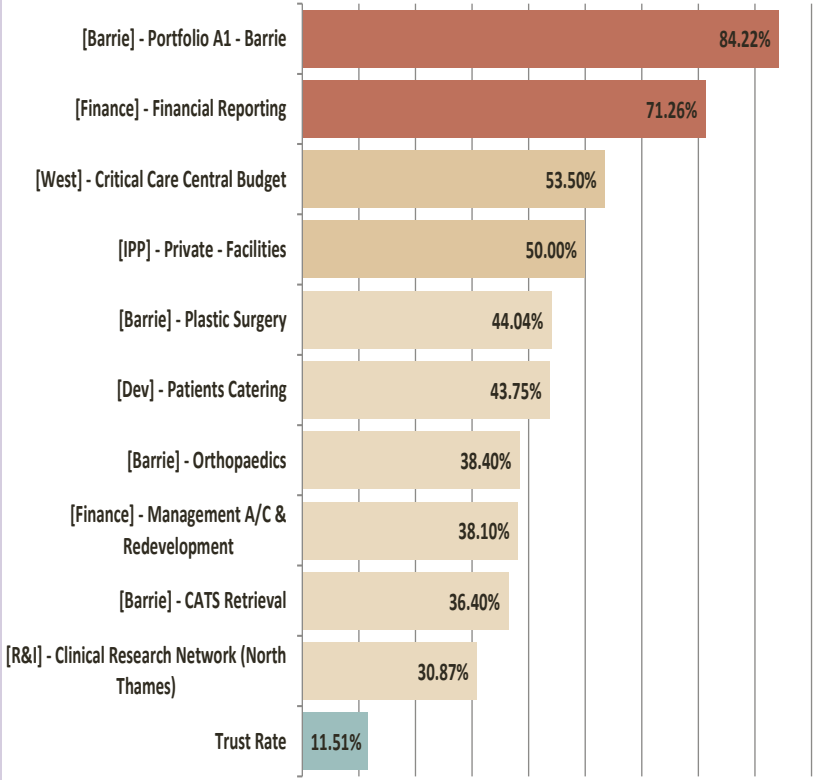


Vacancy: Exception report

Divisional Vacancy Rate (Contractual)

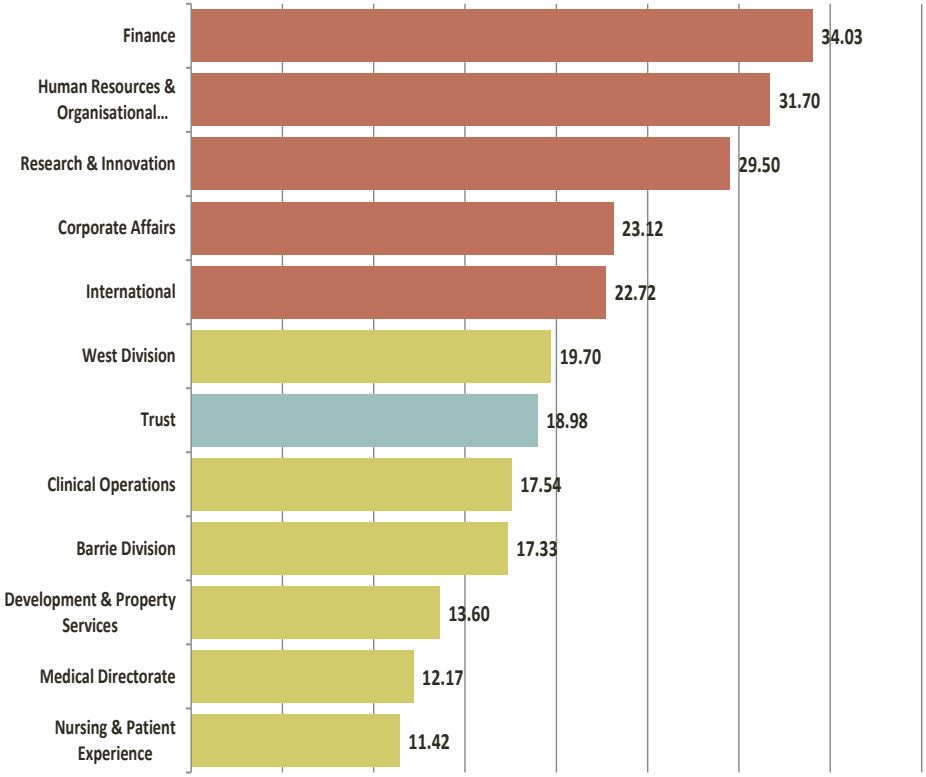


Exception Reporting Vacancy Rate (Dept outliers)

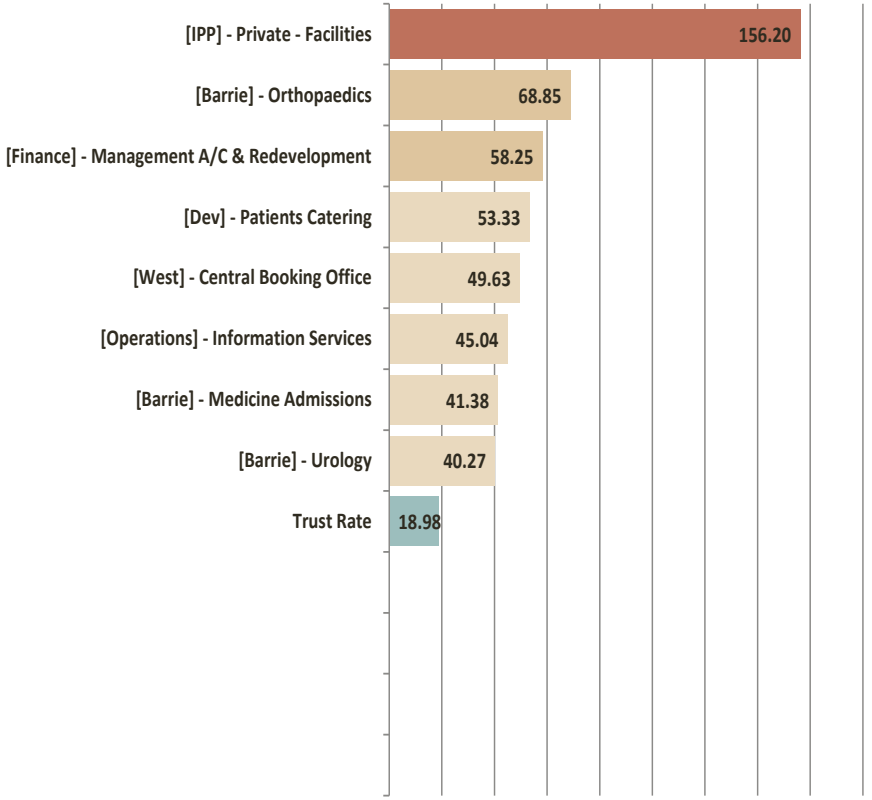


Turnover: Exception report

Divisional Turnover (Voluntary & Non-Voluntary)



Exception Reporting Turnover (Dept outliers)



Workforce: Highlights & Actions

Sickness %

- Continued support to encourage line managers to attend the ER Bitesize training sessions, and bespoke sessions within the Divisions. On a monthly basis the ER team continue to report on the Bradford triggers for those staff that have reached the trigger. Regular meetings are held with Ward Sisters to discuss sickness management. Health and wellbeing; a number of initiatives are being launched in order to support employees at work such as mental health awareness and healthy activities over the next month.
- IPP - HRBP presents sickness absence data and in-depth analysis at IPP Performance Board and working alongside IPP General Manager to agree workstreams to help improve sickness absence levels. Regular meetings held with managers in IPP to discuss employees with sickness concerns which has improved over recent months. This is predominantly made up of short term sickness as they have a very low long term sickness rate.
- Regular meetings set up with service leads to provide additional support in managing sickness cases.
- Monthly sickness absence trigger reports sent out to managers from the HR Advisors to ensure proactively approach to managing sickness.

Agency Spend

- HRBPS are working within the Divisions to reduce agency usage by converting individuals from agency to permanent or bank contracts. This work is inline with NHSI requirements to reduce agency and breaches of payrates and duration.

Voluntary Turnover Rate

- There has been a significant amount of work undertaken over the past few months to better understand the broader turnover position - with specific focus on areas of low stability and high turnover. Whilst this is work in progress, there have been developments in also understanding the reasons why people leave and where they go. In addition, the work around nurse recruitment and retention is now a focused project under the Nursing Workforce Programme Board.
- A retention survey is on-going to obtain feedback from staff after they have been in post for 3 months
- Developing B5s into vacant B6 roles helps to decrease turnover of B5s
- Focus groups have been held and feedback is being reviewed from Band 6 nurses to support retention

Workforce: Highlights & Actions

PDR Completion

- Simplifying the reporting process of PDRs has supported managers in working towards their PDR targets. The HRBPs are continuing to support managers in identifying the PDRs that are required for completion.
- Performance management via divisional reviews continues.
- PDR rates now regularly reported and accessible via the intranet.
- Continued reminders to individuals and line managers
- HRBP working with Director of Ops to develop a plan to improve PDR performance for J.M. Barrie.
- HRBP's escalating long term PDR non-compliance with relative managers
- PDR rates are a rolling agenda item for Performance Meetings within the Divisions / Directorates.

Statutory & Mandatory Training Compliance

- More visibility through LMS
- Learning and Development & ER team will work with managers to identify those who are non-compliant including further developments to the new LMS
- Additional face to face sessions have been run for DPS staff. Information sheets sent out for online courses.
- Simplicity in reporting process to improve compliance
- StatMan rates are a rolling agenda item for Performance Meetings within the Divisions / Directorates.

Effective

Great Ormond Street Hospital for Children NHS Foundation Trust

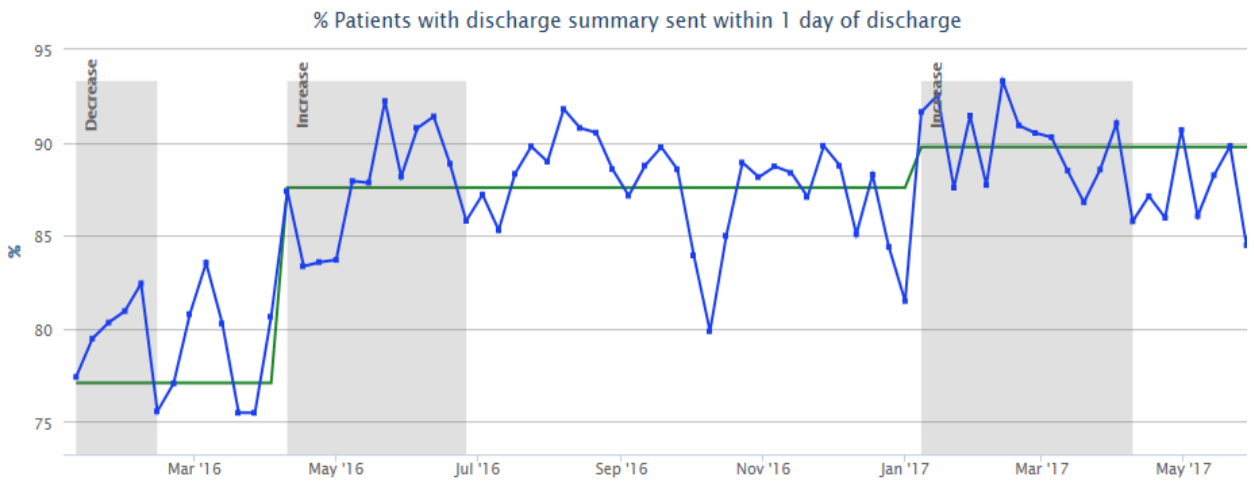
Discharge Summaries

As is evident from the SPC chart and the dashboard, performance in this area continues to fluctuate. As at May the position had improved from April up to 88.79% of Discharge Summaries being sent within 24 hours of discharge, this has subsequently dropped back a little in June to 87.22%

The Clinical Divisions continue to keep this as an areas of focus and for JM Barrie Division they have seen their individual performance exceed 90% at 92.5% in May 2017.

Therefore specialties require particular attention in May were in Charles West Division.

Plans are in place to look at different systems and approaches, reviewing roles & responsibilities , and appropriate escalation. With key involvement from the Heads of Clinical Service in those identified areas.



The quality of the content of the discharge summaries (as per the findings of an audit in Q3 of 16/17 - assessing these across a range of specialties against best practice standards) resulted in positive evidence of good practice across the Trust. These findings were presented to the Patient & Safety Outcomes Committee and with Commissioners.

Clinic Letter Turnaround times

For May performance against 14 day turnaround the Trust is currently at 76.9% which is broadly in line with prior months. As with the above specific specialties are being targeted by the service management teams to ensure turnaround is improved.

Productivity

Great Ormond Street Hospital for Children NHS Foundation Trust

Theatres

Whilst over the last few months there has been an improvement in utilisation, in May a reduction was seen, which has subsequently improved into June 2017. For June there was indicative utilisation of 72.3% (for main theatres). Outside Theatres remains fairly consistent with 56%

As part of the Better Value work streams, theatres is one of the major programmes of work and as such increased focus on process and systems is underway. In support of this programme a new theatres dashboard is being developed, and the way in which utilisation is being reviewed. This is about to go live , and to be discussed at the forth coming Theatres working group. This will provide increased transparency on theatre productivity in future months, and what is presented here may be updated / improved.

An in-depth update is being provided as part of this report.

Beds

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

Occupancy: For the reporting period of May 2017 occupancy has increased on previous levels to 89.9%. June has subsequently seen a slight drop to prior levels of 82.5%. Further analysis will be required with regard to day and overnight occupancy levels, and what the range of occupancy is across the Trust, whether this can be understood because of the case mix and patients using those beds, and where opportunities exist to improve. For the same period the average number of beds closed were higher than the last 2 months at 12.1 in May, but dropped to 6.1 in June across the Wards.

This indicator and methodology is currently under-review as part of the statutory returns review, and as such the metrics should be used as a guide at this time, pending completion of this exercise

Activity

The YTD activity across Day case discharges, critical care bed days and outpatient attendances are all down when compared to the same period last year (YTD), with a slight increase in overnight inpatients. Although in month for June, overnight IPs and OPs are up on the prior year.

Our Money

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary

This section of the IPR includes a year to date position up to and including June 2017 (Month 3). In line with the figures presented, the Trust has a deficit of £0.3m at Month 1, with a control total variance of £0.1m favourable.

- Clinical Income (exc. International Private Patients and Pass through Income) is £3.8m higher than plan
- Non Clinical revenue is £0.7m lower than plan
- Private Patients income is £1.2m lower than plan
- Staff costs are £0.3m lower than plan
- Non-pay costs (excluding pass-through costs) are £3.3m higher than plan.

Appendices

Great Ormond Street Hospital for Children NHS Foundation Trust

Appendix I – Integrated Performance Dashboard

Please see attached covering all the domains in line with this supporting narrative

Appendix II – Definitions

Please see attached the supporting definitions and methodologies for each of the metrics reported upon

Appendix III – Data Quality Kite-Marking

Please find attached the supporting DQ Kite-marking for each of the reportable indicators within the Trust Board report

This is in line with previous updates provided to the Board and Trust Audit Committee, which assesses each of the indicators for:

- Accuracy
- Validity
- Reliability
- Timeliness
- Relevance
- Audit
- Executive Judgement

Any areas where there is insufficient assurance an action plan is needed or is in place, approved and signed off for the relevant SRO / Executive lead for that metric. These will then be monitored by the SRO and then re-assessed at a set point in the year.

A more detailed summary is provided as part of the dashboard.

Trust Board Dashboard - June 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

Caring

		Apr	May	Jun	Trend	Plan	NHS Standard
Access to Healthcare for people with Learning Disability					→		
% Positive Response Friends & Family Test: Inpatients		97.69%	97.72%		↑		95%
Response Rate Friends & Family Test: Inpatients		27.24%	28.42%		↑	40%	
% Positive Response Friends & Family Test: Outpatients		89.94%	93.60%		↑		95%
Mental Health Identifiers: Data Completeness		99.31%	99.14%		↓		97%

Safe

		Apr	May	Jun	Trend	Plan	NHS Standard
Serious Patient Safety Incidents	In-month	1	1		→		
	YTD	2	3				
Never Events	In-month	0	1		↑		0
	YTD	0	1		→		0
Incidents of C. Difficile	In-month	3	0	0	→		1
	YTD	3	3	3	-		
C.Difficile due to Lapses of Care	In-month	0	0	0	→		1
	YTD	0	0	0	→		
Incidents of MRSA	In-month	0	0	0	→		0
	YTD	0	0	0	→		0
CV Line Infection Rate (per 1,000 line days)		1.28	2.7	0.63	↑	1.6	
WHO Checklist Completion		95.10%	98.77%	99.63%	↑	98%	
Arrests Outside of ICU	Cardiac Arrests	4	2	1	↑	5	
	Respiratory Arrests	2	2	1	↑		
Total hospital acquired pressure / device related ulcer rates grade 3 & above		0	0	0	→	0	

Responsive

		Apr	May	Jun	Trend	Plan	NHS Standard
Diagnostics: Patients Waiting <6 Weeks		97.44%	97.49%		↑		99%
Cancer 31 Day: Decision to Treat to First Treatment		100%	100%		→		96%
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Surgery		100%	100%		→		94%
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Drugs		100%	100%		→		98%
Last Minute Non-Clinical Hospital Cancelled Operations		37	55		↓		
Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard		4	2		↑		0
Same day / day before hospital cancelled outpatient appointments		1.14%	1.31%	1.24%	↑		
RTT: Incomplete Pathways (National Reporting)		90.31%	90.36%		↓		92%
RTT: Number of Incomplete Pathways (National Reporting)	<18wks	5696	5669		↓		-
	>18wks	611	605		↓		-
RTT: Incomplete Pathways >52 Weeks - Validated		12	16		↑		0
Number of unknown RTT clock starts	Internal Referrals	13	30		↑		-
	External Referrals	1023	1253		↑		-
RTT: Total Number of Incomplete Pathways Known/Unknown	<18 weeks	6669	6889		↓		-
	>18 weeks	674	670		↑		-

Trend Arrow Key (based on 2 most recent months' data)

↑	Improvement		On / above target
→	Consistent trend		Below target
↓	Deterioration		No target

People, Management & Culture: Well-Led

		Apr	May	Jun	Trend	Plan	NHS Standard
Sickness Rate		2.18%	2.30%	2.22%	↑	3%	
Turnover	Total	18.8%	18.7%	19.0%	↓	18%	
	Voluntary	15.7%	15.5%	15.8%	↓	14%	
Appraisal Rate		90%	91%	88%	↓	90%	
	Consultant	84%	82%	83%	↑		
Mandatory Training		90%	91%	91%	↑	90%	
% Staff Recommending the Trust as a Place to Work: Friends & Family Test						61%	
Vacancy Rate	Contractual	TBC	12.3%	11.5%	↑	10%	
	Nursing	8.4%	12.0%	10.1%	↑		
Bank Spend		5.4%	5.5%	5.7%	↓		
Agency Spend		2.34%	2.30%	2.23%	↑	2%	

Effective

		Apr	May	Jun	Trend	Plan	NHS Standard
Discharge Summary Turnaround within 24hrs		86.99%	88.79%	87.22%	↓		100%
Clinic Letter Turnaround within	7 working days	45.39%	47.45%				
	14 working days	77.61%	76.90%		↓	100%	
Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)		7.71%	7.47%	7.72%	↓	8.36%	

Productivity

			Apr	May	Jun	Trend	Plan	NHS Standard
Main Theatres	Theatre Utilisation		75.5%	68.6%	72.3%	↑		77%
	No. of theatres		12	12	12			
Outside Theatres	Theatre Utilisation		55.7%	56.8%	56.0%	↓		77%
	No. of theatres		*TBC*	*TBC*	*TBC*			
Trust Beds	Bed Occupancy		82.8%	89.9%	82.5%	↓		
	Number of Beds		*TBC*	*TBC*	*TBC*			
Average number of beds closed		Wards	10.8	12.1	6.1	↑		
		ICU	0.0	0.2	0.2	→		
Refused Admissions	Cardiac refusals		2	8	3	↑		
	PICU / NICU refusals		9	13	2	↑		

Activity

			Apr	May	Jun	Trend	Plan	NHS Standard
Daycase Discharges (YOY comparison)		In-month	1,788	2,132	2,140	↑	2,229	
		YTD	1,789	3,921	6,061		6,372	
Overnight Discharges (YOY comparison)		In-month	1,504	1,642	1,705	↑	1,681	
		YTD	1,509	3,151	4,856		4,787	
Critical Care Beddays (YOY comparison)		In-month	1,086	1,083	1,013	↓	1,108	
		YTD	1,086	2,169	3,182		3,397	
Excess Bed Days >=100 Days	No. of patients		*TBC*	*TBC*	*TBC*			
	No. of beddays		*TBC*	*TBC*	*TBC*			
Outpatient Attendances (All) (YOY comparison)		In-month	18,367	22,088	21,575	↓	21,229	
		YTD	18,339	40,427	62,002		60,978	

Our Money

	Apr	May	Jun	Trend	YTD Target	YTD Variance
Net Surplus/(Deficit) v Plan	(2.5)	0.8	(1.4)	↓	(0.0)	(0.2)
Forecast Outturn v Plan	0.2	0.2	0.2	→	0.2	0.0
Better value	0.96	0.96	0.96	→	3.0	(0.1)
Debtor Days (IPP)	183.0	212.0	201.0	↑	120.0	(78.7)
Quick Ratio (Liquidity)	1.88	1.85	1.83	↓	1.70	0.1
NHS KPI Metrics	3.0	3.0	1.0	↑	1.0	0.0

TRUST BOARD PERFORMANCE DASHBOARD: KPI DEFINITIONS

	Measure	Definition	Standard	Calculation formulae	Reporting Frequency
Caring	Access to Healthcare for people with Learning Disability	Covers the NHSI Standard for organisations to meet the 6 criteria for people with a learning disability: 1. Does the NHS foundation trust have a mechanism to identify and flag patients with learning disabilities and protocols that ensure pathways of care are reasonably adjusted to meet the health needs of these patients? 2. Does the NHS foundation trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria? • Treatment options? • Complaints procedures? • Appointments? 3. Does the NHS foundation trust have protocols to provide suitable support for family carers who support patients with learning disabilities? 4. Does the NHS foundation trust have protocols to routinely include training on providing healthcare to patients with learning disabilities for all staff? 5. Does the NHS foundation trust have protocols to encourage representation of people with learning disabilities and their family carers? 6. Does the NHS foundation trust have protocols to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	Yes	Does the service meet the six criteria for meeting the needs of people with a learning disability, based on recommendations in Healthcare for all (DH 2008):29?	Quarterly
	% Positive Response Friends & Family Test: Inpatients	This is an indicator of overall patient experience of the service received. Patients would recommend service to others if they have had a good experience.	>95%	**Numerator:** respondents who would be extremely likely or likely to recommend the service **Denominator:** total respondents	Monthly
	Response Rate Friends & Family Test: Inpatients	This is an indicator of the percentage volume of patients responding to the Friends and Family Test Questionnaire	>40%	**Numerator:** Total number of patients that have completed the FFT Questionnaire. **Denominator:** Total number of patients eligible to respond.	Monthly
	% Positive Response Friends & Family Test: Outpatients	This is an indicator of overall patient experience of the service received. Patients would recommend service to others if they have had a good experience.	>95%	**Numerator:** respondents who would be extremely likely or likely to recommend the service **Denominator:** total respondents	Monthly
	Mental Health Identifiers: Data Completeness	Measurement of data completeness for Mental Health patients covering NHS Number, Date of Birth, Postcode, Gender, Registered GP Practice and Commissioner Code	>97%	**Denominator for NHS number, DOB, postcode, gender, GP practice:** count of distinct patients in that submission **Numerator:** does the patient have a valid NHS number, DOB, postcode, gender, GP practice **Denominator for Commissioner Code:** Count of referrals in submission **Numerator:** Does each referral have a valid commissioner code. All denominators and numerators are added up to create the overall Monitor measure	Monthly
Effective	Discharge Summary Turnaround within 24hrs	The percentage of patients with a completed Discharge Letter and sent within 24hours of the patients Discharge	100%	**Numerator:** number of discharge summaries sent for eligible patients within 24 hours **Denominator**: total number of discharge summaries required for eligible patients	Monthly
	Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)	This based on the number of NHS Patient Attendances and DNA's for all specialties covering Clinic and Ward Attenders but excludes Telephone Consultations	8.36%	**Numerator:** number of non-attendances **Denominator:** total number of expected attendances	Monthly
	Clinic Letter Turnaround within 7 Working Days	The percentage of patients with a completed Clinic Letter within 7 working days of attendance	100%	**Numerator:** number of clinical letters sent for eligible patients within 7 working days **Denominator:** total number of matching clinical letters for eligible patients on Clinical Documents Database	Monthly

	Measure		Definition	Standard	Calculation formulae	Reporting Frequency
Responsive	Diagnostics: Patients Waiting >6 Weeks		The percentage of patients waiting greater than 6 Weeks for a Diagnostic Test at the given month end census date based on the National DM01 Key 15 groupings	99%		Monthly
	Cancer 31 Day: Decision to Treat to First Treatment		The percentage of patients receiving first definitive treatment from diagnosis within 31 days	96%		Monthly
	Cancer 31 Day: Decision to Treat to Subsequent Treatment - Surgery		The percentage of patients receiving subsequent treatment of surgery for new cases of primary or recurrent cancer within 31 Days	94%		Monthly
	Cancer 31 Day: Decision to Treat to Subsequent Treatment - Drugs		The percentage of patients receiving subsequent treatment of drugs for new cases of primary or recurrent cancer within 31 Days	98%		Monthly
	Last Minute Non-Clinical Hospital Cancelled Operations		Count the number of last minute cancellations by the hospital for non clinical reasons in the quarter. Last minute means on the day the patient was due to arrive, after the patient has arrived in hospital or on the day of the operation or surgery.			Monthly
	Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard		Count of the number of patients that have not been treated within 28 days of a last minute cancellation	0		Monthly
	RTT: Incomplete Pathways (National Reporting		Patients waiting below 18 Weeks on an Incomplete RTT Pathway at month end with a known clock date (i.e. clock start and no stop) expressed a percentage	92%	**Numerator:** number of patients waiting below 18 weeks **Denominator:** total number of patients waiting	Monthly
	RTT: Total Number of Incomplete Pathways (National Reporting)	Under 18 Weeks	Patients waiting below 18 Weeks on an Incomplete RTT Pathway at month end with a known clock date (i.e. clock start and no stop).		Total number of patients waiting below 18 weeks	Monthly
		Over 18 Weeks	Patients waiting above 18 Weeks on an Incomplete RTT Pathway at month end with a known clock date (i.e. clock start and no stop).		Total number of patients waiting above 18 weeks	Monthly
	RTT: Incomplete Pathways >52 Weeks	Validated	Patients waiting 52 Weeks and above on an Incomplete RTT Pathway waiting at month end with a known clock date (i.e. clock start and no stop)	0	Total number of patients waiting 52 weeks and above	Monthly
	RTT: Number of Unknown Clock Starts	Internal Referrals	Patients referred internally within Great Ormond Street where the RTT Clock Start Date cannot be verfied		Total number unknown clock starts from an internal referral	Monthly
		External Referrals	Patients referred by other organisations to Great Ormond Street where the RTT Clock Start Date cannot be verfied		Total number unknown clock starts from an external referral	Monthly
	RTT: Total Number of Incomplete Pathways	Under 18 Weeks	Patients waiting below 18 Weeks on an Incomplete RTT Pathway at month end with a known and unknown clock date (i.e. clock start and no stop)		Total number of patients waiting below 18 weeks	Monthly
		Over 18 Weeks	Patients waiting above 18 Weeks on an Incomplete RTT Pathway at month end with a known and unknown clock date (i.e. clock start and no stop)		Total number of patients waiting above 18 weeks	Monthly
	Serious Patient Safety Incidents		Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.	N/A	Total number of Serious Patient Safety Incidents reported in month.	Monthly
	Never Events		Never Events are serious incidents that are wholly preventable Never Events include incidents such as wrong site surgery, retained instrument post operation or wrong route administration of chemotherapy	0	Total number of Never Events reported in month.	Monthly
	Incidents of C. Difficile		This is the number of C.Difficile infections that have been reported in the Trust, regardless of whether they are hospital acquired and/or categorised as infection due to lapses of care.	0	Total number of C. Difficile infections that have been reported in month, in the Trust.	Monthly

	Measure		Definition	Standard	Calculation formulae	Reporting Frequency
SAFE	C.Difficile due to Lapses of Care		The types of issues which would result in the infection being considered to be associated with a lapse in care could be any case where there was evidence of transmission of C. difficile in hospital such as via ribotyping of the infection indicating the same strain is involved, where there were breakdowns in cleaning or hand hygiene, or where there were problems identified with choice, duration, or documentation of antibiotic prescribing. It must be noted that none of these would indicate that the infection was definitely caused by the provider organisation, only that we cannot state that best practice was followed at all times	0	Total number of C. Difficile infections that have been reported in the Trust.	Monthly
	Incidents of MRSA		This is the number of MRSA infections that have been reported in the Trust, regardless of whether they are hospital acquired and/or categorised as infection due to lapses of care.	0	Total number of MRSA infection the have been reported in the Trust in month.	Monthly
	CV Line Infection Rate (per 1,000 line days)		Rate of GOSH acquired central venous catheter related bacteraemia per 1000 line days.	1.6	**Numerator:** Number of GOS acquired CVC related infections in month x 1,000 **Denominator:** Number of line days in month.	Monthly
	Arrests Outside of ICU		The monthly number of cardiac and respiratory arrests outside of intensive care units.	5 (total)	Total number of cardiac and total number of respiratory arrests that have occurred outside ICU in the reportable month. Cardiorespiratory arrests count towards the cardiac arrests total, not the respiratory arrests total.	Monthly
	Total hospital acquired pressure / device related ulcer rates grade III & above		Total number of hospital acquired pressure/device related ulcers (Grade 3 SUPERFICIAL ULCER, full thickness skin loss, damage/necrosis to subcutaneous tissue, Grade 4 DEEP ULCER, extensive destruction, damage to muscle, bone or supporting structures).	N/A	Monthly number of hospital acquired pressure/device related ulcers, Grade III or above.	Monthly
People, Management & Culture: Well-Led	Sickness Rate		The sickness rate is based on the number of calendar days lost to sickness as a percentage of total available working calendar days (for either the 12-month period or the month).	3%	**Numerator**: Number of calendar days lost to sickness **Denominator:** Total available working calendar days.	Monthly
	Turnover Rate	Total Turnover	Turnover represents the number of employees that the Trust must replace as a ratio to the total number of employees across the Trust (excluding junior doctors).	18%	**Numerator**: All employees that the Trust must replace (excluding Junior Doctors) **Denominator:**Total amount of employees across the Trust (excluding Junior Doctors).	Monthly
		Voluntary Turnover	Voluntary Turnover represents the number of employees that the Trust must replace (due to: Flexi Retirement, Mutually Agreed Resignation, Pregnancy or Retirement due to Ill Health/Retirement Age) as a ratio to the total number of employees across the Trust (excluding junior doctors).	14%	**Numerator**: All employees that the Trust must replace due to voluntary resignation (Excluding Junior Doctors) **Denominator:**Total amount of employees across the Trust (excluding Junior Doctors).	Monthly
	Appraisal Rate		This indicators shows the percentage of substantive employees that have had their Performance and Development Review (PDR) appraisal.	90%	**Numerator:** Number of staff members with a complete PDR **Denominator:** Total number of staff members eligible for a PDR.	Monthly
	Mandatory Training		This indicators shows the percentage of substantive employees that have completed the necessary mandatory training courses on GOLD LMS.	90%	**Numerator:** Number of staff members who have succesfully completed all the necessary training courses for their role. **Denominator:** Total number of substantial staff members.	Monthly
	% Staff Recommending the Trust as a Place to Work: Friends & Family Test		This is an indicator of the overall satisfaction of staff members working in the Trust and how likely they are to recommend GOSH as a place to work to their friends and family.	61%	**Numerator:** Total number of staff members that have indicated that they are likely or very likely to recommend the Trust as a place to work. **Denominator:** Total number of patients that have completed the Staff FFT questionnaire	Quarterly
	Vacancy Rate		This indicator shows the percentage of unfilled vacancies within the Trust.	10%	**Numerator:** Established FTE **Denominator:** Actual Budget FTE	Monthly
	Bank Spend		Total amount spent on temporary staff from the GOSH Staff Bank	N/A	**Numerator:** Total amount that has been spent on Bank staff. **Denominator:** Total pay bill.	Monthly
	Agency Spend		Total amount spent on agency staff as a percentage of the total pay bill.	2%	**Numerator:** Total amount that has been spent on Bank staff. **Denominator:** Total pay bill.	Monthly

	Measure	Definition	Standard	Calculation formulae	Reporting Frequency
Our Money	Net Surplus/(Deficit) v Plan	Variance between YTD Net Surplus/(Deficit) - Excluding Capital Donations and Impairments compared to YTD Plan Surplus/(Deficit) - Excluding Capital Donations and Impairments			Monthly
	Forecast Outturn v Plan	Variance between Forecast month 12 Net Surplus/(Deficit) - Excluding Capital Donations and Impairments compared to Annual Plan as at month 12 Surplus/(Deficit) - Excluding Capital Donations and Impairments			Monthly
	P&E Delivery	Actual YTD recurrent savings delivered v YTD Planned Savings			Monthly
	Pay Worked WTE Variance to Plan	Variance between worked WTE in period and plan WTE in period			Monthly
	Debtor Days (IPP)	IPP Debtors / Total Sales x365			Monthly
	Qucik Ratio (Liquidity)	Cash + Receivables divided by current liabilities			Monthly
	NHS KPI Metrics	Composite metric based on performance against plan of the following NHS Improvement Measures: • Liquidity • Capital Service Coverage • I&E Margin • Variance in I&E Margin as % of income • Agency Spend • Each measure is rated 1 to 4 (and RAG rated 1 Green, 2 Amber and 3/4 Red)			Monthly
Productivity	Theatre Utilisation (NHS UO4)	Theatre Utilisation based on the percentage of original scheduled session hours that were used for operating	77%		Monthly
	Bed Occupancy	KH03 definition- day and night occupied bed days divided by total no of available bed days			Monthly
	Number of Beds	KH03 definition of total number of available beds			Monthly
	Average Number of beds closed	Average number of day and night beds closed in the reporting month.			Monthly
	Refused Admissions	Admissions refused due to non clinical reasons. Data excludes refusals based on medical grounds and refusals to a GOSH ICU/Ward that were accepted to a different GOSH ICU/Ward			Monthly
	Trust Activity: Trust activity (Daycase discharges, Overnight Discharges, Critical Care bed days and OP attendances	Discharges based on spells. Overnight discharges include elective, non elective, non elecetive non emergency and regular attenders. OP attendances include both new and follow up. Critical care bed days include elective, non elective and non elective non emergency.			Monthly
	Excess Bed Days >=100 days	No of patients with an extra ordinary length of stay (100 days+) at the end of the reporting period.			Monthly

Appendix IV
Trust Board Kite Marking Update
Trust Board Meeting
July 2017

Background

Throughout the last eighteen months, the Trust has been through a considerable journey in relation to the improvement and assurance of data and data systems across the organisation.

This work has included the Trust seeking to assure the quality of data and data processes related to the calculation and reporting of indicators across the organisation, initially focusing on those included within the Integrated Performance Report.

In order to achieve this, the Trust is utilising the NHS Improvement Well Led Kitemarking approach which has been highlighted as 'best practice.' The approach assesses all indicators and the robustness of the data that is used to calculate them against seven different domains:

- Accuracy
- Validity
- Reliability
- Timeliness
- Relevance
- Audit
- Executive Director Judgment

Each of these domains are scored against a set criteria that provides a score of 'sufficient,' 'insufficient' or 'not yet assessed.' For all those indicators where there is 'insufficient' assurance of one of the domains, we need to develop an action plan which addresses the issues that were identified as part of the exercise.

Progress made to date

This exercise has now been completed for the vast majority of indicators included within the Integrated Performance Report and although slightly behind the originally agreed schedule, this has resulted in an enhanced output for those assessed.

Work continues to develop action plans for those indicators that have been identified as 'insufficient' assurance to improve the position, led by the Executive Director for the area.

Domain	Lead	Total Count	Sufficient Assured		Insufficient Assurend		Yet to be Assured	
			Count	%	Count	%	Count	%
Caring	Juliette Greenwood, David Hicks	49	35	71.4%	0	0.0%	14	28.6%
Safe	Juliette Greenwood, David Hicks	70	56	80.0%	7	10.0%	7	10.0%
Responsive	Nicola Grinstead	98	65	66.3%	33	33.7%	0	0.0%
People, Management & Culture: Well-Led	Ali Mohammed	63	34	54.0%	11	17.5%	18	28.6%
Effective	Nicola Grinstead	28	16	57.1%	12	42.9%	0	0.0%
Productivity	Nicola Grinstead	98	65	66.3%	33	33.7%	0	0.0%
Our Money	Loretta Seamer	49	48	98.0%	1	2.0%	0	0.0%
Grand Total		455	319	70.1%	97	21.3%	39	8.6%

In summary:

- 70.1% of indicators (319) have been assessed as sufficient assurance

- 21.3% of indicators (97) have been assessed as insufficient assurance
- 8.6% of indicators (39) are yet to be assessment, but in the main these relate to on-going review work being completed within Human Resources.

The launch of the Data Assurance Team (in April), together with the data quality dashboard is the mechanism the Trust intends to use to improve the accuracy and reliability of data capture, together with establishing a rolling programme of audit across PiM's based indicators (with the support of internal audit) to provide the necessary level of assurance.

Next Steps

To ensure this work remains on track and that the organisation continues to see the impact that is needed, the Trust needs to ensure that pace is maintained going forward.

- **Finalise the Kite Marking for all outstanding indicators within the Integrated Performance Report -** End of August.

- **Establishment of an Action Plan for all areas-** This will be finalised throughout June and will be managed through the Data Quality Review Group on a monthly basis. (End of August)

- **Roll out of Kitemarking to all other areas-** Current plan:

    - **Human Resources Indicators-** August 2017
    - **Finance KPIs-** August 2017
    - **Quality Improvement Indicators**- August 2017
    - **All other Trust Indicators**- On-going

KITE MARKING SUMMARY JUNE 2017

Domain	Lead	Total Count	Sufficient Assured		Insufficient Assurend		Yet to be Assured	
			Count	%	Count	%	Count	%
Caring	Juliette Greenwood, David Hicks	49	35	71.4%	0	0.0%	14	28.6%
Safe	Juliette Greenwood, David Hicks	70	54	77.1%	7	10.0%	9	12.9%
Responsive	Nicola Grinstead	98	65	66.3%	33	33.7%	0	0.0%
People, Management & Culture: Well-Led	Ali Mohammed	63	34	54.0%	11	17.5%	18	28.6%
Effective	Nicola Grinstead	28	16	57.1%	12	42.9%	0	0.0%
Productivity	Nicola Grinstead	98	64	65.3%	33	33.7%	1	1.0%
Our Money	Loretta Seamer	49	48	98.0%	1	2.0%	0	0.0%
Grand Total		455	316	69.5%	97	21.3%	42	9.2%

Domain	Metric	Accuracy	Validity	Reliability	Timeliness	Relevance	Audit	Executive Judgement
Caring	Access to Healthcare for people with Learning Disability	3	3	3	3	3	3	3
Caring	% Positive Response Friends & Family Test: Inpatients	1	1	1	1	1	1	1
Caring	Response Rate Friends & Family Test: Inpatients	1	1	1	1	1	1	1
Caring	% Positive Response Friends & Family Test: Outpatients	1	1	1	1	1	1	1
Caring	Number of Complaints	1	1	1	1	1	1	1
Caring	Number of Complaints -Red Grade	1	1	1	1	1	1	1
Caring	Mental Health Identifiers: Data Completeness	3	3	3	3	3	3	3
Safe	Reported cases of Clostridium difficile associated disease to the Public Health England mand	1	1	2	1	1	1	1
Safe	Reported cases of MRSA bacteremia to the Public Health England mandatory reporting syste	1	1	1	1	1	1	1
Safe	Total hospital acquired pressure / device related ulcer rates grade II & above	2	2	2	1	1	2	2
Safe	Serious Patient Safety Incidents	1	1	1	1	1	1	1
Safe	Never Events	1	1	1	1	1	1	1
Safe	C.Difficile due to Lapses of Care	1	1	2	1	1	1	1
Safe	CV Line Infection Rate (per 1,000 line days)	1	1	1	1	1	1	1
Safe	WHO Checklist Completion	3	3	3	3	3	3	3
Safe	Cardiac Arrests Outside of ICU	1	1	1	1	1	1	3
Safe	Respiratory Arrests Outside of ICU	1	1	1	1	1	1	3
Responsive	Diagnostics: Patients Waiting >6 Weeks	1	1	1	1	1	2	1
Responsive	Cancer 31 Day: Decision to Treat to First Treatment	2	1	2	1	1	1	1
Responsive	Cancer 31 Day: Decision to Treat to Subsequent Treatment - Surgery	2	1	2	1	1	1	1
Responsive	Cancer 31 Day: Decision to Treat to Subsequent Treatment - Drugs	2	1	2	1	1	1	1
Responsive	Last Minute Non-Clinical Hospital Cancelled Operations	1	1	2	1	2	2	2
Responsive	Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard	1	1	2	1	2	2	2
Responsive	Same day / day before hospital cancelled appointments	1	1	1	1	1	2	1
Responsive	RTT: Incomplete Pathways	2	1	2	1	1	2	1
Responsive	RTT: Number of Incomplete Pathways (Under 18 Weeks)	2	1	2	1	1	1	1
Responsive	RTT: Number of Incomplete Pathways (Over 18 Weeks)	2	1	2	1	1	1	1
Responsive	RTT: Incomplete Pathways >52 Weeks (Unvalidated)	2	2	2	1	1	2	1
Responsive	RTT: Incomplete Pathways >52 Weeks (Validated)	2	2	2	1	1	2	1
Responsive	Number of unknown RTT clock starts (External Referrals)	1	1	2	1	1	1	1
Responsive	Number of unknown RTT clock starts (Internal Referrals)	1	1	2	1	1	1	1
People, Management & Culture: Well-Led	Sickness Rate	2	2	1	1	1	3	3
People, Management & Culture: Well-Led	Turnover - Total	1	1	1	1	1	3	3
People, Management & Culture: Well-Led	Turnover - Voluntary	1	1	1	1	1	3	3
People, Management & Culture: Well-Led	Appraisal Rate	2	1	1	2	1	3	3
People, Management & Culture: Well-Led	Mandatory Training	2	1	1	2	1	3	3
People, Management & Culture: Well-Led	% Staff Recommending the Trust as a Place to Work: Friends & Family Test	1	1	1	1	1	3	3
People, Management & Culture: Well-Led	Vacancy Rate	2	1	1	1	1	3	3
People, Management & Culture: Well-Led	Bank Spend	2	1	1	2	1	3	3
People, Management & Culture: Well-Led	Agency Spend	2	1	1	2	1	3	3
Effective	Discharge Summary Turnaround within 24hrs	1	1	1	1	1	2	2
Effective	Clinic Letter Turnaround within # - 7 working days	2	2	2	1	2	1	2
Effective	Clinic Letter Turnaround within # - 14 working days	2	2	2	1	2	1	1
Effective	Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)	1	1	1	1	1	2	1
Productivity	Average numbers of beds closed - Wards	1	1	2	1	1	2	2
Productivity	Average numbers of beds closed - ICU	1	1	2	1	1	2	2
Productivity	Theatre Utilisation (NHS UO4) - Main theatres	2	2	2	1	2	2	2
Productivity	Excess Beddays >=100 days - number of patients	1	1	1	1	1	2	1
Productivity	Number of Beds	2	1	2	1	1	1	1
Productivity	Excess Beddays >=100 days - number of beddays	1	1	1	1	1	2	1
Productivity	Theatre Utilisation (NHS UO4)	2	2	2	1	2	2	2
Productivity	Bed Occupancy	1	2	2	1	2	2	2
Productivity	Cardiac Refusals	1	1	2	1	1	1	3
Productivity	PICU/NICU Refusals	1	1	2	1	1	1	1
Productivity	Critical Care Beddays	1	1	1	1	1	2	1
Productivity	Daycase Discharges	1	1	1	1	1	2	1
Productivity	Overnight Discharges	1	1	1	1	1	2	1
Productivity	Outpatient Attendances (All)	1	1	1	1	1	2	1
Our Money	Net Surplus/(Deficit) v Plan	1	1	1	1	1	1	1
Our Money	Forecast Outturn v Plan	1	1	1	1	1	1	1
Our Money	P&E Delivery	1	1	1	1	1	1	1
Our Money	Pay Worked WTE Variance to Plan	2	1	1	1	1	1	1
Our Money	Debtor Days (IPP)	1	1	1	1	1	1	1
Our Money	Quick Ratio (Liquidity)	1	1	1	1	1	1	1
Our Money	NHS KPI Metrics	1	1	1	1	1	1	1

Appendix V
Theatre Utilisation Update
Trust Board
July 2017

Introduction

The Trust Board requested a deep-dive review into theatre utilisation based on their previous discussions about the integrated scorecard and their questions about theatre utilisation. The work programme has been established to support delivery of 'we will achieve the best possible outcomes through providing the safest, most efficient and effective care. '

This paper sets out the following:

1. The current operating context for theatres;
2. A detailed update on the Better Value Theatre Utilisation project;
3. A detailed update on progress made on collation and use of theatre productivity data at GOSH.

The Trust Board is asked to **consider** and **note** the content of this paper.

1. Current operating context for theatres

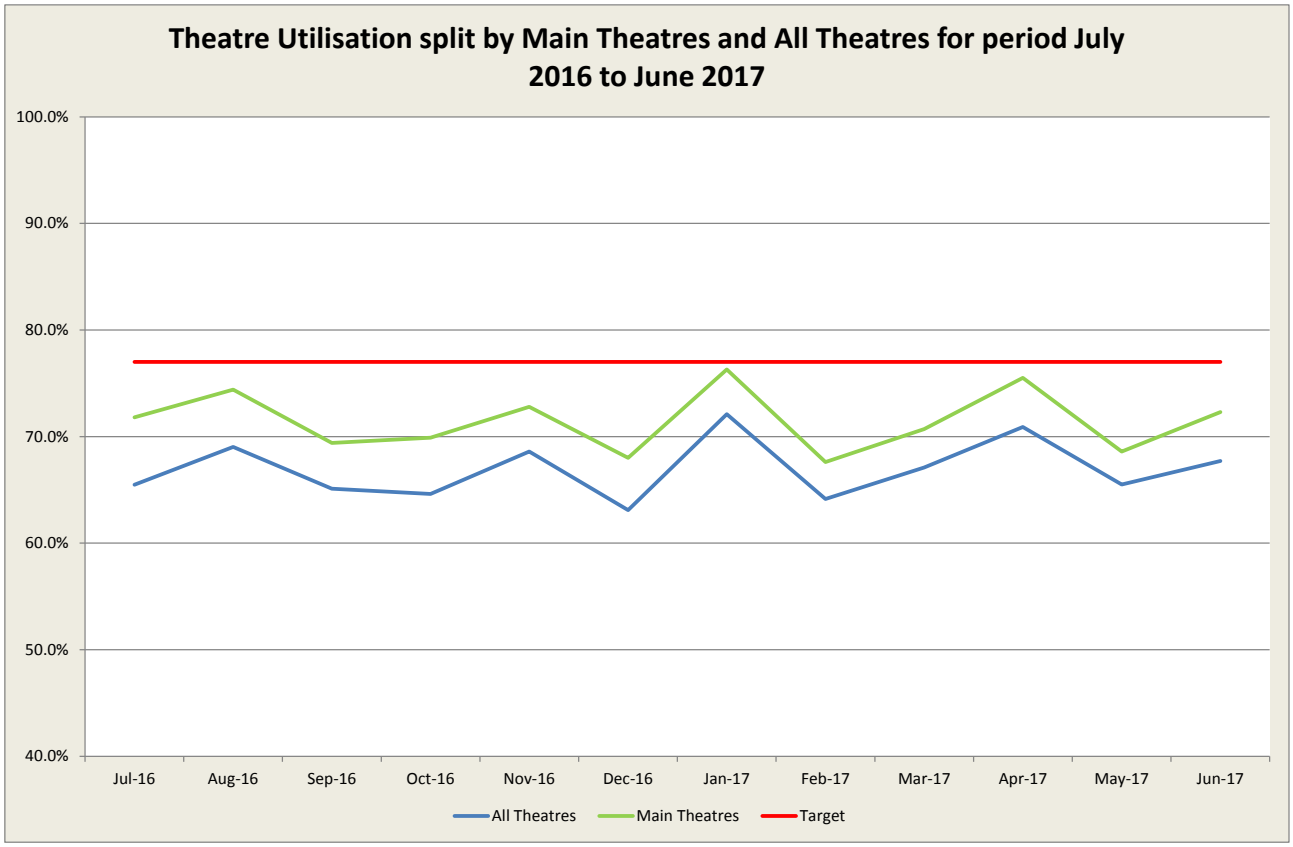
Theatre utilisation has previously been identified as an area where improvement is required to ensure that we maximise the use of resources and improve the quality of experience for our patients by providing more timely care.

Great Ormond Street for Children NHS for Children Foundation Trust has twelve operating theatres, with the new Premier Inn Clinical Building (PICB) providing two additional theatres. Theatre utilisation has become the principal measure of NHS operating theatre service performance and as one of the most expensive resources in an NHS hospital, it is important that the staff, equipment and space within the theatre environment are used effectively. Target theatre utilisation within GOSH is measured against 'the percentage of original scheduled session hours that were used for operating' with standards of:

- Green - 77% and above
- Amber - 67% - 76.9%
- Red - 66.9% & under

These targets are Trust targets and are based on recommendations from the Audit Commission.

For the rolling twelve month period to the end of June 2017, theatre utilisation for all theatres stood at an average of 66.9% for NHS elective care operations (excluding private patients and emergency cases). However the focus of the project has been around the Trust main theatres where theatre utilisation stood at 71.4% on average for the rolling twelve month period. Due to the complexity and specialist nature of the work undertaken at GOSH it may be difficult, in some areas, to regularly achieve 77% utilisation.



2. Detailed update on the Better Value Theatre Utilisation project

The aim of the project is to deliver the allocated target of £1m in the Trust's savings programme. This will be achieved through identification of cash releasing savings in theatres, by way of efficient and effective processes and income generation/absorption of growth through improved list utilisation. This will be delivered in the 2017/18 better value programmes by ensuring that all pass-through non-pay items are billed (£200k) and by creating a number of work streams within specific specialties to enable a higher throughput on existing lists (£800k).

A number of work streams have been developed. Each group is clinically led and focusses on specific issues identified within that specialty:

ENT and Dental & Max-Fax

- Reduce underutilisation due to patient cancellations/DNA by implementing an additional call three days prior to surgery, trial text reminders 2 or 3 weeks in advance and improving the internal communication process for late notice cancellations.
- Review of scheduling to ensure that lists are appropriately booked.

SNAPs and Ophthalmology

- Reduce hospital cancellations of elective patients for emergency/urgent cases by holding time on each elective list for urgent cases.
- Patients are often cancelled days before surgery due to lack of beds. Scope the opportunity to advise patients of the cancellation risk rather than cancelling as beds are often available on the day.
- Review of scheduling 'rules' to ensure that patients requiring pre-meds arrive in the first tranche of staggered arrivals and that an NHS patient from AOD is first on the list (link to 'Golden Patient' project).

- Amend PIMS so that two half day lists are scheduled as an all-day list with flexible lunch allowing more flexibility for longer cases (automatically improving utilisation by 20% with no additional cases).

Interventional Radiology

The programme is linking in with the existing interventional radiology efficiency programme including:

- Improved scheduling of theatre time with dedicated emergency and elective lists. Elective lists are currently booked to set slots of 45 or 90 minutes, improved scheduling may have an impact on overall utilisation and increase throughput once cases are scheduled to accurate time slots.
- This work is likely to have supported the continued improvement in lists running to plan with an average 9% from May-December 2016 rising to 23% from January 2017, and 51% from June 2017.
- Addressing late starts and time lost to turnaround due to patients not being prepared in time. Benefits should include reduced same day cancellations and increased activity leading to improved utilisation.

Haem-Onc, Dermatology and Cardiology

- Review use of Cardiac Cath Lab to identify procedures which could be moved out to allow additional cardiac cases.
- Facilitate all day lists in Cardiac Cath Lab to allow an additional case each week.
- Review Dermatology scheduling and recording of accurate timings in theatre.
- Review scheduling and utilisation of Safari theatre to identify opportunities to increase through-put possibly by over-booking or offering split lists.

Spinal Pathway Review

Review of the spinal pathway to identify and remove or minimise 'problem' areas resulting in cancellations/low utilisation. Key areas of focus are:

- Reviewing the length and wording of the patient surgery confirmation letter
- Agreeing robust anaesthetic criteria for requirement of PICU/HDU beds
- Working with the patient placement programme regarding earlier confirmation of bed availability
- Scope opportunity to introduce longer session days.

Dedicated Private Patient Operating Lists

Explore the potential of the Trust establishing dedicated international private patient theatre list to see if it would have a positive impact on theatre utilisation.

Scheduling

Increase scheduling lead in time to a minimum of four weeks in advance for all areas.

Anaesthetic Pre-Operative Assessment (APOA)

The average percentage of patients who have attended an APOA prior to surgery with a general anaesthetic is 25% (Jan to Mar-17). APOA determines patients' fitness for an anaesthetic/surgery ensuring elective patients are optimised for surgery, reducing delays and cancellations on the day. The project works with identified services to form a plan to invite patients for review.

Anaesthetic and recovery time is recorded on the waiting list request form and is often a pre-recorded standard length of time. A review of actual anaesthetic times to calculate the mean, mode and variation would enable evidence based standard bands of anaesthetic time to be agreed based on procedure and complexity.

Dedicated Emergency Lists
The two objectives of this group are:

- To improve utilisation of the emergency list
- To review what emergency work is done outside the theatre 1 Emergency list

An audit of emergency cases is planned to review; speciality and case-mix, AM lists over-running into the Emergency list and measuring utilisation of the in and out of hours emergency lists.

The Consultant in charge and Theatre Coordinator to meet daily at 11am to identify booked emergency cases and, where possible, reschedule them into under-running elective lists.

There has been a slight drop in the number of same day cancellations for emergency cases, with performance averaging at 5.4% between April 2016 and December 2016, now averaging at 4%. The monthly average number of emergency cancellations has fallen from 12 to 8 for the same period.

Recruitment of a Clinical Operations Manager in J.M. Barrie
The appointment of a Clinical Operations Manager in January 2017 has greatly supported the reduction in cancellations on the day due to bed availability. Same day cancellations have shown a downward trend since January 2017. The monthly average number of cases cancelled for an emergency case between April 2016 and December 2016 stood at 217 cases, this has fallen to 207 since January 2017 (4.6% drop).

Finance

There is a high level of confidence around the delivery of the Better Value scheme related to theatres for the majority of the £1m. Approximately £200k has been flagged as high risk, related to the Haematology, Oncology, Dermatology and Cardiac schemes.

3. Detailed update on progress made on collation and use of theatre productivity data at GOSH.

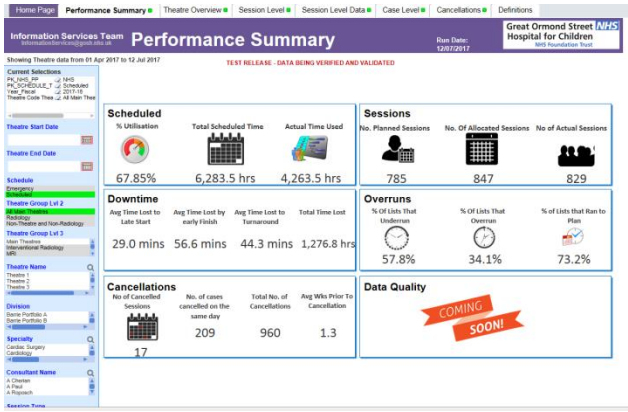
Due to inconsistencies in the reporting and quality of data used to support theatre reporting, the Trust has developed a new theatre dashboard which is just in the final stages of testing and we aim to go live with in August 2017.

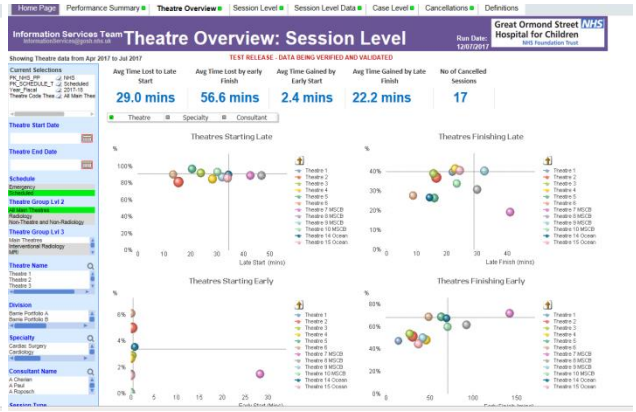
New Theatre Dashboard

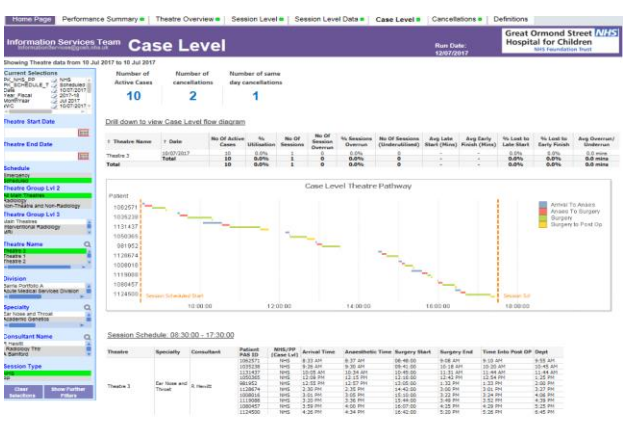
The enhanced reporting functionality this provides allows the Trust to undertake more in-depth analysis, allowing the user to drill down to a more granular level, focusing on an enhanced range of indicators. This includes:

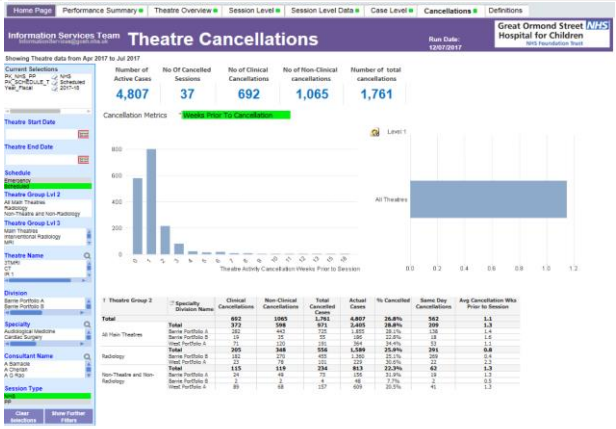
- Summary Performance Metrics
- Comparison of Utilisation metrics – Theatre, specialty, Consultant
- Case level analysis
- Backing Data
- Cancellation Analysis

An example of the dashboard is provided below:









Data Quality Assurance

There has been traditionally concern around the quality of data that is being used to support theatre activity and utilisation reporting and therefore the development of the new dashboard has also been supported by the flagging of data quality concerns into the data quality dashboard to identify where improvement in quality or completeness of data is needed. The Data Assurance Team will work with users to support them in-line with the standard operating procedures in place. This work will be led by a nominated Data Quality Champion who works within the Divisional team.

The theatre dashboard will provide the following functionality:

- 29 individual checks at a patient level
- 6 individual checks at a sessional level

External Benchmarking Work

In addition to the work completed internally, the Trust has contributed to a number of pieces of work related to benchmarking of theatre utilisation performance. This includes working Foureyes Insight as part of an NHS Improvement commissioned piece to compare theatre productivity between providers. Although the benefit for GOSH was slightly limited owing to the specialist nature of the work we complete, it provided some valuable insight into potential future opportunity.

The Trust has also recently implemented and rolled out a ‘magic numbers’ report which compares the expected number of cases that need to be completed as defined within our NHS contract on a monthly and weekly basis. In terms of theatres, this report can be utilised to ensure that procedure throughput is in-line with expected volumes in real time.

Next Steps

As can be seen, considerable work is on-going around theatre utilisation and improvement across the organisation, however a number of specific actions are required going forward.

For the purpose of the Trust Board progress will continue to be tracked through the scorecard and it is proposed that the Board receives an annual deep dive on T U on delivery of the programme.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board Meeting
27 July 2017

2017/18 Finance Report – Month 3 **Submitted by:** **Loretta Seamer, Chief Finance Officer**	**Paper No: Attachment J**

Purpose
The purpose of this paper is to report the Trust Financial Position as at the end of June 2017.

Financial Position – Summary Points
In June 2017 there was a Net Surplus (before capital donations and impairments) of £1.4million which was £0.3million less than plan. Year to date the Trust has a Net deficit of £0.3m which is £0.3m worse than plan.

At the end of the quarter the NHS Income is 5.8% or £3.8million ahead of plan offset by lower pass-through income, IPP and non-clinical income. Overall Income in £0.8million ahead of plan. Pay expenditure is less than plan by £.03million with the main cause of the result non-pay expenditure over plan by £2.1million. The main cause being an increase in the doubtful debt provision, maintenance costs for major equipment over plan.

Year to date income for capital donations is £8.6million less than plan due to lower capital expenditure on donated assets associated with the redevelopment project, medical equipment and ICT.

The control total (which excludes capital donations and depreciation from charitable funded assets) year to date was ahead of plan by £0.1million.

Activity Summary
For Month 3 the activity trend compared to the prior period showed:

- Total Day and Overnight discharges were slightly higher than the prior month by 1.8% or 71, of which day discharges increased by 8 cases.
- Average overnight length of stay decreased by 8.8% or 0.5 of a day.
- Overnight bed days were up 1.2% above the previous 12 months, an increase of 306 bed days.
- Total Critical Care bed days were in line with the prior month and the year to date average; there were 241 ICU bed Days in Month3 which is significantly up on the average bed days in 2016-17.
- Outpatient attendances decreased from the prior month by 2.1% but increased by 1.7% on the prior year's position; in both instances the majority of the change has been within follow up appointments.

Income
At the end of month 3, year to date income is £0.3m higher than plan. NHS income was £1.3m above the plan at Month 3; and £3.8m above plan year to date. The majority of the over delivery in month relates to Cardiac ICU, Haematology and Cardiac Surgery. The year to date position is being driven in part by the BMT and SCIDs over delivery.

International Private Patients is behind plan in Month 3 by £0.9m due to a significant reduction in referrals and specifically, lower PICU bed days. Year to date, IPP is now behind plan by £1.2m.

Other clinical income (excluding pass through) is £0.3m favourable to plan for the month mainly due to R&I income but overall, the position is £0.7m behind plan year to date. It is anticipated that the position will recover by year end.

Expenditure

Pay costs for the month were in line with plan and is £0.3million better than plan year to date. A number of new posts were funded for 2017-18 in line with business planning but remain unfilled.

Trust non pay costs are worse in month by £0.8m than plan and by £2.1m overall. This is in the main activity related costs due in part by the over delivery of NHS Income. Within the position are a number of non-activity related issues including maintenance contracts within radiology and the increase in the doubtful debt provision due to IPP debt increase.

Other Financial Indicators

Indicator	Comment
NHSI Financial Rating	Overall rating of Green
Cash	The closing cash balance was £46million, £0.3million more than plan
NHS Debtor Days	Debtor days remain within target at 14 days
IPP Debtor Days	IPP debtor days increased in month to 212.
Creditor Days	Creditor days increased in month to 29 days and this still remains within target
Inventory Days	Drug inventory days decreased in month to 6. Non-Drug inventory days remained the same as M01 at 62 days.

Risks

Risk/Assumption	Comment
£15m delivery of P&E savings	The full Better Value programme continues to be worked up in more detail; a number of schemes centrally held by the SRO's responsible for delivery have been allocated out but there remains an overall balance of schemes to be identified.
Achievement of CQUIN Income	The negotiation of CQUIN schemes is being considered with the commissioner; 85% delivery is assumed but there remains risk around delivering all aspects of the current plans.
IPP Income	IPP is down against plan year to date due to a drop in referrals. It is anticipated that some of this is due to external factors but recovery to plan is a key deliverable for the remainder of the year. Overall the IPP debt remains high and expedient recovery of monies owing remains a key objective for the trust.
NHS activity and income	NHS contract was based on last year's outturn, additional growth and RTT growth. It also included achievement of the full amount of QUIPP. The new financial year pricing for PbR is based on the new HRG4+ tariffs and adjustments have been made in the contract. At this stage the risk that the contract will not be delivered is low.

Action required from the meeting

- To **note** the financial position as at 30 June 2017.
- To **note** the residual risks to the 2017/18 outturn.

Contribution to the delivery of NHS / Trust strategies and plans

This paper details the Trusts delivery against its agreed Financial Plan to M03 2017/18

Financial implications Not delivering the agreed Control Total would have led to the Trust losing the S&T Fund.
Legal issues None
Who is responsible for implementing the proposals / project and anticipated timescales Chief Finance Officer/Executive Management Team
Who is accountable for the implementation of the proposal / project Chief Finance Officer

Great Ormond Street Hospital for Children NHS Foundation Trust

Board
Finance and Activity Performance Report

Month 3

30 June 2017/18

Summary Reports

Great Ormond Street Hospital for Children NHS Foundation Trust

Finance Scorecard

Our Money	April	May	June	Trend	YTD Target	Variance
Net Surplus/(Deficit) £m	(2.5)	0.8	1.4	↑	(0.0)	(0.3)
Forecast Outturn £m	0.2	0.2	0.2	→	0.2	0.0
Debtor Days (IPP)	183.0	212.0	201	↑	120.0	(78.7)
Quick Ratio (Liquidity)	1.9	1.9	1.8	↓	1.7	0.1
**NHSI KPI Metrics	3	3	1	↑	1	0

NHSI Key Performance Indicators				
KPI	Annual Plan	M3 YTD Plan	M3 YTD Actual	Rating
Liquidity	1	1	1	G
Capital Service Coverage	1	1	1	G
I&E Margin	1	1	1	G
I&E Margin Distance from Plan	1	1	1	G
Agency Spend	1	1	1	G
Overall	1	1	1	G
Overall after Triggers	1	1	1	G

Key Highlights

- In June 2017 there was a Net Surplus (before capital donations and impairments) of £1.4million which was £0.3million less than plan. Year to date the Trust has a Net deficit of £0.3m which is £0.3m worse than plan.
- The overall weighted NHSI rating for Month 3 is Green (Rating 1) which is on plan.
- The debtor days for IPP improved from last month by 11 days.
- Liquidity is strong with cash on hand of £46million, £0.3 more than plan.

Trust Income and Expenditure Performance Summary
Year to Date for the 3 months ending 30 June 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

2017/18											Notes	2016/17	CY vs PY	CY vs PY
Annual	Income & Expenditure	Month 3				Year to Date				Rating		YTD	Variance	
Budget		Budget	Actual	Variance		Budget	Actual	Variance		Current Year Variance		Actual		
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%			(£m)	(£m)	%
272.3	NHS & Other Clinical Revenue	23.3	24.6	1.3	5.6%	66.7	70.6	3.8	5.8%	G	1	63.7	6.8	10.8%
67.8	Pass Through	5.9	5.6	(0.3)	-5.1%	16.9	15.8	(1.1)	-6.5%			14.5	1.3	9.0%
60.7	Private Patient Revenue	5.4	4.5	(0.9)	-16.7%	15.4	14.2	(1.2)	-7.8%	R	2	14.1	0.1	0.7%
53.3	Non-Clinical Revenue	4.4	4.7	0.3	6.8%	12.7	12.0	(0.7)	-5.5%	R		11.1	0.9	8.1%
454.1	**Total Operating Revenue**	**39.0**	**39.4**	**0.3**	**0.9%**	**111.7**	**112.6**	**0.8**	**0.8%**			**103.4**	**9.2**	**8.8%**
(244.4)	Permanent Staff	(20.4)	(18.8)	1.6	7.7%	(60.7)	(56.0)	4.7	7.7%			(51.8)	(4.2)	-8.1%
(1.7)	Agency Staff^	(0.1)	(0.5)	(0.4)	-400.0%	(0.4)	(1.4)	(1.0)	-250.0%	R		(2.2)	0.8	36.4%
(2.7)	Bank Staff	(0.2)	(1.4)	(1.2)	-600.0%	(0.7)	(4.0)	(3.3)	-471.4%			(4.0)	0.0	0.0%
(248.8)	**Total Employee Expenses**	**(20.7)**	**(20.7)**	**(0.0)**	**-0.2%**	**(61.8)**	**(61.4)**	**0.3**	**0.6%**	G	3	**(58.0)**	**(3.4)**	**5.9%**
(12.8)	Drugs and Blood	(1.1)	(1.2)	(0.1)	-9.1%	(3.2)	(3.3)	(0.1)	-3.1%	A		(2.9)	(0.4)	-13.8%
(38.9)	Other Clinical Supplies	(3.2)	(4.2)	(1.0)	-31.3%	(9.7)	(11.8)	(2.1)	-21.6%	R		(11.1)	(0.7)	-6.3%
(57.6)	Other Expenses	(4.3)	(4.3)	(0.0)	-0.9%	(13.8)	(14.9)	(1.2)	-8.4%	R		(12.6)	(2.3)	18.3%
(67.8)	Pass Through	(5.9)	(5.6)	0.3	5.1%	(16.8)	(15.6)	1.2	7.1%			(14.2)	(1.4)	-9.9%
(177.1)	**Total Non-Pay Expenses**	**(14.5)**	**(15.3)**	**(0.8)**	**-5.8%**	**(43.5)**	**(45.6)**	**(2.1)**	**-4.7%**	R	4	**(40.8)**	**(4.8)**	**-11.8%**
(425.9)	**Total Expenses**	**(35.2)**	**(36.0)**	**(0.9)**	**-2.5%**	**(105.3)**	**(107.0)**	**(1.7)**	**-1.6%**	R		**(98.8)**	**(8.2)**	**-8.3%**
28.2	**EBITDA (exc Capital Donations)**	**3.8**	**3.4**	**(0.6)**	**-15.4%**	**6.4**	**5.6**	**(0.8)**	**-11.7%**	R		**4.6**	**1.0**	**20.7%**
(28.0)	Depreciation, Interest and PDC	(2.1)	(2.0)	0.1	-4.8%	(6.4)	(5.9)	0.5	7.8%		5	(6.3)	0.4	6.3%
0.2	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**1.7**	**1.4**	**(0.3)**		**0.0**	**(0.3)**	**(0.3)**				**(1.7)**	**1.4**	**80.0%**
6.2%	**EBITDA %**	**9.8%**	**8.5%**			**5.7%**	**4.9%**					**4.4%**	**0.5%**	**10.8%**
0.0	Impairments	0.0	0.0	0.0	0.0%	0.0	0.0	0.0	0.0%			0.0	0.0	0%
72.1	Capital Donations	5.1	3.3	(1.8)	-35.3%	14.6	6.0	(8.6)	58.9%		6	9.9	(3.9)	-39.4%
72.3	**Net Result**	**6.8**	**4.7**	**(2.1)**	**-30.3%**	**14.6**	**5.7**	**(8.9)**	**-61.2%**			**8.2**	**(2.5)**	**-31.0%**

Footnotes:

^ The Trust has only set bank and agency budgets for planned short term additional resource requirements i.e. RTT and Gastro

Summary

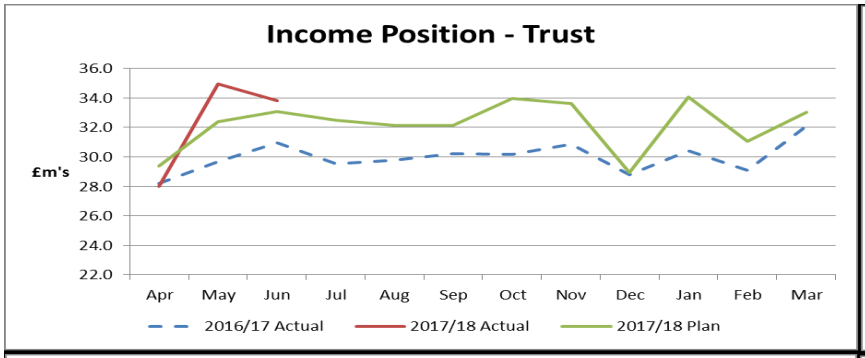
- Year to date the Trust is reporting a £0.3m deficit (excluding capital donations) which is £0.3m adverse to plan.
- Month 3 YTD EBITDA is a £5.6m surplus which is £0.8m adverse to plan.
- The control total (which excludes capital donations and depreciation from charitable funded assets) year to date was ahead of plan by £0.1million.

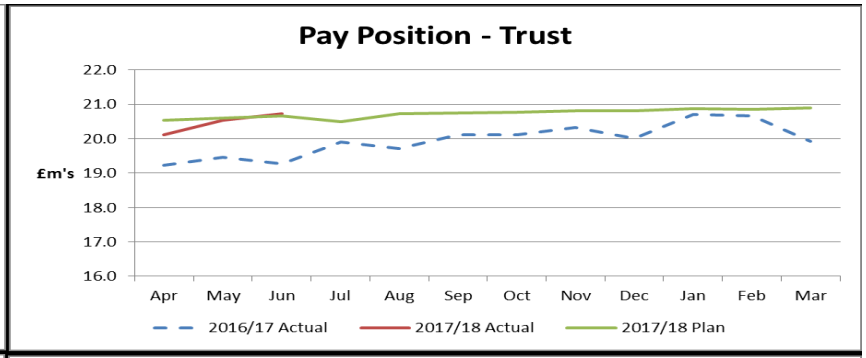
Notes

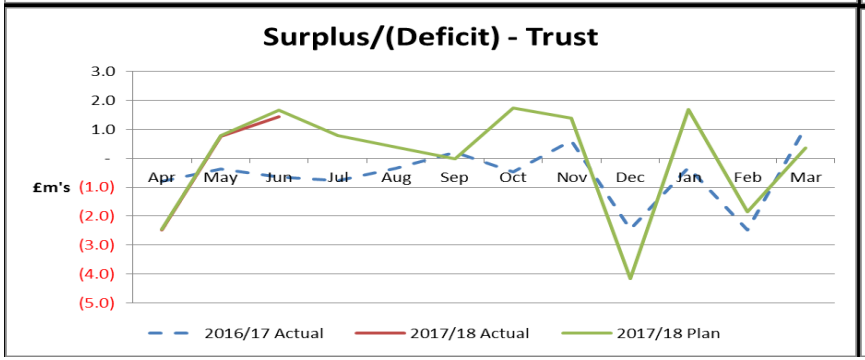
1. NHS income (excluding pass through) YTD is favourable to plan by £3.8m.
2. Private Patient income YTD is £1.2m adverse to plan.
3. Pay is favourable to plan YTD by £0.3m with agency spend below the agency NHSI ceiling.
4. Non pay (excluding pass through) YTD is £3.4m adverse to plan.
5. As capital donations are behind plan, depreciation YTD is favourable.
6. Capital Donations of £6.0m YTD is £8.6m lower than plan.

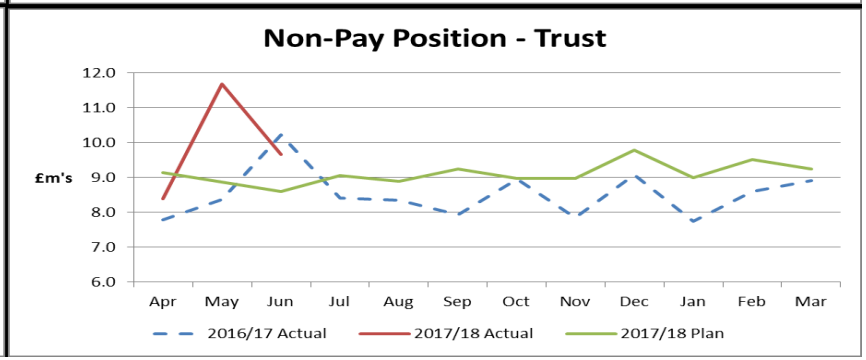
Trust Income and Expenditure Trends
Year to Date for the 3 months ending 30 June 2017

Great Ormond Street Hospital for Children NHS Foundation Trust









Income (excluding pass through)

- NHS & Other Clinical Revenue YTD is £70.6m which is £3.8m favourable to plan.
- Private Patient income YTD s £14.2m which is £1.2m adverse to plan.

Pay

- Year to date pay spend is £61.4m which is £0.3m favourable to plan

Non Pay (excluding pass through)

- Year to date non pay spend (excluding pass through) is £3.4m adverse to plan. This was mainly driven by the following:
    - Radiology maintenance contract costs
    - Increased spend in surgical instruments
    - Increased cost related to cleaning
    - Increased clinical supplies spend due to increased activity in BMT and SCIDs

The following table summaries the net assets and liabilities.

Statement of Financial Position	31 Mar 2017 Audited Accounts £m	30 Jun 2017 Plan £m	30 Jun 2017 Actual £m	YTD Variance £m
Non-Current Assets	431.5	487.2	436.6	(50.6)
Current Assets (exc Cash)	75.9	85.6	80.9	(4.7)
Cash & Cash Equivalents	42.5	45.7	46.0	0.3
Current Liabilities	(56.3)	(73.4)	(64.2)	9.2
Non-Current Liabilities	(5.8)	(5.6)	(5.7)	(0.1)
Total Assets Employed	**487.8**	**539.6**	**493.6**	**(46.0)**

Capital Expenditure	Annual Plan £m	30 Jun 2017 Plan £m	30 Jun 2017 Actual £m	YTD Variance £m
Redevelopment - Donated	37.8	5.6	2.3	(3.3)
Medical Equipment - Donated	19.1	6.7	1.8	(4.9)
Estates - Donated	0.0	0.0	0.0	0.0
ICT - Donated	15.2	2.3	2.0	(0.3)
Total Donated	**72.1**	**14.6**	**6.1**	**(8.5)**
Redevelop & equip - Trust Funded	11.1	2.9	2.3	(0.6)
Estates & Facilities - Trust Funded	3.7	1.3	0.2	(1.1)
ICT - Trust Funded	7.2	2.2	0.7	(1.5)
Contingency	1.0	0.2	0.0	(0.2)
Total Trust Funded	**23.0**	**6.6**	**3.2**	**(3.4)**
Total Expenditure	**95.1**	**21.2**	**9.3**	**(11.9)**

Capital Expenditure Update

Redevelopment donated

Expenditure was less than plan due to slippage on the following projects:

- Bernard St 1st floor fit out £0.6m
- IMRI £1.3m (delay to 2018)
- Mortuary (paused) £1.0m
- Phase 4 £0.8m (delay)

Medical Equipment – Donated

Expenditure was less than plan due to the following:

- Phase 2B equipment procurement delayed due to construction delay £3.9m
- IMRI equipment £0.3m (2018)
- Other equipment £0.6m (awaiting outcome of full replacement review)

Estates and Facilities – Trust Funded

Expenditure was less than plan due to slippage on the following projects:

- Decontamination (endoscopy) project £0.8m

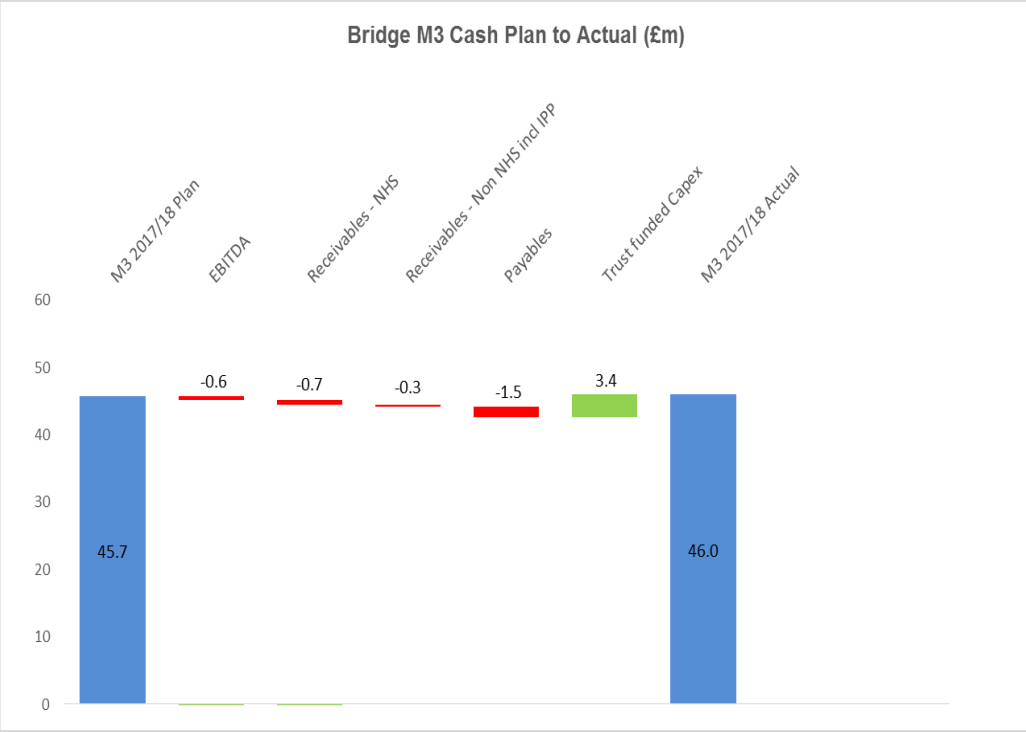
ICT – Trust Funded

Expenditure was less than plan due to slippage on the following projects:

- Vendor neutral archive and network hardware £0.7m
- GMC infrastructure £0.2m
- E-rostering £0.2m

Cash and Working Capital Summary
Year to Date for the 3 months ending 30 June 2017

Great Ormond Street Hospital for Children NHS Foundation Trust



Working Capital	31-Mar-17	31-May-17	30-Jun-17	RAG
NHS Debtor Days (YTD)	19.4	14.2	7.5	G
IPP Debtor Days	182.0	212.0	201.0	R
IPP Overdue Debt (£m)	22.5	24.5	24.4	R
Inventory Days - Drugs	4.0	6.0	6.0	G
Inventory Days - Non Drugs	63.0	62.0	57.0	R
Creditor Days	34.5	29.9	25.2	G
BPPC - Non-NHS (YTD) (number)	82.3%	86.4%	85.5%	A
BPPC - Non-NHS (YTD) (£)	87.8%	87.8%	88.8%	A

Cash

The closing cash balance was £46.0m, £0.2m higher than plan. This was due to lower than planned Trust funded capital expenditure including movement on capital creditors (£3.4m); and the movement on working capital (£2.5m) offset by lower than planned EBITDA (£0.6m)

The movement on working capital (£2.5m) largely relates to higher than planned NHS receivables (£0.7m) Non NHS receivables (£0.3m) and higher than planned trade payables (£1.5m).

NHS Debtor Days

Debtor days decreased in month to 7 days. Quarter 4 (16/17) performance invoices were settled in month by NHS England.

IPP Debtor Days

IPP debtor days decreased in month to 201 days. This is as a result of sizable payments of from Kuwait Health Office (£2.7m) and Saudi Health Office (£1.5m).

Creditor Days

Creditor days decreased in month to 25 days and this still remains within target.

Inventory Days

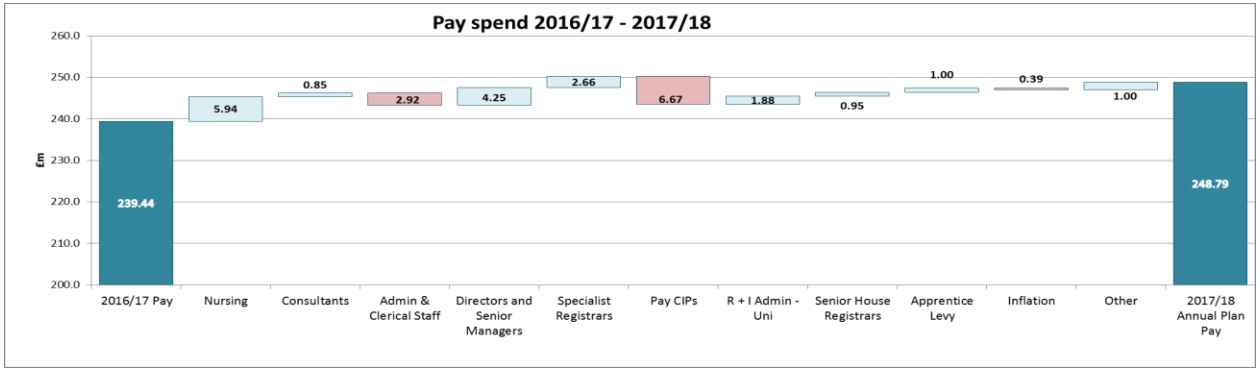
Drug inventory days remained the same as previous months at 6.
Non-Drug inventory days decreased in month to 57 days.

Workforce Summary
For the 3 months ending 30 June 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

£m including Perm, Bank and Agency	2016/17 Pay compared to 2017/18 Pay							
Staff Group	2016/17				2017/18 Q1			
	Qtr 1 Avg (£m)	Qtr 2 Avg (£m)	Qtr 3 Avg (£m)	Qtr 4 Avg (£m)	M1 Actual (£m)	M2 Actual (£m)	M3 Actual (£m)	Qtr 1 Avg (£m)
Admin (inc Director & Senior Managers)	3.4	3.4	3.6	3.7	3.7	3.5	3.8	**3.7**
Consultants	3.5	3.8	3.6	3.9	4.0	4.0	4.1	**4.0**
Estates & Ancillary Staff	0.3	0.3	0.3	0.3	0.3	0.4	0.3	**0.3**
Healthcare Assist & Supp	0.7	0.8	0.7	0.7	0.7	0.7	0.8	**0.7**
Junior Doctors	1.9	2.0	2.0	1.9	2.1	2.1	2.1	**2.1**
Nursing Staff	5.5	5.5	5.8	5.9	5.9	6.2	6.1	**6.1**
Other Staff	0.0	0.0	0.0	(0.1)	0.1	0.1	0.1	**0.1**
Scientific Therap Tech	3.1	3.1	3.2	3.2	3.3	3.6	3.5	**3.5**
Total	**18.5**	**19.0**	**19.2**	**19.5**	**20.1**	**20.5**	**20.7**	**20.5**

WTE Including Perm, Bank and Agency	2016/17 Actual WTE compared to 2017/18 Actual WTE							
Staff Group	2016/17				2017/18 Q1			
	Qtr 1 Avg WTE	Qtr 2 Avg WTE	Qtr 3 Avg WTE	Qtr 4 Avg WTE	M1 Actual WTE	M2 Actual WTE	M3 Actual WTE	Qtr 1 Avg WTE
Admin (inc Director & Senior Managers)	978.9	1,014.0	1,023.9	1,045.1	1,025.9	996.2	1,045.7	**1,022.6**
Consultants	294.9	301.3	305.7	319.7	327.4	319.4	307.9	**318.2**
Estates & Ancillary Staff	127.1	131.2	132.0	132.1	114.1	122.5	113.6	**116.7**
Healthcare Assist & Supp	297.3	299.6	297.7	296.1	296.3	296.8	300.1	**297.7**
Junior Doctors	299.6	308.6	318.7	317.4	322.7	324.5	322.0	**323.1**
Nursing Staff	1,372.2	1,360.1	1,463.7	1,457.5	1,449.8	1,472.3	1,450.6	**1,457.5**
Other Staff	5.8	5.8	5.2	5.1	5.1	6.0	5.1	**5.4**
Scientific Therap Tech	736.7	738.1	762.5	772.2	745.6	777.8	770.7	**764.7**
Total	**4,112.5**	**4,158.6**	**4,309.2**	**4,345.2**	**4,286.8**	**4,315.6**	**4,315.5**	**4,306.0**



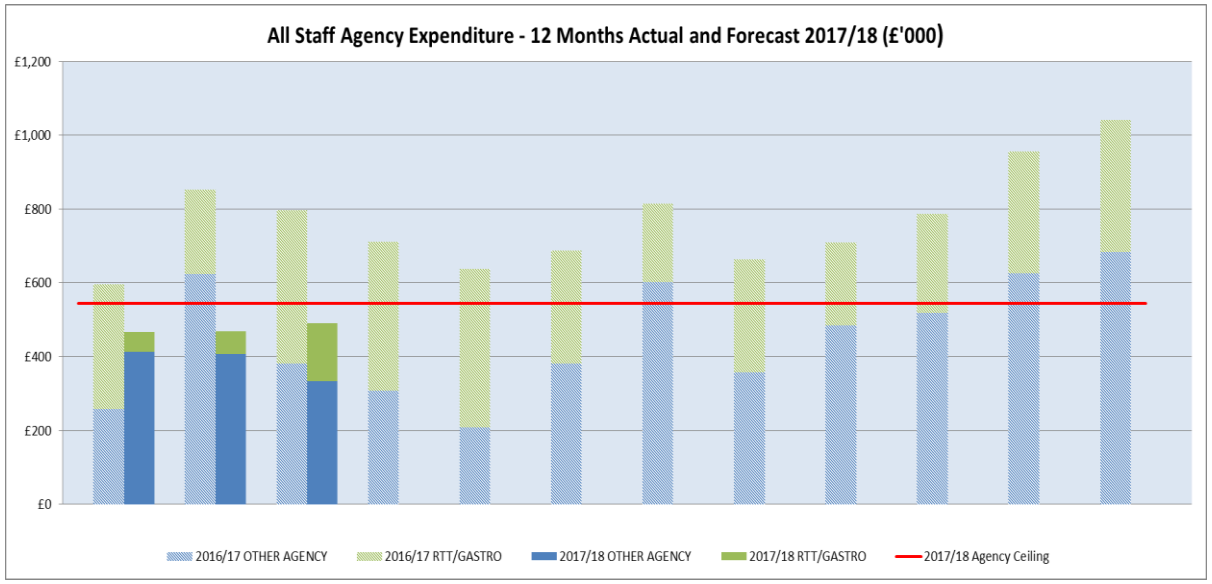
Summary

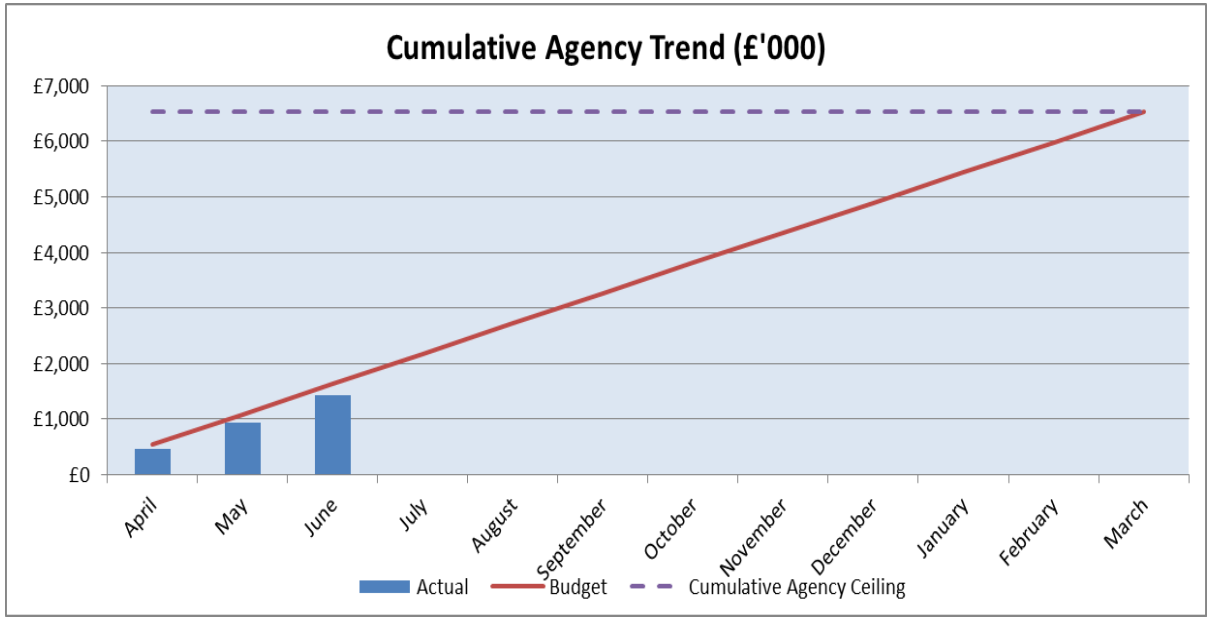
- In Month 3 pay is £20.7m which is on plan.
- Year to date, pay is £0.4m favourable to plan. This is mainly due to numerous vacancies currently across the Trust.
- The agency spend of £0.5m in Month 3 was below the NHSI notified cost ceiling for agency staff which was £1.6m YTD.
- Pay is up compared to 2016/17 due to new posts associated with increased recruitment, inflation and the apprenticeship levy
- the change in workforce numbers between 2016/17 M12 budget and the 2017/18 plan is summarised below *(numbers include inflation)*:

Nursing	£5.9m
Consultants	£0.9m
Administration & Management	£4.3m
Specialist Registrars	£2.7m
R + I Admin – University	£1.9m
Senior House Registrars	£1.0m
Apprentice Levy	£1.0m
Inflation & Incremental Drift Reserve	£0.4m
Offset by:	
Admin and Clerical Staff	£2.9m
Pay CIPs	£6.7m

Agency Expenditure Summary
Year to Date for the 3 months ending 30 June 2017

Great Ormond Street Hospital for Children NHS Foundation Trust





- In Month 3 the Trust is currently running below its NHSI cost ceiling for agency staff.

Trust NHS and Other Clinical Income Summary
Year to Date for the 3 months ending 30 June 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

	2017/18 YTD								2016/17 YTD					
	Income				Activity				Income			Activity		
	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan	Actual *	Variance	Variance %	Actual £'000	Variance 17/18 to 16/17 £'000	Variance 17/18 to 16/17 %	Actual	Variance 17/18 to 16/17	Variance 17/18 to 16/17 %
Day case	**6,175**	**6,021**	**(153)**	**-2.5%**	**5,159**	**4,495**	**(664)**	**-12.9%**	**6,240**	**(219)**	**-3.5%**	**5,298**	**(803)**	**-15.2%**
Elective	14,247	15,915	1,668	11.7%	3,334	3,285	(49)	-1.5%	14,183	1,733	12.2%	3,306	(21)	-0.6%
Elective Excess Bed days	711	641	(70)	-9.9%	1,458	1,176	(282)	-19.4%	737	(96)	-13.1%	1,444	(268)	-18.6%
Elective	**14,958**	**16,556**	**1,598**	**10.7%**					**14,919**	**1,636**	**11.0%**			
Non Elective	4,241	4,301	60	1.4%	402	414	12	3.0%	3,286	1,015	30.9%	393	21	5.3%
Non Elective Excess Bed Days	505	750	245	48.5%	1,583	1,362	(221)	-13.9%	792	(42)	-5.3%	1,567	(205)	-13.1%
Non Elective	**4,746**	**5,051**	**305**	**6.4%**					**4,077**	**974**	**23.9%**			
Outpatient	**9,535**	**9,651**	**116**	**1.2%**	**38,229**	**38,178**	**(51)**	**-0.1%**	**9,362**	**289**	**3.1%**	**36,464**	**1,714**	**4.7%**
Undesignated HDU Bed days	1,200	1,223	23	1.9%	1,149	1,172	23	2.0%	1,147	76	6.6%	1,099	73	6.6%
Picu Consortium HDU	959	933	(27)	-2.8%	906	977	71	7.8%	866	66	7.6%	897	80	8.9%
HDU Beddays	**2,160**	**2,156**	**(4)**	**-0.2%**	**2,055**	**2,149**	**94**	**4.6%**	**2,014**	**142**	**7.1%**	**1,996**	**153**	**7.7%**
													0	
Picu Consortium ITU	8,714	8,191	(523)	-6.0%	2,731	2,865	134	4.9%	6,598	1,593	24.1%	2,704	161	6.0%
PICU ITU Beddays	**8,714**	**8,191**	**(523)**	**-6.0%**	**0**	**2,865**	**134**	**0.0%**	**6,598**	**1,593**	**24.1%**	**2,704**	**161**	**6.0%**
Ecmo Bedday	242	421	179	73.9%	44	83	39	87.6%	250	171	68.3%	46	37	80.4%
Psychological Medicine Bedday	283	322	39	13.7%	702	798	96	13.7%	262	60	22.9%	650	148	22.8%
Rheumatology Rehab Beddays	375	437	62	16.4%	660	629	(31)	-4.6%	270	167	61.8%	475	154	32.4%
Transitional Care Beddays	722	661	(61)	-8.4%	498	456	(42)	-8.4%	752	(91)	-12.1%	519	(63)	-12.1%
Total Beddays	**1,623**	**1,841**	**219**	**13.5%**	**1,904**	**1,966**	**62**	**3.3%**	**1,534**	**307**	**20.0%**	**1,690**	**276**	**16.3%**
Packages Of Care Elective	**1,844**	**2,134**	**290**	**15.7%**					**1,803**	**330**	**18.3%**			
Highly Specialised Services (not above)	7,472	7,562	90	1.2%					7,257	305	4.2%			
Other Clinical	5,956	6,509	554	9.3%					8,108	(1,599)	-19.7%			
Outturn adjustment	0	30	30	0%					(470)	500	-106%			
STF Funding	808	808	0	0%					0	808	0%			
Pricing Adjustment	743	1,150	407	54.8%					0	1,150	0%			
Non NHS Clinical Income	1,941	2,838	897	46.2%					2,238	600	27%			
NHS and Other Clinical Income	**66,674**	**70,498**	**3,824**	**5.7%**					**63,681**	**6,817**	**10.7%**			

*Activity = Billable activity
*Activity is an extract from SLAM taken at Day 1 and is subject to changes following coding completion

Elective/Non Elective

- Elective activity is down 49 spells and is driven by Nephrology that is billed separately via Packages of Care.
- Overall Elective Income is exceeding plan by £1.7m of which Cardiac Surgery £0.6m, Haematology £0.4m, Orthopaedics £0.4m & Spinal £0.3m are the main drivers.

Day case

- Activity variance is driven by Haematology, however these are low value cases, so the adverse income variance is Metabolic and Radiology.

ITU Bed Days

- Critical care activity below trend, average of 13 beds occupied in month compared average of 21 over last 12months

Other Clinical

- This includes income for CQUIN and the target for the local pricing review.
- CQUIN income is below plan to take account of risk to full delivery. 85% CQUIN delivery is assumed here and subject to review.

Trust Inpatient and Outpatient Activity
Year on Year trend analysis

Great Ormond Street Hospital for Children NHS Foundation Trust

Prior Year 2016/17													Activity Analysis	Current Year 2017/18				Change YOY	% Change YOY	Current Year Trend
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD		Apr	May	June	Total YTD			
													Inpatients							
													Number of Discharges							
2,082	2,061	2,229	2,040	2,162	2,031	1,972	2,075	1,799	2,129	1,949	2,204	24,733	Day Case	1,788	2,132	2,140	6,060	(312)	-4.9%	
													Overnight:							
1,155	1,153	1,256	1,248	1,170	1,177	1,101	1,195	1,064	1,083	1,142	1,269	14,013	Elective	1,083	1,197	1,236	3,516	(48)	-1.3%	
64	67	65	63	59	75	62	71	75	75	51	73	800	Non Elective	75	83	100	258	62	31.6%	
164	175	178	152	158	169	156	188	214	197	163	160	2,074	Non Elective (Non Emergency)	170	168	175	513	(4)	-0.8%	
157	171	182	188	181	180	165	186	159	194	189	204	2,156	Regular Attenders	176	194	194	564	54	10.6%	
3,622	3,627	3,910	3,691	3,730	3,632	3,456	3,715	3,311	3,678	3,494	3,910	43,776	Total Discharges	3,292	3,774	3,845	10,911	(248)	-2.2%	
													Beddays							
760	733	841	760	829	847	736	748	651	793	703	775	9,176	Day Case	639	708	724	2,071	(263)	-11.3%	
0	0.36	0.38	0.37	0.38	0.42	0.37	0.36	0.36	0.37	0.36	0.35	0.37	Day ALOS	0.36	0.33	0.34	0.34	(0.02)	-5.1%	
													Overnight:							
5,425	5,852	5,596	5,827	5,571	5,473	5,449	5,895	5,084	5,270	5,201	5,949	66,592	Elective	5,410	5,909	5,526	16,845	(28)	-0.2%	
712	619	556	484	483	449	479	462	528	591	622	858	6,843	Non Elective	710	620	653	1,983	96	5.1%	
2,084	2,153	2,184	2,229	2,298	2,125	2,257	2,041	2,216	2,291	1,855	1,907	25,640	Non Elective (Non Emergency)	2,135	2,253	2,238	6,626	205	3.2%	
85	98	111	113	108	110	97	109	113	130	121	118	1,313	Regular Attenders	104	113	110	327	33	11.2%	
8306	8,722	8,447	8,653	8,460	8157	8,282	8,507	7,941	8,282	7799	8,832	100,388	Total Overnight Beddays	8,359	8,895	8,527	25,781	306	1.2%	
6.01	6.25	5.64	5.91	6.10	5.74	6.28	5.85	5.87	6.11	5.75	5.88	5.94	Overnight ALOS	6.29	6.14	5.64	6.01	0.0	0.0%	
													Midnight Census (ON Bed days)							
4,452	4,853	4,543	4,785	4,557	4,472	4,523	4,866	4,192	4,330	4,244	4,890	54,707	Elective	4,552	4,950	4,574	14,076	228	1.6%	
643	557	494	428	424	373	425	403	458	508	559	751	6,023	Non Elective	636	569	595	1,800	106	6.3%	
1,891	1,973	1,980	2,040	2,105	1,928	2,076	1,854	2,011	2,033	1,687	1,733	23,311	Non Elective (Non Emergency)	1,952	2,084	2,073	6,109	265	4.5%	
		0	1									1	Regular Attenders			1	1	1	100.0%	
6,986	7,383	7,017	7,254	7,086	6,773	7,024	7,123	6,661	6,871	6,490	7,374	84,042	Total	7,140	7,603	7,243	21,986	600	2.8%	
233	238	234	234	229	226	227	237	215	222	232	238	230	Average ON Beds Utilised	238	245	241	725	20	2.8%	
													Critical Care Beddays							
359	397	299	337	346	345	327	474	368	446	414	498	4,610	Elective	336	315	354	1,005	(50)	-4.7%	
196	132	82	90	120	63	62	71	80	162	163	233	1,454	Non Elective	199	198	98	495	85	20.7%	
482	468	596	575	582	612	627	487	625	509	415	425	6,403	Non Elective (Non Emergency)	551	570	561	1,682	136	8.8%	
1,037	997	977	1,002	1,048	1,020	1,016	1,032	1,073	1,117	992	1,156	12,467		1,086	1,083	1,013	3,182	171	5.7%	
35	32	33	32	34	34	33	34	35	36	35	37	34		36	35	34	105	6	5.7%	
													Outpatients							
19,893	19,859	21,229	20,293	20,177	22,067	21,051	23,343	18,434	22,023	21,134	24,132	253,635	Outpatient Attendances (All)	18,367	22,088	21,575	62,030	1,049	1.7%	
3,824	3,872	4,125	3,879	3,840	4,169	3,913	4,305	3,341	4,111	3,976	4,381	47,736	First Outpatient Attendances	3,493	4,241	4,201	11,935	114	1.0%	
16,069	15,987	17,104	16,414	16,337	17,898	17,138	19,038	15,093	17,912	17,158	19,751	205,899	Follow Up Outpatient Attendances	14,874	17,847	17,374	50,095	935	1.9%	
4.2	4.1	4.1	4.2	4.3	4.3	4.4	4.4	4.5	4.4	4.3	4.5	4.3	New to Review Ratio	4.3	4.2	4.1	4.2	0.1	0.0%	

Inpatients:

The total number of inpatients discharged has decreased by 2.2% in the first 3 months of 2017/18. The most significant area of growth has been in Non Elective inpatients (31.6%)

Overnight bed days have increased by 1.2% as would be expected given the growth in inpatient elective activity. Average length of stay is unchanged from the same period in 2016/17.

Overnight beds utilised has increased slightly by 2.8%.

Outpatients:

The total number of outpatients has increased by 1.7% and new to review ratio is 4.2.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 27 July 2017	
Better Value 2017/18 **Summary of the programme and governance arrangements** **Submitted by:** Jon Schick Programme Director	**Paper No: Attachment K**

Aims / summary

This report summarises the 2017/18 Better Value Programme and its associated governance arrangements. The programme is formed from a wide range of local and new cross-organisational work streams, to support delivery of the Trust's strategic objectives and operational plan. Regular updates are provided routinely to Board subcommittees, in particular Finance and Investment and the Quality and Safety Assurance Committee, as well as being incorporated within finance reports to the Trust Board meeting itself. As we move increasingly into in-year delivery, future Better Value reports to the Trust Board will include exception reports on overall programme delivery plus a rolling series of short stocktakes to explain in more detail the key deliverables and progress made on individual enabling work streams.

Action required from the meeting

To note the attached summary and governance arrangements for the Better Value programme.

Contribution to the delivery of NHS Foundation Trust strategies and plans

This Programme, integrating a wide range of significant cross-cutting work streams is a significant contributor to the Trust's overall strategy and plans.

Financial implications

Delivery of the Programme, especially the Better Value (P&E) component, is important in the context of the Trust's control total and sustainability funding, and will help to avoid the potential of consequent more difficult efficiency targets in the future.

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

Senior Responsible Owners for each of the enabling work streams, with support provided from the Programme Office.

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

As above, with overall coordination by the Programme Office reporting to the Deputy Chief Executive.

Great Ormond Street Hospital for Children NHS Foundation Trust

Better value 2017/18

Trust Board July 2017

Summary of the programme and governance arrangements

Jon Schick
Programme Director

Great Ormond Street Hospital for Children NHS Foundation Trust

Contents

Supporting the strategy

The Better Value programme supports delivery of the Trust's refreshed strategy.

In particular, activities to ***deliver efficient care in order to generate a sustainable surplus and allow us to invest in our transformation*** form one of the key deliverables under the strategy objective to achieve best possible outcomes through providing the safest, most effective and efficient care.

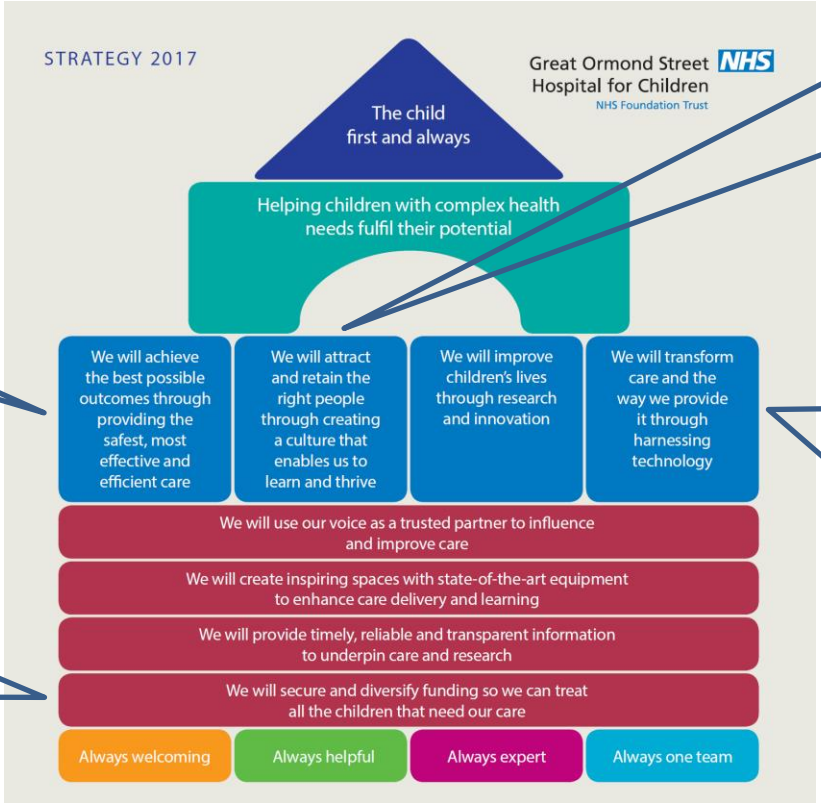
In addition, aspects of the Better Value programme, and the work of the Programme Office, will support the achievement of other strategy priorities and enablers, with a few examples highlighted overleaf:

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

Supporting the strategy

Better value is a key deliverable under this heading, both in terms of maximising funds available to the Trust overall, but also with key related work streams such as those to optimise flow

The cross cutting workforce programmes must support delivery of this objective. And Programme Office work to review, share best practice and benchmark will help support GOSH to be a continually learning organisation



The Better Value programme includes some immediate ICT-enabled improvement opportunities as well as laying the groundwork for more transformational change that will be delivered through EPR implementation

The cross cutting Better Value programme to increase commercial and international funding will be an important contributor to this enabler

The success of the Programme Office and its interactions will require it to demonstrate the Always Values

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

Overall programme 2017/18

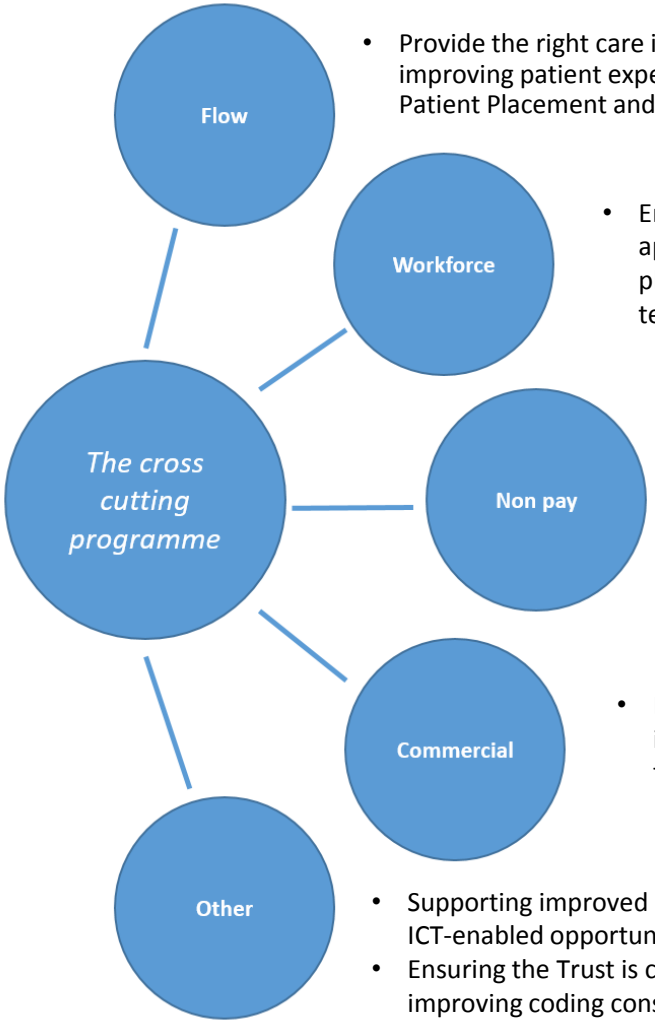
This table summarises the current breakdown of the Better Value programme against the original £15m target built into the 2017/18 Operating Plan.

Each scheme has also been assessed to given an indication of delivery confidence of these opportunities. Currently, 80% (c£12m) of the proposed savings are considered to have high or medium delivery confidence ratings, the remaining c£3m of lower confidence schemes being largely based in the cross-cutting programme.

The Programme Office is therefore continuing to focus attention to higher risk areas, working with SROs to identify mitigations or alternative schemes

Theme	Scheme	Operating plan target £,000	Current plan and schemes in development £,000
Flow	Outpatients Theatres Patient placement/beds	£250 £1,000 £1,000	£195 £1,007 £1,000
Non pay	Procurement, inventory, supply chain Medicines management	£2,000 £589	£2,000 £589
Workforce	Medical Other clinical staff Other workforce schemes	£235 £790 £480	£235 £463 £575
Other	Coding ICT enabled efficiency Agency invoice processes Commercial and IPP	£475 £275 £550 £1,495	£475 £300 £300 £2,140
Total cross cutting		**£9,139**	**£9,279**
Local 1% schemes	Local P&E/CIPS identified by divisions/directorates	£3,138	£3,349
P&E carry forwards	Brought forward from schemes commenced part way through last year	£2,723	£2,459
Overall total		**£15,000**	**£15,087**

Cross cutting workstreams



- Provide the right care in the right place at the right time, improving patient experience, reducing cancellations. Theatres, Patient Placement and Outpatients improvement programmes

- Ensure patients receive care from the right number of appropriately qualified staff using e-rostering and aligning job plans to meet service requirements. Reducing reliance upon temporary staff

- Maximising funds for front line care through a significant procurement programme

- Developing a range of strategic partnerships, offering international fellowships and offering increased services to increase market share

- Supporting improved referrer, clinician and patient experience through ICT-enabled opportunities
- Ensuring the Trust is correctly charging for the activity it undertakes by improving coding consistency and depth

Example cross cutting schemes

Theme	Example cross cutting schemes
Flow	• Theatres programme to identify savings and absorb growth through improved list utilisation • Patient placement programme to ensure capacity matches demand and reduce short notice cancellations, refused admissions and non-clinical delays
Non pay	• Improved procurement, tendering and catalogue management, supply chain and inventory management transformation programme, and improved contract management • Drug price reductions and therapeutic substitutions
Workforce	• Reviews of payments and allowances • Improved roster policy adherence, review of overtime and out of hours payments • Moving agency staff to substantive contracts, reducing admin agency usage • New eRostering system
Other	• Improved depth and completeness of clinical coding • Increased use of collaborative technology, digitisation of paper pathology records, rollout of MS365, introduction of new SMS messaging system • Pursuing new opportunities for IPP collaboration and fellowships, increased market share

Great Ormond Street Hospital for Children NHS Foundation Trust

Developing the programme

The Better Value planning process:

- Divisions set a target of 1% reduction – and worked with their local heads of service and general managers to identify schemes. Schemes subject to discussion/sign off during business planning challenge sessions with Deputy CEO and CFO
- Shift of focus towards larger cross cutting and transformational schemes each with executive sponsors responsible for ensuring that schemes are well-specified and any risks or blockages to delivery are identified and addressed
- Cross cutting themes and targets agreed at executive level and bespoke programme arrangements set up (eg workforce steering group chaired by the Director of HR & OD)
- KPIs to evidence delivery of cross-cutting schemes identified – for use in-year by a joint PMO/finance review team as part of their assurance processes to the executive and Board
- Clearly identified milestones enable proactive tracking by the Programme Office. Project documentation completed to provide clarity about who is responsible for delivery. Work being completed during Q1 to ensure all schemes are identified in budgets at cost centre and account code level
- Quality Impact Assessments undertaken for all applicable schemes, overseen by the QIA Panel jointly chaired by the Chief Nursing Officer and Medical Director
- Identification of new schemes no longer being seen as an annual exercise, with continual priority being given to scoping new opportunities in-year for potential delivery in future years, or for more rapid implementation if required to mitigate slippage in other areas

Programme documentation

The programme is supported by comprehensive information to underpin the programme, ensuring clarity about constituent schemes, responsibilities and timescales for delivery, associated risks and impacts.

Milestone trackers are prepared for each division to summarise the key deliverables and associated timescales and support in-year work to manage delivery.

The Programme Office approach has been to learn from best practice elsewhere and from previous experience at GOSH, aiming for a sensible but proportionate level of documentation, whilst avoiding the requirement for excessively detailed plans which provide little additional assurance.

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

Programme documentation

Project Outline Documents (PODs) for all schemes:

- Overall scheme owner
- Rationale for the scheme
- Key milestones and responsibilities for delivery
- Any resources required to implement
- Interdependencies
- Financial benefits and phasing
- Risks to delivery

Quality impact assessments (QIAs) required for any scheme that could result in changes to skill-mix or headcount, service redesign or changes to a business process or service delivery:

- Engagement as part of scheme development
- Potential beneficial or adverse impact on quality with mitigating actions and controls where required
- Quality indicators to monitor impact (including current KPI value and trigger point for escalation)
- Divisional Clinical Chairs and Corporate Directors have devolved responsibility from the QIA Panel to sign off QIAs for their areas unless a scheme requires escalation to the Panel (see below)
- Schemes must be escalated to the QIA Panel if they impact on other divisions or parts of the hospital, pose Trust-wide risks, contain a quality risk score of 12 or above, or any corporate scheme which could have potential clinical quality or patient safety impacts

Current document sign off

PODs	PODs signed off	PODs nearing sign off	PODs under development
'1%'programme	71	6	2
Cross cutting	19	11	3
Total	**90**	**17**	**5**

QIAs	QIAs signed off	QIAs nearing sign off	QIAs under development
'1%'programme	26	1	2
Cross cutting	12	10*	7
Total	**38**	**11***	**9**

** This figure includes 7 QIAs all related to one cross cutting scheme (Theatres) where individual QIAs are being prepared for each of the under-pinning work streams, rather than just one for the whole programme*

Quality & risk management

From 2016/17, in addition to the existing QIA process to accept schemes into the programme, we began a new process of post-implementation review and also of tracking key quality indicators which could provide early warning of impacts from implementation of the programme.

These processes are overseen by the Quality and Safety Assurance Committee. In addition to providing assurance to the Committee, they are aimed at further embedding local ownership and accountability for successful programme delivery, as well as providing an opportunity to identify and learn lessons to inform future programme implementation.

Great Ormond Street Hospital for Children NHS Foundation Trust

Governance and reporting

Business plan weekly steering group

- Monthly update on Better Value programme delivery
- Exception reports and identification of areas of emerging risk requiring mitigating action
- Oversight of KPIs for routine monitoring (eg to track delivery of cross cutting schemes)

EMT (Better Value Programme Board)

- Regular discussion on programme delivery
- Exception reports on achievement against key milestones for larger and cross cutting schemes, with mitigating actions identified if required
- Agreement of any in-year changes to the programme
- Oversight of actions to continue to develop the programme for future years

Quality & Safety Assurance Committee

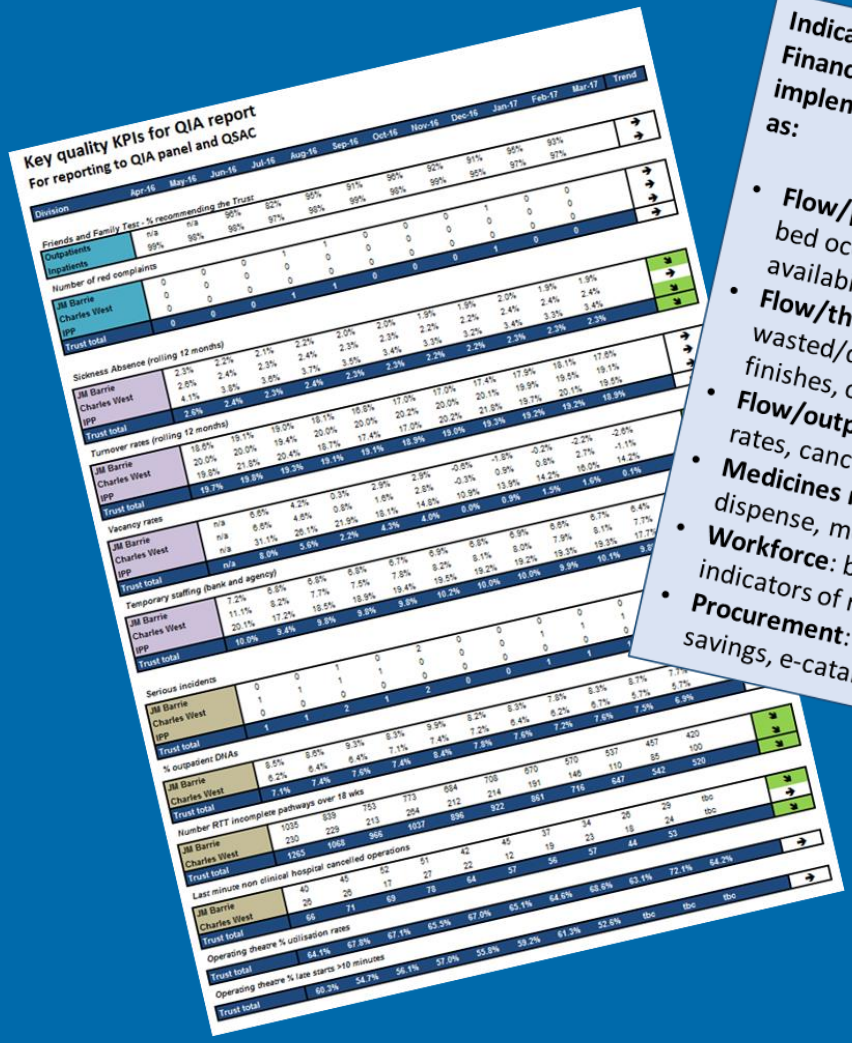
- Feedback from the QIA Panel
- Tracking of quality KPIs, identification of any areas of concern and proposed actions to address
- Post implementation reviews

Finance & Investment Committee

- In month, cumulative and forecast outturn position
- Exception reporting of areas of slippage and contributing reasons, plus agreed recovery actions
- Presentations of larger/cross cutting programmes to provide assurance of scheme specification/delivery

Great Ormond Street Hospital for Children NHS Foundation Trust

Performance and quality KPIs



Indicators used by the Programme Office and Finance to track cross cutting scheme implementation will include measures such as:

- **Flow/patient placement**: lengths of stay, bed occupancy, cancellations due to bed availability
- **Flow/theatres**: utilisation rates, % wasted/dropped sessions, late starts, early finishes, cancellations
- **Flow/outpatients**: did not attends, follow up rates, cancellations
- **Medicines management**: time taken to dispense, medication errors, cost per script
- **Workforce**: bank and agency spend, indicators of roster policy compliance
- **Procurement**: delivery of item-specific savings, e-catalogue compliance rates

In addition to milestone and finance tracking information, assurance of programme delivery and quality impact will also be informed by a range of quality indicators routinely reported to QSAC, plus additional KPIs being developed to track delivery of the cross cutting programme

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

Programme office support

Business partnerships to support Better Value

- The Programme Office team offers advice and support to scope new opportunities and help take forward major schemes requiring extra project management capacity. The team offers an in-house "consultancy" service to support a wide range of projects across the Trust – current examples including:

  - *Productive operating theatres, patient flow and bed management*
  - *Medicines management*
  - *Procurement*
  - *Diagnostic tests and investigations*
  - *Implementation of roster improvements*
  - *PICB*

- Working in partnership with other teams to coordinate improvement activity across the Trust, such as QI and EPIC/EPR implementation
- Working closely with nominated clinicians to share skills and learning and benefit from their experience to support delivery in specific areas with initial projects including:

  - *Hospital at night/handover*
  - *Translation/interpretation services*

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **27th July 2017**	
Medical Revalidation Annual Board report and statement of compliance **Submitted by:** **Dr Andrew Long, Associate Medical Director**	**Paper No: Attachment L**
Aims / summary This report is presented to the Board for assurance that the statutory functions for medical revalidation are being appropriately discharged by the Responsible Officer as assessed against national requirements, and highlights areas of risk and for improvement.	
Action required from the meeting The Board is asked to note the contents of the report, approve the action plan and support the recommendation to sign off the statement of compliance.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Appraisal is an important tool in improving quality and outcomes.	
Financial implications The Trust has a statutory responsibility to provide adequate resources so that the responsible officer can discharge their duties appropriately. The costs are of maintaining an appropriate IT system with support for adequate number of annual licences and 360 feedback, adequate support staff and AMD/RO time. Since there is no budget identified, this places the systems at risk and prevents adequate quality assurance, training and support for doctors within the organisation. There is an urgent need to invest further resources (administrative time, external quality assurance) to ensure that the system is fit to meet national standards and to support the demands of revalidation which will increase significantly during the next two years.	
Who needs to be told about any decision? Higher Level Responsible Officer	
Who is responsible for implementing the proposals / project and anticipated timescales? Associate Medical Director/Responsible Officer	
Who is accountable for the implementation of the proposal / project? Dr Andrew Long, Associate Medical Director/ Responsible Officer	

Annual Board Report and Statement of Compliance: Revalidation of Doctors
(Based on NHS England Revalidation Team Template)

1. Purpose

This report is presented to the Board to provide assurance that the statutory functions of the Responsible Officer are being appropriately fulfilled; to report on performance in relation to those functions; to update the Board on progress since the 2015 annual report (no report to Board in 2016); to highlight current and future issues; and to present action plans to mitigate potential risks.

2. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. It is based on all doctors undertaking an annual appraisal that includes information defined by the GMC.

The purpose of medical revalidation is to assure patients and the public that doctors are up to date and fit to practice.

Each doctor must have a Responsible Officer who must oversee a range of processes including annual appraisal, and who makes, at five yearly intervals, a recommendation to the GMC in respect of the doctor's revalidation.

The Responsible Officer is appointed by the Board of an organisation termed a Designated Body, to which the doctor is linked by a Prescribed Connection. This link is created when a contract of employment, substantive, locum or honorary, is agreed between the doctor and the Designated Body.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that executive teams will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors
- Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation for doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications, experience and language skills appropriate to the work performed

It should be noted that compliance with these regulations also forms part of the Care Quality Commission's surveillance model.

The last report to the Trust Board was submitted in July 2015 for the year 2014-15. Since this date there have been significant changes in both the way in which revalidation is managed internally and externally and the types of challenges faced. The most important of these is that the implementation phase of revalidation has been completed, with a recommendation made in respect of the revalidation of every doctor who held a licence to practice as of 4th December 2012. Hence the majority of doctors in the UK are now in their second cycle of revalidation.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

3. Governance Arrangements

The current Responsible Officer (Andrew Long, Associate Medical Director) was appointed on 1st January 2017 in line with statutory requirements. He works closely with the Deputy Director for HR and OD and the Assistant Director for Human Resources, meeting weekly to discuss current and new activity and meeting monthly with the Medical Director and Director of HR and OD. Outside these regular meetings, supported by the Deputy Medical Director and other Associate Medical Directors, there is an effective Decision Making Group (DMG) to identify early concerns with clinician performance and ensure that potential problems are identified early and action taken where appropriate. Several individuals within the organisation, including those identified above, have undertaken training in Maintaining High Professional Standards (MHPS) to ensure that experienced individuals are involved at an early stage when concerns are raised. There is a clear and transparent link to the Executive Incident Review Meeting (EIRM) where potential Serious Incidents (SI's) are reviewed by the Medical Directors team to identify where there are concerns about individual clinical practice.

The organisation is subject to external quality control processes in two ways:

1) There is regular organisation audit conducted through NHS England requiring quarterly returns of audit activity which contribute to an Annual Organisation Audit (AoA) where organisational activity for appraisal and revalidation are benchmarked against similar organisations.
2) There is an Independent Verification Visit carried out by NHS England which examines the internal governance arrangements and offers external advice on systems and processes which support appraisal and revalidation.

As a designated body, GOSH submitted an annual organisational audit to NHS England in May 2017 (Appendix 2). We responded "no" to 3 questions:

1.6 In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.
This is addressed in the action plan at the end of this paper.

1.12 The designated body has commissioned or undertaken an independent review of its processes relating to appraisal and revalidation.
This is addressed in the action plan at the end of the paper.

2.4 There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template
This is addressed in the action plan at the end of the paper.

The last Independent Verification Visit (IVV) took place in February 2015 (Appendix 3). It is not clear what action took place as a result of the visit, however NHS England wrote to the Trust in March 2017 requesting a response in the form of an Action Plan (Appendix 4). The completed Action Plan was resubmitted to NHS England in May 2017, after discussion with the Medical Director and actions recommended are embedded within the current action plan at the end of this paper.

4. Policy and Guidance

The Trust has had appropriate policies in place for Medical Appraisal and Revalidation for Consultant staff as well as for non-consultant medical staff. They were reviewed in 2016, approved by the LNC and some changes have been requested by the Policy Advisory Group in early 2017. However, it is hoped that a fresh view might be taken as part of an external quality review (see action plan) before the final version is approved.

The Responsible Officer actively contributes to London Region Responsible Officer Network meetings and seeks advice and support from other RO's as well as taking advice internally from the Medical Director and DMG supported by Human Resources.

5. Process of Medical Appraisal and Revalidation

a. Appraisal Performance Data

For 335 consultants (including honorary consultants) appraisal rates for 2016-17 were 88% and almost meets the national target (90%). This is considerably better than 2015-16 when the consultant appraisal rate was 74.3% (local and national comparators 89%) but not as good as 2014-15 (90% cf 87%) In 2013-14 the consultant appraisal rate was 86%. For the 39 consultants in 2016-17 where an appraisal was not completed there was a reported, justified reason (eg maternity leave, long term sickness) in 7 individuals, although personal contact by the current RO to the majority of consultants with 'unapproved, incomplete or missing' appraisal documentation suggests that a small additional number were due to health issues but the majority were due to IT difficulties in using the current appraisal portfolio (PReP) efficiently. The majority of issues with consultant staff have been resolved, although a small number of consultants are still not engaging with their responsibilities under the current system and it is the intention to request that the GMC issue 'Non-engagement' warning letters (REV06 letters – Appendix 5) to consultants that fail to fulfil their contractual commitments.

For SAS grades appraisal rates were 100%.

Although accurate figures are not available for other non-consultant grade doctors (Trust Fellows); where they were required to provide the RO with evidence of appraisals for the purposes of revalidation, most were able to do so in a timely manner, although many needed considerable administrative support. It is the intention to extend the current ePortfolio system (PReP) to all Trust Fellows (and equivalent) as per action plan.

Compliance by Division

Count of Employee	Column Labels			
Row Labels	No	Yes	Grand Total	
271 4AIPP - International		2	2	100%
271 4CDIV1 - West Division	32	130	162	80%
271 4CDIV2 - Barrie Division	25	182	207	88%
271 4DMED - Medical Directorate		4	4	100%
271 4DRAD - Research & Innovation		1	1	100%
Grand Total	**57**	**319**	**376**	84.5%

It will be noted that the figures within the Divisions include Trust Fellows that are on the PReP system giving a higher number of doctors with lower completion rates (84%). There is a minor distortion in the total numbers because consultants annual appraisal cycles do not necessarily fit within the set timeframe (April – June).

Nationally the appraisal rate has risen from 85% in 2015-16 to 91%. For London the average appraisal rate across all organisations is 88% and for 40 NHS Trusts is 89%. There were 9 Trusts in London that had an appraisal rate below 85% and the reported figure of 84% in the AoA places GOSH in the bottom quartile for similar organisations.

b. Appraisers

For 2016-17 the Trust had 125 appraisers who had been trained although many of these had been trained over three years previously. 32 appraisers had refreshed their appraisal training (required every 3 years) using an elearning module, however there were insufficient funds to provide user licences for all those that needed training updates. Of the 125 appraisers, 30 had not appraised anyone within the previous year's cycle (despite 6 of these having undertaken refresher training). 19 appraisers had only appraised one individual however 5 individuals had appraised 10 or more appraisees. The recommendation is that every trained appraiser should appraise at least 3 and no more than 6 doctors within each cycle. The same appraiser/appraisee relationship is only permitted for a maximum of three cycles. Some clinical services have a disproportionate appraiser-appraisee ratio (ie too few appraisers leading to excessive workload for a few individuals)

c. Quality Assurance

External assessment of appraisal policies and procedures is a recommendation and informs NHS England's Annual Organisational Audit.

Formal quality assurance of the content and output of appraisals was planned to start in 2014-15 but was not undertaken due to lack of capacity in the appraisal team although it was hoped that this would start in the following year. This is discussed in the action plan. Discussion at regional Responsible Officer and appraisal lead meetings suggest that a number of organisations are developing a robust QA system at the current time.

d. Revalidation and Appraisal Resources

Currently the appraisal and revalidation support team consists of the Associate Medical Director/RO (2 PA's) and 0.5 WTE Band 6 Medical HR Services Team Leader/Revalidation Support Assistant. There is no specific budget identified for training appraisers, for External Quality Assurance and limitations on the number of licences for the ePortfolio (PReP) system and for Edgecumbe 360 degree feedback (patients and colleagues).

6. Revalidation Recommendations

For 2016-17 34 revalidation recommendations were made on 48 doctors, with 14 deferral recommendations. This gives a deferral rate of 29% which is higher than the national average and reflects the doctors that are in the last 'round' of revalidation before the cycle starts again (ie doctors that were revalidated in 2012-13 who were the first to be revalidated will be seeking recommendation in 2017-18). The numbers in 2016-17 are also significantly lower than the two previous years (220 in 2015-16, 198 in 2014-15), however the numbers will increase in 2018 as the next revalidation cycle starts. This will have implications for administrative support and is discussed in the action plan.

7. Recruitment and engagement background checks

Robust pre-employment checks are conducted on all candidates as per national guidance. A lot of work has been undertaken by HR to strengthen the process around honorary contract holders and ensure full checks are made. One of the current challenges experienced by the organisation is in the GMC Use of English assessment (IELTS) as many of our overseas doctors, primarily from European origin, experience difficulty, particularly in the written communications section. We have therefore implemented 'in house' assessments

of written communications and the GMC allows us to employ doctors who have not reached the required standards in all the component parts of IELTS.

8. Monitoring Performance

The hospital has appropriate mechanisms in place for monitoring the professional performance of doctors. As required by the GMC, never events involving doctors are reported to them and also to NHS England.

9. Review of previous Action Plan (2014-15)

Issue	Action	Responsible	By	Achieved
Inadequate admin support	Review admin support (amount and line management) for short and long term	Dep Dir HR/RO	31 08 15	No
Ensure appraisal lead/RO has sufficient time in job plan	Review with MD	App Lead/RO/MD	31 08 15	No
Process to ensure key items of information are included in the appraisal portfolio	Work with CG team to implement a system of proactive uploading of information by appraisal administrator into appraisal portfolio	App Lead	31 10 15	No
Recording of non-training grade Dr appraisals	Develop more robust system to prompt appraisals and capture	PGME Manager with DME and RO	31 12 15	No
Quality Assurance of appraisal content and output	Appraisal lead to develop and undertake quality assurance process	RO	30 11 15	No

10. Monitoring Performance, Responding to Concerns and Remediation

Concerns about a doctor's performance are managed under the Trust's 'Conduct Capability, III Health and Appeals Policies and Procedures for Medical Practitioners'. Issues are mainly dealt with by the Head of Clinical Service, supported, where appropriate, by the Divisional Director and/or Divisional Chair. Escalation to the Medical Director and/or AMD for Professional Development/RO takes place after discussion and where a more formal process is deemed necessary.

Monthly review meetings take place between the Medical Director, AMD/RO, Director of HR and OD, Deputy Director of HR/OD and Assistant Director of HR to manage the more serious cases. Where appropriate a Non-Executive Director is assigned to each case to monitor compliance with process and ensure a timely resolution. A report on exclusions and involvement in such processes is presented periodically to the Trust Board for information.

The Medical Director, AMD/RO, Deputy Director for HR and OD and the Assistant Director for HR meet with the GMC Employment Liaison Advisor every four months to discuss cases which have been escalated or referred to the GMC.

The AMD/RO meets regularly with the Head of Medical HR & PGME Services and the Medical HR Services Team Leader/Revalidation Support Assistant to discuss Revalidation recommendations and issues related to appraisal.

11. Risks and Issues

As previously outlined the appraisal and revalidation support team is very lean and requires more resources to be identified. The amount of clinician time available and administrative support (and expertise) in using the eportfolio system, supporting the appraisal process, recruiting and training appraisers is currently inadequate. It compares poorly with other Trust of a similar size and complexity and is likely to become unsustainable when the revalidation cycle returns to its expected level in 2017-18. A significant amount of administrative time is also necessary to populate the PReP database with all non-consultant doctors so that there is a single system for recording and managing appraisal rates and supplying evidence for revalidation recommendations.

At the current time, the appraisal system within Great Ormond Street relies on individual doctors choosing their own appraisers. As previously mentioned, there is a paucity of trained appraisers within some specialty areas resulting in an unequal burden of time spent undertaking appraisal by a small number of clinicians. There is no specific time commitment made available within job plans for clinicians to undertake this important process. There is evidence to support that there is a variety of commitment to the appraisal process by both appraisers and appraisees. Because there is no external quality assurance in place there is the risk that some appraisees might choose their appraisers for expedience rather than to ensure a high quality appraisal experience. Many neighbouring Trusts choose to have a system where appraisers are appointed, rather than chosen, which leads to an improvement in appraisal quality and commitment.

In many Trusts within London and the rest of the UK a role of Lead Appraiser has been established at a Division/Directorate level. This helps to manage the appraisal process at a Clinical Service level and allows a level of commitment locally to support the process.

Many consultants maintain honorary contracts with GOSH after retirement. It is an expectation from the GMC that annual appraisal should continue to take place as long as a clinician holds a License to Practice. Doctors on honorary contracts are extremely difficult to manage even though they retain a connection with GOSH as their designated body. It is the view of the AMD/RO that this should be managed at a Divisional level.

Those in joint academic/clinical roles are required to undertake a joint appraisal between their clinical (NHS) representative and their academic representative under the Follett principles. This adds complexity to the appraisal process however it enables their academic commitment to be appropriately recognised. Historically those in senior management roles have requested a joint appraisal with representatives from the Executive Management Team. This has been more difficult to implement recognising the balance between clinical and managerial commitments and informing the individual Personal Development Plan to meet Trust strategic objectives.

12. Corrective Actions, Improvement Plan and Next Steps

Issue	Action	Responsible	By
Inadequate administrative support	Review admin support (amount and line management) for short and long term	Dep Dir HR/AMD/RO	31 08 17
Ensure AMD/RO has sufficient time in job plan	Review with MD	AMD/RO/MD	31 08 17
Ensure that there are adequate numbers of trained appraisers	Work with Executive Management Team to ensure that appraisers are appropriately trained and given time within job plans	AMD/RO/MD	31 12 17

Ensure that appraisee/appraiser relationships are consistent	Work with Executive Management Team to review process of facilitating appraisee/appraiser matching	AMD/RO/MD	31 12 17
Process to ensure key items of information are available to be included in the appraisal portfolio	Work with CG team to implement a system of proactive uploading of information by appraisal administrator into appraisal portfolio	AMD/RO	31 10 17
Recording of non-training grade doctor appraisals	Develop more robust system to prompt appraisals and capture revalidation information	Head of Medical HR & PGME Serv./AMD/RO	31 12 17
Quality Assurance of appraisal content and output	AMD/RO to develop and undertake quality assurance process	AMD/RO	30 11 17
External Quality Assurance	AMD/RO to commission an independent review of its processes relating to appraisal and revalidation	AMD/RO	30 11 17
Identifying movement of doctors in non-training grade posts	Work with PremierIT to develop more robust system for transferring appraisal information between organisations	AMD/RO	31 12 17
Identify role and purpose of secondary appraiser and map accordingly	Work with PremierIT to develop rules for secondary appraiser and refine Trust appraisal policy to meet these needs/	AMD/RO	31 12 17
Clarify responsibility for appraisal for doctors with honorary contracts	Work with Executive Management Team to review process of issuing and maintaining honorary contracts	AMD/RO/MD	31 12 17

13. Recommendation

The Board is asked to receive the contents of the report, noting that it will be shared with the Tier 2 Senior Responsible Officer at NHS England. The Board is also asked to note the Statement of Compliance attached at appendix 1.

Report Prepared by:
Dr Andrew Long, Associate Medical Director

Appendices

1. **Statement of Compliance**
2. **Annual Organisational Audit**
3. **Independent Verification Visit Report (2015)**
4. **IVV Action Plan**
5. **REV06 Report for GMC**

Appendix 1

Designated Body Statement of Compliance

The board of Great Ormond Street Hospital for Children NHS foundation Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments: Following the departure of the Medical Director in December 2016, it was agreed that the Associate Medical Director, who had completed the required Responsible Officer training should assume the role for an indefinite period

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: This is undertaken through GMC Connect

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: It is the opinion of the current Responsible Officer that there is an unequal provision of appraisers within the current Divisional structure and there is inadequate resource for training new, and updating existing appraisers

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments: There is inadequate resource to support this at the current time

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: All licensed medical practitioners are expected to participate in the appraisal process. Those that are failing to comply have been contacted individually and action taken where this does not result in compliance

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments: There is a system in place which meets most of these requirements however there is often difficulty in ensuring that information is available for doctors to include in their appraisal documentation.

[1,2] Doctors with a prescribed connection to the designated body on the date of reporting

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Comments: This system in now more robust

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

   Comments: This has been implemented during 2017

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[3] have qualifications and experience appropriate to the work performed; and

   Comments: This is fulfilled

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

    Comments: An action plan has been recommended to the Trust Board for implementation

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Dr Peter Steer, CEO

Date: _ _ _ _ _ _ _ _ _ _

[3] Doctors with a prescribed connection to the designated body on the date of reporting

NHS England

Annual Organisational Audit (AOA)
End of year questionnaire 2016-17

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	06491
Document Purpose	Resources
Document Name	Annual Organisational Audit Annex C (end of year questionnaire)
Author	Lynda Norton
Publication Date	24 March 2017
Target Audience	Medical Directors, NHS England Regional Directors, GPs
Additional Circulation List	
Description	The AOA (Annex C of the Framework for Quality Assurance) is a standardised template for all responsible officers to complete and return to their higher level responsible officer via the Revalidation Management System. AOAs from all designated bodies will be collated to provide an overarching status report of progress across England.
Cross Reference	A Framework for Quality Assurance for Responsible Officers & Revalidation April 2014 Gateway ref 01142
Superseded Docs (if applicable)	2015/16 AOA cleared with Publications Gateway Reference 04543
Action Required	
Timing / Deadlines (if applicable)	
Contact Details for further information	Lynda Norton Professional Standards Team Quarry House Leeds LS2 7UE 0113 825 1463

Document Status

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Annual Organisational Audit (AOA)

End of year questionnaire 2016-17

Version number: 4.0

First published: 4 April 2014

Updated: 24 March 2015, 18 March 2016 & 24 March 2017

Prepared by: Lynda Norton, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Contents

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1 Introduction

The Framework of Quality Assurance (FQA) and the monitoring processes within it are designed to support all responsible officers in fulfilling their statutory duty, providing a means by which they can demonstrate the effectiveness of the systems they oversee. It has been carefully crafted to ensure that administrative burden is minimised, whilst still driving learning and sharing of best practice. Each element of the FQA process will feed in to a comprehensive report from the national level responsible officer to Ministers and the public, capturing the state of play in implementing medical revalidation across the country.

The reporting processes are intended to be streamlined, coherent and integrated, ensuring that information is captured to contribute to local processes, whilst simultaneously providing the required assurance. The process will be reviewed and revised on a regular basis.

The AOA (Annex C) is a standardised template for all responsible officers to complete and return to their higher level responsible officer. AOAs from all designated bodies will be collated to provide an overarching status report of implementation across England. Where small designated bodies are concerned, or where types of organisation are small in number, these will be appropriately grouped to ensure that data is not identifiable to the level of the individual.

The AOA is designed to assist NHS England regional teams to assure the appropriate higher level responsible officers that designated bodies have a robust consistent approach to revalidation in place, through assessment of their organisational system and processes in place for undertaking medical revalidation.

Learning from the experience of the Organisational Readiness and Self-Assessment (ORSA) the AOA has a dual purpose to provide the required assurance to higher level responsible officers whilst being of maximum help to responsible officers in fulfilling their obligations.

The aims of the annual organisational audit exercise are to:

- gain an understanding of the progress that organisations have made during 2016/17;
- provide a tool that helps responsible officers assure themselves and their boards/management bodies that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors' fitness to practise, the arrangements for medical appraisal and responding to concerns, are in place;
- provide a mechanism for assuring NHS England and the GMC that systems for evaluating doctors' fitness to practice are in place, functioning, effective and consistent.

Please do not use this version of the form to submit your response.

This AOA exercise is divided into five sections:

Section 1: The Designated Body and the Responsible Officer

Section 2: Appraisal

Section 3: Monitoring Performance and Responding to Concerns

Section 4: Recruitment and Engagement

Section 5: Additional Comments

The questionnaire should be completed by the responsible officer on behalf of the designated body, though the input of information to the questionnaire may be appropriately delegated. The questionnaire should be completed **during April and May 2017** for the year ending 31 March 2017. The deadline for submission will be detailed in an email containing the link to the electronic version of the form, which will be sent after 31 March 2017.

Whilst NHS England is a single designated body, for the purpose of this audit, the national and regional offices of NHS England should answer as a 'designated body' in their own right.

Following completion of this AOA exercise, designated bodies should:

- consider using the information gathered to produce a status report and to conduct a review of their organisations' developmental needs.
- complete a statement of compliance and submit it to NHS England by the 29 September 2017.

The audit process will also enable designated bodies to provide assurance that they are fulfilling their statutory obligations and their systems are sufficiently effective to support the responsible officer's recommendations.

For further information, references and resources see pages 31-32
and www.england.nhs.uk/revalidation

Please do not use this version of the form to submit your response.

2 Guidance for submission

Guidance for submission:

- Several questions require a ‘Yes’ or ‘No’ answer. In order to answer ‘Yes’, you must be able to answer ‘Yes’ to all of the statements listed under ‘to answer ‘Yes’’
- Please do not use this version of the questionnaire to submit your designated body’s response.
- You will receive an email with an electronic link to a unique version of this form for your designated body.
- You should only use the link received from NHS England by email, as it is unique to your organisation.
- Once the link is opened, you will be presented with two buttons; one to download a blank copy of the AOA for reference, the second button will take you to the electronic form for submission.
- Submissions can only be received electronically via the link. Please do not complete hardcopies or email copies of the document.
- The form must be completed in its entirety prior to submission; it cannot be part-completed and saved for later submission.
- Once the ‘submit’ button has been pressed, the information will be sent to a central database, collated by NHS England.
- A copy of the completed submission will be automatically sent to the responsible officer.
- Please be advised that Questions 1.1-1.3 may have been automatically populated with information previously held on record by NHS England. The submitter has a responsibility to check that the information is correct and should update the information if required, before submitting the form.

3 Section 1 – The Designated Body and the Responsible Officer

Section 1	The Designated Body and the Responsible Officer	
1.1	**Name of designated body:** Great Ormond Street Hospital for Children NHS Trust	
	Head Office or Registered Office Address if applicable line 1 Great Ormond Street Hospital for Children NHS Foundation	
	Address line 2 Great Ormond Street	
	Address line 3	
	Address line 4	
	City London	
	County	Postcode WC1N 3JH
	Responsible officer: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	GMC registered last name ***** Phone *****
	Medical Director: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Medical Director ☐ GMC registered last name ***** Phone *****
	Clinical Appraisal Lead: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Clinical Appraisal Lead ☐ GMC registered last name ***** Phone *****
	Chief executive (or equivalent): Title ***** First name ***** GMC reference number (if applicable) Email *****	Last name ***** Phone *****

1.2	**Type/sector of designated body:** (tick one)	NHS	Acute hospital/secondary care foundation trust	☑
			Acute hospital/secondary care non-foundation trust	☐
			Mental health foundation trust	☐
			Mental health non-foundation trust	☐
			Other NHS foundation trust (care trust, ambulance trust, etc)	☐
			Other NHS non-foundation trust (care trust, ambulance trust, etc)	☐
			Special health authorities (NHS Litigation Authority, NHS Improvement, NHS Blood and Transplant, etc)	☐
		NHS England	NHS England (local office)	☐
			NHS England (regional office)	☐
			NHS England (national office)	☐
		Independent / non-NHS sector (tick one)	Independent healthcare provider	☐
			Locum agency	☐
			Faculty/professional body (FPH, FOM, FPM, IDF, etc)	☐
			Academic or research organisation	☐
			Government department, non-departmental public body or executive agency	☐
			Armed Forces	☐
			Hospice	☐
			Charity/voluntary sector organisation	☐
			Other non-NHS (please enter type)	☐

1.3	**The responsible officer's higher level responsible officer is based at:** [tick one]	NHS England North	☐
		NHS England Midlands and East	☐
		NHS England London	☑
		NHS England South	☐
		NHS England (National)	☐
		Department of Health	☐
		Faculty of Medical Leadership and Management - for NHS England (national office) only	☐
		Other (Is a suitable person)	☐
1.4	**A responsible officer has been nominated/appointed in compliance with the regulations.** To answer 'Yes': • The responsible officer has been a medical practitioner fully registered under the Medical Act 1983 throughout the previous five years and continues to be fully registered whilst undertaking the role of responsible officer. • There is evidence of formal nomination/appointment by board or executive of each organisation for which the responsible officer undertakes the role.		☑ Yes ☐ No

1.5	**Where a Conflict of Interest or Appearance of Bias has been identified and agreed with the higher level responsible officer; has an alternative responsible officer been appointed?** (Please note that in The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013), an alternative responsible officer is referred to as a second responsible officer) To answer 'Yes': The designated body has nominated an alternative responsible officer in all cases where there is a conflict of interest or appearance of bias between the responsible officer and a doctor with whom the designated body has a prescribed connection. To answer 'No': A potential conflict of interest or appearance of bias has been identified, but an alternative responsible officer has not been appointed. To answer 'N/a': No cases of conflict of interest or appearance of bias have been identified. Additional guidance Each designated body will have one responsible officer but the regulations allow for an alternative responsible officer to be nominated or appointed where a conflict of interest or appearance of bias exists between the responsible officer and a doctor with whom the designated body has a prescribed connection. This will cover the uncommon situations where close family or business relationships exist, or where there has been longstanding interpersonal animosity. In order to ensure consistent thresholds and a common approach to this, potential conflict of interest or appearance of bias should be agreed with the higher level responsible officer. An alternative responsible officer should then be nominated or appointed by the designated body and will require training and support in the same way as the first responsible officer. To ensure there is no conflict of interest or appearance of bias, the alternative responsible officer should be an external appointment and will usually be a current experienced responsible officer from the same region. Further guidance is available in *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).	☐ Yes ☐ No ☑ N/A

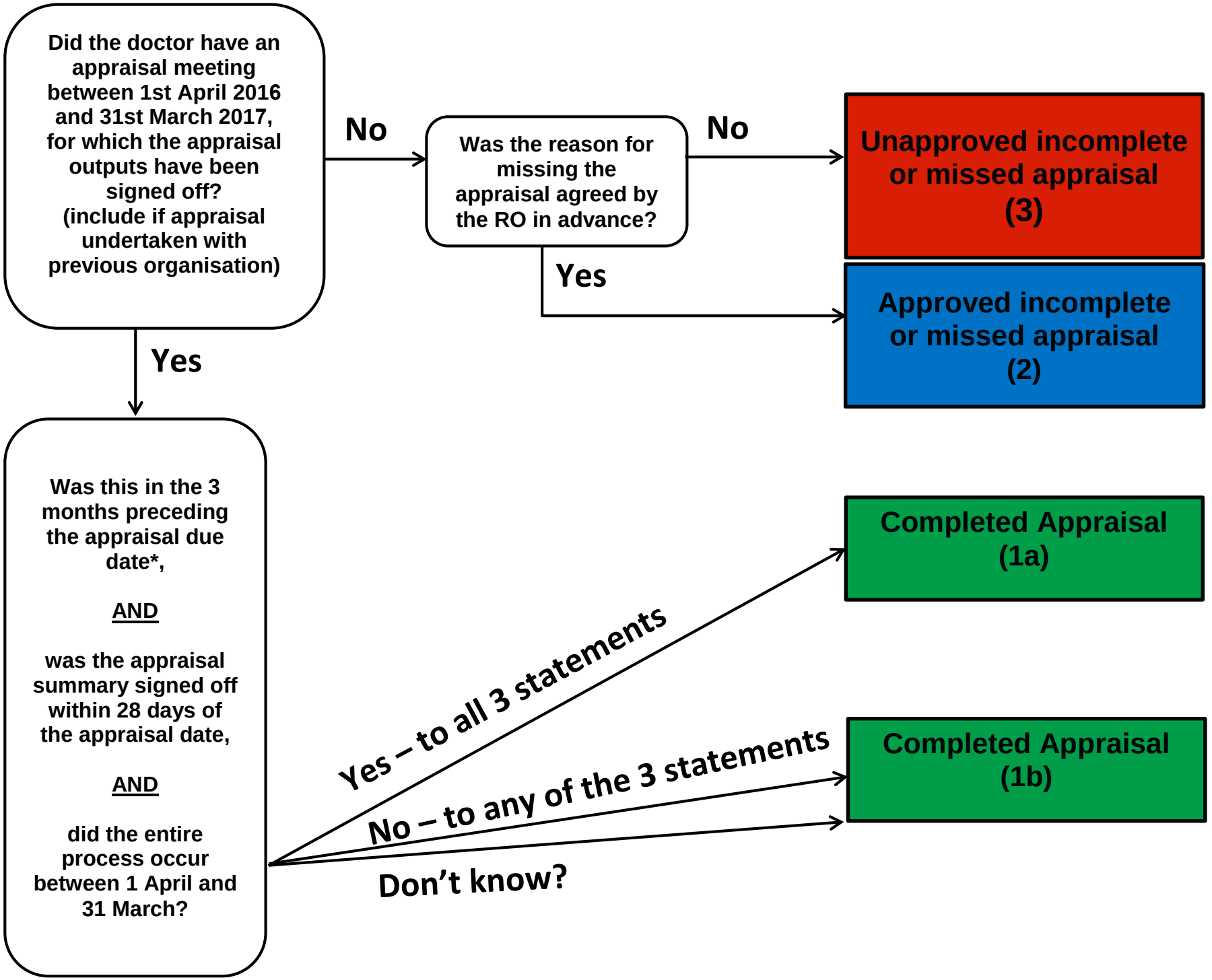
1.6	**In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.** Each designated body must provide the responsible officer with sufficient funding and other resources necessary to fulfil their statutory responsibilities. This may include sufficient time to perform the role, administrative and management support, information management and training. The responsible officer may wish to delegate some of the duties of the role to an associate or deputy responsible officer. It is important that those people acting on behalf of the responsible officer only act within the scope of their authority. Where some or all of the functions are commissioned externally, the designated body must be satisfied that all statutory responsibilities are fulfilled.	☐ Yes ☑ No
1.7	**The responsible officer is appropriately trained and remains up to date and fit to practise in the role of responsible officer.** To answer 'Yes': • Appropriate recognised introductory training has been undertaken (requirement being NHS England's face to face responsible officer training & the precursor e-Learning). • Appropriate ongoing training and development is undertaken in agreement with the responsible officer's appraiser. • The responsible officer has made themselves known to the higher level responsible officer. • The responsible officer is engaged in the regional responsible officer network. • The responsible officer is actively involved in peer review for the purposes of calibrating their decision-making processes and organisational systems. • The responsible officer includes relevant supporting information relating to their responsible officer role in their appraisal and revalidation portfolio including the results of the Annual Organisational Audit and the resulting action plan.	☑ Yes ☐ No

1.8	**The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.** The responsible officer records should include appraisal records, fitness to practise evaluations, investigation and management of concerns, processes relating to 'new starters', etc.	☑ Yes ☐ No
1.9	**The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.** To answer 'Yes': • An evaluation of the fairness of the organisation's policies has been performed (for example, an equality impact assessment).	☑ Yes ☐ No
1.10	**The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.** To answer 'Yes': • The designated body's board report contains explanations for all missed and late recommendations, and reasons for deferral submissions.	☑ Yes ☐ No
1.11	**The governance systems (including clinical governance where appropriate) are subject to external or independent review.** Most designated bodies will be subject to external or independent review by a regulator. Designated bodies which are healthcare providers are subject to review by the national healthcare regulators (the Care Quality Commission, the Human Fertilisation and Embryology Authority or Monitor, now part of NHS Improvement). Where designated bodies will not be regulated or overseen by an external regulator (for example locum agencies and organisations which are not healthcare providers), an alternative external or independent review process should be agreed with the higher level responsible officer.	☑ Yes ☐ No

1.12	**The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation.** **(*including peer review, internal audit or an externally commissioned assessment)**	☐ Yes ☑ No

4 Section 2 – Appraisal

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2017 should be included. Where the answer is 'nil' please enter '0'. **See guidance notes on pages 16-18 for assistance completing this table**		1a	1b	2	3	
		Number of Prescribed Connections	Completed Appraisal (1a)	Completed Appraisal (1b)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	335	0	296	7	32	335
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	7	0	7	0	0	7
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	279	0	220	1	58	279
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	0	0	0	0	0	0
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 – 2.1.6).	621	0	523	8	90	621


Did the doctor have an appraisal meeting between 1st April 2016 and 31st March 2017, for which the appraisal outputs have been signed off? (include if appraisal undertaken with previous organisation)
No
Was the reason for missing the appraisal agreed by the RO in advance?
No
Unapproved incomplete or missed appraisal (3)
Yes
Approved incomplete or missed appraisal (2)
Yes
Was this in the 3 months preceding the appraisal due date*,
AND
was the appraisal summary signed off within 28 days of the appraisal date,
AND
did the entire process occur between 1 April and 31 March?
Yes – to all 3 statements
Completed Appraisal (1a)
No – to any of the 3 statements
Completed Appraisal (1b)
Don't know?

2.1	**Column - Number of Prescribed Connections:** **Number of doctors with whom the designated body has a prescribed connection as at 31 March 2017** The responsible officer should keep an accurate record of all doctors with whom the designated body has a prescribed connection and must be satisfied that the doctors have correctly identified their prescribed connection. Detailed advice on prescribed connections is contained in the responsible officer regulations and guidance and further advice can be obtained from the GMC and the higher level responsible officer. The categories of doctor relate to current roles and job titles rather than qualifications or previous roles. The number of individual doctors in each category should be entered in this column. Where a doctor has more than one role in the same designated body a decision should be made about which category they belong to, based on the amount of work they do in each role. Each doctor should be included in only one category. For a doctor who has recently completed training, if they have attained CCT, then they should be counted as a prescribed connection. If CCT has not yet been awarded, they should be counted as a prescribed connection within the LETB AOA return. **Column - Measure 1a Completed medical appraisal:** A *Category 1a completed annual medical appraisal* is one where the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March. For doctors who have recently completed training, it should be noted that their final ACRP equates to an appraisal in this context. **Column - Measure 1b Completed medical appraisal:** A *Category 1b completed annual medical appraisal* is one in which the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the following apply: - the appraisal did not take place in the window of three months preceding the appraisal due date; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting. However, in the judgement of the responsible officer the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.	

	Where the organisational information systems of the designated body do not permit the parameters of a *Category 1a completed annual medical appraisal* to be confirmed with confidence, the appraisal should be counted as a *Category 1b completed annual medical appraisal*. **Column - Measure 2: Approved incomplete or missed appraisal:** An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. **Column - Measure 3: Unapproved incomplete or missed appraisal:** An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*. **Column Total:** Total of columns 1a+1b+2+3. The total should be equal to that in the first column (Number of Prescribed Connections), the number of doctors with a prescribed connection to the designated body at 31 March 2017. * Appraisal due date: A doctor should have a set date by which their appraisal should normally take place every year (the 'appraisal due date'). The appraisal due date should remain the same each year unless changed by agreement with the doctor's responsible officer. Where a doctor does not have a clearly established appraisal due date, the next appraisal should take place by the last day of the twelfth month after the preceding appraisal. This should then by default become their appraisal due date from that point on. For a designated body which uses an 'appraisal month' for appraisal scheduling, a doctor's appraisal due date is the last day of their appraisal month. For more detail on setting a doctor's appraisal due date see the Medical Appraisal Logistics Handbook (NHS England 2015).	

Please do not use this version of the form to submit your response.

2.2	**Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded** If all appraisals are in Categories 1a and/or 1b, please answer N/A. To answer Yes: • The responsible officer ensures accurate records are kept of all relevant actions and decisions relating to the= responsible officer role. • The designated body's annual report contains an audit of all missed or incomplete appraisals (approved and= unapproved) for the appraisal year 2016/17 including the explanations and agreed postponements. • Recommendations and improvements from the audit are enacted. Additional guidance: A missed or incomplete appraisal, whether approved or unapproved, is an important occurrence which could indicate a problem with the designated body's appraisal system or non-engagement with appraisal by an individual doctor which will need to be followed up. Measure 2: Approved incomplete or missed appraisal: An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. Measure 3: Unapproved incomplete or missed appraisal: An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*.	☑ Yes ☐ No ☐ N/A

Please do not use this version of the form to submit your response.

2.3	**There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group)** To answer 'Yes': • The policy is compliant with national guidance, such as *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014), *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010), *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014). • The policy has been ratified by the designated body's board or an equivalent governance or executive group.	☑ Yes ☐ No
2.4	**There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.** To answer 'Yes': • The appraisal inputs comply with the requirements in *Supporting Information for Appraisal and Revalidation* (GMC, 2012) and *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), which are: o Personal information. o Scope and nature of work. o Supporting information: 1. Continuing professional development, 2. Quality improvement activity, 3. Significant events, 4. Feedback from colleagues, 5. Feedback from patients, 6. Review of complaints and compliments. o Review of last year's PDP. o Achievements, challenges and aspirations. • The appraisal outputs comply with the requirements in the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) which are: o Summary of appraisal, o Appraiser's statement, o Post-appraisal sign-off by doctor and appraiser.	☐ Yes ☑ No

Please do not use this version of the form to submit your response.

	Additional guidance: Quality assurance is an integral part of the role of the responsible officer. The standards for the inputs and outputs of appraisal are detailed in *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013) and the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) and the responsible officer must be assured that these standards are being met consistently. The methodology for quality assurance should be outlined in the designated body's appraisal policy and include a sampling process. Quality assurance activities can be undertaken by those acting on behalf of the responsible officer with appropriate delegated authority.	
2.5	**There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.** To answer 'Yes': • There is a written description within the appraisal policy of the process for ensuring that key items of supporting information are included in the doctor's portfolio and discussed at appraisal. • There is a process in place to ensure that where a request has been made by the responsible officer to include a key item of supporting information in the appraisal portfolio, the appraisal portfolio and summary are checked after completion to ensure this has happened. Additional guidance: It is important that issues and concerns about performance or conduct are addressed at the time they arise. The appraisal meeting is not usually the most appropriate setting for dealing with concerns and in most cases these are dealt with outside the appraisal process in a clinical governance setting. Learning by individuals from such events is an important part of resolving concerns and the appraisal meeting is usually the most appropriate setting to ensure this is planned and prioritised. In a small proportion of cases, the responsible officer may therefore wish to ensure certain key items of supporting information are included in the doctor's portfolio and discussed at appraisal so that development needs are identified and addressed. In these circumstances the responsible officer may require the doctor to include certain key items of supporting information in the portfolio for discussion at appraisal and may need to check in the appraisal summary that the discussion has taken place. The method of sharing key items of supporting information should be described in the appraisal policy. It is important that information is shared in compliance with principles of information governance and security. For further detail, see *Information Management for Revalidation in England* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

2.6	**The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection** To answer 'Yes': The responsible officer ensures that: • Medical appraisers are recruited and selected in accordance with national guidance. • In the opinion of the responsible officer, the number of appropriately trained medical appraisers to doctors being appraised is between 1:5 and 1:20. • In the opinion of the responsible officer, the number of trained appraisers is sufficient for the needs of the designated body. Additional guidance: It is important that the designated body's appraiser workforce is sufficient to provide the number of appraisals needed each year. This assessment may depend on total number of doctors who have a prescribed connection, geographical spread, speciality spread, conflicts of interest and other factors. Depending on the needs of the designated body, doctors from a variety of backgrounds should be considered for the role of appraiser. This includes locums and salaried general practitioners in primary care settings and staff and associate specialist doctors in secondary care settings. An appropriate specialty mix is important though it is not possible for every doctor to have an appraiser from the same specialty. Appraisers should participate in an initial training programme before starting to perform appraisals. The training for medical appraisers should include: • Core appraisal skills and skills required to promote quality improvement and the professional development of the doctor • Skills relating to medical appraisal for revalidation and a clear understanding of how to apply professional judgement in appraisal • Skills that enable the doctor to be an effective appraiser in the setting within which they work, including both local context and any specialty specific elements. Further guidance on the recruitment and training of medical appraisers is available; see *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

2.7	**Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.** To answer 'Yes': The responsible officer ensures that: • Medical appraisers have completed a suitable training programme, with core content compliant with national guidance (Quality Assurance of Medical Appraisers), including equality and diversity and information governance, before starting to perform appraisals. • All appraisers have access to medical leadership and support. • There is a system in place to obtain feedback on the appraisal process from doctors being appraised. • Medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers). Additional guidance: Further guidance on the support for medical appraisers is available in *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

5 Section 3 – Monitoring Performance and Responding to Concerns

Section 3	Monitoring Performance and Responding to Concerns	
3.1	**There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection**. To answer 'Yes': • Relevant information (including clinical outcomes, reports of external reviews of service for example Royal College reviews, governance reviews, Care Quality Commission reports, etc.) is collected to monitor the doctor's fitness to practise and is shared with the doctor for their portfolio. • Relevant information is shared with other organisations in which a doctor works, where necessary. • There is a system for linking complaints, significant events/clinical incidents/SUIs to individual doctors. • Where a doctor is subject to conditions imposed by, or undertakings agreed with the GMC, the responsible officer monitors compliance with those conditions or undertakings. • The responsible officer identifies any issues arising from this information, such as variations in individual performance, and ensures that the designated body takes steps to address such issues. • The quality of the data used to monitor individuals and teams is reviewed. • Advice is taken from GMC employer liaison advisers, National Clinical Assessment Service, local expert resources, specialty and Royal College advisers where appropriate. Additional guidance: Where detailed information can be collected which relates to the practice of an individual doctor, it is important to include it in the annual appraisal process. In many situations, due to the nature of the doctor's work, the collection of detailed information which relates directly to the practice of an individual doctor may not be possible. In these situations, team-based or service-level information should be monitored. The types of information available will be dependent on the setting and the role of the doctor and will include clinical outcome data, audit, complaints, significant events and patient safety issues. An explanation should be sought where an indication of outlying	☑ Yes ☐ No

	quality or practice is discovered. The information/data used for this purpose should be kept under review so that the most appropriate information is collected and the quality of the data (for example, coding accuracy) is improved. In primary care settings this type of information is not always routinely collected from general practitioners or practices and new arrangements may need to be put in place to ensure the responsible officer receives relevant fitness to practise information. In order to monitor the conduct and fitness to practise of trainees, arrangements will need to be agreed between the local education and training board and the trainee's clinical attachments to ensure relevant information is available in both settings.	
3.2	**The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns) which is ratified by the designated body's board (or an equivalent governance or executive group)**. To answer 'Yes': • A policy for responding to concerns, which complies with the responsible officer regulations, has been ratified by the designated body's board (or an equivalent governance or executive group). Additional guidance: It is the responsibility of the responsible officer to respond appropriately when unacceptable variation in individual practice is identified or when concerns exist about the fitness to practise of doctors with whom the designated body has a prescribed connection. The designated body should establish a procedure for initiating and managing investigations. National guidance is available in the following key documents: • *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003). • The National Health Service (Performers Lists) (England) Regulations 2013. • *How to Conduct a Local Performance Investigation* (National Clinical Assessment Service, 2010). The responsible officer regulations outline the following responsibilities: • Ensuring that there are formal procedures in place for colleagues to raise concerns. • Ensuring there is a process established for initiating and managing investigations of capability, conduct,	☑ Yes ☐ No

	health and fitness to practise concerns which complies with national guidance, such as *How to conduct a local performance investigation* (National Clinical Assessment Service, 2010).
	• Ensuring investigators are appropriately qualified.
	• Ensuring that there is an agreed mechanism for assessing the level of concern that takes into account the risk to patients.
	• Ensuring all relevant information is taken into account and that factors relating to capability, conduct, health and fitness to practise are considered.
	• Ensuring that there is a mechanism to seek advice from expert resources, including: GMC employer liaison advisers, the National Clinical Assessment Service, specialty and royal college advisers, regional networks, legal advisers, human resources staff and occupational health.
	• Taking any steps necessary to protect patients.
	• Where appropriate, referring a doctor to the GMC.
	• Where necessary, making a recommendation to the designated body that the doctor should be suspended or have conditions or restrictions placed on their practice.
	• Sharing relevant information relating to a doctor's fitness to practise with other parties, in particular the new responsible officer should the doctor change their prescribed connection.
	• Ensuring that a doctor who is subject to these procedures is kept informed about progress and that the doctor's comments are taken into account where appropriate.
	• Appropriate records are maintained by the responsible officer of all fitness to practise information
	• Ensuring that appropriate measures are taken to address concerns, including but not limited to:
	  • Requiring the doctor to undergo training or retraining,
	  • Offering rehabilitation services,
	  • Providing opportunities to increase the doctor's work experience,
	  • Addressing any systemic issues within the designated body which may contribute to the concerns identified.
	• Ensuring that any necessary further monitoring of the doctor's conduct, performance or fitness to practise is carried out.	

3.3	**The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.**	☑ Yes ☐ No

3.4	**The designated body has arrangements in place to access sufficient trained case investigators and case managers.** To answer 'Yes': The responsible officer ensures that: • Case investigators and case managers are recruited and selected in accordance with national guidance *Supporting Doctors to Provide Safer Healthcare, Responding to concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • Case investigators and case managers have completed a suitable training programme, with essential core content (see guidance documents above). • Personnel involved in responding to concerns have sufficient time to undertake their responsibilities • Individuals (such as case investigators, case managers) and teams involved in responding to concerns participate in ongoing performance review and training/development activities, to include peer review and calibration (see guidance documents above). Additional guidance The standards for training for case investigators and case managers are contained in *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014) and *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014). Case investigators or case managers may be within the designated body or commissioned externally.	☑ Yes ☐ No

6 Section 4 – Recruitment and Engagement

Section 4	Recruitment and Engagement	
4.1	**There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).** In situations where the doctor has moved to a new designated body without a contract of employment, or for the provision of services (for example, through membership of a faculty) the information needs to be available to the new responsible officer as soon as possible after the prescribed connection commences. This will usually involve a formal request for information from the previous responsible officer. Additional guidance The regulations give explicit responsibilities to the responsible officer when a designated body enters into a contract of employment or for the provision of services with a doctor. These responsibilities are to ensure the doctor is sufficiently qualified and experienced to carry out the role. All new doctors are covered under this duty even if the doctor's prescribed connection remains with another designated body. This applies to locum agency contracts and also to the granting of practising privileges by independent health providers. The prospective responsible officer must: • Ensure doctors have qualifications and experience appropriate to the work to be performed, • Ensure that appropriate references are obtained and checked, • Take any steps necessary to verify the identity of doctors, • Ensure that doctors have sufficient knowledge of the English language for the work to be performed, and • For NHS England regional teams, manage admission to the medical performers list in accordance with the regulations. It is also important that the following information is available: • GMC information: fitness to practise investigations, conditions or restrictions, revalidation due date, • Disclosure and Barring Service check (although delays may prevent these being available to the responsible officer before the starting date in every case), and	☑ Yes ☐ No

	• Gender and ethnicity data (to monitor fairness and equality; providing this information is not mandatory). It may be helpful to obtain a structured reference from the current responsible officer which complies with GMC guidance on writing references and includes relevant factual information relating to: • The doctor's competence, performance or conduct, • Appraisal dates in the current revalidation cycle, and, • Local fitness to practise investigations, local conditions or restrictions on the doctor's practice, unresolved fitness to practise concerns. See Good Medical Practice: Supplementary Guidance: Writing References (GMC, 2007) and paragraph 19 of Good Medical Practice (GMC, 2013) for further details. The responsible officer regulations and GMC guidance make it clear that there is an obligation to share information about a doctor when required to support the responsible officer's statutory duties, or to maintain patient safety. Guidance, published in August 2016, on the flow of information to support medical governance and responsible officer statutory function (2016) therefore aims to promote improvements to these processes: • setting out the common legitimate channels along which information about a doctor's medical practice should flow, describing the information that might apply and arrangements to support its smooth flow • providing useful toolkits and examples of good practice The guidance on information flows to support medical governance and responsible officer statutory functions can be accessed via the link below. https://www.england.nhs.uk/revalidation/ro/info-flows/	

7 Section 5 – Comments

Section 5	Comments	
5.1	The current Responsible Officer has identified some weaknesses within the current system which have been discussed within the Senior Management Team. Information has also been provided to NHS London in response to the Higher Level Quality Assurance Visit (Independent) which took place in 2015. A paper is due to go to the GOSH Trust Board in July which will contain recommendations to improve the quality assurance of appraisal and revalidation within the organisation.	

Please do not use this version of the form to submit your response.

8 Reference

Sources used in preparing this document

1. The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013)
2. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 (Her Majesty's Stationery Office, 2013)
3. The Medical Act 1983 (Her Majesty's Stationery Office, 1983)
4. *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003)
5. The National Health Service (Performers Lists) (England) Regulations 2013
6. *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010)
7. *Revalidation: A Statement of Intent* (GMC and others, 2010)
8. *Good Medical Practice* (GMC, 2013)
9. *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013)
10. *Good Medical Practice: Supplementary Guidance - Writing References* (GMC, 2012)
11. *Guidance on Colleague and Patient Questionnaires* (GMC, 2012)
12. *Supporting Information for Appraisal and Revalidation* (GMC, 2012)
13. *Effective Governance to Support Medical Revalidation: A Handbook for Boards and Governing Bodies* (GMC, 2013)
14. *Making Revalidation Recommendations: The GMC Responsible Officer Protocol – Guide for Responsible Officers* (GMC, 2012, updated 2014)
15. *The Medical Appraisal Guide* (NHS Revalidation Support Team, 2014)
16. *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014)
17. *Providing a Professional Appraisal* (NHS Revalidation Support Team, 2012)
18. *Information Management for Medical Revalidation in England* (NHS Revalidation Support Team, 2014)
19. *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013)
20. *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014)
21. *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014).
22. *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).
23. *Guide to Independent Sector Appraisal for Doctors Employed by the NHS and Who Have Practising Privileges at Independent Hospitals: Whole Practice Appraisal* (British Medical Association and Independent Healthcare Forum, 2004)
24. *Joint University and NHS Appraisal Scheme for Clinical Academic Staff* (Universities and Colleges Employers Association, 2002, updated in 2012)
25. *Preparing for the Introduction of Medical Revalidation: a Guide for Independent Sector Leaders in England* (GMC and Independent Healthcare Advisory Services, 2011, updated in 2012)

Please do not use this version of the form to submit your response.

26. *How to Conduct a Local Performance Investigation (National Clinical Assessment Service, 2010)*
27. *Use of NHS Exclusion and Suspension from Work amongst Doctors and Dentists 2011/12 (National Clinical Assessment Service, 2011)*
28. *Return to Practice Guidance (Academy of Medical Royal Colleges, 2012)*
29. *Medical Appraisal Logistics Handbook (NHS England, 2015)*

Please do not use this version of the form to submit your response.

Independent Verification Visit

Great Ormond Street Hospital Meeting room at level 6 old Building, WC1N 3JH		
16th February 2015 9:30am to 16:30pm		
Key Personnel		
Ray Field	Revalidation Lead	NHS England (London)
Ros Crowder	Deputy Director - Revalidation	NHS England (south region)
Dr Ruth Chapman	Regional Lead Appraiser	NHS England (London)
Avinder Grewal	Revalidation Coordinator	NHS England (London)
Dr Catherine Cale	RO and Co-Medical Director	GOSH
TBC	HR/Medical Staffing	GOSH

Agenda Item	
09.30 – 10.00	Pre-Meet with Responsible Officer/Medical Director (and other key personnel)
10.00 – 11.30	Meeting with Revalidation Manager / Team and review of processes and IT systems
11.30 – 12.00	Meeting with Clinical Appraisal Lead
12.00 – 13.00	Meeting with 1 or 2 appraisers
13.00 – 13.30	Lunch
13.30 – 15.00	Review of Appraisal Summaries sample, Revalidation portfolios, case studies for deferrals (or non-engagements)
15.00 – 15.30	Meeting with HR / Medical Staffing
15.30 – 16.30	Meeting with RO and visit summary

Papers	
Item 1: Framework of Quality Assurance for Responsible Officers. Annex A Core Standards (For information purposes)	annex-a-core-standards.xls
Item 2: AOA Report	Great Ormond Street Hospital for Children N
Item 3: AOA Comparator report	NHS England (London region)_Grea
Item 4: Board report	Appraisal revalidation Annual Bo
Item 5: Statement of Compliance	GOSH.pdf
Item 6: Quarterly Reports	Quarterly Report.pdf
Item 7: External Quality Assurance report	N/A
Item 8: Summary of Recommendations	Recommendation Summary .pdf
Item 9: Never Events Summary	ne-prov-data-april-oct-14.pdf ne-prov-q1-q4-data-summ.pdf
Item 10: Care Quality Commission Report	N/A
Item 11: Action plan template	

Great Ormond Street Independent Verification visit from NHS England London Revalidation Team,

16th February 2015

Introduction

The RO and HR lead welcomed the NHS England London team to the hospital and we had an open and helpful meeting that highlighted areas of good practice and developments that the RO is taking forward. The areas of discussion are outlined below. This visit can be considered as an 'external review' and peer review and discussion regarding appraisal practice is recommended as on-going good practice.

Appraisal systems and appraisers

Number of connected doctors to designated body/RO: 485

The RO/lead/MD is also on hospital board and can oversee their statutory responsibility for revalidation. The commitment of board to appraisal and revalidation was described as – 'medium' and needing development. The idea of a NED taking a particular interest in revalidation was raised and will be considered by the RO.

The RO has a good working relationship with the GMC ELA - Tony Americano who has provided helpful advice to the RO.

The RO does not have a formal RO decision making advisory group to calibrate and share the revalidation recommendations.

Appraiser training – Edgecumbe initially, also MIAD and London Deanery (8 x updates a year – topical subjects discussed). Number of appraisers: 99 – each do 3-6 appraisals within April-June. Doctors can choose their appraisers.

Appraisers undertake cross specialty appraisals - not hierarchical. May have three people in room for appraisal.

Use Prep appraisal toolkit for consultants and clinical specialists, but paper based appraisals for trust doctors and fellows. There is an A&R administrator in post.

Appraisal Policy – could add what to do if doctor not following procedure. No QA of appraisal outputs as yet developed. GOS has an appraisal cycle - April-June is when most appraisals are done - with the job plan done beforehand

SI s and Complaints: Not yet feeding in complaints and SIs to appraisal: RO looks at SIs with names of Drs involved. Drs asked in appraisal about SIs. Plan to prompt doctors in future. Look for trends.
Policies are in place. A plan of action relating to appraisal and revalidation has been made - linked to clinical excellence award

Multi-source Feedback (MSF)

Feedback – Edgecumbe tool used for MSF. Sometimes it can be difficult to obtain feedback

Friends and family feedback – not used according to appraiser

Visiting doctors, SAS doctors, bank doctors, trainees, honorary consultants

Many overseas doctors (visiting fellows etc.) – they are assigned an educational supervisor at induction, information about appraisal is on the intranet, HR asks about the date of the last appraisal and revalidation date.

Pre-employment checks on doctors in place

Even if not being revalidated, appraisals are carried out for these doctors if possible – they also do have objective settings and educational supervision. Evidence is accepted from abroad.

GOS does have SAS appraisers. GOS tends to use regular bank doctors rather than unknown locums for extra cover.

Issue of Drs at CCT not being revalidated – to be discussed with Dr Tim Swanick

Honorary consultants - if they see adults, GOS seeks assurance from elsewhere. Vast numbers – 100s. Some are retired. Have uncoupled practise privileges from honorary contracts so will not be connected. Work in progress.

Scope

Academics have joint appraisals.
Private practice – whole scope is included. Appraisers are primed to ask.

Appraiser interview

A doctor will have the same appraiser for 3 consecutive appraisals only
Enough time is allocated to do an appraisal

Asks for portfolio 1 week before, spends an hour preparing, meets for 1-1 ½ hour meeting and writes up summary with appraisee
There is a move towards PREP for non-trainee doctors
No 1:1s or feedback from RO/lead for appraisers
Lead/RO is very approachable and helpful, providing strong leadership.

Academic appraisals are a challenge. Often no reflection with the academic part of the appraisal.

Focus on core standards

Divisional directors nominate doctors to be appraisers. RST spec. Appraisers are not interviewed.

Responding to concerns

After SIs: Look for patterns, discuss and investigate, action plan. Small number of case investigators. RO is the case manager – hasn't done course yet.

Potential Improvements / Actions	
Area	**Action**
Some appraisals are still done on paper	To review and consider MAG and IT retention of appraisal documentation for audit trail and QA, and Information governance purpose
Keeping track of moving trust doctors	RO is considering new manager to monitor movement of doctors.
May have three people in room for appraisal.	Would generally suggest an appraisal is a 1:1 meeting, though as discussed circumstances can require exception
Honorariums and connections	To review – is work in progress
Academics – appraisers and doctors often have little or no reflection on academic element of work	To review and consider Guidance on Reflection, good practice examples, FAQs
Appraiser selection process might be reviewed	To consider selection and interviews
SPAs not specified for appraiser – may need more resource to support appraisers and for their role to be valued QA: varied summaries, PDPs need	We would suggest a formal external/peer review of the appraisal and revalidation process

development and some are long	
QA needs to be addressed: audit of outputs, feedback and 1:1s with appraisers	To be reviewed. We would suggest a formal external/peer review of the appraisal and revalidation process
Appraisal policy – you might like to add a statement to say that there will be a process to follow if appraisals not arranged/completed in time	To consider short addition to policy
The use of the college CPD certificate without more detail relating to the specific CPD event and reflection	To review and ask for more specific reflection that relates CPD with PDP and own professional practice, benefit or not ?

Areas of Good Practice for sharing
Good approach to feedback from patients/clients
Appraisers have updates and cross specialty appraising takes place - not hierarchical
Good doctors' induction and support for appraisal
In house educational supervision feeds into appraisal
Sorting out honorary contracts
RO attends networks, is trained, has good ELA contact, and is considered 'approachable' and helpful by appraisers.

Shared with GOS

Scope of practice list and possible 'no concerns' letter.

Network meeting information and QA resources – info will be available from the revalidation team.

Action plan template

Please complete the below action plan and return to: ENGLAND.revalidation-london@nhs.net

By: (insert date)

Name of designated body	Great Ormond Street Hospital	
Name of responsible officer	Andrew Long	
Area/concern/issue identified at Review Visit	**Action**	**Timescale**
Some appraisals are still done on paper	We have now purchased licences for all doctors employed within the organisation to be enrolled on the PReP system. We are steadily making progress in getting all Associate Specialists/Trust doctors and Fellows however there has been limited HR resource available for this task due to internal pressures. This has been escalated to the Director of HR who has ensured that adequate HR resources will be made available	September 2017
Keeping track of moving trust doctors	We hope to establish a process whereby all non-Deanery doctors have PReP profiles and their movements are recorded and updated through their medical staffing records. PremierIT have informed us that they will be making it easier to transfer information from PReP when doctors move to other organisations	December 2017
May have three people in the room for an appraisal	We have been in discussion with PremierIT about making it a positive decision to include a Secondary Appraiser on the system. As a general rule we have agreed that all those employed on academic contracts will be required to have joint appraisals under the Follett Review Principles and those in senior management	September 2017

	roles may wish to have a senior manager as a secondary appraiser however with those exceptions everyone should have a single appraiser.	
Honorariums and connections	We have recently reviewed our honorary contract procedures and are actively reconsidering every application for honorary contracts. We have therefore removed a number of doctors as connections, although continue to support those in academic posts with global roles as well as those in pure research and public health roles. All are required to participate in annual appraisal	Met
Academics – appraisers and doctors often have little or no reflection on academic element of work	All academics are expected to have joint appraisals with an NHS appointed consultant as well as an academic appraiser undertaking a joint appraisal in line with the Follett Principles.	Met
Appraiser selection process might be reviewed	At the current time we have been engaging with our appraisers to ensure that all have training updates. The RO feels that we may need more appraisers in some areas and there are some appraisers who we feel might be discouraged, either due to inactivity or following a quality assurance review of their performance. We might consider a system of appraiser allocation in the future and encourage a selection process rather than self-nomination	September 2017
SPAs not specified for appraiser – may need more resource to support appraisers and for their role to be valued. QA: varied summaries. PDPs need development and some are long	We are taking a paper to the Trust Board in July 2017 to request more specific resources for appraisal. At the current time there are no defined resource allocations. It is our intention to recommend that there is a recognition for appraisers within the Job Planning process and that there are clearly identified resources for training and updating appraisers. It is our intention to request an external review of the appraisal and revalidation	September 2017

	process and this recommendation will be made to the Trust Board	
QA needs to be addressed: audit of outputs, feedback and 1:1s with appraisers	It is our intention to recommend to the Trust Board that we establish a system of Lead Appraisers within our recently reconfigured Divisional structure	September 2017
Appraisal policy – you might like to add a statement to say there will be a process to follow if appraisals not arranged/completed in time	A new Appraisal and Revalidation Policy was taken to the Policy Approvals Group in January 2017	September 2017
The use of the college CPD certificate without more detail relating to specific CPD event and reflection	We have been in discussion with PremierIT who are the providers both of the GOSH PReP system as well as the RCPCH CPD application. They are actively considering how more information can be drawn from the RCPCH system into the PReP system	September 2017
Follow up meeting / Telecon		
As responsible officer I confirm that the information above has been discussed and agreed with my Board or equivalent	*Signature & Date*	
Date of Board sign-off		

REV6

General Medical Council

Request to send a non-engagement concern letter to a doctor

When to use this form

You have a doctor who is not sufficiently engaging with your local processes and is not meeting the requirements for their revalidation .You want us to send a non-engagement concern communication to them.

You have read the criteria for non-engagement and are satisfied that you are in the process of taking all possible local action to secure the doctor's engagement.

The effect of this form

We will send a non-engagement concern communication to the doctor. This tells the doctor that they must meet the requirements for their revalidation and to contact you.

Next Steps

- Doctor is not under noticeIf they continue not to sufficiently meet the requirements for their revalidation we may bring their revalidation submission date forward so that you can submit a recommendation of non-engagement to us.
- We will contact you shortly after the date you request below to ask if you are satisfied the doctor is now meeting their revalidation requirements.

Doctor is under notice:

- If the doctoris under notice you should make a recommendation by their submission date. You should refer to the recommendation protocol before making your recommendation. If you make a recommendation of non-engagement, we will begin the process to remove the doctor's licence to practise.

How to return this form

Enter the details and click on the 'Submit Form' button in the top right hand corner. Follow the instructions on the screen.

If you have any problems submitting the form please email it to revalidation-support@gmc-uk.org.

This form must be submitted by the Responsible Officer or Suitable Person, or their authorised delegate

Designated body name	Designated body name
Submitted by	Responsible officer name / Authorised delegate name
Date	D D M M Y Y Y Y

The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750)

Details of the doctor you would like us to send a non-engagement concern letter sent to

Doctor's full name	GMC reference number	Date you want the doctor to comply by
Doctor's full name		D D M M Y Y Y Y

I have read the criteria for non-engagement and confirm that:

- The doctor is not engaging in appraisal or other activities to support a recommendation to revalidate or the level of engagement is not sufficient to support a recommendation to revalidate
- Should this continue, I do not anticipate having sufficient information on which to base a recommendation about the doctor's fitness to practise
- The doctor is being provided with sufficient opportunity and support to engage with revalidation
- Based on the information available to me, there are no extenuating circumstances which account for their failure to engage.
- I will continue local efforts to secure the doctor's engagement.
- I have notified the GMC of any outstanding concerns about the fitness to practise of the named doctor, in accordance with GMC guidance on raising concerns about doctors.
- I would like the GMC to send a revalidation non-engagement concern letter to the named doctor.
- I have advised the doctor of this request

Responsible Officer:	Responsible officer name

The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750)

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27th July 2017

Safe Nurse Staffing Report for May and June 2017 **Submitted by: Juliette Greenwood, Chief Nurse**	**Paper No: Attachment M**

Aims / summary
This paper provides the required assurance that GOSH has safe nurse staffing levels across all in- patient ward areas and appropriate systems in place to manage the demand for nursing staff. In order to provide greater transparency the report also includes appropriate nurse quality measures and details of ward safe staffing reports. The paper includes a brief summary of nursing vacancies, nurse turnover and patient acuity data.

Action required from the meeting
To note the information in the report on safe staffing, the continued improvement in retention and the number of recruited newly qualified nurses in the pipeline starting in the Trust in September 2017.

Contribution to the delivery of NHS Foundation Trust strategies and plans
Safe levels of nurse staffing are essential to the delivery of safe patient care and experience.

Compliance with *How to ensure the right people, with the right skills, are in the right place at the right time – A guide to nursing, midwifery and care staffing and capability'* (NHS England, Nov 2013) and the *'Hard Truths Commitments Regarding the Publishing of Staffing Data'* issued by the Care Quality Commission in March 2014. In July 2016 there was further guidance – '*Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time' (National Quality Board, July 2016).* This guidance provides an updated set of NQB expectations for nurse staffing to help Trust boards make local decisions that will deliver high quality care for patients within the available staffing resource.

Financial implications
Already incorporated into 17/18 Division budgets

Who needs to be told about any decision?
Divisional Management Teams
Finance Department
Workforce Planning

Who is responsible for implementing the proposals / project and anticipated timescales?
Chief Nurse; Assistant Chief Nurses, Head of Nursing

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

GOSH Safe Nurse Staffing Report June 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

Capacity:

- May: 2 beds closed on Squirrel Urology ward; 1-2 on Sky; 4 (intermittently) on Peter Pan; 2 on Koala; 1 on MCU; and 1-3 Bumblebee and Bumblebee due to staffing and patient acuity. 1 bed closed on Giraffe, 1 (intermittently) on Fox and 1 on Hedgehog for works.
- June: 2 beds closed on Sky ward and 1 on MCU due to staffing. Occasionally, Squirrel Urology closed 2 beds; Squirrel SNAPS 2 beds; NICU 1 bed; PICU 1-3 beds; Penguin 2 beds; Kingfisher 3, Peter Pan 1 due to staffing. 1 bed closed on Giraffe, 1 on Robin, 3 on Bumblebee and 1-3 on Hedgehog for works.

Staffing:

Turnover rate continues to improve. Staff sickness levels have risen slightly but continue to remain under the Trust target of 3%. After a very successful recruitment campaign 241 Newly qualified nurses are expected to start in the Trust on the 25th September 2017.

Temporary Staffing:

- Overall shift request numbers for May and June 2017 are lower than this time last year.
- May and June's demand in 2017 is slightly higher than April 2017. One shift was covered with agency in May (Butterfly ward), and two shifts in June covering the maternity leave of the HON for CRF.

There were no unsafe shifts reported in May or June 2017.

Nursing Workforce Summary:

Month	UNIFY* Actuals vs plan	CHPPD** Trust average (excl. ITUs)	PANDA Acuity (weighted for cubicle and complexity)				Maternity leave (RN)	Sickness (RN)	Turnover FTE (RN)	Vacancies (RN)	Vacancies (un-registered)	Pipeline recruits (RN)	Pipeline recruits (un-registered)
			WIC (1:1)	HD (1:2)	Normal under 2 (1:3)	Normal over 2 (1:4)							
March	92.9%	11.5	36.4%	18.6%	14.7%	30.4%	Not available	2.8%	16.3%	92.3	53.8	Not available	Not available
April	91.1%	11.6	39.0%	20.9%	13.1%	27.0%	Not available	2.7%	16.4%	110.1	31.7	Not available	Not available
May	98.9%	11.3	39.1%	19.4%	12.6%	29.0%	4.5%	2.9%	16.2%	101.2	31.2	283	1
June	96.8%	11.9	38.6%	21.5%	12.5%	27.4%	4.3%	2.9%	15.9%	94.8	29.7	258	1

Glossary

UNIFY - Unify is an online collection system used for collating, sharing and reporting NHS and social care data.

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

Care hours per patient day =	Hours of registered nurses and midwives alongside Hours of healthcare support workers
	Total number of inpatients

Defining Staffing levels

- **Normal dependency Under 2 Years - 1 Nurse: 3 Patients**
- **Normal dependency Over 2 Years - 1 Nurse: 4 Patients**
- **Ward High Dependency (HD) - 1 Nurse: 2 Patients**
- **Ward Intensive Care (WIC) - 1 Nurse: 1 Patient**

Defining staffing levels for Children's and Young People's services (Royal College of Nursing, July 2013)

May 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

	Nursing Staffing Actual vs Planned						Care Hours per Patient Day			Key Indicators						
Ward	Registered Day	Care Staff Day	Registered Night	Care Staff Night	Total	Comments	Registered	Care Staff	Total	Pressure Ulcer, grade 2	Cardiac Arrest	Respiratory Arrest	PALS	Complaints	Datix	Unsafe shift
Charles West Division																
Badger	96.7%	102.9%	91.5%	92.0%	94.7%	Within 10% of 100% threshold	10.7	1.7	12.5	0	1	2	0	0	0	0
Bear	118.2%	120.1%	111.1%	82.3%	113.4%	Currently over recruited in addition to increased patient activity, high amount of HDU.	8.9	1.4	10.3	1	0	0	0	0	0	0
Flamingo	124.4%	71.1%	110.4%	39.6%	115.3%	Ward safely staffed	26.5	0.6	27.1	5	N/A	N/A	0	0	0	0
Miffy	155.5%	67.8%	90.2%	82.7%	95.6%	75% SSN vacancy which is being backfilled/supported by Bank HCA's. >150% due to small staff numbers.	11.8	8.8	20.6	0	0	0	0	0	0	0
NICU	109.3%	19.4%	102.2%	-	102.0%	The figures provided are a true reflection of the staffing requirements for NICU. During the month of May, There continued to be an number of both long term and short term sickness absences, necessitating an increase in the number of bank staff required to fill vacant shifts.	29.2	0.5	29.8	0	N/A	N/A	0	0	0	0
PICU	110.8%	39.4%	90.0%	0.0%	95.9%	The figures provided are a true reflection of the staffing requirements for PICU. During the month of May, our occupancy levels were less than 85%, therefore there were several shifts whereby bank staff were cancelled; however there has been a continued increase in maternity leave and leavers necessitating the continued use of bank staff to enable PICU to flex up to occupancy. A close eye has been kept on bank fill during this period, cancelling any unnecessary staff.	33.1	0.4	33.4	0	N/A	N/A	0	0	0	0
Elephant	97.3%	67.8%	82.7%	77.6%	87.3%	There are HCA vacancies. Due to trachy patient on Giraffe Ward, Elephants trachy trained HCA's needed to be moved to giraffe. Due to staff sickness following injuries our fill rate has been lowered than required, staff from other areas within the Trust have been moved to support the vacancies	8.0	1.5	9.4	0	0	0	0	0	0	0
Fox	80.2%	70.7%	75.5%	99.2%	78.9%	There are still significant vacancies. Some occasional bed closures and some cancelled BMT patients.	11.1	2.1	13.2	1	0	0	0	0	2	0
Giraffe	104.4%	56.4%	79.3%	62.1%	83.7%	There are less acute patients than usual, staff moved across the whole Unit.	9.2	2.0	11.2	0	0	0	0	0	0	0
Lion	91.8%	61.5%	81.1%	72.7%	83.3%	Due to study and maternity leave. A the variation of patient acuity this resulted in the use of Bank staff that may not have been captures accurately on RosterPro. There were multiply wave of staff movements.	9.4	1.7	11.1	0	0	0	0	0	0	0
Penguin	130.0%	168.0%	83.6%	40.8%	108.6%	There was a need for 1:1 nursing on a child due to Safeguarding reasons. Day figures include Ambulatory Care on Roster Pro.	8.6	3.4	12.1	0	0	0	0	0	0	0
Robin	81.4%	74.5%	74.1%	83.9%	78.2%	This was due to very high sickness, variation in patient acuity and support from other Trustwide patient areas.	9.7	1.8	11.5	0	0	0	0	0	0	0
International Private Patients Division																
Bumblebee	102.7%	105.9%	105.8%	127.6%	107.1%	Qualified staffing deficit and associated risks were mitigated by additional bank HCA's, careful allocation. Staff were moved across the division to account for unfilled bank shifts and to cover sickness and vacancies. Some reduction in the 1:1 specials, but increased patient acuity elsewhere, and failure to fill qualified bank shifts meant additional unqualified bank shifts were used. Some long term sickness in the unqualified workforce impacted the staffing numbers. 3 beds were closed for most of the month to account for an extremely complex patient requiring 2 staff members to care for her.	8.8	2.3	11.1	0	0	0	0	0	0	0
Butterfly	102.3%	305.4%	81.3%	191.0%	112.7%	Qualified staffing deficit and associated risks were mitigated by additional use of bank and careful allocation. Better fill rate of bank shifts at night, so many rostered staff were moved to day shifts where appropriate. Increase in patient acuity, and patients requiring escorted transfers for radiotherapy at other centres, so has utilised additional bank staff both registered and unregistered. Increased unqualified bank usage as cubicalised patient requiring 1:1 special. Increased numbers of unregistered staff at nights to support registered staff in providing safe care for cubicalised patients in transplant period.3 beds were closed to complete a redecoration programme which also allowed for safe staffing levels.	9.0	3.4	12.4	0	0	0	0	0	0	0
Hedgehog	184.1%	119.0%	148.2%	93.3%	146.2%	Some reduced patient numbers especially at nights, due to some day cases, has allowed for staff to move across the division and still ensure safe staffing levels on the ward. Large variable as small ward establishment and some long term sickness issues in qualified and unqualified staff.	9.3	3.0	12.3	0	0	0	0	0	0	0
JM Barrie Division																
Eagle	92.1%	50.3%	99.2%	74.2%	86.7%	Ward safely staffed	9.2	1.6	10.8	0	0	0	0	0	0	0
Kingfisher	63.3%	48.3%	109.8%	-	70.0%	Ward safely staffed	7.8	3.2	11.1	0	0	0	0	0	0	0
Rainforest Gastro	91.0%	46.8%	83.6%	45.0%	68.7%	No unsafe shifts, some increase in staffing over week period to manage post surgical patient out of area	6.9	3.0	9.9	0	1	0	0	0	0	0
Rainforest Endo/Met	108.7%	53.2%	73.8%	75.8%	81.1%	Ward safely staffed	8.3	2.8	11.1	0	0	0	0	0	0	0
Mildred Creak	93.4%	120.0%	89.8%	90.1%	98.3%	has 3 band 5 vacancies hence closed bed, regular bank used to cover until September, shifts safe, also due to patient dependency some nights requiring an extra member of staff to manage patient behaviour	5.2	4.0	9.2	0	0	0	0	0	0	0
Koala	113.6%	166.4%	89.1%	56.0%	102.4%	Koala ward had 113.6% nurses on Long days due to the patient acuity and because some of their HDU patients required cubicles and therefore had to be nursed 1:1 rather than 2:1. Care staff were at 166.3 % during the day as they are utilised more during the day to cover the telemetry unit – this also explains the 56% care staff cover on nights. Nursing staff were at 89.1% on nights due to staff sickness and because of the vacancies on the ward.	12.3	1.4	13.8	0	0	0	0	0	0	0
Peter Pan	99.4%	96.0%	87.6%	-	94.7%	Ward safely staffed	9.8	2.1	11.8	0	0	0	0	0	0	0
Sky	111.0%	115.6%	90.9%	-	104.6%	Sky ward had 115.6 care staff days as the HCAs do not cover the nights but currently only the days. Nursing staffing was low at time and therefore HCA were utilised more.	8.7	1.9	10.6	0	0	0	0	0	0	0
Squirrel SNAPs	108.4%	123.5%	138.0%	51.5%	112.7%	Still awaiting final establishment to be split, to reflect the changes to the ward. Ward safely staffed.	9.7	2.7	12.4	0	0	0	0	0	0	0
Squirrel Urology	131.4%	118.3%	127.4%	72.9%	120.3%	Still awaiting final establishment to be split, to reflect the changes to the ward. Ward safely staffed.	8.3	1.9	10.2	0	0	0	0	0	0	0

June 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

	Nursing Staffing Actual vs Planned						Care Hours per Patient Day			Key Indicators						
Ward	Registered Day	Care Staff Day	Registered Night	Care Staff Night	Total	Comments	Registered	Care Staff	Total	Pressure Ulcer, grade 2	Cardiac Arrest	Respiratory Arrest	PALS	Complaints	Datix	Unsafe shift
Charles West Division																
Badger	91.1%	123.1%	91.9%	88.1%	93.4%	Within 10% of 100% threshold generally, however number of B5 and B6 vacancies in addition recent decrease and increase in HDU and acuity.	9.5	1.7	11.3	1	0	0	—	0	0	0
Bear	122.7%	134.1%	114.5%	81.4%	118.1%	Currently over recruited in Band 5's but not Band 6's and in addition high amount of HDU.	9.8	1.6	11.5	0	0	1	—	0	0	0
Flamingo	120.0%	53.3%	106.5%	11.1%	110.5%	120% fill rate is due to high acuity children on ECMO and other devices.	27.2	0.4	27.6	3	N/A	N/A	—	0	0	0
Miffy	137.8%	80.1%	79.5%	81.2%	93.0%	75% B6 vacancy which is being backfilled/supported by Bank HCA's.	10.5	9.7	20.2	0	0	0	—	0	0	0
NICU	100.9%	10.1%	97.5%	-	95.8%	This is a true reflection of our staffing requirements for the month of June	31.5	0.6	32.1	0	N/A	N/A	—	0	0	0
PICU	102.3%	40.4%	87.7%	0.0%	90.8%	The figures provided are a true reflection of the staffing requirements for PICU. During the month of June, our occupancy levels were frequently less than 85%, therefore there were several shifts whereby bank staff were cancelled; however there has been a continued increase in maternity leave and sickness necessitating the continued use of bank staff to enable PICU to flex up to occupancy. A close eye has been kept on bank fill during this period, cancelling any unnecessary staff.	34.1	0.4	34.5	1	N/A	N/A	—	0	0	0
Elephant	86.6%	73.3%	82.2%	70.1%	82.2%	Deficits in staffing numbers/skill mix due to sickness absences, vacancies & special leave (including Jury Service & Unpaid Leave). Some unfilled Bank shifts. Assistance & support provided by NPEs, CNS Teams, Matron & staff moved from other Wards in the Trust.	8.9	1.7	10.6	0	0	0	—	0	0	0
Fox	80.1%	86.4%	73.2%	93.0%	78.7%	Deficits in staffing numbers/skill mix due to sickness, absences, a substantive vacancies factor and patient acuity. Some unfilled Bank shifts. Assistance & support provided by NPEs, CNS Teams, Matron & staff moved from other Wards in the Trust.	11.9	2.4	14.3	0	0	0	—	0	0	0
Giraffe	97.4%	51.8%	85.9%	40.2%	80.3%	Room 7 closed until 26.5.17 due to much required work to replace bath & sort a persistent bathroom leak. Room 5 closed from 28.5.17 to 31.5.17 due to a leak in the bathroom. As a result, in-patient activity was affected & patients had to be admitted elsewhere. Rostered staff had to be moved elsewhere to support areas where there were deficits.	9.7	1.6	11.3	0	0	0	—	0	0	0
Lion	84.4%	98.8%	82.7%	83.6%	85.1%	Deficits in staffing skill mix/numbers due to vacancies & low level sickness absences. Staff moved from other areas in the Trust to support these deficits on a shift-to-shift basis.	8.7	2.2	10.8	0	0	0	—	0	0	0
Penguin	144.1%	211.5%	88.4%	12.6%	118.1%	Ward establishment covers both inpatient ward and ambulatory unit so does not give a true reflection of actual staffing numbers. For the current vacancies there is a robust recruitment plan. Both areas although very busy have been maintained with minimal use of external staff and staff have been reallocated to areas around the Trust.	10.1	4.0	14.1	0	0	0	—	0	0	0
Robin	84.4%	90.3%	74.9%	102.6%	82.5%	Deficits in staffing numbers/skill mix due to sickness, absences, a substantive vacancies factor. Some unfilled Bank shifts. Assistance & support provided by Ward Educator, CNS Teams, Matron & staff moved from other Wards in the Trust.	11.5	2.6	14.0	0	0	0	—	0	0	0
International Private Patients Division																
Bumblebee	102.2%	153.1%	92.0%	101.2%	101.5%	Initial short term increase in patient acuity at the beginning of the month. HCA staff were utilised to manage a number of 1:1 specials but this decreased by the end of the month. There has been a reduction in the overall staffing establishment due to staff leaving to pursue opportunities outside of the Trust. The ward is continuing to actively recruit. Beds were closed for a short period due to the increased acuity and staffing levels but all are now open.	9.9	2.8	12.7	0	0	0	—	0	0	0
Butterfly	81.8%	222.5%	62.8%	115.7%	85.6%	All beds open. Nursing numbers are good, the ward area was very busy on dayshifts due to a large number of patients receiving chemotherapy.	8.9	2.9	11.8	0	0	0	—	0	0	0
Hedgehog	155.7%	134.0%	153.5%	94.4%	141.2%	All beds open. Increase in use of Bank staff due to short term staff sickness and number of staff leaving to take maternity leave, staffing establishment is unchanged.	11.0	4.1	15.1	0	0	0	—	0	0	0
JM Barrie Division																
Eagle	100.0%	79.0%	101.5%	73.8%	95.4%	*Ward safely staffed.*	9.4	2.1	11.4	0	0	0	—	0	0	0
Kingfisher	81.6%	38.9%	119.5%	-	79.3%	*Ward safely staffed.*	10.4	3.1	13.5	0	0	0	—	0	0	0
Rainforest Gastro	97.5%	46.7%	93.8%	50.6%	74.3%	Curent HCA vancies . Ward Safely staffed	7.1	3.1	10.2	0	1	0	—	0	0	0
Rainforest Endo/Met	123.0%	46.7%	70.2%	73.3%	82.9%	*Ward safely staffed.*	9.9	2.8	12.7	0	0	0	—	0	0	0
Mildred Creak	98.9%	128.5%	84.4%	97.6%	102.8%	Unit safely staffed.	4.8	3.9	8.6	0	0	0	—	0	0	0
Koala	104.3%	153.9%	86.1%	56.5%	96.3%	The variance for the non-registered staff on days was due to the fact that the HCA's on Koala work mainly days in order to cover the telemetry unit, this also accounts for the low rate on nights. Registered nurse staffing on the night shift was at 86.1% due to ongoing vacancies in particular band 6's and more experienced nurses.	10.6	1.3	11.9	0	0	0	—	0	0	0
Peter Pan	108.2%	97.2%	99.9%	-	104.3%		8.8	1.8	10.6	0	0	0	—	0	0	0
Sky	105.7%	107.2%	91.8%	-	101.0%	Ward safely staffed.	9.0	1.8	10.8	0	0	0	—	0	1	0
Squirrel SNAPs	118.9%	142.5%	160.6%	80.9%	130.1%	Increase in patient acuity. Establishments for SNAPs and Urology need to be reallocated to reflect the actual speciality activity.	8.7	2.3	11.0	0	0	0	—	0	0	0
Squirrel Urology	122.6%	80.5%	96.1%	32.5%	95.2%	Ward safely staffed.	8.7	1.7	10.4	0	0	0	—	0	0	0

GOSH Safe Nurse Staffing Report June 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

Capacity:

- May: 2 beds closed on Squirrel Urology ward; 1-2 on Sky; 4 (intermittently) on Peter Pan; 2 on Koala; 1 on MCU; and 1-3 Bumblebee and Bumblebee due to staffing and patient acuity. 1 bed closed on Giraffe, 1 (intermittently) on Fox and 1 on Hedgehog for works.
- June: 2 beds closed on Sky ward and 1 on MCU due to staffing. Occasionally, Squirrel Urology closed 2 beds; Squirrel SNAPS 2 beds; NICU 1 bed; PICU 1-3 beds; Penguin 2 beds; Kingfisher 3, Peter Pan 1 due to staffing. 1 bed closed on Giraffe, 1 on Robin, 3 on Bumblebee and 1-3 on Hedgehog for works.

Staffing:

Turnover rate continues to improve. Staff sickness levels have risen slightly but continue to remain under the Trust target of 3%. After a very successful recruitment campaign 241 Newly qualified nurses are expected to start in the Trust on the 25th September 2017.

Temporary Staffing:

- Overall shift request numbers for May and June 2017 are lower than this time last year.
- May and June's demand in 2017 is slightly higher than April 2017. One shift was covered with agency in May (Butterfly ward), and two shifts in June covering the maternity leave of the HON for CRF.

There were no unsafe shifts reported in May or June 2017.

Nursing Workforce Summary:

Month	UNIFY* Actuals vs plan	CHPPD** Trust average (excl. ITUs)	PANDA Acuity (weighted for cubicle and complexity)				Maternity leave (RN)	Sickness (RN)	Turnover FTE (RN)	Vacancies (RN)	Vacancies (un-registered)	Pipeline recruits (RN)	Pipeline recruits (un-registered)
			WIC (1:1)	HD (1:2)	Normal under 2 (1:3)	Normal over 2 (1:4)							
March	92.9%	11.5	36.4%	18.6%	14.7%	30.4%	Not available	2.8%	16.3%	92.3	53.8	Not available	Not available
April	91.1%	11.6	39.0%	20.9%	13.1%	27.0%	Not available	2.7%	16.4%	110.1	31.7	Not available	Not available
May	98.9%	11.3	39.1%	19.4%	12.6%	29.0%	4.5%	2.9%	16.2%	101.2	31.2	283	1
June	96.8%	11.9	38.6%	21.5%	12.5%	27.4%	4.3%	2.9%	15.9%	94.8	29.7	258	1

Glossary

UNIFY - Unify is an online collection system used for collating, sharing and reporting NHS and social care data.

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

Care hours per patient day =	Hours of registered nurses and midwives alongside Hours of healthcare support workers
	Total number of inpatients

Defining Staffing levels

- **Normal dependency Under 2 Years - 1 Nurse: 3 Patients**
- **Normal dependency Over 2 Years - 1 Nurse: 4 Patients**
- **Ward High Dependency (HD) - 1 Nurse: 2 Patients**
- **Ward Intensive Care (WIC) - 1 Nurse: 1 Patient**

Defining staffing levels for Children's and Young People's services (Royal College of Nursing, July 2013)

May 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

	Nursing Staffing Actual vs Planned						Care Hours per Patient Day			Key Indicators						
Ward	Registered Day	Care Staff Day	Registered Night	Care Staff Night	Total	Comments	Registered	Care Staff	Total	Pressure Ulcer, grade 2	Cardiac Arrest	Respiratory Arrest	PALS	Complaints	Datix	Unsafe shift
Charles West Division																
Badger	96.7%	102.9%	91.5%	92.0%	94.7%	Within 10% of 100% threshold	10.7	1.7	12.5	0	1	2	0	0	0	0
Bear	118.2%	120.1%	111.1%	82.3%	113.4%	Currently over recruited in addition to increased patient activity, high amount of HDU.	8.9	1.4	10.3	1	0	0	0	0	0	0
Flamingo	124.4%	71.1%	110.4%	39.6%	115.3%	Ward safely staffed	26.5	0.6	27.1	5	N/A	N/A	0	0	0	0
Miffy	155.5%	67.8%	90.2%	82.7%	95.6%	75% SSN vacancy which is being backfilled/supported by Bank HCA's. >150% due to small staff numbers.	11.8	8.8	20.6	0	0	0	0	0	0	0
NICU	109.3%	19.4%	102.2%	-	102.0%	The figures provided are a true reflection of the staffing requirements for NICU. During the month of May, There continued to be an number of both long term and short term sickness absences, necessitating an increase in the number of bank staff required to fill vacant shifts.	29.2	0.5	29.8	0	N/A	N/A	0	0	0	0
PICU	110.8%	39.4%	90.0%	0.0%	95.9%	The figures provided are a true reflection of the staffing requirements for PICU. During the month of May, our occupancy levels were less than 85%, therefore there were several shifts whereby bank staff were cancelled; however there has been a continued increase in maternity leave and leavers necessitating the continued use of bank staff to enable PICU to flex up to occupancy. A close eye has been kept on bank fill during this period, cancelling any unnecessary staff.	33.1	0.4	33.4	0	N/A	N/A	0	0	0	0
Elephant	97.3%	67.8%	82.7%	77.6%	87.3%	There are HCA vacancies. Due to trachy patient on Giraffe Ward, Elephants trachy trained HCA's needed to be moved to giraffe. Due to staff sickness following injuries our fill rate has been lowered than required, staff from other areas within the Trust have been moved to support the vacancies	8.0	1.5	9.4	0	0	0	0	0	0	0
Fox	80.2%	70.7%	75.5%	99.2%	78.9%	There are still significant vacancies. Some occasional bed closures and some cancelled BMT patients.	11.1	2.1	13.2	1	0	0	0	0	2	0
Giraffe	104.4%	56.4%	79.3%	62.1%	83.7%	There are less acute patients than usual, staff moved across the whole Unit.	9.2	2.0	11.2	0	0	0	0	0	0	0
Lion	91.8%	61.5%	81.1%	72.7%	83.3%	Due to study and maternity leave. A the variation of patient acuity this resulted in the use of Bank staff that may not have been captures accurately on RosterPro. There were multiply wave of staff movements.	9.4	1.7	11.1	0	0	0	0	0	0	0
Penguin	130.0%	168.0%	83.6%	40.8%	108.6%	There was a need for 1:1 nursing on a child due to Safeguarding reasons. Day figures include Ambulatory Care on Roster Pro.	8.6	3.4	12.1	0	0	0	0	0	0	0
Robin	81.4%	74.5%	74.1%	83.9%	78.2%	This was due to very high sickness, variation in patient acuity and support from other Trustwide patient areas.	9.7	1.8	11.5	0	0	0	0	0	0	0
International Private Patients Division																
Bumblebee	102.7%	105.9%	105.8%	127.6%	107.1%	Qualified staffing deficit and associated risks were mitigated by additional bank HCA's, careful allocation. Staff were moved across the division to account for unfilled bank shifts and to cover sickness and vacancies. Some reduction in the 1:1 specials, but increased patient acuity elsewhere, and failure to fill qualified bank shifts meant additional unqualified bank shifts were used. Some long term sickness in the unqualified workforce impacted the staffing numbers. 3 beds were closed for most of the month to account for an extremely complex patient requiring 2 staff members to care for her.	8.8	2.3	11.1	0	0	0	0	0	0	0
Butterfly	102.3%	305.4%	81.3%	191.0%	112.7%	Qualified staffing deficit and associated risks were mitigated by additional use of bank and careful allocation. Better fill rate of bank shifts at night, so many rostered staff were moved to day shifts where appropriate. Increase in patient acuity, and patients requiring escorted transfers for radiotherapy at other centres, so has utilised additional bank staff both registered and unregistered. Increased unqualified bank usage as cubicalised patient requiring 1:1 special. Increased numbers of unregistered staff at nights to support registered staff in providing safe care for cubicalised patients in transplant period.3 beds were closed to complete a redecoration programme which also allowed for safe staffing levels.	9.0	3.4	12.4	0	0	0	0	0	0	0
Hedgehog	184.1%	119.0%	148.2%	93.3%	146.2%	Some reduced patient numbers especially at nights, due to some day cases, has allowed for staff to move across the division and still ensure safe staffing levels on the ward. Large variable as small ward establishment and some long term sickness issues in qualified and unqualified staff.	9.3	3.0	12.3	0	0	0	0	0	0	0
JM Barrie Division																
Eagle	92.1%	50.3%	99.2%	74.2%	86.7%	Ward safely staffed	9.2	1.6	10.8	0	0	0	0	0	0	0
Kingfisher	63.3%	48.3%	109.8%	-	70.0%	Ward safely staffed	7.8	3.2	11.1	0	0	0	0	0	0	0
Rainforest Gastro	91.0%	46.8%	83.6%	45.0%	68.7%	No unsafe shifts, some increase in staffing over week period to manage post surgical patient out of area	6.9	3.0	9.9	0	1	0	0	0	0	0
Rainforest Endo/Met	108.7%	53.2%	73.8%	75.8%	81.1%	Ward safely staffed	8.3	2.8	11.1	0	0	0	0	0	0	0
Mildred Creak	93.4%	120.0%	89.8%	90.1%	98.3%	has 3 band 5 vacancies hence closed bed, regular bank used to cover until September, shifts safe, also due to patient dependency some nights requiring an extra member of staff to manage patient behaviour	5.2	4.0	9.2	0	0	0	0	0	0	0
Koala	113.6%	166.4%	89.1%	56.0%	102.4%	Koala ward had 113.6% nurses on Long days due to the patient acuity and because some of their HDU patients required cubicles and therefore had to be nursed 1:1 rather than 2:1. Care staff were at 166.3 % during the day as they are utilised more during the day to cover the telemetry unit – this also explains the 56% care staff cover on nights. Nursing staff were at 89.1% on nights due to staff sickness and because of the vacancies on the ward.	12.3	1.4	13.8	0	0	0	0	0	0	0
Peter Pan	99.4%	96.0%	87.6%	-	94.7%	Ward safely staffed	9.8	2.1	11.8	0	0	0	0	0	0	0
Sky	111.0%	115.6%	90.9%	-	104.6%	Sky ward had 115.6 care staff days as the HCAs do not cover the nights but currently only the days. Nursing staffing was low at time and therefore HCA were utilised more.	8.7	1.9	10.6	0	0	0	0	0	0	0
Squirrel SNAPs	108.4%	123.5%	138.0%	51.5%	112.7%	Still awaiting final establishment to be split, to reflect the changes to the ward. Ward safely staffed.	9.7	2.7	12.4	0	0	0	0	0	0	0
Squirrel Urology	131.4%	118.3%	127.4%	72.9%	120.3%	Still awaiting final establishment to be split, to reflect the changes to the ward. Ward safely staffed.	8.3	1.9	10.2	0	0	0	0	0	0	0

June 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

	Nursing Staffing Actual vs Planned						Care Hours per Patient Day			Key Indicators						
Ward	Registered Day	Care Staff Day	Registered Night	Care Staff Night	Total	Comments	Registered	Care Staff	Total	Pressure Ulcer, grade 2	Cardiac Arrest	Respiratory Arrest	PALS	Complaints	Datix	Unsafe shift
Charles West Division																
Badger	91.1%	123.1%	91.9%	88.1%	93.4%	Within 10% of 100% threshold generally, however number of B5 and B6 vacancies in addition recent decrease and increase in HDU and acuity.	9.5	1.7	11.3	1	0	0	—	0	0	0
Bear	122.7%	134.1%	114.5%	81.4%	118.1%	Currently over recruited in Band 5's but not Band 6's and in addition high amount of HDU.	9.8	1.6	11.5	0	0	1	—	0	0	0
Flamingo	120.0%	53.3%	106.5%	11.1%	110.5%	120% fill rate is due to high acuity children on ECMO and other devices.	27.2	0.4	27.6	3	N/A	N/A	—	0	0	0
Miffy	137.8%	80.1%	79.5%	81.2%	93.0%	75% B6 vacancy which is being backfilled/supported by Bank HCA's.	10.5	9.7	20.2	0	0	0	—	0	0	0
NICU	100.9%	10.1%	97.5%	-	95.8%	This is a true reflection of our staffing requirements for the month of June	31.5	0.6	32.1	0	N/A	N/A	—	0	0	0
PICU	102.3%	40.4%	87.7%	0.0%	90.8%	The figures provided are a true reflection of the staffing requirements for PICU. During the month of June, our occupancy levels were frequently less than 85%, therefore there were several shifts whereby bank staff were cancelled; however there has been a continued increase in maternity leave and sickness necessitating the continued use of bank staff to enable PICU to flex up to occupancy. A close eye has been kept on bank fill during this period, cancelling any unnecessary staff.	34.1	0.4	34.5	1	N/A	N/A	—	0	0	0
Elephant	86.6%	73.3%	82.2%	70.1%	82.2%	Deficits in staffing numbers/skill mix due to sickness absences, vacancies & special leave (including Jury Service & Unpaid Leave). Some unfilled Bank shifts. Assistance & support provided by NPEs, CNS Teams, Matron & staff moved from other Wards in the Trust.	8.9	1.7	10.6	0	0	0	—	0	0	0
Fox	80.1%	86.4%	73.2%	93.0%	78.7%	Deficits in staffing numbers/skill mix due to sickness, absences, a substantive vacancies factor and patient acuity. Some unfilled Bank shifts. Assistance & support provided by NPEs, CNS Teams, Matron & staff moved from other Wards in the Trust.	11.9	2.4	14.3	0	0	0	—	0	0	0
Giraffe	97.4%	51.8%	85.9%	40.2%	80.3%	Room 7 closed until 26.5.17 due to much required work to replace bath & sort a persistent bathroom leak. Room 5 closed from 28.5.17 to 31.5.17 due to a leak in the bathroom. As a result, in-patient activity was affected & patients had to be admitted elsewhere. Rostered staff had to be moved elsewhere to support areas where there were deficits.	9.7	1.6	11.3	0	0	0	—	0	0	0
Lion	84.4%	98.8%	82.7%	83.6%	85.1%	Deficits in staffing skill mix/numbers due to vacancies & low level sickness absences. Staff moved from other areas in the Trust to support these deficits on a shift-to-shift basis.	8.7	2.2	10.8	0	0	0	—	0	0	0
Penguin	144.1%	211.5%	88.4%	12.6%	118.1%	Ward establishment covers both inpatient ward and ambulatory unit so does not give a true reflection of actual staffing numbers. For the current vacancies there is a robust recruitment plan. Both areas although very busy have been maintained with minimal use of external staff and staff have been reallocated to areas around the Trust.	10.1	4.0	14.1	0	0	0	—	0	0	0
Robin	84.4%	90.3%	74.9%	102.6%	82.5%	Deficits in staffing numbers/skill mix due to sickness, absences, a substantive vacancies factor. Some unfilled Bank shifts. Assistance & support provided by Ward Educator, CNS Teams, Matron & staff moved from other Wards in the Trust.	11.5	2.6	14.0	0	0	0	—	0	0	0
International Private Patients Division																
Bumblebee	102.2%	153.1%	92.0%	101.2%	101.5%	Initial short term increase in patient acuity at the beginning of the month. HCA staff were utilised to manage a number of 1:1 specials but this decreased by the end of the month. There has been a reduction in the overall staffing establishment due to staff leaving to pursue opportunities outside of the Trust. The ward is continuing to actively recruit. Beds were closed for a short period due to the increased acuity and staffing levels but all are now open.	9.9	2.8	12.7	0	0	0	—	0	0	0
Butterfly	81.8%	222.5%	62.8%	115.7%	85.6%	All beds open. Nursing numbers are good, the ward area was very busy on dayshifts due to a large number of patients receiving chemotherapy.	8.9	2.9	11.8	0	0	0	—	0	0	0
Hedgehog	155.7%	134.0%	153.5%	94.4%	141.2%	All beds open. Increase in use of Bank staff due to short term staff sickness and number of staff leaving to take maternity leave, staffing establishment is unchanged.	11.0	4.1	15.1	0	0	0	—	0	0	0
JM Barrie Division																
Eagle	100.0%	79.0%	101.5%	73.8%	95.4%	*Ward safely staffed.*	9.4	2.1	11.4	0	0	0	—	0	0	0
Kingfisher	81.6%	38.9%	119.5%	-	79.3%	*Ward safely staffed.*	10.4	3.1	13.5	0	0	0	—	0	0	0
Rainforest Gastro	97.5%	46.7%	93.8%	50.6%	74.3%	Curent HCA vancies . Ward Safely staffed	7.1	3.1	10.2	0	1	0	—	0	0	0
Rainforest Endo/Met	123.0%	46.7%	70.2%	73.3%	82.9%	*Ward safely staffed.*	9.9	2.8	12.7	0	0	0	—	0	0	0
Mildred Creak	98.9%	128.5%	84.4%	97.6%	102.8%	Unit safely staffed.	4.8	3.9	8.6	0	0	0	—	0	0	0
Koala	104.3%	153.9%	86.1%	56.5%	96.3%	The variance for the non-registered staff on days was due to the fact that the HCA's on Koala work mainly days in order to cover the telemetry unit, this also accounts for the low rate on nights. Registered nurse staffing on the night shift was at 86.1% due to ongoing vacancies in particular band 6's and more experienced nurses.	10.6	1.3	11.9	0	0	0	—	0	0	0
Peter Pan	108.2%	97.2%	99.9%	-	104.3%		8.8	1.8	10.6	0	0	0	—	0	0	0
Sky	105.7%	107.2%	91.8%	-	101.0%	Ward safely staffed.	9.0	1.8	10.8	0	0	0	—	0	1	0
Squirrel SNAPs	118.9%	142.5%	160.6%	80.9%	130.1%	Increase in patient acuity. Establishments for SNAPs and Urology need to be reallocated to reflect the actual speciality activity.	8.7	2.3	11.0	0	0	0	—	0	0	0
Squirrel Urology	122.6%	80.5%	96.1%	32.5%	95.2%	Ward safely staffed.	8.7	1.7	10.4	0	0	0	—	0	0	0

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **27th July 2017**	
Staff Survey and Listening Events Update **Submitted by:** **Ali Mohammed, Director of HR & OD**	**Paper No: Attachment N**
Aims / summary To provide Trust Board with an update of actions following the 2016 staff survey.	
Action required from the meeting To note the content of the report.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Work supports the Trust strategic objective of creating a culture enabling us to learn and thrive.	
Financial implications Incorporated within current resource allocations and budgets.	
Who needs to be told about any decision? N/A	
Who is responsible for implementing the proposals / project and anticipated timescales? Director of HR&OD Local Divisional and Directorate Management teams	
Who is accountable for the implementation of the proposal / project? Director of HR & OD Local Divisional and Directorate Management teams	

Attachment N

Staff Survey and Staff Listening Events

Introduction

The 2016 GOSH survey saw a return rate of 60% (compared to the average rate of 44%); this was the second highest response rate of any acute specialist trust in England. The survey is due to run again during Sep – Nov 2017.

Headline issues

Key positive areas

One measure relating to feeling unwell due to work related stress in last 12 months showed a statistically significant improvement since 2015. The Trust also compared favourably against the national average for acute specialist trusts.

Our other top ranking scores where we compare most favourably to other acute specialist trusts are:

- Quality of appraisals
- Staff able to contribute to improvements at work
- Quality of non-mandatory training, learning or development
- Satisfaction with level of responsibility and involvement

There were also improvements (although not statistically significant) against the three questions contributing towards the overall measure of recommending the organisation as a place to work or receive treatment.

Top five key concerns

Our top ranking scores where we compare least favourably to other acute specialist trusts are:

- Staff witnessing potential harmful errors, near misses or incidents in last month
- Staff working extra hours
- Staff feeling pressure to attend work when unwell in last three months
- % of staff reporting most recent experience of violence
- % of staff believing that the organisation provides equal opportunities for career progression or promotion

Listening Events

Two listening events were held during May 2017. The aim of these were to engage further with staff around key concerns highlighted by the survey findings and ask staff for ideas of how these could be addressed across the whole of the Trust. The events were well attended by over 40 participants who came from a range of job roles and pay bands.

The events, following the findings of the survey, focused on the following issues:

- Harassment, bullying and violence – mainly from service users, however comments and suggestions we also received around staff on staff behaviours
- Looking after our staff (incorporating working extra hours and attending work when unwell).
- Promotion and progression for all
- Creating a great place to work

Key Themes and Actions Arising

From information gathered at the listening events (Appendix 1) it is apparent that there are opportunities to build on the work already undertaken and support to staff already offered. Any actions taken will be aligned to the Trust's strategic objective of attracting and retaining the right people through creating a culture that enables us to learn and thrive.

Harassment, Bullying and Violence

Numerous recommendations were made by staff around the need to address violence from service users. There were several suggestions made about how the Trust could devise clear messaging around expected parental behaviours. Numerous comments were made about the provision of conflict resolution and mediation training. Issues were raised about the need for a higher profile to be given to encourage staff to report incidents in an appropriate and timely way. It is recognised that issues concerning service users are under the remit of Chief Nurse and information obtained from the listening events will be forwarded as appropriate.

In terms of staff behaviours (harassment & bullying) the following themes consistently came out and will be taken forward:

- Making H&B easier to report
- More communication and information around H&B
- The need for specific H&B training for managers

Actions will include a review of the Freedom to Speak Up Ambassador Service to explore the potential for them to act as another route for staff to discuss H&B concerns; a dedicated communications campaign around behaviours expected from staff, what is (and isn't) acceptable behaviours, how to raise H&B issues etc.; more input for managers around how to recognise and respond to H&B concerns.

Looking After Our Staff

Using information obtained from the listening events a further session, based on the principles of Appreciative Inquiry, was delivered in June 2017 to enable more focussed discussions to take place. The session involved staff side representatives, managers, Occupational Health and HR staff. As a result the following themes will be taken forward:

- Developing a co-ordinated approach to health and wellbeing initiatives
- Increasing communications around staff benefits
- The need to establish a network of health and wellbeing champions
- More training and development for managers
- Reviewing the Sickness and Attendance Policy and the associated documentation

A multi-disciplinary health and wellbeing group has already been established which will concentrate on enhancing the physical and mental health of staff. Other actions proposed include reviewing the training needs of managers to ensure they are able to effectively support staff who suffer ill health, or who are disabled; exploring the provision of mental health first aid training; more bespoke communications and publicity regarding the various benefits available to staff (massage, gym membership, local discounts etc.); a staff health and wellbeing week will take place in January 2018 supported by a roving road show.

Promotion and Progression for All

There were many useful suggestions made and work is already underway including reviewing the inclusion work plan. The HR&OD Directorate is in discussion with relevant individuals to consider the needs of LGBT staff. Actions within this area will be shaped by the Trust's progress against the Workforce Race Equality

Standard, results of will be presented to Trust Board in September 2017, as well as the Trust's staff related equality objectives.

Key themes from the listening events were:

- The need to address behaviours / biases
- Establishing networks to support minority staff
- Reviewing the recruitment and selection processes
- Enhancing diversity across the Trust

Actions to address these will encompass reviewing how and when unconscious bias training happens and the scope for enhancing this or targeting towards specific groups of staff; signing up to the Government's Disability Confident Scheme which will impact on the recruitment & selection processes used; raising the profile of staff diversity in the Trust through events and celebrations. The Trust will also host Project Search interns again from Oct 2017 in conjunction with Camden Council, giving young adults with learning disabilities the opportunity to gain work and life experience.

Creating a Great Place to Work

It is clear from the staff survey results and from the listening events that GOSH staff recognise the Trust as a special place to work.

Key themes from the listening events were:

- Recognising the value of staff and communicating this widely
- The importance of a compassionate workplace culture which promotes mutual respect
- Working as one team
- The importance of living the Always Values

Actions which will be taken forward include supporting the Freedom to Speak Up Ambassadors to promote a speak up culture, developing tools to further embed team working and continuing to develop and embed the Always Values. Following the staff awards ceremony, communications to share award winners' stories will also be developed.

Local Action Plans

HR Business Partners have been working closely with divisional and directorate management teams to support them to develop local actions in response to their particular survey responses.

Action required

Trust Board are asked to note the contents of this report.

Appendix 1

Outputs from the Listening Events

Bullying, Harassment, and Violence: Practical Suggestions

Reporting and Process

- Making the process easier for reporting bullying & harassment
- Create an environment where staff can easily and quickly report issues and create feedback mechanism
- Clearer definitions of H&B
- Give staff the tools to know when enough is enough with aggressive parents and families
- Accessibility to support/debrief local and central. Drop in sessions – clear process to escalate problems
- Evelina project to support staff experiencing conflict
- Clear framework for managing H&B from staff and patients

General Comms

- Positive outcome stories of successful resolution of H&B
- Publish how reported incidences have been followed up

Finding out more

- Ask those who have experienced H&B to talk to HR in confidence to gain greater understanding of issues
- Do a survey to determine more detail about why staff experience H&B. We need to know more about what's going on

Training

- Provide different levels of conflict resolution training (with families) for clinical staff
- Training provided by those who know the topics, to include:
    - Dealing with patients
    - Managing conflict & difficult conversations
    - Manager training skills + communication
    - Managers informed of their responsibilities to support staff – to be trained to be a manager

Culture

- Culture of care
- Trust Board and senior leaders to role model good behaviours
- Develop a coaching conversations culture

Service Users

- Develop rights and responsibilities for patients and families
- Contracts with families regarding behaviours

Attachment N

Place to Work: Practical Suggestions

Communications

- Remind all staff of the value they bring to patient care (2)
- Use promotional videos to see how other departments provide a service to the trust
- Have a dedicated social media platform for staff to share stories

Culture

- Increase values based recruitment
- IHI programme- Joy at work
- Ask the Executive team to shadow a team once a month for them to experience the service
- Try randomised coffee trials
- Staff recognition- not necessarily rewards but a simple thank you card- handwritten.
- Decision making: clarity about responsibility and accountability who can make and are held accountable for decisions
- Quick wins
    - Email culture. Training/top and tail/tone
    - Mindfulness/appreciative input/positive psychology (more useful)
    - Soft skills
        - Reflective time- 'that made me feel'
        - Respectful communication
    - Decisions being made above roles (push back down), culture change

Benefits

- Better communication around benefits available

Teams

- Supporting team such as through away days and other support

Other

- Increase transparency- why we are/are not doing things e.g. vacancy approval forms
- Cutting down mandatory training and ensuring essential for role

Progression and Promotion: Practical Suggestions

Developing career pathways/talent management process

- Look at providing equal progression opportunities for clinical and non-clinical staff
- Consider how would a band 4 clinical assistant can move forward to get new skills
- Recognising that career progression does not (and increasingly will not) link to banding and a pay rise.
- Recognition for more responsibility e.g. health and safety.
- H&OD function to have a stream to look after career progression e.g. L&D team
- Reinstate career development programme
- More bespoke courses for porters, IT, Mechanics etc.

Working with Managers

- Training for managers to draft a career pathway for team roles.
- Provide leadership training for consultants and senior nurses using- role play re: behaviour
- More input required around behaviours including biases

Recruitment Processes

- Advertise vacancies internally before they go external.
- All adverts should include “career progression” routes
- Need to ensure that job applicants’ experience has the same recognition as formal qualifications where possible
- Make it easier for minority to staff to be selected and promoted

Internal Promotions

- Promotion given not depending on a number of fixed years a person has been at the Trust

Other

- More opportunities to network/organised fun during working hours beyond their own department
- Consider identification of rising stars through talent management
- More educational opportunities – training but also coaching, learning new skills.
- More networks required to support minority groups

Taking Care of our Staff: Practical Suggestions

Handovers and paperwork in wards

Lack at staff handovers (nursing) and amount of paperwork – reduce time – staff don’t work late

- QI project

Comms to staff

Monthly forum endorsed by exec team to raise awareness of looking after staff

- Exec talk to cover:
  - Staff wellbeing
  - Work with charity
  - Nutrition
  - Wellbeing Hub

Payments and processes

Staff should get off work on time- should not be the accepted rule that staff work longer

Cross-over of staff for:

- Training
- Work loads
- Annual leave

More consideration of the effect of the application of sickness management procedures on staff with long term illness/conditions and bereavement/carers- can lead to longer period of sickness

Practicing (Athena) which is protected time for meetings to take place. Practiced at UCL

Facilities for staff

Designated staff break area- not healthy to socialize with parents all the time

Support for staff

More opportunities of psychological staff support (PICU do a drop-in)

Manager & staff development and training

Educate managers on managing sickness:

- Educate how staff behaviour affects other behaviour

- HR policies
- How the GOSH absence and support system works
- Explain to employees the purpose of OH referral, some see the OH as a form of punishment.

- Trust Induction to include:
  - Teaching staff responsibility around attendance
  - What happens if they call in sick, what happens if they come in sick
  - More education around consequences of coming in sick

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 27 July 2017	
Update on CQC Action Plan **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment O**

Aims / summary

The Care Quality Commission (CQC) conducted a scheduled acute hospital inspection between 14 and 17 April 2015, with further unannounced inspections occurring between 1 and 3 May 2015.

A Quality Summit was organised by the CQC in February 2016, inviting key stakeholders to discuss the report and actions taken by the Trust. The Trust agreed a final action plan, outlining the actions it will take in response to the CQC's requirement notice and areas for improvement. Accountable leads for each action were identified and responses and timeframes agreed.

The Board is asked to review the summary of actions taken to meet the recommendations.

Action required from the meeting
The Board is asked to note that all the actions are now complete. Work continues in all areas to maintain the standards set by the recommendations.

Contribution to the delivery of NHS Foundation Trust strategies and plans
Safe, effective care that meets regulatory and statutory standards

Financial implications
N/A

Who needs to be told about any decision?
CQC and the Members' Council

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

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

Attachment O

Care Quality Commission Action Plan Update

CQC Action No. and Description	Status
1. RTT – Compliance with Regulation 17 2 (a) (c) and (f). And 4. Ensure that its RTT data and processes are robust and ensure that staff comply with the Trust's patient access policy in all cases.	Completed. Following a successful IST technical review on 31st January 2017, GOSH returned to RTT reporting in February 2017. NHS England Specialised Commissioning has confirmed that the Remedial Action Plan is completed and closed, and as such the contract notice lifted. <u>RTT Incomplete pathways</u> Whilst the Trust remains below the RTT incomplete standard of > 92% (of pathways waiting no longer than 18 weeks), it continues to be above its improvement trajectory. At May 2017 performance was 90.36%, with the trajectory at 88.2% <u>Diagnostics</u> The Trust continues to report improvements in this area, with May 2017 reporting 97.49% against the 99% standard for accessing the 15 diagnostic modalities with 6 weeks of referral / request. This is a marginal improvement on April reporting 97.44%
2. Resume WHO checklist audits in surgery	Completed. WHO checklist audits have taken conducted since the CQC inspection. An observational audit of the WHO checklist was undertaken and the audit showed a good level of performance with the WHO Checklist and an audit conducted in March 2016 showed good engagement in the Team Brief and WHO checklist, and a positive safety checklist culture. The Trust continually monitors compliance with the checklist. The most recent data (June 2017) shows a significant improvement in compliance over the last couple of month, with the Trust reporting Trust-wide delivery of the 98% standard with 98.77%.
3. Ensure that there are clear arrangements for reporting transition care service performance to the Board	Completed. Transition reporting to the Board and the Quality and Safety Assurance Committee commenced in December 2016. Having identified the work required to improve Transition at GOSH for the young people and families, a Quality Improvement Manger for Transition has been appointed. The Assistant Chief Nurse for Patient Experience and Quality is leading this work and a project steering group has been set up to ensure the correct engagement with the patients, families and staff across the Trust. The Board will continue to receive updates on progress with this work.

CQC Action No. and Description	Status
5. Ensure greater uptake of mandatory training relevant to each division to reach the Trust's own target of 95% of staff completing their mandatory training.	Completed. Following the above review, the Trust has revised its own target from 95% to 90% completion requirement for each division. This decision was taken to ensure consistency with other Trusts. In June 2017, the compliance across the Trust was 91%. The improvements to Statutory and Mandatory Training compliance has been driven by: • A Trust-wide focus to drive up compliance at all levels (accessibility of information, publicity via screensavers); • Specific challenge to the appropriateness of training requirements per post within the training needs analysis. • Data collection and quality processes on the GOLD LMS system around Statutory and Mandatory training have been reviewed and refined; data is updated twice weekly and an escalation process is in place for staff where training requirements are outstanding. • Content, relevance and target audience has been reviewed with content owners. Robust systems have been developed to identify and directly address areas of concern around compliance through liaison with HR Business Partners and the Divisions.
6. Ensure that, particularly in critical care, communication between senior nurses and senior medical staff is enhanced and that the contribution of nursing is fully reflected in the hospital's vision	Completed. Key improvements delivered to date include: - Refreshed Divisional leadership team, included an enhanced role for nursing leadership - An external mentorship programme for the Heads of Clinical Service had been introduced. - An away day was held to develop an action plan to address the CQC's recommendation. - New terms of reference for the Critical Care Forum were developed to rotate the Chairing arrangement between nursing and medical leads. - Expanded benchmarking of clinical outcomes with other intensive care units in the UK and internationally and to make these results more visible at our weekly Morbidity & Mortality and critical care forum meetings. Further focused work continues with the teams.
7. Ensure early improvements in the environments of wards	Completed. A number of improvements to the ward environment have been delivered since the CQC inspection, including:

CQC Action No. and Description	Status
which have not been refurbished, rebuilt or relocated.	• In relation to Rainforest ward (which was of particular focus by the CQC), additional toilet facilities had been provided within the area for patients and parents (1 toilet and 1 shower). In addition, Rainforest will be moving to a new/refurbished space as part of the opening of the new Premier Inn Clinical Building (PICB) in 2017 which will significantly improve the environment for the ward. • Mechanisms are in place to monitor the ward environments from patients' and parents' perspectives (Pals, Friends & Family Survey, Patient Family Experience and Engagement Committee walkrounds, etc.) • Executive and non-executive director walk rounds provide an opportunity to monitor ward conditions and provide staff, patients and families with an opportunity to raise concerns with a range of issues including ward environments for them to manage and monitor.
8. Standardise radiation protection training for junior radiologists to overcome inconsistencies caused by short rotations.	Completed. A Radiology Induction Manual has been produced and is now available. A register of radiology trainees that records the date and nature of their most recent radiation protection training is now in place. This allows the Trust to identify any potential deficiencies in training and address them. The Head of Radiology Training reviews the register on a monthly basis and ensures that all trainees have documented their training on the departmental register. Any issues related to radiation protection will be escalated to the Radiation Protection Committee if required.
9. Develop a dedicated advocacy service for CAMHS.	Completed. An advocacy service is now in place. The Advocacy Project (www.advocacyproject.org.uk) provides a customised designed advocacy service relevant to the needs of our patients and their families. A review of the service was conducted 6 months after the contract started and the review concluded that staff and patients were pleased with the service delivery. No problems were reported and communication and reliability was excellent.