Great Ormond Street Hospital for Children NHS Foundation Trust

Meeting of the Trust Board
Tuesday 28th November 2017

Dear Members

There will be a public meeting of the Trust Board on Tuesday 28th November 2017 at 1:30pm in the **Charles West Room**, Great Ormond Street, London, WC1N 3JH.

Company Secretary
Direct Line: 020 7813 8230
Fax: 020 7813 8218

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 27th September 2017**	Chairman	**1**
3.	**Matters Arising/ Action Checklist**	Chairman	**2**
4.	**Chief Executive Report**	Chief Executive	**Verbal**
5.	**Board Committee Updates:** • **Audit Committee Update – October 2017** • **Quality and Safety Assurance Committee update – October 2017** • **Finance and Investment Committee update – September 2017**	Audit Committee Chairman QSAC Chairman F and I Chairman	**Verbal** **Verbal** **Verbal**
6.	**Members' Council Update – September 2017**	Company Secretary	**4**
	STRATEGY		
7.	**Strategy progress update - Digital deep dive**	Deputy Chief Executive	**Presentation**
8.	**Update on Operational plan 2017-19**	Deputy CEO/ Chief Finance Officer	**5**
9.	**GOSH Learning Academy**	Interim Medical Director/ Associate Director of Postgraduate Education	**6**
10.	**Overview of Development and Property Services portfolio**	Director of Development	**Presentation**
	PERFORMANCE		
11.	**Integrated Quality Report - 30 September 2017** **Clinical Outcomes Update**	Interim Medical Director/ Acting Chief Nurse Interim Medical Director	**7** **8**

12.	**Integrated Performance Report – 30 September 2017** **Finance Update (30 September 2017)**	Deputy Chief Executive Chief Finance Officer	**9** **10**
	ASSURANCE		
13.	**Safe Nurse Staffing Report September 2017 – September and October 2017**	Chief Nurse	**11**
14.	**Medical Revalidation Annual Board Report and Statement of Compliance**	Associate Medical Director	**Verbal**
15.	**Guardian of Safe Working Update Report**	Dr Renee McCulloch, Guardian of Safe Working	**12**
	GOVERNANCE		
16.	**Update on progress with Well Led Review Action Plan**	Company Secretary	**13**
17.	**Board Development Update**	Director of HR and OD	**Verbal**
18.	**Register of Seals**	Company Secretary	**14**

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 Wednesday 7th February 2018 in the Charles West Room, Great Ormond Street, London, WC1N 3JH.

ATTACHMENT 1

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT Minutes of the meeting of Trust Board on 27th September 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
Mr Ali Mohammed	Director of Human Resources and OD

In attendance

Mr Matthew Tulley	Director of Development
Mr Tom Burton	Deputy Finance Director
Professor Andrew Taylor	Divisional Co-Chair, West Division
Dr Allan Goldman	Divisional Co-Chair, West Division
Ms Anne Layther	Divisional Director, West Division
Mr Peter Hyland	Director of Operational Performance and Information
Mr Jon Schick	Programme Director
Dr John Hartley	Director of Infection Prevention and Control
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
Ms Rebecca Miller	Members' Council (observer)
Mr Simon Hawtrey-Woore	Members' Council (observer)

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

56	**Apologies for absence**
56.1	Apologies for absence were received from Ms Loretta Seamer, Chief Finance Officer and Ms Nicola Grinstead, Deputy Chief Executive.
57	**Declarations of interest**
57.1	There were no declarations of interest.
58	**Minutes of the meeting held on 25th May 2017**
58.1	The minutes were **approved.**
59	**Matters Arising/ Action Checklist**
59.1	Minutes 54.3 and 152.1: Ms Mary MacLeod, Interim Chairman asked for an update on the level 4 CAMHS tender and Dr Peter Steer, Chief Executive confirmed that there had been no progress made.

59.2	Ms MacLeod asked for an update on the Board development plan. Mr Ali Mohammed, Director of HR and OD said that the specification for a preferred partner had been completed and GOSH would be inviting tenders with the aim of selecting a preferred partner in early November.
60	**Chief Executive's Update**
60.1	Dr Peter Steer, Chief Executive provided an update on the following matters:
60.2	Genetic Laboratory consultation
60.3	GOSH continues to lead a collaboration bid for the North Thames Geographic Region for the NHSE Genetic Laboratory Consolidation and now had agreed collaboration with all relevant organisations in the North Thames region with the exception of one.
60.4	The Trust was exploring the move of the Constitutional Genetic Laboratory services from London North West and it was confirmed that GOSH had sufficient capacity to absorb these services.
60.5	Paediatric Cardiac Services
60.6	It was anticipated that a final decision on the proposed reconfiguration of paediatric cardiac services following the Safe and Sustainable review would be taken in November by NHS England following a community consultation.
60.7	High profile patient
60.8	Dr Steer gave an update on the work that was taking place to support staff following an extremely difficult time during the treatment of a high profile patient. It was reported that the Trust would be producing a communications strategy learning from this case.
61	**Patient Story**
61.1	The Board received a patient story via video from long term GOSH Gastroenterology patient Ruby and her father. They provided the following feedback: • Ruby and Allan commented that the staff on the ward were extremely kind. • Ruby said that during stays on the ward, located in the Southwood building, it was often very hot due to a lack of air conditioning. She said that during hot weather fans were used on the ward, however these were not effective. • Ruby noted that the décor in the Southwood building was significantly less up to date than other parts of the hospital. • Ruby's father was required to leave the ward to make drinks. • The parent bed and area in general was small and it was not possible to get a wheelchair into the room • Only two toilets, one isolation, were available and when the isolation toilet was out of use, patients were required to use a commode. • Ruby's father felt that communication during standard working hours was good however there were issues with out of hours communication when it was likely that it would only be possible to speak to a registrar from a different specialty. • Ruby said that it was important that Doctors spoke directly to patients in a

	language that was easy to understand and it was vital that clinicians and staff members knocked before entering rooms and cubicles which was not always the case. • Whilst meals in the Lagoon restaurant were good value for money, the coffee bar was expensive and out of hours it was not possible buy meals, sweets or fizzy drinks. • The school service was excellent.
61.2	Ms Juliette Greenwood noted the mixed experience for Ruby and her father and said that the environmental issues that the family had experienced in the Southwood Building would be resolved following the forthcoming ward move. She said due to families' often long term association with gastroenterology at GOSH it was important that this move was communicated well.
61.3	Ms Mary MacLeod, Interim Chairman welcomed the patient stories and the strong viewpoints they provided on the issues that arose for young people in the hospital. Dr Steer highlighted the excellent presentation that had taken place at the AGM which spoke well of doctors' ability to speak directly to patients. He said that it was important to ensure that this good practice was consistent across the organisation.
62	**Board Committee Updates**
62.1	<u>Audit Committee Update – May 2017</u>
62.2	Mr Akhter Mateen, Chairman of the Audit Committee presented the Audit Committee update which had been provided verbally at the Trust Board meeting in July. He confirmed that the joint Audit Committee and Quality and Safety Assurance Committee risk meeting was scheduled to take place on 10th October.
62.3	<u>Quality and Safety Assurance Committee (QSAC) update – July 2017 meeting</u>
62.4	Professor Stephen Smith, Chairman of the QSAC presented the update. He said that the committee had noted the increased safeguarding activity in the Trust and it had been confirmed that this was in line with the national trend. The Committee requested that work continued to bring the completion rates of safeguarding training for honorary staff into line with the rest of the workforce. An update with improvements made was requested at the next meeting.
62.5	<u>Finance and Investment Committee Update – June 2017 and September 2017</u>
62.6	**Action:** Mr David Lomas, Chairman of the Finance and Investment Committee said that he had attended a GOSH Children's Charity meeting to consider the available funding over the coming years. He suggested that this should be presented to the Board on an annual or biannual basis and it was agreed that consideration should be given to this within the Board Calendar.
63	**Members' Council Update – June 2017**
63.1	Ms Mary MacLeod, Interim Chairman said that a Members' Council meeting was taking place following the Trust Board, the agenda for which had been discussed with the Interim Lead Councillor.
63.2	Ms MacLeod said that a positive AGM had taken place on 14th September and thanked the Members' Council for their work to support it.

64	**Fulfilling Our Potential: An update on our Trust's strategy: Charles West Division – presentation on implementation of the Trust Strategy**
64.1	Professor Andrew Taylor and Dr Allan Goldman, Divisional Co-Chairs of the West Division gave a presentation which provided an overview of the division's work to fulfil the Trust's strategy.
64.2	Ms Mary MacLeod, Interim Chairman said that it was not possible to get a sense of the Trust's outcome data from the Board papers. She said that if this was present the Board would be able to triangulate the data with serious incidents, complaints data, walkrounds and friends and family feedback amongst other sources.
64.3	**Action:** Dr Peter Steer, Chief Executive said that GOSH posted a large number of outcome measures on the website but suggested that these should be easier to find and more transparently available to the Quality and Safety Assurance Committee and Trust Board. It was agreed that an update on outcomes would be received at the November Board meeting. Dr Goldman said that the division had undertaken real time weekly outcome reviews with trending data and would continue to drive this important work.
64.4	Mr Akhter Mateen, Non-Executive Director welcomed the presentation and suggested that further information could be included about the choices that had been made in order to move ahead with the strategic objectives and the timeline involved. He said that it was important for the Board to have a way of monitoring progress and impact of the work.
64.5	Mr David Lomas, Non-Executive Director said that in his view a strategy included data around the staff numbers and the mix of staff over the next 3-5 years and the outcome in terms of patient numbers and mix of clinical services. He added that the Trust was moving to position itself for the future and should consider how it would do this in five years to enable it to move forwards for the following five to ten years. Mr Lomas suggested that this approach would support the Better Value programme. Dr Steer said that these goals were beginning to be developed however in the current environment it was extremely challenging to look more than three years ahead. He added that there would be layers within the strategy and the operational plan which would be signed off by the Board would give detailed numbers.
65	**Integrated Quality Report - 31 August 2017**
65.1	Mr David Hicks, Interim Medical Director said that Trust mortality rate had remained stable since 2014 and a recent increase in respiratory arrests was attributed to a single patient for whom respiratory arrests was a key feature of their condition.
65.2	Ms Juliette Greenwood, Chief Nurse said that benchmarking of friends and family test data was taking place and GOSH continued to do well compared to others. Analysis was being undertaken with other organisations to consider whether there were lessons that could be learnt across the Trusts.
65.3	Professor Rosalind Smyth, Non-Executive Director expressed some concern about one of the serious incidents which had been reported about consent. She

	noted that one of the actions was to develop consent clinics and she suggested that these should be in place for all surgery to allow a considered and timely discussion to take place.
65.4	Ms Greenwood said that a number of specialties had established pre-assessment clinics and agreed that it was important to ensure that this was the case for all patients. Professor Andrew Taylor, Divisional Co-Chair for West Division said that processes in the cardiac and interventional radiology specialties had been changed to ensure patients were in a named clinic to support this work.
65.5	**Action:** Ms Mary MacLeod, Interim Chairman requested that a deep dive took place on consent at a future QSAC meeting.
65.6	Annual Complaints Report 2016/17
65.7	Ms Greenwood said that the Trust had received its lowest number of complaints in five years and there had also been a reduction in red complaints. No themes had been established within the red complaints. She added that it was disappointing that patients' ethnicity had been captured in only 50% of cases as this was a mandatory requirement.
65.8	**Action:** Mr Akhter Mateen, Non-Executive Director said that he had recently attended a GOSH Children's Charity event to learn from commercial organisations focusing on customer experience. He said it had been clear that they used Net Promoter Scores to monitor compliments and complaints. Mr Mateen asked that consideration was given to using developing a score like this to look at a combination of complaints, legal issues, social media and compliments.
65.9	Annual PALS Report 2016/17
65.10	Ms Greenwood said there had been a large increase in annual PALS contacts, however a reduction in the number that had been escalated to formal complaints showing that the team had been able to address concerns. The key theme of contacts was communications and work was taking place to ensure that there was a more consistent approach to communications Trust wide.
65.11	Learning from deaths
65.12	Mr Hicks said that the Trust currently satisfied all requirements of the 'learning from deaths' guidance and it was noted that Professor Stephen Smith was the Non-Executive lead. It was noted that there was currently a backlog of cases to review, however this had not led to a breach of requirements and work was taking place to agree additional members of the mortality review group.
66	**Integrated Performance Report – 31 August 2017 including report on theatre utilisation**
66.1	Mr Peter Hyland, Director of Operational Performance and Information said that work continued around RTT and confirmed that Rheumatology and Genetics continued to have challenges with Genetics comprising 10% of the waiting list.
66.2	**Action:** It was agreed that performance in education would be presented to the Board on a biannual basis.
66.3	**Action:** It was agreed that consideration would be given to the target for

	discharge summaries which was currently set at 100% and whether this was realistic.
66.4	Mr Akhter Mateen, Non-Executive Director noted that there continued to be a negative trend in terms of PDR completion and the target for NHS agency spend continued to be red.
66.5	Kitemarking and theatre utilisation
66.6	Mr Hyland said that the guidance suggested that to achieve a significantly assured dataset an error rate of less than 3% was required. He said that this was extremely challenging and currently the Trust was working at a rate of between 5%-10% which was a significant improvement.
66.7	Dr Peter Steer, Chief Executive said that evidence of the quality of data had been triangulated and other organisations were now consulting GOSH on the improvement approach taken. Dr Steer added that on average theatre lists were starting 29 minutes late largely as a result of issues with flow. He said this was a challenge but also a significant opportunity.
66.8	**Action:** It was agreed that any indicators in the performance report which had been rated red for three consecutive months would include a narrative on actions taken to move the indicator to a green status and the timeline against which the change would be delivered.
66.9	Ms MacLeod welcomed the substantial decrease in cancellations and asked for the thanks of the Board to be passed to the team.
67	**Annual Infection Control Report 2016/17**
67.1	Dr John Hartley, Director of Infection Prevention and Control presented the report and said that the Trust had achieved the lowest antimicrobial resistance ever contrary to the international trend showing the substantial effort being made in the organisation. Dr Hartley said that although a robust hand hygiene programme was in place overall, there were some areas which required additional attention. In response to this, the West and Barrie Divisions were taking differing approaches with close oversight from the Infection Prevention and Control Committee.
67.2	Professor Rosalind Smyth, Non-Executive Director asked for assurance that the Trust was providing a safe environment in this regard and Ms Juliette Greenwood, Chief Nurse confirmed it was. Dr Peter Steer, Chief Executive confirmed that the Trust continued to perform well in international benchmarking.
68	**Finance and Workforce Update (31 July 2017)**
68.1	Mr Tom Burton, Deputy Finance Director said that the Trust had an in month net deficit of 0.1million which was £0.5million below plan. Year to date the Trust has a net surplus of £0.3m which was £0.8m worse than plan driven by a lower than plan clinical and non-clinical income.
68.2	Professor Stephen Smith, Non-Executive Director asked if the team was confident that the position could be recovered and Mr Burton said that this could be done although it would be challenging. Dr Peter Steer, Chief Executive agreed and said that there had been more assurance brought to the Better Value programme

	however additional schemes would be required to bring the position back to plan.
68.3	**Action:** Mr Akhter Mateen, Non-Executive Director noted that provisions had been made for some debt which was not yet due and it was agreed that further information would be provided at the next meeting.
68.4	**Action:** Mr David Lomas, Non-Executive Director highlighted the importance of the nursing workforce and requested that a paper was presented to the Board on a biannual basis on staff, particularly retention, attrition and reasons for staff leaving.
69	**Better Value 2017/18 Summary**
69.1	Mr Jon Schick, Programme Director presented the update and said that the current forecast outturn was approximately £10million and when including the current pipeline of schemes it was anticipated that the actual value would be greater. Procurement and workforce schemes were the areas which required the greatest support to bring them to completion and several strands of work were currently on-going.
69.2	Dr Peter Steer, Chief Executive said that procurement was a good example of how a lead time was required to produce savings as it was projected that approximately £2.5million would be saved in 2018/19 but it was unlikely that this could be brought forward.
70	**Safe Nurse Staffing Report: May - August 2017**
70.1	Ms Juliette Greenwood, Chief Nurse said that work was taking place to validate data and agree how to capture staffing levels when beds had been closed and nurses deployed to other areas. She confirmed that staffing was safe during this period.
70.2	On 25th November, 207 newly qualified nurses had started at GOSH and therefore the Trust was employing more nurses than vacancies which was positive, and turnover had reduced from 18% to 16%.
71	**Staff Survey and Listening Events Update**
71.1	Mr Ali Mohammed, Director of HR and OD said that the next round of staff surveys would begin on 9th October.
72	**CQC Action Plan Update**
72.1	Dr Anna Ferrant, Company Secretary presented the report showing the completion of the action plan. She said the Trust would receive a routine scheduled inspection as part of the CQC's new process in 2018.
73	**NHS Workforce Race Equality Standard**
73.1	Mr Ali Mohammed, Director of HR and OD presented the paper and said that the Trust's findings in relation to the Workforce Race Equality Standard (WRES) were broadly in line with levels across the NHS and improvements had been made in comparison to the previous year in the majority of cases.
74	**Register of Seals**

74.1	The Board endorsed the use of the company seal.
75	**Any Other Business**
75.1	It was noted that it was Ms Juliette Greenwood, Chief Nurse's last Trust Board meeting. Ms Mary MacLeod, Interim Chairman thanked Ms Greenwood for her wonderful service to the Trust, the Board and patients and families.
75.2	It was also Ms MacLeod's last Board meeting and Dr Peter Steer, Chief Executive thanked Ms MacLeod for her support and excellent work with the Trust during her tenure.
76	**Medical Revalidation Annual Board Report and Statement of Compliance**
	This item was discussed during the confidential meeting and it was agreed that the discussion would be included with the public minutes.
76.1	Mr David Hicks, Interim Medical Director presented the paper which was required to be presented to the Board on an annual basis. He said that the majority of doctors would have completed their first cycle of revalidation by at the end of 2017 however the administrative burden would be greatly increased at the new revalidation cycle.
76.2	Professor Rosalind Smyth, Non-Executive Director expressed some concern at the 29% deferral rate and asked for assurance that this had been done for valid reasons.. Mr Hicks acknowledged that the Trust was not fully compliant and highlighted the improvement action plan that had been developed with actions due by the end of 2017. He confirmed that deferrals had taken place for valid reasons.
76.3	**Action:** The Board agreed that the paper would be considered at the next meeting for further discussion.

ATTACHMENT 2

Attachment B

TRUST BOARD – PUBLIC ACTION CHECKLIST
November 2017

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
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 2018 (as part of strategy reporting to Board)	Not yet due
14.2	25/05/17	The Finance and Investment 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.	MT	November 2017	On agenda
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	The presentation is no longer in date. An update on recruitment issues is reported in the strategy presentations during the year
62.6	27/09/17	Mr David Lomas, Chairman of the Finance and Investment Committee said that he had attended a GOSH Children's Charity meeting to consider the available funding over the coming years. He suggested that this should be presented to the Board on an annual or biannual basis and it was agreed that consideration should be given to this within the Board Calendar.	LS	November 2017	To be included in the Board calendar

Attachment B

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
64.3	27/09/17	Dr Peter Steer, Chief Executive said that GOSH posted a large number of outcome measures on the website but suggested that these should be easier to find and more transparently available to the Quality and Safety Assurance Committee and Trust Board. It was agreed that an update on outcomes would be received at the November Board meeting. Dr Goldman said that the division had undertaken real time weekly outcome reviews with trending data and would continue to drive this important work.	DH	November 2017	On agenda
65.5	27/09/17	Ms Mary MacLeod, Interim Chairman requested that a deep dive took place on consent at a future QSAC meeting.	DH	January 2018	Noted for QSAC agenda
65.8		Mr Akhter Mateen, Non-Executive Director said that he had recently attended a GOSH Children's Charity event to learn from commercial organisations focusing on customer experience. He said it had been clear that they used Net Promoter Scores to monitor compliments and complaints. Mr Mateen asked that consideration was given to using developing a score like this to look at a combination of complaints, legal issues, social media and compliments.	JW	January 2018	Not yet due
	27/09/17	It was agreed that performance in education would be presented to the Board on a biannual basis.	AM		Actioned: Added to the Board calendar – update due January and July each year

Attachment B

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
66.3	27/09/17	It was agreed that consideration would be given to the target for discharge summaries which was currently set at 100% and whether this was realistic.	NG	November 2017	It is a contractual requirement for us to send all discharge summaries within 24 hours of discharge
66.8	27/09/17	It was agreed that any indicators in the performance report which had been rated red for three consecutive months would include a narrative on actions taken to move the indicator to a green status and the timeline against which the change would be delivered.	NG	November 2017	These indicators all have narrative, and in areas headline actions. Not all have timelines at this stage (and for some it will not be possible to provide). This can be improved for future months. Some will need correlating with the Q&S report
68.3	27/09/17	Mr Akhter Mateen, Non-Executive Director noted that provisions had been made for some debt which was not yet due and it was agreed that further information would be provided at the next meeting.	LS	November 2017	This action is now closed. The methodology has now been reviewed and amended to reduce provision for debt not yet due.
68.4	27/09/17	Mr David Lomas, Non-Executive Director highlighted the importance of the nursing workforce and requested that a paper was presented to the Board on a biannual basis on staff, particularly retention, attrition and reasons for staff leaving.	AM, JW		To be included as part of integrated performance report – reporting schedule to be agreed
76.3	27/09/17	The revalidation paper to be re-presented to the November meeting for further discussion	DH	November 2017	On agenda

ATTACHMENT 4

Attachment 4

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of the Members' Council meeting on 27th September 2017

Updates from the Membership Engagement, Recruitment and Representation Committee (MERRC)

The Council noted that nominations for the Members' Council election opened in November and information sessions were being held in October. Discussion took place around the AGM which had been held in September and it was noted that it had been a positive event.

Update from the Young People's Forum (YPF)

It was noted that GOSH was hosting the first national YPF with 120 confirmed attendees. Discussion took place around whether the YPF was a suitable forum from which to draw potential young person Councillors. It was agreed that discussion about the Members' Council would take place at a future YPF meeting and engagement would take place with the Young People's Advisory Group.

Update from the Patient and Family Experience and Engagement Committee

Work continued to take place to benchmark results of friends and family tests particularly considering the Trusts who had received a recent positive CQC inspection.

Chief Executive Report (Highlights and Performance)

The Chief Executive gave an update on following matters:

- Gastroenterology service
- RTT
- Finance position
- Genetic laboratory consolidation
- Update following high profile case

Discussion took place around IPP debtor days and the significant contribution made by IPP to NHS services was emphasised along with the lack of bad debt with the exception of a failed state. The Trust's auditors had confirmed that GOSH's recovery rates were better than others and that the actions taken were consistent with best practice.

Care Quality Commission Compliance Update

It was confirmed that the completed action plan had been presented to the Board at its September meeting and the CQC had confirmed that an announced inspection would be taking place in early 2018.

Reports from Board Assurance Committees

The Council received updates from the Quality and Safety Assurance Committee and the Finance and Investment Committee, both of which had Members' Council observers in attendance.

Any Other Business

It was confirmed that the Board had received assurance around the safety of the materials used on its buildings.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
28 November 2017

Update on Operational plan 2017-19 **Submitted by:** Nicola Grinstead, Deputy Chief Executive	**Paper No: Attachment 5**

Aims / summary

The aim of this paper is to update the Board on the planning process for 2018/19. The Trust submitted a two year operational plan for 2017-19 in December 2016. There is currently no national guidance in relation to further processes to update the second year of this plan, 2018/19. However, GOSH will undertake an internal refresh process in the following areas: income/activity, Better Value programme, strategy and budgets. This will be in the context of the submitted plan and the overall budgetary envelope will reflect this and, in particular, the control total set by NHSI for 2018/19.

The intention is that this would be submitted to the Board for approval in March – however, further guidance may be provided by NHS Improvement regarding a national refresh process in Q4 which may affect the timing of this.

Action required from the meeting

The Board is asked to **note** this update on the planning process for 2018/19.

Contribution to the delivery of NHS Foundation Trust strategies and plans

This paper provides an update on the process for updating the second year of the two year Operational Plan 2017-19.

Financial implications

The Trust is required to establish a robust financial and operating plan for 2018/19 that ensure it remains safe and sustainable whilst delivering its strategic objectives.

Who needs to be told about any decision?

Peter Hyland, Director of Operational Performance and Information and Divisions and Departments

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

Peter Hyland, Director of Operational Performance and Information

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

Nicola Grinstead, Deputy Chief Executive

Attachment 5

Great Ormond Street Hospital for Children NHS Foundation Trust

Update on planning process for 2018/19

1. Introduction

This paper provides an update on the planning process for the second year of the Operational Plan 2017-19 submitted to NHS Improvement in December 2016.

2. National guidance and process

In September 2016, NHS Improvement and NHS England published the NHS Operational Planning and Contracting Guidance 2017-19. For the first time, this set out a process for agreeing *two* year operational plans *and* contracts with commissioners, and in the context of a national tariff that was set for two years. The process then followed an accelerated national planning timetable, with submission of a draft plan in November 2016 and a final plan in December 2016, with contracts between commissioners and providers also signed at that time. This is in contrast to previous years, in which final plans submission and contract sign-off was generally around year end.

One reason for the two year contract period was to reduce the time spent by the system on planning. Significant time is taken up each year, across all NHS organisations, in updating the national tariff document (developing, consulting, road testing and impact assessing) and in negotiating and agreeing contracts with commissioners taking this, and other developments into account. The aim (nationally) was to avoid some of this to allow more time to implement system plans and saving programmes.

In this context, no further planning guidance has been issued nationally, with the assumption that the national tariff, contracts and operational plans have already been set for the 2017-19 period, from a national perspective. (However, it has been indicated that a resubmission would be required in the event of significant changes to national planning assumptions – e.g. as a result of any pay award in the 2017 budget).

3. GOSH refresh process for 2018/19

Internally, GOSH will undertake a process to refresh the assumptions in the 2018/19 plan, in order to ensure that:

- Ongoing discussions with commissioners in relation to income levels, CQUIN and QIPP take into account the latest information;
- Activity plans reflect the latest information in relation to utilising PICB capacity and the RTT position;
- The Better Value programme takes into account the latest view on required and identified savings;
- The newly launched strategy is appropriately reflected and embedded;

- Budgets reflect, for example, the latest expectations around inflation, approved business cases (particularly in relation to the opening of the Premier Inn Clinical Building (PICB)) and additional unavoidable cost pressures identified during the year.

It is also considered likely that NHSI will require at least a 'technical refresh' of the operational plan to be submitted in Q4 – although, as noted above, no formal guidance has yet been published.

This refresh process will follow standard annual planning processes, to the extent appropriate and in the context of the approved plan for 2017-19.

3.1 Contracting

In line with this refresh process, and following the standard commissioning timetable, the Trust sent a 'Contracting and Service Development Intentions' letter to NHS England, as the lead commissioner, on 29th September. This set out key contracting issues and proposed service developments as a basis for further discussion with commissioners for 2018/19.

The Trust received a response to this letter on 19th October, emphasising that NHS England is operating within a very limited resource allocation and that any developments will need to demonstrate a net saving to the system. Any changes for 2018/19 will be implemented through a contract variation in Q4 of 2017/18 to ensure a smooth transition into the next financial year.

3.2 Activity plans

Activity planning will take place over the coming months based on final M6 billing and activity information, which becomes available in November. The key assumptions that require refreshing from the submission of the operational plan relate to:

- **PICB** - as noted at the time of submitted the operational plan 2017-19, work was ongoing to identify the optimum use and phased opening of the additional capacity made available through PICB (both directly in that building, and in other areas made available as a result of relocation to PICB). This further work has led to some changes compared to the position in December 2016, which need to be reflected in service annual plans.

- **RTT** - demand and capacity modelling has been expanded to further specialties and updated, and the implications of this need to be reflected in services annual plans to ensure this is appropriately monitored.

3.3 Better Value

The Better Value programme was set out at a high level at the time of submission of the Operational Plan 2017-19 in December 2016. For 2018/19, the refresh will take into account:

- Any update in the savings requirement as a result of the 2017/18 financial position

- Unachieved schemes from 2017/18

- Further development of the cross-cutting programmes, taking into account achievements and issues to date and further areas of savings identified.

- Further development of the process.

3.4 Trust strategy

Significant detailed work was undertaken on the Trust strategy after submission of the Operational Plan 2017-19 in December 2016, during the subsequent process of setting detailed divisional plans and budgets. This strategy was launched during the inaugural Open House week (w/c 6th November) and has been covered in detail in the Board strategy day on 8th November.

The refresh process for 2018/19 will be part of ensuring that this is embedded throughout the organisation, and that service plans are aligned to it.

3.5 Budgets

Budgets were set in line with the Operational Plan 2017-19. The intention is that these will be rolled forward for 2018/19, and updated to reflect the issues noted above, as well as any other additional business cases approved or additional unavoidable cost pressures identified during 2017/18. This process will take place in the context of the plan set in the submitted Operational plan 2017-19, and the overall budgetary envelope will reflect this and, in particular, the control total set by NHSI for 2018/19.

3.6 Challenge process

A challenge process will take place to ensure refreshed plans are appropriate and co-ordinated across the Trust, requiring justification of identified cost pressures, and addressing budgets not utilised in 2017/18 – for example, posts that have been vacant for more than one financial year (excluding ward areas).

4. Next steps and action required

The refresh process will be developed and implemented in the key areas set out above. The conclusion of this will be presented to Board for approval in March – although the timing of this is subject to further requirements from regulators that the Trust may be notified of in the coming months.

The Board is asked **to note** this update.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
28th November 2017

GOSH Learning Academy: Outline Business Case	**Paper No: Attachment 6**
Submitted by: Lynn Shields, Associate Director of Education Sanjiv Sharma, Deputy Medical Director Anna Falconer, Head of Learning and Development and Leadership *Executive Sponsors:* Janet Williss, Interim Chief Nurse David Hicks, Medical Director Ali Mohammad, Director of HR&OD	

Aims / summary

Our vision and aim is to provide a dedicated education and training facility accessible for all staff members—a lean, collaborative service under unified governance, accountable to a Non-executive Director of Education, with a central service professionally responsible to the respective education leads.

The GOSH Learning Academy in its broadest scope would exist as both an international and national brand—an opportunity to advertise and market all education and training activity and explore both small scale and large scale commercial opportunities. This brand would exist for stakeholders outside of the Trust, but most importantly, its primary purpose is to serve all members of the GOSH workforce—all areas of staff within the organisation would have access to and be affected by this umbrella of education. Central education teams would be at the heart of this structure, under a Non-executive Director of Education, leading the provision and ensuring governance and quality assurance of education and training activity inside and outside the Trust.

Our vision seeks not just off-precinct development, but to encompass all education and training activity and unify all space utilised for education and training inside and outside the Trust.

The redevelopment of the GOSH Frontage Building—referred to as Phase IV in the Precinct Redevelopment Masterplan—has rightly prioritised clinical needs above education in allocation of available space.

The review of Phase IV has provided the opportunity to scope an education facility that would be able to provide the services required now and for the next 15 years. The GOSH Learning Academy vision allows the service to grow and develop in line with the Masterplan until options are reviewed in Phase V.

Action required from the meeting

- Agreement on the strategic direction for the GOSH Learning Academy

Contribution to the delivery of NHS Foundation Trust strategies and plans

Aligned to the *GOSH Trust Strategy: Fulfilling Our Potential*.

Vital to the successful aims and objectives of the Trust, the education and training of our entire workforce must be a vital focus in Trust's priorities. Education and training, much like the building blocks of the Trust Strategy, forms a foundation for Trust staff from which all other objectives succeed or fail. Without the necessary education, staff are unable to perform to the standard required in order to carry forward the Strategy as a success, and without the demonstrated commitment and investment to their development to these ends, the risk to the recruitment and retention of these staff remains paramount.

Financial implications

The two options for the development of a GOSH Learning Academy require different levels of capital and annual investment over a period of 15 years.

Attachment 6

Outlined below are the financial cases for each option:

Description	Option 1 (Do nothing)	Option 2 (Rent)	Option 3 (Buy)
Capital costs	N/A	(£7,141,216)	(£28,463,216)
Capital income	N/A	N/A	£21,222,000
Annual costs	(£787,500)	(£39,055,140)	(£13,902,480)
Annual income	N/A	£6,366,375	£6,366,375
Grand Total	**(£787,500)**	**(£39,829,981)**	**(£14,777,321)**

Who needs to be told about any decision?

Nursing & Non-medical Education
Postgraduate Medical Education
Learning & Development
Redevelopment
Finance
Executive Management Team

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

Associate Director of Education
Deputy Medical Director
Head of Learning and Development and Leadership

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

Interim Chief Nurse
Medical Director
Director of HR&OD

Great Ormond Street Hospital for Children NHS Foundation Trust

THE GOSH LEARNING ACADEMY

Outline Business Case

Version 8.5 DRAFT

Version Control

Trust	Great Ormond Street Hospital for Children NHS Foundation Trust
Document Title	The GOSH Learning Academy: Outline Business Case
Version	8.5
Status	Draft
SRO	Sanjiv Sharma
Contact	Lynn Shields

Version	Date of Revision	Key Changes	Status
1.0	25/08/17	1st Draft	1st Draft
2.0	20/09/17	1st Draft	1st Draft
3.0	26/09/17	1st Draft	1st Draft
4.0	26/09/17	1st Draft	1st Draft
4.2	27/09/17	1st Draft	1st Draft
4.3	27/09/17	1st Draft	1st Draft
5.0	02/10/17	1st Draft	1st Draft
6.1	11/10/17	1st Draft	1st Draft
6.2	13/10/17	1st Draft	1st Draft
6.3	14/10/17	1st Draft	1st Draft
6.4	19/10/17	1st Draft	1st Draft
7.0	23/10/17	1st Draft	1st Draft
7.1	24/10/17	1st Draft	Submitted to EMT
8.0	25/10/17	2nd Draft	2nd Draft
8.1	10/11/17	2nd Draft	2nd Draft
8.2	17/11/17	2nd Draft	2nd Draft
8.3	20/11/17	2nd Draft	Submitted to EMT for Comment
8.4	21/11/17	3rd Draft	3rd Draft
8.5	23/11/17	3rd Draft Reviewed	Draft to Board for Comment

GOSH Stakeholders Consulted

The following stakeholders have been consulted in the development of the draft business case.

Name	Role	Division	Version Reviewed	Date of Review
Peter Steer	Chief Executive Officer	Corporate	8.3	21/11/17
Loretta Seamer	Chief Financial Officer	Finance	8.3	21/11/17
Nicola Grinstead	Deputy Chief Executive Officer	Corporate	8.3	21/11/17
Matthew Tulley	Director of Development	Redevelopment	8.3	21/11/17
David Hicks	Medical Director	Medical	8.3	21/11/17
Janet Williss	Chief Nurse	Chief Nursing Office	8.3	21/11/17
Ali Mohammed	Director of HR and OD	HR & OD	8.3	21/11/17
Sanjiv Sharma	Deputy Medical Director for Medical and Dental Education	Medical Directorate	8.4	21/11/17
Lynn Shields	Associate Director of Education, Nursing and Non-Medical	Chief Nursing Office	8.4	21/11/17
Anna Falconer	Head of Leadership	HR & OD	8.4	21/11/17
Stephanie Williamson	Deputy Director of Development	Redevelopment	8.3	21/11/17
Aaron Shah	Finance Manager	Finance	8.2	17/11/17
Linda Martin	Deputy Director of Estates and Facilities	Estates	7.0	23/10/17
Adrian Peak	Head of ICT Programmes and Projects	ICT		

Contents

1 Executive Summary

1.1 Background

In 1853, the first Annual Report by Charles West was presented for the Great Ormond Street Hospital for Sick Children. It stated:

'The Objects of the Institution are;-

I--THE MEDICAL AND SURGICAL TREATMENT OF POOR CHILDREN

II—THE ATTAINMENT AND DIFFUSION OF KNOWLEDGE REGARDING THE DISEASES OF CHILDREN

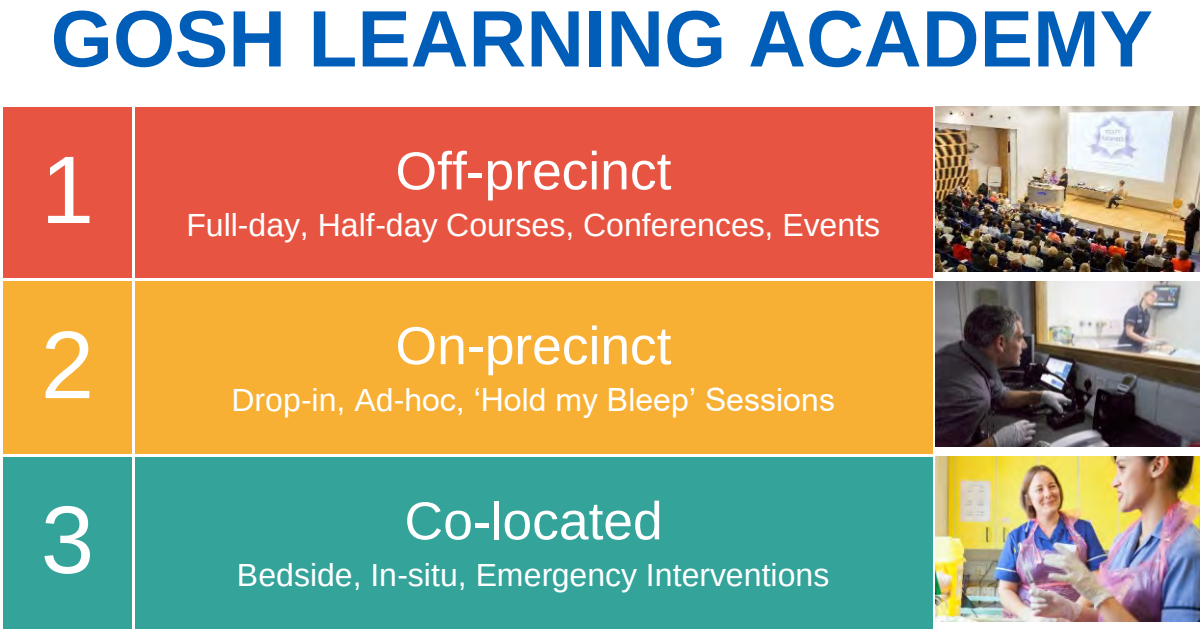
III—THE TRAINING OF NURSES FOR CHILDREN'

Though we focus on many professions at the Trust in our wider strategic objectives—whether this be doctors, nurses, or the multitudes of other staff within our workforce—education and training has formed a fundamental part of our purpose since the first patient was admitted. Space within the hospital has changed dramatically since that era, with many iterations of size and purpose, but as early as its origination, this hospital has sought to educate and train not just its workforce but the wider community. We, as education professionals, can only achieve this mission if we have a room to offer it in.

1.2 Our Vision

1.2.1 The Space

Our vision seeks not just off-precinct development, but to encompass all education and training activity and unify all space utilised for education and training inside and outside the Trust.



1.2.2 The Service

Our vision is one to provide for all staff members—a lean, collaborative service under unified governance, accountable to a Non-executive Director of Education, with a central service professionally responsible to the respective education leads. This structure provides the most efficient and effective service to enable the expansion of a unified brand and broaden our marketing opportunities.

The GOSH Learning Academy in its broadest scope would exist as both an international and national brand—an opportunity to advertise and market all education and training activity and explore both small scale and large scale commercial opportunities. This brand would exist for stakeholders outside of the Trust, but most importantly, its primary purpose is to serve all members of the GOSH workforce—all areas of staff within the organisation would have access to and be affected by this umbrella of education. Central education teams would be at the heart of this structure, under a Non-executive Director of Education, leading the provision and ensuring governance and quality assurance of education and training activity inside and outside the Trust.

1.3 Options

The redevelopment of the GOSH Frontage Building—referred to as Phase IV in the Precinct Redevelopment Masterplan—has rightly prioritised clinical needs above education in allocation of available space.

The review of Phase IV has provided the opportunity to scope an education facility that would be able to provide the services required now and for the next 15 years. The GOSH Learning Academy vision allows the service to grow and develop in line with the Masterplan until options are reviewed in PhaseV.

The options reviewed include:

- **Option 1** - Do nothing, accepting the impact on the education provision and reputation of the Trust.
- **Option 2** - Rental of property and development of an off-precinct, dedicated education and training facility.
- **Option 3** – Purchase of a freehold property and development of an off-precinct, dedicated education and training facility.

1.4 Benefits

The development of the GOSH Learning Academy will deliver the following benefits to both the Trust and staff in line with the **strategic vision**:

- Improved facilities to provide statutory and mandatory training, induction, and continued professional development (CPD) to the workforce
- Remain as an international leading centre of excellence for paediatric healthcare
- Improved recruitment and retention through an increased education portfolio, demonstrating the Trust's commitment to personal development
- Potential off-site revenue investment by leasing of space to external agencies
- Improved education environment for the workforce.

Other Benefits:

- Enhancing the Trust's reputation as an educational centre of excellence
- Utilisation of vacated on-precinct space by other Trust departments.

1.5 Trust Demand and Capacity Requirements

An audit of a period of two years of central education team activity has been quantified and reviewed from July 2015-17.

Note: The analysis includes 7,183 sessions of education and training activity, however, this does not encompass the entirety of trust education activity, only that which is captured by the central education teams.

This has been further projected to 2020 to anticipate the space needs required for the recruitment of registered and unregistered staff, the integration of technology-enhanced learning, the implementation of simulation throughout trust wide education programmes, the redevelopment of the Leadership and Management portfolio, the franchisement of internal postgraduate courses, and the consolidation, expansion, and marketing of the Trust Education and Training Prospectus.

The Trust demand & capacity modelling system for Education is presented below by week for sessions held, candidates attending and rooms utilised:

Education	2015/16	2016/17	2020
Sessions (per week)	63	75	90
Candidates (per week)	1,100	1,300	1,700
Rooms (per week)	80	100	140

On average, the central education teams use 101 rooms per week to run a basic education provision. The rooms are inclusive of external venues requisitioned. The capacity for education and training on-precinct is far above what is currently available, and as shown, is expected to increase to approximately **137 rooms per week by 2020**.

The projection of future needs is built upon, not just increased candidates, but with recognition of the need for dynamic learning spaces, specifically focused around implementing clinical simulation into all clinical training.

1.6 Financial

Infrastructure

The financial assessment is based on the costs of acquiring additional space for the enhanced education strategy as per the options outlined below.

Option	Financial Impact
Option 1 Do Nothing	This option assumes that the trust would continue to rent additional space for overflow from current facilities
Option 2 Rent additional space	This option includes the cost of renting an additional 2000m2 of space and includes additional income generated from hiring facilities.
Option 3 Purchase property	This option includes the cost of purchasing a property includes additional income generated from hiring facilities with sale in 15 years assuming Phase V of the masterplan will provide new centre.

The two options for the development of a GOSH Learning Academy require different levels of capital and annual investment over a period of 15 years.

Outlined below are the Total Net Costs and Net Present Value over 15 years for each option:

Description	Option 1 (Do nothing)	Option 2 (Rent)	Option 3 (Buy)
Capital costs (net)	-5.8	-7.2	-28.4
Capital income	-	-	+44.3
Annual costs	-2.9	-44.5	-15.4
Annual income	-	+6.9	+6.9
Total Net Cost 15 Yrs	**-8.7**	**-44.8**	**+7.5**
NPV	**-5.9**	**-29.8**	**-11.2**

Section Two – Recurrent Education Income and Costs

The second section outlines the current staff involved in providing education and the current funding sources forecast. The model indicates that there will be a shortfall in funding from sources such as Health Education England and commercial income to cover the base requirements to support the education model. The Trust will need to review the level of contribution to education from tariff income that it should contribute to deliver on the strategy.

2 Introduction

2.1 Background

In 1853, the first Annual Report by Charles West was presented for the Great Ormond Street Hospital for Sick Children. It stated:

'The Objects of the Institution are;-

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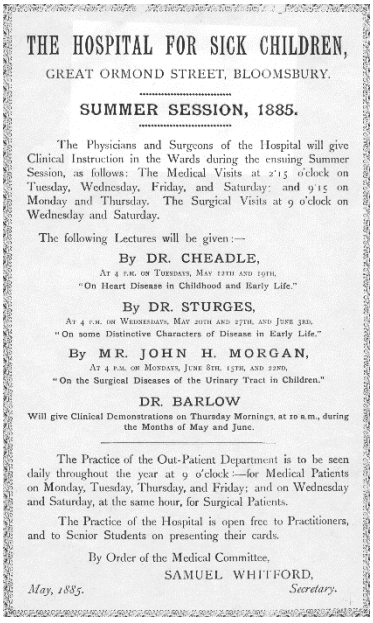
Though we focus on many professions at the Trust in our wider strategic objectives—whether this be doctors, nurses, or the multitudes of other staff within our workforce—education and training has formed a fundamental part of our purpose since the first patient was admitted. Space within the hospital has changed dramatically since that era, with many iterations of size and purpose, but as early as its origination, this hospital has sought to educate and train not just its workforce but the wider community. We, as education professionals, can only achieve this mission if we have a room to offer it in.



THE HOSPITAL FOR SICK CHILDREN,

GREAT ORMOND STREET, BLOOMSBURY.

SUMMER SESSION, 1885.

The Physicians and Surgeons of the Hospital will give Clinical Instruction in the Wards during the ensuing Summer Session, as follows: The Medical Visits at 2·15 o'clock on Tuesday, Wednesday, Friday, and Saturday: and 9·15 on Monday and Thursday. The Surgical Visits at 9 o'clock on Wednesday and Saturday.

The following Lectures will be given:—

By DR. CHEADLE,

At 4 P.M. on Tuesdays, May 12th and 19th,

"On Heart Disease in Childhood and Early Life."

By DR. STURGES,

At 4 P.M. on Wednesdays, May 20th and 27th, and June 3rd,

"On some Distinctive Characters of Disease in Early Life."

By MR. JOHN H. MORGAN,

At 4 P.M. on Mondays, June 8th, 15th, and 22nd,

"On the Surgical Diseases of the Urinary Tract in Children."

DR. BARLOW

Will give Clinical Demonstrations on Thursday Mornings, at 10 a.m., during the Months of May and June.

The Practice of the Out-Patient Department is to be seen daily throughout the year at 9 o'clock:—for Medical Patients on Monday, Tuesday, Thursday, and Friday; and on Wednesday and Saturday, at the same hour, for Surgical Patients.

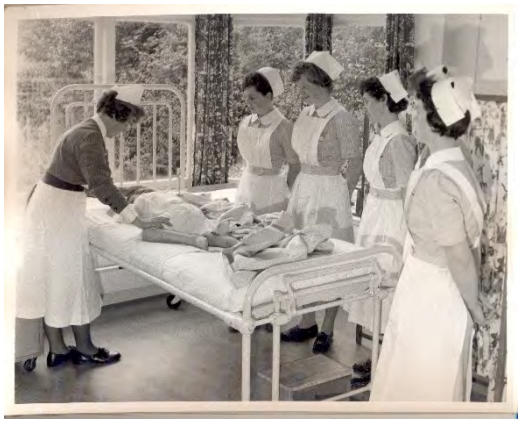
The Practice of the Hospital is open free to Practitioners, and to Senior Students on presenting their cards.

By Order of the Medical Committee,

SAMUEL WHITFORD,

May, 1885. *Secretary.*

Dedicated space for any purpose within the constraints of central London remains a difficult challenge for all institutions; Great Ormond Street—though exceptional—is not excluded from this. There have been several attempts to create dedicated clinical schools within the trust—*Hospital for Sick Children Medical School* in 1909, the *Institute of Child Health* established in the Southwood Building 1938, and the *Charles West School of Nursing*, established 1959. As the Medical School has long been disestablished, the ICH decanted to its current location under the management of UCL, and the *Charles West School of Nursing* transferred to *London South Bank University* in 1995, replaced with what is now the Octav Botnar Wing, the only remaining areas of the trust purely dedicated to the training and education of internal or external workforce remains on the 4th floor of the Main Nurses Home.



Though other areas still serve for education space, such as Weston House—whose lower and ground floors were originally envisioned as a dedicated area to education—this need has been superseded by the wider needs of a swiftly expanding organisation. Meetings, conferences, and any other manner of event now rely almost solely on these rooms for operation. If education and training constitutes a foundation of our purpose, it should not be competing with other needs of the trust in order to function as a service. Courses and study days for our specialist workforce are now regularly relegated to ward seminar rooms intended for handovers, external venues in Bloomsbury requiring considerable expense to an already strained Trust budget, and in even some cases, converted storage cupboards.

Figure 1: Laparoscopic Training Cupboard

Laparoscopic Training Cupboard

We are nationally and internationally recognised as a leading provider of paediatric surgical care. We aim to provide innovative and state-of-the-art surgical interventions for our children and young people. This includes but is not limited to laparoscopic procedures.

Simulation is a key element of developing this skill set in our surgical team. Currently, our Surgical Consultants can only be facilitated laparoscopic simulation training in a 7.56m^2, converted storage cupboard on the 4th floor of the Main Nurses Home.

If the Trust wishes to continue to develop and lead the way for the advancement of surgical procedures in children and young people, investment in equipment and space is desperately needed.

In understanding the impact of growth and development across GOSH and the imperative of the education departments to provide excellent and competitive learning spaces to facilitate this, this document provides the narrative to accompany the data reviewed and describes the education vision for a dedicated learning centre—the GOSH Learning Academy. Multiple in-depth reviews of the day-to-day functions of each education department have been carried out, and the data for provision of service has been evaluated over a period of two years and projected to 2020. This summary is examined further in section 3.4.

The central education teams and the wider teams across the Trust have in the past two years begun to highlight the risks to service due to the current space provision. This has culminated in several reviews of space provided, needs of the service, and identified risks to the trust:

- *Education and Training Space Review, January 2017* (Appendix 1)
- *Course Logistics Report, March 2017* (Appendix 2)

As the risks to service provision and expansion became known, the Executive Team, in response, commissioned Redevelopment to compile a study regarding education and training space requirements and the options for an off-precinct dedicated space:

- *Education and Training Space Requirement, June 2017* (Appendix 3)

Further audits and collection of data have continued under the guidance of the Redevelopment Team and are included in this document. Case studies undergone with the workforce, workforce and retention data, and research into best practices and environments for clinical and non-clinical education have all been assessed and partake in the conclusions gathered. The data analysed overwhelmingly indicates that current space dedicated to training does meet the space requirement identified through audits and reviews. The service need already far outweighs the spaces available and now limits the expansion of education and training provision expected for the success of the Trust Strategic Objectives.

Appropriate and available space is the fundamental requirement in the provision of education and training. Our ability as an organisation to function as a Centre of Excellence for workforce and families is directly correlated to our ability to continually educate and train our workforce to the highest level; this is furthermore intertwined with our ability to recruit and retain staff of the highest calibre, the reputation of the GOSH brand, and our ability to project our organisation commercially. The commercial impact of this vision is not restrained just to the departments described in this document. Other larger services in

the Trust, such as International and Private Patients, have ambitions to bring clinical staff from countries near and far to study and utilise the knowledge we have available—these commercial ambitions must be matched with investment in space which can facilitate this.

The space requirement presented herein has been extrapolated from the data analysed and benchmarked against identified service need and the provision of our competitors. In reiteration, the requested space is not just to provide a basic education provision to the workforce, but to develop all of GOSH education and training into the larger vision of a GOSH Learning Academy—a service for every member of staff employed at the Trust and a service with the ability to impact the treatment of children and young people across the globe. The evidence analysed supports investment in an off-precinct, dedicated education and training facility within the area to achieve this goal and fulfil the needs of the Trust Strategy. The space will not be restrained solely to the purposes of the central education teams; it will designed and moulded in recognition of the multitudes of education needs a specialised quaternary institution requires—whether this be conference, lecture, or collaborative learning.

Off-precinct development forms a predominant part of this document but does not omit the other areas of education provision in the overall GOSH Learning Academy Vision. This vision includes not just central education teams, but all education providers within GOSH, whether this be ward-based education staff—Clinical Supervisors, Educational Supervisors, Mentors, Preceptors, Practice Educators, or Practice Facilitators—or any of GOSH's senior, knowledgeable, experienced workforce. The vision detailed in this document seeks to accommodate any and all iterations of education and training within GOSH:

Figure 2: The Space

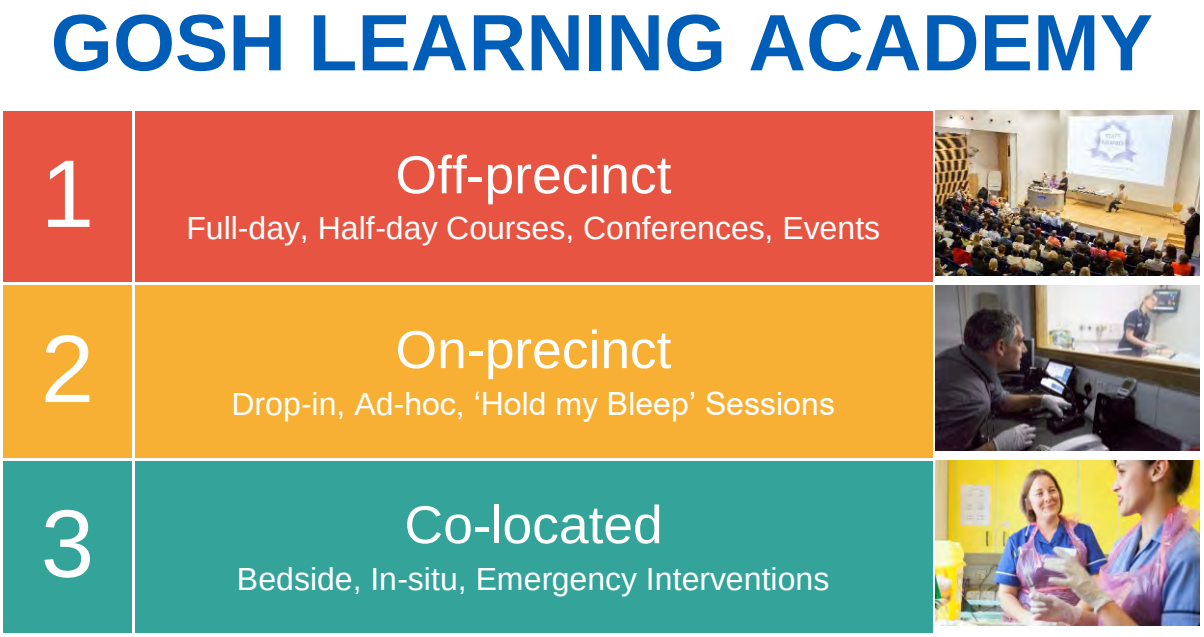


Figure 3: The Service

The current space provision has been benchmarked against case studies from a variety of institutions both nationally and internationally. Analysis indicates GOSH has strong potential to become a leading provider of paediatric education, but its greatest limiting factor to its potential remains available, modern teaching facilities. Without timely investment, GOSH stands to lose a foothold in the contemporary market, both in the recruitment of a new generation of staff and commercial education opportunities. With timely investment, GOSH can expect a sustained, expanding service over the next 15 years which would preserve a competitive level of provision for possible world-leading development in Phase V. If we are to be defined as a world-class hospital—moreover, a teaching hospital—we must have the space and equipment to match.

2.2 Purpose of this Business Case

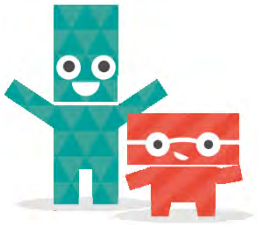
This outline business case has been prepared to support an investment decision by Trust Board supported by GOSH Charity for a dedicated 'off-precinct' education centre. This outline business case sets out the overall best offer for the Trust, documents the proposed contractual arrangements, confirms funding and affordability, and sets out the detailed management arrangements and plans for successful delivery and post implementation evaluation.

2.3 Structure of this 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

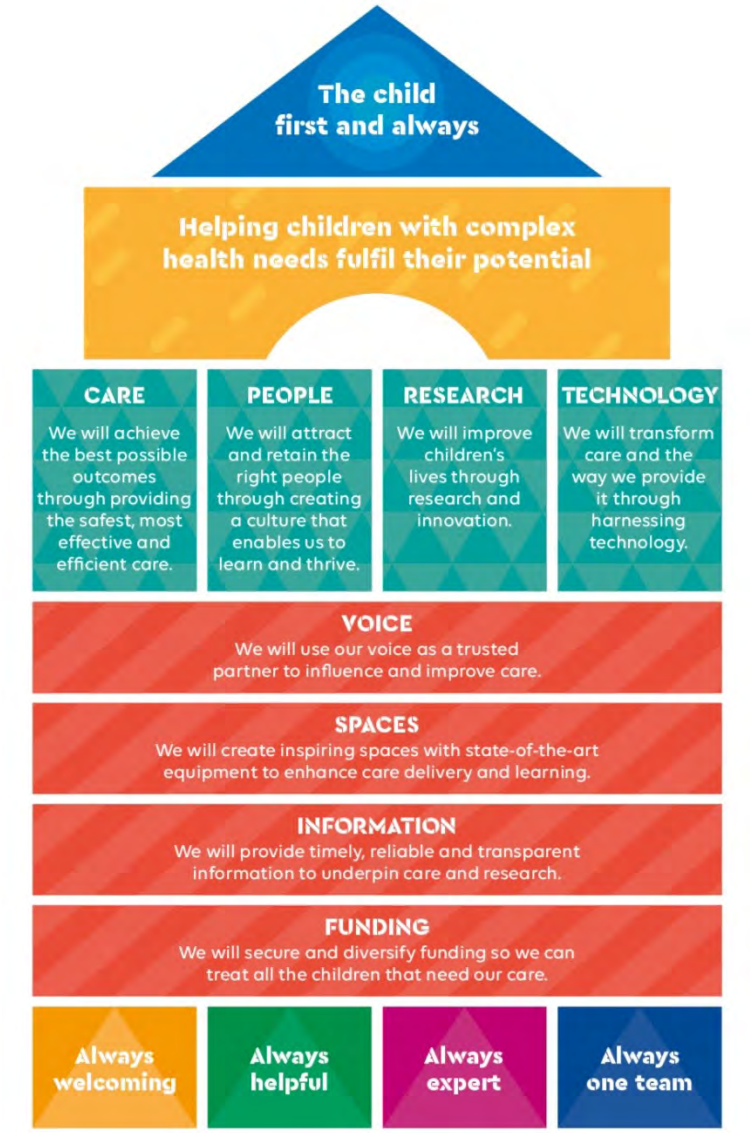


Vital to the successful aims and objectives of the Trust, the education and training of our entire workforce must be a vital focus in Trust's priorities. Education and training, much like the building blocks of the Trust Strategy, forms a foundation for Trust staff from which all other objectives succeed or fail. Without the necessary education, staff are unable to perform to the standard required in order to carry forward the Strategy as a success, and without the demonstrated commitment and investment to their development to these ends, the risk to the recruitment and retention of these staff remains paramount.

3.1 Strategic Alignment

3.1.1 Supporting Trust Strategic Objectives

The Trust Strategy launch refresh and launch has coincided with the development of this document. Central education has identified the specific objectives which will be, as a result of this business case, enhanced to ensure their success.



The contributions of this project to each objective is examined further in section 3.1.2.

PEOPLE **We will attract and retain the right people through creating a culture that enables us to learn and thrive.**	**Culture**	2.1	Use our values and behaviours to build a positive and diverse culture where staff are inspired to give their best
	Talent	2.2	Be renowned for our talented staff and for the ever improving quality of work they do
	Leadership	2.3	Have leaders at all levels of the Trust who are effective, visible, supportive, and respected by their teams
	Education	2.4	Provide our staff with the skills and capabilities needed to deliver exceptional care from world-class facilities
RESEARCH **We will improve children's lives through research and innovation.**	**Reward**	3.2	Build a culture of innovation and continuous improvement where the talent and creativity of all staff is harnessed
TECHNOLOGY **We will transform care and the way we provide it through harnessing technology.**	**Technology**	4.2	Ensure rapid uptake of the latest clinical and non-clinical technologies to improve patient outcomes and our productivity
VOICE **We will use our voice as a trusted partner to influence and improve care.**	**Networks & Partners**	5.2	Play a leading role in the UK system and international children's alliance, and to ensure our networks across UK best serve the patient's needs
SPACES **We will create inspiring spaces with state-of-the-art equipment to enhance care delivery and learning.**	**Site**	6.2	Maximise our site's potential to meet current and future healthcare needs
FUNDING **We will secure and diversify funding so we can treat all the children that need our care.**	**Commercial funding**	8.3	Develop and grow new sources of commercial income within the UK and internationally by making best use of our specialist expertise in patient care, education, diagnosis, and research

3.1.2 Contributions of this project

3.1.2.1 We will attract and retain the right people through creating a culture that enables us to learn and thrive

'Attract and retain'—synonymous with recruitment and retention—this is one of the greatest drivers of success at any hospital. In the modern healthcare landscape, registered and unregistered workforce expect a high level of professional development both from and within their organisations; employers that provide the highest level of such are at a prime position to attract and retain the highest level of practitioner.

Case studies within the GOSH workforce have found that staff members' priorities when choosing GOSH as a workplace include, as a fundamental, specialist education and training. Our values and behaviours as an organisation must consider this when prioritising areas of the Trust for development. The inspiration for staff to invest themselves is interlinked with how much they feel their organisation has invested in them.

Figure 4: Reasons for choosing GOSH, a focus group

Reasons for choosing GOSH, a focus group

In order to enhance the nursing recruitment and retention strategy, in 2017 the GOSH Charity was commissioned to run case studies and focus groups with potential and current nursing workforce to understand their views and needs. Interviewees were asked their reasons for choosing GOSH as an employer as well as reasons for staying within the Trust. Education and training focused often in the interviews and verbatim comments are presented below:

"It's not a general hospital. It provides you with training in specialist areas of nursing, and throughout the hospital, everyone is keen to teach you as much as possible." – Joel Williams, Staff Nurse

"I think it helped that I had been trained in a general paediatric setting, and the range and quality of education I've had at GOSH means I can now work in a specialised environment too." – Verity Spencer, Staff Nurse

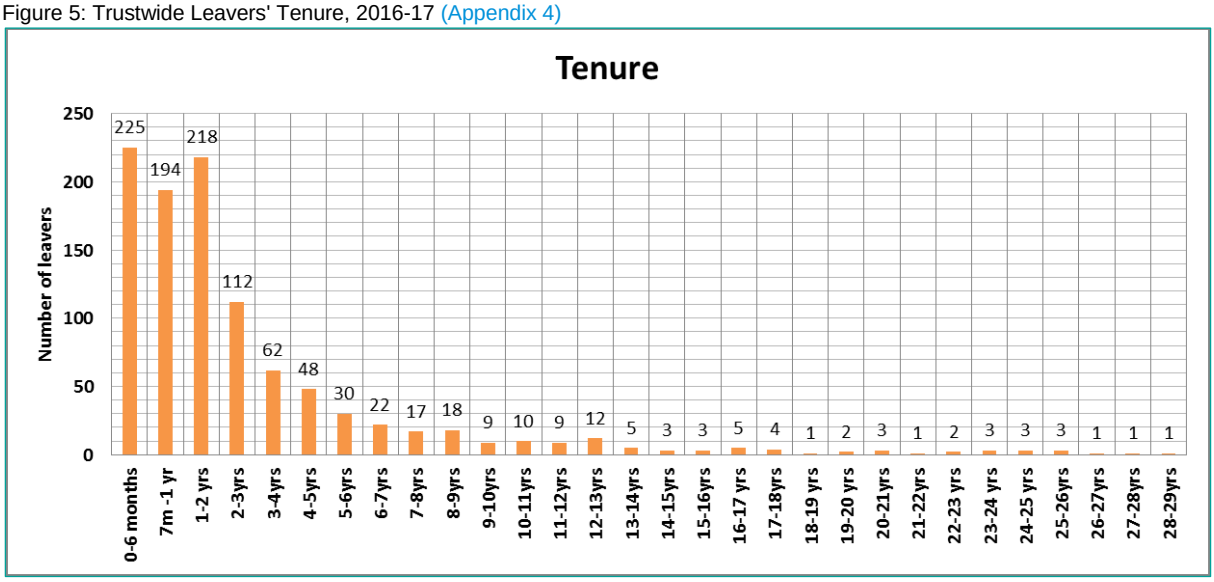
"I have competencies I thought would take me years to complete." – Nia Binding, Staff Nurse

"GOSH had a [Newly Registered Nurse] programme that gave me the support I needed and helped me become a confident, competent practitioner. I am undertaking the Intensive Care Course [run] by GOSH which is part time with London Southbank University. The course will enable me to expand my knowledge and skills and become a more competent Intensive Care Nurse. It is a nationally recognised course going towards my Masters." – Gemma Morris, Staff Nurse

"In the space of 12 months at GOSH I had completed 3 accredited courses towards my Masters. I now have a full Masters and am looking to publish it soon. I've come from trusts where there is no such thing as an educator, so it's fantastic that GOSH offers its nurses this level of support." – Cindy Sparkes, Practice Educator

Recent struggles in the NHS to retain and recruit staff, in the Trust in particular, is one the most crucial issues needing urgent solutions. Many studies have reiterated the same findings—staff retained at the beginning of their tenure are more likely to be retained in the long-term. Local, quantitative data analysed by Workforce in the *GOSH Leavers Report, May 2016 – April 2017* has demonstrated that 62% of attrition occurs within the first two years of employment:

Figure 5: Trustwide Leavers' Tenure, 2016-17 (Appendix 4)



This is particularly impactful around specially-trained, registered staff, as the investment in recruiting or replacing these staff members is a massive source of revenue loss. Survey data has further indicated education and the investment in developing these staff plays a key role in retention (Appendix 4). Case studies have indicated that education interventions, both small and large scale, are therefore necessary to ensure the investment in recruiting these valuable staff is not forfeited.

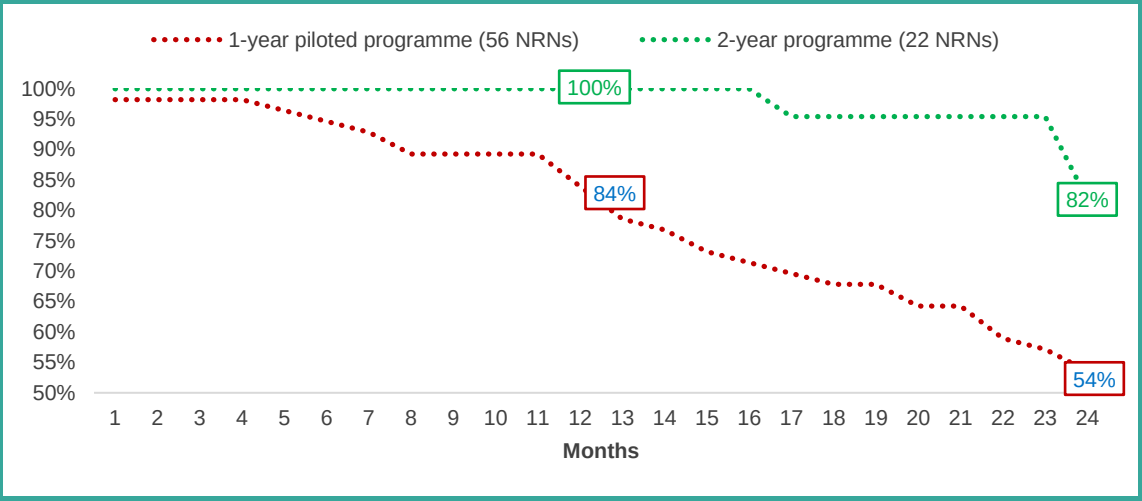
Figure 6: The Professional Development and Band 5 Nurse Development Programmes for Newly Registered Nurses

The Professional Development and Band 5 Nurses Development Programmes for Newly Registered Nurses

One Newly Registered Nurse (NRN), Elizabeth Washington, commented, "During my induction period I received a two-year plan, which detailed a broad range of study days I would be booked on to. This removed a lot of stress!"

This specific investment in education interventions refers to two programmes—the Professional Development Programme for Newly Registered Nurses (1st year of employment) and the Band 5 Nurse Development Programme (2nd year of employment). In the Trust's recent drive to increase recruitment and retention, education was analysed in its role as a catalyst for retention. During this research, specifically in the Nursing and Non-medical Education Team (NNME), it was discovered that a specific form of education intervention was resulting in higher than normal rates for new nurses recruited into the Trust. This specific subset of new nurses were being offered a programme called the Rotation Programme: a 2-year education programme begun upon induction in a planned rotation through three wards, but most importantly, with tailored study days and complete oversight and management by the central NNME team for a period 2 years. Within the programme, these nurses were offered a variety of specially created study days to improve their competency attainment rates, professional development, and enhance pastoral and formative support. In recognition of its success, a 1-year piloted programme was adapted for implementation in much larger general cohorts of Newly Registered Nurses as of September 2014. Retention rates were plotted against the two offers:

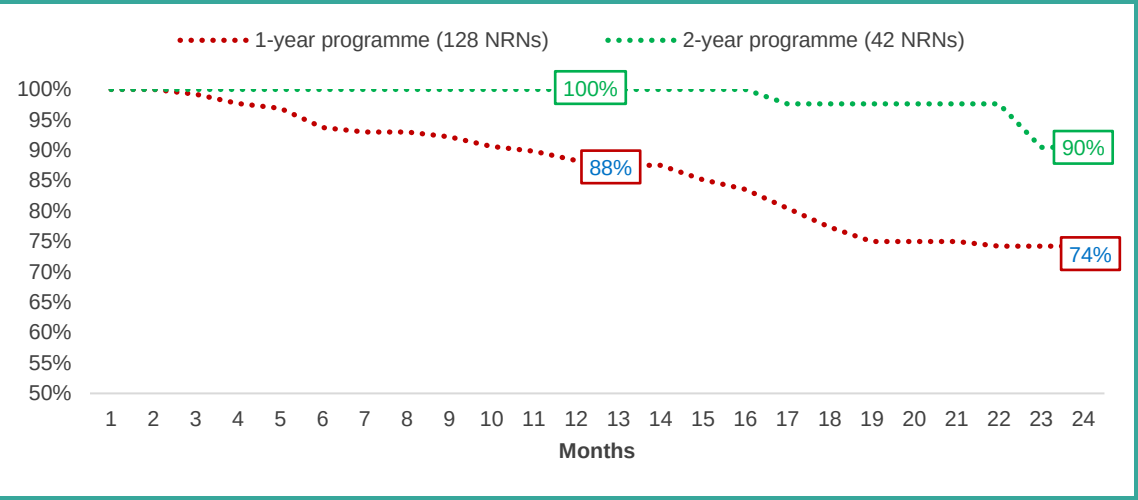
Figure 7: September 2014 - February 2015 (Appendix 5)



Though the 1-year piloted programme for general Newly Registered Nurses increased retention up to 12-months, the divergence between the two programmes at 2-years was 18%. The 1-year

piloted programme was further developed, adapted, and then implemented for all further cohorts from March 2015.

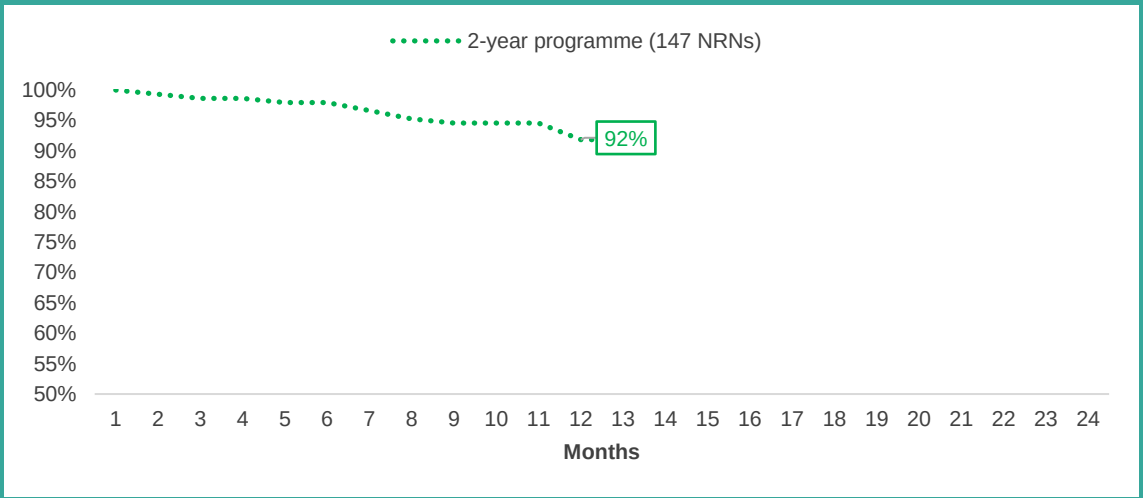
Figure 8: March 2014 - February 2015 (Appendix 5)



From March 2015 – March 2016, the established 2-year programme continued to provide exemplary retention, and even though it had been recently adapted for all Newly Registered Nurses, the fully implemented 1-year programme already yielded substantial increases in retention over a period of two years, in the realm of 20% by the end of the 2nd year.

After further development, adaptation, and re-design, the 2-year programme was fully implemented for all Newly Registered Nurses from September 2016:

Figure 9: March 2015 - August 2017 (Appendix 5)



The fully developed and adapted 2-year programme for all Newly Registered Nurses yielded significant improved retention rates. 2nd year retention rates remain to be evaluated but are expected to continue to yield similar if not improved results. In response to the success of this education intervention, this programme continues to run and has been integrated into the Trust's largest ever intake of **206 Newly Registered Nurses** in September 2017.

The financial implications of this education provision have been evaluated according to studies performed in 2016, commissioned by the Nurse Advisory Board Appendix 6, which revealed that the "average cost associated with turnover of one nurse" is **£39,330**. From September 2014 – September 2016, the increase in retention rates associated with this 2-year education programme resulted in increased retention of approximately 49 nurses, yielding a cost saving to the Trust of **£1,927,170**. The fully implemented 2-year programme indicates at current rates (82%) that this programme will result in the retention of at least 42 more Newly Registered Nurses than at rates evaluated during 2014, resulting in a further cost savings of **£1,651,860**. **In total, between September 2014 – September 2018, this 2-year education intervention would retain at least 91 more registered nurses and save the Trust approximately £3,579,030.**

The space implications of this programme, however, have not yet been addressed. A full 2-year programme for the September 2017 intake of 206 nurses requires 11 cohorts of approximately 20 nurses, on 9 study days, requiring an average of 4 adaptable rooms daily—**a total of 396 rooms**. The entirety of this programme has therefore been run externally in the Bloomsbury area, with reiterated complications of loss of vicinity to the Trust, inappropriate room accommodations, difficulties of hire and availability, high Central London rental costs, and overall, is not in line with the reputation and brand appropriate for GOSH. Over the 2-year programme, the latest iteration of this programme at an average of £800 per study day for the September 2017 intake of 206 Newly Registered Nurses will cost **£79,200**.

In order to not only recruit valuable registered and unregistered workforce—and then retain these workforce after initial investment—education as part of their development must be provided. As demonstrated above, due to space constraints, even the most successful education programmes are not able to be provided on-precinct. This results in either the education not being provided or at a premium cost in a commercial venue within the Bloomsbury area. This has an effect on the success of these programmes due to numerous complications—availability of the venues, no proximity to the Trust, inappropriate facilities, and large revenue cost. The Trust, since January 2015, has spent approximately **£252,107** in order to facilitate a basic level of education provision:

Table 2: External Venue Costs, January 2015 - September 2017 Appendix 7

Venue	Cost
Anglo Educational Services	£19,238
Bridewell Centre	£7,328
Doubletree Hotel by Hilton	£156,184
Goodenough College	£4,785
Lumen United	£23,208
Mary Ward Centre	£5,410
NCVO	£14,486
October Gallery Trust	£6,536
Royal College of Paediatrics and Child Health	£14,932
Total	**£252,107**

3.1.2.1.1 Culture: Use our values and behaviours to build a positive and diverse culture where staff are inspired to give their best

The Always Values are the foundation from which our staff's behaviours are grown. Staff are encouraged to emulate these, but the organisation itself must demonstrate these qualities and role model them if it expects its employees to follow in suit. A values structure within an organisation is only worthwhile if staff believe this exists throughout all strata of the organisation, above and below.

'Always Expert' staff can only become such with a robust education and training provision provided beneath them. Personal development must be synonymous with every Trust objective if we expect our staff to provide this highest level of care. Whether this is education in an off-precinct, on-precinct, or co-located space, it must demonstrate to learners that the organisation has invested properly in ensuring the learning environment matches the organisations' expectations. Cramped, unsuitable locations with poor facilities demonstrate to staff that the organisation does not value their comfort or the learning that is being provided.

The most frequent source of complaint in course evaluations is not to do with the teaching, but with the accommodation provided. Post study day evaluations are inundated with comments complaints about the sweltering, packed areas, squirreled away in meeting rooms without proper equipment. Learners are expected to sustain concentration while being asked to spend 8 hours in a basement room with poor ventilation and no natural light.

A learning environment first and foremost requires 'fundamental human needs like comfort, natural light, operable windows, good social ambience' (Scottish Funding Council and AMA Alexi Marmot Associates, 2006); we ask our staff to devote their time and effort to learn how to be 'Always Expert', but the commitment shown to their learning environment pales in comparison. Staff choose to stay within organisations that demonstrate commitment to their development; this includes recognising their valuable time spent away from clinical or non-clinical areas, learning valuable skills to ensure best patient care and safety, and ensuring it is spent in proper facilities conducive to their needs.

Figure 10: Learning and Development Agreement

Learning and Development Agreement

The Learning and Development Agreement (LDA) is a contract between Health Education England (HEE) and Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH). The agreement ensures that the GOSH provides high quality learning and training environments that support the learning and development of junior doctors in HEE training posts and medical students from London universities that undertake placements at GOSH. The agreement also sets out the obligations of GOSH as a placement provider to provide support, education, training, and workforce development:

4.2 Medical Placement Obligations

4.2.6 Teaching Space

4.2.6.1 Ensure the provision of appropriate teaching space or designation of clinical space for teaching purpose adjacent to the `main clinical areas available to Undergraduate Medical Education Training for teaching sessions to take place with a group of Medical Students and which allows Medical Students to clerk patients where necessary. (p. 71)

Currently it is extremely difficult to attain space for medical student inductions and teaching sessions; there have even been instances where medical student inductions are held in the

PGME reception area. This presents our future doctors a very poor first impression, especially as they attend placements at other London hospitals with dedicated education space.

GOSH currently hosts 20-30 medical students at any one time, and PGME are in the process of developing education sessions for all medical students and observers as we actively seek to increase the number of medical students at GOSH. This has very large potential for income generation, but this growth will only be achieved with investment in the space to provide it.

3.1.2.1.2 Talent: Be renowned for our talented staff and for the ever improving quality of work they do

GOSH Conference 2017 – Advances in Paediatrics, 6th October 2017

In the spirit of the Trust Values, PGME set out to create an event that would bring all departments and professions together to share their amazing work across the Trust. An organisation with a reputation like GOSH should have an event that not only shares best practice but also imparts knowledge and expertise internally and externally. This is what has motivated us to create the very first GOSH Conference – Advances in Paediatrics.

In December 2016, the PGME department began sourcing venues for the GOSH Conference. The Weston House Lecture Theatre was not big enough for our ambitions, and ICH were not able to confirm our booking in advance. The PGME team scoured the Bloomsbury area for a venue that would provide the basic needs: i.e. close proximity to the hospital, room large enough for over 100 people with breakout rooms in close proximity to the lecture hall, and space for poster displays.

After many viewings, suitable rooms were found at Senate House, University of London that met the space requirements and did not exceed the conference's budget. Signed contract and purchase order were provided to Senate House in March 2017 to confirm this. The PGME team continued to plan various elements of the conference following this confirmation, including advertising, ticket sales, call for abstracts, and acquiring custom posters and materials for the space in Senate House.

Six weeks before the conference, Senate House notified PGME stating that they have changed the location of the breakout rooms. Alternate rooms had been allocated on the other side of the building to our main lecture hall. This would have required more resources and staffing and caused significant disruption to the conference. This also affected custom displays that were designed around specific space in Senate House. However, Senate House's position on this was immovable. With six weeks remaining, PGME attempted to source an alternative venue that would meet need. As Newly Registered Nurse orientation had fortunately already been sourced at Goodenough College, which decanted to other smaller rooms in Goodenough College. However, the cost of Goodenough College was significantly higher, but this was reasoned justified for the quality required of an inaugural GOSH Conference.

Details of expenditure:

Table 3

GOSH Conference 2017 – Venue Hire Goodenough College	
Expenditure	**Amount**
Venue & catering	£16,518.00
Night before setup	£1,260.00
Total	**£17,778**

GOSH Conference 2017 – Venue Hire Senate House	
Expenditure	**Amount**
Venue & catering	£10,550.10
Total	**£10,550.10**

Using the new venue increased expenditure to £7,000. A GOSH Conference venue would have provided a brand-associated, revenue neutral venue and possibly generated revenue to be invested in the development of the conference. Furthermore, catering costs would have gone into internal catering revenue opposed to external organisations.

The conference was a resounding success. It was a day full of great speakers and thought provoking workshops—a day that embodied the Trust values from start to finish. This will now be an annual fixture in the Trust calendar and we hope expand and attract more external delegates both nationally and internationally. A dedicated education and conference facility would solidify the Trust's commitment to be an excellent place to work and learn and be a world leader in Paediatric and Child Health.

3.1.2.1.3 Leadership: Have leaders at all levels of the Trust who are effective, visible, supportive and respected by their teams

In order to support the Trust strategy, it is critical that we are able to develop our leaders and managers through the delivery of effective and engaging leadership learning. The Care Quality Commission report, *The State of Health Care and Adult Social Care in England* highlighted that "you can't have a well-performing organisation that isn't well led" (Care Quality Commission, 2016). The NHS Thames Valley and Wessex Leadership Academy further states, "We know successful leadership improves the performance of organisations. Nowhere is that more important than in the NHS where better performance actually saves lives. The NHS needs great leaders in all professions and at all levels."

Figure 11: GOSH Exit Survey 2016/17

GOSH Exit Survey 2016/17

GOSH received feedback through the 2016/2017 Exit Survey that leadership was an area that needed improvement. Examples of verbatim comments presented below:

- *'Better communication between management and staff and listening to staff ideas and suggestions in regards to making a job improvement. Management taking ownership/accountability for their poor decision making. Making sure resources are available to do your job properly.'*
- *'Line manager was very poor, somewhat soul destroying. Work delegation was very poor and staff morale was at rock bottom.'*
- *'There needs to be better leadership. It was apparent not everyone was treated fairly at all times.'*
- *'GOSH is very hierarchical. Dissemination of information needs to happen in a more open and timely manner. I feel I had to leave GOSH because of a lack of support.'*

Successful leadership brings increased efficiency and productivity and a higher staff retention rate; staff who feel engaged and valued deliver a better service to patients. The King's Fund, *Leadership and Engagement for Improvement in the NHS: Together we can* report states, "Organisations with more engaged clinicians and staff achieve better outcomes and experiences for the patients they serve" (The King's Fund, 2012).

As part of the Leadership Strategy, Learning and Development (LEaD) will be redesigning and redeveloping comprehensive leadership and management learning programmes for all levels within the organisation. To ensure that we meet the Trust's Leadership objectives, it is essential that we have the resources and the space to deliver these programmes. To maximise their success, the programmes will be rolled out and delivered in a facilitated environment with the opportunity for discussion, interactivity, and skills practice, with scope to break out into smaller groups (either breakout rooms or pods) to help embed learning.

One of the key skills in the leadership and management programmes is 'coaching'. It is vital that managers have the capability on how to provide feedback and coach team members; therefore, appropriate spaces within the education footprint are necessary to practice this skill in a safe environment; e.g. a minimum of space for six pairs per study day.

These programmes, as part of the redevelopment of the Leadership Strategy, will put continued strain on the very finite space available. By 2020, it will be unsustainable to improve and increase these programmes to adequate levels without additional space investment.

Figure 12: PGME Profesional Development Programme

PGME Professional Development Programme

As detailed above, leadership development is vital for our clinical and non-clinical staff and much akin to the NHS Leadership Academy, at GOSH we believe that better leadership leads to better patient care, experience, and outcomes. The PGME department, in partnership with the clinical leads for quality improvement and mentoring, has developed a holistic Professional Development Programme for all staff at different grades.

Professional Development: Level 1 – Basics of professional development and is open to Junior Doctors ST3 and above and multi-professionals at Band 5-6.

Professional Development: Level 2 – Looks at building NHS wisdom. This 3-month course helps individuals build awareness, practical skills, and insight into the different elements of their working lives.

Professional Development: Level 3 – A six-month course that will give delegates an opportunity to explore their potential, offering valuable insight and opportunities into management, quality improvement, and education.

However, in reiteration to previous case studies, obtaining rooms to hold these session was exceptionally difficult. The PGME team scoured internally and externally to find no rooms available for the course provision; and if there were, they were at extortionate prices.

Due to the Trust's relationship with Morgan Stanley, we have fortunately been able to hold our programme at their offices in Canary Wharf. This is a great opportunity to expand this relationship, and it has the added benefit of providing delegates with an external environment to immerse themselves in the education.

However, this does add challenges to programme logistics, as administrative staff now much travel to an external locale each study day prepare and close the programme; it presents extreme difficulty for speakers and facilitators that need to leave and return to work; and staff members attending the course may find that this adds an extra thirty minutes to their journey each day at additional cost.

An off-precinct facility mitigates all of these issues, as it would be a short walk from the Trust will enable courses such as these to run more efficiently, at lower cost, and is infinitely more convenient and appropriate for delegates, speakers, and facilitators, increasing course engagement, satisfaction, and knowledge acquisition.

3.1.2.1.4 Education: Provide our staff with the skills and capabilities needed to deliver exceptional care from world-class facilities

Statutory and Mandatory Training

The Trust has a responsibility to ensure that their workforce complete the appropriate training to comply with the statutory and mandatory training requirements set out in the UK Core Skills Training Framework (CSTF). This includes nationally agreed learning outcomes and training delivery standards as stipulated by NHS England (Skills for Health, 2016).

The purpose of statutory and mandatory training is to ensure that our staff are always safe and competent to safeguard our patients and to provide statutory and regulatory compliance assurance and monitoring arrangements to the Education and Workforce Board and further to Trust Board. The Trust has an overall compliance target of 90% for statutory and mandatory training; as demonstrated in the data provided, the limited and non-dedicated availability of space for training has created a significant risk to maintaining our compliance targets and mitigating risks to staff and patients.

Induction

Many of the topics covered within the CSTF are covered as part of central Trust Induction and Local Induction. Along with ensuring that our new staff are safe and secure at work, it is vital to engage with them on our culture, ways of working, and expectations. An excellent induction should set the tone and values of the organisation, motivating and exciting the new employee—it's the first impression that new hires get of how learning works in GOSH, so it's critical that this impression is resoundingly positive. Induction and orientation are also about emotional engagement and communication with the new employee, helping them to come to the conclusion that they made the right decision to join GOSH.

Failure to provide an effective induction carries risks such as:

- Low productivity: Productivity of new starters can be low and the productivity of their immediate colleagues may also be impacted. Effective and comprehensive induction training can reduce the time to needed to achieve full competence expected.
- Poor customer service: Lack of knowledge and training can increase the risk of mistakes or poor service when dealing with patients.
- Compliance risks: If new starters work in regulated areas, there is a risk they may fail to comply with appropriate procedures or policies.
- Staff turnover: Evidence from staff exit surveys show that many staff make a decision to leave within their first month of joining an organisation—poor induction/orientation can definitely play a part in that decision.

With the acknowledged importance of induction on the performance of our staff and the impact it has upon retention, it should be noted that induction has now regularly been relegated to external non-GOSH venues.

Table 4: Newly Registred Nurse Induction and Orientation - September 2017

Newly Registered Nurse Induction and Orientation – September 2017
With the recent nursing workforce shortages within the NHS and the opening of PICB, NNME as well as Nursing Workforce have faced significant pressure to increase the number of registered nurses recruited in 2017. With some extraordinary efforts, this was achieved with the highest ever intake of in Newly Registered Nurses in GOSH history—206. However, despite this achievement, there were significant difficulties encountered with the space required to induct and orientate these staff. It was recognised early on that Weston House would not have the capacity to house the entirety of the NRNs in one sitting. Action plans were put in place

to mitigate possible complications, and it was decided that the group must be split between two locations—one internal and one external.

The complications this caused were numerous:

- Instead of standard practice of induction (1st week, run by Workforce and LEaD) and orientation (2nd week, run by NNME), one-half of the nurses would receive induction on-precinct (1st week, facilitated by Nursing Workforce and LEaD) while one-half would receive orientation off-precinct (1st week, facilitated by NNME). This would be reversed in the 2nd week. This is not ideal standard of practice and does not match the required tone for an excellent induction. Furthermore, this effectively required all three teams to devote an extra week of manpower to achieve full induction and orientation of these nurses at a significant staff cost.
- In the 2nd week, Orientation was decanted from their original location within Goodenough College into less appropriate accommodation due to the complications encountered by the GOSH Conference relocation. This was entirely due to externally-sourced venues being outside the control of the Trust.
- The externally-sourced venues—Imperial Hotels and Goodenough College—were not appropriate for an NHS orientation. The nature of these venues being non-GOSH related has an impact on the ability for staff to achieve proper induction and is not suitable to achieve an excellent orientation to their workplace.
- The externally-sourced venues came at significant cost: **approximately £17,000**.

Continued Professional Development

The consistent delivery of high quality, compassionate, exceptional care is underpinned by the provision of continued professional development that provides staff with the skills and capabilities to ensure 'the right person, with the right skills, are in the right place at the right time' (Cummings).

Legislative bodies, such as the GMC (General Medical Council) and NMC (Nursing and Midwifery Council) set standards for education and training that are an expectation of the minimum requirement for the Trust. In addition, medical and nursing staff choose to apply to GOSH confident in the offering of exceptional, innovative, and up-to-date paediatric clinical teaching and the opportunity for professional development throughout their tenure.

The ability of the joint education and training teams to provide specialist teaching that can support and develop all staff begins with the learning environment itself. If the claim as a specialist, teaching hospital is to be substantiated, our clinical and non-clinical staff require some of the highest level of training available in order to provide inclusive, compassionate care and build a workforce with the capacity to improve and innovate. Our ability to maintain the expectations of both legislative bodies and staff themselves is pulled into sharp focus when discussing the capacity of the Trust to not only offer the most up-to-date, best-practice teaching but to have the ability to be a leader in the changing picture of healthcare. The vision of the GOSH Learning Academy, and the spaces it would provide, would allow the central education provision to enhance its already established education programmes and its ability to offer new, creative learning that meets the needs of the workforce, allowing the Trust to project itself commercially and be competitive in the marketplace nationally and internationally.

3.1.2.2 We will improve children's lives through research and innovation

3.1.2.1.5 Build a culture of innovation and continuous improvement where the talent and creativity of all staff is harnessed

As shown in this document, much of the teaching that occurs in the Trust happens within wholly inappropriate or insufficient spaces. To build a culture that embraces and encourages creative learning and development, the physical space should match need. A dedicated learning space would give staff the opportunity to focus their learning, work collaboratively, and build the important network relationships that promote innovation and creativity.

In comparison to our competitors—e.g. University College London Hospital, King's College London, Birmingham Children's Hospital—each have dedicated education and training centres with modern facilities; the current learning spaces offered within the Trust falls far short of each. Staff have very little opportunity to come together in groups to share knowledge and develop a multi-disciplinary education environment.

The Weston Education Centre, King's College Hospital

One of the markers of a leader in an industry is how well the stack up against their competitors. With the assistance of GOSHCC, central education has done several case studies into what our competitors offer. With aspirations to be a world leader, we must be able to adapt and learn from best practice and also benchmark ourselves accordingly. One example in the London area is King's College Hospital NHS Foundation Trust and the dedicated on-precinct facility of the Weston Education Centre.

The Weston Education Centre is one of two dedicated education centres for King's Clinical Training—the other being the PRUH Education Centre at the Princess Royal University Hospital campus—located on the south side of the King's College Hospital campus. It houses the departments Postgraduate Medical and Dental Education and King's Clinical Training. The facilities include a conference centre, a medical school library, and a dedicated simulation training centre.

A large lecture theatre, tiered classrooms, and meeting space are all provided within short walking distance of the main hospital. These rooms are devoted to education and training but are available for leasing when not in use. The spaces are adaptable, most with partitioning allowing for varying sizes of spaces. Tiered classrooms are also available.

Within the facilities is a modern, dedicated simulation centre consisting of up-to-date equipment enabling best practice. The rooms available are 4 multi-purpose clinical skill rooms, adaptable for partitioning, a simulation ward with 6 beds including a paediatric bay, and accompanying debrief and control rooms.

King's College London would not be defined as a world leader in clinical simulation, but its space allocation already far exceeds GOSH in every way. If we hope to keep pace with the contemporary education landscape, a realistic recognition of GOSH's current place in the marketplace is urgently required.

3.1.2.3 We will transform care and the way we provide it through harnessing technology

3.1.2.1.6 Ensure rapid uptake of the latest clinical and non-clinical technologies to improve patient outcomes and our productivity

The current Clinical Simulation Centre (CSC) was created in 2009 out of converted storerooms; now situated across 2 small simulation rooms, a small debrief room, and a small control room, it provides clinical education to over 2,000 healthcare staff per year. With additional space, staffing, and infrastructure, this business case seeks to develop a world-class simulation service, matching leaders in the field of innovative learning. The current centre has a high sessional occupancy, approximately 95% in the previous quarter, and very limited ability to run more than one event at a time. The size of debrief room is also a significant fact in limiting candidate numbers upscaling. The current space allocation at this point in the CSC growth cycle is heavily curtailing the agenda for multitudes of new course and programmes.

The core aims in this business case re simulation have formed around two concepts:

1. GOSH is a national and international provider of specialist paediatric services, and therefore, our portfolio of specialist courses should mirror this unique role and responsibility.

2. Healthcare is the only high-risk industry where teams do not come together regularly to rehearse before performance. Rehearsal forms a large segment of training for nuclear workers, soldiers, pilots, orchestras, sports, etc.—for them, it makes huge financial sense to do so. World-class teams require countless hours of practice, irrespective of individual skills. We would not accept being a plane passenger should the pilot lack numerous hours of simulated emergency experience. Traditional education formulates the presentation and acquisition of ‘knowledge’; simulation can assist acquisition of knowledge, but it holds the unique ability to provide insight into ‘performance’. The knowledge (well-trained individuals) to performance (expert team delivery) gap is estimated to be >75% of adverse performance issues in the cockpit, power station, or battlefield. Simulation is the only mode of education that demonstrates crisis performance to learners and closes this gap, defining solutions to mitigate the unavoidable influence that stress has, in an emergency situation, on human nature and mental capacity. Healthcare should be no different—it is the most expensive and impactful service a country provides, yet it has been standard practice to only practice with real patients, with the natural limitations of self-reflection and unacceptable patient impact in the event of an adverse outcome. At GOSH, patients have a particularly high percentage of co-morbidity and complex care provided by silo-subspecialty teams. Incorporating tailored regular rehearsal of our specialist teams’ responses—training as a Multidisciplinary Team—in to a simulated patient in difficulty, as part of GOSH’s culture, will logically have a stronger potential benefit to patient safety and outcomes.

The current allocation to clinical simulation not fit for the purpose of the above aims. At maximum capacity within the rooms themselves, the CSC team explores all avenues of ‘in-situ’ training on the wards and in departments to expand the simulation portfolio and its incorporation into as much training in the hospital as possible. In order to build a high-level, innovative GOSH Learning Academy Prospectus for wide scale marketing, clinical simulation, as the forefront of cutting edge healthcare education, must be of paramount priority.

The proposed plans for clinical simulation development will match the vision laid out in this document. The simulation provision will match the proposed three areas of education space:

1. On-precinct

Envisaged in partial redevelopment of Weston House, Level 1 are 2 simulation rooms, 1 control room, and 1 debrief room for a ‘Departmental Team Rehearsal (DTR) and Drop-in Centre’ facilitating

drop-in part-task sessions and a base for the 'In-situ Simulation Programme' and its faculty. This facility will be vital to capture staff who are only able to participate for short periods during their working day—during predicted quiet times—but can still return to the clinical environment rapidly if an emergency presents itself. These 'hold your bleep' sessions in the DTR massively increase the number of education episodes open to staff, when off-duty and study leave days are so restricted due to the significant payroll costs they incur and filled with other mandatory training requirements.

2. Off-precinct

The off-precinct development in this business case would yield 2 simulation rooms, adaptable into 3 parallel simulation spaces, allowing for three session instances to run concurrently. While modest on the international stage in terms of size, it will provide a massive increase in our capacity to train staff and enable the delivery of the wide, innovative, specialised portfolio envisaged in the GOSH Learning Academy Prospectus, and, very importantly, will be open to external candidates and the associated external revenue.

The decanting of the Clinical Simulation Team, and the rest of central education, to a centralised off-precinct centre will bring synergistic benefits in providing the opportunity for simulation-based learning elements to be incorporated in more traditional teaching across all GOSH education and training—the equipment and staff expertise need will be available. Other classroom space in the vicinity will be adaptable to deliver impromptu simulation courses, using environmental reality aids, or post-simulation scenario debriefing rooms if required. This development off-precinct will have potential well beyond its floor space.

The proposed room allocated to part-task Virtual Reality (VR) trainers will enable the CSC to provide external courses and stepwise training programmes around these contemporary learning aids.

A Haptics space enables users to full immerse and participate in their animated environment; it will enable the provision of specialised 'created' spaces, such as an Outpatients room, ambulance, or helicopter. This method is currently in its infancy for healthcare education, but we intend to establish GOSH, in conjunction with the newly-established Innovation Hub at 40 Bernard Street, as one of its first pioneers.

The small, proposed Technology Laboratory is designed in the mind that many of the subspecialty teams within the organisation require specific aids to augment their simulated learning. These aids are not commercially available; using 3D printing and latex forming techniques, we have been able to create some of our own, such as our own Sternotomy/Beating Heart and laparoscopy manikins. This development will allow us to continue to explore and develop this area of innovation.

3. Co-located

It is always important to note the continued need for simulation to occur in co-located areas across the Trust. The 'In-situ Simulation Programme' provides very high realism and fidelity for teams by rehearsing their performances in the actual environments where they work. This enables a unique 'system test' of the environment's resources and equipment, revealing many latent system safety errors, which can, thus, be analysed and addressed by interventional change or staff education to enable awareness and safe work, pre-empting potential harm during the next similar, critical illness episode for a real patient. This in-situ simulation teaching is not solely facilitated by the central Clinical Simulation Team, but intrinsically involves all level of ward education staff, e.g. Practice Educators. Practice Facilitators, etc.

Gastroenterology Simulator – Kingfisher Doctor's Office

The PGME department regularly conducts focus group meetings with junior doctors on a speciality basis in their departments. At a recent focus group with the Gastroenterology department, junior doctors expressed frustration at the lack of space for simulation equipment. The department has an Endoscopy and Colonoscopy simulator available to junior doctors, however there is no dedicated space to use the simulator.

It is currently only able to be kept in the Kingfisher Doctor's Office, where there is barely sufficient space for use by one person and no ability facilitate a training session for groups of doctors. It is paramount to patient care that junior doctors are able to practice their skills in a dedicated space that is fit for purpose and that they have this access when the need arises.

3.1.2.4 We will use our voice as a trusted partner to influence and improve care

3.1.2.1.7 Play a leading role in the UK system and international children's alliance, and to ensure our networks across UK best serve the patient's needs

As a leading provider, we have an obligation to not only educate our own staff but to utilise our brand, our expertise, and our influence to educate providers within Greater London and the wider UK network.

Education is one of the greatest forms of affecting change within healthcare, and our ability to educate wider providers is reliant on our ability, not just to reach out into the wider community, but to bring the wider community into our own environment to adapt and to learn. We are increasingly hampered by poor facilities to affect change across these networks and are, as such, woefully underperforming in relation to the potential the GOSH brand provides.

So many of our objectives will hinge greatly on areas such as transition and the wider NHS ability to care for our patients with highly complex conditions. To help these children and young people fulfil their potential, we must be actively engaging all areas of the wider network to ensure that their care does not end when they leave these buildings.

There is a massive appetite within the NHS alone for education and courses provided by GOSH. With such a strong, reputable brand, central education and training is persistently approached to hold events and courses by wider national stakeholders. Unfortunately, we are currently unable to fulfil this potential, as the facilities available prevent us from capitalising on these opportunities. By having the ability to offer education and training to the wider community, we not only enhance our brand, reputation, and commercial opportunities, but we enhance the voice and for the care of all children and young people with complex conditions.

3.1.2.5 We will create inspiring spaces with state-of-the-art equipment to enhance care delivery and learning

3.1.2.1.8 Maximise our site's potential to meet current and future healthcare needs

While classrooms remain core for education, a host of new factors and opportunities has dramatically changed the learning landscape. The traditional set classroom space is expanding and evolving as new methods of teaching and learning match new and advancing technology. For example, the development of wireless connectivity allows for interactivity and synchronicity between teacher and student. Mobile computing and wireless laptops make collaborative working easier and more efficient, while online communication tools, such as video conference calling negates the need to consistently use space inefficiently and allows for real-time group working. More learning takes place outside the classroom than before.

With an increased emphasis on collaboration and group working for courses and projects, learners need the appropriate environment to successfully carry out their learning tasks and to be able to network, build relationships, and access a social learning environment. A national report on student retention in higher education (Yorke, 2008) proposed that students discontinued their studies due to a lack of fit within courses, financial strain, poor teaching quality, limited student-workforce interaction, and slow academic process. In light of this, it is clear that in our plan to support teaching and learning, we must adopt a broader frame of reference than just the static classroom. The challenge for educators is to create a seamless, technology-enabled learning environment for students and faculty.

Recent studies into the impact of the physical environment for education and learning has shown extremely positive results in terms of learning outcomes, student satisfaction, collaborative working, building relationships, and defining a learning culture (Baeplar, 2014). With an enriched emphasis on the education of our workforce has come a drive to increase the educational opportunities for both undergraduate and postgraduate training. Many of these opportunities are aligned with supporting the curriculum requirements, mandatory training needs, and professional development forums. Many are set out explicitly in learning agreements and all contribute to the value felt by workforce in their working environment. This underpinning approach will yield success for the Trust objective above.

'Spaces for Learning, a review of learning spaces in further and higher education' (Scottish Funding Council and AMA Alexi Marmot Associates, 2006) defines three main types of successful learning practice by students:

1. Learning through reflection
2. Learning by 'doing'
3. Learning through conversation

Physical spaces are central to creating this new paradigm for learning. The modern classroom needs to support kinetic teaching and dynamic learning where students are engaged, actively learning and interacting. Common now in education are aspects of blended learning, the 'flipped classroom', and small group interaction breaking a larger class into groups during the learning session. Learning spaces need to adapt to accommodate multiple modes of learning (discussion, experiential learning, reflection, and individual feedback). Because active, collaborative learning is so important, space should support authentic, project-based activities. In addition, space may support informal learning, such as using the walls to post current research or to use as 'think stops' to brainstorm and share ideas. Spaces adjacent to classrooms may be utilised for informal gatherings, small group discussions, and individual student reflection.

The following is a guide to the physical functions and forms of contemporary education space:

Table 5: Contemporary Education Spaces

Contemporary Education Spaces

Whole groups: Adaptable classroom

It is important, when considering classrooms that they should be as adaptable as possible where chairs and, if necessary, tables can be easily reconfigured to match the teaching style. Quite usual is the u-shaped layout, with seating around 3 sides of the room. This allows for presenting from the front and also encourages easy discussion and question.

Figure 13: Royal Derby Training Centre, Derby Teaching Hospitals NHS Foundation Trust

Whole groups: Tiered seating

Tiered seating is suitable for a large cohort where everyone is close to the teacher and is a time of collective engagement and useful for reinforcing cohort identity. Even in a large space, it is usual for the teacher to be heard on a conversational level without a raised voice or amplification.

Figur;e 14: Kennedy Lecture Theatre, GOSH UCL Institute of Child Health

Three-sided spaces: Pods

Useful for small group collaboration, 'pod' areas can be used for a variety of teaching and learning where the group is perhaps no larger than 4 to 6. The space allows for a feeling of intimacy and can be less distracting than sitting at a table surrounded by others. This type of space is useful for problem-solving and focus on a particular task as well as giving a certain amount of privacy for conversation.

Figure 15: Cardiff University Teaching Hospital

Collaborative/conversation tables

Learning tasks often need a period of planning, conversation, collaboration and sharing. Most often this is a small group activity and best suited to small, defined table areas similar to coffee shops. Limiting the number of seats and keeping the table small all help to structure the parameters of the activity. Quiet conversation is the aim.

Figure 16: Education Centre, Birmingham Children's Hospital

Quiet study areas

Students need to be offered areas of study and reflection and for personal work tasks. Knowing that there are comfortable, quiet areas for students is often an attraction to frequent utilisation of the space and keeps students connected to their education centre.

Figure 17: The Learning Centre, Derby University

3.1.2.6 We will secure and diversify funding so we can treat all the children that need our care

3.1.2.1.9 Develop and grow new sources of commercial income within the UK and internationally by making best use of our specialist expertise in patient care, education, diagnosis and research

A recognition of the Trust's financial restraints is required at all times, and pragmatic objectives with pragmatic solutions are crucial to ensure the Trust operates within its means. GOSH education and training is not excluded from the financial pressures currently faced in the Trust and the wider NHS. Each year, the central education teams explore the opportunities available to bid and attain additional funding from a variety of different areas, including first and foremost, Health Education England (HEE) and GOSH Children's Charity (GOSHCC). However, due to recent reductions in HEE funding and the inherent risk to the education provision, other revenue streams and income mitigation strategies should and must be explored in order to sustain the provision of education and training with the Trust, ensuring retention and development of highly-trained staff—this is a key foundation to achieving all aspects of the Trust Strategy.

Income Risk

Historically, NHS education and training funding was centralised by the Department of Health within Health Education England (HEE), commissioned to Local Education and Training Boards (LETBs), and then disseminated to trusts within their designated area. This came in multiple streams distributed within the Learning and Development Agreement (LDA), highlighted earlier in this document. However, in 2013, Health Education England were notified of imminent, significant funding reductions. This focused on multitudes of streams, both direct funding to trusts and removal of significant areas such as the Student Nurse Bursary. The expectation was that responsibility for education and training funding would begin to integrate back into trusts themselves.

This culminated in 2014, when trusts were notified to expect from 35-40% reduction in funding to areas such as Workforce Development Funding, Student Placement Tariffs, and the reduction in bespoke bids for specialised funding streams. This has continued year-on-year, significantly depleting Workforce Development Funding (approximate deficit of £400,000 from 2014-17). There has therefore been a significant and expected decrease in CPD provided to all areas of the Trust, clinical and non-clinical; however, the most significant risk is lack of resources for the education staff to train the workforce and for workforce to access additional training to ensure we have the right staff with the knowledge, skills, and values to care for our highly complex patients.

Staffing within central education has been, in all areas, predominantly provided by Health Education England, and the education provision has expanded and sustained itself in large part due to these income streams. This provides a number of risks and complications due to the inherently precarious nature of year-on-year external funding provision—staff must be kept on fixed-term contracts, resulting in high staff turnover, no guarantee of continued funding, and lack of efficiency due to persistent inductions of new staff. The programmes and the success they provide are built and sustained by these staff and now face severe risk due to HEE funding limitations. Locally, the Trust has not alleviated the external funding reduction through revenue investment, and vital areas of the central education provision remains precariously sustained under significant cost pressures without an assured future.

The Trust has been notified through all available reporting structures, including Local Risk action Group, Education & Workforce Development Board, the Board Assurance Framework, and Trust Board. With the significant risk of space potentially ameliorated as a result of off-precinct development, the central education provision still faces a greater risk in not having the staff members required for the provision. **The current cost pressure to the 2018-19 central education service is approximately £727,386.**

The ability to ensure the Trust offers a robust, central education provision to sustain ‘always expert’ care and quality assurance of the education provision is a primary theme of this document. A suitable environment is paramount, but it is of no consequence if an educator isn’t there to provide the service. Central education not only provides education and training but also serves the vital need to assure quality of all education provided by all areas on the Trust—standardisation, adherence to best practice, implementing change, and enhancing provision are but a few of the aims of central education trustwide. It would be remiss of central education’s responsibilities to not highlight the severe risk posed to staff funding and its impact on the overall provision of GOSH education and training and the success of the Trust Strategy.

Income Risk Mitigation

To ensure the Trust upholds its value of ‘always expert’ staff, central education has begun to look at innovative ways of funding and providing the necessary education and training. Previous avenues of HEE bidding are now, in the current climate, predominantly extinct. As a result of this, first and foremost, central education has notified the Charity of the current financial predicaments, in order that they are appraised of the potential damage to GOSH services in the event of staffing removals. The Charity has partially embraced this funding responsibility, and this will be further examined in the following section.

As part of the current and future risk to areas, such as CPD funding, GOSH, in conjunction with Higher Education Institutes (HEIs) such as London South Bank University, has developed a franchise model of education specifically tailored to our current and future needs. Using this business model, in-house clinical expertise and knowledge is utilised to develop education pathways with academic credit and quality assurance being provided by the HEI. These education pathways are available to external candidates from outside the Trust with any profits received provided to the Divisions associated to fund further education opportunities. This model of education delivery has been incredibly successful in its first two years with projected increases over coming years. A new role—Head of Commercial Academic Education—has been recruited into to market these pathways and increase revenue. The expertise in GOSH is vast and the most immediate limiting factor and risk to expansion and reputation is lack of viable academic space in which to provide this education.

Figure 18: Franchising ICU Nursing Education

Figure 19: Jo Garwood, NICU Staff Nurse

Franchising ICU Nursing Education

Great Ormond Street has three intensive care units—CICU, NICU, and PICU. Nursing staff within these units are required to undergo a formal education programme to prepare them to be a skilled practitioner within a critical care unit. This includes three modules as part of an ICU programme (Foundations of PICU, Care of the Child with Cardiac and Respiratory Compromise, and Nursing Interventions for the Child in Paediatric Intensive Care). Historically, this would be achieved by sending each student to an HEI at a cost of approximately £3,555 per student. GOSH would send approximately 20 nurses each year at a cost of £71,100 per year.

As a leader in critical care in London, this course has historically been led by a GOSH PICU Lecturer Practitioner and had extensive input from the many clinical experts within the Trust. By bringing this course into Great Ormond Street in a franchise agreement with London South Bank University (LSBU), we are now able to deliver this course at a cost of around £30,000 per year, including staff costs, which save the Trust approximately £40,000 each year. In addition, GOSH receives the amount of £3,555 for any external candidates that attend. This number is currently about approximately six students a year, yielding additional revenue of £21,330.

The demand for this course is very high and we have to regularly refuse places to external candidates each year. Space continues to be the only limiting factor to the revenue increase, and the need to hire appropriate external venues reduces the overall cost savings to the Trust. Due to space constraints, the course is held almost entirely in external venues in standard Bloomsbury-size rooms of maximum 25 candidates at an approximate cost annually of £9,000. This is in addition to spaces not being within Trust vicinity, requiring staff to miss more working hours to facilitate teaching and often provides inappropriate spaces for specialised clinical teaching. With the appropriate facilities in an education centre, we would be able to increase candidate numbers and significantly increase revenue. With the space provided, an easily achievable increase of 20 candidates would result in a revenue increase of **£92,430**.

The university partnership model are one of the most effective methods of reducing internal costs, increasing external revenue, and enhancing the GOSH brand. By 2020, NNME alone will have franchised approximately nine postgraduate nursing modules, overseen by the Head of Commercial Academic Education. Evidenced by the amount of candidates rejected due to space constraints, there is sufficient external need in London and beyond for specialist, paediatric courses to warrant an expansion of these programmes. It is important to note that this model of education needs to expand with haste in order to cement GOSH as the leading provider of paediatric postgraduate specialist education within Greater London and the UK. GOSHCC has been commissioned to assist with this branding and marketing of these programmes, in order to maximise the outreach to external candidates and ensure maximum revenue is attained.

Franchised Courses	Income
Principles and Practice in Quality and Safety	£15,250
Stabilisation and Transport of the Critically Ill Child (IC)	£15,250
Paediatric Critical Care (General)(IC)	£15,250

Franchised Courses	Income
Cardiac critical care	£15,250
Safeguarding and Children in Society	£15,250
Adolescent Health and Medicine	£15,250
Advanced Genetic Technologies and their Clinical Applications	£15,250
Child Development and Disability: Inclusive Approaches in Global Contexts	£12,530
Education of Children and Young People with Medical Needs	£1,750
Paediatric and Adolescent Sports and Performance Injury Prevention and Management	£11,000
Foundations of Paediatric Intensive Care Nursing	£18,700
Care of Child with Cardiac and Respiratory Compromise	£18,700
Nursing Interventions for the Child in Paediatric Intensive Care	£18,700
Caring for Child and Young People within a High Dependency Unit	£37,400
Advanced Clinical Skills in Paediatric Ventilator Management	£18,700
Caring for Children & Young People with a Renal Condition	£18,700
Caring for Children & Young People with a Cardiac Condition	£9,350
Extracorporeal Membrane Life Support (ECLS) for Children and Young People	£28,050
Acute Transport for Children and Young People	£18,700
Advanced Paediatric Life Support	£25,000
European Paediatric Life Support	£50,000
Clinical Simulation Study Days (varying topics)	£18,000
Bespoke Study Days (varying topics, £50 per external candidate, 1/week)	£125,000
Total	**£537,030**

This type of expansion will join with both medical and leadership courses to finalise a GOSH Learning Academy Prospectus which can be advertised both nationally and internationally to external candidates. Central education is in hopes that this will work in partnership with the needs and ambitions of International and Private Patients drive to bring medical and non-medical staff to train at GOSH with significant associated revenue. However, without investment in a dedicated facility, it will be difficult, if not impossible, to compete with other trusts with far superior education facilities, designed and equipped at a far higher calibre than GOSH at present can offer.

Alternative methods by which to partially offset the annual revenue investment in a dedicated, off-precinct facility have already been explored. This includes, foremost, funding gained by daily leasing of

any space within the Learning Academy that is not being utilised for Great Ormond Street Hospital activities. From the Trust's own experiences of leasing within our locale, there is a definitive need within the Bloomsbury area for meeting rooms, conference venues, classrooms, etc.

Current plans for the GOSH Learning Academy would yield seven modern, 50-seat teaching rooms, a 300-seat adaptable lecture theatre, and specialised simulation spaces—a rare premium in the area. Each would be adaptable spaces that could be divided into smaller rooms depending on need. Target capacity for internal need is approximately 65%. If a remaining and achievable 15% of this space was leased at competitive prices Appendix 1, it would yield low-end, annual income estimates as below:

Rooms	Cost per day	Annual Income[1]
Teaching Rooms (50-seat)	£500[2]	£110,000
Lecture Theatre	£2,800[3]	£55,000
Simulation Rooms	£1,400[4]	£295,000
	Total	**£460,000**

3.1.2.1.10 In conjunction with GOSHCC, maximise value and impact of charitable funding in support of the GOSH strategy

As our greatest partner in our mission 'to help children with complex health needs fulfil their potential', central education seeks advice, input, and support continually from GOSHCC.

Akin to research, education has the ability to transcend local care and affect the care of children and young people globally. Successful education initiatives are replicated, integrated, and transform care across the NHS and the entire world. Many institutions look to GOSH for the wealth of knowledge that is available within our staff and within the specialties of our patients. Our research portfolio and the breadth and depth with which it affects paediatric care is world-renowned—our education portfolio for such an institution and its ability to improve children and young people's lives should match.

Central education seeks annually to bid for available GOSHCC funding to support dwindling resources. The Charity has stepped in to temporarily assist funding clinical simulation staff and equipment and has bolstered the CPD funding provision to moderate the effects of HEE funding reductions. The GOSH Learning Academy will seek as much help as is available from GOSHCC in its endeavours to match the ambitions of this vision and the objectives of the Trust Strategy.

3.2 Scope of Services

3.2.1 Central Education

Central education at Great Ormond Street is currently divided into three main departments:

- **Post Graduate Medical Education (PGME)** - Developing and supporting the delivery of training for doctors throughout the Trust. In addition, current and new teaching is often offered to other, external medics and/or other internal workforce.
- **Nursing and Non-medical Education (NNME)** - Leading on the provision of all nursing and non-medical education, training, and continued professional development. This also includes

[1] Calculated at 260 working days per year

[2] Benchmarked against 25-seat rooms in the Bloomsbury area (low-end estimate)

[3] Benchmarked against Kennedy Lecture Theatre, Institute of Child Health

[4] Benchmarked against UCH Education Centre

nurses, healthcare support workers, administration and clerical, allied health professionals, and healthcare scientists.

- **Learning and Development (LEaD)** - Concentrating on all internal workforce statutory and mandatory training, leadership and managerial skills, GOSH induction, and administrative training.

Other secondary education departments include:

- **Clinical Simulation Centre (CSC)** – The Clinical Simulation Centre is part of the NNMET umbrella but is considered a separate operating entity. Their purpose as the Clinical Simulation Team is to run the Clinical Simulation Centre but also to oversee all simulation education, bespoke or otherwise, throughout the Trust.
- **Resuscitation (Resus)** – The Resuscitation Team falls under Nursing Workforce. They are responsible for the mandatory resuscitation training provided to Trust staff as well as other specialist courses such as European and Advanced Paediatric Life Support (EPLS and APLS).
- **Moving and Handling** – The Moving and Handling Team is overseen by Occupational Health and oversees all mandatory moving and handling training provided to each member of trust staff at varying levels.

3.2.2 Trustwide

The vision presented in this document would be remiss not to acknowledge other modes of education taking place trustwide. Many additional methods of training are available outside the offer of the central education teams. These courses and study days can be found run by ward education staff (Practice Educators and Facilitators) or by individual teams and departments—doctors, nurses, scientists, allied health professionals, pharmacists, etc. However, these courses encounter the same space pressures as the central education teams, and feedback across the Trust reiterates the lack of off-precinct space as a significant risk to their provision.

The vision of a GOSH Learning Academy would be inadequate if not to give proper recognition of the day-to-day clinical teaching which occurs on any ward or on-precinct area at any given moment, otherwise known as ‘in-situ’ training. ‘In-situ’ training in co-located areas is a vital and large portion of the learning acquired by staff. Whether this be bedside teaching or a short presentation in a co-located space, these methods of teaching will always be integral to the success of all of our education and training objectives.

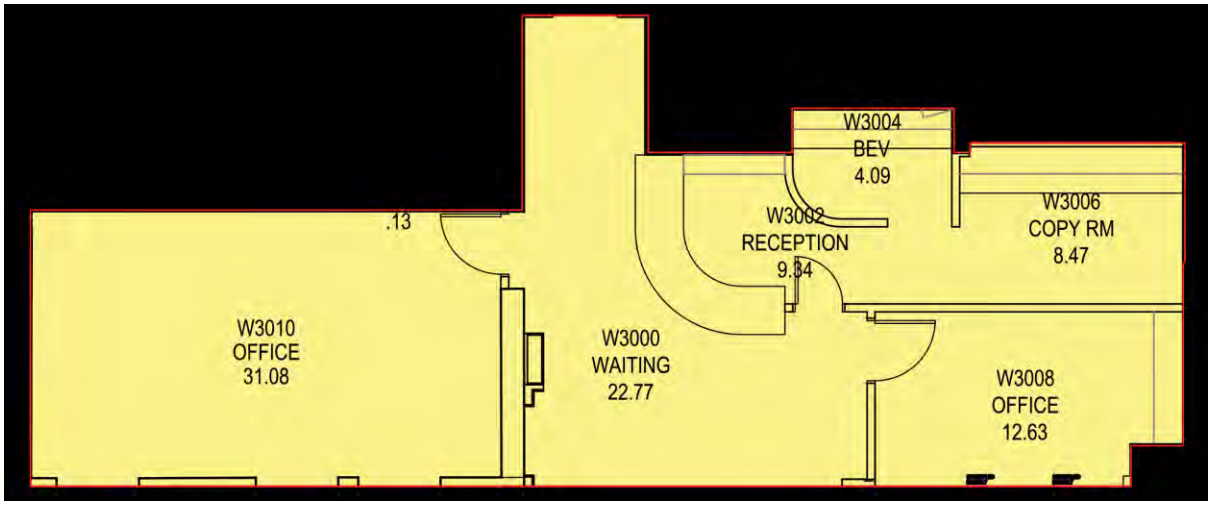
3.3 Current Facilities

All central education departments are primarily located between two buildings, the Main Nurses Home Level 4 and Weston House, Levels 1, 2, and 3.

3.3.1 Departments

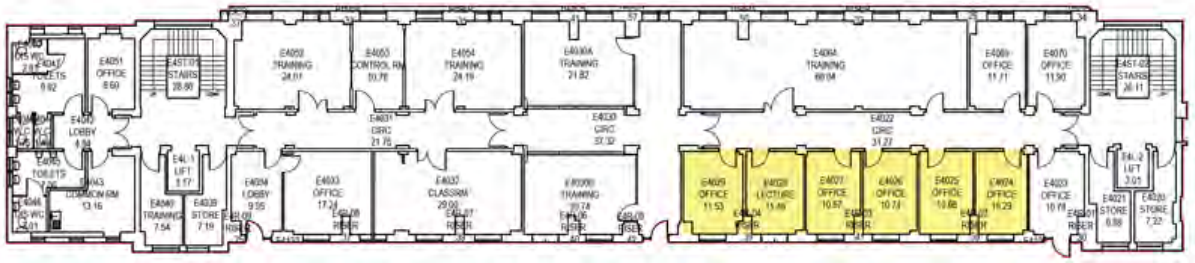
Postgraduate Medical Education – Situated across two sites currently, PGME is based on Level 3, Weston House and some agile working space in Russell Square. Both sites hold administrative workforce only and there is no room for dedicated for education activity. Level 3, Weston House has the capacity to hold 9 WTE and Russell Square HR and OD holds 3 WTE. Space for education activities is identified in the Weston House facilities when possible, but as the competition for this space is extremely high, PGME usually need to identify teaching space throughout the hospital campus or hire external venues.

Figure 20: Weston House, Level 3, PGME



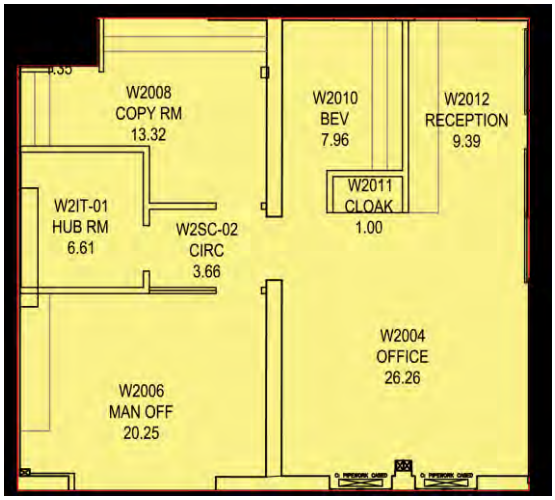
Nursing and Non-medical Education – NNME is based on Level 4, Nurses' Home solely in administrative offices. Six rooms hold 29.4 WTE at 17 workstations, or 1.73 WTE per workstation, far above the Agile Working Policy. Space for education activities is identified in the Weston House facilities when possible, but as the competition for this space is extremely high, NNME predominantly to identify teaching space throughout the hospital campus or hire external venues.

Figure 21: Main Nurses Home, Level 4, NNME



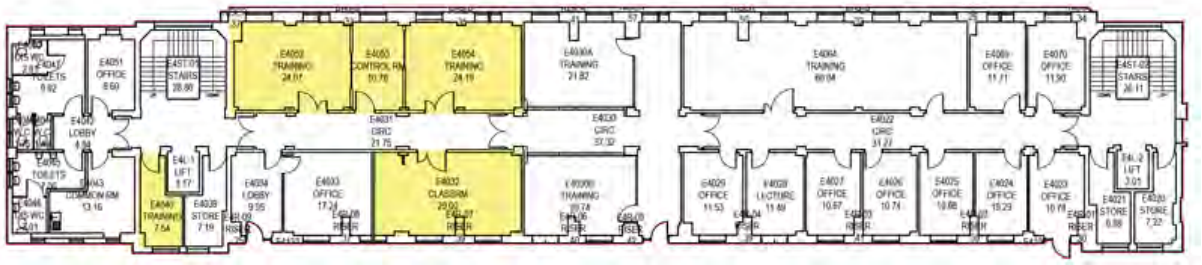
Learning and Development – LEaD is based partially in two administrative offices, Weston House, behind reception with 7 workstations for 7 WTE, and 1 WTE in Russell Square HR and OD.

Figure 22: Weston House, Level 2, LEaD



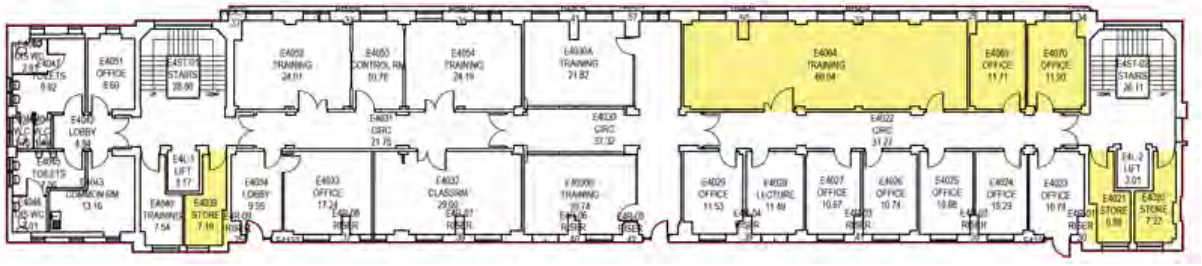
Clinical Simulation Centre – The Clinical Simulation Team retains one office as part of NNME for purely administrative needs. The Clinical Simulation Centre resides in the 2 simulation rooms, 1 control room, 1 debrief room, and the laparoscopic training cupboard.

Figure 23: Main Nurses Home, Level 4, Clinical Simulation Centre



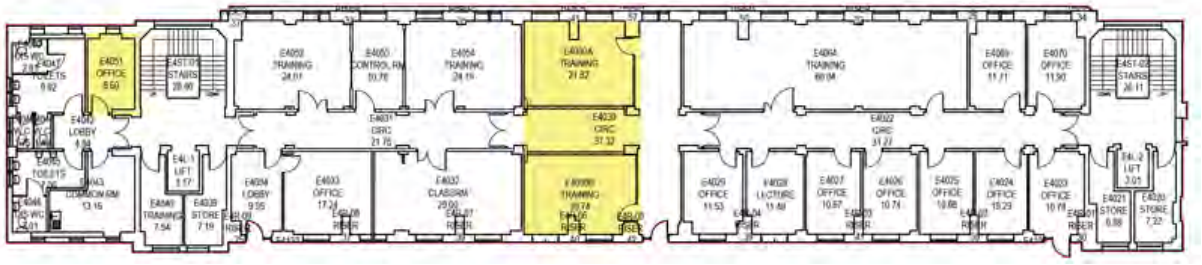
Resuscitation – Resuscitation consists of two office spaces with 5 workstations for 6 WTE, 1 classroom, and 3 storage areas.

Figure 24: Main Nurses Home, Level 4, Resus



Moving and Handling – Moving and Handling contains two classrooms which can be opened up into a larger space incorporating the hallway and 1 office space with 2 workstations for 2 WTE.

Figure 25: Main Nurses Home, Level 4



All three education teams have undergone expansion over the past two years in order to meet the increased demands of our workforce. At present there is insufficient place for each team to sit together even with lean use of office space. Housing all three teams together has the potential to improve collaboration, reduce duplication, and enhance the delivery of lean, coordinated education to take the Trust to the position of a leading institute for the delivery of training for paediatric healthcare.

The three education teams sit across three different locations. There are significant benefits to co-location:

- Opportunities to improve integrated planning for education and workforce development
- Improved ability to share skills and knowledge across education teams
- A more cohesive education offering and greater clarity for the Trust
- Opportunity to develop process efficiencies, including room bookings
- Greater opportunity for cross cover arrangements between teams
- Cost savings in modern agile-working spaces.

3.3.2 Education and Training Space

Weston House, Levels 1 and 2

Figure 26: Weston House, Level 2

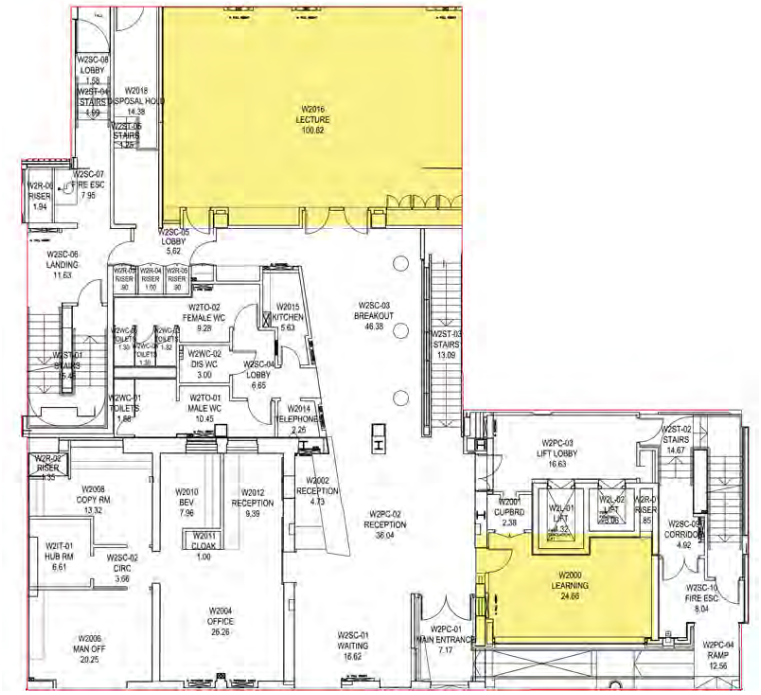


Figure 27: Weston House, Level 1

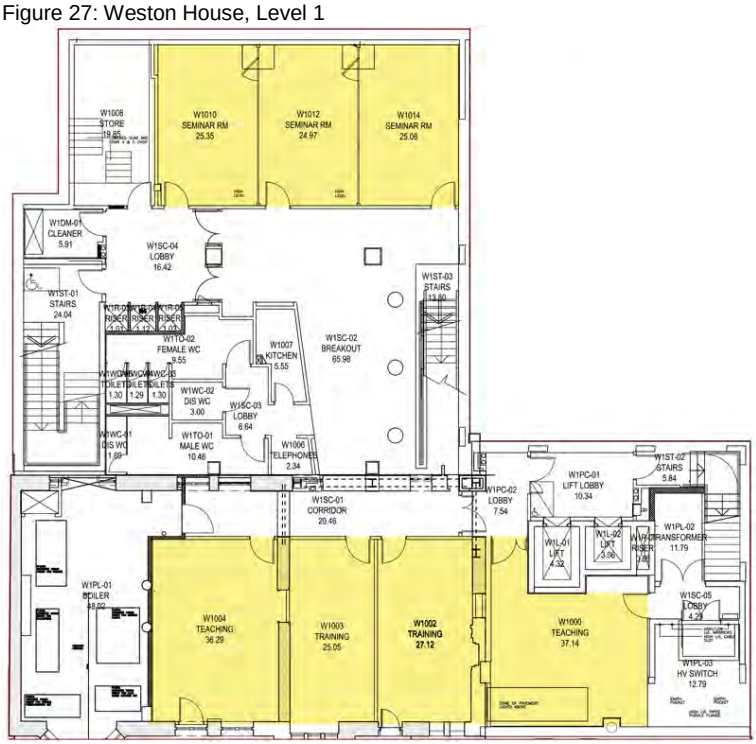


Table 5: Education and Training Space – Weston House, Levels 1 & 2

Type	Qty.	Area (m^2)	Description
Lecture Theatre	1	101	Holding approximately 70 people
Teaching Rooms	2	74	Holding approximately 20 people per room
Seminar Rooms	3	76	An adaptable space that individually holds a maximum of 8-10 people in each room. When the walls are pushed back, the space can accommodate 30-40 people.
IT Training Rooms	2	53	Laid out with desks and computers, these rooms can accommodate 8-10 people.
IT Learning Lab	1	25	As above.

Weston House, in its current state is predominantly used for:

- Mandatory training (the drive to achieve and maintain the target of 90% compliance is resulting in increased numbers of face-to-face sessions being required)
- Induction (corporate induction, junior doctor induction, student nurse induction)
- Education courses run by all three education teams
- Large corporate meetings, e.g. SMT, EMT, AGM, etc.
- Courses of any type run by any department
- Assessment centres (key to Trust's the recruitment strategy, e.g. Healthcare Assistants and Newly Registered Nurses)
- Events open to external delegates (which may or may not generate income)
- Other activities such as trustwide presentations and workshops
- External bookings out of normal working hours, e.g. by local training organisations—a small source of income generation
- The IT Training Room 2 and IT Learning Lab have recently been taken by RTT Validators. This poses a particular challenge when large cohorts of new workforce (in particular junior doctors) need clinical systems training and for the overall workforce to undertake mandatory e-learning.

Main Nurses Home, Level 4

Figure 28: Main Nurses Home, Level 4

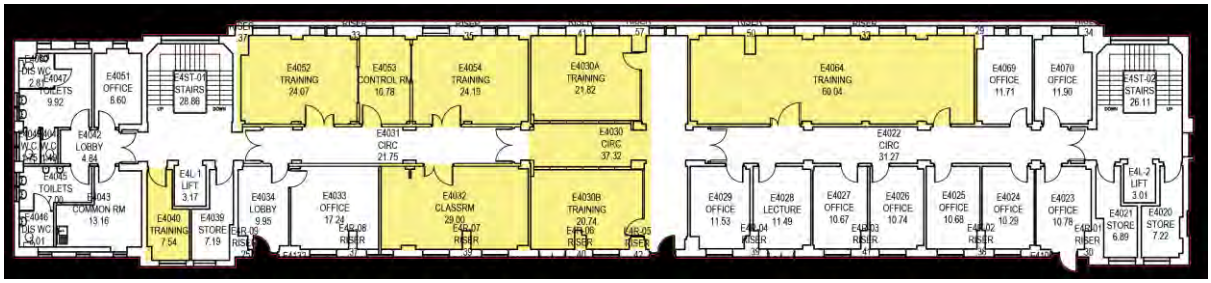


Table 6: Education and Training Space – Main Nurses Home, Level 4

Type	Qty.	Area (m^2)	Description
Simulation Rooms	2	48	Clinical skills rooms
Debrief Room	1	29	Clinical debrief room holding maximum 18 candidates
Simulation Control Room	1	11	Control room to facilitate training within both simulation room
Laparoscopic Training Cupboard	1	8	Laparoscopic simulation training room
Resuscitation Classroom	1	60	Classroom for mandatory resuscitation for all clinical staff workforce in the Trust, holds maximum 12 candidates for a resuscitation course
Moving and Handling Classrooms	1	42	1 practical room and 1 theory room, walls facing hallway can be folded away allowing one space

The Main Nurses Home, Level 4 is used for office space for four education teams—NNME, CSC, Resuscitation, and Moving and Handling. It has some classroom space which is earmarked solely for the use detailed above. If vacant, these classrooms can be utilised for other purposes, but at the critical capacity they are currently, availability is almost null.

Figure 29: Moving & Handling Training Rooms

Moving and Handling Training Rooms

Skills for Health states categorically that Moving and Handling is one of the primary areas of statutory and mandatory training for "ensuring equity, promoting effective risk management and ensuring quality" (Skills for Health, 2016). NHS England monitors the compliance of this training in order mitigate risk and injury to patients and staff, and the Care Quality Commission (CQC) includes this amongst its regulated activities (Care Quality Commission, 2014).

In order to streamline and improve efficiency, all areas of statuatory and mandatory training have been examined and now have identified, integrated e-learning available on the Trust Learning Management System to prevent duplication and reduce face-to-face necessity. Moving and Handling has adapated the maximum allowable content as e-learning, however, the physical nature of the skills and behaviours requires a large degree of face-to-face demonstration and practice.

The National Back Exchange (NBE)organisation provide standards for the teaching of manual handling, and advise training to take place in;

'A dedicated room/s large enough to provide sufficient space for practical activities, and equipped to match the needs of the workplace' (National Back Exchange, 2010).

The current Moving and Handling Suite, is comprised of a small theory room (20.74 m^2) and a practical room of the same size (21.82 m^2).Despite being purposed for the training of moving and handling of both clinical and non-clinical staff, the practical room cannot even hold the equipment necessary to complete the training while holding occupants.

The rooms are divided by the hallway on Main Nurses Home, Level 4. False walls were installed on both rooms to allow for this space to open up to incorporate the hallway and create an open space. Though this allows for freer movement, it presents difficulties, as the hallway has frequent traffic from staff who need to use the kitchens and bathroom facilities at the end of the corridor, as well as frequent traffic from Clinical Simulation and Resuscitation trainees. Moving and handling sessions are in this case, persistently interrupted, damaging the ability for candidates to concentrate and facilitators to impart teaching.

The nature of moving and handling training is inherently space intensive. The movement and transfer of patients is a delicate process which requires the utmost care. In order to facilitate the correct process, the facilitators require space enough to demonstrate good practice. The rooms provided are not fit-for-purpose, and from evaluations, this has been the most frequent complaint from staff:

- *"We had to use the corridor between 2 rooms as there was not enough space."*
- *"People were able to walk through throughout."*
- *"Venue was too small / too many people."*
- *"Small space and only one of each bit of equipment."*
- *"Wasn't enough room in training venue."*

The quality of teaching allowed in such cramped conditions notwithstanding, in addition, there is limited to no available storage space. Equipment has to be moved out of the rooms and left in the hallways on a daily basis to facilitate training. This creates fire hazards for both staff on this floor and trainees, which there seems to be no available solution. If the safety and comfort for our patients is our first priority—and the training of moving them as such, a priority—our priority for the safety and comfort of our staff must come at least second. The space provided shows very little recognition of the importance of moving and handling training to prevent injury to both staff and patients.

Co-located Space

As introduced earlier in this document, co-located space—shared space within the Trust—contributes to many of the space provided for education. Though co-located spaces are beneficial to the provision of in-situ or other immediate, opportunistic education interventions, it is detrimental when forced to accommodate all other forms of education. These spaces have limited and unreliable availability, are inappropriate for most modes of learning, and their usage has detrimental effects on their original purpose. Education and training within the Trust has become extremely reliant on shared, non-dedicated spaces such as ward seminar rooms and meeting rooms to meet a basic education provision. This arrangement is not suitable to meet the excellent standards aspired to in this document and in the Trust Strategy.

The pressure to find suitable learning spaces within GOSH has become untenable and severely impacts on the ability to expand services any further than the status quo at 2017-18. In taking students' expectations and needs into account, the learning spaces available to GOSH faculty are close to extinct

in function and form when considering the theory of best practice in education and remaining current in a digital world. The education provision data analysed clearly defines not only the requirement for more teaching space but shows the growth capability of all three departments if sufficient, suitable learning spaces were available (see section 3.4).

3.3.3 Change in Infrastructure Capacity

Changes in infrastructure capacity are proposed as below.

Table 6: Current Allocation (from floor plans and rooms assessment)

Description	Area (m^2)
Lecture Theatre	101
Teaching Rooms	260
IT Teaching Rooms	77
Clinical Simulation Rooms	88
Office Space	189
Storage	21
Breakout Space	135
Reception	59
Meeting Space	8
Total area	**938**

It has been acknowledged through analysis that while a dedicated, off-precinct centre would provide ideal space for full-day and half-day sessions, on-site education and training space is still a requirement to function adequately. Examples of this would be in-situ and drop-in in clinical simulation teaching which would need to remain geographically on-precinct (Weston House) to allow for clinical staff to facilitate sessions while still being able to fulfil their duties on-precinct. Other on-precinct requirements would be limited office space for on-precinct education purposes, e.g. Resuscitation Officers and Practice Facilitators for Student Nurses and Newly Qualified Nurses. This allows for learners to drop-in for pastoral and formative support as well as allowing for facilitators to fulfil their clinical duties on the wards.

If the project receives investment within the near future, growth in education and training would place the Trust at a competitive level to explore industry-leading development in Phase V. The infrastructure plan below has been drafted in mind of needed continual growth. Lack of immediate investment risks the Trust's ability to sustain a competitive level within the market, and ambitions to remain close to world-leading centres would no longer feasible by Phase V. Far larger investment would be required at these later stages to establish the reputation of the Trust as a Top-5 teaching hospital and education provider if a foothold in the market is not established within the near future.

For the purpose of the above, in the redevelopment, Main Nurses Home, Level 4 and Weston House, Level 3 would be relinquished. Weston House, Levels 1 and 2 would be retained.

Table 7: Project Requirements (On-precinct, Weston House)

Description	Qty.	Area (m^2)	Total Area (m^2)
Lecture Theatre	1	101	101
Teaching Rooms	4	25	100
Simulation Room – Debrief Room (air conditioned)	1	36	36
Simulation Room (air conditioned, compressed air supply)	1	27	27
Simulation Room (air conditioned, compressed air supply)	1	25	25
Simulation Room – Control Room (air conditioned)	1	37	37
Office Space	10	5.67	57
Breakout Space	N/A	135	135
Reception	N/A	59	59
		Total area	**577**

Table 8: Project Requirements (Off-precinct)

Description	Qty.	Area (m^2)	Total Area (m^2)
Lecture Theatre (flexible, tiered, ability to partition into 3 small lecture theatres)	1	510	510
Teaching Rooms (flexible, ability to partition into 3 smaller teaching rooms)	6	85	510
Shared Learning Space (breakout space w/ pods)	1	85	85
Simulation Room – 2 Bed Ward Room (air conditioned, compressed air supply)	1	60	60
Simulation Room – ITU/Theatre Room (air conditioned, compressed air supply)	1	40	40
Simulation Room – Control Rooms (air conditioned)	2	15	30
Simulation Room – Debrief Room (air conditioned, ability to partition)	1	60	60
Simulation Room – Debrief Room (air conditioned)	1	30	30
Simulation Room – VR / Part-task Room (air conditioned)	1	45	45
Simulation Room – Immersive Environment / Haptics Room (air conditioned)	1	40	40
Simulation Room – Technology Laboratory	1	25	25
Changing Facilities (lockers, toilets, showers)	1	20	20
Office Space (determined by the Agile Working Policy Appendix 8)	55	5.67	312
Storage	1	60	60
Storage	2	30	60
Housekeeping Accommodation	1	28	28
Staff Kitchen	1	25	25
Reheat Kitchen	1	25	25
		Total area	**1965**

It is important to note, the decanting of the central education teams into the off-precinct development frees up significant space on-precinct for agile workstations, holding approximately 69 staff. This could result in a cost saving for departments in need of relocation.

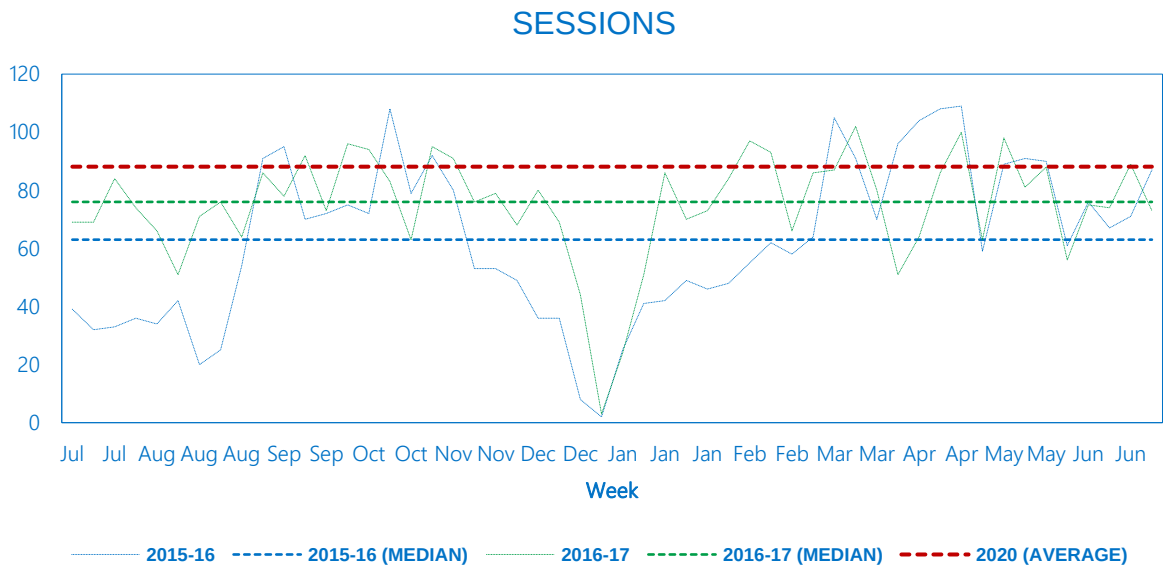
Location	Area (m^2)	Capacity (5.67 m^2 / person)
Main Nurses Home, Level 4	317	55
Weston House, Level 3	84	14
Total	**401**	**69**

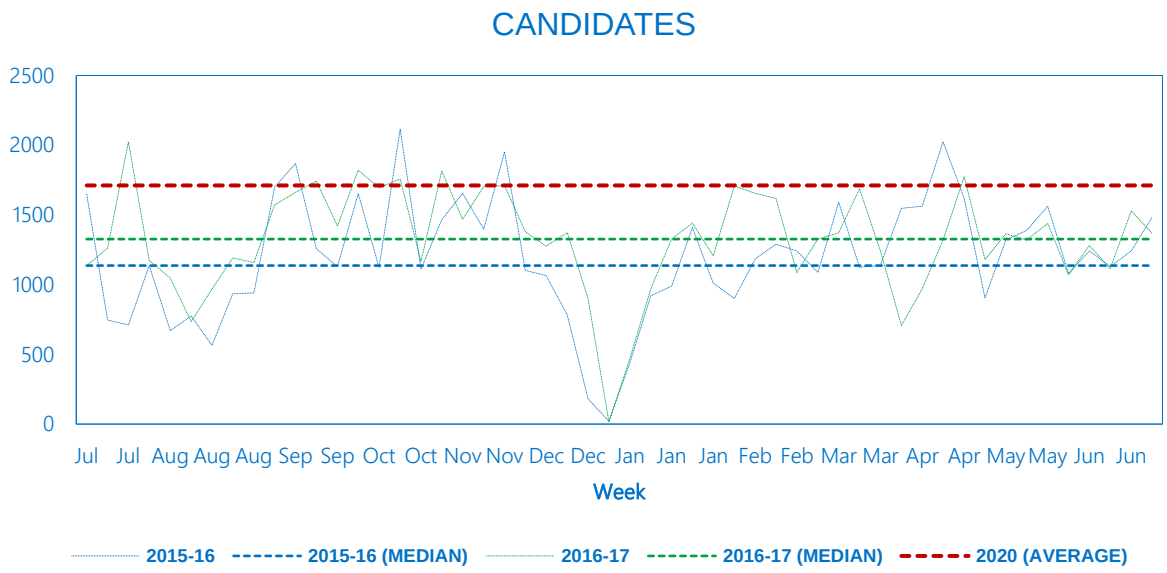
3.4 GOSH Activity

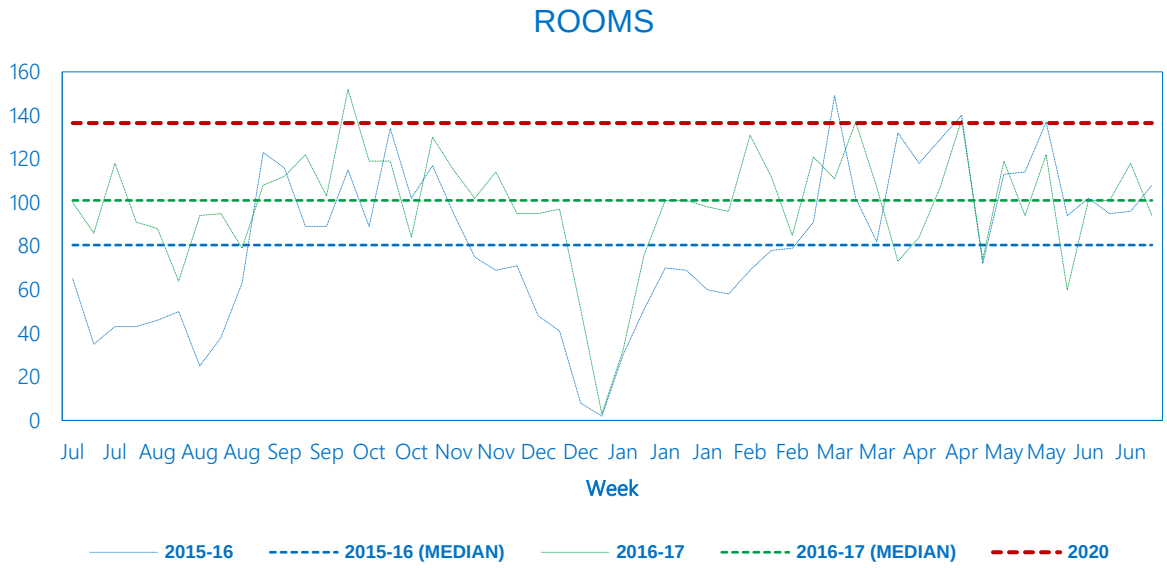
An audit of a period of two years of central education team activity has been quantified and reviewed from July 2015-17. NB: The analysis includes 7,183 sessions of education and training activity, however, this does not encompass the entirety of trust education activity, only that which is captured by the central education teams.

This has been further projected to 2020 to anticipate the space needs required for the recruitment of registered and unregistered staff, the integration of technology-enhanced learning, the implementation of simulation throughout trust wide education programmes, the redevelopment of the Leadership and Management portfolio, the franchisement of internal postgraduate courses, and the consolidation, expansion, and marketing of the Trust Education and Training Prospectus.

The data is presented below by week in sessions held, candidates attending, and rooms utilised.







On average, the central education teams use 101 rooms per week to run a basic education provision. The rooms are inclusive of external venues requisitioned. The capacity for education and training on-precinct is far above what is currently available, and as shown, is expected to increase to approximately **137 rooms per week by 2020**. The projection of future needs is built upon, not just increased candidates, but with a recognition of the need for dynamic learning spaces, specifically focused around implementing clinical simulation into all clinical training.

In its current state, by 2020 the space allotment for education and training provided by the Trust would no longer have the capacity to provide even a basic education provision. The quality of teaching would begin to degrade; the costs for externally provided space would exponentially rise; the integration of simulation and other technology-enhanced learning would not be possible; and the growth of commercial marketed education would be null.

3.5 Benefits

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. The BRP will also define how and when outcomes and benefits are measured.

The potential benefits of the project include:

Table 5: Benefits

Benefit	Current state	Future state
Improved facilities to provide statutory and mandatory training, induction, and CPD to the workforce within GOSH	• Lack of space on and off-precinct to be able to fulfil current requirements. • Currently heavily reliant on use of private facilities at a cost to the Trust of in excess of £100,000 each year.	• Appropriate space will be available both on and off-precinct to fulfil all the educational needs of the Trust. • Half-day and-full day sessions to relocate to new off-precinct centre with drop-in and 'ad-hoc' sessions to remain in Weston House. • Elimination of the need to rely on external private venues for academic space. • This will result in an increased skills set and motivational aspiration for the workforce within GOSH.
Remain as an international leading centre of excellence for paediatric healthcare	• Medical teams are developing advanced skill sets related to developments in clinical practice in inappropriate locations with suboptimal equipment, e.g. surgical teams practicing laparoscopic surgery in a cupboard.	• Bespoke simulation and virtual reality teaching facilities will be available allowing clinical staff to visualise themselves in the surgical environment and enhance and consolidate new and innovative skill sets.
Improved recruitment and retention	• The current facilities do not allow for a complete and exemplary education provision necessary to develop a highly skilled workforce. As with the removal of the Student Nurse bursary, the trust is now in direct competition with other trusts. The education offer to new workforce must be competitive. Exit interviews indicate lack of workforce development is a significant contributor to attrition.	• A new facility dedicated to the education of internal workforce will allow for more frequent course instances, increased education portfolio, and demonstrate to the workforce the Trust's commitment to their personal development.
Improved ability to market GOSH expertise and knowledge on a commercial basis	• GOSH has the expertise to provide significant commercial CPD educational opportunities to both the PGME and NNME population. • The development and expansion of this commercial opportunity is restricted by a lack of space to teach larger groups on a more frequent basis.	• The development of a programme of high quality CPD education on a commercial basis. • This will be housed within the new education centre with appropriate facilities to maximise learning and commercial opportunity.
Off-setting revenue investment by leasing of space	• Funding streams that previously existed by leasing of education space to external agencies such	• Space not being utilised for GOSH education provision at any time will be leased out to

to external agencies	as HEIs have been lost due of lack of availability.	external private agencies providing revenue.
Improved education environment for workforce	• Current accommodation makes new models of education-delivery difficult to implement and unrewarding for workforce learning in cramped and outdated facilities.	• Improved facilities demonstrates a clear investment and commitment from the Trust in the development to the workforce.
Enhanced reputation	• Current facilities do not represent the profile that GOSH as a centre of international excellence.	• Opportunity for an exemplar environment for both internal and external candidates.
Vacated on-precinct space for utilisation by other Trust departments	• The Trust struggles to house on-precinct teams in limited office space. Many education and training staff could be relocated off-precinct without detriment, freeing much needed office accommodation.	• Aside from Levels 1 and 2 of Weston House, all other space will be vacated by the central Education Teams. All bids for space in Phase IV will also be relinquished.

3.6 Risks

Risks to the overall vision of this business case come in two forms—risk to the development of off-precinct facilities and risk to the staffing associated with education provision. These are detailed further below.

3.6.1 Capital Risks

Key Risks	Mitigation
Finding an appropriate site	• Development to examine multiple sites within the area • All education stakeholders to be advised and included within the project
Distance from the main hospital	• Maximum distance established at 15 minutes walk
Future proofing	• Analysed current growth • Analysed technological growth – acknowledged there is driver for simulation and digital VR integration • Must be answer for foreseeable future • Capital investment must acknowledge the need for 10+ years accommodation
Lease which enables development	• Lease should allow for further development if needed • Lease should allow for subletting to external agencies to attain revenue from unused space
Lost time during redevelopment of Weston House, Level 1	• Main Nurses Home, Level 4 will not be vacated until redevelopment of clinical simulation rooms within Weston House has been completed

Risk to service provision during relocation	• Staged move of education facilities and team ensuring all essential training continues to be provided during the transition period

3.6.2 Staffing Risks

Key Risks	Mitigation
Health Education England (HEE) funding reductions	• Highlighted to all levels of Trust reporting structures • Bids for GOSHCC investment • Bids for HEE bespoke funding (rarely now available as a result of said reductions) • Off-setting revenue lost by expanding commercial portfolio, i.e. off-precinct development • Off-setting revenue through other innovative education developments

As detailed below, the current education provision faces a cost pressure of approximately **£1,340,000** for 2018-19. The success of this business case will hinge greatly on recognition and alleviation of current financial risks to the service, contributing to the success of central education programmes, improving the retention of staff, quality and safety of care, assurance of trustwide education, and the expansion of GOSH commercially.

At risk posts

As of 1st April 2018, the below posts will be at risk.

Title	Department	Funding	Band	WTE	Cost
Practice Facilitator	Clinical Simulation Centre	AT RISK	6	1	£46,005
Practice Educator	Clinical Simulation Centre	AT RISK	7	1	£54,060
Technician	Clinical Simulation Centre	AT RISK	4	1	£31,559
Practice Facilitator, Newly Registered Nurses	Nursing & Non-medical Education	AT RISK	6	1	£46,005
Practice Facilitator, Newly Registered Nurses	Nursing & Non-medical Education	AT RISK	6	1	£46,005
Practice Facilitator, Newly Registered Nurses	Nursing & Non-medical Education	AT RISK	6	1	£46,005
Practice Facilitator, Newly Registered Nurses	Nursing & Non-medical Education	AT RISK	6	1	£46,005
Practice Facilitator, Talent for Care (Bands 2-4)	Nursing & Non-medical Education	AT RISK	6	1	£46,005
Practice Educator, Allied Health Professionals	Nursing & Non-medical Education	AT RISK	7	0.5	£27,030
Practice Educator, Healthcare Scientists	Nursing & Non-medical Education	AT RISK	7	0.5	£27,030
Practice Educator, High-dependency Care	Nursing & Non-medical Education	AT RISK	7	1	£54,060
Practice Educator, Mentorship	Nursing & Non-medical Education	AT RISK	7	1	£54,060
Practice Educator, Neonates	Nursing & Non-medical Education	AT RISK	7	1	£54,060
Lead Practice Educator, Quality Improvement	Nursing & Non-medical Education	AT RISK	8a	1	£64,997
Lead Allied Health Professional	Nursing & Non-medical Education	AT RISK	8b	0.2	£15,220
Lead Healthcare Scientist	Nursing & Non-medical Education	AT RISK	8b	0.2	£15,220
Resuscitation Officer	Resuscitation	AT RISK	7	1	£54,060
				Total	**£**727,386

Health Education England funded posts

Some posts within central education remain funded by Health Education England by streams which are not currently at risk. Though risk is not imminent, this is not to say this funding model will be sustainable in the future.

Title	Department	Funding	Band	WTE	Cost
Student Practice Facilitator, Student Nurses	Nursing & Non-medical Education	HEE	6	1	£46,005
Student Practice Facilitator, Student Nurses	Nursing & Non-medical Education	HEE	6	1	£46,005
Student Practice Facilitator, Student Nurses	Nursing & Non-medical Education	HEE	6	1	£46,005
Student Practice Facilitator, Student Nurses	Nursing & Non-medical Education	HEE	6	1	£46,005
Practice Educator, Student Nurses	Nursing & Non-medical Education	HEE	7	1	£54,060
PGME Assistant (Apprentice)	Postgraduate Medical Education	HEE	2	1	£25,436
Digital Design & Innovation Officer	Postgraduate Medical Education	HEE	5	1	£38,150
Senior PGME Officer	Postgraduate Medical Education	HEE	5	1	£38,150
PGME Programme Manager	Postgraduate Medical Education	HEE	6	1	£46,005
College Tutor, Anaesthetics	Postgraduate Medical Education	HEE	N/A	1PA	£9,000
College Tutor, Paediatrics	Postgraduate Medical Education	HEE	N/A	2PA	£18,000
College Tutor, Surgery	Postgraduate Medical Education	HEE	N/A	1PA	£9,000
Education Lead, Clinical Simulation	Postgraduate Medical Education	HEE	N/A	2PA	£25,000
Education Lead, International Medical Graduates	Postgraduate Medical Education	HEE	N/A	2PA	£25,000
Education Lead, Technology-enhanced Learning	Postgraduate Medical Education	HEE	N/A	2PA	£25,000
Education Lead, Undergraduate Medical Education	Postgraduate Medical Education	HEE	N/A	2PA	£25,000
Medical Education Fellow	Postgraduate Medical Education	HEE	N/A	1	£55,000
Medical Education Fellow	Postgraduate Medical Education	HEE	N/A	1	£55,000
				Total	**£631,821**

New posts

New posts have further been identified as required as part of a 5-year phased growth of the GOSH Learning Academy, vital to income generation strategies for all areas, e.g. Clinical Simulation, Interprofessional Education, Commercial Education. These areas have been identified as key drivers in revenue expansion and will require Trust support as they demonstrate growth.

Title	Department	Funding	Band	WTE	Cost
Practice Educator	Clinical Simulation Centre	New	7	1	£54,060
Business Support Officer, Interprofessional Education	GOSH Learning Academy	New	4	1	£31,559
Digital Design & Innovation Officer	GOSH Learning Academy	New	5	1	£38,150
Business Support Manager, Interprofessional Education	GOSH Learning Academy	New	6	1	£46,005
Digital Design & Innovation Manager	GOSH Learning Academy	New	6	1	£46,005
Marketing Manager, Interprofessional Education	GOSH Learning Academy	New	7	1	£54,060

Title	Department	Funding	Band	WTE	Cost
Business Support Officer, Commercial Education	Nursing & Non-medical Education	New	4	1	£31,559
Senior Business Support Officer	Nursing & Non-medical Education	New	5	1	£38,150
Senior Business Support Officer, Commercial Education	Nursing & Non-medical Education	New	5	1	£38,150
Practice Facilitator	Nursing & Non-medical Education	New	6	1	£46,005
Practice Facilitator	Nursing & Non-medical Education	New	6	1	£46,005
NNME Manager	Nursing & Non-medical Education	New	7	1	£54,060
Lead Practice Educator, Commercial Education	Nursing & Non-medical Education	New	8a	1	£64,997
Head of NNME	Nursing & Non-medical Education	New	8b	1	£76,101
Business Support Officer	Postgraduate Medical Education	New	4	1	£31,559
PGME Programme Development Lead	Postgraduate Medical Education	New	7	1	£54,060
PGME Academic Programme Lead	Postgraduate Medical Education	New	8a	1	£64,997
PGME Lead	Postgraduate Medical Education	New	8a	1	£64,997
Head of PGME	Postgraduate Medical Education	New	8b	1	£76,101
Business Support Officer	Resuscitation	New	4	1	£31,559
Practice Facilitator	Resuscitation	New	6	1	£46,005
				Total	**£1,034,144**

Trust funded posts

Title	Department	Funding	Band	WTE	Cost
Technician	Clinical Simulation Centre	Trust	4	1	£31,559
Non-medical Lead	Clinical Simulation Centre	Trust	8a	1	£64,997
Business Support Officer	Nursing & Non-medical Education	Trust	4	1	£31,559
Business Support Manager	Nursing & Non-medical Education	Trust	6	1	£46,005
Practice Educator, Newly Registered Nurses	Nursing & Non-medical Education	Trust	7	1	£54,060
Practice Educator, Talent for Care (Bands 2-4)	Nursing & Non-medical Education	Trust	7	1	£54,060
Lead Practice Educator, NNME	Nursing & Non-medical Education	Trust	8a	1	£64,997
Head of Commercial Academic Education	Nursing & Non-medical Education	Trust	8b	1	£76,101
Associate Director of Education	Nursing & Non-medical Education	Trust	8c	1	£87,890
PGME Officer	Postgraduate Medical Education	Trust	4	1	£31,559
PGME Officer	Postgraduate Medical Education	Trust	4	1	£31,559
PGME Manager	Postgraduate Medical Education	Trust	8a	1	£64,997
Deputy Director, Medical & Dental Education	Postgraduate Medical Education	Trust	N/A	4PA	£55,468
Senior Business Support Officer	Resuscitation	Trust	5	1	£38,150
Resuscitation Officer	Resuscitation	Trust	7	1	£54,060
Resuscitation Officer	Resuscitation	Trust	7	1	£54,060

Resuscitation Officer	Resuscitation	Trust	7	1	£54,060
Lead Resuscitation Officer	Resuscitation	Trust	8a	1	£64,997
				Total	**£960,138**

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 delivers the expected benefits identified in the strategic case.

4.1 Options Development

4.1.1 Project Options

Following the confirmation of Phase IV being unsuitable for education development due to the limited space available, there are only two options currently available for the trust:

1. Do nothing
2. Do the minimum (development in Phase IV, no longer viable after Phase IV functional content debate)
3. Off-precinct development

4.1.2 Options Appraisal

These options were presented to Education and Workforce Development Board which approved the recommendation for the preferred option of an 'off precinct' education and learning facility that could offer commercial benefits and enhance the Trust reputation.

Table 7: Options Appraisal

Option	Benefits	Limitations
Do nothing	• No additional costs incurred by the Trust. • The current education provision, although minimal when compared to its potential, is of the minimum standard required in the space currently available. • External venues are available for larger cohorts in the surrounding area.	• The evidence demonstrates that recruitment and retention of all professions within the Trust will degrade. • No commercial expansion of educational provision leading to significant loss of potential income. • No expansion of specialist training within the Trust. • Unable to act to our full potential and be a lead provider of local paediatrics nationally and internationally. • A realistically competitive education offer for potential and existing staff will be non-existent. • Reputation of GOSH as a world-leading centre will degrade.
Rental and development an off-precinct, dedicated education and training facility for use minimum 15 years.	• Significant office space will be made available on-precinct. • Space will be readily available for the education needs of all staff members, including statuary and mandatory training, continued professional development, conferences, etc.	• Significant investment in rental arrangements will not be possible to recoup. • Possible constraints to leasing of space to external agencies. • Due to the constraints of real estate availability in the locality, it is unlikely we would be able to develop an industry-leading facility. It is felt that the planned

	• With adequate facilities, would we would be in prime position to develop a leading prospectus of training and educational opportunities in the marketplace. • Commercial revenue from external agencies using any space that is not being utilised by GOSH.	work is ambitious and is future proofed against development over the next ten years. • Options for redevelopment will be limited until Phase V.
Purchase and development of an off-precinct, dedicated education and training facility for use minimum 15 years.	• Significant office space will be made available on-precinct. • Space will be readily available for the education needs of all staff members, including statuary and mandatory training, continued professional development, conferences, etc. • With adequate facilities, would we would be in prime position to develop a leading prospectus of training and educational opportunities in the marketplace. • Commercial revenue from external agencies using any space that is not being utilised by GOSH.	• Due to the constraints of real estate availability in the locality, it is unlikely we would be able to develop an industry-leading facility. It is felt that the planned work is ambitious and is future proofed against development over the next ten years. • Options for redevelopment will be limited until Phase V.

4.2 Preferred Option

Following several reviews at the Education and Workforce Development Board and the Executive Management Team, the option to deliver an off-precinct facility for a period of 15 years has been determined as the best strategic fit. The preferred financial option, on the basis of return on investment analyses indicates the option to buy would be fiscally beneficial. This option supports the aims described in the Strategic Case. But both options to rent or buy indicate new cost pressures for the organisation.

This overall project plan falls under the vision of a GOSH Learning Academy—not just a building, but a brand and marketable symbol of all education and training provision within and outside the Trust. This vision would impact every staff member employed in the Trust and has the potential to affect clinical training for paediatric care worldwide. The investment described above and in the vision below is the first stages on the road to becoming one of the leading education centres in paediatric healthcare, nationally and internationally, and provides the necessary initial investment to provide a foundation for sustained growth of the service for the next 15 years, further ensuring the building blocks required for the ambition of a world-leading centre in Phase V.

4.2.1 On-precinct

The overall footprint of education delivered in this project continues to retain Weston House as a prime area for immediate or ad-hoc education. The advantage of on-precinct education facilities still allows for expert staff with clinical duties to provide education without being required off-shift, e.g. a doctor or nurse with a bleep. It is acknowledged that the largest cost pressure to education is the releasing of staff; this is mitigated by allowing staff the ability to provide opportunistic education without being fully removed clinically.

The Main Nurses Home, Level 4 and Weston House, Level 3 would be completely relinquished during relocation, but Weston House, Levels 1 and 2 would be retained. Weston House, Level 2 would keep

the Lecture Theatre, still an adequate teaching and meeting space, and the learning lab would be developed into a small classroom.

In Weston House, Level 1, Seminar Rooms 1, 2, and 3 would remain as is, used for drop-in and ad-hoc sessions as noted above. Teaching Rooms 1 and 2 and IT Training Rooms 1 and 2 would undergo development into a Simulation Suite akin to that provided on Main Nurses Home, Level 4. The reasoning behind this being that simulation sessions on-precinct are still of massive benefit and money for value. The ability for simulation to facilitate drop-in and ad-hoc sessions, often run by clinicians with bleeps, allows these staff to share their expertise without coming at the cost of full-day release; learners are also easier released for these sessions.

4.2.2 Off-precinct

Off-precinct development has many benefits and would be the largest development taking place as a result of this business case. In this new space, learners would be within 10-15 minutes of the Trust, allowing them to attend full or half-day courses within a short walk. This allows the learner to fully engage with learning without the distraction of pressures within the working environment. The ability for our learners to step outside this environment, literally and metaphorically, enhances the quality of education absorbed and the skills gathered.

A 300-seat tiered lecture theatre, adaptable to split into three rooms of different seating style, e.g. cabaret, would be an exemplary environment to host large-scale events, including inductions and conferences, both international and national. Large, adaptable, technology-enhanced learning spaces would be available for booking for any education facilitated by the Trust; rooms able to be partitioned, equipped with modern AV, and with mobile video-conferencing available. Alongside would be a shared learning space, a large open breakout space with pods for small-scale collaboration. Mobile technology in the form of tablets would be freely available in this area for staff to complete e-learning or utilise for study.

A modern simulation centre would be developed, based on the most recent research of best practice available, including a theatre suite and a 2-bed, adaptable ward room, with accompanying debrief and control rooms. The most advanced space would the development of both a VR and Haptics room, with collaboration from the new GOSH Innovation Hub recently founded in 40 Bernard Street; these would be the perfect place to explore the boundaries of immersive technology and its abilities to enhance paediatric care. A Technology Laboratory would be close by, allowing simulation to flourish within its space, developing new equipment and methods of delivery. Changing facilities also would be available in order to allow staff to fully immerse themselves in their simulated clinical environment and return to their clinical areas if need be.

The other space within this building would be utilised for office space housing the central education teams. Modern, agile workstations in an office plan akin to the recently installed HR & OD offices in Russell Square would allow for the best collaboration possible to sustain and grow the service under the GOSH Learning Academy Vision.

4.2.3 Co-located

The third element of an envisaged GOSH Learning Academy includes what has been introduced previously as co-located space—shared space within the Trust that will always be needed intermittently for education interventions. Many facets of clinical education can never be fully removed from the clinical area, as the impact of this form of education is much to do with its immediacy and opportunistic quality. In-situ training remains a core element in the proposed vision.

Within the clinical divisions, ward-based education staff work day-in-day-out in all capacities—full day course facilitation, lectures, bedside teaching, mentoring students, coaching, and participating in simulation. Though not part of central education teams, they are just as integral to the success of the GOSH Learning Academy; central education works to ensure quality, standardisation, and enhancement of trustwide education, but a massive portion of this education is delivered on the ward, in these co-located areas, by ward-based staff. The nature of healthcare teaching requires much more

than standard lecture-based teaching, and the vision within this business case seeks to encompass all methods utilised within our capacity to ensure we have the right staff with the right skills.

Whether this is a Consultant or a Ward Manager taking part of a team aside into a Ward Meeting Room to explain the needs behind new equipment, or whether this is a debrief re a particularly difficult clinical encounter—education and training occurs at all hours and at all corners of the hospital. By decanting large-scale education programmes to more appropriate off-precinct locations, we are able to mitigate much of the pressures caused by unneeded on-precinct usage; however, this is not intended to eliminate the benefits of necessary in-situ and ad-hoc training provided in co-located spaces which is still of vital need in the overall GOSH Learning Academy vision.

5 Commercial Case

5.1 Procurement Approach

The Trust has some options for the procurement of the design and works; either through our Procure 22 partner or a more traditional approach of establishing a design team and then separately procuring a contractor (model used for Russel Square House Project).

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 workforce 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 manage the design and cost teams to deliver the project within budget. Following completion of the design Kier 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.

Alternatively, the Trust will procure a small design team to undertake the development of the design solution and will then tender the works contract.

The GOSH projects team will manage the performance of the appointed team in delivering the contracted works. An in-house dedicated project manager is responsible for overseeing works on-site and working to deliver the project to cost and programme. Project progress is reported to the Capital Investment Group and or the Redevelopment 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.

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:

Table 7: Design Principles

Area	Design Principles
Academic challenge	Learning spaces should support students' active engagement with content and include technologies that support multiple modes of teaching and learning.
Learning with peers	Learning spaces should permit students to work both individually and collaboratively.
Experiences with faculty	Learning spaces should facilitate communication and interaction between students and faculty.
High-Impact Practices (HIPs)	Learning spaces should be usable for a variety of learning approaches, including high impact practices inside and outside the classroom. There should be coherence and continuity across both formal and informal learning spaces.
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'.

Reference will be made to the detailed design principles described in *Research-Informed Principles for (Re)designing Teaching and Learning Spaces* (Finkelstein, Ferris, Weston, & Winer, 2016).

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 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).

5.4 Implementation Timescales

Completed tasks to date:

The project timetable is set up below:

Table 8: Project Timetable

Task	Period
Location search	4 weeks
Location acquisition	4 weeks
Appoint suppliers (design and construct)	3 weeks
Design and tender period	3 months design + 1 month tender
GMP / final tender price received	1 month
Update Business Case with final GMP for Board Update and Approval	As above
Construction Commences on site	4 weeks after GMP
Construction completion	16 – 20 weeks
Occupational commissioning	4 weeks
Total Duration	**60 weeks**

6 Financial Case

6.1 Overview

The financial section provides an overview of the impact of the infrastructure options for the Trust and the second section provides an overview of the current resources involved in education and the funding sources.

Section One - Infrastructure NPV Summary

The financial case below has been analysed and established according to the Project Options outlay in the Economic Case. The financial summary outlines the three options relating to infrastructure and the Net Present Value over 15 years.

The off-precinct and on-precinct infrastructure developments are projected for both capital and annual costs over a 15 year period. Staffing costs are projected over a period of five years up to 2023.

Outlined below are the Total Net Costs and Net Present Value over 15 years for each option:

Description	Option 1 (Do nothing)	Option 2 (Rent)	Option 3 (Buy)
Capital costs (net)	-5.8	-7.2	-28.4
Capital income	-	-	+44.3
Annual costs	-2.9	-44.5	-15.4
Annual income	-	+6.9	+6.9
Total Net Cost 15 Yrs	**-8.7**	**-44.8**	**+7.5**
NPV	**-5.9**	**-29.8**	**-11.2**

Section Two – Recurrent Education Income and Costs

The second section outlines the current staff involved in providing education and the current funding sources forecast. The model indicates that there will be a shortfall in funding from sources such as Health Education England and commercial income to cover the base requirements to support the education model.

6.2 Infrastructure

6.2.1 Capital costs

The following table summarises the capital costs for the Options.

Description	Option 1 (Do nothing)	Option 2 (Rent)	Option 3 (Buy)	
Capital costs				
Freehold property purchase[5]	N/A	N/A	(£21,222,000)	
Construction costs (Off-precinct) [6]	N/A	(£3,537,000)	(£3,537,000)	
Construction costs (On-precinct – simulation, compressed air supply, electric, etc.)	N/A	(£120,000)	(£120,000)	
GOSH internal project management costs, building control & planning fees[7]	N/A	(£198,956)	(£198,956)	
Contingency[8]	N/A	(£294,750)	(£294,750)	
Acquisition costs (agents' fees)	N/A	(£50,000)	(£150,000)	
Inflation to 5%	N/A	(£145,275)	(£145,275)	
Office Equipment	N/A	(£549,000)	(£549,000)	
ICT Equipment	N/A	(£640,000)	(£640,000)	
Clinical Simulation Equipment	N/A	(£840,000)	(£840,000)	
Professional Fees (Architectural, M&E, Cost & CDM)[9]	N/A	(£697,320)	(£697,320)	
Contribution to public art (as per Trust policy)[10]	N/A	(£29,475)	(£29,475)	
BT Fibre Link (installation)	N/A	(£7,440)	(£7,440)	
Decant costs (removal costs)	N/A	(£18,000)	(£18,000)	
Legal costs (lease and license for alterations)	N/A	(£14,000)	(£14,000)	
Total	**£0**	**(£7,241,216)**	**(£28,463,216)**	
Capital income				
Resale value (year 15)	N/A	N/A	**£44,344,763**	
Net Capital Cost (not discounted)	**£0**	**(£7,241,216)**	**£15,881,547)**	

[5] 1,965 m^2 @ £10,800/m^2

[6] 1,965 m^2 @ £1,500/m^2 + VAT

[7] 6.75% construction costs

[8] 10% constructions costs

[9] 20% construction costs

[10] 1% construction costs

6.2.2 Summary NPV Options

These estimates are based around a potential rental of 15 years, in keeping with current Phase V development plans.

	Option 1 Do Nothing	Option 2 Rent	Option 3 Buy
Capital Options			
Building	0	0	(21,222,000)
Refurbishment	(5,798,467)	(7,241,216)	(7,241,216)
Sale Building	0	0	44,344,763
	(5,798,467)	**(7,241,216)**	**15,881,547**
Expenditure Operate Facility			
Pay	0	(1,997,470)	(1,997,470)
Non-Pay (Rates, FM Operating)	(433,881)	(14,425,403)	(11,312,691)
Non-Pay (Education related)	(694,209)	(2,499,152)	(2,499,152)
Rent / Room Hire	(1,735,522)	(25,989,293)	0
Non-Pay Reduced costs current site	0	433,881	433,881
	(2,863,612)	(44,477,438)	(15,375,433)
Income (new or avoidance)			
Revenue from venue hire	0	5,196,588	5,196,588
Reduction in external room hire	0	1,735,522	1,735,522
	0	6,932,111	6,932,111
Net Expenditure Cost	**(2,863,612)**	**(37,545,327)**	**(8,443,322)**
Net Cash Flow	**(8,662,079)**	**(44,786,543)**	**7,438,225**
NPV	**(5,852,974)**	**(29,849,276)**	**(11,166,800)**

6.3 Education Resources and Funding

As detailed in section 3.6.2, funding for central education staffing has been historically reliant on external funding streams. Due to recent precarities to Department of Health funding and the resultant impact on Health Education England, the success of the GOSH Learning Academy vision and the ability for central education to sustain and enhance its current education provision, will hinge largely on a recognition and mitigation of current risks to staff posts.

A 5-year layout for central education pay and non-pay costs and income projections are detailed below. Further detail re staffing is provided in Appendix 9.9.

Description	2018	2021	2023
Pay costs			
Clinical Simulation Centre	(£228,181)	(£289,297)	(£303,943)
GOSH Learning Academy	N/A	(£221,175)	(£232,371)
Learning & Development	(£610,320)	(£657,248)	(£690,521)
Nursing & Non-medical Education	(£1,224,322)	(£1,653,662)	(£1,737,379)
Postgraduate Medical Education	(£591,758)	(£782,310)	(£821,914)
Resuscitation	(£327,310)	(£470,083)	(£493,881)
Total	**(£ 2,981,891)**	**(£ 4,073,775)**	**(£ 4,280,009)**
Non-pay costs			
Continued Professional Development (NNME)	(£381,100)	(£155,295)	(£159,989)
Continued Professional Development (PGME)	(£1,682,362)	(£1,542,971)	(£1,454,316)
Room Bookings	(£100,000)	N/A	N/A
Total	**(£ 2,163,462)**	**(£ 1,698,266)**	**(£ 1,614,305)**
Income			
Commercial			
Conferences	N/A	£135,000	£137,025
Courses (NNME)	£20,300	£411,075	£417,241
Courses (PGME)	£20,605	£176,762	£194,880
Courses (LEaD)	£4,683	£4,897	£5,045
Weston House Venue Hire	£15,912	£16,639	£17,142
Medical Illustration (PGME)	N/A	£25,296	£26,061
Health Education England			
Medical Undergraduate & Postgraduate Tariff (PGME)	£2,070,237	£1,948,490	£1,871,330
Non-medical Tariff (NNME)	£400,000	£376,477	£361,000
Workforce Development – provided to GOSH (NNME)	£96,000	£29,736	£7,000
Workforce Development – provided to HEI (NNME)	£103,000	£22,248	£8,000
Apprenticeships	£54,720	£54,720	£54,720
Trust			
Clinical Simulation Centre (Pay)	£91,250	£98,266	£103,241
Nursing & Non-medical Education (Pay)	£366,942	£395,156	£415,161
Postgraduate Medical Education (Pay)	£188,173	£202,641	£212,900
Resuscitation (Pay)	£271,961	£278,760	£285,729
Total	**£3,703,783**	**£4,176,163**	**£4,116,475**
Grand total	**(£ 1,441,570)**	**(£1,595,878)**	**(£ 1,777,839)**

6.4 Charity Capital Funding Support

The charity and Trust have agreed to explore how the charity may be able to provide additional support for education provision at the Trust.

Significant support is also already provided through the 'patient, family and staff support' service delivery projects stream, and this needs to be considered within the context of wider Trust and other external funding towards education.

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 and smaller capital schemes. The Trust evaluates its projects and refines its management approaches accordingly; the "lessons learned" from previous projects will be applied to the this project to ensure best practice.

Key lessons include:

Communication with teams and departments (but also the wider Trust) being affected

Early involvement of teams helped with strategic planning, space planning and commissioning of rooms and floors.

All stakeholders should feel included and represented as all parties are part of the overall operation of the space.

Consistent standardised documentation throughout, from action and meeting logs through to operational policy development and project planning. This

7.3 Project Management Arrangements

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

- Be integrated into the Trust's ongoing programme of change
- Be managed to minimise its impact on the continued operation of GOSH as the UK's largest quaternary 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.

7.3.1 Project Management Roles

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

Project Owner: This role will be undertaken by Matthew Tulley as Accountable Officer, who will retain personal accountability for project delivery. The Project Owner 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 will be undertaken by Stephanie Williamson.

Design Lead: is responsible for establishing the vision and the development of the design brief from inception through to completion of the project. A member of the Healthcare Planning or Projects Team 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.

7.4 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

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

7.5 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.

The Trust uses a number of different methods for workshops including a web based interactive board and workshops.

8 References

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9 Appendices

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Education & Training Space Revie

9.2 Appendix 2

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9.3 Appendix 3

Education & Training Space Requ

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GOSH Leavers Report, May 2016 - A

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Newly Registered Nurses - Starters & L

9.6 Appendix 6

Advisory Board.pdf

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External Venues - 2015-17.xlsx

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Agile Working Policy.doc

9.9 Appendix 9

GOSH Learning Academy Staffing Cost

Attachment 7

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 28 November 2017	
Integrated Quality Report **Submitted by:** Dr David Hicks, Interim Medical Director Janet Williss, Interim Chief Nurse	**Paper No: Attachment 7**
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).	
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	

Great Ormond Street Hospital for Children NHS Foundation Trust

Integrated Quality Report

Dr David Hicks, Interim Medical Director
Janet Williss, Interim Chief Nurse

November 2017 (covering September-October 2017)

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Great Ormond Street Hospital for Children NHS Foundation Trust

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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.	This measure is currently being reviewed by the Resuscitation Lead Nurse and the ICU Information Manager. Issues have been identified with the data in this measure but they are expected to the have been resolved and re-presented within the next month.
	**Cardiac 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 this measure at 2 cardiac arrests per month; this has remained stable since 2015 with the exception of one outlier in January 2017. The process is currently in normal variation at GOSH; there have been no runs, trends or recent outliers identified.
	Cardiac arrests outside of ICU	**Respiratory Arrests outside of ICU**
September 2017	3 (Badger, Giraffe, Sky)	4(Badger x 3, Bumblebee x 1)
October 2017	3 (Theatres, Bear, Bumblebee)	3 (Reception x 1, Sky x 1, Squirrel x 1)
	**Mortality**	The data remains stable at 6.3 deaths per 1000 discharges; the process is in normal variation and has been since 2014. There have been no runs, trends or outliers identified.

Has patient care been safe in the past?

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Data Quality Kite-Mark	Measure	Comment
	**Never Events**	The last Never Event was on 20th October 2017 (24days ago; this was 150 days after the previous Never Event). The process remains in normal variation at one event every 220 days on average. The baseline for this data is from 2010 until 2014. The Never Event declared in October 2017 is for wrong site surgery while the previous Never Event was due to a retained object.
	**Serious Incidents**** ****by date of incident not declaration of SI**	The data remains stable at 1.2 SIs per month. There was just 1 SI reported in October, 2 in September and 0 in August 2017 . If we look at a more sensitive measure (days since previous SI) then it looks as though they have become less frequent but more data is needed before a judgement can be made.
	**Hospital acquired pressure ulcers reported (grades 2+)**	Performance remains within normal variation at 6.7 per month.

	August 2017	September 2017	October 2017
Grade 2 hospital acquired pressure ulcers	**5** (3 are device related)	**5** (4 are device related)	**8** (3 are device related)
Grade 3 hospital acquired pressure ulcers	**1** (1 device related)	**0**	**0**
Grade 4 hospital acquired pressure ulcers	**0**	**0**	**0**

Has patient care been safe in the past?

Measures where we have no concerns

Great Ormond Street Hospital for Children NHS Foundation Trust

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

Data Quality Kite-Mark	Measure	Comment
	**GOSH-acquired CVL infections**	The data remains stable at 1.8 CVL infections per 1000 line days In September 2017 there were 5 CVL infections
	**The number of PALS cases**	Following the outliers during the summer period, the number of PALS cases reported has reverted to expected numbers which is 160 per month on average. In October, 149 cases were recorded.

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 September- October 2017			
No of new SIs declared in September- October 2017:	2	No of new Never Events declared in September - October 2017:	1
No of closed SIs/ Never Events in September – October 2017:	2	No of de-escalated SIs/Never Events in September - October 2017:	0

New SIs/Never Events declared in September - October(3)

STEIS Ref	Incident Date	Date Report Due	Description of Incident	Divisions Involved	Senior Responsible Officer (SRO)	Patient Safety Manager	Executive Sign Off	Divisional Contact
2017/23251	07/09/17	**12/12/17**	Unexpected death following deterioration and cardiac arrest	Charles West	Associate Medical Director	Patient Safety Manager and Lead Patient Safety Manager	Interim Medical Director	Divisional Co-Chair, Charles West
2017/26155	20/10/17	**19/01/18**	Never event. Wrong site surgery; wrong tooth extracted	JM Barrie	Associate Medical Director	Patient Safety Manager	Interim Medical Director	Divisional Director, JM Barrie
2017/26574	22/09/17	**25/01/18**	Information Governance Breach	JM Barrie	Associate Medical Director	Patient Safety Manager	Interim Medical Director	Divisional Director, JM Barrie

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 September - October 2017 (2):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
SI 2017/ 13562	**Retained foreign object during spinal surgery** The patient had posterior spinal fusion surgery which at the time was thought to have been uneventful. Post operatively an object (metallic reduction head known as a 'pair of ears') was noticed on a routine x-ray- it had been left attached to a screw which had been inserted during surgery and should have been removed. The patient did not need to have any additional treatment or investigations as a result of the incident. The clinical team have advised that the retained object will not cause any harm to the patient but it is recognised that the incident has caused considerable anxiety for the patient's parents. The was no direct impact on the service although additional safety measures were considered and implemented on discovery of the incident.	A screw was not included in the surgical count and this was due to a combination of circumstances including human factors, staffing, the fast paced nature of the operating theatre, and the complexity and availability of required surgical instrumentation. There was no formal process in place to confirm that the number of screws inserted corresponded with the documented number of screws on the whiteboard and to identify any inconsistencies.	Introduce a documented 'final extended tab (ear) check' (manual/visual) by lead surgeon of screws inserted (for any system that has ears) to confirm the surgical count prior to skin closure. a) Discuss with spinal surgery consultant team and inform of requirement to carry out this check and for it to be documented b) Surgeons to document this check on the operation note c) Theatre staff to record this on the consolidation count section of theatre care plan d) Write a Local Safety Standards for Invasive Procedures (LoCSSIP) to explain this process, including actions a-c **Action update-. Surgical team are aware and there have been no reported issues re compliance- planned audit will help assess this, LoCSSIP in progress** Ensure that there is appropriate scrub staffing for spinal surgery lists which will be detailed in a LocSSIP a) Allocate 3 trained nurses to each spinal list b) Write LoCSSIP which will detail workforce considerations and will specify circumstances where it is imperative to have 3 nurses, and those where 2 is sufficient. This will also include advise to communicate any on the day staffing changes to the theatre coordinator **Action update- The team are usually able to allocate 3 trained per list; There has been times where sickness within the department has meant less, but the team leader is actively working on it. There are two new spinal trained scrub nurses starting in the new year. LoCSSIP in progress** One member of circulating staff to be allocated specifically to record the board count for each spinal case (company representatives will not be part of the counting process a) Team Leader to inform all staff of this requirement **Action complete.** An additional count board should be used for all spinal cases where implants are used- this extra board will be used to record count of implants only a) obtain additional count board for each theatre used for spinal surgery b) ensure all staff working in spinal theatres are aware that this board must be used **Action update- Boards are on order (first order did not go through)- once they arrive will be installed in theatres 14 and 15. Currently a section of bigger board is being marked off for this use and staff are aware.** Where possible, scheduling should avoid having two complex cases on the same operating list. It is recognised that this may not be possible due to the predominance of complex cases, so theatre staff should be given advance warning of this so that staffing can be considered to provide adequate relief/ breaks a) discuss at weekly scheduling meeting which is attended by admissions coordinator, Nurse Practitioner, Service Manager and ensure theatre staff aware of outcome b) Spinal team to review booking process and consider options such as ranking the complexity and urgency of individual patients at the MDT meeting, and using this information to help plan lists **Action update- in progress**	Where possible, scheduling should avoid having two complex cases on the same operating list. It is recognised that this may not be possible due to the predominance of complex cases, so theatre staff should be given advance warning of this so that staffing can be considered to provide adequate relief/ breaks

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 September – October 2017 (2):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
SI 2017/ 9747	**Cardiorespiratory arrest secondary to aspiration of water from a ventilator tubing circuit** The patient suffered a cardiorespiratory arrest secondary to aspiration of water from the ventilator tubing circuit and required active resuscitation and reintubation to support respiration. This delayed overall recovery and prolonged length of stay in the neonatal unit. The patient required active resuscitation, reintubation and a prolonged length of stay in the neonatal unit but there is no evidence to date suggestive of any long term physical harm from this incident.	The humidifier system for the Fabian Optiflow was not set up as advised (the water bag to fill the humidifier chamber was placed on a drip stand above the level of the ventilator) and the clamp to stop water from flowing into the humidifier chamber was either not applied or inadvertently not effectively clamped closed.	Clear signage on Fabian Optiflow with Manual fill humidifier systems • Signage for the Fabian Optiflow reminding of specific actions required in managing the system **Action complete** Communication to staff reminding of risk and recommended management with the Fabian Optiflow System • Communication to staff re the Fabian Optiflow reminding of specific actions required in managing the system **Action complete** Replacement of ventilator tubing circuits when available • Ventilator technicians to liaise with manufacturer and clinical staff re availability of and then introduction of the new ventilator circuits and autofill humidifier systems. **Action complete** Identify any specific training needs for this ventilator system for staff on the unit. • Contact the manufacturer to raise issues encountered. • Identify any training resources that could be employed • Ensure all training is documented centrally **Action update: The manufacturer was contacted and a medical representative attended the unit and delivered specific training.**	Consideration of a checklist for all staff to complete when a patient is attached to a ventilator so baseline settings are documented.

Are we responding and Improving?

Patient and Family Feedback: Red Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

Red Complaints in September- October 2017

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

Open red complaints- September- October 2017 (1)

Ref	Opened Date	Report Due	Description of Complaint	Divisions Involved	Exec Lead	Division Lead
17/053	18/10/17	06/12/17	Parent has raised numerous issues of varying severity concerning the care received prior to their child's death; and regarding a hospital acquired infection which contributed to the patients deterioration.	JM Barrie, Portfolio B1	Interim Medical Director	General Manager- JM Barrie Portfolio B1

Are we responding and Improving?

Patient and Family Feedback: Learning from Red Complaints

Learning from closed red complaints in September- October 2017 (2):

Ref:	Summary of complaint:	Outcomes/Learning:
17/018	Patient attended for an ablation procedure, during procedure the guide wire became stuck in the coronary sinus, guide could not be removed. During manipulation and injection of contrast the patient had a cardiac arrest. Emergency sternotomy was carried out, guide was removed, patient was transferred to Ward.	The complaint was investigated and a report was provided to the family which outlines the decision making processes that were followed. The following action point was identified for learning: • A number of debrief sessions have taken place in different forums, starting prior to the receipt of the complaint from the family. This included debrief with peers and senior colleagues individually and in small groups, and in a formal multidisciplinary meeting attended by members of staff from all groups. Within and following these processes the team, have undertaken considerable deep personal reflection of the whole event, including communications with the family.
17/025	Mother raises concerns regarding a perforation of the bowel which was discovered following the patient's recent stoma closure procedure. Also concerns regarding the length of time taken for the patient to be reviewed after they began exhibiting symptoms.	The complaint was investigated and a report was provided to the family which outlines the decision making processes that were followed. The investigation found that it is thought that the device used to perform dilatation (the Hegar device) caused a small perforation of the patient's bowel. Emergency surgery was considered, but it was decided to delay surgery and re-review at the surgical meeting the following morning. The investigation found that the decision to delay surgery until the following day meant that the team had a much clearer understanding of what was causing the symptoms. Once the team identified the bowel perforation , the patient was taken for surgery immediately.

Are we responding and improving?

PALS Data- quarter 2 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

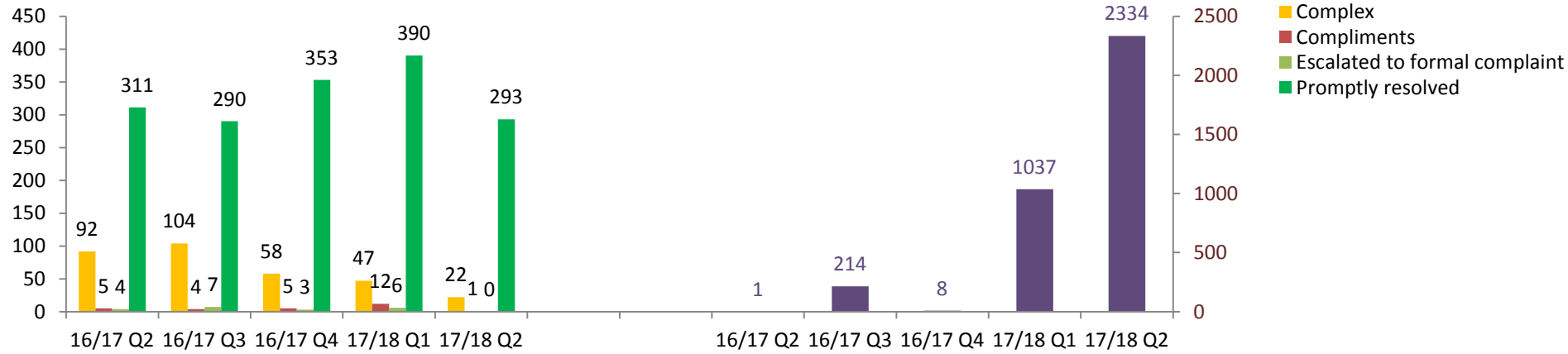
Comparison of PALS cases received in Q2 2017/18:

Cases	Q2 16/17	Q1 17/18	Q2 17/18
Promptly resolved cases (-48h)	311	390	293
Complex Cases (48h+)	92	47	22
Escalated to Formal Complaints	4	6	0
Compliments	5	12	1
Special cases	1	1033	2334
Total	411	1488	2650

Cases received by the PALS compared with previous quarters:

A significant number of "special cases" were reported in the Q1 report and the issue extended into Q2.

Comparison of cases received in Q2 2017/18:

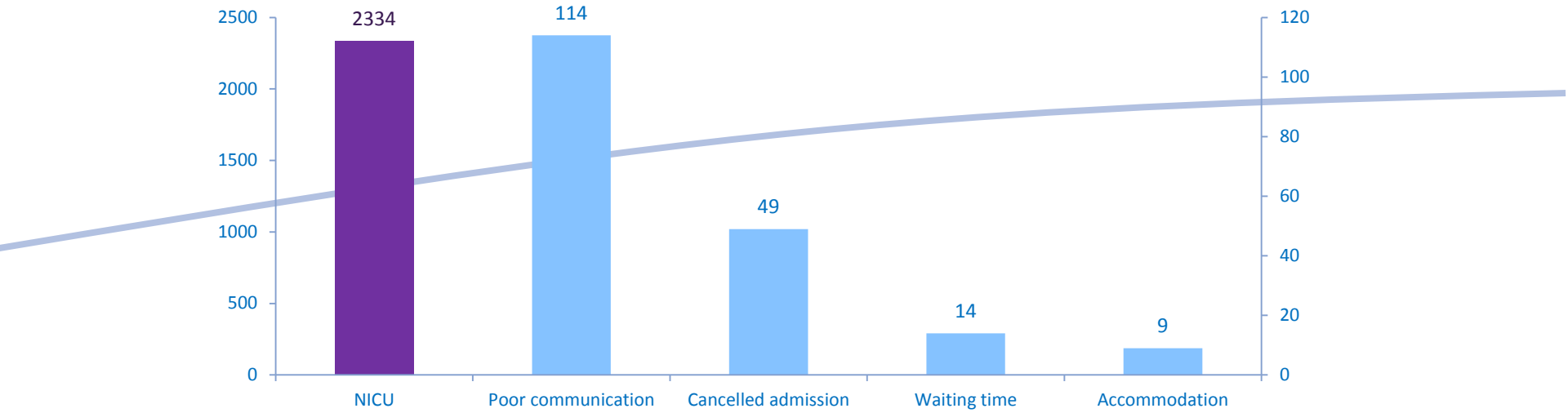


Are we responding and improving?

PALS Data- quarter 2 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

Most common cases received by PALS in Q2 2017/18:



Trends for number of PALS cases received per quarter

The chart above shows the 5 most common sub themes raised in PALS during Q2

PALS Trends

NICU	•This cases is the prominent case in the media. In addition to the 2234 individual contacts, we received in excess of 20,000 contacts via an online petition
Communication/ letters	•The top five specialities that Pals received contacts for regarding poor communication were Gastroenterology; Cardiology; Neuromuscular; Ophthalmology and General Surgery. All were resolved to the family satisfaction. Pals meets regularly with the Gastro Assistant Service Manager to ensure prompt solutions.
Cancellations	•The top five specialities that contributed towards cases for this sub theme- Spinal surgery; Cardiology; Dental; Ophthalmology and Dermatology

Are we responding and improving?

Learning from Friends and Family Test- Inpatient Data

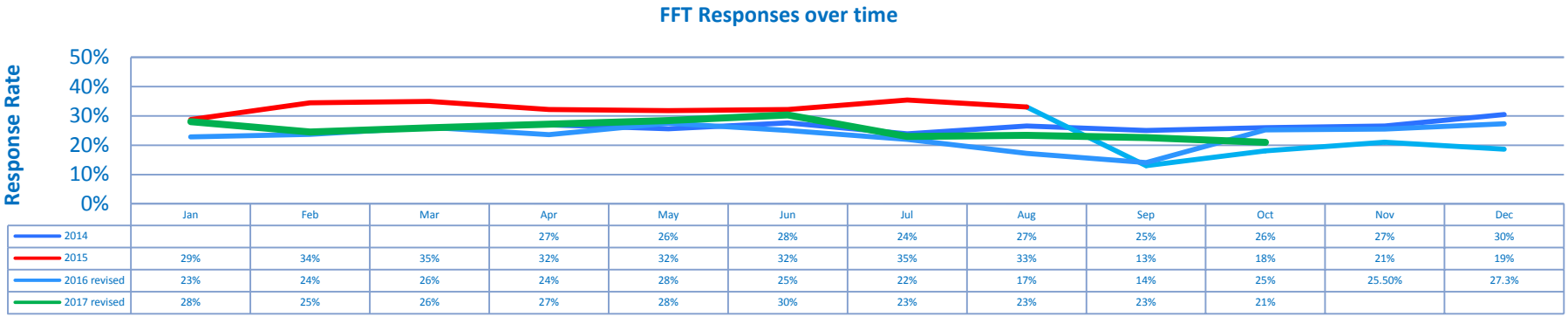
Great Ormond Street Hospital for Children NHS Foundation Trust

Data Quality Kite-Mark	Inpatient Results September 2017	Inpatient Results October 2017

September 2017
Overall FFT Response Rate = 22.6%
Overall % to Recommend = 97.6%

October 2017
Overall FFT Response Rate = 21%
Overall % to Recommend = 97%

Lowest % to Recommend since July 2016



	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%	30%	23%	23%	23%	21%		

September 2017 Top 3 Themes (by %)			October 2017 Top 3 Themes (by %)		
Positive Themes:	**No +ve comments**	**Total comments**	**Positive Themes:**	**No +ve comments**	**Total comments**
Always Helpful	181	182	Always Expert	163	166
Always Expert	188	195	Always Welcoming	104	107
Always Welcoming	113	118	Always Helpful	272	277
Negative Themes:	**No -ve comments**	**Total comments**	**Negative Themes:**	**No -ve comments**	**Total comments**
Access Admission Discharge and Transfer	13	17	Access / Admission / Transfer / Discharge	22	28
Always One Team	4	8	Catering / Food	7	16
Staffing Levels	2	2	Staffing Levels	**6**	**7**

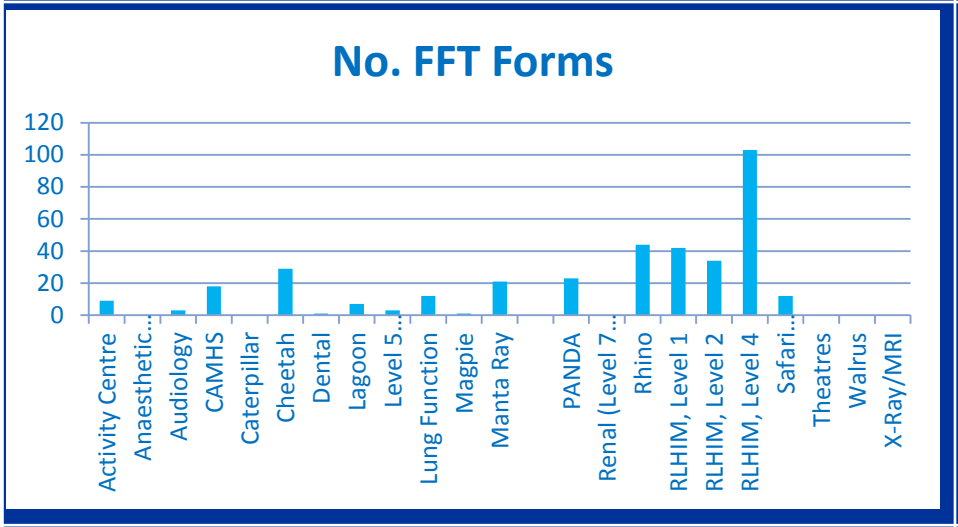
Are we responding and improving?

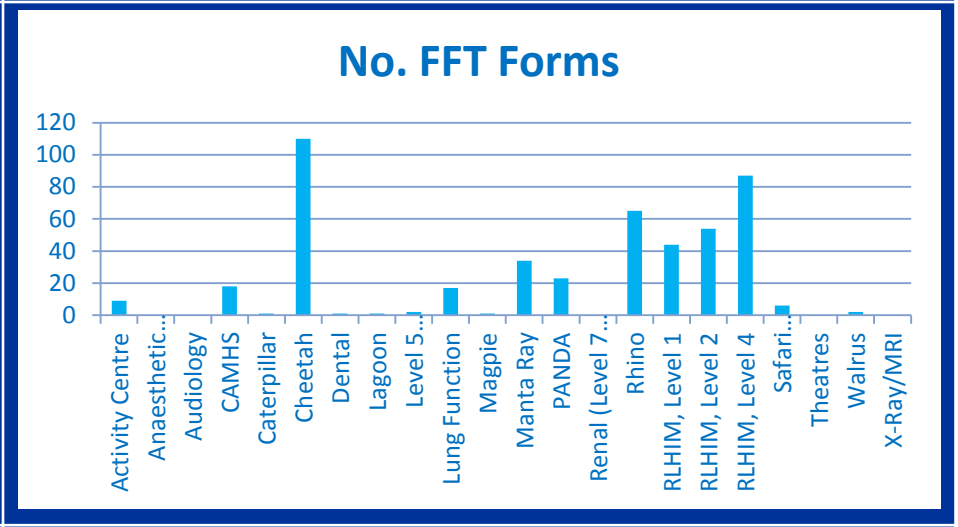
Learning from Friends and Family Test- Outpatient Data

Great Ormond Street Hospital for Children NHS Foundation Trust

Data Quality Kite-Mark	Narrative:
	The average percentage to recommend for Outpatients in October 2017 has increased to 93.38% Regular meetings between the PE Team and outpatients have been organised to increase the amount of feedback received in outpatients. The number of comments received for November so far is high.

Outpatient Results September 2017	Outpatient Results October 2017
September 2017 Overall % to Recommend = **90.65%**	**October 2017** Overall % to Recommend = **93.38%**





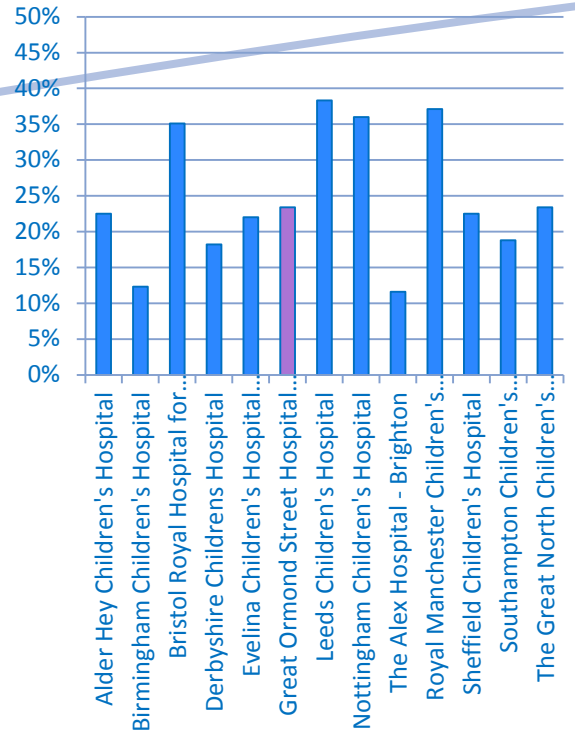
Are we responding and improving?

Benchmarking

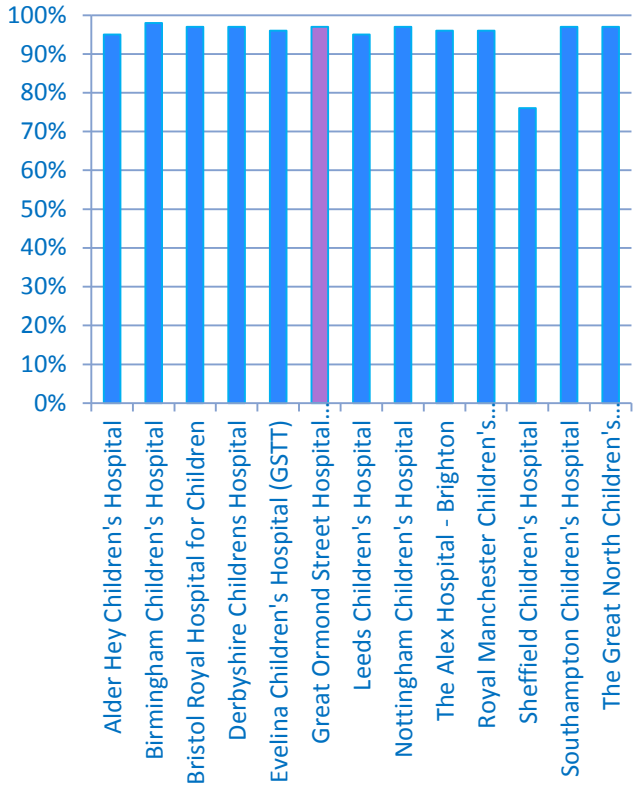
Great Ormond Street Hospital for Children NHS Foundation Trust

Data from NHS Choices – August 2017

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

Everyone is nice. Hospital is bright and friendly. Liked the books and colouring. The lady in reception is lovely, smiley and friendly. Calm environment.

It was good how friendly all the nurses, doctors and staff were kind and understanding. The whole experience was great!

Everything is great and the food is great when I have it because I'm rarely here for a long time every time I come

They have a lot of activities. Painting, drawing, colouring and lots more.

I like how everyone on the ward is nice and treat us like we are family/friends.

Parent/Carer Feedback

The activity centre play workers are amazing. Being in a room on your own all day can be extremely lonely for the children. The interaction the play team provide is brilliant, age relevant and personal. They introduced themselves to the children and play accordingly - they also know when the child is tired or had enough. The ward would be lost without them.

We can't thank all the amazing staff enough for helping our little boy. We have felt very informed even when he suddenly got really ill ,they were reassuring us and making us not panic.

The hospital understands and facilities are available for parents to cater for the child's feeding and anxiety issues. The staff are friendly and sensitive and their is assurance of everything that can be done will be.

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

Food orders over the weekend were terrible, son received wrong orders and orders were late on both days.

Ward sisters have met with the Housekeepers to discuss the issues. The housekeepers have now been invited to the safety huddles to improve communication between staff.

Ward and staff fantastic. Lack of communication from theatre booking. My son had to fast for 24 hours in total. Waited for 6 hours to be called to theatre. Reported a complaint to PALS.

There was a breakdown of communication from the waiting list coordinators to us on the ward and we have met with the admission coordinators this week to try and ensure that this does not occur again.

I find there's too much pressure on the nurses and as there's no admin it's double work for nurses. An administrator is needed!

This is correct, the Physiologist usually has to rush out to answer the door/phone when we are short off staff which has put pressure on us.

I am pleased to confirm we are in the process of negotiating an Administrator role who will be based on the lung function reception and will also help with our admin load.

Are we responding and improving?

Featured Project: Tracheostomy care

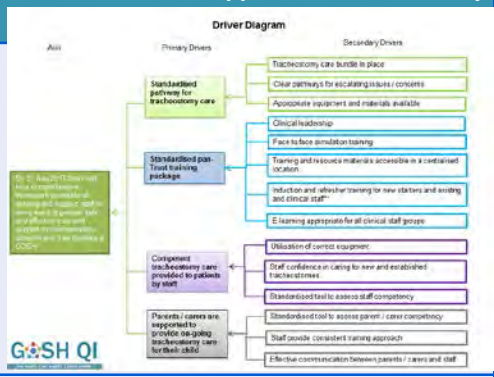
Great Ormond Street Hospital for Children NHS Foundation Trust

Project aim:

By 31 Aug 2017 there will be a comprehensive framework to enable nursing and support staff on every ward to provide safe and effective care and support for tracheostomy patients and their families at GOSH

Great Ormond Street Hospital (GOSH) carries out approximately 70-90 tracheostomies per annum, with approximately 2000-2500 in and out-patient cases per annum being managed as a whole. Children with tracheostomies require constant supervision from those fully trained in trache care; this means that parents/carers require both theoretical and practical teaching to enable them to manage day-to-day care and emergency situations for their child following discharge.

Concerns were raised at the November 2016 Patient Safety and Outcomes Committee (PSOC) regarding the wider competence and confidence of staff across the Trust in relation to the number of wards that were able to receive tracheostomy patients. Concerns were also raised regarding the number of 2222 calls related to tracheostomy complications. Some consistent themes were identified, highlighting a need for standardisation. It was agreed by PSOC that a proactive, strategic Trust-wide approach was required to ensure ongoing improvement and standardisation of tracheostomy care at GOSH, and the Trust-wide QI project was initiated in December 2016. The project was led by Jo Cooke, Trache ANP with Executive Sponsorship from Dagmar Gohil, Assistant Chief Nurse and quality improvement support from Emma Scott, QI Facilitator.



Expected Benefits of the Project:

- Provide standardised, consistent, best practice care and support to patients and families
- Enable greater capability to provide tracheostomy training for both existing and new starters
- Improve staff access to information/resources
- Improve data collection on the tracheostomy service to enable assurance of the quality and safety of the service

Primary Drivers

- Standardised pan-Trust training package
- Competent tracheostomy care provided to patients by staff
- Standardised pathway for tracheostomy care
- Parents / carers are supported to provide on-going tracheostomy care for their child

Measures for Improvement:

Audit and survey data will be used to measure results of the project.

Outcome measures:

- Completion and delivery of the comprehensive framework outlined in the project aim

Process measures:

- Staff confidence in tracheostomy care
- Staff competence in tracheostomy care
- Patient / parent / carer experience regarding tracheostomy care / training
- Number of incidents relating to tracheostomy care
- Number of avoidable complications
- Identification of trache patients across the Trust
- Number of times trache patients refused from a ward
- Compliance with tracheostomy training targets
- Practice Educator capacity to deliver trache training alongside other priorities

Progress to date:

The framework is in place excluding two outstanding deliverables: the publication of the e-learning and the addition of the competencies on LMS. (see next steps)

- Developed a new Trust-wide training strategy – agreed a training aim that 95% of staff members on wards with a high frequency of trache patients and 50% of staff on other wards have completed the tracheostomy training package, based on data collection through project measures
- Created a new competency framework – a standardised training workbook and e-learning
- Devised a train-the-trainer package and training resources, including two video podcasts
- Improved measurement of training compliance
- Developed a trache intranet homepage for all tracheostomy resources and training for staff
- Improved access to trache training and support on the GOSH website for parents / carers
- Created an audit tool to provide a greater level of direct surveillance through weekly measurement of occurrences of avoidable complications
- Developed measures to improve visibility of the location and frequency of tracheostomy patients across the Trust and demand on trache service over time

Next Steps:

- Completion of e-learning component
- Review training strategy and targets, led by Central Education Team – February 18
- Carry out a sustainability and impact review of the project, including reviewing the existing and newly developed project measures, led by QI - 6-12 months after the project close (to be agreed in the February training target review)

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
Neonates	To improve the quality and safety of care within inpatient neonates/ small infants* at GOSH by January 2018[*<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 and ward folders live • E-learning module for blood spot available on GOLD, Jaundice to be launched soon. Proposal to make these mandatory for key neonatal wards to be submitted to Workforce and Education Development Board • New measure developed to audit compliance again new fluid management guideline – audit now underway • Neonatal PEs rolling out education package, developing train the trainer materials to ensure sustainability • Automated email prompts for bloodspots rolled out to 10 wards • On-going testing of Neonatal documentation to ensure fit for purpose – learning from previous PDSAs incorporated into new approach • Incorporation of neonatal prompts in existing systems and documentation – CareVue, Discharge Summaries, Neonatal round summary documentation • Neonatal November planned as opportunity to raise awareness of neonatal care and launch the new neonatal resources and education programme – stalls, ward hot topics, talks etc
PEWS	To replace the Children's Early Warning System (CEWS) with the Paediatric Early Warning System (PEWS) for wards across GOSH by January 2018	Executive Sponsor- **Chief Nurse** Medical Lead- **Consultant Intensivist** Nursing Lead- **Clinical Site Practitioner**	Progress: • PEWS is set to launch in January 2018 • Both Nervecentre and CareVue are currently in the process of building the new scoring system within their digital platforms. The testing phase for this will begin in November / December and the updates include new Sepsis alerts to improve the recognition and treatment of the condition. • The PEWS education package is nearly complete and will predominantly take a 'train the trainer' approach. The Lead Educators would like to see a 6 week time period to embed the training and the package is also expected to include a re-education around clinical observations . • The PEWS communication strategy is currently being finalised and is set to incorporate the launch of the new trust strategy. PEWS will be showcased as an exemplar piece of work that is currently underway across the trust

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 Q1 CQUIN 2017-18 submitted Progress: • Benchmarking tool piloted to ensure all Trust transition information meets minimum standards • Work started on Transition Policy and Specialty Specific Standard Operating Procedure templates • Work underway on live clinic report for clinicians showing age, number of appointments in previous year and transition plan status • Agreement from web-team/Charity to support development of video information for YP and parents Next steps: • eCOF Transition status tab pilot • Development of YP/parent/carer information (paper and video) • Development of transition clinic 'template' packages
Extravasation	To reduce the incidence of extravasation injury at GOSH	Executive Sponsor- **Chief Nurse** Clinical Lead- **Consultant Anaesthetist**	Progress to date: • VHP Framework & Tool - 1 month trial of new process and framework complete. Feedback gathered. Process (sticker- content and where to be placed) is being improved. Proposal to increase testing in further wards: Bear and Walrus. • Communication group – Developing an online strategy to share the journey and experiences to date. Communication strategy available once decision to roll out has been agreed. • Training video – Filming completed, under development. • Long lines - new nursing guidelines approved. Currently training sessions are being conducted. • Plastics referrals – Developing an improved database of referrals (categories & details). Aim to link with Datix to ensure consistency of data. • Acyclovir study set up on Koala – led by Reg, to assess impact of delays in IV access in relation to therapeutic management.

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 2: SPC Frequently Asked Questions

Contents

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:

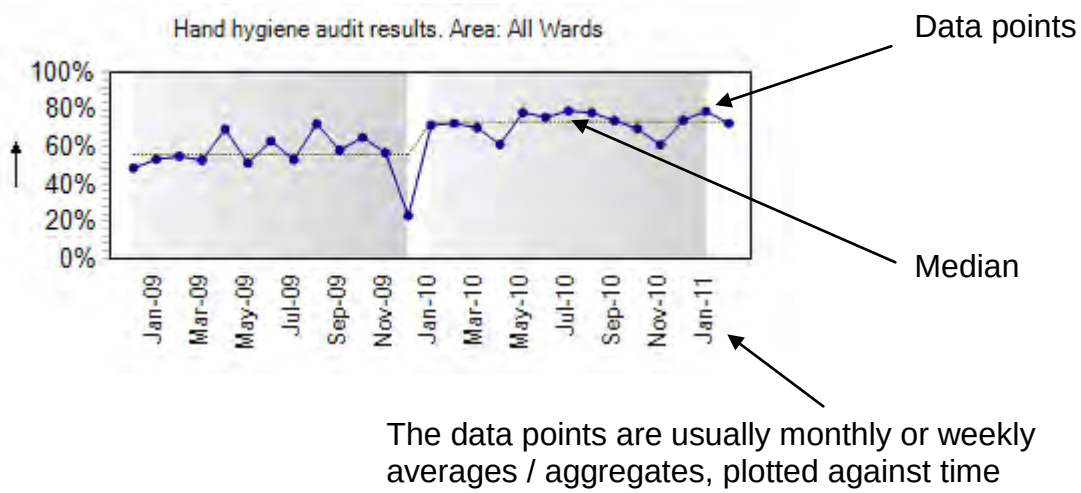
- are an excellent way of **measuring for improvement**
- Use the pattern of events in the past to predict with some degree of certainty where future events should fall.
- distinguish between the natural/common cause variation and special cause variation
- enable you to look for problems when they are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

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

What is a Run Chart?

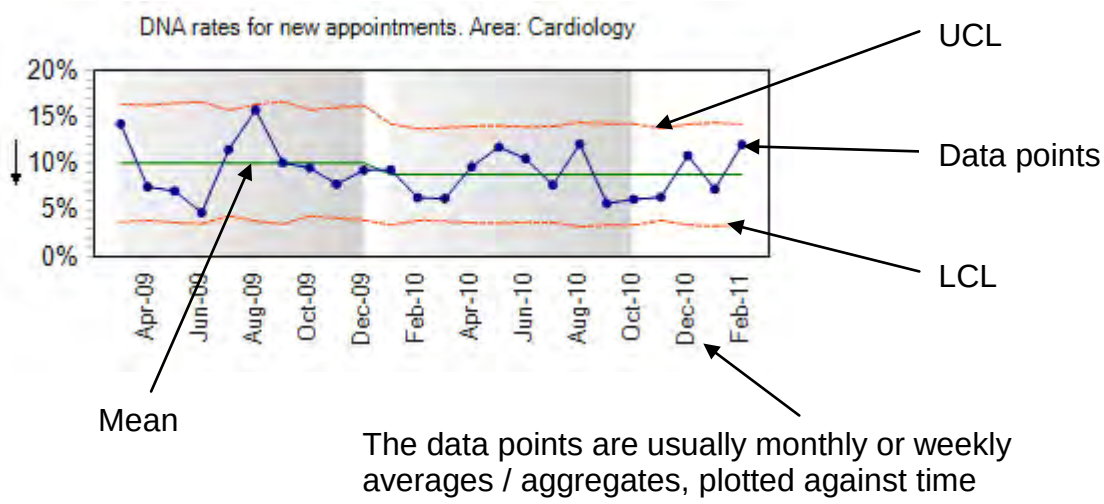
A run chart is used when analysing more than one process, when the data is summed (or aggregated). For instance, if we want to analyse medication errors Trust wide, we would use a run chart - there is more than one process because there are multiple wards in a the Trust with each ward having its own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



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.

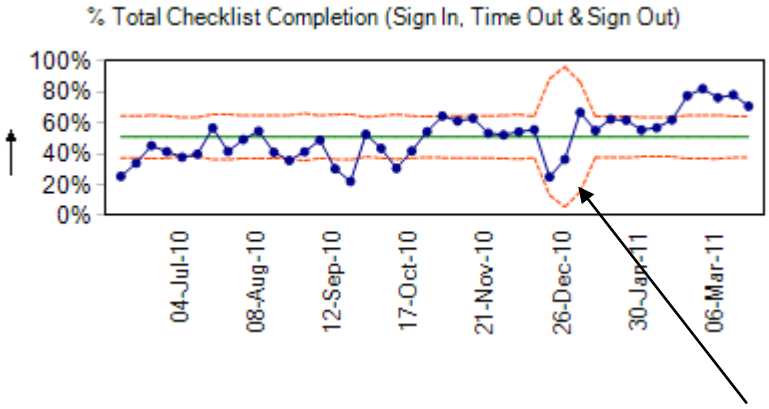
What are the Upper and Lower Control Limits?

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.

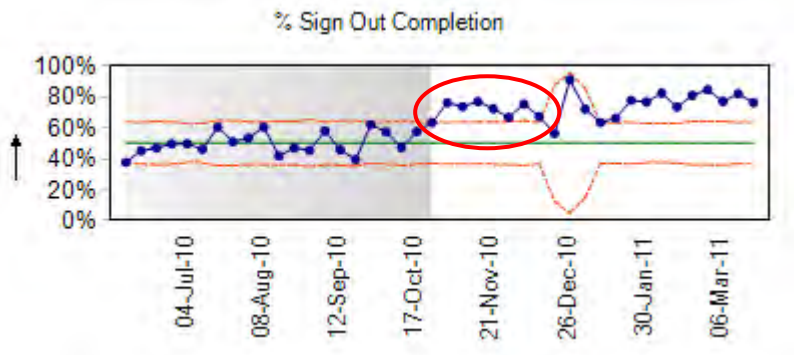
c. **Outliers**. An outlier is a data point which is outside of the control limits.

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.

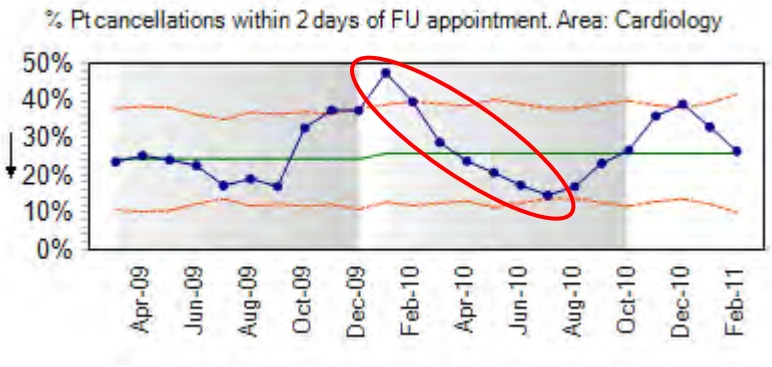
What is a Run?

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



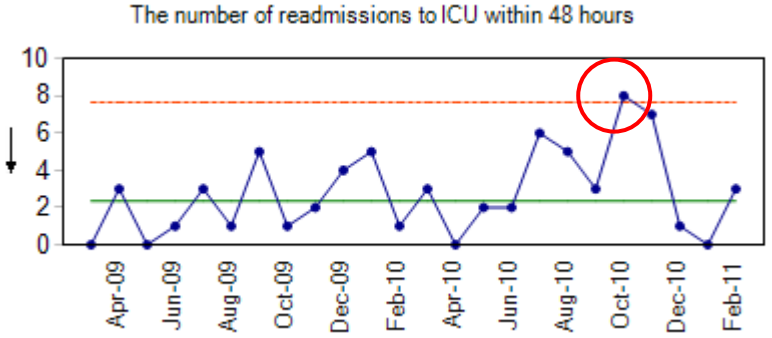
What is a Trend?

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



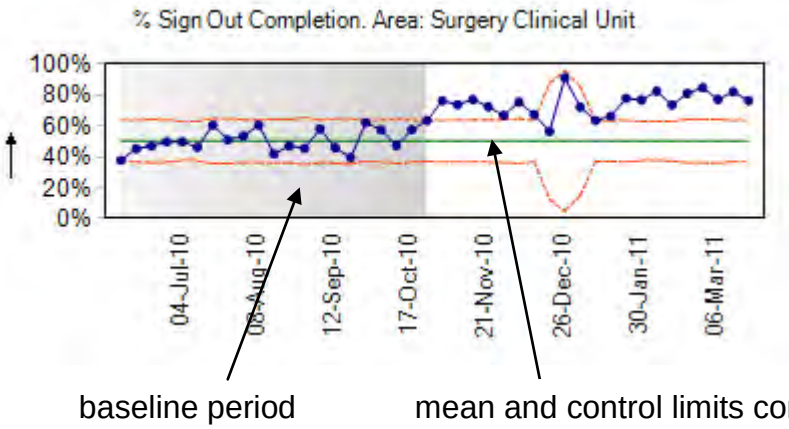
What is an Outlier?

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

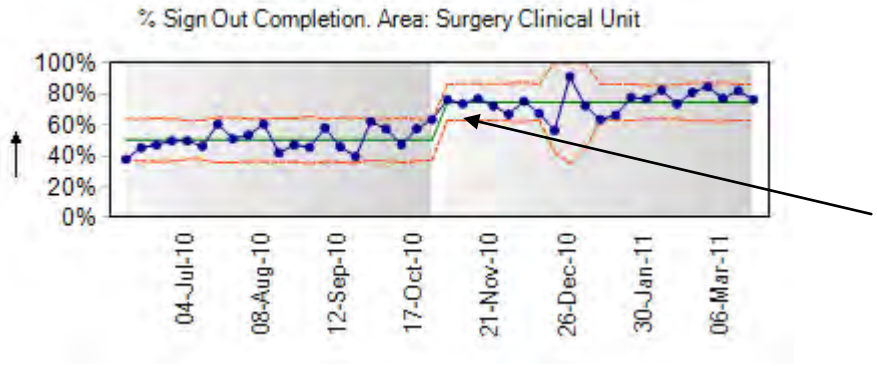
mean and control limits continued from baseline

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:



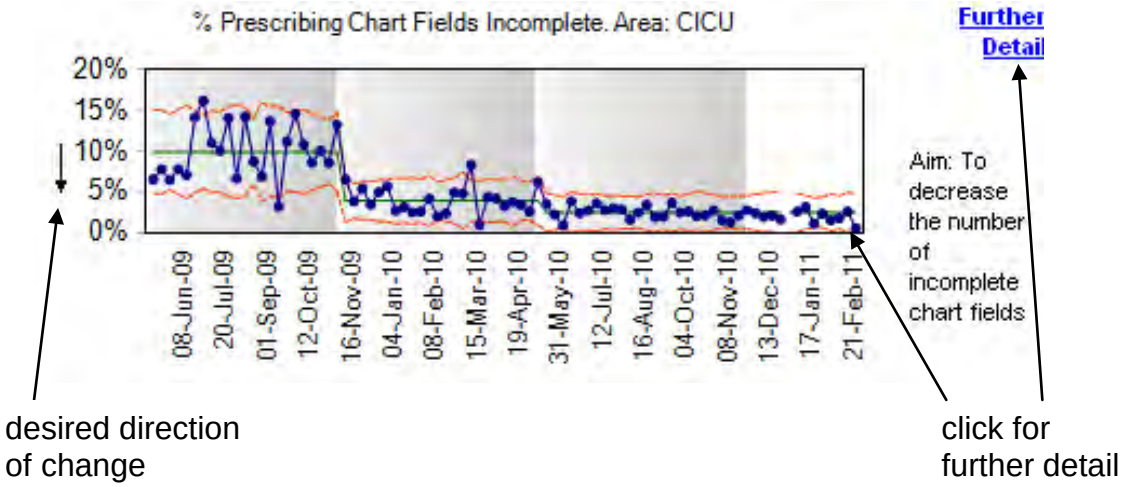
Outliers: If you spot an outlier, it must be investigated. It indicates that something either very good or very bad has happened and action needs to be taken either to correct the problem so that it doesn't happen again, or to learn from the good practice so that it can be applied in future.

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.

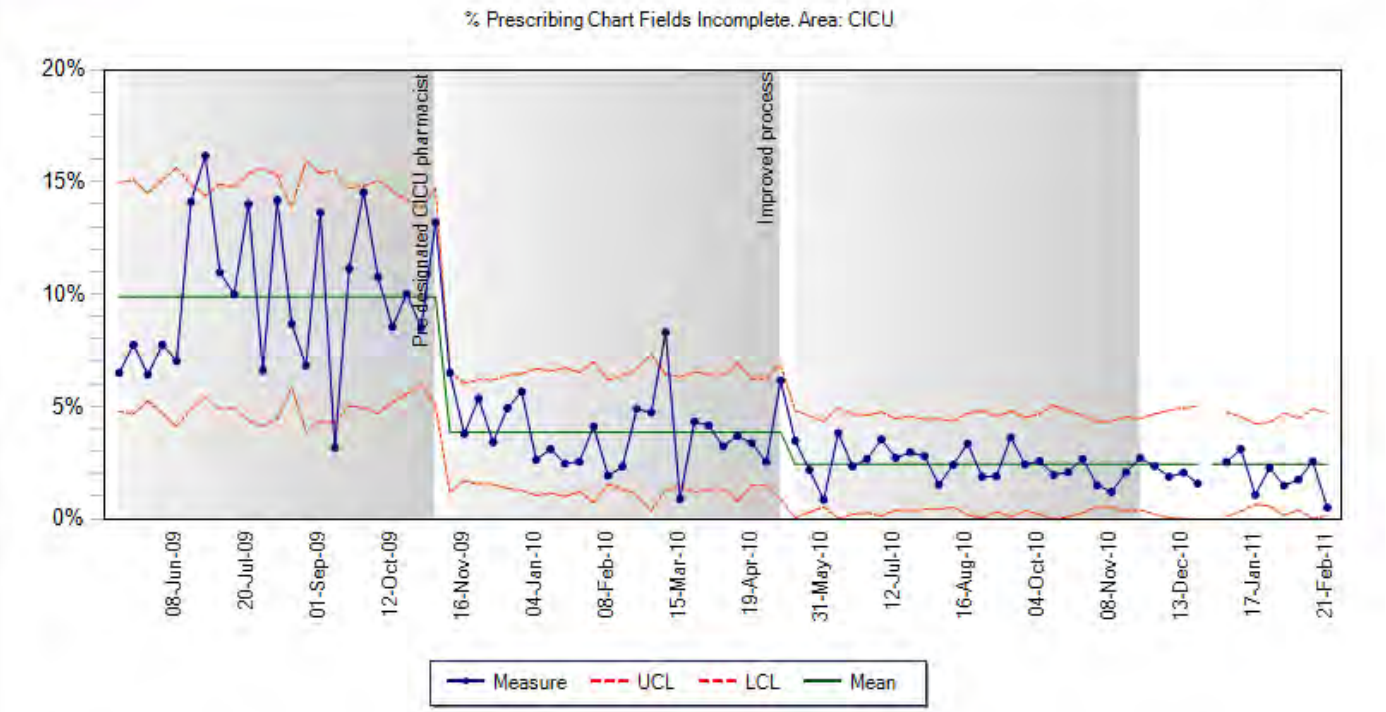
To access **Further Detail and Definitions** for a particular measure on one of the improvement dashboards, either click on a data point or the 'Further Detail' link next to the dashboard charts



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)

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

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.

Attachment 8

Great Ormond Street Hospital for Children NHS Foundation Trust

Update to Trust Board

Clinical Outcomes Development Programme

The GOSH Clinical Outcomes Programme has the following aims:

- Robust clinical outcome measures identified in each specialty
- Accurate, prospective data collection against these measures
- Robust analysis of outcomes data
- Availability of specialties' outcomes on the intranet for greater internal visibility
- Publication of outcomes to the Trust website for public visibility
- National and international benchmarking of outcomes, with other paediatric centres of excellence

External visibility: Website publication of outcomes data

- GOSH publishes more of its outcomes to the hospital's public website than any other paediatric hospital in the world.

- Outcomes data for 25 services is published on the Trust website; six of which include data benchmarked with other UK and/or international centres (Cardiology and Cardiac Surgery; Intensive Care Unit; HIV; Nephrology; Neurosurgery; Cystic Fibrosis)

- In the past six months, the following specialties' outcomes have been added or updated on the Trust website:

  - Beckwith-Wiedemann syndrome
  - Cardiology and Cardiac Surgery
  - Clinical Genetics
  - Gastroenterology
  - Immunology
  - Metabolic Medicine
  - Neurodisability (Osteogenesis Imperfecta)
  - Neurosurgery
  - Orthopaedics and Physiotherapy (Ponseti)
  - Palliative Care
  - Plastic Surgery (thumb pollicisation)
  - Psychological Medicine (Tourette syndrome and Non-Epileptic Seizure)
  - Completed and awaiting sign off: Cystic Fibrosis; Cleft Lip and Palate; Haemophilia

Attachment 8

Internal visibility: Clinical Outcomes Hub on GOSHweb

The Clinical Outcomes Hub provides an in-house one-stop-shop for:

- Information about the outcomes programme
- Specialty outcomes dashboards
- National Specialised Services Quality Dashboard reports
- Data input tools
- Other resources and a link to outcomes on the Trust website

The specialty outcomes dashboards are developed in partnership with clinical teams. These dashboards are used in clinical team meetings to discuss outcomes and stimulate discussion about improvement. Growing visibility is bringing increased interest. More and more teams want to see their clinical outcomes displayed internally to enable them to refer to their data quickly and easily and use it in discussions about their services.

New dashboards:

- Neurosurgery (internal link only)
- SNAPS (awaiting clinical team sign off)
- Urology (awaiting clinical team sign off)

Under development:

- Craniofacial
- Tracheal

In addition, the national reports for the 14 NHSE Specialised Services Quality Dashboards we submit for are available on the Hub, along with the exception reports for commissioners.

Benchmarking outcomes

- 9/10 Children's Alliance hospitals are signed up to benchmarking of the Specialised Services Quality Dashboards. Awaiting confirmation from NHSE of technical solution that will enable easy comparison. Process for review of measures to be developed once technical support confirmed.
- Implementation underway of International Consortium for Health Outcomes Measurement (ICHOM) set for craniofacial microsomia. Cleft lip and palate ICHOM set will follow.
- GOSH participation in the emerging European Children's Hospitals Organisation (ECHO)

Meredith Mora, Clinical Outcomes Development Lead, 17 Nov 2107

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 28 November 2017	
Integrated Performance Report: November (reporting M7 October 2017) **Submitted by:** Nicola Grinstead, Deputy Chief Executive	**Paper No: Attachment 9**

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 & families, Trust Board and our commissioners & 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.

Data quality kite-marking has now been added to the report as per the Board's request.

Action required from the meeting

Board members to note and agree on actions where necessary

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
November 2017
(Month 7 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

October 2017 (Month 7 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. 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 7 (October 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 (96.65% for Oct 2017)

- The rate (%) of those responding (for Inpatients) having seen signs of significant improvement (i.e. 30% plus for May and June) has tailed off over the last couple of months, to circa 20% (being 20.96% in October Trust wide). There remains variability across the three Divisions and the wards. The IPP division continues to be compliant against the 40% standard, achieving 47.6% in October. The West division has seen an improvement this month, achieving 33.45%, whilst Barrie division has seen a significant drop (12.76%). This was mainly due to two wards moving over to PICB which meant that the collation of FFT responses was impacted on a few wards. An action plan is in place in both divisions to improve the response rate. Work has been undertaken assessing the variability and those typically more challenging areas that have frequent attenders during the reporting period and recommendations have been made in terms of setting ward based targets.

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, there was one serious incident and one never event reported in October. The YTD positions are:

- Serious Incidents = 10
- Never Events = 2

Further detail is provided in the Quality and Safety report

Healthcare Associated Infections (HCAIs)

Incidents of C. Difficile

The Trust has now reported two additional incidents of C Diff in October, taking the Trust YTD position to 11 (at M7). Seven out of the eleven cases of C Diff were trust acquired i.e. they occurred on or after the fourth day of the patients' admission. At this time, none of these have been found to have resulted in lapses of care, and these continue to be reviewed with Commissioners). The Trust's total allowance for 2017/18 is 15 cases, as set nationally.

Incidents of MRSA

The Trust continues to report zero incidents of MRSA for the whole year (which is a continuation of the trend from the last few months, and where only three cases were reported in 2016/17)

CV Line Infections

The Trust continues to maintain compliance against the standard (1.28 against 1.6 per 1000 line days). All incidents have or will be investigated by the lead nursing staff with involvement from the Infection Control team. As per the Quality & Safety report, the ongoing trend / position over time is within expected levels showing no sustained outlying behaviour.

WHO Surgical Checklist Completion (> 98%)

As reported last time, the Trust has now been consistently delivering above 98% for the past few months. There has been continued delivery across the board, reflecting the improvements made operationally.

Hospital Acquired pressure / device related ulcer: Grade 3 & above

The Trust did not report any grade three and above pressure ulcers in October.

Responsive

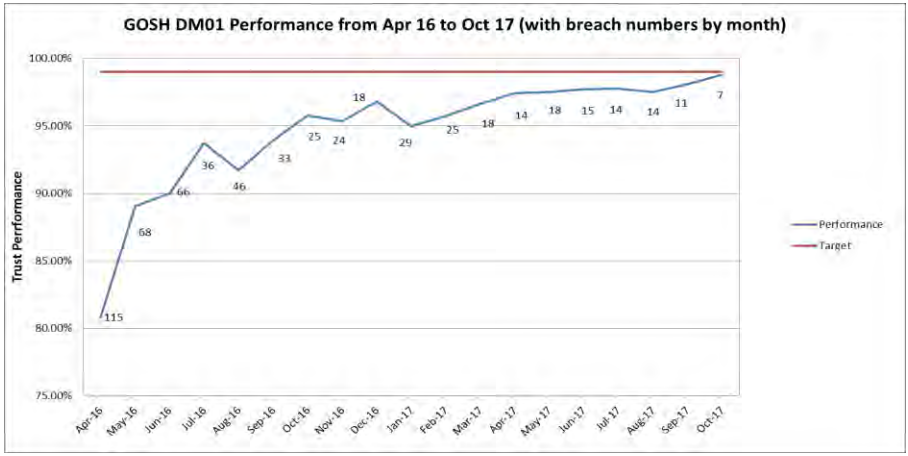
Great Ormond Street Hospital for Children NHS Foundation Trust

Diagnostics (99% < 6 weeks) – October 2017 position

The Trust continues to report improvements in this area, although not delivering to the standard of 99% for patients accessing the 15 diagnostic modalities within 6 weeks of referral / request. The Trust improved significantly this month, achieving 98.69%; as well as reducing the number of patients waiting in excess of 6 weeks by more than 50% in comparison to the start of the financial year (reduction from 18 in May to 7 in October). This is the lowest number of breaches since the Trust returned to reporting in April 2016 data. The Trust is currently working to a compliance date of December 2017 (reported in January 2018).

As shown in the table opposite, the overall number of breaches for October was seven (minus four from September). Breaches occurred in MRI (3), Flex Sigmoidoscopy (1), Gastroscopy (1), Non Obstetric Ultrasound (1) and Urodynamics (1). Four of the seven breaches can be attributable to process / booking issues where unreasonable dates were offered to patients, and these have been investigated by the services and are being addressed. Two breaches occurred due to patients being cancelled due to list overrun and one breach was due to patient not attending an unreasonable offered appointment which was later rescheduled beyond breach date to coordinate with their outpatient appointment.

The areas concerned are being reviewed to ensure that process/ booking issues are being addressed sufficiently as possible and that where patients / families cancel, the Trust has been in a position to provide reasonable notice in booking that initial diagnostic appointment.



Diagnostic	Breach	No Breach	Grand Total	Performance
Audiology - Audiology Assessments		17	17	100.00%
Barium Enema		1	1	100.00%
Colonoscopy		5	5	100.00%
Computed Tomography		27	27	100.00%
Cystoscopy		14	14	100.00%
DEXA Scan		2	2	100.00%
Flexi sigmoidoscopy	1		1	0.00%
Gastroscopy	1	18	19	94.74%
Magnetic Resonance Imaging	3	233	236	98.73%
Neurophysiology - peripheral neurophysiology		35	35	100.00%
Non-obstetric ultrasound	1	63	64	98.44%
Urodynamics - pressures & flows	1	19	20	95.00%
Respiratory physiology - sleep studies		95	95	100.00%
Total	**7**	**529**	**536**	**98.69%**

Contextually when comparing GOSH with other Children's Trusts or other London tertiary / specialist providers, the Trust is not an outlier with differential levels of performance. Nationally out of 365 providers reporting against the standard (NHS and Independent sector) 246 in September were delivering 99% or better (it must be noted that 150 of these trusts reported a waiting list of less than 100 and a number are also providers just offering certain specific diagnostics, rather than a full range). 128 providers reported 98-99% (of which GOSH was one), 23 at 97-98% and 53 reported <97%.

Cancer Wait Times

For the reporting period up to October 2017, there have been zero patient pathway breaches reported against the Cancer Wait time standards applicable to the Trust.

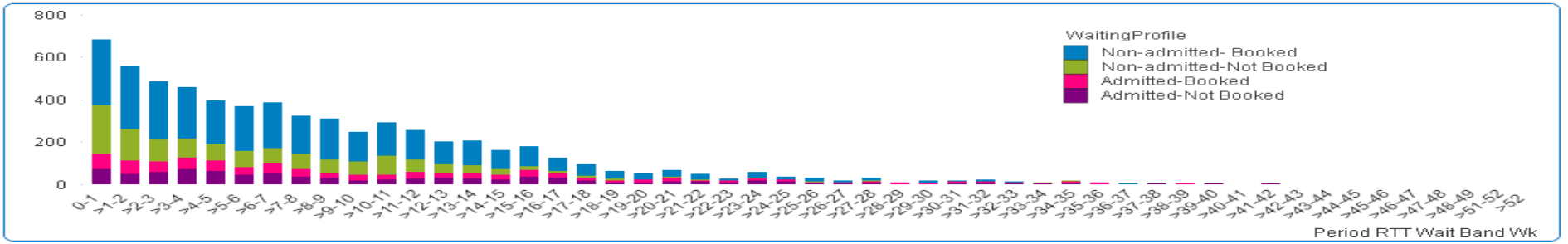
Responsive

Great Ormond Street Hospital for Children NHS Foundation Trust

Referral to Treatment Time (incomplete standard > 92%) – October 2017

The Trust remains below the RTT incomplete standard of > 92% (of pathways waiting no longer than 18 weeks), and has also not met its improvement trajectory for the past two months. At the time of writing the most up to date submitted position for October was 90.59%, against a trajectory of 91.17% Specialties of concern are Audiology (clinician long term absence for a single handed specialised service), ENT (cancellations and DNA Rates plus extended wait in non-admitted part of the pathway), Dental and MaxFax (long term consultant absence), Spinal Surgery (complexity of procedures and theatre space), Plastic Surgery (sub-specialisation within the service), Urology (consultant absence, complex patients and theatre capacity) and Rheumatology (clearing of the backlog following earlier wailing list issues). Improvement trajectories at a speciality level have been refreshed following the recent demand & capacity reviews. Revised improvement trajectories have been submitted by specialty and these are monitored weekly via the Deputy Chief Exec led Weekly RTT Meeting which is attended by Director of Operations, General Managers, Heads of Clinical Service and Performance Team. The meeting enables in depth discussion to be undertaken on challenged specialties, early warning of potential risks to delivery and plans in place to meet the agreed trajectory.

The graph below provides an overview of the distribution of the Trust's RTT wait times (for those with known clock start pathways). As is evident the number of long waiters >52 weeks continues to improve.



52 week waits:

The Trust reported one patient waiting over 52 weeks as at the end of October 2017, urology who has now been treated. The position this month has significantly improved from the last few months which were mainly associated with the specialty level issues flagged previously.

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) has decreased over recent months. This was seen off the back of a further push in engaging with referring Trusts and escalating where necessary (reducing it to 20%, and week on week improvements continue to be seen). This month's submitted position was the lowest reported number of unknown clock stops, reflecting the continued hard work within the divisions.

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.

For Q2 17/18 the Trust reported a continued improvement in this area (compared to Q4 16/17 = 180 and Q1 17/18 = 137 last minute non-clinical hospital cancelled operations), with 119. The areas contributing most to this are Radiology and Cardiac Surgery.

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 have been put in place with operational senior management teams.

Q2 also reported a significant improvement in rebooking last minute cancelled operations within 28 days of the cancellation, with only seven (compared to 14 in Q1 17/18 and 25 in Q4 16/17). 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:** Substantive staff in post increased to 4372.1 FTE (full-time equivalent) in October. This is 304.1FTE (7.5%) higher than the same month last year. Substantive Nursing staff numbers have increased by 155.9 FTE, largely due to the enlarged Newly Qualified Nurse cohort that joined the trust in late September.

- **Unfilled vacancy rate:** The Trust's unfilled vacancy rate has reduced to 3.55%, down from 9% in August.

- **Turnover** is reported as voluntary turnover in addition to the standard total turnover. Voluntary turnover currently stands at 14.7%; this reported value excludes non-voluntary forms of leavers. Total (voluntary and non-voluntary) turnover has reduced to 18.42% in October 2017.

- **Agency usage** for 2017/18 (year to date) stands at 2.1% of total paybill. Although this is slightly above the local stretch target, it is well below the NHS I target for GOSH 2017/18 of 3% (£6.5 million) and below the same month last year (3.79%). The Trust has established a Better Value Scheme scrutinising all agency spend.

- **Statutory & Mandatory training compliance:** In October the compliance across the Trust was 91%. Currently, all directorates/divisions are meeting the in-year 90% compliance requirement.

- **Sickness absence** remains below target at 2.23% and below the London average figure of 2.8%. Short-term sickness (STS) (episodes of sickness up to 4-weeks) is 1.36%, while long term sickness is at 0.99%

- **PDR completion rates** The appraisal rate has increased to 86% (from 85% in August), but remains below target, however the Trust continues to benchmark well and is above it's long term average. The reduction reflects an expected seasonal trend which will be reversed in the next few months.

Well-Led

Great Ormond Street Hospital for Children NHS Foundation Trust

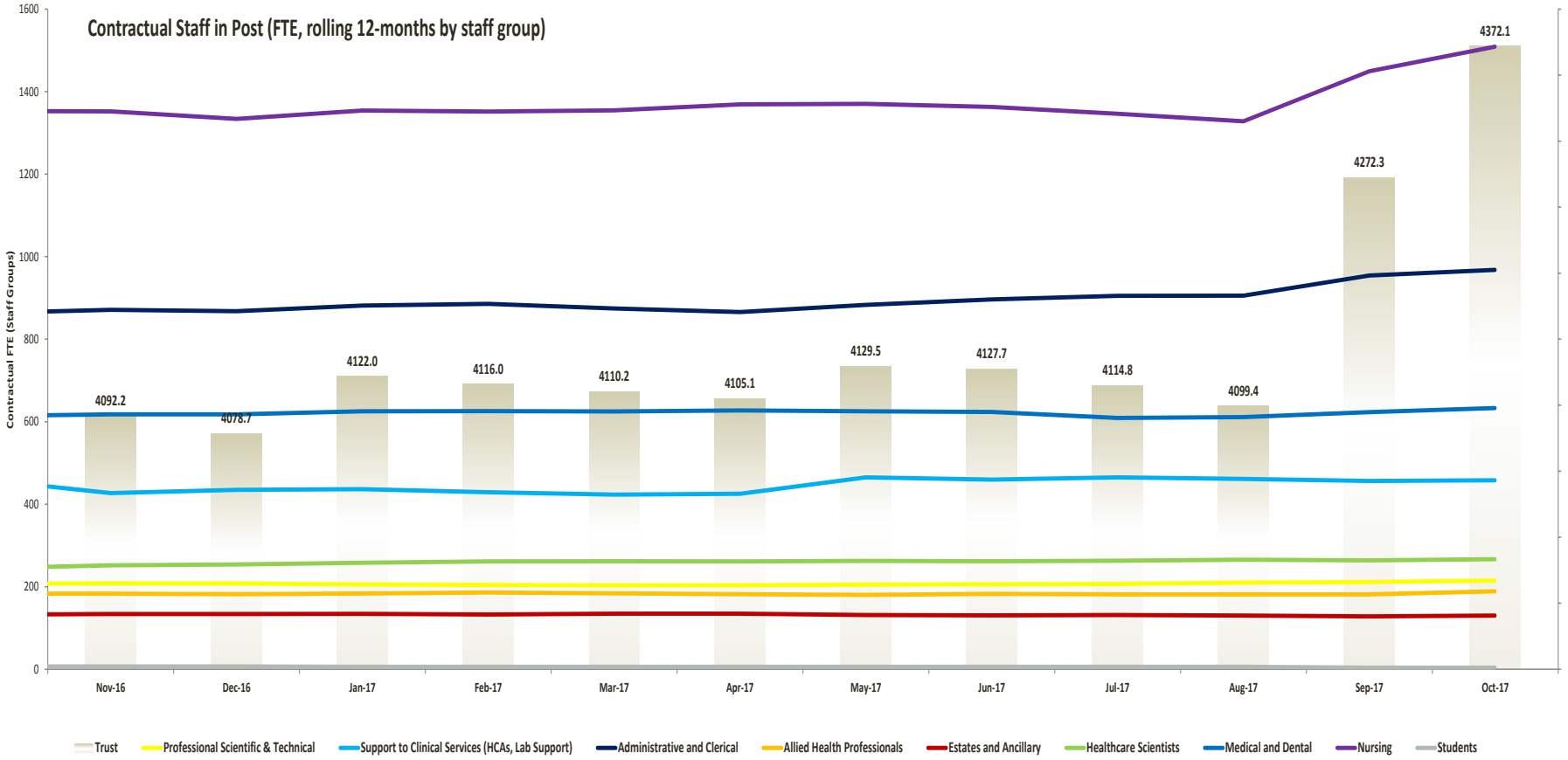
Trust KPI performance October 2017

Metric	Plan	Oct-17	3m average	12m average
Voluntary Turnover	14%	14.7%	15.1%	15.7%
Total Turnover	18%	18.4%	18.5%	18.8%
Sickness (12m)	3%	2.2%	2.3%	2.3%
Vacancy	10%	3.6%	6.2%	7.4%
Agency spend	2%	2.2%	2.3%	2.9%
PDR %	90%	86%	85%	86%
Statutory & Mandatory training	90%	90%	90%	89%

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

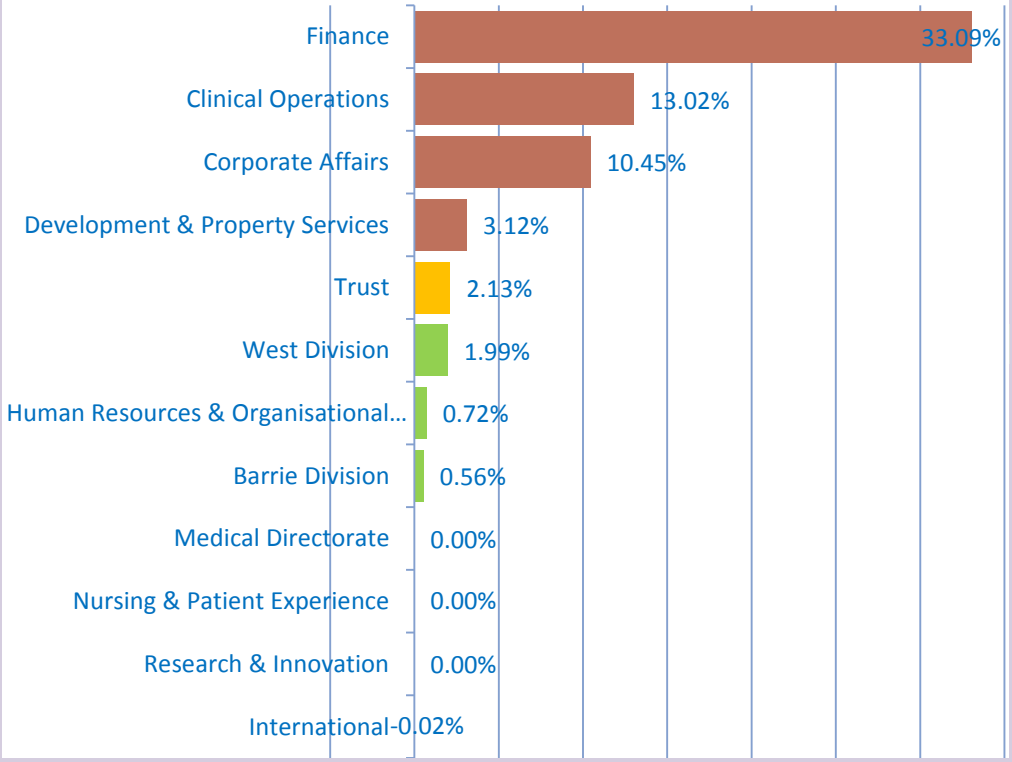
Well-Led

Substantive staff in post by staff group

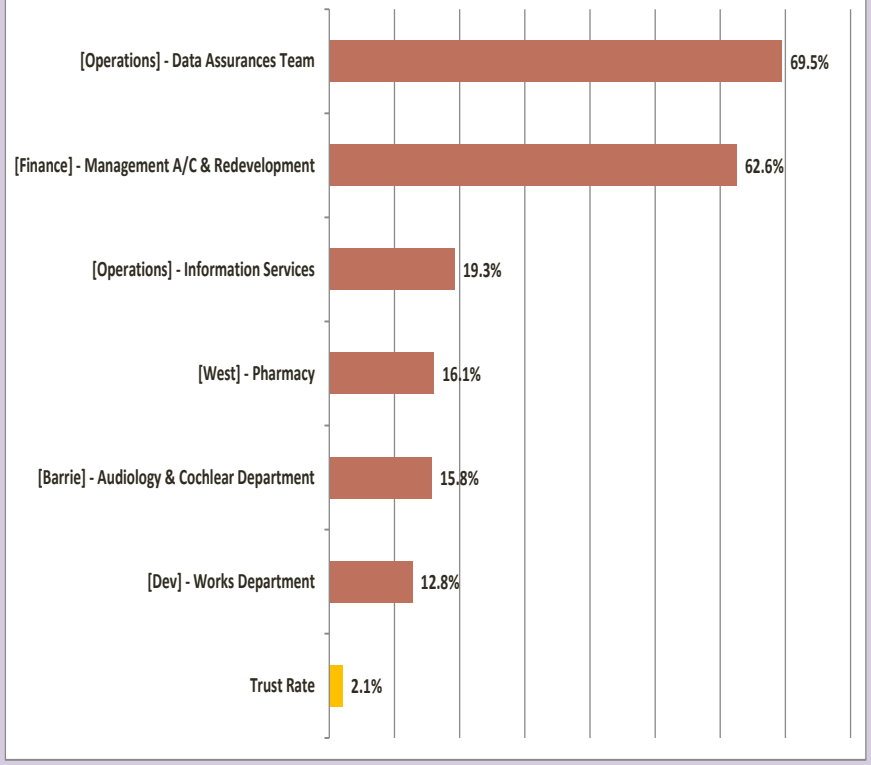


Agency Spend: Exception report

Divisional Agency as % of paybill

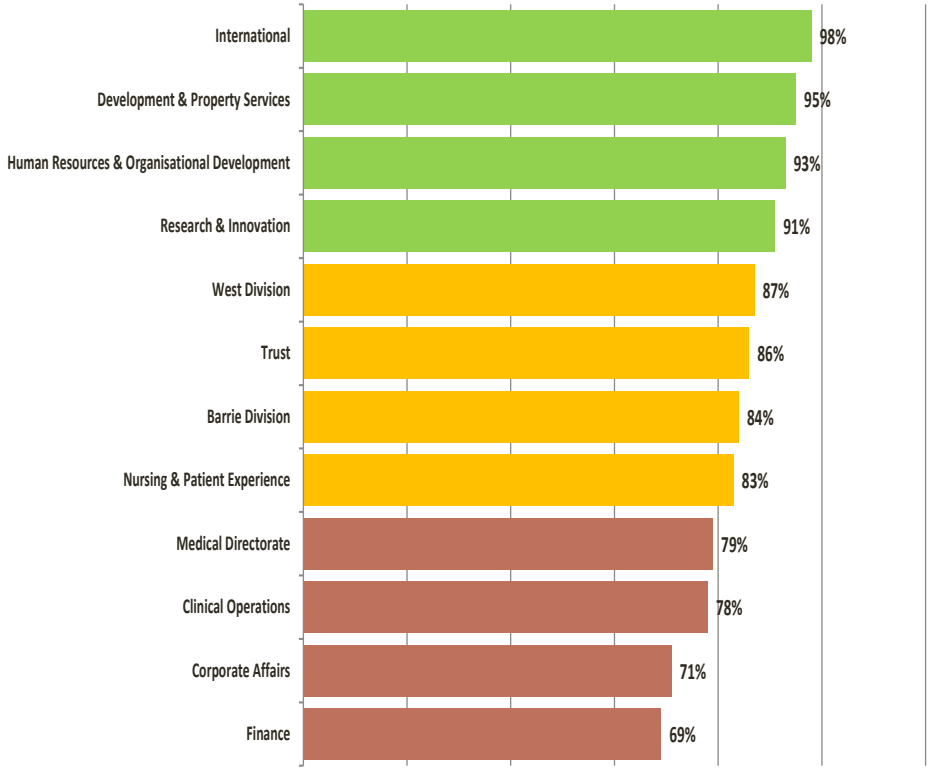


Exception Reporting Agency as % of Paybill

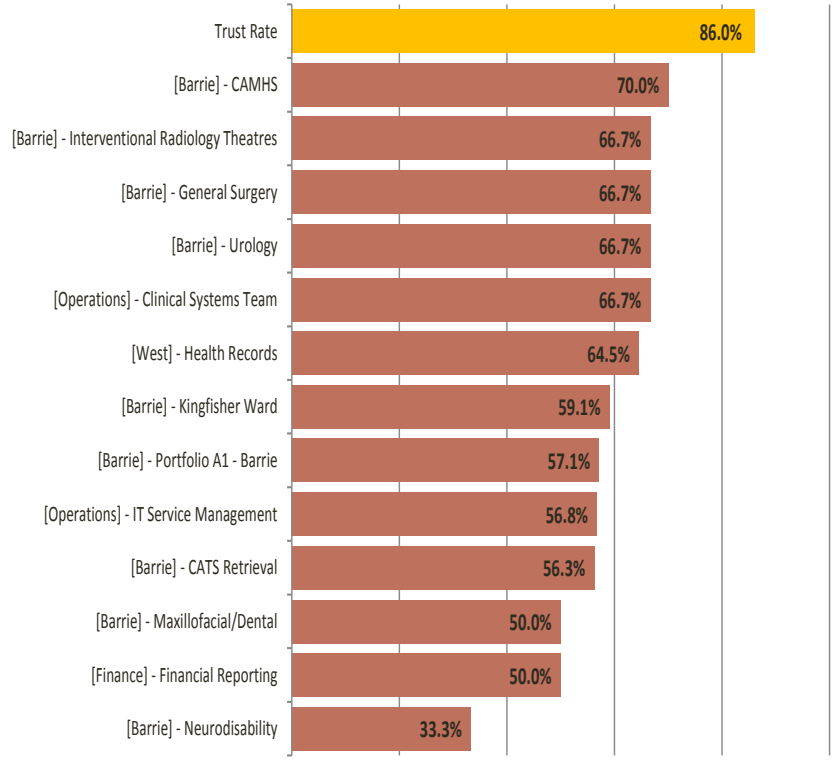


PDR: Exception report October

Divisional PDR (Target 90%)



Exception Reporting PDR (Dept outliers)



Workforce: Highlights & Actions

Sickness %

- 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 have been launched in order to support employees at work such as mental health awareness and healthy activities.
- IPP - HRBP presented sickness absence data and in-depth analysis at IPP Performance Board and working alongside IPP Management 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 absence
- HRBP working with management teams in DPS to ensure sickness absence is being logged using the correct system so reporting can be accurate.

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.
- 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
- HRBP for IPP completing a deep dive into turnover and presenting data and information at Performance Review
- HRBP for R&I completing a deep dive into turnover and sharing with Deputy Director of R&I to discuss further
- Nursing posts within R&I have been made permanent from fixed term to help towards retention of the nursing team and turnover

Well-Led

Great Ormond Street Hospital for Children NHS Foundation Trust

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 improve PDR performance - now sending out PDRs plans for 17/18 for services in 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

- Improved visibility through LMS - staff encouraged to check their own records on GOLD
- 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.
- HR BP and HR Advisor for DPS working with the DPS Performance Management team to create some more effective ways of StatMan training (outside of online learning) to help support staff who do not regularly use computers and are not in desk based roles.

Effective

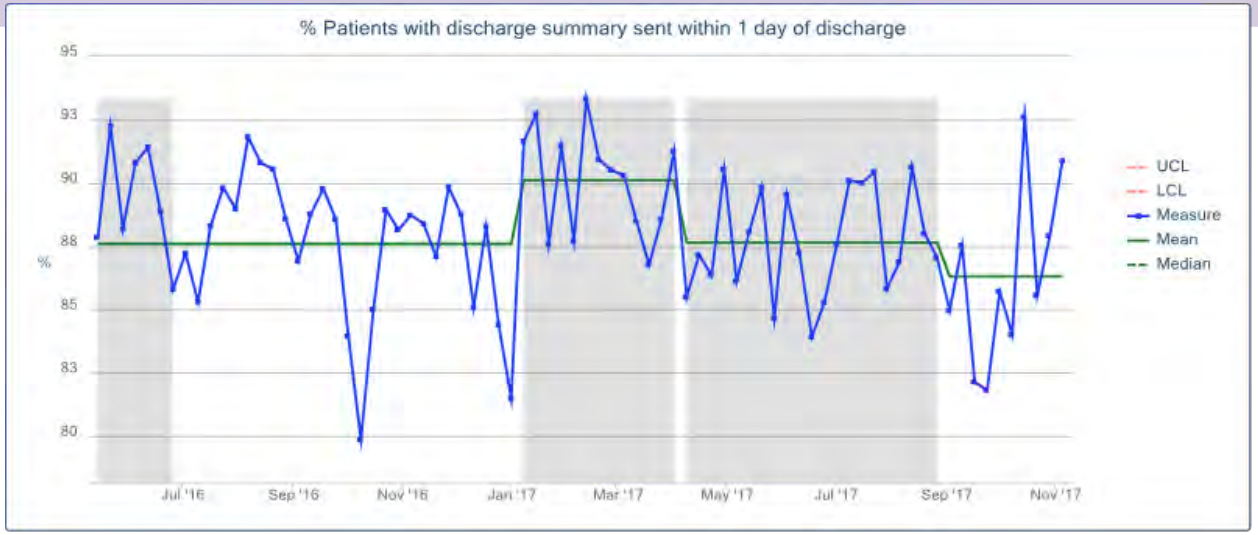
Great Ormond Street Hospital for Children NHS Foundation Trust

Discharge Summaries

As is evident from the SPC chart and the dashboard, performance in this area continues to fluctuate. For October 2017, the position was 86.89% sent within 24hrs of discharge, which is a slight improvement from September's performance. As per definitions of this metrics, the expectation for the Trust is to to send all discharge summaries within 24 hours.

The Clinical Divisions continue to keep this as an areas of focus, and reported into their monthly performance meetings.

Some of the on going actions in place in divisions include daily reminders to HoCS/SM/fellows to complete the DS within 24h, weekly reports generated by RTT validators, sent to the Service and Ward Clerks, ensure Discharges flagged as exclude are clinically validated, documented and signed off and presentation for the Junior Doctors local induction on discharge summaries. Long term plans include introducing an automated system to send discharge summaries to GPs in real time.



Clinic Letter Turnaround times

For September (as this indicator is reported a month in arrears), there has been a deterioration in performance in relation to 14 day turnaround, 70.20% from 76.84% in August. For those sent within 7 working days, performance has deteriorated too, 39.17% from 47.68% in August. As with the above, specific specialties are being targeted by the service management teams to ensure turnaround is improved. Some of the actions in place in divisions include weekly reminders for clinical teams to sign of letters, providing remote access to clinicians so they can sign off letters electronically, create and administer a robust monitoring system for administrators to be used on a weekly basis to check the upload and downloading of letters.

Productivity

Great Ormond Street Hospital for Children NHS Foundation Trust

Theatres

Reporting in this area has now migrated and is based on the newly implemented Trust Theatres Dashboard. The reported positions have changed marginally, however remains largely in line. The dashboard, now provides theatres and operational teams with much more accessible and detailed information on their usage of Trust theatres.

As at October, utilisation of Main Theatres has dropped to 65.1%. 13 sessions were cancelled in October (compared to 9 in Sept) and 359 cases (non clinical and clinical) cancelled, compared to 290 in Sept. 5.9% of lists had a late start and 13.4% had an early finish (compared to 5.4% and 11.8% in Sept respectively). As part of the Better Value work streams this provides increased transparency on theatre productivity in future months, and what is presented here may be updated / improved.

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 October 2017 occupancy has increased slightly on previous levels to 90.6%. 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 has reduced in comparison to the previous month (16.5 in comparison to 20.9 in September).

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 and critical care bed days are lower than the same reporting period for last year (i.e. up to M7). Inpatient and outpatient attendances are above previous year's activity.

Included for this month is the populated indicator looking at long stay patients. This looks at any patient discharged that month with a length of stay (LOS) greater than 100 days, and the combined number of days in the hospital. For October, the Trust had three patients discharged that had amassed a combined LOS of 737 days. In future reports, further information will be given to provide context behind the stay etc.

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 October 2017 (Month 7). In line with the figures presented, the Trust has a YTD surplus of £2.6m which is £0.2m behind plan. The Trust is currently £0.1m ahead of the control total.

- Clinical Income (exc. International Private Patients and Pass through Income) is £3.0m higher than plan
- Non Clinical revenue is £0.6m lower than plan
- Private Patients income is £2.9m lower than plan
- Staff costs are £1.0m lower than plan
- Non-pay costs (excluding pass-through costs) are £2.3m 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 - October 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

Caring

	Aug	Sep	Oct	Trend	Plan	NHS Standard
Access to Healthcare for people with Learning Disability				⇨		
% Positive Response Friends & Family Test: Inpatients	97.11%	97.56%	96.65%	⇩		95%
Response Rate Friends & Family Test: Inpatients	23.37%	22.62%	20.96%	⇩	40%	
% Positive Response Friends & Family Test: Outpatients	90.77%	90.65%	93.39%	⇧		95%
Mental Health Identifiers: Data Completeness	98.89%	98.82%	98.95%	⇧		97%

Safe

		Aug	Sep	Oct	Trend	Plan	NHS Standard
Serious Patient Safety Incidents	In-month	0	1	1	⇨		
	YTD	7	9	10			
Never Events	In-month	0	0	1	⇩		0
	YTD	1	1	2	⇩		0
Incidents of C. Difficile	In-month	3	2	2	⇨		
	YTD	7	9	11	-		
C.Difficile due to Lapses of Care	In-month	0	0	0	⇨		
	YTD	0	0	0	⇨		15
Incidents of MRSA	In-month	0	0	0	⇨		0
	YTD	0	0	0	⇨		0
CV Line Infection Rate (per 1,000 line days)		1.42	1.16	1.28	⇩	1.6	
WHO Checklist Completion		98.77%	98.53%	99.36%	⇧	98%	
Arrests Outside of ICU	Cardiac Arrests	2	3	3	⇨	5	
	Respiratory Arrests	9	4	3	⇧		
Total hospital acquired pressure / device related ulcer rates grade 3 & above		1	0	0	⇨	0	

Responsive

		Aug	Sep	Oct	Trend	Plan	NHS Standard
Diagnostics: Patients Waiting <6 Weeks		97.49%	98.09%	98.69%	⇧		99%
Cancer 31 Day: Referral to First Treatment		100%	100%		⇨		85%
Cancer 31 Day: Decision to Treat to First Treatment		100%	100%	TBC	⇨		96%
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Surgery		100%	100%	TBC	⇨		94%
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Drugs		100%	100%	TBC	⇨		98%
Cancer 62 day: Consultant Upgrade of Urgency of a referral to first treatment		100%	93%		⇩		
Last Minute Non-Clinical Hospital Cancelled Operations		42	37		⇧		
Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard		1	3		⇩		0
Same day / day before hospital cancelled outpatient appointments		1.03%	1.10%	1.14%	⇩		
RTT: Incomplete Pathways (National Reporting)		90.07%	89.67%	90.59%	⇧		92%
RTT: Number of Incomplete Pathways (National Reporting)	<18wks	5654	5503	5717	⇧		-
	>18wks	623	634	594	⇧		-
RTT: Incomplete Pathways >52 Weeks - Validated		4	2	1	⇧		0
Number of unknown RTT clock starts	Internal Referrals	0	0	1	⇩		-
	External Referrals	1396	1001	707	⇧		-
RTT: Total Number of Incomplete Pathways Known/Unknown	<18 weeks	7011	6484	6398	⇩		-
	>18 weeks	662	654	621	⇧		-

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

⇧ Improvement — On / above target

People, Management & Culture: Well-Led

		Aug	Sep	Oct	Trend	Plan	NHS Standard
Sickness Rate		2.25%	2.30%	2.20%	⇧	3%	
Turnover	Total	18.4%	18.6%	18.4%	⇧	18%	
	Voluntary	15.4%	15.1%	14.7%	⇧	14%	
Appraisal Rate		85%	83%	86%	⇧	90%	
	Consultant	78%	77%	77%	⇨		
Mandatory Training		91%	90%	90%	⇧	90%	
% Staff Recommending the Trust as a Place to Work: Friends & Family Test						61%	
Vacancy Rate	Contractual	9.0%	6.0%	3.6%	⇧	10%	
	Nursing	N/A	3.4%	-1.3%	⇧		
Bank Spend		5.7%	5.8%	6.1%	⇩		
Agency Spend		2.22%	2.18%	2.13%	⇧	2%	

Effective

		Aug	Sep	Oct	Trend	Plan	NHS Standard
Discharge Summary Turnaround within 24hrs		87.54%	84.15%	86.86%	⇧		100%
Clinic Letter Turnaround within	7 working days	47.68%	39.15%				
	14 working days	76.84%	70.20%		⇩	100%	
Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)		7.75%	7.50%	7.77%	⇩	8.36%	

Productivity

			Aug	Sep	Oct	Trend	Plan	NHS Standard
Main Theatres	Theatre Utilisation		66.5%	66.1%	65.1%	⇩		77%
	No. of theatres		16	16	16			
Outside Theatres	Theatre Utilisation		55.4%	56.1%	53.5%	⇩		77%
	No. of theatres		11	11	11			
Trust Beds	Bed Occupancy		87.7%	86.6%	90.6%	⇧		
	Number of available beds		391	396	400	⇩		
Average number of trust beds closed		Wards	15.6	20.9	16.5	⇧		
		ICU	0.4	0.1	0.1	⇨		
Refused Admissions	Cardiac refusals		1	2	2	⇨		
	PICU / NICU refusals		7	9	18	⇩		

Activity

			Aug	Sep	Oct	Trend	Plan	NHS Standard
Daycase Discharges (YOY comparison)		In-month	2,206	2,018	2,135	⇧	1,972	
		YTD	10,296	12,314	14,449		14,578	
Overnight Discharges (YOY comparison)		In-month	1,710	1,588	1,621	⇧	1,484	
		YTD	8,239	9,827	11,448		11,090	
Critical Care Beddays (YOY comparison)		In-month	1,088	1,018	1,164	⇧	1,123	
		YTD	5,312	6,330	7,494		7,981	
Bed Days >=100 Days	No. of patients		4	1	3	⇩		
	No. of beddays		756	168	737	⇩		
Outpatient Attendances (All) (YOY comparison)		In-month	20,805	21,310	21,071	⇩	21,050	
		YTD	105,297	126,607	147,678		144,559	

Our Money

	Aug	Sep	Oct	Trend	YTD Target	YTD Variance
Net Surplus/(Deficit) v Plan	(0.1)	0.4	1.9	⇧	2.8	(0.8)
Forecast Outturn v Plan	0.2	0.2	0.6	⇩	0.2	0.0
Better value	1.5	1.4	1.3	⇩	8.7	0.0
Pay Worked WTE Variance to Plan	300.0	319.1		⇧		
Debtor Days (IPP)	194.0	199.0	212.0	⇩	120.0	(92.0)
Quick Ratio (Liquidity)	1.80	1.80	1.80	⇨	1.60	0.2
NHS KPI Metrics	1.0	1.0	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

KITE MARKING SUMMARY SEPTEMBER 2017

Domain	Lead	Total Count	Sufficient Assured		Insufficient Assured		Yet to be Assured		Action Plans Reqd	Action Plans Outstanding		Action Plans Over Due	
			Count	%	Count	%	Count	%		Count	%	Count	%
Caring	Juliette Greenwood, David Hicks	49	35	71.4%	0	0.0%	14	28.6%	0				
Safe	Juliette Greenwood, David Hicks	70	61	87.1%	2	2.9%	7	10.0%	2	2	100%	2	100%
Responsive	Nicola Grinstead	98	78	79.6%	20	20.4%	0	0.0%	14	3	21%	4	29%
People, Management & Culture: Well-Led	Ali Mohammed	63	45	71.4%	18	28.6%	0	0.0%	5	0	0%	0	0%
Effective	Nicola Grinstead	28	15	53.6%	13	46.4%	0	0.0%	4	0	0%	4	100%
Productivity	Nicola Grinstead	98	74	75.5%	24	24.5%	0	0.0%	14	4	29%	10	71%
Our Money	Loretta Seamer	49	48	98.0%	1	2.0%	0	0.0%	1	0	0%	1	100%
Grand Total		455	356	78.2%	78	17.1%	21	4.6%	40	9	23%	21	53%

Domain	Metric	Accuracy	Validity	Reliability	Timeliness	Relevance	Audit	Executive Judgement	Action Plan Reqd	Action Plan in Place	Action Plan Due Date
Caring	Access to Healthcare for people with Learning Disability	3	3	3	3	3	3	3	NK	NK	
Caring	% Positive Response Friends & Family Test: Inpatients	1	1	1	1	1	1	1	N	N/A	N/A
Caring	Response Rate Friends & Family Test: Inpatients	1	1	1	1	1	1	1	N	N/A	N/A
Caring	% Positive Response Friends & Family Test: Outpatients	1	1	1	1	1	1	1	N	N/A	N/A
Caring	Number of Complaints	1	1	1	1	1	1	1	N	N/A	N/A
Caring	Number of Complaints -Red Grade	1	1	1	1	1	1	1	N	N/A	N/A
Caring	Mental Health Identifiers: Data Completeness	3	3	3	3	3	3	3	NK	NK	
Safe	Total hospital acquired pressure / device related ulcer rates grade II & above	1	1	1	1	1	1	1	N	N/A	N/A
Safe	Reported cases of MRSA bacteremia to the Public Health England mandatory reporting system	1	1	1	1	1	1	1	N	N/A	N/A
Safe	Reported cases of Clostridium difficile associated disease to the Public Health England mandatory re	1	1	2	1	1	1	1	Y	N	
Safe	Serious Patient Safety Incidents	1	1	1	1	1	1	1	N	N/A	N/A
Safe	Never Events	1	1	1	1	1	1	1	N	N/A	N/A
Safe	C.Difficile due to Lapses of Care	1	1	2	1	1	1	1	Y	N	
Safe	CV Line Infection Rate (per 1,000 line days)	1	1	1	1	1	1	1	N	N/A	N/A
Safe	WHO Checklist Completion	3	3	3	3	3	3	3	NK	NK	
Safe	Cardiac Arrests Outside of ICU	1	1	1	1	1	1	1	N	N/A	N/A
Safe	Respiratory Arrests Outside of ICU	1	1	1	1	1	1	1	N	N/A	N/A
Responsive	RTT: Incomplete Pathways >52 Weeks (Validated)	2	1	1	1	1	1	1	Y	Y	On-going through DQ Dashboard
Responsive	RTT: Incomplete Pathways >52 Weeks (Unvalidated)	2	1	1	1	1	1	1	Y	Y	On-going through DQ Dashboard
Responsive	RTT: Incomplete Pathways	2	1	1	1	1	1	1	Y	Y	On-going through DQ Dashboard
Responsive	RTT: Number of Incomplete Pathways (Over 18 Weeks)	2	1	1	1	1	1	1	Y	Y	On-going through DQ Dashboard
Responsive	RTT: Number of Incomplete Pathways (Under 18 Weeks)	2	1	1	1	1	1	1	Y	Y	On-going through DQ Dashboard
Responsive	Number of unknown RTT clock starts (Internal Referrals)	2	1	1	1	1	1	1	Y	Y	On-going audits
Responsive	Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard	2	1	1	1	1	2	2	Y	N	
Responsive	Number of unknown RTT clock starts (External Referrals)	2	1	1	1	1	1	1	Y	Y	On-going audits
Responsive	Same day / day before hospital cancelled appointments	2	1	1	1	1	2	2	Y	Y	Audits not yet started
Responsive	Diagnostics: Patients Waiting >6 Weeks	2	1	1	1	1	1	1	Y	N	
Responsive	Cancer 31 Day: Decision to Treat to First Treatment	2	1	1	1	1	1	1	Y	Y	Audits not yet started
Responsive	Cancer 31 Day: Decision to Treat to Subsequent Treatment - Surgery	2	1	1	1	1	1	1	Y	Y	Audits not yet started
Responsive	Cancer 31 Day: Decision to Treat to Subsequent Treatment - Drugs	2	1	1	1	1	1	1	Y	Y	Audits not yet started
Responsive	Last Minute Non-Clinical Hospital Cancelled Operations	2	1	1	1	1	2	2	Y	N	
People, Management & Culture: Well-Led	Sickness Rate	2	2	1	1	1	2	1	Y	Y	01-Jul-18
People, Management & Culture: Well-Led	Turnover - Total	1	1	1	1	1	2	1	NK	NK	
People, Management & Culture: Well-Led	Turnover - Voluntary	1	1	1	1	1	2	1	NK	NK	
People, Management & Culture: Well-Led	Appraisal Rate	2	1	1	2	1	2	1	Y	Y	01-Jul-18
People, Management & Culture: Well-Led	Mandatory Training	1	1	1	1	1	2	1	Y	Y	
People, Management & Culture: Well-Led	% Staff Recommending the Trust as a Place to Work: Friends & Family Test	1	1	1	1	1	2	1	NK	NK	
People, Management & Culture: Well-Led	Vacancy Rate	2	1	1	1	1	2	1	Y	Y	31-Mar-18
People, Management & Culture: Well-Led	Bank Spend	2	1	1	2	1	2	1	Y	Y	01-Jul-18
People, Management & Culture: Well-Led	Agency Spend	2	1	1	2	1	2	1	Y	Y	01-Jul-18
Effective	Discharge Summary Turnaround within 24hrs	1	1	1	1	1	2	2	Y	Y	31-Jul-17
Effective	Clinic Letter Turnaround within # - 7 working days	2	2	2	1	2	1	2	Y	Y	31-Jul-17
Effective	Clinic Letter Turnaround within # - 14 working days	2	2	2	1	2	1	2	Y	Y	31-Jul-17
Effective	Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)	1	1	1	1	1	2	1	Y	Y	31-Jul-17
Productivity	Excess Beddays >=100 days - number of patients	1	1	1	1	1	2	1	Y	N	
Productivity	Excess Beddays >=100 days - number of beddays	1	1	1	1	1	2	1	Y	N	
Productivity	Critical Care Beddays	1	1	1	1	1	2	1	Y	Y	31-Aug-17
Productivity	Outpatient Attendances (All)	1	1	1	1	1	2	1	Y	Y	31-Jul-17
Productivity	Overnight Discharges	1	1	1	1	1	2	1	Y	Y	31-Jul-17
Productivity	Theatre Utilisation (NHS UO4) - Main theatres	2	1	2	1	1	1	1	Y	Y	31-Jul-17
Productivity	Average numbers of beds closed - Wards	1	1	2	1	1	2	2	Y	Y	31-Aug-17
Productivity	Daycase Discharges	1	1	1	1	1	2	1	Y	Y	31-Jul-17
Productivity	Average numbers of beds closed - ICU	1	1	2	1	1	2	2	Y	Y	31-Aug-17
Productivity	Theatre Utilisation (NHS UO4)	2	1	2	1	1	1	1	Y	Y	31-Jul-17
Productivity	Bed Occupancy	2	2	1	1	2	2	2	Y	Y	31-Jul-17
Productivity	Number of Beds	2	1	1	1	1	1	1	Y	Y	31-Aug-17
Productivity	Cardiac Refusals	1	1	2	1	1	1	1	Y	N	
Productivity	PICU/NICU Refusals	1	1	2	1	1	1	1	Y	N	
Our Money	Net Surplus/(Deficit) v Plan	1	1	1	1	1	1	1	N	N/A	N/A
Our Money	Forecast Outturn v Plan	1	1	1	1	1	1	1	N	N/A	N/A
Our Money	P&E Delivery	1	1	1	1	1	1	1	N	N/A	N/A
Our Money	Pay Worked WTE Variance to Plan	2	1	1	1	1	1	1	Y	Y	01-Apr-17
Our Money	Debtor Days (IPP)	1	1	1	1	1	1	1	N	N/A	N/A
Our Money	Quick Ratio (Liquidity)	1	1	1	1	1	1	1	N	N/A	N/A
Our Money	NHS KPI Metrics	1	1	1	1	1	1	1	N	N/A	N/A

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
28th November 2017

2017/18 Finance Update – Month 7 **Submitted by:** **Loretta Seamer, Chief Finance Officer**	**Paper No: Attachment 10** **Enc: Finance report**

Purpose
The purpose of this paper is to report the Trust Financial Position as at the end of October 2017 (Month 7).

Financial Position – Summary points
In October 2017 there was a Net Surplus (before capital donations and impairments) of £1.9 million which is £0.2 million better than plan. Year to date the Trust has a net surplus of £2.6 million which is £0.2 million worse than plan.

At the end of Month 7 NHS Income is 1.9% or £3.0 million ahead of plan which is due in part to a more complex case mix and the new tariff higher than planned; offset by lower pass-through income, IPP and non-clinical income. Overall Income is £2.1 million behind plan.

Pay expenditure is favourable to plan by £1.0 million due to vacancies not offset by bank and agency spend however, in Month 7, pay has fallen behind plan due to retrospective costs associated with the nursing recruitment drive that related in part to month 6. Non-pay expenditure is over plan by £0.7 million due to the IPP Debt provision, unachieved CIP and activity related pressures in certain areas.

Year to date income for capital donations has slipped further behind and is now £21.3 million less than plan due to lower capital expenditure on donated assets associated with the redevelopment project, medical equipment programme and ICT. Depreciation, Interest and PDC is lower than plan due in part to the capital delays above and this is supporting the Trust's overall bottom line.

The better value programme remains under delivered at Month 7 due principally to slippage across a number of cross cutting schemes though is offset by the favourable variances set out above.

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

Financial Forecast – Summary points
In October 2017, the forecast position reported internally is that there will be a net surplus of £0.6m before capital donations; this represents a delivery of £0.5m favourable against the control total. This assumes full expenditure of the provision set aside for PICB in year.

The makeup of the forecast variance at a divisional level is as follows:

Division	Forecast	Notes
Charles West	£3.6m	Over delivery of income driven by cardiac both within NHS activity and IPP. Pay is forecast to be in line with plan; non pay will be underspent at year end, predominantly due to under spending on pass through drugs. The forecast has

		improved from month 6 by £0.8m due to continued over delivery of income in IPP and NHS cardiac.
JM Barrie	(£8.5m)	The forecast has improved from month 6 by £0.5m due to anticipated improvements in the recovery of some of the income within Neuro, Spinal and IPP and wider non-pay schemes. The main challenges driving the adverse position include under delivery of income, predominantly within PICU / NICU and similar issues within IPP which are being analysed in depth as part of the wider recovery programme.
IPP	(£2.7m)	The IPP position has improved by £1.1m from the previous forecast due principally to additional income delivery and anticipated recovery over the remainder of the year. Income is in line with prior years but is down overall against plan due to reduced demand in the first half of the year.
R&I	(£0.1m)	This represents a movement of £0.3m from the prior forecast and is mainly activity related in relation to additional income for trials.
Corporate and Central	£8m	The forecast position has been revised down from Month 6 due to the addressing of overspends within DPS on existing contracts for cleaning and energy, this is offset by centrally held income provisions.

Income

At the end of Month 7, year to date income is £2.1m lower than plan. NHS income was on plan at Month 7 but £3.0m above plan year to date which is being driven by favourable case mix income and the improved tariff. At Month 7, areas below the income plan were predominantly within PICU/NICU and Gastro.

International Private Patients is behind plan in Month 7 by £0.1m which represents a significant improvement from prior year and underpins the improved forecast position. Year to date, remains behind plan by £3.0m. There have been positive variances seen within cardiac including within Cardiac Critical Care though general demand is down against plan driven by reduced activity in key specialties, including PICU / NICU. Also included in the plan is the stretch target for commercial income under the Better Value scheme.

Other non-clinical income (excluding pass through) is £0.3m ahead plan for the month and £0.6m behind plan year to date. It is anticipated that the position will recover by year end.

Expenditure

Pay costs for the month were worse than plan by £0.3 million but remain favourable YTD compared to plan by £1.0 million. This is predominantly due to the high level of vacancies across the Trust which are not offset fully by equivalent bank and agency costs. In month, the position included some retrospective costs of the nursing recruitment intake which began in September but did not hit the positon until Month 7 due to the late starts within the month. Agency costs total £3.0m and remain under the cap YTD.

Non-pay expenditure excluding pass through is £2.3m adverse to plan YTD; overall there was an improvement in non-pay in month 7 due to an improvement within JM Barrie following the

identification of additional stock in hand within spinal which had a £0.5m benefit to the YTD position.

Other Financial Indicators Month 7

Indicator	Comment
NHSI Financial Rating	All KPI ratings are Green.
Cash	The closing cash balance was £44.4m, £4.2m less than plan.

Variance/movement	Cash variance against YTD plan £m
EBITDA (excl donations and Impairments)	(1.8)
Trade and other Receivables – higher than plan	(8.1)
Trade and Other Payables - lower than plan	(1.8)
Capital expenditure (net of capital donations) – lower than plan	7.5
Decrease to cash position	(4.2)

NHS Debtor Days	Debtor days increased from the previous month to 8 days but remains within plan.
IPP Debtor Days	IPP debtor days increased in month to 199 days from 212 days.
Creditor Days	Creditor days decreased in month to 31 days.
Inventory Days	Drug inventory days increased in month to 7. Non-Drug inventory days increased in month to 65 days from 54 days mainly as a result of the identification of spinal metal stock not included in previous stock takes.

Risks

Risk/Assumption	Comment
£15m delivery of P&E savings	The full Better Value programme has not identified schemes for the full target. A number of schemes centrally held by the SRO's responsible for delivery have been allocated to the relevant Division, but there remains an overall balance of schemes to be identified and it is becoming less likely that these will deliver by year end.
Achievement of CQUIN Income	The negotiation of CQUIN schemes is not yet complete for 2017/18 with the commissioner; 85% delivery is assumed but there remains risk around delivering all aspects of the current plans. There is 1 scheme that GOSH has withdrawn from valued at £1.m. The CUR scheme is a national scheme and the commissioners are indicating that this cannot be replaced with a local scheme. The AMR/Sepsis scheme valued at £378k is now included in the list of schemes and underassessment as to the level of achievement. To date £3.3m of the £4.73m has been agreed with commissioners.
IPP Income / Debt	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 maximum recovery is a key deliverable for the remainder of the year and a strategic priority for the Trust and this increased recovery is factored into the current forecasts. Overall the IPP debt remains high but to date there has not been any debt written off. The income includes a BV scheme for commercial income and several new projects have now been approved to contribute to this target.

Great Ormond Street Hospital for Children NHS Foundation Trust

Action required from the meeting • To **note** the financial position as at 31 October 2017. • To **note** the residual risks to the 2017/18 outturn. • To **note** the forecast position for 2017/18.
Contribution to the delivery of NHS / Trust strategies and plans This paper details the Trusts delivery against its agreed Financial Plan to M07 2017/18
Financial implications Not delivering the Control Total would have led to the Trust losing the S&T Fund. Other affects include the NHSI ratings of the Single Oversight Framework.
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 7

October 2017

Summary Reports

Great Ormond Street Hospital for Children NHS Foundation Trust

Finance Scorecard

Our Money	August	September	October	Trend	YTD Target	Variance
Net Surplus/(Deficit)	(0.1)	0.4	1.9	↑	2.8	(0.2)
Forecast Outturn	0.2	0.4	0.6	↑	0.2	0.4
P&E Delivery	1.5	1.4	1.3	↓	8.7	0.0
Debtor Days (IPP)	194	199	212	↑	120.0	(92.0)
Quick Ratio (Liquidity)	1.8	1.8	1.8	→	1.6	0.2
**NHSI KPI Metrics	1	1	1	→	1.0	0

NHSI Key Performance Indicators				
KPI	Annual Plan	M7 YTD Plan	M7 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 October 2017 there was a Net surplus (before capital donations and impairments) of £1.9m which was £0.2m above plan. Year to date the Trust has a Net surplus of £2.6m which is £0.2m adverse to plan.
- The Trust is reporting year to date £0.1m favourable position against the control total.
- The overall weighted NHSI rating for Month 7 is Green (Rating 1) which is on plan.
- The debtor days for IPP increased from last month by 13 days.
- Cash is £4.2m below plan, liquidity remains strong with cash in hand of £44.4m.
- The Trust is forecasting a full year surplus of £0.6m which is £0.4m favourable to the annual plan.

Trust Income and Expenditure Performance Summary
Year to Date for the 7 months ending 31 October 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

2017/18											Notes	2016/17	CY vs PY	
Annual Budget	Income & Expenditure	Month 7				Year to Date				Rating		YTD Actual	Variance	
		Budget	Actual	Variance		Budget	Actual	Variance		Current Year Variance				
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%			(£m)	(£m)	%
272.4	NHS & Other Clinical Revenue	23.89	23.85	(0.04)	(0.17%)	159.02	162.01	2.99	1.88%	G	1	149.50	12.51	8.37%
67.80	Pass Through	5.90	5.39	(0.51)	(8.64%)	39.93	38.35	(1.58)	(3.96%)			35.80	2.55	7.12%
60.67	Private Patient Revenue	5.38	5.50	0.12	2.23%	35.96	33.06	(2.90)	(8.06%)	R	2	32.40	0.66	2.04%
53.26	Non-Clinical Revenue	4.70	5.04	0.34	7.23%	30.62	30.03	(0.59)	(1.93%)	R		26.60	3.43	12.89%
454.13	**Total Operating Revenue**	**39.87**	**39.78**	**(0.09)**	**(0.23%)**	**265.53**	**263.45**	**(2.08)**	**(0.78%)**			**244.30**	**19.15**	**7.84%**
(244.42)	Permanent Staff	(20.39)	(19.22)	1.17	5.74%	(141.83)	(130.75)	11.08	7.81%			(122.80)	(7.95)	(6.47%)
(1.68)	Agency Staff^	(0.14)	(0.31)	(0.17)	(121.43%)	(0.98)	(2.97)	(1.99)	(203.06%)			(5.20)	2.23	42.88%
(2.68)	Bank Staff	(0.25)	(1.55)	(1.30)	(520.00%)	(1.72)	(9.83)	(8.11)	(471.51%)			(9.80)	(0.03)	(0.31%)
(248.78)	**Total Employee Expenses**	**(20.78)**	**(21.08)**	**(0.30)**	**(1.44%)**	**(144.53)**	**(143.55)**	**0.98**	**0.68%**	G	3	**(137.80)**	**(5.75)**	**(4.17%)**
(12.35)	Drugs and Blood	(1.03)	(1.15)	(0.12)	(11.65%)	(7.21)	(6.98)	0.23	3.19%	G		(7.60)	0.62	8.16%
(39.14)	Other Clinical Supplies	(3.26)	(2.83)	0.43	13.19%	(22.83)	(24.49)	(1.66)	(7.27%)	R		(23.40)	(1.09)	(4.66%)
(57.83)	Other Expenses	(4.69)	(5.43)	(0.74)	(15.78%)	(32.76)	(33.60)	(0.84)	(2.56%)	R		(29.30)	(4.30)	(14.68%)
(67.80)	Pass Through	(5.90)	(5.39)	0.51	8.64%	(39.93)	(38.35)	1.58	3.96%			(35.40)	(2.95)	(8.33%)
(177.12)	**Total Non-Pay Expenses**	**(14.88)**	**(14.79)**	**0.08**	**0.54%**	**(102.73)**	**(103.42)**	**(0.69)**	**(0.67%)**	R	4	**(95.70)**	**(7.72)**	**(8.07%)**
(425.90)	**Total Expenses**	**(35.66)**	**(35.87)**	**(0.22)**	**(0.62%)**	**(247.26)**	**(246.97)**	**0.29**	**0.12%**	G		**(233.50)**	**(13.47)**	**(5.77%)**
28.23	**EBITDA (exc Capital Donations)**	**4.21**	**3.91**	**(0.31)**	**(7.36%)**	**18.27**	**16.48**	**(1.79)**	**(9.80%)**	R		**10.80**	**5.68**	**52.59%**
(28.01)	Depreciation, Interest and PDC	(2.47)	(1.99)	0.48	19.43%	(15.43)	(13.85)	1.58	10.24%		6	(14.00)	0.15	1.07%
0.22	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**1.74**	**1.92**	**0.18**	**10.34%**	**2.84**	**2.63**	**(0.21)**	**(7.39%)**	R		**(3.20)**	**5.83**	**182.19%**
6.22%	**EBITDA %**	**10.56%**	**9.83%**			**6.88%**	**6.26%**					**4.42%**	**1.83%**	**41.50%**
(8.00)	Impairments	0.00	0.00	0.00	0.00%	0.00	0.00	0.00	0.00%			0.00	0.00	0%
72.11	Capital Donations	4.16	0.82	(3.34)	(80.29%)	34.35	13.03	(21.32)	(62.07%)		5	23.60	(10.57)	(44.79%)
64.33	**Net Result**	**5.90**	**2.74**	**(3.16)**	**(53.56%)**	**37.19**	**15.67**	**(21.52)**	**(57.87%)**			**20.40**	**(4.73)**	**(23.19%)**

Footnotes:

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

Summary

- The Trust is reporting a YTD £0.1m favourable position against the control total.
- In Month 7 the Trust is reporting a £1.9m net surplus which is £0.2m favourable to plan
- Year to date the Trust is reporting a £2.6m net surplus (excluding capital donations) which is £0.2m adverse to plan.

Notes

1. NHS income (excluding pass through) year to date is favourable to plan by £3.0m.
2. Private Patient income year to date is £2.9m adverse to plan.
3. Pay is favourable to plan year to date by £1.0m with agency spend of £3.0m which is below the cumulative NHSI notified agency cost ceiling of £3.8m.
4. Non pay (excluding pass through) year to date is £2.3m adverse to plan. In Month 7 the non pay (excluding pass through) is £0.4m adverse to plan.
5. Year to date income for capital donations is £21.3m less than plan.
6. Depreciation YTD is favourable to plan due to reduced capital expenditure.

Trust Income and Expenditure Performance Summary
Year to Date for the 7 months ending 31 October 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

	31 October 2017						Notes
Full Year	Income & Expenditure	Annual	Internal Forecast			Rating	
Actual 2016/17		Budget	Full-Yr	Variance to Plan		Current Year Variance	
(£m)		(£m)	(£m)	(£m)	%		
257.70	NHS & Other Clinical Revenue	272.40	282.50	10.10	3.58%	G	1
63.80	Pass Through	67.80	65.70	(2.10)	-3.20%		
55.10	Private Patient Revenue	60.67	57.90	(2.77)	-4.78%	R	2
47.00	Non-Clinical Revenue	53.26	56.90	3.64	6.40%	G	
423.60	**Total Operating Revenue**	**454.13**	**463.00**	**8.87**	**1.92%**		
(213.10)	Permanent Staff	(244.42)	(230.30)	14.12	-6.13%		
(9.30)	Agency Staff	(1.68)	(4.50)	(2.82)	62.67%		
(17.00)	Bank Staff	(2.68)	(16.70)	(14.02)	83.95%		
(239.40)	**Total Employee Expenses**	**(248.78)**	**(251.50)**	**(2.72)**	**1.08%**	R	3
(11.50)	Drugs and Blood	(12.35)	(11.70)	0.65	-5.56%	G	
(41.20)	Other Clinical Supplies	(39.14)	(42.50)	(3.36)	7.91%	R	
(49.50)	Other Expenses	(57.83)	(65.70)	(7.87)	11.98%	R	
(63.80)	Pass Through	(67.80)	(65.70)	2.10	-3.20%		
(166.00)	**Total Non-Pay Expenses**	**(177.12)**	**(185.60)**	**(8.48)**	**4.57%**	R	4
(405.40)	**Total Expenses**	**(425.90)**	**(437.10)**	**(11.20)**	**2.56%**	R	5
18.20	**EBITDA (exc Capital Donations)**	**28.23**	**25.90**	**(2.33)**	**-9.00%**	R	
(25.00)	Depreciation, Interest and PDC	(28.01)	(25.30)	2.71	-10.71%		6
(6.80)	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**0.22**	**0.60**	**0.38**	**63.33%**	G	
4.30%	**EBITDA %**	**6.22%**	**5.59%**		**0.00%**		
(13.50)	Impairments	(8.00)	(8.00)	0.00	0.00%		
32.10	Capital Donations	72.11	36.76	(35.35)	-96.15%		7
11.80	**Net Result**	**64.33**	**29.36**	**(34.97)**	**-119.09%**		

Summary

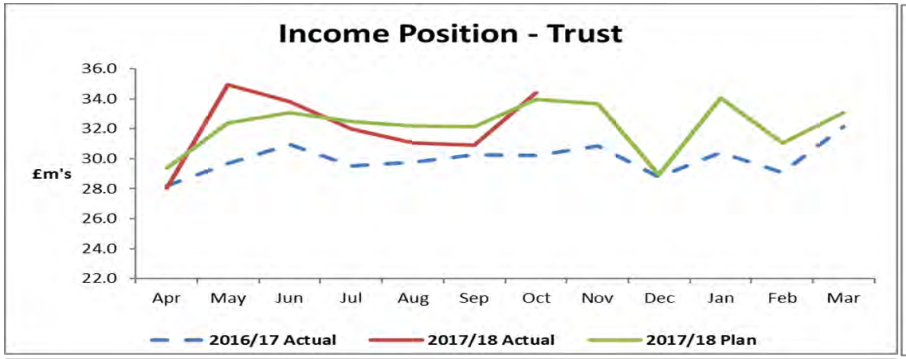
- The Trust is forecasting a full year surplus of £0.6m which is £0.4m favourable to plan.
- The Trust is forecasting a £0.5m favourable position against the control total.

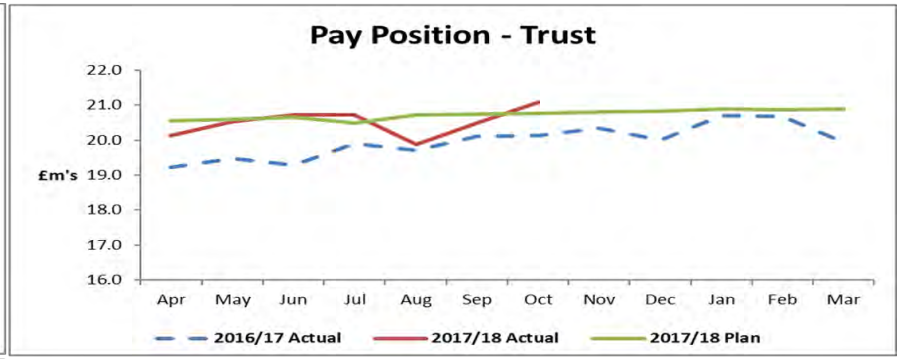
Notes

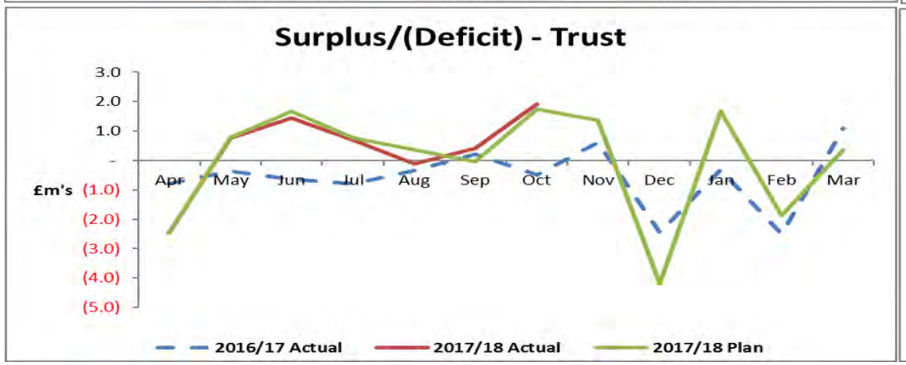
1. NHS income (excluding pass through) based on forecast outturn will be £10.1m favourable to plan. The favourable variance is due to higher tariffs associated with more complex cases that have been delivered in the first six months of the year and it is expected that additional RTT activity will be delivered in the second half of the year.
2. Private patient income based on forecast outturn will be £2.7m adverse to plan. This is due to low activity in Butterfly, temporary closure of Hedgehog ward in Month 6 and low activity in PICU YTD.
3. Pay based on forecast outturn will be £2.7m adverse to plan due to bank and agency staff being used to cover vacancies in the Trust at a premium. There is anticipated to be increased pay spend in second half of the year due to PICB opening and 207 newly qualified nurses starting in the Trust who will need additional support and training.
4. Non pay (excluding pass through) is forecast to be £10.6m adverse to plan to match the increased activity forecast.
5. The forecast includes expenditure associated with PICB of £5.9m with £2.7m of this allocated to the clinical and corporate divisions forecasts.
6. Depreciation is forecast to be £2.7m favourable to plan. This is due to slippage in the capital programme reducing the value of the asset base being depreciated.
7. Capital donations are forecast to be £35.4m adverse to plan due to slippage in the capital programme and therefore a reduction in the charitable donations funding linked to the programme is forecast.

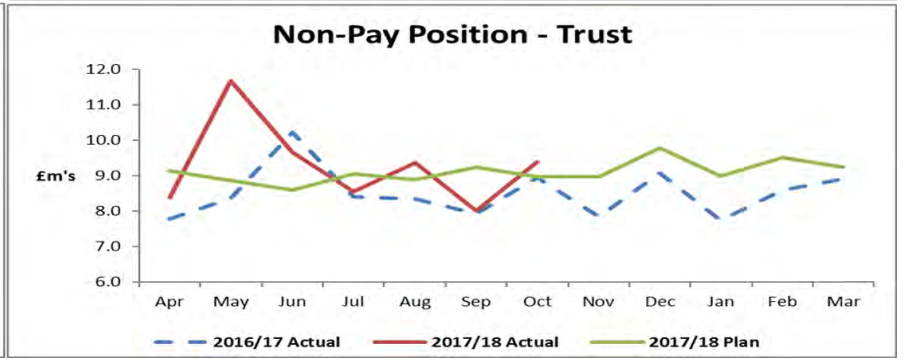
Trust Income and Expenditure Trends
Year to Date for the 7 months ending 31 October 2017

Great Ormond Street Hospital for Children NHS Foundation Trust









Income (excluding pass through)

- NHS & Other Clinical Revenue YTD is £225.1m which is £0.5m adverse to plan.
- Private Patient income YTD is £33.1m which is 2.9m adverse to plan.

Pay

- Year to date pay spend is £143.5m which is £1.0m favourable to plan

Non Pay (excluding pass through)

- Year to date non pay spend (excluding pass through) is £2.3m adverse to plan. This was mainly driven by the following:
    - Impairment of debtors £0.6m
    - Development and Property Services, including Bernard Street £0.4m (rent and rates); cleaning contract £0.4m over budget year to date, with £0.3m relating to 16/17; gas costs £0.1m adverse in month, and YTD £0.2m adverse to plan

Financial Position and Capital Expenditure
Year to Date for the 7 months ending 31 October 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

The following table summaries the net assets and liabilities.

31 Mar 2017 Audited Accounts £m	Statement of Financial Position	YTD Plan 31 Oct 2017 £m	YTD Actual 31 Oct 2017 £m	YTD Variance £m
431.50	Non-Current Assets	509.30	441.66	(67.64)
75.90	Current Assets (exc Cash)	89.99	92.51	2.52
42.50	Cash & Cash Equivalents	48.60	44.39	(4.21)
(56.30)	Current Liabilities	(80.29)	(69.59)	10.70
(5.80)	Non-Current Liabilities	(5.36)	(5.51)	(0.15)
487.80	**Total Assets Employed**	**562.24**	**503.46**	**(58.78)**

Annual Plan £m	Capital Expenditure	YTD Plan 31 Oct £m	YTD Actual 31 Oct £m	YTD Variance £m
37.76	Redevelopment - Donated	15.82	2.69	13.13
19.09	Medical Equipment - Donated	13.79	6.45	7.34
0.00	Estates - Donated	0.00	0.00	0.00
15.26	ICT - Donated	5.94	3.89	2.05
72.11	**Total Donated**	**35.55**	**13.03**	**22.52**
11.06	Redevelop& equip - Trust Funded	6.30	3.19	3.11
3.70	Estates & Facilities - Trust Funded	3.18	0.82	2.36
7.18	ICT - Trust Funded	4.57	2.87	1.70
1.00	Contingency	0.38	0.00	0.38
22.94	**Total Trust Funded**	**14.43**	**6.88**	**7.55**
95.05	**Total Expenditure**	**49.98**	**19.91**	**30.07**

Capital Expenditure Update

Redevelopment donated

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

- £1.0m Barclay House office refurb
- £1.5m chillers
- £0.6m CICU

Medical Equipment – Donated

Expenditure was less than plan due to the following:

- Phase 2B equipment procurement delayed due to construction delay £4.3m
- IMRI equipment £0.8m (to be procured later than plan) due to delay in infrastructure planning
- Other equipment £0.8m (awaiting outcome of full replacement review audit)
- £0.7m Cath lab equipment delivery awaiting building works completion

ICT – Donated

- EPR Programme £2.0m behind initial plan with commencement of team commencing later than initially planned

Estates and Facilities – Trust Funded

Expenditure less than plan due to slippage on the Decontamination washer suite project £1.6m

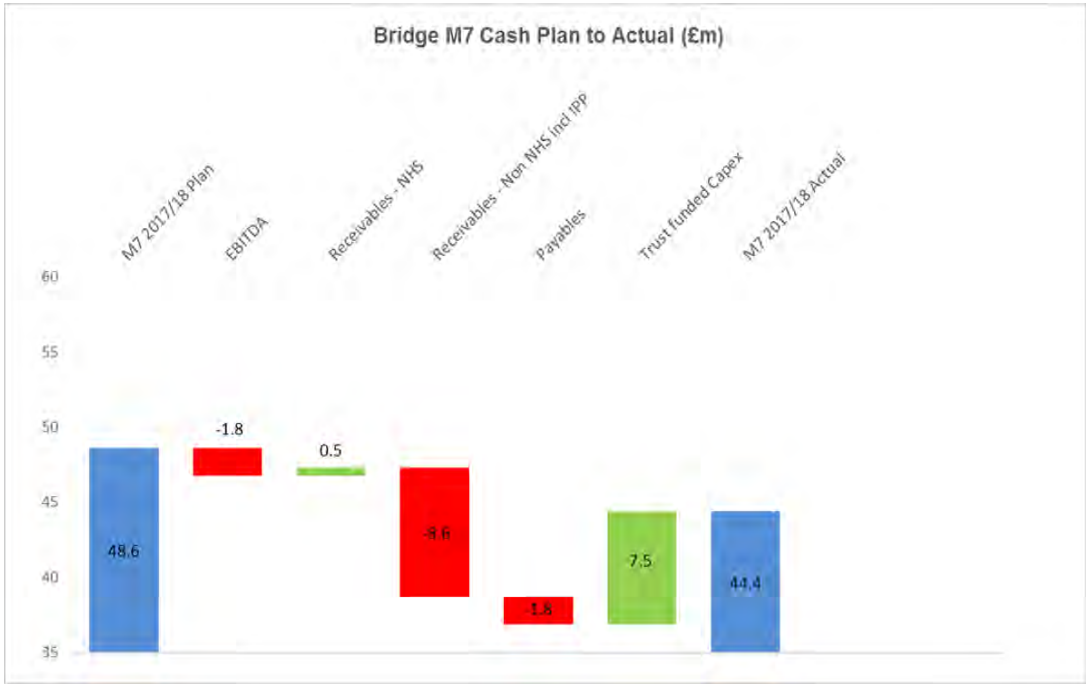
ICT – Trust Funded

Expenditure less than plan due to delay on the following projects:

- Vendor neutral archive and network hardware £1.0m
- GMC infrastructure £0.3m
- E-rostering system £0.3m (approved in November 2017)
- £0.5m Cybersecurity

Cash and Working Capital Summary
Year to Date for the 7 months ending 31 October 2017

Great Ormond Street Hospital for Children NHS Foundation Trust



Working Capital	31-Mar-17	30-Sep-17	31-Oct-17	RAG
NHS Debtor Days (YTD)	19.40	10.2	8.2	G
IPP Debtor Days	182.00	199.0	212.0	R
IPP Overdue Debt (£m)	22.50	23.5	23.5	R
Inventory Days - Drugs	4.00	8.0	7.0	G
Inventory Days - Non Drugs	63.00	54.0	65.0	R
Creditor Days	34.50	28.0	31.4	G
BPPC - Non-NHS (YTD) (number)	0.82	0.9	0.9	A
BPPC - Non-NHS (YTD) (£)	0.88	0.9	0.9	A

Cash
The closing cash balance was £44.4m, £4.2m lower than plan. This was due to a positive movement due to lower than anticipated capital expenditure (£7.5m), offset by a reduction in working capital from plan (£11.6m) and lower overall EBITDA of (£0.1m).

The working capital movement was made up by trade and other receivables (£8.1m) and trade and other payables (£3.5m) being worse than plan.

NHS Debtor Days
Debtor days decreased in month to 8 days and this remains within target.

IPP Debtor Days
IPP debtor days increased from 199 days to 212 days. Receipts in month totalled £2.9m (£2.9m lower than the previous month).

Creditor Days
Creditor days increased in month to 31 days.

Inventory Days
Drug inventory days decreased in month to 7. Non-Drug inventory days increased in month to 65 days.

Workforce Summary
For the 7 months ending 31 October 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

2016/17 Actual (£m)	2017/18 Annual Plan (£m)	£m including Perm, Bank and Agency Staff Group	2017/18 Month 7 Budget (£m)	Actual (£m)	Variance (£m)	Variance %	Year to Date Budget (£m)	Actual (£m)	Variance (£m)	Variance %
38.05	48.22	Admin (inc Director & Senior Managers)	4.02	3.44	0.58	14.53%	28.06	24.02	4.04	14.41%
46.62	47.33	Consultants	3.95	3.92	0.03	0.68%	27.54	27.82	(0.28)	-1.00%
3.59	3.92	Estates & Ancillary Staff	0.33	0.24	0.08	25.58%	2.28	2.05	0.24	10.32%
8.83	9.24	Healthcare Assist & Supp	0.77	0.69	0.08	10.18%	5.38	5.25	0.13	2.35%
24.19	25.51	Junior Doctors	2.13	2.16	(0.03)	-1.34%	14.85	14.45	0.39	2.64%
69.54	73.14	Nursing Staff	6.10	6.60	(0.49)	-8.10%	42.56	42.51	0.05	0.12%
0.28	0.36	Other Staff	0.03	0.02	0.01	20.65%	0.21	0.17	0.04	17.38%
39.52	43.26	Scientific Therap Tech	3.61	3.63	(0.03)	-0.71%	25.17	23.84	1.34	5.30%
230.60	**250.98**	**Total substantive and bank staff costs**	**20.94**	**20.70**	**0.23**	**1.11%**	**146.05**	**140.11**	**5.95**	**4.07%**
9.32	1.68	Agency	0.14	0.31	(0.17)	-123.58%	0.98	2.97	(1.99)	-203.04%
239.92	**252.67**	**Total substantive, bank and agency cost**	**21.08**	**21.02**	**0.06**	**0.28%**	**147.03**	**143.07**	**3.96**	**-198.97%**
0.00	(6.19)	Better Value Scheme	(0.52)	0.00	(0.52)	100.00%	(3.61)	0.00	(3.61)	100.00%
(0.48)	(0.09)	Reserve	(0.09)	0.06	(0.15)	169.35%	0.20	0.46	(0.26)	-128.57%
0.00	2.40	PICB reserves	0.30	0.00	0.30	100.00%	0.90	0.00	0.90	100.00%
239.44	**248.79**	**Total pay cost**	**20.78**	**21.08**	**(0.30)**	**-1.48%**	**144.53**	**143.55**	**0.98**	**0.69%**

2016/17 Average WTE	2017/18 Annual Plan Average WTE	WTE Including Perm, Bank and Agency Staff Group	2017/18 Month 7 Budget WTE	Actual WTE	Variance WTE	Variance %	Year to Date (average WTE) Budget WTE	Actual WTE	Variance WTE	Variance %
948.53	1,080.04	Admin (inc Director & Senior Managers)	1,081.68	989.88	91.80	8.49%	1,078.87	989.24	89.63	8.31%
305.38	346.39	Consultants	346.15	316.46	29.69	8.58%	346.56	312.38	34.18	9.86%
117.95	132.36	Estates & Ancillary Staff	132.56	99.10	33.46	25.24%	132.22	110.70	21.52	16.28%
295.84	314.70	Healthcare Assist & Supp	316.54	293.46	23.08	7.29%	313.38	300.23	13.15	4.20%
311.29	333.18	Junior Doctors	333.18	319.61	13.57	4.07%	333.18	318.99	14.19	4.26%
1,405.15	1,542.61	Nursing Staff	1,543.87	1,647.81	(103.94)	-6.73%	1,541.71	1,467.08	74.63	4.84%
5.46	7.60	Other Staff	7.60	5.12	2.48	32.63%	7.60	5.24	2.36	31.07%
736.59	826.96	Scientific Therap Tech	827.01	754.90	72.11	8.72%	826.92	743.41	83.52	10.10%
4,126.19	**4,583.84**	**Total substantive and bank staff**	**4,588.59**	**4,426.34**	**162.25**	**3.54%**	**4,580.44**	**4,247.26**	**333.18**	**10.10%**
105.20	33.90	Agency	33.90	74.12	(40.22)	-118.64%	33.90	94.51	(60.61)	-178.78%
4,231.40	**4,617.74**	**Total substantive, bank and agency**	**4,622.49**	**4,500.46**	**122.03**	**2.64%**	**4,614.34**	**4,341.77**	**272.57**	**-168.68%**
0.00	(116.08)	Better Value Scheme	(112.63)	0.00	(112.63)	100.00%	(118.43)	0.00	(118.43)	100.00%
0.00	0.00	Reserve	0.00	0.00	0.00	0.00%	0.00	0.00	0.00	0.00%
0.00	0.00	PICB reserves	0.00	0.00	0.00	0.00%	0.00	0.00	0.00	0.00%
4,231.40	**4,501.66**	**Total Staff**	**4,509.86**	**4,500.46**	**9.40**	**0.21%**	**4,495.91**	**4,341.77**	**154.15**	**3.43%**

Summary

In Month 7 pay spend is £21.1m which is £0.3m adverse to plan.

Year to date, pay spend for substantive and bank staff is £6.0m favourable to plan due to numerous vacancies across the Trust 334 WTE YTD average.

Year to date, the Trust has spent £3.0m on agency staff. This is below the cumulative NHSI notified agency cost ceiling of £3.8m.

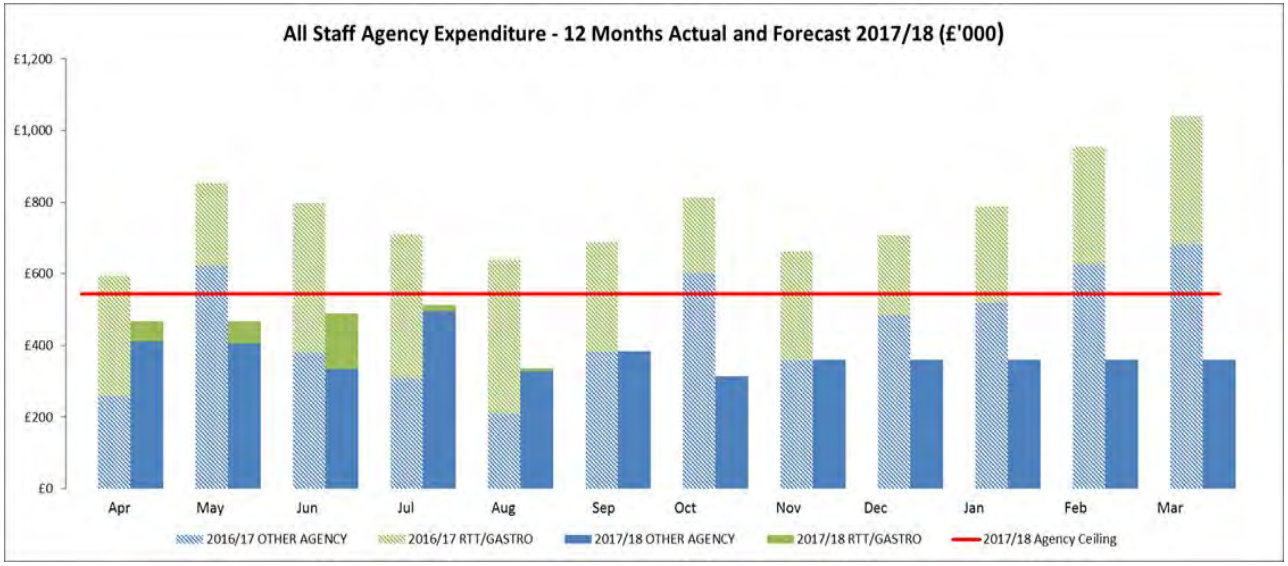
The 2017/18 Annual Plan for PICB is £2.4m and is currently sitting in reserves pending final PICB budget approval to be completed in November 2017. Therefore the WTE budgeted for PICB has not been adjusted at this stage.

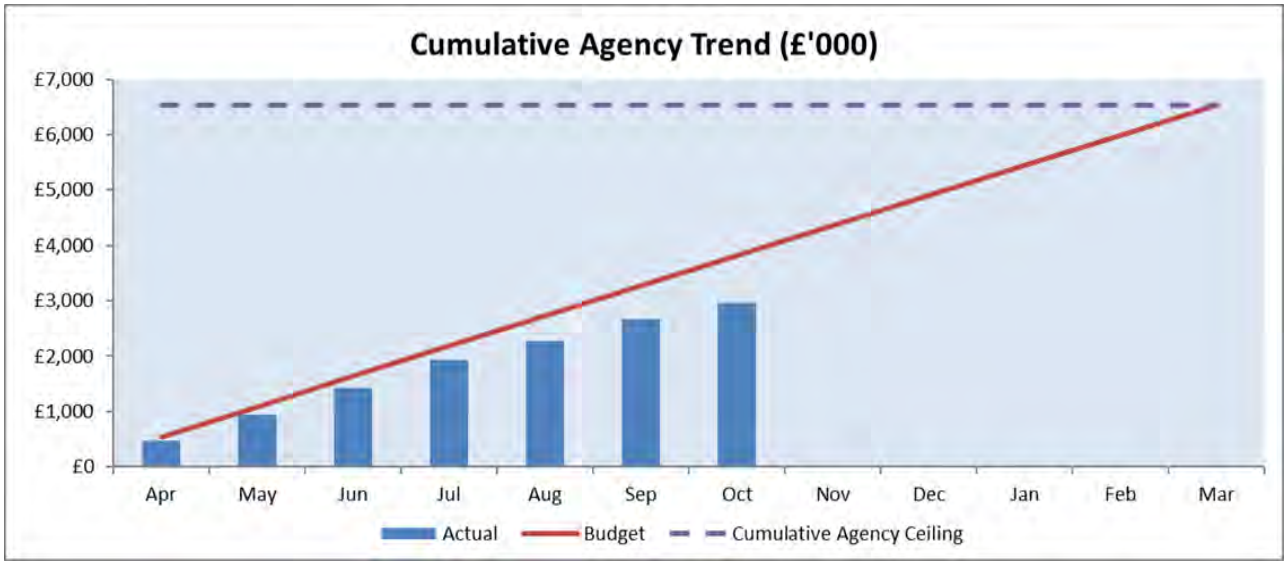
The pay portion of the Better Value Scheme annual plan of £6.7m is made up of the following:

Cross Cutting Scheme	
Theatres	£1.0m
Bed Flow	£1.0m
Outpatients	£0.2m
Workforce	£1.5m
Coding	£0.5m
ICT Enabled	£0.3m
Agencies & VAT	£0.6m
Local Schemes/Vacancy Factor	
JM Barrie	£1.0m
Charles West	£0.6m
Total	**£6.7m**

Agency Expenditure Summary
Year to Date for the 7 months ending 31 October 2017

Great Ormond Street Hospital for Children NHS Foundation Trust





- At Month 7 year to date the Trust is currently below its NHSI cost ceiling for agency staff and it is forecasted that the Trust will not exceed this ceiling for this financial year.

Trust NHS and Other Clinical Income Summary
Year to Date for the 7 months ending 31 October 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	**14,699**	**14,586**	**(114)**	**-0.8%**	**12,280**	**12,065**	**(215)**	**-1.8%**	**13,775**	**811**	**5.9%**	**10,443**	**1,622**	**15.5%**
Elective	35,262	34,997	(265)	-0.8%	8,035	7,975	(60)	-0.7%	33,093	1,904	5.8%	7,641	334	4.4%
Elective Excess Bed days	1,707	1,692	(15)	-0.9%	3,033	2,977	(56)	-1.8%	1,855	(163)	-8.8%	3,763	(786)	-20.9%
Elective	**36,970**	**36,689**	**(281)**	**-0.8%**					**34,949**	**1,740**	**5.0%**			
Non Elective	9,969	10,539	569	5.7%	944	1,543	599	63.4%	7,916	2,623	33.1%	916	627	68.4%
Non Elective Excess Bed Days	1,187	1,798	612	51.5%	2,051	3,102	1,051	51.3%	1,179	619	52.5%	2,348	754	32.1%
Non Elective	**11,156**	**12,337**	**1,181**	**10.6%**					**9,095**	**3,242**	**35.6%**			
Outpatient	**22,841**	**22,734**	**(108)**	**-0.5%**	**91,837**	**91,568**	**(269)**	**-0.3%**	**22,392**	**342**	**1.5%**	**86,642**	**4,926**	**5.7%**
Undesignated HDU Bed days	2,871	3,064	192	6.7%	2,749	2,932	183	6.7%	2,944	120	4.1%	2,821	111	3.9%
Picu Consortium HDU	2,251	1,819	(432)	-19.2%	2,472	1,848	(624)	-25.2%	2,076	(257)	-12.4%	2,159	(311)	-14.4%
HDU Beddays	**5,122**	**4,882**	**(240)**	**-4.7%**	**5,221**	**4,780**	**(441)**	**-8.4%**	**5,020**	**(138)**	**-2.7%**	**4,980**	**(200)**	**-4.0%**
													0	
Picu Consortium ITU	20,508	18,698	(1,810)	-8.8%	7,157	6,465	(692)	-9.7%	15,519	3,179	20.5%	6,313	152	2.4%
PICU ITU Beddays	**20,508**	**18,698**	**(1,810)**	**-8.8%**	**7,157**	**6,465**	**(692)**	**-9.7%**	**15,519**	**3,179**	**20.5%**	**6,313**	**152**	**2.4%**
Ecmo Bedday	569	920	351	61.6%	104	169	65	62.4%	503	417	83.0%	92	77	83.7%
Psychological Medicine Bedday	667	642	(24)	-3.7%	1,651	1,590	(61)	-3.7%	644	(2)	-0.3%	1,597	(7)	-0.4%
Rheumatology Rehab Beddays	882	1,073	191	21.6%	1,551	1,748	197	12.7%	847	227	26.8%	1,490	258	17.3%
Transitional Care Beddays	1,698	1,446	(252)	-14.9%	1,171	997	(174)	-14.9%	1,591	(145)	-9.1%	1,098	(101)	-9.2%
Total Beddays	**3,816**	**4,081**	**265**	**6.9%**	**4,477**	**4,504**	**27**	**0.6%**	**3,584**	**497**	**13.9%**	**4,277**	**227**	**5.3%**
Packages Of Care Elective	**4,302**	**4,864**	**562**	**13.1%**					**4,209**	**655**	**15.6%**			
Highly Specialised Services (not above)	17,647	17,343	(303)	-1.7%					16,968	375	2.2%			
Other Clinical	17,124	18,985	1,861	10.9%					22,031	(3,047)	-13.8%			
Outturn adjustment	0	(123)	(123)	0%					(808)	685	-85%			
STF Funding	2,423	2,423	0	0%					0	2,423	0%			
Pricing Adjustment	2,959	2,959	0	0.0%					0	2,959	0%			
Non NHS Clinical Income	1,874	3,975	2,101	112.1%					2,752	1,223	44%			
NHS and Other Clinical Income	**161,441**	**164,434**	**2,992**	**1.9%**					**149,488**	**14,946**	**10.0%**			

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

Day case

- Day case is behind plan YTD by 215 which includes reduced activity in Urology due to reduced staff numbers (338 day cases) and the radiology theatre being closed periodically since Month 2 due to maintenance. The Radiology theatre has reopened in Month 7.

Outpatients

- In Month 7 there is increased activity in the plan for PICB which has causes reduced activity against plan for Ophthalmology. Increased performance from ENT and Radiology offsets previous month underperformance.

HDU beds

- HDU activity is behind plan in Cardiology due to closure of the chest wall service.

ITU Bed Days

- PICU/NICU activity YTD remains broadly on trend from 16/17 levels but less than plan which included the growth in capacity of 4 beds built into the 2017/18 annual plan, due to not all resources available for all 4 beds at this stage.

Packages of Care (POC)

- Renal and Respiratory packages of care are above plan year to date due to increasing patient cohorts combined with activity growth.

Other Clinical

- This includes income for CQUIN and the target for the local pricing review. CQUIN income is below plan as the Clinical Utilisation Review scheme was not accepted by GOSH.

- From Month 5 onwards activity relating to block contracts and packages of care has been reported under Other Clinical.

Trust Inpatient and Outpatient Activity
Year on Year trend analysis

Great Ormond Street Hospital for Children NHS Foundation Trust

NHS and IPP Activity (Combined)													
Prior Year 2016/17				Current Year 2017/18				NHS Activity			IPP Activity		
Mth 7 Oct	Total 16/17	YTD Mth 7 16/17	Activity Type	Oct	Total YTD	Change YOY	% Change YOY	NHS YTD 17/18	Change YOY	% Change YOY	IPP YTD 17/18	Change YOY	% Change YOY
			Inpatients										
			Number of Discharges										
1,972	24,730	14,577	Day Case	2,135	14,448	(129)	-0.9%	13,785	(214)	-1.5%	663	85	14.7%
			Overnight:										
1,101	13,989	8,259	Elective	1,168	8,384	125	1.5%	7,712	0	0.0%	672	125	22.9%
62	800	455	Non Elective	83	569	114	25.1%	501	107	27.2%	68	7	11.5%
156	2,080	1,156	Non Elective (Non Emergency)	190	1,198	42	3.6%	1,175	51	4.5%	23	(9)	-28.1%
165	2,156	1,224	Regular Attenders	180	1,292	68	5.6%	1,288	75	6.2%	4	(7)	-63.6%
3,456	43,755	25,671	Total Discharges	3,756	25,891	220	0.9%	24,461	19	0.1%	1,430	201	16.4%
			Beddays										
737	9,178	5,507	Day Case	673	4,821	(686)	-12.5%	4,580	(710)	-13.4%	241	24	11.1%
0.70	0.37	0.38	Day ALOS	0.32	0.33	(0.04)	-11.7%	0.33	(0.05)	-12.1%	0.36	(0.01)	-3.2%
			Overnight:										
5,449	66,583	39,192	Elective	5,760	39,095	(97)	-0.2%	31,119	(1,190)	-3.7%	7,976	1,093	15.9%
479	6,842	3,781	Non Elective	581	4,402	621	16.4%	3,830	825	27.5%	572	(204)	-26.3%
2,257	25,639	15,330	Non Elective (Non Emergency)	2,382	15,482	152	1.0%	14,782	133	0.9%	700	19	2.8%
97	1,313	722	Regular Attenders	107	758	36	5.0%	756	40	5.6%	2	(4)	-66.7%
8,282	100,377	59,025	Total Overnight* Beddays	8,830	59,737	712	1.2%	50,487	(192)	-0.4%	9,250	904	10.8%
6.21	5.87	5.91	Overnight ALOS	6.05	5.81	- 0.10	-1.6%	5.30	- 0.12	-2.1%	12.45	- 0.58	-4.4%
			Midnight Census (ON Bed days)										
4,523	54,699	32,184	Elective	4,777	32,358	174	0.5%	25,057	(794)	-3.1%	7,301	968	15.3%
425	6,022	3,342	Non Elective	518	3,958	616	18.4%	3,438	805	30.6%	520	(189)	-26.7%
2,076	23,310	13,992	Non Elective (Non Emergency)	2,189	14,205	213	1.5%	13,540	196	1.5%	665	17	2.6%
0	1	1	Regular Attenders	0	1	0	0.0%	0	(1)	-100.0%	1	1	100.0%
7,024	84,032	49,519	Total	7,484	50,522	1,003	2.0%	42,035	206	0.5%	8,487	797	10.4%
227	230	231	Average ON Beds Utilised	241	236	5	2.0%	196	1	0.5%	41	5	14.6%
			Critical Care Beddays (NICU|PICU|CICU)										
327	4,610	2,410	Elective	470	2,716	306	12.7%	2,072	246	13.5%	644	60	10.3%
62	1,452	744	Non Elective	45	771	27	3.6%	731	93	14.6%	40	(66)	-62.3%
627	6,404	3,943	Non Elective (Non Emergency)	649	4,007	64	1.6%	3,826	(56)	-1.4%	181	120	196.7%
1,016	12,466	7,097	Total CC Beddays	1,164	7,494	397	5.6%	6,629	283	4.5%	865	114	15.2%
32.8	34.2	33.2	Average CC Beddays	37.5	35.0	1.9	5.6%	31.0	1.3	4.5%	4.0	0.5	15.2%
			Outpatients										
21,052	253,706	144,572	Outpatient Attendances (All)	21,071	147,678	3,106	2.1%	136,499	2,691	1.1%	11,179	415	3.9%
3,915	47,746	27,625	First Outpatient Attendances	3,729	27,651	26	0.1%	23,098	(228)	-1.0%	4,553	254	5.9%
17,137	205,960	116,947	Follow Up Outpatient Attendances	17,342	120,027	3,080	2.6%	113,401	2,919	2.6%	6,626	161	2.5%
4.4	4.3	4.2	New to Review Ratio	4.7	4.3	0.1	2.6%	4.9	0.2	3.8%	1.5	(0.0)	-3.2%

Comments on key changes to prior year:

Day Cases
Overall Day case and Regular attenders YTD have decreased by 129 (0.9%) compared with 16/17, relating to a reduction in NHS activity. This mainly relates to: radiology (reduction of 89) partly due to intermittent closure of the radiology theatre caused by a leaking roof, which was fixed in September (but also affected by coding changes affecting the categorisation between specialties); and urology (reduction of 338) due to reduced staff numbers. This is offset by smaller increases in a number of other specialties – particularly haematology, which is partly related to the radiology coding issue. This coding issue has been fixed from Month 4 onwards, and radiology has been showing an increase over prior year in the subsequent months.

Overnight discharges
Overnight discharges YTD have increased by 210 (3%) compared to 16/17 with the most significant factors being NHS non-elective (increase of 114) and IPP elective activity (increase of 125). The NHS non-elective increase mainly relates to: cardiology (increase of 93) due to growing demand particularly from ICVD; and nephrology (increase of 29) enabled by the opening of a 15th nephrology bed.

Critical care
Critical care bed days YTD have increased by 5.6% compared to 16/17. Although this is a proportionately higher increase compared to inpatient activity, it represents activity below planned levels - 4 additional PICU/NICU beds were planned to be opened but demand has been below expectations. However, NICU/PICU activity has been increasing over recent months, with October showing a 17% increase over September.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
28 November 2017

Safe Nurse Staffing Report for September and October 2017 **Submitted by:** Janet Williss, Interim Chief Nurse	**Paper No: Attachment 11**

Aims / summary

This paper provides the required assurance that GOSH had safe nurse staffing levels across all in- patient ward areas for September. In October there were 3 unsafe shifts reported but no adverse incidents were reported as a result of this. The appropriate escalation process was followed in all three cases. 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 and in particular:

- 3 unsafe shifts were reported in October, 1 Fox ward, 1 Penguin ward and I Rainforest ward due to an increase in sickness levels. All shifts were appropriately escalated to Divisional Assistant Chief Nurse or Clinical Site Nurse Practitioners out of hours. Nurses were moved across wards as appropriate and additional beds closed to ensure patient safety, no adverse incident has been reported as a result of these unsafe shifts.
- 210 Newly Qualified Nurses started in the Trust on 25th September who have undertaken a 4 week induction and orientation period in order to complete all mandatory training and essential clinical competencies.

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

Legal issues

None

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 September & October 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

Capacity: A number of beds have been closed over the last two months

- September: Hedgehog was closed for 2 weeks due to a reduction in activity, Fox closed for 2 weeks for maintenance work. Plus additional ad hoc closures.
- October: Ad hoc bed closures across a number of wards due to staffing numbers. The main area affected were in the ICI and surgical wards.

Staffing:

- There were 3 unsafe shifts reported in October which had been escalated to the Clinical Site Practitioners due to staffing levels, 2 on the ICI wards and 1 on Rainforest, no adverse incident occurred on these shifts as a result.
- Care hours per patient day have generally been higher in last 2 months compared to the previous 2 months.
- Approximately 210 WTE Newly Qualified Nurses started in the Trust on 25th September 2017. They have undertaken a 4 week induction and orientation period to ensure all mandatory training and essential competencies have been completed.

Temporary Staffing:

- Overall shift request numbers for September have been lower compared to August. There was a significant increase in demand in October mainly to cover an increase in sickness. The average fill rate of shifts continues to be very good at 90%. Only 2 shifts have been filled by agency over the last 2 months.

Month	UNIFY * Actuals vs plan	CHPPD* * Trust average	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)							
July	91.6%	11.5	38.3%	20.8%	12.3%	28.6%	4.7%	2.7%	15.9%	105	28	254	11
August	90.29%	10.5	37.5%	21.3%	12.8%	28.4%	4.6%	2.8%	16%	108	28	244	11
Sept	89.85%	13.8	40.88%	20.84%	24.79%	24.79%	4.2%	2.3%	16.2%	-35	28	4	11
Oct	90.28%	13.9	44.91%	15.63%	13.07%	26.38%	4.4%	2.9%	16.2%	-24	26	19	9

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

CHPPD provides more granular data providing the actual number of nursing and HCA hours available for each patient for everyday for the month and is another way of displaying staffing levels.

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)

September 2017

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

Ward	Nursing Staffing Actual vs Planned					Care Hours per Patient Day			Key Indicators						
	Registered Day	Care Staff Day	Registered Night	Care Staff Night	Comments	Registered	Care Staff	Total	Pressure Ulcer, grade 2	Cardiac Arrest	Respiratory Arrest	PALS	Complaints	Datix	Unsafe shift
Charles West Division															
Badger	75.6%	96.1%	80.2%	95.1%	Activity was down for the month. Ward safely staffed though there are vacancies at Band 5 & 6.	9.1	1.8	10.9		2	1	0	0		0
Bear	120.2%	117.5%	103.0%	93.9%	Ward safely staffed. Nurses moved to other wards when needed	9.4	1.6	11.0				0	0		0
Flamingo	116.1%	15.0%	100.0%	24.0%	Unit safely staffed.	27.9	0.2	28.1	4			0	0		0
Miffy	85.5%	75.0%	73.8%	63.4%	One patient on home leave so staffing rquirements were less.	7.4	8.2	15.6				0	0		0
NICU	116.1%	20.1%	102.1%	-	Unit safely staffed. Additional bed opened requiring additional staffing	27.6	0.5	28.1	1			0	0		0
PICU	110.0%	10.1%	87.0%	13.4%	Unit safely staffed	28.8	0.2	29.0				0	0		0
Elephant	92.3%	76.8%	83.0%	61.7%	Staff moved from Robin ward to ensure safe staffing	7.9	1.4	9.3				0	0		0
Fox	93.3%	51.0%	71.4%	62.9%	Ward opened following air handling work. Staff moved from Robin as required. No Bank staff required.	9.2	1.1	10.3				0	0		0
Giraffe	87.8%	52.1%	74.4%	49.2%	Staff moved from Robin ward to ensure safe staffing	8.7	1.8	10.6		1		0	0		0
Lion	98.7%	82.2%	109.2%	91.9%	Ward safely staffed	10.7	2.1	12.8				0	0		0
Penguin	103.5%	200.4%	92.9%	32.3%	Ward safely staffed.	9.7	4.8	14.5				0	0		0
Robin	105.3%	250.0%	84.5%	47.0%	Ward only opened for 5 days due to air handling work. Staff moved to other ICI wards.	5.9	1.7	7.6				0	0		0
International Private Patients Division															
Bumblebee	98.4%	188.3%	89.4%	66.9%	Ward safely staffed and nurses moved from Hedgehog	8.4	2.2	10.6			1	0	0		0
Butterfly	70.9%	202.5%	54.9%	103.6%	The ward has a number of vacancies but nurses moved form Hedgehog to enusre ward safely staffed	8.1	2.8	10.9				0	0		0
Hedgehog	172.0%	114.0%	131.8%	89.5%	Small ward establishment accounts for larger variation in staffing percentages. Ward closed for 2 weeks due to reduction in referrals following Ramadan,staff moved to cover Butterfly and Bumblee as required.	10.4	3.5	13.9				0	0		0
JM Barrie Division															
Eagle	91.3%	90.8%	109.1%	131.9%	Ward safely staffed	9.9	3.0	13.0				0	0		0
Kingfisher	69.1%	48.3%	100.6%	-	Increase in nurse sickness, CNSs and Educator used to cover day shifts as needed.	10.6	3.9	14.5				0	0		0
Rainforest Gastro	106.4%	50.8%	95.2%	56.0%	Vacant band 3 posts account for low un registered fill rates.	9.2	4.1	13.3				0	0		0
Rainforest Endo/Met	99.9%	43.3%	62.8%	82.0%	Ward safely staffed. Increase in daycase activity so less nuring required overnight.	7.9	2.7	10.6				0	0		0
Mildred Creak	103.4%	66.6%	87.8%	102.8%	The unit has some vacant posts but safely staffed	4.4	2.4	6.9				0	0		0
Koala	99.1%	165.4%	87.2%	67.4%	High HCA use during the day used to cover telemetry unit.	9.7	1.3	11.0				0	0		0
Peter Pan	94.3%	105.0%	95.0%	-	Ward safely staffed	8.8	2.3	11.0				0	0		0
Sky	117.9%	126.8%	89.1%	-	Increase nurse staffing required for an increase in patient acuity	8.8	2.3	11.1			1	0	0		0
Squirrel SNAPs	119.7%	111.9%	155.0%	120.1%	Increase in activity and acuity requiring additional staffing	8.9	2.5	11.4				0	0		0
Squirrel Urology	149.3%	84.6%	95.1%	26.9%	Increase in nursing required to care for a child who required specialing.	10.0	1.7	11.7				0	0		0

October 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	Comments	Registered	Care Staff	Total	Pressure Ulcer, grade 2	Cardiac Arrest	Respiratory Arrest	PALS	Complaints	Datix	Unsafe shift
Charles West Division															
Badger	90.3%	123.8%	78.3%	107.8%	A number of NQNs have started on the ward but are still supernumary and completing their competencies.Ward safely staffed.	9.4	2.0	11.4		1	3	0	0		0
Bear	148.4%	112.9%	103.8%	76.3%	Ward safely staffed	10.3	1.4	11.7				0	0		0
Flamingo	112.3%	19.4%	102.4%	21.0%	Ward safely staffed	26.6	0.2	26.8	3			0	0		0
Miffy	92.9%	86.4%	68.8%	80.8%	Some Band 5 and 6 vacanies but ward safely staffed	7.5	9.7	17.2				0	0		0
NICU	105.1%	25.9%	93.5%	-	Unit safely staffed	25.3	0.5	25.7				0	0		0
PICU	111.3%	24.4%	98.4%	6.5%	Unit safely staffed	27.2	0.2	27.5	2			0	0		0
Elephant	140.2%	73.9%	94.8%	65.1%	Ward safely staffed. Nurses moved to other ICI wards when required.	9.4	1.2	10.6				0	0		0
Fox	86.0%	56.0%	63.7%	69.1%	The wards across ICI had some significant staffing challenges in the first two weeks of October. Whilst there has been a large number of NQNs starting on the wards they were in their supernummary period and completing their competencies. There was one unsafe shift reported on 10th October. This was appropriately escalated to Divisional ACN and CSPs. Daily bed meetings took place to review staffing and staff moved as required.	9.8	1.4	11.3				0	0	2	2
Giraffe	107.4%	55.4%	75.7%	75.0%	Please see comments above	8.6	2.0	10.6		1		0	0	1	0
Lion	102.4%	109.2%	74.0%	84.7%	Please see comments above	9.0	2.2	11.2				0	0		0
Penguin	90.5%	215.1%	55.2%	17.0%	Ward closed on several shifts and over the weekends. Patients and staff were moved to other wards to sure patient safety.	10.4	6.8	17.1				0	0		0
Robin	73.6%	59.5%	70.4%	57.1%	Please see comments above for Fox ward	9.5	1.4	10.9				0	0		0
International Private Patients Division															
Bumblebee	121.9%	176.0%	99.8%	86.2%	Ward safely staffed	9.0	2.2	11.2			1	0	0		0
Butterfly	72.7%	167.5%	57.5%	120.3%	Ward has some vacancies and there has been increased sickness. 4 beds closed on two occassions to ensure safe staffing levels	7.2	2.2	9.5				0	0		0
Hedgehog	172.5%	102.6%	133.6%	69.3%	An increase in patient acuity required additional nursing	9.3	2.6	12.0				0	0		0
JM Barrie Division															
Eagle	103.6%	65.8%	110.6%	106.2%	Ward safely staffed	10.8	2.3	13.1				0	0		0
Kingfisher	85.5%	40.2%	118.9%	-	Ward safely staffed. CNSs and educators worked some clinical shifts and some nurses moved from Squirrel as required	9.9	2.9	12.7				0	0		0
Rainforest Gastro	172.0%	49.9%	100.1%	51.2%	Increased number of NQNs working clinically but requring increased support. One shift not deemed to be safe and reported to CSPs. No adverse incidents occurred as a result of this.	9.0	2.7	11.7				0	0	1	1
Rainforest Endo/Met	113.7%	39.3%	70.0%	74.8%	Nursing number down at night due to increased day case activity.	8.3	2.3	10.7				0	0		0
Mildred Creak	144.4%	104.9%	87.8%	122.4%	Unit safely staffed	9.1	5.3	14.4				0	0		0
Koala	100.2%	65.9%	84.4%	50.3%	Nurses moved from night shifts to cover increased activity during the day. Ward safely staffed.	9.2	0.6	9.8	3			0	0		0
Peter Pan	112.8%	109.8%	99.8%	-	Ward safely staffed	9.4	2.1	11.5				0	0		0
Sky	146.6%	121.5%	101.7%	-	Increase in patient activity and acuity requiring more registered nurses. Ward safely staffed	10.5	2.1	12.6		1		0	0		0
Squirrel SNAPs	137.5%	71.8%	157.1%	74.0%	Ward safely staffed	9.6	1.5	11.1				0	0		0
Squirrel Urology	153.7%	66.5%	98.0%	18.9%	Ward safely staffed. Some nurses moved to cover other wards when required	10.6	1.4	12.0				0	0		0

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 28 November 2017	
Guardian of Safe Working – quarterly report **Submitted by:** Dr Renee McCulloch, Guardian of Safe Working	**Paper No: Attachment 12**
Aims / summary This report is the first report to the Board regarding the mechanisms within the new Junior Doctor contract for monitoring safe working practices. This report covers the period February to October 2017.	
Action required from the meeting The board is asked to note the report and continue to monitor compliance with the TCS 2016.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Effective implementation of the new TCS, specifically the work of the Guardian of Safe Working, contributes to creating a safe and positive working and training environment for junior doctors – supporting the trusts strategic objective relating to education.	
Financial implications Not applicable	
Who needs to be told about any decision? Not applicable	
Who is responsible for implementing the proposals / project and anticipated timescales? Dr Renee McCulloch, Guardian of Safe Working Dr Sanjiv Sharma, Deputy Medical Director for Medical & Dental Education Sarah Ottaway, Head of Medical HR & PGME Services	
Who is accountable for the implementation of the proposal / project? Dr David Hicks, Interim Medical Director	

Attachment 12

Guardian of Safe Working – Quarterly Board Report

1. Purpose

1.1 To inform the board on progress made in implementing the new junior doctors contract and the work of the Guardian of Safe Working (GOSW).

2. Background

2.1 The new Terms and Conditions of Service for Doctors in Training (TCS) include provision of a GOSW. The role of the GOSW is to act as champion for safe working hours and monitor compliance with the terms and conditions within the new contract. As part of this role the GOSW is expected to report to the board on a quarterly basis.

2.2 The 2016 TCS went live nationally on the 3rd August 2016 and has been implemented in a phased approach, concluding October 2017. At GOSH the first junior doctors to move to the new TCS did so on 1st February 2017 and as of 2nd October 2017, all junior doctors in training have transferred to the new TCS.

3. High level data (as at 2nd October 2017)

Number of doctors / dentists in training	141 established posts
Number of doctors / dentists in training on 2016 TCS	134 (7 vacant posts)
Number of doctors on local (non-training) TCS	147
Amount of time available in job plan for guardian to do the role	2 PAs
Amount of job-planned time for educational supervisors	0.25 PAs per trainee

4. Implementation progress

4.1 GOSW Appointment

4.2 The 2016 TCS require trusts to appoint at GOSW who is responsible for providing assurance to the trust on compliance with safe working hours by the trust and junior doctors. Ellen Rawlinson, Consultant Anaesthetist, was appointed GOSW in July 2016 and stepped down from the post in September 2017. From 1st October 2017 Renee McCulloch, Consultant in Paediatric Palliative Medicine took up the post.

4.2 Rota redesign

4.3 The 2016 TCS introduced a number of new or updated rules and restrictions relating to working hours, shift patterns and rest requirements. This has necessitated redesign of 45 different rota patterns currently in place within the trust. All junior doctor rotas have now been redesigned and are compliant with the 2016 TCS.

4.4 Junior Doctors' Forum

4.5 The 2016 TCS required the establishment of a Junior Doctors Forum (JDF) to serve as a key point of liaison between junior doctors, the GOSW and Director of Medical Education. The JDF includes junior doctors from across the trust, and representatives from the trust Local Negotiating Committee and the BMA.

4.7 JDF terms of reference were agreed in April 2017 and the forum has been meeting monthly since December 2016. To date issues discussed have included; provision of accommodation for rest following night shifts, exception reporting and educational supervisor engagement.

5. Exception reports

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

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

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

5.4 The GOSW is required to regularly provide reports to trust board regarding exception reporting. During the period 2nd February to date a total of 67 exception reports have been submitted, broken down by specialty and grade as below:

Specialty	Rota grade	Exceptions relating to hours of work	Exceptions relating to educational opportunities
Audiology	SpR	0	1
Cardiology	SHO	1	0
CATS	SpR	2	0
CICU	SpR	3	0
ENT SpR	SpR	2	0
Immunology/ID	SHO	1	0
Neurology	SHO	3	1
Neurology	SpR	23	5
Neurosurgery	SpR	1	0
NICU/PICU	SpR	8	0
Rheumatology	SpR	16	0
	Total	**60**	**7**

5.5 The main issues were extra hours worked and occasional concern with accessing education provision.

The predominant themes behind the extra hours being worked were:

- Staying late to complete clinical paperwork
- Minimal staffing through annual or sick leave or unfilled posts putting pressure on time to complete daily workload

6. Vacancies

6.1 As of 16th October 2017 the following junior doctor posts were vacant:

Specialty	Rota grade	Rota establishment	Vacant posts	Vacancy rate %
Cardiothoracic	SpR	8	1	13%
Gastroenterology	SpR	8	2	25%

Urology	SpR	8	1	13%
Surgery (SNAPS, Ortho, ENT, Urol)	SHO	18	3	17%
Renal	SpR	5	1	20%
Endocrinology	SpR	3	1	33%

6.2 The overall vacancy rate across junior doctor rotas is 3.2% - with 9 FTE vacant out of a total of 284 rota slots.

7. Locums - Bank and Agency use

7.1 Below is a breakdown of locum (bank and agency) usage across junior doctor rotas, for the period 1st February to 30th September 2017.

Specialty	Number of shifts	Cost
BMT	2	£732
Cardiology SHOs	37	£12,005
Cardiology SpRs	31	£13,370
Cardiothoracic SpRs	155	£72,051
CATS	2	£1,212
CICU	68	£51,960
Dermatology	6	£1,818
Haematology/Oncology	192	£95,320
MEGGA SpR	172	£88,245
MEGGA SHO	189	£67,501
Neurology SpR	6	£2,904
Neurology SHO	3	£1,475
NICU PICU ICON	172	£131,230
Neurosurgery	4	£733
IPP	410	£182,069
Spinal/Orthopaedics SpR	32	£9,730
Surgery SHOs	708	£268,458
Surgery SpRs	144	£54,013
Symptom Care Team	5	£2,121
Total	**2338**	**£1,056,946**

7.2 Of the 2,338 shifts covered as locums – 2,328 were covered by doctors directly engaged via the GOSH in-house bank, with only 10 shifts covered by locums via agencies. This represents a significantly lower reliance on premium rate agency locum staff to cover rota gaps, when compared with other trusts.

8.0 Fines and payments

All closed exception reports have recommended time off in lieu (TOIL) or paid extra hours owed. No fines have been levied to date. It is not possible on the current exception reporting system to know if the doctor has actually taken this TOIL. It is possible that when the outstanding exception reports are closed fines may be levied. However it is difficult to work out easily whether the fines are simple payments to be made to the doctor or if in addition to the payment to the doctor fines will be levied and given to the junior doctors'. We are in contact with

the software provider who are making improvements to the system based on GOSH recommendations.

9.0 Issues Arising

9.1 Responses by educational supervisors (ES) to exception reports have been slow. In general, there is a lack of knowledge of the process and its implications. ES represent a heterogeneous group of consultants who commit to supporting junior doctor's training and education. ES undertake refresher training every 3 years, so there is no easy mechanism by which to engage large numbers. GOSW is planning to raise the profile of ER and engage ES further over the next few months to ensure improvement in this process.

9.2 Junior doctors remain apprehensive about the implications of raising exception within their departments with concerns that it will be seen negatively. A variety of strategies are being developed to encourage all medical staff to view this as a positive process by which rota problems can be identified and addressed.

8.3 Website development with supporting materials are being designed to ensure suitable guidance is available across the Trust.

10. Summary

10.1 All junior doctors in training within the trust have moved onto the 2016 contract. The exception reporting system has been implemented to allow working hours and training issues to be expressed and addressed in real time.

10.2 The doctors moving onto the 2016 contract have received their compliant rotas within the appropriate time frame (6 weeks prior to commencement) and have been encouraged to exception report. The process to resolve individual reports has been slower than anticipated; as such further engagement with educational supervisors is required to address this.

10.3 A review of junior doctor staffing requirements to support service expansion associated with the opening of PICB is being undertaken to ensure this has been appropriately planned.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
28th November 2017

Well Led Governance Review Action Plan Update **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment 13**

Aims / summary

To provide the Trust Board with an update on progress with the Well Led Governance Review action plan.

The Executive Management Team (EMT) monitors progress with the actions and provides assurance to the Trust Board. The Trust Board retains overall responsibility for ensuring that the recommendations are acted upon in a timely manner, and is responsible for agreeing any required changes to actions or timescales, where appropriately evidenced.

Twenty six recommendations have been actioned. A summary of the outstanding actions is attached at **Appendix 1**.

Action required from the meeting

The Board is asked to note the progress with the actions against the recommendations.

Contribution to the delivery of NHS Foundation Trust strategies and plans

External assessment of safety, effectiveness and governance arrangements at GOSH informs the Board as to the effectiveness of leadership and sustainability of the systems and processes in place to deliver the strategy.

Financial implications

None

Who needs to be told about any decision?

The report will be shared with the Members' Council (November 2017).

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

Trust Board members. The timescales for delivery of the actions are stated in the action plan. It should be noted that one recommendation requires the Board to undertake a follow up review to assess progress against the well led criteria.

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

The Chairman retains overall accountability.

Appendix 1

CQC Action Plan Update

CQC Action No. and Description	Status
1. RTT – Compliance with Regulation 17 2 (a) (c) and (f).	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.
2. Resume WHO checklist audits in surgery	Completed in July 2016.
3. Ensure that there are clear arrangements for reporting transition care service performance to the Board	Completed. Transition reporting to the Board and QSAC commenced in December 2016.
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. See action 1 above.
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.	In progress (agreed anticipated completion date of April 2017). Trust-wide mandatory training compliance is currently at 90% (February 2017). The new LMS system has been launched. The task-and-finish group has reviewed the frequency and content of almost all mandatory training courses, with a view to improve the content and relevance of mandatory training. The priorities in the coming months are: • Agree and implement changes to level 3 safeguarding children • Continue to implement more robust performance management of mandatory training • Further engaging subject matter experts in key training topics to work with Divisions to ensure training is completed.
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

CQC Action No. and Description	Status
	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 which have not been refurbished, rebuilt or relocated.	Completed. A number of improvements to the ward environment have been delivered since the CQC inspection, including: - 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 Rainforest ward. - Mechanisms are in place to monitor the ward environments from patients' and parents' perspectives (Pals, Friends & Family Survey, etc) - Executive 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. Staff training is also recorded in a local training register.
9. Develop a dedicated advocacy service for CAMHS.	Completed. An advocacy service is now in place.

Rec Red recs will be discussed with the MC	WL Ref	Priority	Recommendation	Executive Owner	Proposed actions (1 row per action)	Action Owner	Timescale (all dates are for end of month)	Monitored by (state management committee/ assurance committee or Board)	Progress/ Comments
4	1A	Medium	**Improve the communication of the Trust's recently refreshed strategy to staff and key external stakeholders.**	**Director of Comms**	Once the strategy has been refreshed, create comms and engagement plan. To include hard copy summary and digital copy as well as senior management presentation. In meantime ensure dissemination of operational plan	Director of Comms	Q4 2017/18	Plan signed off at EMT Signed off at EMT and TB	The Fulfilling our Potential strategy has now been refreshed and the Communications Team is proactively working with the strategy team to ensure its disseminated and embedded throughout organisation. Activity to date includes: - Communication on strategy to senior managers at SMT meeting. - Communication on strategy in All Staff Forum - Open House week 6–10 November, launched refreshed strategy to all staff with a whole week of activities and focus - Strategy intranet page in place as hub for content There is an ongoing plan to embed strategy and continue communication and engagement with staff. Further strategy documents to be developed to support leaders and managers in talking to their teams about the strategy, helping to embed it into daily processes.
10	2A	High	**Commission an ongoing Board development programme.This programme should include informal time for BMs to meet togetherand opportunities to reflect on the Board's effectiveness and contribution towards enabling GOSH to become the leading children's hospital in the world.**	**Director of HR and OD**	Board Development Programme Output specification to be developed and agreed at EMT and Board	Director of HR and OD	Mar-18	Trust Board	Tender issued for preferred partner to appropriately competent suppliers. Selection of preferred partner to develop programme to take place on 8 December 2017. Programme to be developed by March 2018.
11	2A	High	**A follow-up review by Deloitte in the Summer of 2017 to independently verify the progress that has been made in implementing the recommendations of this report.**	**Company Secretary**	Discuss with Trust Board on timing and terms of reference	Company Secretary	2018/19	Trust Board	To be agreed with new Chairman and Board for 2018
13	2A	Medium	**Introduce 360 degree feedback for EDs and NEDs from Board colleagues and from Councillors to improve the quality of appraisal discussions.**	**Director of HR and OD**	Informal councillor and executive feedback on NED appraisals was conducted in January 2017. A formal process will be designed and implemented for the 2017 appraisal round (in collaboration with the Council and the new Chairman)	Director of HR and OD	Mar-18	Trust Board	A draft proposal has been shared with theBoard This is based on the NHS Leadership Academy Healthcare Leadership Model and national 360 degree scheme. Chairman to be updated on progress with the proposed appraisal scheme by January 2018.
15	2A	Medium	**As part of the Board development programme, ensure that sufficient time is allocated to considering why GOSH is successful, the risks to that continued success and the role of the Board in sustaining and furthering that success.**	**Director of HR and OD**	Combine with 10/2A	Director of HR and OD	Mar-18	Trust Board	Board members assessment of development priorities have been collated. This recommendation is now rolled in to recommendation 10A (seee above)
16	2B	High	**Align the Board Code of Conduct to the Trust's 'Always' values and ensure that BM objectives include reference to the importance of role modelling these values and behaviours.**	**Company Secretary**	Refresh the Code of Conduct for the Board and the Council after work on the MC and TB relationship (rec 29). Executive Board members (along with all staff) are already assessed as to the demonstration of the Always Values in their appraisals. The framework for NED appraisals also refers to demonstrating a commitment to the Always Values.	Company Secretary	31/01/2018 and onwards	Trust Board/ Members' Council	The Code of Conduct will be updated at the same time as revising the constitution.

20	2B	Medium	**Comprehensively explore the culture of the organisation to identify whether any changes need to be made.**	**Director of HR and OD (Director of Comms/ DCEO)**	Use the CIPD (Chartered Institute of Personnel and Development) 2016 research report to construct an appropriate framework for cultural analysis in the context of organisational governance	Director of HR and OD	Mar-18	Trust Board	The new Head of OD will lead on this. The approach will need to be congruent and consistent with the Board and wider leadership development needs analysis - both of which are now underway a This work will form part of the approach to Board development and wider organisational development. See revised timetable at 10/2A.
21	2B	Medium	**Introduce a tool, such as a 'culture barometer', to measure and monitor aspects of GOSH's culture to provide greater Board oversight of this important area.**	**Director of HR and OD (Director of Comms/ DCEO)**	Combine with 20/2B	Director of HR and OD	Mar-18	EMT/Trust Board	
26	3A	Medium	**Introduce improvements to the Board and Committee administration to ensure smooth-running support.**	**Company Secretary**	Review of structure of corporate governance team and systems and processes in place	Company Secretary	Mar-18	EMT	Funding for a deputy company secretray or equivalent has been approved for 2017/18 and interviews arranged for 11 December 2017. Work is ongoing to identify an interim postholder whilst the appointment takes place. Once this post has been appointed to, a review of the duties and workload of the team will be conducted to ensure we are fit for purpose for 2018/19
28	3C	Medium	**Improve the internal staff communication methods to ensure that they are effective and optimal.**	**Director of Comms**	Resourcing of internal communications is underway, leading to a refreshed programme of work to enhance internal comms	Director of Comms	Q4 2017/18	EMT	Team members have been recruited and recruitment continues. An Interim Head of Internal Comms in place. A new intranet has been agreed and our intranet manager is in liaison with agencies - development is expected to take a few months. Delivery of intranet relies on IT projects and migration to Office 365, so exact timings are TBC. All channels are being assessed as part of an internal communications deep-dive - Internal comms channels are being reviewed and refreshed in line with strategy and to ensure channels work for their intended purpose and target audience, delivering the best possible engagement. Specifically new newsletter software is also being purchased to provide statsistics on open rates, allowing us to respond to the ways in which staff interact with it
29	3C	High	**Commission an independently facilitated programme of development between the Board and the MC. This programme should successfully address:** **- the respective roles of the Board (primary governance) and the MC (secondary governance);** **- MC meeting arrangements;** **- the behaviours expected of both parties.**	**Company Secretary (Director of HR and OD)**	Discuss this recommendation at Trust Board and Members' Council (and with the Well Led Review Working Group) and agree how to take the action forward. In the meantime seek information on possible organisations/ individuals with the necessary expertise and skills to facilitate a development programme	Company Secretary	31/01/2018 and onwards	Trust Board and Members' Council	Discussion on the timescales for the faciliation work will take place with the new Chairman, the Board and the Council in January 2018 .
30	3C	High	**Engage with other FTs that have good levels of engagement between Councillors / Governors and Boards (details to be provided by Deloitte).**	**Company Secretary**	Speak with Deloite and gather names of other Trusts and contact the Company Secretaries to discuss their different ways of working. May include attending governor meetings. This should feed into and inform the external facilitation work (Rec 29)	Company Secretary	31/01/2018 and onwards	Trust Board and Members' Council	Well Led Review Working Group representatives have met with 5-6 other trusts to find out how engagement works between board and councils. The findings from this work will be fed in to the facilitation exercise (see above).
31	3C	High	**Given the seriousness of the relationship issues between the Board and the MC, as part of the independent follow-up review of recommendations in the Summer of 2017, there should be a review of whether the relationship between the two governing bodies has improved.**	**Company Secretary (CEO)**	Discuss the terms of reference of the independent follow up review and ensure that it includes a review of whether the relationship between the two bodies has improved.	Company Secretary	2018/19	Trust Board and Members' Council	See recommendation 11 above.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
28th November 2017

Register of Seals **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment 14**

Aims / summary
Under paragraph 39 of the NHS Foundation Trust Standing Orders, the Trust is required to keep a register of the sealing of documents. The attached table details the seal affixed and authorised since end of September 2017.

Date	Description	Signed by
1/11/2017	Land agreement: 37-46 Guilford Street and 83 Lambs Conduit Street	PS

Action required from the meeting
To endorse the application of the common seal and executive signatures.

Contribution to the delivery of NHS / Trust strategies and plans
Compliance with Standing Orders and the Constitution

Financial implications
N/A

Legal issues
Compliance with Standing Orders and the Constitution

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

Who is accountable for the implementation of the proposal / project
Anna Ferrant, Company Secretary oversees the register of seals