

**Meeting of the Trust Board
Wednesday 3rd April 2019**

Dear Members

There will be a public meeting of the Trust Board on Wednesday 3 April 2019 at 1:45pm in the Charles West Boardroom, Great Ormond Street, London, WC1N 3JH.

Company Secretary

Direct Line: 020 7813 8230

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AGENDA

	Agenda Item <u>STANDARD ITEMS</u>	Presented by	Attachment	Time
1.	Apologies for absence	Chair	Verbal	1:45pm
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 7 February 2019	Chair	A	1:50pm
3.	Matters Arising/ Action Checklist	Chair	B	
4.	Chief Executive Update	Chief Executive	C	2:00pm
<u>STRATEGY and RISK</u>				
5.	Patient Story	Chief Nurse	D	2:10pm
6.	Final GOSH Operational Plan 2019/20	Acting Chief Operating Officer/ Chief Finance Officer	E	2:25pm
7.	GOSH Draft Leadership Strategy	Chief Nurse/ Acting Medical Director	G	2:40pm
8.	GOSH Draft Clinical Strategy	Acting Medical Director	H	2:50pm
9.	New and Novel Medicines	Acting Medical Director	I	3:00pm
10.	2018/19 National Cost Collection Presubmission (formerly Reference Costs)	Chief Finance Officer	J	3:10pm
<u>PERFORMANCE</u>				
11.	Integrated Quality and Performance Update Report – 28 February 2019	Acting Medical Director/ Chief Nurse/ Acting Chief Operating Officer	K	3:20pm
12.	Safety and Reliability Improvement Programme Update – Speak Up	Acting Medical Director	L	3:30pm
13.	Finance Update – 28 February 2019	Chief Finance Officer	N	3:35pm

	ASSURANCE			
14.	GOSH Staff Survey Results 2018 and Action Plan	Director of HR and OD	O	3:45pm
15.	CQC Readiness Update (including well led update)	Acting Medical Director/ Chief Executive	P	3:55pm
16.	Safe Nurse Staffing Report (January and February 2019) including Retention Action Plan for Nursing	Chief Nurse	Q	4:05pm
17.	Workforce Equality Objectives Update 2018/19 Equality, Diversity & Inclusion: Update against service delivery Equality Objectives	Director of HR and OD Chief Nurse	R 10	4:15pm
18.	Gender Pay Gap Report	Director of HR and OD	9	4:25pm
19.	Guardian of Safe Working <ul style="list-style-type: none"> • Quarter 4 2018/19 report • Annual report 2018/19 	Acting Medical Director	S 8	4:35pm
	GOVERNANCE			
20.	London North Genomic Laboratory Hub Governance	Chief Finance Officer	T	4:45pm
21.	Draft Risk Management Strategy and Policy	Acting Medical Director	V	5:05pm
22.	GOSH Trust Board work-plan	Company Secretary	U	5:15pm
23.	Board Assurance Committee reports <ul style="list-style-type: none"> • Finance and Investment Committee Update February 2019 	Chair of the Finance and Investment Committee	W	
24.	Update from the Council of Governors' meeting on 6 February 2019	Company Secretary	X	
25.	Declarations of Interest Register – Trust Board members	Company Secretary	Y	
26.	Register of Seals	Company Secretary	Z	
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 Public Trust Board meeting will be held on Wednesday 22 May 2019 in the Charles West Room, Great Ormond Street, London, WC1N 3JH.				

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**DRAFT Minutes of the meeting of Trust Board on
7th February 2019**

Present

Sir Michael Rake	Chairman
Mr Matthew Shaw	Chief Executive
Lady Amanda Ellingworth	Non-Executive Director
Mr James Hatchley	Non-Executive Director
Mr Chris Kennedy	Non-Executive Director
Ms Kathryn Ludlow	Non-Executive Director
Mr Akhter Mateen	Non-Executive Director
Professor Rosalind Smyth*	Non-Executive Director
Dr Sanjiv Sharma	Acting Medical Director
Ms Alison Robertson	Chief Nurse
Ms Helen Jameson	Chief Finance Officer

In attendance

Mr Matthew Tulley	Director of Development
Ms Cymbeline Moore	Director of Communications
Mr Peter Hyland	Director of Operational Performance and Information
Professor Paolo De Coppi*	Head of Stem Cells and Regenerative Medicine and Professor of Paediatric Surgery
Alfie*	GOSH patient
Dr Anna Ferrant	Company Secretary
Ms Victoria Goddard	Trust Board Administrator (minutes)
Mr Paul Gough	Staff Governor
Mr Colin Sincock	Public Governor
Ms Jenny Rivers*	Deputy Director of Research and Innovation

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

** Denotes a person who was present by telephone

156	Apologies for absence
156.1	Apologies for absence were received from Ms Alison Hall, Acting Director of HR and OD and Professor Andrew Taylor, Acting Chief Operating Officer. It was noted that Mr Peter Hyland, Director of Operational Performance and Information was in attendance in Professor Taylor's stead.
157	Declarations of Interest
157.1	No declarations of interest were received.
158	Delivery of the Research Hospital (with a focus on the Zayed Centre for Research)
158.1	Professor Paolo De Coppi, Head of Stem Cells and Regenerative Medicine and Professor of Paediatric Surgery gave a presentation about the innovative work being undertaken at GOSH including the transplantation of tracheas which had been seeded with stem cells from the recipient patient. The treatment of the

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	tracheas had taken place at a laboratory at another centre as there was insufficient capacity in the GOSH laboratories. Professor De Coppi said that with the opening of the Zayed Centre for Research and the Good Manufacturing Practice (GMP) facility researchers would not be reliant on the availability of other centres and materials would not need to be moved offsite. Professor De Coppi said that this research included two patents which would be valuable in the new centre.
158.2	Sir Michael Rake, Chairman highlighted that this work required close engagement with patients and families and asked about their reaction to the interventions taking place. He said that the Clinical Ethics Committee was instrumental particularly when working with patients who may not survive and it was vital to be very open and publish data even when outcomes were not positive.
158.3	Professor De Coppi said that foetal surgery such as for spina bifida currently took place at UCLH with a GOSH team however other sites in North America had developed specialist foetal surgery units within children's hospitals. He said he felt that a similar approach should be taken at GOSH and added this this would provide considerable benefit to the Trust in terms of providing both pre and post-natal care.
158.4	Ms Alison Robertson, Chief Nurse said that although she understood the potentially positive impact, GOSH did not have a maternity service which could support a foetal surgery team if required.
158.5	Professor David Goldblatt, Director of Research and Innovation said that it was important to ensure that research governance structures were such that whatever innovative treatment was being pursued, the relevant structures were in place. He suggested that consideration should be given to the opportunity cost of GOSH Children's Charity funding being primarily used for development projects to ensure that research was being optimally supported.
159	Patient Story
159.1	The Board received a patient story in person from Alfie, an 11 year old patient who received a bone graft treatment for his cleft lip and palate. Alfie provided the voiceover for an animated film designed to help patients and families understand more about cleft lip and palate and how it is treated.
159.2	Alfie said that he had been an inpatient on two wards and had found that doctors and nurses had shown excellent compassion. He said that he didn't feel scared during his stay because he knew that the team would help him. Alfie said that he enjoyed the food and was particularly happy that suitable food was provided given the treatment that a patient had received. He had only been able to eat soft food following his operation and this was provided.
159.3	Alfie said that although toys and activities were available for younger children, there were not many activities available for older children or teenagers. He added that it would be beneficial if the toys and activities provided encouraged children and young people to socialise with one another.
159.4	Mr Alison Robertson, Chief Nurse asked whether Alfie felt that a video or booklet would more appropriate for children and young people to gain an understanding about their treatment and Alfie suggested that it was important to have a range of materials as younger children would find a video easier to understand whilst

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159.5	teenagers may prefer to read. The Chair and the Board thanked Alfie for attending the meeting with his father and presenting his views.
160	Minutes of Meeting held on
160.1	The minutes were approved by the Board.
161	Matters Arising/ Action Checklist
161.1	The actions taken since the last meeting were noted.
162	Chief Executive Update
162.1	Mr Matthew Shaw, Chief Executive said that the Executive Team was establishing a development programme which would begin in March 2019 supported by The King's Fund. Discussion would take place around masterclasses for the Board supported by both the Advisory Board and King's Fund.
162.3	A Brexit Steering Group had been established and a number of Executive Directors were involved. It was possible that weekly returns to the centre would be required on progress being made. Current concerns were the availability of isotopes, reagents and drugs following Brexit and the Trust would be writing to suppliers to understand their supply chain and seek assurance.
162.4	Mr Shaw said that GOSH continued to host the North Thames Paediatric Network and this was likely to continue for the next three years.
162.5	Action: Mr James Hatchley, Non-Executive Director highlighted that mental health was a key feature of the NHS Long Term Plan and said it would be helpful for the Board to receive an update on the vision for mental health provision at the Trust. Mr Shaw said that he had spoken at a meeting for the mental health services across the Trust to discuss their strategy going forward and agreed that the Chief of Mental Health Services should be invited to the Board to discuss the strategy. He added that there was a clear need for an increase in inpatient beds for patients with both physical and mental ill health as there were currently very few nationally.
162.6	Action: Mr Shaw said that the Executive Team would be developing a position statement in the context of the NHS Long Term Plan and this would be presented to the Board.
162.7	Mr James Hatchley, Non-Executive Director noted that ULCH were developing a proton beam therapy centre and asked about the access that GOSH would have to this resource. Mr Shaw said that there would be two national proton beam centres and access would be prioritised through a national multidisciplinary team meeting. He said that GOSH had excellent links with UCLH and many of the Trust's patients transitioned to the centre at an early age.
163	GOSH Operational Plan 2019/20
163.1	Mr Peter Hyland, Director of Operational Performance and Information presented a paper which set out the initial approach which had been taken to developing the

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163.2	<p>Trust's financial and operational plans for 2019/20. The plans had been discussed at the Finance and Investment Committee on 1st February and the deadline for the first submission was 12th February 2019 before final submission on 4th April 2019.</p> <p>Mr Hyland highlighted to the Board that as the Trust was planning for a reduction in activity in the four weeks post EPR go-live, it was expected that RTT performance would be reduced by 0.7% and therefore it was likely that the target would not be achieved in April 2019. He added that it was anticipated that GOSH would return to compliance with the target during the financial year. Mr Akhter Mateen, Non-Executive Director queried the likely response from the regulators who had the ability to impose fines for non-compliance and Mr Hyland said that the matter had been highlighted to NHS England who had requested the Trust's recovery plan once it was available.</p>
163.3	<p>Mr Mateen queried the scale of the reduction in activity and how long this would be for and Mr Hyland said that there would be an initial reduction in outpatients of 40% in week one which would improve over the subsequent three weeks. Ms Helen Jameson, Chief Finance Officer confirmed that overall activity would remain the same but would be re-profiled over the year.</p>
163.4	<p>Ms Jameson said that the Control Total for 2019/20 was a £3.7surplus and assumptions for meeting this included a £20million better value programme which was very challenging.</p>
163.5	<p>The Board agreed to work towards trying to meet the control total and to delegate authority to the Chief Executive and Chief Finance Officer to approve the draft for submission on 12th February. The Board confirmed it was satisfied that adequate governance measures were in place to ensure the accuracy of information included within the plans.</p>
164	Integrated Quality Update Report – 31 December 2018
164.1	<p>Dr Sanjiv Sharma, Acting Medical Director presented the report and requested feedback on its new format. He said that there had been an increase in unplanned admissions to ICU and a decrease in arrests outside ICU which showed improving recognition of deteriorating patients. There had been one new Serious Incident in the period which was related to information governance and two serious incident reports were overdue and would be finalised by 15th February 2019.</p>
164.2	<p>Ms Alison Robertson, Chief Nurse said that complaints data had been moved into the patient experience section so that it could align with the FFT and PALs data to support the triangulation of themes. She also commented that Heads of Nursing and Patient Experience would be asked to report their actions arising from FFT/Complaints/PALs feedback to the Patient and Family Experience and Engagement Committee. In future reports specialties would be asked to provide updates on actions arising from PALS and FFT feedback.</p>
164.3	<p>There had been an increase in complaints in October however half of the eight complaints in the heart and lung directorate were as a result of one specific service and a known issue.</p>
164.4	<p>Ms Robertson said that it had been challenging to reach the Trust agreed 25% response rate for FFT and heads of nursing had been asked to present an action plan for meeting t their directorate target. Once improvement is evident focus will shift to understanding the information and acting on feedback.</p>

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164.5	A concerning number of complaints had been related to core aspects of nursing care and therefore a 'core care' programme had been introduced and practice educators had undertaken audits on 18 wards to establish compliance with fundamental aspects of care. A four week programme was developed focusing on improving nursing practice and a post programme audit showed improvements in the majority of areas.
164.6	Mr Matthew Shaw, Chief Executive said that GOSH was in the top quartile nationally for being a high incident reporting organisation which was positive. He said that it was challenging to complete serious incident reports within deadlines and additional resources had been provided. Mr Shaw emphasised the importance of ensuring these deadlines were met as it was part of a family's expectation of the Trust.
164.7	Mr James Hatchley, Non-Executive Director expressed some concern about whether the process for disseminating learning from serious incidents reached all appropriate staff given issues such as shift patterns and access to computers during a busy clinical shift. He said that it was important to be leading in terms of learning. Dr Sharma said that there were opportunities to maximise learning from datix, serious incidents and mortality and a group was being established to work on this. He added that learning should be a section in the integrated quality report.
164.8	Mr Hatchley highlighted the excellent reduction in cardiac arrests outside of ICU. He queried whether this was as a result of action taken by the Trust or other factors. Dr Sharma agreed that this was multifactorial but action taken by the Trust had contributed to the improvement.
164.9	Mr Akhter Mateen, Non-Executive Director highlighted the FFT comment about a parent who was not able to contact the Trust for a number of months. Ms Robertson said that work was taking place in outpatients around the system for ensuring that patients and families were able to get through on the telephone or have their call returned. She added that this was a recurrent theme and work was taking place with Heads of Nursing who had responsibility for patient experience to discuss how best to support them to lead in this area. Ms Robertson confirmed that all feedback was provided to the relevant teams for a response.
164.10	Mr Chris Kennedy, Non-Executive Director asked how far the patient portal within the electronic patient record would support patient experience work. Ms Robertson said it had potential to support this work but it was vital to ensure it was carefully managed and consistently used across specialties with some general principles developed.
165	Learning from Deaths Mortality Review Group - Report of deaths in Q2 2018/2019
165.1	Dr Sanjiv Sharma, Acting Medical Director said that the Mortality Review Group have been developed in 2012 and comprised clinicians from different specialties review all deaths in the Trust for potentially modifiable factors and learning points.
165.2	During Q2 (2018/19), 18 deaths had been reviewed and no modifiable factors were identified. A statutory child death review process had been introduced and the Trust was required to be compliant by September 2019. Dr Sharma said that due to the complexity and national profile of GOSH patients and the requirement to receive correspondence from external parties, the timeframes for reporting would be extremely challenging. Work was taking place with NHS England and

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	NHS Improvement to support the Trust to achieve the standards set.
166	Finance Update – 31 December 2018
166.1	Ms Helen Jameson, Chief Finance Officer said that the Trust was in line with plan at month 9 and continued to report that the Control Total would be met. GOSH was ahead of its income target by £3.6million and NHS clinical income remained ahead of plan offset by reduced IPP activity which was behind plan by £0.6million year to date. Ms Jameson said the debt was being closely monitored and one overseas territory had agreed to pay. Cash remains strong.
167	Integrated Performance Report - 31 December 2018
167.1	Mr Peter Hyland, Director of Operational Performance and Information presented the report and said that it continued to be challenging to meet the diagnostic waits target. He said that patients who had waited longer than 6 weeks would be seen by the end of February 2019. Sir Michael Rake, Chair asked how far a shortage of radiologists and issues in radiology contributed to the challenge of meeting targets. Mr Hyland said that although high staff turnover was unhelpful, and an excellent assistant service manager had left the team, there were a number of administration issues which continued to be managed.
167.2	Mr Hyland said that the Trust had achieved the 92% RTT target for a 12 th consecutive month compared to a national position of approximately 88% however there had been one breach of the 52 week wait in month. The patient had been referred from another Trust at over 60 weeks however from 2019/20 a fine would be levied against the Trust for these breaches. The Board emphasised the importance of challenging any fines to GOSH when breaches had been outside the Trust's control.
167.3	There had been an increase in cancelled operations in the last quarter however good work had taken place on flow which had led to an overall decrease in cancellations.
168	CQC Readiness Update
168.1	Dr Sanjiv Sharma, Acting Medical Director said that the CQC had given notification that they would be inspecting the Trust in 2019 however given the challenge of the EPR roll-out they had agreed to defer the inspection to the second half of the year. The inspection would focus on at least one core service and well led however the readiness programme which had been developed would ensure that CQC readiness was part of business as usual.
168.2	A mock inspection programme was being implemented which would be based on the CQC Key Lines Of Enquiry (KLOEs) and directorates would be paired up to inspect each other with information then being shared within team. This method would facilitate peer review and sharing of good practice as well as ensuring that staff understood the KLOEs.
168.3	Sir Michael Rake welcomed the approach to embed CQC as business as usual and Mr Matthew Shaw, Chief Executive said that it was vital that teams ensured that basic practices were in hand such as the completion of mandatory training and PDRs.

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169	Well Led Assessment Action Plan
169.1	Mr Matthew Shaw, Chief Executive said that action plans arising from previous inspections had been reviewed and any gaps added to an overall action plan. The executive team had begun collating evidence against each of the 8 KLOEs along with narrative and explanation of any gaps.
170	Safe Nurse Staffing Report (November and December 2018)
170.1	Ms Alison Robertson, Chief Nurse said that actual versus planned nursing hours had reduced since August 2018. In November six wards recorded having lower actual hours than the recommended 90% parameter however in all cases there had been an appropriate level of care hours per patient per day indicating that this was likely to be caused by an increased level of acuity leading to reduced levels of activity.
170.2	Sir Michael Rake asked for a steer on the success of the induction process for new nurses and the morale amongst the large groups of newly qualified nurses who had joined the Trust in the last two years. Ms Robertson said that nurses receive a good introduction to the Trust with a two week period during which they receive the corporate and local inductions. Work was taking place to look at the attrition rate per cohort and identify if there were any particular points within the two year professional development programme at which nurses chose to leave. Approximately 62% of the first large cohort of nurses introduced to the Trust were still in post and they would be individually invited to a career clinic to discuss how the Trust could continue to support their career development in order to retain this group of experienced nurses.
170.3	A retention plan would be presented to the Board in April and NHS Improvement would be visiting the Trust to run a challenge session to help GOSH ensure that appropriate areas for focus had been identified. Ms Robertson said that the highest area of vacancy and turnover was IPP and the team were keen for the Trust to explore international recruitment, which would require considerable planning.
170.4	Professor Rosalind Smyth, Non-Executive Director asked if the team had sufficient insight into the reasons for nurses leaving the Trust. Ms Robertson said that work had taken place to substantially change the leavers' survey for all staff. Feedback from these surveys had been triangulated with areas of high turnover to support work around teamwork and leadership however feedback was not always as granular as it could be. It was anticipated that the new survey coupled with exit interviews would provide better insight.
170.5	Lady Amanda Ellingworth, Non-Executive Director asked if there was sufficient capacity to give IPP the nursing workforce focus that was required and Ms Robertson said that the substantive Deputy Chief Nurse had now been appointed which meant that the Assistant Chief Nurse for Workforce would have additional capacity to do this as we can now proceed to substantively recruiting to this post.
170.6	Mr James Hatchley, Non-Executive Director asked if work was taking place to highlight the proportion of nurses from non-UK EU countries in different bands and directorates. It was greatest acknowledged that the greatest proportion of EU

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	staff at GOSH were in the Estates and Facilities and that work was underway to consider any deficits in nursing.
171	Corporate Governance Update
171.1	<u>Review of the Quality and Safety Assurance Committee (QSAC)</u>
171.2	Dr Anna Ferrant, Company Secretary said that following feedback received in the Quality and Safety Assurance Committee effectiveness discussion had taken place around ensuring that the views and experiences of patients were considered in reporting. Respondents to the effectiveness review had also requested more benchmarking information and reference to external reviews both of GOSH and other Trusts. In order to acknowledge the inclusion of patient and family experience the Committee recommended that the committee be renamed the Quality, Safety and Experience Assurance Committee (QSEAC). Dr Ferrant said that the Terms of Reference and workplan had been updated to reflect the feedback from the survey. It was agreed that reference to staff experience would be removed from paragraph 2.7 of the Terms of Reference.
171.3	The Board approved the Terms of Reference, workplan and revised committee name.
171.4	Dr Ferrant said that the Committee had only been able to spend a small proportion of its time considering matters related to workforce, culture and service innovation. It was proposed that a separate committee was established in order to focus on these issues. It had not been agreed whether this would be a working group or an assurance committee.
171.5	Sir Michael Rake said that although he was reluctant for there to be a large number of committees this was a key area for the Trust. He suggested that the group was in place for a year and then reviewed.
171.6	Professor Rosalind Smyth, Non-Executive Director expressed concern around the cross working between the committees. She said that the impact of decisions made at one committee would often require consideration by other committees from a different perspective. She said it would be challenging to separate workforce and cultural considerations from quality discussions. Mr Matthew Shaw, Chief Executive agreed that co-ordination between committees was an important factor but said that he was extremely supportive of introducing a workforce group. He said that given the results of the staff survey and the importance of the cultural change programme taking place at the Trust the time available as part of the QSAC agenda was inadequate. Mr Akhter Mateen, Non-Executive Director added that the only actions arising from internal audit recommendations which remained outstanding were those related to workforce and agreed that additional work was required in this area.
171.7	Sir Michael said that there would inevitable be some overlap as part of any governance structure and added that he felt this was a key area for GOSH.
171.8	Action: The Board agreed to establish the committee which would be known as the People and Education Assurance Committee. The decision would be reviewed after a year.
171.9	Professor Smyth said that the Board had received a number of draft versions of an education strategy in the past and one issue had been around the need to

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	draw together the required training for the GOSH workforce and the ability to commercialise external training opportunities. Professor Smyth recommended that these matters were considered separately.
171.10	<u>Final Board Assurance Framework (BAF) Risk Statements for 2019-20</u>
171.11	The Board had requested that the Audit Committee chair review the proposed new BAF risks which had been developed by the Risk Assurance and Compliance Group. Mr Mateen said that he felt the key issue was that the assurance committees had sufficient capacity to review the risks as required but noted that some risks were likely to be on BAF for a limited time. Discussion had taken place at the Audit Committee about increase in risks on the Board Assurance Framework from 12 to 18 however KPMG had confirmed that this remained low compared to other Trusts.
171.12	The Board approved the final BAF risk statements for 2019/20.
171.13	<u>Appointment of a Chief Information Officer/ Chief Clinical Information Officer (CCIO)/ or Chief Research Information Officer (CRIO) to the Board (non-voting)</u>
171.14	Mr Shaw said that the Secretary of State for Health had recently emphasised the importance of Trusts making good use of their data and had recommended that Board should consider including the Chief Information Officer on the Board. Mr Shaw said that the position would be on a non-voting basis but would give the CIO, CCIO or CRIO the authority to attend all Board meetings and relevant assurance committee meetings in the same way as other non-voting Directors.
171.15	Sir Michael Rake said that although it was important to hear from individuals who were close to issues, the Board was already large and it was vital that effective discussions and decision making could taking place. He suggested that the CIO, CCIO or CRIO was invited to all or part of the meeting.
171.16	Mr Chris Kennedy, Non-Executive Director said that if taking part in Board discussions would encourage the individual to take different action in the organisation then it would be a beneficial use of time.
171.17	Professor Smyth said that given the impact of technology she felt it was important that someone attended the Board and that careful consideration should be given as to who this should be.
171.18	Action: The Board agreed that the CIO, CCIO, CNIO or CRIO would be invited to attend the Board meeting (on a non-voting basis) and discussion would take place outside the meeting to determine who this would be.
171.19	<u>Consideration of appointment of an Associate Non-Executive Director on the Board</u>
171.20	Mr Shaw asked the Board to consider whether an Associate Non-Executive Director with experience in workforce was required on the Board in order to drive through the cultural change programme.
171.21	Mr Mateen said that in the context of succession planning he felt this would be beneficial however if the individual was only involved in the People and Workforce Assurance Committee it would be a considerable challenge to become sufficiently familiar with the organisation.

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171.22	Sir Michael reiterated that a larger Board meant that it was challenging to have appropriately involved discussions and Professor Smyth said that the majority of Non-Executive Directors who had experience working in large organisations had worked on workforce and culture issues.
171.23	The Board agreed that the proposal would not be taken forward.
171.24	<u>External Well Led Effectiveness Review at GOSH</u>
171.25	Dr Ferrant said that NHS Improvement guidance on 'Developmental reviews of leadership and governance using the well-led framework' encouraged providers to carry out externally facilitated reviews using the well-led framework every three years in addition to the CQC regulatory assessments of well led which should be used to inform the external inspection.
171.26	Dr Ferrant proposed that a review was undertaken in the first quarter of 2020/21 and although this was a longer time frame than suggested in the guidance the CQC inspection would be taking place in autumn 2019 and the additional time would provide newly appointed substantive Board members sufficient time to develop an understanding of the remit of their role and the Trust.
171.27	Sir Michael Rake said that it was vital that the Trust had time to focus on business as usual and suggested that the outcome of the CQC inspection should be received before a further review was scheduled. The Board noted the importance of undertaking an externally facilitated well led review and agreed to revisit this following the CQC inspection in 2019.
172	Board Assurance Committee reports
172.1	<u>Quality and Safety Assurance Committee update – January 2019 meeting</u>
172.2	Lady Amanda Ellingworth, Chair of the QSAC highlighted that a full update had been provided to the Council of Governors' meeting. She thanked Mr James Hatchley who had stepped down from the committee for his work and support over the past few years.
172.3	<u>Audit Committee – January 2019</u>
172.4	Mr Akhter Mateen, Chair of the Audit Committee said that prior to the committee meeting he had undertaken a walkround of the EPR training centre with Mr Hatchley which had been impressive. He added that EPR would continue to be reviewed at each Audit Committee and Board meeting. Mr Hatchley said that there had been a mix of a number of different roles at the EPR training centre and clinicians were embedded in various areas of the team. The Epic team was also embedded with the GOSH team.
172.5	Three internal audit reports were received all with a rating of significant assurance with minor improvement potential and a report on data quality and GDPR had been received which highlighted the large number of email search requests that were being received by the Trust. Mr Chris Kennedy, Non-Executive Director said that although the email searches involved substantial resources, agreement had not been reached on the process for the very large requests. Sir Michael Rake, Chairman said that Ms Kathryn Ludlow, Non-Executive Director was providing support in this area to consider when it was necessary to receive external

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	direction.
172.6	<u>Finance and Investment Committee Update – December 2018</u>
172.7	Mr Hatchley said that a full update had been provided at the Council of Governors' meeting the day before and that all information was included in the written report to the Board.
173	Code of Conduct for Board Directors
173.1	Dr Anna Ferrant, Company Secretary said that the Trust Board was required to have a Code of Conduct under Monitor's Code of Governance and the document had been revised in light of the changes to the Constitution.
173.2	Action: The Board approved the revised Code of Conduct and Dr Ferrant confirmed that she would circulate it to the Board for signing.
174	Any other business
174.1	There were no items of other business.

**TRUST BOARD – PUBLIC ACTION CHECKLIST
April 2019**

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
94.5	27/09/18	Sir Michael Rake, Chairman requested that the top causes of GOSH costs per patient being greater than other organisations were presented at a future meeting.	HJ, AT	April 2019	Plans are underway to benchmark GOSH costs against other similar providers to understand hospital running costs.
134.6	05/12/18	Dr Peter Steer, Chief Executive agreed that the use of novel therapies would continue to be a key issue for the Board and suggested a deep dive take place on the process that the Trust undertook to begin using the drug Nusinersen.	SS	April 2019	On agenda with a focus on new treatments on compassionate grounds
162.5	07/02/19	Mr James Hatchley, Non-Executive Director highlighted that mental health was a key feature of the NHS Long Term Plan and said it would be helpful for the Board to receive an update on the vision for mental health provision at the Trust. Mr Shaw said that he had spoken at a meeting for the mental health services across the Trust to discuss their strategy going forward and agreed that the Chief of Mental Health Services should be invited to the Board to discuss the strategy.	AF	April 2019	To be presented at a future Board (May or July 2019 – TBC)
162.6	07/02/19	Mr Shaw said that the Executive Team would be developing a position statement in the context of the NHS Long Term Plan and this would be presented to the Board.	MS	April 2019	Executive Team have met with SMT members to discuss the statement – on agenda under CEO Update
171.8	07/02/19	The Board agreed to establish the committee which would be known as the People and Education Assurance Committee. The decision would be reviewed after a year.	AF	April 2019	Actioned: ToR drafted for review at the first meeting of the committee
171.18	07/02/19	The Board agreed that the CIO, CCIO or CRIO would be invited to attend the Board meeting and discussion	MS	April 2019	CCIO has been invited to attend the Board

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Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
		would take place outside the meeting to determine who this would be.			
173.2	07/02/19	The Board approved the revised Code of Conduct and Dr Ferrant confirmed that she would circulate it to the Board for signing.	AF	February 2019	Actioned – circulated to all Board members on 13 February 2019

Attachment C

Trust Board 3rd April 2019	
Chief Executive Report	Paper No: Attachment C
Submitted by: Matthew Shaw, Chief Executive	
Aims / summary Update on key operational and strategic issues.	
Action required from the meeting For noting.	
Contribution to the delivery of NHS Foundation Trust strategies and plans <ul style="list-style-type: none"> • Compliance with CQC Well-Led framework • Delivery of trust strategy 'Fulfilling Our Potential' 	
Financial implications <ul style="list-style-type: none"> • None (business as usual) 	
Who needs to be told about any decision? Not applicable	
Who is responsible for implementing the proposals / project and anticipated timescales? CEO and executive colleagues	
Who is accountable for the implementation of the proposal / project? CEO	

Attachment C

Proposed changes to specialised services tariff

After many months highlighting the impacts of the proposed changes to the Specialised Service Tariff in discussions with NHS Improvement we have now joined forces with the other standalone children's hospitals to request an urgent resolution. The significant real-terms reduction in the tariff for complex children's services will have a destabilising impact on our services and understanding the scale and identifying a solution to minimise the impact is our top priority.

We are grateful to the Chair for writing to NHS Improvement to escalate the issue on our behalf and for raising it with Health Minister the Rt Hon Stephen Hammond MP during his visit to GOSH on 7th March 2019 for National Apprenticeships Week. Discussions are ongoing and there is no resolution as yet, so a verbal update will be provided during our meeting.

Staff wellbeing – culture and behaviours

The annual NHS Staff Survey results were published on 26th February 2019. We were pleased that 2,287 staff contributed, and some good progress recognised, but the results overall were disappointing. Tackling the poor behaviours that affect staff wellbeing and developing a kinder and more supportive culture is clearly a key strategic priority for us through this year, as is monitoring progress with the action plan that will be presented during the Board meeting.

Creating the necessary scale of organisational change is going to require our focus and effort to offer visible, compassionate leadership. During the all-staff briefing sessions and across staff communications we have encouraged people to be open about tackling these issues. I have invited anyone who is facing harassment, bullying or abuse at work and doesn't feel supported in raising their concerns to come directly to me. Several staff members have visited me over the past few weeks. In some cases I have just provided a listening ear, in others I have been able to connect them with the appropriate HR support or to connect them with our Freedom to Speak Up Guardian. This approach will help inform me on the kind of issues some staff are facing and, run in tandem with the wider action plan, is an expression of support for those who feel that they haven't been sufficiently heard by our leadership to date.

Board membership and development update

We were pleased to welcome our new Director of HR and Organisational Development, Caroline Anderson on 18th March 2019. Already Caroline is providing valuable input and fresh perspective for our executive team discussions and it's great to have her with us.

We are also pleased to welcome Shankar Sridharan, our Chief Clinical Information Officer, to board meetings as a non-voting director. Shankar will provide the board with expert knowledge in the field of NHS digital transformation to help ensure our decision-making is

Attachment C

informed by a professional with oversight on how to maximise the use of data and technology to benefit our patients.

Applications for the Medical Director post have now closed and interviews are scheduled to run at the end of the month.

We are grateful to the chair and non-executive directors for their support in meeting with the King's Fund team who are working with us to create a Board Development Programme responding to elements of the CQC's Well Led Framework. We hope you will find these discussions interesting and thank you in advance for your input to shape the programme.

GOSH Strategy consultation

We have progressed our plans to engage and consult with staff, patients and families, external partners and other stakeholders to develop and build on the Trust's Strategy *Fulfilling Our Potential*.

Staff have been invited to participate in one of six engagement workshops during May to contribute ideas on the vision and priorities for our long term strategy. I have asked our senior leadership team to use the workshops as a model for ongoing discussion and development of the strategy within their own teams.

Our in-house experts on the patient experience are developing a programme of activities to take place during June and July to engage with patients and families. We have booked in workshops for our Council of Governors during April and the Young People's Forum in Summer and are scheduling a series of meetings with external partners. Board members are very welcome to participate in any of these sessions and invited to hold a discussion on vision and priorities at a session booked for this purpose on 23rd May 2019.

The feedback from the engagement phase will be used to create content for an exhibition and themed workshops to socialise and develop elements of the strategy. This will take place in the staff side of the Lagoon throughout the week commencing 16th September 2019. The Board are invited to visit the exhibition during their meeting on 18th September 2019 to speak with staff about the displays.

We propose that the strategy is then discussed, refined and tested during the Board Seminar in October 2019 with a view to finalising and publishing it soon thereafter.

Brexit preparedness

The Brexit Working Group continues to meet weekly and produce situation reports daily to prepare for the various impacts of a no-deal Brexit. Staff have worked through government guidance, participated in scenario planning exercises, attended workshops with key partners, completed all the necessary information returns, updated business continuity plans, undertaken stock takes and kept in regular contact with suppliers to identify and mitigate the risks identified on the Board Assurance Framework.

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The communications team have produced and distributed materials to signpost EU staff towards the settlement scheme and support clinical teams in reassuring patients and handling their questions.

EPR programme update

The Electronic Patient Record (EPR) Programme remains on plan to implement our new Epic clinical system over the Easter weekend (19th April 2019). The design, configuration and testing phases are now complete and we are now in the Training and Go-Live Phase. 68% of all staff have now been trained. Attendance and pass rates are excellent and feedback positive. Following training staff are given access to an environment to allow them to further develop their skills and the confidence to ensure a faster stabilisation following go-live. Deployment of final technical devices is in progress, as is the testing of each individual device with Epic (Technical Dress Rehearsal). A full go-live Dress-Rehearsal has allowed us to test cutover process and timings against the plan.

Planning for the transition is being overseen by our Directorate leadership teams, supported by our EPR Programme team and our main supplier, Epic. Our governance groups are managing existing risks and issues and progress against a specific set of 'go / no-go' criteria will be managed through Trust Board and its sub-committees, ensuring we minimise, as far as possible, the impact of this hospital-wide transformation programme on our staff and mitigate any potential clinical safety risks for our patients. The Programme is forecast to complete the implementation phase within the budget originally set by the Trust Board in April 2017.

External stakeholder engagement

UK Children's Hospitals Alliance

The CEO, Chief Nurse, Interim Medical Director and Strategic Partnerships Advisor attended a meeting of the UK Children's Hospitals Alliance on 5th March 2019. At a pre-meeting of the CEOs for the standalone children's hospitals last year it was agreed that the purpose of the session should be to agree on the strategic objectives and delivery structure for the organisation.

In the event, the session facilitator relinquished the agenda for a discussion on delivery areas for NHS England's Children and Young People's Transformation Board – one of many structures proposed to implement the NHS Long Term Plan. Attendees stressed the importance of alignment with ongoing work in clinical networks and other national and regional structures to avoid duplication of effort and resources. Several potential focus areas were suggested by participants but there was no indication that these would be carried forward and the discussion was ultimately inconclusive.

During a short session on the alliance the purpose and objectives of the partnership were approved and a working group established on the development of a National Paediatric Pathology Network established, with GOSH nominated to lead. We are continuing work at

Attachment C

various levels to help shape and realise the potential of the alliance, including on some promising work to pilot a benchmarking framework and to provide a shared evidence base for improvement activities across member trusts.

Federation of Specialist Hospitals

GOSH has joined the Federation of Specialist Hospitals, a CEO-led alliance which is focused on broad collaboration and engagement to define, develop and deliver on the valuable role that specialised hospitals play in the healthcare system.

The group commissioned an interesting report *Understanding the Performance and Potential of Specialist Hospitals* (attachment 1) through two Academic Health Science Centre partners in London (UCL Partners) and the North East. Articulating the largely unrealised potential of specialised hospitals to provide NHS system leadership, the issues that they face in realising this potential and case studies that illustrate their innovative approach, the report has proved to be a useful tool to engage policy and political stakeholders. Further materials are being prepared to respond to the themes within the NHS Long Term Plan, and GOSH is contributing case study material.

Attachment 1: Understanding the Performance and Potential of Specialist Hospitals

Flu vaccination uptake rates

Last year all NHS Trusts and NHS Foundation Trusts were asked to publicly report information on frontline healthcare worker flu vaccination via their boards. The attached report provides information on our latest take-up rate by frontline healthcare workers (currently at 60 per cent), the reasons given for opting-out and the comprehensive set of interventions in place to increase take-up.

Attachment 2: Trust Board update on Healthcare Workers flu vaccination uptake

[Ends]



INNOVATION AGENCY
Academic Health Science Network
for the North West Coast

UCLPartners
Academic Health Science Partnership

UNDERSTANDING THE PERFORMANCE AND POTENTIAL OF SPECIALIST HOSPITALS

NOVEMBER 2018

EXECUTIVE SUMMARY

All specialist hospitals are unique but they are similar in that they bring or have the potential to bring value into the system in terms of improving quality standards.

A number of specialist trusts are rolling out treatments that have proven clinical value (as judged by NICE) but have not yet received financial viability approval. When these treatment methods are refined, they then receive financial approval from commissioners and can be rolled out more widely to patients. This should be recognised as giving much benefit to the patients and the healthcare system.

Specialist trusts are leading crosscutting work streams in their local system, which are adding much value to partners. However, there is sometimes a tension in the system with other providers interpreting a leadership role as an attempt to take more control.

Specialist trusts cite their international expertise but more work could be done to formalise these links and spread good practice from the UK. These comparisons could be used by Specialised Commissioning to ensure performance and standards are truly the best in class.

Innovation and its adoption, which is commonly demonstrated in specialist hospitals, creates a culture that can attract the best staff, bring in the best research/researchers and develop better outcomes for patients. The focus on this area could be replicated in other hospitals, supported by AHSNs.

Indicators such as CQC ratings, Friends and Family Test, staff survey and other measures of performance and patient experience consistently show high scores for specialist trusts. It is thought this is helped by a more focused provision of services and by the smaller size of specialist trusts, which enables greater staff engagement, a feeling of community; and by a great sense of pride in clinical specialism.

The study shows that there are many examples of specialist hospitals sharing expertise, pursuing adoption of standardised pathways or outcome improvement and undertaking leadership roles. A large proportion of this existing involvement is based on the use of their internal funding provision. Many specialist hospitals recognise they are on a transformational journey; adapting to changing healthcare policy, financial funding priorities and their engagement roles with the rest of the healthcare system.

Many expressed the need to formalise this wider 'public service responsibility role' with a mechanism for commissioners to formally contract with specific providers to assist with the development and redesign of commissioned services; the adoption and implementation of service innovation; and assistance with the improvement of outcomes.

However, supporting permissions, service delivery adoption infrastructure and pump priming financial support are required to ensure that transitions to new care models are embedded.

RECOMMENDATIONS

1. Our interviews have shown that many of the specialist trusts who are successfully innovating employ a senior level post to lead this function and link into supportive agencies such as AHSNs, NIHR infrastructure etc, as well as appropriate commercial partnerships (as strongly evidenced by The Christie Hospital NHS Foundation Trust experience). This approach should be adopted in a systematic manner across specialist hospitals and into the wider hospital sector.

Recommendation: All trusts should consider the development of senior level post with a designated innovation role.

2. The majority of specialist trusts said they would welcome the development of a more systematic best practice approach to help fast track service innovations of value with availability of expert advice.

Recommendation: The AHSN Network should take the lead in collaboration with Specialised Commissioners and the specialist trusts group on the development of a best practice approach to service innovation and a supporting expert team capability that is accessible to all trusts.

3. A role for Specialised Commissioners may be to formalise international links and benchmark specialist trusts against international best in class standards for innovation and performance to ensure world-leading services.

Recommendation: Specialised Commissioners should consider supporting the international benchmarking of specialist trusts, using some of the service outcomes standards as part of the core specification with all providers.

4. The current role of some specialist trusts in funding and improving financial efficiencies of innovative treatments, which benefit patients, should be celebrated and recognised in the system.

Recommendation: A pump priming innovation fund should be established by NHS England to be accessed via bids from specialist trusts and other providers, to take forward wider service advances, on the condition they help to promote the roll out of the service innovation.

5. The narrower condition/treatment focus in most specialist trusts has allowed an enhanced focus on a supportive, collegiate culture where colleagues can unite around a theme and share a common language.

Recommendation: We recommend that the proposed NHS Confederation work explores whether this culture could be replicated in other provider organisations.

6. Where specialist hospitals have adopted population health roles as part of their mission, this is valued by the system and may be a role that more specialist hospitals would like to promote into their system and/or at a national level. In Merseyside, specialist trusts are integrated into their STP and leading a number of work streams on population health to benefit the health and care system. In some areas, AHSNs are helping to form a bridge between specialist hospitals and the wider NHS including STPs.

Recommendation: NHS England should consider how specialist hospitals could provide a supportive population health management role in STP work around the standardisation of care pathways and adoption of prevention activities.

7. Although many of the specialist hospitals are national and sometimes global leaders in translating their discovery science and clinical expertise into innovative treatments, they are often unaware of the national policies, levers and funding streams that might encourage faster adoption and spread.

Recommendation: Every specialist hospital should establish a formalised partnership with their local AHSN to take forward service innovation and accelerate adoption and spread.

SECTION ONE: INTRODUCTION

1.1 INTRODUCTION

Specialist hospitals are widely recognised for their excellence within individual specialties, including rare and complex cases. The contribution that specialist hospitals provide to the English healthcare system has previously been documented in several reports from the Federation of Specialist Hospitals, namely:

- Harnessing the potential of specialist hospitals 2009
- A report on the outcomes achieved by specialist hospitals May 2014
- Driving innovation in the NHS November 2015
- Building a successful NHS workforce October 2016

These reports are available on request by emailing: secretariat@fsh.uk.net

The value of specialist hospitals has been well documented in many of these reports with examples of how they have achieved high quality and service standards, pioneered new treatments and developed a global reputation for research and service innovation. These reports have contained case studies outlining both excellent service innovation and in many cases, clinical services excellence.

It is recognised that specialist hospitals consistently perform well and are seen as demonstrating a stronger culture of service innovation. It was felt by both the Federation of Specialist Hospitals and a number of the Academic Health Science Networks that a deeper understanding of the performance of specialist hospitals would be helpful in:

- a) Spreading any learning to other organisations and
- b) Gaining a greater understanding of how specialist hospitals can use their strengths to better connect with and benefit other providers in the wider NHS in their integrated care systems and place-based health and care systems.

1.2 APPROACH TAKEN

The Federation of Specialist Hospitals commissioned the Innovation Agency (AHN for the North West Coast) and UCLPartners to undertake this study. Both organisations are contiguous with two main clusters of specialist hospitals. The analysis and supporting co-ordination of this report has been supported by Paul Wood, independent management consultant.

The study has involved the following activities:

- 1) A series of structured interviews with a selection of stand-alone specialist hospitals and specialist services that are part of a wider group of hospitals. In total, 12 out of 21 specialist hospitals have contributed to this study. In addition, three chief executives/chairs of larger trusts with specialist services that are now part of their larger group of hospitals were interviewed.
- 2) A series of structured interviews was undertaken with leading stakeholders in the NHS, NHSI, Specialised Commissioning, Shelford Group, NIHR and a regional transformation partnership leader.

The full list of participants in the interview process is included in Appendix 2.

- 3) Comparative analysis of the current published information around the performance of specialist hospitals and some extracts of published analysis undertaken by the national GIRFT team has been undertaken. We acknowledge the contribution provided by this national team and individual contributions made by specialist trusts to this part of the report.
- 4) Assessment of the relative importance of different factors raised by interviewees supporting the underlying reasons for relatively higher performance.
- 5) Capturing the current roles and activity undertaken by specialist hospitals in the leadership and delivery of wider system transformation work and assessment of the potential of specialist hospitals in testing, developing and disseminating innovation.
- 6) Highlighting case studies of key service innovations or service transformation approaches being adopted by specialist trusts, which have potential wider relevance or which could be spread into the wider health sector.

This work was undertaken during the period July to September 2018.

1.3 STRUCTURE OF THE REPORT

The report structure is as follows:

Section 2: An understanding of specialist hospitals' performance and the underlying factors, which may explain relatively higher performance; this section covers a short summary of the availability of the relevant data on the performance of specialist and other aligned hospitals.

Section 3: A summary of the roles that specialist hospitals are undertaking in regional STPs (Strategic Transformation Partnerships) or national roles in which they are promoting or leading service innovation or improvement initiatives. This section also covers some of the key areas highlighted where specialist hospitals could either extend or develop their role in systems based place based care or service transformation work.

Section 4: A description of the scale of service innovation taking place and an overview of the potential of specialist hospitals in disseminating innovation.

SECTION TWO: UNDERSTANDING THE PERFORMANCE OF SPECIALIST HOSPITALS

2.1 INTRODUCTION

Our interviews highlighted that there are at least four dimensions of performance in which specialist hospitals can be considered. These are:

- 1) Performance against the regulatory provider license framework that is monitored by NHS Improvement.
- 2) Comparisons with similar specialist service providers internationally in particular in the areas of cancer, orthopaedics and children's services. Although published information in this area is limited, clusters of specialist trusts are undertaking this comparative performance on a regular basis, as part of their service innovation focus and an aim to provide world class performance, service standards and outcomes.
- 3) Calibre of applied scientific research undertaken across specialist hospitals in conjunction with local academics and researchers.
- 4) Effectiveness of specialist hospital roles in contributing towards improving the wider health system performance through:
 - reducing the scale of unwarranted performance variation
 - leading the standardisation of specific pathways
 - leadership roles in the development of clinical care networks

2.2 AVAILABILITY AND USE OF INFORMATION

A review of information that is readily available suggests that current performance metrics are focused around service access targets, CQC ratings, and patient satisfaction levels.

The NHS Specialised Commissioning function collects and reviews differential performance of all providers they fund, focusing on financial performance, time to treat and other quality indicator dashboards. Any comparative performance review is on an individual provider basis against agreed service activity contract terms and compliance with the delivery of any prescribed service specification or commission of specialist hospitals as a group.

Specialist trusts are providing many of the benchmarks of qualitative best practice or standards used in improving value initiatives such as Getting It Right First Time (GIRFT).

2.2.1 INTERNATIONAL BENCHMARKING – EVIDENCE ON OUTCOMES

For many specialist trusts, there are few UK providers with a similar patient case mix on which to compare outcomes on a like for like for basis. A few specialist trusts compare their outcomes performance with a peer group of international provider comparators.

Several specialist trusts gave examples where their outcomes for particular services are known to be best in the world or compare favourably with 'best in class'. However, as commented by interviewees, meaningful comparisons on outcomes data are often limited to just a few indicators on cancer survival rates and PROM style indicators around orthopaedic surgery.

There is limited published international benchmarking information around specialist hospitals used by the national Specialised Commissioning function as part of their performance intelligence or evaluation of investment levels. This is an area for consideration by clusters of specialist hospitals in partnership with the national Specialised Commissioner.

In terms of performance and contribution to the wider system, as outlined later (section 3), there is a wide spectrum of different roles being played by specialist hospitals in their local systems or with a national focus, with limited defined measurement or contribution.

Clinical Excellence awards may be viewed as an indicator of high service standards, outcomes and service capability. However, they rely heavily on individual self-reporting and often do not reflect system benefits. Information is not currently reported by grouping of specialist hospitals as compared with large teaching or acute hospitals. Clinical Research ratings are linked to their associated alliances with universities.

2.2.2 GIRFT REPORTS – EVIDENCE AROUND BEST PRACTICE PATHWAYS

Evidence of compliance to best practice standards and appropriate reduction or increase in care and resource use is beginning to emerge as part of the GIRFT report and supporting processes. We outline in Section 3 the pioneering role that certain specialist hospitals have made already to the development of this performance review and improvement approach. As outlined by one interviewee, there is an overriding need to develop the evidence base of NHS service outcomes and standards.

"There is a real opportunity using the evidence base for supporting innovation to make a significant impact far in excess of their relative size. It is important to encourage specialist hospitals to deliver this and to understand that innovation is part and parcel of what they should be doing.

2.3 OPERATIONAL COMPARATIVE PERFORMANCE

Hypothesis: Specialist hospitals are achieving higher performance ratings against the areas of common performance measurement.

In an attempt to test this hypothesis, we have used the NHS Improvement performance datasets and other readily available datasets. Overall analysis of the cumulative performance in the final quarter of 2017/18, indicates that a large cohort of both stand-alone specialist hospitals and specialist hospitals that are part of a wider hospital group do record higher levels of performance ratings in the areas routinely measured by the NHS sector.

As outlined below, although a greater proportion of specialist trusts have good to outstanding CQC ratings, this is not a consistent picture across the board.

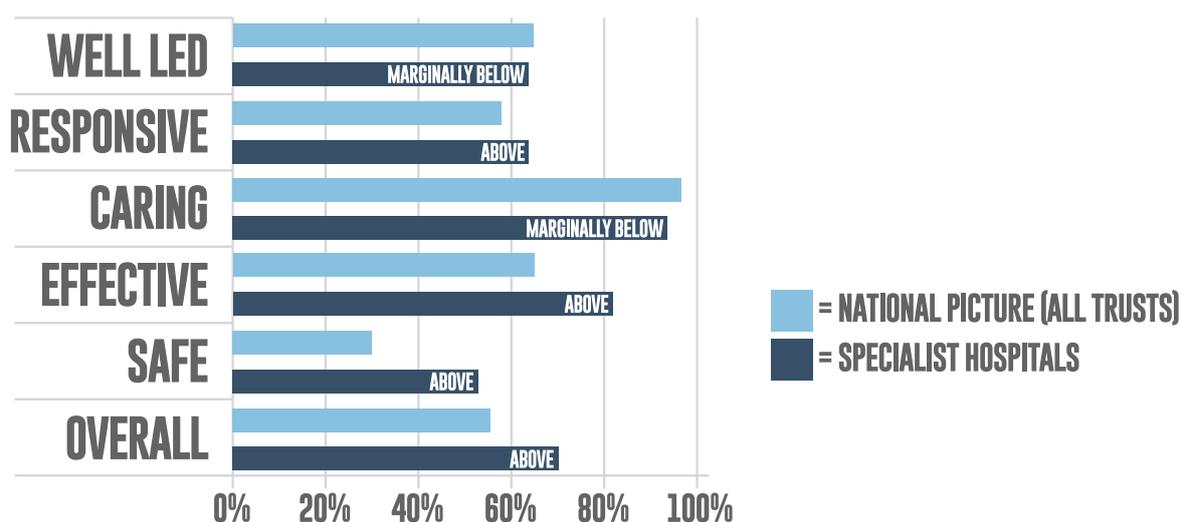
2.4 CQC RATINGS PERFORMANCE

In total, 71 per cent of specialist trusts are rated good or outstanding compared to 56 per cent of all trust providers group.

The chart below summarises the profile of CQC ratings as at final quarter of 17/18:

The review of the current CQC ratings database for all providers as at July 2018, suggests that:

- Stand-alone specialist hospitals group has a higher level of overall good and outstanding ratings than the other hospital provider groups
- Specialist hospitals record higher levels of good and outstanding ratings on safe, resource effective, responsive ratings compared to all other trusts groups
- Specialist trusts group have a similar profile of good and similar ratings on Well Led and Caring compared with other NHS trusts groups
- Specialist hospitals that are part of a larger group of hospitals appear to perform well on CQC ratings – four out of five.



2.5 FINANCIAL CONTROLS TOTAL POSITION

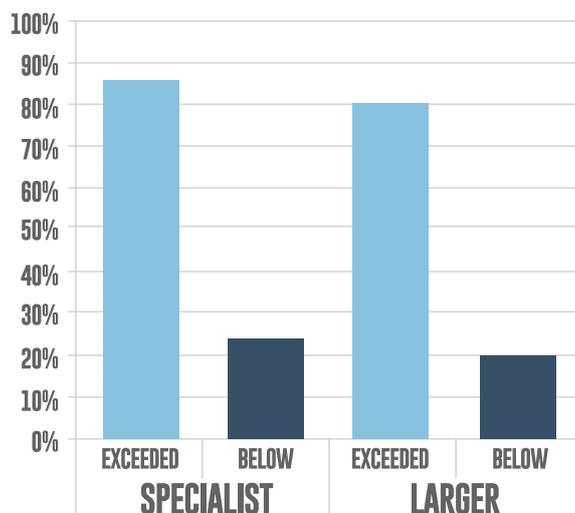
Table 1 below summarises the targeted financial position of NHS trusts in 17/18 compared to the actual reported within the NHS Improvement reporting framework. It shows that specialist hospitals in overall net return delivered a higher surplus position than expected in the region of £265m. This is compared with non-specialist trusts' reported deficit position increasing by £422m.

GROUP CATEGORY	YEAR TO DATE TARGET (£M)	ACTUAL £M	VARIANCE	% OF TRUSTS ACHIEVED
Non Specialist Trusts Group	- 937.6	- 1359.62	- 422.02	67%
Specialist Hospitals Group	25.8	248.22	222.42	76%
Specialist Hospitals Part of Larger Hospital Groups	12.3	45.1	32.8	80%
Overall Provider Sector	- 899.5	- 1066.3	- 166.8	

SOURCE: NHS I QUARTERLY REPORTS

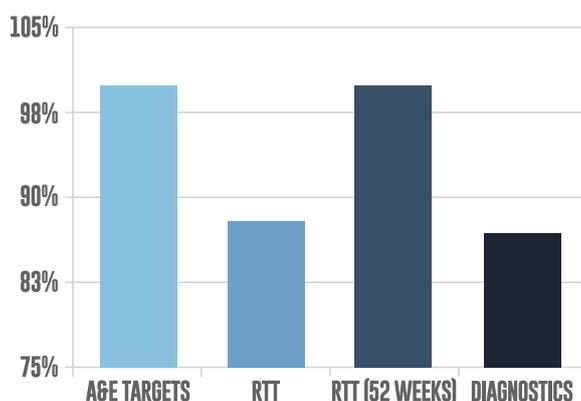
The chart below shows that 75 to 80 per cent of specialist hospitals achieved their financial control position compared with 67 per cent of all other trusts.

Chart: Proportion of stand-alone specialist trusts exceeding their financial control target compared to their specialist providers that are part of larger group



2.6 SERVICE ACCESS PERFORMANCE

Specialist trusts perform well above the average across all the service access performance measures.



SUMMARY TABLE	A&E TARGETS (%)	RTT COMPLETE (%)	RTT (52 WEEKS) NO	DISAGNOSTICS W TIME (%)
National Average Non Specialist Hospitals	83.55 %	86.78 %	526.80	2.13 %
Specialist Hospitals Group	97.20 %	85.90 %	4.94 %	1.28 %
% of Specialist Hospitals - Above National Average	6 out of 6	15 out of 17	17 out of 17	14 out of 16
Overall Provider Sector National Average Performance	100 %	88 %	100%	87 %
Specialist Hospitals Within Larger Groups	62.1%	68.96 %	40.8	1.28

2.7 NATIONAL CANCER TARGETS

Reported performance in this area is overall well above the national average among all providers. Chart 3 below illustrates the profile.

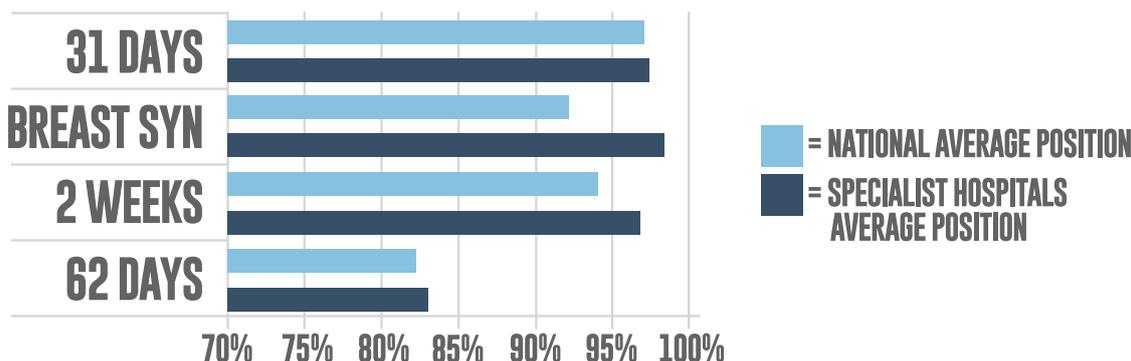


Table 3: Supporting Summary Table – Cancer Targets Performance

SPECIALIST HOSPITAL TRUST	CANCER 62 DAYS (%)	CANCER 2 WEEKS (%)	CANCER BREAST SYN	CANCER 31 DAYS
No. of Trusts	15 %	11 %	2 %	15 %
Average Position (Spec Hospitals)	83.1 %	96.7 %	98.4 %	97.5 %
National Average Position	82.3 %	94.1 %	92.3 %	97.2 %
% of Specialist Hospitals - Above The National Average Performance Level	8 out of 15	9 out of 11	2 out of 5	12 out of 15

2.8 PATIENT EXPERIENCE RATING

The majority of specialist trusts perform very well against the national patient experience ratings. The majority of specialist trusts record an above average percentage of recommendations re Friends and Family Test and all score highly in the inpatient survey.

Table 4: Summary Position on Patient Experience Rating

TRUST PROVIDER GROUPINGS	FRIENDS & FAMILY TEST (% RECOMMENDED)	IN PATIENT SURVEY (EXPERIENCE RATING OUT OF 10)
National Average (All Trusts)	96.0 %	8.20
Stand-Alone Specialist Hospitals	95.8 %	8.87
Specialist Hospitals as part of a larger group	94.3 %	8.18
No of specialist hospitals above the national average rating	13 out of 17	13 out of 13

Source: NHS Inpatient Survey and Friends & Family Test

Orthopaedic trusts perform in the top upper quartile, top 10 percent. As outlined by many specialist trusts, the single client or service focus provides the opportunity to focus on patients and families’ experience of the key pathways and the quality.

2.9 KEY REASONS FOR SPECIALIST TRUSTS PERFORMING WELL

The level of empirical and longitudinal evidence based around the key factors underpinning the higher levels of performance ratings is very limited. But the views of specialist trusts providers and system leaders interviewed were relatively consistent on the key factors that they see every day that are underlying factors in delivering a higher level of performance. Table 4 below summarises the key reasons given for the higher performance levels. None of these key factors is unique to specialist hospitals but many interviewees believe a higher number is evident in these providers.

Table 4: Summary of the key reasons provided for higher performance

SPECIALIST HOSPITAL TRUST	% MENTIONED BY SPECIALIST TRUST INTERVIEWEES	% MENTIONED BY OTHER STAKEHOLDER INTERVIEWEES
Single Specialty / Client Group Focus	80 %	100 %
Culture of Research / Service Excellence & Continuous Improvement of Patient Services	100 %	80 %
Focus on scheduled Patient Care Interventions Rather Than Emergency /unscheduled	70 %	90 %
Clinical & Managerial Leadership Capability	100 %	80 %
Calibre of Staff & Their Focus on Outcome Excellence	100 %	100 %
Sense of Identity / Staff Motivation Linked to Culture	90 %	60 %
Funding Position of Specialist Trusts	50 %	80 %
Co-Location of Specialist Services	50 %	30 %
Smaller Size of the Organisation	80 %	80 %

Source: Interviews held with specialist trust leaders and other system stakeholders and factors highlighted for the good performance

2.10 KEY REASONS: VIEWS OF SPECIALIST HOSPITAL LEADERS & SYSTEM LEADERS

Single specialty focus & scale of scheduled workload

The most common observation made by nearly all interviewees is the inherent advantage that specialist hospitals have in being able to focus both clinical leadership and management on a single specialty focus that is predominantly around scheduled care.

This is compared with the typical DGH or large hospital role of managing the scale of non-elective/emergency activity with up to 90 service specialty lines in major teaching hospitals.



So, that's one of the real drivers from the financial performance that I think allows specialist organisations to be much more planned, to work to standard operating procedures much more, to be clear about end to end processes and so the relative efficiency becomes quite clear.

I think being a single specialty organisation means that we can focus what we do and also, are protected from the pressures of other specialties. So, if we think for example about our A&E performance, I think we are consistently the best performing hospital in London and that is by focus of our specialism. So, not only are ophthalmic patients rarely admitted when they come to A&E, we're also not having to make difficult decisions in terms of prioritising ophthalmic patients attending A&E compared with other people perhaps coming in with more critical life-threatening illnesses.

MOORFIELDS EYE HOSPITAL





Due to the specialism they can focus, ensure that things happen and having this clear focus means that staff and clinicians easily understand each other, which helps them to accelerate innovation and improved performance, partly due to the peer support.

THE WALTON CENTRE NHS FOUNDATION TRUST

Due to the size of the trust there is the opportunity for clinicians to coalesce around something in common. This size and focus allows some headspace for staff, compared to big DGHs who are always fighting fires.

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST



Specialist hospitals have the inherent advantage of being able to focus scheduled care of a limited number of service lines rather than 90 plus of typical large hospitals or DGHs that are managing large volumes of emergency activity, every day.

NHS IMPROVEMENT LEADER

Particularly how do you optimise specialist services as part of a busy organisation? How do you ensure that you maintain the quality as you start to bring in new translational medicines and translational innovation is an interesting topic. We are having quite an active discussion with NHSE about excess treatment costs."

GUY'S & ST THOMAS' NHS FOUNDATION TRUST



Culture, research & continuous improvement

The culture developed by many specialist trusts was highlighted by many as one of the key differences that results in better outcomes and performance levels. Both the scale and focus of research and the drive for continuous improvement was also raised by many specialist trusts as a major contributing factor.



The philosophy is that the trust is one big team and the execs are very visible, which is not the case in bigger trusts. The culture has developed over the last 10 years and our vision is to be the best. Cardiac procedures, surgery and cancer are all subject to national scrutiny and this means that there is a competitive consultant environment, which breeds excellence. Staff know that what they say will be taken seriously and the workforce is like a family, who all know each other.

LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST



I think what's so exciting for me in my organisation is if we can add that culture of really supporting innovation and improvement and it becomes part of what we do, bottom up as opposed to sort of top down, I think the opportunities that will be unlocked will be massive.

MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST



Clinical & managerial leadership



The trust has an unstinting focus on leadership and quality and there is an in-depth understanding by all staff of the work of the organisation. The trust is robust in measurement, assessment and monitoring and sees itself as being on a continuous improvement journey. As the trust is small, there is exec engagement with staff. The trust listens to its staff; a huddle is held every day with executive team, clinical and back office teams, including HR, medical engineering and others.

LIVERPOOL HEART & CHEST HOSPITAL NHS FOUNDATION TRUST

The trust has a robust clinical leadership model and has an external governance review in place. Staff don't have to ask for permission for making changes that will improve safety, care or patient experience issues.

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST

I guess the thing that particularly differentiated between that and some of the previous ratings was assessments around leadership and two particular things came out quite strongly if you read through our CQC report.

BIRMINGHAM WOMEN'S & CHILDREN'S NHS FOUNDATION TRUST

It is clear from viewing the performance of NHS providers, although specialist hospitals have many inherent advantages, these would not be harnessed if they didn't have a very strong calibre of leadership.

NHS IMPROVEMENT



Culture, research & continuous improvement

All specialist hospital stakeholders highlighted their aligned culture throughout the workforce as one of the major factors in performing well both on process measurements and clinical service outcomes.



Smaller specialist hospitals have a particular work ethic, focused on making them centres of excellence.

We tend to be reasonably comfortable that we can deliver on the process; it gives us the time and the capacity to focus on the outcome measures. So, I don't know that I could evidence this but the fact that we don't have to get our clinicians spending huge amounts of time prioritising who they allocate theatre time to in order to meet RTT, means they have got time to think about their PROM indicators, the appropriate clinical outcome measures for their patients and to focus their discussions and their time on that.

About 50 per cent of our focus is given to research and the application of how we can advance treatments and services for the benefit of our local population.

ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST

All staff, no matter what professional grouping, are encouraged to be engaged in either research or service innovation and improvement.

THE CHRISTIE NHS FOUNDATION TRUST

The difference with working in a specialist hospital was that our clinicians - and I don't just mean doctors - but nurses, AHPs and everyone were travelling round the country, travelling round the world presenting examples of their research and service innovation that they were doing; they were learning what other people were doing.



ALDER HEY CHILDREN'S NHS FOUNDATION TRUST

Calibre of staff & alignment of motivation to focus on outcomes

A major underlying factor of their relative success raised by all interviewees from specialist hospitals is the calibre of staff they attract and their motivation to undertake research and service innovation. It is seen by many as an important differential that facilitates the higher performance levels and delivery of service excellence.

“ I couldn't point you to any evidence of this, but I wonder whether it has a positive impact in terms of the staff as well. Our clinical staff are more motivated because they've got the time to focus on clinical indicators rather than RTT, which is understandable. The process measures which are important are understandably less likely to motivate a clinician than a conversation about outcomes.

**MOORFIELDS EYE HOSPITAL
NHS FOUNDATION TRUST**

Commitment of staff and outlook. Staff are mission driven and have a quasi-religious belief that the trust has a special role. There is uniqueness in what they do and for patients, the care is better. This creates the characteristics. Facilities are antiquated but patient experience is always in the upper 90 per cent in surveys. As they deal in end-stage disease, they are the last station for many patients and many will die. They are grateful for their care and staff reflect that approach.

**ROYAL BROMPTON & HAREFIELD
NHS FOUNDATION TRUST**

Unlike the rest of the hospital sector, our ability to recruit the most capable of staff and retain them is one of our greatest strengths; our temporary staff cost profile represents less than one per cent of our total trust costs. We have never had to use a large temporary staff profile.

**THE CHRISTIE NHS
FOUNDATION TRUST**

“ The viability of specialist institutions does seem to be stronger than it is for some of our smaller DGHs where there is little population movement, it is difficult to recruit, disconnected from the academic mainstream and their core can become isolated and nucleus hard to maintain.

We are surrounded by a few of the best academic institutions in the world. So, there are smart people everywhere.

**UNIVERSITY COLLEGE LONDON
HOSPITALS FOUNDATION TRUST**

I think that something else that differentiates specialist hospitals from other organisations, even university teaching hospitals, is that generally staff satisfaction levels are much higher. They are always in the high 90s which possibly reinforces the narrative that life is easier and better and nicer; but you can flip that over and say well what is it about a positive experience that people are having?

**MOORFIELDS EYE HOSPITAL
NHS FOUNDATION TRUST**

“ I think the fact that we do perform consistently well in specialist hospitals on things like staff surveys and friends and family feedback is something that's embedded in the culture, the patient experience side of the things, and the organisation's pride in what it does. And that's I think what binds us rather than the clinical speciality – it's the cultural thing we are really analysing here.

**ROYAL NATIONAL ORTHOPAEDIC
HOSPITAL NHS TRUST**

“ We have constantly engaged patients and carers in the design of our services and regular monitoring of performance. As a result of this we provide service consultations in many local hospitals and have developed our chemo@work service offering.

**THE CLATTERBRIDGE CANCER
CENTRE NHS FOUNDATION TRUST**

Financial funding profile

The scale of financial funding available to most specialist hospitals was considered by many of the system-wide stakeholders as a major contributing factor. Historically, the margins received for undertaking specialised services work have been very different – in many instances based on local price negotiation. Up until recently, they have not experienced the capping of prices or the application of marginal tariff rates for increased activity. The national model hospital work has shown that the margins for undertaking non-specialist emergency work have been eroded over the years with changes in non-elective PbR tariffs and the ceilings placed on income received for increasing non elective activity.

However, the picture for specialist trusts is varied; some are dependent on block contracts that have not kept pace with clinical developments. In addition, the move of some contractual activity to local CCG basis is changing the certainty of specialist trusts' income base alongside the cash constraints being imposed on specialised commissioning budgets.



Clearly people are exercised about the size of the specialised services budget.

There is a general feeling that they do tend to attract more money rather than if they were focusing on elderly or chronic long term conditions needs.

STP LEAD



It should be noted however, that the evidence based on funding per capita is not currently used by NHS commissioning bodies and those patients who are both frail and have chronic long term conditions are the same patients who benefit from the services provided by specialist hospitals.

However, as raised by many interviewees, the real issue is the scale of focus and subsequent investment in population health management compared with the provision of treatments.

International specialist provider benchmarking

Many of the specialist hospitals have an international reputation built up over decades of both research and service innovation. The track record on treatment advances and developing services is recognised as world class in several areas of ophthalmology, cancer, orthopaedics and cardiac procedures.

The wider publication of the international benchmarking of service outcomes in these service areas appears limited to organisations' annual reports but more importantly, it is not currently used by national or local commissioners to set standards that become a baseline for commissioning of services.

The use of international standards benchmarking around service model standards and outcomes expected was raised by several stakeholders as a major deficiency in the current English healthcare commissioning system. As outlined later, it is a perceived 'public responsibility' role that all specialist hospitals, if they are to remain relevant in the future, need to undertake, to support their role as change agents for regional and national commissioning systems.



Several specialist hospitals record and monitor their outcomes against an international peer group.

In the context of RNOH, this provider records low infection rates (less than 0.19%), largest scoliosis unit in Europe, one of the largest sarcoma units in the world. A unique treatment of patients from as young as six months all the way throughout their life. They are producing outcomes that set a benchmark, which others could follow.

If you then take into account their wider R and D, teaching and training role - RNOH trains 15-20% of orthopedic surgeons in the country - their role in training is a benefit to the wider system.

ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST OUTCOMES POSITION – INTERNATIONAL COMPARISON



There is good evidence that high volume centres have better outcomes, particularly in the areas of ileal pouch surgery and polyposis services, and only a specialist hospital can be a high volume centre in some of the more niche areas, listed above. St Mark's Hospital cares for the largest number of patients with Type 3 intestinal failure in the country. As a result, we have established treatment protocols for complications that are only rarely seen in low volume centres and the survival rates for patients on home parenteral nutrition are some of the best in the world.

"Studies have demonstrated improved outcomes for patients having colorectal cancer surgery provided at higher volume centres (Huo et al, 2017).

ST MARK'S HOSPITAL EXPERIENCE



**SECTION THREE:
SPECIALIST HOSPITAL
ROLES IN STRATEGIC
TRANSFORMATION
PARTNERSHIPS
AND SYSTEM WIDE
TRANSFORMATION**

3.1 ROLES UNDERTAKEN BY SPECIALIST HOSPITALS

Historically, certain specialist hospitals have worked together in national provider alliances, which help with the review and testing of new service pathways and treatments through to their involvement in setting standards. The major alliances highlighted in this interview programme were:

- Orthopaedic specialist trusts alliance that has evolved into the establishment of the GIRFT team and review processes hosted by Royal National Orthopaedic Hospital
- Children trusts alliance that has been involved in national service policy formation and the commissioning of new services and standard setting
- Cancer provider alliances that have led the development of new service advances and have supported specific commissioning initiatives
- Other specialist hospitals' input into developing national service standards and new service models for NHS England

The recent roles described by specialist hospitals highlight the potential leadership and advisory roles that are still being undertaken by specialist hospitals as part of their wider responsibilities to provide expertise and service planning leadership that will benefit the wider NHS. Some key examples highlighted are below:



Members of the specialist children hospitals group worked together to develop an appropriate product, national standard and the development of care bundles to provide a safety monitor for children's services.

There was previously no equivalent for children. It started like many other service innovations from the interests and ideas of an individual clinician and chief nurse at Birmingham Children's Hospital. The paediatric alliance was used to take soundings with colleagues to see if there was interest in developing a product and approach.

There was initial work undertaken by Alder Hey, GOSH and Birmingham Children's Hospital. A joint team looked at what safety monitoring might look like, to review other existing service models - UK-wide, locally and internationally. They looked at some of the work that has happened particularly in the care bundle approach and with the paediatric early warning tools to build a set of standards and best practice.

NHS England then supported a rollout of equivalent safety monitoring for children and the care bundle approach. The children alliance is now involved in evaluating its application nationally – taking it from creation through testing, adoption and spread.

WORK OF THE CHILDREN SPECIALIST HOSPITALS ALLIANCE - DEVELOPMENT OF THE CHILDREN SAFETY MONITOR



3.2 LEADERSHIP AND DEVELOPMENT OF NATIONAL IMPROVEMENT APPROACH – GIRFT

The inherent capability of specialist hospitals is also shown by the evolution of the orthopaedic specialist trusts alliance and leadership from RNOH clinicians and managers to the development of the GIRFT team. This team is now providing leadership in national programmes identifying the best in class pathways and setting out outcome benchmarks.

Summarised below are the outcomes achieved to date from the focus on specialist orthopaedic pathways. However, with the expansion of the programme into many other areas, it is notable that all specialist and teaching hospitals are contributing to the programmes around formulating 'what good looks like'. These programmes are using the expertise across the system but particularly specialist hospitals to improve service innovation, outcomes and patient pathways.

Case study – Impact of the orthopaedic services improvement and reducing unwarranted variations GIRFT

As outlined by Professor Tim Briggs, the potential value of harnessing the expertise and clinical leadership of specialist hospitals to help raise the bar of the whole system has been evidenced by the impact of applying GIRFT principles to orthopaedics. The extract below illustrates the reported progress.

Extract: Impact to date of the GIRFT orthopaedic study

- Reduced length of stay, reduced readmission rates, reduction in litigation in orthopedics (bucking the trend)
- Cost saving in the last three years of over £79m in reduced litigation costs alone. Reduction in number of centres carrying out low volume of interventions. Great examples in neurology, paediatric surgery, cardiothoracic surgery
- Number of patients over the age of 60 requiring knee replacements in a year has now reduced in some centres from 28 per cent of their patients to two per cent because of implementing the best practice and revised pathways. Similarly, for hip replacement in patients over 70, a significant drive to use evidence base for patients needing knee and hip replacements has resulted in better outcomes for patients and better procurement costs. This would suggest that investment in MSK programmes can go further in virtually every trust in the country

This role of leading an evidence based improvement approach across target areas both nationally and at a regional level has the potential for growing into a large-scale service innovation, as part of the solutions development work. There is a potential role in leading and executing specific service change and innovation for strategic commissioners, either in clusters or in individual specialist trusts working with other providers in a partnership model.

The style of approach may have to be adapted to lead service change around medical or cancer services particularly for patient pathways involving various co-morbidities. However, the requirement for the role clearly exists as illustrated by the work of specialist GIRFT teams and the existing work being undertaken by specialist cancer trusts.

It was raised by several specialist trusts that although GIRFT work is welcome to raise standards, there is a danger that unless undertaken in genuine partnership with all providers it could be perceived as simply promoting the service excellence of specialist trusts.

A comment from GOSH highlights this point:

"There's a fine line between us as specialist hospitals stepping out to do that and having fertile ground and willingness of other players to partner and form a partnership. The reason being that without that readiness it starts to be perceived as arrogance rather than a genuine partnership for the benefit of our shared patients."

3.3 OVERALL PICTURE –CHALLENGES FACED BY SPECIALIST TRUSTS

Discussions with specialist trusts and system wide leaders highlights that although there are some compelling stories and effective approaches taking place, across the NHS system we are still poor at rolling out best practice and enhancing standards and patient outcomes. There are some individual examples of how some of the recommendations outlined in the FSH report *Driving Innovation Forward*, are being executed but the wider position is of inconsistent application. As outlined by many, the barriers to innovation and system wide transformation as highlighted in the 2011 Department of Health report *Innovation, Health and Wealth* still exist. These barriers can be categorised as follows:

- Leadership culture (both clinical and managerial) to support innovation and system wide transformation is inconsistent or lacking;
- Commissioners (both specialised and CCGs) lack the tools or capability to drive innovation forward in their commissioning and contracting work;
- Lack of effective and systematic innovation architecture available to support large scale innovations;
- System financial incentives are not geared towards rewarding the innovators and can act as a disincentive to adoption; but it is acknowledged that the Innovation and Technology Tariff/Payment introduced for 2017-19 has potential for development in this regard, alongside assistance from AHSNs.
- Poor access to and use of evidence, data and metrics around service innovation.

The interviews undertaken for this report have identified that there is a mixed picture of the real involvement or contribution provided by specialist hospitals.

As outlined in the case study below, specialist hospitals around Liverpool are all providing major leadership roles in developing further standardised networks of care services and taking forward the implementation of standardised care pathways. Other specialist hospitals are beginning to lead strategic reviews of their specialty across their local system that is not confined to tertiary pathways. Some are also leading on improving service provision or service reconfiguration – acting as the 'honest broker'.

For some specialist trusts, their logical role in strategic transformation partnership working is more difficult due to their national service coverage (eg GOSH, Royal Brompton). Others outlined the resistance from other providers in the development of a networked care model due to perceptions of a take-over of particular services rather than helping to raise standards.

As outlined by one specialist hospital, there are tensions around the roll out of standardisation of pathway protocols and service models.

"I do think we enter a room and there's an element of understandable tension because we have this network model. It's sometimes harder for us to have those collaborative conversations with other providers because their understandable first assumption is that we want to acquire them which is rarely the motivation."

Specialised commissioning perspective - lack of alignment

Several expressed concerns about the perceived non-alignment of their roles and service portfolio in the context of the specialised commissioning agenda around developing and implementing standard service specifications.

"Are we attempting to commission services on the basis of known world class standards or lowest common denominator?"

"Where do we start with the commissioning system; I have rarely seen any commissioners take action to improve the standards and outcomes of particular services when information on poor outcomes is evident?"

"Our commissioning system needs urgent reform – otherwise the inherent strengths of services provided by specialist hospitals/centres will be eroded."

Commissioners' perspective

The other perspective outlined is that specialist hospitals are a legacy of having no coherent provider strategy and not being aligned with the need to provide modern medicine or elective care.

The view was expressed that some stand-alone specialist hospitals may not be relevant as a service provider model given the direction of travel of locally based service commissioning. However, others highlighted single specialty hospitals as having the potential to lead, provide or manage services that are focused on the health management of a particular population segment.

Contribution of specialist hospitals

Despite the inherent difficulties and challenges of system wide transformation work, several specialist hospitals can point to how they now have emergent or established leadership roles within their regional STP process. Some have established leadership positions with permission to engage the wider system in specific service innovation initiatives or to roll out best practice standards that can benefit patients across all hospitals or the wider system.

Each specialist hospital is unique in its service capability or inherent strengths but all possess a culture and a workforce who are passionate about improving services, delivering service excellence and advancing treatments or services.

We outline below some notable examples that illustrate both the capability and range of roles that many specialist hospitals are undertaking. These include work with STPs; national service development; and in some cases, international experience in raising service standards and helping other healthcare systems. These demonstrate:

- How specialist trusts can lead a system wide review and service pathway standardisation programme
- How specialists trusts can lead and facilitate the collaborative working of many providers and commissioners to develop population health management approaches and design services to support prevention and detection
- How specialist trusts have developed standardised models of care across a large care network involving many hospitals and large populations

System leadership roles – spread of standardisation of best practice pathways and population health management work

Although specialist hospitals may have had difficulty in dispelling the myths of specialism elitism or tensions with other providers, there are excellent examples of how specialist trusts are leading system wide transformation and helping to standardise key pathways. The roles being undertaken by four Merseyside based specialist trusts highlights the potential leadership role that can be undertaken and the value they bring to engaging with population health management issues and solutions.

An extract of the roles is below.

TRUST	DESCRIPTION OF ROLE
Alder Hey NHS Foundation Trust	Leading a women and children’s work stream, which is setting up a route map to develop a hub and spoke service. Working with commissioners in assisting the development of a revised children service model network. Providing training support, eg anaesthetist training.
Liverpool Heart and Chest Hospital NHS Foundation Trust	There is a clear, defined role for the cardiac specialism in the STP and this work stream has been running for three years. The trust provides work stream leadership and it is governed by a strong Board including third sector stakeholders, academia, the networks, primary care. RightCare data is used. LHCH have funded this work stream for three years but have not done this as a ‘feather in their cap’; they have focused half the work on prevention to change population health in the longer term and they are proud of this. They have led the clinical network. “Working with primary care helps LHCH clinicians to understand their issues and for primary care to understand the issues of the consultants.”
The Walton Centre NHS Foundation Trust	STP work is very positive, as they have been working collaboratively for years. The STP has helped The Walton Centre to standardise pathways, joining the dots across the system to support patients and trusts. Spreading pathways that they do well – eg first seizure; and in acute trusts, pathways for headache National pathway – back pain evaluation of pain management not drugs Community pain management – taking a medicines management role Parkinson’s disease and MS - the trust has been asked to lead on standardising pathways The trust has built good relationships regionally, providing neurologists to all hospitals in a network of local outreach care with standardised pathways
The Clatterbridge Cancer Centre NHS Foundation Trust	A leadership role in the development of the Cancer Alliance across STP population Specialists working in a local outreach standardised service model Working with GPs and system providers on development of prevention health plans and use of staff. Innovation occurring with the design and delivery of chem@workplace Developing the capabilities of MDTs around cancer therapy programmes Development of closer to home plans with Specialised Commissioning team Transforming Cancer Care Team development re internal transformation alongside changes to roles to support population health management approaches

Roll out of the Moorfields clinical service model

One of the best examples of dissemination of service innovation is the development across 30 plus hospitals of the virtual glaucoma and cataract service model that is improving outcomes at Moorfields Eye Hospital NHS Foundation Trust.

Moorfields participated in the national Vanguard programme and were keen to share knowledge about their network model. Their view was that adopting a standardised approach by sharing learning was applicable to every specialty rather than just ophthalmology.

“So, I think because we have the time to think differently and I suppose actually for us there is an element of survival of our independence, this forced us to think differently about our model. This meant we were able to innovate and then share it more widely. And I think it’s something that we definitely have the potential to do more of; if I was going to be a bit self-critical on reflection I’m not sure we always do that as effectively as we could do.”

3.4 OTHER ROLES FOR SPECIALIST HOSPITALS

The survey also revealed the potential breadth of roles that specialist trust leaders are undertaking, for instance:

- National clinical lead roles for cancer and oncology acute services
- National roles in leading the review of maternity services
- Vanguard roles in sharing best practice re cancer collaboratives
- Leadership of the STP secondary care service model and reconfiguration options
- Leadership facilitation role around exploring a future provider federation model being explored in Birmingham and Solihull
- The Christie Hospital leadership role in the Manchester-wide cancer service strategy development and working with local authorities and health commissioners
- The Christie Hospital outcome improvement partner role, helping other hospitals to deliver service and outcome improvement
- Recent invitation for St Mark's clinical team to lead and strengthen the local STP work focus on raising service standards
- Work of GOSH on genetics

All specialist hospitals consulted could highlight areas where they are beginning to make a significant contribution to STPs.

3.5 RECOGNITION OF NEW ROLES FOR SPECIALIST HOSPITALS IN POPULATION HEALTH MANAGEMENT

Several specialist hospitals identified that changes are required in engagement with the wider system to make the service portfolio relevant to population health management and the use of staff in prevention.

"I think particularly with this most recent policy shift to population, this has probably been the single biggest challenge especially to specialist hospitals. I think when we were operating in the environment as we were 10 years ago, actually it was pretty much dominated by secondary and tertiary as a system and therefore we could relate to and engage with other providers that were sort of similar to us, but not single specialty. I think this latest shift to thinking about the population has been more difficult."

The specialist cancer trusts are embracing this agenda and being proactive with their clinicians taking on prevention and detection roles within the development of place based health.

3.6 CONCLUSIONS

Overall, we would conclude that there is an appetite among specialist hospitals to share expertise, pursue adoption of standardised pathways or outcome improvement and undertake leadership roles across systems and networks. A large proportion of the existing involvement is based on the use of their internal funding provision. Many specialist hospitals recognise they are on a transformational journey; adapting to changing healthcare policy, financial funding priorities and their engagement roles with the rest of the healthcare system.

Many expressed the need to formalise this wider public responsibility with a mechanism for commissioners to formally contract with specific providers to assist with the development and redesign of commissioned services, the adoption and implementation of service innovation and assistance with the improvement of outcomes.

However, supporting permissions and pump priming financial support are required to ensure that transitions to new care models become embedded.

**SECTION 4:
SERVICE INNOVATION
WITHIN SPECIALIST
HOSPITALS AND HOW
WE CAN IMPROVE THE
DISSEMINATION AND
ADOPTION OF INNOVATION**

As outlined in many previous reports, specialist hospitals have a long established culture of research and service innovation. We outline in this section the approaches of trusts to developing a service innovation culture and taking forward major innovations. We summarise the key themes and lessons of value to the wider system.

This section also summarises the key areas highlighted by participants as areas for improvement in the development of service innovation, dissemination of opportunities and subsequent adoption.

4.1 WHAT ARE SPECIALIST HOSPITALS DOING WITH REGARD TO SERVICE INNOVATION?

The interview programme has suggested that all specialist hospitals are undertaking many service innovation initiatives. Much of this activity is financed by specialist trusts themselves with some pump priming support from AHSNs or other modernisation monies.

The table below summarises some areas of service innovation either in the pipeline or which have been adopted.

Table 1 – Examples of specialist trusts’ major service innovation

SPECIALIST TRUSTS	SERVICE INNOVATION ACTIVITY
NORTH WEST TRUSTS	
Liverpool Heart and Chest Hospital NHS Foundation Trust	<ul style="list-style-type: none"> • Patient pathway redesigns using process improvement techniques • Workforce roles redesign and development of a single system wide workforce • Robotics innovation • CareCube scheduling tool taken to the commercial market that supports all their service delivery models • Clinical service model redesign – use of day case model for cardiac procedures
The Walton Centre NHS Foundation Trust	<ul style="list-style-type: none"> • Ongoing development of the outreach network model • Artificial intelligence application in redesign of rehabilitation service models
Alder Hey NHS Foundation Trust	<ul style="list-style-type: none"> • Partnership working with Toronto Sick Kids • Development of a regional network of children services in line with known best practice children models in Philadelphia
The Christie NHS Foundation Trust	<ul style="list-style-type: none"> • Proton beam therapy centre – first one in the UK • Big data project with several commercial partners, university and research bodies • Large commercial partnerships that have funded service innovation in diagnostic imaging service models and pathology services (international partnerships)
The Clatterbridge Cancer Centre NHS Foundation Trust	<ul style="list-style-type: none"> • Ongoing development of their outreach care network model • Development of a chemo@work service model • Digital transformation plans – implication of pathways and facilitating local working across the whole cancer care network

Table 1 – Examples of specialist trusts' major service innovation . Continued...

SPECIALIST TRUSTS	SERVICE INNOVATION ACTIVITY
OTHER TRUSTS	
Royal National Orthopaedic Hospital NHS Trust	<ul style="list-style-type: none"> • Implants developments – established source of new devices • Assisted living technologies – and development of specific products • Digital diagnostic pathology lab ideas
Moorfields Eye Hospital NHS Foundation Trust	<ul style="list-style-type: none"> • Roll out of their virtual cataract and glaucoma service model • AI retinal diagnostics with Google Deepmind
St Mark's Hospital	<ul style="list-style-type: none"> • Development of two novel techniques, in conjunction with The Royal National Orthopaedic Hospital, Stanmore, to allow a select group of patients to be offered re-sectional surgery where in the past they had been deemed inoperable. Both techniques have been published in peer-reviewed journals. • Develop the polyposis registry in the UK (also the second largest in the world) that provides advice and guidance service by telephone • A smartphone app has been developed which provides current published management guidelines for polyposis syndromes in a user-friendly format. This has been downloaded over 2500 times worldwide • Development of the largest biofeedback team in the world
Birmingham Women's and Children's NHS Foundation Trust	<ul style="list-style-type: none"> • Development of innovative devices that facilitate improved theatre productivity; and improving the early warning systems in intensive care • Development of a health partners alliance working with the University of Birmingham and University Hospitals Birmingham NHS FT and West Midlands AHSN • Involvement in genomics project • Projects with technology and pharma commercial partners
Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH)	<ul style="list-style-type: none"> • Focus on being research based hospital • Rheumatology Dept has enhanced both outreach and transition with a seamless children and young persons' highly specialised service that has created a significant national network. Neurologists and neurosurgeons within the epilepsy framework have advanced nationally to provide equity of access to highly specialised diagnostic therapeutic options around rare and uncommon epilepsies even to the point of surgical treatments for epilepsy

The interview process highlighted a significant range of both small and large service innovation projects that are being pursued by specialist hospitals, many in partnership with commercial organisations including both SMEs and much larger industry partners.

The key themes of service innovation are reflecting the focus of technology development (AI technology, digital diagnostic testing); the growth of population health management; self-care treatment approaches; improving future predictive planning; and operational issues such as the need to improve scheduling and patient flow management.

4.2 TYPE OF APPROACH

All specialist hospitals interviewed said that their culture emphasised staff engagement, encouraging staff to explore and pursue research opportunities and service innovation ideas. This is combined with an emphasis on organisational strategies and specialist hospital service planning on research and service innovation. However, few could articulate a systematic approach for assessing service innovation ideas or disseminating evaluated projects into full-scale adoption.

Several of the larger specialist trusts do have more formalised processes and as much focus is given to research and innovation as it is to operational service delivery. Many are engaging clinicians and patient groups but few are formally evaluating ideas and developing a dissemination pathway.

The other key specialist trust approaches are:

- Many trusts have invested in a Director of Innovation or equivalent as a way of demonstrating the priority given to innovation and research
- Many of the trusts are refreshing their service strategy, engaging both staff and a wide spectrum of external stakeholders; they all talk about service innovation, pioneering patient care and sharing knowledge
- Specialist hospitals are using their local AHSN and/or AHSC for facilitation and innovation development support and development of commercial partners. Hackathons are particularly valued by both staff and trusts in working with their AHSNs to develop specific innovations
- Innovation hubs have been developed with the support of AHSNs to explore the use of new technologies and datasets in service innovation
- Joint working of front line clinicians, researchers and academics that leads to service innovation proposals and use of evidence based assessments
- Cancer specialist trusts outlined the extensive use of clinical trials to inform service treatment advances and new pathways
- Training and use of improvement methodologies and toolkits
- Development of long established commercial partnerships by certain specialist trusts in supporting their clinical service models

Big data application to improve service innovation and outcomes

Several specialist trusts highlighted they are pursuing big data improvement projects. As an example of the scale and ambition, The Christie Hospital's real time data outcomes project is aimed at improving clinical outcomes with faster access to comprehensive patient data and reduced variability in care.

Patient reported outcome data (PROMs) is currently available for a small number of patients. The Christie are exploring how this could be extended to the majority of patients and linked to other relevant patient data including genomics and radiomics.

In partnership with several partners, the Christie project is exploring natural language processing and machine learning to make this data widely usable. They are also attempting to use a greater breadth of data to fill the gap in outcomes such as with primary care data.

Through collaboration with global software company SAP, they are undertaking a proof of concept to support the sustainable delivery of a comprehensive digital enterprise strategy.

The key features of this innovative work is to:

- Integrate data from four disease sites - head and neck, lung, colorectal and gynaecology patients and present a comprehensive view of their pathway within the trust for each patient with one of these cancers. This will be available to the clinical teams in real time;
- A data interrogation tool will be provided alongside this to allow cohorts of patients to be identified with key criteria supporting the faster identification of patients suitable for clinical trials;
- Explore the use of Natural Language Processing (NLP) for unstructured data like radiology, pathology or genomics reports.

The project is still at the early development stage but is an important part of the trust's service innovation culture.

4.3 SCALE OF ROLL OUT ADOPTION AND DISSEMINATION

Although there is no shortage of ideas and service innovation initiatives it is interesting to reflect on how many are being disseminated into the wider system. Some of those interviewed, including the Specialised Commissioning finance team, highlighted that with one or two exceptions the specialist trusts lack both capacity and capability to take many of the innovations forward at pace or scale.

Key issues raised were:

- Insufficient capacity and infrastructure to take forward service innovations that were shown in the Vanguard initiative to accelerate the uptake of new approaches
- The need for a coherent national approach and policy for supporting innovation
- The need to improve the quality of good clinical research of service innovations that have the capacity to become a commissioned service
- Technical expertise to develop and apply for intellectual property protection and patents
- The capacity to support clinical staff thorough service product development phases and then translation into the wider NHS market
- Limited availability of economic modelling and systematic assessment of propositions around potential commercial value as well as NHS system value
- Developing the right financial support and partnership collaborations to take forward propositions and support roll out
- The funds to support change management and an improvement science approach to embed service innovation and realise the return on investment

Key comments on barriers to implementation of service innovation at scale



“So, we have enterprising tools, we have improving patient experience and we have the discovery element around research. I’m not sure that we are very good at formalising and building the ground works to build an innovative hospital. I think that happens from the fact that we attract innovative people because of our BRC status, because of our university and our research agenda. So, I think it’s not that we’ve necessarily built a whizzy way of doing it. I think they’ve come here because that is the nature of what Moorfields and the Institute do.

“I don’t think we’ve got the structures and processes. I don’t think it has come because we set up cultures and process but probably a bit of the learning we need to do is we would benefit from having a little bit of structure.”

THE NEED FOR STRUCTURE AND PROCESSES TO SUPPORT INNOVATION

“Taking it from the idea, the sandpit-session, it is a challenge in a special institution just dealing with niche complex patients. How do you ensure that addressing one need is also addressing the mass population burden – that we are not just going to sort out one spinal cord injury patient a year compared to the provision of treatment option that is going to benefit the wider population and in some cases whole of Europe?

“It’s how to translate into a much broader patient population. So, you have to consider that factor in the 100 ideas that you take forward to the next stage.”

NEED FOR EVALUATION SUPPORT – UNDERSTANDING THE POPULATION HEALTH IMPACT

“How do you then take it to the next stage of investment? Often that requires money, a scale of investment. It requires a bigger grant or consideration of the commercial side of things. And often I’ve found a lot of barriers along the way in terms of how the NHS can really unlock investment and support those ideas coming through and the governance arrangements around that and understand why they are all there.”

RNOH CHALLENGES – TAKING FORWARD A CONCEPT TO POTENTIAL COMMERCIAL VALUE

“I don’t think our issue is getting innovation in technology or drugs into the organisation. The biggest challenge, which came out very clearly from the Accelerated Access Review, is how to standardise and generalise that in a way that supports clinicians. So it’s the change management process as much as the technology that matters. It’s in the improvement science agenda where the biggest strides are to be made going forward.”

NEED FOR INVESTMENT IN CHANGE MANAGEMENT AND IMPROVEMENT SCIENCE

“Our ability to benefit from that in terms of commercialisation has been poor and we are in the process of creating a strategy to improve our capacity where appropriate and relevant to commercialise that sort of discovery.

“We are starting to think about this stuff, starting to think about not just the discovery because in our business there is no point in discovering if it’s not made accessible. I think a risk not just for GOSH and children’s complex disease but the whole sector - these discoveries in rare diseases are going to be bloody expensive. We are going to need a whole new model around access.”

IMPROVING THE ACCESSIBILITY OF NEW TREATMENTS – GOSH PERSPECTIVE



4.4 WAYS IN WHICH SERVICE INNOVATIONS ARE CURRENTLY SPREAD

The approach to spreading service innovations in most instances is relatively low key, unless there is a commercial venture partnership or a plan to use staff networks. Few are using the STP process, with the exception of the roles outlined by specialist trusts across the Cheshire and Merseyside STP. Several of the larger specialist trusts have well established commercial joint ventures that are generating significant dividends, which are being ploughed back into patient care.

However, as outlined in the interviews, there are limitations on the use of reported surpluses and they have to resort to using their charitable funds. The scale of charitable funds varies significantly between specialist trusts.

Several specialist trusts have a significant national training role, for example:

- Twenty per cent of orthopaedic surgeons in the UK have come through Stanmore training rotation. They provide insight into specialist services and involvement in some of the service innovations
- A similar picture in Moorfields and ophthalmology, where a large proportion of trainees and clinical staff have some exposure to the centre as part of their training and are aware of the newer treatment advances. Moorfields have used this network to spread their virtual diagnosis and assessment service
- Innovations have spread through external networking of clinicians in both the UK and internationally, eg Liverpool Heart and Chest Hospital's day case model with the introduction of business style lounges, originated from a service approach in the Netherlands; and their use of real time scheduling and a tele-tracking system of a patient's needs and journey originated from private sector manufacturing applications
- Use of commercial partnerships to promote the service innovation concept and management of support with regard to their roll out. For example, Liverpool Heart and Chest Hospital set up a joint venture company to promote and roll out the CareCube scheduling tool (see case study). The trust has an equity stake and the aim is to grow the company turnover and customer base with a view to a sale in five to ten years to realise a value to the trust
- Use of commercial partners to undertake engagement of patient groups in the co-design of ideas (RNOH example)
- Engagement with the Specialised Commissioning team by The Clatterbridge Cancer Centre in their development of their care closer to home service model, to increase engagement and support.

Key comments on service innovation



"With Teen (Teenager) Tech, a small engagement company, we recently have been showcasing and doing workshops at the teen tech event. It's a fantastic organisation and it is amazing because what they do is promote science and technology to kids aged 10 to 17. They engage in schools, create competitions arrange work experience and so on. And we have engaged with them for the last two years and we are team tech at the NHS and the idea is to bring healthcare technologies and the appetite for healthcare technologies to those young individuals."

RNOH APPROACH TO SERVICE IDEAS TESTING

A CEO view of the requirement for further support on incentivisation of the right service innovation: "I guess we were saying earlier in all of that policy narrative that incentivisation funding is going to be around populations, but we still often think about one scientific breakthrough that initially helps two people, then hopefully spreads to a bigger population base. So, I think there's more we need to do to think about how we incentivise staff and organisations to do population based research and the use of this to develop service innovation.

"But there is also that service delivery process. And again, I don't think at the moment we incentivise and we don't celebrate it. I think my observation, being an academic is that the scientific gene discovery is always celebrated and promoted more than you've completely radically changed the patient's experience in clinic."

NEED TO ENCOURAGE AND INCENTIVISE POPULATION BASED RESEARCH AND SERVICE DELIVERY INNOVATION

View expressed by Specialised Commissioning: "We seem to have a real paucity of clinicians leading good research at the moment in the UK. So, we need to generate that and re-generate that. So, for us, if there's any new innovation it's got good evidence and it's got a sound basis then we have a methodology to roll it out across the system quite rapidly. If you look at what we achieved with hep C drugs for example, the way we changed the system very, very rapidly. So, being a single commissioner helps a lot. But what's holding us back is the evidence - the paucity of good quality clinical research at the moment coming out of UK centres. We need to support clinical evidence and research that is focused on the impact on patient populations."

PAUCITY OF GOOD CLINICAL EVIDENCE AROUND SERVICE INNOVATIONS

"Whilst we have done this I don't think we're great at spreading service innovation. The thing we do which is not always necessarily by design - half the UK's ophthalmologists come through us at some stage. They then pick up whatever they do here and take that all over the country and you can tell that happens by research collaboration. But that's a good opportunity and many specialist trusts have that, particularly London specialist trusts have the opportunity to drive leadership."

MOORFIELDS' EXPERIENCE IN THEIR CATARACT AND VIRTUAL GLAUCOMA CLINICS



CONCLUSIONS & RECOMMENDATIONS

1. Our interviews have shown that many of the specialist trusts who are successfully innovating employ a senior level post to lead this function and link into supportive agencies such as AHSNs, NIHR infrastructure etc, as well as appropriate commercial partnerships (as strongly evidenced by The Christie Hospital NHS Foundation Trust experience). This approach should be adopted in a systematic manner across specialist hospitals and into the wider hospital sector.

Recommendation: All trusts should consider the development of senior level post with a designated innovation role.

2. The majority of specialist trusts said they would welcome the development of a more systematic best practice approach to help fast track service innovations of value with availability of expert advice.

Recommendation: The AHSN Network should take the lead in collaboration with Specialised Commissioners and the specialist trusts group on the development of a best practice approach to service innovation and a supporting expert team capability that is accessible to all trusts.

3. A role for Specialised Commissioners may be to formalise international links and benchmark specialist trusts against international best in class standards for innovation and performance to ensure world-leading services.

Recommendation: Specialised Commissioners should consider supporting the international benchmarking of specialist trusts, using some of the service outcomes standards as part of the core specification with all providers.

4. The current role of some specialist trusts in funding and improving financial efficiencies of innovative treatments, which benefit patients, should be celebrated and recognised in the system.

Recommendation: A pump priming innovation fund should be established by NHS England to be accessed via bids from

specialist trusts and other providers, to take forward wider service advances, on the condition they help to promote the roll out of the service innovation.

5. The narrower condition/treatment focus in most specialist trusts has allowed an enhanced focus on a supportive, collegiate culture where colleagues can unite around a theme and share a common language.

Recommendation: We recommend that the proposed NHS Confederation work explores whether this culture could be replicated in other provider organisations.

6. Where specialist hospitals have adopted population health roles as part of their mission, this is valued by the system and may be a role that more specialist hospitals would like to promote into their system and/or at a national level. In Merseyside, specialist trusts are integrated into their STP and leading a number of work streams on population health to benefit the health and care system. In some areas, AHSNs are helping to form a bridge between specialist hospitals and the wider NHS including STPs.

Recommendation: NHS England should consider how specialist hospitals could provide a supportive population health management role in STP work around the standardisation of care pathways and adoption of prevention activities.

7. Although many of the specialist hospitals are national and sometimes global leaders in translating their discovery science and clinical expertise into innovative treatments, they are often unaware of the national policies, levers and funding streams that might encourage faster adoption and spread.

Recommendation: Every specialist hospital should establish a formalised partnership with their local AHSN to take forward service innovation and accelerate adoption and spread.

APPENDIX 1 - ACRONYMS USED IN THE REPORT

NICE	National Institute for Health and Care Excellence
AHSN	Academic Health Science Network
AHSC	Academic Health Science Centre
NIHR	National Institute for Health Research
NHS I	NHS Improvement
UCL	University College London
GIRFT	Getting It Right First Time
CQC	Care Quality Commission
RTT	Referral Time to Treatment
A&E	Accident and Emergency
PROM	Patient Reported Outcome Measure
RNOH	Royal National Orthopaedic Hospital
R & D	Research and Development
GOSH	Great Ormond Street Hospital
LHCH	Liverpool Heart and Chest Hospital
BRC	Biomedical Research Centre
STP	Strategic Transformation Partnership

APPENDIX 2 - INTERVIEW PARTICIPANTS

SPECIALIST TRUSTS	NAME AND TITLE
Birmingham Women's and Children's NHS Foundation Trust	Dr Vin Diwakar, Paediatric Consultant and former Medical Director. Currently Medical Director NHS London Matt Boazman, Director for Strategy and Innovation
Royal National Orthopaedic Hospital NHS Trust	Rob Hurd, Chief Executive Dr Rui Loureiro, Head of Clinical Research and Head of Institute of Orthopaedics
Moorfields Eye Hospital NHS Foundation Trust	David Probert, Chief Executive Johanna Moss, Director of Strategy and Business Development
Alder Hey Children's NHS Foundation Trust	Louise Shepherd, Chief Executive Dr Steve Ryder, Medical Director
Liverpool Heart and Chest Hospital NHS Foundation Trust	Jane Tomkinson, Chief Executive Dr Raphael Perry, Medical Director Sue Pemberton, Nursing Director Mark Jackson, Director of Research and Innovation
The Walton Centre NHS Foundation Trust	Hayley Citrine, Chief Executive Dr Andrew Nicolson, Medical Director
Royal Brompton and Harefield NHS Foundation Trust	Robert Bell, Chief Executive
The Christie NHS Foundation Trust	Roger Spencer, Chief Executive Wes Dale, Head of Research and Facilitation Professor Rob Bristow, Chief Academic Officer Professor John Radford, Director of Research
The Clatterbridge Cancer Centre NHS Foundation Trust	Anna Farrar, Interim Chief Executive Dr Sheena Khanduri, Medical Director
St Mark's Hospital (part of North West London Hospitals NHS Trust)	Prof Omar Faiz, Clinical Director Mr Simon Crawford, Deputy CEO (NWLUH) Miss Carolynne Vaisey, Colorectal Surgeon, Mr Matthew Fitzpatrick, Divisional General Manager for Surgery and St Mark's William Banister, General Manager, St Mark's Surgery Directorate
Great Ormond Street Hospital for Children NHS Foundation Trust	Peter Steer, Chief Executive
OTHER STAKEHOLDERS INTERVIEWED:	
University College London NHS Foundation Trust	Professor Marcel Levi, Chief Executive
NHS England Specialist Commissioning	Dr James Palmer, Medical Director Jonathan Powell, Director of Finance
Department of Health and National Institute for Health Research	Dr Louise Wood, Director of Science, Research and Evidence
North London Partners STP (5 CCGs in North Central London)	Will Huxter, Director of Strategy and former Regional Director Specialised Commissioning London
Guy's and St Thomas' NHS Foundation Trust	Hugh Taylor, Chair Dr Ian Abbs, Medical Director
Federation of Specialist Hospitals	Professor Tim Briggs, Chair
NHS Improvement	Kathy McClean, Medical Director
Shelford Group	Nick Kirby, Managing Director

APPENDIX 3 – CASE STUDIES

CASE STUDY 1

USING MACHINE LEARNING TO DETECT COMMON EYE DISEASES: A COLLABORATION BETWEEN MOORFIELDS EYE HOSPITAL AND GOOGLE DEEPMIND

Moorfields Eye Hospital, University College London and Google DeepMind have collaborated to develop a new machine-learning system that is as good as the best human experts at detecting eye problems and referring patients for treatment.

Why is this important?

More than 285 million people worldwide live with some form of sight loss, including more than two million people in the UK. Eye diseases remain one of the biggest causes of sight loss, and many can be prevented with early detection and treatment.

By speeding up diagnosis for patients with eye diseases, treatment can be started sooner, increasing the chance of saving individuals sight.

The challenge

The challenge is to speed up the time it takes for patients to be seen to discuss diagnosis and treatment of eye health complaints following an optical coherence tomography (OCT) scan.

Ophthalmologists use these highly complex scans to help diagnose common eye diseases. However, their complexity means the scans can take eye health professionals a long time to analyse, affecting how quickly patients can be seen to discuss outcomes.

Actions taken

Moorfields Eye Hospital, University College London and Google DeepMind teamed up to investigate whether AI technology could help improve the care of patients with sight-threatening diseases, such as age-related macular degeneration and diabetic eye disease, by making the analysis of OCT scans faster without losing any of the accuracy in diagnosis.

Machine learning systems were trained to identify ten features of eye disease from OCT scans. The system was then able to recommend a referral decision based on the most urgent conditions detected.

To establish whether the AI system was making correct referrals, clinicians also viewed the same OCT scans and made their own referral decisions.

As well as giving a diagnosis decision, the system also provides information explaining how it arrived at its recommendation, as well as a confidence rating expressed as a percentage.

The system is adaptable to different types of eye scanner, which could significantly increase the number of people who benefit from this technology, as it can still be used even as OCT scanners are upgraded or replaced over time.



Outcomes

The AI system developed can recommend the correct referral decision for over 50 eye diseases with 94 per cent accuracy, matching world-leading eye experts.

Plans for the future

This research now needs to go through clinical trials to explore how this technology might improve patient care in practice, and regulatory approval is needed before it can be used in hospitals and other clinical settings.

If clinical trials are successful in demonstrating that the technology can be used safely and effectively, Moorfields Eye Hospital will be able to use an eventual, regulatory-approved product, free across all 30 of their UK hospitals and community clinics, for an initial period of five years.

The work which has gone into this project will also help accelerate wider NHS research for many years to come.

Reference: Clinically applicable deep learning for diagnosis and referral in retinal disease. Jeffrey De Fauw, Joseph R Ledsam, Olaf Ronneberger. Nature Medicine volume 24, pages 1342–1350 (2018).

CASE STUDY 2

DEVELOPMENT OF A HIGH VOLUME, AMBULATORY CARE MODEL USING AN INNOVATIVE SCHEDULING AND TRACKING TOOL BASED ON LEAN MANAGEMENT PRINCIPLES

Context

An ambulatory day case service has been developed by Liverpool Heart and Chest Hospital in partnership with CareCube that has radically changed the experience of patients requiring cardiac procedures. It is supported by an innovative, integrated scheduling platform to improve safety, resource utilisation and efficiency in cardiology.

Summary: The change proposition and service innovation

In reviewing their planned care processes and feedback from patients, the trust decided to redesign their planned care pathways. They researched internationally what others were doing and visited Amsterdam to view at first hand a very different style of providing day cases. This involved the use of patient lounges and a different approach to carrying out diagnostic investigations that allowed patients to remain in their own clothes.

The trust adopted the concept and took it further, creating an airport-style lounge where patients could relax between investigations or invasive procedures. They enjoy a café environment with wifi and massage services. Liverpool Heart and Chest Hospital collaborated with experts from within both healthcare and automotive sectors to develop a multi-function scheduling platform enabling real time co-ordination and tracking of patient interventions.

Why this is important:

The demand for cardiology procedures has grown dramatically, not just because we have an ageing population, but also due to the availability of new procedures. In the last 10 years, death rates have halved in the UK through excellent clinical interventions. However, it is essential to optimise resources in order to deliver this care efficiently while maintaining a high standard of care. Cardiology has evolved as a speciality based on evidence based medicine and robust clinical data, yet when it comes to effective use of resources, healthcare organisations are not using this outcome evidence to change service delivery approaches.

The challenge:

Patients undergoing cardiology procedures arrive at the catheter lab through different routes, for instance as elective cases, inter-hospital acute transfers or in ambulances and schedules change constantly throughout the day. Delivering clinical care to every patient with a high standard of both clinical and patient engagement, is a challenge for all such centres.

Actions taken:

Liverpool Heart and Chest Hospital collaborated with CareCube, who have expertise in delivering a process flow solution that link actions and people, bringing learnings from the automotive and healthcare industries. Engaging with the whole multi-disciplinary team, regardless of role or location, led to the development of a single platform covering the entire patient journey within the hospital. Aside from clinical outcomes, the system supports timely decision-making, safety standards, maximized use of resources, and the ability to visualise outcomes through front-end reporting data that drives continued improvement.

Outcomes:

With 360 people in the multi-disciplinary team networked real-time in what is a dynamic space, communication is improved, linking each patient to the most effective pathway. Liverpool Heart and Chest Hospital is rated 'outstanding' by the CQC and this is borne out by this innovative work. The Cath lab now delivers checklists and team briefs about all patients, has reduced turnaround times between patients to nine minutes, and routinely allocates 100 per cent of lab sessions. Data is needed for many reasons and by different teams – such as the daily safety huddle, weekly cath lab meeting, or data for audit/reporting, compliance with NatSSIPs and LocSSIPs audit data. Here, all data is in one platform.

Testimonial:

Jeanette Broome, Cath Lab Manager said: "CareCube has allowed a single platform that is accessible for consultants, ANPs, PAs, scheduling teams and clinical teams to allow safe, visible planning of both planned and emergency procedures with up to date list changes available to all. It gives a platform to share relevant and vital information for individual patient procedures. It offers a unique, interactive checklist process, which complies with NatSSIPs and LocSSIPs and includes patient participation.

"Data is readily available which gives the ability to feedback to teams daily and drive quality improvements and efficiency between the wards and Cath Lab areas."

CASE STUDY 3

PROTON BEAM THERAPY SERVICE INNOVATION AT A COMPREHENSIVE CANCER CENTRE

Background and evolution

From 2018, The Christie is home to the UK's first high-energy NHS proton beam therapy centre. This is an advanced form of radiotherapy using protons rather than X-rays. Proton beam therapy directs the radiation treatment to precisely where it is needed with minimal damage to surrounding tissue, reducing the possible long-term side effects. As a result, it is particularly beneficial to patients with hard to treat tumours close to sensitive areas such as the brain or the spine, and to children whose tissues are still developing.

The NHS currently pays for some patients to be treated overseas but this option is tough for patients. Treatment typically lasts six weeks and patients are without their wider families and support networks. Indeed, some patients are too unwell to travel overseas.

The NHS in England has provided £250m for a national proton beam therapy service with two centres, one at The Christie in Manchester, and one at University College London Hospitals NHS Foundation Trust.

Key stakeholders

Patients have been very involved in the development of this service, helping to design the patient environment, patient care and wrap around support services. This complex and innovative project in terms of construction, physics and engineering, radiotherapy training and familiarisation, treatment planning, clinical support, international collaboration and research has required the co-ordination of a complex network of stakeholders.

What stage is service innovation?

The Christie team has been central to developing the UK service, producing clinical protocols and pathways for NHS England. Their position as a specialist NHS comprehensive cancer centre with over 100 years of innovation and a well-earned international reputation has enabled them to overcome many unique challenges arising from this project.

- **Equipment complexity:** The cyclotron accelerates protons to two-thirds the speed of light, at temperatures only 3 degrees above absolute zero. The gantries guiding the beam are three stories high. The radiotherapy department is the largest in the UK and therefore had the breadth and depth of physics and engineering expertise to assist Varian, the equipment manufacturer, install and commission the equipment.
- **Treatment planning:** Radiotherapy treatment plans are developed by highly expert multi-disciplinary teams. The critical mass of clinicians, physicists, radiographers and other specialists at The Christie mean they can specialise in specific areas, ensuring that each patient will receive the very best plan.

- **Complexity of paediatric patient pathway** – The exceptional level of planning across all stages of the paediatric patient journey, from reception through to the preparation of patients, scanning and treatment delivery, demonstrates that outstanding results are achieved when there is a critical mass of expertise.
- **National workforce shortages:** As a specialist centre, they have access to a large pool of expert staff, including radiographers, to ensure a resilient service in both the existing radiotherapy service and the new proton beam therapy service.
- **Wider patient requirements:** Patients receiving proton beam therapy have other health and non-health needs; locating the centre at The Christie gives patients and families access to an unparalleled range of clinical and support groups helping to provide a comprehensive wrap around service and ensuring best outcomes.
- **Dedicated research facilities and programme:** Proton beam therapy is still in its infancy and there are a number of scientific and technological challenges to be addressed for it to achieve its full potential. The research team has a programme of activities and a dedicated £6m research room (funded by The Christie charity) aiming to tackle these key scientific and technological challenges.

This expert knowledge and experience will be available to others through The Christie International Proton School. Their multidisciplinary team includes clinical (radiation) oncologists, radiation therapists and non-clinical specialists in oncology, dosimetry, radiotherapy physics, and engineering, as well as experts in commissioning, project management, capital and building development and equipment commissioning, providing specialist proton education to the clinical and academic communities.

Expected benefits of the innovation proposed

The UK's first high-energy NHS proton beam therapy centre at The Christie is expected to deliver many benefits for patients:

- **Wider access and speedier referral process** for patients who will clinically benefit from proton beam therapy, with treatment much closer to home.
- **Fewer side effects and better long-term outcomes** for patients, particularly children, with cancers close to areas such as the brain and spine.

Co-location of the service within a specialist NHS comprehensive cancer centre ensures:

- Access to specialist clinical experience with rare cancers and expert knowledge of patient pathways providing better opportunities for trials and outcome data collection.
- Integration with other services including chemotherapy, X-ray therapy, surgery, an-aesthesia, emergency/critical care, onsite diagnostics and specialised paediatric, teenage/young adult, and older adult oncology services.
- Comprehensive patient information, wrap around support and accommodation.
- Resilience if there are any gantry issues or the proton beam is not available.
- Advanced imaging capabilities, upgradable as technology develops.
- Integration of the clinical service with their research trial infrastructure and outcome tracking from referral through to follow up. This approach will ensure that the NHS becomes a world leader in the evidence-based use of proton beam therapy.

Lessons learned and plans for the future

The Christie team is committed to actively sharing knowledge and expertise, including the many crucial lessons learned, through the Christie International Proton School. Once the new service is operational, there are plans for further innovation and groundbreaking opportunities:

- Collect highly detailed outcomes data from every patient treated for many years to come. This UK approach will be unique in the world. The data collected will enable clinicians to enhance and deliver innovate treatments for future patients.
- With dedicated research facilities and expertise, the prospect of exciting develop-ments and further innovation are very strong as exceptional minds from The Christie and The University of Manchester work together to harness the full potential of pro-ton beam therapy.

CASE STUDY 4

CHEMO@WORK SERVICE INNOVATION FROM THE CLATTERBRIDGE CANCER CENTRE

How the idea developed

The Clatterbridge Cancer Centre NHS Foundation Trust have been providing for a number of years a specialist nurses support service for treating patients at home with chemotherapy. Patient feedback on the use of the service highlighted a need to support certain patients getting back to work as quickly as possible or reducing their time away from work. In particular, this affected those patients who had to take time off work to attend local hospitals or the specialist cancer centre and had difficulties with access to public transport.

Responding to the feedback, the trust took the decision to explore the feasibility of extending the chemotherapy support service into the workplace with an initial selected number of patients.

They secured some AHSN pump priming support over a 15-month period to develop the service. The extension into the workplace began in the early part of 2018 and at present is only available for patients receiving Trastuzumab (Herceptin), or other treatments delivered by subcutaneous injection.

Use of the service

There are currently around 12 to 16 patients using the service and receiving treatment in the workplace; this number is expected to increase as people extend their working lives into their late sixties and early seventies. In the future, clinicians will explore the extension of the service to other cancer treatments such as SACT (systemic anti-cancer therapy) and developing immunotherapy treatments.

Challenges overcome to develop the service proposition

The response from employers to the proposed service was 100 per cent positive and they were all willing to make available a suitable room to be adapted as a treatment room, meeting health and safety standards expected for chemotherapy interventions. Both large and small employers have converted a room to a suitable standard.

The greatest challenge was to put in place the appropriate legal contractual, service liability and governance framework required to provide cancer treatments in many different outside of hospital settings. This took more than six months of review, consultation with authorities and support from legal experts. Now, a contractual and suitable governance framework is in place, so the service can be rolled out more quickly to further workplaces following agreement by patients and employers.

The other major activity is around ensuring there are sufficient numbers of trained staff to deliver the service, in particular advanced practitioner nurse roles.

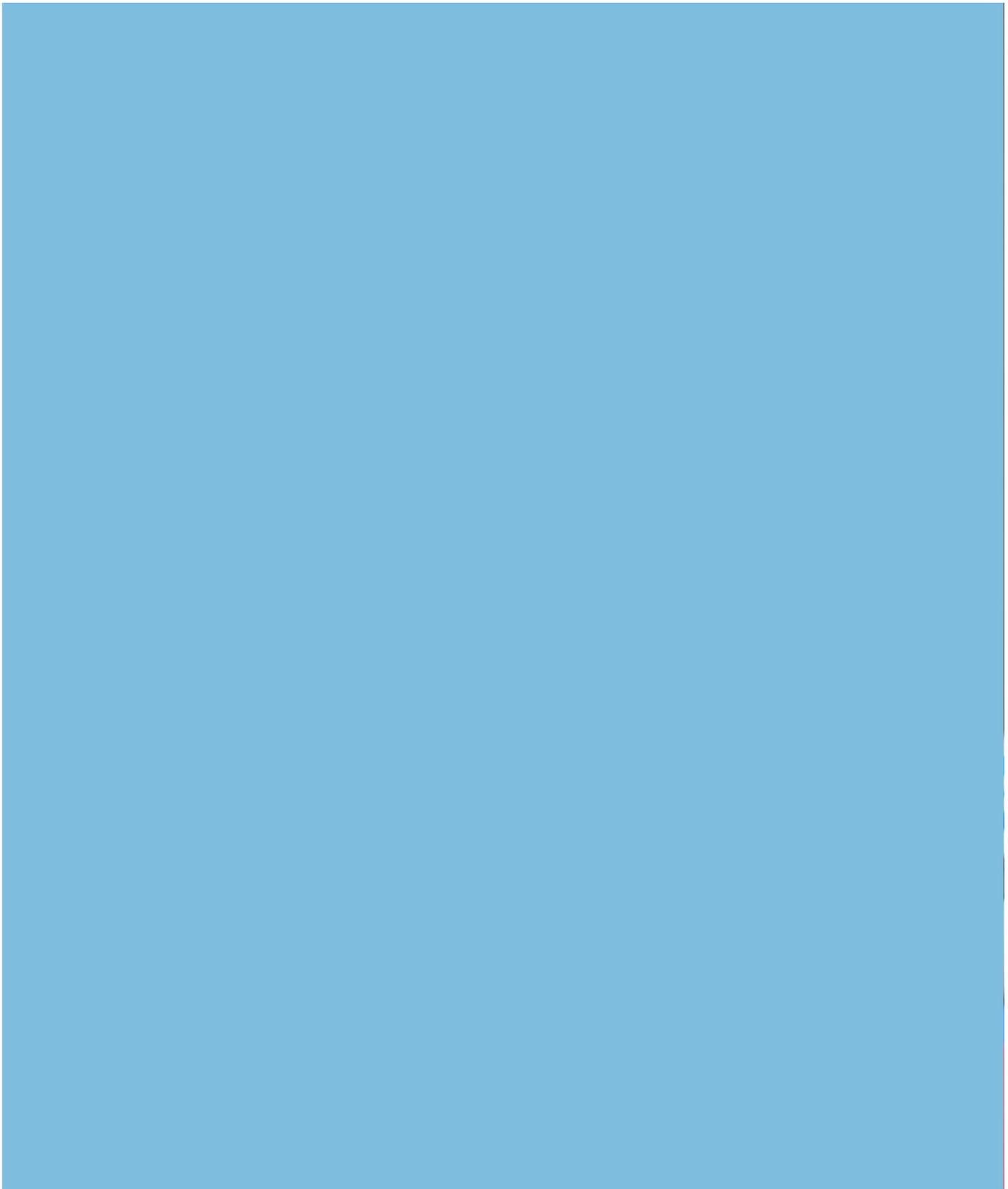
Areas of support required – lessons learnt

In terms of reviewing this service innovation, the case for this service like many others could have benefited from some upfront economic modelling around the potential impact for particular communities to share with commissioners. In addition, early guidance on addressing service liability and clinical governance implications would have reduced the timelines involved in the feasibility testing.

Outcomes to date

The service is still its initial year, but it is proposed to undertake an annual patient audit and survey and to publish abstracts of this patient audit around this innovative workplace treatment service.

In addition, the trust is exploring with AHSNs the need to support the impact assessment with some economic modelling.



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Trust Board update on Healthcare Workers flu vaccination uptake
12 March 2019

1: Total uptake and opt-out rates (all trusts publish this information monthly)

	Total numbers	Rates
Number of frontline HCW	4125	%
Uptake of vaccine by frontline HCW	2473	60%
Opt-out of vaccine by frontline HCW	75	1.8%

2: Higher-risk areas

Area name	Total number of frontline staff	Number who have had vaccine	Number who have opted-out	Staff redeployed? Y/N	Actions taken
Heart & Lung	876	411	7	N	
Blood, cells & cancer	463	224	3	N	

3: Actions taken to work towards 100% uptake

There is a comprehensive communications plan in place involving screen savers, posters, information on static clinics, contact details for vaccinators, myth busters and uptake figures. Board members are thanked for taking part in the campaign by having their vaccinations photographed.

Other interventions include:

- Uptake reported weekly to the senior leadership team.
- Peer vaccinators are trained in all directorates and access to vaccines is made as easy as possible for the vaccinators whilst maintaining the cold chain.
- An online flu system has been purchased to enable speedy and accurate recording of consents and data for all involved.
- Roving vaccinators are out every day across all departments within the hospital from 1st Oct to end Feb.
- A static clinic is held in outpatients each afternoon for drop in sessions.
- Vaccinators are available at Trust events and meetings.

4: Reasons given for opt-out

Reason	Number
I don't like needles	8
I don't think I'll get flu	12
I don't believe the evidence that being vaccinated is beneficial	30
I'm concerned about possible side effects	19
I don't know how or where to get vaccinated	1
It was too inconvenient to get to a place where I could get the vaccine	
The times when the vaccination is available are not convenient	
Other reason	5

Trust Board 3 April 2019	
Patient Story- JH	Paper No: Attachment D
<p>Submitted on behalf of Alison Robertson, Chief Nurse Author, Claire Williams, Interim Head of Patient Experience</p>	
<p>Aims / summary</p> <p>The Great Ormond Street Hospital Patient Experience Team works in partnership with ward and service managers, the Patient Advice and Liaison Service (PALS), and the Complaints and Patient Safety Teams to identify, prepare and present suitable patient stories which are selected to represent a range of experiences across a variety of wards and service areas spanning different directorates and ensuring that the experiences of families are captured.</p> <p>The story to be shared on 3 April 2019 is pre-recorded. Sophie will share her experiences of admission to GOSH when her daughter Verity was just four weeks old.</p> <p>Sophie found the care Verity received at GOSH was excellent but that the facilities for parents are lacking. Specifically:</p> <ul style="list-style-type: none"> • As a breastfeeding mother it was not feasible for her to leave the ward for food and meals were not provided for her. • There was insufficient support for breastfeeding mothers who are alone and a long way from home. • No accommodation was available for her husband and he had to sleep on a chair in the room she was in. 	
<p>Action required from the meeting Review and comment</p>	
<p>Contribution to the delivery of NHS Foundation Trust strategies and plans</p> <ul style="list-style-type: none"> • The Health and Social Care Act 2010 • The NHS Constitution 2010 • The NHS Operating Framework 2012/13 • The NHS Outcomes Framework 2012/13 • Trust Values and Behaviours work • Trust PPIEC strategy • Quality Strategy 	
<p>Financial implications None</p>	
<p>Who needs to be told about any decision? N/a</p>	
<p>Who is responsible for implementing the proposals / project and anticipated timescales? Claire Williams, Interim Head of Patient Experience and Engagement</p>	
<p>Who is accountable for the implementation of the proposal / project? Claire Williams, Interim Head of Patient Experience and Engagement</p>	

Sophie's Story

The child first and always 



Sophie's experiences...

- Sophie and her baby daughter, Verity (then aged 4 weeks old), stayed at GOSH for 15 days in February 2019
- Sophie raised concerns via the Friends and Family Test about the lack of facilities for parents who are a long way from home particularly for her as a breast feeding mother. She also talked about the lack of accommodation available for her husband.
- This story explores Sophie's experiences at GOSH and how this compares with facilities at other hospitals. It is shared in the interests of highlighting possible areas for improvement particularly as Sophie and Verity will be regularly attending GOSH.

What other families tell us* ...

"The facilities and support are also great, especially the use of the parent accommodation and the breast feeding vouchers"

"We had a short notice rearrangement for an overnight stay ,things were rather disorganised and not everyone knew we were coming . But as ever ,we were treated very well. Thank you."

"I would highly recommend the care here at GOSH. The only disappointment is two parents cant stay overnight."

"Facilities....no parent shower room. With lack of sleep, being able to have a shower would be great. Parent's room -needs television/a bit more warmth."

"Staff are amazing. the only negative is our son was booked for more surgery on Monday. Over the weekend no one was helpful in sorting accommodation for dad returning. We are not local and had no money for private room. Lack of help and contact point. was given a single mum room which was not ideal."

"The fact that we can stay in accommodation nearby takes a lot of stress out of the situation."

"Ensuite is wonderful! Room size and facilities in general very good!"

**FFT feedback June 2018-February 2019*

The child first and always

Any questions?

The child first and always



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Introduction

Strategic context

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) is an acute paediatric provider of specialised and highly specialised treatment and care for children presenting with rare and complex diseases and conditions. This is why our vision, which sets our direction, is ‘helping children with complex health needs fulfil their potential’. Our mission is to put ‘the child first and always’, which is supported by our ‘always values’ - to be always welcoming, always helpful, always expert and always one team.



In 2018, more than 260,000 patients from all over the country attended GOSH, around half from outside London. We provide over 50 different specialist and sub-specialist paediatric services – the widest range on any one site in the UK. 90% of our funding is from NHS England specialised commissioning. These factors do set us apart from other providers, but they do not hide us from the very challenging environment across the NHS. GOSH continues to experience pressures such as increasing operating costs; rising demand across core services like cardiac, neuroscience, and cancer; staff shortages; and a requirement to find a place in the new structures and reforms and wider-NHS strategies.

However, the environment also presents exciting opportunities. We are committed to becoming a hospital where research is integral and drives treatment and outcomes. We have seen some exceptional research outcomes this year, many of which have immediately improved children's lives. During

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treatment, patients and their families might be going through the toughest times of their lives, so great importance is put on creating nurturing environments, and high-quality facilities for providing specialised and highly-specialised care - our estates and facilities are therefore critical. We will use technology to move towards a digital future, to access information and share information, make decisions, engage patients and partners and drive safety. In the context of funding pressures for specialised and highly specialised services as well as the high costs associated with providing these service, funding and financial stability remain critical. The funding we receive for NHS activity is not sufficient to cover the cost of delivering it, and we rely on the contribution from private patients to balance our financial position. It also helps us to continue to grow our portfolio of research grants and research posts, while the GOSH charity helps to fund buildings, equipment and a number of other areas.

Our strategic objectives are aligned to eight areas of focus that reflect these challenges and opportunities – care, people, research, technology, voice, space, funding, and information.

Transformational change

In line with our strategy are key large scale transformational programmes, for which 2019/20 will represent a very significant year. These aim to transform the estate, culture and clinical information systems of the Trust to support a step change in the quality of care we provide and the working environment for our staff and patients.

Our Electronic Patient Record (EPR) programme aims to **transform the clinical information systems** of the Trust. Deployment of EPR is a critical and core requirement to move towards being a digital hospital, which will enable improvements in quality of care, operational efficiencies, development of new models of care and treatments, improve communication with our families and patients, and implement a platform to enhance innovative research and enhanced analytics. The potential benefits are enormous, and an immense amount of work has taken place across the Trust in 2018/19 to develop this and ensure operational readiness. The system will go live on April 2019 and therefore EPR will be one of the key focuses of the Trust in 2019/20, with a period of rapid stabilisation followed by an optimisation phase.

Our Safety and Reliability Improvement Programme aims to **transform culture**, by developing our leadership capability and enabling all staff, including front line staff, to take responsibility and be held accountable for behaviours and attitudes that create a culture of safety and reliability. In January 2018, we embarked on a partnership with The Cognitive Institute to deliver the Safety and Reliability Improvement Programme. During 2018/19, workshops took place for senior leaders, and we launched our Speak up for Safety Programme with selection of Safety Champions. In 2019/20, the roll out of the programme will continue, with the overarching aim of working together to develop our leadership capability and embed a safety culture across the organisation.

Our redevelopment programme aims to **transform the estate** to provide world class facilities for patients, opportunities for new models of care and collaborative research environments. In November 2017, we opened the Premier Inn Clinical building which allowed 77 beds to be transferred into the brand new facilities, with additional space to open an additional 64 beds. In 2018/19, construction has continued on the Zayed Centre for Research into Rare Diseases in Children (ZCR), which is due to open in 2019/20. This provides a shared working environment for UCL academics and GOSH clinicians, along with new laboratories and outpatient facilities, which together provide the space for delivery of a world leading centre of research excellence that will tackle some of the most challenging scientific questions in rare disease research. This is another step in delivery of GOSH's research hospital strategy. Beyond this, work will continue on the next steps of the redevelopment programme, which include a new Sight and Sound Hospital to open in 2020/21 and development of the Outline Business Case for the Children's Cancer Centre (Phase 4 of the Trust's master plan).

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Key achievements in 2018/19

In summary, our key achievements in 2018/19 included:

- Reorganisation of the structure of clinical operations teams at the Trust to improve the clarity of lines of accountability, reduce the gap between Trust leadership and front line services, and create attractive leadership roles within the Trust.
- Delivery of the national Referral to Treatment target in each consecutive month in the year to date
- Delivery of £12.3m of savings through the Trust's 'Better value' programme
- Completion of EPR system design, configuration and testing as well as preparation for organisation training ahead of the April 2019 go-live.
- Progress in our redevelopment programme, including:
 - construction of the Zayed Centre for Research into Rare Diseases in Children (to open in 2019/20)
 - the new Sight and Sound Hospital (to open in 2020/21)
 - Ongoing development of the business case for construction of a new Children's Cancer Centre in line with the Trust's master plan (Phase 4).

Key objectives for 2019/20

In 2019/20, we plan to:

- Deliver a £20m Better Value programme
- Improve recruitment and retention at the Trust, including through participating in the Nursing Retention Support collaborative with NHS Improvement
- Further develop the GOSH Learning Academy
- Successfully implement EPR and move into the Optimisation Phase
- Return to compliance with the RTT target after an initial reduction in the EPR go live period
- Continue the roll out of our Safety & Reliability Improvement Programme to deliver cultural transformation
- Open the Zayed Research Centre into Rare Diseases in Children
- Complete the Outline Business Case for the Children's Cancer Centre (Phase 4)

The following sections of this operational plan refresh set out further details relating to these and other areas, following the format and prescribed content areas required by NHS Improvement.

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Operational Plan

2019/20

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1 Approach to activity planning

1.1 NHS activity plan

The following table summarising the NHS activity plan for 2019/20, under the data definitions prescribed by NHS Improvement:

	18/19 forecast	Recurrent growth	Pathway change	19/20 plan	Recurrent growth %	Pathway change %
Consultant Led First Outpatient Attendances	34,455	118		34,573	0.3%	0.0%
Consultant Led Follow-Up Outpatient Attendances	185,075	1,516		186,591	0.8%	0.0%
Day case admissions	24,513	109	(1,087)	23,535	0.4%	-4.4%
Elective Admissions	12,134	186		12,320	1.5%	0.0%
Non-Elective Admissions	2,291	25		2,316	1.1%	0.0%

The key assumptions this is based on are set out below. Note that these assumptions are subject to negotiation and agreement with commissioners, principally NHS England.

Key assumptions:

- **Underlying growth:** this is the assumed level of growth on forecast outturn. Outpatients growth is assumed in a number of areas, with the most significant relating to inherited cardiovascular disease patients, based on long term trend. It also assumes additional outpatients due to increased utilisation of anaesthetic pre-operative assessments. Inpatient growth is particularly driven by recovery of a downturn in activity in Q3 and not forecast to be fully recovered in Q4. See further discussion under section 1.2 below.
- **Demographic changes:** based on review of activity trends, and given the nature of services at GOSH, material impacts of activity changes have been identified for specific services only. A generic demographic change assumption has not been applied. Demographic growth projections by the ONS for ages 0 - 18 range from 1.2% for North Central London area and 0.8% nationally.

Additional service developments

- **CAR T-cell:** In November 2019, GOSH became the first Trust to offer this ground breaking cancer treatment under the NHS. The activity plan for 2019/20 includes an additional 5 cases (10 CAR T-cell, offset by reduction of 5 BMT case) and we will be working closely with NHS England to ensure appropriate remuneration.
- **Cochlear:** new NICE guidance lowers the eligibility threshold for this, which is expected to lead to demand for additional 12 cases of this high cost treatment.
- **Selective Dorsal Rhizotomy:** the full year effect of an agreement with NHS England to provide this service is expected to lead to an additional 12 cases in 2019/20.

Pathway changes

- **Rheumatology:** changes to the pathway for non-inflammatory Rheumatology patients are expected to lead to a reduction in rheumatology rehabilitation activity in 2019/20 – a reduction of c. 20%. This accounts for a large volume of day case activity for the trust, and this reduction equates to a decrease of 4.4% in day cases for the Trust as a whole.

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We have sufficient bed and theatre capacity to deliver these plans, with the focus now on ensuring appropriate staffing is in place (for example, through improved recruitment and retention – see section 3.4) and maximising efficiency of staffed capacity through improved patient flow (see further detail in the Better Value section of the finance plan).

1.2 Access targets

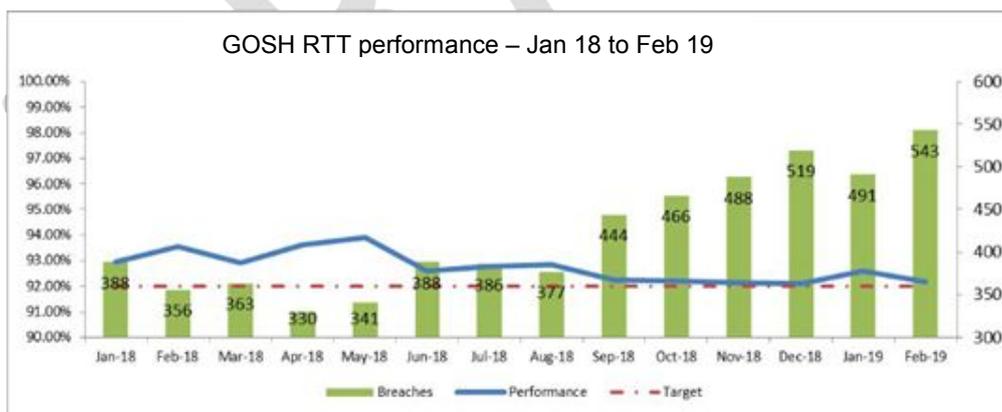
Delivering the activity changes required for sustainable delivery of access targets has continues to be a focus for the Trust, and we continue to work closely with the specialist commissioner, NHS England, the CQC and NHS Improvement, to address the associated challenges and requirements.

Referral to Treatment target (RTT)

Following support from the NHS Improvement Intensive Support Team (IST) in 2015/16, the Trust has used IST tools to model demand and capacity on a rolling annual basis, particularly focusing on key challenged specialties for RTT compliance. The challenged specialties include:

- Orthopaedics
- Spinal
- Urology
- Specialist neonatal and paediatric surgery (SNAPS)
- Plastic Surgery
- Dental
- Dermatology
- Endocrinology

The Trust made significant improvements to its processes in 2016/17 and this, coupled with the opening of additional capacity through the Premier Inn Clinical Building, enabled achievement of the RTT standard in 2017/18.



The Trust has now achieved the target of 92% for fourteen consecutive months, which compares to the national position of below 88% throughout most of this period. However, the Trust has seen an unplanned reduction in activity in the second half of the year (with a number of different causes, including staff shortages). This increases the risk to RTT compliance, demonstrated in the graph above which shows deterioration from the summer period onwards.

The plan for 2019/20 includes additional activity to recover this decline (under ‘underlying growth’).

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We are planning for a reduction in activity in the four weeks post EPR go live which we have modelled as reducing RTT performance by 1.0% and therefore likely to mean we do not achieve the target from April 2019. We plan to return to compliance with the target by the end of the financial year, but this assumes that we can deliver additional activity through our current resource to make up for this reduction.

Diagnostics target

This target will always be a challenge for GOSH due to the very small margin allowed in terms of number of patients breaching (the target will be failed if there are c. 7 breaches in a month). However, performance in 2018/19 has been particularly challenged.



Through the year there have been a number of different causes of this. Many of these have been quickly resolved – for example, in relation to administrative processes within Audiology which caused 24 of the August breaches. However additional problems have arisen in other areas, some relating to administrative processes, and some relating to temporary capacity issues.

There will continue to be significant focus on resolving these issues, and returning to compliance in 2019/20 (although, as noted above, there will always be month on month variability and risk due to the minimal margin for error). No change in the activity plan is required for this.

Cancer target

The Trust has delivered against the applicable cancer targets throughout 2017/18 and 2018/19 with the exception of November 2018, in which there were two breaches against the 31 Day Subsequent Treatment – Surgery standards, due to incidents of the patient and consultant being unwell on the day.

The Trust commits to deliver all the required operational standards throughout 2019/20 and no change in the activity plan is required for this.

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2 Quality planning

2.1 Approach to quality improvement, leadership and governance

Under the Executive directorship of the Medical Director, Quality Improvement at the Trust is part of the broad remit of the Quality and Safety team which incorporates Clinical Audit, Patient Safety, Clinical Outcomes, Complaints and Compliance in addition to a team of Quality Improvement specialists working together to ensure an organisational approach to maintaining and improving our quality governance processes.

Executive oversight of Patient Experience and Engagement is through the Chief Nurse who, with the Medical Director, ensures an organisation wide approach to integrated delivery of the Quality Governance agenda. They are supported in this work by a number of senior roles including the Head of Quality and Safety, Head of Patient Experience and the Deputy Chief Nurse.

Working with the Directorate management teams the aim is to continue to develop a culture of continual identification of learning from events and making changes that are effective, sustainable and improve the quality of the service and experience of our children, young people and their families.

The Quality and Safety team work collaboratively with the Trust's Project Management Office (PMO) to ensure the right resources are available to the right work streams at the right time. This will reduce the risk of duplication of efforts and support the transition of projects to 'business as usual' whilst providing effective support to sustain changes and monitor outcomes.

Each of the priority quality improvement projects have an allocated Executive Director, operational lead and allocated specialist from the quality and safety team, who, along with other key specialists, form a steering group to oversee and support delivery.

Each improvement project has a steering group that reports to relevant Trust committees such as the Quality Improvement Committee (QIC), the Patient Safety and Outcomes Committee (PSOC) or the Patient Family Experience and Engagement Committee (PFEEC). These committees, alongside a newly-established Education and Workforce Committee, provide assurance to the Trust Board on the quality and safety programme.

Using the Institute for Health Improvement (IHI) model for improvement, the Quality and Safety team use data to encourage improvement activity and to demonstrate and evidence the impact of the improvement programme.

2.2 Summary of Quality Improvement plan

The Quality Improvement specialists work to support, enable and empower teams to continuously improve the quality of care provided to patients across GOSH. In the past year the teams have successfully completed the migration of the Early Warning Scoring system to a nationally validated system. PEWS (Paediatric Early Warning System) is a score based system designed to identify potential deterioration in children and young people using a combination of factors such as physiological findings, escalation responses and a strong communication framework.

This year also saw the completion of the Sepsis 6 campaign and the Improving Tracheostomy care and education. These projects have been closed following sustained improvement and handed over to operational 'business as usual'.

The team continue to focus on the following projects:

- Improving Patient Flow through the Hospital

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- Improvement activities requested as part of [Commissioning for Quality and Innovation \(CQUIN\)](#)
- Medication Safety
- Transition
- Vessel Health project
- Reducing pre-analytical lab sampling rejections

All Quality Improvement (QI) projects are monitored through QI project dashboards. The data is predominantly displayed using Statistical Process Control (SPC) charts, developed by the QI analyst team, displayed within Quality & Safety, on the GOSH intranet. The measures include: outcome, process and balancing measures as required. These dashboards are reviewed for improvement or deterioration by the steering group for each project, and these report to the Quality Improvement Committee, chaired by the Medical Director with clinical and operational representation from the clinical divisions.

As an example, the Vessel Health project has a number of key measures to demonstrate success, one of which is below; 'Average unsuccessful peripheral cannulation attempts per child before referral to VAFs'. Through earlier escalation of difficult to cannulate children, there has been a statistically significant reduction in the cannulation attempts, prior to escalation to the specialist team (VAF).



Further to the support of large trust-wide projects, the QI team also provides a service to support smaller improvement projects, providing QI advice, training and support to clinical or non-clinical staff who wish to run a QI project in their area. The QI team provide comprehensive training in improvement methodologies and tools to clinical and non-clinical staff across the Trust. This is part of the ongoing support and encouragement we provide to staff who wish to undertake QI projects throughout the Trust.

Participation in national clinical audits is monitored by the Clinical Audit Manager within the Quality and Safety Team. There is a central clinical audit plan where work is prioritised to provide assurance and to review implementation of learning from serious incidents, risk, patient complaints, and to identify areas for improvement.

The priorities of our Quality Improvement Programme are as follows:

- **Enable delivery of our strategic objectives**
 - Enable change that will help us to achieve our strategic aims whilst also supporting innovation and creative ideas from the front line
 - Align with other enablers of transformational change such as our redevelopment programme, electronic patient records and research and innovation

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- **Facilitate continuous improvement in clinical outcomes and the experience of our children, young people and families**
 - Have a direct impact on outcomes, safety and the experience of patients and staff
 - Strengthen partnerships through co-leadership with patients and families
 - Transform operational management and business intelligence through the use of data
- **Transform the culture of Great Ormond Street Hospital so that everyone is looking for ways to improve patient care every day**
 - The programme is overseen by the QIC and is currently supporting various projects to improve patient flow (ICU & Outpatients), and embed a culture where all staff are empowered, encouraged and feel safe to speak up for safety.

Frontline/ business unit-level clinicians can request support from the Quality & Safety team; Clinical Outcomes, Clinical Audit or Quality Improvement on any of these aspects, for both formal and informal projects and initiatives. 90 minutes – see emails/

2.2.1 Transforming culture - Safety and Reliability Programme (SRIP)

SRIP is a key part of transforming the culture of the Trust. The first phase of this has been rolled out by appointing 11 Safety Champions who have all be accredited as delivers of the Speak up for Safety programme. Following a pilot on one of our clinical directorates (Brain) the Trust will be rolling out the programme to the rest of the Trust. To support this, a further 10 Safety Champions have been recruited to and trained

The programme will be introducing the second phase of the SRIP, Promoting Professional Accountability (PPA) in June 2019 following a robust training and selection programme.

2.2.2 Extending collection of clinical outcomes and safety measures and ensuring they are appropriately benchmarked

Every specialty collects clinical outcomes. Support is on-going to see all identified outcome measures collected, and consistently. The Electronic Patient Record (EPR) will be a significant enabler and the team is actively engaged with the EPR delivery team to maximise the benefits that can be derived from this.

The Trust continues to develop the number of dashboards with the functionality of the clinical outcomes hub in a cycle of refinement and growth.

Work continues on benchmarking with ICHOM and the Children's Alliance. The European collaborative (ECHO) work is also underway with the Clinical Outcomes Lead appointed as the co-chair of Quality, Outcomes and Value working group, with Erasmus. 10/10 Children's Alliance hospitals signed up to benchmarking of the Specialised Services Quality Dashboards. NHSE has confirmed the provision of technical support for this project.

2.2.3 Learning from Deaths

All deceased patients are discussed at a Local Case Review Meeting, with an outcomes form completed and shared with the Trust-wide Mortality Review Group (MRG) which reviews all deaths in the hospital. Every case is then independently reviewed by MRG within 8 weeks of the child's death. This provides a Trust-level overview of themes/risks which would be used to identify improvement actions where relevant. The MRG also functions to provide assurance that the patient pathway has been managed appropriately by the organisation, and coordinates information for relevant programmes e.g. national audits, Child Death Overview Panels where appropriate.

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The Trust is also working with NHS England to establish a national system for peer review of in-hospital deaths of children and young people.

The Trust is well placed to participate in publication of avoidable deaths.

Further work continues to ensure compliance with the learning from deaths publication, and plans are being reviewed by the MRG and Medical Education team

2.2.4 Care Quality Commission

The Trust has a programme of work in order to ensure CQC readiness and to achieve an Outstanding rating for the Trust. This work is being rolled out with a view that compliance and governance are interlinked with quality, safety and experience and embedded in day to day working within the Trust.

Following the CQC inspection in January 2018, the Trust has produced an action plan which is managed by the Directorates and monitored via service line meetings with the Medical Director, Chief Nurse and the Compliance team. The Trust had received one requirement notice for 'Regulation 17 HSCA (RA) Regulations 2014 Good governance'; extensive work has been undertaken within the Trust to ensure that the required improvements were made and the CQC has agreed that the work submitted meets the requirements.

In addition to monitoring the action plan from the previous CQC visit, the Trust is committed to ensuring that compliance and governance is embedded in to every day work. A peer review quality round framework, based on CQC inspections, is being devised and rolled out across the Trust to ensure a rolling programme which promotes compliance and encourages shared learning. Work is underway to review and take learning from CQC inspections of other paediatric Trusts. . The Trust has also resumed lunchtime learning events which provide a presentation from Trust staff regarding an SI/complaint/SCR/trend of incidents to ensure that learning is disseminated across the Trust. The events are also filmed and uploaded to the GOSH intranet to enable all staff to view them. Weekly Steering Groups are being held with the Compliance team and Deputy Chiefs of Service to ensure that compliance and governance is regularly discussed and fed back to the Directorates.

2.2.5 Gram-negative bloodstream infections

Nationally, there is a focus on gram-negative bloodstream infections and an ambition to reduce these by 50% by 2020/21. As a paediatric trust we have seen substantially lower rates of gram negative bloodstream infection since the introduction of mandatory surveillance. Nevertheless, to date we have identified areas of improvement when they have been seen. This has included the introduction of an updated urinary catheter clinical guidelines and an associated care bundle which is audited on a quarterly basis. Further work is underway to create standardised care plans for patients with catheters.

In addition we plan to carry out a full gap analysis around compliance with the Health & Social Care act which will include the NHSI GNBSI system overview tools. Results from this will be used to inform our work plan for the upcoming year and provide an update for our operational assurance framework.

2.3 Summary of Quality Impact Assessment

In order to improve and embed a thorough QIA process within the Trust - following the input and advice from an external consultancy partner, a new Programme Management Office (PMO) was established in 2016/17 to oversee the Trust's CIP (and other major) plans, and business partners were recruited to support Directorates with the scoping and delivery of their contributing plans. Over the last years this process has been refined and enhanced further, meaning the PMO now has a very well-developed integrated system to scope each plan and assess its quality impact. The PMO - working with the Medical Director, Chief Nurse - has an agreed QIA process in line with Internal Audit recommendations.

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In support of the new directorate structure with its reinforcement of greater directorate responsibility, a new QIA scheme of delegation is in place:

- Directorate management teams (Chief/Deputy Chiefs of Service – Clinical Role, General Managers and Head of Nursing and Patient Experience) to review and approve all QIAs in the first instance;
- The QIA panel (co-chaired by the Medical Director and Chief Nurse) to be kept informed of the approval status of all schemes including those signed off at directorate level;
- The QIA panel to assess and sign off all QIAs for any proposal likely to have more significant potential impact (including for example those of a cross-cutting nature).

QIAs are required for any scheme with a potential to directly or indirectly impact quality. This includes back office and support services. The required framework considers impacts on patient safety, clinical outcomes, patient experience and staff experience.

According to the Trust's agreed policy, if any of the following criteria are applicable to a scheme then a QIA will be required:

- Change to skill mix and/or headcount
- Service redesign
- Change to a business process or service delivery
- Cross-Directorate schemes
- Over £50k in value

These schemes are then subject to the QIA process reporting to the QIA Panel as described above.

In addition to regular meetings of the QIA panel, QIA updates are provided to each meeting of the Quality & Safety Assurance Committee (QSAC) which reports to the Trust Board. The QSAC is provided with updates on completion of QIAs and any concerns arising, undertakes deep dives and receives post implementation reviews into individual schemes at each of its meetings, and considers reports on quality key performance indicators which could be used to provide early warning of impacts (both positive and negative) that may be attributable to the Better Value programme. A wide range of such indicators is already reported through monthly dashboards as part of the directorate performance review process. In addition, a set has now been developed for routine reporting in QIA updates to the QSAC, covering issues such as:

- patient feedback (Friends and family test feedback, 'red' complaints – with plans to include patient Real Time Patient Feedback in future);
- workforce issues (Sickness absence, turnover, vacancies and temporary staffing);
- clinical indicators (Serious incidents, outpatient DNA rates, incomplete RTT pathways over 18 weeks, cancelled operations, theatre utilisation rates and late starts).

In 2019/20 there will be an increased emphasis on KPI monitoring, especially for schemes rated as high risk, to ensure there are no on-going adverse impacts on quality and that quality is maintained as indicated in completed QIAs. This will be assisted through the newly established assurance meetings that now take place on a monthly cycle with each directorate.

2.4 Summary of triangulation of quality with workforce and finance

Directorate performance reviews take place on a monthly basis, attended by Directorate management and Trust executives. These reviews are designed to facilitate a triangulated and risk-focused discussion across a number of key domains: Caring, Safe, Responsive, Well-led (people, management and culture), Effective, Finance, Productivity.

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The review packs contain an integrated dashboard which provides a one page summary of key metrics across the domains, allowing rapid identification of linked risks and issues. The packs also contain more in-depth dashboards for each domain.

An integrated performance report is then scrutinised at each Board meeting. This provides a summary of the key issues in each domain and actions planned to resolve, as well as an integrated dashboard – this provides trust level data using the same format as the Directorate integrated dashboard reviewed in the monthly performance reviews. Examples of metrics contained in the integrated dashboard are:

- **Caring:** Friends and family scores and number of complaints
- **Safe:** serious incidents and never events
- **Responsive:** performance against access targets
- **Well led:** sickness, turnover, appraisal rates, mandatory training compliance
- **Effective:** DNA rate
- **Productivity:** theatre utilisation, bed occupancy
- **Finances:** variance to plan

2.5 Clinical sign-off for staffing element of plans

The Medical Director and Chief Nurse are engaged throughout the planning process – developing plans have been presented to the Medical Director and Chief Nurse for challenge, QIAs for savings schemes are reviewed and signed-off, and business cases are approved through the Executive Management Team meeting.

Ward establishments are reviewed on an annual basis as per National Quality Board standard. Each review sees if there have been any significant changes in patient activity, acuity, case mix, professional judgement etc. requiring and change in ward establishment. This is reported by the Chief Nurse to the Nursing Board, Executive Management Team and then taken to Trust Board. Removing or changes to any nursing posts has to be signed off Chief Nurse.

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3 Workforce planning

3.1 Workforce plan summary

	18/19 forecast	19/20 plan	Change	Change %
Non Medical - Clinical Staff	3,154	3,155	1	0.0%
Non Medical - Non-Clinical Staff	656	684	28	4.3%
Medical and Dental Staff	670	721	51	7.6%
Total	4,480	4,560	81	1.8%

3.2 Workforce planning methodology and alignment to integrated plans

The Trust undertakes workforce planning throughout the organisation as part of its business planning and operational activities in order to support the Trust's strategic approach to workforce. The plan is informed by activity and finance planning to establish demand requirements at POD/specialty level for future years. Furthermore, considerations regarding national, international and local drivers are included in the drawing up of plans. A gap analysis, in conjunction with a risk analysis, is carried out to support the Trust's business plans to meet the level of anticipated demand. New positions and business developments identified through this process are aligned with our operational plans.

Business developments, either within the activity planning cycle, or outside are subject to scrutiny by clinical and corporate professionals to ensure business plans are fit for purpose, have considered risk and mitigations, considered downside strategies and retain or improve quality and outcomes. Similarly, organisational change across the Trust is subject to similar considerations, prior to and during consultations. Workforce implications are considered in a similar way.

The Trust recognises the challenging financial environment it must adapt to and, as such, stresses quality and workforce risk as an integral part to its productivity and efficiency programme. Proposed schemes, during scoping and revisited throughout the programme, have an associated Quality Impact Assessment (QIA) undertaken to address consequence and likelihood of risk occurring (See section 2.3).

3.3 Governance of Workforce challenges, risks and issues

The Trust Board regularly receives workforce analysis and key performance indicators, benchmarkable metrics including staffing profile, voluntary and non-voluntary turnover, sickness, agency usage (as percentage of paybill) and vacancies. Monthly Directorate performance reviews are Executive-led and consider this workforce data at a drill-down level in conjunction with finance, activity and quality data to identify themes or impact on service delivery. Nurse recruitment and retention workstreams are overseen by the Nursing Workforce Advisory Board which reports to the Executive team.

The Education and Workforce Development Board ensures the alignment of clinical and non-clinical education and development with our workforce requirements. This Board additionally has oversight of identified workforce risks in the organisation.

As part of its workforce planning processes and safe staffing assessments, the Trust also uses PANDA (the paediatric acuity and nurse dependency assessment tool), which the Trust co-designed, as an acuity tool for inpatient paediatric services. In 2019 the Trust will implement the SafeCare system (following the roll out of Allocate – rostering system), which will integrate the existing PANDA acuity information with information from the new rostering system.

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Services, specialties and directorates hold risk registers that are reviewed and updated to provide a feedback mechanism to Trust risk registers. Trust-wide strategies to mitigate workforce risks are formulated which include nurse recruitment strategies, an integrated Nursing Workforce Programme Board, overseas fellowship programme (for medical staff) and other actions which all form part of the Trust's developing workforce plans.

3.4 Current Workforce Challenges

The Director of HR&OD leads a senior HR team that has identified a number of programmes that are managed through a Workforce programme Board.

Workforce Challenge	Impact on Workforce	Initiatives in place
Recruitment & Retention	Increased pressure on remaining staff & potential for increased vacancies	Trustwide Recruitment & Retention group established -Participation in NHSI Retention Direct Support Programme (Nursing) -Exit survey refresh to gather more qualitative data. -New Leadership strategy. -Nursing career conversations. Reward and Recognition programme Publication of benefits available Flexible working options PGME and NNME development programmes Improved visibility and management of vacancies
Vacancies in hotspot areas	Although Trust rate is low, in certain grades and areas there are more challenges. (i.e.) <ul style="list-style-type: none"> • Band 6 Nurses (13.6%) • Jnr Drs (7.6%) • Healthcare Assistant (17.5%) 	-Participation in STP working group on international recruitment. -Improvements to recruitment technology and processes. Development of new roles such as physician associates and nursing associates (pilot site)
Brexit	13% of our workforce are EU citizens increasing to 22% of our medical staff.	-Regular communications to EU staff. -Support with Settled Status applications.
Staff Experience	Lower levels of staff engagement lead to reductions in productivity	- 2018 "Census" Staff Survey -Development of Forums to support Equality, Diversity & Inclusion agenda. -Embedding Values & Behaviours training. -Coaching & mentoring network. -Implementation of new rostering system.

3.5 Current Workforce Risks

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Workforce risks are managed locally through the HR and Directorate risk registers. These are monitored and managed locally, with strategic risks highlighted to the Board via the Board Assurance Framework. Currently retention is flagged as the key workforce risk on the Board Assurance framework.

Description of workforce risk	Impact of risk (high, medium, low)	Risk response strategy	Timescales and progress
Staff Turnover has increased in 2018 to above local target (14%)	Medium	-Development of retention plan -Participation in NHSI nursing retention programme	In progress (12 months)
Gaps in Junior Dr rotas	Medium	-International recruitment campaign. -Rota redesign.	In progress (6 months)
Replacement of retiring workforce in specialist areas	Medium	-Identification of affected staff, and focussed support in succession planning	In progress (3 months)
10 (33%) Statutory & Mandatory training topics are below target compliance.	Medium	-Improved visibility of training records. -Refresh of Statutory & Mandatory Training policy. -Training Needs Analysis review	In progress (6 months)

3.6 Long term Vacancies

The Trust does not currently monitor length of vacancies as the budgets are not held on ESR. A project group to rectify this has been established. Overall the Trust has low vacancy rates and have been below the 10% target for several years. The Month 9 vacancy rate is 0.4%. The table below indicates our key areas of focus.

Description of long-term vacancy.	Whole-time equivalent (WTE) impact	Impact on service delivery	Initiatives in place, along with timescales
Band 6 Nurses	73.5	Potential for gaps in roster. Mitigated with use of temporary staff.	-Development programme for band 6s -New Junior sister Band 6 role -Over-recruitment of band 5s
Healthcare Assistants	55.3	Potential for gaps in roster. Mitigated with use of temporary staff.	-Ongoing recruitment campaigns. - Nursing Associates
Description of long-term vacancy.	Whole-time equivalent (WTE) impact	Impact on service delivery	Initiatives in place, along with timescales
Junior Dr (StR)	27	Potential for gaps in rota. Mitigated with use of temporary staff.	-Exploring international recruitment campaign with STP.

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3.7 Transformational change

The Trust is rolling out the **Safety and Reliability Improvement Programme (SRIP)** which aims to deliver transformational cultural change. The programme will involve working together to develop our leadership capability and embed a safety culture across the organisation. This will ensure that we are in line with the ambitions articulated in our strategy – we always deliver the safest, most reliable treatment and care for our patients, from the moment they come into contact with GOSH and throughout their patient journey.

Another significant transformational change is the Trust's implementation of a new **Electronic Patient Record** system during 2019/20 which represents a significant change for almost every member of staff and has the potential to deliver a wide range of benefits for staff and patients. We have established a Workforce Change Group to identify ways the new system will make changes to how we deliver patient care and manage our support systems more efficiently. This will include the development of new roles and skills to ensure maximum benefits realisation of the new system for staff and patients.

Other areas of continuing change and improvement in 2019/20 include:

- Completion of the rollout of our new rostering system allowing rostering of non-nursing staff groups, with increased abilities to plan workforce utilisation and monitor temporary staffing usage. The link to the Trust's patient acuity system will be operational from May 2019 offering further opportunities to monitor and influence safer staffing levels on a daily basis.
- The Trust is developing a business case for a new Learning Academy space, as well options for a Virtual Learning Environment.
- We continue to develop apprenticeship programmes that attract and retain staff. We currently have over 100 apprentices across the organisation. During 2019 we will explore further apprenticeship routes into both clinical and non-clinical roles and ways to spend the Apprentice Levy creatively for the benefit of patients.
- The development of new roles is integral to delivering our staffing requirements; we continue to explore expansions of roles such as Physicians Assistants and Nursing Associates.

3.8 Collaborative Working

The Trust actively participates in STP forums, with the Director of HR&OD contributing to NCL (North Central London) STP activities. In 2018/19, the Trust worked on several STP workforce schemes, including

- Streamlining recruitment and onboarding processes
- Streamlining Statutory & Mandatory training processes, the Trust is exploring implementing the national OLM system in 2019.
- Participating in international recruitment campaigns
- Calling off on a shared framework for the provision of temporary staff
- Exploring a collaborative STP bank model.
- Reviewing the NCL STP apprenticeship programme.
- Capital Nurse programmes

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4 Financial Planning

Please see separate financial plan document

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5 Membership and Elections

6.1 Council of Governors elections in previous years and plans for the coming 12 months

In February 2018 it was agreed that the Members' Council would be renamed the Council of Governors and Councillors referred to as Governors from 1 April 2018.

In July 2018 the Constitution Working Group reported to the Council of Governors on its review of the Constitution. The review's aim was to strengthen governance arrangements for the membership, Council of Governors and Trust Board. The following recommendations were approved:

- Appoint two new Governors from the Young People's Forum, replacing the SelfManagement UK and GOSH School Governors.
- Keep the minimum age of members at 10 years of age.
- Set a lifetime maximum tenure for Governors of six years in total, with no return after this period of appointment has been served.
- Review the constituencies to ensure that they adequately represent the membership of the Trust.
- Review the phasing of elections so as to appropriately manage consistent Governor turnover

Following these changes, the GOSH Council of Governors continues to be made up of 27 elected and appointed Governors as below:

10 patient/parent/carer governors

- 2 Patients from London
- 2 Patients from Outside London
- 3 Parents and carers from London
- 3 Parents and carers from outside London

7 public governors

- 4 North London and surrounding area
- 1 South London and surrounding area
- 2 Rest of England and Wales

5 staff governors

5 appointed Governors

- 2 Young Person's Forum Governors
- 1 Camden Council Governor
- 1 GOSH/ICH/UCL Governor

The last Trust election was held in February 2018. Twenty-two seats in the Patient, Parent and Carer, Public and Staff constituencies were subject to an election. There are no planned elections for 2019/20.

6.2 Governor recruitment, training and development, and activities to facilitate engagement between councillors, members and the public

6.2.1 Governor training and development

Governors attended three induction sessions between April and August 2018. The sessions prepared and supported Governors to discharge their duties and complete mandatory training.

The Governor Induction programme for the recent intake concluded in August 2018 and transitioned into a series of Governor development sessions. These sessions were developed in partnership with Governors to provide them with the skills and knowledge needed to deliver their key duties over their tenure.

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6.2.2 Governors' and Chair meeting

Prior to each Council of Governors' meeting, the Chair meets with all Governors in a private session. This gives the Governors an opportunity to discuss any issues directly with the Chair.

6.2.3 'Buddying' with Non-Executive Directors

The Trust established a buddying programme between Non-Executive Directors (NEDs) and Governors from September 2018. The buddying programme provides Governors with direct contact with a NED to support their role and share information on matters of interest or concern. The programme will be evaluated after 12 months.

6.2.4 Governors' online library

In February 2019 Governors will have access to an online library of resources. This will provide Governors with 24/7 access to key documents and information.

6.2.5 Governors' newsletter

In 2019 Governors will receive a monthly newsletter from the Corporate Affairs team containing key dates, developments and training and development opportunities.

6.3 Membership and Public Engagement

The bi annual magazine *Member Matters* and monthly *Get Involved* newsletters offer a variety of opportunities for members to engage with the Trust and its Governors, including:

- The Young People's Forum - a group of current and ex-patients who guide and support the hospital on a range of topics and issues.
- Other forums and committees such as the Young people's Advisory Group.
- Events such as the opening of the new Disney Reef, the Big Youth Forum Meet Up and the Annual General Meeting and Annual Members' Meeting.
- An open invitation to attend Council of Governors' meetings in public throughout the year.
- Governors write personalised articles in *Member Matters* and *Roundabout*, the staff newsletter; a letter from the Lead Governor is also included in our updated Welcome Pack for new members.
- An online link to contact a Governor is included on the website and in all membership eCommunications; members can also contact a Governor via the Trust's new Twitter profile.

6.4 Membership strategy

The Trust's Membership Strategy has been revised for 2018-2021, with the objectives of recruiting, communicating and engaging with our members using a refreshed approach. We hope to strengthen the link between the hospital and its members by maximising involvement and engagement opportunities and focusing on better representing our younger membership community.

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6 Link to the local sustainability and transformation plan

The Trust is located within the footprint for the North Central London STP and has been increasing the level of joint working with the STP throughout 2018/19. Trust is fully supportive of joined up local planning process to deliver transformational change and continues to engage with local plans to improve processes and deliver efficiencies. Section 3 (Workforce planning) provides a number of examples of how we are working across the STP.

The Trust believes that over the next five years, further collaborative service models should be developed to include tertiary paediatric services and that GOSH has a pivotal role to play in developing and in many cases leading such networks. In a number of services there are already informal shared care and network arrangements being developed. Exemplars already exist for Epilepsy Surgery and Cystic Fibrosis by which the Trust provides leadership for the system in a particular region. The models of operation will depend on the service and the types of collaborative partners and may range across a spectrum from basic outreach models, through to integrated networks with services commissioned from the network lead provider.

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Trust Board 3rd April 2019	
2019/20 Final Operational plan narrative (finance section provided separately)	Paper No: Attachment E
Submitted by: Andrew Taylor, Acting Chief Operating Officer	Enc Final GOSH Operational Plan narrative 2019-20
<p>Purpose This paper provides the final version of the operational plan narrative due for submission to NHS Improvement (NHSI) on 4th April. This coversheet sets out the background for this and key changes from the draft version approved by the Board in February.</p> <p>Background In December and January, NHSI and NHS England (NHSE) issued the combined planning guidance for 2019/20. In keeping with prior years, this requires the Trust to submit:</p> <ul style="list-style-type: none"> • An operational plan narrative • Annual financial plan (a detailed template) • Annual workforce plan (a detailed template) • Annual activity plan (a detailed template) • Triangulation return, to demonstrate alignment across the plan (a detailed template) <p>The Board reviewed the draft operational plan on 7th February, which was subsequently submitted to NHS Improvement. We are now required to submit the final plan on 4th April, and this version is provided here for Board review and approval.</p> <p>By section, the key changes to the draft version from February are set out below:</p> <ul style="list-style-type: none"> • Activity: negotiation with commissioners still continues, however the activity plan has been revised based on progress to date. The key changes are the removal of a number of service developments which have been removed due to funding constraints. Also now included is the expected impact of a pathway change in Rheumatology. • Quality: further information provided related to support provided to front line staff and how the impact of projects is measured, following feedback from NHSI • Workforce: assumptions updated to align with finance and activity. • Finance: this has been provided in a separate paper. 	
<p>Action required from the meeting</p> <ul style="list-style-type: none"> • Indicate that the Board is satisfied that adequate governance measures are in place to ensure the accuracy of information included within the plans. • Approve the operational plan for submission to NHS Improvement on 4th April 	
<p>Contribution to the delivery of NHS / Trust strategies and plans The delivery of the operational plan is key to the Trust strategy as a whole.</p>	
<p>Financial implications The financial implications of the operational plan are set out in the separate finance plan paper.</p>	

Attachment E

Legal issues None
Who is responsible for implementing the proposals / project and anticipated timescales Executive Management Team
Who is accountable for the implementation of the proposal / project Chief Operating Officer

Trust Board 03 April 2019	
GOSH Leadership Strategy Submitted by: Lynn Shields, Director of Education Exec Sponsor – Alison Robertson, Chief Nurse	Paper No: Attachment G
Aims / summary The draft <i>GOSH Leadership Strategy</i> has been developed to ensure we, as an organisation, <i>have leaders at all levels of the trust who are effective, visible, supportive and respected. (Fulfilling Our Potential, 2017)</i> Our Leadership Framework focuses on helping GOSH staff to develop four critical leadership capabilities: <ul style="list-style-type: none"> • Inclusive and compassionate leadership, so that all staff are listened to, understood and supported, and that leaders of every level truly reflect our Values and the talents and diversity of staff working within GOSH. This includes ensuring staff engagement and creating a culture that gives our staff a strong voice. • Talent management to support GOSH, ensuring we are able to attract, identify and develop people, matching them to opportunities as they arise, allowing us to have the right talent to meet our operational needs. • Systems leadership to ensure our staff are equipped to develop high quality partnerships and networks with leaders across organisational, professional and geographical boundaries, informing service design and delivery to achieve high quality care for our patients. • Change leadership, ensuring the core leadership capabilities necessary to deliver organisational change, in both its culture and ways of working. Our <i>GOSH Leadership Strategy</i> sets out the direction by which GOSH intends to develop and supports our leaders. Investing in our leadership potential will drive higher performance and translate to higher-quality care and outcomes for our patients whilst ensuring our leaders understand the system that they work in.	
Action required from the meeting <ul style="list-style-type: none"> • Trust Board to approve the GOSH Leadership Strategy 	
Contribution to the delivery of NHS Foundation Trust strategies and plans <ul style="list-style-type: none"> • This strategy was developed to ensure the delivery of the Trust strategic priorities within <i>Fulfilling Our Potential</i>. 	
Financial implications <ul style="list-style-type: none"> • None – will be included within the Charity Grants Case submission in June 2019 for the <i>GOSH Learning Academy</i>. 	
Who needs to be told about any decision? <ul style="list-style-type: none"> • Lynn Shields, Director of Education 	

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

- Lynn Shields, Director of Education

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

- Alison Robertson, Chief Nurse
- Caroline Anderson, Director of HR and OD
- Sanjiv Sharma, Acting Medical Director

GOSH Leadership Strategy

1. Our Ambition

Our vision is for team leaders at every level within GOSH to develop leadership capability among their staff and themselves. Our ambition is to accelerate their journey towards exemplary leadership ensuring we can attract, develop, and retain leadership of the highest capability across our organisation.

The changing demands within the NHS and the increasing complexity of our patients create different, individual development needs. Our aim is to equip and encourage our staff while developing their leadership profile, ensuring it matches and enhances our world-class clinical services.

Our Leadership Framework focuses on helping GOSH staff to develop four critical leadership capabilities:

- **Inclusive and compassionate leadership**, so that all staff are listened to, understood and supported, and that leaders of every level truly reflect our Values and the talents and diversity of staff working within GOSH. This includes ensuring staff engagement and creating a culture that gives our staff a strong voice.
- **Talent management** to support GOSH, ensuring we are able to attract, identify and develop people, matching them to opportunities as they arise, allowing us to have the right talent to meet our operational needs.
- **Systems leadership** to ensure our staff are equipped to develop high quality partnerships and networks with leaders across organisational, professional and geographical boundaries, informing service design and delivery to achieve high quality care for our patients.
- **Change leadership**, ensuring the core leadership capabilities necessary to deliver organisational change, in both its culture and ways of working.

Our GOSH *Leadership Strategy* sets out the direction by which GOSH intends to develop and supports our leaders. Investing in our leadership potential will drive higher performance and translate to higher-quality care and outcomes for our patients whilst ensuring our leaders understand the system and teams that they work in.

2. The Context

Having identified Leadership and Talent Management skills and capability as one of the key priorities within the approved Education & Training Strategy - *the GOSH Learning Academy*, the *GOSH Leadership Strategy* has been developed to ensure we, as an organisation, *have leaders at all levels of the trust who are effective, visible, supportive and respected.* (*Fulfilling Our Potential*, 2017)

This strategy acknowledges that, as a tertiary and quaternary institution providing specialist and highly-specialist care, we require leaders with knowledge of high-level, system leadership and our place within the NHS overall vision, as well as competence in delivering organisational change and the skills and capabilities to effectively manage and develop teams.

Recognising that leadership development is included within the wider programme of work around culture change, our strategy aims to ensure the success of vital projects in this area, such as *Speaking Up for Safety*. It also sets out the expectations for our leaders at all levels:

- Aware of themselves and their impact on others
- Empowering and nurturing
- Open-minded and curious
- Positive in their influence and impact
- Integrated and connected

Successful leadership development is essential to continuously improve cost effective, high quality care at GOSH.

3. Our Challenge

At GOSH, we care for patients with very complex needs, working within an increasingly ambiguous, unpredictable, and variable healthcare system. Areas of challenge include:

- **Building new NHS wisdom** – GOSH has been able to confidently demonstrate strong and consistent clinical expertise, but there has been a lesser focus on capabilities that are essential for success, including resilience, leadership, and quality improvement.
- **GOSH is a complex, unique healthcare setting** – Leading within this environment requires a new version of leadership that is agile, distributive, and compassionate.
- **CQC assessment** – The 2018 CQC report highlighted room for improvement in the well-led domain and in leadership capability development.
- **Core leadership skills development** – The Trust requires well-rounded leaders, both in their functions and as corporate leaders within the organisation. This is reflected in the senior core managerial disciplines as well as service planning, project delivery, commercial skills, and change management.

4. External Landscape

Within national planning, including *The NHS Long Term Plan* (NHS England, 2019) and *The Topol Review* (Topol, 2019), leadership development factors significantly into future planning for success.

Our brand and our strong alliance with the GOSH Children's Charity and UCL Great Ormond Street Institute of Child Health (ICH) places GOSH in a unique space in which to operate. Within the Leadership Strategic Framework, partnerships factors in as a cross cutting theme; it is our key to new opportunities, perspectives, and expertise to accelerate journeys towards exemplary leadership.

We have mandatory obligations to our quality assurance partners, e.g. the Care Quality Commission (CQC) and NHS Improvement/England (NHSI/E), to have a robust and contemporary leadership strategy.

5. Strategic Summary and Links to Trust Strategy

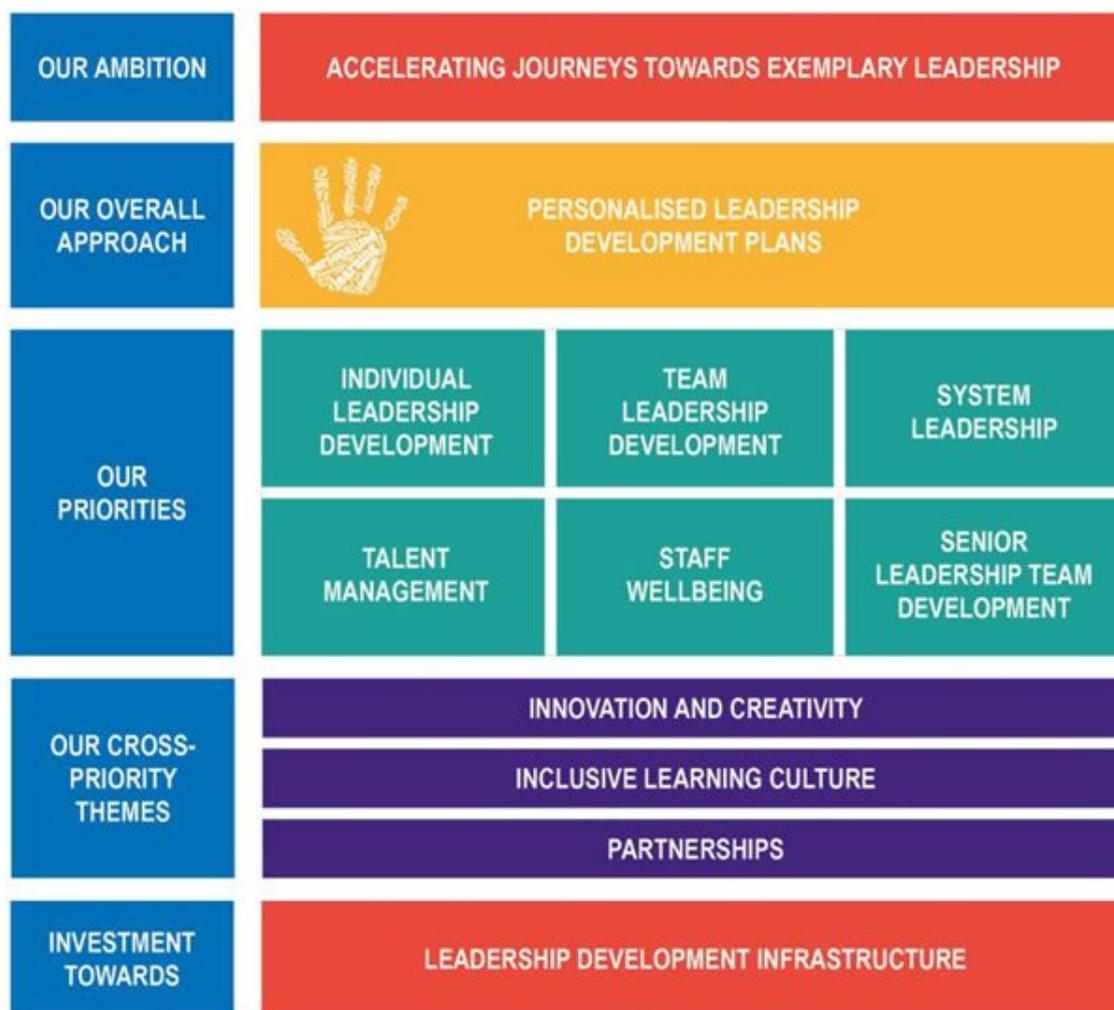
Fulfilling our Potential prioritises *attracting and retaining the right people through creating a culture that enables us to learn and thrive* and sets out four related objectives:

1. *Build a positive and diverse culture where staff are inspired to give their best*
2. *Be renowned for our talented staff and for the ever-improving quality of work they do*
3. *Have leaders at all levels of the trust who are effective, visible, supportive and respected*
4. *Providing our staff with the skills and capabilities needed to deliver exceptional care*

Our Leadership Strategic Framework integrates these objectives as core while embedding the knowledge gained through staff listening events and the pan-Trust learning needs analysis around culture, behaviours, and leadership; kindness and compassion stood out as essential behaviours that were the most important for our staff.

6. Strategic Framework

To deliver on our strategy, the ambition is underpinned by a strategic framework which details the ambition, overall approach, priorities, cross-priority themes, and investment towards. This strategic framework has been developed in order to detail our focus over the next 5 years:



7. Metrics

One of the key considerations in our strategy is to ensure we are utilising contemporary, data-driven methods through the leadership development process and that there are identified outcome measures for appraising the success of our programmes of work including staff surveys, recruitment and retention rates, exit interviews, sickness rates, vacancies in key leadership roles, operational performance, and external assurance reports.

8. Moving Forward

It would be pragmatic to recognise that current financial resources are not sufficient to ensure the success of this strategy. Outcomes will be contingent on funding attained through the *GOSH Learning Academy: Outline Business Case*, pending submission to the GOSH Children’s Charity Grants Committee in June 2019.

Once resources have been secured through this process, the GOSH Learning Academy—as the primary source of operational delivery—will identify key deliverables and measures over the next five years within the *GOSH Learning Academy: Operational Plan*. These will be approved and monitored through appropriate assurance structures, namely Education and Workforce Development Board and the People and Workforce Assurance Committee.

Trust Board 3rd April 2019	
Clinical Strategy	Paper No: Attachment H
Submitted by: Sanjiv Sharma, Acting Medical Director	
Aims / summary Our clinical strategy, which is outlined in this paper, sets out how we will manage the current environment and build our organisation for the future. We want to help shape the future of paediatric care and given our history it is logical we continue to plan to be at its leading edge. The strategy sets out the following aims: <ol style="list-style-type: none"> 1. Strengthening our specialist and highly-specialist services 2. Leading in future fields <ol style="list-style-type: none"> a. Cancer b. Cardiac Surgery c. Neuro d. Rare Diseases <p>The document sets out the direction of travel for the clinical strategy. The formal strategy will need to be developed in line with our clinical leaders and external stakeholders, and alongside work to refresh the hospital strategy.</p>	
Action required from the meeting Board members to note and approve the document and endorse the proposed actions to move forward.	
Contribution to the delivery of NHS Foundation Trust strategies and plans The paper sets out how we will manage the current environment and build our organisation for the future.	
Financial implications The delivery of the clinical strategy and particularly the aim of ensuring that we are leading the way in children's services will require investment. Not simply in the services which are prioritised within the strategy, but also in the horizontal services which support them e.g. imaging and pathology. The paper sets out some of the investments which may be required to support the delivery of this strategy in the coming years.	
Who needs to be told about any decision? Sanjiv Sharma, Acting Medical Director Alison Robertson, Chief Nurse Andrew Taylor, Acting Chief Operating Officer James Scott, Head of Strategy & Planning	

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

Sanjiv Sharma, Acting Medical Director
James Scott, Head of Strategy & Planning

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

Sanjiv Sharma, Acting Medical Director

Attachment H

Clinical Strategy: Strengthening our specialist and highly-specialist services and leading in future fields

**“We want to help shape the future of paediatric care and given our history it is logical we
continue to plan to be at its leading edge.”**

INTRODUCTION

Great Ormond Street Hospital for Children NHS Foundation Trust (“GOSH”) was founded in 1852 as the country’s first specialist medical institution for children. We have pioneered paediatric cardiac surgery, treatments for childhood cancers, and research for complex and rare conditions. Our past strategies have continued to encourage us to be pioneering helping to grow our services.

We believe our growth has also been driven by: (i) an ongoing rationalisation of specialist services; (ii) an increasing birth rate in England, particularly in North London; (iii) improved survival rates for premature births and complicated childhood conditions; and (vi) improved detection and intervention of childhood conditions We now provide more than 50 different specialist and highly-specialist paediatric services – the most extensive range by a single provider¹.

However, the affordability of specialist work, problems attracting and retaining a specialist workforce, and new reforms and structures means the National Health Service (NHS) is operating in a difficult environment. It also means GOSH will need to manage some unprecedented challenges.

Our clinical strategy, which is outlined in this paper, sets out how we will manage the current environment and build our organisation for the future. We want to help shape the future of paediatric care and given our history it is logical we continue to plan to be at its leading edge.

¹ Highly specialised services are commissioned by NHS England because of their rarity. 90% of the tertiary (i.e. specialist) and quaternary (i.e. highly specialist) services provided at GOSH are commissioned nationally. The remaining 10% of our routine care is commissioned by Clinical Commissioning Groups (CCGs).

Attachment H

“Being clear about the specialist and highly-specialist paediatric services we provide, and leading in future fields will help us to shape the future of paediatric healthcare.”

DEFINING OUR CLINICAL STRATEGY

We can only help to shape paediatric services if we have a positive influence on children’s health. We recognise that being better, more active, and successful will depend on the services we provide, the aspirations we choose to set, and competencies we develop (i.e. we define ‘where we chose to play and win’). Therefore, our clinical strategy will have two elements:

1. Strengthening our specialist and highly-specialist paediatric services
2. Leading in future fields

Our patients, quality² and outcomes will be prominent features of our clinical strategy. Further, the clinical strategy will link to other core strategies within our organisation (e.g. quality, leadership, and patient experience).

1. Strengthening our specialist and highly-specialist services

We have analysed our service portfolio³ and identified four services that are core to our strategy: cancer, cardiac, neuro, and rare diseases. These services are discussed in more detail under ‘Leading in future fields’ below.

Across our clinical services we will: (I) consider growing some services and pathways; (II) reviewing the viability of services that do not have the same critical requirement for co-location⁴; (III) focusing on pathways that must occur at GOSH and discharging patients earlier when they can receive the right care closer to home; and (IV) in more extreme cases delivering a more concentrated portfolio of services. Some of these questions will be difficult to answer, so it is critical that our staff are

² A single definition of quality in the NHS was first set out in “High Quality Care for All ” (2008)

³ That process has included looking at the work we are doing today, why we are doing it, how it aligns with our future, and what else we could do. In parallel we have looked at the current environment, undertake SWOT and PEST analyses, held focus groups, analysed and debated our position, etc.

⁴ The complex nature of our patients requires a broad base of internal specialty expertise to manage critical interdependencies, essential for comprehensive co-ordinated care for patients with the most complex needs.

Attachment H

equipped to respond and adapt⁵. Therefore, we will intensify our efforts on Transformation, Quality Improvement, and Strategy and Planning.

A three-to-five year transformation programme will co-ordinate and monitor the impact of our re-design and improvement projects that are intended to modernise our services. It will help our clinical teams to shift, realign or make fundamental changes to how we work. Quality Improvement and Strategy and Planning will help us to improve quality, outcomes and performance, and be more strategic about how we think and act. At the same time, good outcomes, require safe care, and a positive patient experience.

Therefore, quality will have a fundamental role in our clinical strategy. For example, we must continue to understand the experiences of our patients and their families as we continue to move towards patient-centred care. Feedback from the Friends and Family Test (FFT) will inform how we design and deliver our services as part of a patient experience strategy.

While we face unprecedented financial pressures and recognise that controlling costs will feature heavily during the next few years, we must also look to the future. We must balance doing things more efficiently with innovation. This is why we will aim to be leading in future fields. As one of our Chiefs of Service has said, “if we don’t do anything new, we get bored and we get boring.”

“Our Cancer, cardiac, neuro, and rare disease services have prominent national and international profiles. They are core to our business and present opportunities to play a leading role in our local health economy and to be leading in future fields.”

2. Leading in future fields

The social determinants of health and new comorbidities facing children, adolescents and young adults will continue to shape the future of paediatrics. As we continue to recognise life limiting and life threatening conditions, family-centred care will become ever more important as will new treatments, surgery, and diagnostics. The four services mentioned above – cancer, cardiac, neuro, and rare diseases – have prominent profiles. They are high volume services that are core to our business and how we will be leading edge. There are other important facts, for example, our local health economy is scrutinising cancer and cardiac services.

⁵ The FSH (Federation of Specialised Hospitals) has outlined a position on present and prospective changes in specialised services. Similarly, NHS Providers have considered developments within specialised commissioning and the impact on hospitals, alliances, expertise, etc. Our clinical strategy will need to consider this.

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2.1 Cancer

GOSH has the biggest children's cancer unit in the UK and our researchers have helped to dramatically improve survival rates for young people. We are also one of the largest services in Europe – we have the largest paediatric bone marrow transplant (BMT) service in Europe – and North America. We have an excellent links to networks, such as the North Thames children's cancer network coordinating group (CCNCG) and a strong research infrastructure. Our future research will focus on understanding the genetic profile of each child's cancer, so doctors can match young patients to the clinical trials and treatments most likely to work for them.

2.2 Cardiac surgery.

GOSH has the largest cardiac surgery centre in the UK and second biggest centre in Europe. Consequently, nearly one-in-four paediatric heart operations in England happens at GOSH and we have excellent outcomes and world-renowned surgeons. There are good foetal links with various maternity units, and well-established transitional links at University College London Hospitals (UCLH) for patients with heart conditions approaching adulthood. The recent PICB (Premier Inn Clinical Building) will strengthen further our services, but it is important we define our position in the future state of London Paediatric Congenital Heart Disease surgery service.

2.3 Neuro

Our commitment to education and training; networks and partnerships; pioneering surgery and techniques; and academic work research is unwavering. Through our partnerships, for example, Children's Epilepsy Surgery Services (CESS) works closely with UCL ICH (University College London Institute of Child Health) and in collaboration with King's Health Partners (KHP) and Young Epilepsy (YE) to evaluate new techniques.

Through research the Dubowitz Neuromuscular (DNC) is a leading clinical research centre specialising in neuromuscular disorders affecting children and understanding the cause of neuromuscular disease in childhood and identifying novel therapeutic interventions. Neurology has active research programmes in epilepsy, stroke, neurovascular disease and non-accidental brain injury – GOSH has the largest brain tumour neurosurgery service in the UK and is the largest centre delivering epilepsy surgery.

Attachment H

2.4 Rare diseases.

GOSH sees children from more than 80 countries worldwide and specialises in the treatment of children with rare diseases and conditions including rare heart and neurological conditions. We work closely with our partners to find new treatments and cures for children who often have nowhere else to go. Recent advances in science and technology offer new hope, particularly in the realms of genetics and stem cell therapies. The Zayed Centre for Research provides state-of-the-art laboratory facilities and a large outpatient's facility that will allow us to continue to bring the latest technology and patients to make breakthroughs and develop cures for rare diseases quicker than ever before.

However, the complex nature and needs of our patients requires a comprehensive, co-ordinated approach and therefore a broad base of internal services. As a result, our clinical strategy must also consider our support services because they are essential to the functioning of GOSH. In contrast to our vertical services that provide tests, advice, methods, etc. for a specific group of patients, our horizontal (or support) services for assessments, tests, advice, methods, etc. for a far wider range of patients. Consequently, our vertical services are highly-reliant on the quality of the services that support them, such as imaging, mental health, and pathology.

Below are some of the developments that will be pursued in key clinical support services.

- Imaging.
 - Invest in a fifth magnetic resonance imaging (MRI) scanner.
 - Invest in a fifth angiography suite
- Genetics.
 - Be at the forefront of whole DNA sequencing
 - Be a national leader of non-invasive pre-natal testing
- Laboratory Medicine.
 - Develop new diagnostics and translating them into routine clinical service

WHAT WE NEED TO DO NEXT

- This paper has outlined the direction of our clinical strategy. It is important that we now write the formal strategy in partnership with our clinical leaders.
- Develop our clinical strategy alongside the work that is being undertaken to refresh Fulfilling our Potential as well as other core strategies.
- Continue to engage with national partners and support discussions with regulators and commissioning (e.g. NHSE, NHSI, DoH, and advocacy groups)

New and Novel Medicines Use at Great Ormond Street Hospital

Introduction

At Great Ormond Street Hospital (GOSH) we do some of the most difficult and complex approaches to treat the most difficult and complex patients. This requires us to research and innovate in order to find new treatments and cures for our patients as in circumstances where no effective alternative exists. This paper sets out the governance processes and structures in place at GOSH so that we can do this.

Sometimes we work with families to try treatments that have not been trialled or extensively tested because otherwise a child would not survive. We do this in order to ensure:

- Children are treated to the best of our ability
- We deliver equitable care
- Our practice has a sound evidence base
- We remain cognoscente of risk
- We practice with cost effective medicine
- Our staff are professionally supported through a strong medicines governance policy

The Drugs and Therapeutics Committee (DTC) is responsible for the development and implementation of guidelines and policies to ensure the safe, effective and appropriate use of medicines in the Trust. The committee is co-chaired by a nominated senior clinician and the Chief Pharmacist. The Medical Director has authority over any unresolved issues. The DTC reports to the Patient Safety and Outcomes Committee (PSOC), but PSOC has no authority over DTC decisions.

The Review Process

Standard Medicines

Each medicine is reviewed individually by a multifaceted review process which includes the general considerations:

- If medicines are covered by Commissioning or via NICE then acceptance of use is automatic and the role of DTC is to ensure the Trust is in a position to use the medicines (for example via an appropriate guideline).

Attachment I

- If a medicine is licensed for the age group and condition in which it is to be used, then the role of DTC is to ensure appropriate funding is in place to use the medicine. This may be Trust-based or via NHS England.

Novel and Unlicensed Medicines

If the medicine is licensed but being used outside of the licence (*off-label use*), then DTC will examine its pharmacology to ensure the use is rational and safe, and any supporting evidence for its use. If use is in a group such as neonates then excipients may be reviewed to ensure it remains a quality product in that age group.

If the medicine is unlicensed, then both the quality of the product and the clinical evidence base will be reviewed. GOSH Pharmacy Quality Assurance department will formally assess the product to be examined and the medication fully risk assessed.

If the medicine is Free of Charge (FOC) it will still be evaluated against all of the above criteria. In addition to this it will also be looked at on the following basis:

- Exceptional circumstance / compassionate access will generally be accepted if it is thought that all other “normal” treatments have been tried and there is consensus that the evidence would suggest that the use is in the child’s best interest.
- Early Access of Medicines Scheme (EAMS) access will be reviewed in terms of the ethics of initiating a treatment which may or may not be later commissioned for use within the NHS. The contract with the company will be reviewed to ensure that the EAMS is not being used as a simple way for the company to gain more data; or a way of getting the product in use to sway opinion.
- All FOC medicines must come with Contract (signed by the Chief Pharmacist on behalf of the Trust) defining how long the company will fund the treatment. Ideally funding will be until such time that NHSE will commission the medicine for the required indication. If the contract is for any other, lesser, time period then there will be discussions to decide if GOSH would accept the funding after that date (for an individual and any other similar cohort patients).
- All FOC medicines must only initiate with carers written consent, including agreement to cease treatment if implied by the company contract.

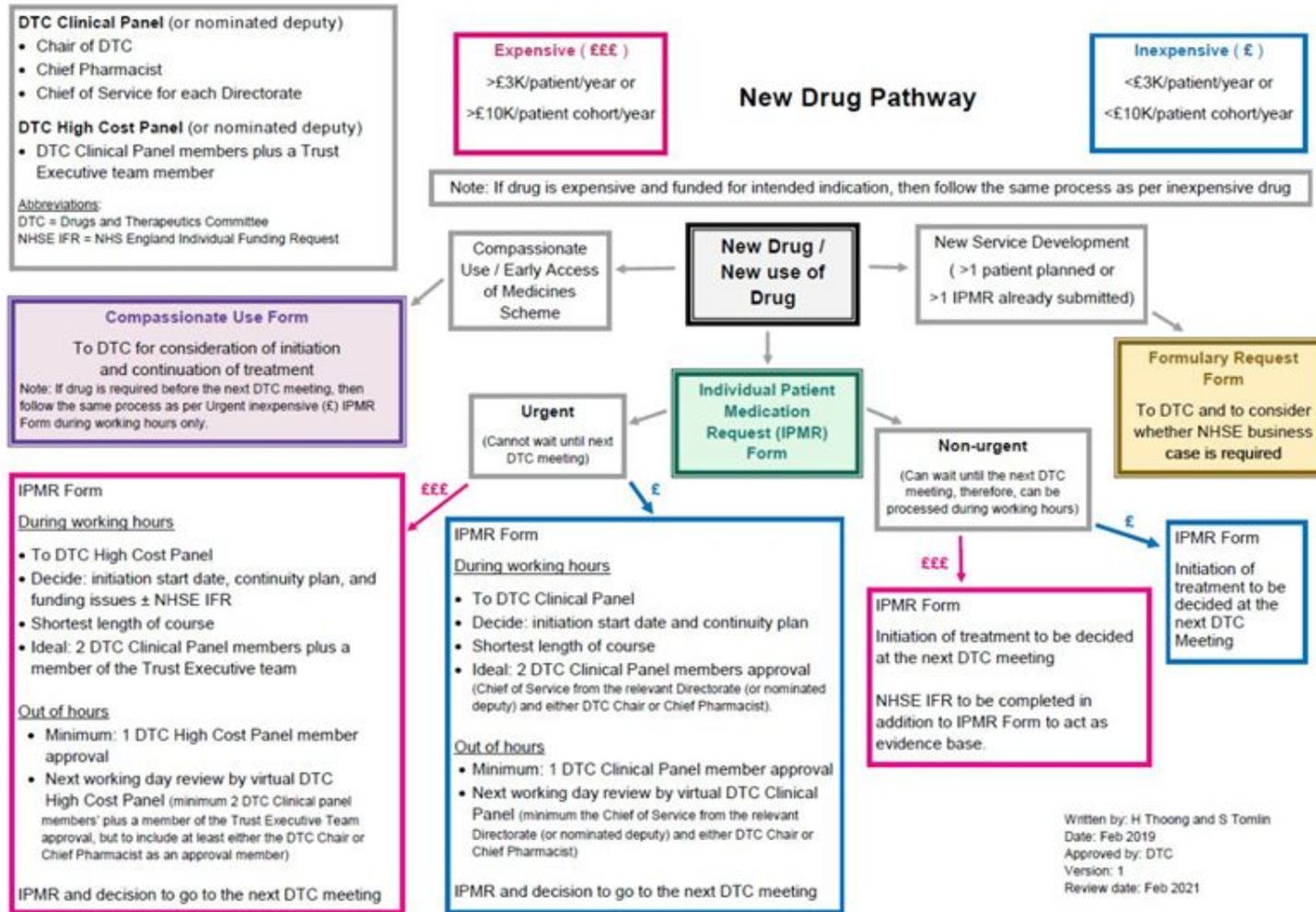
DTC Remit

DTC has the remit and authority to carry out the responsibilities listed below.

Attachment I

- Review and approve all medicines use within the Trust, including:
 - New and novel drug treatment for formulary approval
 - New unapproved indications for existing approved drugs
 - Free of Charge (FOC) medicines including Early Access to Medicines Schemes (EAMS) and Compassionate Use (CU) medicines
 - Individual Patient Medication Requests (IPMRs)
- Promote best practice concerning the proper use of medicines through development, implementation and monitoring of local guidelines and policies based on national advice when necessary.
- To review and approve all medicine related prescribing guideline and policies used within the Trust and externally, for example Shared Care Guidelines (SCGs)
- To ratify and approve Patient Group Directions
- To ratify and approve all prescribing documentation either by the Committee directly or it's nominated sub-committees
- To oversee the following DTC sub-committees
 - Antibiotic Policy Group
 - Chemotherapy Group
 - Immunoglobulin Advisory Panel
 - Medicines Optimisation Group
- To liaise closely with the following committees
 - Medicines Safety Committee
 - North Central London Joint Formulary Committee and their subgroups

Process for the Management of Medicines



Trust Board 3rd April 2019	
New and Novel Medicines	Paper No: Attachment I
Submitted by: Sanjiv Sharma, Acting Medical Director	
Aims / summary In striving to serve the complex needs of our patients and innovate with pharmacological treatments, clinical teams will use treatments that have not been trialled or extensively tested. This is largely confined to situations where no effective alternative treatment is available and where otherwise a child would continue to suffer chronic illness or die. Good governance needs to be wrapped around these circumstances so that there is a consideration of effectiveness, risk and cost. This paper sets out the Trust's current approach to consideration of new and novel medicines; embedded in this is the approach to compassionate use of medicines.	
Action required from the meeting Board members to note and agree action if required.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Defines the process by which complex medication needs of our patients are met while balancing regulatory, financial and contractual requirements.	
Financial implications Paper describes the current process regarding the financial aspects of new and novel medicines management, including who is involved in decision making.	
Who needs to be told about any decision? Sanjiv Sharma, Acting Medical Director Steven Tomlinson, Chief Pharmacist	
Who is responsible for implementing the proposals / project and anticipated timescales? Chief Pharmacist	
Who is accountable for the implementation of the proposal / project? Medical Director	

Trust Board 3rd April 2019													
<p>2018/19 National Cost Collection Pre-submission (formerly Reference Costs)</p> <p>Submitted by: Helen Jameson, Chief Finance Officer</p>	<p>Paper no: Attachment J Enc 2018/19 National Cost Collection backing paper.</p>												
<ol style="list-style-type: none"> 1. The mandated reference cost collection has been replaced by the 'National Cost Collection'. 2. The new collection mandates that Trusts submit Patient Level Costing data (PLICS) for inpatient and outpatient activity. A number of other services e.g. radiology will continue to be collected on an average level using the old reference cost methodology, but this will be phased into a single return over the next few years. 3. Though the PLICS collection is now mandated, GOSH has been an early adopter of the new standard and has submitted PLICS data for a number of years. 4. There is currently no mandatory additional submission for education and training costs but the Trust continues to support national teams in developing a standard template. 5. The Trust is required to formally adopt the methodology for cost collection which is set out in this report. 													
<p><u>Purpose</u></p> <p>The purpose of this paper is to inform the Trust Board on changes to the National Cost collection methodology for 2018/19, provide a refresh of the aims and objectives of the collection, and to seek approval for the methodology that is to be used for completing the return.</p> <p>The board are asked to delegate responsibilities to the Finance and Investment Committee to approve the 2018/19 National Cost collection submission on their behalf.</p> <p><u>Summary</u></p> <p>The Trust will be submitting the following cost returns for 2018/19 in line with national requirements:</p> <ul style="list-style-type: none"> • Patient level cost collection (PLICS). • Reference Cost collection <p>As part of the national Costing Transformation Programme (CTP), the PLICS collection has been mandated for 2018/19 and will be replacing the inpatient and outpatient cost and activity return in Reference Costs.</p> <p>The PLICS collection aims to provide the true full cost of providing care to patients instead of the average cost, as previously collected in Reference costs. All other unbundled services will continue to collect the average costs in a separate Reference Cost return, until the services are phased into the PLICS collection over the next 3 years.</p> <p>The provisional timetable for collection this year is as follows:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Return</th> <th style="text-align: left;">Submission Date</th> </tr> </thead> <tbody> <tr> <td><i>Patient level costing & reference costs</i></td> <td></td> </tr> <tr> <td>Collection window opens</td> <td>17th June 2019</td> </tr> <tr> <td>Chief Finance Officer sign off</td> <td>w/c 19th August 2019</td> </tr> <tr> <td>Collection window closes</td> <td>23rd August 2019</td> </tr> <tr> <td><i>Education & training pilot collection</i></td> <td>Autumn 2019</td> </tr> </tbody> </table>		Return	Submission Date	<i>Patient level costing & reference costs</i>		Collection window opens	17th June 2019	Chief Finance Officer sign off	w/c 19th August 2019	Collection window closes	23rd August 2019	<i>Education & training pilot collection</i>	Autumn 2019
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The Trust has in place a Patient Level Costing System (PLICS) which continues to evolve in order to improve the detailed financial reporting for the divisions. The development of the system is an iterative process and it is developed on an on-going basis with input from clinical staff and in accordance with national guidance.

The patient level costing and reference cost outputs will be reviewed with clinical teams and service staff over a period of six weeks comparing the outcomes to prior years and national averages. The outcome of these reviews will be considered as part of the overall approval process by the Chief Finance Officer.

Action required from the meeting

- To **note** the changes to the National cost collection process for the 2018/19 return.
- To **approve** the costing process that has been adopted for 2018/19 and to delegate responsibilities to The Finance and Investment Committee to approve the 2018/19 National Cost collection submission for the Trust on behalf of the Trust Board

Contribution to the delivery of NHS Foundation Trust strategies and plans

The National cost collection is mandatory and one of the key financial annual submissions to NHSI.

Financial implications

These are minimal however inaccurate costs for paediatric hyper specialist care do have the potential to affect national prices owing to the high market share provided by GOSH.

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

2018/19 National Cost Collection

Executive Summary

This paper sets out the planned approach to preparing the 2018/19 National cost collection, and notifies the Board of its responsibilities for approving the Trust's costing process.

The Trust Board is asked to approve this process to support the national cost collection and to delegate to The Finance and Investment Committee approval of the national cost collection submission for the Trust.

1. Definition

The national cost collection for 2018/19 will comprise two cost returns which are mandated:

- **Patient level costing collection (PLICS)**
 The actual cost of each individual episode of care by finished consultant episodes (FCE) and outpatient appointments in a given financial year including resources used by the patient and associated resource costs. This replaces the previously mandated national reference cost return.
- **Reference Costs**
 Reference costs will be collected for the average unit costs of providing unbundled healthcare services not covered by the PLICS collection. These unbundled services will be phased into the PLICS collection as the NHS transitions to a single national cost collection at patient level.

The collection of Education & Training costs has been removed as a requirement in 2018/19, as the Education & Training cost standards are still being developed. The Trust participated in the 2017/18 pilot collection to test Education and Training costing standards and is still awaiting feedback from the national return.

2. Board Approval and Sign Off

The Trust Board is required to confirm the following in respect of the 2018/19 PLICS and Reference Cost collection:

- That it has approved the PLICS costing process ahead of the collection,
- The plan is sufficient to meet the requirements to produce the required costing submission by the deadline date,
- The return has been prepared in accordance with NHSI Approved Costing Guidance, which includes the national cost collection covering both PLICS and Reference costs.
- Information, data and systems underpinning the returns are reliable and accurate.
- There are proper approved internal controls over the collection and reporting of the information included in both the reference cost and PLICS collection.
- Costing teams are appropriately resourced to complete the return, including the self-assessment quality checklist and validations.
- The content of the return is consistent with internal and external sources of information.
- Any actions from previous NHS Improvement audits of costing have been formally followed up and completed (as appropriate).

Prior to the final submission, additional assurance will be sought and provided for that:

- The Chief Financial Officer has approved the final returns.
- Information gap analysis and Costing standards gap analysis have both been completed and any issues will be addressed as part of the submission process.

3. Costing Assurance

The costs are prepared with in line with the seven costing principles of the 'Approved Costing Guidance' and will be reviewed in a systematic way following best practice. The adoption of these principles is mandated and will form part of the CFO's review of the costing process.

4. 2018/19 Changes to PLICS & Reference Costs collection

There have been a number of changes in the 2018/19 collection to more closely align patient level cost collection and reference costs that are listed below.

- All finished consultant episodes (FCE) activity under inpatients will be included and costed in the return, including those where dates of care do not fall completely within the financial year.
- Unbundled services will continue to be submitted within the Reference cost return until it is phased into the PLICS collection over the next three years.
- The requirement to calculate excess bed days' costs and activity will no longer be mandatory, as calculation will be completed centrally by the national teams.
- A new currency has been introduced to submit homecare drugs cost and activity where the drug is classified as 'high cost'.
- Further guidance has been developed on the treatment of agreements and services between NHS organisations.
- Centrally funded Clinical Excellence Awards has been redefined as allowable income in order to adjust the quantum down.

5. Quality Assurance

The costing team will liaise with the Trust to review and sign-off the submission and to ensure that activity and unit costs within the submission are accurate.

The costing team have implemented a number of measures to ensure that the costing information self-assessment quality is complied with. For 2018/19, in addition to the self-assessment checklist there is also a Costing Assessment Tool (CAT) available against which the Trust will assess its data.

6. PLICS Costing improvements

The costing team continue to refine costing data through the year and number of improvements have been made since the 2017/18 submission including:

- The costing team are piloting a PLICS project to focus on Urology clinical service with the Clinical Lead and Service manager to review PLICS costs and qualitative activity.

Attachment J

- Reviewing and updating the current costing allocations and methodologies to reflect service delivery and to be compliant with the PLICS clinical costing standards.

7. Team Resource and Timetable

The team is adequately resourced to complete the submission on time and has both prior experience and expertise in PLICs collection and reference costs. The timetable for agreement is as follows:

Date (Provisional)	Milestone
12th August 2019	Reference Cost & PLICS sign-off
W/C 19th August 2019	Submission of PLICS & Reference Cost Collection to national portal.

8. Recommendations

The Trust Board are asked to approve the costing process that supports both the 2018/19 PLICS Collection and Reference Cost submission for the Trust and to delegate the Trust Board of its responsibilities to The Finance and Investment Committee to approve the National Cost collection submission for the Trust on behalf of the Trust Board.

<p>Trust Board 3rd April 2019</p>	
<p>Integrated Quality and Performance Report March 2019 (Reporting on February 2019 data)</p> <p>Submitted by: Sanjiv Sharma, Acting Medical Director Alison Robertson, Chief Nurse Andrew Taylor, Acting Chief Operating Officer</p>	<p>Paper No: Attachment K</p>
<p>Aims / summary</p> <p>The Integrated Quality and Performance Report (IQPR) is a new report which combines (and replaces) the Integrated Quality Report (IQR) and the Integrated Performance Report (IPR). This brings together a range of essential hospital metrics aligned to the CQC key lines of enquiry: Safe, Effective, Caring, Responsive and Well Led. It asks the question: are our patients receiving high quality care?</p> <p>The report includes all metrics previously included in the Integrated Performance Report alongside many additional key quality metrics. These new metrics have been delivered in consultation with the Quality and Safety Team, Patient Experience Team, Human Resources, Safeguarding and the Corporate Secretary's office. Combining the reports together enables us to take a more holistic view of hospital performance, and identify areas of good practice as well as areas for improvement.</p> <p>The report includes qualitative analysis from Quality & Safety, Patient Experience, Performance, Human Resources & Finance in response to areas of underperformance, and to highlight key issues for consideration.</p> <p>The new metrics and new style of reporting have been developed over the course of March, and it is anticipated that the report will evolve over time in response to the needs of the organisation, external stakeholders and regulators. The parameters/targets for some of the KPIs are still in discussion (marked TBC) and it has been agreed that parameters/targets are not appropriate for some measures, but the metric is included because we recognise it is valuable to understand volume and trends each month.</p> <p>Key areas for consideration (as requested by QSEAC):</p> <p>Quality of Care:</p> <p>The CVL infections per 1000 bed days rate has been higher than expected in January (2.1) and February (2.5). However 5 of the 18 reported CVC related bacteraemias are attributable to one patient and are believed to be unavoidable given clinical context (2 in Jan, 3 in Feb). With this data removed, the February rate would be 1.7.</p> <p>WHO checklist completion on PIMS is recorded at 93% for February 2019. It is anticipated that the changes brought in with EPIC will enhance compliance with this documentation metric, and observational audits will supply more comprehensive data on team engagement with the safety process. It has been over a year since the hospital's last never event (retained swab incident on 23rd March 2018).</p>	

Attachment K

There was 1 serious incident reported in February 2019. This is an aggregated root cause analysis review relating to ongoing problems with the delivery of sterilised sets for theatres. There is one overdue SI at the time of reporting. Emerging trends in patient safety include: equipment issues with Carefusion pumps, violence and aggression towards frontline staff and refused admissions/delayed discharges from P/NICU.

Incident closure rates (i.e. whether incidents have been investigated and closed within policy timescale) have improved in February 2019 (to 60%), but overall are underperforming. Significant work took place in January 2019 to close overdue incidents (1497 closed) and this will continue, with the patient safety team supporting the directorates to target overdue incidents. Although there is only 60% compliance with closure within 45 working days, the average days taken to close incidents in February was 46.1 which suggests that a lot of incidents are being investigated and dealt with appropriately.

The Friends and Family Test response rate rose to 26.8% in February which is a significant improvement on 16.5% in December 2018, and is due to hard work and collaboration between the Patient Experience team and the Ward teams. The FFT inpatient recommend rate for February was 95.4% and 92.8% for outpatient services.

Operational Performance:

There have been no breaches in cancer performance attributable to the Trust in 2019 (at the time of reporting). There has been a significant reduction in breaches for diagnostic waiting times in month (2.3% improvement from Jan 2019) although overall we continue to underachieve against the 99% national target (97.5%). The Trust achieved the RTT 92% standard (92.18%). There were 28 patients waiting 40+ weeks, and 2 patients waiting over 52 weeks.

Performance in discharge summary completion within 24 and 48 hours continues to fluctuate and fall short of expected levels. 79% of discharge summaries were sent within 24 hours, and 82% sent within 48 hours. Contributory factors are thought to include reduced junior doctor coverage with recruitment ongoing. There has been a 7.6% improvement in the 14 day turnaround for clinic letters (73.9%).

There has been a reduction in main theatres utilisation (65% from 66.3%) and short notice cancellations (for clinical and non-clinical reasons) have peaked for the financial year in February at 353.

Workforce:

Statutory and Mandatory Training compliance for the organisation is 92%. Only one directorate has overall performance of <90%. However, 8 of the 30 Stat&Man topics are <90% compliance. The appraisal rate for all staff has increased in February (83% for consultants, 85% for all other staff).

There have been no new bullying and harassment cases reported to HR, and no whistleblowing cases reported this year. There were 8 recorded Freedom to Speak Up cases.

Finance:

The Trust has a YTD control total surplus of £11.0m which is £0.7m below plan. The Trust is generating a YTD net surplus of £0.6m which is £0.5m below plan.

Action required from the meeting

Board members to note and agree on actions where necessary

Attachment K

<p>Contribution to the delivery of NHS Foundation Trust strategies and plans The report aims to focus the organisation’s attention on areas where we can improve the quality of care delivered to our patients. All the indicators within the IQPR contribute to the delivery of either regulatory or commissioner requirements, and as such are aligned to the objectives and strategy of the Trust.</p>
<p>Financial implications For indicators that have a contractual consequence there could be financial implications for under-delivery</p>
<p>Who needs to be told about any decision? Where appropriate and applicable: Internal stakeholders, NHS Improvement and NHS England Special Services Commissioners</p>
<p>Who is responsible for implementing the proposals / project and anticipated timescales? Each Domain / Section has a nominated Executive Lead</p>
<p>Who is accountable for the implementation of the proposal / project? As above</p>

Integrated Quality & Performance Report March 2019

(Reporting on Dec 2018 - Feb 2019 data)

Sanjiv Sharma
Acting Medical
Director

Alison Robertson
Chief Nurse

Andrew Taylor
Acting Chief
Operating Officer

Data correct as of: 22nd March 2019

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Performing well
 Room for improvement
 Significant improvement required
Direction of trend from previous month
 Data not previously requested/available
 T
B
C Parameter not needed/not agreed

Always



Welcoming Helpful Expert One Team

The child first and always

Hospital Quality Performance – March 2019 (February Data)

Are our patients receiving safe, harm-free care?

	Parameters	Dec 18	Jan 19	Feb 19
Incident Reporting Rate (per 1000 bed days)	R<60 A 61-70 G>70	76.8	79.1	73.4
Incident Closure Rate (% of incidents closed within 45 working days)	R 0-64% A>65-75% G>76-100%	54.9%	38.2%	60%
Number of incidents closed	Trending performance	664	1497	612
Average days to close (2018 -2019 incidents)	R >50, A <50 G <45	59.9	61.7	46.1
Medication Incidents (% of total PSI)	TBC	25%	21%	20%
Near Miss reports (% of incidents reported)	R <8%, A 8-9%, G>10%	8%	6%	5%
Serious Incidents (Severe Harm, Death)	R >1, A -1 G - 0	1	3	1
Overdue SI	R >1, A -1, G - 0	N/A	N/A	1
Safety Alerts overdue	R >1 G - 0	1	3	1
Safeguarding Children's Reviews	New	1	0	0
	Open and ongoing	6	6	6
Safeguarding Adults Board Reviews	New	0	0	1
	Open and ongoing	0	0	1

Are we delivering effective, evidence based care?

	Target	Dec 18	Jan 19	Feb 19
Specialty Led Clinical Audits on Track	R 0- 69%, A>60-75% G>75-100%	76%	73%	76%
Number of completed specialty led clinical audits per year	Aim =100 p.a G= YTD total at month end is on target	N/A	N/A	119
NICE guidance overdue for assessment of relevance	R=1+, G=0	N/A	N/A	0
Relevant NICE national guidance without a gap analysis	R=1+, G=0	0	0	0
Participation in mandatory relevant national audits	G=100%	N/A	N/A	100%

Are our patients having a good experience of care?

	Parameters	Dec 18	Jan 19	Feb 19
Friends and Family Test Recommend rate Inpatient	G – 95+, A- 90-94, R<90	96.8%	96.6%	95.4%
Friends and Family Test Recommend rate (Outpatient)	G – 95+, A- 90-94,R<90		93.5%	92.8%
Friends and Family Test - response rate (Inpatient)	25%	16.54 %	24.45%	26.8%
PALS - Volume	N/A	115	143	146
Complaints rate (per 1000 bed days)	N/A	0.79	0.51	1.25
Red Complaints (%total complaints YTD)	R>12% A- 10-12% G- <10%	5%	5%	5%
Re-opened complaints (% of total complaints YTD)	R>12% A- 10-12% G- <10%	9%	10%	12%

Are our People Ready to Deliver High Quality Care?

	Parameters	Dec 18	Jan 19	Feb 19
Mandatory Training Compliance	R<80%,A-80-90% G>90%	91%	91%	91%
PDR	R<80%,A-80-90% G>90%	83%	84%	85%
Appraisal Compliance (Consultant)	R<80%,A-80-90% G>90%	79%	79%	83%
Safeguarding Children Level 3 Training compliance	R<80%,A-80-90% G>90%	79%	83%	83%
Safeguarding Adults Training Compliance	R<80%,A-80-90% G>90%	86%	89%	91%
Sickness Rate	R -3+% G= <3%	2.4%	2.4%	2.4%
Turnover - Total	R>18% G<18%	17.5%	17.5%	17.6%
Turnover - Voluntary	R>14% G<14%	14.8%	14.7%	14.7%
Vacancy Rate – Contractual	R- >10% G- <10%	0.4%	0.1%	0.4%
Vacancy rate - Nursing		3.6%	3.7%	4.2%
Bank Spend		6%	5.8%	5.8%
Agency Spend	R>2% G<2%	1.05%	1.04%	1.01%

Are we delivering effective and responsive care for patients to ensure they have the best possible outcomes?

Responsive Hospital Metrics		Dec 2018	Jan 2019	Feb 2019	Effective & Productive Hospital Metrics		Dec 2018	Jan 2019	Feb 2019
Diagnostics: patient waiting <6 weeks	R<99% G -99-100%	93.14%	95.19%	97.54%	Discharge summary 24 hours	R=<100% G=100%	80.38%	73.23%	79.07%
Cancer 31 day: referral to first treatment	R<85% G 85%-100%	100%	No Pts	100%	Clinic Letter– 7 working days		38.34%	41.54%	TBC
Cancer 31 day: Decision to treat to First Treatment	R<96% G 96-100%	100%	100%	100%	Clinic Letter– 14 working days		66.33%	73.90%	TBC
Cancer 31 day: Decision to treat to subsequent treatment - surgery	R<94% G94-100%	100%	100%	100%	Was Not Brought (DNA) rate		9.10%	8.55%	7.94%
Cancer 31 day: decision to treat to subsequent treatment - drugs	R<98% G 98-100%	100%	100%	100%	Theatre Utilisation – Main Theatres	R<77% G>77%	62.0%	66.3%	65.0%
Cancer 62 day: Consultant upgrade of urgency of a referral to first treatment	-	100%	100%	100%	Theatre Utilisation – Outside Theatres	R<77% G>77%	54.4%	54.0%	56.1%
Theatre Cancellation for non-clinical reason	-	36	40	TBC	Trust Beds				
Last minute non-clinical hospital cancelled operations - breach of 28 day standard	R 1+ G=0	8	5	TBC	Bed Occupancy		78.5%	81.9%	82.4%
Urgent operations cancelled for a second time.	R 1+ G=0	0	0	0	Beds available		406	406	406
Same day/day before hospital cancelled outpatients appointments	-	1.41%	1.37%	1.55%	Avg. Ward beds closed		32	37	27
RTT Incomplete pathways (national reporting)	92%	92.09%	92.59%	92.18%	ICU Beds Closed		6	5	6
RTT number of incomplete pathways <18 weeks	-	6040	6137	6397	Refused Admissions				
RTT number of incomplete pathways <18 weeks	-	519	491	543	Cardiac		0	1	1
RTT Incomplete pathways >52 weeks Validated	R - >0, G=0	1	3	2	P/NICU		22	17	25
RTT incomplete pathways >40 weeks validated	R - >0, G=0	24	29	28	PICU Delayed Discharge				
Number of unknown RTT clock starts – Internal Ref	-	3	0	0	Internal 8-24 hours		7	2	1
Number of unknown RTT clock starts – External Ref	-	225	268	194	Internal 24h +		17	10	6
RTT: Total number of incomplete pathways known/unknown - <18 weeks	-	6263	6399	6587	External 8-24 hr		7	1	3
RTT: Total number of incomplete pathways known/unknown - >18 weeks	-	524	500	547	External 24h+		6	6	4
					Total 8-24h		14	3	4
					Total 24h +		23	16	10
					PICU Emergency Readmission <48h		0	1	1
					Daycase Discharges				
					In Month		1,992	2,498	2,285
					YTD		21,562	24,060	26,345
					Overnight Discharges				
					In Month		1,194	1,394	1,339
					YTD		12,534	13,928	15,267
					Critical Care Beddays				
					In Month		862	894	777
					YTD		9,078	9,972	107,49
					Bed Days >100 days				
					No of Patients		12	7	11
					No of Beddays		1,968	1,569	1,953
					Outpatient attendances (All)				
					In Month		18,099	23,745	21,579
					YTD		199,185	222,930	244,509

Well Led Dashboard

Is our culture right for delivering high quality care?

	Target	Dec 2018	Jan 2019	Feb 2019
High Risk Review (% reviewed within date)	R<80, A 81-90% G>90%	N/A	87%	71%
Serious Incident Action Plan Completion (number of actions overdue)	R- >2 A- 1-2 G- 0	Data collection will start for March data		
Red Complaints Action Plan Completion (number of actions overdue)	R- >2 A- 1-2 G- 0	N/A	N/A	2
Duty of Candour compliance	TBC	Data collection will start for March data		
Policies (% in date)	R 0- 79%, A>80% G>90%	N/A	59%	56%
Fit and Proper Person Test Compliance (self assessment)	R - <90% A 90-99% G – 100%	100%	100%	100%
Actions for Staff survey within timescale	TBC	N/A	N/A	N/A
Diversity % BAME staff	TBC	29.9%	29.8%	29.7%
Quality Improvement Projects – Trust Wide	Volume monitoring	3	3	3
Quality Improvement Projects – Local Level	Volume monitoring	7	7	7
Freedom to speak up cases	Volume monitoring	5	3	8
HR Whistleblowing cases	Volume monitoring	0	0	0
New Bullying and Harassment Cases (reported to HR)	Volume monitoring	0	0	0

Are we managing our data?

	Target	Dec 18	Jan 19	Feb 19
FOI requests	Volume	29	72	68
FOI % responded to within timescale	R- <65% A – 65-80% G- >80%	69.5%	87.7%	Still in reporting cycle
FOI - Number requiring internal review	R>1 A=1 G=0	1	0	0
FOI Number referred to ICO	G=0 R=1+	0	0	0
Information Governance Incidents	volume	8	13	17
IG incidents reported to ICO	volume	0	0	0
Mental Health Identifier: data completeness	R<97% G 97-100%	99.5%	99.5%	99.6%
Mental Health Ethnicity Completion %	R<90% G 90-100%	63.6%	62%	66.2%
% of patients with a valid NHS number - inpatients	R<99% G99-100%	92.5%	92.7%	TBC
% of patients with a valid NHS number - outpatients	R<99% G99-100%	93.7%	93.8%	TBC

Are we managing our money?

	YTD	Variance	Dec 18	Jan 19	Feb 19
Control Total	11.7	(0.8)	0.6	1.9	(0.2)
Forecast Outturn Control Total	12.1	0.0	12.1	12.1	12.1
Debtor days (IPP)	120	123	207	232	243
Quick Ratio (liquidity)	1.6	0.2	1.9	1.9	1.8
NHS KPI Metrics	1	0.0	1	1	1

Does our care help to ensure the best possible outcomes for our patients?

Care Outcome Metric	Parameters	Dec 2018	Jan 2019	Feb 2019	TREND
Bacteraemias (mandatory reporting – MRSA, MSSA, Ecoli, Pseudomas Klebsiella)	In Month	9	4	7	
	YTD	71	75	82	
C Difficile	In month	0	1	1	
	YTD	4	5	6	
C difficile due to lapses in care (Trust Assigned)	In Month	0	1	1	
	YTD	4	5	6	
Central Venous Line infections (per 1000 bed days)	R>1.6	1	2.1	2.5	
	G<1.6				
Hospital Acquired Pressure Ulcer (2+)	R – 12+, A 6-11	6	11	2	
	G =0-5				
Arrests outside ICU	Cardiac	0	1	1	
	Respiratory	3	0	1	
WHO Checklist completion	R- <98%	92%	94%	93%	
	G 98-100%				
Mortality Rate (deaths per 1000 discharges)	TBC	5.36	10.61	9.51	
% of reported medication incidents causing harm	TBC	11%	13%	14%	

Emerging trends in Patient Safety

Refused admissions and delayed discharges from PICU and NICU

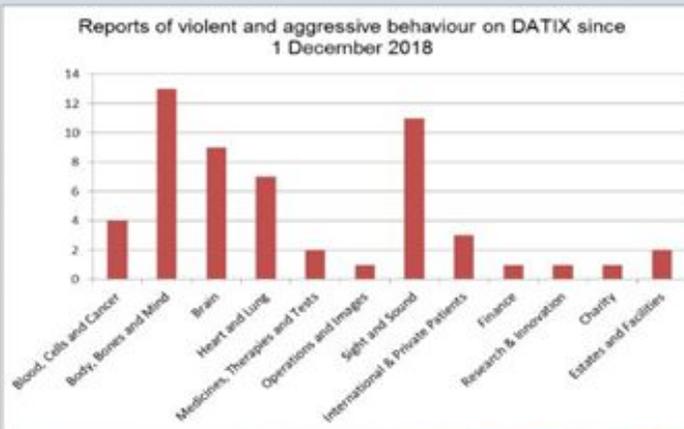
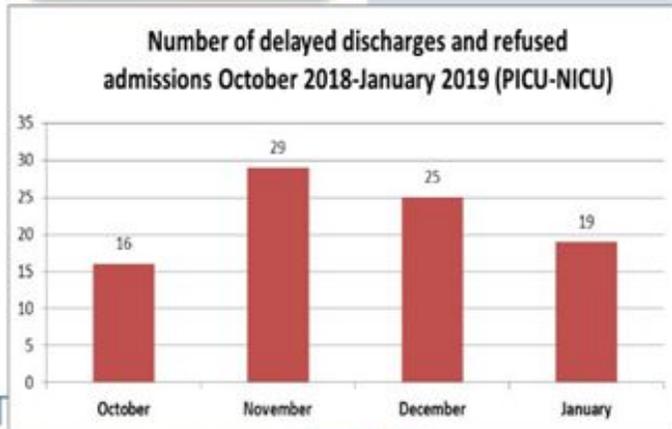
- Towards the end of 2018 and through early 2019 a higher than normal amount of patients have been refused admission to the paediatric and neonatal intensive care units.
- These have been flagged through the DATIX system for audit purposes to understand the impact this will have on patient flow as well as the potential financial impact it could have on the Trust.
- The main cause of this issue is short staffing across the intensive care resulting in bed closures reducing capacity combined with delays discharging patients internally due to appropriate specialty bed availability and externally to local units. A Trust-wide flow project is identifying the key challenges to be addressed.

Violence and Aggression towards front line staff

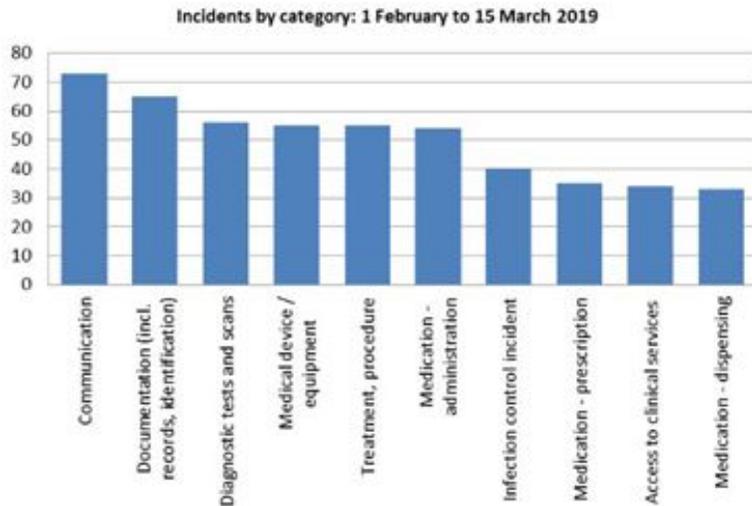
- There has been an increased reporting of violent and/or aggressive behaviour towards frontline staff.
- This includes clinical staff, administrative staff and security staff.
- Staff and teams have been supported by their immediate managers, their senior management teams and the patient safety teams in implementing the conflict resolution policy where appropriate and also liaising with security, social work and other key teams to ensure staff and patients are kept safe from harm.

Carefusion BD pumps

- There have been a large number of incidents reported regarding BD pumps experiencing flow issues and occlusion when administering TPN or chemotherapy. This has impacted on patient safety where patients have not received appropriate nutrition or necessary medication.
- BD (manufacturer) are now on site rolling out a series of software upgrades and replacing pump flow sensors which will hopefully address these issues.
- Staff have been advised on appropriate processes for retaining faulty equipment for investigation.



Understanding incidents



Communication remains the most reported category across the Trust. Communication is often a ‘no harm’ incident but the impact it has on the patient experience, as well as flow of patients, can mean the actual impact is greater than it originally seems. One example of this is delays with patients attending theatres, which can result in cancellations of other patients scheduled later on the surgical list. The ZAPPP project, implemented in February 2019 to improve IR utilisation, has shown a decrease in cancellations for patients attending IR for procedures.

Documentation is another key issue at present. Although good documentation is always a hot topic for staff, reported incidents have shown that there are risks of patient records being misfiled, images being uploaded to the wrong record on PACS and incorrect information being sent to families. This is an issue which EPIC is expected to help with.

Medication: Incidents regarding medication errors have flagged in three areas; administration, prescribing and dispensing. Medication errors are reviewed and discussed at Risk Action Groups across the trust. Some clinical areas have set up specific training and teaching sessions tailored to incidents reported in their areas. A medication safety committee is also now in place to review medicines management across the organisation.

Managing Incidents – Learning in practice

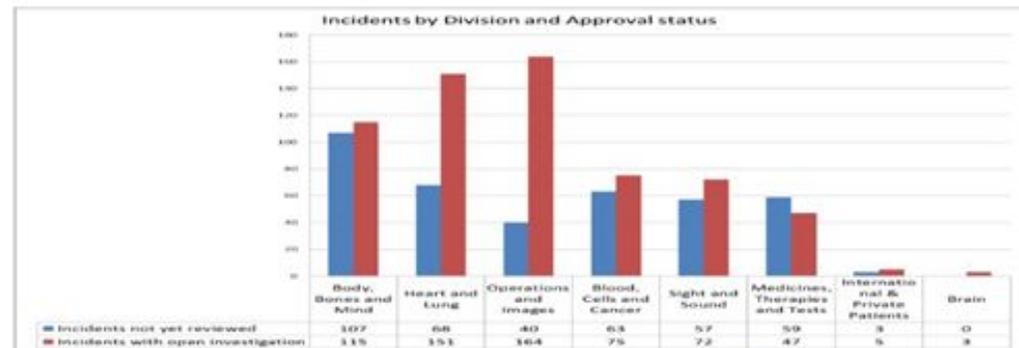
There are currently over a thousand incidents trust-wide which are overdue and require investigation. Some of these date back more than 2 years.

The main causes of this are managers leaving and not being replaced, staff not logging into DATIX to check their outstanding incidents and staff allocating the wrong specialty or manager when reporting the incident.

We try to mitigate against these factors by discussing the issues at Risk Action Groups (RAGs), with staff during DATIX training, and by updating managers when staff leave.

Notable Practice: Brain and IPP have worked hard to review and clear their outstanding incidents and usually have less than ten each.

This is important as there is a limited amount of time when an effective investigation can take place.



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Welcoming Helpful Expert One Team

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Patient Safety Alerts

New and ongoing Patient Safety Alerts

NHS/PSA/RE/2018/006: **Resources to support safe and timely management of hyperkalaemia** (Aug 2018)

Update: Meeting to be scheduled to discuss progression and action plan requirements. **Due:** May 2019

NHS/PSA/D/2019/001: **Wrong selection of orthopaedic fracture fixation plates.** (Feb 2019)

Update: Clinical Lead for alert still to be assigned, but alert has been shared with orthopaedic consultants. **Due:** May 2019

NHS/PSA/W/2018/009: **Risk of harm from inappropriate placement of pulse oximeter probes** (December 2018)

Update: Alert shared with Senior Nursing Lead for Education. Action Plan development required. **Due:** June 2019

NHS/PSA/RE/2018/004: **Resources to support safer modification of food and drink** (April 2019)

Update: Action plan in place lead by dietetics **Due:** April 2019

Recently Closed Patient Safety Alerts

NHS/PSA/RE/2018/007: **Management of life threatening bleeds from arteriovenous fistulae and grafts**

Update – Closed on time - Training started using pre-needling assessment tool. Training incorporated into ward vascular access teaching, renal course, foundation course and doctors teaching programme. AVF care plan is updated

NHS/PSA/D/2016/008 - **Restricted use of open systems for injectable medication**

Update: Closed late (due June 2017) following presentation to CQRG

NHS/PSA/RE/2018/005: **Resources To Support Safer Care For Patients At Risk Of Autonomic Dysreflexia**

Update: Closed late (due Jan 2019) with all actions complete

Overdue Patient Safety Alerts

NHS/PSA/RE/2017/004: Resources to support safe transition from the Luer connector to NRfit for intrathecal and epidural procedures, and delivery of regional blocks. **DUE: December 2017**

Latest update: Members of the Patient Safety and Outcomes Committee (PSOC) made aware of status for all current open safety alerts

National Learning:

Healthcare Safety Investigation Branch

Piped supply of medical air and oxygen [report](#)

This report was in response to a near miss incident with an 85 year old woman being administered piped air rather than piped oxygen in response to sats of 85%.

The HSIB report highlights the inconsistency of implementation of national safety alerts noting that an NHSI Patient Safety Alert relating to management of risks with piped air and oxygen was issued in 2016 which did not prevent this error.

The HSIB calls on the National Committee for Safety Alerts to introduce a robust assessment process for alerts which includes advice on implementation and ongoing monitoring.

Wrong Site Nerve Block – RCoA [response](#)

Update: Following publication of a HSIB [report](#) in September 2018, the Royal College of Anaesthetists and Safe Anaesthesia Liaison Group will form a working group to examine the practice, and evaluate any human factors changes that can be made to improve the safety of this procedure.

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Patient Safety – Serious Incident Summary

New & Ongoing Serious Incidents				
Directorate	Ref	Due	Headline	Update
Heart & Lung	2018/24654	09/01/2019	Major Haemorrhage	Final report being drafted
Estates & Facilities	2019/346	1/4/2019	Serious harm to staff member	Report v.3 circulated. Due 01/04/2019
Body, Bones & Mind	2019/442	2/04/2019	Bowel obstruction	Awaiting notes from local hospital. Plan to apply for an extension.
Blood, Cells & Cancer	2019/2382	26/04/2019	MST dose	Panel meeting held and final report being drafted
Operations & Images <i>*new*</i>	2019/3789	14/06/2019	Set Sterilisation issues (aggregated)	Timeline in progress

Serious Incident Performance 2018/7559:
 This investigation was on a stop clock as we awaited clarification on NHSE regarding scope. This has now been signed off by the medical director and is ready for sharing with NHSE.

- **2018/21816:** There was a delay whilst we compiled the report however this has now been sent to the medical director for approval.
- **2018/24654:** This event was reviewed at several different forums and was also subject to external scrutiny and a coroners inquest. The delay has been amalgamating the outcomes into one comprehensive report. This is now being finalised and is expected to be with the exec for sign-off within the week.

Sharing Lessons Learned: SI 2018/22439

Situation: Patient harm (3 x moderate harm) and poor experience for neuro-disability patients due to delays in communication with the MDT

Background - The Neurodisability service are required to produce a multidisciplinary clinic report within 21 days of seeing a patient. These multidisciplinary reports advise local care teams of recommended treatments (incl. medication dosages and therapy) to be continued in the community.

Analysis - The reasons for this are multifactorial but largely due to variations in consultant practice of the multiple processes required to produce and send the report.

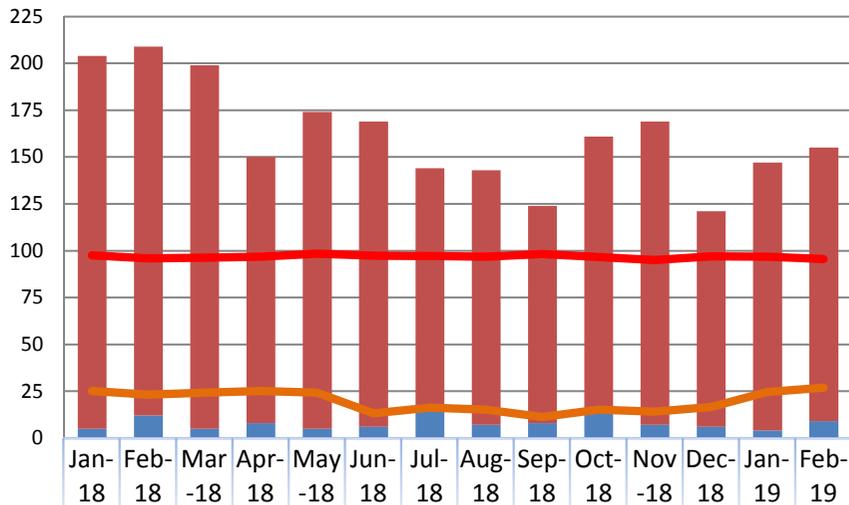
Recommendations – Local: Develop realistic guidelines on communication pathways between the MDS staff and patients and other colleagues, and review team and individual development and support mechanisms.

Trust Wide: Need for a hospital standard identifying how clinical harm reviews are triggered due to delayed letters



Patient Experience Overview

Are we responding and improving?
 Patients, families and carers are able to share their experiences via numerous routes including PALS, Complaints and the Friends and Family Test (FFT).



■ PALS	199	197	194	142	169	163	129	136	116	146	162	115	143	146
■ Formal Complaints	5	12	5	8	5	6	15	7	8	15	7	6	4	9
— FFT recommendation rate %	97.4	95.7	96.1	96.7	98.2	97.1	97	96.7	98.1	96.5	94.8	96.8	96.6	95.4
— FFT % response rate	25	23	24	25	24	13	16	15	11	15	14	16.5	24.5	26.8

Integrated Patient Experience Commentary

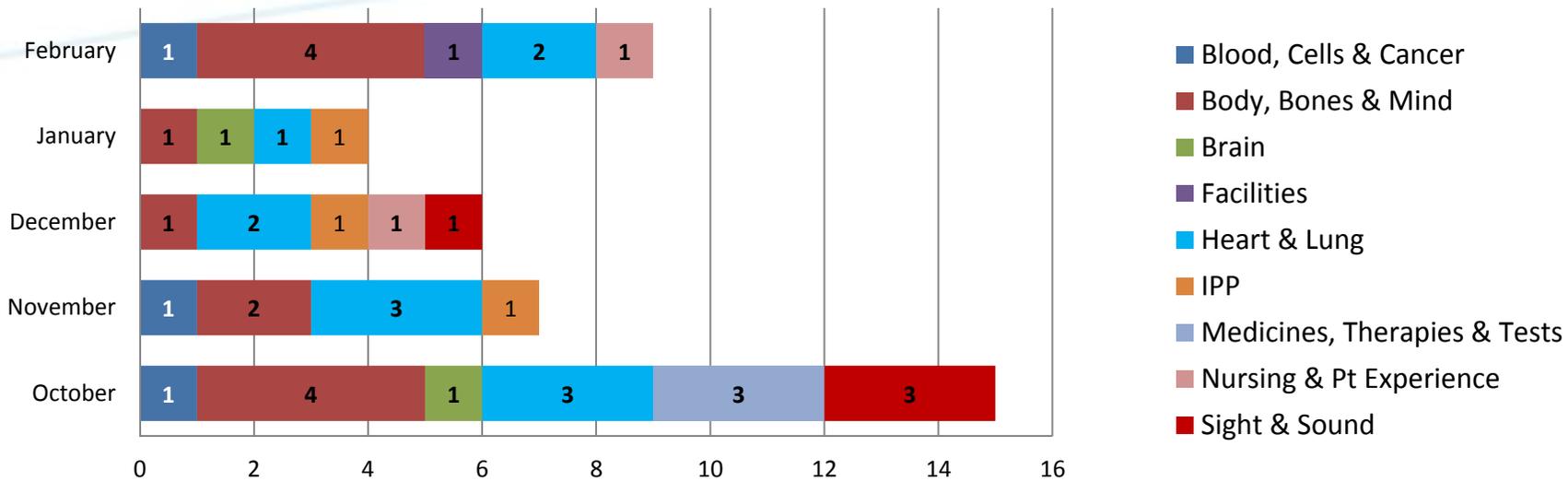
There was an increase in feedback received across the Trust in February. Of note, the FFT response rate (26.8%) exceeded the Trust target for the first time since April 2018. While there was a drop in the FFT recommendation rate overall (95.4%), there was no marked reduction with any specific directorate.

In the context of relatively low complaint numbers, it can be challenging to identify themes. However, in February two complainants raised concerns about the security of their personal data (one through the disclosure of their secure home address and another through a letter sent to an unknown clinician). Although these complaint investigations are ongoing, a further complaint closed in February also highlighted Trust learning regarding how we manage personal information. This complaint related specifically to the Trust’s handling of a subject access request (SAR) for personal data and unsatisfactory redaction processes. In response to this, the Trust’s SAR policy and procedures are being looked at through an external review which will inform a new policy (expected in May 2019). Additional quality checks are in place before any information is released to prevent disclosure of third party data. There is also sustained focus on ensuring trust wide compliance with mandatory Information Governance training. Learning from incidents and complaints relating to information governance is also shared across the Trust through team briefs, meetings and learning events to emphasise the importance of taking time whenever releasing information outside of the trust to ensure that all details are always correct.

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Complaints: Are we responding and improving?



There was an increase in formal complaints (n=9) in February. However, this is consistent with increased numbers of complaints received in February 2018 and 2017. Complaints about the Body, Bones & Mind directorate this month related to Orthopaedics (1), Nephrology (2) and Specialist Neonatal and Paediatric Surgery- SNAPS (1) specialities. These complaints highlighted concerns about delayed diagnosis and treatment, standards of care, accommodation and facilities, and management of patient information.

Other complaints in February related to concerns about/ that:

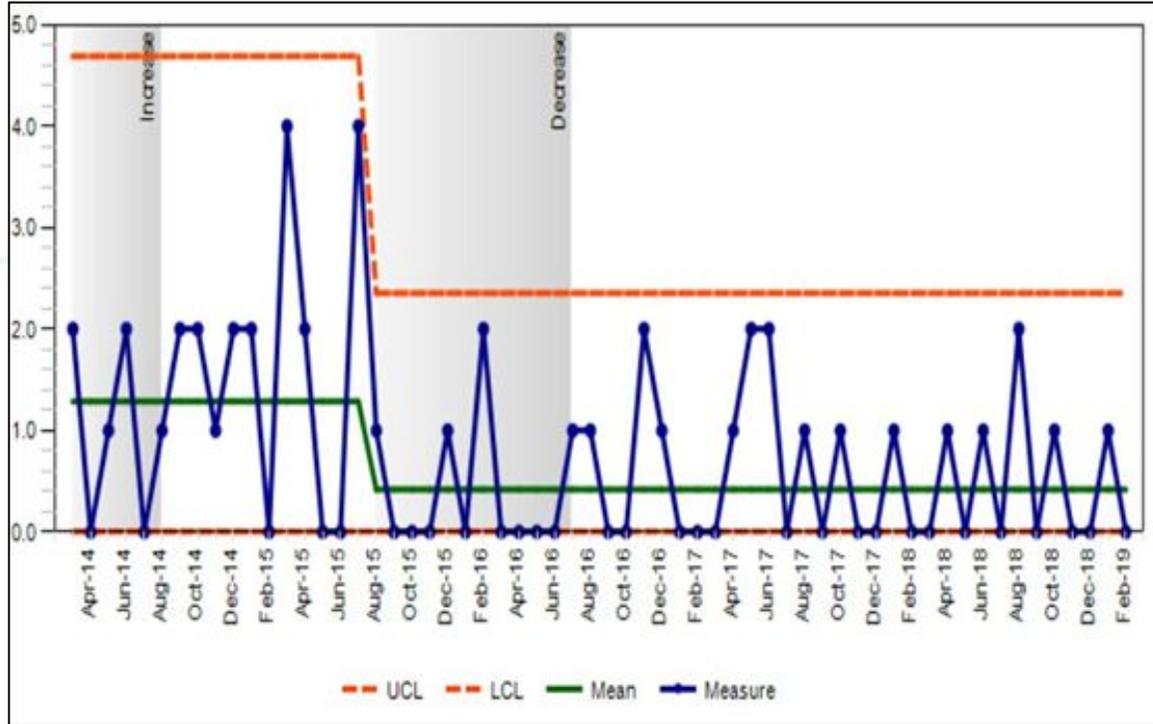
- Decision to discharge a patient from GOSH and communication regarding this
- Cleanliness of toilets
- Information provided to a local authority
- Delays and standards of care provided by several specialities at GOSH between 2006 and 2012
- Communication regarding the rationale of treatment decisions and referrals for further clinical opinions

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Red Complaints: Are we responding and improving?



No of new red complaints YTD 2018/19: <i>*one complaint was later withdrawn</i>	7*
New Red complaints opened in January/ February 2019	1
No of re-opened red complaints YTD 2018/19:	1
Open red complaints (new and reopened) as at 28/02/2019	1

Red complaints in 2018/ 19 look set to exceed 2017/18 (n=8). Red complaints this year related to serious concerns about care and treatment across the Blood, Cells & Cancer, Body, Bones & Mind, Heart & Lung and IPP divisions. Review is underway to identify any clear themes/ trends in red complaints.

New red complaint

Ref	Opened Date	Date Report Due	Description of Complaint	Divisions Involved	Next Steps:
18/081	29/01/19	26/03/19	Parent is concerned that there was a delay in providing treatment for sepsis which caused multiple complications.	IPP (Urology)	Review of draft report highlighted the need for further information from those involved in patient's care. Awaiting further clarification.

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PALS – Are we responding and improving?

Cases – Month	02/18	01/19	02/19
Promptly resolved (24-48 hour resolution)	155	136	136
Complex cases (multiple questions, 48 hour+ resolution)	32	2	9
Escalated to formal complaints	0	0	0
Compliments about specialities	7	2	1
*Special cases (e.g large volume of contact following media interest)	3	0	0
Total	197	140	146

There has been a decrease in Pals cases in February 2019 compared to February 2018.

Over the last year Pals have been working to improve timeframes for actions and ensure prompt replies to families. We believe this early intervention and resolution is driving the reduction in complex cases.

Themes for the top five specialities	02/18	01/19	02/19
Lack of communication (lack of communication with family, telephone calls not returned; incorrect information sent to families, transport)	65	49	63
Admission/Discharge /Referrals (Waiting times; Advice on making a NHS referral; advice on making an IPP referral, cancellation; waiting times to hear about admissions; lack of communication with families, Accommodation)	23	14	22
Staff attitude (Rude staff, poor communication with parents, not listening to parents, care advise)	37	15	14
Outpatient (Cancellation; Failure to arrange appointment; poor communication, franking of letters)	26	29	9
Transport (Eligibility, delay in providing transport, failure to provide transport)	3	5	3

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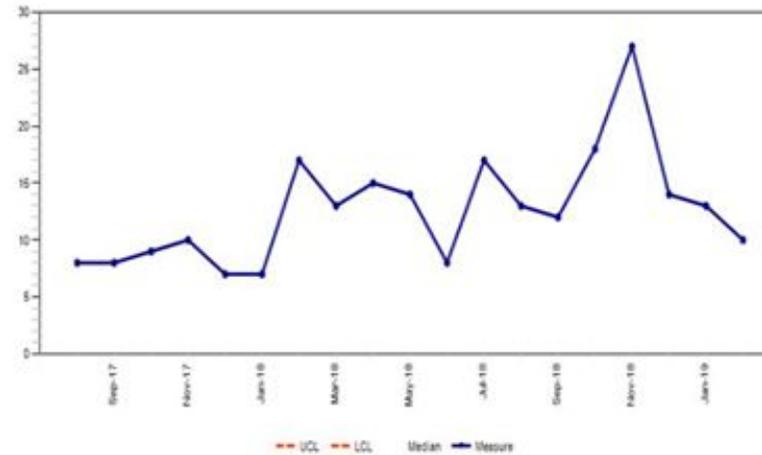


PALS – Are we responding and improving?

Gastroenterology cases

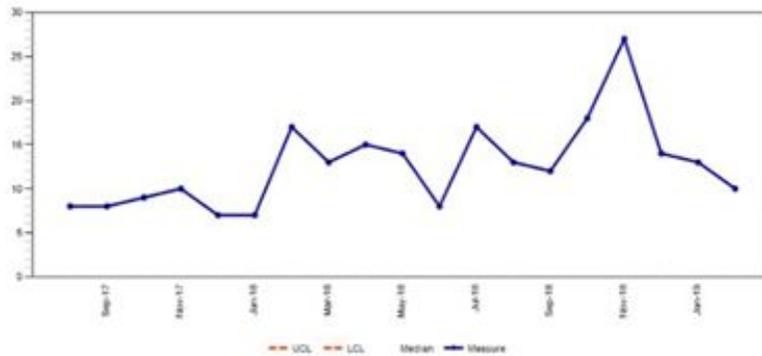
Specialities - Month	02/18	01/19	02/19
Gastroenterology	16	12	14
Cardiology	16	12	10
General Surgery	11	8	8
*Dental	10	7	7
Endocrinology	7	6	6

*Dental and Maxillofacial discovered contact numbers that were not directing to the correct extensions and had incorrect voicemails. They have now rectified this problem so hope to see a decrease in Pals cases with regards to communication. GOSH website is up to date and they have informed switchboard of the new telephone numbers.



Theme Feb 2019	total
Lack of Communication	9
Delays/Waiting	3
Facilities	1
Care Advise	1

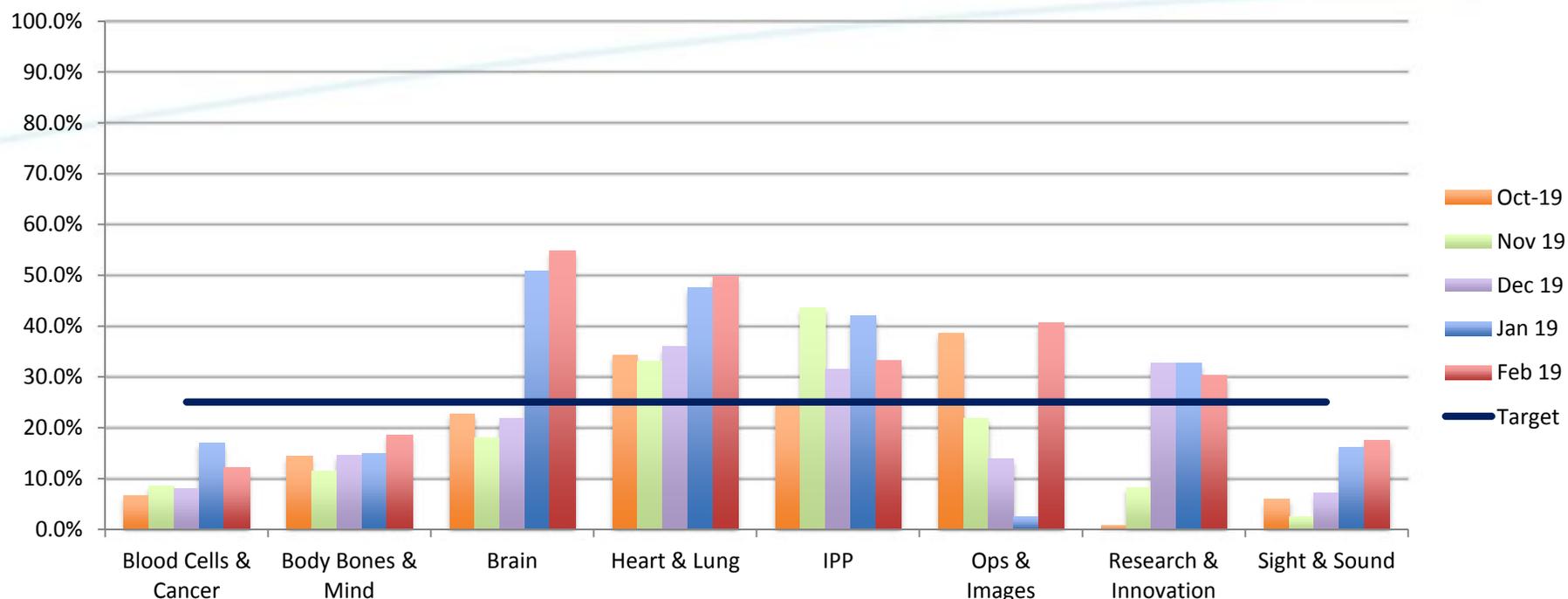
Cardiology cases



Theme Feb 2019	total
Care Advise	3
Lack of Communication	3
Delays/Waiting	2
Facilities	2

FFT: Are we responding and improving?

FFT Response Rate by Directorate - February 2019



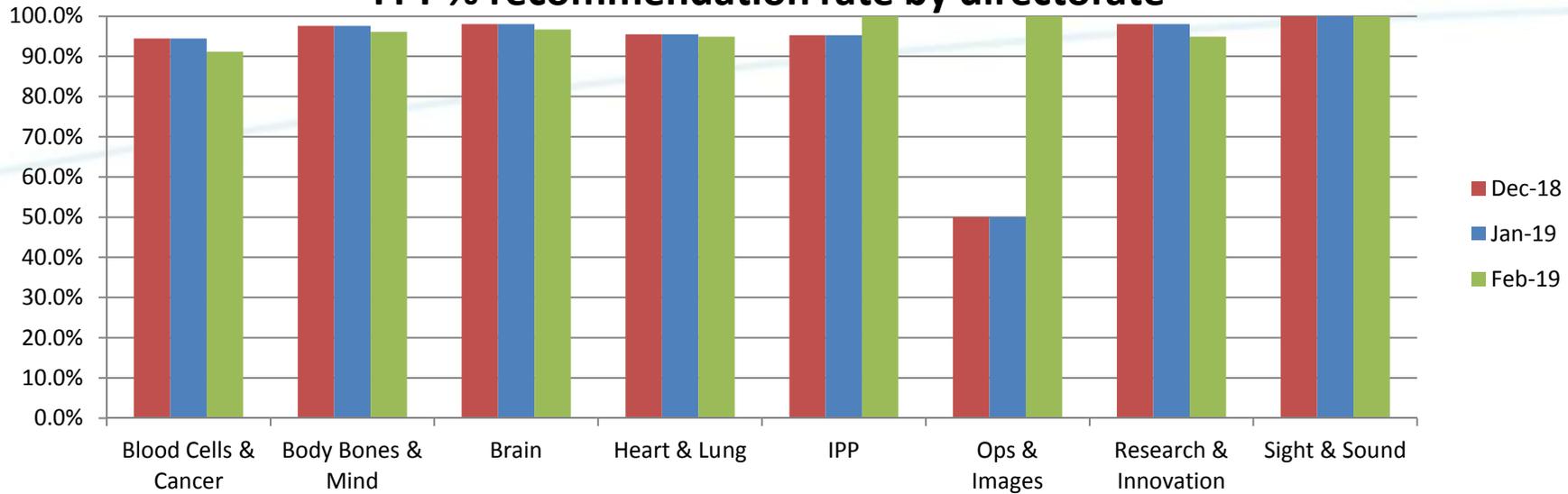
The overall FFT response rates in February exceeded the Trust target of 25%.

Five directorates achieved above the 25% target. Two of those who did not achieve the target, did show an improvement in their responses.

Benchmarking against 11 paediatric other hospitals (January 19 data) FFT response rates varied between 12% and 91%. The January rate of 24.5% places the Trust at the upper end of the scale.

FFT: Are we responding and improving?

FFT % recommendation rate by directorate



	Inpatient Comments	Outpatient Comments	IPP Comments	Total Feedback	% with qualitative comments (All areas)
Dec 18	471	832	47	1350	78.6%
Jan 19	860	1099	63	2022	63.9%
Feb 19	877	780	48	1705	82.2%

FFT feedback at GOSH includes a high proportion of qualitative feedback (82.2%) indicating that families are willing to share their experiences.

The recommendation rate in February was 95.4%. This is one of the lowest scores in the last year. Despite this, feedback was positive with families particularly commenting on the welcoming and caring attitude of staff and their professionalism and expertise.

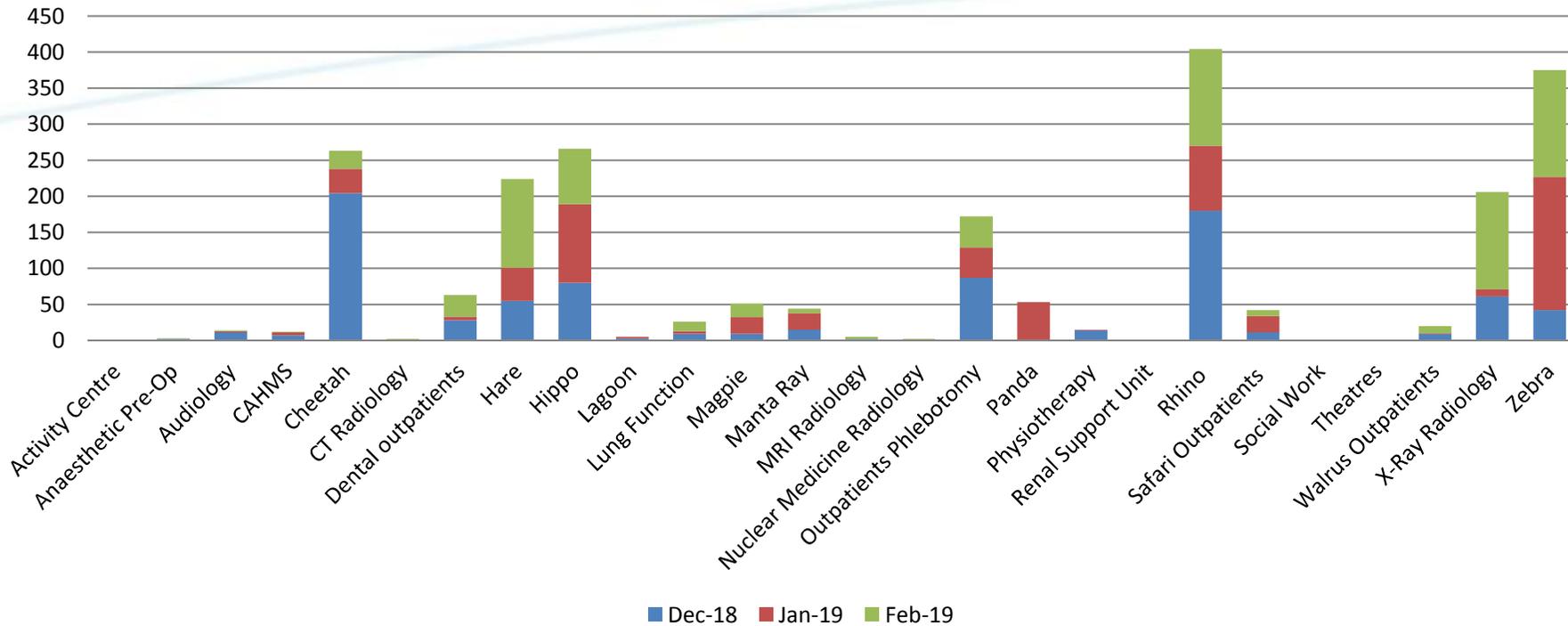
The Trust was at midpoint (97%) when benchmarked against other paediatric hospitals (range 76% to 99%) in January 2019.

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FFT: Are we responding and improving?

FFT Outpatient responses



The above chart outlines the number of the FFT responses within Outpatients. There is no Trust or NHS target around outpatient feedback. There has been a large decrease in outpatient numbers in February which has been followed up with the Outpatient team. Despite this, outpatient feedback increased from 657 in January to 781 in February.

All negative comments are followed up with the relevant service and with families (where contact details are provided).



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FFT: Are we responding and improving?

Qualitative Comments

Positive	Negative
<p data-bbox="156 287 555 821"> “The nurses, students nurses and doctors have been fantastic, very attentive and listened to concerns and answered all our questions. We felt safe in a calm environment in what as parents felt like was a stressful time so thank you all so much!” Panther Ward </p> <p data-bbox="156 877 459 1244"> “Staff are world class. The hospital is clean and welcoming. The wards are fresh and well laid out” Nightingale Ward </p> <p data-bbox="577 287 952 821"> “Staff are amazingly helpful, attentive and reassuring. GOSH really is an exemplary hospital. I always feel my son is in very safe hands here and will be given the very best care. Thank you” Otter Imaging Suite </p> <p data-bbox="577 877 952 1244"> “Staff are extremely professional, from reception through to consultants. Our experience is always made less stressful by everyone’s cheeriness!” Zebra Outpatients </p>	<p data-bbox="1008 287 2072 646"> “The appointment letter we got said appointment 8.30 but turn up 20 mins earlier for other tests. So we rushed from South London to be there for 8 only to find department not open. Apparently Audiology do not work that way. Also, we were promised the result for the following Friday. 2 weeks later we are still waiting. We did email to chase, but no reply ... (we are still waiting) However, the people we saw and the testing was very good, just the organisation has let them down” – Audiology </p> <p data-bbox="1008 702 2072 1061"> “We got onto the ward at 07.30 by 12.00 we still had not had her procedure. No one could tell us why we were in isolation we weren't isolated last time and there's been no change to the medical status. She was Nil By Mouth for more that 12 hours no one suggested checking her blood sugar or iv fluids she's on steroids. She's only 2 years old. We found this whole experience totally unfair and confusing, total lack of communication. When the nurse specialist went to find out why we were last ,no one knew.” Safari Ward </p> <p data-bbox="1008 1101 2072 1228"> <i>Both negative comments were followed up with the families. Learning around good communication both between staff and importantly with families is being shared with the relevant teams.</i> </p>

Clinical Audit

Specialty Led Clinical Audits on Track

What are overdue Clinical Audits?

These are clinical audits where no update has been given to the clinical audit dept as to whether the audit is on progress, requires support or more time, or has been completed. Reminders are sent each month by the Clinical Audit team.

Why does it matter?

It is important to have timely oversight of the outcomes of specialty led clinical audit in order to be assured that teams are engaging in reviews of the quality of care provided, and that the outcomes of those can be monitored. The Trust is expected to provide evidence to regulators, including the CQC, that specialty led clinical audit activity takes place.

Actions taken

1. Have been highlighted in monthly reports to Directorates and the Patient Safety and Outcomes Committees
2. Reminder and escalation email sent to all audit owners
3. Clinical Audit Prize to promote sharing of clinical audit
4. Added as a metric on the IQR

Relevant NICE national guidance overdue a completed gap analysis. A gap analysis of Mental Capacity Act (MCA) guidance was overdue at the end of February. The gap analysis has now been completed.

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Specialty led audit Clinical Audit prize winners

Clinical Audit Prize Why? To promote, value, and incentivise sharing of clinical audit in the Trust. In addition this will support our mandatory reporting of clinical audit activity for regulatory purposes (CQC, Quality Report)

Three teams have been reviewed as winners, from entries submitted at the end of 2018.

Dental and Maxillofacial

Alveolar Bone Grafting in patients with a Cleft Lip and Palate

"this audit has demonstrated excellent treatment outcomes as well as effective and efficient patient care. As a department we have learnt greatly from the audit results and will continue to persevere with maintaining and improving our current standards"

"This idea of acknowledging audit works throughout the Trust is brilliant and am sure will encourage more good work."

Urology SPR

Kangaroo and Leopard Ward

Ventilator prescriptions

Why we liked this audit actions were taken to learn from harm and to reduce risk. This is a nurse led audit that resulted in clear improvements

"This has led to there being no clinical incidents surrounding ventilator prescriptions with inpatients. Nurses feel more empowered to be able to ask for a ventilator prescription if it is not present due to it being on the safety checklist. It is acknowledged amongst the medical team that every child on a ventilator must have a ventilator prescription and they have been more engaging in completing these as needed."

Urology

Referral pathway for Urodynamic Requests

Why we liked this audit clear improvements made to benefit patient experience and safety, this audit 'closed the loop'

"We have achieved better resource utilisation and added multiple check-points; thus improving patient service and safety."



Clinical Audit Plan

A clinical audit plan prioritises clinical audit work related to incidents, risk, complaints, and areas for improvement in quality and safety. These items are facilitated by the Clinical Audit Manager who engages with relevant staff as appropriate. This outlines some of the highlights of items in the priority plan

Source	Context	Progress
Surgical Safety Checklist audit	We do audits to assess and support improvement, therefore it was agreed by the Natsipps steering group and Medical Director that the quarterly observations should support improvement by focusing on areas outside of main theatres. Compliance with documentation of completion of the checklist continues to be monitored as a Trust Performance Measure	Excellent completion of checks and engagement noted in Laser which should be highlighted We are not seeing significant improvements in completion in all stages of the checklist in areas outside of main theatres Next steps to be agreed by Natssips steering group
Implementation of patient safety alert (NG Tubes)	An best practice of naso-gastric tube management was reported to PSOC in April 2018 and showed: <ul style="list-style-type: none"> positive practice of testing the position of Nasogastric tube testing , and awareness of the techniques that should be avoided . non-compliance with standards for documentation of process. 	Re-audit of cases in December 2018 has not shown that there have not been any significant improvements in documentation standards since the first audit . The limiting factor as to full compliance with core standards is around the absence of standardised processes to support documentation. Reviewed at PSOC A further audit will take place three months post EPIC implementation, to help assess whether the system facilitates an improvement in the documentation of practice.
Documentation of post-operative infection in the consent process Spinal Surgery	Audit found that the documented risk of infection as part of the consent process for neuromuscular patients having spinal surgery was not in line with the infection rates noted at GOSH. In many cases a 1% risk was being documented as being discussed, when the infection rate can be between 3-8%. RE-audit of change in practice	Data collection in progress
Implementation of learning from an incident - Consent in Cardiac Surgery	Re-audit requested by Heart and Lung Chief of Service, and Cardiothoracic Surgery Lead to assess progress with avoidance of on the day consents for elective cardiac surgery	Data collection in progress



Responsive – Diagnostic Waiting Times

February 2019 Summary

- The Trust continues to underachieve against the 99% national standard, reporting 97.5% of patients waiting within 6 weeks for the 15 diagnostic modalities
- This is a 2.3% improvement from January 2019
- The number of reported breaches has significantly decreased to 18, a reduction of 19 breaches



Of the 18 breaches, 15 are attributable to modalities within Imaging and the remaining 3 relate to Urological diagnostic tests.

The breaches fall into four distinct themes, 7 were tolerance breaches (complex patient, equipment failure MR5 breakdown, failed feed and wrap), 5 were due to Trust process issues (late requests), 4 were due to Trust booking processes (no reasonable offers made) and 2 were due to capacity issues (MR5 and no available bed)

The Trust continues to monitor the diagnostic recovery plan, with the reported number of breaches for February being ahead of trajectory.

Cancer Wait Times

At the time of writing the report for the month of January 2019 no breaches against the cancer standards attributable to the Trust were reported, with performance being at 100%. Indicative performance for February projects compliance against all standards.

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Responsive – Referral to Treatment

February 2019 Summary

- The Trust achieved the RTT 92% standard, submitting performance of 92.18%, with 543 patients waiting longer than 18 weeks.
- Specialties which continue not to meet the standard are Plastic Surgery (sub-specialisation within the service), SNAPS (bed capacity), Dental and Maxillofacial Surgery (theatre capacity and consultant absence), ENT (inherited breach waits from other providers) and Urology (complex patients and capacity).
- Five of the seven NHS directorates have met the 92% standard, with all specialties in Blood, Cells and Cancer achieving the national standard
- The number of patients waiting 40 weeks+ has decreased to 28 patients in February



52 Week Waits:

The Trust reported 2 patients waiting over 52 weeks in February. One in Urology which is a complex patient with multiple cancellations due to illness, the patient requested Easter for treatment with a TCI 18th April 2019. One in ENT received at the Trust at week 55 from London North West, the patient has a TCI 22nd March 2019.

National Benchmarking:

For the month of January half of the patients on the Trusts incomplete PTL were waiting less than 7 weeks (nationally 8 weeks), and 92 out of every 100 patients were waiting less than 18 weeks (nationally 23 weeks) on a PTL size of 6,628 patients.

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 184 providers reporting against the standard (NHS Trusts only) 78 in January were delivering 92% or better. 18 providers reported 90-92%, 70 at 80-90% and 18 reported <80%. 3 providers did not report.

Nationally, GOSH is ranked as the 64th best performing Trust out of 184 providers. In London, GOSH is the 13th best performing Trust out of 28 Providers reporting RTT performance.

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

Last minute non-clinical hospital cancelled operations:

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

For month of January 2019, the Trust reported an increase in the number of patients cancelled, with 40 patient cancelled compared to 36 in December. The areas contributing most to the monthly position are Cardiology/Cardiac Surgery (10), Radiology (7), Plastic Surgery (4), Orthopaedics (3), Urology (3) and ENT (3). The top three reasons recorded for the month are emergency/trauma patients taking priority (10), theatre list over run (8) & ward bed unavailable (9).



Last minute non-clinical hospital cancelled operations: Breach of 28 day standard

The Trust reported 5 last minute cancelled operations within 28 days of the cancellation in January (compared to 8 in December). This included two Dental/Maxfax patients, one Haematology patient, one Cardiac Surgery patient and one Radiology patient.

Urgent operations cancelled for a second time

- This indicator has been added the Dashboard for 2018/19 following agreement with NHSE the content of Schedule 4 of the NHS Contract.
- Since the start of the new financial year the Trust has reported no patient being cancelled for an urgent operation for the last eleven consecutive months.

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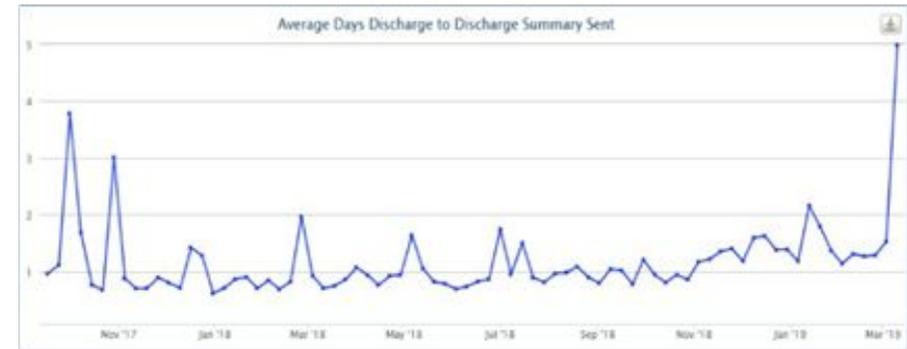
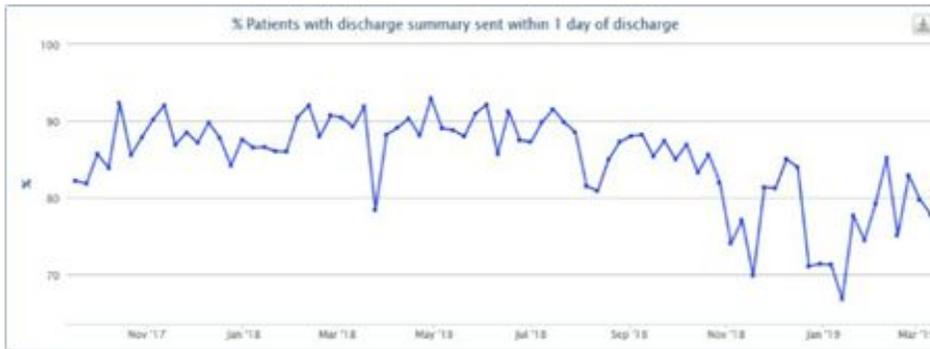
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Effective – Discharge Summaries

February 2019 Summary

- Performance within this metric continues to fluctuate and be challenging to directorates with February 2019 seeing 79.09% of discharge summaries being sent within 24 hours, which is an improvement from January performance (73.23%).
- 82.18% of discharge summaries were sent within 2 days, rising to 89.27% within 3 days. Average performance for 18/19 is 84.42%
- Actions in place include daily reminders to HoCS/SM/fellows to complete the DS within 24 hours, weekly reports generated and sent to the Service and Ward Clerks, ensure discharges flagged as exclude are clinically validated and documented. There is also a lack of adequate junior doctor clinical cover between all specialties which is impacting this measure. In some instances recruitment to posts has been unsuccessful on a number of occasions, work with HR and senior clinical leads is ongoing.



Clinic Letter Turnaround Times

For January 2019 (as this indicator is reported a month in arrears), there has been an improvement in relation to 14 day turnaround 73.9% from 66.3% in December. Some of the actions in place to improve performance are operational teams focusing on identifying where delays in the process reside within each specialty and implementing actions e.g. targeting sign off where weekly reminders for clinical teams to sign off letters are circulated, 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, clinic letter turnaround being part of service reviews, and extra admin time to work through the backlog of letters in specific areas. It should be noted that as part of investigating the deterioration a data discrepancy has been identified, the size of the impact is yet to be fully understood but is in the process of being resolved.



Data Completeness – Mental Health Identifiers

Mental Health Identifiers: Data Completeness

The Trust is nationally required to monitor the proportion of patient accessing Mental Health Services at the Trust that have a valid NHS number, date of birth, postcode, gender, GP practice and commissioner code. Within this area the Trust consistently meets the 97% standard with 99.56% of patients having valid data in February.

Mental Health: Ethnicity Completion - %

This indicator has been added the Dashboard for 2018/19 following agreement with NHSE the content of Schedule 4 of the NHS Contract.

The Trust has seen an increase in collating ethnicity for patients accessing mental health services, with 66.26% (+4.19%) in February having a valid ethnic code. This is continues to be addressed with operational teams via weekly monitoring, refreshed training and focused Data Assurance work.

Patients with a valid NHS Number

% of patients with a valid NHS Number Inpatients and Outpatients

This indicator has been added the Dashboard for 2018/19 following agreement with NHSE the content of Schedule 4 of the NHS Contract.

Nationally the Trust is monitored against achieving 99% of patients having a valid NHS Number across all services being accessed. As the report depicts for both Inpatients and Outpatients this is below the standard, nationally the average for both indicators is above 99%. Work is continues to improve collating our patient’s NHS number.

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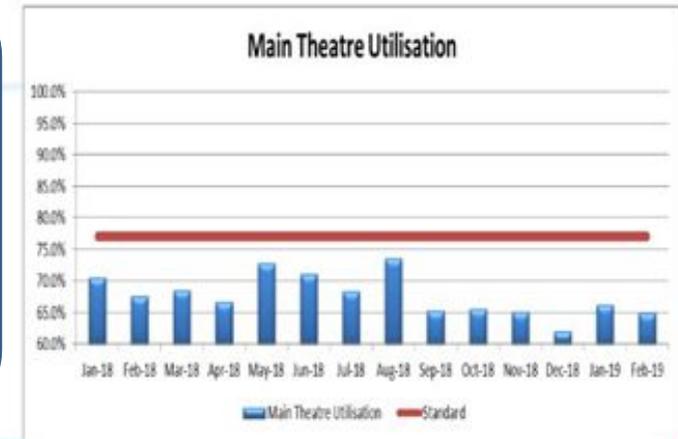


Productivity – Theatre Utilisation

Utilisation of main theatres has decreased in February to 65.0% from 66.3% (January). Specialties with utilisation above 70% are Craniofacial (90%), ENT (75%) Ophthalmology (71%) and Surgery (71%). Areas of concern Spinal Surgery (57%) and Orthopaedics (60%).

Short notice cancellations (on the day and the day before) for both clinical and non-clinical reasons were the highest for this financial year at 353 for the month. 152 (43%) cancellations were attributable to the patient being unfit, not following pre-op instructions or the patient cancelling. 37 patients were cancelled due to beds being unavailable and 23 due to an emergency patient.

Work continues on targeting fully utilising lists and addressing delays with clerking and consenting of patients.



Bed Occupancy and Closures

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 February, occupancy has increase to 82.4%. This indicator and methodology is currently under-review as part of the statutory returns work being completed to support EPR implementation.

Bed closures: There has been a decrease in the average number of beds closed in February (26) compared to 36 in January, the reasons recorded are linked to staffing. This was mainly due to Sky having an average of 8 beds closed and Bumblebee 10 beds closed. NICU/PICU have experienced an average of 6 beds closed

Trust Activity

Trust activity: February activity for day case discharges are above the same reporting period for last year ytd, outpatient attendances, critical care bed-days and overnight discharges are below the same reporting period ytd. Further detail will be provided within the Finance Report.

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 February, the Trust reported 11 patient discharges that had amassed a combined LOS of 1,9653 days of which 804 are attributable to critical care. 4 of the 11 patients discharged in February had 200 days plus LOS. The clinical coding of the admissions relate to the patients having many having complex conditions and comorbidities warranting that LOS.



Productivity – PICU Metrics

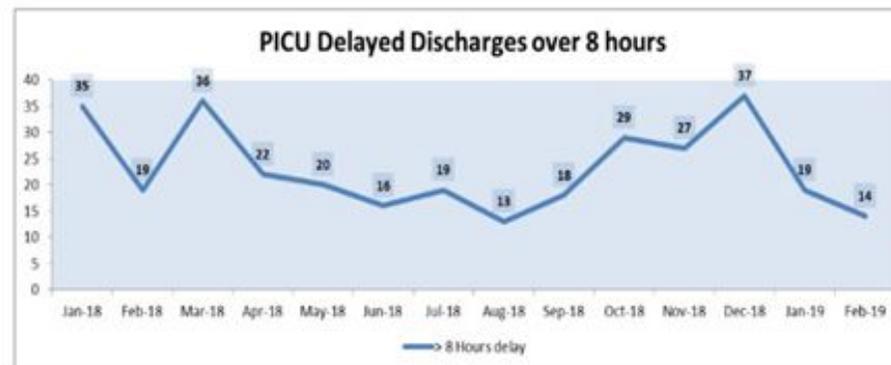
As previously reported the metrics supporting PICU shared in this month's IPR are the first iteration of KPIs. The KPIs have been agreed collaboratively with the Trusts PICU consultants and are designed to provide a triangulated picture of the service. Further analysis and intelligence will be added in future reports.

CATS PICU/NICU Refusals: The number of CATS referral refusals into PICU/NICU from other providers during February has increased to 25 from a January position of 17. Compared to the first eleven months of 17/18 (172 refusals) the number of refusals in 18/19 is 175 (+3). During April – February 2018 the Trust received 339 patients via the CATs retrieval service into PICU/NICU.

It should be noted that although The Trust has seen an improvement in the number of refusals, the Trust remains a national outlier. As part of the specialised services Quality Dashboard, a KPI is monitored on emergency admission refusals. It clearly shows the Trust refuses a higher percentage of patients than the national average, as demonstrated in the table below.

PICU Delayed Discharges:

Delayed discharges over 8 hours from PICU can demonstrate the challenges being faced internally and externally with regards to capacity issues on accessing beds. February has seen 14 patients delayed over 8 hours compared to 19 in January.



PICU Emergency Readmissions:

Readmissions back into PICU within 48 hours is one patient for the month of February. During April to February 2018 twelve patients have been re-admitted to the department.

Quarter	GOSH PICU/NICU/C ICU refusals	GOSH admission requests	GOSH % refused	National % refused
Q2 18/19	45	127	35.4	8.09
Q1 18/19	27	112	24.1	6.27
Q4 17/18	No Data	No Data	No Data	No Data
Q3 17/18	99	226	43.8	19.8

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Well Led: Are our people ready to deliver high quality care?

Workforce Headlines

- Contractual staff in post: Substantive staff in post numbers in February were 4700 FTE which is a slight decrease from January (4711.3). However this is 242.7FTE (5.4%) higher than the same month last year.
- Unfilled vacancy rate: The Trust vacancy rate for February increased to 0.4% (-19FTE), but remains well below the Trust target of 10%. Trust vacancy rates have been below target since July 2017.
- Turnover is reported as voluntary turnover. Voluntary turnover has reduced since December and stabilised at 14.7% since January. While this remains above target, turnover is expected to continue reducing over the next few months. Relocation and promotion were the most common reported leaving reason. Total turnover (including Fixed Term Contracts) increased to 17.6% which is below target.
- Agency usage for 2018/19 (year to date) stands at 1.0% of total pay bill, which is below the local stretch target, and is also well below the same month last year (1.8%). Human Resources Business Partners continue to work with the divisions and corporate areas to address local pockets of agency usage. The target for 2018/19 remains 2% of total pay bill.
- Statutory & Mandatory training compliance: In February the compliance rate across the Trust was 92%. All but 1 Directorate reported above target (90%) compliance, however 8 of the 30 topics were below target. Directorates with below target compliance are being offered support. The target for 2018/19 remains 90%.
- Sickness absence remains below target at 2.4% and below the London average figure of 2.8%. The Trust is implementing an integrated rostering system. The system will support improvements in the accuracy of absence reporting, which may lead to fluctuations in reported rates. The 2018/19 target remains 3%
- Appraisal/PDR completion The non-medical appraisal rate has increased to 85% but remains below the Trust target, however the Trust continues to benchmark well. Consultant appraisals have also increased to 83%

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Well Led: Are our people able to deliver high quality care?

Trust KPI Performance February 2019

Metric	Plan	February 2019	3m average	12m average
Voluntary Turnover	14%	14.7%	14.7%	14.4%
Sickness (12m)	3%	2.4%	2.4%	2.4%
Vacancy	10%	-0.4%	-0.1%	2.2%
Agency spend	2%	1.0%	1.0%	1.1%
PDR %	90%	85%	84%	84%
Consultant Appraisal %	90%	83%	80%	84%
Statutory & Mandatory training	90%	92%	92%	91%

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

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Well Led: Are our people ready to deliver high quality care?

Directorate (Clinical) KPI Performance February 2019

Metric	Plan	Trust	Blood, Cells & Cancer	Body, Bones & Mind	Brain	Heart & Lung	Medicine, Therapies & Tests	Operations & Images	Sight & Sound	IPP
Voluntary Turnover	14%	14.7%	15.7%	14.9%	13.2%	16.3%	11.1%	11.1%	17.5%	25.5%
Sickness (12m)	3%	2.4%	2.2%	1.9%	2.3%	2.9%	1.9%	2.5%	3.4%	4.2%
Vacancy	10%	-0.4%	-15.4%	-4.0%	-1.2%	4.5%	-18.0%	0.9%	2.6%	15.3%
Agency spend	2%	1.0%	0.1%	0.2%	0.0%	0.2%	2.8%	1.1%	1.5%	0.0%
PDR %	90%	85%	93%	88%	99%	85%	89%	76%	92%	95%
Stat/Mand Training	90%	92%	92%	91%	94%	88%	93%	92%	91%	96%

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

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Directorate (Corporate) KPI Performance February 2019

Metric	Plan	Trust	Clinical Operations	Corporate Affairs	DPS	Finance	HR&OD	Medical Director	Nursing & Patient Experience	Research & Innovation
Voluntary Turnover	14%	14.7%	15.5%	25.3%	11.2%	15.0%	17.1%	16.8%	13.4%	28.1%
Sickness (12m)	3%	2.4%	1.4%	0.0%	2.9%	0.9%	4.4%	1.1%	1.3%	1.8%
Vacancy	10%	-0.4%	17.4%	13.0%	14.7%	23.9%	10.9%	0.7%	-0.8%	-76.6%
Agency spend	2%	1.0%	0.5%	-0.2%	3.4%	5.3%	7.2%	0.0%	0.5%	0.0%
PDR %	90%	85%	75%	86%	86%	91%	93%	54%	79%	73%
Stat/Mand Training	90%	92%	93%	86%	96%	99%	97%	92%	97%	97%

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

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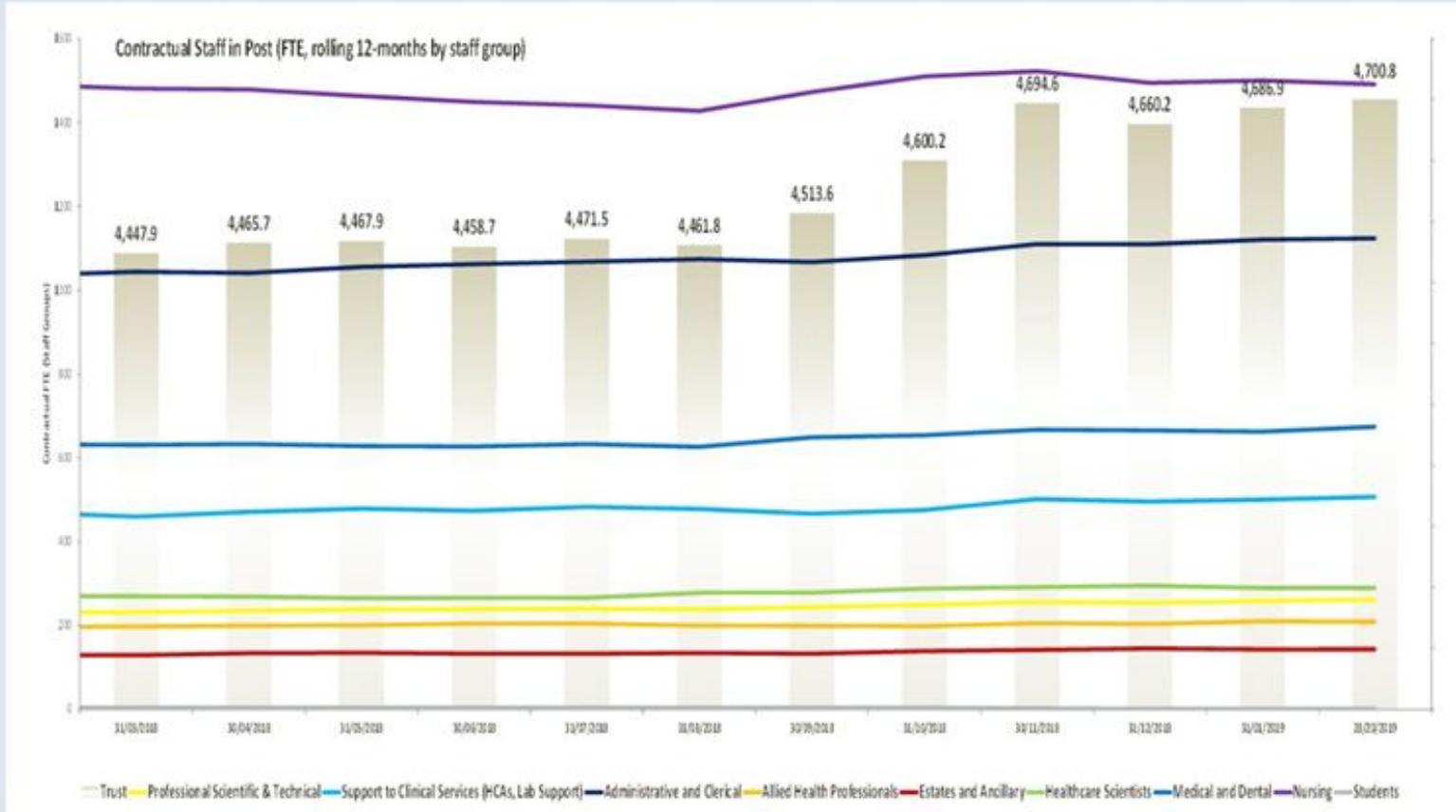


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Well Led: Are our people ready to deliver high quality care?

Substantive staff in post by staff group



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Well Led: Are our people ready to deliver high quality care?

Non Compliant Statutory & Mandatory Training by Staff Group

Topic	Non Compliant	Allied Health Professional	Admin & Clerical	Additional Clinical Services	Add Prof Scientific & Technical	Estates & Ancillary	Healthcare Scientist	Medical & Dental	Nursing & Midwifery Registered	All Staff
Blood Transfusion - Level 2 - 2 years	146				20%			72%		70%
Resuscitation - Level 3 - Medical Staff – 1yr	141	100%			100%			79%	100%	79%
Resuscitation - Level 3 - Nursing Staff – 1yr	262		0%	50%	75%				84%	83%
Safeguarding Children (V2) - Level 3 - 1 yr	449	89%	73%	90%	82%		85%	75%	87%	83%
Resuscitation - Level 2 - BLS New Staff (HCAs & AHPs) – 1yr	111	90%	60%	85%	78%	100%	89%	0%	69%	85%
Blood Transfusion - Paediatric - Lvl 1 – 2yr	218		0%	33%	87%		67%		85%	85%
Compliance		95%	95%	93%	93%	93%	94%	83%	93%	92%

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

This is the first monthly report which includes a detailed staff group breakdown of non-compliant statutory & mandatory training. Some data quality issues, based on the recorded training needs analysis for some members within certain staff groups. These are being worked through by the team.

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Well Led: Are our people ready to deliver high quality care?

Workforce: Highlights and Actions

Sickness %

- Monthly sickness absence reports distributed to managers from the HR Advisors to encourage a proactive approach to managing sickness absence.
- Regular meetings are held with Ward Sisters, service leads and departmental managers to discuss and provide support for sickness absence 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.
- HRBP undertook a refreshed deep dive into sickness for IPP with the General Manager in September, to be reviewed against one undertaken the previous year. Sickness in month of September was just over target, and the deep dive gave assurances that sickness was being reported accurately and managed appropriately.
- HRBP working with management teams to ensure sickness absence is being logged using the correct system so reporting can be accurate.
- Allocate HealthRoster is being rolled out across the Trust during 2018/19. The new system will enable more accurate reporting.

Voluntary Turnover Rate

- There has been a significant amount of work undertaken to better understand the broader turnover position - with specific focus on areas of low stability and high turnover. 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 Advisory Board.
- Developing B5s into vacant B6 roles helps to decrease turnover of B5s
- Analysis of exit surveys received and recommendations for improvements to the process have been presented to the Trust Operational Board and Education and Workforce Development Committee.
- HRBPs actively involved in undertaking exit interviews with leavers for their areas to get underneath the reasons for leaving, then working with the specific areas with lessons learned
- HR&OD are actively engaging with EU colleagues to advise them of support available with applications for the governments Settled Status scheme after Brexit.



Well Led: Are our people ready to deliver high quality care?

Workforce: Highlights and Actions

Agency Spend

- HRBPs continue to work within the Directorates to reduce agency usage. This includes converting individuals from agency to permanent or bank contracts.
- This work is inline with NHSI requirements to reduce agency and breaches of pay rates and duration.

PDR Completion

- PDR reminders are now sent to managers on a monthly basis, flagging expired and upcoming PDRs.
- Simplifying the reporting process of PDRs has supported managers in working towards their PDR targets.
- HRBPs are continuing to support managers in identifying the PDRs that are required for completion, this includes consultant appraisals.
- PDR rates are a rolling agenda item for Performance Meetings within the Directorates.
- A Working group has been established to ensure changes to Agenda for Change are incorporated in to the PDR process from April 2019.

Statutory & Mandatory Training Compliance

- GOLD sends automatic reminders to staff and managers when they are due and overdue the training.
- L&D sends reminders to staff who are not compliant on the subjects that are currently below 90% overall Trust wide (excluding Resus) on a monthly basis.
- Improved visibility through LMS - staff encouraged to check their own records on GOLD
- Learning and Development & ER team work with managers to identify those who are non-compliant including further developments to the Trust GOLD LMS
- StatMan rates are a rolling agenda item for Performance Meetings within the Directorates.





Well Led: Are we managing our money well?

This section of the IQPR includes a year to date position up to and including February 2019 (Month 11). In line with the figures presented at slide 5, the Trust has a YTD Control Total Surplus of £11.0m which is £0.7m below plan. The Trust is generating a YTD net surplus of £0.6m which is £0.5m below plan.

- Clinical Income (exc. International Private Patients and Pass through Income) is £4.7m higher than plan
- Non Clinical revenue is £4.7m higher than plan
- Private Patients income is £1.0m lower than plan
- Staff costs are £4.3m higher than plan
- Non-pay costs (excluding pass-through costs) are £5.0m higher than plan

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Quality improvement at GOSH

The QI Team works to support, enable and empower teams to continuously improve the quality of care provided to patients across GOSH. The following maps where QI activity is taking place across the Trust:

By Quality Improvement (QI), we mean a systematic approach to “making changes that will lead to better patient outcomes, better system performance, and better professional development”
(Batalden and Davidoff, 2007)

At GOSH, we use [the Model for Improvement](#) as a framework for developing, testing, implementing and measuring change
(Associates for Process Improvement)

**Click links to open project dashboard*



Brain

- To reduce walk-ins during metabolic outpatient clinics

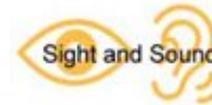


Body, Bones and Mind

- TOF/OE Pathway
- Gastro/SNAPS debriefs
- Reduce unnecessary coagulation testing in SNAPS



Operations and Images



Sight and Sound



Blood, Cells and Cancer

- Optimising Antimicrobial Stewardship programme
- Reducing IR delays & cancellations



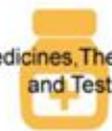
Heart and Lung

- Reducing blocked lumens in CVLs
- Improving handover quality and continuity of care for outliers in cardiology



International and Private Patients

- IPP flow
- Discharge Summaries



Medicines, Therapies and Tests

Trust-wide projects*
Reducing incidences of extravasation harm and repeated cannulation
Reducing rejected laboratory samples
Improving Transition

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Local QI projects

The QI team provides a service offering QI mentoring and support to staff delivering local projects.

The team also offers a process to register any QI work going on across the Trust. This helps capture and share learning and improvement, prevent duplication, and provides a platform to raise the profile of quality improvement.

Area of work	Project lead:
1 To streamline the management of patients with oesophageal atresia (OE) and tracheoesophageal fistula (TOF)	Caroline Gainsbury, SNAPS CNS
2 Implementing daily debriefs in Rainforest Gastro and Chameleon Wards	Carly Vassar, Matron SNAPS, Gastro and CAMHS
3 Optimising the Antimicrobial Stewardship Programme at GOSH	Alasdair Bamford, Infectious Diseases Consultant
4 Improving the maintenance of central venous lines and reducing blocked lumens on CICU	Alfredo Javier Alvarez Gavela, Cardiac Fellow
5 Decrease IR delays or cancellations in Blood, Cells and Cancer Directorate caused by patients not being ready / in IR on time	Anupama Rao, Haem/onc Consultant & Beth Corley, Haem/onc Fellow
6 Improve handover quality and continuity of care for outlying patients in the cardiology service	Craig Laurence, Cardiology Fellow
7 To reduce the number of unnecessary clotting samples on SNAPS	Sonia Basson, SNAPS SpR

If you have any improvement work going on in your area that you wish to share or would like to seek QI support, contact the team to discuss further or complete the [Quality Improvement Project Notification Form](#) and submit this to Gosh.QI@gosh.nhs.uk.

For more information, visit the [QI intranet page](#) (search 'quality improvement')

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Trust Board 3 April 2019	
Safety and Reliability Improvement Programme – Speak Up	Paper No: Attachment L
Submitted by: Sanjiv Sharma, Acting Medical Director	
Aims / summary Update to Trust Board on the progress of the Safety and Reliability Improvement Programme – ‘Speak Up’.	
<p>To ensure the safest care for patients GOSH want our staff to feel confident, empowered and supported to be able to speak up in the moment. In January 2018 we launched our programme with Cognitive Institute/Medical Protection Society as the first UK partner in their Safety and Reliability Improvement Programme.</p> <p>This is a Trust-wide training programme to help our staff to speak up in the moment for the safety of our patients and colleagues.</p> <p>To aid with the dissemination of the training we have trained and accredited 20 internal Safety Champions, volunteers across all staff groups and at different levels in their careers, whose role it is to champion the importance of speaking up in the moment for the safety of our patients and colleagues, in addition to delivering the workshops to our 6400 staff and volunteers to assist staff in developing the skills and insights to respectfully raise issues when concerned about safety.</p> <p>Building on this training and to assist in embedding the right culture at GOSH we are also implementing a graduated intervention model (Promoting Professional Accountability) to help us address behaviours that have the ability to both undermine Trust values and our culture of safety and quality.</p> <p>Signing up to this partnership demonstrates GOSH’s commitment to achieving zero preventable harm and delivering the best possible outcomes through providing the safest, most effective and efficient care as outlined in “Fulfilling our Potential”.</p>	
Action required from the meeting Update for noting	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Programme links to “Fulfilling Our Potential”	
Financial implications N/A	
Who needs to be told about any decision? Paper for noting only	
Who is responsible for implementing the proposals / project and anticipated timescales? Senior RO Andrew Long	
Who is accountable for the implementation of the proposal / project? Karen Panesar, Programme Lead	

Safety and Reliability Improvement Programme – Speak Up

In January 2018 we launched our programme with Cognitive Institute/MPS as the first UK partner in their Safety and Reliability Improvement Programme (SRIP). Signing up to this partnership demonstrates our commitment to achieving zero preventable harm and delivering the best possible outcomes through providing the safest, most effective and efficient care as outlined in “Fulfilling our Potential”.

Key activities to date

- 21 Safety Champions trained and accredited to support and deliver Speaking Up for Safety (March 19)
- Speaking Up for Safety workshops now delivered to 12% of Trust
- 7 new training videos produced in line with feedback from pilot (March 19).
- Speaking Up for Safety workshops scheduled on LMS ready for launch.
- Work has commenced in relation to Promoting Professional Accountability. Platform build in process to capture feedback on colleagues who have either championed or undermined our Trust values. Work has also commenced with the HR and OD department to align the programme with current policies and processes.
- Programme Board Agreed on branding. Programme to be launched as Speak Up.
- Communications and engagement across the Trust has commenced across a number of planned channels.
- Training continues to amongst the 800+ volunteer body.
- Correspondence highlighting the programme has been shared with NHSE, HEE, CQC, RCPCH, which was followed by an invitation to present at the Commissioners Quarterly Review Group.

Next stage

- In mid-2018 the timeline for the programme was re-scoped to avoid clashing with the roll-out of EPIC. With Speak Up for Safety roll-out scheduled to commence June 2019 and Promoting Professional Accountability go-live scheduled for September 2019 the programme is now well on track to meet these key mile stones.
- Selection and training of Peer Messengers to support Promoting Professional Accountability.
- Filming of Speak Up Introductory Video scheduled for 5 April 2019.
- Roll-out of Speaking Up for Safety planned for June 2019.
- Speaking Up for Safety to be included in Trust induction from April 2019.
- Promoting Professional Accountability Trust awareness sessions and comms to commence.
- Promoting Professional Accountability go-live scheduled for September 2019.
- GOSH to host 1 day of the Cognitive Institute’s International Study Tour . This will be an opportunity to share and demonstrate examples of reliability and safety innovations . Planning for day underway (draft schedule attached).

Key Risks

There is a risk that any issues experienced in the EPIC rollout will have an impact on the planned Trust roll out of SUFS (June 19)

Internal Communication capacity issues . Communication and engagement recognised to be key to the success of the Programme.

Mitigation

Continue with rollout amongst staff not effected by EPIC ie volunteers

Alternative comms support sought.

Trust Board Finance Report 3rd April 2019	
Month 11 2018/19 Finance Report	Paper No: Attachment N
Submitted by: Helen Jameson, Chief Finance Officer	Attachment Finance Report M11
Key Points to take away	
<ol style="list-style-type: none"> 1. The Trust is required to achieve an overall control total that is agreed with NHSI annually. The Trust is in behind with its control total in Month 11 by £0.8m. In order to support the Trust's position, £3.1m has been released from contingency YTD. 2. The Trust is ahead of its income target by £8.4m (excluding pass through) at Month 11. NHS Clinical Income remains ahead of plan by £4.7m. This is offset by reduced IPP activity which was behind plan and is now £1.0m behind YTD. 3. Pay was overspent YTD by £4.3m largely due to the £2.9m that relates to the implementation of the national Agenda for Change pay award (the expenditure is within pay but under NHSI requirements, we have to account for the funding under income). There continue to be a number of vacancies across the Trust though these are being partially filled by bank and agency staff which carry a premium over equivalent substantive posts and are contributing to the pay overspend. 4. Non pay is £4.9m overspent year to date (excluding pass through). This predominantly relates to the provision for bad debt increasing relating mainly to IPP income. It is also driven by additional costs associated with increased research activity and non-delivery of non-pay better value schemes in month, partially offset by underspends in drug costs and the release of further contingency in M9 which sits in non-pay. 5. The Trust continues forecasting a breakeven position at the year end to the control total. It is anticipated that there will be continued over delivery on income (which includes the additional funding available for genomics). The Trust will need to maintain a tight grip on activity and expenditure to ensure delivery of the financial position. 6. Cash is higher than plan by £6.2m (£47.0m against a plan of £40.8m) which is mainly due to underspends against Trust funded capital projects. Overall, Trust debt is £96.0m which is £16.5m greater than plan. Overall, overdue Trust IPP debt has increased to £34.8m from £30.8m in M10. 	
Introduction	
<p>This paper reports the Trust's Financial Position as at the end of February 2019 (Month 11). The Trust is required to achieve an overall control total surplus of £12.1m for the year which is an increase from 2017/18. In order to achieve this, the Trust must deliver additional income over and above the prior year and achieve the Better Value program of £15m.</p> <p>The Trust is currently reporting an adverse position to the control total though is forecasting to achieve it by year end. In order to do this, a number of non-recurrent adjustments have been made YTD to support the Trust's position including the release of £3.1m of contingency and it is</p>	

forecasting to release an additional £1.9m by year end.

Financial Position – Summary Points

NHS & other clinical revenue (excluding pass through) is favourable to plan by £4.7m YTD. There are some services across the Trust that are behind their activity target including PICU / NICU, SNAPs, trauma and orthopaedics and cardiac surgery. There are benefits for new income from the North, East and West London (NEW London) Genetic Hub and favourable to plan performance within non-elective services, as well as over performance from non-specialised activity commissioned by CCG's. The Trust agreed a block settlement with NHS England for 2018/19 which is included within the position.

Private patient income was on plan in month and is £1.0m behind plan YTD. There continues to be significant over-delivery of income in a number of areas including in PICU / NICU and CICU though this is offset by lower activity within Cancer and Respiratory. Income has fluctuated throughout the year with low activity at the start of the year and over the seasonal period but this was offset by increased income in M5 and M6. IPP has shown recent strong growth which has included the first privately funded laser ablation patient and CAR-T treatment.

Non-clinical income is £4.7m favourable to plan YTD and £1.7m favourable in month. £2.9m of this relates to the AfC pay award funding. The remainder is due to increases in research activity and charitable income. This is however offset by better value targets held against non-clinical income which are being largely delivered through other means.

Pay is overspent by £1.1m in month and £4.3m YTD which includes the additional costs associated with the AfC pay award of £2.9m. If this is excluded, the pay budget is overspent by £1.4m. Pay overspends are being driven by the increased research activity being undertaken at the Trust along with the continued use of bank staff and agency costs within PICU and pharmacy. The Trust is currently below the NHSI agency cost ceiling that it agrees as part of its annual plan and is forecasting to be below this by year end.

Non-Pay expenditure (excluding pass through) is adverse to plan by £4.9m YTD. This is driven largely by the increased R&I activity and further increases to the impairment of receivables associated with private patient income in month. The IPP team, supported by Accounts Receivable are endeavouring to maximise debt recovery prior to year-end. The adverse impact of this has been partially offset by below plan drug expenditure associated with lower than planned activity levels.

Financial Forecast – Summary Points

The Trust is forecasting to achieve break even in line with its control total target by year end. This includes the full release of the central contingency that will be required to hit the Trust's control total.

Statement of Financial Position – Summary Points

Indicator	Comment	
NHSI Financial Rating	Four of the five KPIs are green year to date; this is due to the variance from control total in month which flags as amber. The forecast outturn overall is green as it is being forecast in line with plan.	
Cash	Variance/movement	Cash variance vs plan YTD (£m)
	EBITDA – lower than plan	(0.9)
	Interest – higher than plan	0.3
	Inventories – higher than plan	(0.3)

	Trade and other Receivables – higher than plan	(16.8)
	Trade and Other Payables - higher than plan	15.8
	Provisions – higher than plan	0.2
	Other liabilities – lower than plan	(2.4)
	Capital expenditure – lower than plan	9.3
	PDC received – higher than plan	1.0
	Cash variance to plan	6.2
NHS Debtor Days	NHS Debtor days in month was 10 days which remains within target. This is because the majority of the Trust's NHS invoices by value relate to contractual monthly SLA payments which are settled on the 15th of each month.	
IPP Debtor Days	IPP debtor days increased from 232 to 243 days due to increases to the aged debt from embassies. This is in spite of increased payments in month.	
Creditor Days	Creditor days increased in month from 28 to 30 days but is still in line with plan.	
Inventory Days	Drug inventory days decreased in month from 7 to 6 days. Non-Drug inventory days increased in month from 71 to 79 days.	
Action required from the meeting		
<ul style="list-style-type: none"> To note the Month 11 Financial Position 		
Contribution to the delivery of NHS / Trust strategies and plans		
The delivery of the financial plan is a key strategic objective to ensure we have sufficient funding to meet the needs of our delivery of care.		
Financial implications		
The Trust has achieved its control total in Q1, Q2 and Q3 leading to the receipt of £4.9m of PSF funding to date. Missing the Control Total would result in the loss of the PSF which is back ended to the remainder of the financial year. £2.7m of PSF funding remains to be delivered in the final quarter of the financial year 2018/19 without which, the Trust will struggle to achieve financial balance.		
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.		

Finance and Workforce Performance Report Month 11 2018/19

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Trust Performance Summary for the 11 months ending 28 Feb 2019

KEY PERFORMANCE DASHBOARD

FINANCIAL PERFORMANCE

	In month			Year to date			Full Year Forecast	
	Plan	Actual	RAG	Plan	Actual	RAG	Fcst	RAG
INCOME <small>incl. passthrough</small>	£37.7m	£40.1m	●	£430.5m	£437.8m	●	£477.8m	●
PAY	£21.9m	£23.0m	●	£240.1m	£244.4m	●	£266.4m	●
NON-PAY <small>incl. passthrough</small>	£14.3m	£15.9m	●	£163.4m	£167.3m	●	£182.5m	●
CONTROL TOTAL	£0.0m	(£0.2m)	●	£11.7m	£11.0m	●	£12.1m	●

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

AREAS OF NOTE:

As at the end of Month 11, the Trust position is £0.7m adverse to the planned control total; this includes the release of £3.1m of contingency. The Trust has entered into a block agreement with NHSE for 2018/19 and the YTD position reflects this settlement as well as the CCG income which remains above plan. YTD Pay costs are £4.3m adverse to plan due to the £2.9m A/C pay award and research costs driven by greater activity within R&I. Non-pay is £3.8m adverse to plan which reflects the increased impairment of receivables in year and the above plan costs of delivering higher levels of Research activity. Contingency release of £3.1m offsets under delivery of the better value programme.

INCOME BREAKDOWN RELATED TO ACTIVITY

Income breakdown Year to Date	Plan (£m)	Actual (£m)	Var (£m)	RAG
NHS & Other Clinical Revenue	£256.3m	£261.0m	£4.7m	●
Pass Through	£58.2m	£57.1m	(£1.1m)	
Private Patient Revenue	£58.0m	£56.9m	(£1.0m)	●
Non-Clinical Revenue	£58.1m	£62.8m	£4.7m	●
Total Operating Revenue	£430.5m	£437.8m	£7.3m	●

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

AREAS OF NOTE:

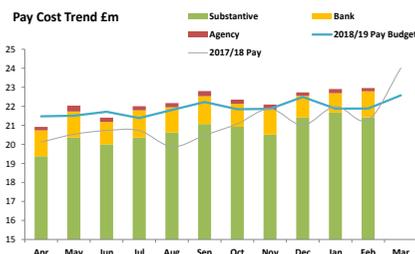
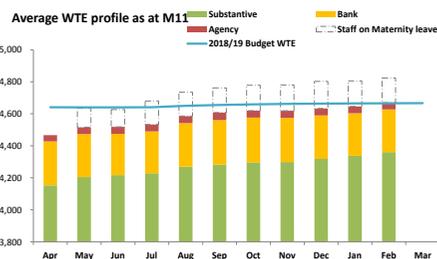
Operating revenue remains favourable to plan YTD (£7.3m). The Trust has entered into a block contract with NHSE for 2018/19, this is represented in the YTD NHS & Other Clinical Income. YTD non-clinical income is £4.7m ahead of plan which is driven by the £2.5m A/C pay review income and over performance of research income YTD of £4.7m. These are offset by the Better Value target that is being partially achieved through clinical income. IPP income is on plan in month which is an improvement on the prior months, this has resulted in a YTD adverse position to plan (£1.0m).

PEOPLE

	M11 Plan Av. WTE	M11 Actual Av. WTE	Variance
PERMANENT	4,616.5	4,356.0	260.5
BANK	42.4	266.8	(224.4)
AGENCY	8.1	41.9	(33.8)
TOTAL	4,667.0	4,664.7	2.3

AREAS OF NOTE:

The pay costs have risen throughout the year due to the increased A/C award and incremental progression of staff combined with increased service provision linked to the Cardiac business case, Genetics service transfer and increased Research activity. Vacancies in the permanent workforce are being covered by a combination of bank and agency staff. The calculation excludes 154.1 contractual WTE's on maternity leave within the Trust. The Trust agency spend is £3.1m below the agency ceiling.



CASH, CAPITAL AND OTHER KPIS

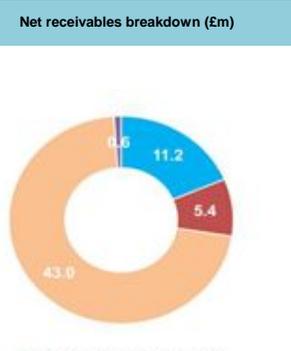
Key metrics	Plan	Actual
Cash	£40.8m	£47.0m
IPP Debtor days	120	243
Creditor days	30	30
NHS Debtor days	30	11

Capital Programme	YTD Plan M11	YTD Actual M11	Full Year Fcst
Total Trust-funded	£25.3m	£17.5m	£20.2m
Total Donated	£42.3m	£31.0m	£33.0m
Grand Total	£67.6m	£48.5m	£53.2m

NHSI metrics	Plan M11	Actual M11
CAPITAL SERVICE COVER	1	1
LIQUIDITY	1	1
I&E MARGIN	1	1
VAR. FROM CONTROL TOTAL		2
AGENCY		1
TOTAL		1

AREAS OF NOTE:

- Cash held by the Trust is higher than plan by £6.2m.
- The capital programme is £19.1m behind plan (£7.8m Trust funded and £11.3m donated) due to slippage on a number of IT and Estates projects.
- The forecast capital expenditure outturn is reviewed and updated monthly on a scheme by scheme basis. The forecast outturn for trust-funded capital expenditure is £7.8m lower than plan. The two most significant projects contributing to this are the Medical Equipment Decontamination Unit (MEDU) and Children's Cancer Centre. Charity-funded expenditure outturn is forecast at £12.0m lower than plan. The two most significant projects contributing to this are the Sight and Sound Hospital and Southwood Courtyard developments.
- NHSI metrics are on plan.



Trust Income and Expenditure Performance Summary for the 11 months ending 28 Feb 2019

Annual Budget	Income & Expenditure	2018/19								Notes	2017/18			CY vs PY		
		Month 11				Year to Date					YTD Actual	Variance		YTD Variance	Variance	
		Budget	Actual	Variance	Rating	Budget	Actual	Variance	Rating			(£m)	(£m)		%	(£m)
(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%	(£m)	(£m)	%		
279.92	NHS & Other Clinical Revenue	22.01	22.31	0.30	1.36%	256.29	260.98	4.69	1.83%	G	1	253.20	7.78	3.07%		
63.49	Pass Through	5.02	5.47	0.45	8.96%	58.22	57.11	(1.11)	(1.91%)	R	2	60.20	(3.09)	(5.13%)		
63.55	Private Patient Revenue	5.27	5.25	(0.02)	(0.38%)	57.96	56.94	(1.02)	(1.76%)	R	3	52.00	4.94	9.50%		
63.60	Non-Clinical Revenue	5.35	7.06	1.71	31.96%	58.06	62.79	4.73	8.15%	G	3	53.90	8.89	16.49%		
470.56	Total Operating Revenue	37.65	40.09	2.44	6.48%	430.53	437.82	7.29	1.69%	G		419.30	18.52	4.42%		
(260.28)	Permanent Staff	(21.69)	(21.42)	0.27	1.24%	(237.90)	(227.76)	10.14	4.26%	G		(210.30)	(17.46)	(8.30%)		
(0.50)	Agency Staff	(0.04)	(0.17)	(0.13)	(325.00%)	(0.46)	(2.48)	(2.02)	(439.13%)	R		(4.10)	1.62	39.51%		
(1.87)	Bank Staff	(0.16)	(1.37)	(1.21)	(756.25%)	(1.71)	(14.17)	(12.46)	(728.65%)	R		(15.30)		0%		
(262.65)	Total Employee Expenses	(21.89)	(22.96)	(1.07)	(4.89%)	(240.07)	(244.41)	(4.34)	(1.81%)	R	4	(229.70)	(14.71)	(6.40%)		
(13.48)	Drugs and Blood	(1.09)	(0.97)	0.12	11.01%	(12.35)	(11.27)	1.08	8.74%	G		(12.10)	0.83	6.86%		
(41.45)	Other Clinical Supplies	(3.26)	(3.60)	(0.34)	(10.43%)	(38.16)	(39.29)	(1.13)	(2.96%)	R		(39.60)	0.31	0.78%		
(60.62)	Other Expenses	(4.88)	(5.87)	(0.99)	(20.29%)	(54.68)	(59.58)	(4.90)	(8.96%)	R		(55.40)	(4.18)	(7.55%)		
(63.49)	Pass Through	(5.02)	(5.47)	(0.45)	(8.96%)	(58.22)	(57.11)	1.11	1.91%	R		(59.50)	2.39	4.02%		
(179.04)	Total Non-Pay Expenses	(14.25)	(15.91)	(1.66)	(11.65%)	(163.41)	(167.25)	(3.84)	(2.35%)	R	5	(166.60)	(0.65)	(0.39%)		
(441.69)	Total Expenses	(36.14)	(38.87)	(2.73)	(7.55%)	(403.48)	(411.66)	(8.18)	(2.03%)	R		(396.30)	(15.36)	(3.88%)		
28.87	EBITDA (exc Capital Donations)	1.51	1.22	(0.29)	(19.21%)	27.05	26.16	(0.89)	(3.29%)	R		23.00	3.16	13.74%		
(16.79)	Owned depreciation, Interest and PDC	(1.47)	(1.44)	0.02	1.50%	(15.33)	(15.18)	0.14	0.93%	G	7	(18.40)	3.22	17.48%		
12.08	Control total	0.04	(0.22)	(0.27)	(595.56%)	11.72	10.98	(0.75)	(6.37%)	R		4.60	6.38	138.63%		
(11.60)	Donated depreciation	(1.04)	(0.98)	0.06	5.60%	(10.56)	(10.34)	0.2	2.15%	G		(4.40)	(5.94)	(134.93%)		
0.48	Net (Deficit)/Surplus (exc Cap. Don. & Impairments)	(0.99)	(1.20)	(0.21)	(21.21%)	1.16	0.64	(0.52)	(44.83%)	R		0.20	0.44	220.00%		
(2.52)	Impairments	0.00	0.00	0.00	0.00%	0.00	0.00	0.00	0.00%	G		0.00	0.00	0%		
44.97	Capital Donations	2.32	0.87	(1.45)	(62.50%)	42.28	31.00	(11.28)	(26.68%)	R	6	22.20	8.80	39.64%		
42.93	Adjusted Net Result	1.33	(0.33)	(1.66)	(124.81%)	43.44	31.64	(11.80)	(27.16%)	R		22.40	9.24	41.25%		

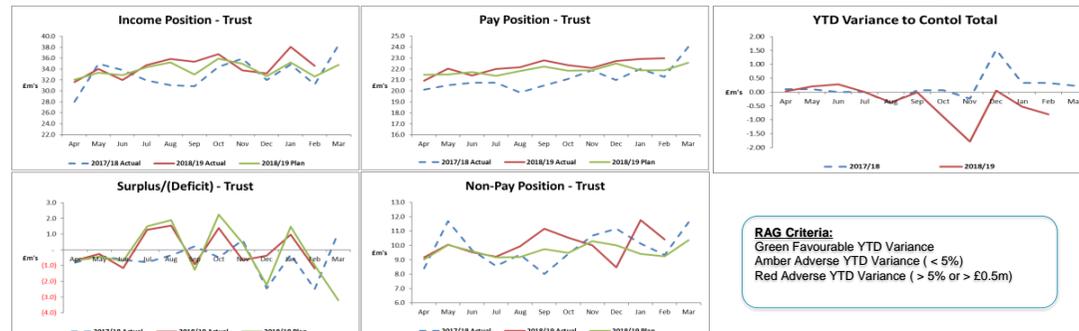
Summary

- In month the Trust is reporting an adverse position to the control total (£0.3m). Private patient income in month was on plan but the YTD position remains adverse (£1.0m). Income remains ahead of plan due to agenda for change funding, Research income and the Settlement of the NHSE contract on a block. YTD income and the release of the contingency (£3.1m) is partially offsetting under delivery within the Better Value Program.

Notes

- NHS & other clinical revenue (excluding pass through) is favourable to plan by £4.7m YTD. This is driven by overperformance on CCG activity and additional income for the provision Genomics and CAR-T that was not budgeted for in 2018/19.
- Private Patient income remains £1.0m adverse to plan YTD; closure of beds over the last few months due to nursing vacancies availability of ICU beds reducing referral acceptance leading to further reductions in activity.
- Non-clinical income is £4.7m favourable YTD which includes £2.5m of income for the AfC pay award, increased research and development grants and achievement of R&D milestones above plan.
- YTD pay is adverse to plan by £4.3m due to the additional cost of the AfC pay award of £2.9m, staffing costs of delivering increased Research activity and spend associated with increased bank cover in M11.
- Non pay (excluding pass through) is £5.0m adverse to plan YTD largely due to increased impairments of receivables for IPP income and the costs associated with increased Research grant income.
- Income from capital donations is £11.3m less than plan due to slippage on a number of donated projects. These include in particular the Cardiac Cath Lab as the project start date has been delayed to coincide with the replacement of MRI number 4.

Plan Annual	Directorates	2018/19								Rating
		Month				Year to Date				
		Budget (£m)	Actual (£m)	Var (£m)	Var %	Budget (£m)	Actual (£m)	Var (£m)	Var %	
15.04	Blood Cells & Cancer	1.04	0.90	(0.14)	(13.46%)	13.77	13.38	(0.39)	(2.83%)	A
22.41	Body Bones & Mind	1.67	0.67	(1.00)	(59.88%)	20.50	15.42	(5.08)	(24.78%)	R
19.86	Brain	1.45	1.90	0.45	31.03%	18.19	19.81	1.62	8.91%	G
54.38	Heart & Lung	3.96	3.49	(0.47)	(11.87%)	49.70	46.64	(3.06)	(6.16%)	R
(18.71)	Medicines Therapies & Tests	(1.64)	(1.37)	0.27	16.46%	(17.18)	(16.36)	0.82	4.77%	G
(30.12)	Operations & Images	(2.49)	(2.21)	0.28	11.24%	(27.63)	(27.13)	0.50	1.81%	G
10.23	Sight & Sound	0.73	1.08	0.35	47.95%	9.35	10.30	0.95	10.16%	G
24.88	International Private Patients	1.99	1.41	(0.58)	(29.15%)	22.70	19.08	(3.62)	(15.95%)	R
1.87	Research And Innovation	0.13	0.24	0.11	84.62%	1.65	3.03	1.38	83.64%	G
(87.76)	Corporate/Other	(6.80)	(6.33)	0.47	6.91%	(79.33)	(73.19)	6.14	7.74%	G
12.08	Control total	0.04	(0.22)	(0.26)	(650.00%)	11.72	10.98	(0.74)	(6.31%)	R



Trust Income and Expenditure Forecast Outturn Summary for the 11 months ending 28 Feb 2019

Full Year Actual 2017/18 (£m)	28 Feb 2019		Internal Forecast				Rating Forecast Variance to plan
	Income & Expenditure	Annual Budget	Full-Yr	Variance to Plan			
				(£m)	(£m)	(£m)	
280.64	NHS & Other Clinical Revenue	279.92	285.75	5.83	2.04%	G	
64.33	Pass Through	63.49	61.67	(1.82)	(2.95%)		
57.26	Private Patient Revenue	63.55	63.24	(0.31)	(0.49%)	A	
59.65	Non-Clinical Revenue	63.60	67.13	3.53	5.26%	G	
461.88	Total Operating Revenue	470.56	477.79	7.23	1.51%		
(231.99)	Permanent Staff	(260.28)	(248.11)	12.17	(4.91%)		
(4.38)	Agency Staff	(0.50)	(2.84)	(2.34)	82.39%		
(17.34)	Bank Staff	(1.87)	(15.40)	(13.53)	87.86%		
(253.71)	Total Employee Expenses	(262.65)	(266.35)	(3.70)	1.39%	R	
(12.37)	Drugs and Blood	(13.48)	(13.08)	0.40	(3.03%)	G	
(43.66)	Other Clinical Supplies	(41.45)	(43.30)	(1.85)	4.28%	R	
(61.97)	Other Expenses	(60.62)	(64.48)	(3.86)	5.98%	R	
(64.33)	Pass Through	(63.49)	(61.67)	1.82	(2.95%)		
(182.33)	Total Non-Pay Expenses	(179.04)	(182.53)	(3.49)	1.91%	R	
(436.04)	Total Expenses	(441.69)	(448.88)	(7.19)	1.60%	R	
25.84	EBITDA (exc Capital Donations)	28.87	28.91	0.04	0.13%	G	
(15.93)	Owned Depreciation, Interest and PDC	(16.79)	(16.83)	(0.04)	0.21%		
9.91	Control total	12.08	12.08	0.00	0.01%	G	
(9.30)	Donated depreciation	(11.60)	(11.60)	0.00	(0.02%)		
0.61	Net (Deficit)/Surplus (exc Cap. Don. & Impairments)	0.48	0.48	0.00	(633.33%)		
(2.81)	Impairments	(2.52)	(5.43)	(2.91)	53.63%		
24.65	Capital Donations	44.97	32.97	(12.00)	(36.40%)		
22.45	Adjusted Net Result	42.93	28.02	(14.91)	(53.22%)		

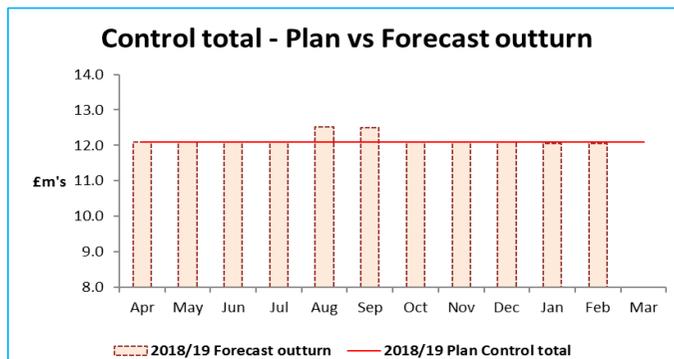
Notes

Summary

- The Trust is forecasting a year end position that breaks even with the Trust control total of a £12.1m surplus.
- A block contract has been agreed with NHSE for 2018/19 and is included in the NHS Clinical income and non clinical income numbers of the forecast.

Notes

- NHS Clinical income is forecast to be £5.8m favourable to plan which is driven by the increased income associated with genomics and other services (e.g. CAR-T) since the start of the year along with over-performance on CCG activity
- Private patient income is forecast to be £0.3m adverse to the plan. Work to ensure Private Patients can access services in line with plans is essential in the final quarter of the year as delivery of the private patient forecast is key to delivering the control total.
- Pay is forecast to be £3.7m adverse to plan by the year end. The adverse variance is due to the additional AfC pay review payments to staff which is offset by income. The increased spend within the final months of the year is related to new starters and additional research income.
- Non-pay is forecast to be £5.3m adverse at the year end excluding pass through. The higher than planned spend reflects increases in the level of impairments for IPP debt and increased costs associated with increased research. A key focus for the Trust will be to ensure the aged debt is paid and thus reduce the provision, reducing non pay costs for the remainder of the year.
- The forecast assumes full achievement of the Provider Sustainability Fund (£7.6m) and the full release of the contingency. The Trust has fully achieved its control total in Q1, Q2 and Q3 and is planning to breakeven at the year end. In order to deliver the control total and achieve the PSF it is important that the Private patient forecast is achieved. If this does not occur then the control total will be missed and PSF will not be achieved further deteriorating the position.



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

2018/19 NHS Income & Activity for the 11 months ending 28 Feb 2019

Summary by Point of Delivery excluding pass through & CQUIN

Point of Delivery	Activity plan	Activity actual	Activity variance	Income plan £000's	Income actual £000's	Income variance £000's	RAG YTD Variance	Ave price per plan	Ave price received	Ave price var %	Price variance £000's	Activity variance £000's
Day Case	19,633	19,523	(110)	£23,131	£24,546	£1,415	G	£1,178	£1,257	6.7%	£1,545	(£130)
Elective	12,893	12,500	(393)	£59,648	£56,455	(£3,193)	R	£4,626	£4,516	(2.4%)	(£1,375)	(£1,818)
Hdu Bed Days	3,170	3,192	22	£2,335	£3,111	£776	G	£737	£975	32.3%	£760	£16
Highly Specialised Services	17,098	15,734	(1,364)	£27,803	£26,974	(£829)	R	£1,626	£1,714	5.4%	£1,389	(£2,218)
Inpatient excess bed days	7,845	5,669	(2,176)	£4,502	£3,236	(£1,266)	R	£574	£571	(0.5%)	(£17)	(£1,249)
ITU Bed Days	10,434	9,229	(1,205)	£30,340	£28,914	(£1,426)	R	£2,908	£3,133	7.7%	£2,078	(£3,504)
Non Nhs Clinical Income	1,543	2,012	469	£4,027	£3,706	(£321)	A	£2,610	£1,842	(29.4%)	(£1,545)	£1,224
Non-Elective	1,495	1,616	121	£16,486	£19,169	£2,683	G	£11,027	£11,862	7.6%	£1,349	£1,334
Other Nhs Clinical	58,324	58,846	522	£46,618	£52,202	£5,584	G	£799	£887	11.0%	£5,167	£417
Outpatients	148,487	152,327	3,840	£37,329	£38,561	£1,232	G	£251	£253	0.8%	£268	£964
Total	280,922	280,648	(274)	£252,219	£256,874	£4,655	G				£4,901	(£246)

Summary

Income is favourable against plan due to changes in respect of the national genomics contract and the overperformance on CCG commissioned income. The adverse activity variance is partially due reduced elective activity including critical care within the organisation partially driven by beds and increased complexity.

The key activity year to date variances are summarised below:-

Elective is 393 adverse to plan excluding excess bed days and this is due to the under-performance within paediatric surgery, urology and paediatric trauma & orthopaedics where additional assumed planned activity for business cases is not being delivered along with an under-performance for nephrology inpatient admissions.

ITU bed days (PICU, CICU & NICU) has an adverse variance of 1,205 year to date. This is due to reduced levels for PICU & CICU as some beds remain unoccupied across the Trust.

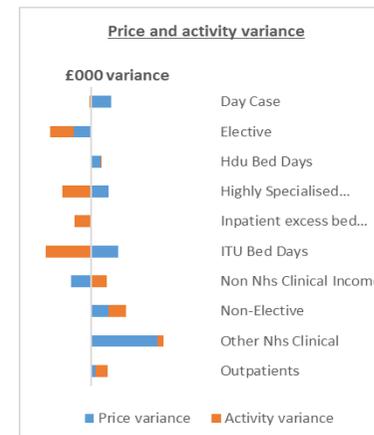
Highly specialised services contain a mix of low volume, high cost and high volume, low cost services and this can cause volatility in the activity variances from month to month. The year to date activity variance is largely the result of ECMO being below plan.

Non-elective activity is overperforming due to increases in paediatric surgery, nephrology, neurology and neurosurgery.

Other NHS clinical income Includes:-

- Additional funding for delivery cystic fibrosis second line screening £73k
- Genetics funding driving the price variance
- Prior year benefit of £184k between year end and final activity values

Outpatients activity is favourable driven by increased radiology attendance from July.



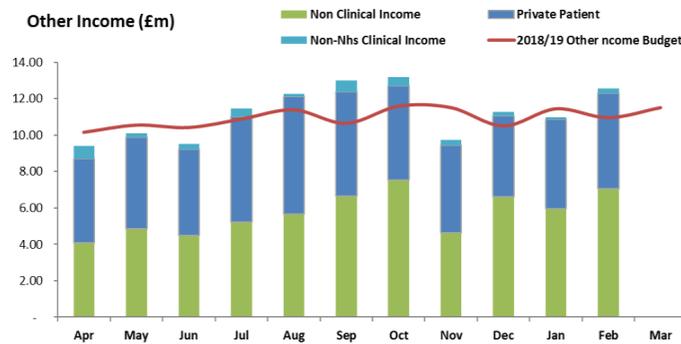
RAG Criteria:

Green Favourable Variance to plan
Amber Adverse Variance to plan (< 5%)
Red Adverse Variance to plan (> 5% or > £0.5m)

2018/19 Other Income for the 11 months ending 28 Feb 2019

Other Income Summary

	Annual plan £000's	Current month			Year to date			RAG	YTD Variance
		Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's		
Private Patient	£63,545	£5,265	£5,252	(£13)	£57,955	£56,936	(£1,019)	R	
Non NHS Clinical Income	£4,396	£346	£242	(£104)	£4,028	£3,777	(£251)	A	
Non-NHS Clinical Income	£67,941	£5,611	£5,494	(£117)	£61,983	£60,713	(£1,270)	R	
Education & Training	£8,676	£723	£1,510	£787	£7,953	£8,373	£420	G	
Research & Development	£22,530	£1,781	£2,585	£804	£20,660	£25,319	£4,659	G	
Non-Patient Services	£771	£61	£56	(£5)	£707	£703	(£4)	G	
Commercial	£1,603	£127	£118	(£9)	£1,470	£1,374	(£96)	A	
Charitable Contributions	£6,248	£494	£600	£106	£5,729	£6,982	£1,253	G	
Other Non-Clinical	£23,769	£2,163	£2,191	£28	£21,539	£20,035	(£1,504)	R	
Non Clinical Income	£63,597	£5,349	£7,060	£1,711	£58,058	£62,786	£4,728	G	



RAG Criteria:

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

Summary

- Private patient income is breakeven in month but remains £1.0m adverse to plan YTD. Revenue within Cardiac Surgery, Neurology, ENT and PICU is above plan offset by lower activity within Gastroenterology, Cancer, Cardiac and Respiratory.
- Research income is above plan in-month (£0.8m) and YTD (£4.7m). The in month position is due to the release of Capacity Building income and additional BRC allocations. The YTD position is being driven by increased grants and additional income linked to the achievement of milestones above plan.
- Education & Training income is £0.5m favourable to plan YTD driven by the recognition of the Q5 LDA financials.
- Other Non-Clinical income is broadly on plan in month. Within the YTD position is the income to fund the AfC pay award, of which £2.5m has been received YTD; this is not budgeted for (in line with NHSI guidance). However this has been offset by the Trust wide income better value targets being included here within the Trust annual plan.

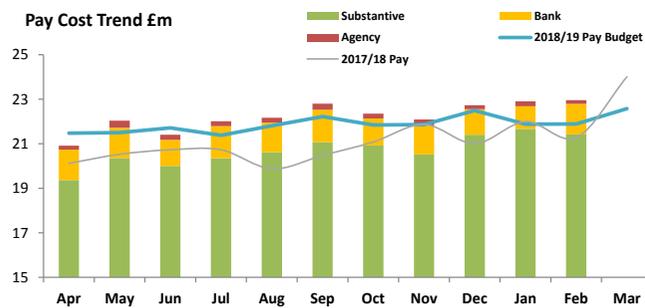
Workforce Summary for the 11 months ending 28 Feb 2019

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

Staff Group	2018/19 plan			2018/19 actual			Variance				RAG
	YTD (£m)	YTD Average WTE	£000 / WTE	YTD (£m)	YTD Average WTE	£000 / WTE	YTD (£m)	Average WTE Vacancies	Volume Var (£m)	Price Var (£m)	
Admin (inc Director & Senior Managers)	45.1	1,135.6	43.3	42.8	1,081.6	43.2	2.3	54.1	2.1	0.2	G
Consultants	48.0	355.9	147.1	46.6	343.1	148.1	1.4	12.8	1.7	(0.3)	G
Estates & Ancillary Staff	3.7	130.5	30.8	3.7	124.6	32.0	0.0	5.9	0.2	(0.1)	G
Healthcare Assist & Supp	8.9	315.3	30.8	8.1	282.9	31.1	0.8	32.4	0.9	(0.1)	G
Junior Doctors	23.4	355.8	71.8	24.4	338.5	78.5	(0.9)	17.4	1.1	(2.1)	R
Nursing Staff	72.8	1,622.2	48.9	71.6	1,557.0	50.2	1.2	65.2	2.9	(1.8)	G
Other Staff	0.4	8.7	54.1	0.3	5.3	59.9	0.1	3.4	0.2	(0.0)	G
Scientific Therap Tech	44.2	919.0	52.4	43.6	889.9	53.4	0.6	29.1	1.4	(0.8)	G
Total substantive and bank staff costs	246.5	4,843.1	55.5	241.0	4,622.8	56.9	5.5	220.3	11.2	(5.7)	G
Agency	0.5	8.1	61.3	2.5	41.9	64.5	(2.0)	(33.8)	(1.7)	(0.3)	R
Total substantive, bank and agency cost	246.9	4,851.2	55.5	243.4	4,664.7	56.9	3.5	186.5	9.5	(6.0)	G
Reserve*	(6.8)	(184.2)	0.0	1.0	0.0	0.0	(7.8)	(184.2)	(9.4)	1.6	R
Total pay cost	240.1	4,667.0	56.1	244.4	4,664.7	57.2	(4.3)	2.3	0.1	(4.4)	R
Remove Maternity leave cost				(2.9)			2.9			2.9	G
Total excluding Maternity Costs	240.1	4,667.0	56.1	241.5	4,664.7	56.5	(1.4)	2.3	0.1	(1.5)	R

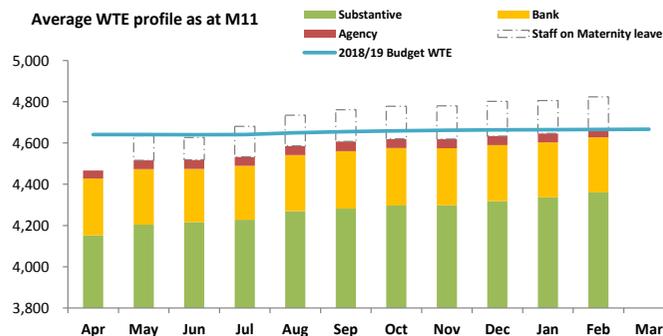
*Plan reserve includes WTEs relating to the better value programme

Pay Cost Trend £m



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

Average WTE profile as at M11



Summary

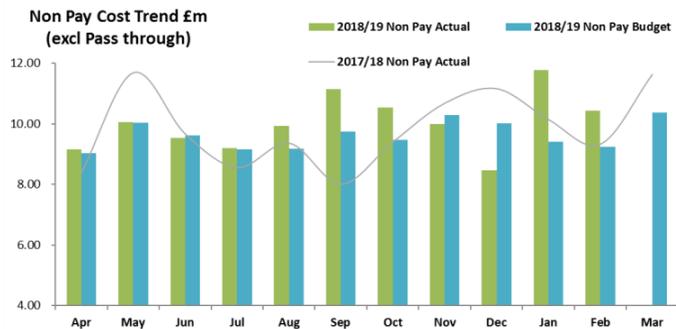
- YTD actual pay spend is £244.4m which is £4.3m adverse to plan. A key contributor to this overspend is the additional pay in relation to the AfC Pay Award (£2.9m); funding of £2.5m has been provided for but is captured within Non-Clinical Revenue. The value of funding to GOSH has been reduced following an increase in the clawback value by the DoH for staff working on Private Patients (£0.4m).
- The table above does not include 154.1 contractual WTE for staff on maternity leave which cost £2.9m YTD. If this cost is excluded then the average cost per WTE is higher than plan by £0.4k per WTE.
- Substantive and bank staff YTD costs are £5.5m below plan, due to vacancies which can be seen by the £11.0m volume variance. These vacancies are being partially offset by the increased cost of staff (partially offset by AfC funding) and the £2.5m agency spend predominantly within PICU & Pharmacy.
- The reserve line contains the unallocated pay better value target which is offsetting the underspend within pay.
- We are not expecting to breach the agency ceiling set by NHSI and the Trust is currently below the YTD agency ceiling.

Non-Pay Summary for the 11 months ending 28 Feb 2019

Non-Pay Costs (excl Pass through) YTD				
	Budget (£m)	Actual (£m)	Variance	RAG YTD Actual variance
Drugs Costs	10.43	9.38	1.05	G
Blood Costs	1.92	1.89	0.02	G
Business Rates	3.63	3.58	0.05	G
Clinical Negligence	6.49	6.49	0.00	G
Supplies & Services - Clinical	38.16	39.29	(1.14)	R
Supplies & Services - General	3.43	4.70	(1.26)	R
Premises Costs	30.39	30.08	0.31	G
Other Non Pay	10.73	14.72	(3.99)	R
Total Non-Pay costs	105.18	110.14	(4.96)	R
Depreciation	19.08	18.76	0.32	G
PDC Dividend Payable	6.89	7.13	(0.24)	A
Total	131.15	136.03	(4.89)	R

Top 5 YTD Clinical* Non Pay overspends by Speciality (£m)				
	YTD 2018/19 Budget (£k)	YTD 2018/19 Actual (£k)	Variance (£k)	Trend
Genetics	2,721	3,491	(770)	↕
Nephrology	2,595	3,350	(756)	↕
Cardiac Critical Care	1,593	2,227	(634)	↕
Bone Marrow Transplant	2,408	2,791	(383)	↕
Wards (Exc. Haem/Onc)	947	1,113	(167)	↕

Top 5 YTD Clinical* Non Pay underspends by Speciality (£m)				
	YTD 2018/19 Budget (£k)	YTD 2018/19 Actual (£k)	Variance (£k)	Trend
Cardiac Serv	4,669	3,659	1,010	↕
Theatre	8,151	7,643	508	↕
Neuromuscular	896	448	448	↕
Snaps	775	489	287	↕
Critical Care Barrie	3,344	3,116	227	↕



*Clinical non-pay excludes passthrough

Summary

- YTD non-pay excluding pass through is adverse to plan by £4.9m. A key driver is the YTD increase in the impairment of receivables of £3.2m. This is driven by the delayed payment of private patient income and this drives the Other Non Pay variance.
- The increase in the impairment of receivables was partially offset by the continued underspend in premises associated with reductions in software maintenance contracts and below plan drugs costs linked to activity. Supplies & Services General continues to be overspent due to increased catering costs (£0.4m) and unachieved better value.

Top 5 clinical over/under spends

The key areas with Non-pay overspends are:

- **Genetics** - higher than plan Next Generation Sequencing and lab consumables linked to increased activity due to the transfer of activity from London NW Hospitals
- **Nephrology** – The overspend relates to Drugs costs and Blood costs which correlates to the over performance in NHS Clinical Income.
- **Cardiac Critical care** - This overspend is driven by ECMO related expenditure for high value patient activity
- **Bone Marrow Transplant** - Driven by spend on blood and in line with over-performance on activity versus plan.
- **Wards (Exc. Haem/Onc)** - Driven by spend on Ward drugs in line with activity.

The key areas of Non-pay underspends are:

- **Cardiac Service** - underspent due to delays in opening of Alligator Ward.
- **Theatre** - underspend due to lower activity against plan.
- **Neuromuscular** - continues to underspend on splints, braces and drugs.
- **SNAPS** - consumables underspend due to lower activity.
- **Critical Care (PICU/NICU)** - underspends due to NHS activity volume shortfall against plan driven by low referrals.

RAG Criteria:

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

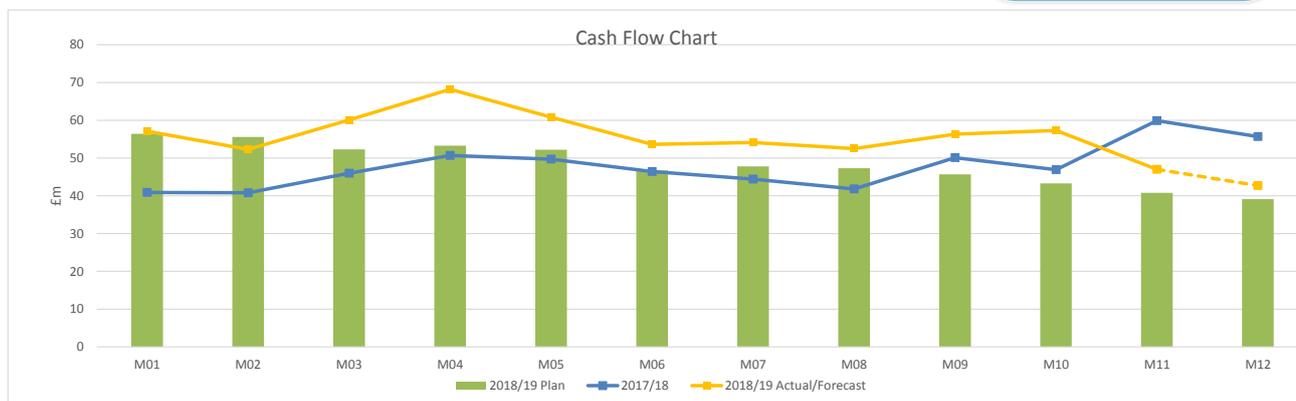
Cash, Capital and Statement of Financial Position Summary for the 11 months ending 28 Feb 2019

31 Mar 2018 Audited Accounts £m	Statement of Financial Position	28 Feb 2019 Plan £m	YTD Actual 28 Feb 2019 £m	YTD Variance £m	Forecast Outturn 31 Mar 2019 £m	YTD Actual 31 Jan 2019 £m	In month Movement £m
463.29	Non-Current Assets	511.39	492.81	(18.58)	499.52	487.32	5.49
85.92	Current Assets (exc Cash)	88.90	106.04	17.14	84.18	102.94	3.10
55.69	Cash & Cash Equivalents	40.76	47.00	6.24	55.76	57.29	(10.29)
(69.95)	Current Liabilities	(63.24)	(78.73)	(15.49)	(66.20)	(80.08)	1.35
(5.51)	Non-Current Liabilities	(4.93)	(5.04)	(0.11)	(4.88)	(5.08)	0.04
529.44	Total Assets Employed	572.88	562.08	(10.80)	568.38	562.39	(0.31)

31 Mar 2018 Audited Accounts £m	Capital Expenditure	28 Feb 2019 Plan £m	YTD Actual 28 Feb 2019 £m	YTD Variance £m	Forecast Outturn 31 Mar 2019 £m	RAG YTD variance
5.81	Redevelopment - Donated	21.12	9.65	11.47	10.88	R
9.06	Medical Equipment - Donated	5.04	7.07	(2.03)	8.40	R
9.78	ICT - Donated	16.00	14.28	1.72	14.28	A
24.65	Total Donated	42.16	31.00	11.16	33.56	A
6.99	Redevelopment & equipment - Trust Funded	8.81	3.92	4.89	4.49	R
1.61	Estates & Facilities - Trust Funded	3.04	1.81	1.23	2.02	R
4.73	ICT - Trust Funded	11.97	11.74	0.23	13.72	G
13.33	Total Trust Funded	23.82	17.47	6.35	20.23	A
37.98	Total Expenditure	65.98	48.47	17.51	53.79	A

31-Mar-18	Working Capital	31-Jan-19	28-Feb-19	RAG	KPI
19.00	NHS Debtor Days (YTD)	8.0	11.0	G	< 30.0
189.00	IPP Debtor Days	232.0	243.0	R	< 120.0
27.70	IPP Overdue Debt (£m)	30.8	34.8	R	0.0
5.00	Inventory Days - Drugs	7.0	6.0	G	7.0
70.00	Inventory Days - Non Drugs	71.0	79.0	R	30.0
35.00	Creditor Days	28.0	30.0	A	< 30.0
43.3%	BPPC - NHS (YTD) (number)	43.4%	43.5%	R	> 95.0%
70.3%	BPPC - NHS (YTD) (£)	82.0%	82.4%	R	> 95.0%
85.0%	BPPC - Non-NHS (YTD) (number)	85.1%	85.1%	A	> 95.0%
89.3%	BPPC - Non-NHS (YTD) (£)	90.3%	90.8%	A	> 95.0%

RAG Criteria:
 NHS Debtor and Creditor Days: Green (under 30); Amber (30-40); Red (over 40)
 BPPC Number and £: Green (over 95%); Amber (95-90%); Red (under 90%)
 IPP debtor days: Green (under 120 days); Amber (120-150 days); Red (over 150 days)
 Inventory days: Green (under 21 days); Amber (22-30 days); Red (over 30 days)



Comments:

- The capital programme is £19.1m behind plan (£7.8m Trust funded and £11.3m donated). The following Trust funded programmes have slipped against plan); MEDU (£2.4m); various estates projects (£1.2m); Children’s Cancer Centre (£1.3m); Camelia Botnar Lift (£0.6m).
- Cash held by the Trust is higher than plan by £6.2m. The variance was largely as a result of lower than planned expenditure on Trust funded capital projects (£4.2m).
- Total Assets employed at M11 was £10.8m lower than plan as a result of the following:
 - Non current assets totalled £492.8m (£18.6m less than plan largely as a result of the slippage on Redevelopment and Estates);
 - Current assets excluding cash less Current liabilities totalled £27.3m (£1.6m higher than plan).
 - Cash held by the Trust totalled £47.0m (£6.2m higher than plan)
 - Non current liabilities totalled £5.0m (£0.1m higher than plan)
- Overdue IPP debt increased in month to £34.8m (£30.8m in M10). This increase is as a result of lower than average receipts in month (£2.0m).
- IPP debtor days increased from 232 days to 243 days.
- The cumulative BPPC for NHS invoices (by value) slightly improved by in month to 82.4% (82.0% in M10). This represented 43.5% of the number of invoices settled within 30 days (43.4% in M10)
- The cumulative BPPC for Non NHS invoices (by value) slightly improved in month to 90.8% (90.3% in M10). This represented 85.1% of the number of invoices settled within 30 days (85.1% in M10).
- Creditor days increased in month to 30 days.

TRUST BOARD	
NHS Staff Survey 2018 Results Submitted by: Caroline Anderson, Director of HR and OD	Paper No: Attachment O
Aims / summary To update Trust Board with results of the 2018 NHS Staff Survey, and provide initial indication of planned actions	
Action required from the meeting To note the results and proposed actions	
Contribution to the delivery of NHS / Trust strategies and plans The results provide evidence of areas for development in staff experience, allowing improvement plans to be developed in a range of themes and issues. CQC and commissioners review our results and action plans.	
Financial implications None	
Legal issues No legal issues	
Who is responsible for implementing the proposals / project and anticipated timescales Executive Management Team, Trust Senior Leadership Teams and HR&OD Directorate	
Who is accountable for the implementation of the proposal / project Director of HR & OD	

NHS Staff Survey 2018 Results

1.0 Introduction

The NHS Staff Survey was carried out from 1st October to 30th November 2018 and results for all trusts were publicly published at the end of February 2019. The purpose of this paper is to provide the Board with a summary of the results and key themes, and initial proposals for actions as a result of the findings.

2.0 Survey Methodology

At GOSH the survey has, since its inception, been undertaken on a sample basis, with 25% of staff invited to take part via a paper survey form. In 2017 536 responses were submitted representing approximately 10% of the total workforce. To maximise the evidence base from the survey, in 2018 all staff were invited to take part and both online and paper surveys were used. This resulted in 2,251 responses being received, representing approximately 50% of the workforce.

3.0 Organisational Context

At the time of the survey a number of significant events had recently taken place which may have influenced feedback provided by staff:

- The Clinical Operations restructure had recently concluded – with new directorate structures launching on 1st October
- The Chief Executive's resignation had been announced, but replacement not yet recruited
- The reduction bank pay rates for some nursing grades was implemented in August 2018

4.0 Results

The survey is made up of 90 questions, with results grouped across 10 themes: Equality, Diversity & Inclusion; Health & Wellbeing; Immediate Managers; Morale; Quality of appraisals; Quality of Care; Safe Environment – Bullying & harassment; Safe Environment – Violence; Safety Culture; and Staff Engagement

Theme Results, Four Year Trend, and theme scores broken down by Directorate and Professional Group are included at Appendix 1. A breakdown of question and theme groupings is included at Appendix 2.

Key headlines from the results:

- GOSH scores are below average across nine out of ten themes compared to other Acute Specialist trusts: Equality, Diversity & Inclusion; Health & Wellbeing; Immediate Managers; Morale; Quality of appraisals; Quality of Care; Safe Environment – Bullying & harassment; Safety Culture; and Staff Engagement
- GOSH results are average amongst comparator group for one theme - Safe Environment – Violence
- Amongst comparator group GOSH is worst performing trust for "Safe Environment – bullying and harassment" and "Safety Culture"
- GOSH is significantly below average for "Health and Well being" and "Morale"
- The trend over the last four years has been a deterioration across all themes – excluding Safe Environment – Violence which has remained consistent

5.0 Action Plan

The key actions associated with addressing survey findings will be incorporated into development of the Integrated People Strategy, summarised below:



The survey results indicate the need to prioritise the Culture & Engagement work stream of the People strategy:

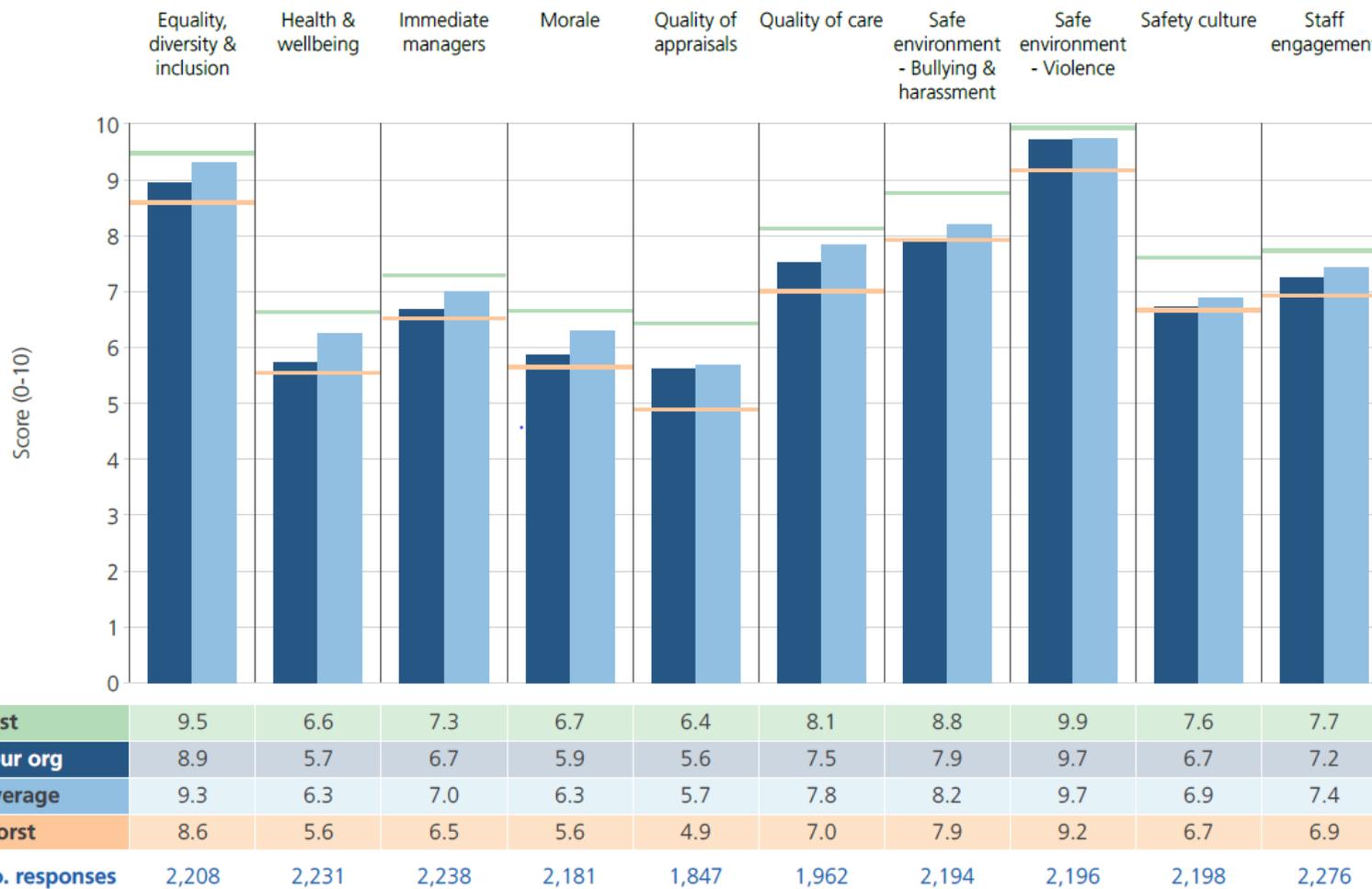


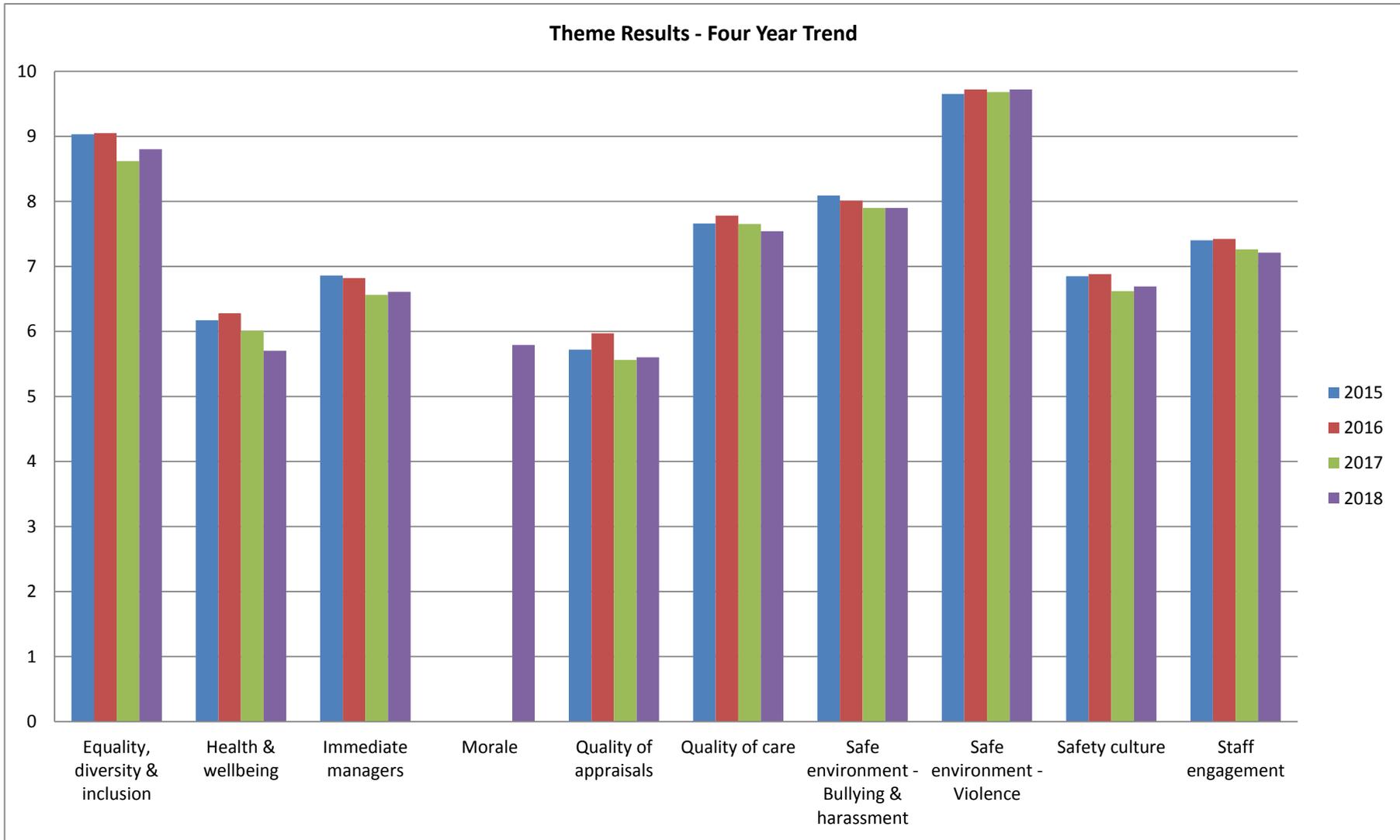
6.0 Next Steps

- Further analysis of the results will be carried out to identify significant outliers (Directorates, Departments, staff groups) at theme and question level, and develop specific actions to address
- Key stakeholders will be engaged in development of Integrated People Strategy

2018 Staff Survey – Theme Results Overview

Appendix 1





*Morale new theme for 2018

2018 Staff Survey – Theme Results by Directorate

	Respondents	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe Environment - Bullying & Harassment	Safe Environment - Violence	Safety Culture	Staff Engagement
Trust	2251	8.9	5.7	6.7	5.9	5.6	7.5	7.9	9.7	6.7	7.3
Blood Cells & Cancer	198	9.1	5.8	6.9	6.1	5.8	7.9	8.1	9.7	7	7.5
Body, Bones & Mind	168	9.1	5.7	6.8	5.9	5.5	7.5	7.3	9.4	6.8	7.4
Brain	117	9.1	5.7	6.8	6.1	5.5	7.3	7.3	9.6	6.8	7.3
Heart & Lung	283	8.5	5.7	6.3	5.8	5.2	7.5	7	9.6	6.7	7
International & Private Patients	103	9.1	6	7.1	5.8	6	7.5	7.6	9.8	6.8	7.2
Medicine, Therapies & Tests	371	9.1	5.6	6.6	6.1	5.6	7.4	8.1	9.9	6.7	7.4
Operations & Images	292	8.6	5.2	5.7	5.4	5.3	7.5	7.4	9.5	6.3	6.8
Sight & Sound	159	8.6	5.7	6.6	5.8	5.6	7.5	7.8	9.7	6.7	7.3
Clinical Operations	157	9.3	6.3	7.1	6.2	6.2	7.2	8.9	10	7	7.5
Development & Property Services	101	8.6	5.9	6.9	5.8	5.9	7.8	8.5	9.6	6.9	7.3
Finance	38	9.1	6.2	6.7	5.1	5.6	6.9	8.8	9.9	6.7	7
HR & OD	64	9.1	6	6.9	5.2	5.8	7.4	9	9.9	6.2	6.9
Medical Director	37	9.3	6.4	7.8	6.2	5.5	6.8	9.8	10	7.2	7.8
Nursing & Patient Experience	98	9.1	6	7.5	6.4	6.2	7.9	8.3	9.9	6.8	7.7
Research & Innovation	65	8.9	6	6.8	5.5	4.9	7.3	8.8	9.9	6.9	7.1

Key: ■ Highest (Best) score in Theme ■ Lowest (Worst) Score in Theme

2018 Staff Survey – Theme Results by Professional Group

Group	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe Environment - Bullying & Harassment	Safe Environment - Violence	Safety Culture	Staff Engagement
Trust	8.9	5.7	6.7	5.9	5.6	7.5	7.9	9.7	6.7	7.3
Allied Health Professionals / Healthcare Scientists / Scientific & Technical	9.2	5.6	6.7	6.1	5.7	7.5	8.2	9.8	6.8	7.4
Medical & Dental	8.5	6.1	6.1	6.4	4.5	7.4	6.9	9.8	6.3	7.3
Nursing & Healthcare Assistants	8.7	6.0	6.6	5.7	5.9	8.2	7.9	9.5	7.2	7.2
Wider Healthcare Team	9.0	5.9	7.0	5.7	5.6	7.5	8.6	9.9	6.7	7.2
General Management	8.9	5.7	6.9	5.8	5.5	7.1	8.4	10.0	7.0	7.6
Maintenance / Ancillary	9.1	6.1	6.9	6.1	6.7	7.7	8.6	9.6	7.0	7.3

Key: ■ Highest (Best) score in Theme ■ Lowest (Worst) Score in Theme

2018 Staff Survey – Question & Theme Groupings

Appendix 2

Theme	Description
Equality, Diversity & inclusion	Organisation acts fairly: career progression
	I have experienced discrimination from patients/service users, their relatives or other members of the public
	I have experienced discrimination from manager/team leader or other colleagues
	Disability: organisation has not made adequate adjustment(s) to enable me to carry out work
Health & wellbeing	Organisation definitely takes positive action on health and well-being
	In last 12 months, I have experienced musculoskeletal (MSK) problems as a result of work activities
	I have felt unwell due to work related stress in last 12 months
	In last 3 months, I have come to work when not feeling well enough to perform duties
	Satisfied with opportunities for flexible working patterns
Immediate managers	Supported by manager to receive training, learning or development definitely identified in appraisal
	Satisfied with support from immediate manager
	Immediate manager gives clear feedback on my work
	Immediate manager asks for my opinion before making decisions that affect my work
	Immediate manager takes a positive interest in my health & well-being
	Immediate manager values my work
Morale	I often think about leaving this organisation
	I am likely to look for a job at a new organisation in the next 12 months
	I am planning on leaving this organisation as soon as I find another job.
	Involved in deciding changes that affect work
	I receive the respect I deserve from my colleagues at work
	I have realistic time pressures
	I have a choice in deciding how to do my work
	Relationships at work are unstrained
My immediate manager encourages me at work	
Quality of appraisals	Appraisal/review definitely helped me improve how I do my job
	Clear work objectives definitely agreed during appraisal
	Appraisal/performance review: definitely left feeling work is valued
	Appraisal/performance review: organisational values definitely discussed
Quality of care	Satisfied with quality of care I give to patients/service users
	Feel my role makes a difference to patients/service users
	Able to provide the care I aspire to
Safe Environment - Bullying & Harassment	I have experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public
	I have experienced harassment, bullying or abuse from managers
	I have experienced harassment, bullying or abuse from other colleagues
Safe Environment - Violence	I have experienced physical violence from patients/service users, their relatives or other members of the public
	I have experienced physical violence from managers
	I have experienced physical violence from other colleagues
Safety Culture	Organisation treats staff involved in errors fairly
	Organisation takes action to ensure errors are not repeated
	Staff given feedback about changes made in response to reported errors
	Would feel secure raising concerns about unsafe clinical practice
	Would feel confident that organisation would address concerns about unsafe clinical practice
	Organisation acts on concerns raised by patients/service users
Staff Engagement	Care of patients/service users is organisation's top priority
	Would recommend organisation as place to work
	If friend/relative needed treatment would be happy with standard of care provided by organisation

	Often/always look forward to going to work
	Often/always enthusiastic about my job
	Time often/always passes quickly when I am working
	Opportunities to show initiative frequent in my role
	Able to make suggestions to improve the work of my team/dept
	Able to make improvements happen in my area of work
Equality, Diversity & inclusion	Organisation acts fairly: career progression
	I have experienced discrimination from patients/service users, their relatives or other members of the public
	I have experienced discrimination from manager/team leader or other colleagues
	Disability: organisation has not made adequate adjustment(s) to enable me to carry out work
Health & wellbeing	Organisation definitely takes positive action on health and well-being
	In last 12 months, I have experienced musculoskeletal (MSK) problems as a result of work activities
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	Immediate manager values my work
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	I am likely to look for a job at a new organisation in the next 12 months
	I am planning on leaving this organisation as soon as I find another job.
	Involved in deciding changes that affect work
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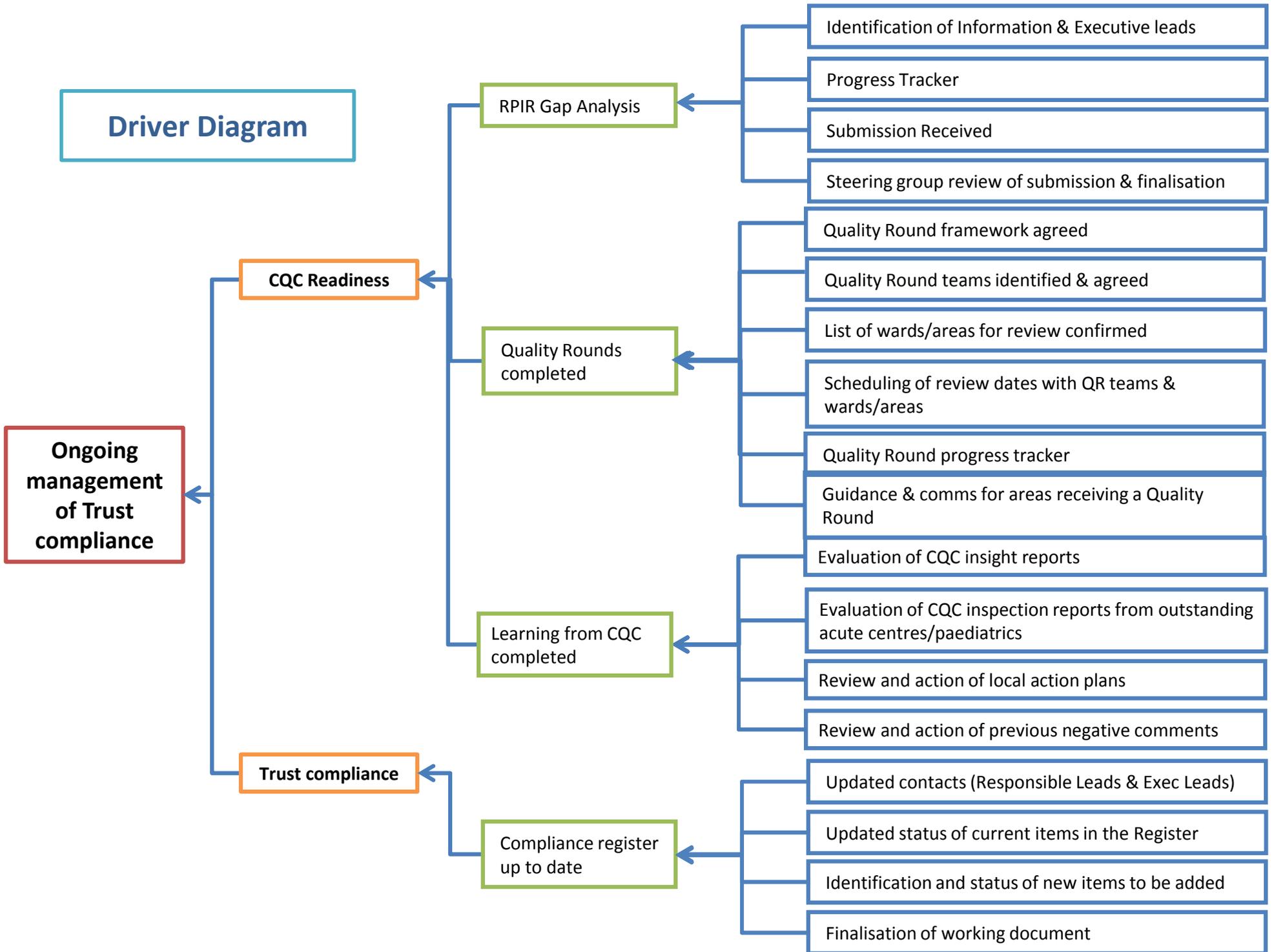
Staff Engagement	Care of patients/service users is organisation's top priority
	Would recommend organisation as place to work
	If friend/relative needed treatment would be happy with standard of care provided by organisation
	Often/always look forward to going to work
	Often/always enthusiastic about my job
	Time often/always passes quickly when I am working
	Opportunities to show initiative frequent in my role
	Able to make suggestions to improve the work of my team/dept
	Able to make improvements happen in my area of work

Attachment P

Trust Board 3rd April 2019	
CQC Readiness Update	Paper No: Attachment P
Submitted by: Salina Parkyn, Head of Quality and Safety	
Aims / summary To provide the Trust Board with an update on the CQC readiness plan.	
Action required from the meeting To support the approach and the ongoing work.	
Contribution to the delivery of NHS Foundation Trust strategies and plans CQC readiness is crucial to the delivery of NHS services and the Trusts' aim to achieve the best possible outcomes through providing the safest most effective and efficient care.	
Who needs to be told about any decision? Head of Quality and Safety, Chiefs of Service, Operational Management team	
Who is responsible for implementing the proposals / project and anticipated timescales? Head of Quality and Safety	
Who is accountable for the implementation of the proposal / project? Medical Director	

CQC Readiness update

March 2019



Routine Provider Information Return (RPIR) Gap Analysis

- The RPIR is sent to an organisation by CQC prior to inspection and provides a provider's view of their own quality, some quantitative and qualitative data and some contextual information around services provided or national data.
- Gap Analysis of GOSH response to be completed by May 2019
- Areas that need improvement to be identified and an improvement plan created.

Quality Rounds

- Handbook for staff devised
- Pilot on Lion Ward and Outpatients
- Online system being reviewed and improved
- Schedule of quality rounds begin May 2019

Learning from CQC

- A number of CQC reports have been published
- General themes of attention include Statutory and Mandatory training, Violence and Aggression by Patients, staffing numbers.
- General areas of good practice include visible leadership, high levels of experience at Board Level.

Well Led Update

- Progress with the GOSH Well Led action plan includes:
 - development of a draft Clinical Strategy (on agenda),
 - Development of a draft Leadership Strategy (on agenda);
 - Revised code of conduct forms for directors and governors
 - Commencement of executive team development programme
 - Progress with development of a stakeholder strategy
 - Programme of regular executive walkrounds established
 - Plans under development in response to the Staff Survey

Manchester University NHS Foundation Trust

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good	Good	Outstanding	Good	Good	Good
Mar 2019	Mar 2019	Mar 2019	Mar 2019	Mar 2019	Mar 2019

Report published on the 19/03/2019
Ratings are from the first inspection of the newly formed trust which was established on the 1 October 2017. Aggregated results have been based on eleven hospital inspections.

MUFT – Received **Good** overall:

Key points: Trust wide for Well-led

- Dedicated to continuous improvement across the Trust.
- High level of experience and capability amongst the board members.
- Board level development programme.
- Clear strategies and plans that are aligned to the wider health economy.
- Clear responsibilities and accountability.

Royal Manchester Children's Hospital

Good & Outstanding:

- Family centred.
- More proactive than reactive.
- Using best practice guidelines.
- Adequate skill mix – foreword clinical planning.
- High mandatory training rates.
- Good medicines management (inc storing medicines).
- Examples of lessons learned with local and wider teams.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Medical care (including older people's care)	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Surgery	Good Mar 2019	Good Mar 2019	Outstanding Mar 2019	Outstanding Mar 2019	Good Mar 2019	Outstanding Mar 2019
Critical care	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Transition services	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
End of life care	Good Mar 2019	Good Mar 2019	Outstanding Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Outpatients	Good Mar 2019	Good Mar 2019	Outstanding Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Overall*	Good Mar 2019	Good Mar 2019	Outstanding Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019

- Open and honest when things go wrong.
- Shared vision and values.
- Managers are accessible and visible.
- Staff felt values.

Moorfields Eye Hospital NHS Foundation Trust

Requiring Improvement:

- Long waiting times & frequent delays in the service.
- Not meeting 18 week RTT targets.

Outstanding:

- Easy access to clear & up to date policies.
- Competent staff
- Frequent MDT.
- Participation in research projects.

Ratings for the whole trust



Report published on the 12/03/2019. Aggregated results have been based on four hospital inspections.

- High patient outcomes.
- Patient centred.
- Sharing lessons learned to wider teams.
- Visible leadership.
- Staff feel valued and managers encouraged development.
- Clear clinical governance structure.

Royal National Orthopaedic Hospital NHS Trust

Good:

- Frequent MDT.
- Seeking out opportunities to improve.
- Patient centred.
- Visible leaders
- Effective meetings that focused on reviewing processes.
- Clear oversight of trust activity through a series of committees and working groups.
- Clear vision and values.

Ratings for the whole trust



Report published on the 22/03/2019. Aggregated results have been based on two hospital inspections.

- Working with outside experts.
- Use of innovation.
-

Requiring Improvement:

- Short staffing
- Issues with patient aggressions and abuse

University Hospitals Bristol NHS Foundation Trust

- Rated as **Requiring Improvement** in Dec 2014
- Improvements needed in safety, responsiveness and leadership.
- Key areas requiring improvement –
 - low staff morale (staff not being listened to)
 - lack of leadership (lack of internal messaging from leadership team to staff)
- Improvements –
 - cultural change (staff experience and patient involvement)
 - Vision & values (Embedded across the Trust)
 - Governance (Clearly assigned roles & responsibilities)
 - Improving safety (lack of processes and increased variation)
- Rated as **Outstanding** in March 2017

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Outstanding	Good	Requires improvement	Outstanding	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Outstanding	Good	Outstanding	Outstanding
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Outstanding	Good	Requires improvement	Outstanding	Outstanding

Compliance Register

- Online Portal has replaced the excel spreadsheet, launch date of 1st April 2019
- Directorates updating their information on the online tool
- Scheduled monitoring of the register by the Corporate Compliance Team
- Develop performance dashboards to Exec Boards

Attachment Q

Trust Board Date 03/04/19	
Safe Nurse Staffing Report for January and February 2019	Paper No: Attachment Q
Submitted by: Alison Robertson, Chief Nurse.	
<p>Aims / summary This report provides the Board with an overview of the Nursing workforce during the month of January and February 2018 and is set out in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing published in 2016 and further supplemented in 2018.</p> <p>It provides assurance that arrangements are in place to safely staff the inpatient wards with the right number of nurses with the right skills and at the right time.</p>	
<p>Action required from the meeting To note the information in this report on safe staffing including:</p> <ol style="list-style-type: none"> 1. The assurance of the safe staffing levels on the inpatient wards for January and February. 2. The high number of leavers from the Heart and Lung directorate since November 2018 (62.5 FTE). 3. The decrease in patient acuity recording Ward Intensive Care over January and February, from 57.2% in November 18 to 42.8% in February. . 4. The detailed retention plan to be submitted to NHSI on 22nd March 2019 with the aim to reduce turnover by 1% (appendix one). 5. The ongoing work to ensure budgeted establishment are correct and aligned to the correct wards after to organisational restructure. Further detail will be reported to the May Board. 	
<p>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.</p>	
<p>Financial implications Already incorporated into 18/19 Division budgets.</p>	
<p>Who needs to be told about any decision? Divisional Management Teams Finance Department Workforce Planning</p>	
<p>Who is responsible for implementing the proposals / project and anticipated timescales? Chief Nurse; Assistant Chief Nurses and Head of Nursing</p>	
<p>Who is accountable for the implementation of the proposal / project? Chief Nurse; Divisional Management Teams</p>	



Great Ormond Street
Hospital for Children
NHS Foundation Trust

Safer Staffing Report January/February 2019

The child first and always

Always

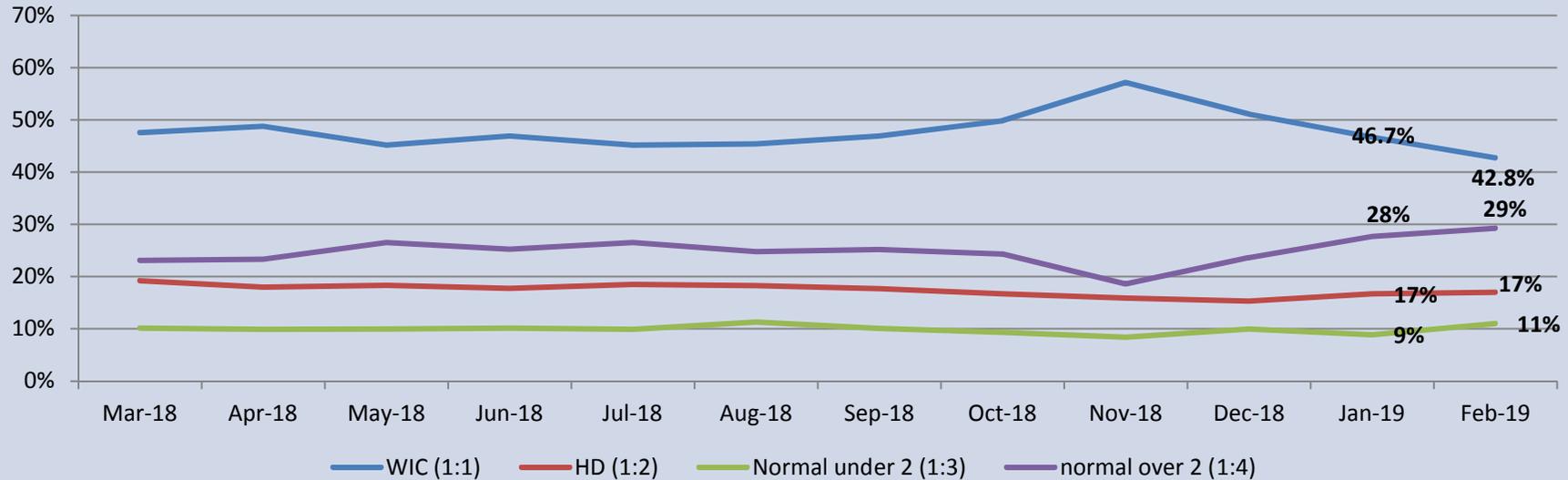


Nursing & HCA Safe Staffing- January/February 2019

Definition	Trend	Comments																										
<p>Actual vs Planned Hours shows the percentage of Nursing & Care staff who worked (including Bank) as a percentage of planned care hours in month. The National Quality Board recommendations are the parameters should be between 90-110%.</p>	<h3 style="text-align: center;">Unify Actual vs Planned Hours</h3> <table border="1"> <caption>Unify Actual vs Planned Hours Data</caption> <thead> <tr> <th>Month</th> <th>Percentage</th> </tr> </thead> <tbody> <tr><td>Mar-18</td><td>~98%</td></tr> <tr><td>Apr-18</td><td>~99%</td></tr> <tr><td>May-18</td><td>~103%</td></tr> <tr><td>Jun-18</td><td>~104%</td></tr> <tr><td>Jul-18</td><td>~107%</td></tr> <tr><td>Aug-18</td><td>~111%</td></tr> <tr><td>Sep-18</td><td>~104%</td></tr> <tr><td>Oct-18</td><td>~100%</td></tr> <tr><td>Nov-18</td><td>~92%</td></tr> <tr><td>Dec-18</td><td>~91%</td></tr> <tr><td>Jan-19</td><td>111.70%</td></tr> <tr><td>Feb-19</td><td>100.30%</td></tr> </tbody> </table>	Month	Percentage	Mar-18	~98%	Apr-18	~99%	May-18	~103%	Jun-18	~104%	Jul-18	~107%	Aug-18	~111%	Sep-18	~104%	Oct-18	~100%	Nov-18	~92%	Dec-18	~91%	Jan-19	111.70%	Feb-19	100.30%	<p>The average Actual vs Planned Hours across all inpatient wards was 100.3% in February and 111.7% in January, higher than the last 4 months. All wards were above the recommended parameter of 90%</p> <p>Nursing hours for February during the day were 114.4% (119% in January) against plan and 89.8% at night (100.7% in January).</p> <p>HCA actual hours in February were 99.6% (119% in January) for day shifts, and 73.7% at night (111.4% in January.)</p> <p>No unsafe shifts were reported in January or February</p>
Month	Percentage																											
Mar-18	~98%																											
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<p>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.</p>	<h3 style="text-align: center;">Care Hours Per Patient Day</h3> <p style="text-align: center;">(excluding ICU's)</p> <table border="1"> <caption>Care Hours Per Patient Day Data</caption> <thead> <tr> <th>Month</th> <th>CHPPD</th> </tr> </thead> <tbody> <tr><td>Mar-18</td><td>~13.0</td></tr> <tr><td>Apr-18</td><td>~13.0</td></tr> <tr><td>May-18</td><td>~12.8</td></tr> <tr><td>Jun-18</td><td>~12.5</td></tr> <tr><td>Jul-18</td><td>~12.8</td></tr> <tr><td>Aug-18</td><td>~13.5</td></tr> <tr><td>Sep-18</td><td>~11.8</td></tr> <tr><td>Oct-18</td><td>~12.2</td></tr> <tr><td>Nov-18</td><td>~11.0</td></tr> <tr><td>Dec-18</td><td>~10.8</td></tr> <tr><td>Jan-19</td><td>11.5</td></tr> <tr><td>Feb-19</td><td>9.0</td></tr> </tbody> </table>	Month	CHPPD	Mar-18	~13.0	Apr-18	~13.0	May-18	~12.8	Jun-18	~12.5	Jul-18	~12.8	Aug-18	~13.5	Sep-18	~11.8	Oct-18	~12.2	Nov-18	~11.0	Dec-18	~10.8	Jan-19	11.5	Feb-19	9.0	<p>CHPPD for February was 13.3 This is lower than the January figure (14.6) but higher than the same month last year (12.7).</p> <p>This figure is an indication of “care” hours given to patients, so if the total was 24, that indicates every patient received 1:1 nursing. The figures for February indicate that patients received, on average, just over 1:2 nursing.</p> <p>This is used to reflect the actual</p>
Month	CHPPD																											
Mar-18	~13.0																											
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Nursing & HCA Safe Staffing- January/February 2019

Patient Acuity (PANDA)



PANDA acuity data measures patient dependency based on the actual acuity and dependency of children. These are the following categories that are evaluated:

- 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

Patient acuity requiring a nurse to patient ratio of 1:1 or 1:2 level of care has seen a reduction since the beginning of the year however still accounts for 60% of patients in February. Patients requiring 1:1 level of care has reduced to 42.8% in February compared to the peak of 57.2% in November 2018. Patients with normal dependency of 1:3 and 1:4 has remained fairly constant over the last year . This is a trend that is continually reviewed and discussed to ensure that correct numbers and skill mix of staff are available for the needs of the wards and departments.

Nursing & HCA Safe Staffing- January/February 2019

Recruitment & Retention	Comments																																							
<h3 style="text-align: center;">Vacancies & Pipeline</h3> <table border="1"> <caption>Vacancies & Pipeline Data</caption> <thead> <tr> <th>Month</th> <th>Vacancies (RN)</th> <th>Vacancies (Unregistered)</th> </tr> </thead> <tbody> <tr><td>Mar-18</td><td>55</td><td>65</td></tr> <tr><td>Apr-18</td><td>60</td><td>60</td></tr> <tr><td>May-18</td><td>70</td><td>50</td></tr> <tr><td>Jun-18</td><td>80</td><td>55</td></tr> <tr><td>Jul-18</td><td>75</td><td>40</td></tr> <tr><td>Aug-18</td><td>110</td><td>45</td></tr> <tr><td>Sep-18</td><td>65</td><td>50</td></tr> <tr><td>Oct-18</td><td>20</td><td>55</td></tr> <tr><td>Nov-18</td><td>25</td><td>55</td></tr> <tr><td>Dec-18</td><td>35</td><td>55</td></tr> <tr><td>Jan-19</td><td>68.8</td><td>44.7</td></tr> <tr><td>Feb-19</td><td>69.3</td><td>43.2</td></tr> </tbody> </table>	Month	Vacancies (RN)	Vacancies (Unregistered)	Mar-18	55	65	Apr-18	60	60	May-18	70	50	Jun-18	80	55	Jul-18	75	40	Aug-18	110	45	Sep-18	65	50	Oct-18	20	55	Nov-18	25	55	Dec-18	35	55	Jan-19	68.8	44.7	Feb-19	69.3	43.2	<p>The RN Vacancy rate for February was 1.9% (30.4 WTE)</p> <p>Unregistered Vacancies in February were 14.3% (44.7 WTE) which was a slight increase on January (13.8%: 43.2 WTE)</p> <p>While the Trust rate is low. Vacancy hotspots remain in IPP & Sky Ward. There has recently been some positive recruitment activity in NICU/PICU.</p>
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<h3 style="text-align: center;">Voluntary Turnover & Leavers</h3> <table border="1"> <caption>Voluntary Turnover & Leavers Data</caption> <thead> <tr> <th>Month</th> <th>Leavers in Month (RN)</th> <th>Turnover % (RN)</th> </tr> </thead> <tbody> <tr><td>Mar-18</td><td>21</td><td>15.5%</td></tr> <tr><td>Apr-18</td><td>23</td><td>16.0%</td></tr> <tr><td>May-18</td><td>22</td><td>16.5%</td></tr> <tr><td>Jun-18</td><td>17</td><td>17.0%</td></tr> <tr><td>Jul-18</td><td>16</td><td>17.5%</td></tr> <tr><td>Aug-18</td><td>23</td><td>17.5%</td></tr> <tr><td>Sep-18</td><td>38</td><td>18.5%</td></tr> <tr><td>Oct-18</td><td>15</td><td>16.5%</td></tr> <tr><td>Nov-18</td><td>16</td><td>17.0%</td></tr> <tr><td>Dec-18</td><td>33</td><td>17.0%</td></tr> <tr><td>Jan-19</td><td>16</td><td>17.0%</td></tr> <tr><td>Feb-19</td><td>19</td><td>17.2%</td></tr> </tbody> </table>	Month	Leavers in Month (RN)	Turnover % (RN)	Mar-18	21	15.5%	Apr-18	23	16.0%	May-18	22	16.5%	Jun-18	17	17.0%	Jul-18	16	17.5%	Aug-18	23	17.5%	Sep-18	38	18.5%	Oct-18	15	16.5%	Nov-18	16	17.0%	Dec-18	33	17.0%	Jan-19	16	17.0%	Feb-19	19	17.2%	<p>Turnover in February increased to 17.2% from 17% in January, with a net joiners ratio of -11 as 19 nurses left and 8 joined the Trust.</p> <p>The Trust is participating in an NHS Improvement supported retention improvement programme. The programme's overall objective is to improve registered nurse retention rates by 1% over the next year.</p> <p>Of the leavers in the last twelve months identified reasons for leaving include: - relocation (39%) and work life balance (24%).</p>
Month	Leavers in Month (RN)	Turnover % (RN)																																						
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Nursing & HCA Safe Staffing- January/February 2019

Nursing Workforce Metrics by Division: January							
Directorate	Actual vs Planned %	CHPPD (exc ICUs)	RN Vacancies (FTE)	RN Vacancies (%)	Turnover %	Sickness %	Maternity %
Blood, Cells & Cancer	103.4%	14.3	1.3	0.6%	19.0%	3.1%	2.4%
Body, Bones & Mind	113.0%	17.9	17.1	6.9%	14.7%	2.5%	4.0%
Brain	115.9%	17.4	0.5	0.4%	14.4%	3.0%	3.7%
Heart & Lung	107.7%	13.7	30.5	6.1%	18.4%	3.7%	3.2%
International & PP	122.1%	13.7	34.1	30.7%	27.7%	4.3%	6.5%
Operations & Images	-	-	0.2	0.1%	11.9%	3.8%	2.8%
Sight & Sound	133.3%	14.8	-18.4	-59.5%	17.6%	4.1%	3.4%
Trust	111.7%	14.6	29.9	1.2%	17.0%	3.2%	3.6%

The recommended six monthly review of ward establishments is currently being undertaken to ensure all budgeted establishments are correct and allocated to the right wards and directorates. Establishments are also being aligned to the number of beds open and the activity plan for 2019/20. IPP continues to have the highest RN vacancy rate (62.5%).

Nursing & HCA Safe Staffing- January/February 2019

Nursing Workforce Metrics by Division: February

Division	Actual vs Planned %	CHPPD (exc ICUs)	RN Vacancies (FTE)	RN Vacancies (%)	Turnover %	Sickness %	Maternity %
Blood, Cells & Cancer	93.5%	13.9	4.3	2.0%	18.2%	2.8%	2.0%
Body, Bones & Mind	100.9%	14.0	24.0	9.7%	13.8%	2.3%	4.4%
Brain	97.2%	13.1	-2.2	-1.8%	16.0%	2.8%	5.4%
Heart & Lung	107.0%	13.7	25.9	5.3%	19.0%	3.7%	3.0%
International & PP	104.2%	13.2	31.6	28.5%	30.4%	4.2%	6.4%
Operations & Images	-	-	6.1	3.2%	11.5%	3.7%	2.3%
Sight & Sound	110.5%	10.9	-21.9	-70.8%	17.9%	4.1%	3.4%
Trust	100.3%	13.3	30.4	1.9%	17.2%	3.0%	3.6%

Targeted recruitment initiatives are focusing on IPP, Sky and the ITU's, including working up an overseas recruitment campaign for IPP and hosting an open day for the ITUs in May.

Highlights -

Successes

- Hosted a successful site visit for NHSI as part of the retention programme where we presented our draft retention action plan to improve the Trust turnover rate by 1%. Final plan to be submitted to NHSI on the 22nd March (appendix one).
- Launched an @GOSH Nursing Twitter account now with over 190 followers.
- 22 NQNs started in March 2019.
- Assessment days for the next cohort of NQNs who qualify in September planned for March with over 170 shortlisted candidates.
- The changes to ward leadership in IPP have been well received by staff.

Challenges

- Finalising the methodology to identify the number of NQNs that can be offered posts to start in September.
- The potential impact on future student numbers if we are unable to recruit all current students wanting employment at GOSH.
- Only 6 Band 2 healthcare support workers starting the clinical apprenticeship programme in March rather than the planned 10.
- Ongoing work to ensure budgeted establishments are correct for bed numbers and activity and are aligned to the correct wards and departments following the organisational restructure in October 2018.

Appendix 1

GOSH Nurse Retention Plan

National Nursing Profile

- Approximately 40,000 WTE RN vacancies
- Of which 10.9% are children's nurses
- Highest vacancy rates are found to be in London/South.

London

- 20% of newly qualified nurses leave within the 1st year.

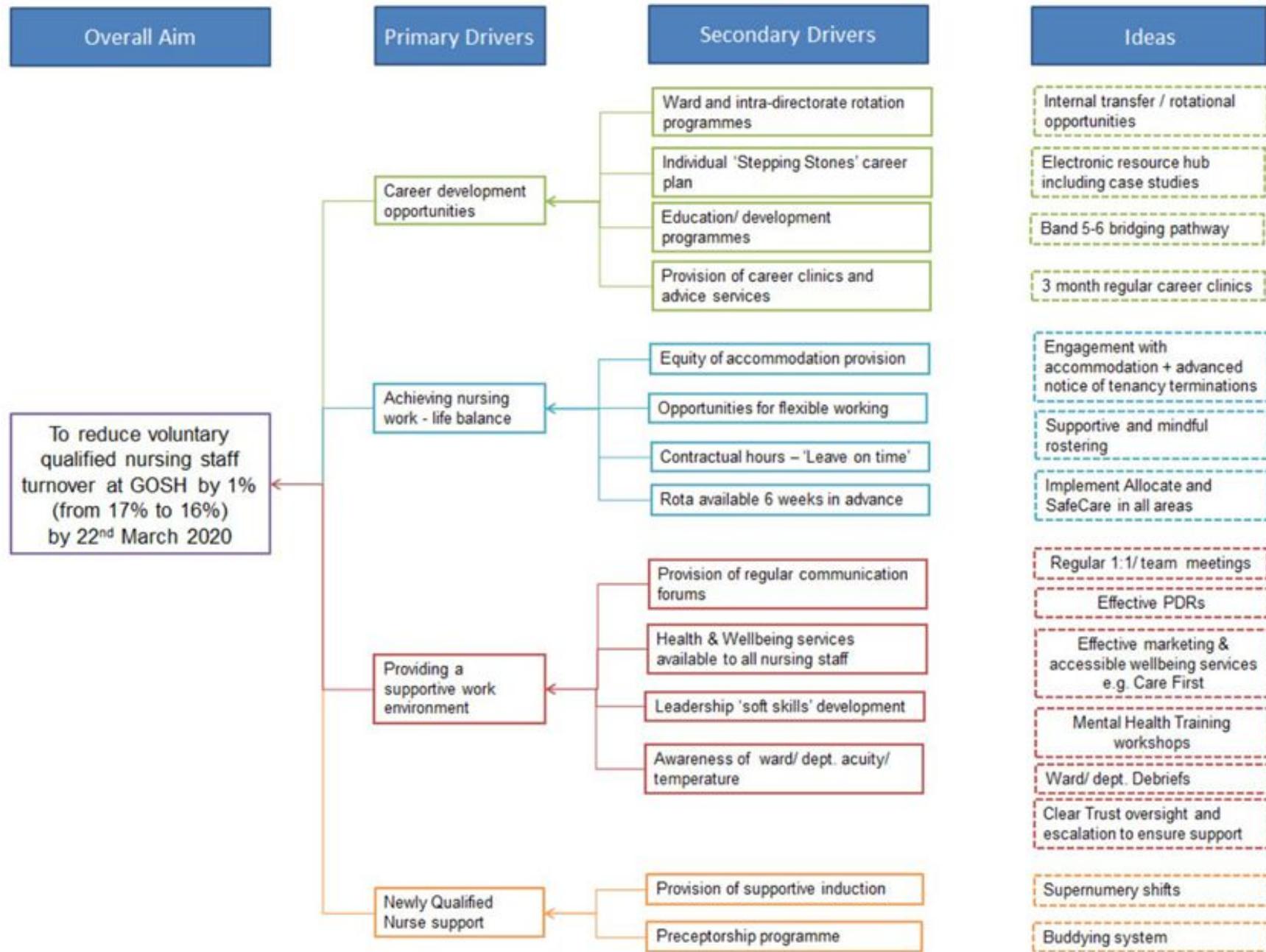
GOSH Nursing Profile

- 1876 WTE (RN, Nursing Associate, Health Care Assistant)
- 1567 WTE (77%) Band 5 + 6
- 69 WTE (4.2%) * RN posts are vacant but 8% are at Band 6
- 41% of Band 5 joiners in 2016 have now left the organisations.

GOSH Retention Plan

- Having analysed our workforce data and studied our exit survey information
- Our focus: Band 5 + 6 retention
- Our themes: Career development opportunities, achieving work life balance, providing a supportive work environment and newly qualified nurse support
- Our objective: To reduce voluntary turnover by 1% in one year.

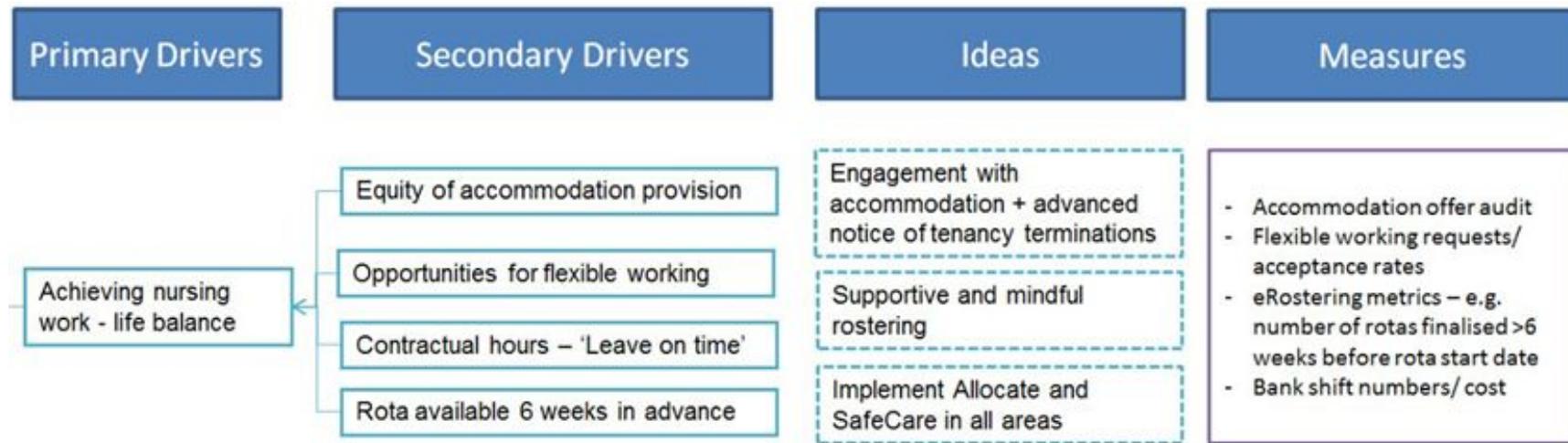
* This % is inclusive of posts which are currently established as 'bank lines'.



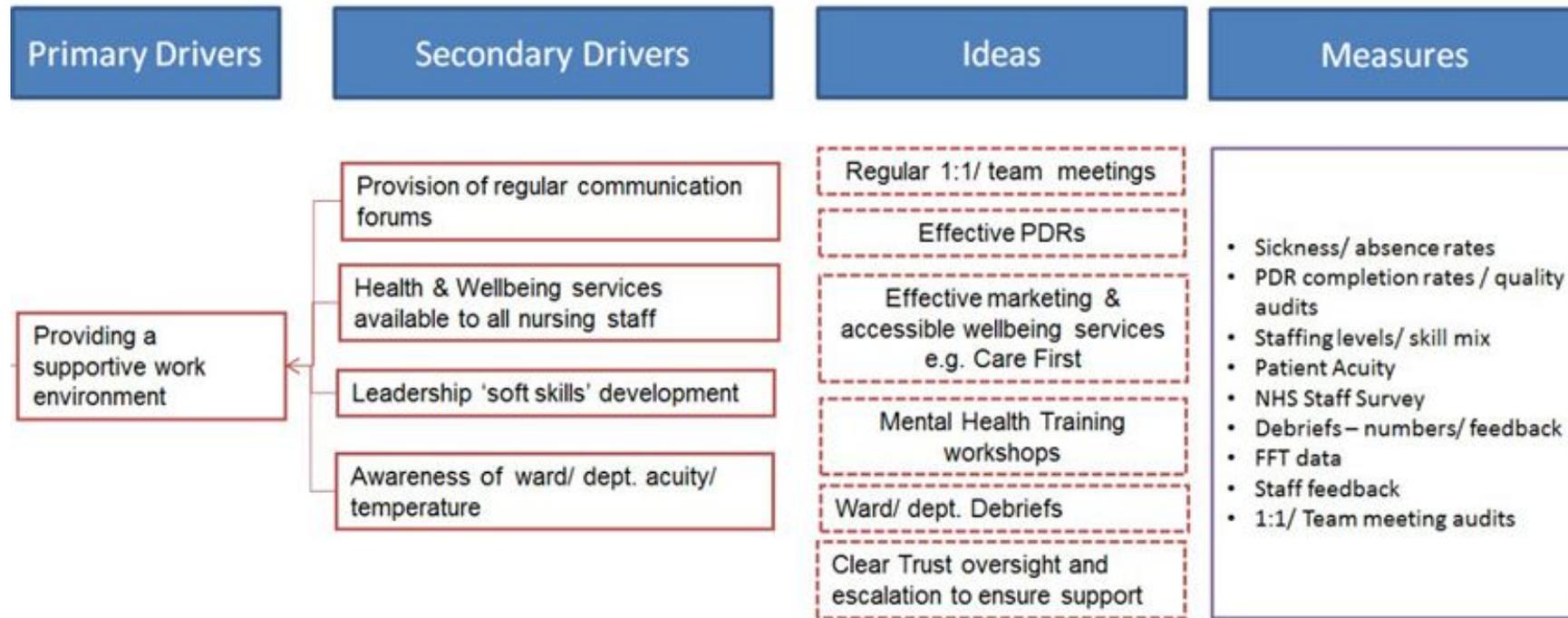
Primary Driver 1: Career Pathway Opportunities



Primary Driver 2: Achieving nursing work/ life balance



Primary Driver 3: Providing a supportive work environment



Primary Driver 4: Newly Qualified Nurse Support



TRUST BOARD 3 April 2019	
Workforce Equality Objectives Update 2018/19 Submitted by: Caroline Anderson, Director of HR and OD	Paper No: Attachment R
Aims / summary This paper updates the board on actions and progress towards achieving the Equality Objectives set for 2016-2020	
Action required from the meeting Trust Board are asked to note the contents of this report.	
Contribution to the delivery of NHS / Trust strategies and plans We will attract and retain the right people through a culture that enables us to learn and thrive.	
Financial implications None	
Legal issues None	
Who is responsible for implementing the proposals / project and anticipated timescales Director of HR and OD	
Who is accountable for the implementation of the proposal / project Director of HR and OD	

Equality, Diversity & Inclusion Annual Report 2018/19

1.0 Introduction

- 1.1 The Equality Act 2010 simplifies equalities law into one single source of Statute. In addition to the Act, the statutory Equality Duty came into force in April 2011 which applies to all public sector bodies. As a Trust, we are legally required to demonstrate that we comply with the Equality Act and are meeting the Equality Duty through; the work we do, Trust Board's involvement in this work and through publishing a range of equalities data on an annual basis.
- 1.2 To comply with the first specific duty of the Act, the Trust is legally required to annually publish equality data relating to both service users and staff. The latest data via the GOSH website: www.gosh.nhs.uk/about-us/equality-and-diversity/.
- 1.3 The second part of the specific duty requires the Trust to prepare and publish specific and measurable equality objectives. This paper provides an update against the objectives as agreed by the Trust Board in 2016, and an update on Equality, Diversity and Inclusion activity undertaken throughout 2018/19.

2.0 GOSH Workforce Equality Objectives for 2016 to 2020

- 2.1 The themes below were chosen to form equality objectives through staff engagement events during 2015 and as a result of NHS Equality Delivery System (EDS2) scoring showing that they scored within the "underdeveloped" grade.

Objective 1 – to increase the overall visibility of the Trust Board and Senior Leaders

Objective 2 - to develop the understanding of managers and employees in recognising and managing Harassment & Bullying in the workplace, with the longer term intention of a reduction in the instances of bullying and harassment concerns being raised by staff.

Objective 3 - To improve the representation of BAME staff in senior posts

3.0 Progress During 2018

Objective 1: Increase the overall visibility of the Trust Board and Senior Leaders

Progress to date

The measure of success is the percentage of staff reporting effective communication between senior management and staff via NHS Staff Survey. The Staff Survey 2018 score against this metric was 34.5%. A deterioration of 2.3% when compared with the 2017 survey. GOSH scored below average when compared with other acute specialist trusts, the average for this group is 46.2%.

Actions During 2018

Whilst positive changes in the staff survey results are yet to be achieved, a new Executive Team has been established in early 2019 and the following actions implemented:

- New format CEO staff briefing sessions
- Executive and Directorate Leadership Team visibility walk rounds continue to be well established
- CEO blog and new style all staff emails
- CEO monthly physical and virtual ‘open door’ due to launch shortly
- GOSH celebrated and communicated its strategy in the Open House event during Oct 2018
- Breakfast with the CEO events held during 2018.
- Senior Trust leaders supported Black History Month, and LGBT+ history month
- Three staff inclusion forums established each with a visible and engaged Executive Sponsor.

Objective 2: To develop the understanding of managers and employees in recognising and managing Harassment & Bullying in the workplace, with the longer term intention of a reduction in the instances of bullying and harassment concerns being raised by staff.

Progress to date

The results of the 2018 staff survey continue to show that there is still much work to do around addressing and reducing harassment and bullying across the organisation, with 22% of respondents indicating they have experienced harassment, bullying or abuse from colleagues.

Actions During 2018

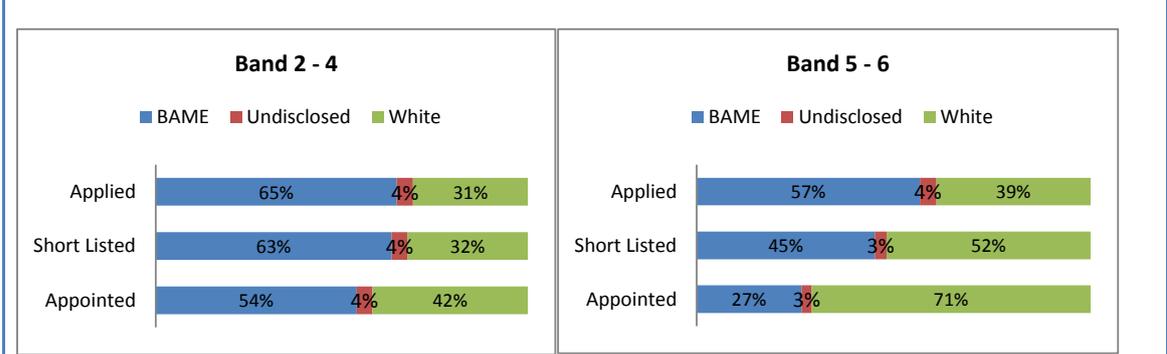
- THE GOSH Freedom to Speak Up (FTSU) Ambassador service has been well established and a FTSU Guardian was appointed in Jan 2018. The service has been used by staff to raise harassment and bullying concerns during 2018.
- A learning process following the conclusion of a formal case of harassment and bullying was introduced by the Employee Relations team to determine whether issues could have been identified / addressed earlier and to promote shared learning between managers
- Facilitated workshops on banter and behaviour have been developed and delivered as a targeted intervention. These will be made available to teams on a case by case basis.
- The Dignity at Work Policy was reviewed, with particular attention paid to the ‘tone of voice’ used.

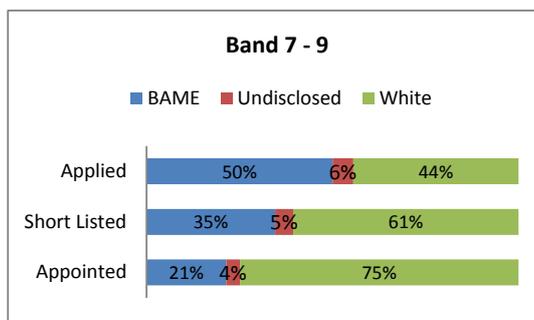
Objective 3: To improve the representation of BAME staff in senior posts

Progress to date

As of 2018 the overall proportion of staff at GOSH from BAME background was 29%, whilst in senior posts the proportion was 22%. This shows an improvement from 2016 when the figures were 27% and 16% respectively.

However, there continues to be disparity in the proportion of BAME candidates progressing through the stages of recruitment when compared to white candidates across all three pay band ranges.





There have been some improvements apparent across two pay bands compared with 2017:

BAME applicants	% Appointed 2017		% Appointed 2018	
	Bands 2 – 4	45%	Band 2 – 4	54%
Bands 5 – 6	25%	Bands 5 – 6	27%	
Bands 7 – 9	23%	Bands 7 – 9	21%	

Actions During 2018

- BAME staff were supported to apply for the national “Step Up” and “Ready Now” leadership development programmes.
- The BAME Forum has worked with the Organisational Development team to engage with the Trust’s new Career Mentoring programme and BAME staff are represented in the first cohort of trained mentors
- In 2018 unconscious bias training was given to Clinical Excellence Award panel members to promote fair and robust decision making; this is also reflected in the Trust’s recruitment and PDR training content

4.0 Equality, Diversity & Inclusion Activity 2018-2019

4.1 Staff Inclusion Forums

Two forums were established in 2018: LGBT+ and BAME forums. The GOSH Women’s forum launched in March 2019 and a Disability / Long Term Health Conditions forum will launch during 2019. These Forums were introduced as a way of improving staff experience by supporting the Trust’s strategic aim of ‘Attracting and retaining the right people through creating a culture of inclusivity that enables us to learn and thrive’ as well as enabling the staff voices to be better heard, particularly those from protected groups.

Headlines from the LGBT+ Forum



- Walked at Pride 2018 for the first time and have applied for places in 2019.
- Celebrated LGBT history month during February 2019 which involved lots of events for members and the raising of the Rainbow flag at GOSH; the first time this has happened in the Hospital’s history.
- Worked with Epic to clarify how sex and gender information should be captured.
- Held numerous social events for member

Headlines from the BAME Forum

- Forum launched Autumn 2018; currently 143 members and membership growing through events
- A representative from the BAME forum is working with NHS England on Workforce Race Equality Standard initiatives across the country
- Two of the Executive Forum members have secured places on national leadership development programmes



4.2 **Other Equality, Diversity & Inclusion Activities**

- In 2018 we undertook an all-staff staff survey allowing everyone to have their voice heard and tell us about their experiences.
- Close links have been forged with colleagues at ICH in order to benefit from shared learning and opportunities for GOSH staff.
- Eight Project Search interns graduated in 2017 and a further seven are on the 2018/19 scheme. The Scheme connects GOSH with the local community to support young people with learning disabilities obtain work and life skills
- A pre-disciplinary investigation checklist has been implemented to ensure consistency and fairness of approach before a decision to formally investigate under the Disciplinary Policy is made. This is particularly important as the GOSH WRES data, in common with many other trusts in the London region, shows disparity between the disciplinary rates between white and BAME staff.
- The Trust maintained its Disability Committed status

5.0 **Future Plans**

- Developing new set of Equality Objective, to apply from 2020 onwards. This will be led by the Inclusions forums – with engagement across the organisation
- Creation of the GOSH People strategy – including specific actions related to Diversity & Inclusion
- Launch of the Disability and Long Term Health Conditions staff inclusion forum
- Achieve Disability Confident Employer (Level 2) status
- Refresh and relaunch of the GOSH Always Values & Behaviours

Attachment 10

Trust Board 3 April 2019	
Equality, Diversity & Inclusion: Update against service delivery Equality Objectives	Paper No: Attachment 10
Submitted on behalf of Alison Robertson, Chief Nurse Author: Beki Moul, Health Information/Language Manager	
Aims / summary To provide the Trust Board with assurance that the Trust continues to meet its statutory obligations under the Equality Act 2010.	
Action required from the meeting To note the content of the report and the activity delivered	
Contribution to the delivery of NHS Foundation Trust strategies and plans <ul style="list-style-type: none"> • Meeting statutory duties to report publically on Diversity and Inclusion. • Promotes fairness and equity in service delivery 	
Financial implications Incorporated within current resource allocations and budgets.	
Who needs to be told about any decision? N/A	
Who is responsible for implementing the proposals / project and anticipated timescales? Family Equality and Diversity Group (patient and families).	
Who is accountable for the implementation of the proposal / project? Deputy Chief Nurse (Chair of Family Equality and Diversity Group)	

Improving the experience of children, young people and families visiting Great Ormond Street Hospital

Meeting the duties of the Equality Act 2010

March 2018

Summary report for Trust Board

The Equality Act 2010 (the Act) simplifies equalities law into one single source of Statute. In addition to the Act, the statutory Equality Duty came into force in April 2011 which is applicable to all public sector bodies. As a Trust, we are legally required to demonstrate that we comply with the Act and are meeting the Equality Duty through the work we do, the Trust Board's involvement in this work and through publishing a range of equalities data annually.

To comply with the first specific duty of the Act, the Trust is legally required to annually publish equality data relating to both service users and staff. A copy of the latest edition of this report will be available on the GOSH website at www.gosh.nhs.uk/about-us/equality-and-diversity/. The second part of the specific duty requires the Trust to prepare and publish equality objectives, setting out progress towards meeting the objectives.

Equality objectives relating to children, young people and families for period 2016 to 2020/21:

The following objectives were selected previously in conjunction with children, young people, families and staff members and continue to provide the main focus for the Family Equality and Diversity group at GOSH.

Objective 1: Achieve Accessible Information Standard within timescale

The Accessible Information Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. This objective was time-limited as NHS England had required the Standard to be met by the end of July 2016.

The 'additional needs' tab on the Trust's Patient Information Management System (PiMS) enables staff to record these requirements. A handful of requests have been received during 2018, including one for large print information and two requests for telephone contact rather than letters.

Attachment 10

Negotiations with the team implementing the Electronic Patient Record system have been successful in transferring this functionality as well as expanding it to record additional needs of all who hold Parental Responsibility for a patient.

The range of Easy Read information has also increased and a set of Easy Read information sheets to support the 'Growing Up Gaining Independence' (GUGI) programme (see objective 3) has been developed in association with the Improvement Manager for that project. The range of information sheets to support the GUGI programme will continue to expand as the programme is evaluated by young people and their families.

The Family Equality and Diversity group will continue to monitor compliance with this standard, in terms of usage levels of the additional needs tab and provision of communication and information support on request.

Objective 2: Publicise support for families including support organisations

There are a wide range of support mechanisms for families both within and outside GOSH. However, families tell GOSH, in surveys and other encounters, that these are not always promoted as well as they could be. While many excellent support organisations exist, families may not always be aware of their existence so work is ongoing to support clinical staff in providing this information more systematically. Recording of information given will become easier following the introduction of the Electronic Patient Record.

The Patient Advice and Liaison Service (Pals) has developed a new service in conjunction with the Volunteers Service. The Pals Outreach Project, known as "Popping" was launched in September 2018 and is designed to meet patients and families face to face on wards and in outpatient clinics to promote access to GOSH information on health and GOSH services. Many people find accessing information through the internet quick and convenient but others struggle to access information in this way. Navigating the hospital website can be a challenge for those with limited reading skills, those with a learning disability or those who might be looking for information in other languages. The Popping service supports parents and young people in accessing information by providing face to face support.

Provision of information trolleys outside the Pals Office, supplying information sheets about support, details of organisations that can help and benefits advice, continues to be popular (evidenced by monthly monitoring of the information sheets supplied). The associated costs of stocking the trolleys are also being monitored to ensure that it is sustainable and worthwhile.

A wide variety of support organisations visit GOSH on a regular basis to promote the services they offer to children, young people and families. These range from umbrella organisations such as Contact (previously known as Contact a Family) to condition specific groups such as Young Epilepsy. This is in addition to therapeutic and entertainment volunteers, such as Therapy Dogs and Spread a Smile. Families can also access support through the Citizens' Advice Bureau.

Attachment 10

Objective 3: Support on-going work to improve transition to adolescent or adult services

The information and support needs of young people and their families have been prioritised by building on the previous year's work to develop the 'Growing Up Gaining Independence' (GUGI) framework. The framework clearly explains the life skills relevant to all young people, particularly those who will transfer to adult healthcare.

This is a major component of enabling a young person to become as independent as possible in managing their health, for instance, taking medicines, preparing for appointments and understanding the impact of lifestyle issues on their particular conditions.

Various clinical teams have been working with the Improvement Manager to develop condition specific information to prepare for the transfer to adult services, including multiple sclerosis, complex epilepsy and congenital hyperinsulinism. In most cases, an Easy Read information sheet is being developed alongside to meet the needs of young people with learning disabilities.

Family Equality and Diversity (FED) Group

The Family Equality and Diversity Group has continued to meet during 2018. Presentations were received from:

- Andrew Pearson, Clinical Audit Manager – the Learning Disabilities Mortality Review (LeDeR) Programme
- Dr Elaine Clarke, Neurodisability Consultant – working with and supporting children and young people with autism spectrum disorder
- Representatives from the Electronic Patient Record team – components of the EPIC (supplier) system pertinent to equality, diversity and inclusion, such as demographic data, learning needs and education assessment and the After Visit Summary.

In addition, regular data reporting has improved with the development of an automated report showing data from the Friends and Family Test, broken down by gender, ethnicity and additional need to measure parity. This data is reviewed regularly and did not highlight any concerns as where there was a difference in percentage to recommend, this was usually from a very small number of responses so not deemed to be statistically significant.

GOSH continues to be represented on the Pan London NHS Equality and Diversity Leads Network, with the aim of learning from successful initiatives at other Trusts and sharing what we have learnt at GOSH. The two GOSH departments with overall responsibility for delivering against these objectives (Nursing and Patient Experience via the Health Information/Language Manager and Human Resources and Organisational Development) also meet more regularly to plan joint working such as improvement of equality analysis and coordination of reporting.

Trust Board 3 April 2019	
Gender Pay Gap Board Report	Paper No: Attachment 9
Submitted by: Caroline Anderson, Director of HR and OD	
Aims / summary To update Trust Board with information on the 2018 Gender Pay Gap	
Action required from the meeting For information and comment	
Contribution to the delivery of NHS / Trust strategies and plans We will attract and retain the right people through a culture that enables us to learn and thrive.	
Financial implications None	
Legal issues No legal issues	
Who is responsible for implementing the proposals / project and anticipated timescales Director of HR & OD	
Who is accountable for the implementation of the proposal / project Director of HR & OD	

Gender Pay Gap Report 2018

1.0 Introduction

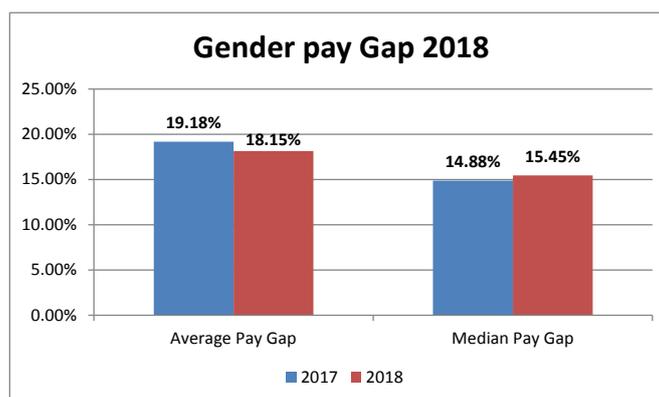
1.1 As with all other employers with more than 250 staff, the Trust is required to report data relating to the Gender Pay Gap. The data reported in this paper shows the pay gap as at 1st March 2018, as required by the Regulations.

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

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

2.0 Gender Pay Gap

2.1 In common with many organisations (including NHS Trusts) GOSH has a gender pay gap. In 2018 the average pay for a male employee was £4.58 (18.15%) higher than the average female hourly rate. The median hourly rate gap was slightly lower at £3.32 (15.45%) per hour.

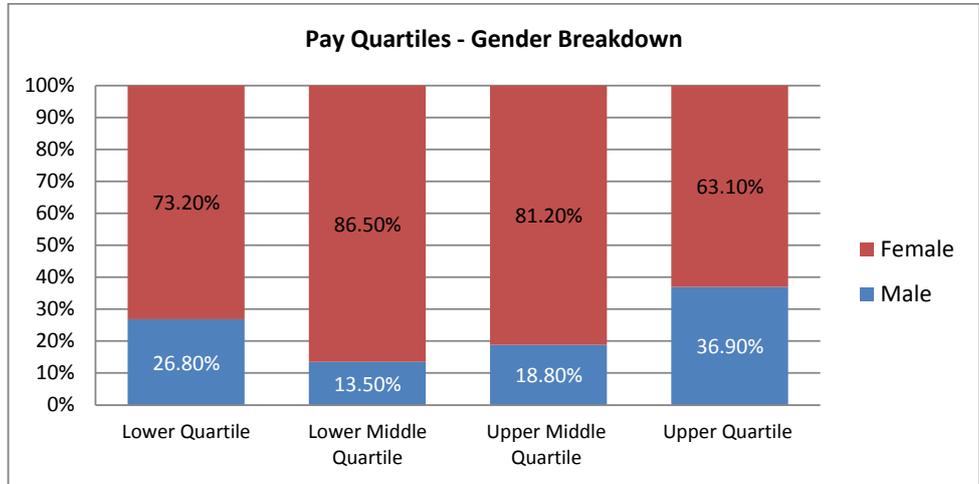


2.2 Reasons for a pay gap are complex and driven by the traditional demographics of the healthcare workforce. For example the Nursing and Administrative & Clerical professions are predominately female, and make up 77% of the overall workforce.

	Female Headcount	Male Headcount	Total	Female	Male
Add Prof Scientific & Technical	231	74	305	76%	24%
Additional Clinical Services	435	106	541	80%	20%
Administrative & Clerical	769	384	1153	67%	33%
Allied Health Professionals	242	22	264	92%	8%
Estates & Ancillary	70	77	147	48%	52%
Healthcare Scientists	232	82	314	74%	26%
Medical & Dental	408	310	718	57%	43%
Nursing	1518	88	1606	95%	5%

Grand Total	3905	1143	5048	77%	23%
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2.3 Whilst the GOSH pay quartile data shows that the highest percentage of staff across all pay quartiles are females, the highest proportion (relatively) of male staff are to be found in the highest pay quartile:



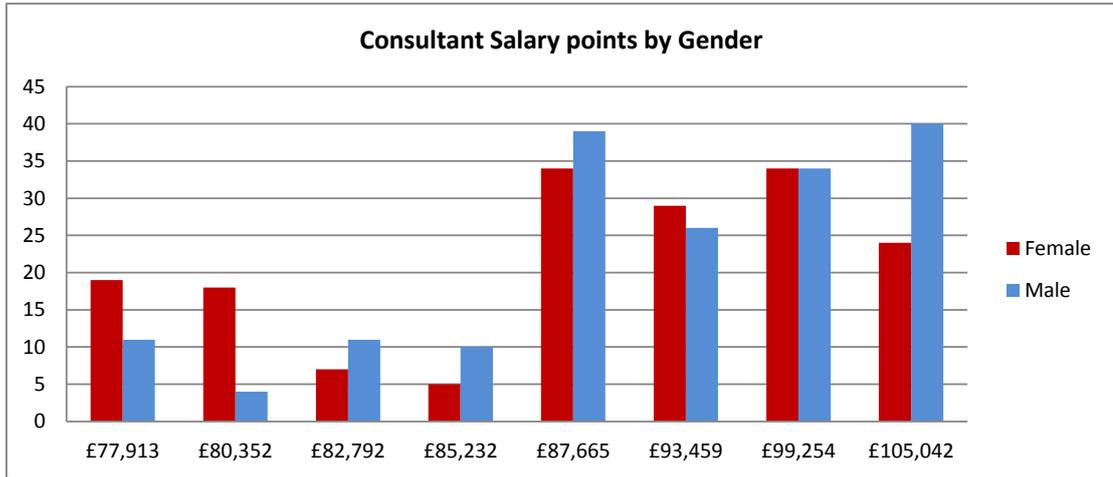
3.0 Medical vs. Non-Medical Gender Pay Gap

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

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

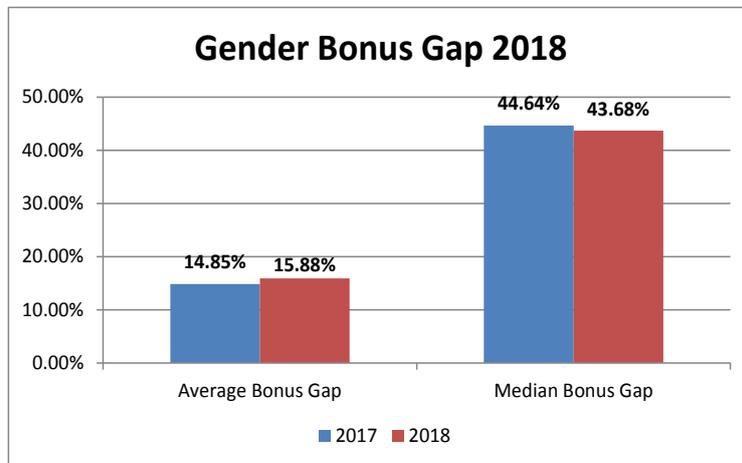
Gender pay gap (non-medical)		Gender pay gap (medical/dental)	
Mean	Median	Mean	Median
			
Men on a mean average earn 35p per hour more than women.	Women on a median average earn 89p per hour more than men.	Men on a mean average earn £3.53 per hour more than women.	Men on a median average earn £5.06 per hour more than women.
1.87%	-5.42%	8.59%	11.8%

3.3 Within the consultant workforce the distribution of men and women along the consultant payscale broadly represents the traditional demographic of the medical workforce (i.e. predominately male). Over time, as the demographic shift within the trainee medical workforce (currently approximately 60% female) filters through to the consultant workforce, and female consultants progress up the payscale, the ratio of female consultants at higher points of scale will increase and contribute to a reduction in gender pay gap at GOSH.



4.0 Bonus Gender Pay Gap

4.1 Earnings in the calculation for bonus payments relate to Clinical Excellence Awards (CEAs) for consultant medical staff. The average gender pay gap currently stands at £2,977 (15.88%), and the median £6,856 (43.68%) (both similar gaps to 2017).



4.2 The proportion of staff receiving bonus pay was 6.32% (male) and 1.37% (female) – based on the total workforce at GOSH. It should be noted only Consultant medical staff are eligible to receive CEAs – 42% of the consultant workforce hold a CEA. This breaks down to 35% of female consultants and 49% of male consultants holding a CEA.

	Consultant Headcount	Award holders	Award Holders
Male	175	86	49%
Female	171	59	35%
Total	346	145	42%

4.2 Local clinical excellence awards are decided by a GOSH panel which consists of a diverse range of participants, representing the diversity the consultant workforce at GOSH including ethnicities, gender and specialities. Applications and allocation of awards are monitored against a range of protected characteristics including Gender.

5.0 Benchmarking

5.1 The Gender Pay Gap has many similarities across the NHS workforce and the London HR Directors Network commissioned a pan London analysis by Health Education England (HEE) to review each Trust's 2017 report and analysis, and validate the methodology used. While most trusts correctly interpreted the data around hourly rates, there were some discrepancies about bonus reporting. GOSH was not among the trusts where any issues with data were flagged. It is expected a similar analysis will be undertaken following publication of the 2018 data.

5.2 The 2017 data indicated a range of pay gaps with almost all trusts reporting a pay gap favourable to men in the range of 6% to 41% (average hourly pay) or 23% to 0.3% for median hourly pay. Bonus pay gaps ranged from 59% to -30.6% (average) with a median gap range of 72.7% to -62%. GOSH was not an outlier in this benchmarking but was in the lowest quartile of London trusts.

6.0 Pay Measures in Place

6.1 GOSH uses the following pay systems to ensure pay is equal and consistent regardless of gender:

- Agenda for Change: National pay system which covers all job roles excepting those given below:
 - Trust contracts - for senior managers and directors
 - National Junior Doctors' contract.
 - National Consultants' contract.

6.2 Under Agenda for Change, NHS Foundation Trusts have the ability to negotiate local terms and conditions. In common with all other NHS Foundation Trusts GOSH has chosen to remain with Agenda for Change rather than move to locally created pay systems due to the protection it affords in terms of ensuring work of equal value is paid equally. Agenda for Change was designed to evaluate the job rather than the person in it and by doing so, ensuring equity between similar jobs in different areas.

7.0 Future actions

- Continue to support development of the GOSH Women's Forum (launched March 2019) and work closely with the forum to address relevant issues, support policy development and culture change as well as promoting positive discussion and develop further awareness of the issues around the gender pay gap.
- The Trust will continue to encourage training and career pathways as well as ensuring our processes around local CEAs remain fair and equitable.
- Embed the recently launched GOSH career mentoring programme by developing more mentors and encouraging staff to request a mentor, particularly those from protected groups where career progression may be more difficult.
- Continue to support all staff including those returning from time away from the workplace for carer responsibilities. We offer childcare vouchers and an onsite nursery in order to help staff remain in work after having children. We also have a variety of family friendly policies, open to both genders.
- Continue to provide training and education to managers to address issues related to unconscious bias in recruitment and selection, Personal Development reviews (PDR) and clinical excellence award decisions.

Attachment S

Trust Board 3rd April 2019	
Guardian of Safe Working report	Paper No: Attachment S
Submitted by: Dr Renée McCulloch, Guardian of Safe Working	
Aims / summary This report is the fourth quarter report to the Board regarding Junior Doctor working practice at GOSH. This report covers the period 1 st October to 31 st December 2018 inclusive.	
Action required from the meeting The board is asked to note the report and the issues influencing junior doctor's working, the challenges in monitoring compliance with the TCS 2016 and the achievements to date.	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Guardian of Safe Working supports and enables a safe and positive working and learning environment for junior doctors. This contributes to the Trusts strategic objective relating to providing safe patient care and an excellent place to work and learn.	
Financial implications Continuing payment for overtime hours documented through the exception reporting practice.	
Who needs to be told about any decision? n/a	
Who is responsible for implementing the proposals / project and anticipated timescales? Dr Renee McCulloch, Guardian of Safe Working Mr Simon Blackman and Dr Jonathan Smith, Acting Deputy Medical Directors for Medical & Dental Education	
Who is accountable for the implementation of the proposal / project? Dr Sanjiv Sharma, Acting Medical Director	

Attachment S

Trust Board Report
Guardian of Safe Working
Fourth Quarter: 1st October – 31st December 2018

1. Purpose

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

2. Background: See Appendix 1**3. GOSH Junior Doctor Rotas**

- 3.1.** Number of Trust Doctors as of 31 December 2018 = 134.4
 Number of Training Doctors as of 31st December 2018 = 183.4
- 3.2.** The **overall vacancy rate** across junior doctor rotas as of 31/12/2018 is 5.3 % with 15 FTE vacant out of a total of 284 rota slots.
- 3.3.** As of the 31st December 2018 the following junior doctor posts were vacant:

Specialty	Rota grade	Establishment	Vacant posts	Vacancy rate %
Cardiology	SpR	22	2	9
Respiratory	SpR	8	2	25
Haem/Onc	SpR	17	2	11.5
Clinical Genetics	SpR	3	1	33
IPP	SpR	14	3	21.5
Orthopaedic	SpR	3	1	33
Orthopaedic	SHO	8	1	12.5
CICU	SpR	16	1	6
ENT	SHO	3	1	33
Plastics	SHO	3	1	33

Attachment S

4. Exception Reports**4.1. Number of Exception Reports Fourth Quarter 2018**

Exception Reports October to December 2018 inclusive						
Number of ERs:		50		Number closed:		45
Details by Specialty, Grade and Reason						
Specialty	Rota grade		ERs: hours	ERs: missed educational opportunities	ERs: Missed breaks	Service
	SHO	SpR / Fellow				
Haem Onc	1	9	8	1		1
Respiratory	3		3			
CAMHS		2	1		1	
Immunology/ ID		9	9			
Neurology		2	2			
IPP		24	24			
Total	4	46	47	1	1	1

4.2. Exception Report Outcomes:

Exception Report Outcomes (Per Episode- some have >1 outcome) October to December 2018 incl.					
Compensation with payment	TOIL	Work Schedule review	Further information	Pending ES meeting	Level 1 review
39	6	1	-	5	-

4.3. Exception Report Themes:

- Rota gaps
- Work flow & volume (arriving early and staying late to complete clinical duties)

5. Compliance with 2016 TCS

5.1. ER system is not used consistently and universally by all doctors. However it enables valuable information sharing and focus on specific issues and departments.

5.2. The current Allocate software does not support complete longitudinal data set collection or routine reporting against individual doctor's work schedule. As such it is difficult to determine 'breaches' unless alerted by the doctor themselves and a manual check is undertaken. This makes it challenging to determine whether doctors are working beyond the limits set out in schedule 3 of the 2016 TCS

6. Fines and Payments

6.1. No fines have been levied by GOSW at GOSH. Fines would only apply for the doctors on the 2016 TCS on formal training programs. There is no automated system for checking breaches and doctors must raise concerns regarding their breaching their hours within the ER system. This has not yet occurred at GOSH.

Attachment S

- 6.2.** Financial compensation has been paid to the majority of doctors submitting an ERs. Time off in lieu is often unachievable particularly if a rota is short staffed. The payment pathway is slow and cumbersome.

7. Junior Doctors' Forum

GOSW is positively engaged with the junior doctors via a number of routes and meetings. In q4 2018 attendance at JDF waned. Despite this quality of discussion is high and actions remain constructive. The JDF has now taken a 'roadshow' approach for 2019 and is moving around different departments with pizza on a monthly basis.

8. Issues arising

- 8.1. The MEGGA rota** has been highlighted as a potential safety risk by the junior doctors who requested a meeting with the GOSW- work volume is high and there are potential patient safety concerns mainly related to volume of external calls, although no incidents have been formally reported. A response meeting was held on October 31st 2018 to consider various options for increasing SpR numbers. An agreement that doctors on the MEGGA rota would exception report any concerns was requested. No ERs have since been submitted relating to the MEGGA rota. There are various suggestions related to potential solutions to improve work flow at night. These are being addressed in the #24/7 JD Task Finish Group.

- 8.2. Rest Facilities** Lack of access to rest facilities have been highlighted as an issue for doctors across the Trust and escalated to the Clinical Operations team and the Medical Director's Office (MDO). GOSW and the JDF president completed a survey of junior doctor's access to rest facilities for every rota level (see appendix 2). This was submitted to the LNC and MDO. GOSH has committed to support the BMA Sleep Charter.

- 8.3. Rota Gaps** (due to unfilled positions and sickness) put significant pressure on the system and result in doctors working over hours and not accessing training and education opportunities. The average rota gap across the trust is 5%, far is less than the national average in paediatrics (15-20%). However problems arise when specific rotas are compromised by more than 10% such as in respiratory in q4. To mitigate low doctor numbers the middle grade doctors were taken off the out of hours rota and consultants have worked down to back fill day time gaps.

- 8.4. Work Flow Pressure:** there are some departments reported as being under staffed with juniors. BMT is currently highlighted and ERs are being used to monitor staffing and inform workforce planning discussions (juniors in Haem Onc and Immunology cover BMT). IPP has also been chronically understaffed and Trust doctors are reporting working over their scheduled hours.

9. Actions:

- 9.1.** The medical director's office has established a Modernising Medical Workforce Group to address the current challenges of the medical workforce. Much of this work relates to improving the recruitment and retention of junior doctors and ensuring that medical careers at GOSH remain sustainable and fulfilling.
- 9.2.** A task finish work stream addressing the specific issues relating to junior doctors (#JD24/7) is now in progress consisting of junior and senior medics working together. Work streams include:
- 9.2.1.** Assessment and Management of medical workforce risk – in development: a risk stratification tool to enable an operational response to junior doctor rota gaps (ensuring 'safe doctor' numbers')

Attachment S

- 9.2.2. Hospital at Night review of rota establishments and suggestions for new working models for out of hours
- 9.2.3. Understanding work flow for junior doctors at GOSH and core medical tasks.
- 9.2.4. Assessing barriers to and improving access to education and training opportunities at GOSH
- 9.2.5. Externality – benchmarking against other paediatric hospitals
- 9.3.** Associate Medical Director for Medical Workforce is planned – post in development

10. Summary

- 10.1.** The MEGGA rota has been highlighted as a potential safety risk and action is being taken to ensure exception reporting is taking place. The hospital at night review will examine work flow and suggest new models of working.
- 10.2.** Lack of access to appropriate rest facilities has been demonstrated by a recent survey by GOSW and the JDF. Plans for improving current facilities and considering a longer term plan are underway.
- 10.3.** In the absence of any firm evidence to the contrary, GOSH is currently compliant with the 2016 TCS. However GoSW is aware that incidents of non-compliance are not always adequately reported through ER system. Rota gaps will adversely affect compliance and safety of junior doctor staffing in addition to access to education and training opportunities. GOSH has improved in its anticipatory planning and response to rota gaps however more work is underway to establish a 'real time' dashboard.
- 10.4.** Modernising the GOSH junior doctor working experience, addressing the local and national challenges of the paediatric medical workforce, are now being addressed as part of a wider medical workforce strategy..

Attachment S

Appendix 1 Background Information

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

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

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

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

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

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

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

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

There are 45 different rota patterns currently in place within the Trust. All are compliant with 2016 TCS.

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

Allocate have improvement updates due in 2019 to include:

- Ability to close exception when trainee fails to respond
- Guardian quarterly board report
- Simplify the adding of overtime hours
- Process for tracking time of in lieu and overtime payments
- Allow supervisor and Guardian role for the same user
- Standardised themes for breach types

Attachment 8

Trust Board 3rd April 2019	
Guardian of Safe Working Annual Report 2018	Paper No: Attachment 8
Submitted by: Dr Renée McCulloch, Guardian of Safe Working	
Aims / summary This report is first annual report for the GOSH Guardian of Safe Working Hours	
Action required from the meeting	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Guardian of Safe Working supports and enables a safe and positive working and learning environment for junior doctors. This contributes to the Trusts strategic objective relating to providing safe patient care and an excellent place to work and learn.	
Financial implications Continuing payment for overtime hours documented through the exception reporting practice.	
Who needs to be told about any decision? n/a	
Who is responsible for implementing the proposals / project and anticipated timescales? Dr Renee McCulloch, Guardian of Safe Working Mr Simon Blackman and Dr Jonathan Smith, Acting Deputy Medical Directors for Medical & Dental Education	
Who is accountable for the implementation of the proposal / project? Dr Sanjiv Sharma Acting Medical Director	

Attachment 8

GOSH Guardian of Safe Working Annual Trust Board Report January to December 2018

Executive Summary

- GOSH has an active and engaged core group of junior doctors who have contributed significantly to the collection exception reporting and rest facilities surveys, information relating to the wellbeing and concerns of specific groups of junior doctors and the progress made in relation to the inclusion of Trust doctors in the exception reporting system.
- The exception reporting (ER) system has been implemented to allow issues to be addressed in real time however there are significant problems with engagement, implementation and process. The culture of an exception reporting system in medicine, understanding and acceptability of the ER process across junior and senior medical workforce and the accessibility of the reporting system software continue to affect reliability.
- GOSH rotas are theoretically compliant with 2016 TCS however when rota gaps occur they put significant pressure on the system. Tracking real time compliance is an ongoing issue.
- From May 2018 all junior doctors, including Trust Fellows (non-training grades), can exception report at GOSH although with differing compensation. The provision of an equitable reporting system is an essential expectation of the GOSH junior doctor workforce. GOSH was one of the first Trusts in the country to enable an equitable exception reporting system.
- GOSH has been reflective and open regarding its ER experience and has been presented at the national RCPCH annual meeting, Health Education England Medical Education meetings and the BMA, with data shared directly with NHS improvement.
- Access to adequate rest and sleep facilitates is a continued, unresolved issue at GOSH.
- Vacancy rates and rota gaps are less than the reported national average at GOSH however impact of rota gaps on junior doctor working patterns remains significant and close monitoring including anticipatory planning is ongoing.
- The establishment of the Modernising Medical Workforce Group through the Medical Director's Office in November 2018 is in direct response to the issues raised in this report, in addition to other factors impacting the wider medical workforce. The group is designed to assist the Great Ormond Street Hospital Board and Executive in the recruitment, support and retention of doctors focusing on the sustainability of the medical workforce. The goal of the group is to problem solve and think innovatively about the Trust-wide issues and challenges facing the medical workforce.

Attachment 8

GOSH Guardian of Safe Working Annual Trust Board Report January to December 2018

Introduction

The 2016 Terms and Conditions of Service (TCS) clearly indicate the importance of appropriate working hours and attendance at training and education for junior doctors. Both issues have a direct effect on the quality and safety of patient care. The 2016 TCS set firm limits to the number of hours trainee doctors can spend on duty and provided a process for:

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

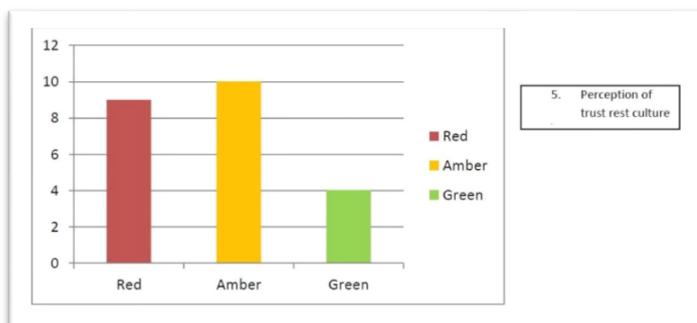
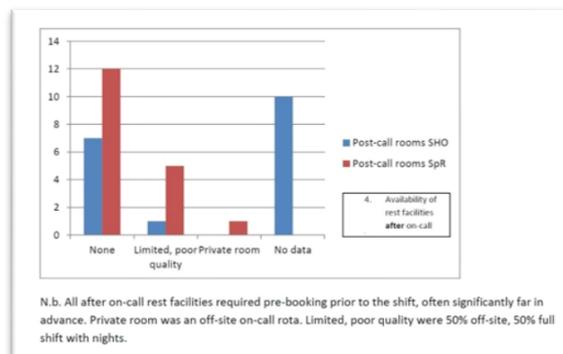
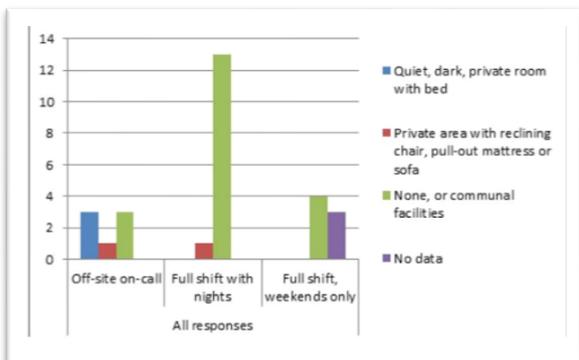
The contract also requires that every Trust has a Guardian of Safe Working (GoSW), a senior appointment who ensures that issues of compliance with safe working hours are addressed by the doctor and/or employer/host organisation, as appropriate and provides assurance to the Board of the employing organisation that doctors' working hours are safe.

Patient Safety

- There have been no immediate safety concerns reported directly through the exception reporting ER system (however the box has been ticked inadvertently on several occasions raising a responsive alert system).
- Concern regarding the significant burden of administrative and basic clinical tasks undertaken by doctors at GOSH has been raised indirectly through statements in ERs, qualitative information gathering in surveys, discussion at JDF and directly with the GoSW. These tasks can negatively affect patient safety and quality of experience by detracting from time available for tasks that specifically require doctors.
- In general GOSH has poor rest and sleep facilities for junior doctors. This was confirmed by the GoSW 2018 Rest and Sleep Survey where a doctor from each rota establishment was interviewed. Provision of rest space is challenging for the Trust and is in part due to the central London location and distance that doctors need to travel to be available for on call (non-resident on call can often not be done from home as most staff live considerable distance from site). Rest provision contributes to safe patient care by ensuring staff are making safe effective decisions. The 2016 TCS mandates the provision of adequate rest facilities or alternative arrangements for safe travel home. In 2018 GOSH committed to the BMA Sleep Charter for Junior Doctors. Short term solutions are yet to be activated at GOSH. Some results from 2018 rest and Sleep Survey below:

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**GOSH Guardian of Safe Working Annual Trust Board Report
January to December 2018**



- Engagement of doctors is directly linked to improved quality and safety outcomes, reducing clinical error and mortality rates. Junior doctor morale and engagement is low on a national level. It waxes and wanes at GOSH however we have a core of exceptionally committed trainees and fellows who with the continued support of PGME (post graduate medical education) and senior colleagues are able to activate their peers. GoSW has shown that doctor engagement improves with active listening and responsive action when concerns are raised at departmental level. Often small changes can make significant difference to experience.
- Exception reports in 2018 have highlighted that escalation plans for doctor cover due to both known and unscheduled rota gaps are not formalised. Rota gaps for doctors' present direct risk to patient safety, affecting quality of patient care and the wellbeing of doctors.

Work Schedules

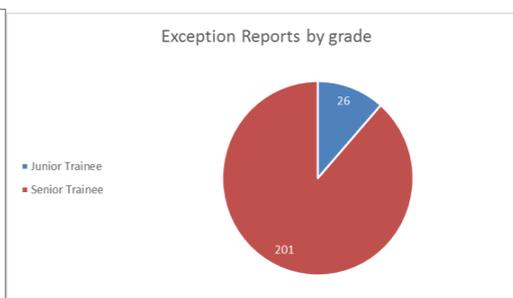
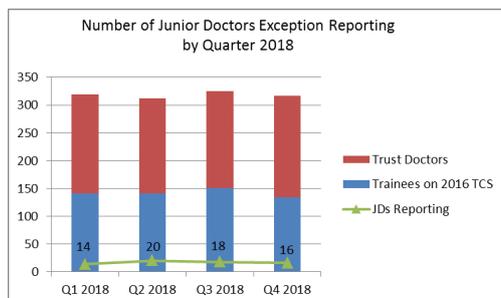
- Receiving advanced information regarding their next job/ training post is known to improve morale and reduce stress in doctors. NHS employers advise that doctors in training should receive information, including their work schedule, 8 weeks before commencement. On call rotas should be finalised and available 6 weeks prior to commencement of the new post. Medical staffing work hard to meet these targets however this has not always been possible due to the late notification of the necessary information from HEE. This has been raised at the London HEE meetings and the explanation is related to issues with their software processing the information.
- The content of work schedules is not standardised and can be highly variable, often not reflecting the reality of the post. Working patterns of doctors in training are also significantly influenced by rota gaps and changes in service requirements which in turn effects access to training and educational opportunities.

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**GOSH Guardian of Safe Working Annual Trust Board Report
January to December 2018**

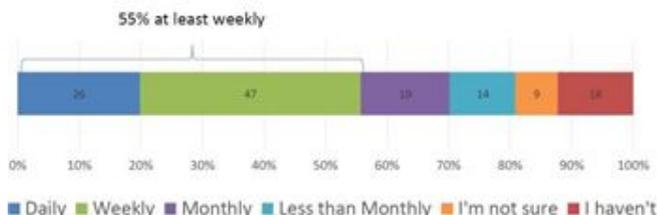
Exception Reporting

- Exception reporting is the contractually mandated mechanism used by doctors to inform the Trust when their day-to-day work varies significantly and/or regularly from the agreed work schedule of their post. The purpose of exception reports is to ensure prompt resolution and / or remedial action to ensure that safe working hours are maintained.
- Exception reports are submitted electronically by doctors to their educational supervisor. Upon receipt of an exception report, the educational supervisor will discuss with the doctor what action is necessary to address the reported variation or concern. The outcome of an exception report may be compensation, in the form of time off in lieu or payment for additional hours worked, or an adjustment to the work schedule of the post.
- Whilst exception reporting is a mechanism of the 2016 contract for doctors in training, GOSH has elected to extend the use of the system to doctors employed under local (non-training) TCS, in order to encourage safe working practices for all doctors, provide equity and obtain a more comprehensive view of junior doctors working hours across the Trust.
- In 2018 we received 227 exception reports submitted by a total of 46 doctors. Presented quarterly this is 5 to 7% of the junior doctor workforce. This is a small proportion of doctors but aligns with the national knowledge and our local ER survey in January 2018.



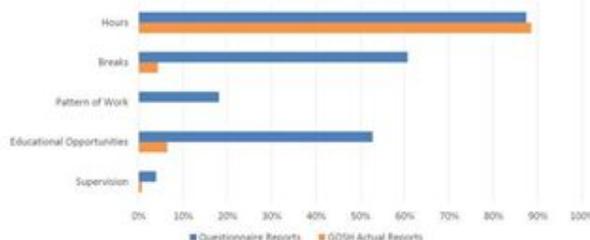
- In January 2018 an exception reporting survey of GOSH junior doctors received a total of 131 responses (approx. 48% response rate).

How often have you worked outside of your agreed working pattern?



"I would report it if it was just an 'exception', but in our department it is a daily occurrence that we registrars stay on much longer than our contracted hours"

In what ways have you worked outside your agreed working conditions?

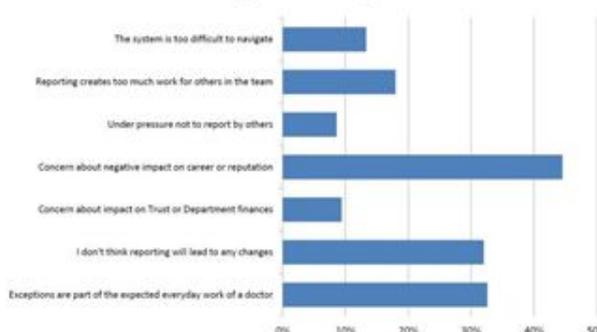


"It is such an ingrained culture that we are expected to stay past our rostered hours that I am not sure how this will change. It has been especially disappointing over the past 2 rotas that we have been short on the rota and this has impacted our educational and training opportunities"

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**GOSH Guardian of Safe Working Annual Trust Board Report
January to December 2018**

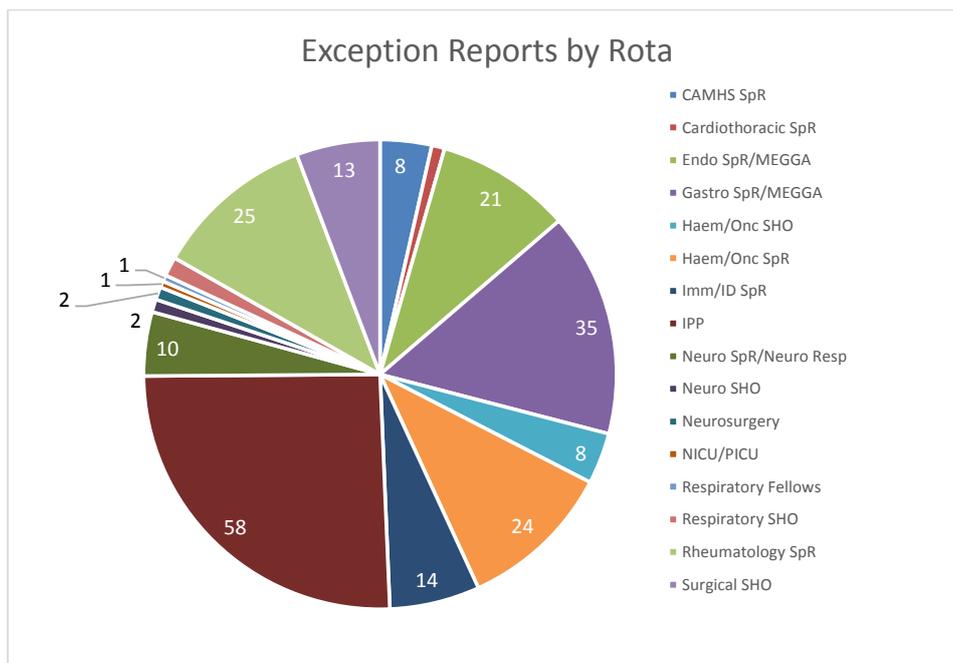
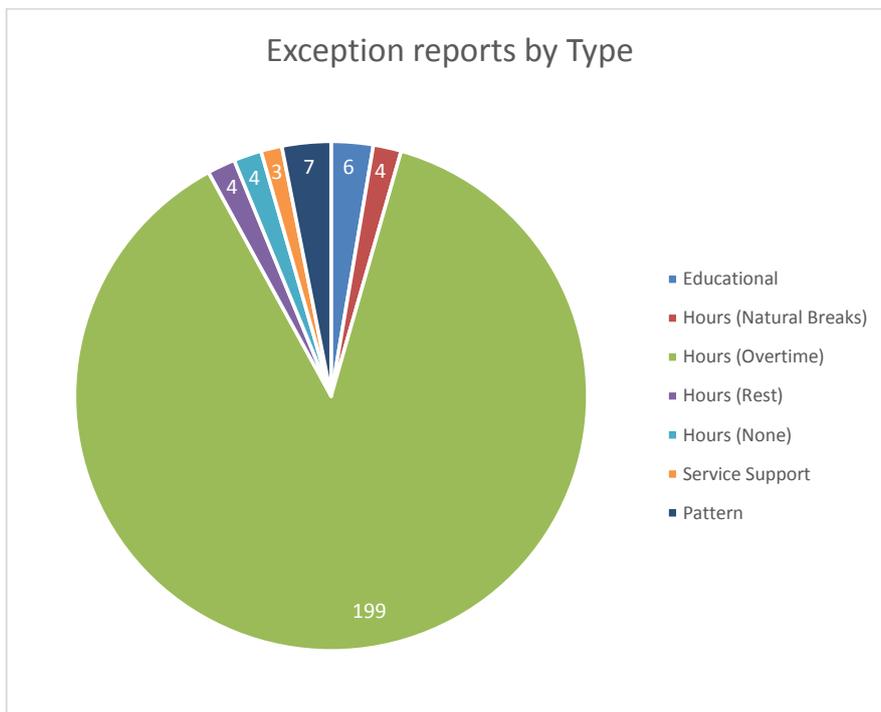
What stopped you from filling in an exception report?



- The results of the GOSH survey were presented at the RCPCH annual meeting; the BMA; HEE London. NHS improvement requested a copy for the review of the ER process. It is widely known that the GOSH results reflect the opinion and views of junior doctors across the country. There is generally less reporting from senior doctors in training, which reflects the majority of the GOSH JD workforce. There is a clear issue related to distinguishing system and patient safety vs. time management and service requirements. Action related to this survey included GoSW meeting every department; attending local faculty meetings; ensuring induction process is clear; liaising with software company (Allocate) to suggest improvements and celebrating success related to ERs across the hospital.
- The majority of ERs are related to additional hours work, suggesting that overworking is common and is an element of reporting that doctors are more comfortable with. It is likely that the ER system is not appropriate for reporting lack of rest and natural breaks and poor access to education and training opportunities. Positively, ERs have been presented by multiple specialties. The frequency of reporting in 'hot spot' areas (often due to rota gaps) is related to the GoSW meeting with various doctors on various rota groups encouraging ER.

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**GOSH Guardian of Safe Working Annual Trust Board Report
January to December 2018**

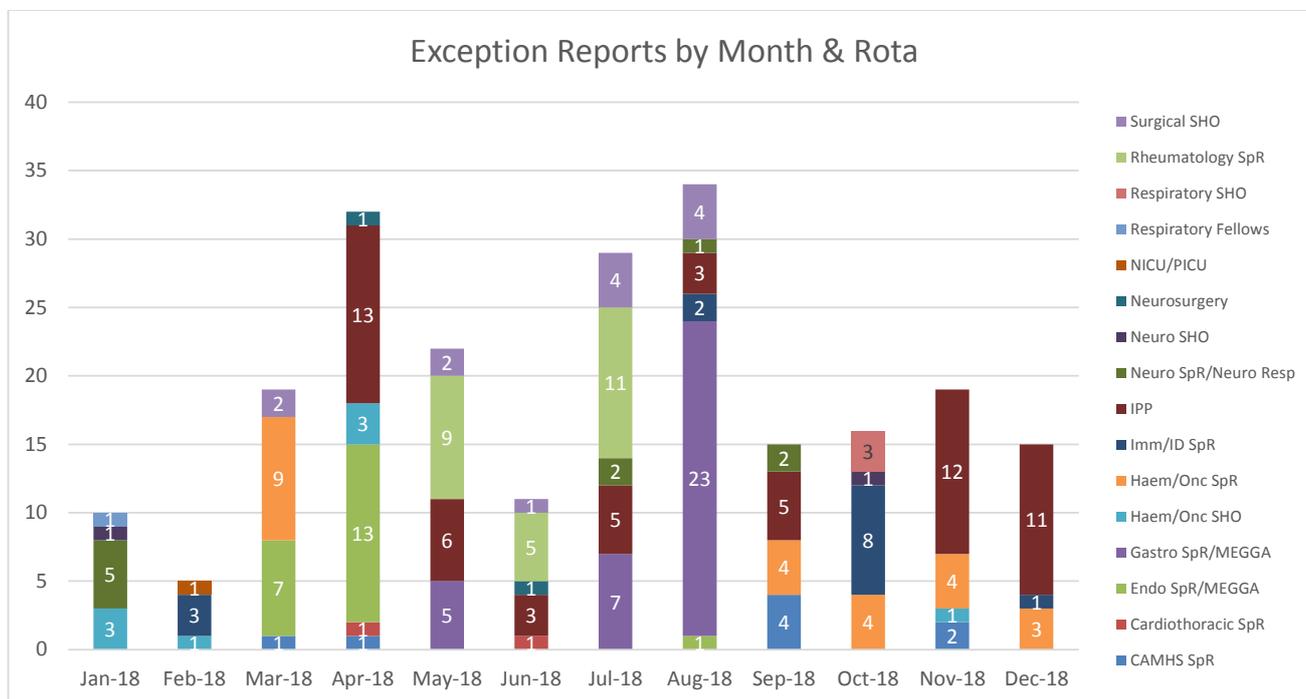


- There is variation in reporting patterns through the year. Incidence of reporting can be seen in specialities that have experienced rota gaps and high volume work flow. Successful interventions in rheumatology and gastroenterology reduced ER numbers. There is currently an increase in reports

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**GOSH Guardian of Safe Working Annual Trust Board Report
January to December 2018**

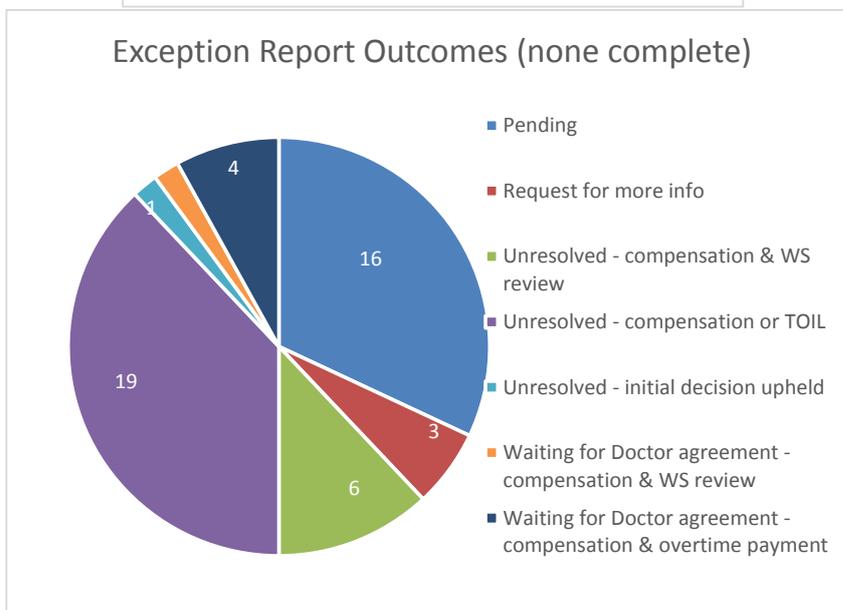
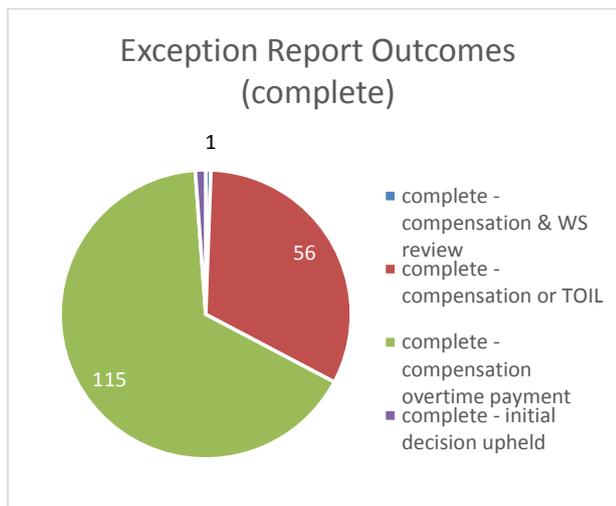
from BMT and International Private Patients. The latter remains understaffed and a change in working pattern is being considered.



- Tracking the outcomes of ERs continues to be challenging. Many clinical and education educational supervisors complete their responses to the ERs swiftly. However some struggle with the electronic system data entry, and say they manage the report locally, offering time off in lieu but do not record these actions. Variability of data input is also a problem. 'Unresolved' ERs may include some that are not 'approved' by the junior doctor and not closed the report. Unfortunately, in addition, there is no way of tracking whether TOIL is actually taken. Some ERs 'pending' on the system have also been actioned by the GoSW but as there is no edit function to close the ER on the system, data cannot be updated.

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**GOSH Guardian of Safe Working Annual Trust Board Report
January to December 2018**



- Software updates enabling improvement in data capture are due in Allocate imminently including the ability to edit the ER by the GoSW. Ongoing education regarding ER data input is offered to supervisors and junior doctors on an ongoing basis, in addition GoSW and medical HR are accessible and continually contact supervisors with support and information.

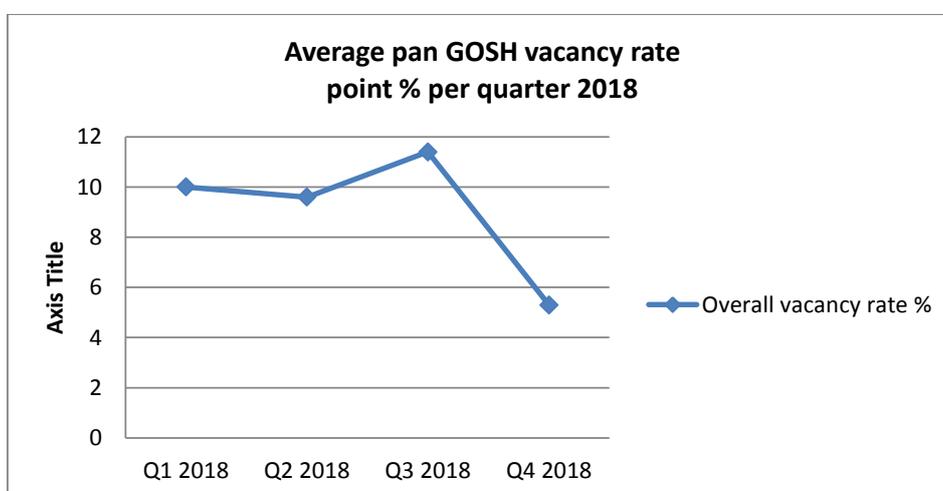
Rota Gaps

- Vacancy rates and rota gaps are a constant area of change within the organisation. They reflect the end point of multiple workforce issues, including short term unplanned absence, delays in recruitment process and rotational pathways, alongside a national reduction in the medical paediatric workforce. Rota gaps have been highlighted as an organisational pressure and measures are being taken to mitigate the situation at GOSH.

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**GOSH Guardian of Safe Working Annual Trust Board Report
January to December 2018**

- The modernising medical workforce group has been established through the Medical Director's Office in direct response to the issues impacting the medical workforce at local and national level. The group is designed to assist in the recruitment, support and retention of doctors focusing on the sustainability of the medical workforce. Rota gap pressures for junior doctors and the Trust response is a particular focus.
- We have become aware of the requirement for 'real time' continuous data collection regarding vacancy rates and rota gaps which is currently not routinely centralised or disseminated. Therefore we are currently developing a mechanism to capture this data to ensure that there is consideration to both the immediate and medium term impact of rota gaps across the organisation. In parallel to this we are creating a clear plan for the escalation process to support doctors on rotas that have short and medium term vacancies. Below are 2018 vacancy rates, as average point data per quarter across the organisation. The average national vacancy rate in paediatrics is 18%. Of note a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps is, from 2019, to be included in the Trust's Annual Quality Report.

**Fines**

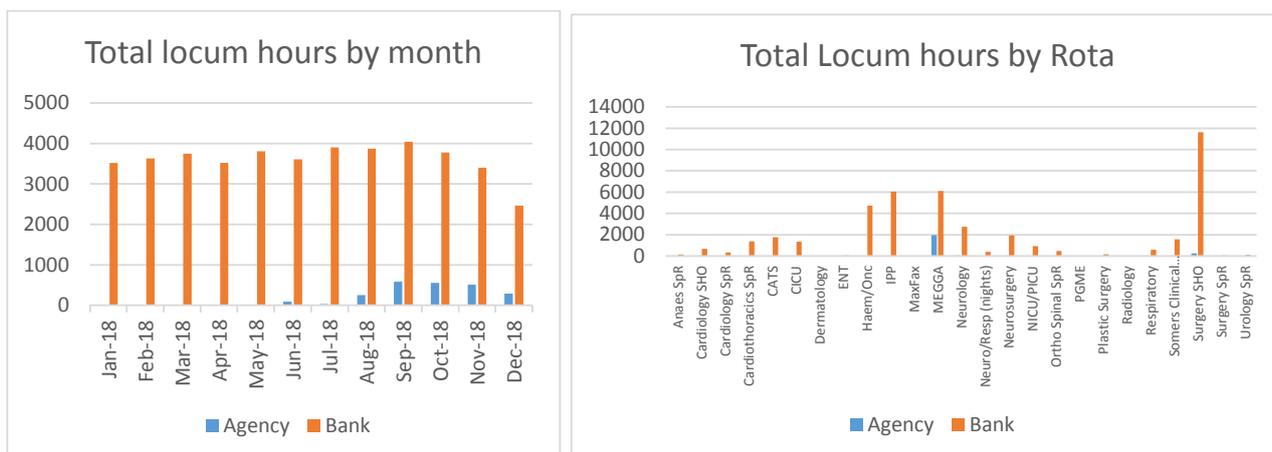
- To date the GoSW has not levied any fines. This reflects the work of the medical staffing team and the rota coordinators who have created compliant rotas and enable junior doctors to avoid shifts that will breach safe working limits. However it also reflects that there is no robust system for identifying breaches as the system is dependent on the doctors to report breaches in their TCS which, as seen from the survey and the ER data, they are often reluctant to do.
- Some rotas are close to the maximum permitted hours and it makes it difficult to swap on call shifts and annual leave which can affect morale.

Bank Hours

- Numbers of locum hours remain consistent throughout 2018. Bank shifts are filled 'in house' as opposed to locum agencies.

Attachment 8

**GOSH Guardian of Safe Working Annual Trust Board Report
January to December 2018**



- Better tracking of doctors hours is required when doing bank shifts as it is likely that locum hours will cause breaches in working time if done in addition to normal working hours. Doctors themselves have a responsibility and duty of care for regulating their own hours of working, in addition to the organisation.
- Further analysis of speciality areas that are requiring high volume locum hours is required and consideration for more innovative ways of working should be considered. Stretching the existing workforce to plug rota gaps has detrimental effects on both staff wellbeing and patient safety.

Junior Doctors Forum (JDF)

- The JDF was first established in spring 2017. Theoretically there is a requirement for every speciality to be represented at each meeting. In reality this does not occur. In 2018 a new JDF was created, merging the DocsReps Committee and the statutory JDF to improve attendance. The meeting is currently split into two sections: the first being related to junior doctor events and discussions, the second attended by senior colleagues including the Director of Medical Education, Post Graduate Training Centre representatives; Local Negotiating Representatives and co-chaired by the GoSW and the JDF President.
- The JDF is attempting to engage more doctors through rotating through a different department every month with the offer of lunch.
- In general the junior doctors are engaged on multiple levels through social events and educational opportunities. The GoSW also does 'walk-about's which encourages direct discussion and information sharing with the junior doctors. Junior doctors have a strong influence on Trust performance however they are often unaware of existing systems and processes and issues occurring within the wider organisation.

The Joy and activation at Work Initiative (JAWs)

- The GoSW led on the development of this initiative in recognition of the need to identify issues relating to the consultant body that despite being 'up the chain' from the junior doctors, have a direct impact on

Attachment 8

**GOSH Guardian of Safe Working Annual Trust Board Report
January to December 2018**

the experience of the trainees at GOSH. There is international acknowledgment of the stress and pressures faced by consultants, with focus on increasing clinician burnout. The aim of the JAWs is to develop a working group, supporting the GOSH consultant body to own the challenge of their demanding work patterns and stresses; looking creatively within and outside healthcare for innovative ideas to create a more positive environment that energises and motivates the workforce.

- The JAWs group has been supported by the executive team to run workshops with the consultant body offering identifying stressors, offering constructive reflection and suggestions for improvement. Increasing social cohesion and activating the consultant body is an important element of the improving the experience of junior doctors.

Matters for the Board:

- Ongoing consideration of how the organisation facilitates two way communications with the clinical workforce is required including recommendations for improving the engagement of junior and senior colleagues.
- Consideration of a Junior Doctor representation at Executive and Board level.

Trust Board 3rd April 2019	
London North Genomic Laboratory Hub Governance Submitted by: Helen Jameson, Chief Finance Officer	Paper no: Attachment T
<p>Key Points to take away</p> <p>As the lead contractor of the London North Genomic Laboratory Hub (GLH) GOSH is responsible to NHSE for:</p> <ul style="list-style-type: none"> • Delivery of current testing, including performance and quality across all the laboratories in the partnership • The consolidation of testing services across the patch to the 2 main laboratories • Leading the management of the contract and financial flows (c£35m per annum) <p>NHSE have confirmed they expect the senior management team of GLH to report to an SRO at GOSH, to ensure the GOSH Board has the appropriate oversight of the service.</p> <p>The original GOSH Laboratory had a turnover c£5m per annum and as part of the operational restructure was positioned within the Medicines, Therapies and Tests Directorate. As such it would be very difficult to meet NHSE requirements if the service remained in this location and may have detrimental impact on the other services within the Directorate due to its size and scope and requirement of the teams management time. This is because:</p> <ul style="list-style-type: none"> • NHSE have dictated the management structure which includes a COO and Medical director, which would be more senior than the Directorate management structure posts • The roles would be very externally focused as greater than 90% would relate to patients outside of GOSH and over 50% of the testing would be delivered outside of GOSH • NHSE have required the senior management team to report directly to an executive SRO • The GLH annual budget will be c£35 million which is equivalent to the total current Directorate budget including the North Thames Regional Genetic Laboratory • There is an approved governance structure with partners across the patch which would sit alongside but be independent of the GOSH operational structure <p>Therefore it is proposed that the GLH transfers out of the Medicines, Therapies and Tests Directorate to ensure it has appropriate governance and oversight.</p>	
<p>Purpose</p> <p>NHS England has established a national genomics medicine service, building on the 100,000 Genomes Project, which will ensure the delivery of comprehensive, personalised and equitable genomic testing for patients with rare diseases and cancer. To deliver this testing NHSE has commissioned 7 genomic laboratory hubs (GLHs) as part of a national network. Contracts were awarded in September 2018 and the new service went live on 1 October 2018. At this time the North East Thames Regional Genetics Laboratory at GOSH ceased to exist and became part of the London North GLH. As a result of this GOSH is funded for the GLH via its specialised commissioning contract during 2018/19 and 2019/20, after which time a new contract will be signed with NHS England</p>	

<p>specifically covering this service.</p> <p>In order to address NHSE requirements above the Executive Management Team reviewed and discussed the position of the GLH in the Trust governance structure. It proposes that the London North GLH should :</p> <ul style="list-style-type: none"> • Sit alongside the directorate structures • Report to the GOSH CFO as the SRO, recognising her involvement to date leading the tender response for the partnership as well as her current role as SRO for the GMC (which will ultimately roll into the GLH as the research becomes operationalised into NHS care). • The GLH would be subject to GOSH governance processes including standing orders, Standing financial instructions and scheme of delegation • The FIC would provide financial and governance oversight on behalf of the Board, in line with all other Directorates and a review of the GLH would be included in the FIC forward planner. • The GLH would hold monthly performance reviews and finance and performance reporting would be included in future EMT/FIC and Board reporting papers. • Close links to the operational GOSH management structure would be maintained by including the GOSH Director of Operations on the GLH Delivery Board and by the GLH COO and Medical Director attending appropriate internal GOSH management groups including Operational Board and Senior Leadership Team.
<p>Action required from the meeting</p> <p>The Board is asked to confirm it is happy to update the Trust governance structure to reflect the NHSE reporting requirements and to ensure appropriate scrutiny of the GLH finance and governance going forwards.</p>
<p>Contribution to the delivery of NHS / Trust strategies and plans</p> <p>Consolidating genomic testing services at GOSH and leading the London North partnership will maintain GOSHs voice as a leader in the field of genomic medicine and research into rare disease. Making GOSH a one-stop-shop for translational research for the diagnosis, monitoring and treatment of rare diseases by bringing together genomic services, genomic research and the laboratory medicine service at GOSH to deliver the best possible outcomes for our patients.</p>
<p>Financial implications</p> <p>N/A.</p>
<p>Legal issues</p> <p>None</p>
<p>Who is responsible for implementing the proposals / project and anticipated timescales</p> <p>Chief Finance Officer</p>
<p>Who is accountable for the implementation of the proposal / project</p> <p>Chief Finance Officer</p>

Attachment T

London North Genomic Laboratory Hub Governance

NHS England has established a national genomics medicine service, building on the 100,000 Genomes Project, which will ensure the delivery of comprehensive, personalised and equitable genomic testing for patients with rare diseases and cancer. To deliver this testing NHSE has commissioned 7 genomic laboratory hubs (GLHs) as part of a national network. Contracts were awarded in September 2018 and the new service went live on 1 October 2018. At this time the North East Thames Regional Genetics Laboratory at GOSH ceased to exist and became part of the London North GLH. As a result of this GOSH is funded for the GLH via its specialised commissioning contract during 2018/19 and 2019/20, after which time a new contract will be signed with NHS England specifically covering this service.

The London North hub (formally known as the **N**orth **E**ast and **W**est (NEW) London GLH) is a partnership between a number of organisations across North London. Led by Great Ormond Street NHS Foundation Trust the laboratory partners include:

- Barts Health,
- Imperial College Hospital and its partner laboratory North West London Pathology,
- The Royal Marsden Hospital,
- UCLH NHS Foundation Trust, with its partner laboratory Health Services Laboratory
- Royal Free Hospital, with its partner laboratory Health Services Laboratory,
- Royal National Orthopaedic Hospital

Further to this although Moorfields Eye Hospital which doesn't have a laboratory is a key partner due to its specialist knowledge and expertise.

The organisations currently delivering genomic testing for rare diseases and cancer, adults, children and prenatal, will continue to provide all core Rare Disease and Cancer testing for north London, Essex and Hertfordshire and a significant volume of specialist Rare Disease testing at a sub-national level in the short-term. A requirement of the contract is to streamline laboratory services, consolidating to enable delivery of high throughput testing to drive efficiencies. As such the majority of laboratory services will be centralised to two main laboratories, one for rare disease based at GOSH and one for cancer based at the Royal Marsden Hospital. As the lead contractor GOSH will be responsible for overseeing the delivery of the consolidation.

Therefore, going forwards GOSH is responsible to NHSE for:

- Delivery of current testing, including performance and quality across all the laboratories in the partnership
- The consolidation of testing services across the patch to the 2 main laboratories
- Leading the management of the contract and financial flows (c£35m per annum)

To ensure successful delivery of the new service NHS England have mandated (and funded) a management structure for the GLHs which are to be led by a Chief Operating Officer, Medical Director and Scientific Director who will oversee a management team (Appendix 1). NHSE have confirmed they expect the senior management team of GLH to report to an SRO at GOSH, to ensure the GOSH Board has the appropriate oversight of the service.

Although the delivery of the GLH service and contract management will need to follow the GOSH governance processes including Standing Orders, Standing Financial Instructions and Scheme of

Attachment T

Delegation - In light of the requirements and the size and scope of the service it is appropriate to consider where it should sit in the GOSH organisational structure. The North Thames Regional Genetic Laboratory Service had a turnover c£5m per annum and as part of the operational restructure was positioned within the Medicines, Therapies and Tests Directorate. As such it would be very difficult to meet NHSE requirements if the service remained in this location and may have detrimental impact on the other services within the Directorate due to its size and scope and requirement of the teams management time. This is because:

- NHSE have dictated the management structure which includes a COO and Medical director, which would be more senior than the Directorate management structure posts
- The roles would be very externally focused as greater than 90% would relate to patients outside of GOSH and over 50% of the testing would be delivered outside of GOSH
- NHSE have required the senior management team to report directly to an executive SRO
- The GLH annual budget will be c£35 million which is equivalent to the total current Directorate budget including the North Thames Regional Genetic Laboratory
- There is an approved governance structure (Appendix 2) with partners across the patch which would sit alongside but be independent of the GOSH operational structure

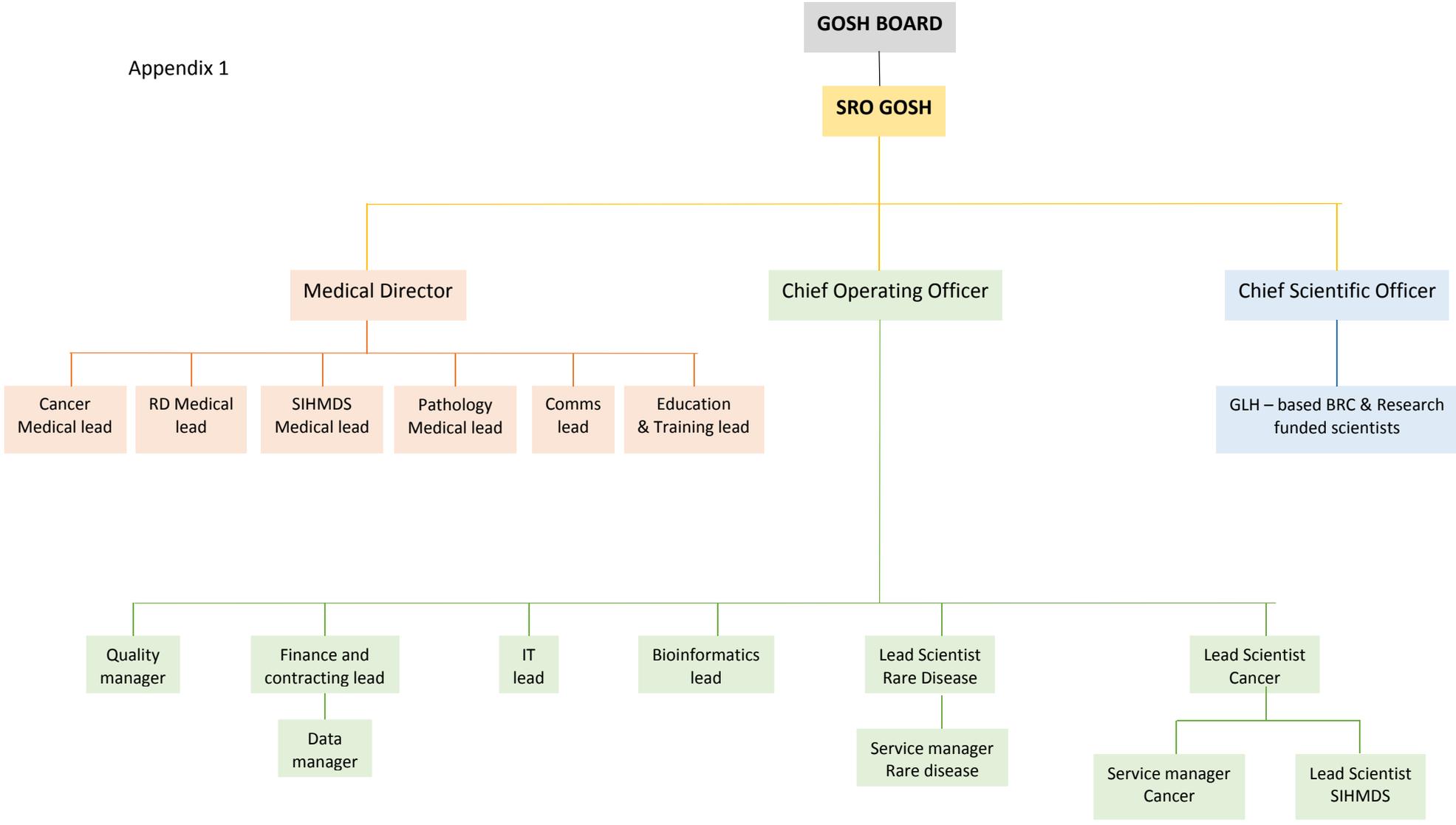
Recommendation

Following an Executive Management Team review and discussion it is proposed that the London North GLH should (Appendix 3):

- Sit alongside the directorate structures
- Report to the GOSH CFO as the SRO, recognising her involvement to date leading the tender response for the partnership as well as her current role as SRO for the GMC (which will ultimately roll into the GLH as the research becomes operationalised into NHS care).
- The GLH would be subject to GOSH governance processes including standing orders, Standing financial instructions and scheme of delegation
- The FIC would provide financial and governance oversight on behalf of the Board, in line with all other Directorates and a review of the GLH would be included in the FIC forward planner.
- The GLH would hold monthly performance reviews and finance and performance reporting would be included in future EMT/FIC and Board reporting papers.
- Close links to the operational GOSH management structure would be maintained by including the GOSH Director of Operations on the GLH Delivery Board and by the GLH COO and Medical Director attending appropriate internal GOSH management groups including Operational Board and Senior Leadership Team.

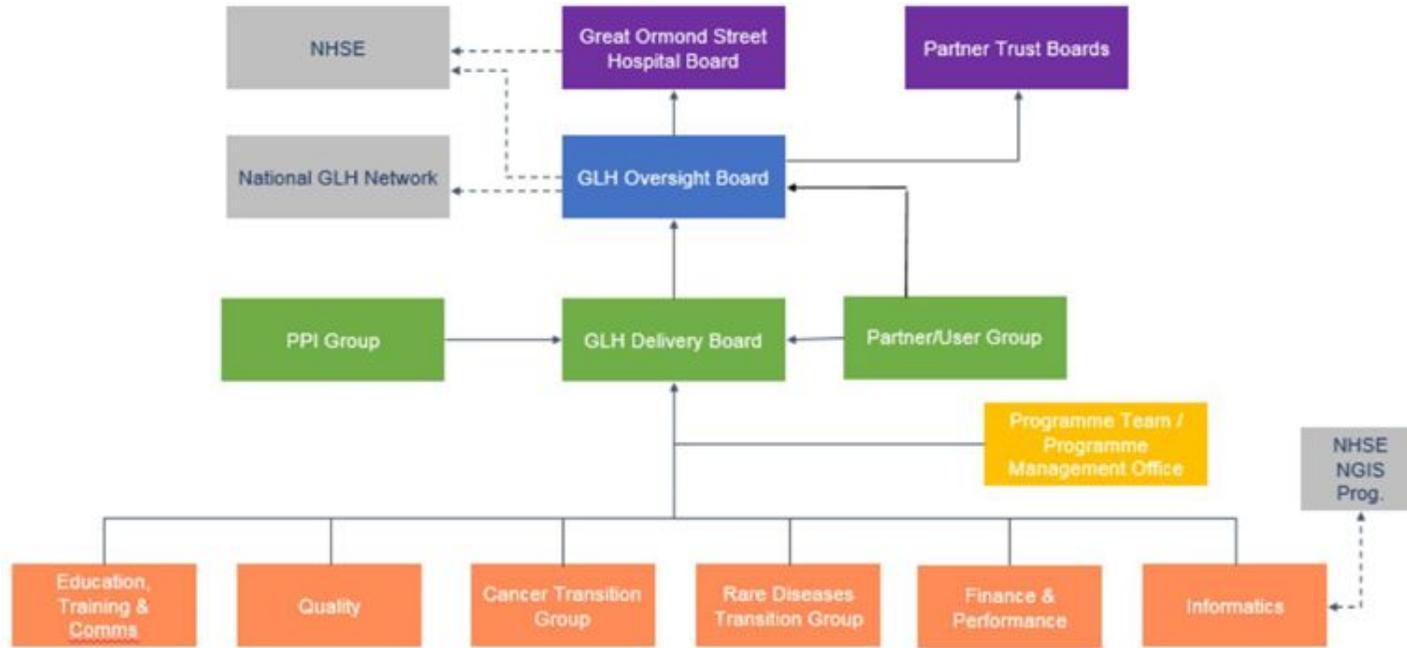
The Board is asked to confirm it is happy to update the Trust governance structure to reflect the NHSE reporting requirements and to ensure appropriate scrutiny of the GLH finance and governance going forwards.

Appendix 1



NEW London Genomic Laboratory Hub management structure

Appendix 2: NEW London GLH Transitional Governance Structure (to 31 March 2020)



Education, training and comms groups all have externally appointed, GLH funded leads and are responsible for GLH activities across the whole geography, with comms extending to stakeholders nationally

Quality lead, GLH funded, competitively appointed, responsible for quality across all partner laboratories, working with local lab quality leads

Cancer transition group comprises laboratory and managerial leads from all participating laboratories. Chaired by GLH funded medical cancer lead. The consolidated cancer lab will be located at RMH, with other contributing labs at GOSH, Barts Health, Imperial College Hospital (NWL), UCLH (HSL), RNOH

Rare disease transition group comprises laboratory and managerial leads from all participating laboratories. Chaired by GLH funded rare disease lead. The consolidated RD lab will be located at GOSH. There are other contributing labs at UCLH (HSL), Barts Health, and the Royal Free Hospital

Finance and performance leads will be employed by and based at GOSH and will lead this work but will work with counterparts across partner laboratories

Informatics led by GOSH, working with IT leads across all Trusts. Initially those providing laboratory services but later all that will order tests

Who's who at Great Ormond Street Hospital

April 2019



Great Ormond Street Hospital for Children
NHS Foundation Trust

Chairman

Sir Michael Rake ♦

Non-executive Directors

Deputy Chairman Akhter Mateen ♦	Senior Independent Director James Hatchley ♦	Non-Executive Director and Director UCL Great Ormond Street Institute of Child Health Professor Rosalind Smyth ♦	Non-Executive Director Lady Amanda Ellingworth ♦	Non-Executive Director Chris Kennedy ♦	Non-Executive Director Kathryn Ludlow ♦
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♦ Denotes voting member of Board of Directors ○ Denotes member of Operational Delivery Group

Council of Governors

Lead Governor Mariam Ali

Patients: London
Elena-May Reading
Zoe Bacon

Patients: outside London
Alice Rath
Faiza Yasin

Parents and Carers: London
Emily Shaw
Stephanie Nash

Parents and Carers: outside London
Claire Cooper-Jones
Lisa Allera

Public: North London and surrounding area
Simon Hawtrey-Woore
Teskeen Gilani
Theo Kayode-osiyemi
Simon Tan

Public: South London and surrounding area
Fran Stewart

Public: Rest of England and Wales
Colin Sincock
Julian Evans

Staff
Nigel Mills
Paul Gough
Quen Mok
Sarah Aylett
Vacant

Young Person Forum Governor
Vacant

UCL GOS Institute of Child Health
Jugnoo Rahi

London Borough of Camden
Lazzaro Pietragnoli

Chief Executive	Acting Chief Operating Officer	Chief Nurse	Interim Medical Director	Chief Finance Officer	Director of HR and Organisational Development	Director of Built Environment	Director of Research and Innovation	Director of Communications	Commercial Director
Matthew Shaw ♦ Company Secretary Dr Anna Ferrant Senior Advisor Louisa Desborough	Andrew Taylor ♦ ○ Director of Operational Performance and Information Peter Hyland ○ Director of ICT Ward Priestman ○ Director of PMO Jon Schick ○ Director of Operations IPP Trevor Clarke ○ Clinical Director of Operations Andrew Taylor ○ Nursing Director of Operations Herdip Sidhu-Bevan ○ Director of Operations Anne Layther ○	Alison Robertson ○ Deputy Chief Nurse Polly Hodgson ○ Head of Patient Experience Claire Williams Assistant Chief Nurse for Workforce Tricia Bennett ○ Director of Education Lynn Shields ○ Deputy Chief Nurse for Research and Orchid Faith Gibson Chief Nursing Information Officer Sarah Newcombe Named Doctor Dr Alison Steele Named Nurse Jan Baker Head of Social Work Jenny Brickell Director of Infection Prevention and Control John Hartley Lead Nurse, Infection Prevention and Control Helen Dunn	Dr. Sanjiv Sharma ♦ ○ Deputy Medical Director & Responsible Officer Andrew Long ○ Deputy Medical Director Vacant Head of Quality and Safety Salina Parkyn ○ Caldicott Guardian Rob Evans Chief Clinical Information Officer Shankar Sridharan Chief Research Information Officer Neil Sebire Associate Medical Directors Daljit Hothi ○ Sophie Skellett Guardian of Safe Working Renee McCulloch Freedom to Speak Up Guardian Luke Murphy	Helen Jameson ♦ Deputy Chief Finance Officer Tom Burton ○ Head of Financial Management Jonathan Wharton Head of Contracts Sue Blannin Head of Financial Control Neil Redfern Head of Procurement Diane Wilson Director of Estates and Facilities Graham Sherlock ○ London North Genomic Laboratory Hub Chief Operating Officer TBC Medical Director TBC Scientific Director TBC Acting Rare Disease Laboratory Lead Lucy Jenkins	Caroline Anderson ♦ Deputy Director of HR and Organisational Development Alison Hall Assistant Director of HR and Organisational Development Sarah Ottaway Acting Assistant Director of HR and Organisational Development Matt Guilfoyle Assistant Manager of Workforce Development Jo Weeks	Matthew Tulley ♦ Deputy Director of Built Environment Stephanie Williamson ○ Assistant Director - Capital Projects Joe McGonagle	David Goldblatt ♦ Deputy Director of Research and Innovation Dr Jenny Rivers ○ Director of NIHR GOSH Clinical Research Facility Dr William van't Hoff Director of NIHR GOSH Biomedical Research Centre Professor Thomas Voit	Cymbeline Moore ♦ Deputy Director of Communications Jon Bennett ○ Head of External Communications Naomi Owen Head of Internal Communications Zoe Chiverton Deputy Director of Brand and Content Nick Radmore ○ Head of Digital Engagement Yasmin Georgiou	Vacant

<p>Brain</p> <p>Chief of Service: Sophie Varadkar ○ Deputy Chief of Service: Martin Tisdall Head of Nursing & Patient Experience: Alison Taberner-Stokes General Manager: Anthony Sullivan</p> <p>Specialty Leads: Neurosurgery, Neurology, Neuromuscular, Neurodisability, Neurophysiology, Endocrine, Metabolic, Epilepsy and Children's Epilepsy Surgery Service (CESS)</p>	<p>Body, Bones and Mind</p> <p>Chief of Service: Allan Goldman ○ Deputy Chief of Service: Sian Pincott Head of Nursing & Patient Experience: Jilly Hale General Manager: Camella Melody</p> <p>Specialty Leads: Nephrology, Urology, SNAPs, General Paediatrics, Spinal and Orthopaedics, CAMHS, Gastroenterology</p>	<p>Operations and Images</p> <p>Chief of Service: Eithne Polke ○ Deputy Chief of Service: Tim Liversedge Head of Nursing & Patient Experience: Ciara McMullin General Manager: Ruth Leighton</p> <p>Specialty Leads: Imaging, Anaesthetics, Pain</p>	<p>Sight and Sound</p> <p>Chief of Service: Liz Jackson ○ Deputy Chief of Service: Chris Jephson Head of Nursing & Patient Experience: Carolyn Akyil General Manager: Daniella Soar</p> <p>Specialty Leads: Audiology, ENT and Cochlear, Ophthalmology, Plastics, Dental and Maxillofacial, Clinical Director - North Thames Cleft Lip and Palate Team</p>
<p>Blood, Cells and Cancer</p> <p>Chief of Service: Clarissa Pilkington ○ Deputy Chief of Service: Anupama Rao Head of Nursing & Patient Experience: Tricia Bennett (currently seconded to Nursing Workforce) General Manager: Laura Walters</p> <p>Specialty Leads: Rheumatology, Dermatology, Haematology and Oncology, Haemophilia, Bone Marrow Transplant, Palliative Care, Immunology, Infectious Diseases</p>	<p>Heart and Lung</p> <p>Chief of Service: Daniel Lutman ○ Deputy Chief of Service: Rob Yates / Simon Hannam Head of Nursing & Patient Experience: Dagmar Gohil General Manager: Katherine Joe</p> <p>Specialty Leads: Cardiology, Cardiac Surgery, Respiratory, NICU, PICU, CICU, CATS</p>	<p>International and Private Patients</p> <p>Chief of Service: Melanie Hiorns ○ Head of Nursing: Kate Rivett General Manager: Chris Rockenbach</p>	<p>Medicines, Therapies and Tests</p> <p>Chief of Service: Allan Goldman ○ Chief Pharmacist: Steve Tomlin Chief Allied Health Professional: Philippa Wright Chief of Laboratory Medicine: Simon Heales Chief of Mental Health Services: Lee Hudson Chief of Clinical Genetics: Angela Barnicoat General Manager: Chris Longster</p>

Trust Board 3 April 2019	
Draft Trust Board Workplan 2019/20	Paper No: Attachment U
Submitted by: Anna Ferrant, Company Secretary	
Aims / summary A revised work-plan has been drafted for the Trust Board in 2019/20. This work-plan has been presented under the eight key lines of enquiry headings of CQC's Well Led assessment. It provides a summary of the papers that the Board will expect to receive at meetings throughout the next financial year. It reflects the following: <ul style="list-style-type: none"> • Schedule of matters reserved for the Trust Board and Scheme of Delegation requirements; • Statutory and regulatory reporting requirements; • Patient stories; • Requests from Board members to enable directorate teams the opportunity to regularly report at Board; • Key streams of work from the executive team annual work-plan requiring reporting at Board. 	
Action required from the meeting The Board is asked to review the work-plan, provide comments and subject to these comments, approve the work-plan for 2019/20.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Good governance – clarity of reporting to Board	
Financial implications None	
Who needs to be told about any decision? Report authors	
Who is responsible for implementing the proposals / project and anticipated timescales? Company Secretary	
Who is accountable for the implementation of the proposal / project? Chief Executive	

Trust Board Work-plan 2019 (incorporating assurance committee work)

CQC Domain	Topic	Executive Director	February 2020	03 April 2019	22 May 2019	18 July 2019	18 September 2019	30 October 2019 (Strategy Day)	27 November 2019	
Well Led	W1: Is there the leadership capacity and capability to deliver high-quality, sustainable care?									
	Report from Board and Council Nominations Committees and Remuneration Committee	Company Secretary		X Appraisals (NEDs and Executives) Recruitment Remuneration					X Appraisals (NEDs and Executives) Recruitment Remuneration	
	Executive/ Board Development	Chief Executive			X					
	W2: Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?									
	Strategy progress update	CEO and responsible executives	Research Strategy Progress Report	Leadership Strategy Approval Clinical Strategy Approval Risk Management Strategy	Overview of refreshed objectives and plans Stakeholder Engagement Strategy	Learning Academy Business Case IPP Strategy and Commercial Opportunities Update Patient Experience and Engagement Strategy	Workforce and Education Strategy Progress Report Risk Management Strategy Compliance	Full strategy & progress with objectives and plans 3-5 year Transformation Plan		
	Operational/ Financial Plan	Chief Operating Officer/Chief Finance Officer		Final annual plan for submission to NHSI					Draft annual plan including Capital programme	
	Redevelopment of site					The case for the Children's Cancer Centre	Children's Cancer Centre OBC		Progress with Sight and Sound Hospital	

CQC Domain	Topic	Executive Director	February 2020	03 April 2019	22 May 2019	18 July 2019	18 September 2019	30 October 2019 (Strategy Day)	27 November 2019	
	Directorate Team Presentations*	Chief Operating Officer and Directorates	Brain and Medicines, Therapies and Tests	Operations and Imaging	Body, Bones and Mind	IPP Sight and Sound	Heart and Lung		Blood, Cells and Cancer	
	W3: Is there a culture of high-quality, sustainable care?									
	Report from Guardian (Q)	Guardian of Safe Working	X	X		X			X	
	Report from Freedom to Speak Up Guardian	Freedom to Speak Up Guardian			Annual Report					
	Sustainability Report	Dir of Redev			Annual Report					
	Responsible Officer Report	Medical Director				Annual Report				
	Mediation and Open Employment Tribunals	Dir of HR and OD/ Medical Director		X					X	
	Business Continuity Report	Chief Operating Officer		Annual Report						
	Health and Safety Report	Dir of HR and OD			Annual Report					
	Safeguarding Report	Chief Nurse			Annual Report					
Operational matters	Relevant executive(s)		Update on Cognitive pilot			Parent/carer accommodation review Progress with Flow Safari		Update on Cognitive		

CQC Domain	Topic	Executive Director	February 2020	03 April 2019	22 May 2019	18 July 2019	18 September 2019	30 October 2019 (Strategy Day)	27 November 2019	
	W4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?									
	Review of compliance	Company Secretary			Code of Governance/ NHSI Licence Review	CQC Progress update including well led	CQC Progress update including well led	CQC Progress update including well led	CQC Progress update including well led	
	Council of Governors' Update	Company Secretary		X	X		X		X	
	Board ToR/ workplan/ Matters reserved - Board and Council/SFIs	Company Secretary				Schedule of matters reserved for the Board and Council			Board ToR/ Workplan	
	Register of Interests & Gifts & Hospitality & Register of seals	Company Secretary	Seals	Seals/ Gifts and Interests	Seals	Seals	Seals		Seals	
	W5: Are there clear and effective processes for managing risks, issues and performance?									
	W6: Is appropriate and accurate information being effectively processed, challenged and acted on?									
	Integrated Quality and Performance Report	COO/ Dir HR & OD/ MD/CN	X	X	X + Focus on clinical outcomes	X	X		X + Focus on clinical outcomes	
	Infection Control Report (from DIPC)	Chief Nurse/ DIPC	X			Annual Report			X	
	Finance Report	Chief Finance Officer	X	X	X	X	X		X + PLICS	
Board Assurance Framework Overview	Company Secretary	X (January AC and QSAC Non-Clinical risks review)	X BAF Brexit risk	X (April AC and QSAC Non-Clinical risks review)	X BAF Culture risk	Risk Meeting (September/ October) (July AC and QSAC Non-Clinical risks review)		X (Oct AC and QSAC Non-Clinical risks review)		
Safe Staffing/ 6 monthly staffing	Chief Nurse	X	X	X +6 monthly	X	X		X +6 monthly staffing		

CQC Domain	Topic	Executive Director	February 2020	03 April 2019	22 May 2019	18 July 2019	18 September 2019	30 October 2019 (Strategy Day)	27 November 2019
	review				staffing review				review
	Update on NHS contract negotiations	Chief Finance Officer	X	X	X	X	X	X	X
	Audit Committee assurance report to Board – matters to be raised at Board	AC Chair	Whistle-blowing update/ Assurance of Risk Management processes		Annual Accounts and Annual Report assurance	Whistle-blowing update/ Assurance of Risk Management processes			Whistle-blow update/ Assurance of Risk Management processes
	QSEAC assurance report to Board – matters to be raised at Board	QSEAC Chair	Freedom to Speak Up Update/ Safeguarding			Freedom to Speak Up Update/ Safeguarding			Freedom to Speak Up Update/ Safeguarding
	Finance and Investment Committee report to Board – matters to be raised at Board	F & I Chair	TBC	TBC	TBC	TBC	TBC	TBC	TBC
	People and Education Assurance Committee report to Board – matters to be raised at Board	PEAC Chair		TBC			TBC		TBC
	W7: Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?								
	Patient/ Carer Story	Chief Nurse	X	X	X	X	X		X
	Charity update	Charity			Planning for Charity B2B			X	
	Inpatient/ Outpatient/ Staff Annual Surveys	Chief Nurse/ Dir HR & OD		Staff survey results		Patient/ carer survey results			

CQC Domain	Topic	Executive Director	February 2020	03 April 2019	22 May 2019	18 July 2019	18 September 2019	30 October 2019 (Strategy Day)	27 November 2019	
	Annual Report & Accounts/ Quality Report/ Auditor Letters/ Annual Gov Statement	Chief Finance Officer/ Company Secretary			X					
	WRES Report and Equality Objectives	Dir of HR and OD		Equality Objectives		Annual Report				
	Stakeholder Engagement Strategy	Dir of Comms			Draft Strategy				Progress with plan	
	Patient Experience and Engagement Strategy	Chief Nurse				X				
	W8: Are there robust systems and processes for learning, continuous improvement and innovation?									
	Annual Patient Experience report					X				
	Assurance and Escalation Framework Update						X			
Update on EPIC and DRIVE			EPIC	EPIC	EPIC	EPIC DRIVE	EPIC	EPIC	EPIC DRIVE	

*These will follow the programme of presentations at Operational Board (monthly). The relevant directorate that month will be asked to nominate a speciality to present their plans and progress with delivery of the Trust Strategy to the OB and make the same presentation to Trust Board (mapping has been conducted as closely as fits with the TB diary of meetings).

Attachment W

Trust Board 3 April 2019	
Finance and Investment Committee Update – February 2019	Paper No: Attachment W
Submitted by: Paul Balson – Deputy Company Secretary	
Aims / summary This report summarises the Finance and Investment Committee’s (FIC) work since its last written report to the Trust Board on 7 February 2019. The FIC held formal meetings on 1 February 2019 and 25 March 2019. Highlights from the 1 February 2019 meeting are covered below. The Chair will provide a verbal update of key issues from the 25 March 2019 meeting.	
Action required from the meeting Board members are asked to note the key issues highlighted by the Committee, note the rest of the report, and pursue any points of clarification or interest.	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Finance and Investment Committee reports on financial strategy and planning, financial policy, investment and treasury matters and reviewing and recommending for approval major financial transactions. The Committee also maintains an oversight of the Trust’s financial position, and relevant activity data and productivity metrics.	
Financial implications None.	
Who needs to be told about any decision? N/a	
Who is responsible for implementing the proposals / project and anticipated timescales? N/a	
Who is accountable for the implementation of the proposal / project? N/a	

Attachment W

Key issues for the Trust Board's attention

- The Trust ended Month nine of the 2018/19 financial year in line with its control total.
- The closing cash balance was £10.6m higher than plan.
- The Committee discussed the operational performance of the Trust and has requested further analysis of the route cause behind the higher number of bed closures within the Trust.
- The move to Guy's and St Thomas' NHS Foundation Trust procurement's team had been positive for the Trust and the plan for finding additional efficiencies looked promising.
- The Better Value schemes for 2019/20 will be challenging.
- Flow experts from Easy Jet would will assist the PMO team with reviews.
- The Trust needed to focus on IPP debtors and activity as well as general cost control to achieve financial control total.

Performance and finance standing updates

Finance report 2018/19 Month nine finance report

- The Trust was in line with its control total in Month 9. To support the Trust's position, £3.1m had been released from contingency YTD. A tight grip on activity and expenditure was required to deliver the control total for the year
- The Trust forecasted a breakeven position at the year end to the control total. It is anticipated that activity would increase in the remaining quarter.
- The closing cash balance was £10.6m higher than plan.
- It was noted that the Trust had switched to a block contract for total commissioned activity for the remainder of 2018/19.

Integrated Performance Report

The discussion focused on: RTT tracking especially in the light of the new fine regime that will be relevant from April 2019, IPP debt and staff appraisal rates.

It was noted that the staff appraisal rate remained red rated. The Chief Executive reported that the Workforce Assurance Committee would focus on improving this performance measure.

Magic numbers

Performance in December 2018 was lower than plan due to a number of factors including:

- an increase in the number of closed beds across the Trust due to a number of issues including staffing.
- The impact of annual leave over the Christmas holiday period, which reduced outpatient and inpatient activity.

The Chair requested that the next iteration of the report included the number of bed closures as a percentage of total capacity by directorate and a clear evaluation of Trust staffing gaps and any specific actions required to address any such gaps.

Procurement services update

The Trust moved from its previous provider PPS to a new provider (Guy's and St Thomas's Trust via their 'SmartTogether service) in August 2018. This was after a number of performance issues with the previous service were identified.

The new service has been well received within the Trust and quality and satisfaction levels have improved since the transfer took place.

Attachment W

Productivity and Efficiency (Better Value) Monthly update

- Progress on a programme for 2019/20 was underway with the PMO team identifying additional schemes with the Acting Chief Operating Officer and Director of Operations.
- The PMO were working up a number of schemes that will take three to five years to deliver savings.
- The scale of the targeted savings was noted by the Committee as ambitious and it was suggested that it may be appropriate to engineer a fresh perspective through an active debate with the new CEO and through external triangulation.

Children's Cancer Centre

The Chief Executive presented a summary of the planned assurance work with the GOSH Charity to give them sufficient confidence to release funding for the Trust to further invest in the project which was reported to the Trust Board.

EPIC update

The Committee noted the reports and requested assurance that there are remedial plans for all identified issues, that EPIC would interface with all other Trust systems and that there were back up processes if the interfaces do not work.

The discussion covered coding concern, delivery of circuits and confirmation of further assurance meetings on the road to go live.

Sustainability at GOSH

The Committee noted the report and the opportunity for GOSH to lead and innovate on air quality.

The Chair requested additional financial rigour in the presentation and additional information on the KPIs that would be selected to measure performance of sustainability at the Trust.

Post project update – Chillers

The Committee reviewed the Chillers business case and lessons learned from the corresponding overspend on part one of the project. The committee requested that the business case for the next phase of the project is re-presented for approval at the next meeting of the Finance and Investment Committee.

Attachment X

Summary of the Council of Governors meeting
held on 6th February 2019

Matters arising

An update was provided on work that was taking place to prepare for Britain's exit from the EU and the Trust had agreed to write to suppliers to understand potential issues in their supply chain. Governors said that families may be anxious about the supply of drugs for their children and it was agreed that the Brexit Steering Group would discuss communication with patients and families.

GOSH - The research hospital. How the Children's Cancer Centre supports our long term vision

A presentation was received on the plan to move forward with the development of a GOSH Children's Cancer Centre which aimed to provide a flexible estate to promote the delivery of excellence through research. The development would include cancer services, pharmacy and the hospital school. Discussion would be taking place with the GOSH Children's Charity around the funding of the building. The team confirmed that although the business case was for a cancer centre there was equipment involved which would be used by other specialties.

Chief Executive Report

Key priorities were to ensure that the Executive Team were working well together, and a focus would be placed on developing the Trust's strategy to ensure that it was a plan for what would be achieved and how this would be done. It was noted that the CQC had confirmed that they would be inspecting the Trust in the second half of 2019. Discussion took place around theatre utilisation rates which had reduced in December. It was noted that this was as a result of planning and shutdown over Christmas rather than a low bank nurse fill rate and November 2018 had been the highest fill rate for bank shifts in the year. The structure for bank rates was being reviewed in order to develop a consistent system that was available to all nurses and AHPs. Information Governance incidents had developed as a theme and it was noted that this was an important area for the Trust. The Audit Committee continued to review IG and work was required before the Trust could be confident that all mitigations were in place. Work continued to take place and the implementation of new software would support the Trust, however it was vital to continue to raise awareness with staff around their responsibilities and information governance standards.

The Trust was reporting a breakeven financial position for the year to date.

Reports from Board Assurance Committees

- Quality and Safety Assurance Committee (January 2019)

Culture had been a key part of discussions and it had been recognised that there was insufficient time within the existing QSAC meetings to address this. Discussion had taken place about a proposal to implement a People and Education Assurance Committee and this would be discussed by the Trust Board. The Council emphasised the importance of ensuring that the Executive Team were visible in the Trust and that engagement with young people continued.

- Finance and Investment Committee (November, December 2018 and January 2019)

The Committee had reviewed areas of underperformance across the Trust ensuring that recovery plans were in place for those areas. Plans were considered for the Children's Cancer Centre and it

Attachment X

was agreed that the Trust should move forward with the project without taking on debt acknowledging that the impact on patients must be maximised. Discussion took place about the implications of a delay to EPR go live which would incur substantial costs however each committee and Board was receiving assurance from the EPR governance process until go live.

Update from the Young People's Forum (YPF)

The YPF had supported work to develop guidelines around transition and had emphasised the inclusion of the emotional factor when transitioning. It was noted that the NHS 10 year plan suggested that the age of transition for patients with rare diseases could be raised to 25.

Appointment of a Lead Governor and Deputy Lead Governor

All elected Governors were eligible to stand for both Lead Governor and Deputy Lead Governor roles and those who were interested in nominating themselves were asked to email or post their nomination form to the Company Secretary between 18th February and 11th March 2019.

Update on Well Led Assessment at GOSH

The CQC inspection in the second half of 2019 would involve the assessment of Well Led and would include interviews with Board members and Governors. Outstanding actions from two previous Well Led assessments had been collated into one action plan which was being monitored on a monthly basis at the Executive Management Team meeting. It was noted that culture was a key priority amongst the actions.

Governance Update

The Council approved the recommendation from the Constitution Working Group to contact the next highest polling candidates to fill to the Governor vacancies. They also approved the revised Membership Strategy which had been simplified in order to provide greater focus on key areas. Governors were asked to complete their online mandatory training.

NED appraisal process

Two Non-Executive Directors were due to for their appraisal and soundings would be collated from the Council of Governors and Executive Team.

Operational Plan 2019/20 Update

The operation plan is due for submission NHS Improvement on 4th April 2019 and would be signed off by the Board on 3rd April 2019. It was confirmed that draft documents had been considered by the Finance and Investment Committee and would be considered by the Board in advance of the sign off date. Discussion took place around the Better Value programme for 2018/19 which would be challenging to achieve and it was confirmed that it would be reviewed at each Finance and Investment Committee meeting. It was noted that work was taking place in procurement to maximise buying power within the group of Trusts.

Selection by Councillors of a Local Quality Indicator for external data testing and inclusion in the Quality Report 18/19

Governors were asked to email a first and second preference for a local indicator to be review for data quality by the external auditors in the Quality Report.

Attachment Y

Trust Board 3rd April 2019	
Declarations of Interest Register – Trust Board members	Paper No: Attachment Y
Submitted by: Anna Ferrant, Company Secretary	
<p>Aims / summary</p> <p>The Board of Director’s Standing Orders outlines the requirements for directors to disclose any pecuniary, personal or family interest, whether that interest is direct or indirect, in any proposed contract or other matter that is under consideration or is to be considered by the Board.</p> <p>A conflict of interest occurs when the private or personal interests of a Board member could affect their role at the Trust in terms of bringing some possible advantage to them or close relatives.</p> <p>Any declared interests are reconfirmed annually until such time as the Board member leaves GOSH or the potential for a conflict of interest no longer exists.</p> <p>The Company Secretary is required to draw up a register of interests declared by members of staff and members of the Board and to report on this annually in the public part of a Trust Board meeting. The returns are maintained in a register which is open for inspection. The registers for Trust Board members (Appendix 1) are attached with this report. The register for staff will be presented at the May 2019 Board meeting.</p>	
<p>Action required from the meeting</p> <p>To note the content of the register for 2018/19 for Board members.</p>	
<p>Contribution to the delivery of NHS Foundation Trust strategies and plans</p> <p>Transparency</p>	
<p>Financial implications</p> <p>None</p>	
<p>Who needs to be told about any decision?</p> <p>N/A</p>	
<p>Who is responsible for implementing the proposals / project and anticipated timescales?</p> <p>The Company Secretary</p>	
<p>Who is accountable for the implementation of the proposal / project?</p> <p>The Company Secretary</p>	

Register of Interests 2018-19
Great Ormond Street Hospital for Children NHS Foundation Trust
Directors
Non – Executive Directors (Voting)

Name	Declared Interests
Sir Michael Rake	<p>Chairman Newday Ltd Vice President, Royal National Institute of Blind People Director, S&P Global Inc (stepping down 7th May 2019) Chairman, Majid Al Futtaim Holdings (UAE) Adviser, Teneo Holdings LLC Senior Advisor, Chatham House Member of Open Britain (Director) Member of Oxford University Centre for Corporate Reputation Global Advisory Board Member of International Business and Diplomatic Exchange Advisory Board Chair of Advisory Council for A Blueprint for Better Business. Chairman of the Advisory Board, Engie Ltd Chairman, Phoenix Global Resources Chairman of the International Chamber of Commerce UK Director, (owner) MDVR Services Ltd Director – University College London Partners (UCLP)</p>
Mr Akhter Mateen	<p>Non-Executive Director CABI (Centre for Agriculture and Biosciences International) Trustee – Malala Fund UK Trustee – Developments in Literacy (DIL) UK</p>
Professor Rosalind Smyth CBE	<p>Director, UCL Great Ormond Street Institute of Child Health (GOS ICH) As Director of GOS ICH, I have overall responsibility for all research funding applications and awards to staff in GOS ICH. Honorary Consultant, Great Ormond Street Hospital for Children NHS FT Trustee, Charitable Incorporated Organisation UCL Great Ormond Street Institute of Child Health. Chair of the MRC Clinical Fellowship Panel. Governor, The Health Foundation Member of the Reform Club Trustee, Cystic Fibrosis Trust Murdoch Children’s Research Institute - Member of External Advisory Panel Scientific Advisory Group for the International Centre for Diarrhoeal Disease Research, Bangladesh Scientific Advisory Board at SickKids Toronto Canada</p> <p>My brother is a Professor at the University of Nottingham. My daughter is at KPMG.</p>
Professor Stephen Smith until 31 st May 2018	<p>Non-Executive Director Netscientific PLC Trustee Pancreatic Cancer Draper and Dash United Medicine Ltd Biotechspert Ltd Signum Health Ltd. Chairman of East Kent NHS Foundation Trust from 1 March 2018. Retaining NED position at GOSH until May 2018.</p>
Mr James Hatchley	<p>Group Strategy Director 3i Group Plc Member of the 3i Group plc Investment Committee</p>

Register of Interests 2018-19
Great Ormond Street Hospital for Children NHS Foundation Trust
Directors

Name	Declared Interests
	Board member of Scandlines Infrastructure ApS, a Danish Ferry business of which 3i own 35%.
Lady Amanda Ellingworth	Director, Plan International Inc Trustee Plan International UK Deputy Chair, Barnardo's Lay Adviser Royal Collage Emergency Medicine
Mr Chris Kennedy	CFO ITV Plc Non-Executive Director, Whitbread PLC Non-Executive Director, The EMI Archive Trust Ltd
Ms Kathryn Ludlow	Partner Consultant at Linklaters LLP Special Advisor to G3, the Good Governance Group Trustee of the International Rescue Committee, UK Trustee of The Hall for Cornwall Member of The Advisory Board of The Bingham Centre for the Rule of Law Director of Garden Bridge Trading Limited

Executive Directors

Name	Declared Interests
Mr Matthew Shaw, Medical Director (until December 2018, Chief Executive from 15 th December 2018)	Partner – Consultant Anaesthetist at GOSH
Professor Andrew Taylor, Acting Chief Operating Officer (from 17 th December 2018)	Employed by UCL as Professor of Cardiovascular Imaging Head of Department for Children's Cardiovascular Disease, UCL Institute of Cardiovascular Science Research agreement with Siemens Medical Solutions Member of the NHS England Congenital Heart Disease Clinical Reference Group Partner – Consultancy to Medtronic.
Ms Caroline Anderson, Director of HR and OD from 18 th March 2019.	None
Ms Alison Robertson, Chief Nurse (from 9 th April 2018)	Visiting Professor, School of Health Sciences, City University, London.
Dr Sanjiv Sharma, Acting Medical Director (from 17 th December)	Clinical consultant practice Portland Hospital (PICU) Partner, Senior Manager, HEE.
Ms Helen Jameson, Chief Finance Officer	None
Dr Peter Steer, Chief Executive (until 31 st December 2018)	Director – University College London Partners (UCLP) Director – Children's Hospital Group Board, Ireland

Register of Interests 2018-19
Great Ormond Street Hospital for Children NHS Foundation Trust
Directors

Name	Declared Interests
Ms Nicola Grinstead, Deputy Chief Executive (until 16 th December 2018)	Director of World Association of Girl Guides and Girl Scouts Europe Region – a not for profit (L'association internationale sans but lucrative) in Belgium. Resigned September 2017 but this is not yet reflected on the Belgian public registry.
Mr Ali Mohammed, Director of HR and OD until 31 st July 2018	None
Ms Alison Hall, Acting Director of HR from 1 st August 2018 – 17 th March 2019	None
Ms Polly Hodgson, Interim Chief Nurse (until 8th April 2018)	None

Other Directors (Non-Voting)

Mr Matthew Tulley	None
Professor David Goldblatt	Department of Health JCVI subcommittees: meningococcal and pneumococcal. UCL-ICH laboratory performs contract research with GSK, Merck, Sanofi. Occasional expert member of panels for WHO, GSK, Sanofi and Merck. Treasurer, International Society of Pneumococci and Pneumococcal Disease (ISPPD) Chair, Scientific Advisory Board, LimmaTech Biologics AG Chair, International Scientific Advisory Board, Malawi-Liverpool-Wellcome Trust Clinical Research Programme, Blantyre, Malawi Chair, External Advisory Board, NIHR Health Protection Research Unit, London School of Tropical Medicine and Hygiene.
Ms Cymbeline Moore	None

Attachment Z

Trust Board 4 th April 2019		
Register of Seals		Paper No: Attachment Z
Submitted by: Anna Ferrant, Company Secretary		
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 December 2018.		
Date	Description	Signed by
13/02/2019	Appointment letter - Terms of the appointment of Premier Moves Ltd in relation to the provisions of an Equipping Consultancy Service for Phase 3 of the Redevelopment Plan.	HJ, MS
Action required from the meeting To endorse the application of the common seal and executive signatures.		
Contribution to the delivery of NHS / Trust strategies and plans Compliance with Standing Orders and the Constitution		
Financial implications N/A		
Legal issues Compliance with Standing Orders and the Constitution		
Who is responsible for implementing the proposals / project and anticipated timescales N/A		
Who is accountable for the implementation of the proposal / project Anna Ferrant, Company Secretary oversees the register of seals		



GOSH Leadership Strategy

V2.1 DRAFT
MARCH 2019

Attachment G

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1. Document Details

Title	GOSH Leadership Strategy
Date	11 March 2019
Version	2.1
Status	Draft
Executive Sponsors	Alison Hall, Interim Director of HR & OD Alison Robertson, Chief Nurse Sanjiv Sharma, Acting Medical Director
Authors	Benjamin Levy, Nursing & Non-medical Education Manager Daljit Hothi, Associate Medical Director: Leadership Emilia Piera-Adamczyk, Leadership & Management Partner James Scott, Head of Strategy and Planning Joanna Weeks, Associate Director: Workforce Development Justin Poisson, Postgraduate Medical Education Lead Lynn Shields, Director of Education Sally Robertson, Head of Education: Nursing & Non-medical Education / Leadership Simon Blackburn, Deputy Medical Director: Dental & Medical Education

2. Our Ambition

Our ambition is accelerating journeys towards exemplary leadership to ensure we attract, develop, and retain leadership of the highest capability across the workforce.

Our aim is to produce a leadership profile that matches and enhances our world-class clinical services, demonstrates a commitment to the wellbeing and development of our staff; and is fit for purpose within the evolving NHS and our expanding networks of practice worldwide.

The biggest influence on culture is the leadership in an organisation. Collective leadership—people empowered to lead in all areas at all levels—is the key to creating cultures that will give NHS staff the freedom and confidence to act in the interests of patients, and will lead to sustainable, operational and financial performance.
(NHS Improvement, 2017)

This strategy sets out the direction and establishes the means by which GOSH intends to develop and supports our leaders. Successful leadership development is a vehicle purpose-built to consolidate our values, shape our culture, and increase our combined capacity for kindness. Investing in our leadership potential will drive higher performance and translate to higher-quality clinical care and outcomes for our patients.

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Our commitment to leadership development is only possible if there is a willingness from the entire organisation to acknowledge it as a priority. World-renowned organisations that are held in high regard for their outstanding ability to engage with their staff and nurture a culture of compassion, inclusion, and collaboration have one thing in common—they prioritise leadership development. We aspire for GOSH to be placed amongst them.

3. Our Challenge

At GOSH, we care for patients with very complex needs, working within an increasingly ambiguous, unpredictable, and variable healthcare system. It is pertinent to start by acknowledging the specific challenges that we face to provide reassurance that these have been addressed within our strategy.

Building new NHS wisdom – ‘Coping with the complexity of clinical practice requires not just competency but capability, the ability throughout one’s career to adapt, to change, generate new knowledge and continuously improve performance’ (Tomlinson, 2015). *The NHS Long Term Plan* has highlighted the pressing need to develop and sustain effective leadership within all disciplines, both clinical and non-clinical (NHS England, 2019). GOSH has always been able to confidently demonstrate strong and consistent medical and nursing expertise, but there has been a lag in developing additional capabilities that are becoming essential within the NHS, including resilience, leadership, and quality improvement.

GOSH is a complex, unique healthcare setting – Our organisation sits within a complex, fast-moving world which requires the co-existence of a marketed, highly-reliable healthcare system and an adaptive system that can respond with sensitivity and compassion to patients in its care. The GOSH brand has presence and influence that affords us several opportunities but also attracts scrutiny and judgement from both a national and international audience through media and other outlets. Leading within this environment requires a new version of leadership that is agile, distributive, and compassionate.

GOSH 2018 CQC assessment – The report highlighted room for improvement in the well-led domain. There is mounting evidence that leadership, especially clinical leadership, correlates with the performance of a healthcare organisation and its culture. In recognising the impact of leadership on our organisational culture and the depth and breadth of its influence, an investment into leadership development is a crucial and wise choice (Schein, *Organizational Culture and Leadership*, 2016).

Raising the profile of leadership development – ‘People rise to their level of incompetence’ (Peter, 2014). The majority of us are promoted due to our success in our previous role, but our skills and capabilities may be inadequate to meet the demands of the new role. The lack of staff investment in leadership potential and talent earlier and throughout careers limits our organisational potential and prevents us from matching staff to roles where they will be able to flourish. By placing joint responsibility on the organisation and individual to achieve the necessary skills to do the job well, we have a real chance of reframing our staff’s perception and relationship with leadership within our workplace.

Staff engagement and wellbeing – The experience of staff at work is critical to both their own and their patients’ wellbeing and is a critical factor in setting the tone for our culture at GOSH. There is also a growing recognition of the importance and relevance of compassion to patient outcomes and, perhaps more pertinently, to the damage and suffering that ensues when it is absent or attenuated in the healthcare setting. Furthermore, we face challenges to recruit and retain staff across several specialties and departments. A consultant survey in March 2018 highlighted a sense of disempowerment, low morale, personal sacrifice, and compromise with resultant high levels of stress and burnout. Benchmarking against other organisations, our 2018 Staff Survey placed GOSH as a negative outlier within the bullying and harassment, health and wellbeing, and morale domains. Staff

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reported a strong sense of commitment to their patients but are struggling with their level of connection with the organisation.

4. External Landscape

The external landscape has a strong influence on our themes of work and direction of travel at GOSH. Within the NHS, leadership development factors significantly into the wider organisation's future planning:

- *NHS Five Year Forward View* (Department of Health, 2014) – Developing leadership capabilities and providing teams with the time and support required to implement them is a key priority. The paper described four leadership domains:
 - Systems leadership skills
 - Improvement skills for staff at all levels
 - Compassionate, inclusive leadership skills for leaders at all levels
 - Talent management
- *The NHS Long Term Plan* (NHS England, 2019) – Following years of austerity, the Government announced additional funding for the NHS alongside a 10-year plan which includes reforms to care and access and the development of a workforce to meet these changes. In recognition of the evidence confirming the direct impact leadership has on high-quality patient care, it features within the plan as one of the primary focuses for workforce development.
- *Clinical leadership – a framework for action* (NHS Improvement, 2019) – This framework has been developed nationally to guide improvement and leadership development across the NHS, requiring team leaders at every level to develop a critical set of improvement and leadership capabilities among staff.
- *The Topol Review* (Topol, 2019) – This recently published paper challenges us with a vision of an imminent and rapidly progressive technology-enhanced NHS. This will alter the roles and functions of clinical staff in healthcare and command additional skills to be effective in this environment. We will require a different form of leadership to prepare, adapt, and flourish in this digital world with a genuine tension with how best to preserve the humanistic and relational elements of care within our services.

Each of these papers presents leadership as a definitive strategic priority for NHS organisations and presents multiple leadership models for their success. Leadership within the NHS will require new ways of working to survive and thrive in the contemporary financial and political climate. This is more important now than ever as the health service attempts to deliver new models of care as a response to the efficiency challenge set out in the *NHS Five Year Forward View* and the focus on integrated care networks within the *NHS Long Term Plan*. The external landscape provides local, regional, and national challenges that affect leadership across the organisation and compounds our internal challenges.

The brand and our strong alliance with the GOSH Children's Charity and UCL Great Ormond Street Institute of Child Health (ICH) places GOSH in a unique space in which to operate. We work hard at creating partnerships and collaborations with educational partners, e.g. Higher Education Institutes (HEIs) and Royal Colleges, and experts in leadership, e.g. Morgan Stanley, Cognitive Institute, and Faculty of Medical Leadership & Management (FMLM). Despite the effort, our networks are smaller than envisaged—it is our responsibility to change that. Within the Leadership Strategic Framework, partnerships is a cross cutting theme across all priorities and our key to new opportunities, perspectives, and expertise to accelerate journeys towards exemplary leadership.

Our brand is an asset, but it also invites greater scrutiny. We are typically benchmarked against specialist and highly-specialist providers nationally and internationally and the standards to which we are judged are set high. We have mandatory obligations to our quality assurance partners, e.g. the Care Quality Commission (CQC) and NHS Improvement/England (NHSI/E), to have a robust and contemporary leadership strategy. As a tertiary and quaternary provider, we have a responsibility

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within our Sustainability and Transformation Plan (STP) to provide excellent patient care and demonstrate effective leadership. We also need to broaden our responsibilities in designing, shaping, and influencing Integrated Care Organisations and Systems, as our patients have complex needs with pathways across primary, secondary, and tertiary care in multiple regions of the UK.

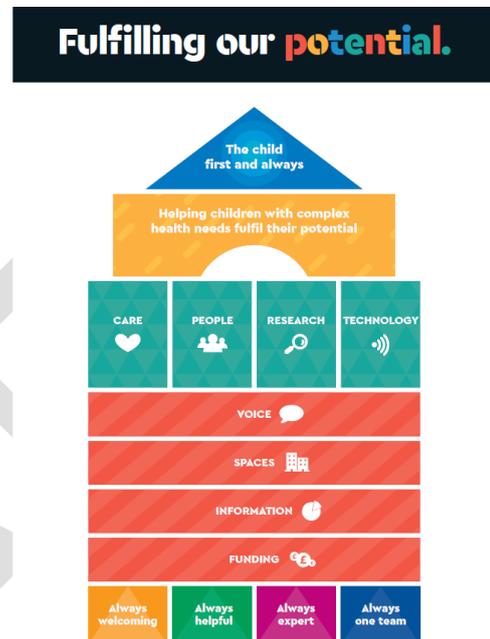
5. Developing the Strategy

In November 2017, the new GOSH Strategy, *Fulfilling our Potential*, was published to set the tone and guide the development of our services into the future.

The GOSH Learning Academy is committed to the success of our primary domain—people. We believe that through a leadership strategy which focuses on supporting and developing individuals, we will be better able to help our patients fulfil their potential; and through a skilled, motivated, and empowered workforce, we will be able to fulfil ours.

The *GOSH Leadership Strategy* outlines our ambitions and plans for leadership development across the organisation. It was developed collaboratively in consultation with internal stakeholders, namely Corporate Affairs, the Medical Directorate, Nursing and Patient Experience, Human Resources and Organisational Development, the GOSH Children's Charity, and the GOSH Head of Strategy and Planning. It has also incorporated the views of experts in leadership development such as Morgan Stanley, FMLM, and Professional Colleges.

Figure 1: Trust Strategy



6. Strategic Summary and Links to Trust Strategy

This strategy seeks to enhance leadership development to support the Trust's strategic objectives.

Fulfilling our Potential prioritises attracting and retaining the right people through creating a culture that enables us to learn and thrive and sets out four related objectives:

1. *Build a positive and diverse culture where staff are inspired to give their best*
2. *Be renowned for our talented staff and for the ever-improving quality of work they do*
3. *Have leaders at all levels of the trust who are effective, visible, supportive and respected*
4. *Providing our staff with the skills and capabilities needed to deliver exceptional care*

Our Leadership Strategic Framework integrates these objectives as core while embedding the knowledge gained through staff listening events and the pan-Trust learning needs analysis around culture, behaviours, and leadership; kindness and compassion stood out as essential behaviours that were the most important for our staff.

Our strategy aims to deliver an ambition of continuously striving to 'do better.' In the era of benchmarking and ranking, GOSH aspires to exemplary performance. However, the label of being 'the best' is not our desired endpoint, as we believe there is always the possibility of getting better, to excel a little bit more, to stretch ourselves further.

You cannot have a well-performing organisation that is not well led.

Care Quality Commission (CQC)

Attachment G

7. Strategic Framework

To deliver on our strategy, the ambition is underpinned by a strategic framework which details the ambition, overall approach, priorities, cross-priority themes, and investment towards. This strategic framework has been developed in order to detail our focus over the next 5 years:

Figure 2: Leadership Strategic Framework



7.1 Our Overall Approach: Personalised Leadership Development Plans

The leadership development needs of every individual within the organisation is unique to them and dependent on a number of factors including their personality traits; their knowledge, skills, and experiences; and their previous development opportunities. Through our Strategic Framework, we aim to accelerate the organisation’s journey towards exemplary leadership by improving the breadth and depth of our development offer significantly, providing exceptional learning experiences for all areas of the workforce, from aspiring leaders to executive leadership. To maximise individual leadership talent and effectiveness, we aim to create personalised development plans mapping out a unique leadership journey which enables individuals to visualise areas for development, their growth, and potential areas for enhanced growth.

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Currently at GOSH, we employ individuals within official leadership roles, but there are an even larger number of 'silent leaders' that influence and connect colleagues in the service of our patients or the organisation. Our approach will ensure that GOSH grows an expanding pool of clinical and non-clinical leaders across the organisation with the skills, behaviours, and capabilities to navigate through periods of change, vulnerability, and uncertainty. Leadership capability is now becoming a core requirement for anyone working within the NHS. Structures are flattening, which requires a culture of collective responsibility with the whole team pulling together, rather than relying on a select few at the top to implement change (Till, McKimm, & Edwards, 2018).

Figure 3

Professional Development Programme: Levels 1 – 3

The PGME department, in partnership with the Associate Medical Directors for Leadership, Quality Improvement, and Mentoring developed a holistic Professional Development Programme for all staff, clinical and non-clinical. The Programme first launched in October 2017, and offers three levels of training:

- Level 1- Professionalism: explores the various lens through which we view professionals and the impact that is having in the NHS
- Level 2 – Building NHS Wisdom: raises awareness and helps develop a broader set of skills necessary for our working lives today.
- Level 3- What's My Potential: provides a deeper insight and development opportunity in management, quality improvement, and education.

“

The Professional Development course allowed me to gain greater knowledge and understanding to effectively identify and implement change within an organisation.

The programme also taught me how to evaluate change outcomes and decide whether a change can be classed as a success. I had the opportunity to network with many staff that I otherwise would not have the opportunity to meet. I now have a skill set that will help to improve the work I provide across multiple roles.



Michael Speakman
Senior Business Support Officer



7.2 Our Priorities

7.2.1 Individual Leadership Development

The consistent delivery of high-quality, compassionate care is underpinned by effective leadership; effective leadership requires the provision of continued professional development that supports individuals to develop the leadership and management skills to ensure best practice.

In order to attract health professionals to a career in leadership, we need clarity on what is required from our leaders. This is not easy, as there are a growing number of leadership portfolios emerging within the NHS; as educationalists, this amplifies our challenge of developing leadership capability; however, as individuals, this presents opportunities for people from different backgrounds, interests, and experiences to meet the broader remit for emerging leadership roles at GOSH.

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We aim to create multiple learning communities centered on three dominant leadership models. Our emphasis will be on multi-professional, multi-level development opportunities that are meaningful to everyone, with experiences ranging from raising awareness to building expertise:

- **Agile leadership** – Leaders that thrive and navigate their teams through uncertainty and change; a leadership practice that is based on inclusivity, influence, and authenticity, rather than authority; leaders that model a good balance of directive leadership with the application of softer power, enabling others to lead while disseminating their expertise and power.
- **Compassionate leadership** – Leaders that actively promote compassion, supporting others to achieve a healthy containment of their anxiety and develop resilience against challenges and adversity; leaders that role model a culture of learning, openness, and attentive kindness while advocating for a positive work/life balance.
- **Digitally-intelligent leadership** – Leaders that understand the opportunities, regulations, technicality, and limitations of telemedicine; a leadership practice navigating patients, individuals, and teams through digitally-enhanced clinical pathways and practices.

Figure 4

Allied Health Professionals (AHP) Development Programme

The AHP Development Programme is comprised of two separate but linked courses—'Leading and Developing Teams' and 'Developing as Leaders'.

The 'Leading and Developing Teams' course is aimed at those individuals who already have responsibility for team management and focuses on achieving optimum team performance. The 'Developing as Leaders' course is for those with some leadership responsibilities, e.g. leading service improvements, but who do not have team management responsibilities.

“

I enjoyed many aspects of the programme, including the opportunity to meet fellow AHP leads and share experiences. The skills I developed through the training included how to have more effective conversations and not being afraid to say 'no'. It will help me in my profession by allowing me to identify my own learning needs and goals as well as helping my staff achieve theirs.




Bronwen Walters
Lead Orthotist

7.2.2 Team Leadership Development

The NHS relies on teams to design, develop, and deliver world-class patient care. Effective team-working in healthcare is shown to reduce errors, increase patient safety, and improve patient mortality rates (Royal College of Physicians, 2017). Crucially, it also leads to reduced stress, higher job satisfaction, and increased empowerment and self-efficacy (West, et al., 2015). FMLM have outlined capabilities for effective team leadership. These include:

- Building a robust vision
- Cultivating the necessary culture and skill mix
- Managing clear, challenging, and measurable (Faculty of Medical Leadership and Management, 2017)

Building and maintaining healthy teams, both within and across directorates, is a key priority within our framework. Team leadership involves finding a shared vision, values, and culture within teams. In complex systems such as healthcare, the success of a leader is measured by the quality of their

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team's working relationships and performance and its wellbeing, satisfaction, and sense of being valued and respected. Our aim is to create a shared culture within teams which incorporates our Trust Values in order to promote effective teamwork and to progress toward our shared goals. We aim to support team dynamics and functions through an emphasis on building trust, high-quality communication, productivity, collaboration, creativity, and continuous learning and improvement. Effective team working must involve the recognition of the unique contributions of all team members—multi-professional, both clinical and non-clinical.

As part of this priority, we will collaborate and co-design a comprehensive team development offering that includes existing and newly developed leadership programmes, modelling our Trust Values with patients at its core, to support a team-working culture which strives for exceptional patient care.

Figure 5

Team Building

Within team building, team interventions and listening events all play a part, helping to bring people together and improve and encourage productivity, motivation, collaboration, creativity, and communication.

In January 2019, the Finance Directorate held an away day as part of their on-going team building activities. There were two key purposes:

- Using the DISC tool to help team members look at preferred behaviours in various work situations and to reflect on how they respond to challenges and influence others.
- Expand the teams' knowledge of what was happening in other areas of the hospital, particularly digital, and what part they play in it.

“

I think it is imperative that teams come together to develop and grow as a group and that this is done in dedicated time, away from the office. I wanted us to focus on how we differ from one another and recognise that you can't engage everybody in the same way, that there are many facets to every team, and you need to ensure that you have the skills across the board to make a successful team. It showcased how you should engage with your colleagues and what motivates them.

Tom Burton
Deputy Finance Director





7.2.3 System Leadership

The King's Fund acknowledges the importance of working across organisational boundaries and networking, optimising patient care by bringing together services around the needs of the person at the centre of the healthcare system (Timmins, 2015). Being able to work effectively at the system level will ensure that GOSH maintains the principle of 'The Child First and Always' by influencing the design of the healthcare system of the future.

A system-level leadership perspective is essential to delivering future-focused, patient-centred care. Its success is dependent on the confidence to deal with ambiguity and uncertainty and capability to influence across organisational boundaries.

The three key components of system leadership are outlined by FMLM:

- Managing demand
- Optimising patient flow

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- Effective continuity of care (Aldrich, 2015)

At GOSH, we treat a high percentage of complex patients with multiple co-morbidities that are cared through the coordinated efforts of a number of specialist teams internal and external to the organisation. Collaborating with them, there are a number of key stakeholders that connect for the purpose of integrating our patients care pathways. We operate within a complex system of care, as illustrated below. While system leadership capability is non-negotiable for senior leaders who regularly work at the system level, every GOSH leader, at all levels, will need to develop their understanding of system leadership and their ability to deal with increasing levels of complexity and ambiguity in a rapidly changing wider healthcare and political environment.

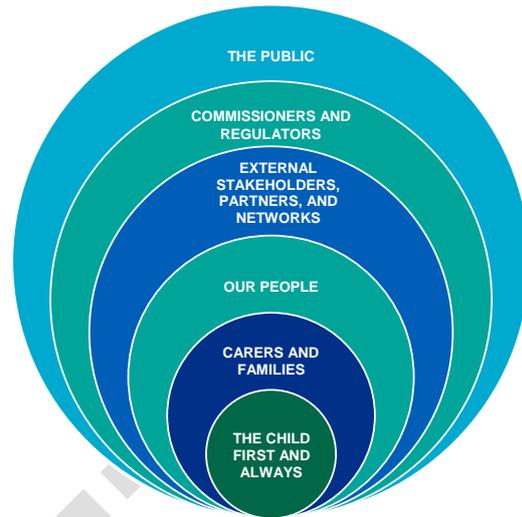


Figure 6: GOSH within the system

We aim to develop learning opportunities for a multi-professional audience, designed to help build relationships; break professional, social barriers, and assumptions; and foster collaborative working. We aim to nurture capabilities in seeing systems, patterns, and values; in interdependent working, building alliances and collaborations; and in comfortably coping with multiple opinions and tensions.

By developing individuals capable of system leadership, we will create the means by which we can transition from organisational service improvements to successfully transforming the shape of healthcare systems nationally.

7.2.4 Talent Management

It is critical to the success of GOSH that we develop, manage, and retain talented people at all levels to create a more mobile, motivated, and empowered workforce. Factors impacting on talent management in the NHS include demographic change, labour markets, and competition; the importance of a strategy in which talent can flourish; and a need to transform and change (NHS Leadership Academy, 2016).

We aim to ensure that there are robust processes for staff to discuss and co-create personalised development opportunities with their line managers at regular intervals throughout their career. It is our responsibility to offer a stimulating environment with diverse options for personal and professional development. This will enable staff to develop their non-clinical and operational skills. We can support career aspirations by informing staff of future opportunities/vacancies with advanced notice but at the same time offering them greater ownership and flexibility in planning their careers, especially those wishing for a new challenge or change in direction.

Targeting and Retaining High-potentials

We will be vigilant in our development of individuals with high potential, both internal and external to GOSH. While we look to develop and promote from within, not all growth can be organic. With the pace of technological change, economic change, and developments in research, we will require flexible resourcing. We aim for our recruitment processes to have a greater focus than just filling vacancies; it is an opportunity to bring in people with new skills and talent who fit our culture and model the right behaviours and values.

We aim to introduce a new High-Potential Programme that nurtures growth through stretch assignments and projects, providing alternative perspectives and experiences through rotations,

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secondments, and sideways movements. We want to be recognised as a place that rewards the aspiration to develop your career.

Succession Planning

Leadership succession planning is essential in healthcare, especially in very specialist areas where the talent pool may be limited.

We see four priority areas for succession planning at GOSH:

- Highly-specialist roles that will require several years to develop potential successors
- Identifying recurring gaps and planning recruitment interventions both internally and externally
- Planning in advance; developing and matching our high-potential staff against future opportunities, creating a talent pipeline for leadership
- Developing skills and capabilities in individuals now for emergent new roles in the future

7.2.5 Staff Wellbeing

To make GOSH a consistently great place to work, this requires a non-negotiable focus on wellbeing—the overall emotional and physical conditions of individuals, teams, and the organisation as a whole. Wellbeing affects all aspects of working life, from the quality and safety of the physical environment to how staff emotionally relate to their work and the organisation.

Through an education and training lens, there are several opportunities for improving staff wellbeing. The basis of the work is creating the conditions for agency (the capacity of an individual to make their own choices and to take action in a given environment) and actualisation (realising one's full potential). Through coaching conversations, we aim to support individuals in choosing a goal that is either:

- i. Growth, connection, and contribution orientated; or
- ii. Interesting and personally meaningful

The result will be highly driven, internally-motivated staff that feel emotionally and physically well with a strong sense of being valued and safe at work.

In addition, we aim to incorporate the *NHS Health and Wellbeing Framework* (NHS England, 2018) that includes recommendations from the *Stevenson / Farmer Review of mental health and employers* (Stevenson & Farmer, 2017). We will ensure our leadership offer includes:

- Building resilience
- Compassionate leadership
- Developing skills in self-awareness and emotional intelligence
- Recognition of the people behind the tasks; the unsung heroes; the people that support and assist and our 'One Team' value
- Fostering and promoting strong social cohesion, placing value on relationships, networking, multi-professional conversations

Though the development support networks links with Human Resources, we aim to create a pathway for deploying the right people in the right roles and supporting them in their new roles. We need to disband the myth that people are 'bad'; as the more likely scenario is that people are 'good' that have been 'miscalc'. This will build a mental and cognitive space that encourages interconnectedness; disseminates expertise; embraces inclusion, co-creation, creativity, and innovation; and acknowledges and shares the learning from failures as well successes. Our ambition is create an environment at GOSH where people flourish and feel safe.

7.2.6 Senior Leadership Team Development

Senior leaders are essential for the success of our organisation; however, the traditional 'command and control' models of leadership are no longer appropriate, such that the power invested in and

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represented by established hierarchies is diminishing, while change is happening at an ever-increasing pace and is becoming more disruptive in nature (NHS England, 2019).

GOSH has undergone a recent Directorate restructure resulting in a number of senior leaders in new roles. In order to support them, a 'Senior Leadership Development Proposal' was submitted and approved by the Executive Team in January 2019. This programme is comprised of a more generic leadership and management development component in combination with a bespoke personalised plan for individual team members after considering variations in their roles, experience, and requirements.

The programme design is a result of discussions and feedback gained from the Senior Leaders Induction Development Workshop held in September 2018. As part of the Directorate Induction and Orientation Programme, our 'ways of being' as senior leaders were explored and established and subsequently aligned with the expected behaviours of senior leaders outlined in the *NHS Long Term Plan*. To achieve our Trust strategic priorities, we need leaders who are capable of being:

- Aware of themselves and their impact on others
- Empowering and nurturing
- Open-minded and curious
- Positive in their influence and impact
- Integrated and connected

Owing to a priority on collaborative working across the Directorates, we aim to build capability to cultivate partnerships and system leadership. This involves leaders, managers, and their teams taking collective responsibility for making decisions, leading their service, and fulfilling their potential. The programme will focus on the following areas for development:

- Working with others
- Leading the service
- Self-as-leader
- Leading teams
- Core management skills

At the most senior level, the GOSH executive team is working in partnership with the King's Fund to co-design a two-year Board Development Programme. It will be tailored to the developmental needs and priorities of board members with two separate workstreams, recognising the different but complementary roles of the executive team and the chairman and non-executive directors.

Importantly, it will address key elements within the Care Quality Commission's *Well Led Framework*, including Key Lines of Enquiry, 1: Leadership capacity and capability to deliver high-quality, sustainable care, 2: Clear vision and strategy for high-quality, sustainable care with robust delivery plans, and 3: Culture of high quality, sustainable care (Care Quality Commission, 2018).

In parallel, the King's Fund is also rolling out phase one of a pilot Board Development Programme for NHS Improvement at 13 other NHS trusts. This scheme is based on the National Framework for Capability Building, *Developing People — Improving Care*, which focuses on leadership for quality improvement as a core enabler to achieving improvements in patient experience, population health, and value for money (NHS Improvement, 2016). Significant learnings from the pilot will be applied to the GOSH programme as part of a deliberate quarterly programme review process.

7.3 Our Cross-priority Themes

7.3.1 Innovation and Creativity

Within GOSH, there are a number of generations working together, ranging from Baby Boomers to Generation Z. Based on the evidence from sociologists and educationalists, the preferred communication and learning styles for each generation are unique. Therefore, we will be creative in designing our leadership infrastructure and offerings to ensure we have reach and appeal across all

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generations. We aim to incorporate a variety of education platforms such as online learning modules, virtual book clubs, skills and simulation workshops, and networking events to deliver the knowledge and skills (capacity) element of the offering. In addition, we need to be creative about the implementation of the support networks for nurturing capability; this will include face-to-face and virtual coaching and mentoring opportunities, connecting to networks internationally. Partnering with technology, leadership and communication experts, we have a chance to be bold and innovative in our infrastructure and approach to leadership development.

7.3.2 Inclusive Learning Culture

The Always Values describe the expectation of the workforce behaviours: 'Always Welcoming, Always Helpful, Always Expert, Always One Team'. Staff role model these behaviours, but being 'Always Expert' is especially contingent on an inclusive learning culture, where all members of staff feel supported in accessing educational opportunities.

Staff leadership development has not always been seen as a priority across clinical and non-clinical disciplines. Though the ambition set out in our strategy, however, we feel confident of the Trust's commitment to achieving our vision. We aim to create learning opportunities that are meaningful and relevant and recognised by line managers, thus creating the time, mental space, and appetite for every individual to learn.

7.3.3 Partnerships

In today's society, expertise does not just sit with one person. Our effectiveness, influence, and impact lies in our ability to recruit experts, create networks, and build relationships for a common purpose. Strategic partnerships benefit everyone, provide employees with development opportunities, and expose leaders to new perspectives and expertise.

Similar to our ambition of a collegiate approach within the Trust, we envisage that each priority area of the strategy will be strengthened and enhanced through their relationships with partners. We aim to support and drive the establishment of effective working networks with:

- Internal partners, e.g. DRIVE, Clinical Directorates, the GOSH Charity
- Academic partners, e.g. ICH, HEIs
- Expert partners, e.g. FMLM, Cognitive Institute
- Department of Health organisations, e.g. NHS Digital, NHSI/E
- Industry and commercial partners, e.g. Morgan Stanley

Through partnerships, we aim to continuously learn and improve on the content and quality of our development offering. We aim to create new experiences through secondments and placements to advance our thinking and perspectives and to potentially improve and innovate all aspects of our work at GOSH. Finally we aim to generate income by partnering with other NHS Organisations and Professional Colleges, creating a regional learning collaborative bound by a 'Leadership Portfolio', aligning learning experiences through a 'Learning Passport', where individuals outside of GOSH can pay to access internal learning opportunities while maintaining a record of their progress.

7.4 Investment Towards: Leadership Development Infrastructure

Success at the next level of leadership responsibility requires different skills and often a different mind-set. Lack of self-awareness, limited emotional intelligence, limited skills, or sense of position entitlement can significantly impact performance at advancing levels of management responsibility (Goldsmith, 2008). The next step into exemplary leadership requires a robust, underpinning development platform and the investment in its infrastructure.

What got you here, won't get you there.

Marshall Goldsmith

We aim to create an infrastructure that:

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- Builds capacity – the addition of more knowledge and skills
- Develops capability – translating knowledge to a change in behaviours and actions to develop and flex to meet future needs
- Nurtures vertical development – the advancement of a person’s thinking capability; becoming a more complex, systemic, strategic, and interdependent thinker
- Establishes development support networks – ‘supervision’ to track achievement of goals, skills, knowledge; ‘mentoring’ to guide and provide emotional and cognitive support while navigating the journey; and ‘coaching’ to support individuals and teams to improve working relationships

Figure 7: Vertical Development



and advance their thinking and thus their capability

(Petrie, 2014)

In order to achieve the ambitions set out in our strategy, we will invest in developing a dedicated leadership faculty and secure reliable, regular access to classrooms to deliver the desired education and training. In addition, we aim to procure external trainers for highly specialist or specific training needs and to build training capability internally, namely training the trainers.

We will invest in a trust-wide mentoring and coaching network with a capacity to serve the entire workforces. Evidence suggests that offering these interventions early will maximise the impact and the return on our investment. Reflective learning, challenging assumptions, and broadening perspectives are key functions of coaching and mentoring programmes that have been shown to facilitate individuals towards a mind-set of continuously learning, both from successes and failures. Within organisations, these programmes enable development of systems and collaborative leadership, inclusive system-focused talent management and succession planning, organisational change, and cultural transformation (NHS Leadership Academy, 2018).

Finally, we will invest in the professional development of our GOSH leadership development faculty to advance their thinking knowledge and skills and encourage these staff to attend conferences for additional learning and to showcase our experiences and successes, both nationally and internationally.

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8. Leadership Metrics

One of the key considerations in our strategy is to ensure we are utilising contemporary, data-driven methods through the leadership development process and that there are identified outcome measures for appraising the success of our programmes of work.

Our processes for leadership development require reliable methods to assess personality traits and behaviours that influence leadership style and preferences; in addition, we need to create a valid process for assessing an individual's progress in their development journey. 'DISC' is a widely recognised assessment tool that allows us to gain insight into our natural traits and behaviours. The Leadership Circle Profile™ provides a 360° assessment of leadership competencies, drawing attention to hidden motivators driving successful/unsuccessful behaviors. We plan to procure access and training for internal accreditation to correctly apply these tools. Our aim thereafter is to offer individuals these assessments in combination with coaching conversations to help them understand what the results means in the context of their current leadership style and preferences and to determine future leadership development goals and needs.

The outcomes of our leadership strategy are two-fold: the perceived value and impact of development offering. For the former, we will quantify the interest, quality, and content of programmes from registration data and attendee evaluations. For the latter, we will analyse data from a number of sources, including:

- Staff Survey – wellbeing, morale, staff engagement, diversity and inclusion domains
- Staff recruitment and retention rates
- Staff exit interviews
- Staff sickness rates – numbers referred to occupational health or externally for stress/burnout
- Number, quality, and vacancies in key leadership roles
- Operational performance
- External assurance, i.e. CQC assessment, NHSI/E Annual Quality Report

In order to ensure regular monitoring and quality assurance, we will develop an easily accessible and reliable dashboard to allow comprehensive oversight by our assurance committee, Education and Workforce Development Board.

9. Moving Forward

It would be pragmatic to recognise that current financial resources are not sufficient to ensure the success of this strategy. Outcomes will be contingent on funding attained through the *GOSH Learning Academy: Outline Business Case*, pending submission to the GOSH Children's Charity Grants Committee in June 2019.

Once resources have been secured through this process, the GOSH Learning Academy—as the primary source of operational delivery—will identify key deliverables and measures over the next five years within the *GOSH Learning Academy: Operational Plan*. These will be approved and monitored through appropriate assurance structures, namely Education and Workforce Development Board and the People and Workforce Assurance Committee.

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You are invited

2019 International Study Tour – London

Exclusive to CEOs and Executives of Safety and Reliability Partners

2-7 June 2019

Your opportunity to join fellow partner senior executives in London to participate in Cognitive Institute's second International Study Tour.

The Study Tour provides exclusive opportunities for you to visit and experience services in Great Ormond Street Hospital, and engage in forums with esteemed international guest speakers such as Charles Vincent, Martin Bromiley and Guy Hirst who will share their safety and reliability insights.

The tour includes full registration to the world-renowned three-day [Risky Business Conference](#), where you will share experiences and synthesise ideas between those who operate in risky environments. Hear from keynote speakers on how to manage risk, harness innovation, improve teamwork and leadership – vital ingredients to achieving safer and reliable patient care.

You will also have the opportunity to collaborate with fellow partners to share ideas and present your organisation's key learnings on safety and reliability innovation and sustainability initiatives.

Audience CEOs and senior executives (*up to 3 per organisation*)
Cost AU\$4,950 (+gst) per person (*refer to registration form for inclusions*)
Dress Business

Inclusions The following activities are included in the participation fee:

- 4 x morning and afternoon teas
- All lunches
- 3 x dinners
- CEO breakfast forum
- All site visits
- Masterclass
- Extensive networking opportunities
- Risky Business Conference admission (5-7 June)

RSVP 25 March 2019, Trina Lautier, events.team@cognitiveinstitute.org



LONDON STUDY TOUR

Exclusive to CEOs and Executives of Safety and Reliability Partners

Programme

Day 1 – Arrival and Welcome Dinner

Sunday 2 June

Dinner with Martin Bromiley

Mr Bromiley is an advocate for patient safety and founder of Clinical Human Factors Group. [View full bio](#)

Day 2 – Reliability in Action

Monday 3 June

Reliability with Guy Hirst

Mr Hirst was a former British Airways pilot and pioneer of Human Factors (HF) Training. [View full bio](#)

Visit to aviation simulation centre

Masterclass with Professor Paul Bowie NHS

Professor Bowie is Programme Director for Patient Safety and Quality Improvement with NHS Education for Scotland. [View full bio](#)

Day 3 – Insights and Excellence from Great Ormond Street Hospital (GOSH)

Tuesday 4 June

Site tours of

- Paediatric 3D limb reconstruction service
- Precision medicine research (rare diseases)
- Simulation/Avatar training centre

Reliability innovation presentations on

- Digital heart mapping
- Dragons Den
- DRIVE

An evening with Professor Charles Vincent – Safer Healthcare: Strategies For The Real World

Professor Vincent is Director of Oxford Healthcare Improvement and author of *Patient Safety (2nd ed 2010)* and many papers on medical error, risk and patient safety. [View full bio](#)

Day 4 – Risky Business Conference

Wednesday 5 June

Learning from Paediatric Centres of Excellence

View the full [Risky Business Conference programme](#)

Day 5 – Risky Business Conference

Thursday 6 June

Crisis Management, Leadership and Wellbeing

View the full [Risky Business Conference programme](#)

Networking dinner

Day 6 – Risky Business Conference

Friday 7 June

CEO breakfast forum with Safety and Reliability Partner speaker

Human Factors & Systems Failures, Innovation & Disruption Technologies, Developing “all” of our youth

View the full [Risky Business Conference programme](#)

Safety and Reliability Partner lunch wrap-up



LONDON STUDY TOUR

Exclusive to CEOs and Executives of Safety and Reliability Partners

Registration Form

Participation fee

A fee of AU\$4,950 (ex. GST where applicable) is payable per person to Cognitive Institute.

Participant fee inclusions

- Dinner with Martin Bromiley (2 June)
- Dinner – *An evening with Charles Vincent* (4 June)
- Networking Dinner (6 June)
- Masterclass – Professor Paul Bowie
- Reliability in Action with Guy Hirst
- Site visit to aviation training centre
- Site visit to Great Ormond Street Hospital
- Risky Business conference (5-7 June)
 - Includes CEO breakfast forum (7 June)
- 4 morning and afternoon teas
- Lunch daily (3-7 June)

Programme is correct at the time of publishing and is subject to change.

Participant fee exclusions

- All travel arrangements including flights where required, and airport transfers
- Accommodation and related expenses
- Food and beverages except where indicated above
- Any miscellaneous costs associated with participation e.g. travel insurance, medical expenses and airport taxes, if required

To confirm your registration, please return signed Registration Form by 25 March to:

Trina Lautier
events.team@cognitiveinstitute.org
ph: +61 7 3511 5000

Name:

Signature:

Organisation:

Date:

I agree to the Booking Conditions below.

Booking Conditions

- If participation is cancelled after receiving confirmation the Study Tour is proceeding, the following cancellation fee will apply:
 - 75% of the participation fee
- No refund will be made for any unused services which are included in the registration fee.
- Where a participant is no longer able to attend, the participant fee may be transferred to another Executive from the same organisation. The acceptance of the substitute participant is subject to approval by Cognitive Institute.
- In the event that the Study Tour is cancelled due to Force Majeure, Cognitive Institute will refund the registration fee, however is not liable for other expenses such as travel and accommodation. We recommend you take out travel insurance.

Important Notes

- The Study Tour proceeding is subject to minimum registration numbers
- An invoice will be sent upon receipt of the registration
- By April 12, Cognitive Institute will confirm minimum registrations have been received and that the Study Tour is proceeding
- Cancellation fees will automatically be applied after that date
- Do not book airfares or accommodation until advised the Study Tour is proceeding