Great Ormond Street Hospital for Children NHS Foundation Trust

Meeting of the Trust Board
23rd July 2014

Dear Members

There will be a public meeting of the Trust Board on Wednesday 23rd July 2014 at 2:00pm in the **Charles West Room**, Great Ormond Street, London, WC1N 3JH.

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

AGENDA

	Agenda Item STANDARD ITEMS	Presented by	Author
1.	**Apologies for absence**	Chairman	**Verbal**
Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.			
2.	**Minutes of Meeting held on 23rd May 2014**	Chairman	**I**
3.	**Matters Arising/ Action Checklist** • **Update on Staff Survey Results**	Chairman Director of HR and OD	**2** **3**
4.	**Interim Chief Executive Report**	Chief Executive	**Verbal**
	STRATEGIC ISSUES		
5.	**Public presentation of strategy**	Director of Planning and Information	**Presentation**
6.	**Research and Innovation Report July 2014**	Director of Research and Innovation	**J**
7.	**Trainee Doctors Report Update**	Co-Medical Director (CC)	**K**
8.	**Theatre 10 business case**	Chief Operating Officer	**L**
9.	**Medical Appraisal and Revalidation – Annual Board Report**	Co-Medical Director	**M**
	PERFORMANCE		
10.	**Performance Report** • **Quality and Safety** • **Targets and Indicators** • **Workforce** • **Finance**	Chief Executive Co-Medical Director Chief Operating Officer Director of Human Resources &OD Deputy Finance Director	**N**

	• **Complaints**	Chief Operating Officer	
11.	**Discharge Summaries**	Dr Clarissa Pilkington, Consultant Rheumatologist/ Chief Operating Officer	**Presentation**
12.	**PALS patient experience annual report 2013/14**	Chief Nurse	**P**
13.	**Safe Nurse Staffing Report – June 2014**	Chief Nurse	**Q**
14.	**Annual Health and Safety Report 2013/14**	Director of HR and OD	**R**
15.	**2013/14 Annual Infection Prevention and Control Report – Executive Summary**	Director of Infection, Prevention and Control	**S**
16.	**Results from first Staff Friends and Family Test survey**	Director of HR and OD	**T**
	GOVERNANCE		
17.	**Quarter 1 Monitor Return (3 months to 30 June 2014)**	Chief Finance Officer	**U**
18.	**Update from the risk management meeting (21st July)**	Chair of the Audit Committee	**Verbal**
19.	**Revised Trust Board Terms of Reference and Workplan**	Company Secretary	**V**
20.	**Register of Seals**	Company Secretary	**W**
	REPORTS FROM COMMITTEES		
21.	**Audit Committee update – May 2014 meeting**	Chair of the Audit Committee	**X**
22.	**Clinical Governance Committee update – July 2014 meeting**	Chair of the Clinical Governance Committee	**Y**
23.	**Finance and Investment Committee Update – April and June 2014**	Chair of the Finance and Investment Committee	**Z**
24.	**Members' Council Update – May and June 2014**	Chairman of the Members' Council	**1**

Any Other Business
(Please note that matters to be raised under any other business should be notified to the Company Secretary before the start of the Board meeting.)

Next meeting
The next Trust Board meeting will be held on Wednesday 24th September 2014 in the York House Conference Room, York House, Great Ormond Street, London, WC1N 3JH.

ATTACHMENT I

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT Minutes of the meeting of Trust Board on 23rd May 2014

Present

Baroness Tessa Blackstone	Chairman
Mr Julian Nettel	Interim Chief Executive
Ms Mary MacLeod	Non-Executive Director
Ms Yvonne Brown	Non-Executive Director
Mr John Ripley	Non-Executive Director
Mr David Lomas	Non-Executive Director
Professor Rosalind Smyth	Non-Executive Director
Mr Charles Tilley	Non-Executive Director
Mr Robert Burns	Director of Planning and Information
Dr Catherine Cale	Interim Co-Medical Director
Professor Martin Elliott	Co-Medical Director
Mr Ali Mohammed	Director of Human Resources and OD
Mrs Liz Morgan	Chief Nurse and Families' Champion
Mrs Claire Newton	Chief Finance Officer
Ms Rachel Williams	Chief Operating Officer

In attendance

Mr Robert Burns	Director of Planning and Information
Mr Matthew Tulley	Director of Redevelopment
Dr Anna Ferrant	Company Secretary
Ms Victoria Goddard	Trust Board Administrator (minutes)
Mr Campbell McKerracher*	Chief Operating Officer, Meridian Productivity
Mr Steve Davies*	Financial Recovery (Productivity and Efficiency) Advisor

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

24	**Apologies for absence**
24.1	No apologies for absence were received.
25	**Declarations of interest**
25.1	No declarations of interest were received.
26	**Minutes from the meeting on 27th March 2014**
26.1	The minutes from the previous meeting were **approved**.
27	**Matters arising/action checklist**
27.1 27.2	The actions which had been taken were **noted**. Minute 167.3: **Action** It was agreed that the results of the staff survey would be discussed at the next meeting.

28	**Interim Chief Executive Report**
28.1	Mr Julian Nettel, Interim Chief Executive reported that the Trust's 'Zero Harm, No Waste, No Waits' programme had won the BMJ Patient Safety Team Award 2014. He confirmed that the level of patient harm had been reduced from 15% - 10% since the launch of the programme in 2007.
28.2	Mr Nettel said that he had shadowed the Clinical Site Practitioner team one evening and had been impressed by the methodical and systematic approach to caring for patients at risk of deterioration. He confirmed that the number of arrests outside of ICU had decreased as a result of this work.
28.3	The Board **noted** the update.
29	**NHS Foundation Trust Final Accounts and Annual Report 2013-14**
29.1	Mr Charles Tilley, Chair of the Audit Committee and Non-Executive Director reported that both the Audit Committee and auditors were satisfied with the Trust's annual accounts. He said that the auditors were comfortable with the level of debt and agreed that the Trust's policies for negotiation and collection of payment were in line with those of other Trusts.
29.2	Mr Tilley told the Board that there had been significant property valuation increases but that following a benchmarking exercise with other comparable buildings the auditors were comfortable with this. Mr Tilley added that it was not a requirement to revalue property every year and therefore the Trust would not continue to do this.
29.3	The Audit Committee recommended the annual accounts to the Board for approval.
29.4	The letter of representation would be amended to add in the issue of materiality and subject to this amendment was recommended for approval by the Board.
29.5	The Trust Board **approved** the annual accounts and letter of representation.
29.6	Mr Tilley noted that the annual report had developed significantly from previous years. He confirmed that the Audit Committee had recommended the report to the Board for approval.
29.7	The Board **approved** the draft annual report.
29.8	It was confirmed that the Audit Committee Annual Report and the Annual Governance Statement had also been recommended to the Board for approval by the Audit Committee. The Board **approved** these documents.
29.9	The Board confirmed that all information required for Audit purposes had been provided.
29.10	Mr Tilley said that the Head of Internal Audit Opinion had given a very strong opinion in terms of risk process and the Board Assurance Framework and the highest available score of 'adequate' for incident reporting.
29.11	The Board thanked those involved for their work on the Annual Report and Annual Accounts.

30	**Quality Report 2013-14**
30.1	Mr Tilley said that the Quality Report had been presented to the Audit Committee and had received a positive review from Deloitte, the external auditors.
30.2	The Board thanked Meredith Mora, Clinical Outcomes Development Lead for her work on the report.
30.3	The Board **approved** the Quality Report.
31	**Annual Report of the Audit Committee 2013-14**
31.1	Mrs Claire Newton, Chief Finance Officer reported that the Audit Committee functioned in line with best practice. She added that the Audit Committee had completed a self-evaluation survey and recommendations were being taken forward.
31.2	It was noted that the Trust's internal auditors had recommended that the next Audit Committee self-evaluation should survey members of the Trust Board who were not members of the Committee as well as those who were.
31.3	The Board **noted** the report.
32	**Outpatient Improvement Project**
32.1	Mr Campbell McKerracher, Chief Operating Officer, Meridian Productivity reported that the outpatient improvement project had considered the efficient use of outpatient resources and the implications for patient care, the team and the physical space available.
32.2	Mr McKerracher said that with strong support from the Executive team, Meridian had developed an implementation plan and worked with each specialty to work through how the teams could operate differently. He added that this approach had led to internal ownership of action plans which had supported implementation and led to increased productivity.
32.3	Mr McKerracher told the Board that clinics were being developed outside working hours which had met the needs of patients and families and reduced waiting lists.
32.4	It was reported that the project had agreed over one hundred and fifty actions with 90% having been implemented in the first six months. An audit undertaken by Meridian showed earlier and more consistent clinic start times, a more efficient use of space and an increase in the number of NHS appointments. It was also noted that the capacity used to deliver the improvements had fallen. The average productivity of clinic rooms had increased by 22% which would result in an increase in revenue of almost £4m over the year. The Board welcomed the results of the project.
32.5	Mr David Lomas, Non-Executive Director expressed some concern that there was some front loading of patients in early slots during clinics which led to longer waiting times for patients. Mr Robert Burns, Director of Planning and Information said that this was being looked into.
32.6	**Action:** Mr Lomas asked if outpatients would be surveyed to look at levels of

	satisfaction. Mrs Liz Morgan, Chief Nurse reported that surveys were usually undertaken biannually but that consideration would be given to doing this in October 2014 following the changes.
32.7	Mr McKerracher stressed that many of the actions arising from the project were developed with the objective of increasing quality rather than improving efficiency.
32.8	It was confirmed that the approach set out by Meridian would be adopted in newly redeveloped buildings and would be used to inform the longer term planning including clinical adjacencies which would also bring efficiencies.
32.9	Mr John Ripley, Non-Executive Director emphasised the importance of the patient's experience and suggested that it would be helpful to present the results of the outpatient project in light of the 'always values' which had been adopted by the Board.
32.10	The Board **noted** the update.
33	**Safe Nurse Staffing**
33.1	Mrs Liz Morgan told the Board that the Francis Report required Boards to receive nurse staffing reports and for all Trusts to undertake an establishment review twice a year which GOSH had completed. She confirmed that each ward had worked to consider their activity and expansion plans when undertaking the review.
33.2	Mrs Morgan said that the number of nursing vacancies was 111 registers and 31 non-registered, however 48 nurses would be starting with the Trust in June.
33.3	It was reported that all beds in PICU were open which had increased pressure on wards as they were taking high acuity patients as a result.
33.4	**Action:** It was agreed that a further report on nursing productivity would be presented to the Board at the next meeting. This would include establishment, vacancies by ward and where the Trust would need to use innovative ideas to support recruitment.
33.5	The Board **noted** the update.
34	**Audit Committee Update**
34.1	Mr Charles Tilley, Chair of the Audit Committee presented the report. He said that the Committee had been presented with a very positive report from internal audit around the Trust's risk framework. He added that KPMG provided recommendations around the Board Assurance Framework becoming more efficient and increasing the proportion of strategic risks. It was confirmed that this would be discussed at a special risk management meeting in July 2014.
34.2	The Board **noted** the update.
35	**Schedule of matters reserved for the Board and Members' Council and responsibilities of the Chairman and Chief Executive**
35.1	The Board **approved** the document.

36	**Productivity and Efficiency – the new programme**
36.1	Ms Rachel Williams, Chief Operating Officer reported that GOSH had set a £14.8m target for efficiency savings for 2014/15 of which almost 56% had been identified and 2.3% delivered. She outlined the initial assessment which had been undertaken by Mr Steve Davies, Financial Recovery (Productivity and Efficiency) Adviser, including ideas around engaging with staff and a wider communications strategy. She said that it had previously been difficult to engage staff who were aware that the Trust reported a surplus.
36.2	Mr Davies stressed that it was vital to engage with clinicians in a patient centred way. The Board welcomed this approach and suggested that a focus on patients and their experience was an important driver for efficiencies.
36.4	The Board **endorsed** the proposed approach to productivity and efficiency.
37	**Extended working update**
37.1	Mr Robert Burns, Director of Planning and Information reported that results from patient surveys had shown that families and patients were strongly in favour of extended working. He said that Senior Management Team had given unanimous support for all routine services to provide seven day services to 7:00pm. Mr Burns added that some outpatient clinics would be provided on Saturdays during late Summer/ early Autumn using 30 consulting rooms all day which was over a third of available capacity.
37.2	The Board welcomed the progress made and Mr John Ripley, Non-Executive Director noted that given the results of the patient surveys, Saturday was the most valuable time of the week and should therefore be used to create better patient satisfaction.
37.3	Mr Ali Mohammed, Director of HR and OD said that a key result in the values consultation was that families did not like long waits and suggested that the start of Saturday outpatient clinics could be put forward as a solution in a 'you said, we did' format.
37.4	Mr Burns said that extended working was a cost pressure as a result of Agenda for Change contracts requiring additional remuneration of 30% on Saturdays and 60% on Sundays. Mr Mohammed told the Board that the consultant contract was currently being renegotiated nationally - one of the issues being discussed is the removal from the contract of the clause which provides a consultant with the right to refuse additional work in certain circumstances. Any changes to the contract could be expected between April 2015 - 2016.
37.5	**Action:** It was agreed that an update on progress would be received at the November meeting.
37.6	The Board **noted** the update.
38	**Update on referrer work**
38.1	Dr Catherine Cale, Interim Co-Medical Director reported that work was focusing on three key areas: timeliness of discharge summaries, timeliness of clinic letters and closer working on communication and service development with key referrers.

38.2	Dr Cale said that work piloted in Rheumatology with a prepopulated discharge summary was currently being rolled out to a number of specialties with a wider cascade to all teams planned for July. She acknowledged that there was still a lot of work to be done in clinic letter turnaround time but said that the average time take to send a letter had reduced.
38.3	Dr Cale reported that the next step was to look at how to cascade positive examples of working with referrers throughout the Trust.
38.4	**Action:** Mr David Lomas, Non-Executive Director suggested that a position should be created to focus entirely on work with referrers. It was agreed that this would be considered.
38.5	The Board **noted** the update.
39	**Performance Report**
39.1	Mr Robert Burns, Director of Planning and Information reported that Monitor had confirmed that they would be taking no further action over the Trust's report of 13 cases of Clostridium Difficile against the de minimis threshold of 12 and that the Trust's governance rating would remain green.
39.2	**Action:** It was agreed that the number of lost bed days would be included as an indicator in the nurse staffing report.
39.3	The Board **noted** the performance report.
40	**IPSOS Mori Inpatient Survey 2014**
40.1	Mrs Liz Morgan, Chief Nurse reported that patient and family satisfaction rates remained strong at 94% however some areas such as responding to the needs of families of patients with a disability required further work. She added that satisfaction with pain management had decreased and work was on-going to understand this.
40.2	Baroness Blackstone asked about the use of the play rooms on wards which often seemed to be unused.
40.3	Ms Rachel Williams, Chief Operating Officer said that in some cases children were not well enough to use the rooms and in other cases play support staff were being used in other areas.
40.4	**Action:** It was agreed that the Trust would look at benchmarking data around play support.
40.5	Professor Martin Elliott, Co-Medical Director expressed concern at the 18% of children whose families said they were kept awake at night by noise. He said that there were known long term developmental consequences of this. Baroness Blackstone added that a policy should be in place to support nurses to turn off televisions by patients' bedsides.
40.6	Mrs Morgan told the Board that each area would have an action plan developed as a response to the survey.

40.7	The Board **noted** the update.
41	**Safeguarding annual report**
41.1	Mrs Morgan said that the increasing Trust activity had led to additional child protection issues being raised. She added that there had been an increase in the number of Serious Case Reviews with which the Trust was involved.
41.2	Mrs Morgan said that an extensive investigation had been undertaken responding to an allegation made under Operation Yewtree, and that the report had been signed off by Verita and the police. She said the national report would be published soon.
41.3	The Board **noted** the report.
42	**Education annual report**
42.1	Mr Ali Mohammed, Director of HR and OD reported that a new learning management system would be adopted during the year.
42.2	**Action:** Mr Mohammed said that an education visioning event would be held on 16th June 2014 and agreed to send information to Board members.
42.3	The Board **noted** the report.
43	**Compliance with the NHS provider licence**
43.1	The Board **noted** that the Internal Auditors have reviewed the processes in place to ensure compliance with the licence and awarded an adequate rating.
44	**Annual Risk Report 2013-14**
44.1	The Board **noted** the report.
45	**Update on CQC registration**
45.1	The Board **noted** the update.
46	**Register of Seals**
46.1	The Board **ratified** the use of the company seal.
47	**Clinical Governance Committee update – April 2014 meeting**
47.1	The Board considered the report and noted that a full verbal update had been provided at the April meeting of the Members' Council.
47.2	The Board **noted** the update.
48	**Board of Directors Remuneration Committee update – March 2014**
48.1	Ms Yvonne Brown, Chair of the Board of Directors Remuneration Committee and Non-Executive Director said that the Director of HR would be sending the draft

	contract for the new appointed Chief Executive for agreement.
48.2	The Board **noted** the update.
49	**Board of Directors Nominations Committee update – March 2014**
49.1	The Board **noted** the update.
50	**Finance and Investment Committee update – April 2014**
50.1	The Board **noted** the update.
51	**Members' Council update – April 2014**
51.1	Baroness Blackstone, Chairman reported that an extraordinary meeting of the Members' Council had taken place in May to confirm the appointment of Dr Peter Steer as Chief Executive. She added that a Members' Council development session had taken place following the meeting.
51.2	The Board **noted** the update.
52	**Any other business**
52.1	There were no other items of business.

ATTACHMENT 2

Attachment 2

TRUST BOARD – PUBLIC ACTION CHECKLIST
July 2014

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
125.6	27/11/13	It was agreed that DNAs and clinic cancellations would be revisited at a future meeting.	RW	May 2014	On agenda
127.2	27/11/13	It was agreed that the next update on extended working should provide information about the potential additional activity and the clinical and financial benefits which would arise from extended working.	RB	May 2014	On agenda
147.3	28/01/14	It was agreed that future Research and Innovation reports would continue to include two or three case studies of research which was affecting patient outcomes even if the information provided was only qualitative. It was also agreed that consideration would be given to receiving presentations from researchers.	Director of Research and Innovation	On-going	On agenda
27.2	23/05/14	It was agreed that the results of the staff survey would be discussed at the next meeting.	AM	July 2014	On agenda under matters arising – verbal update
32.6	23/05/14	Mr Lomas asked if outpatients would be surveyed to look at levels of satisfaction as a result of the outpatient improvement project. Mrs Liz Morgan, Chief Nurse reported surveys were usually undertaken biannually but that consideration would be given to doing this in October 2014 following the changes.	LM	October 2014	Not yet due

Attachment 2

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
33.4	23/05/14	It was agreed that a further report on nursing productivity would be presented to the Board at the next meeting. This would include establishment, vacancies by ward and where the Trust would need to use innovative ideas to support recruitment.	LM	July 2014	This report was received at the June Board Seminar
37.5	23/05/14	It was agreed that an update on progress with extended working would be received at the November meeting.	RB	November 2014	Not yet due
38.4	23/05/14	Mr David Lomas, Non-Executive Director suggested that a post should be in place that was entirely focussed on work with referrers. It was agreed that this would be considered further.	CC	On-going	Verbal Update
39.2	23/05/14	It was agreed that the number of lost bed days would be included as an indicator in the nurse staffing report.	LM	On-going	On agenda
40.4	23/05/14	It was agreed that the Trust would look at benchmarking data around play support.	LM	September 2014	Not yet due
42.2	23/05/14	Mr Mohammed said that an education visioning event would be held on 16th June 2014 and agreed to send information to Board members.	AM	June 2014	Actioned

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board Meeting
23rd July 2014

Update on Actions from 2013 Annual Staff Survey **Submitted by** Director of Human Resources and Organisational Development	**Paper No: Attachment 3**

Aims / summary

Trust Board received a full paper on the results of the 2013 annual staff survey in March 2013.

An update on actions is as follows:

- All divisions and directorates were asked to develop local action plans, so they could respond to the priorities indicated by their own staff. These have been produced, and are being formally reviewed in July as part of Divisional quarterly reviews.
- Examples of actions that are already underway:
  - In response to the higher than average rates of work-related stress in a specialty within ICI, a group of managers have attended the modular "Creating a positive workplace" programme run by OD and OH. This has been well evaluated by them.
  - To address staff concerns that they are not fully engaged in making changes at work or achieving good communication with senior managers, the Redevelopment Directorate is establishing an improvement group made up of and led by team members and reporting to the senior management team.
  - To support HR&OD teams to see the link between their roles and patient care, a number of activities have taken place including shadowing of clinical staff and whole directorate sessions that focus on individual/team achievements and how these contribute the care of patients/families
- Directorates and divisions will be encouraged to communicate their actions to their teams in the run up to the next survey round, which will commence in October. Corporate publicity framed as: "you told us – we did" will take place to encourage staff to see the value in completing the surveys. A link will also be made between the Staff FFT, the annual staff survey, and Our Always Values.

Action required from the meeting

To note the progress of actions from the 2013 annual staff survey

Contribution to the delivery of NHS Foundation Trust strategies and plans

Monitor and CQC note results of annual staff survey.
The annual staff survey will inform delivery and measurement of Strategic Priority 1: All staff champion our strategy with common behaviours and values
Responding to the issues raised in the survey is an important component of demonstrably delivering our values as well as delivering a high quality workplace to secure recruitment and retention of staff.

Financial implications

None identified

Who needs to be told about any decision

Divisions and directorates should communicate locally on actions. Corporate communications will support coherent messaging about the range of surveys and actions that have been/continue to take place.

Who is responsible for implementing the proposals / project and anticipated timescales General Managers, Directors Helen Cooke, Assistant Director of Organisational Development
Who is accountable for the implementation of the proposal / project Divisional Directors Director of HR and OD

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
23rd July 2014

Research and Innovation Report July 2014 **Submitted by**: Professor David Goldblatt and Emma Pendleton	**Paper No: Attachment J**

Aims / summary

This report provides Trust Board with:

1. An oversight of research activity and performance at GOSH.
2. An executive summary of recommendations for GOSH/ICH to consider following our first Biomedical Research Centre External Advisory Board review.

Action required from the meeting

1. Trust Board is asked to note our current research activity data.
2. Consider the wider recommendation made by the External Advisory Board that GOSH strongly consider more fully integrating research into its clinical and overall mission.

Contribution to the delivery of NHS Foundation Trust strategies and plans

Research is one of the Trust's strategic objectives: With partners maintain and develop our position as the UK's top children's research and innovation organisation.

Financial implications

Loss of research income is on the Trust's Risk Register, the Trust needs to ensure there is a strategy and systems in place to retain and increase research income.

Who needs to be told about any decision?

Professor David Goldblatt, Director of Clinical Research and Development

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

Emma Pendleton, Deputy Director of Research and Innovation

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

Professor David Goldblatt, Director of Clinical Research and Development

Great Ormond Street Hospital for Children NHS Foundation Trust

Research and Innovation July 2014

This report is to provide Trust Board with an oversight of research activity and performance at GOSH. In addition the report includes an executive summary of recommendations for GOSH/ICH to consider following our first Biomedical Research Centre External Advisory Board review.

Research Inputs

1. **Research Income**
   The table below provides details of Trust research income at month 12 for 13/14 and month 2 for 14/15, with income at month 2 13/14 provided for direct comparison.

Table 1 Direct Funding to GOSH

Funding Type	Funding Source	Income as at M12 13/14 (£000)	Income as at M2 13/14 (£000)	Income as at M2 14/15 (£000)
A. Centre Grants and Infrastructure, Research Delivery Support				
Biomedical Research Centre	NIHR	7,306	1,071	1,355
Research Capability Funding	NIHR	1,975	329	375
Local Comprehensive Research Network	NIHR	2,013	137	376
Medicines for Children Research Network[1]	NIHR	811	183	0
B. Programme and Project Grants				
NIHR Programme, Project Grants	NIHR	1,065	113	232
Charity Research Project Grants	Variable[2]	1,873	250	331
European Union Research Project Grants	EU	121	10	5
Commercial Research Contracts	Variable	955	225	135
Other	Variable	388	22	150
Total income		**16,507**	**2,340**	**2,961**
Total Budget		**15,962**	**2,485**	**2,747**

1. The NIHR research network infrastructure has been restructured nationally and the Medicines for Children Research Network (MCRN) no longer exists, this activity is now part of the Local Comprehensive Research Network (LCRN) this explains zero income for the MCRN and the associated income increase for the LCRN
Charity funding is mostly GOSH Children's Charity
2. Charity funding is mostly GOSH Children's Charity

3. **Directly funded research staff**:
   As at month 2 14/15 there are 138 WTE directly funded through the research income sources detailed in Table 1 above.

Table 2: Directly funded research staff
The table below provides details of directly funded staff at month 2 for 14/15 with staff WTE at month 2 for 13/14 shown for comparison.

Staff Group	Number M12 13/14	Number M2 14/15
Administration, Data Managers, Trial Coordinators	42	46
Consultants	13	11
Directors & Senior Managers	4	5
Junior Doctors	2	1
Nursing Staff	32	33
Nursing Staff Bank	2	2
Scientific, Therapeutic, Technical	40	40
TOTAL	**135**	**138**

Note**:** This does not include research active clinicians whose substantive employment contract is with UCL, nor the research components of a clinician's job plan where this is not directly funded through the sources in Table 1. R&I will initiate a project in quarter 3 of 2014 with Divisional Directors / General Managers to review research activity and clinical contracts to help quantify the latter.

Research outputs

4. **Research Projects**:
   The table below provides details of the number of projects directly funded by the Programme and Project Grant income detailed above in Table 1B only. Activity is defined by spend on a grant account. Final year figures are provided for month 12 13/14 along with activity at month 2 for 14/15, with activity at month 2 13/14 provided for comparison.

Table 3: Directly funded research projects

Funding Stream (Direct Income to GOSH)	Number Active YTD M12 13-14	Number Active YTD M2 13-14	Number Active YTD M2 14-15
NIHR Programme and Project Grants	11	7	7
Charity Research Project Grants	50	37	30
European Union Research Project Grants	6	5	2
Commercial Research Contracts	120	20	21
Total	**187**	69	**60**

In addition, many research projects taking place at GOSH are:

a. Funded through grants held at UCL-ICH (and more recently the UCL Institute of Cardiovascular Sciences) where (i) GOSH costs are not eligible as research costs; or (ii) the Principal Investigator and research staff are substantively employed by UCL-ICH (with honorary GOSH contracts) and there are minimal GOSH costs.
b. Small pilot studies or student projects which do not have independent funding sources (classed as own account).

Table 4: Total number of research projects (directly and indirectly funded, plus own account) by Clinical Division

The table below provides details of the number of research projects undertaken during 13/14 along with activity at month 2 14/15 with activity at month 2 13/14 provided for comparison.

Division	Total number of projects YTD M12 13/14	Total number of projects YTD M2 13/14	Total number of projects YTD M2 14/15	NIHR portfolio projects YTD M2 14/15
Critical Care and Cardio-Respiratory	93	59	80	22
Medicine, Diagnostic and Therapeutic Services	210	154	174	71
Infection, Cancer and Immunity-LM	200	166	165	62
Neurosciences	117	80	96	35
Surgery	47	34	31	6
Other GOSH	22	17	23	5
Total	687	510	**569**	**201***

*This number will include projects in set-up, active to recruitment and closed to recruitment (M2 13/14 = 197).

5. **Research recruitment**

Accurate recruitment to research projects is currently only recorded for projects accepted on to the NIHR Research portfolio (acceptance is based on projects in receipt of external funding awarded via open competition and peer review), GOSH receives additional income for each patient recruited hence the need to keep accurate records.

Note: Although recruitment is listed by Division recruitment across Divisions is not directly comparable as this will be relevant to the patient base.

Table 5: Patient recruitment to NIHR portfolio studies as at month 12 13/14 (compared to recruitment at month 12 12/13)

Division	Patient Recruitment M12 13/14	Patient Recruitment M2 13/14	Patient Recruitment M2 14/15
Critical Care and Cardio-Respiratory	276	15	145
Medicine, Diagnostic and Therapeutic Services	1652	246	220
Infection, Cancer and Immunity-LM	579	68	66
Neurosciences	471	93	53
Surgery	170	21	36
Other GOSH	6	3	5
Total	**3154**	**446**	**525**

For comparison recruitment to portfolio studies across children's NHS Trusts is provided below. There is a lag in recruitment upload for nationally reported data which accounts for the small difference between total number of patients recruited in Table 5 above and Table 6 below.

Table 6: Comparison of patient recruitment to NIHR portfolio studies across children's NHS Trusts

Trust	No. Recruiting Portfolio studies 12/13	No. Recruiting Portfolio studies 13/14	Interventional studies 13/14	Observational studies 13/14	No. of patients recruited 13/14
GOSH	105	129	52	77	3104
Alder Hey Children's NHS Trust	80	85	35	50	4378
Birmingham Children's Hospital NHS Trust	80	75	29	46	2291
Sheffield Children's Hospital NHS Trust	59	58	21	37	758

6. **NIHR performance metrics in initiating and delivering clinical research**
   All NHS organisations in receipt of NIHR funding are required to report performance against the following two metrics on a quarterly basis:
   a) The time it takes high-impact clinical projects to pass from a valid application to recruitment of the first participant (project initiation) – target 70 days; and
   b) The number of commercially-sponsored high-impact clinical projects that recruit the agreed number of participants within the agreed timeframe (project delivery).

Performance against these metrics will influence the Trusts NIHR Research Capability Funding allocation from 15/16 (poor performing Trusts will have their allocations reduced by approximately 5%).

Table 7: NIHR Performance in initiating and delivering clinical research targets

GOSH Performance	Q2 13-14	Q3 13/14	Q4 13/14
Percentage of studies achieving 70 day benchmark	40%	61%	83%
GOSH Rank/number of Trusts	34/52	20/51	13/61
Mean days VRA to 1st patient	116	91	67
Percentage of studies delivering to time and target	54.8%	54.8%	66.7%

Research Outcomes

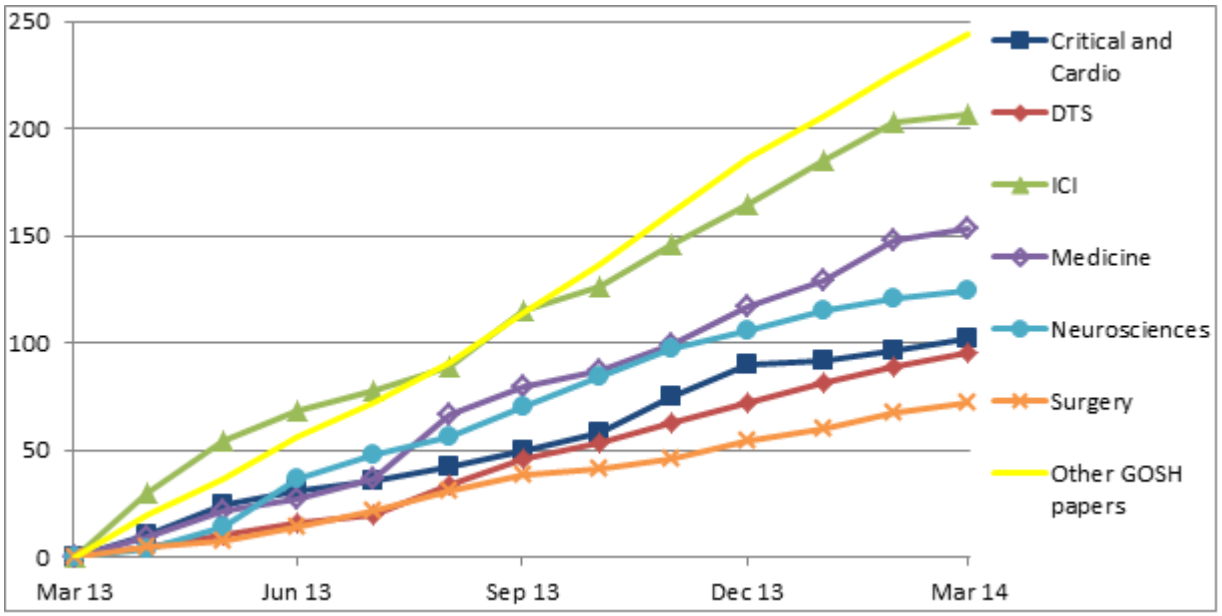
7. **Publications**
   Publication numbers for a 5 year period (2009-2013) are shown below; the numbers include all publication types (articles, reviews, proceedings papers, letters, editorials, book chapters etc.) and are recorded based on organisation address as listed on the publication. Trust Board is asked to note the year on year increase in publications, with a particularly large increase in 2012.

Table 8: Number of publications over the last 5 financial years

	09-10	10-11	11-12	12-13	13-14
GOSH-only and GOSH/ICH	721	845	745	987	884
ICH-only	577	613	614	719	523
TOTAL	**1298**	**1458**	**1359**	**1706**	**1407***

*13/14 final year figures will continue to increase due to lag in upload to the web of science database.

Figure 1: Number of publications during the 13/14 financial year by Clinical Division



Case Studies

This section of the report provides details of two high impact case studies, the first highlights a genetic breakthrough and how this will lead to the investigation of new treatments the second is a focus on regenerative medicine.

Case Study 1: Dr Veronica Kinsler, Academic Lead Clinician Paediatric Dermatology

Dr Veronica Kinsler is the Academic Lead Clinician in the Paediatric Dermatology department. She has worked at Great Ormond Street Hospital (GOSH) since 1997 (continuously since 2001) and at the UCL Institute of Child Health (ICH) since 2008.

Veronica's research career was pump primed through a three year salary award from a patient support group 'Caring Matters Now', after which she received a Wellcome Trust Research Training Fellowship. Since then Veronica's research has been supported through funding from Caring Matters Now, the ICH Livingstone Skin Research Centre, the GOSH NIHR Biomedical Research Centre, the Leah Wigmore Melanoma Fund and the Butterfly AVM Charity. Two months ago Veronica was awarded a highly competitive and prestigious Intermediate Level Wellcome Trust Fellowship to continue her studies into the molecular basis of malignant melanoma.

Veronica's research interest is rare paediatric genetic skin diseases and in particular a condition called congenital melanocytic naevi (CMN). CMN causes large dark moles on the skin that are present at birth. They can vary in size and number and the incidence of larger or multiple moles is approximately one in 20,000 new births per year. Major complications are neurological abnormalities of different types, and a predisposition to malignant melanoma (skin cancer). The majority of children born with this condition in the UK will be seen at GOSH. Referral to GOSH, which has expertise in diagnosis and management of CMN, mean parents are provided with much-needed information early on. In weekly clinics moles are checked to ensure they are safe and children are assessed to see whether they need a brain scan.

In 2013, Veronica's research, as part of the Genetics Research Team at ICH and Molecular Basis of Childhood Diseases Biomedical Research Centre theme, led to a major breakthrough in identifying the gene that causes multiple CMN and its associated neurological problems. This is caused by a mutation in a gene called NRAS, which occurs while the baby is growing in the womb, and means that parents can be reassured that this is not inherited. The gene mutation is found in at least 80 per cent of the patients with CMN. The other 20 per cent are still being investigated. The research also found the genetic cause of the progression of the moles to skin cancer in some cases. Other genes which predispose to getting CMN and to developing melanoma without CMN have been identified recently.

Future: The discovery of the genetic cause means that treatments can now be investigated. In addition this research could also help understand other conditions. The gene identified is also known to be involved in the development of melanomas and explains why patients have an increased risk of melanoma (patients need to develop a second mutation to change the moles into cancer). Veronica has also set up the GOSH Rare Dermatology Diseases Resource, which opened in 2013. This resource will harness the enormous potential that exists within the Paediatric Dermatology Department at GOSH. By systematically collecting samples from patients who attend the clinic, research can be accelerated into identifying the causes of these conditions and work towards developing new treatment options. Her Intermediate Wellcome Trust Fellowship will focus in more detail on the genetics of melanoma.

Publication: Kinsler, V. A., Thomas, A. C., Ishida, M., Abu-Amero, S., Moore, G. E., Bulstrode, N. W., Sebire, N. J. (2013). Multiple congenital melanocytic nevi and neurocutaneous melanosis are caused by postzygotic mutations in codon 61 of NRAS. Journal of Investigative Dermatology, 133 (9), 2229-2236. doi:10.1038/jid.2013.70

Veronica received a prize from the Academy of Medical Sciences and the CDA trophy from the Association of Dermatologists in 2013 in recognition of this research.

Great Ormond Street Hospital for Children NHS Foundation Trust

Case Study 2: Paolo de Coppi – Regenerative Medicine

Paolo de Coppi started his career in Italy before moving to Harvard to learn about regenerative technology. He joined GOSH/ICH in 2005 as a Trust Fellow and honorary Research Fellow before being appointed, in 2006, to a joint clinical academic position; Consultant Paediatric Surgeon and Clinical Senior Lecturer. In 2013 Paolo was promoted to Reader and last month was promoted to full Professor by UCL. In June 2014 he was also awarded a highly competitive NIHR Professorship. Only two applications per Higher Education organisation can be submitted to the NIHR; the NIHR received 29 applications, 5 of which were successful. This award will allow Paolo to further advance his regenerative medicine research programme. To date Paolo has also received research funding from the Royal College of Surgeons, the Newlife Foundation and GOSH Children's Charity.

Paolo's interest in regenerative medicine grew from a frustration of not being able to do enough for children born with missing tissue or organs. Transplantation or implanted prosthetics that mimic tissue functionality are used but do not grow with a child; this can result in children having multiple operations. This has a severe impact on both the child and family's life and a high life time cost to the NHS.
Regenerative medicine combines advances in gene therapy, biomaterials and nanotechnology in an attempt to mimic the human body's complex growth and healing pathways. Paolo's vision is to build transplantable organs from a patient's own cells, avoiding the use of immunosuppressant drugs that are associated with a high risk of infection and tumour formation.

Over the last decade Paolo working with Professors Martin Elliott and Martin Birchall began to experiment with transplanting donated tracheas. Initially, to avoid rejection, they had to strip off the donor's cells, reducing the structure to just a supportive collagen scaffold. The therapy allowed the team to establish Europe's only specialised airway clinic. Nevertheless the technique only had a 65 per cent 12-year survival rate.

In 2010 the team undertook a pioneering new treatment and Ciaran Finn-Lynch was the first child to undergo this treatment. They took stem cells from his bone marrow and incubated them with a de-cellularised windpipe along with growth signalling molecules. This engineered organ was then implanted successfully, with the stem cells forming an airway lining, and triggering growth of a functional blood supply to the trachea. Following a lengthy recovery Ciaran returned home.

Paolo's research has expanded into exciting new areas, to apply advances in regenerative medicine to the clinical treatment of children with rare diseases such as heart defects, diaphragmatic hernia and gut and neuromuscular diseases. His research has found ways to isolate stem cells from a sample of amniotic fluid surrounding the growing infant in their mother's womb and the team has been able to show that these cells can be transformed into pluripotent cells, capable of growing into any tissue in the body. The aim is to use these stem cells alongside the latest developments in nanotechonology, to design and grow personalised replacement tissues for children who urgently need surgery at the point they are born, or whose organs are failing.

Research funded through Paolo's new NIHR Professorship aims to build and test an artificial oesophagus as a model treatment for paediatric patients with oesophageal atresia. This condition is characterised by the congenital absence of part of the gullet, which occurs in about 1 out of 3,500 births and often cannot be repaired by simply suturing the upper and lower segments. The study will also provide a platform for treating other congenital and acquired diseases using regenerative medicine approaches.

Publication: Elliott MJ, De Coppi P, Speggiorin S, Roebuck D, Butler CR, et al. (2012) Stem-cell-based, tissue engineered tracheal replacement in a child: a 2-year follow-up study. Lancet 380: 994-1000.

Biomedical Research Centre: External Advisory Board (EAB) Review

Following on from the renewal of the BRC in 2012 for a further 5 years funding, the BRC Board decided to establish an International External Advisory Board with a remit to provide the BRC Scientific and Strategy Boards with an overall assessment of the performance of the BRC and advice about the BRC strategy going forward. The EAB consists of a group of international experts (see annex 1).

The first visit of the EAB took place in May 2014. For this first visit the EAB were asked to specifically consider the following points:

1. Assess the BRC research strategy, infrastructure investments and current level of success in fulfilling the NIHR objectives to (i) drive innovation in the prevention, diagnosis and treatment of ill-health; (ii) translate advances in biomedical research into benefits for patients; (iii) deliver a portfolio of excellent collaborative research, especially with industrial partners and (iv) harness the collective biomedical strengths of UCL through collaborative research partnerships.
2. Provide views on whether the BRC portfolio of research and research infrastructure will continue to deliver and support internationally competitive translational research in future.
3. Provide views on the BRCs current level of engagement with research, healthcare and regulatory organisations, and with industry? Are there any particular partnerships that will strengthen our existing strategy?
4. Consider if there is anything that the BRC can add to the educational, patient and public involvement and communications programmes so that they continue to be robust and tailored to the BRC research strategy? Are there additional programmes to which the BRC should give thought?

The EAB met at GOSH/ICH on 13th/ 14th May 2014. They received a pack of supporting information in advance of their visit, attended a day long BRC symposium and had the opportunity to meet with the BRC Director and Deputy Director, Theme Leads, CEO, UCL Vice Provost and Institute Director. The full report is attached and the main points summarised below:

1. Overall the EAB agreed that the BRC is a highly successful and unique programme that sits at the centre of the research and clinical spectrum of GOSH with effective leadership provided by Professor Goldblatt (BRC Director) and Professor Gaspar (BRC Deputy Director).
2. The BRC is on track to meet its performance metrics (partnership with industry, leverage of external grant income, commercial income, number of academic publications, increase in early phase recruitment and increase in intellectual assets). However the BRC should consider how to present this data for maximum impact (for example before and after figures).
3. A high level critique of themes was provided and there will be a more detailed review of themes during two subsequent visits. Our strongest themes are Gene, Stem and Cellular Therapies and Novel Biological Therapies for Translation in Childhood Diseases.
4. GOSH has an international reputation focused heavily in clinical excellence, it is critical that hospital leadership understand the importance of science in this reputation currently and the importance of this in the future. GOSH should strongly consider more fully integrating research into its clinical and overall mission:
   - Providing patients information on research and access to research, by offering opportunities to have data and specimens used for research, as well as by gaining permission to contact families should relevant research studies emerge.
   - The alignment between GOSH, BRC and ICH is critical since leveraging the enormous advantage of the GOSH patient populations require science to be embedded in the fabric of the clinical programmes.
   - GOSH/ICH/BRC may want to consider if hospital funds can be better used to match NIHR funds and support the research mission of the Trust (for example training, building on Genomics England pilot).
5. There are many examples of national, international and commercial collaborations. However, GOSH has a unique opportunity to serve as a catalyst and supporter of multiple collaborative efforts in the UK and internationally in paediatric rare disease and should more fully embrace this goal, moving away from GOSH centric work in order to be viewed as spear heading paediatric research in the UK.
6. There should be a concerted effort to attract larger multi-institutional grants.
7. The BRC should have a focus on training the next generation of physician scientists (this may require protected research time for prolonged periods to be competitive with other institutions).

Great Ormond Street Hospital for Children NHS Foundation Trust

Annex 1

EAB membership:

Professor David Williams, Leland Fikes Professor of Paediatrics, Harvard Medical School

Professor Mary Rutherford, Head of Perinatal Imaging, KCL

Dr Petra Kaufmann, Director of Office of Clinical Research, National Institute of Neurological Disorders and Stroke, National Institutes of Health

Dr Kym Boycott, Investigator CHEO Research Institute, Clinical Geneticist, CHEO, Associate Professor Department of Paediatrics, Faculty of Medicine, University of Ottawa

Dr Stephen W Scherer, Director, The Centre for Applied Genomics, The Hospital for Sick Children, Director and Professor of Medicine, McLaughlin Centre for Molecular Medicine University of Toronto

Dr Julia Dunne, NDA Regulatory Ltd

Professor Karen Temple, Professor of Medical Genetics, Southampton Medical School

Executive Summary of the External Advisory Board (EAB) to the BRC Scientific Board, GOSH/UCL

The EAB met for a 1.5 days on May 12/13 at GOSH in London. The EAB was provided with a large amount of supporting material in advance of the meeting and Professor David Goldblatt provided a short history of at GOSH NHS research funding and the evolution of NIHR programmatic funding. He also provided some background about the BRC including the initial application, the subsequent renewal and the communications ("refresh") with the NIHR. The purpose of the EAB is to provide specific feedback about the current theme areas and to assist the BRC Scientific Board in preparing for competitive renewal in the upcoming years.

During this first meeting of the EAB, scientific progress was presented in a one day symposium featuring the themes of the BRC with each theme leader presenting a short overview and then selected areas of each theme presented by their lead investigators. A poster session was also presented at lunch. These presentations supported the written material and confirmed that the BRC is on track to meet its stated goals of partnerships with industry, commercial income, increase in intellectual assets, number of academic publications, increase in enrollment of early phase human trials and nearly on track to reach the goal of a 4:1 leverage of external grant support for BRC funding. Each theme area is separately critiqued below, although the EAB uniformly felt that this assessment was not as detailed as the board would like due to the organization of the data provided and the context in which the presentations were provided. We provide below specific recommendations about how this process might be improved. Overall, the EAB felt that the BRC is a highly successful and unique program that sits at the 'center' of the research and clinical spectrum of GOSH, with research excellence across a broad portfolio and facilitating translation of basic biomedical discoveries into improving patient health in pediatric diseases. There are many examples of national, international and commercial collaborations. Some, but not all, of the themes represent research that is international in reputation and scope taking advantage of the unique position GOSH plays in the area of pediatric rare disease expertise. The EAB was impressed with the extent to which all themes areas are leveraging collaborations with investigators at UCL, specific examples of which were provided in nearly every presentation. Overall, the organizational structure outlined for the BRC appears well thought out and functioning.

In addition to the comments provided later in this report about specific theme areas, the EAB also recognized some themes that were cross-cutting. While GOSH has an international reputation focused heavily in clinical excellence, it is critical that hospital leadership understand the importance of science in this reputation currently and likely increasingly into the future. Thus, alignment between the hospital, BRC and ICH is absolutely critical since leveraging the enormous advantage of the GOSH patient populations (specifically in rare diseases) requires science embedded in the very fabric of the clinical programs. It was not clear to the EAB to what extent this is currently the case. As one example, patients with rare monogenic diseases from outside the EU could be treated on gene therapy trials at GOSH, but instead are being enrolled in other institutions because these institutions provide funding for such patients to be enrolled in important clinical trials. Given the requirement of NIHR funding to accelerate scientific discoveries into enhanced therapies for patient, GOSH/BRC/ICH may want to consider if hospital funds can be better utilized to match NIHR funds to support the research mission of the institution.

GOSH also has a unique opportunity to serve as a catalyst and supporter of multiple collaborative efforts in the UK and internationally in pediatric rare disease research and should more fully embrace this goal. The group needs to show that their 'privileged position' equates to outputs that are shared with the community. While there is sensitivity around the preeminence

of GOSH in the UK, BRC themes should constantly think of ways of proving what they are doing and ways of moving out of the GOS centric work so that they are viewed as spear heading pediatric research in the UK.

In spite of the success of the BRC at leveraging funding for additional external grants, the EAB recognized the NIHR concern about external funding of GOSH investigators. The EAB suggests a specific and concerted focus on increasing larger grants, such as MRC funds, including multi-disciplinary, multi-institutional grants that may better reflect GOSH's position as preeminent in rare pediatric disease research.

With respect to training, the EAB suggests a focus on training the next generation of physician-scientists, leveraging the outstanding and unique populations of patients with rare diseases at GOSH with the remarkable scientific environments at UCL and ICH. This training may require support of protected research training for prolonged periods of time to be competitive with other institutions and to be successful at positioning these individuals for successful independent research careers. There are relatively few pediatric academic centers in the world with the patient and financial resources capable of carrying out this mission and the BRC should seize this unique opportunity as a major goal.

In preparation for the upcoming renewal of the NIHR BRC grant and to provide more detailed feedback of each theme, the EAB suggests some changes in the process of EAB meetings in the future. We suggest detailed analysis of two themes/visit over the next 18 months. The EAB envisions each theme would require ½ day of intensive review with presentations supplemented by supporting documents *organized by theme* listing publications of all supported investigators, grant funding, patents, industrial collaborations, clinical trial activities and future plans. The EAB visit should also include time for one on one interviews with key leaders of each theme to allow a more comprehensive view of the challenges faced in each area. These EAB meetings might include one or two ad hoc reviewers which are chosen as theme-experts. We propose to work closely with Professor Goldblatt and his staff to effect these meetings.

Leadership

Effective leadership has been provided by **Professor David Goldblatt and Professor Bobby Gaspar.** Dr. Goldblatt is Professor of Vaccinology and Immunology ICH, and a Consultant Paediatric Immunologist at GOSH. He has been Clinical Director of R&D for GOSH/ the 2006 bid to create an NIHR specialist BRC at GOSH/ICH (of which he is currently the director). In vaccines/vaccine immunology, Professor Goldblatt has significant management experience through his Executive Director and through his key strategic R&D role. In 2009 he was appointed Program Director for Academic Health Science Centre to lead strategic efforts to translate research into benefits for patients. He spent 11 years as a member of the DH Joint Committee on Vaccination and Immunisation and until recently co-chaired the now disbanded Wellcome Trust Infectious Disease and Immunology Committee. Professor Bobby Gaspar is the BRC Deputy Director. He is Professor of Paediatrics and Immunology. He is a recognized Immunologist with an interest in primary immunodeficiencies. He is co-founder of GOSgene, the BRC fund to increase the capacity of BRC/GOSH/ICH to discover the molecular basis for single gene disorders. In addition he chairs the Clinical Research Committee, which reviews all patient focused research in the joint organization and is thus an integral component of the BRC Framework.

Professor Goldblatt has been integral in positioning the BRC to best leverage clinical programs at GOSH and discovery/translational research at UCL/ICH. He brings effective management, strategic vision and important discovery science perspective to the organization. During the EAB

visit, it was clear that Professor Goldblatt had successfully developed the renewal of the BRC and subsequently facilitated the refreshed BRC strategy in response to the NIHR review. The current management structure should facilitate the role of BRC as the 'facilitating mechanism' by which GOSH leverages the basic science organized in the ICH and UCL for the betterment of patient with rare diseases in pediatrics. Professor Gaspar brings a wealth of experience in clinical and translational research to the leadership team.

Theme 1: "Molecular basis of childhood diseases – identification of disease-causing genes"

Summary

The Centre for Translational Genomics (GOSgene) brings together clinicians and researchers from all disciplines to work toward understanding the molecular causes of childhood diseases. Envisioned in 2010, research as part of GOSgene began in April of 2012. GOSH UCL BRC has committed £3.2 million to GOSgene to undertake rapid gene discovery and identification of uncharacterised congenital disorders and other rare diseases.

The team meets every 6 weeks to decide on the projects to be studied and the strategies for disease mutation discovery. GOSgene uses a range of companies to perform genomic sequencing. GOSgene has also established a strong collaborative link with Ingenuity Systems. The Centre is staffed by a Project Manager, Genome Analyst, Research Assistant, Bioinformatician and Computer Programmer. One Pharmacogenetics Principle Research Associate in GOSgene is also funded from the training budget.

The report summarizes the work of GOSgene over the past 2-years – the team has studied over 320 samples covering 46 clinical phenotypes and report a success rate near 60%. The team reports identification of 32 disease genes, 19 of which are novel gene discoveries. Professor Beales presented a summary at the symposium that contained slightly more recent numbers but the overall message was essentially unchanged. Two publications directly credit this infrastructure.

New programs linked to the GOSgene infrastructure include 1) Genomics England (2000 RD trio genomes); 2) RACE (rapid exome analysis); 3), HIGH 5 (omic approaches to 5 rare diseases – 25 pts each); and, 4) Mobile Health.

General Comments

- Leadership is excellent for this theme (Professor Phil Beales).
- The position of GOSH as a national and international referral centre presents this wonderful opportunity to study a wide spectrum of childhood genetic diseases, the BRC is to be commended for taking this opportunity forward as part of their research strategy.
- The success rate of 60% reflects the types of phenotypes being studied, enriched for a high likelihood of the phenotype being secondary to a highly penetrant coding Mendelian mutation and thus discoverable by WES.

Specific Comments

i. Drive innovation in prevention, diagnosis and treatment of ill-health

- There is a remarkable opportunity with GOSgene to take this program to the next level – and garner international recognition prior to 2017. The two publications stemming from this infrastructure are both in high impact journals and nicely highlights the types of outputs possible; these types of successes should be significantly expanded

given the richness of the phenotypes being studied and the value of the investment in GOSgene (£3.2 million).

- It is probable that some, if not most, of the 'solved' diseases that are currently unpublished are excellent candidate genes awaiting genetic or functional validation as disease-causing – see strategy suggestions below.
- More detailed information on control datasets for filtering variants based on rarity would be of interest – how is this done efficiently when more than one service provider is employed to generate WES data?
- Once optimal performance is achieved for rare genetic diseases secondary to coding mutations it will be important to show innovation for other disease mechanisms – the HIGH5 efforts will help build this aspect of the research strategy going forward.
- The application of these technologies to more complex and prevalent diseases – such as childhood diabetes, obesity etc – may be something to explore in the years to come.

ii. Translate advances in biomedical research into benefits for patients

- What is the clinical integration plan for WES/WGS/Clinome type approaches more generally within GOSH from the infrastructure being developed as part of GOSgene? There is a Pharmacogenetics training position, are there other positions needed to bring this out of the research setting and into the clinic? – this is very likely to be the case.

iii. Deliver a portfolio of excellent collaborative research, especially with industry

- It is important that centers of excellence share their experience and have partnerships with other health professionals and scientists from other centers who have not benefitted from such a huge investment. More partnerships with other institutions, particularly those that refer to GOS could be highlighted. The way that you have identified 'international partners' on publications could also be used for local collaborators, as a measure of how well you collaborate with UK partners from other Trusts.
- GOS gene will be compared to other centers, such as DDD/Sanger, that have engaged with all UK hospitals to identify new genes for patients with rare diseases and, in the instance of DDD have just reported their first 1000 cases. How does GOSgene interact with these types of complimentary initiatives?
- Other international efforts – many of them part of the International Rare Diseases Research Consortium - have already begun to think about platforms for data sharing to enable gene discovery through identification of 2nd and 3rd families – this type of infrastructure would catalyze some of these unreported findings to the point of publication as well as potentially solve some of the unsolved families. These linkages should be encouraged and GOSgene has much to bring to these wider efforts and will benefit from the resources such linkages will bring.
- How will the GOSH component of Genomics England operate – what will this contribute to the infrastructure at GOSH and how will this enable data sharing platform development etc? This is a wonderful opportunity to leverage this additional investment and can be highlighted in the 2017 application.
- What is the nature of the collaboration with Ingenuity Systems?

iv. Harness the collective biomedical strengths of UCL through collaborative research partnerships

- GOSgene has an opportunity here to expand linkages locally through UCL for functional characterization of novel disease genes with local expertise. A mechanism to enable such collaborations, including small amounts of seed funding, would increase the rate of publication as well as the profile of these partnerships.

Theme 2: Diagnostic and Imaging

Led by Professor Neil Sebire, **t**he panel recognizes that this is a new theme and consideration needs to be given on its role within the next bid. It is also appreciated that we were not really able to form a comprehensive assessment of ongoing work. However given that the eventual BRC application will involve similar written documentation this needs to be strengthened if included in the next bid.

It covers slightly disparate fields although it is appreciated that imaging represents a new and highly relevant form of biomarker research. There is however a lot of competition within London alone in this field.

Imaging

For imaging to stand independently within this theme would necessitate novel imaging technology and approaches for which GOS does not have a track record and is probably not well equipped. There are obviously issues currently on imaging capacity given the heavy clinical burden on current MR scanners. UCL does have expertise in this area, particularly in animal model imaging. It would be appropriate therefore to concentrate and develop existing animal imaging collaborations in addition to developing the role of imaging as an in vivo biomarker in human pediatric disease interventions. The approach needs to appear more cohesive and may be helped by a larger collaborative grant.

The cardiac presentation was excellent, incorporating industry, clinical practice, computing and imaging. It appeared rather stand alone and it may be appropriate to consider expanding that theme for other tissue replacement / transplant programs if not already doing so. The renal imaging appeared strong and expanding and encouraging collaborations with the pediatric surgeons in work on NEC and in congenital anomalies would seem a logical progression. The role of imaging in neuromuscular research was not emphasized so any ongoing innovative work cannot be assessed.

It is less clear what role in research the image autopsy work would have but we were unable to view this work in any depth. What would be the key research directions and how beneficial would they really be to understanding and clinical practice within both rare disease and childhood mortality? An issue with post-mortem work is of course speed of return of the body for burial as much as the lack of invasive procedures. This has a defined clinical role but would need to be re thought to be a competitive and attractive program for extrinsic translational funding.

The free fetal DNA work through UCL is relevant and attractive because of its relatively immediate translational potential. It is unclear whether this is best placed within this theme as appeared somewhat disconnected from GOS.

The panel would greatly value to opportunity to spend more time looking into work being conducted within the theme with the view of being able to comment more constructively. Plans for new developments and collaborations have to include the ability of the research to compete with other programs both nationally and internationally.

Theme 3: Gene, Stem and Cellular Therapies

Led by Professor Adrian Thrasher and Professor Bobby Gaspar, this program is internationally recognized in the area of gene therapy. The activities encompassed in this theme include not only hematopoietic stem cell gene therapy, but also other gene modified products (eg T cells) and other adoptive immunotherapies and stem cell transplantation itself. These activities are organized around specific focus groups in inherited diseases, cancer and infectious diseases, and transplantation technologies. Of these, it would appear to date that the inherited diseases group has been most successful at translating advances into patients.

The BRC also supports a GMP/clean room facility which, although quite small, has developed a large number of products for human clinical experimentation and is currently in the process of developing 4 new products for preclinical scale-ups. The BRC funding also supports directly several investigators, at clinical trials coordinator, a QA office and a clean room technician.

The program is actively involved in multiple phase I or phase I/II trials in rare diseases, many of which are international in scope. These include open trials in severe combined immunodeficiency (SCID, both ADA deficient and X-linked), chronic granulomatous disease, childhood cerebral adrenoleukodystrophy and Wiskott-Aldrich Disease. In this area, GOSH and this program are viewed as one of the top centers in the world.

Additional projects focus on leukemia, neuroblastoma, glioblastoma, metabolic diseases, and depleted marrow grafts. Projects presented include the expansion and use of amniotic fluid cells for treatment of esophageal atresia, neuromuscular diseases treatments, a consortium approach to use of anti-sense oligomers, an international trial in renal tumors, use of new target antigens in brain tumors. Thus this theme area represents highly translational research in which successful application into humans for the treatment of rare diseases has already successfully occurred on multiple occasions.

Impressively throughout the day of presentations at the symposium, this theme area was mentioned in multiple other theme presentations, showing the extent to which the BRC investment in this area is impacting experimental medicine more broadly and also the extent to which this theme area sustains collaborations with a number of scientists across UCL. An example of this is the development of biomarkers to evaluate success of gene therapy trials,

In addition to the international scope of this theme area, there have also been some limited successes with commercial. This includes a specific collaborative research effort with Miltenyi to develop and validate a completely closed system for cell expansion and transduction in which BRC has invested up-front funding. If successful, this new technology could revolutionize gene therapy applications by making this treatment modality widely available in centers which currently do not perform these treatments. There are also a number of nascent and ongoing discussions with other biotech and pharmaceutical concerns.

Theme 4: Novel Biological Therapies for Translation in Childhood Diseases

This area was considered a strength, with internationally recognized expert leadership. Based on written material provided to the EAB, there are currently nine clinical areas involved in phase I and II trials as part of this BRC theme. As a general comment, the EAB would suggest titling this theme “novel therapies for translation in childhood diseases” because the theme is not necessarily restricted to biological therapies, but could include chemical entities or devices.

More detailed information was provided on the neuromuscular disease group which has MRC funding, in partnership with the UCL Institute of Neurology, and the University of Newcastle and

is supporting more than 50 neuromuscular projects. The group is successfully partnering with international collaborators and industry, and is making important contributions to outcomes, biomarker and therapeutics development.

Another area under this theme that was highlighted in the presentation was Dr. Pritchard-Jones' program on childhood renal tumors which is remarkable for its international outreach, and the fact that it has received almost £300K in external funding from "Cancer Research UK".

Based on the observations described above, the EAB considered this theme to be successful, and to represent an area of internationally recognized excellence. The EAB considered the following issues as important, and would find it helpful to receive more detailed information at a future review time:

1. Therapeutics development programs by disease area indicating for each the current status or plans regarding:
    a. Pre-clinical efficacy, pre-clinical safety and toxicology?
    b. Early-phase clinical trial plans (population, number of patients, endpoints)
    c. Plans for efficacy trials
    d. Regulatory pathway
    e. IP, partners, financing, plan for next steps or hand-off
2. Programs aimed at setting the stage for successful therapeutics development, such as
    a. Biobanks
    b. Registries and natural history studies (harmonized with international efforts)
    c. Clinical outcomes and biomarker development
    d. Engagement of relevant patient communities.
    e. Establishing national and international collaborations

General Comments on Clinical Research

As a referral center, GOSH will draw families whose medical needs are not met by their local clinicians. For these patients, there are often no satisfactory treatment options so that research towards improved health becomes an important hope. Therefore, GOSH should strongly consider more fully integrating research into its clinical and overall mission.

This could be accomplished by offering patients information on research and access to research, by offering opportunities to have data or specimens used for research, as well as by obtaining permission to contact families should relevant research studies emerge. With appropriate ethics permissions and privacy measures, clinical data such as sequencing data or outcomes data could be used to accelerate research. This could enhance the positive public image of GOSH when implemented along with a thoughtful, patient-centered communication and engagement plan. In addition, GOSH may want to look for opportunities to inform and involve referring clinicians and hospitals of ongoing results. This would also likely improve patient recruitment.

There may also be opportunities to streamline and standardize the collection of clinical, imaging, and genetic data as well as specimens across disease areas, and to harmonize with national and international initiatives so that GOSH is positioned as a strong, collaborative leader and partner.

General Comments on Commercial Partnerships, Intellectual Property and Strategic Collaborations

Numerous examples of commercial partnerships, intellectual property and strategic collaborations were presented in the report. There seems to be significant strength in this area and also new opportunities arising. These relationships range from memorandum of understanding, to collaborative agreement, to patenting and licensing, to formal private partnerships, dozens of collaborations, as well as direct investment. Examples include partnerships (or different types) with Agilent, Cellectic, Genzyme, GSK-Nanogenetics, HealthRacker, Ingenuity Systems, Miltenyi Biotech, Prosensa, Sarepta Therapeutics, Simulia, Verinata, and others, as presented throughout the document. There was also good demonstration of how the BRC works with the University College London Business Development Office. For example, since opening in 2008 the number of industry-sponsored clinical trials is reported to have grown on average by 35% year on year. This is accompanied by a reported 49% annual growth in revenue from industry-sponsored studies. Specific licensing deals have been made with companies such Ectopharma and others. By all indications the overall portfolio seems robust, in particular at a time where most institutions are still acclimatizing to the need for more business and strategic applications of the science they pursue. There was, perhaps, too much emphasis on some of the arrangement such as 'in kind' work performed with companies such as Illumina and Ingenuity. It might be better to capture a more usable metric for what the true value of this type of relationship is to both the BRC group and the vendor. There seems to be clear strengths in the gene therapy program that are also now starting to be realized on the business development side. The EAB was not surprised to see less activity in the gene patenting since this mimics the overall trend elsewhere. For the next meeting, it might be useful to hear what the general strategy will be with respect to gene/biomarker patenting in light of the decisions against Myriad and other companies of late. Most North American institutions are just working their way through this issue now and it will be interesting to see the perspective from the U.K.

A recommendation for the next report includes presenting metrics that better allow us to capture progress of 'before and after' funding. The stated activity outputs are a (i) 4:1 leverage of BRC funds, (ii) increase in patient recruitment by 3-fold, (iii) increase in number of experimental medicine research publications in peer-review papers, (iv) increase of intellectual property assets two-fold and (v) increase collaboration with industry by 50% and (vi) in general increase partnerships and collaboration. For the next meeting, it is really that important for GOSH-BRC to discuss with the EAB the plan of how to collect and present this data in the next grant, so that maximal impact is best demonstrated. The data will need to be presented in the context of funding periods, divisions, staff, and themes, including perhaps in a more liberal way, to capture the most optimistic data. A good understanding of what the review committee might look like would also be useful. There should also be constructive discussion of those items that the group decides they want to emphasize more, or not pursue at all. They have been assigned an expansive agenda, which is perhaps better approached by being focused instead of broad.

In summary, it appears there has been excellent progress in this area. Setting realistic milestones will be important to achieve, and most importantly, the renewal grant needs to capture this data in the most impactful way to the stakeholders.

EAB members:

Dr. Kym Boycott (Investigator, CHEO Research Institute, Clinical Geneticist, Department of Genetics, CHEO, Associate Professor, Department of Pediatrics, Faculty of Medicine, University of Ottawa).

Dr. Stephen W. Scherer (Director, The Centre for Applied Genomics, The Hospital for Sick Children, Director, McLaughlin Centre for Molecular Medicine, University of Toronto, Senior Scientist, The Hospital for Sick Children, Professor of Medicine, University of Toronto).

Dr. Julia Dunne (NDA Regulatory Ltd)Professor Karen Temple (Professor of Medical Genetics, Southampton Medical School).

Professor Mary Rutherford (Head of Perinatal Imaging, KCL),

Dr. Petra Kaufmann (Director of the Division of Clinical Innovation, National Institute for Advancing Translational Science, National Institutes of Health.

Dr. David Williams, (Chief, Hematology/Oncology and Director of Clinical and Translational Research, Boston Children's Hospital; Leland Fikes Professor of Pediatrics, Harvard Medical School.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
23rd July 2014

Trainee Doctors Report Update **Submitted by:** Dr Catherine Cale, Interim Co-Medical	**Paper No: Attachment K**

Aims / summary
This paper reviews the findings of the Coalface report, HENCEL Visit of concern, actions taken to date and implications.

Action required from the meeting
The committee is asked to note the contents of both the Coalface report and the HENCEL reports and its potential impact on the organisation if issues are not addressed. Many of these issues are longstanding and will require significant time and culture and working practice change to fully and robustly address.

The committee should note that there may be a need for increased investment to enable robust and sustainable changes to be made

Contribution to the delivery of NHS Foundation Trust strategies and plans
The Trust Strategy makes a clear commitment to education and training. In addition, we need a sustainable and well trained workforce to maintain activity and achieve growth of high quality, safe clinical service.

Financial implications
TO be determined, increased investment may be required

Who needs to be told about any decision?
Ongoing internal involvement of Director of Medical Education, Doc Reps committee, Director of HR and OD.
External: HENCEL

Who is responsible for implementing the proposals / project and anticipated timescales?
Director of Medical Education

Who is accountable for the implementation of the proposal / project?
Co-Medical Director (CC)

Attachment K

Trainee Doctors Review - Update

Review of Findings "From the Coalface" report

Introduction

GOSH employs approximately 300 junior doctors. About half of these are posts in part supported by funding from Health Education England (normally 50% of their basic salary with the other 50% and all on call costs met by GOSH). There are specific training curricula and requirements for these posts. The other half are Trust Doctor posts. These vary from SHO grade equivalent to very experienced post CCT fellows. There is a system of Doc Reps for the juniors who meet monthly with the post graduate medical education department and the Director of Medical Education (previously part of the Co-Medical Director role, now separate).

Over the summer of 2013 the Doc Rep Committee collated concerns from junior doctors throughout the organisation. This was done by means of emails and electronic surveys to all junior doctors, direct discussion by each member of the committee requesting information from the group they represented and a suggestion box in the Doctors mess. There was an open forum facilitated by PGME in August 2013. This was attended by a representative of most specialties. Although the Doc Reps committee have not provided specific information on how many individual doctors inputted to report, in informal discussions they discussed that at least half the 300+ junior doctors gave specific input, and that all specialties had been given the opportunity to comment and the vast majority did.

The "From the Coalface" report was written by the Doc Rep Committee using this information. The final version of this was sent to the Co-Medical Director as part of the papers for the Post Graduate Training committee to be held on March 26th 2014. A draft version had been sent externally (**not** by the Doc Reps), and this prompted the "Conversation of Concern" visit from Health Education England North Central and East London (letter dated 24th March 2014).

Specific Findings

Both the report and its authors were keen to stress the positive aspects of working at GOSH. These included:

- Consultant, administrative and colleague support
- PGME training/ local teaching
- CSPs
- Clinician Assistants
- Flexibility within the rota to attend clinics
- Controlled patient numbers in clinics
- Opportunities to be involved in research and facilitating higher degrees
- Clinical experience

Other findings were grouped into 3 themes:

- Patient Safety
- Training
- Workforce

The report authors made 10 recommendations (Appendix 1). The full report is attached separately which gives more background into the reasons for these recommendations from the Doc Rep committee.

HENCEL Conversation of Concern

The Trust was visited by HENCEL on 22nd April 2014. A draft report was provided for comment on 27th May 2014 and the final report received on 6th June 2014. The final report is available separately. Themes noted in the report mirrored closely those of the Coalface report. 15 specific findings were raised. These are summarised in Appendix 2 with a summary of action to date.

A further informal visit occurred on 4th July. This was helpful and supportive. The minutes have not yet been received, but the visiting panel was satisfied with our initial responses and keen to support work going forwards to address education and workforce issues.

A further formal visit is planned for October 2014

GMC survey

The GMC conducts an annual survey of junior doctors nationally. The 2013 report picked up similar themes. This report has just been released for 2014 and initial analysis is, not unexpectedly, similar.

Actions to Date

A clear theme has emerged that our Junior medical workforce do not perceive that education is valued and prioritised in the organisation, and that their skills , training needs and contribution (both actual and potential) is not being recognised. Although there is clearly work to be done, some of these aspects can be improved with clearer communication and a drive to actively involve juniors in specialty and other decision making processes. This involvement of itself will contribute to their training.

1. The report was circulated to the Executive team, and discussion held at relevant executive team meetings.
2. The Co-Medical Director met with members of the Doc Rep committee to discuss the report in detail.
3. An email was sent to all Doctors in the organisation acknowledging the report and committing to work towards resolution of the issues.
4. The report was also discussed at GMSC
5. It should be noted that there was a significant (6 month) time delay between the information gathering and the issue of the report. A number of workstreams had already been started that will address issues raised.
6. A Director of Medical Education (Dr Quen Mok) was appointed in April 2014, the need to separate this role from the Medical Director roles to improve the focus on education had been recognised by the Trust prior to the Coalface report.
7. The DME post has facilitated closer working both with the Doc Reps committee, PGME and the PGTC. This should not only drive educational improvement, but also help with better information sharing

8. Following the Conversation of Concern, the Co-MD met with all the Divisional Directors who are fully engaged in the required workstreams
9. Action plans for the immediate actions from HENCEL are in place and being implemented.
10. Action plans are in place or being developed for the non-immediate actions
11. A separate piece of work is underway to look at the Medical education income, and how we use this money so we can identify any resource gap.
12. The Trust education strategy is currently being developed, and medical education will form an important part of this.
13. The equity of training and service aspects for trainees and Trust doctor posts is a challenge. This has not been addressed explicitly in the past in a uniform way across the organisation, and expectations may have arisen for Trust posts that we cannot meet going forwards. More clarity is required regarding the expectations of the postholders and our commitments as their employer. This work will be taken forwards by the Co-MD and Director of HR/OD with the Divisions and Doc Rep Committee.
14. Separate projects are currently underway (their initiation being unrelated to these reports) looking at pan Trust phlebotomy service, out of hours cover, SHO teaching and improving access to existing teaching opportunities in the organisation.

Implications for GOSH

- HENCEL funds a significant proportion of our junior doctor workforce. If they deem that the training we provide is not adequate, then these posts and the associated funding could be withdrawn.

- There is a significant reputational risk if we do not address these concerns robustly. This may impact on our ability to recruit to junior doctor posts, which would compound the workforce issues raised.

- The importance of education has been recognised in our strategic objectives. This aligns with the Education strategic objective of our academic partner ICH.

Action Required from Trust Board

The committee is asked to note the contents of both the Coalface report and the HENCEL reports and its potential impact on the organisation if issues are not addressed. Many of these issues are longstanding and will require significant time and culture and working practice change to fully and robustly address.

The Board should note that there may be a need for increased investment to enable robust and sustainable changes to be made.

Dr Catherine Cale, Co-Medical Director (Interim), 12th July 2014

Appendix 1

Recommendations from "From the Coalface" report

1. There should be an urgent review of Trust Policy managing predictable and long term rota gaps. Trust policy should include
    a. Identification of key members of staff who are to remain responsible for filling the rota at all times
    b. Ensuring there is a clear Trust pathway for junior staff or management to escalate concerns regarding critical staff shortages
    c. Providing the necessary support for appropriate reduction in workload when there is a gap
    d. Ensuring junior doctors are involved in rota management and consulted on rota design/planning. Rotas should not be managed solely by non-clinical staff
2. Staffing levels of junior doctors should be taken into account when planning elective clinics and admissions. Where there is a critical shortage of juniors, clinics should be re-scheduled and admissions should be restricted (such policies already exist with regard to nursing staff)
3. Teaching of SHOs should be better prioritised in relation to service pressures. There should be an hour of protected bleep free teaching every week for SHOs and a regular cross-departmental SHO teaching programme should be initiated, which could also incorporate MRCPCH teaching
4. Unsupported registrar only clinics should be discontinued. Clinics should always have a consultant available to supervise junior doctors
5. A review of conditions for those in non-training posts compared to trainees across specialties. This would include examining equity in pay, training opportunities, night shifts worked and access to study leave.
6. Wider use of non-medical staff including phlebotomists and administrative support should be explored in order to free up junior doctors time for more clinically productive activities.
7. Junior doctors and Doc Reps should be consulted on all decisions regarding workforce numbers, training and working practices that affect junior doctors
8. Yearly forum/listening exercise to be carried out to understand the views of junior staff
9. Consultant workload: a review is needed of consultant time available for delivering clinical supervision and training. Consultants should have the nationally recommended SPAs for educational supervision.
10. There needs to be a greater degree of honesty, transparency and understanding of each others roles within and across departments in order to achieve common aims and learn from good practice. All staff (clinical and non-clinical) should be regularly encouraged to contribute to discussions on patient care, service provision and training and their input valued.

Attachment K

Appendix 2

Summary of HENCEL recommendations

RAG rating	Specific Finding	Realistic and Achievable outcome required	GOSH Progress
Immediate	Consent for interventional radiology is currently being undertaken by untrained medical staff.	Either interventional radiologists to perform consent or an educational programme to be implemented for doctors taking consent to understand procedures and complications	Procedures identified Training programmes implemented. No junior Doc IR consenting whilst this was implemented
	The radiology trainees are required to attend the ICU and wards to complete potable ultrasound examinations with no direct supervision.	Radiology trainees undertaking ultrasound examinations outside the Xray Department need to have access to a consultant for supervision and case discussion.	DME discussing with radiology
Immediate	Clinics are being conducted without consultant supervision.	Every clinic should have a designated consultant, ideally in the clinic but certainly in the hospital.	Divisions asked to stop such clinics. Audit to be undertaken Aug 2014
Immediate	Serious incidents involving trainees are not being reported to HENCEL either by the six month portal or in real time.	This should start forthwith.	In place
Immediate	Paediatric trainees in oncology and infectious diseases have little or no outpatients experience and are at risk of failing this year's ARCP.	The Trust needs to implement a plan otherwise we will be recommending a suspension of subspecialty training in both of these posts.	Addressed with specialties. Issues in ID with allocation of multiple grid trainees at the same time diminishing training opportunities
	Trainees have limited opportunities to attend outpatient clinics.	All Level 3 Paediatric trainees (with the exception of PICU) need to have Outpatient experience in line with their particular subspecialty curricula. The College Specialty Advisory Committees (CSACs) can advise the specifics however, this needs to be implemented into rota design and acute ward responsibilities must not regularly be prioritised over Outpatient training experience. In Respiratory and Gastroenterology the same premise applies to bronchoscopy/endoscopy training.	MD/DME addressing with specialties
	Trainees have reported to the DocReps that there is a lack of understanding from HR about the structure of training and the roles of the different medical staff.	The visit team recommends a review of how to support HR to understand the model and administration of postgraduate education.	Dir HR/OD leading.
	Trainees are staying later than their rostered hours, and there have been two failed diary card exercises	A diary card exercise should be completed, commencing in June 2014, for all trainees (particularly oncology who expressed concerns) and the findings of which should be put into a report – the results of the exercise must be shared in full with the relevant trainees and confirmation that they agree or disagree with its findings should be shared with HENCEL.	Diary card exercise complete, results awaited.
	There are no Paediatric ST2/3 trainees in the hospital at night, the registrars are bleeped for simple tasks such as prescribing antibiotics.	The diary card exercise (6.1) should include details about out of hours work. A review of this area in particular should be used to review the work and acuity of the Hospital at Night.	As above. Separate review of H@N being led by Co-MD/COO
	There is lack of clarity about trainees caring for private patients at night and during the weekend.	This issue needs to be clarified during trust induction to ensure all trainees are aware of their involvement and protocol.	Induction information being clarified
	The Educational Supervisors do not appear to have the appropriate allocation of PAs in their consultant job plans.	A job planning review should be undertaken for all consultants to ensure all are correctly remunerated and have allocated time to perform their educational role in line with	Job planning round currently being completed, and PGME updating Ed Supervisor database. Further work to be done once these complete

Attachment K

RAG rating	Specific Finding	Realistic and Achievable outcome required	GOSH Progress
		the requirements of the London Professional Development Framework.	
	There is a lack of formal teaching or educational focus across all specialties within the Trust.	A formal teaching programme with protected time should be created for all specialties. Further plans must be put in place to increase the amount, and quality of, bedside and 'on the job' teaching.	DME addressing with PGME
	Trust induction is excellent; however the quality of departmental induction is patchy.	An audit of local departmental induction needs to be undertaken to ensure consistent quality across the hospital.	PGME audit of local induction already underway
	There is a culture of pervasive bullying on PICU of trainees by nursing staff.	The Trust is required to produce a report within one month on how this will be addressed.	Being addressed as part of the wider ICUs cultures and values work
	The visit team raised their concerns that 2PAs was not a sufficient allocation of time for the tasks of a DME; these concerns were also shared by members of the Trust faculty who felt that it was an impossible job within the time allocated.	A review of the role of Director of Medical Education in the trust is needed and it would seem sensible to undertake this once the new Chief Executive is in post. This role should ideally have 4PAs in the Job Plan and membership of the Trust Executive Body is recommended in an institution with the international reputation of GOSH.	No further action required at present.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board July 2014	
Theatre 10 Business Case **Submitted by:** Rachel Williams, Chief Operating Officer	**Paper No: Attachment L**

Aims / summary

In November 2012 Trust Board approved the transfer of the angiography equipment in theatre 10 into a new build co-located with the 2 angiography suites being developed as part of 2B enabling. This approval included £1.9million (plus a share of £0.3m equipment contingency) to convert the space into a fully functioning theatre.

Until this time the hospital had sufficient theatre space to cope with demand (2A delivered an extra theatre) however, all theatre capacity is now allocated.

Current predicted growth indicates that the Trust requires at least an additional 12 theatre sessions per week in the next 2 years to meet NHS demand. In addition to this the Trust has developed a strategy to grow IPP activity by 10% per annum over the next five years which indicates a requirement for an additional 4.6 theatre sessions per week. Extra elective workload will reciprocally increase the emergency workload and emergency theatre time is also likely to require growth.

The capacity required cannot be delivered through increased efficiency alone. In order to meet the increasing demand for theatre time this paper outlines a 2 phased approach to increase capacity through the opening of an additional theatre, combined with a strategy to run routine operating lists outside of the current 'normal' working week. Both the opening of a new theatre and the move to extended working across the week require detailed planning, and timescales to deliver these are outlined.

The Trust has, within the new Morgan Stanley Clinical Building, an unequipped theatre shell (Theatre 10) that allows us the ability to increase our theatre capacity by opening an additional operating theatre.

The commissioning of a new theatre offers a unique opportunity to create a state of the art 'Integrated Theatre' that would put Great Ormond Street at the forefront of operating technology. This advanced theatre will allow us to have a prestigious facility, available to all GOSH surgeons to showcase their expertise and enhance the reputation of the hospital as a centre of surgical excellence.

The Special Trustees have agreed a £1 million contribution toward the cost of creating an integrated theatre, subject to the approval of the Trust board.

The attached paper provides an overview of the current capacity, growth, financial implications and timescales for the proposed conversion.

Action required from the meeting
To approve the conversion of Theatre 10 into an integrated theatre.

Contribution to the delivery of NHS / Trust strategies and plans
The additional theatre capacity will enable the Trust to meet the predicted growth in NHS demand and increase IPP activity in line with our IPP Strategy.

Financial implications The capital expenditure is £3.2m (of which £1m will be donated from GOSHCC) The annual contribution when fully operational is £1.5m (excluding non-cash expenditure) and the payback period is 27 months.
Legal issues NA
Who is responsible for implementing the proposals / project and anticipated timescales Rachel Williams, Chief Operating Officer Matthew Tulley, Director of Redevelopment (Capital Development)
Who is accountable for the implementation of the proposal / project Rachel Williams, Chief Operating Officer Matthew Tulley, Director of Redevelopment (Capital Development)

Current theatre capacity

The Trust has 11 functioning operating theatres located in the Variety Club Building, Octav Botnar and MSCB. Surgery takes place from 8.30am to 5.30pm (7pm for cardiac list), Monday to Friday with IPP lists on Saturdays.

Every list is allocated to surgical specialties and since 2010 there has been focus on how well these lists are used. Elective utilisation is measured against the Audit Commission national target of 77%. We also use other measures of theatre efficiency/productivity such as "total number of cases" and "total hours of theatre time used". These do not include work done out of hours in theatres, procedure rooms or in intensive care units.

The overall theatre utilisation is currently running at a mean of 72%; under-utilisation will vary amongst specialties and divisions. The improvement work is on-going and we anticipate that the Pre-operative Anaesthetic Assessment Service which will open in November will greatly reduce the amount of theatre time lost due to patients being un-prepared or unfit for surgery on the day. Our aim is to close the gap and bring our under-utilisation down from current 28% to the national target of 23%.

However, improvements in theatre utilisation will not deliver the capacity that is required to support our NHS and IPP growth requirements.

Activity Growth

The Trust five year activity plan indicates that we will see growth in many surgical services, in line with that experienced historically. Current predicted growth assumptions indicate NHS activity will require 12 theatre sessions across Neurosurgery (2), Ophthalmology (1), Cardiac Surgery (2), Spinal Surgery (2), Plastic Surgery (2), Orthopaedics (2) and Urology (1) prior to 2016/17.

In contrast to the predicted growth in NHS demand, NHS tariffs are forecast to fall over the period of the strategic plan. This will increase the importance of the contribution of IPP activity to the Trust's overall financial position and ability to deliver and improve high quality NHS care.

The proposed strategy to increase the Trust IPP workload by 10% per year includes a focus on surgical services which will require additional theatre capacity. The demand assumptions have been based on stakeholder conversations to date. It has been estimated that this will be approximately 4.6 theatre lists used by various surgical specialties.

The opportunity for integrated theatre technology

The MSCB theatres (7 to10) were built initially as a result of the fundraising initiative for cardiac, neuro and craniofacial surgery. Theatre 10 was built as a 'hybrid' theatre - equipped as an angio suite to allow simultaneous open and radiological procedures or either to be performed separately in the same theatre. Unfortunately the hybrid has proven unsuitable to perform elective surgery because the design of the operating table and other features were not compatible with open surgery. Because of this craniofacial do not have an allocated theatre, although much of the fundraising was done on their behalf. To address these issues it was decided to re-locate the imaging equipment to the new angiography suite in VCB so that Theatre 10 can become a fully operational operating theatre.

The refurbishment of Theatre 10 presents a unique opportunity to the Trust to create one of the most advanced operating theatres in the world at Great Ormond Street Hospital.

"Integrated Theatre" is a term used to define an operating theatre which provides the optimum ergonomic working environment for minimally invasive surgery using laparoscopic equipment and facilitated via audiovisual links. With the increased use of minimally invasive surgery, particularly in General Surgery and Urology, a purpose-designed operating theatre will optimise the activity of these high volume specialties.

The central position in the operating department, the very large size of the theatre itself and the adjacent control room is unlikely to be replicated at GOSH or many other operating theatre development worldwide. By investing in the higher specification of integrated theatre technology, Theatre 10 would become a show theatre able to accommodate any speciality required to use it. It would enhance teaching, training, the development and dissemination of new surgical ideas and a full engagement and leadership role for the Trust in the worldwide network of children's surgery.

Integrated theatres offer state of the art video surgical capabilities delivering high quality surgical interventions and increased safety. They are applicable to all surgical specialities and are the standard operating theatre format that we should be striving for at GOSH.

The benefits of an integrated theatre include safer, effective, surgery through the best possible visualisation of the operating field plus the integration of all the theatre equipment through a centralised surgeon controlled workstation that also interfaces with imaging systems, laboratories and patient management systems.

This will be the standard of facility in which future world class surgical teams are being trained and will expect to work. Our opportunity to provide an outstanding operating theatre would be very attractive to potential future employees.

The ability to record and store operative procedures, which will become an important part of the computerised patient record, evolving patient care and clinical governance.

Increased efficiency as the system allows individual surgeon configurations to be stored and set, reducing set up times and turnaround times. It's ergonomic design and greater automation is expected to reduce the staff costs of running this theatre, compared with a standard operating theatre.

The size of the theatre will accommodate multi team participation in complex procedures, such as conjoined twin separation, and donor-recipient procedures. There will also be space to accommodate additional equipment, such as advanced imaging modalities, robotic surgery and new surgical tools. In addition the demonstration of procedures to visiting surgeons will be available from the adjacent state of the art viewing room.

Importantly this will give us state of the art recording and broadcasting capabilities and the opportunity to conduct interactive teaching and dissemination of ideas, to demonstrate procedures to conferences at ICH and with other institutions worldwide, fulfilling the role of GOSH surgeons at the pioneering edge of developments in all specialities.

In terms of which services will use the new integrated theatre, we anticipate that existing craniofacial lists and the new neurosurgery list will move to theatre 10 to meet fund raising pledges. The theatre would also be used by surgical teams who would give the most patient benefit from the facility, this is likely to include general surgeons and urologists, but would be available to all surgical teams. We are anticipating business cases from Plastic Surgery, Orthopaedics and Spinal surgery for additional theatre time and this can be accommodated in the vacated sessions which we will arrange as productively as possible to ensure sensible co locations for lists

Potential models for using additional theatre capacity

Even with an additional theatre, the predicted growth cannot be undertaken in weekday, day time theatre space. In order to address this, the Trust is developing a strategy to offer routine elective lists

outside of 'normal' working hours. This crucial piece of work must be resolved to link the expansion of both NHS and IPP capacity across the week.

Currently IPP operating is provided using different models, for some specialties it is on dedicated regular or ad hoc (in cancelled sessions) "IPP Lists" in the week or at weekends. Other specialties are able to run mixed lists flexibly with NHS activity during the teams/consultants regular theatre lists. Some teams particularly cardiac and neurosurgery undertake most of their activity using this model.

There are various models that could deliver both NHS and IPP theatre capacity flexibly across the week and weekends to accommodate all surgical growth. To protect IPP income, an operating model is needed that can emulate 'the protected time' offered by a dedicated theatre. It is likely that a combination of mixed lists available to all, plus some dedicated theatre lists, along with weekend working, will offer this flexibility whilst safeguarding both IPP and NHS cases.

Dependant Resources

The growth outlined can only be delivered if we also invest in the dependant resources required to support both NHS and IPP activity across the Trust. Services that wish to bid for time in the newly created theatre capacity will have to do so through the Trust's Revenue Investment Group (RIG). The RIG is responsible for scrutinising all bids to ensure they are robust and will make a financial and/or quality contribution. It is through this process that all dependant resources such as beds and support services must be quantified and costed.

It is anticipated that the increased patient occupancy generated by an additional operating theatre will require a commensurate increase in the number of inpatient beds. Current modelling puts the expected number of additional beds required at 11, which is achievable within the current number of physical beds. The increased theatre capacity will also mean that additional outpatient space will be required as and when new services develop. Additional outpatient space is being developed in 2014 in the main entrance and 2017 in the Centre for Children's Rare Diseases Research

Implementation Timescales – these work streams can run in parallel

Work stream:	Duration (estimate)
1. Building work to create additional integrated theatre	12 months
2. Procurement of Integrated Theatre Equipment	3-6 months
3. Recruitment and training of additional theatre staff	6 months
4. Creation of additional bed capacity	12 months
5. Business case submission and approval for specialties bidding for theatre time	3 months
6. Recruitment related to successful business cases	6 months
7. Development of strategy, planning, pilot and roll out of extended working	6-12 months
8. Development of strategy, planning and introduction of mixed (NHS/IPP theatre lists)	6 months

Financial analysis

The capital cost of this investment is £3.2m.In a full year of operation the contribution is 13.54% with income being £10.8m less direct costs of this activity being £9.3m and a contribution of £1.5m.
The contribution levels are reasonably low and this reflects a degree of prudence we have added in to this business case in respect of costs and incremental income that is booked against the revenue. Nevertheless this business case has a 27 month payback period and an NPV of £8.2m over a 10 year period. Net revenue impact is positive by over £1m from year 2 onwards.

Financial Summary

a. Estimated Capital Costs

	Integrated Theatre £
Construction cost incl. design cost *(note 1)	871,126
Specialist integrated theatre Equipment	425,250
Subtotal	*1,296,376*
Theatre instrument equipping cost	1,100,000
Commissioning	100,000
ICT	75,000
Fees	66,620
Non-works	20,983
Contingency	157,369
VAT	414,197
Total Capital Costs	**3,230,544**

b. Full Year Revenue & Expenditure Analysis

		10 NHS Sessions		2 IPP Sessions	Total
	£	£	£	£	
Full year Direct Clinical Income incl. Bed days		7,381,399		3,430,588	10,811,987
*Theatre Session Direct Staffing Cost *(note 2)*	*(878,768)*		*(96,629)*		
*Specialty Medical Staffing for Inpatients *(note3)*	*(328,935)*		*0*		
*Bed days Cost *(Note 4)*	*(1,787,131)*		*(357,426)*		
Subtotal		(2,994,834)		(454,055)	(3,448,889)
Theatre Non-Pay Cost	*(1,187,669)*		*(237,534)*		
*Clinical Support Services Cost *(note 5)*	*(538,842)*		*(107,768)*		
*Non Clinical Support Services Cost *(note 6)*	*(344,391)*		*(31,002)*		
Subtotal		(2,070,901)		(376,304)	(2,447,205)
Risk provision: Contribution Scale-back		(1,564,857)		(1,886,824)	(3,451,680)
Full Year Contribution excl. non cash expenditure		**750,807**		**713,406**	**1,464,213**
% Contribution		10.17%		20.80%	13.54%

c. Revenue Statement Impact

	Year 0 2014/15 £	Year 1 2015/16 £	Year 2 2016/17 £	Year 3 2017/18 £	Year 4 2018/19 £	Year 5 2019/20 £	Year 6 2020/21 £	Year 7 2021/22 £	Year 8 2022/23 £	Year 9 2023/24 £	Year 10 2024/25 £
Total Income *(note 7)	0	5,405,994	10,811,987	10,811,987	10,811,987	10,811,987	10,811,987	10,811,987	10,811,987	10,811,987	10,811,987
Total Revenue Expenditure	0	(4,673,887)	(9,347,775)	(9,347,775)	(9,347,775)	(9,347,775)	(9,347,775)	(9,347,775)	(9,347,775)	(9,347,775)	(9,347,775)
Subtotal	*0*	*732,106*	*1,464,213*	*1,464,213*	*1,464,213*	*1,464,213*	*1,464,213*	*1,464,213*	*1,464,213*	*1,464,213*	*1,464,213*
Depreciation	0	(144,412)	(288,824)	(288,824)	(288,824)	(288,824)	(281,324)	(273,824)	(153,297)	(32,770)	(32,770)
Public Dividend Capital	(15,731)	(69,739)	(102,960)	(92,851)	(82,743)	(72,634)	(62,656)	(52,941)	(45,466)	(42,210)	(41,063)
Subtotal - Non Cash Expenditure	*(15,731)*	*(214,151)*	*(391,784)*	*(381,675)*	*(371,567)*	*(361,458)*	*(343,980)*	*(326,765)*	*(198,763)*	*(74,980)*	*(73,833)*
Net Revenue Impact incl. Non Cash Expenditure	**(15,731)**	**517,956**	**1,072,428**	**1,082,537**	**1,092,646**	**1,102,755**	**1,120,232**	**1,137,447**	**1,265,449**	**1,389,232**	**1,390,379**
Contribution Excl. Non Cash Expenditure	0.00%	13.54%	13.54%	13.54%	13.54%	13.54%	13.54%	13.54%	13.54%	13.54%	13.54%

d Net Present Value of Future Cash Flow

	Year 0 2014/15 £	Year 1 2015/16 £	Year 2 2016/17 £	Year 3 2017/18 £	Year 4 2018/19 £	Year 5 2019/20 £	Year 6 2020/21 £	Year 7 2021/22 £	Year 8 2022/23 £	Year 9 2023/24 £	Year 10 2024/25 £
Revenue	0	5,405,994	10,811,987	10,811,987	10,811,987	10,811,987	10,811,987	10,811,987	10,811,987	10,811,987	10,811,987
Expenditure	0	(4,673,887)	(9,347,775)	(9,347,775)	(9,347,775)	(9,347,775)	(9,347,775)	(9,347,775)	(9,347,775)	(9,347,775)	(9,347,775)
Capital Investments	(898,926)	(2,331,618)	0	0	0	0	0	0	0	0	0
Subtotal	*(898,926)*	*(1,599,512)*	*1,464,213*	*1,464,213*	*1,464,213*	*1,464,213*	*1,464,213*	*1,464,213*	*1,464,213*	*1,464,213*	*1,464,213*
Discounting Factor 3.5%	1.0000	0.9650	0.9312	0.8986	0.8672	0.8368	0.8075	0.7793	0.7520	0.7257	0.7003
Present Value	**(898,926)**	**(1,543,529)**	**1,363,511**	**1,315,788**	**1,269,736**	**1,225,295**	**1,182,410**	**1,141,025**	**1,101,090**	**1,062,551**	**1,025,362**

Net Present Value Over 10 years	**8,244,314**
Pay back Period	**2 years 3 months**

Notes:

1. Capital costs at this stage are not based on a detailed design, a 10% planning contingency has therefore been included.
2. Theatre session direct staffing costs are based on a typical theatre list operating Monday to Saturday. IPP consultant Anaesthetist costs are excluded, as they bill private patients directly.
3. IPP consultant costs are excluded, as they bill private patients directly.
4. Based on detailed analysis, 11 additional beds are required including ITU, HDU and standard beds.
5. Clinical support services include pharmacy, pathology, radiology, psychosocial, therapies and pain services.
6. Non clinical support services include theatre instrument decontamination and on going equipment maintenance.
7. Revenue generation and depreciation start from October 2015.
8. Outpatient Income and expenditure are not included in the above analysis.

Summary

The Trust needs to increase its operating theatre capacity in order to meet its NHS obligations, as well as to deliver the growth in IPP that is required to underpin financial stability in the future. The growth required cannot be met through better utilisation of existing theatres alone, so in order to create adequate capacity we need to open an additional theatre. We also need to begin the major Trust-wide change project of routine working outside of what is considered to be the 'normal' working week. Both of these options will take time to implement.

The opportunity to refurbish Theatre 10 as an integrated theatre will allow us to have a prestigious facility, available to all GOSH surgeons to showcase their expertise and enhance the reputation of the hospital as a centre of surgical excellence.

The development will also deliver a recurring contribution to the Trust and the payback period is 27 months.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **23rd July 2014**	
Medical Appraisal and Revalidation – Annual Board Report **Submitted by:** Dr Catherine Cale, Interim Co-Medical Director	**Paper No: Attachment M**
Aims / summary The paper provides a summary of the organisational obligations for medical revalidation and a summary of medical appraisal for 2013/14 and progress in 2014/15.	
Action required from the meeting The Board is asked to note the contents of the report and agree with the statement of compliance attached at appendix 1	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Trust has statutory responsibilities to support systems and processes that enable effective governance and medical staff appraisal which in turn will support Medical revalidation	
Financial implications The Trust has a statutory responsibility to provide adequate resource so that the responsible officer can discharge their duties appropriately. Financial resources provided to date have been adequate.	
Who needs to be told about any decision? Higher Level Responsible Officer	
Who is responsible for implementing the proposals / project and anticipated timescales? Dr Catherine Cale/ Mrs Christine Lowe	
Who is accountable for the implementation of the proposal / project? Dr Catherine Cale	

Annual Board Report : Medical Appraisal and Revalidation

1. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

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

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

2. Policies and Procedures

Medical Appraisal at GOSH is conducted in accordance with the GOSH Medical Appraisal and Revalidation Policy developed from guidance provided by the GMC and NHS England (formally the NHS Revalidation support team). For consultants and SAS doctors, appraisals are undertaken on a web based system that includes all the required elements and allows easy central administration and retention of all documentation. For Trust Doctors/fellows specific paperwork is used that is tailored to their needs and available on the intranet.

Appraisals for consultants/SAS should be undertaken between April and end June for the preceding financial year. Trust doctors/Fellows undergo appraisal in the final month of their appointment or in month 12 (which ever is sooner).

The Trust has a policy on Responding to concerns, available on the document library. In addition, it complies with Maintaining High Professional Standards in the NHS (HSC 2003/12 MHPS) (Internal policy: Conduct, Capability, Ill Health and Appeals policies and procedures for Medical Practitioners).

The Responsible officer meets quarterly with the GMC Employer Liaison Adviser, who provides a link with the GMC and is able to address concerns and provide advice.

3. Medical Appraisal

a. Appraisal and Revalidation Performance Data

For 2012-13 appraisal round 86% of consultants/SAS doctors completed an appraisal. This has previously been reported as 81% but a number of individuals had done their appraisal but it wasn't fully signed off so had been omitted in previous reports.

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

As of 12th July 2014: 50% of SAS have completed an appraisal for 2013-14. Of those incomplete, a large number are in progress. 7 have been recorded as not completed due to maternity/compassionate/sick leave. Reminder letters will be sent in the next few weeks. The progress to date is significantly better than last year, so it is anticipated final rates will at least be comparable to last year. Doctors without a completed appraisal will not be able to apply for excellence awards and it may impact on pay progression. A full audit of reasons for non-completion will be conducted by the end of September.

b. Appraisers

The trust has 99 trained appraisers. 48 of these had an update prior to the current appraisal round. Each appraiser receives a feedback report annually from feedback provided by all their appraisees. In addition, educational supervisors (who are trained in giving feedback as part of their educational supervisor requirements) provide appraisals for grades below consultant/SAS.

c. Quality Assurance

That all areas of the appraisal form are completed and who has undertaken the appraisal can be monitored via the appraisal system used. Monitoring of appraisal rates is done via the RO dashboard of the appraisal system which gives real time reporting of completed appraisals. Quality assurance of appraisers is provided in part by feedback from appraisees. Quality assurance of the content of appraisals will be undertaken using an audit after the end of the appraisal cycle (Autumn 2014) so that findings can be fed into appraiser updates and the appraisal cycle for 2014/15

4. Revalidation Recommendations

Since June 2013 (first date when we started to make revalidation recommendations) a total of 130 recommendations have been made on 124 doctors. 83 of these were made prior to April 2014. All recommendations were made by the date required by the GMC.

Of the recommendations there have been 109 positive recommendations and 1 non-engagement recommendation. This individual has since engaged with the process.

There have been 20 deferrals. For the 6 deferrals where their revised revalidation date has been reached to date, a positive recommendation has been made in all cases. Of the deferrals, 2 were for maternity leave, 1 compassionate leave and 1 because of an ongoing conduct investigation. For all others insufficient evidence had been presented, in the vast majority this is because of the length of time needed to obtain sufficient amounts of patient feedback. Our deferral rate is currently above the reported national average of approximately 10%, although it was within this at the start of 2014. There may be 2 reasons for this:

a) The timing of our appraisal cycle
b) Difficulties in obtaining patient feedback forms in adequate numbers are significant for many specialties, including those with small patient numbers and non-outpatient based disciplines.

5. Recruitment and engagement background checks

Robust pre-employment checks are conducted on all candidates as per published national guidance. HR are currently strengthening processes for honorary contract holders.

6. Monitoring Performance

Maintaining the performance of all doctors and monitoring this is crucial to the provision of high quality care. A number of specialties have robust monitoring of outcomes and these are being actively developed for all specialties. The Medical Directors encourage the climate of openness and reporting of concerns by all staff. Incidents are monitored via Datix, and SIs have the required root cause analysis and careful attention is paid to the outcome of complaints. Doctors can request a reports of complaints/SIs that they have been involved in from the patient safety and risk team. With a new system upgrade, it is hoped that next year this will be provided to all doctors directly prior to their appraisal.

3 investigations have been initiated in the last 12 months (2 conduct, 1 capability and conduct) concerning consultants. Two are ongoing. The doctor involved in the third has left the organisation, and a referral has been made to the GMC.

2 Junior doctors where concerns have arisen have been managed with the School of Paediatrics/LETB. 1 has resigned from the organisation and has returned abroad.

Should there be any concerns with Doctors moving to another organisation or who currently also works in another organisation, these will be shared by the RO (or the other Co-Medical Director) with the RO of that organisation.

7. Risk and Issues

- There has been limited capacity to undertake work around appraisal and revalidation. A band 6 post supported the team for 9 months in 2013. The work is not spread evenly throughout the year. This has been replaced by a part time band 3, who will support the recruitment team in any quieter periods. The Deputy Medical Director with responsibility for appraisal and revalidation is currently the Interim Co-Medical Director. In the longer term once there is a substantive MD appointment the Deputy MD role will need to be replaced as the RO cannot sustain all the functions required.

- Robust mechanisms are not in place to ensure that data on SIs and complaints is fed into all appraisals. Although the individual has professional responsibility to report their involvement, a new system has been developed with the complaints and risk teams to make this more robust next year.

- Mechanisms for ensuring Trust Doctors/Fellows undertake appraisals and we have a record of this are not robust. This is a key focus of work between medical HR and PGME this year.

- Quality assurance of appraisal contents is under development and will continue to evolve. Our current level of QA is in line with other organisations.

8. Recommendations

The Board is asked to note the contents of the report and agree with the statement of compliance attached at appendix 1

Designated Body Statement of Compliance

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

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

   Comments:

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

   Comments:

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

   Comments:

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

   Comments:

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

   Comments:

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

   Comments:

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Comments:

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Comments:

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[3] have qualifications and experience appropriate to the work performed; and

Comments:

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments:

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

[chief executive or chairman a board member (or executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _ _

[3] Doctors with a prescribed connection to the designated body on the date of reporting.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 23rd July 2014	
Performance Summary Report **Submitted by:** Julian Nettel, Chief Executive	**Paper No: Attachment N**

Quality and Safety

In June, three cases of C.difficile were reported. The number of cases of C.difficile remains the most significant risk to achieving the Monitor quality governance risk rating throughout 14/15, however we continue to closely monitor this indicator as a key priority.

No cases of MRSA were reported in June, with no cases reported in the first quarter.

There has been a pan-trust effort to increase the awareness of the deteriorating patient, which has been facilitated through a number of actions including increased exposure to simulation training, review of all 2222 calls and feedback to the teams involved, introduction of ward huddles to highlight patients of concern and an increase in the number of staff trained in resuscitation skills.

The International and Private Division (IPP) have undertaken targeted work on the early identification and escalation of the deteriorating child. In June, the Division achieved a statistically significant improvement with the accuracy of the Children's Early Warning Score (CEWS) reported at the electronic Patient Status at a Glance (ePSAG) board during a daily huddle, compared to the actual CEWS written on the observation charts at the bedside. The measure identifies the percentage of inaccurate scores reported at the huddle when compared to the recorded CEWS scores at the bedside. There have been a number of changes that have resulted in this improvement including improved accuracy in CEWS scoring, no 'observations in pockets' and increased educational support at the bedside.

Targets and Activity

Patient spells remain above plan year to date. The Trust continues to deliver above plan on Intensive Care Unit bed days reflecting our successful implementation of our plan to increase Intensive Care Unit beds. The number of outpatient attendances remains significantly above plan.

The Trust received 40 complaints in the first quarter of this year which is higher year on year than quarter one 2013 when we received 28 complaints. This is thought likely to be due to further promotion of the complaints service and PALS following feedback from families. The key themes in quarter one have been communication with families including trouble contacting teams and a lack of information about diagnosis and care, delay in arranging admissions and the attitude of staff. Action plans are developed following investigation where it is felt appropriate to ensure that issues are addressed. These cases are added to an 'actions log' and followed up by the Complaints Team to ensure that the agreed actions have been put into practice. The actions log is shared with all divisions on a monthly basis to ensure Trust wide learning. A detailed quarterly report of complaints, trends and action plans is presented to the Learning, Implementation and Monitoring Board.

Discharge summary rates continue to remain above 80%, with a June position reported at 85.1%.

The Trust remained 'green' against Monitor's governance risk rating in May, demonstrating compliance against all service performance measures including all cancer, elective admitted and non-admitted treatment waiting times. It is anticipated that compliancy will continue in June.

Complaints

40 new formal complaints were received this quarter plus an additional two complaints which were over the time limit.

There was an increase of 11 complaints received this quarter compared to last quarter.

There were four complaints graded as red in Q1 compared to six in the previous quarter.

Overall, the Trust saw the number of formal complaints received increase by 26% in quarter. The rise may be due to increased promotion of the complaints service within GOSH.

Workforce
GOSH decreased its contractual FTE (full-time equivalent) figure by 5 in June to 3632 (early reporting in April falsely reported a decrease).

Sickness absence has had a slight increase to 2.54% (+0.03%) remains significantly below the London benchmark figure of 3.07% (which has reported an increase in sickness across London).

Turnover has decreased to 17.06% (-0.42%) in June, this represents the lowest turnover for the Trust for 12-months. Adjusting the figure to account for the unusually large number of TUPE transfers over the last 12 months and for staff on fixed-term and short-term contracts (which are felt to be higher at GOSH than in benchmarked Trusts) reduces the figure to 12.59%% in June. The (unadjusted) London benchmark figure is 13.12%. It is not unusual for London data to show more significant fluctuations (for example, in response to major TUPE events).

The reported vacancy rate has reduced from 4.10% in May to 3.70% in June. The Board's attention is drawn to the commentary provided in the previous month's report which indicates that the vacancy rate should be treated with caution until review of its accuracy is completed.

Agency usage (as a percentage of pay bill) stands unchanged at 2.64% in June. The largest increase can be seen within Clinical & Medical Operations, which stands at 7.73%.

In relation to PDR completion rates, the Trust overall appraisal rate has decreased compared to the level reported in May, at 77.3%. No divisions/directorates are currently meeting the target of 95%. Significant decrease reported for Estates with 9.4% PDRs in-date.

Statutory and mandatory training compliance rates are not reported as part of this month's suite of reports, but will be included in future following integration of new LEaD reporting.

Finance and Productivity & Efficiency (Chief Finance Officer)
The Trust is reporting a net deficit of £-2.5M, £1.3m worse than Plan

EBITDA of £4.4m (4.7%) is also £1.3m below the planned EBITDA of £5.7m (6%)

Total income excluding pass through is £0.9m below plan principally due to doubt over the receipt of £1.2m of specialist funding from NHSE and the lower activity in private patients. as well as lower day case, elective, non-elective net of increased outpatients

Overall NHS patient activity is ahead of plan with NHS income excluding pass through ahead of plan by 0.4M

Cash levels are £4.7m higher than plan due a higher starting point at the beginning of the year and delays in Trust funded capital expenditure

International Patient revenue is £1.7m below plan due to lower than targeted patient activity in ICU and surgical wards

Non clinical revenue is below plan, due to the uncertainty on the specialist funding

The estimated value of P&E benefits deliverable in the year is £4.6m below the target of £14.8m

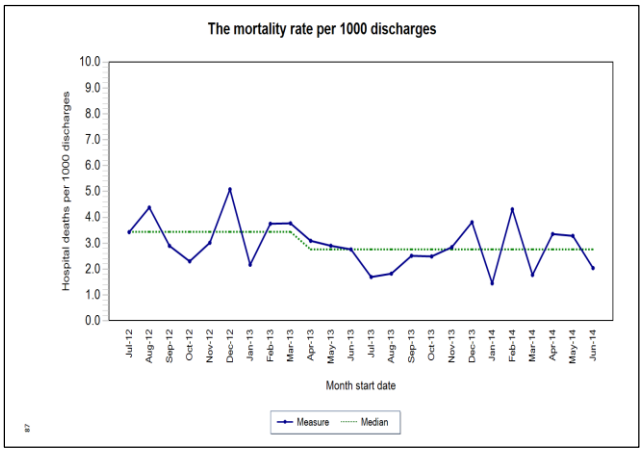
Action required from the meeting
Trust Board to note performance for the period.

Contribution to the delivery of NHS Foundation Trust strategies and plans
To assist in monitoring performance across external and internal objectives.

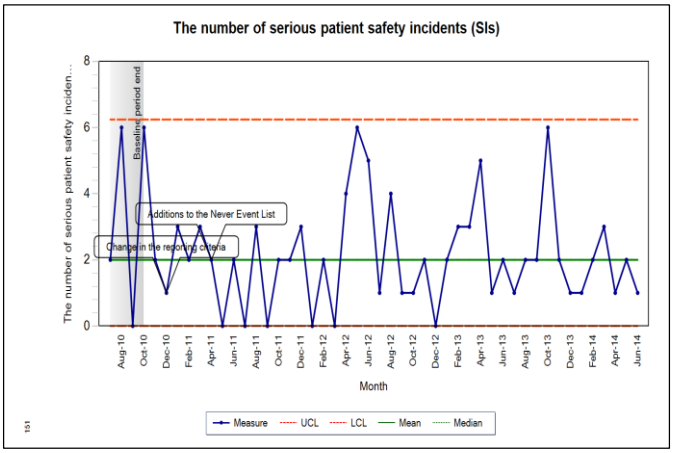
Financial implications Failure to achieve contractual performance measures may result in financial penalties.
Legal issues N/A
Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place? The Members' Council receive a copy of the performance report and Commissioners receive a sub-section of the performance report monthly.
Who needs to be told about any decision? Executive Directors.
Who is responsible for implementing the proposals / project and anticipated timescales? Executive Directors.
Who is accountable for the implementation of the proposal / project? Executive Directors.

Quality and Safety report

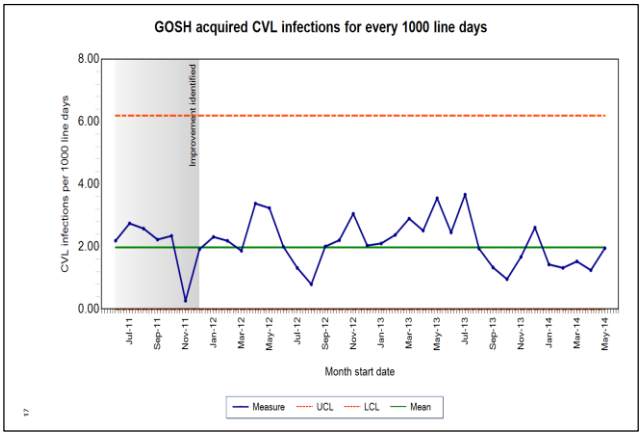
Quality and Safety Indicators



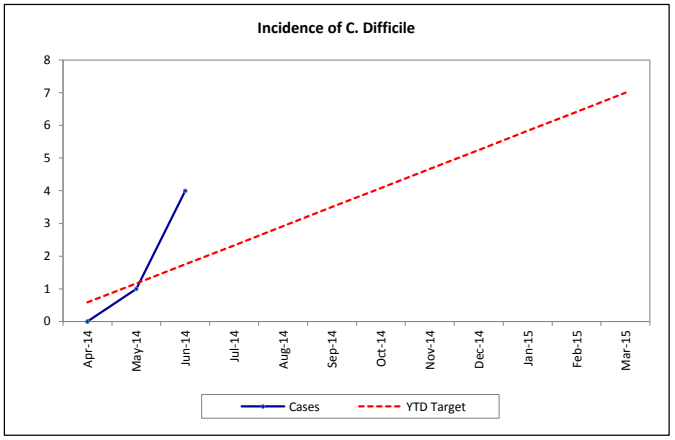
Description: The mortality rate per 1000 discharges
Target: Internal target: Year on year reduction
Trend: Performance sustained
Comment: Special cause variation has been detected and will be monitored to determine if it has been sustained. This indicates a reduction in mortality from 3.4 to (currently) 2.8 deaths per 1000 discharges.



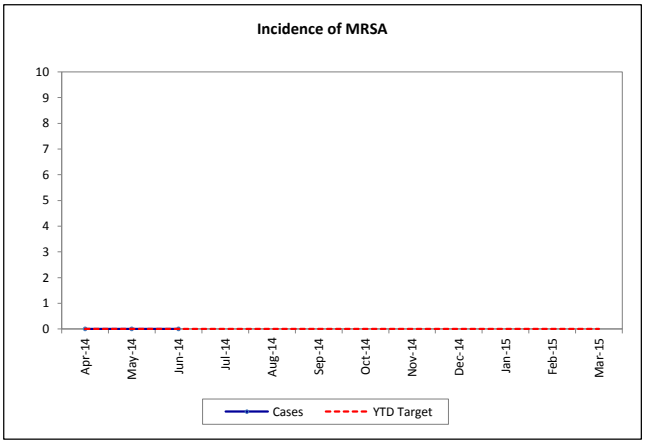
Description: Defined as either - Unexpected/avoidable death of patient(s), staff visitors or members of public. Serious harm to patient(s), staff, visitors or members of public. Allegations of abuse. One of the core sets of 'Never Events'
Target: Internal target: To remain within control limits
Trend: Performance sustained
Comment: Variation remains within expected levels



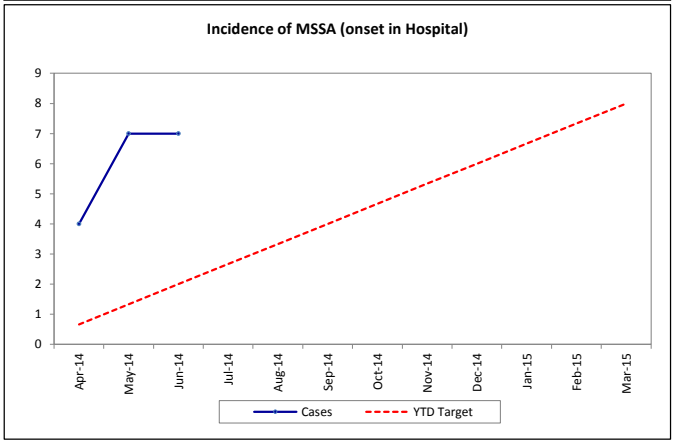
Description: The number of CVLInfections for every 1000 Bed Days acquired at the Trust
Target: Internal target: <=1.5
Trend: Performance sustained.
Comment: Variation remains within expected levels.



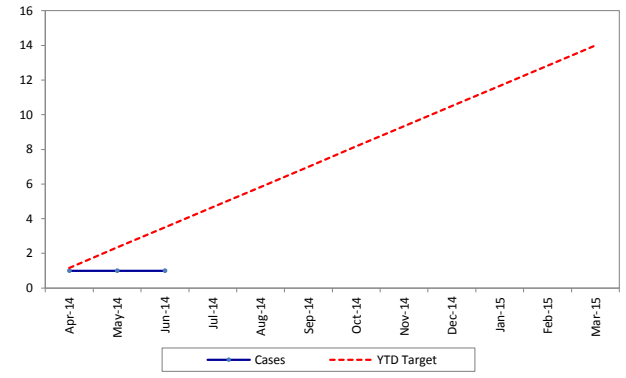
Description:	**Cases detected after 3 days (admission day = day 1) are assigned against trust trajectory**
Target:	No more than seven cases per year
Trend:	Trend above trajectory
Comment:	3 cases reported at M3. The number of cases of C.difficile remains the most significant risk to achieving the Monitor quality governance risk rating throughout 14/15.



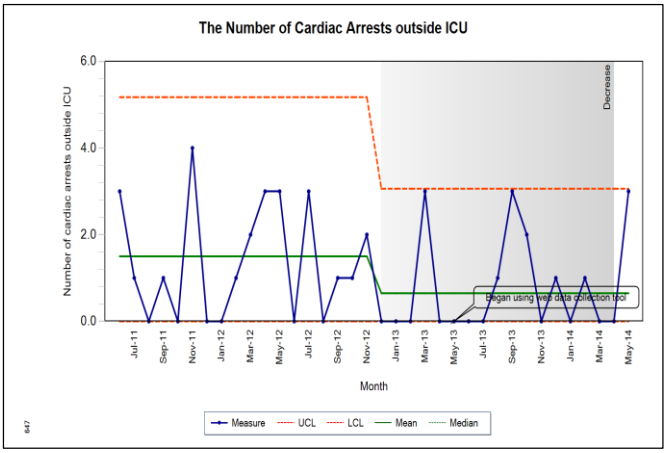
Description: MRSA bacteraemias
Target: Zero cases
Trend: 0 cases reported to date
Comment: Performance sustained at zero cases



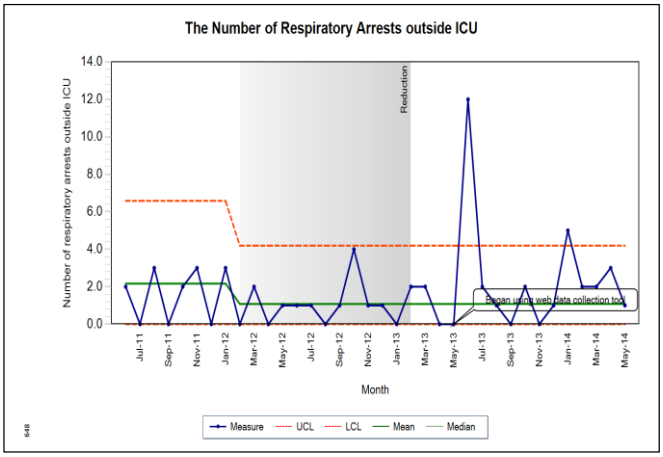
Description: Cumulative incidence of MSSA bacteraemia episodes (Methicillin sensitive S. aureus)
Target: Internal Target no more than eight cases
Trend: Performance continues above trajectory
Comment: Performance being monitored closely



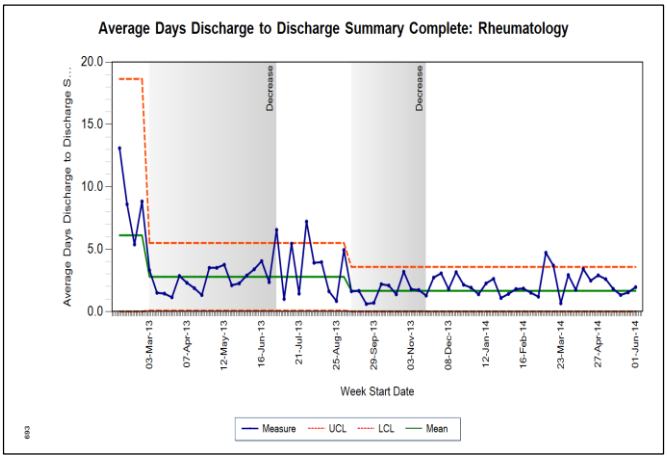
Description: **Cumulative incidence of E. coli bacteraemia**
Target: Internal Target no more than fourteen cases
Trend: Performance reported below trajectory at M3
Comment: Performance being monitored closely



Description: The monthly number of arrests (cardiac) outside of ICU wards (recorded from calls made to the 2222 Clincal Emergency Team)
Target: Internal target: 50% reduction
Trend: Performance sustained
Comment: We have separated the cardiac and respiratory arrest data for future reports because they use different criteria. Variation remains within expected levels.



Description: The monthly number of arrests (respiratory) outside of ICU wards (recorded from calls made to the 2222 Clincal Emergency Team)
Target: Internal target: 50% reduction
Trend: Performance sustained
Comment: Variation remains within expected levels.



Description: Harm index comprised of hospital acquired infections (CVL, serious incidents, non-ICU arrests, medication errors, falls, and pressure ulcers
Target:
Trend:
Comment: Variation remains within expected levels for Rheumatology. The focus has shifted from the doctors to administration processes, where there blocks to address in getting summaries sent. Other specialties have joined the project, with Dermatology and SNAPS showing rapid improvement.

Targets & Indicators Report

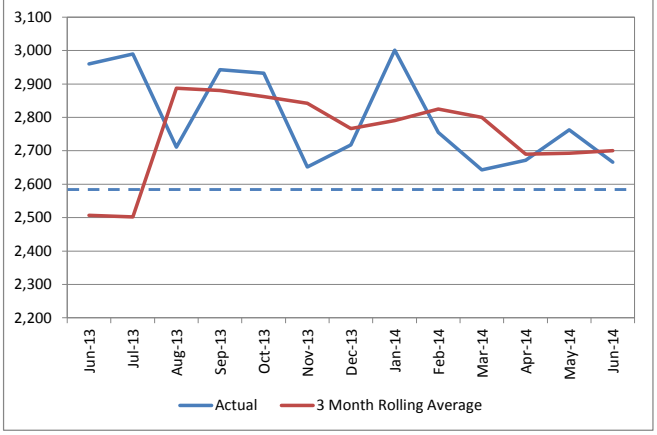
	Indicator	Graph	YTD Target	YTD Performance	Monthly Trend					
					Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Activity & Use of Resources	Number of patient spells	1	7,859	**8,101**	3,001	2,755	2,643	2,672	2,763	2,666
	Number of outpatient attendances	2	36,032	**38,032**	14,130	12,867	13,467	12,224	12,475	13,333
	DNA rate (new & f/up) (%)		<10	**7.8**	7.5	7.8	8.0	8.1	7.5	7.7
	Number of ITU bed days	3	2,275	**2,646**	1031	738	789	798	831	1,017
	Number of unused theatre sessions		58	**46**	11	13	21	14	17	15
	Average number of beds closed - Total Ward		-	**21**	34.0	28.7	30.4	26.3	18.8	18.0
	Average number of beds closed - Total ICU		-	**1**	1.3	2.9	3.0	1.9	1.3	0.9
Patient Access	18 week referral to treatment time performance - Admitted (%)	4	90	**91.6**	91.0	90.0	90.3	92.0	91.2	
	18 week referral to treatment time performance - Non-Admitted (%)	4	95	**96.3**	95.8	95.6	96.0	95.5	97.0	
	18 week referral to treatment time performance - Incomplete Pathways (%)	4	92	**92.4**	92.6	93.5	94.6	92.6	92.2	
	Cancer patients waiting no more than 31 days for second of subsequent treatment (%)		98	**100**	100	100	100	100	100	100
	Proportion of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests (%)	5	<=1	**0.55**	0.70	0.00	0.22	0.82	0.65	0.19
Patient / Referrer Experience	Number of complaints		28	**40**	7	9	12	12	12	16
	Number of complaints - high grade		5	**4**	3	1	1	0	2	2
	Discharge summary completion (%)	6	85	**82.8**	88.2	87.2	88.5	82.2	81.1	85.1
	Clinic Letter Turnaround, % letters on CDD - sent within 5 working days	7	50	**23.5**	29.7	27.9	24.8	23.5		
	Clinic Letter Turnaround, Average Days Letter Sent		-	**14.7**	16.8	17.6	17.2	14.7		
	Patient refusals		<128	**91**	36	35	54	34	29	28
Work - force	Sickness Rate (%)		2.99	**2.5**	2.7	2.6	2.6	2.5	2.5	2.5
	Trust Turnover (%)		14.13	**17.3**	17.6	17.7	17.4	17.3	17.5	17.1

Monitor	YTD Target	YTD Performance	Quarter 4			Quarter 1		
Monitor governance risk rating 14/15	0 - 0.9	0	0	0	Green	0	0	

Activity and Use of Resources

1. Patient Spells

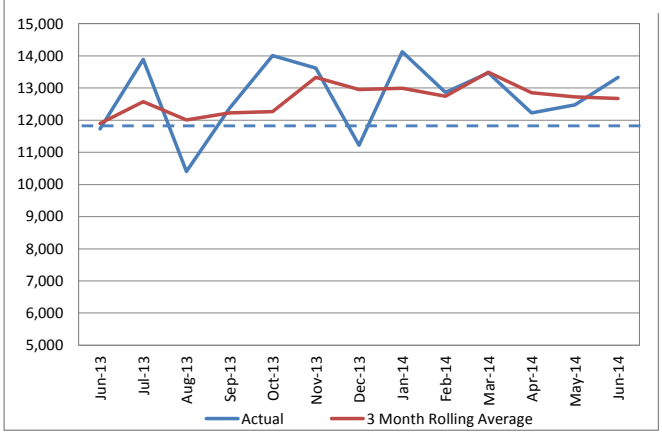
Desired direction of travel ↑



Description:	**The total number of patient spells (including day case, elective and non-elective)**
Target:	*Contractual target:* 2576 spells per month
Trend:	Downward Trend against previous month
Comment:	Performance remains above plan year to date, which is largely due to a significant increase in daycases

2. Outpatient Attendances

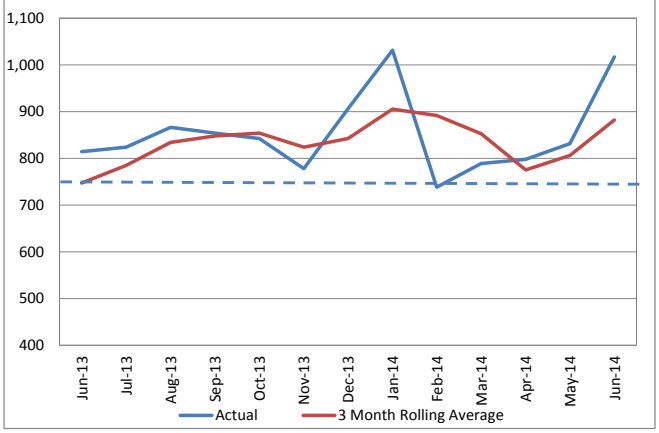
Desired direction of travel ↑



Description:	**Total number of new & follow-up consultant-led chargeable appointments**
Target:	*Contractual target:* 11,814 attendances per month
Trend:	Upward trend against previous month
Comment:	Performance remains above plan year to date

3. ITU Bed Days

Desired direction of travel ↑

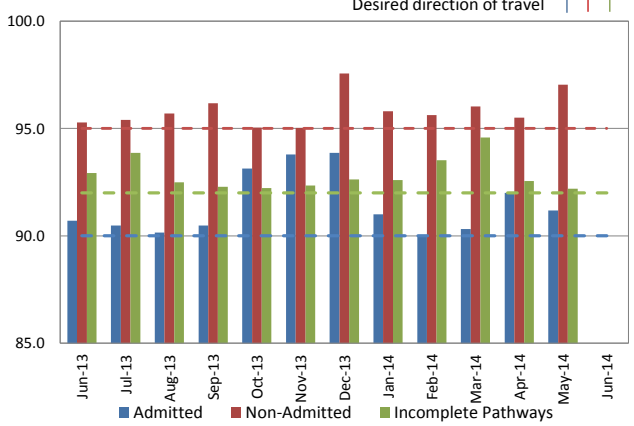


Description:	**Total number of ITU bed days used per month**
Target:	*Contractual target:* 758 bed days per month
Trend:	Increase in ITU Bed days against the previous month
Comment:	Year to date performance remains significantly above plan

Patient Access

4. Referral to Treatment Waiting Times (% within 18 weeks)

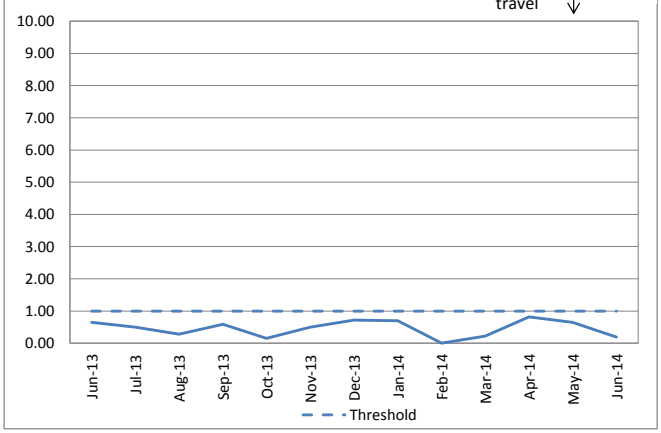
Desired direction of travel ↑ ↑ ↑



Description:	**Referral to treatment waiting times for admitted and non-admitted patient pathways**
Target:	*Monitor/Contractual target:* Admitted 90%, Non-admitted 95%, Incomplete pathways 92%
Trend:	Performance sustained above standards. Trend continues to mirror activity levels
Comment:	Higher number of breaching admitted patients identified in Surgery impacting on performance. Plan in place to reduce

5. Diagnostic Waiting Times - % not seen within 6 wks

Desired direction of travel ↓

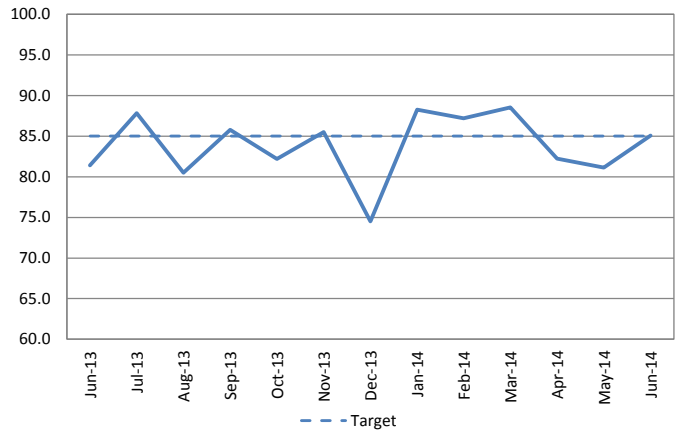


Description:	**The proportion of patients waiting no more than 6 weeks for diagnostic test (across 15 national key diagnostic areas)**
Threshold:	*Contractual target* <1%
Trend:	Small upward movement against previous month
Comment:	Performance sustained under 1% threshold

Patient / Referrer Experience

6. Discharge Summary Completeness (%)

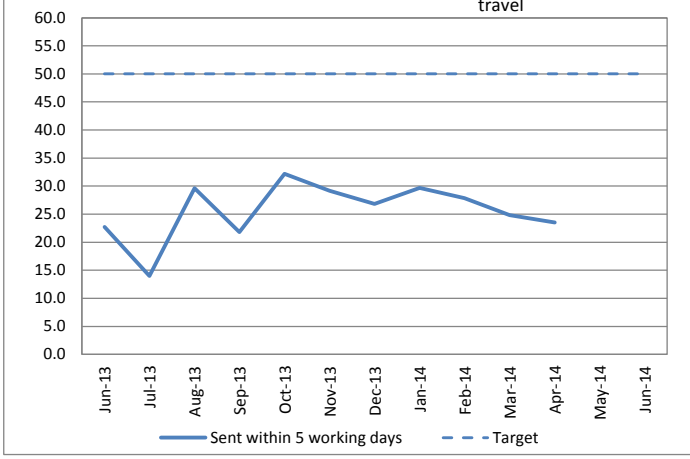
Desired direction of travel ↑



Description: **The percentage discharge summaries completed and sent within 24 hours of patient discharge**
Target: *Internal target:* 85%
Trend: Upward Trend against previous month
Comment: Discharge Summary completion improvement project currently underway

7. Clinic Letter Turnaround - % sent within 5 days

Desired direction of travel ↑



Description: **The percentage of clinic letters sent within five working (and average days) following patient clinic attendance & recorded on the Clinical Document Database (CDD)**
Target: *Internal target:* 50%
Trend: Decrease against previous month
Comment: The project team continue to focus on improving performance with the aim of achieving the 50% target by year end.

Monitor Governance Risk Rating

	Targets - weighted (national requirements)	Threshold	Score Weighting	Reporting Frequency	Score Weighting Q1			
					M1	M2	M3	Q1
1	MRSA - meeting the MRSA objective *	0	1	Quarterly	0	0		
2	Clostridium difficile year on year reduction (to fit with trajectory for the year as agreed with PCT)**	0	1	Quarterly	0	0		
3	All cancers: 31-day wait for second or subsequent treatment comprising either:		1	Quarterly	0	0		
	Surgery	94%			0	0		
	Anti cancer drug treatments	98%			0	0		
	Radiotherapy (from 1 Jan 2011)	94%			0	0		
4	Non Admitted within 18 weeks	95%	1	Quarterly	0	0		
5	92% - 18 week referral to treatment time Incomplete Pathways Performance	92%		Quarterly	0	0		
6	Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96%	0.5	Quarterly	0	0		
7	Certification against compliance with requirements regarding access to healthcare for peopl e with a learning disability	N/A	0.5	Annual	0	0		
				Total	**0**	**0**		
				Overall governance risk rating	**Green**	**Green**		

Monitor governance rating matrix	
Green	from 0 to 0.9
Red	0.9 or more

*Where an NHS foundation trust has an annual MRSA objective of six cases or fewer (the de minimis limit) and has reported six cases or fewer in the year to date, the MRSA objective will not apply for the purposes of Monitor's Compliance Framework

**Monitor's annual de minimis limit for cases of C. difficile is set at 12

Risk rating	**Description (risk of significant breach of authorisation)**
Green	No material concerns
Amber-green	Emerging concerns
Amber-red	Potential future significant breach if not rectified
Red	Likely or actual significant breach

TRUST BOARD WORKFORCE METRICS & EXCEPTION REPORTING – JUNE 2014

Introduction
This is the fourth of a new suite of workforce reports, which shows:

- Turnover;
- Sickness absence;
- Vacancy rates;
- PDR rates;
- Agency usage as a percentage of paybill;
- Statutory and mandatory training rates (*please note this has been removed from this suite following redesign of the LEaD reports until they can be integrated).

Each report shows divisional and directorate performance, and an exception report that indicates the cost centres which are the most statistically significant outliers against average performance. Where data exists to provide an external comparator (London trusts) this is indicated on each graph.

Headlines
GOSH decreased its contractual FTE (full-time equivalent) figure by 5 in June to 3632 (early reporting in April falsely reported a decrease).

Sickness absence has had a slight increase to 2.54% (+0.03%) remains significantly below the London benchmark figure of 3.07% (which has reported an increase in sickness across London).

Turnover has decreased to 17.06% (-0.42%) in June, this represents the lowest turnover for the Trust for 12-months. Adjusting the figure to account for the unusually large number of TUPE transfers over the last 12 months and for staff on fixed-term and short-term contracts (which are felt to be higher at GOSH than in benchmarked Trusts) reduces the figure to 12.59%% in June. The (unadjusted) London benchmark figure is 13.12%. It is not unusual for London data to show more significant fluctuations (for example, in response to major TUPE events).

The reported **vacancy rate** has reduced from 4.10% in May to 3.70% in June. The Board's attention is drawn to the commentary provided in the previous month's report which indicates that the vacancy rate should be treated with caution until review of its accuracy is completed.

Agency usage (as a percentage of pay bill) stands unchanged at 2.64% in June. The largest increase can be seen within Clinical & Medical Operations, which stands at 7.73%.

PDR completion rates The Trust overall appraisal rate has decreased compared to the level reported in May, at 77.3%. No divisions/directorates are currently meeting the target of 95%. Significant decrease reported for Estates with 9.4% PDRs in-date.

Statutory and mandatory training compliance rates are not reported as part of this month's suite of reports, but will be included in future following integration of new LEaD reporting.

Key issues

Vacancy and turnover rates at these levels are indicative of stability within the overall workforce and also across the majority of the clinical divisions. However, more detailed data demonstrates high turnover/vacancy rates within individual wards/departments. Steps outlined in February with regard to nurse recruitment, such as overseas recruitment and job fairs, are continuing but all London Trusts are reporting a challenging picture with regard to nurse staffing.

PDR rates, largely have all decreased (with the exception of International, ICI-LM and Clinical & Medical Operations) across the Trust since April. The table to the right shows the variances and direction of travel for divisions.

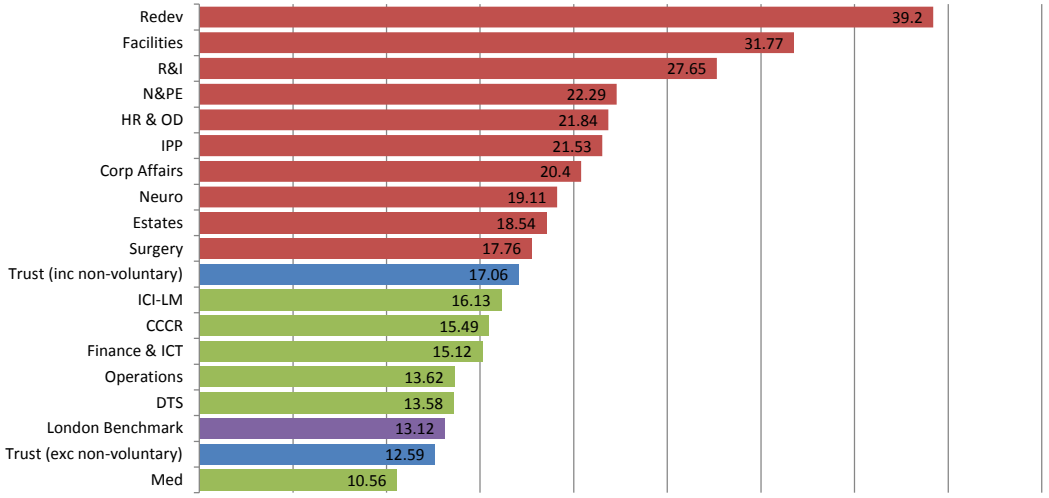
	April	June	
Division	PDR	PDR	Variance
Nursing & Patient Experience	96.70%	85.70%	-11.00%
Surgery	88.50%	85.10%	-3.40%
Human Resources & OD	88.20%	85.20%	-3.00%
Diagnostic & Therapeutic Services	87.20%	77.50%	-9.70%
Neurosciences	87.00%	86.40%	-0.60%
International	86.90%	87.10%	0.20%
Trust	80.80%	77.30%	-3.50%
Medicine	79.10%	78.70%	-0.40%
Infection, Cancer & Immunity	79.00%	79.50%	0.50%
Estates	78.80%	9.40%	-69.40%
Critical Care & Cardio-Respiratory	72.90%	70.60%	-2.30%
Redevelopment	72.70%	58.80%	-13.90%
Clinical & Medical Operations	71.70%	86.00%	14.30%
Finance & ICT	70.90%	66.30%	-4.60%
Corporate Facilities	68.20%	60.70%	-7.50%
Corporate Affairs	66.70%	55.60%	-11.10%
Research & Development	65.20%	62.00%	-3.20%

HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - JUNE 2014 REPORT

Division	Turnover Rate (%)	Sickness Rate (%)	PDR Completion (%) (target 95%)	Vacancy Rate (%) (Unfilled vacancies, 0-10% green; overestablished white)	Agency (as % of total paybill)
Critical Care & Cardio-Respiratory	15.5	3.3	70.6%	6.2%	1.5%
Diagnostic & Therapeutic Services	13.6	2.0	77.5%	5.3%	2.5%
Infection, Cancer & Immunity	16.1	2.5	79.5%	6.4%	0.4%
International	21.5	3.8	87.1%	9.7%	8.8%
Medicine	10.6	2.3	78.7%	-2.2%	2.5%
Neurosciences	19.1	2.1	86.4%	6.2%	0.0%
Surgery	17.8	2.9	85.1%	3.6%	0.3%
Clinical & Medical Operations	13.6	1.0	86.0%	6.4%	7.7%
Corporate Affairs	20.4	0.1	55.6%	44.1%	0.0%
Corporate Facilities	31.8	2.3	60.7%	1.7%	7.9%
Estates	18.5	3.9	9.4%	-6.2%	14.2%
Finance & ICT	15.1	2.0	66.3%	5.2%	27.0%
Human Resources & OD	21.8	1.8	85.2%	-4.0%	0.9%
Nursing & Patient Experience	22.3	2.3	85.7%	12.4%	0.0%
Redevelopment	39.2	0.8	58.8%	-31.1%	0.0%
Research & Development	27.7	1.2	62.0%	-6.2%	1.2%
Trust	**17.1**	**2.5**	**77.3%**	**3.7%**	**2.6%**

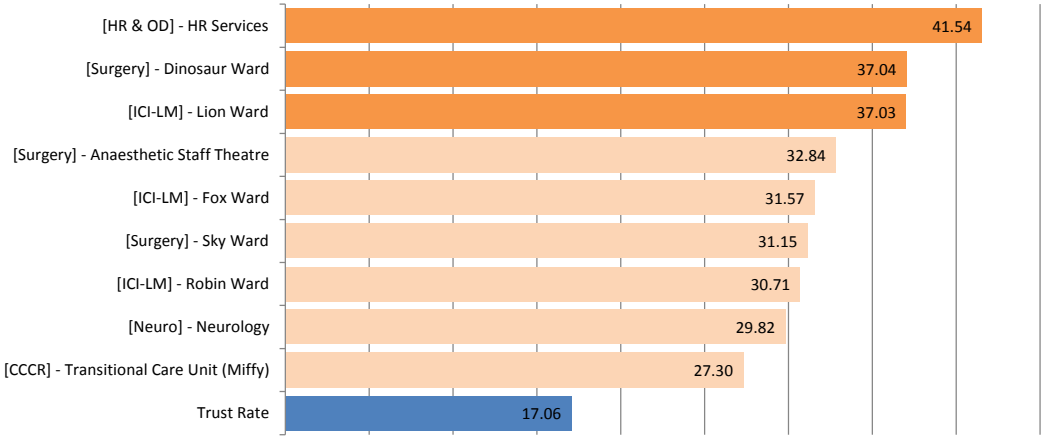
HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - JUNE 2014 REPORT

Divisional Turnover



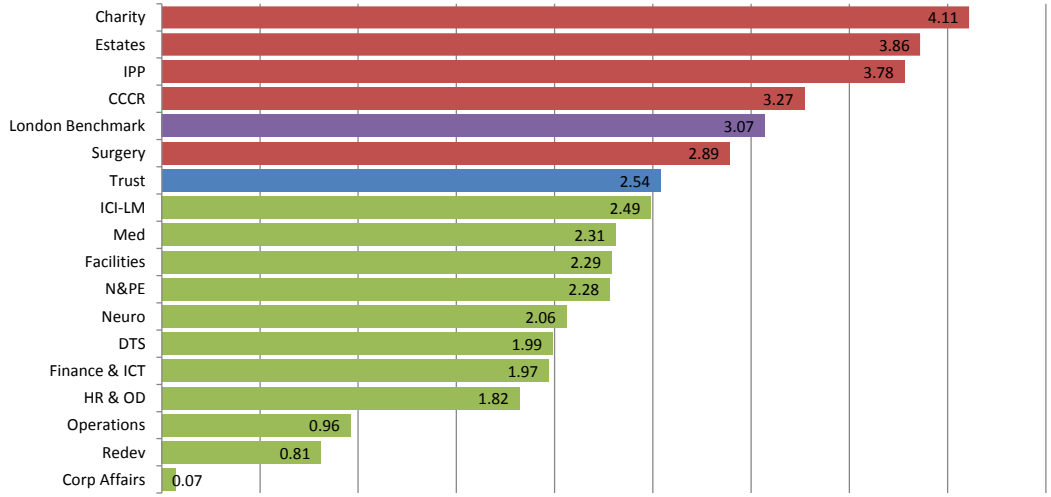
Very high turnover reported for Corporate Facilities primarily due to TUPE events (decontamination services, supply chain etc). Non-voluntary leavers (inc fixed-term contracts, TUPE etc) remains stable and contributes 4.47% to Trust turnover.

Exception Reporting Turnover

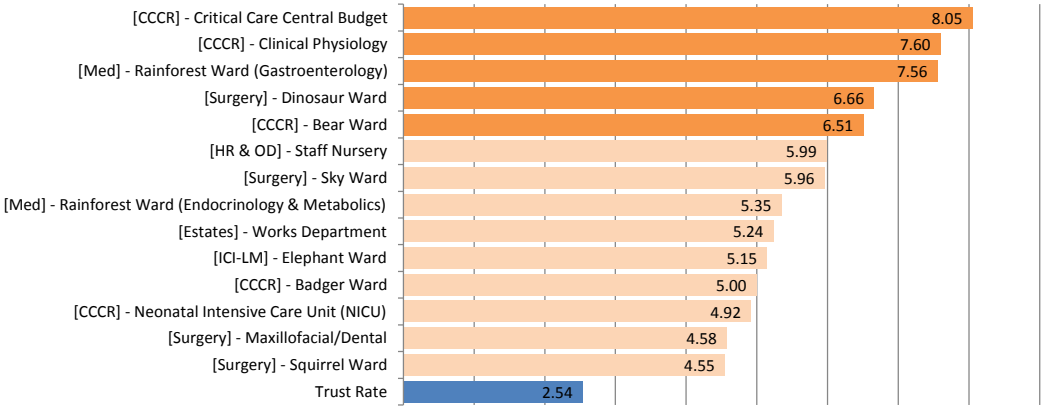


DTS (pharmacy) – pre reg pharmacists are on 12 month fixed term contracts around 20 staff on average; Surgery (Anaesthetic Staff Theatres) – majority of the staff are ODPs come and work at the Trust for 6 months to develop, the band 6 roles have low turnover so they are appointed to band 6 and 7 roles externally as there are limited opportunities elsewhere in the Trust. R&I (CRF) – research funding, majority of staff on fixed term contracts in line with funding

Divisional Sickness

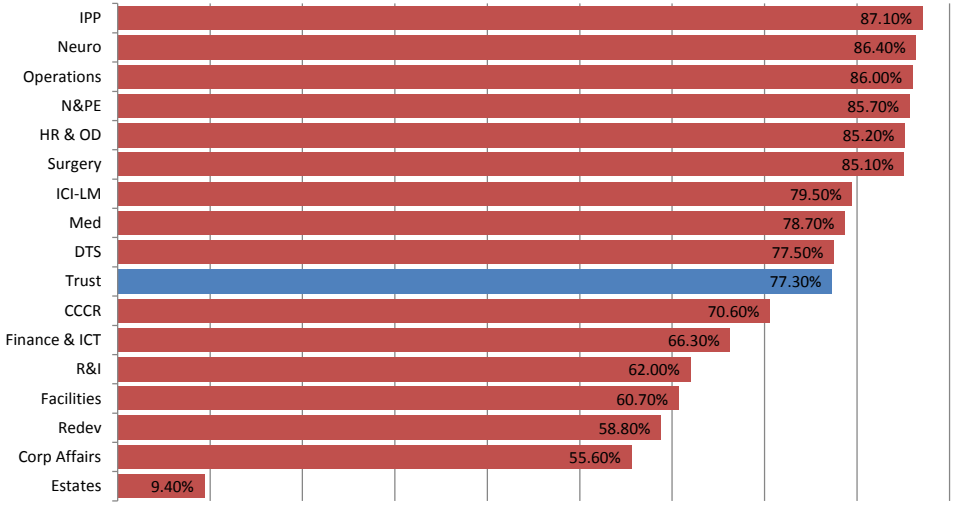


Exception Reporting Sickness

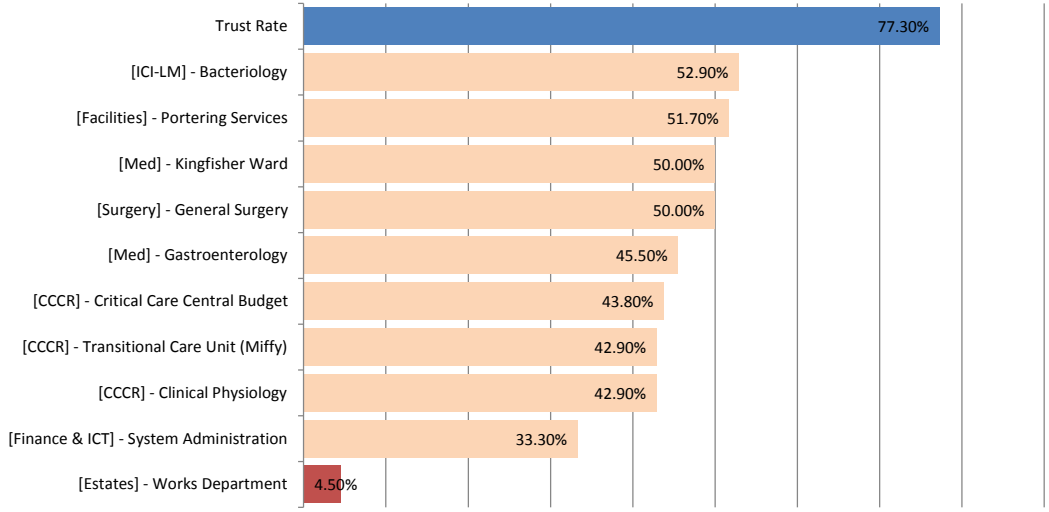


HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - JUNE 2014 REPORT

Divisional PDR (Target 95%)

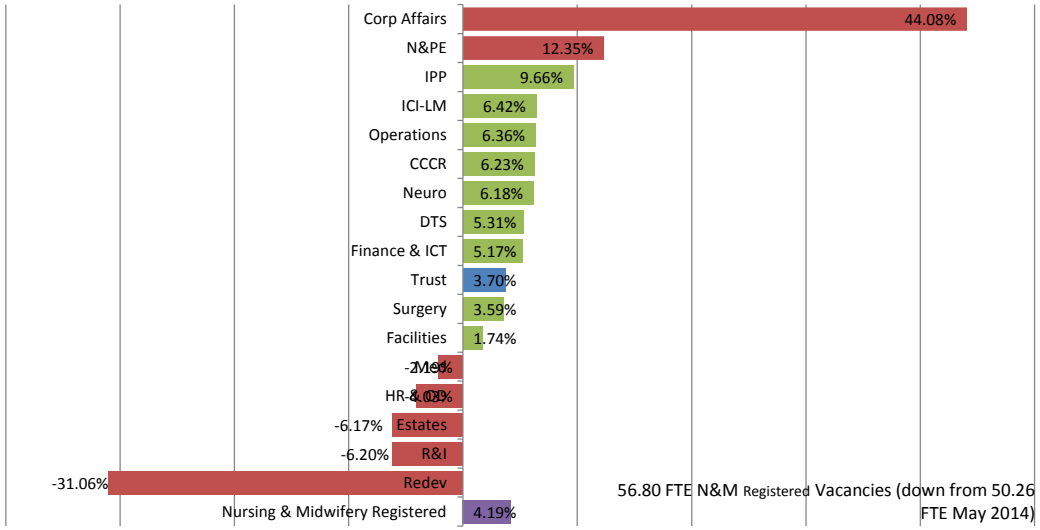


Exception Reporting PDR

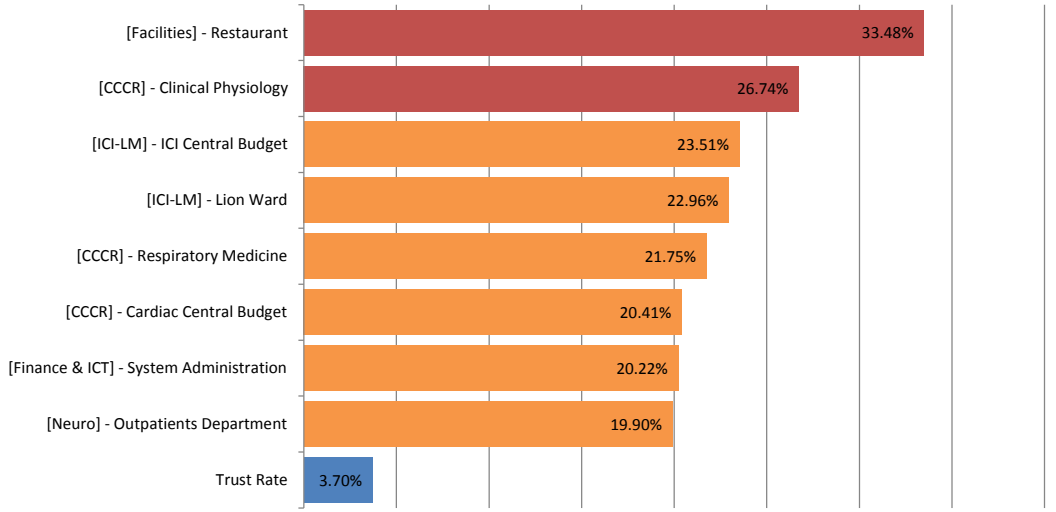


HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - JUNE 2014 REPORT

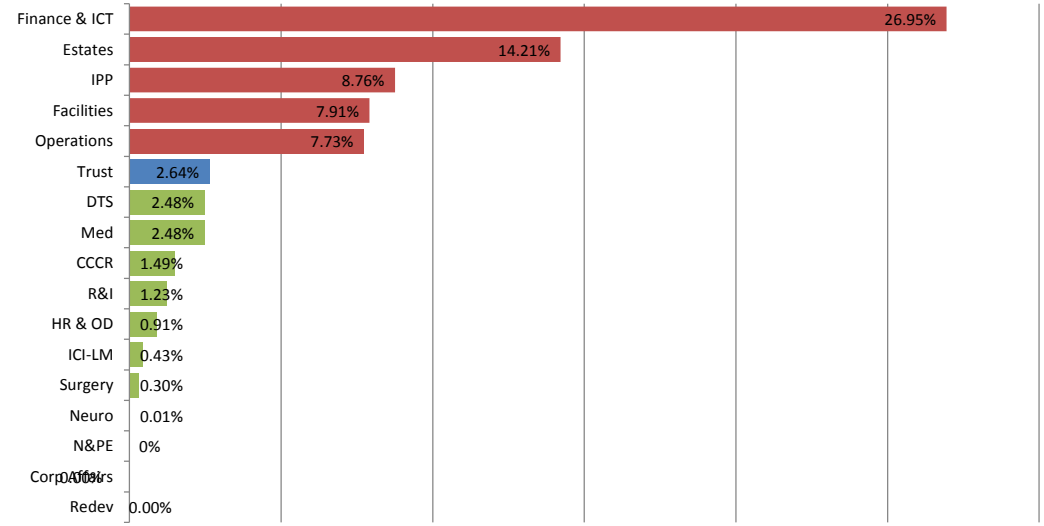
Divisional Vacancy Rate



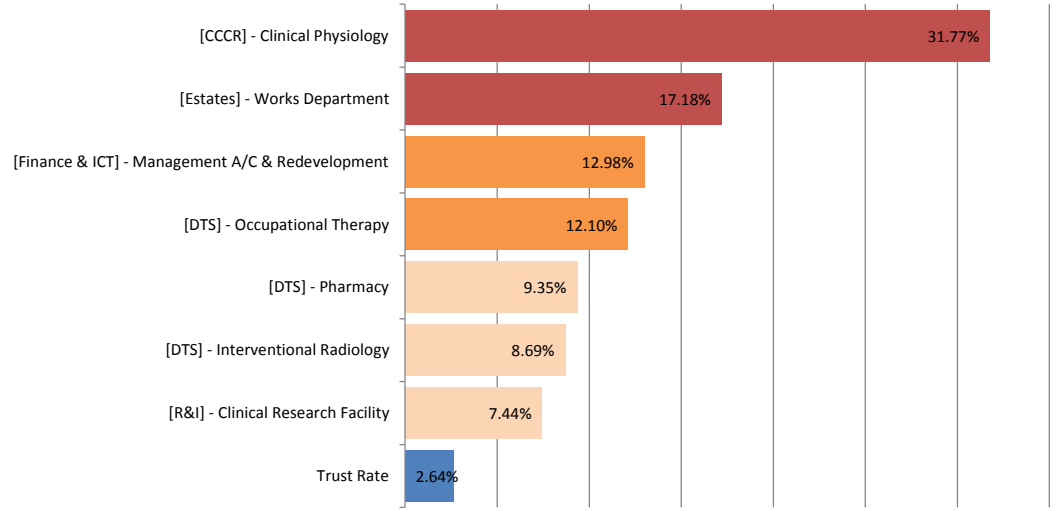
Exception Reporting Vacancy Rate



Divisional Agency as % of paybill



Exception Reporting Agency as % of Paybill



Great Ormond Street Hospital for Children NHS FT - Summary Financial Performance Report. 3 Months to 30 June 2014

Commentary :

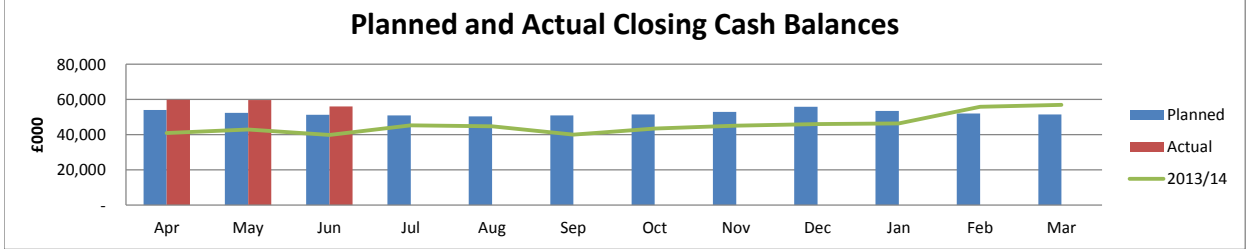
* The Trust is reporting a net deficit of £-2.5M , £1.3m worse than Plan
* EBITDA of £4.4m (4.7%) is also £1..3m below the planned EBITDA of £5.7m (6%)
* Total income excluding pass through is £0.9m below plan principally due to doubt over the receipt of £1.2m of specialist funding from NHSE and the lower activity in private patients. as well as lower day case, elective, non -elective net of increased outpatients
* Overall NHS patient activity is ahead of plan with NHS income excluding pass through ahead of plan by 0.4M
* Cash levels are £4.7m higher than plan due a higher starting point at the beginning of the yearr and delays in Trust funded capital expenditure

Challenges:

International Patient revenue is £1.7m below plan due to lower than targeted patient activity in ICU and surgical wards
Non clinical revenue is below plan, due to the uncertainty on the specialist fundings
The estimated value of P&E benefits deliverable in the year is £4.6m below the target of £14.8m

I&E	Current Month		Current Year Year to Date			YTD Prior Year Year to Date		RAG Rating
	Actual (£m)	Variance (£m)	Budget (£m)	Actual (£m)	Variance (£m)	Actual 2013/14 (£m)	Variance CY vs PY (£m)	Current Year Variance
NHS Clinical Revenue	20.4	1.6	56.9	58.5	1.6	55.7	2.7	G
Pass Through	4.6	0.6	11.8	10.7	(1.1)	10.8	(0.1)	A
Private Patient Revenue	3.1	(0.6)	11.5	9.8	(1.7)	11.7	(1.9)	R
Non-Clinical Revenue	5.5	(0.1)	14.8	14.1	(0.7)	12.5	1.7	A
Total Operating Revenue	**33.6**	**1.4**	**95.0**	**93.0**	**(2.0)**	**90.7**	**2.4**	
Permanent Staff	(16.3)	(0.0)	(48.9)	(48.7)	0.2	(47.1)	(1.6)	G
Agency Staff	(0.4)	0.0	(1.3)	(1.4)	(0.1)	(1.1)	(0.3)	R
Bank Staff	(0.95)	0.1	(3.0)	(3.0)	0.1	(2.9)	(0.1)	G
Total Employee Expenses	**(17.7)**	**0.0**	**(53.2)**	**(53.1)**	**0.1**	**(51.1)**	**(2.0)**	
Drugs and Blood	(1.4)	(0.5)	(2.9)	(3.5)	(0.6)	(3.9)	0.4	R
Other Clinical Supplies	(3.6)	(0.7)	(8.7)	(9.4)	(0.6)	(7.9)	(1.4)	A
Other Expenses	(4.4)	0.5	(12.8)	(12.1)	0.7	(10.9)	(1.2)	G
Pass Through	(4.6)	(0.6)	(11.8)	(10.7)	1.1	(10.8)	0.1	G
Total Non-Pay Expenses	**(13.9)**	**(1.3)**	**(36.1)**	**(35.6)**	**0.5**	**(33.4)**	**(2.2)**	
EBITDA (exc Capital Donations)	**2.0**	**0.1**	**5.7**	**4.4**	**(1.3)**	**6.2**	**(1.8)**	
Depreciation, Interest and PDC	(1.8)	0.0	(6.9)	(6.9)	0.0	(7.4)	0.5	
Net Surplus (exc Cap. Don. & Impairments)	0.3	0.1	(1.2)	(2.5)	(1.3)	(1.3)	(1.2)	
EBITDA %	**6.0%**		**6.0%**	**4.7%**				
Capital Donations	0.5	(3.6)	14.0	4.1	(9.9)	4.5	(0.4)	

Closing Cash Balance



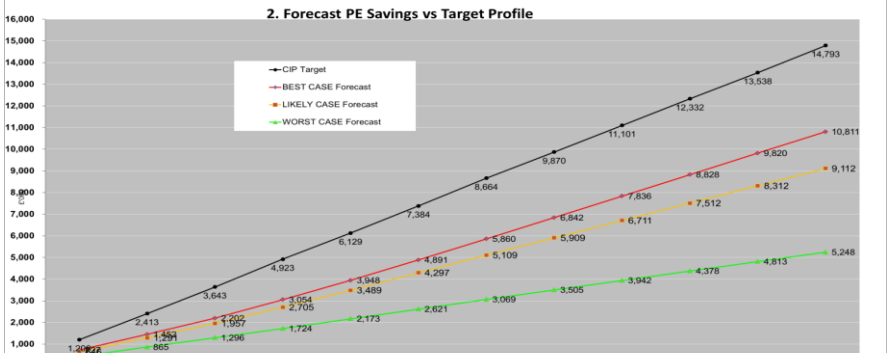
Statement of Financial Position	31 March 2014 Actual £m	30 June 2014 Planned £m	30 June 2014 Actual £m
Non-Current Assets	371.0	401.0	370.8
Current Assets (exc Cash)	58.2	55.7	53.8
Cash & Cash Equivalents	57.0	51.3	56.0
Current Liabilities	(56.8)	(57.1)	(49.8)
Non-Current Liabilities	(7.3)	(7.1)	(7.1)
Total Assets Employed	**422.1**	**443.8**	**423.7**

Capital Expenditure	Annual Plan £m	30 June 2014 Planned £m	30 June 2014 Actual £m
Redevelopment - Donated	18.8	8.6	2.9
Medical Equipment - Donated	8.9	5.0	1.1
Estates - Donated	1.2	1.3	0.0
ICT - Donated	0.0	0.0	0.1
Total Donated	28.9	14.9	4.1
Redevelopment - Trust Funded	0.0	0.0	0.3
Estates & Facilities - Trust Funded	6.4	2.2	0.0
ICT - Trust Funded	8.5	1.9	0.4
Medical Equipment - Trust Funded	6.6	1.2	0.3
Total Trust Funded	21.5	5.3	1.0
Total Expenditure	**50.4**	**20.2**	**5.1**

Continuity of Service Risk Rating	2014/15 Plan	31-May-14	30-Jun-14	RAG Rating
Liquidity	4	4	4	G
Capital Servicing Capacity	4	3	4	G

	31 March 2014	31 May 2014	30 June 2014	RAG Rating
NHS Debtor Days (YTD)	17.35	15.87	12.31	G
IPP Debtor Days	124.99	123.30	120.70	A
Creditor Days	35.65	30.07	32.43	G
BPPC - Non-NHS (YTD) (number)	86.8%	87.8%	87.9%	A
BPPC - Non-NHS (YTD) (£)	90.8%	91.1%	90.5%	G

Productivity & Efficiency

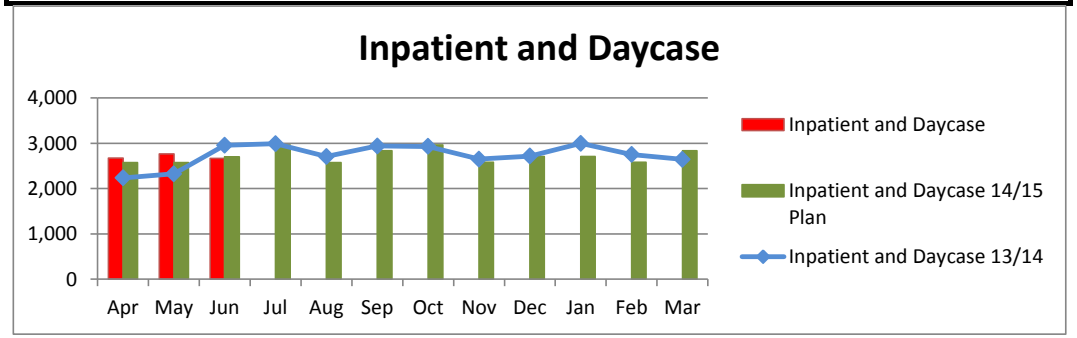


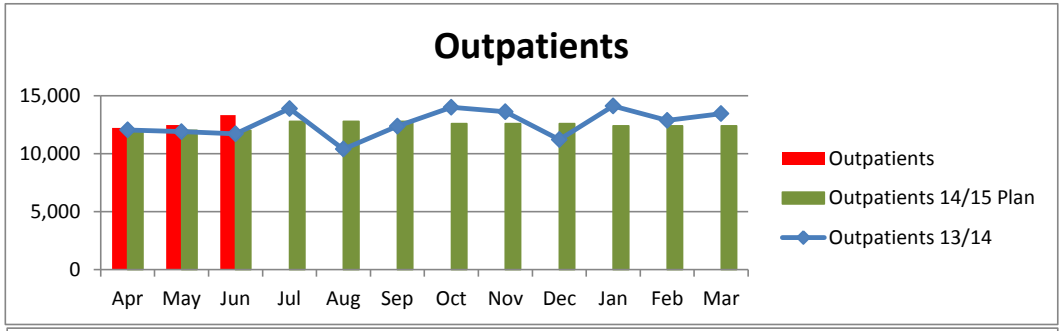
ACTIVITY AND INCOME

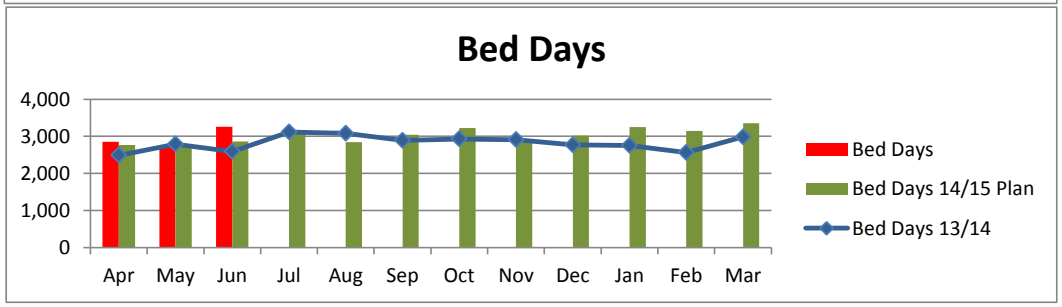
	Income from NHS clinical activity £M year to date				
	YTD Actual (£m)	Variance to plan (£m)	Variance to plan (%)	Variance to Prior Year (£m)	Variance to Prior Year (%)
Inpatients/ Daycases	**21.9**	(1.5)	-6.7%	0.1	0.3%
Bed days	**11.1**	0.8	7.0%	1.1	11.2%
Outpatients	**9.5**	0.5	5.6%	0.7	7.7%
Other eg. Highly Specialised	**16.0**	1.7	10.6%	0.9	6.1%
Total	**58.5**	1.6	2.7%	2.8	5.0%

Activity				
YTD Actual	Variance to plan	Variance to plan (%)	Variance to Prior	Variance to Prior Year (%)
8,101	242	3.1%	579	7.7%
8,868	478	5.4%	999	12.7%
38,032	2,720	7.2%	2,340	6.6%

PATIENT ACTIVITY

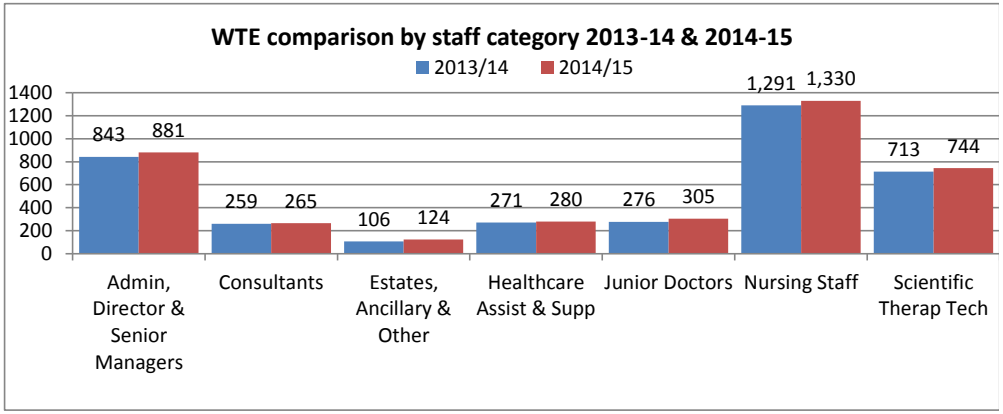


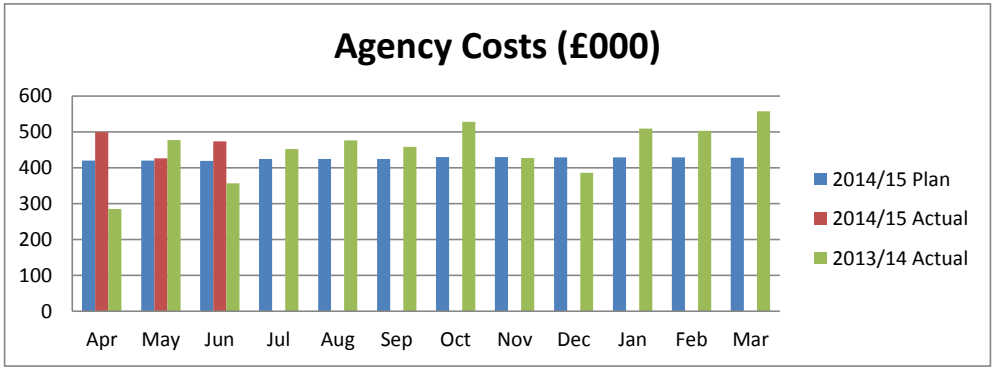




STAFF

Year	WTE	YTD Total Pay (£m)	YTD Agency (£m)	Agency as % of Total Pay	YTD Bank (£m)	Bank as % of Total Pay
2014/15	3,938	53,064	1,398	2.63	3,253	6.13
2013/14	3,766	51,076	1,117	2.19	3,004	5.88
Movement	172	1,988	281	0.45	249	0.25





Complaints Report
Quarter 1, 2014/15

Summary of key points

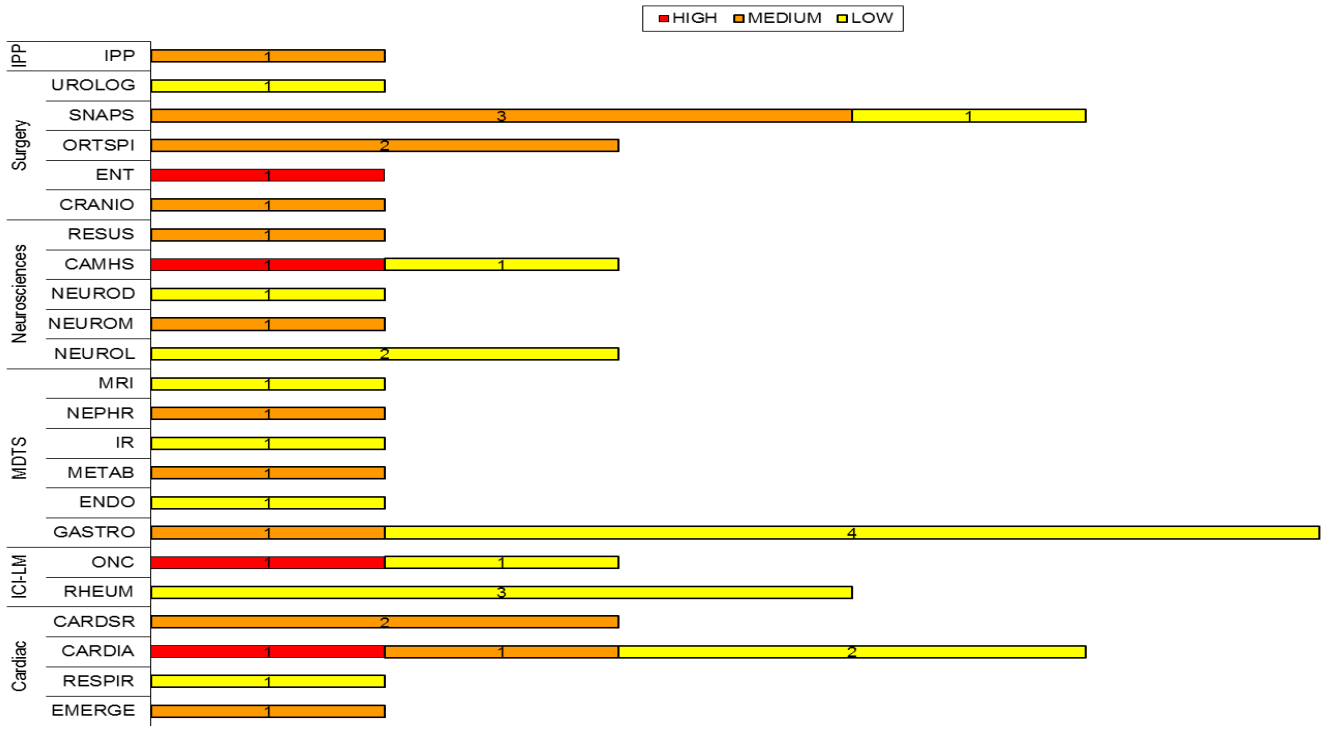
The key points identified from this report are:

- 40 new formal complaints were received this quarter plus an additional two complaints which were over the time limit.
- There was an increase of 11 complaints received this quarter compared to last quarter.
- There were four (4) complaints graded as red in Q1 compared to six (6) in the previous quarter.

Number of formal complaints received by the Trust

The Trust saw the number of formal complaints received increase by 26% in quarter. The rise may be due to increased promotion of the complaints service within GOSH.

Number of complaints received by division, speciality and grading



Red complaints - severe harm to patient or family or reputation threat to the Trust.
Amber complaints - lesser than severed but still poor service, communication or quality evident.
Yellow complaints - minor issues or difference of opinion rather than deficient service.

Percentage of complaints received compared to patient activity for each division

Directorate	Total # of Complaints	Adjusted patient activity	Amount of Complaints per 1000 Adjusted Patient Days	% of Complaints per 1000 Adjusted Patient Days
MDTS	10	2766.07	3.62	25%
Surgery	9	3253.22	2.77	19%
Cardio-respiratory Services	8	3153.66	2.54	17%
Neurosciences	7	2067.84	3.39	23%
ICI-LM	5	3575.05	1.40	10%
IPP	1	1125.14	0.89	6%
Totals:	40	15940.98	2.51	100%

Adjusted Patient Activity is a measure which weights outpatients, inpatients and critical care bed days into a combined figure representative of overall healthcare resource activity.

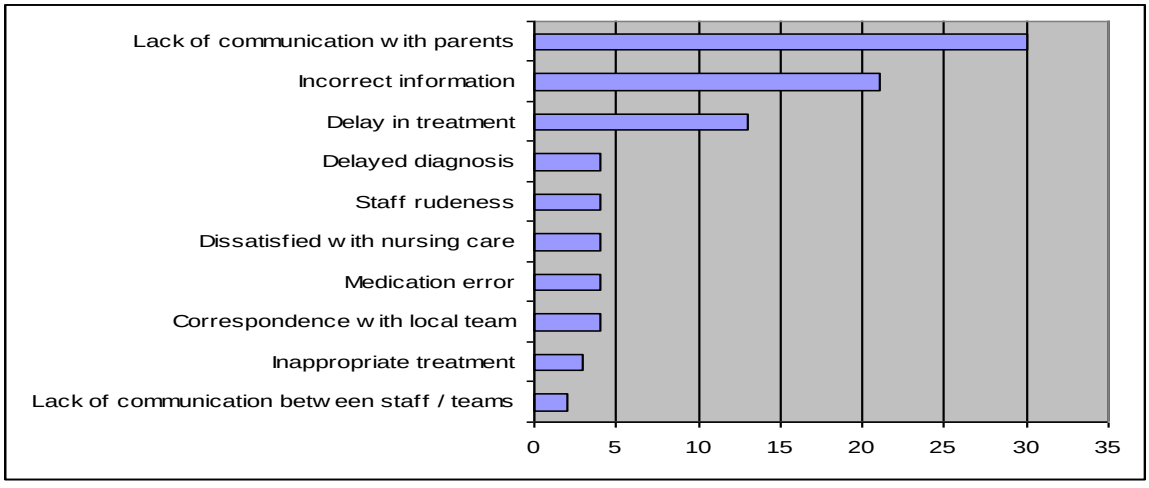
Complaints closed within the agreed timescale

64.3% of all complaints closed this quarter were responded to on time. The Complaints Team received 65.8% of draft responses on time from the divisions. The Patient Safety and Complaints Manager is working with the Head of Clinical Governance and Safety to review the quarterly data to analyse the reason for the decrease in complaints responded to on time and to work with the Divisional Management and Corporate Teams to increase the rate responded on time.

Trend analysis of complaints received in Q1

- Issues raised in complaints

Some complaints raise multiple issues regarding a number of services and specialities. The chart below shows the issues raised in complaints received this quarter.



All complaint responses have action plans which are followed up by the Patient Safety and Complaints team and monitored through the LIMB.

Themes in complaints

The following themes have been apparent during this quarter:

- Patients with autism

- Care by Parent
- Lack of communication with parents

Learning from complaints

The Patient Safety and Complaints team will update the Board in the next report with the learning identified from the three (3) themes above.

Re-opened complaints from dissatisfied complainants

Five complaints were reopened this quarter, 3 of the families accepted the Trust's offer of a meeting to close the complaint. The remaining 2 will receive a further written report.

Health Service Ombudsman

The Health Service Ombudsman is responsible for managing the second and final stage of the NHS complaints procedure, where the complainant is dissatisfied with the Trust's final response.

- **New cases**

No new cases have been raised by the Ombudsman this quarter.

- **Update on cases with the Parliamentary Health Service Ombudsman (PHSO)**

There was one update received on a complaint that had been made regarding the removal of a tumour in the patient's eye. The PHSO issued the Trust and Family with a draft response which t eh family have commented on, the PHSO is therefore reviewing the draft response.

- **Cases closed this quarter**

One case was closed by the PHSO this quarter which related to a complaint about surgery taking place in an unfamiliar environment, this was a joint complaint with another Trust. The PHSO closed the case without further review.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **23rd July 2014**	
Pals Patient Experience Annual Report 2013/14 **Submitted by:** Liz Morgan, Chief Nurse & Families Champion	**Paper No: Attachment P**
Aims / summary This report summarises the casework activity and concerns raised by patients and families through the Pals (Patient Advice & Liaison service) in 2013/14 and the Trust's response to concerns raised.	
Action required from the meeting To note the concerns identified by Pals.	
Contribution to the delivery of NHS Foundation Trust strategies and plans GOSH seeks to provide services that exceed patient and families expectations and does this best by involving and engaging with them to learn how to provide the best possible experience for patients, families and visitors.	
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? Grainne Morby. Head of PALS & PPI	

Great Ormond Street Hospital for Children NHS Foundation Trust

Great Ormond Street Hospital for Children NHS Foundation Trust

Annual Pals Report 2013-2014

This report provides a summary and overview of Pals activity over the last year.

1. Activity at a glance

- Over 2,500 families assisted
- 1167 information enquiries/contacts, plus
- 1351 cases opened, of which
  - 1059 cases promptly resolved
  - 238 complex and longer-term cases
  - 54 (35 last year) cases escalated to Complaints/Risk teams
- 18% increase in overall casework
- 17% increase in complex casework
- 8% increase in routine, promptly resolved cases
- 30% decrease in information enquiries/contacts

2. Key casework themes

- Cancelled Cardiac surgery exacerbated by poor communications
- Admission delays, cancellations and lack of communication with families within the Surgery Division – notably in General Surgery, Orthopaedics and Spinal surgery
- A rise in families' concerns about parents accommodation, appointment booking and fares reimbursement (distress levels as well as volume)
- Lack of pre-planning for families required to attend X-ray prior to clinic appointment
- Managing challenging and disruptive behaviour on wards and in clinic
- Uncomfortable parent beds on wards in the new Morgan Stanley Building.

3. Overall Volume of Activity

- Pals helped over 2,500 families and patients during the course of the year.

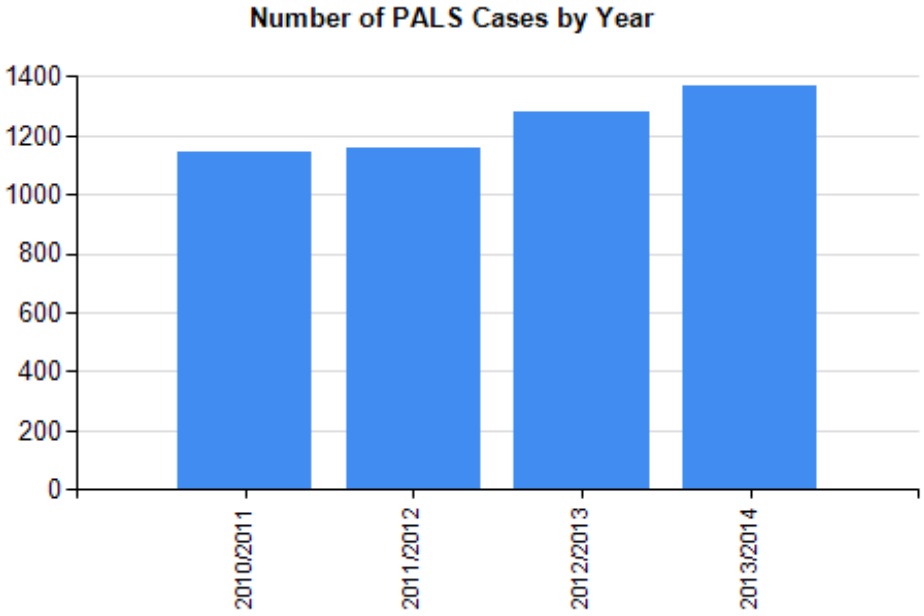
- Pals recorded 1351 cases of which 54 were escalated to Complaints /risk teams, 238 were complex and 1059 were cases that could be promptly resolved. In addition there were 1167 information enquiries/contacts recorded.

- Pals experienced another substantial increase of 18% in overall casework in 2012/2013. (this follows a 12% increase last year, 2.5% the year before and a

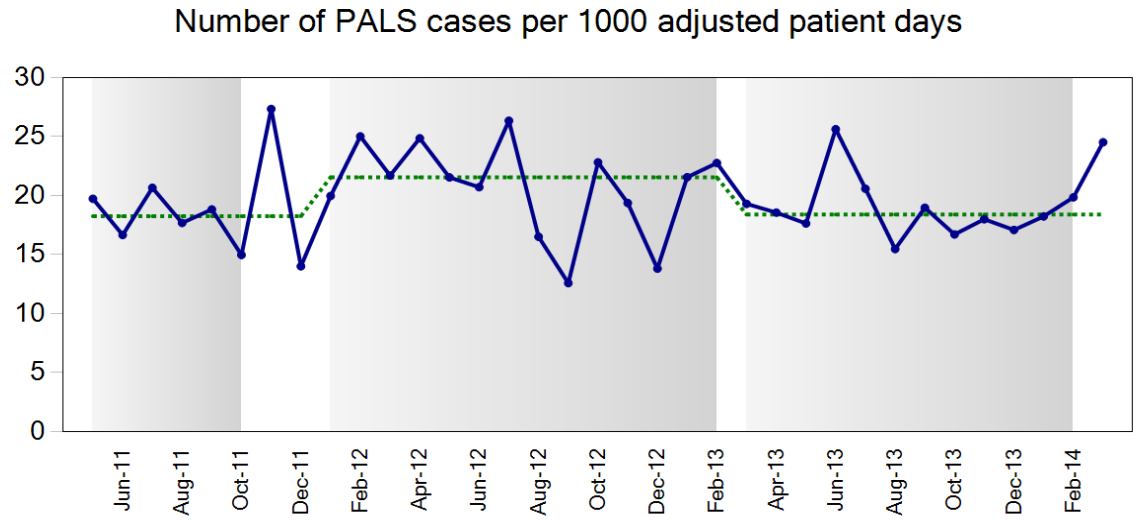
55% increase the previous year). There was a 17% increase in complex cases and an 8% increase in cases that were able to be promptly resolved. There was though a substantial decrease in straightforward information queries which Pals thinks is due to improved information-giving service at Reception.

- Cases escalated to formal Complaints or to patient safety staff involving serious clinical risk increased this year but remained low at less than 4% of total Pals casework.

4. Number of Pals cases by year



a. Number of Pals episodes per 1000 patients



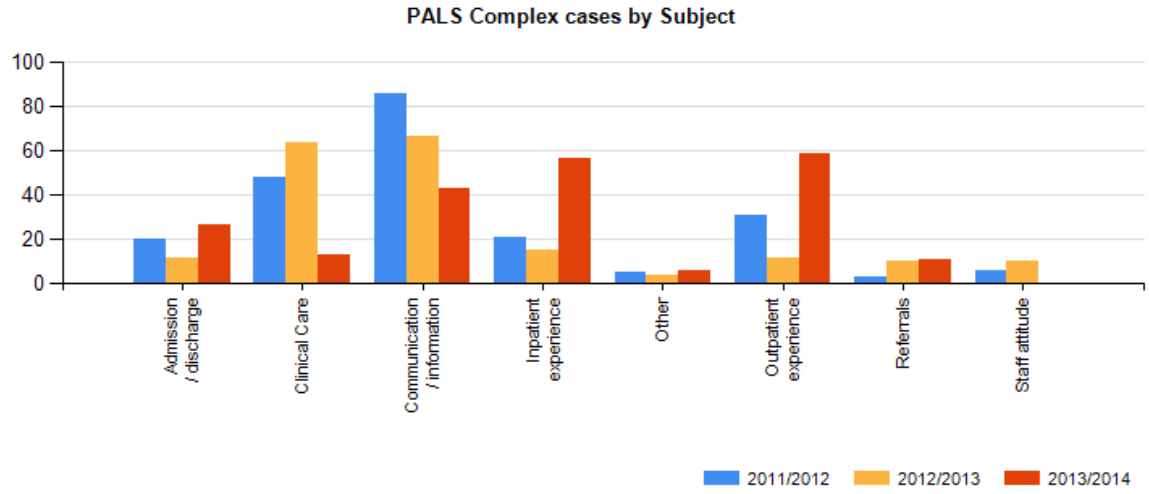
5. Escalated cases 54

54 cases were referred from Pals to the Trust's formal Complaints and Patient safety team; this is less than 4% of the total Pals casework. These cases involved significant clinical risk, grossly sub-standard care or instances where the enquirer

was not prepared to countenance informal local resolution (regardless of any 'severity' grade created and allocated by GOSH staff or external regulators).

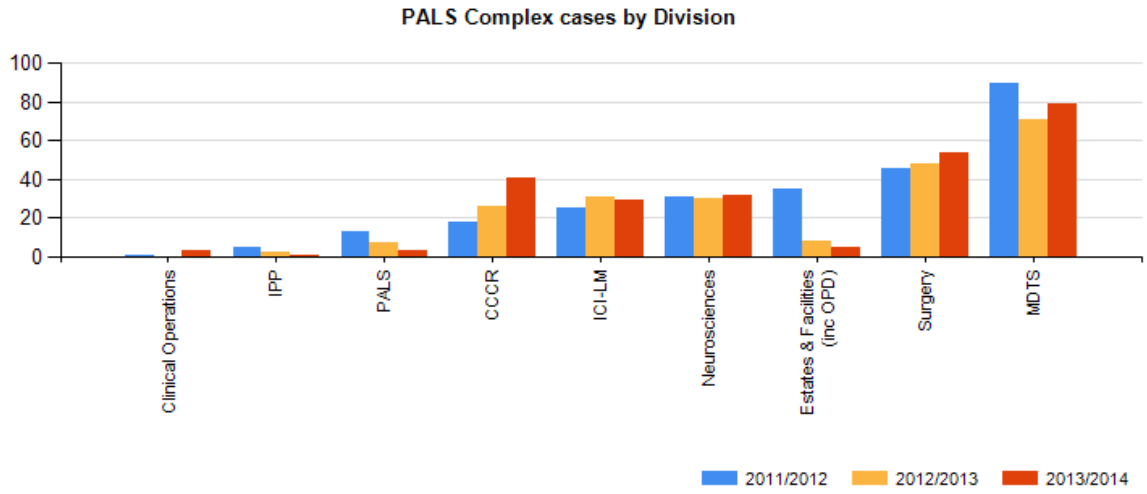
6. Complex cases 238

6.1 Complex cases by Subject



The graph shows that most of Pals complex and longer-term cases relate to communication issues, and relate equally to in-patient and out-patient experience.

6.2 Complex cases by Division

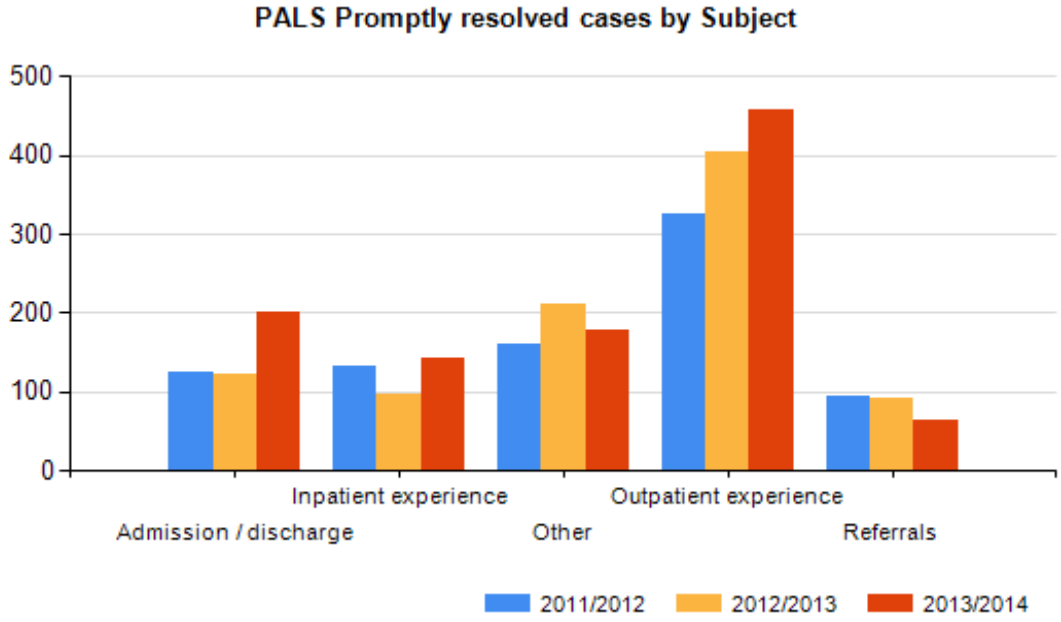


This graph shows that many of the complex issues that Pals became involved in related to Medicine & DTS (particularly Gastroenterology), Neurosciences (particularly Ophthalmology and Neurology), Surgery (particularly General surgery and Orthopaedics/Spinal) and ICI (particularly Rheumatology/Physiotherapy). This also reflects the Trust's focus on clarifying admission and other criteria for these

services which did not always coincide with the desires of families to continue to be seen at GOSH.

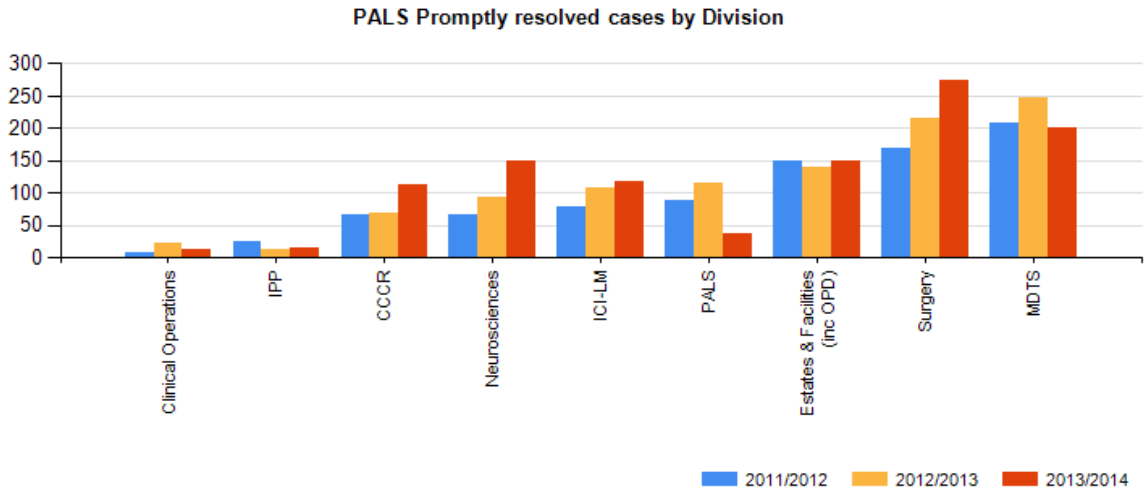
7. Promptly resolved cases 1059

7.1 Promptly resolved cases by Subject



This graph shows that most promptly resolved cases concerned outpatients – clinic letters, clinic cancellations, waiting times, obtaining test results. Issues arising on the day of appointment are usually dealt with quickly by Outpatient staff, sometimes in liaison with Pals, and escalation avoided.

7.2 Promptly resolved cases by Division



8. Learning from experience – issues identified by Pals in 2013/14

8.1. Cardiac surgery cancellations and poor communications

Pals experienced a substantial increase in concerns raised by Cardiac patients and their families in April-June 2013, due to a high numbers of patients cancelled for Cardiac surgery at short notice or on the day. This was due to having to prioritise a significant number of urgent cardiac cases, Cardiac intensive care (CICU) being very busy and Insufficient staff to operate at full capacity. Cancellations affected families who incurred additional, sometimes substantial costs and suffered the psychological effects of having 'steeled themselves' for an operation 'and then having to do it all over again'.
Cardiac's response was that they were trying hard to recruit nurses and grow the CICU but that takes time. However there was a welcome focus on the messages (and messenger) given to families when cancellation occurs, giving more consideration to families expectations and ensuring that cardiologists were better informed as to timelines for 'routine ' surgeries. This response helped, and the issue became much less significant for Pals as the year progressed.

8. 2. Poor communications about admissions and clinics, and admission delays/cancellations within the Surgery Division
These issues were highlighted in Pals quarterly reports (Q1, Q2 and after some improvement in Q3, returned to dominate Pals casework again in Q4).

Pals met with Surgery management on several occasions to discuss these concerns in detail. Surgery management have been responsive – the Division has invested in its administrative teams and employed an additional 3 members of staff to try to provide a better service to families and reduce frustration. In addition the Division has committed to improving communication through improving the information and contact details that are given on outgoing messages, revising the admission letters to include informed contact points, agreeing standing operating procedures and a tracking tool for use by office managers and trying to get Consultants to give consistent and clear information when admission is first discussed. In addition Surgery has begun an improvement project to streamline and automate the admission process with the aim of being able to plan further ahead, with more certainty and so be able to inform families about their admission with greater notice.

8.3. A rise in families concerns about parents accommodation
This is a perennial issue for Pals in that there is limited family accommodation and the Trust allocates it as fairly as it can. The expectations of families must be better managed in advance of arrival but this does not always happen and failures in pre-admission can lead to unpleasant and avoidable upset for families (and other staff); when compounded by unhelpful or frustrated staff there is always the potential for conflict.
Facilities, who manage patient accommodation state that demand for accommodation has risen - an increase of 2% utilisation of rooms in Weston House in the first half of this year in comparison to 2012/13, and a 36% increase in external hotel costs when Weston House is fully occupied. A satisfaction survey was carried out in early 2013 of Weston House users. Key actions identified included improving staff customer service skills, improving the communication of eligibility for accommodation (website), as well as better facilities such as guest wi-fi in some of the accommodation. Provision of parent accommodation is an issue for the Trust as activity increases and discussions with the Charity and other organisations are taking place
to try and identify solutions to help solve the demand issues that we face.

8.4. A rise in families concerns about fares reimbursement (distress levels as well as volume)

There was a noticeable increase in families raising concerns about getting their fares reimbursed. The fares reimbursement office experienced increased postal and face to face claims in line with the increased growth in Outpatient activity. Families who may not have claimed in the past where keener to claim their entitlement and there were still families unaware they could have claimed travel costs. A common source of conflict between staff and families occurs when families have no/wrong/or out of date evidence of eligibility and this year saw an increase in families having been duped by Congestion Charge 'scams' leaving parents upset, out of pocket and unable to be reimbursed through then national transport reimbursement scheme.

In response, an updated information booklet detailing procedure and eligibility for fares reimbursement. was launched in January 2014. It is provided to all new patients by the Central Bookings Office with the first appointment letter and will also be provided with appointment reminder letters over a six month period. Transport for London (TFL) are monitoring unauthorised sites and will be closing down all illegal sites promoting congestion charge payment. GOSH website gives accurate information and directs families to the TFL site.

8.5. Families experienced long waits and unanswered calls on the Central Bookings/Appointments line in Q3

There has been an increase in outpatient activity over the past 3 years with no additional staffing. An increase of 10% activity was seen last year. The appointment line calls average 300 per day. However, Pals experienced an improvement by Q4 when the service moved to a quiet, bespoke location which it is not front of house i.e. not at a reception desk as it was before. A business case is being submitted to increase the staffing establishment for Outpatients which includes reception/ appointment line staff in order to be able to both answer the appointment line queries and manage the demand with the increase in activity

8.6. Families would prefer to know in advance if they will be required to attend X-ray before they attend their clinic appointment

Several families fed back to Pals that they feel that they waste time waiting in clinic when they could have gone to X-ray. However, this issue needs a service by service response as the X-ray service does not book appointments – it is a walk-in service and patients requiring X-rays are identified by clinicians. An X-ray can be noted as needed before a clinic appointment or on the day of the consultation but this varies by clinic. In order to arrange for families to either have their X-ray before, or after an appointment, and direct them to the main GOSH site if needed before coming to RLHIM (X-ray in RHLIM is not always open) clinicians would have to identify whether an X-ray is required prior to that appointment and this would have to be communicated in advance to families. This issue remains unresolved and we do not know the scale of the problem.

8.7. Managing disruptive behaviour and handling conflict between staff and families

Pals was involved with advising many families, and staff, on what is usually described as "inappropriate behaviour" - on several wards (for example Squirrel, Flamingo, Badger, Bear, Rainforest and PICU) and in some outpatient clinics. It was identified that not all relevant staff have had appropriate training, that documentation of 'inappropriate behaviours' is sometimes patchy (often in relation to the most challenging behaviours), and speedier recourse to the policy is often in both parents, patients and staff interests.

There is now increasing understanding that there is a difference between current conflict management training and the training needed for doctors and ward managers to better implement the Resolving Conflict policy (which fully supports the institution when implemented). The Head of Training is developing a formal Conflict Resolution training strategy for GOSH over Summer 2014.

8.8. Parent beds on wards in Morgan Stanley Building
Many parents complained. One parent described them particularly vividly :

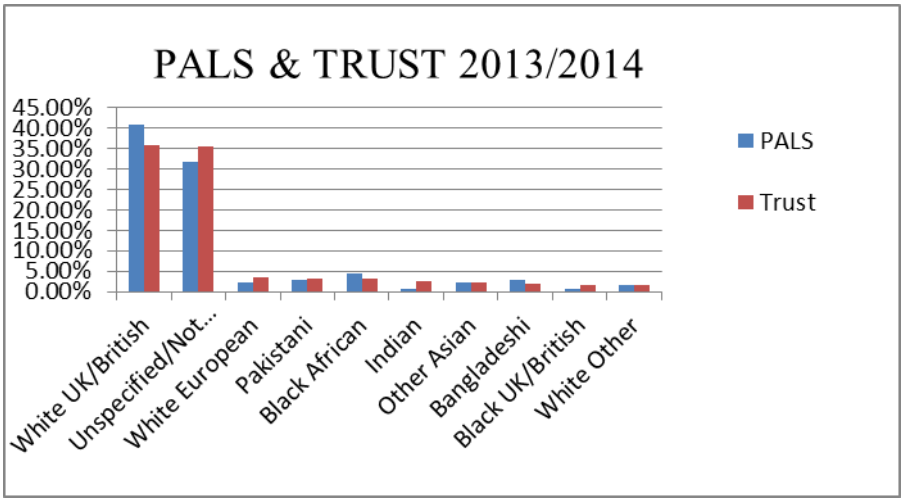
"The beds for the parent/carer in these new wards are shockingly awful. At 5ft 4, I stretched from end to end so goodness knows how anyone taller copes. Then to add to this, the outer bits go lower than the central bit which means that your head is angled down unless you have a host of pillows. Then to add to this further, because they are leatherette material, sheets and pillows slip off so you end up tangled up in a sheet/blanket mixture with your pillow on the floor within an hour of going to sleep. And then the crowning glory is that there is a ridge right the way through the centre of your back. So whoever provided the hospital with these needs to give you a refund as I can honestly say that they do not work at all in any shape or form. Bring back the Z-beds!"

Following an audit of beds in the Morgan Stanley Building it was agreed to mend all broken beds for recycling as sofas, and to source and replace all parent beds ensuring that they are properly sleep tested before purchase.

9. Source of Referrals
Pals is available via drop-in, appointment, telephone, letter and email. Self-referrals and staff referrals are the major source of Pals activity and approximately half of all referrals come either directly or indirectly from GOSH staff.

Pals welcomes staff referrals and they are overwhelmingly appropriate referrals. More than half of self-referrals come via telephone and email. A drop-in service remains important and improved signage for the new Pals Office location in Reception has been ordered.

10. Cases by Ethnicity



This chart shows that Pals users mirror the overall ethnicity of GOSH patients, the only notable feature being that Pals was used by a slightly greater proportion of Black Africans. Pals user ethnicity details are collected through the Trust's patient information system which shows that most GOSH patients are recorded as white

UK/British, or are not asked and are reported as having 'unspecified' ethnicity on the patient database.

11. Pals User Satisfaction

Satisfaction surveys were sent to Pals casework clients on case closure throughout 2013/14. Pals users were asked why they had contacted Pals, how they heard about the service, whether they had been given clear information about access, whether they were concerned that they might be treated badly if they raised a concern, whether relationships with staff improved after accessing Pals, whether their concerns were addressed in a timely manner, whether contact with Pals had led to change that resolved their concerns, what Pals had done well and what Pals could improve upon.

Overall results were positive and there were no instances of any enquirer stating that they had been treated adversely by clinical or other staff after having raised a concern.

Pals is keen to ensure that patients and families know about the process for raising concerns and annual patient surveys are used to monitor awareness of Pals, the process for making a complaint and how to give feedback. The results of the recent 2014 Ipsos Mori annual tracker survey showed a small increase in patient/family awareness of Pals following new promotional material. Pals has also helped develop posters that enable patients and their families to know the name of the ward manager or out-patient supervisor on any given shift and offers choice as to addressing their concerns locally or 'escalating' to Pals.

12. Pals Input to Staff Learning and Development

Following a number of challenging incidents on the Surgical wards Pals has provided training on the *Resolving Conflict* policy. This includes an overview of the goals of the policy, how to use it, when to escalate its use, and how to maintain appropriate records to enable escalation. Pals continues to contribute to the provision of the mandatory Conflict Resolution Training (CRT) to new staff in the Trust helping to keep staff safe and to appropriately de-escalate conflicts between staff and the public.

Pals provided customer service bespoke training for ICI/Rheumatology Consultants, junior doctors, Clinical Nurse Specialists and secretaries, and for International Private patients (IPP) and Neuroscience nursing staff. Pals staff also contributed to the Foundation Development Programme and the Principles of Care programme for health care assistants and also provided case based learning for new staff across the Trust. Pals recently contributed to ICU Consultant Interviews through participation in multi-disciplinary role plays.

13. PPIE (Patient and Public Involvement and Experience)

Pals staff continued to play a major role in PPI activity during the year, supporting the Trust's PPI/Engagement strategy 2012/15, the 2013/14 Patient Experience Action Plan and contributing to the Trust's consultations on values, extended hours and annual plan. The Pals service has increased its support for families who use the Ethics Committee and also contributes directly to the committee's work.

Pals Annual Report 2013/14 will be presented to LIMB, PPIEC, and Members Council, and it will also be made available to July 2014 Trust Board.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
23rd July 2014

Safe Nurse Staffing Report **Submitted by:** Liz Morgan Chief Nurse	**Paper No: Attachment Q**

Aims / summary

This paper provides assurance that the Trust has safe nurse staffing levels on wards, and systems in place to manage the demand for nursing staff. In order to provide greater transparency the report also includes nurse quality measures, and details of ward safe staffing reports. The paper includes an overview of vacancies and nurse recruitment.

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

- The content of the report and be assured that appropriate information is being provided to meet the national and local requirements.
- The information on safe staffing and the impact on quality of care.
- To note the key challenges around recruitment and the actions being taken.

Contribution to the delivery of NHS Foundation Trust strategies and plans
Safe levels of nurse staffing are essential to the delivery of safe patient care and experience.

Compliance with *How to ensure the right people, with the right skills, are in the right place at the right time – A guide to nursing, midwifery and care staffing and capability'* (NHS England, Nov 2013) and the *'Hard Truths Commitments Regarding the Publishing of Staffing Data'* issued by the Care Quality Commission in March 2014.

Financial implications
Already incorporated into 14/15 Division budgets

Who needs to be told about any decision?
Division Management Teams
Finance Department

Who is responsible for implementing the proposals / project and anticipated timescales?
Chief Nurse; Assistant Chief Nurse – Workforce; Heads of Nursing

Who is accountable for the implementation of the proposal / project?
Chief Nurse; Division Management Teams

Great Ormond Street Hospital for Children NHS Foundation Trust

GOSH NURSE SAFE STAFFING REPORT

June 2014

1. Introduction

1.1 The June 2014 Trust Board received the first GOSH Safe Nurse Staffing Report relating to May. This is the second such report and relates to June 2014. The report follows the previous format providing information on staff in post, incidents reported, nurse vacancies and a number of quality measures. The full list of quality measures was presented to the June Trust Board - this Board and future Trust Boards will receive exception reports only.

2. Context and Background.

2.1 The expectation is the Board '*take full responsibility for the care provided to patients and, as a key determinant of quality, take full and collective responsibility for nursing care capacity and capability*'.

2.2 *'Hard Truths'* states "*Boards must, at any point in time be able to demonstrate to their patients, carers and families, commissioners, the care Quality Commission, the NHS Development Authority or Monitor that robust systems and process are in place to assure themselves that the nursing and midwifery capacity and capability in their organisation is sufficient to deliver safe and effective care"*. To achieve this, the Board should receive a report every six months on staffing capacity and capability (provided May 2014).

2.3 In addition, monthly update reports are required to be submitted to NHS England and the Trust Board with the following information:

1. The number of staff on duty the previous month compared to planned staffing levels.
2. The reasons for any gaps, highlighting those wards where this is a consistent feature and impacts on the quality of care, to include actions being taken to address issues.
3. The impact on key quality and safety measures.

2.4 The monthly report to Trust Board should cover all three points and be available on the Trust website. Attached as Appendix 1 is the UNIFY data which will be published on NHS choices website. In May 2014, GOSH appeared as 103% staffed. Other paediatric centres staffing on NHS Choices website revealed: Birmingham 100%, Bristol 104%, Alder Hey 85% and Sheffield 87%.

3. GOSH Ward Nurse Staffing Information for Trust Board (June 2014)

3.1 Safe Staffing

3.1.1 A copy of the UNIFY submission is attached as Appendix 1. The spreadsheet contains:

- Total monthly planned staff hours derived from Heads of Nursing (HoN) submitting an agreed safe staffing level for each of their wards.
- Total monthly actual staff hours are taken from ROSTERPRO, and provides information on registered and non-registered staff dedicated to the ward area, this includes supervisory roles, staff working additional hours, CNS shifts, extra staff booked to cope with changes in patient dependency and acuity from the Nurse Bank. This may exceed 100% to meet the demands of increased dependency and acuity. Heads of Nursing comments regarding staffing numbers in 3.1.2 below.

- Bed closure information is used to adjust the planned staffing levels.
- It must be noted that presentation of data in this way is open to misinterpretation as the non-registered pool is small in comparison to the registered pool, therefore one Health Care Assistant (HCA) vacancy will have a disproportionate effect on the % level.

3.1.2 Commentary:

ICI – No unsafe shifts reported Beds closed across ICI wards periodically, due to staff sickness and vacancies. 14 new nurses going through pre-employment checks. Following assessment of patient dependency where possible, more HCAs employed to compensate for short fall in Registered Nurses especially on night duty. Staff moved between wards to maintain skill mix and patient safety.
Surgery – No unsafe shifts reported Squirrel Ward: increase in specials requiring extra Registered Nurses. Sky Ward: Beds closed due to vacancies and difficult to fill night shifts.
CCCR – No unsafe Shifts reported Badger- moving to a new ward with 3 zones has created safety and staffing concerns requiring extra staff. Bear Ward – increased patient acuity requiring additional staff. Flamingo (CICU) – have flexed above 17 funded beds up to 20 on occasions, extra staff required. NICU – increased sickness has required extra temporary staff PICU – have flexed above 13 funded beds on occasions requiring extra staff.
MDTS - No unsafe shifts reported Eagle ward: higher than normal dependency in June due to having 5 transplants in 2 weeks, plus additional patients requiring 1:1 care. Kingfisher: patient numbers at night over normal numbers (10) hence more staff required. The short falls in HCA's covered by other departmental nurses. Rainforest Endocrine/Metabolic: sickness issues for registered staff, and unable to fill shifts at short notice. Where skill mix allowed, HCA's were used to cover outstanding registered nurse shifts. Rainforest Gastro: increased IV work load in June, and unable to cover the outstanding HCA shifts at times due to 1:1 care of one patient. Trained staff worked across both sides of Rainforest to ensure safe care.
Neurosciences – No unsafe shifts reported Mildred Creek Unit – levels of staff adjusted due to fluctuations in the required level of supervision of patients.
IPP – No unsafe shifts reported Bumblebee – Increased acuity and dependency of patients requiring extra staff. Butterfly – staff redeployed for whole or part of shift to meet patient needs and shortfalls in staffing.

3.1.3 No wards reported unsafe staffing. Staff were moved within divisions to maintain safe staffing levels. 18 out of 22 inpatient wards closed beds at various points during June due to short notice nurse sickness and increased patient dependency.

3.1.4 The Clinical Site Practitioners report 10 occasions where staff were moved for part or a whole shift to maintain safe care. Two occasions relate to NICU.

3.2 General Staffing Information

3.2.1 A GOSH Recruitment Fair was held on 6th June and in excess of 150 attended, as anticipated and over 170 applications were received from experienced nurses and those due to qualify in September 2014. The shortlisted applicants will proceed to one of five assessment centres booked throughout July. GOSH staff attended the July Royal College of Nursing (RCN) Recruitment Fair in Manchester. Visitor numbers to the event were lower than expected - there were approximately 30 nurses interested in working at GOSH (a mixture of experienced nurses and those about to qualify).

3.2.2 Appendix 2 provides data at 30th June 2014, listing staff in post, vacancies and staff in the recruitment pipeline and also includes bed closures. The average bed closures has reduced from 20/day in May to 18.5/day in June. Registered and Non Registered vacancies are reported as 124 Whole Time Equivalents, 83 for registered nurses and 41 for non-registered staff. 49 registered nurses and 13 non registered staff are proceeding through pre-employment checks. Temporary Nurses (mainly from Trust Bank) employed on wards totalled 106 WTE, reducing the vacancy rate to 17 WTE.

3.2.4 It is important to note that approximately 30 of the vacancies reported last month were new posts resulting from ward nurse establishment changes and implementation of business cases e.g. Rainforest Ward reconfiguration. In addition we aim to work within the Paediatric Intensive Care Society standards of 7.1 Whole Time Equivalent Nurses for each Intensive Care bed.

4 Key Challenges

4.1 Work is underway to ensure that sufficient accommodation is available for a large number of new starters expected in September. Current band 5 and 6 staff already using hospital accommodation are being advised of the extension to the rental period from one year to eighteen months.

5 Key Quality and Safety Measures and Information

5.1 *Hard Truths* (Care Quality Commission, March 2014) states '*data alone cannot assure anyone that safe care is being delivered. However research demonstrates that staffing levels are linked to the safety of care and that fewer staff increases the risks of patient safety incidents occurring.*' In order to assure the Board of safe staffing on wards, the following nursing quality and patient experience information has been collated to demonstrate that the wards were safe during June 2014.

5.2 The following quality measures provide a base line report for Trust Board. Many are KPIs which are regularly monitored, poor results are challenged and investigated through the Nursing quarterly performance reviews led by the Chief Nurse with each Divisional Nursing team.

5.3 Infection control

- 0 - MRSA bacteraemia
- 1 MSSA bacteraemia (<48hrs after admission) Kingfisher
- 1 E-coli bacteraemia (<48hrs after admission) Butterfly
- 3 Cdiff- cases reported (>3 days after admission) all on Bear ward (small outbreak contained with no bed or ward closures required)

- 2 small outbreaks of norovirus on Butterfly and Robin wards both contained with no bed or ward closures required.
- Nursing hand hygiene compliance achieved 99%

5.3.1 All incidents are investigated via a route cause analysis and additional support put in place by the Infection Prevention and Control team. In addition, those areas that experienced small outbreaks of infection are subject to comprehensive chlorine cleans.

5.4 **Pressure ulcers**

- No grade 3 pressure ulcers reported
- 2 grade 2 pressure ulcers reported

5.5 **Deteriorating patient**

- 8 emergency calls – No cardiac arrests

5.6 **Numbers of safety incidents reported about inadequate nurse staffing levels**

7 Datix reports were received reporting inadequate nursing staff levels or skill mix by staff:

- 3 on Badger ward, these relate specifically to the impact of relocation to a new larger ward. A business case was approved for expansion of the old ward to take additional patients which included extra nursing staff to make the new layout safe. However, the temporary relocation of Miffy ward to the extra bed spaces in this area means that the business case has not been fully implemented. Badger remains at 13 beds but has the scope to increase to 15 beds, these 2 newly funded beds are declared as closed pending further recruitment.
- 2 Rainforest
- 1 Bear
- 1 NICU

These incidents are reported to the Heads of Nursing for investigation and resolution.

5.7 **PALS concerns raised by families**

- 1 concern raised about insufficient nursing staff on Bear ward
- 1 concern raised for each of the following re no bed available: Squirrel Ward, Bumblebee Ward, Walrus, Koala

5.7.1 PALS ensure that distressed families are supported and liaise with clinical teams to ensure that issues raised are addressed and that those families who have been cancelled are provided with a new date for their admission.

5.8 **Complaints**

- 1 complaint received about Kingfisher ward citing inadequate numbers of nursing staff to care for a patient. Staffing numbers were as planned but the family had not been advised that the unit was care-by-parent overnight.

5.9 **Friends and family test (FFT) data**

- Overall response rate 23.41% (target is 15%)
- FFT score 80 – up from 62 in May (Number of patients who would strongly recommend minus those who would not recommend or are indifferent. This is measured against a scale between -100 and +100)
- 81.7% of families were extremely likely and 15.6% were likely to recommend the hospital - this is a very positive improvement on the May 2014 responses.
- There were no negative responses to the FFT question.

6. Conclusion

6.1 This paper has provided Trust Board with a general overview and assurance that all wards were safely staffed during June 2014 and that appropriate actions were taken when concerns were raised. This is the second Board report on safe staffing and the Board will receive similar reports each month. We are required to ensure the validity of data by triangulating information from different sources, which has been key in compiling this report.

7 Recommendations

7.1 Trust Board to note:

7.1.1 The content of the report and be assured that appropriate information is being provided to meet the national and local requirements.

7.1.2 The information on safe staffing and the impact on quality of care.

7.1.3 To note the key challenges around recruitment and the actions being taken.

7.1.4 The Board to receive a safe staffing report on a monthly basis.

Appendix 1

			Day				Night				Day		Night	
Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
Badger Ward	340 - RESPIRATORY MEDICINE		1880	2332.6	313	230	1567	1960.05	313	100	124.1%	73.5%	125.1%	31.9%
Bear Ward	170 - CARDIOTHORACIC SURGERY	321 - PAEDIATRIC CARDIOLOGY	2497	2733.25	530	584.75	2497	2357.4	312	478	109.5%	110.3%	94.4%	153.2%
Flamingo Ward	192 - CRITICAL CARE MEDICINE		5401	6507.15	344	338	5160	6221.08	194	97.2	120.5%	98.3%	120.6%	50.1%
Miffy Ward (TCU)	340 - RESPIRATORY MEDICINE		644	673.1	322	331.75	644	539.7	322	330.3	104.5%	103.0%	83.8%	102.6%
Neonatal Intensive Care Unit	192 - CRITICAL CARE MEDICINE		2579	3361.75			2256	2745.5			130.4%		121.7%	
Paediatric Intensive Care Unit	192 - CRITICAL CARE MEDICINE		5707	6028.4	335	320.6	5707	4852.5	335	129.6	105.6%	95.7%	85.0%	38.7%
Elephant Ward	370 - MEDICAL ONCOLOGY	823 - HAEMATOLOGY	2343	2172	304	356.5	2130	1423.65	304	362.7	92.7%	117.3%	66.8%	119.3%
Fox Ward	303 - CLINICAL HAEMATOLOGY	313 - CLINICAL IMMUNOLOGY and ALLERGY	1816	1656.65	318	184	1774	1384.5	318	206.6	91.2%	57.9%	78.0%	65.0%
Lion Ward	370 - MEDICAL ONCOLOGY	303 - CLINICAL HAEMATOLOGY	1926	1797.7	287	241.5	1437	1160	287	211.5	93.3%	84.1%	80.7%	73.7%
Penguin Ward	330 - DERMATOLOGY	410 - RHEUMATOLOGY	1160	1282	341	425.5	682	684.6	341	205.25	110.5%	124.8%	100.4%	60.2%
Robin Ward	350 - INFECTIOUS DISEASES	313 - CLINICAL IMMUNOLOGY and ALLERGY	1505	1401	320	305	1462	1177.3	320	342.5	93.1%	95.3%	80.5%	107.0%
Bumblebee Ward	171 - PAEDIATRIC SURGERY	420 - PAEDIATRICS	2289	2670.6	327	517.5	1962	2267	654	347	116.7%	158.3%	115.5%	53.1%
Butterfly Ward	370 - MEDICAL ONCOLOGY	420 - PAEDIATRICS	2305	2476.6	688	687	2064	1473.7	344	336.9	107.4%	99.9%	71.4%	97.9%
Eagle Ward	361 - NEPHROLOGY		2170	2993	678	990	1356	1349	339	254	137.9%	146.0%	99.5%	74.9%
Kingfisher Ward	420 - PAEDIATRICS		1440	1561.45	864	575	307	446.3	0	11.5	108.4%	66.6%	145.4%	#DIV/0!
Rainforest Ward (Gastro)	301 - GASTROENTEROLOGY		611	802.35	611	555.5	611	641.4	611	470.1	131.3%	90.9%	105.0%	76.9%
Rainforest Ward (Endo/Met)	302 - ENDOCRINOLOGY		1016	996.5	677	486	1016	660.9	338	336.05	98.1%	71.8%	65.0%	99.4%
Mildred Creak	711- CHILD and ADOLESCENT PSYCHIATRY		828	1225.35	690	433.5	345	455.2	540	370	148.0%	62.8%	131.9%	68.5%
Koala Ward	150 - NEUROSURGERY	421 - PAEDIATRIC NEUROLOGY	2748	3011.95	327	253	3130	2715.9			109.6%	77.4%	86.8%	
Peter Pan Ward	120 - ENT	160 - PLASTIC SURGERY	1192	1185.5	460	437	1120	1073.1	0	138	99.5%	95.0%	95.8%	#DIV/0!
Sky Ward	110 - TRAUMA & ORTHOPAEDICS	171 - PAEDIATRIC SURGERY	1956	2017.8	686	727.15	1910	1578.6	0	10.8	103.2%	106.0%	82.6%	#DIV/0!
Squirrel Ward	171 - PAEDIATRIC SURGERY	101 - UROLOGY	2791	3196.7	664	729.5	2514	2412.29	0	11.5	114.5%	109.9%	96.0%	#DIV/0!

Appendix 2

Division	Ward	Established Bed Numbers	Registered Nursing staff			Non Registered							Recruitment Pipeline			
			Proposed Funded Establishment	Staff in Post	Vacancies	Proposed Funded establishment	Staff in Post	Vacancies	Total Estabslishment	Total Vacancies	Bank Used	Net Vacant	Registered Starters	Non-registered Starters	Number of unsafe shifts	Average Bed Closures
CCCR	Badger	13	32.5	33.6	-1.1	8.6	2.0	6.6	41.1	5.5	4.0	1.5	3.0	5	0	1.2
	Bear	22	47.8	42.0	5.8	9.0	7.0	2.0	56.8	7.8	7.9	-0.1	5.0	2	0	2.1
	Flamingo	17	119.0	106.0	13.0	13.1	0.0	13.1	132.1	26.1	16.4	9.7	3.0		0	0.0
	Miffy (TCU)	5	14.0	8.7	5.3	7.8	5.0	2.8	21.8	8.1	2.9	5.2	3.0		0	0.3
	NICU	8	51.5	46.4	5.1	5.2	2.0	3.2	56.7	8.3	8.4	-0.1	2.0	0	0	0.5
	PICU	13	86.0	90.3	-4.3	8.9	4.0	4.9	94.9	0.6	9.5	-8.9	5.0		0	0.4
ICI-LM	Elephant	17	35.0	26.0	9.0	5.0	4.0	1.0	40.0	10.0	2.3	7.7	6.0	0.6	0	2.0
	Fox	10	32.2	27.2	5.0	4.0	4.0	0.0	36.2	5.0	3.6	1.4	5.0		0	0.8
	Lion	14	31.0	28.0	3.0	4.0	4.0	0.0	35.0	3.0	3.0	0.0	3.0		0	2.3
	Penguin	9	15.4	13.4	2.0	4.0	4.0	0.0	19.4	2.0	2.9	-0.9			0	0.1
	Robin	10	27.0	24.5	2.5	4.0	4.0	0.0	31.0	2.5	2.7	-0.2			0	0.7
IPP	Bumblebee	21	35.0	30.2	4.8	7.8	8.0	-0.2	42.8	4.6	9.9	-5.3	6.0	2	0	1.1
	Butterfly	18	37.3	31.0	6.3	9.3	9.4	-0.1	46.6	6.2	5.1	1.1		1.4	0	0.0
MDTS	Eagle	14	39.5	36.0	3.5	10.5	11.0	-0.5	50.0	3.0	3.3	-0.3			0	0.2
	Kingfisher	16	18.2	15.3	2.9	6.3	6.0	0.3	24.5	3.2	1.6	1.6			0	0.3
	Rainforest Gastro	8	13.8	13.6	0.2	5.2	4.0	1.2	19.0	1.4	5.1	-3.7			0	0.9
	Rainforest Endo/Met	8	15.7	14.0	1.7	5.2	6.0	-0.8	20.9	0.9	3.5	-2.6	2.0		0	0.1
Neuro-sciences	Mildred Creak	10	11.8	13.0	-1.2	7.8	5.5	2.3	19.6	1.1	0.6	0.5	1.0		0	0.0
	Koala	24	45.9	42.2	3.7	5.2	5.0	0.2	51.1	3.9	4.3	-0.4	2.0	2	0	1.2
Surgery	Peter Pan	16	24.5	20.5	4.0	5.0	4.0	1.0	29.5	5.0	3.1	1.9	2.0		0	3.4
	Sky	18	31.0	25.0	6.0	5.2	5.0	0.2	36.2	6.2	2.0	4.2			0	0.1
	Squirrel	22	43.6	37.6	6.0	7.0	3.0	4.0	50.6	10.0	4.9	5.1	1.0		0	0.8
	TRUST TOTAL:	**313**	**807.7**	**724.5**	**83.2**	**148.1**	**106.9**	**41.2**	**955.8**	**124.4**	**106.8**	**17.7**	**49.0**	**13.0**	**0.0**	**18.5**

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
23rd July 2014

Annual Health and Safety Report 2013-14 **Submitted by** Director of Human Resources and Organisational Development	**Paper No: Attachment R**

Aims / summary

The annual report provides an account of non-clinical health and safety management and progress during 2013-14.

Of particular note during the year has been the establishment of new fire response protocols, new regular liaison meetings between GOSH and ICH facilities and health and safety staff, much closer integrated working within Estates and Facilities and between Redevelopment and Estates & Facilities.

Action required from the meeting

To note the annual report 2013-14.

Contribution to the delivery of NHS Foundation Trust strategies and plans

Providing an environment of zero harm for staff, patients, families and visitors is a key aim of the Trust.

The report shows that as much care and attention should continue to be provided to non-clinical health and safety management as to clinical quality and safety issues in order to demonstrably show progress towards this aim.

Financial implications

None identified

Who needs to be told about any decision

Health and Safety Committee

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

N/A

Who is accountable for health and safety

Director of Estates and Facilities
Health and Safety team
Director of HR and OD
Chief Operating Officer
Chief Executive

Health and Safety Annual Report

2013 -2014

1. Introduction

The annual Health and Safety report provides information about non-clinical health and safety incidents across the Trust for the Health and Safety Committee (HSC); an update on involvement with external agencies; and, information about key work undertaken by the Health and Safety team during the previous financial year.

2. Context

- The team is made up of two members whose role is to advise the entire Trust on all health and safety matters.
- The Health and Safety Team (HST) sits within the Estates and Facilities Directorate.
- There is no specific budget for health and safety within the department.
- Health and safety issues are reported to the Health and Safety Committee.
- The Director of HR & OD is the director responsible for Health and Safety assurance.

3. Headlines

- The number of incidents reported remains steady after the introduction of the online reporting system.
- There is a need for mandatory risk assessment training for some staff groups as currently there is a gap across the organisation.
- The pan trust intranet site is up and ready and will be overseen by the HST.
- The annual audit will be merged with the fire risk assessment process to take advantage of the merger of the teams.
- The on-going redevelopment places a strain on the day to day workings of the Trust. All construction work must have a Risk Impact Assessment in place to mitigate the risks associated with patient care and any significant impact on the Trust.
- Communication remained an issue within serious incidents. New emphasis on escalating incidents was undertaken to reduce the likelihood of a recurrence.

4. Priorities

4.1 Incident Reporting:

Regular incident reporting throughout the Trust allows the HST to investigate incidents and accidents and identify themes that may be prevalent. GOSH employees reported 862 health and safety incidents from the 1st of April 2013 to the 31st of March 2014 including 120 patient safety incidents. To help the learning process; the HST contact the reporter of incidents to ascertain the wellbeing of those involved in the incident and to establish whether there is an opportunity for learning. Subsequent learning is then spread to the relevant individuals/groups either through the Risk Action Groups, Safety Alerts or training sessions/tool box talks.

During the period, there were:

- 6 RIDDOR reportable incidents (0 reported as severe)
- 2 incidents graded as severe (Both were reported as serious incidents)
- 30 incidents reported as moderate severity.
- 283 incidents reported as low harm, and
- 427 incidents reported as no harm.

There were four serious health and safety incidents reported during the year. Each incident had a comprehensive investigation undertaken, in line with National Patient Safety Agency guidance, and subsequent action plans to promote learning and mitigate the chance of any recurrence.

4.2 Training

Staff in local areas are receiving bespoke training to meet their health and safety needs and keep them abreast of any changes in health and safety legislation. Training has been earmarked as an area for improvement following feedback from the staff survey.

With a new director starting in position and the merging of the Estates and Facilities Directorates, there has been greater emphasis placed on enhancing the safety culture within the entire Directorate. An aspect of this has been a bolstering of safety training. Staff are openly encouraged to undertake relevant courses incorporating safety aspects.

4.3 Control of Substances Hazardous to Health

COSHH issues within the Trust continue to evolve as newer, safer substances become available. COSHH folders have been implemented for staff on the wards for a number of years and are a source of knowledge relating to substances and processes. Generic COSHH assessments have been undertaken by the HST for all substances used in the clinical and non-clinical areas of the Trust.

4.4 Redevelopment Work – Cardiac Wing

Further redevelopment work will take place over the next financial year. The HST has established a good working relationship with Skanska (Primary contractor) and hold twice weekly meetings to discuss future work and any possible impact on the workings of the Trust. This will help to keep accidents to a minimum and ensure that any accidents that do occur are investigated thoroughly and openly.

4.5 Audit

The Trust has a systematic audit process in place with department types having bespoke audits for the type of work they undertake. Checklists are used in conjunction with the audits as a means of a reminder for staff to help them, and the Trust, meet its statutory targets and facilitate a process of continual improvement.

5. Progress

5.1 Successes

- Introduction of new fire response protocols.
- Closer working relationship forged with the Projects Team.
- Improved access to all health and safety risk assessments through the creation of local health and safety intranet sites with follow up 'nudge' reminders for action plans/risk assessment reviews.
- Introduction of new Control of Substances Hazardous to Health assessments.
- The team aim to respond to all incidents within one working day of reporting (100% compliance following audit of random sample incidents).
- Generic assessments undertaken of all hazardous substances used in the Trust to facilitate local area bespoke assessments.
- Improved electronic audit tool for fire assessments and health and safety room checklists introduced to improve efficiency and prevent harm.
- Training for all local areas in risk assessment (including COSHH) was introduced.

5.2 Other issues

Communication has remained a trend throughout every RCA and SI. This is not exclusively a health and safety issue. Improvements can still be made to the timeliness of reporting of issues to the HST.

Accidents reported under RIDDOR have *decreased* from 9 to 6. The prevention of serious incidents is a priority for the Health and Safety Team.

6. Conclusions

The HST has moved and now sits within the Estates and Facilities Directorate. The HST and Fire Advisor now work as one team. An electronic audit toolkit that covers both health and safety and fire risk assessments is being devised which will make most of the obvious synergies in the roles. Any remedial actions coming out of the audits will be emailed to the relevant departments to remedy in a timely fashion and monitored by the HST and Fire Team. The HSC will receive reports on all aspects of fire and health and safety, including evidence of statutory and mandatory compliance, holding all parties to account and promoting continuous improvement.

The Health and Safety Executive states that if an organisational reporting profile does not comprise of at least 70% near misses/no harm events, there is a need to raise awareness of the importance of reporting near misses. Near misses and no harm events are free safety lessons. The percentage of all health and safety incidents at GOSH comprising of near misses and no harm events is 95.7%. The Trust Board should be assured that this indicates that GOSH has a positive reporting culture and staff are aware of their health and safety responsibilities. The number of incidents reported under RIDDOR has reduced but there is no room for complacency.

There are some areas outlined above that can be improved but overall the health and safety performance of the Trust has been good.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **23rd July 2014**	
Annual Report on Infection Prevention and Control 2013-14 **Submitted by: Dr John Hartley, DIPC**	**Paper No: Attachment S**
Aims / summary To inform Board of progress and issue within Infection Prevention and Control in 2013/14	
Action required from the meeting To note and consider the content of the report and approve it for publishing on the GOSH public web site	
Contribution to the delivery of NHS Foundation Trust strategies and plans Essential to achieve zero harm; minimising risk of infection is a central Trust goal	
Financial implications Failure to prevent or control infections leads to harm and cost. Individual penalties may follow specific HCAIs in future.	
Who needs to be told about any decision? Infection prevention and control is responsibility of all staff.	
Who is responsible for implementing the proposals / project and anticipated timescales? Divisional and Corporate Units and all staff Infection Prevention and Control Team.	
Who is accountable for the implementation of the proposal / project? Director of Infection Prevention and Control	

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST INFECTION PREVENTION AND CONTROL (IPC) ANNUAL REPORT April 13 - March 14

AUTHOR: **Dr John Hartley - Director of Infection Prevention and Control (DIPC)**
Part A **Executive summary**

1 Introduction

Great Ormond Street Hospital for Children NHS Foundation Trust recognises the obligation placed upon it by the Health Act 2006, (updated 2008) to comply with the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.
The Trust supports the principle that infections should be prevented wherever possible or, where this is not possible, minimised to an irreducible level and that effective systematic arrangements for the surveillance, prevention and control of infection are provided within the Trust. This is recognised as a key Trust strategy in the Quality Statement for 2014/15:

Standard 3 Decrease and eliminate hospital acquired infections

The aim of this programme is to focus on

- prevention of exposure to and acquisition of colonisation with antibiotic resistant and other potentially pathogenic microorganisms
- Antimicrobial stewardship
- Healthcare associated infections to be eliminated - Vascular access related infection, gastrointestinal and respiratory viral infections, Surgical Site Infections (SSIs), Post intubation respiratory infection (including ventilator associated infection), *Clostridium difficile* (C. Diff) infection, urinary tract infections from indwelling catheters

The IPC programme is described in the Trust Policy 'Infection Prevention and Control Assurance Framework and Operational Policy', July 2012 (which will be updated in July 2014). This report lists the IPC team structure (and team plan) and some aspects of the policy but mainly reports the results of process (control) and outcome (infection) surveillance and audit. The data shows that a great effort is employed to reduce HCAI, but that they still occur and some are preventable. Health care associated infection is an ever present risk for patients and staff and requires constant application of best practice to reduce to a truly unavoidable minimum. In recognition of the ever growing needs for IPC input, the Trust has agreed to fund a new IPC nurse which will significantly increase the team's capacity to develop, educate, encourage and enforce best practice.

2) Description of infection control arrangements

Director of Infection Prevention and Control (DIPC) - Dr John Hartley, Microbiologist
Executive lead for IPC - Chief Nurse, Liz Morgan
Lead Nurse for Infection Prevention and Control – 1 wte, (vacant Feb to June 2014)
Deputy Lead Nurse in IP&C 1 wte, 0.4 wte Clinical Scientist in IP&C
Other consultant microbiologists – 3 PAs
IPC Administrative support and Data Management – 1 wte band 4
(The CNSs for Tuberculosis and ID lead on Tuberculosis related issues;
ID consultants contribute to the out of hours advice.)

New IPC Nurse 2014 - The IPC Team have been unable to undertake all planned activities due to staff constraints. This has been acknowledged by the Trust and an additional full time IPC Nurse post has been funded and filled in June 2014.
Antibiotic pharmacist - Part time post within pharmacy
Transformation Team Support – dashboard development and display

Divisional Responsibility
Under the terms of the Trust IPC Strategy set out previously, each Division developed a local Divisional group to drive local planning and implementation of IPC actions.

Divisions have chosen to structure this in different ways with an active IPC Board now formed and meeting regularly for the Surgical, Cardiorespiratory, International and Private Patients, Infection Cancer and Immunity and Neurosciences divisions, and as part of the Quality and Risk group for MDTS.

2:3 The Infection Prevention and Control Committee (ICC) meets every two months.

2:4 Reporting lines
The DIPC is accountable to the Chief Executive and reports to the Board and Senior Management Team.

The DIPC and Lead nurse for IPC meets weekly with the Executive lead.

A highlight report of all significant IPC issues is presented weekly to the Safety Team.

An annual plan is written and included in each annual report.

2:5 Links to Drugs and Therapeutics Committee
A Consultant Microbiologist and Infectious Disease Physician are members of the Drugs and Therapeutics Committee. There are antimicrobial working and stewardship groups.

2:7 **IPC advice and On call service.** Continuous advice service provided by IPC Team, Microbiology and Infectious Disease consultants.

3:3 Outbreak Reports
Contemporaneous outbreak reports are written by the IPC Team and fed back to clinicians and managers and disseminated through the IPC Committee.

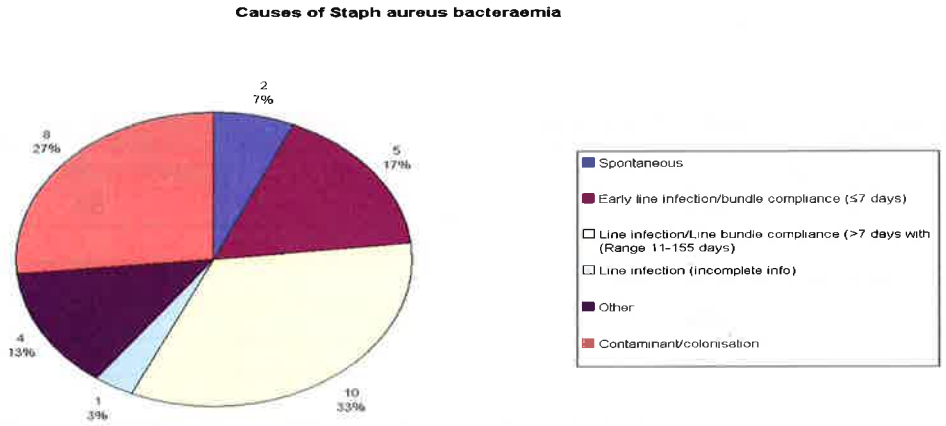
4 Budget allocation to IP&C activities

4:1 Staff
Staff budget are in Department of Microbiology, Virology and IPC, Laboratory Medicine, ICI LM

4:2 Support
IT Support and hardware is supplied within the departmental budget.
There is no separate IPC budget, but emergency outbreak funding is provided by the Trust.

5 HCAI Statistics *2013/14*

5:1 **MRSA bacteraemia =** 1 (most likely a contaminant).
5:2 MSSA bacteraemia = 32 RCAs showed line infection is the most common cause:



5:3 E. coli bacteraemias = 23 episodes

5:4 *Glycopeptide resistant enterococcal bacteraemia (GRE)* = *0*

***5:5 Clostridium difficile* associated disease** = 13 (against objective of less than 8). Case details were presented to the NHS England, London lead for Infection Prevention and Control and the Clinical Commissioning Group. It was agreed that the majority of cases do not represent a care failing and fines for exceeding the objective were not implemented.

5:7 GOS acquired Central Venous Catheter related bacteraemia = 2.1/1000 line days. While this is a low rate, there were 114 episodes. Effort is underway to reduce further.

5:9 Surgical Site Infection Surveillance

The Trust goal is elimination of all avoidable infection through implementation of a GOSH paediatric model of care (incorporating HII, NICE and WHO guidelines) and active surveillance and investigation of serious infections.

Surgical division – has established a SSIS programme including at least one procedure from each specialty. Regular reporting, including dashboard reports on important control points, has started. For the 225 procedures surveyed in 13/14, the total rate was 10%. These were mainly parent reported and further investigation is required.

Critical care and cardiorespiratory – an intermittent surveillance programme has been possible. Overall surveillance for months December 13 to April 14 covered 362 cardiac procedures and demonstrated a total % surgical infection rate of 6.6%, with no organ space infection.

Neurosciences – continuous audit is performed for permanent shunt procedures, and displayed on the dashboard. RCAs are performed for each infection and a separate audit is performed of compliance with the shunt insertion protocol.

5:10 Viral infections detected while at hospital

Children, parents and staff frequently enter the Trust incubating these common infections and act as sources for localised outbreaks. GOSH Trust outbreak and prevention policy includes isolation of children with suspected viral respiratory infection or gastro-enteritis with emphasis on recognition and early intervention.

Respiratory viral infections detected in 2013/14:			
	Total	Community onset	Hospital onset
Total	252	172	80
Enteric viral infections detected in 2013/4			
Total	360	229	131

Overall, there has been an increase in detection of viruses in children admitted to the trust. No wards were closed in 2013/14.

5:11 MRSA Admission Screening and rates

Nose and throat swab screening rate at 48 hours for inpatient admissions remaining in for > 48 hours, all patients. Target > 95%: 2013 screen compliance = 95%

Screening compliance for ICU inpatient admissions (30 day prior or within 24 hours) to critical care areas in 2013. Target 100%: 2013 PICU 98%, NICU 98%, CICU 85%.

MRSA cases of colonisation/carriage at GOSH

In 2013 there were 171 children with first detections,14 probably or possibly acquired in the hospital. Each case is investigated and no outbreaks were detected.

5:12 Multiple resistant 'gram negative' (MDRGN) organisms screening and rates

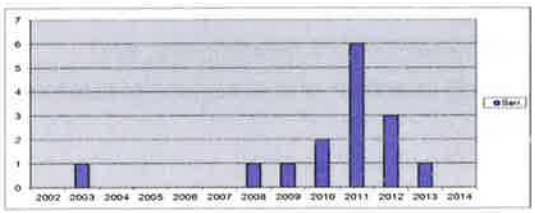
Faecal screening for inpatients remaining in for > 48 hours; target >75%: 2013 rate = 86%

MDR-GN carriage/colonisation - In 2013, testing revealed 158 first detections, 119 came in colonised, 39 were possible cross infection. No outbreaks were detected.

The organisation is at its limit in ability to apply controls mechanisms without adverse impact on other aspects of care provision, however we feel it is essential to continue to do so.

Carbapenemase resistant gram negatives and the CPE Tool Kit

There is national concern regarding the increase in carbapenemase producing enterobacteriaceae, reflected in the publication of a control Toolkit by Public Health England. CPEs have been screened for at GOSH for some years, number detected per year is shown in bar chart:



The Toolkit guidance was reviewed and debated in the Trust IPC committee. We have elected to continue with the current universal stool admission screen request (not introducing rectal swabs) and aim to improve compliance with the admission risk assessment and screening rate through education of staff. Future developments of the Trust admission documentation will need to include specific questions in the risk assessment.

5:13 Serious Untoward incidents involving Infection and major outbreaks - In the 2013/14 there was one SIs regarding admission screening for risk of developing chickenpox.

6 Hand Hygiene and Aseptic Protocols

Hand Hygiene and CVC on going care guidelines

The Trust clinical practice guidelines are available on the GOSH Web within the Infection Control link. Alcohol gel hand hygiene products are placed inside all ward areas to encourage staff, visitors and patients to decontaminate their hands within the clinical area. Compliance with the CVL ongoing care bundle is essential for the prevention of line infections. Regular audit is undertaken (see section 9).

7) Facilities Annual Report Summary - 2014

(Report from Ms Margaret Hollis, Head of Decontamination)

Estates and Facilities became one Directorate from April 2014. End users across the Trust have noted a more responsive service is being provided since the transition.

PLACE

Early indication is the PLACE 2014 assessment scores have shown significant improvement from 2013. This is sttributable to the increased involvement of a young person in the process.

Catering

Over the past year Catering has put in place a Catering Improvement Plan in response to the 2013 PLACE assessment.

Environment

Additional measures have been put in place to monitor the cleanliness of the environment.

Decontamination

The Sterile Services provision of service for GOSH transferred to Guys and ST Thomas Hospitals NHS Foundation Trust September 2013. The quality of service delivered has been monitored as deemed acceptable by the Clinical staff at GOSH.

GOSH have maintained accreditation status to BS ISO 13485:2003 for Endoscopy and Medical Equipment decontamination.

8. Estates annual report summary for IPC

(Report from Mr Brain Needham, Senior Operations Manager)

The Estate team continue to work closely with the IPC team in improving the practices of maintenance and monitoring of the ventilation and water systems. An Authorised engineer has been appointed in both disciplines.There is a programme now in place and circulated for all critical ventilation systems and acknowledged by signature from all clinical leads responsible for these areas.

Water systems continue to be tested, monitored and reported on in liaison with the IPC. MSCB continues to be closely monitored as being operated outside of the guideline under derogation, at the lower temperature of 43^0C without any problems.

Pseudomonas aeruginosa continues to be tested for but presently does not present itself as a risk under the on-going control measures undertaken by the Estates and clinical teams.

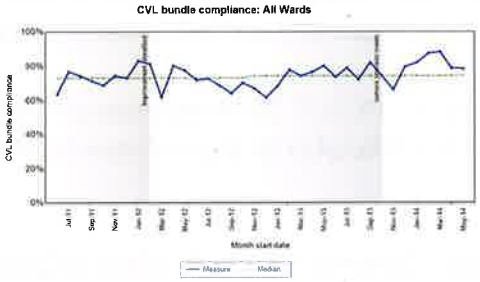
The education to all leads of the importance of having the ventilation system verification take place is in their interest to enable Estates to providing a safe operation environment for all.

The ward user manuals have been written and distributed and mainly acknowledged by all, with only two areas, being more complicated, asking for further simplification of the write up.

9 Audit

A Trust annual IPC audit programme is followed. Due to staff constraints, additional independent IPC team audit and monitoring of practice has not been carried out as planned. Individual ward and 'All Trust' compliance is published monthly on the dashboards and reviewed by Divisional and Nursing boards.

Hand hygiene and CVC care bundle audit:



Compliance rates have increased but are still not at 100% across all clinical areas.

Central Venous Line Ongoing Care

Audit of the Saving Lives HII CVL care bundle is performed monthly from all areas with frequent CVLs. A concerted effort was made during 2013/14 to elevate rate above 90%, and this was achieved, the figure for March 2014 representing 251 satisfactory observation out of 273 (rate 91%). However it has since fallen and we need to re-address this.

9:5 Antibiotic prescribing and audit

Antimicrobial stewardship was included as a CQUIN target for 13/14, based on 3 key indicators. Our CQUIN target was to improve the stewardship KPI percentage from a baseline of 45% by 20% i.e. to 54% in the March audit. We achieved 66%, so the CQUIN was achieved. Additional targets for AMS have been included as a CQUIN in 2014/15.

10 Occupational Health

OH continues to provide 'new entrants' screening, "Exposure Prone Procedures" clearance, staff immunisation (including influenza, final uptake 40%, 8% up on last year)) and blood borne virus exposure follow up (84 attendees).

11 Targets and Outcomes

11:1 MRSA bacteraemia - 1 MRSA Bacteraemias in 2013/14, with an objective of 0.

11.2 *Clostridium difficile* infection - GOSH reported 13 cases in 2013/14, against objective of 7. The target remains at less than 8. These were reviewed with the Commissioners and the Trust was not subjected to the possible fines.

11.3 MRSA Screening See 5:11

11.4 Reduction in GOS acquired CVL related bacteraemia

2013/14 CQUIN target (to maintain, within 10%, the base line from 11/12 (2.0 / 1000 line days) was achieved, with an overall rate 2.1/1000 line days.

11.6 Surgical site infection In 2013/14 the Divisions were asked to establish their own surveillance mechanisms, which they have achieved (but not sustained in CCCR). Target for 14/15 is to continue surveillance with regular feedback and undertake RCAs of all organ space infections.

11.7 Root cause analysis for S, aureus bacteraemias

For S. aureus bacteraemias with onset in GOSH. aim to achieve RCA in 100% with onset after 48 hours and not incubating before admission. This was achieved.

12. Training activities

Basic IPC training and update is provided for all staff through either e-learning, face to face teaching from the IPC team or both. Update is now only through e-learning, including assessment questions. Attendance is monitored and records are maintained by the Training Department. More detailed IPC training is provided in quarterly training days.

Hand hygiene training for staff on wards is provided locally, and by the IPC team for staff without a ward. All episodes should be recorded by the training department.

IV and aseptic non-touch technique training and update is provided for nursing staff locally but currently there is no assurance that this is provided to all medical staff.

Training and competency assessment for intravascular catheter insertion is provided locally and all divisions should be working towards a standard policy. This is not yet completed.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 23rd July 2014	
Results from first Staff Friends and Family Test survey **Submitted by** Director of Human Resources and Organisational Development	**Paper No: Attachment T**
Aims / summary To inform Trust Board of the results of the first Staff Friends and Family test survey to be run at GOSH.	
Action required from the meeting To note the results and support the actions.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Staff FFT takes place quarterly, with the results reported to NHS England and published by them. It is not yet clear how agencies such as CQC will use this information but it will form part of our evidence to them for how we meet standards. The Staff FFT provides a more frequent opportunity for the Trust to be able to test the views of staff on two key questions of whether they would recommend as a place to be treated and as a place to work, as well as providing a mechanism for asking other questions on issues such as Our Always Values. The work on Staff and Patient FFT is being undertaken collaboratively with communication and learning across the workstreams.	
Financial implications A cost pressure of £6,750 per year was identified to commission Picker to undertake the surveying and reporting work for staff FFT.	
Who needs to be told about any decision Communication of results will be via Roundabout and the Newsletter/website. Consideration will be given about how to best feedback the results by area (in particular, verbatim comments about why staff would/would not recommend GOSH).	
Who is responsible for implementing the proposals / project and anticipated timescales Helen Cooke, Assistant Director of Organisational Development	
Who is accountable for the implementation of the proposal / project Director of HR and OD	

Great Ormond Street Hospital for Children NHS Foundation Trust
Paper to the Trust Board from the Director of HR&OD
July 2014

Update on the first Staff Friends and Family Test Results

The Department of Health introduced the Staff Friends and Family Test in April 2014, with an instruction that the first test must take place by the end of June 2014. The Staff FFT is similar to the Patient Friends and Family Test – both ask whether the respondent would recommend the trust as a place to be treated - but the staff test asks also whether the respondent would recommend the trust as a place to work; the arrangements for the two tests are very different; and the Patient FFT is currently running as a pilot at GOSH.

Staff FFT

The Staff FFT questionnaire must be sent out in three of the four quarters (the annual staff survey runs in the fourth quarter). All staff in the organisation, over the course of the three quarters, must be given the opportunity to complete the questionnaire.
The results are reported to NHS England, who will make the first set available on the NHS England website in August.
The Trust has engaged Picker, who run the annual staff survey, to manage the survey process.
A "target" for each of the two questions has been set by NHS England
There is the capacity for trusts to ask additional questions. GOSH did not do so in this quarter but is likely to use this facility to track awareness and embedding of Our Always Values and other initiatives in the future.

Staff FFT at GOSH

The first Staff FFT at GOSH was run 9th-27th June.
The survey was available only electronically. A link to the survey was made available to all staff, but emails were sent to a third of our staff (approximately 1,100) as the Trust had taken the decision to survey a third of our staffing population each quarter rather than risk survey fatigue by asking all staff the same questions each quarter.

Survey results

Friends & Family Test questions

Question	Base	Picker Average	% score	Target	Target met	Change vs. last quarter	Lowest (to date)	Highest (to date)
How likely are you to recommend this organisation to friends and family if they needed care or treatment?	504	79%	96%	67%		N/A	96%	96%
How likely are you to recommend this organisation to friends and family as a place to work?	510	63%	70%	61%		N/A	70%	70%

Additional questions

Note: "Picker average" relates to scores from other trusts for whom Picker runs this survey. This will be a wide range of organisations but not all trusts use Picker and care should therefore be taken in drawing comparisons between the GOSH score and this figure.

In the absence of any comparable data specifically on the Staff FFT, these scores have been set against similar questions asked in the annual staff survey. It should be noted that the wording of these questions is not identical and the results cannot therefore be directly comparable.

TEST	QUESTION- Place to work	Agree/ strongly agree	QUESTION – Place to be treated	Agree/ Strongly agree
Staff Friends and Family Test	How likely are you to recommend this organisation to friends and family as a place to work	70%	How likely are you to recommend this organisation to friends and family if they needed care or treatment	96%
Annual Staff Survey question	I would recommend my organisation as a place to work	76%	If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	87%
Median for acute specialist trusts in **annual** staff survey *only*	I would recommend my organisation as a place to work	74%	If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	88%

The annual staff survey is a much lengthier survey, which may make staff reflect on their experience and draw a different conclusion compared to when they are responding to a single question, as in the staff FFT. However, the comments provided by staff in support of each answer in the Staff FFT (see below) will provide more qualitative rationale for staff scores which has not been available via the annual survey.
Nonetheless, the scores for these questions in both the Staff FFT and the annual staff survey show high levels of satisfaction by staff.

Comments from staff
Staff were asked if they wished to provide reasons for their answer in each case. Almost 5000 comments were received for each answer. These comments are reported to the Trust but not made public. They can be broken down by staff group and/or division but the nature of the survey process ensures that no individual or group can be identified.

Response rate
The response rate based on 1,199 recipients was 45%, ie 542 staff replied. This was much higher than expected, particularly in light of the fact that the survey was only sent out on email.

Although a third of staff were targeted by email, the questionnaire was available to all staff via a web link. For this reason, Picker indicate a response rate in their reporting to us of 14%. They advise that the Trust can choose what rate it reports (nb the response rate is not reported nationally, primarily for this reason). We believe a tiny number of staff who were not sent an email would have been aware that they were able to complete a questionnaire and we therefore consider that the 45% response rate is most accurate.

Communication

The results of the Staff FFT will be published in Roundabout and on the GOSH intranet. An article will appear in the all user electronic newsletter with highlights and referring staff to the intranet page for more information.

The next quarterly Staff FFT survey will take place between August 18th and September 5th.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
23rd July 2014

Quarter 1 Monitor Return (3 months to 30 June 2014) **Submitted by:** Claire Newton, CFO	**Paper No: Attachment U**

Aims / summary

This paper summarises the Trust's 2014/15 Quarter 1 (Q1) Return to Monitor, the independent regulator of NHS Foundation Trusts.

The Trust is reporting a Continuity of Service Risk Rating of **4** for the period 1 April to 30 June 2014.

Key points:

Finance

- The financial information included in the MONITOR template for Q1 is entirely consistent with the Month 3 Board report.
- The Trust is forecasting a Capital Service Cover rating and Liquidity rating of 4 for each quarter of the financial years 2014/15 and 2015/16.
- The Monitor plan was finalised before completion of the 2013/14 final accounts and, as a result, the capital plan for 2014/15 included some expenditure which was accounted for in 2013/14, some which is now expected to occur later and some which may be booked as revenue as it is revenue in nature, along with some changes to the capital programme and revised estimates of spend on 14015. We are required to resubmit a capital forecast for 2014/15. The summary analysis is shown in the appendix.
- Monitor have provided the opportunity for a reforecast of 2014/15 capital expenditure; this is attached at Appendix 1.

Governance

- In June, three cases of C.difficile were reported. The number of cases of C.difficile remains the most significant risk to achieving the Monitor quality governance risk rating throughout 2014/15. The Trust continues to monitor this indicator closely as a key priority. No cases of MRSA were reported in June, with no cases reported for the first quarter.
- The Trust remained 'green' against Monitor's governance risk rating in May, demonstrating compliance against all service performance measures including all cancer, elective admitted and non-admitted treatment waiting times. It is anticipated that compliance will continue in June.
- The Trust has plans in place to ensure on-going compliance with all relevant governance targets and is committed to comply with all known targets going forward.

Other

- There are no other matters arising in the quarter requiring an exception report to Monitor.

Action required from the meeting

The Board is asked to approve the Quarter 1 'In-Year Governance Statement' and Capital Expenditure Declaration (see overpage) prior to submission to Monitor.

Contribution to the delivery of NHS Foundation Trust strategies and plans

Financial Stability and Health

Financial implications An unqualified return is important for ongoing sustainability
Who needs to be told about any decision? Monitor
Who is responsible for implementing the proposals / project and anticipated timescales? CFO re the submission
Who is accountable for the implementation of the proposal / project? CEO re the good governance of the Trust

In Year Governance Statement from the Board of Great Ormond Street Hospital for Children

The board are required to respond "Confirmed" or "Not confirmed" to the following statements

Board Response

For finance, that:

The board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.

For governance, that:

The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.

Otherwise:

The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework page 22, Diagram 6) which have not already been reported.

Consolidated subsidiaries:

Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds.

Signed on behalf of the board of directors

Signature _____ Signature _____

Name Baroness Tessa Blackstone **Name** Julian Nettel

Capacity	Chair	**Capacity**	Interim Chief Executive
Date	23 July 2014	**Date**	23 July 2014

The proposed response to the first three statements is 'CONFIMRED'. The Trust has no subsidiaries.

Capital Expenditure Declaration for Great Ormond Street Hospital for Children

Declaration 1

The Board anticipates that the trust's capital expenditure for the remainder of the financial year will not materially differ from the attached reforecast plan.

Signed: _____

On behalf of the Board of Directors

Acting in Capacity as: Chief Finance Officer

Great Ormond Street Hospital for Children NHS Foundation Trust
Trust Board - July 2014
Q1 capital re-forecast - Summary

		Total
Plan submitted to Monitor		55.106
Re-forecast		34.586
Difference	**-**	**20.520**
Expenditure planned in 14/15 but incurred in 13/14	-	2.432
Revenue items	-	2.742
Phase 2B demolition costs	-	3.519
Slippage into 15/16	-	3.454
Re-forecast spend (e.g. revised timing)	-	7.569
Estimated in-year VAT recovery on prior year expenditure	-	0.500
Other	-	0.304
Total	**-**	**20.520**

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 23rd July 2014	
Trust Board Terms of Reference and Board Calendar **Submitted by:** Dr Anna Ferrant, Company Secretary	**Paper no: Attachment V** For approval

Aims / summary

The terms of reference have been reviewed and updated. A revised version of the terms of reference is attached at appendix 1 and amendments are shown in highlighted text. The terms of reference have been reviewed against the recently approved 'Schedule of Matters Reserved to the Board of Directors' (Monitoring and leadership responsibility of the Board).

The Board Calendar has been reviewed and updated in light of the changes to national reporting requirements (safe staffing report) and monitoring of the various strands of the Trust strategy. Following agreement at the Board for the Clinical Governance Committee to receive patient stories (4 times a year), and the Board to receive one patient story, the Calendar has been updated to reflect this. The Calendar is attached with this paper.

Review of compliance with the Board terms of reference in 2013-14

Attendance at meetings
There have been no changes to the Board membership during the previous 12 months.

Voting members of the Board all attended at least 5 formal Board meetings a year, including the two strategy days.

Publication of papers

Agendas and papers for the public section of all Board meetings are placed on the Trust website two working days prior to the meeting.

Board evaluation

The Board of Directors had planned to undergo an independent evaluation in the fourth quarter of 2013/14. However, the Board agreed that an independent assessment should be conducted after a substantive Chief Executive has been appointed, in the fourth quarter of 2014/15.

During 2013-14, the Board agreed to undergo a self-assessment evaluation of its focus on quality and safety and its assurances of the management of risk and the frameworks in place to support business planning. The results of the self-assessment evaluation were positive and recommendations arising from the evaluation are in the process of being implemented.

The directors on the Board undergo an annual performance review against agreed objectives, skills and competences and agree personal development plans for the forthcoming year.

Action required from the meeting To approve the amendments to the terms of reference and the updated Board Calendar.
Contribution to the delivery of NHS / Trust strategies and plans The terms of reference provide a written framework of how the Board operates.
Financial implications No direct financial implications.
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? N/A
Who needs to be told about any decision N/A
Who is responsible for implementing the proposals / project and anticipated timescales? The Board of Directors and Company Secretary.
Who is accountable for the implementation of the proposal / project The Board of Directors

Great Ormond Street Hospital for Children NHS Foundation Trust

BOARD OF DIRECTORS' TERMS OF REFERENCE

The Trust has Standing Orders for the practice and procedures of the Board of Directors (Annex 9 of the Constitution). For the avoidance of doubt, those Standing Orders take precedence over these Terms of Reference, which do not form part of the Trust's Constitution.

1. Constitution

The Trust is governed by the NHS Act 2006 (as amended by the Health and Social Care Act 2012), its Constitution and its Terms of Authorisation granted by the Independent Regulator (the Regulatory Framework).

2. Role

The role of the Great Ormond Street Hospital NHS Foundation Board of Directors is:

- To provide leadership in establishing and promoting the values and standards of conduct and ethical behaviour for the Trust and its staff;
- To establish a clear strategic direction, by setting strategic objectives that are reflected in an explicit set of key deliverables and performance indicators;
- To seek and receive assurance on the quality of the Trust's services, promoting high standards of effectiveness, patient safety and patient experience;
- To monitor the Trust's performance, ensuring that the necessary financial and human resources are in place for the organisation to meet its objectives and deliver its business plans; that systems are in place to minimise the risk of adverse performance; and, to take account of independent scrutiny of performance including scrutiny from councillors, regulators and other external stakeholders;
- To ensure the Trust develops and implements appropriate risk management strategies and policies to deliver its Annual Plan and comply with its Care Quality Commission registration and Monitor's Terms of Authorisation and licence conditions, systematically assessing and managing its clinical, financial and corporate risks.
- To ensure that strategic development proposals have been informed by open and accountable consultation and involvement processes with staff, patients, councillors, members, the wider community and other key external stakeholders, as appropriate.

- To exercise financial stewardship, ensuring that the Trust is operating effectively, efficiently and economically and with probity in the use of resources;

- To demonstrate a commitment to learning and improvement and development of extensive internal and external feedback systems.

- To demonstrate a commitment to openness and transparency in the Trust's relationship with staff, patients, the public, councillors, members and other stakeholders;

- To ensure that the Trust is operating within the law and in accordance with its constitution, statutory duties and the principles of good corporate governance.

The annual work-plan documents the Board of Directors' reporting and monitoring arrangements, including reporting from the following committees:

- Audit Committee
- Clinical Governance Committee
- Finance and Investment Committee

In addition, a report of the business conducted at each of the Members' Council meetings shall be presented at a meeting of the Board of Directors for information.

3. Membership

The Board of Directors shall comprise 12 directors excluding the Chairman.

There shall be 6 non-executive directors. The Deputy Chairman may deputise for the Chairman. No other person will be authorised to deputise for a non-executive director.

There shall be 6 executive directors:

- the Chief Executive
- Chief Finance Officer
- Chief Operating Officer
- Co - Medical Directors (2) (Co-Medical Director) – joint appointment and vote
- Chief Nurse and Families' Champion
- Director of Human Resources and Organisational Development

The Non-Executive and Executive Directors listed above hold a vote.

The Board may approve deputies with formal acting up status.

4. Attendance at meetings

The Board of Directors is committed to openness and transparency**.**

The main body of the meeting shall be held in public and representatives of the press and any other members of the public or staff shall be entitled to attend.

Members of the public and staff shall be excluded from the first part of the meeting due to the confidential nature of business to be transacted, or due to special reasons stated in the resolution and arising from the nature of the business of the proceedings.

In addition to Board of Directors' members, the following individuals shall be entitled to remain during confidential business:

- Director of Planning and Information
- Director of Redevelopment
- Director of Research and Innovation
- Director of International Private Patients

Other senior members of staff may be requested to attend the confidential session by invitation of the Chairman.

These invited individuals do not hold a vote.

5. Quorum

No business shall be transacted at a meeting unless at least five directors are present including not less than two independent non-executive directors, one of whom must be the Chairman of the Trust or the Deputy Chairman of the Board; and not less than two executive directors, one of whom must be the Chief Executive or another executive director nominated by the Chief Executive.

An officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

Participation in a meeting by telephone, video or computer link shall constitute presence in person at the meeting.

6. Frequency of meetings

The Board of Directors shall normally hold 6 formal Board meetings a year

In addition to the above meetings, the Board of Directors shall reserve the right to convene additional meetings as appropriate.

Executive directors and non-executive directors are expected to attend a minimum of 5 formal Board meetings per year.

7. Performance evaluation

The Board of Directors will undertake an evaluation of its own performance on an annual basis. Every third year evaluation of the Board will be led by an external facilitator.

Directors will be subject to individual performance evaluation on an annual basis:

- The Chief Executive will evaluate the performance of the executive directors;
- The Chairman will evaluate the performance of the non-executive directors and the chief executive;
- The Senior Independent director will evaluate the performance of the Chairman.

Committees of the Board will conduct an evaluation of their effectiveness on an annual basis.

Appropriate action will be taken where recommendations are highlighted.

8. Secretariat

The Company Secretary shall act as Secretary to the Board of Directors.

The minutes of the proceedings of Board of Directors meetings shall be drawn up for agreement and signature at the following meeting.

Signed minutes shall be maintained by the Secretariat.

Agendas and papers for the public section of all Board meetings shall be placed on the Trust website two working days prior to the meeting.

9. Review of the terms of reference

These Terms of Reference shall be reviewed annually by the Board of Directors or following amendments to the Trust's Standing Orders, Reservation and Delegation of Powers.

July 2014

TRUST BOARD CALENDAR 2014-15

Area of Work	Responsible Executive/Director/ Company Secretary	January	February	March	April	May	June	July	August - NO MEETING	September	October	November	December - NO MEETING
CONFIDENTIAL ITEMS													
Legal Report including claims	CC	√						√ Annual					
Serious Incident Report	ME	√		√		√		√		√		√	
Red complaints report	RW	√				√		√				√	
Remuneration Committee Summary of Minutes	AF	√				√							
Nominations Committee Summary of Minutes	AF	√				√							
PUBLIC ITEMS													
Performance, Quality and Risk													
Patient/ Carer Experience Story	LM									√			
Inpatient/ Outpatient Survey results	LM												
Staff survey results	AM												
Infection Control Report including HoN input	LM			√				√ and annual DIPC report				√	
Child Protection and Safeguarding Report	LM					√ (annual							
Annual Health and Safety report	ME							√					
Performance Report -Targets and indicators & P&E & **compliance with licence (MonLic)** - Finance and activity - Workforce - Quality and Safety - Patient Experience (PExp) -**Overview of complaints (Comp)**	Executives	√ Pexp & MonLic & Comp		√		√ Pexp & MonLic & Comp		√PExp Annual & MonLic & Comp		√		√ Pexp & MonLic & Comp	

TRUST BOARD CALENDAR 2014-15

Area of Work	Responsible Executive/Director/ Company Secretary	January	February	March	April	May	June	July	August - NO MEETING	September	October	November	December - NO MEETING
Safe Staffing Report	LM	√	√	√	√	√	√	√	√	√	√	√	√
Equality and Diversity Annual Report	CC	√											
Assurance framework	RB	Summary				√				Summary			
Clinical Presentation **(TO BE REVIEWED)**	RW	√		√		√		√		√		√	
Trust wide risk register summary	ME					√							
Redevelopment Update	MT	√ - sustainable dev plan								√			
Update on research activities	DG	√						√					
Strategy and Planning													
Annual Plan Strategic Objectives (progress with goals)	RB	√				√				√			
Annual Plan Strategic Objectives (review for forthcoming year)	RB										√		
Quality Strategy	ME	√				Quality Report							
Risk Management Strategy	RW									√			
Annual Plan approval	RB			√									
Corporate Governance													
Approval of annual accounts	CN					√							
Approvall of annual report	AF					√							
External Auditor Management Letter	AF											√	
Monitor self-certification statements	RB/CN	√			√			√			√		

TRUST BOARD CALENDAR 2014-15

Area of Work	Responsible Executive/Director/ Company Secretary	January	February	March	April	May	June	July	August - NO MEETING	September	October	November	December - NO MEETING
CQC registration overview - Intelligent Monitoring Report (CGC reviews)	AF					√						√	
Review of compliance with the Code of Governance	AF					√							
Trust Board ToR and Board Calendar	AF							√					
Review of Matters reserved to the Board and Members' Council	AF					√							
Review of Scheme of Delegation, Standing Financial Instructions and Standing Orders	CN											√	
Clinical Governance Committee Summary of meeting	AF			√		√		√				√	
Finance and Investmant Committee Summary of meeting	CN			√		√		√				√	
Audit Committee Summary of meeting	AF			√		√		√				√	
Members' Council Report including update on membership	AF			√		√		√				√	
Risk Management Training/ Code of Conduct update	AF			√ - Conduct				√ - Risk					
Register of Interests and gifts (annual)	AF			√									
Register of Seals	AF	x		x		x		x		x		x	
Board evaluation	AF			√									

√ = Standing Item

x = By exception

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
23rd July 2014

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

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 November 2013.

Date	Description	Signed by
26/06/14	Postgraduate medical training verification form	ME

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

ATTACHMENT X

Great Ormond Street Hospital for Children NHS Foundation Trust

Update from the Audit Committee meeting held on 23rd May

The focus of the agenda and discussion was the year end account and other year end reports along with risk.

Internal Audit

The Committee noted three final internal audit reports: Risk Management and the Board Assurance Framework; Compliance with Monitor's NHS provider licence; and Incident reporting which had all provided 'adequate assurance', the highest possible level.

The Trust's internal auditors KPMG described the Trust's risk management systems and processes as robust but suggested the Board consider streamlining the process. The Committee agreed that this should be done alongside action currently being taken to base risk identification on the Trust's business model. This review would commence at the special risk management meeting in July.

It was reported that KPMG had reviewed the processes in place for raising concerns and agreed that these processes were also rated 'adequate'. KPMG explained that as there were no cases of whistleblowing (within the meaning of the Public Interest Disclosure Act) a full internal audit could not be conducted.

The Committee agreed that it would consider the Trust's disaster recovery and business continuity plans at its October meeting.

Chief Finance Officer's Review of the Annual Accounts 2013-14

The Committee welcomed the Trust's strong performance during the year and the significant rise in clinical income across all divisions. The Chief Finance Officer said that in areas of subjectivity the Trust had applied a consistent approach to previous years.

Commissioning Contract for 2014/15

The Committee received an update on discussions around the 2014/15 commissioning contract with NHS England and noted that it was expected that a signed contract would be in place by the end of June 2014.

External Audit Report on the Financial Statement Audit for the 12 month period ended 31st March 2014

The Committee noted that the significant increase in property valuation had been looked at by a specialist and there had been similar increases in the per hectare value of neighbouring plots. It was agreed that going forward the Trust would only commission valuations once every five years as required.

Deloitte confirmed that they were comfortable with the Trust's debtor position and the position with the NHS England commissioning contract for 2014/15.

Foundation Trust Final Accounts and Remuneration Report (1st April 2013 – 31st March 2014)

The Committee discussed the accounts and agreed that they were understandable to external parties. The Committee recommended the annual accounts to the Board for approval subject to a number of less material matters which were raised by Committee members outside the meeting.

The Audit Committee also recommended the following document to the Trust Board for approval:

- Letter of Representation – subject to the addition of the issue of materiality
- Annual Report (1st April 2013 – 31st March 2014) including the Annual Governance Statement
- Audit Committee Annual Report to the Trust Board

Quality Report

It was noted that the external auditors had provided a positive review of the report. The Committee noted the concerns around waits in pharmacy which had not been reduced through the year. The Audit Committee recommended the report to the Board for approval.

Head of Internal Audit Opinion

The Committee noted that the Head of Internal Audit Opinion is that substantial assurance can be given that there is generally a sound system of internal control in place at the Trust.

Compliance with the Code of Governance

It was reported that the Trust would be giving explanations in two areas: the schedule of matters reserved for the Board and Members' Council and the responsibilities of the Chair and Chief Executive; and in terms of fit and proper person documentation. It was noted that the fit and proper person test had only been implemented since January 2014 and so the Trust was unable to report compliance for the full year.

Assurance Framework and high level risks

It was reported that reputational risk had been added to the assurance framework following comment at the previous Audit Committee meeting. It was agreed that all risks with a catastrophic outcome, strategic and reputational risks would be considered by Board assurance committees and other risks would be reviewed by the Risk Assurance and Compliance Group.

The Chief Executive said that his primary concerns were capacity constraints associated with staffing levels and instilling a culture of efficiency and productivity.

The Committee considered the following high level risks:

<u>Risk 8A: Reduction in funding available to NHS organisations and Risk 8D: Failure to deliver a feasible commissioning contract</u>

The Committee agreed that it was important to look at the risk going forward in terms of the external environment, risks in relation to changes in specialist tariffs and market forces uplifts. It was stressed that GOSH was influencing this where possible through membership of national groups and also working with the Children's Alliance. It was agreed that modelling would take place based on how the Trust would react to various potential future scenarios.

<u>Risk 8I: Failure to have the right framework in place to make fully informed business decisions</u>

It was agreed that the focus placed on this risk through the work on strategy and the prioritisation of the Executive Team had put the Trust in a good position in this regard.

ATTACHMENT Y

Great Ormond Street Hospital for Children NHS Foundation Trust

Update from the Clinical Governance Committee meeting held on 9th July 2014

Patient Story

The Committee received a patient story from a former patient treated under three specialties. Alongside reporting a generally positive experience, recommendations to improve patient experience were made in three areas: waits, co-ordination of care; and, transition. The requested that the recommendations are followed up.

It was agreed that the Committee would continue to receive patient stories in a similar style.

Development of Integrated Care Pathways

The Committee noted the value and work required in developing care pathways and suggested that a core template approach be taken. It was agreed that updates in this area would continue to come to the Committee.

Assurance Framework

The Committee welcomed the 'adequate' rating which had been provided following the internal audit on risk processes and the Board Assurance Framework and the recommendation to streamline risk processes to make them more efficient.

It was noted that Health Education England had agreed to host a roundtable of specialist paediatric Trusts and other organisations to look at issues with the number of children's nurses nationally .

The Committee looked at risk 1D: *Lack of a systematic approach to development of organisation and people may compromise our effectiveness of service and compromise our ability to deliver a compassionate and effective service*. It was reported that following the work on the Trust strategy, the risk score had been reduced.

Review of findings outlined in 'From the Coalface'

It was confirmed that issues raised in the 'visit of concern' by Health Education North Central and East London had been addressed as had others which could be completed in the short term. Some longer term issues had solutions in progress. It was reported than an interim informal visit had been undertaken and was positive.

The Committee acknowledged that there was likely to be resource implications arising from the recommendations and it was reported that an offer had been made to provide funding if specific proposals were made.

Quality and safety impact of the Productivity and Efficiency programme

The Committee noted that of the three schemes considered , two had delivered an improvement in patient experience and there had been no reduction in quality for the remaining scheme.

Gastroenterology

It was reported that further meetings would take place to continue to define issues and actions to support the gastroenterology team. It was confirmed that work had taken place to map the desired organisational structure for the team and it was stressed that work must be consistent following previous work with the team.

The Committee agreed that they would receive regular updates around this work.

CQC Compliance

It was reported that the Trust had moved from a six to a five in the CQC intelligent monitoring report based on results from the PLACE inspection. It was confirmed that clarification was being sought about when the results from the most recent PLACE inspection would be used.

Update from Learning, Improvement and Monitoring Board (LIMB)

It was reported that work was being undertaken with the Head of Internal Communications to discuss the way in which the outcomes from LIMB were communicated across the Trust.

Head of Nursing Report

The Committee congratulated the nursing team on work undertaken to improve education on the reduction of pressure ulcers which had resulted in 99% pressure ulcer compliance and 50% reduction in grade 3 pressure ulcers.

Child Protection and Safeguarding Update

It was noted that safeguarding training levels were good in comparison with other Trusts. It was reported that work was on-going to ensure it was clear to honorary consultants when updates on training are required.

Internal Audit Progress Report

It was confirmed that ‘adequate’ assurance had been provided for incident reporting and the processes in place for raising concerns.

Clinical Audit Update

It was reported that an issue with the management of neonatal jaundice had been recognised by the Quality and Safety Group and a real time audit was being undertaken. It was confirmed that the materials issued to nurses was being redesigned.

ATTACHMENT Z

Meeting Summary

FINANCE AND INVESTMENT COMMITTEE

Monday 28 April 2014

NHS England Contract status

The committee were briefed on the status of negotiation with NHS England and advised that expected date for completion was now June

2013/14 Financial Performance

The committee discussed the analysis of the financial performance:

- activity had risen at higher rates than clinical income due to the overall average tariff deflator of -1.3%. Private patient activity was below plan in areas outside the dedicated facilities;
- capital expenditure was lower than plan, particularly for medical equipment but this was due to procurement timescales and had not adversely impacted services;
- The Trust's efficiency target had been achieved through a combination of growth in activity and cost reductions.

Productivity Report

It was noted that:

- haematology oncology growth levels was higher than other providers and that activity per staff member had also increased;
- the Trust had seen an increase in outpatient activity and part of this was a result of changes following a review of outpatient capacity utilisation;
- average length of stay was falling but the Committee asked whether there was any adverse impact of this such as readmission rates rising;
- it was agreed that further information would be reported in the future to enable patient activity lost due to nursing staff constraints to be monitored.

Southwood Imaging Suite

The Committee discussed the reasons for the cost overrun and **agreed to recommend to the Trust Board for approval**.

Procurement Strategy Update

- The role of the Procurement team was discussed and whether they should be more involved in demand management.
- JR challenged the reasons why there were so many waivers .
- It was agreed that a review of the performance of the new consortium arrangements would be carried out and options for introducing additional expertise and reported at the next meeting.

Terms of Reference

The Committee agreed that there was overlap with the Audit Committee and that this would be rationalised.

Strategy Process - Finance and Funding

The Committee discussed key elements of a future funding strategy and agreed that a recommendation should be taken to the Board.

Great Ormond Street Hospital for Children NHS Foundation Trust

Update from the Finance and Investment Committee meeting held on 13th June 2014

2014/15 to 2018/19 Five Year Strategic Plan

The Committee discussed what should be included in the narrative and agreed that further discussion would take place at the June Trust Board. A discussion took place around the assumptions feeding into the planned numbers and the level of capital investment. It was agreed that some changes would be reflected and an updated version be circulated. The Committee were alos provided with the Corporate Governance Statement.

Productivity and Efficiency Programme

The Committee discussed the programme and agreed that a detailed paper be discussed at the August meeting.

NHS eProcurement Strategy Brief

The Committee agreed to defer discussion on the eProcurement strategy to the August meeting.

Reference Costs Statement

The Committee discussed the process and the learning points that had arisen. The Committee supported the submission.

Committee Terms of Reference

The Committee agreed to defer this item to the August meeting.

ATTACHMENT 1

Attachment 1

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council update

A Members' Council meeting was held on Wednesday, 25th June

The Council discussed an update which was provided on the provision of parent/carer beds in the Morgan Stanley Clinical Building. It was stressed that along with the beds not being as robust as expected, they were also very uncomfortable. It was agreed that prior to purchase, beds should be trialled by parents in a ward setting.

A presentation was received on the results of the Inpatient Experience Survey 2014. The Council welcomed the improvements made in a number of areas identified as priorities following the 2013 survey but expressed disappointment in the unexpected reduction in satisfaction with pain management. It was confirmed that work had begun to look into the causes and it was noted that the pain team were not a Trust wide resource and it was expected that doctors and nurses were able to manage pain.

The Council received an update on the work which had been done to engage with volunteers in advance of changes to the staff constituency. The Chairman emphasised that the change was not in any way indicative of volunteers not being valued and that this would be communicated. It was noted that the communications plan was being developed in conjunction with the Membership and Engagement Committee.

The Council discussed a revision to the policy for non-audit work which would be implemented in the event that the Trust's external auditors offered to provide pro-bono support. The Council stressed that it was vital to ensure that there was no conflict of interest in the event that such an offer was accepted and asked that the Trust consider whether the firm offering pro-bono support were the best organisation to undertake the work. The amendment was approved on a one year basis and it was agreed that this would be considered again in a year's time to ensure the Council were satisfied with the agreement.

The Council expressed some concern at the drop in IPP income based on the same point in 2013/14. It was confirmed that this was not due to competition from other providers and was likely to be caused by high levels on activity at the beginning of 2013/14 and Ramadan at the beginning of 2014/15 reducing activity levels.

The Council discussed the issue of a lead consultant and agreed that it was vital for families to be able to make contact with relevant individuals when necessary. It was agreed that the suggestion of having a separate team which could be contacted by families of children with complex conditions would be explored further as would rolling out 'my daily plan' from the pilot in Koala Ward to include the name of a child's consultant.

The Council discussed the public consultation on the development of the Centre for Research into Rare Disease in Children which would be discussing the proposal with Camden Council. The Members' Council recommended that a senior team should attend meetings with Camden Council.