Great Ormond Street Hospital for Children NHS Foundation Trust

Meeting of the Trust Board
27th September 2017

Dear Members

There will be a public meeting of the Trust Board on Wednesday 27th September 2017 at 10:30am in the **Charles West Room**, Great Ormond Street, London, WC1N 3JH.

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

AGENDA

	Agenda Item **STANDARD ITEMS**	Presented by	Attachment
1.	**Apologies for absence**	Chairman	**Verbal**
Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.			
2.	**Minutes of Meeting held on 25 May 2017**	Chairman	**A**
3.	**Matters Arising/ Action Checklist**	Chairman	**B**
4.	**Chief Executive Report**	Chief Executive	**Verbal**
5.	**Patient story**	Chief Nurse	**C**
6.	**Board Committee Updates:** • **Audit Committee Update – May 2017** • **Quality and Safety Assurance Committee update – July 2017 meeting** • **Finance and Investment Committee Update – June 2017 and September 2017 (Verbal)**	Audit Committee Chairman QSAC Chairman Finance and Investment Committee Chairman	**D** **E** **F**
7.	**Members' Council Update – June 2017**	Interim Chairman	**G**
	STRATEGY		
8.	**Fulfilling Our Potential: An update on our Trust's strategy** **Charles West Division – presentation on implementation of the Trust Strategy**	Director of Planning and Information Divisional Chair (Charles West Division)	**H**
	PERFORMANCE		
9.	**Integrated Quality Report - 31 August 2017** **Including:** • **Annual Complaints Report 2016/17**	Interim Medical Director/ Chief Nurse Chief Nurse	**I** **J**

	• **Annual PALS Report 2016/17** • **Learning from deaths** • **Annual Infection Control Report 2016/17**	Chief Nurse Interim Medical Director Director of Infection, Prevention and Control	**K** **L** **M**
10.	**Integrated Performance Report – 31 August 2017 including report on theatre utilisation** **Finance and Workforce Update (31 July 2017)**	Director of Planning and Information Chief Finance Officer/ Director of HR and OD	**N** **O**
11.	**Better Value 2017/18 Summary**	Programme Director	**P**
	ASSURANCE		
12.	**Safe Nurse Staffing Report: May - August 2017**	Chief Nurse	**Q to follow**
13.	**Medical Revalidation Annual Board Report and Statement of Compliance**	Associate Medical Director	**R**
14.	**Staff Survey and Listening Events Update**	Director of HR and OD	**S**
15.	**CQC Action Plan Update**	Company Secretary	**T**
16.	**NHS Workforce Race Equality Standard**	Director of HR and OD	**U**
	GOVERNANCE		
17.	**Register of Seals**	Company Secretary	**V**

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 29th November 2017 in the Charles West Room, Great Ormond Street, London, WC1N 3JH.

ATTACHMENT A

Attachment A

Great Ormond Street Hospital for Children NHS Foundation Trust

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

Present

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

In attendance

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

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

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

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

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

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

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

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

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

ATTACHMENT B

Attachment B

TRUST BOARD – PUBLIC ACTION CHECKLIST
September 2017

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
54.3	20/07/16	It was agreed that work would take place to investigate the status of the tier 4 mental health services tender and to give consideration to highlighting the gap in services. It was agreed that an update and recommendation on these matters would be provided at the next meeting.	NG	TBC	Not yet due. An update will be provided to the Board once the national tender for the service has been published
152.1	01/02/17	Baroness Blackstone, Chairman asked whether the national tender for tier 4 mental health services had been published. Dr Peter Steer, Chief Executive said that it was expected to be received in the near future and GOSH had already begun to engage with other London organisations around the mental health landscape.			
158.8	01/02/17	It was agreed that the next research and innovation report would include focus on non-grant based direct funding such as enterprise. The report would also include the impact that the Zayed Centre for Research into Rare Disease in Children would have once on line to research as a whole and to the Trust's income.	DG	January 2018 (as part of strategy reporting to Board)	Not yet due
192.5	29/03/17	A report on theatre utilisation would be provided at the next meeting.	NG	July 2017	On agenda as an appendix to the Integrated Performance Report
197.5	29/03/17	It was agreed that feedback from the GOSH Children's Charity and UCL GOS Institute of Child Health would be provided at Trust Board seminar sessions in rotation.	AF	May 2017	To be built in to the Board Development Programme

Attachment B

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
10.3	25/05/17	Discussion took place about a proposal to work with the Cognitive Institute. It was suggested that there was no other organisation which could provide the package of work which was required and work would take place to ensure this was the case for procurement purposes.	DH	June 2017	Actioned
11.5	25/05/17	It was agreed that the Interim Chairman would write to the patients and families involved in the patient story to thank them and provide them with an update on actions.	MM	July 2017	Actioned
13.3	25/05/17	Mr Akhter Mateen, Non-Executive Director said that he had attended the staff listening events and requested the raw data collected from this session. It was agreed that an update would be provided to the Board on the key issues arising from the staff listening event including proposals to take forward solutions.	AM	September 2017	On agenda: Item 15
14.2	25/05/17	The Committee had reviewed the Trust's property estate and Mr Lomas recommended that this was also reviewed by the Board. It was agreed that this would be incorporated into an update on facilities. The Committee had emphasised the importance of learning from the development of the Centre for Research in Rare Disease in Children before the Trust progressed phase 4.	MT	November 2017	Not yet due
16.6	25/05/17	It was agreed that in future years an annual report from the Finance and Investment Committee would also be included in overall annual report.	AF/DL	May 2018	Noted
18.1	25/05/17	Dr Ferrant presented the paper and highlighted the areas which GOSH were required to undertake on a 'comply or explain' basis. It	MM	May 2017	Actioned

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
		was agreed that typographical errors would be provided to Dr Ferrant outside the meeting.			
19.2	25/05/17	Professor Rosalind Smyth, Non-Executive Director asked when there was likely to be an improvement in cancellations as a result of the focused work that was taking place in this area. Ms Grinstead said that currently work was taking place to consider the protocol that was in place to cancel operations. She said that GOSH was applying the full definition for the cancellations and it was clear than many organisations did not do this. It was agreed that a deep dive would be presented at the next meeting of the Quality and Safety Assurance Committee.	NG	July 2017	Considered at July 2017 QSAC meeting
19.3	25/05/17	Mr David Lomas, Non-Executive Director commended the improvements made to the layout of the report. He suggested the inclusion of the attrition rates of nurses after one and two years at GOSH and the ratio of nurse vacancies to the number of offers made. It was agreed that this would be considered outside the meeting. Further consideration would also be given to including research information in future performance reports.	NG/JG	September 2017	On agenda
20.2	25/05/17	Staff Friends and Family Test results: Discussion took place around being clear on the Trust's vision and it was noted that only 42% of staff were clear what this was. It was agreed that consideration would be given to updating the wording to be clear about what staff were required to understand.	AM	September 2017	The wording under the Staff FFT will be revised following consultation during 'Strategy Week' and then used in Q4 Staff FFT.

Attachment B

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
21.3	25/05/17	It was agreed that a deep dive would take place at QSAC on the relationship between the social work and safeguarding teams.	JG	July 2017	Added to QSAC action checklist
21.4	25/05/17	It was agreed that the QSAC statement in the report should be amended to be clear that safeguarding issues were escalated by the Committee to the Board.	JG	July 2017	Actioned
22.2	25/05/17	It was agreed that the definition for the standard nursing ratios by patient age and ward would be included in the next safe nurse staffing report along with a glossary of terms.	NG	July 2017	On agenda
23.2	25/05/17	A presentation which had been provided to the General Medical Staffing Committee on nurse recruitment and retention would be provided to the Board.	JG	TBC	To be considered for the November Strategy Board Meeting
24.1	25/05/17	The following amendments to the Quality Report were agreed: • Add in mention of the Trust's excellent cardiac outcomes • Make the paragraph on journal presentations more prominent	DH	May 2017	Actioned
25.2	25/05/17	Dr Peter Steer, Chief Executive confirmed that learning was disseminated quickly and it was agreed that consideration would be given to including dates in the report that these actions had been completed.	JG/DH	July 2017	On agenda under Integrated Quality Report
25.4	25/05/17	It was agreed that QSAC would consider the process that was currently in place around the national guidance on learning from deaths.	DH	July 2017	Added to QSAC action checklist

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27 September 2017

Patient Story – RJ **Submitted on behalf of** Juliette Greenwood, Chief Nurse	**Paper No: Attachment C**

Aims / summary

The Great Ormond Street Hospital Patient Experience Team works in partnership with ward and service managers, the Patient Advice and Liaison Service (PALS), and the Complaints and Patient Safety Teams to identify, prepare and present suitable patient stories. Each story includes information of actions which were taken to improve aspects of a service, if applicable and share good practice. Stories which are selected represent a range of families' experiences across a variety of wards and service areas, ensuring that the experience of families is captured.

The story to be shared on Wednesday 27 September 2017 has been pre-recorded and details a parent's and patient's observations of their experiences at Great Ormond Street Hospital over the past eight years (she is currently 10 years old). There are examples of their past and recent experiences as an inpatient (she still visits GOSH regularly). The video shown will be a shortened version of a longer film which will be available to staff via the intranet.

Action required from the meeting

Review and comment

Contribution to the delivery of NHS / Trust strategies and plans

- The Health and Social Care Act 2010
- The NHS Constitution 2010
- The NHS Operating Framework 2012/13
- The NHS Outcomes Framework 2012/13
- Trust Values and Behaviors work
- Trust PPIEC strategy
- Quality Strategy

Financial implications

None

Who needs to be told about any decision

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

Emma James – Patient Experience and Engagement Officer

Who is accountable for the implementation of the proposal / project

Herdip Sidhu-Bevan– Assistant Chief Nurse Quality and Patient Experience

Author and date

Emma James – Patient Experience and Engagement Officer – Sept 2017

ATTACHMENT D

Attachment D

Update from the Audit Committee meeting held on 25 May 2017

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

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

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

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

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

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

Quality Report 2016/17

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

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

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

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

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

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

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

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

Board Assurance Framework at 31 March 2017

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

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

- Risk 9: Unreliable data

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

- Risk 13: Business Continuity

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

Risks identified at/or since the last meeting:

- IR35 Compliance

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

- Cyber security incident

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

Review of non-audit work conducted by the external auditors

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

Assurance of compliance with the Bribery Act 2011

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

Update on raising concerns

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

Matters to be raised at Trust Board

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

ATTACHMENT E

Attachment E

Great Ormond Street Hospital for Children NHS Foundation Trust

Quality and Safety Assurance Committee update
12th July 2017

Integrated Quality and Safety Update

The Committee noted that a Never Event had taken place which was being fully investigated and that negative feedback had been received around catering. It was confirmed that an external catering organisation were currently engaged and were working closely with the estates team. A red complaint had been received and it was confirmed that once the investigation had been completed, learning would be disseminated in the usual way and followed up.

Update on Gastroenterology

It was reported that the Royal College of Paediatrics and Child Health had returned to begin their follow up review of the gastroenterology service.

Quarterly Safeguarding Report (April - June 2017)

The continued increase in safeguarding activity was highlighted and it was confirmed that this was in line with national activity levels.

The Committee discussed the safeguarding training of honorary staff and it was confirmed that an action plan had been put into place to bring training completion levels into line with the rest of the workforce. The Chief Nurse and Director of HR agreed to would work with the HR team at the UCL GOS Institute of Child Health, reporting to the Director of the Institute if any input was required.

Update on issues arising from patient stories presented at Trust Board in January and March 2017

It was confirmed that the previous committee chairman had written to the families and patients to thank them and provide an update on the recommendations that had been made in their stories.

Education and Training Update (an excellent place to work and learn)

The Committee noted the importance of the two year nurse development programme in recruiting the majority of newly qualified nurses nationally.

The Committee noted that a staff listening event had taken place and that the most frequently received feedback had been about career pathways for administrative staff. It was agreed that an update on this would be presented at the next meeting.

Board Assurance Framework (BAF) Update

The Committee received updates on the following high level risks:

- Risk 7 Recruitment: The risk that due to external factors, there will be insufficient nursing graduates available to work at GOSH

It was agreed that a deep dive would take place to model the potential impact of the removal of bursaries and Britain's exit from the European Union.

- Risk 11 Research Hospital Status: The Trust may not deliver its full Research Hospital vision if key research alliances are not fostered

A number of ongoing actions were in place around building an embedding a research infrastructure within the Trust. It was confirmed that research hospital updates would be included in strategy updates to the Board and research related patient stories would be received.

Update on media case

The Committee received an update on the high profile media case and reiterated the support of the Board for the Executive Team's work under very difficult circumstances.

Compliance Update

It was reported that all actions arising from the CQC report had been completed and 17 of 33 recommendations from the Well Led Review had also been closed. A positive meeting had taken place with NHS Improvement to discuss progress with the Well Led Review.

Health and Safety Update

Work on the sharps programme was coming to an end and it was anticipated that the Trust would be fully compliant by the next meeting.

Whistle blowing update

It was confirmed that the Trust had thoroughly reviewed the issues raised in an incidence of whistleblowing to the CQC and Health Education England had described GOSH's response as 'comprehensive'.

Update from Audit Committee (April and May 2017)

It was reported that the Audit Committee had expressed some concern about the number of staff who had experienced violence, bullying and harassment which was higher than had been anticipated. When triangulated with information from sources such as leavers' surveys the Committee had felt that further work was required. It was agreed that this would be considered at the October QSAC meeting.

Internal Audit Progress Report (April - June 2017)

The internal audit report on complaints was presented which had provided significant assurance with minor improvement potential.

Internal and external audit recommendations update

KPMG reported that they were satisfied with the Trust's progress to reduce the number of outstanding recommendations.

Clinical Audit update April– March 2017 including clinical audit workplan for 2017/18 including action

An audit had shown that the Trust had not fully implemented learning points arising from a Serious Incident investigation into falls. Mr Pearson confirmed that an action plan was in place and this would be followed up with a re-audit in October 2017.

Discussion took place around 7 day services and an audit that had been undertaken on the Trust's capacity for timely consultant reviews and ongoing reviews for emergency admissions. A consultation was taking place on a proposal around the consultant rota. It was reported that this

was a national issue and that when benchmarking had taken place with other PICUs, GOSH had not been an outlier. The Committee requested an update at the next meeting including data collated from weekend activity such as complaints to help the committee be assured about the availability of consultants.

Update on quality and safety impact of Fit for the Future programme (linked to BAF risk 2: Productivity)

The Committee approved the proposal for post implementation reviews.

ATTACHMENT F

Attachment F

Great Ormond Street Hospital for Children NHS Foundation Trust

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

Productivity and Efficiency Review 2017/18 Plan

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

International Private Patients Capacity Growth Business Case – Post Implementation Review

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

Phase 4 – Health Service Plan

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

Finance Report 2017/18 Month 2

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

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

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

Review of aged debt profile over 181 days

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

Initial approach and agreement of bench marking to other paediatric Trusts

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

NHS Contract Update 2017/18

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

Procurement Update including dashboard

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

Capital Programme Update

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

Patient/Reference Cost Annual Submission

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

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

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

ATTACHMENT G

Attachment G

Great Ormond Street Hospital for Children NHS Foundation Trust

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

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

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

Audit Committee May 2017

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

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

Process for appointment of two NEDs

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

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

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

Update on implementation of the Always Values

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

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

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

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

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

Councillor activities
The following activities were reported:

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

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

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

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

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

Chief Executive Update

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

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

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 27 September 2017	
Fulfilling Our Potential: An update on our Trust's strategy **Submitted by:** Nicola Grinstead, Deputy Chief Executive/ Peter Hyland, Director of Planning and Performance	**Paper No: Attachment H**
Summary This paper presents an update on Great Ormond Street Hospital NHS Foundation Trust's Strategy Refresh. It also describes the 'Strategy Festival' planned to launch the strategy within the organisation.	
Action required from the meeting The Board is asked to note the refreshed strategy and the proposed strategy "festival".	
Contribution to the delivery of NHS Foundation Trust strategies and plans Timely refresh of the strategy and direction.	
Financial implications Secure and diversified funding underpins the strategy	
Who needs to be told about any decision? Trust Board and internal stakeholders. Key external contacts of the Trust need to be kept informed of progress.	
Who is responsible for implementing the proposals / project and anticipated timescales? Deputy Chief Executive / Director of Operational Performance and Information	
Who is accountable for the implementation of the proposal / project? Chief Executive	

Part One: Fulfilling Our Potential, a Trust Strategy Update

1. Fulfilling Our Potential

Over the past eight months, the organisation has refreshed the organisational strategy in a document called 'Fulfilling Our Potential'.

The process of refreshing our strategy enabled a reassessment of the challenges and opportunities that exist in the current environment and to evaluate the current strategy as an adequate response and roadmap for our future direction. The process has helped to revise our goals, bolster programme ownership, and further clarify the necessary actions to ensure we deliver on our mission. A series of events supported the refresh process and included:

- 100+ focused interviews with key stakeholders across the Trust.
- Executive Management Team (EMT) sessions to review and feedback.
- Away day to collect feedback from the Senior Management team (SMT).
- Trust Board reviews in February and March 2017.

2. Our strategy, Fulfilling Our Potential, sets out our vision, mission, and priorities and links them to our organisational values

Fig. 1 shows our strategy as a house "designed from" children's building blocks.

Fig. 1: Fulfilling Our Potential is our strategy for placing the "child first and always" and ensuring we are helping children with complex health needs fulfil their potential.

Our mission, why Great Ormond Street Hospital (GOSH) exists, is to ensure the child is first and always. While our mission describes our purpose, our vision, what we hope GOSH will be in the future, is help children with complex health needs to fulfil their potential. This has been and remains the inspiration for all our staff.

Our vision is underpinned by four priorities or goals - safe, efficient, and effective care (children); recruitment and retention (people); research and innovation (research); and harnessing technology (technology). These priorities require the organisation to have the right capabilities, resources, and programmes of work, defined by our four enablers -working with our partners; use state-of-the-art equipment; use of information and evidence; and we will diversify our sources of funding.

Our aim is for our vision and mission to inspire all staff, with our strategy forming a framework for choices and decisions that will impact positively on our patients experience. As a consequence, our values form its foundation. They confirm our commitment to being always welcoming, always helpful, always expert, and always one team. These values will guide our clinical, operational, and corporate activities (e.g. how we implement service improvements and drive research). A series of deliverables sit under this plan and are shown in appendix 1.

3. Engagement and strengthening our ongoing strategy-development process are two important areas that will help to drive our future work.

While the senior teams have already adopted our refreshed strategy, the focus must now move to the rest of the Trust. We are taking several actions to help strengthen engagement and ensure all staff understand the strategy and their role in its execution. Critically, we will hold a 'strategy festival' in November to launch our refreshed strategy across the organisation. The "Festival" will run for one week with a launch day and a focus on each of the four pillars over the other days. The programme will include activities around our core projects, brainstorming sessions, patient stories, an inspiration wall, and speaking events, all aimed to integrate the strategy into organisation. We want staff to own the strategy and to empower them to have choice and control in delivering against the strategic vision.

Appendix 1: Objectives and Enablers

Priority	Objective			Exec sponsor
We will achieve the best possible outcomes through providing the safest, most effective and efficient care	Clinical services	1.1	Be recognised for our expertise and clinical innovation in developing, delivering and leading specialised paediatric services	CEO
	Quality	1.2	Be recognised for our quality of care, positive health outcomes and experience for children and families	MD & CN
	Access	1.3	Provide timely access to care for all GOSH patients	Dep. CEO
	Better value	1.4	Deliver efficient care in order to generate a sustainable surplus and allow us to invest in our transformation	Dep. CEO
We will attract and retain the right people through creating a culture that enables us to learn and thrive	Culture	2.1	Use our values and behaviours to build a positive and diverse culture where staff are inspired to give their best	Dir. HROD
	Talent	2.2	Be renowned for our talented staff and for the ever improving quality of work they do	Dir. HROD
	Leadership	2.3	Have leaders at all levels of the Trust who are effective, visible, supportive and respected by their teams	Dir. HROD
	Education	2.4	Provide our staff with the skills and capabilities needed to deliver exceptional care from world-class facilities	MD
We will improve children's lives through research and innovation	Research	3.1	Accelerate the translation of all research into improved patient outcomes	Dir. R&D
	Reward	3.2	Build a culture of innovation and continuous improvement where the talent and creativity of all staff is harnessed	CEO
We will transform care and the way we provide it through harnessing technology	Digital	4.1	Become a digitally mature organisation, radically transforming patient, family and staff experience of our services	Dep. CEO
	Technology	4.2	Ensure rapid uptake of the latest clinical and non-clinical technologies to improve patient outcomes and our productivity	Dep. CEO

Enabler	Objective			Exec sponsor
We will use our voice as a trusted partner to influence and improve care	Voice & advocacy	5.1	Use the voice of GOSH to promote issues that directly affect the children and families who need us the most	Dir. Comms
	Networks & partners	5.2	Play a leading role in the UK system and international children's alliance, and to ensure our networks across UK best serve the patient's needs	Dir. Comms
We will create inspiring spaces with state-of-the-art equipment to enhance care delivery and learning	Environ-ment	6.1	Be recognised as the most environmentally sustainable healthcare provider in the UK with all staff recognising their stewardship role	Dir. Redev
	Site	6.2	Maximise our site's potential to meet current and future healthcare needs	Dir. Redev
	Equipment	6.3	Provide our clinical teams with the equipment they need to deliver cutting-edge care to our patients	Dir. Redev
We will provide timely, reliable and transparent information to underpin care and research	Informatics	7.1	Develop the Business Intelligence Unit to be the single integrated source of accurate, timely and reliable performance data (incorporating operations, finance and workforce)	Dep. CEO
	EPR	7.2	Create a comprehensive, unified electronic single patient record, providing the single reliable source of clinical data to maximise staff productivity and deliver excellent care	CFO
	Research data	7.3	Combine advanced analytics with a comprehensive set of data, to inform and improve care	Dir. R&D
We will secure and diversify funding so we can treat all the children that need our care	NHS funding	8.1	Develop and negotiate a funding model which reflects the true cost of care, the new collaborative clinical pathways, and allows capacity to be flexed for variable levels of demand	CFO
	Charity funding	8.2	In conjunction with GOSHCC, maximise value and impact of charitable funding in support of the GOSH strategy	CFO
	Commercial funding	8.3	Develop and grow new sources of commercial income within the UK and internationally by making best use of our specialist expertise in patient care, education, diagnosis and research	CFO

Attachment I

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27th September 2017

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

Aims / summary

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

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

Action update: (for July 2017 meeting)

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

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

The Trust is currently part of a pilot scheme with NHS England which allows SI reports to be submitted without an action plan; action plans may then be submitted six weeks after the report. The aim of the pilot is to ensure that action plans are appropriately disseminated and actions are allocated correctly.

Action required from the meeting

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

Contribution to the delivery of NHS Foundation Trust strategies and plans

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

Financial implications

No additional resource requirements identified

Who needs to be told about any decision?

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

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

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

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

Medical Director and Chief Nurse

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

Integrated Quality Report

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

September 2017 (covering June-August 2017)

Index

Great Ormond Street Hospital for Children NHS Foundation Trust

Safety

Care/ Experience

Outcomes/ Effectiveness

Improvement

Has patient care been safe in the past?

Measures where we have no concerns

Great Ormond Street Hospital for Children NHS Foundation Trust

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

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

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

Data Quality Kite-mark	Measure	Comment
	**Non-2222 patients transferred to ICU by CSPs**** ** patients should be transferred to ICU before they have an arrest where possible which would indicate the early identification of a deterioration prior to an arrest.	This measure is currently being reviewed by the Resuscitation Lead Nurse and the ICU Information Manager. Issues have been identified with the data in this measure but they are expected to the have been resolved and re-presented within the next month.
	**Cardiac arrests**** **The figures within the Integrated Quality Report includes arrests within all areas outside of ICUs (including day case Wards, day units, outpatient areas and non-clinical areas e.g. main reception) whilst the Safe Staffing Report arrest data only refers to arrests on in-patient Wards . The data will therefore differ between the two reports as the Integrated Quality Report includes additional areas.	Overall, the data remains stable for this measure at 2 cardiac arrests per month; this has remained stable since 2015 with the exception of one outlier in January 2017 however this was not statistically significant. The process is in normal variation at GOSH; there have been no runs, trends or outliers identified.
	Cardiac arrests outside of ICU	**Respiratory Arrests outside of ICU (see slide 5 for more information)**
June 2017	1 (Rainforest Gastro)	1 (Bear)
July 2017	0	2 (Badger x2)
August 2017	2 (Butterfly, Bear)	9 (Badger x 7, Giraffe x1 and Lion x1)
	**Mortality**	The data remains stable at 6.3 deaths per 1000 discharges; the process is in normal variation and has been since 2014. There have been no runs, trends or outliers identified.

Has patient care been safe in the past?

Measures where we have no concerns

Great Ormond Street Hospital for Children NHS Foundation Trust

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Data Quality Kite-Mark	Measure	Comment
	**Never Events**	The last Never Event was in May 2017 (111 days ago; this was 332 days after the previous Never Event). The process remains in normal variation at one event every 425 days on average. The baseline for this data is from 2010 until 2014. The Never Event declared in May 2017 is for a retained object while the previous Never Event was due to medication given via a misplaced NG tube.
	**Serious Incidents**** ****by date of incident not declaration of SI**	The data had shown a reduction in serious incidents reported per month from 1.2 to 0.7 however the most recent 3 months performance indicate that this reduction has **not** been sustained and therefore a step change will not be implemented for the measure. There have been 1 SI reported in June 2017 and 1 in July 2017 . None were reported in August. If we look at a more sensitive measure (days since previous SI) then it looks as though they have become less frequent but more data is needed before a judgement can be made.
	**Hospital acquired pressure ulcers reported (grades 2+)**	Performance remains within normal variation at 6.7 per month.

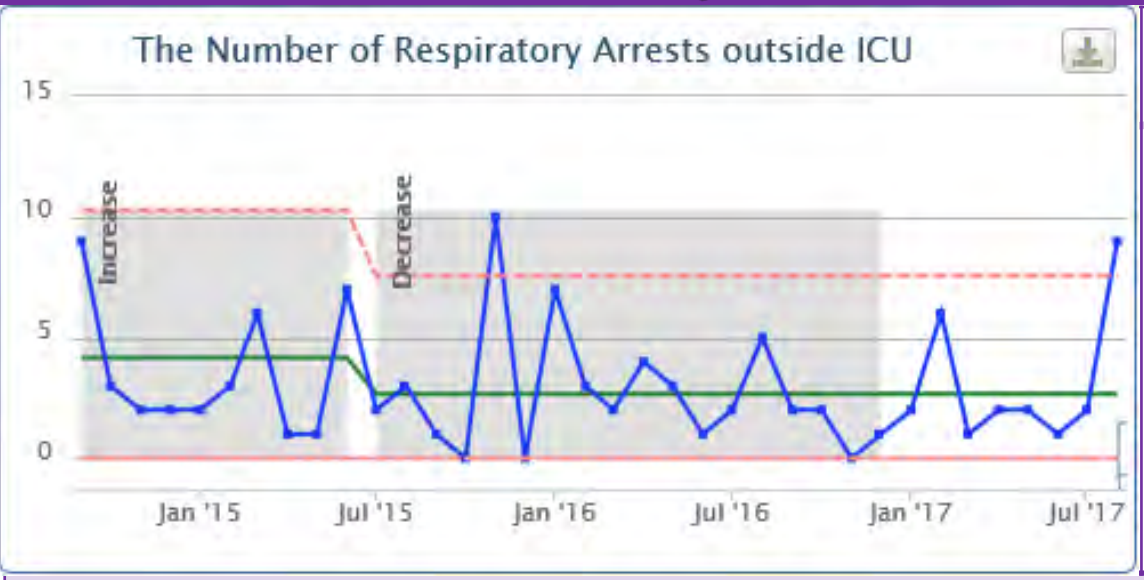
	June 2017	July 2017	August 2017
Grade 2 hospital acquired pressure ulcers	**5** (4 are device related)	**3** (3 are device related)	**5** (3 are device related)
Grade 3 hospital acquired pressure ulcers	**0**	**0**	**1** (1 device related)
Grade 4 hospital acquired pressure ulcers	**0**	**0**	**0**

	**GOSH-acquired CVL infections**	The data remains stable at 1.8 CVL infections per 1000 line days.* The grade 3 hospital acquired pressure ulcer is device related; an RCA has been undertaken with senior input and the pressure ulcer has been deemed unavoidable. **The Quality and Safety team use Statistical Process Control (SPC) for measuring performance. This enables us to analyse the variation in a process and differentiate between 'common cause' and 'special cause' variation. This allows us to determine with some statistical rigour when there are improvements in processes. The methodology used in the 'Integrated Performance Report' is different where the trend is determined by comparing the performance of the 2 previous months.* *SPC also enables us to calculate average performance for a process which is the figure we quote. The 'Integrated Performance Report' gives the performance figures for the 3 most recent months only.*

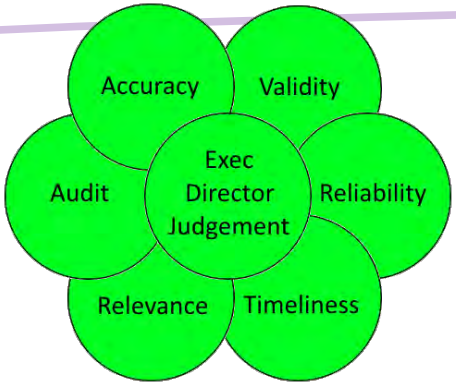
Has patient care been safe in the past?

Important measures of interest

Great Ormond Street Hospital for Children NHS Foundation Trust



Data Quality Kitemark:



Respiratory Arrests Outside of ICU

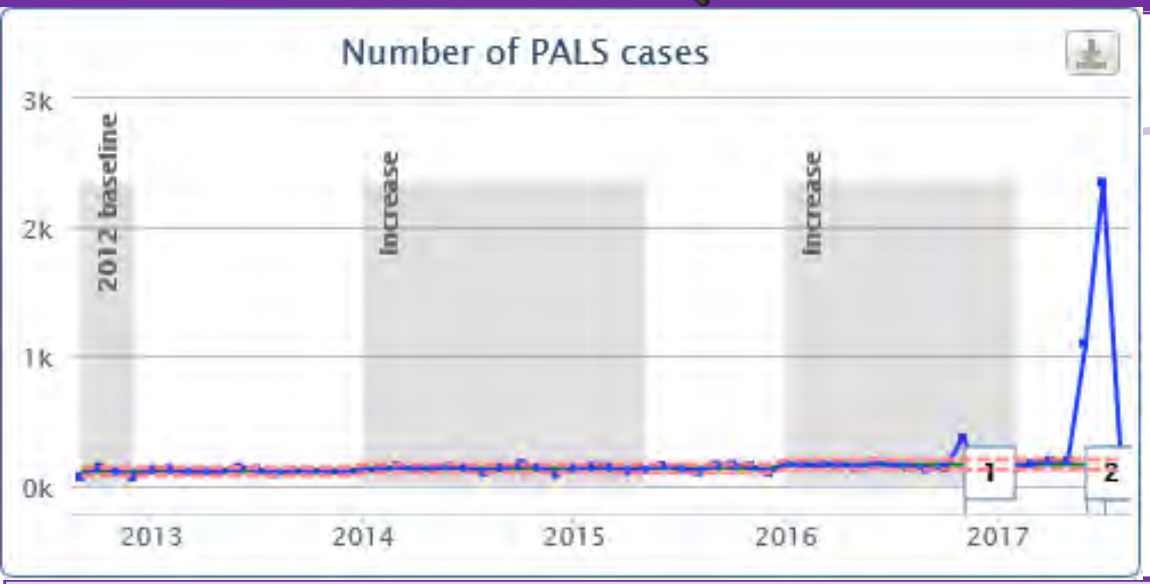
	Respiratory Arrests outside of ICU
June 2017	1 (Bear)
July 2017	2 (Badger x2)
August 2017	9 (Badger x 7, Giraffe x1 and Lion x1)

This month there has been a rise in respiratory arrests. The main reason is due to a patient admitted for management of respiratory arrests.
Over the month ward teams have demonstrated excellent management of the respiratory arrests. All respiratory arrests were classified on the RECALL as not preventable.

Has patient care been safe in the past?

Important measures of interest

Great Ormond Street Hospital for Children NHS Foundation Trust



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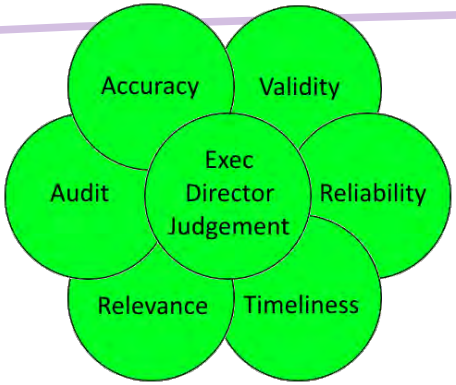


PALS cases

Since 2012 onwards the total numbers of Pals cases have increased incrementally but in small degree each year.

Social media campaigns are becoming more prominent causing a significant increase in Pals cases in relation to specific issues.
There have been three recent issues in social media and two of these issues have been picked up by traditional media too.
The three issues include :

1. The campaign by London Black Taxi Cabs being unhappy about the GOSH website advertising the use of mini cabs
2. The response to ill-chosen words used by a GOSH staff member on the BBC Question Time program.
3. The prominent case of a child on NICU at GOSH and the plans for his end of life care.

In the graph above, the two largest of these three issues are visible. We expect that social media campaigns will happen again and the Trust needs to review how it receives and responds to these social media campaigns and how patients, families and staff are supported.

Has patient care been safe in the past?

Serious Incidents and Never Events

Great Ormond Street Hospital for Children NHS Foundation Trust

Serious Incidents and Never Events June-August 2017			
No of new SIs declared in June-August 2017:	3	No of new Never Events declared in June-August 2017:	0
No of closed SIs/ Never Events in June-August 2017:	2	No of de-escalated SIs/Never Events in June-August 2017:	0

New SIs/Never Events declared in June-August(3)

STEIS Ref	Incident Date	Date Report Due	Description of Incident	Divisions Involved	Senior Responsible Officer (SRO)	Patient Safety Manager	Executive Sign Off	Divisional Contact
2017/ 15541	18/05/17	13/09/17	Deterioration – probable preventable hypoglycaemic seizure	Charles West	Associate Medical Director	Lead Patient Safety Manager	Interim Medical Director	Divisional Co-Chair, Charles West
2017/ 15567	08/06/17	13/09/17	Delay to remove infected central line	JM Barrie/ Charles West	Associate Medical Director	Patient Safety Manager	Interim Medical Director	Divisional Co-Chair, Charles West
2017/ 20094	26/07/17	09/10/17	Patient had worsening lower limb neurology after diagnostic MRI for spinal surgery under general anaesthetic.	JM Barrie	Deputy Medical Director	Lead Patient Safety Manager	Interim Medical Director	Divisional Director for Portfolio B, JM Barrie

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Great Ormond Street Hospital for Children NHS Foundation Trust

Learning from closed/de-escalated SIs in June- August 2017 (2):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:

SI 2017/ 10146	A human tissue sample was sent to the Great Ormond Street Hospital (GOSH) cytogenetics team for genetic analysis from the patient's local hospital, Basildon and Thurrock University NHS Trust (BTUH). Once analysis was complete the intention was to send it back to the patient's local hospital. GOSH sent the sample via Royal Mail recorded delivery on 14 February 2017. A signature was obtained by Royal Mail for acceptance of this sample but this did not specify which hospital had received the sample.
	Staff at BTUH realised that they had not received the sample and contacted GOSH on the 24 March 2017 to inform staff that this sample was missing. GOSH launched an investigation via Royal Mail and, on 7 April, it became apparent that the sample had been sent to Broomfield NHS Trust in error. The sample has since been located and retrieved from Broomfield Hospital and sent on to Basildon and Thurrock University Hospital as originally intended.
		The storage of all address labels for all recipient hospitals together meant that that administrative staff accidentally selected the incorrect location for the parcel to be sent to.	• To ensure that all address labels for all hospitals are kept separately
			  • Each hospital in the Essex area to be allocated its own plastic wallet
			  Action complete
			• To ensure that all paperwork for sending back human tissue from pregnancy loss is second checked as per local protocols
			  • Send out sheet to be amended to include checklist which needs to be initialled and dated by both staff members.
			  Action complete
			• To communicate more effectively with external trusts when samples are being returned by courier
			  • Individual hospital to be notified when GOSH has sent them a sample by Royal Mail Recorded delivery.
			  • To be included as part of the process for sending back human tissue as a result of pregnancy loss
			  Action complete
			• Ensure that the named person and address details are correct for each individual trust
			  • Each hospital to be contacted to ensure that the GOSH cytogenetics team have the correct information regarding named person, ward/location in the trust is correct.
			  • To be repeated annually (this is done when the SOP is reviewed)
			  Action complete
				It is essential to create physical barriers between items of a similar appearance to prevent human error occurring.

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Great Ormond Street Hospital for Children NHS Foundation Trust

Learning from closed/de-escalated SIs in June- August 2017 (2):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:

SI 2017/ 3562	A neonatal patient with a complex variant of Tetralogy of Fallot (ToF) repair underwent emergency surgery. The surgery undertaken differed from the strategy that had been proposed at the multidisciplinary team meeting.
	At the end of the operation it was not possible to wean the patient from cardiopulmonary bypass therefore Extracorporeal Membrane Oxygenation (ECMO) support was instituted prior to transfer to the cardiac intensive care unit.
	The patient had a prolonged stay on the cardiac unit and sadly did not survive. The patient had a very complex underlying cardiac condition and it is not known whether the patient would have survived had a different treatment pathway been followed.
		The surgeon deviated from the consensus surgical plan agreed at the multidisciplinary team meetings. The rationale for which was not clearly communicated across the teams at the time. This was an emergency procedure with absent or inconsistent descriptions of the proposed surgical intervention in a multitude of sources. This led to lack of clarity of the surgery that was due to take place.	• Review how the information at the multidisciplinary Tuesday Cardiac Pump meeting is recorded with a plan to standardise the report to describe the discussion, any points of contention and the outcome of the discussion
			  • A designated recorder should be identified to formally document the cardiac pump meeting.
			  • Divisional director to discuss with consultant body who chair the cardiac pump meeting so that a summary of all the discussion is outlined and not just the outcome of the discussion.
			Action status: work on-going; timescale of action to be agreed (as part of the current action plan pilot scheme)
			• Support the introduction of a dedicated consent clinic designing and delivering a process to achieve informed consent
			  • Senior management team to propose and plan the consent clinic with the appropriate support, resources and recognition in consultant surgeons' job plans.
			  • Review the data from the recently completed consent audit and link findings to plan for consent clinic.
			  • Present the data to the cardiac services in appropriate forums eg: Cardiac Board , consultants meeting, M&M
			  • Review the information provided to families ahead of admission for elective procedures, how it is presented to them and when it is presented to them.
			  • Consider use of technology to consider alternative means to obtain consent such as skype.
			Action status: the Consent Clinic is due to commence in Autumn 2017; work is on-going for the planning of the clinic.
			•The need to ensure that each theatre case whether elective or emergency is subject to a full team brief, sign in and timeout with all core members in attendance and all equipment, medications and blood products available.
			  • Consider incorporating these into cardiothoracic local safety standards for invasive procedures
			  • (LocSSIPs)
			Action status: Work is on-going; there is a Trust wide plan for the production of LocSSIPs and a working group has been set up.
				Review of the current consent processes with a plan to improve and further develop current consent processes.

Are we responding and Improving?

Patient and Family Feedback: Red Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

Red Complaints in June- August 2017

No of new red complaints declared in June-August 2017:	3	No of re-opened red complaints in June- August 2017:	1
No of closed red complaints in June- August 2017:	1		

Open red complaints- March-May 2017 (3)

Ref	Opened Date	Report Due	Description of Complaint	Divisions Involved	Exec Lead	Division Lead
17/025	20/06/17	15/09/17	Concerns raised regarding a perforation of the bowel which was discovered following a patient's recent stoma closure procedure. Also concerns regarding the length of time taken for the patient to be reviewed after he began exhibiting symptoms.	JM Barrie A	Chief Nurse	General Manager-JM Barrie
17/027	22/06/17	31/09/17	Concerns raised regarding two surgical episodes and subsequent care on the Ward.	Charles West	Chief Nurse	Clinical Governance Manager, Charles West
17/040	03/08/17	16/10/17	Concerns raised regarding a renal transplant which took place in 2005.	JM Barrie (A2)	Interim Medical Director	Head of Nursing, JM Barrie

Re-opened red complaints (1)

Ref	Re-opened Date	Description of Complaint	Divisions Involved	Exec Lead	Division Lead
16/039	21/07/2017	Original complaint is regarding: Concerns raised regarding clinic appointment, examination and subsequent discharge of patient. Patient subsequently admitted to local hospital who queried the condition of the patient. Queries regarding previous treatment provided by GOSH for the patient. Complainant has raised additional queries following receipt of the Trust's complaint response.	JM Barrie	David Hicks, Interim Medical Director	General Manager-JM Barrie

Are we responding and Improving?

Patient and Family Feedback: Learning from Red Complaints

Learning from closed red complaints in June- August 2017 (1):

Ref:	Summary of complaint:	Outcomes/Learning:
17/011	Patient raised concerns regarding a procedure that took place in 2004 following receipt of new information which prompted the patient to complain.	The complaint was investigated by the Trust and the medical records for the patient were reviewed. The investigation concluded that although the procedure undertaken was complex, it proceeded according to plan and there were no concerns raised during or after the surgery.

Are we responding and improving?

Learning from Friends and Family Test- Inpatient Data

Great Ormond Street Hospital for Children NHS Foundation Trust

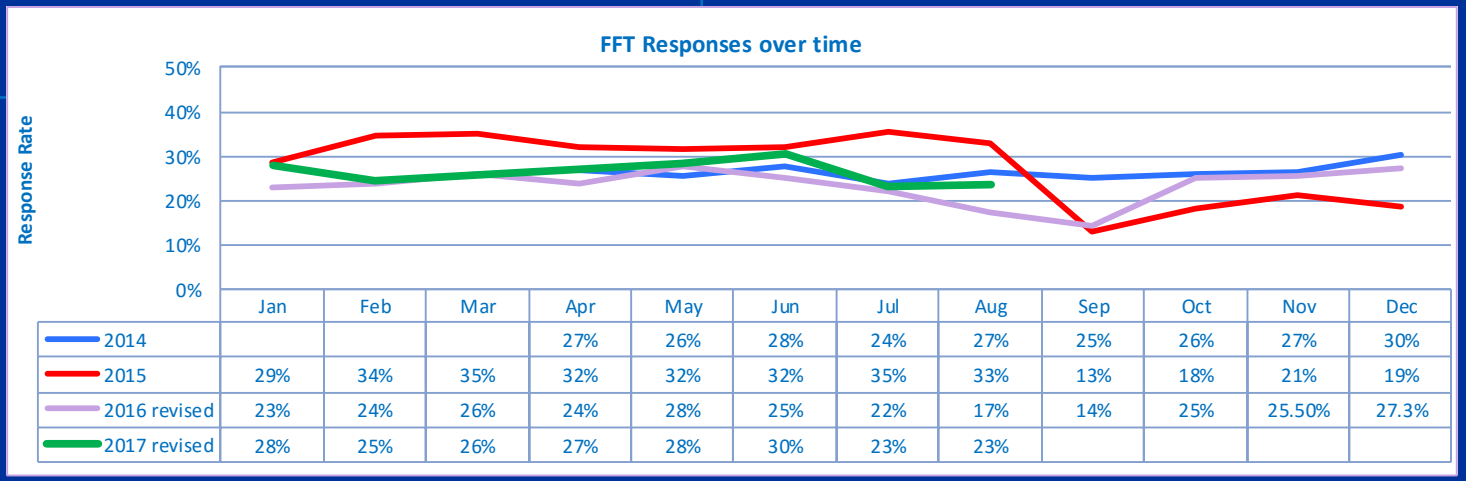
Data Quality Kite-Mark

Inpatient Results June 2017

June 2017
Overall FFT Response Rate = 30.3%
Overall % to Recommend = 98%

Inpatient Results July 2017

July 2017
Overall FFT Response Rate = 23.3%
Overall % to Recommend = 97%



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

June 2017 Top 3 Themes

Positive Themes:	No +ve comments	Total comments
Always Welcoming	144	145
Always Helpful	340	345
Always Expert	208	219

Negative Themes:	No -ve comments	Total comments
Staffing Levels	4	5
Access / Admission / Transfer / Discharge	23	34
Always One Team	7	16

July 2017 Top 3 Themes

Positive Themes:	No +ve comments	Total comments
Always Helpful	237	239
Always Welcoming	187	194
Housekeeping / Cleanliness	23	24

Negative Themes:	No -ve comments	Total comments
Staffing Levels	1	1
Access / Admission / Transfer / Discharge	12	13
Catering / Food	15	34

Are we responding and improving?

Learning from Friends and Family Test- Outpatient Data

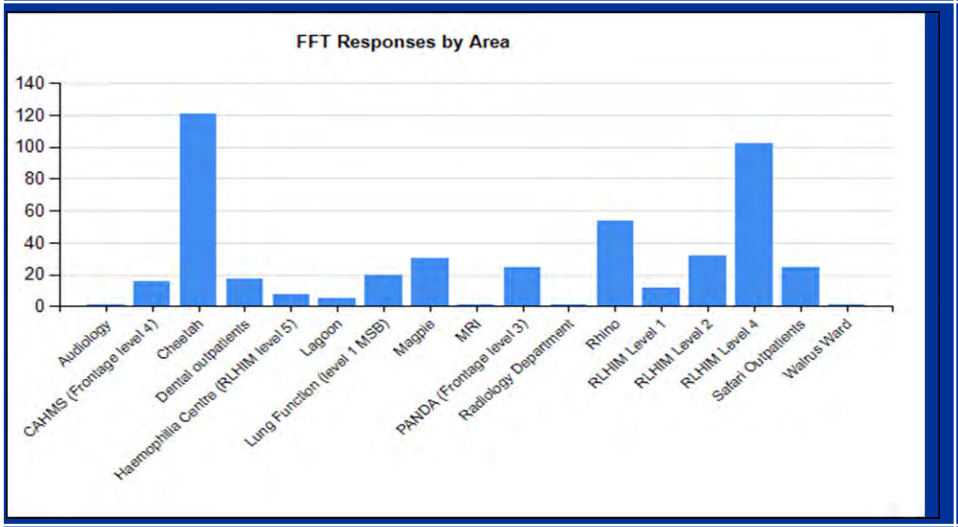
Great Ormond Street Hospital for Children NHS Foundation Trust

Data Quality Kite-Mark	Narrative:
	**The average percentage to recommend for Outpatients in July 2017 has increased to 94.3%.** **Regular meetings between the PE Team and outpatients have been organised to increase the amount of feedback received in outpatients.**

Outpatient Results June 2017

June 2017

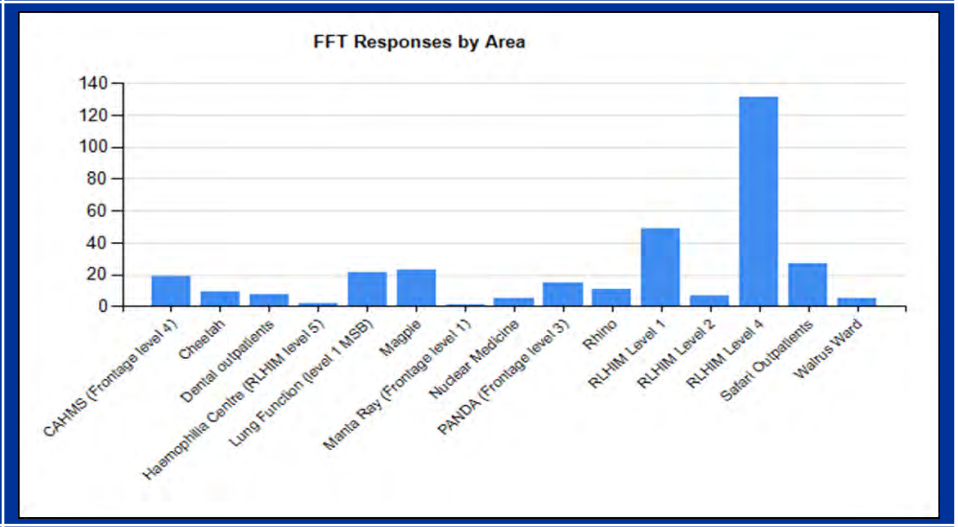
Overall % to Recommend = 93.7%



Outpatient Results July 2017

July 2017

Overall % to Recommend = 94.3%

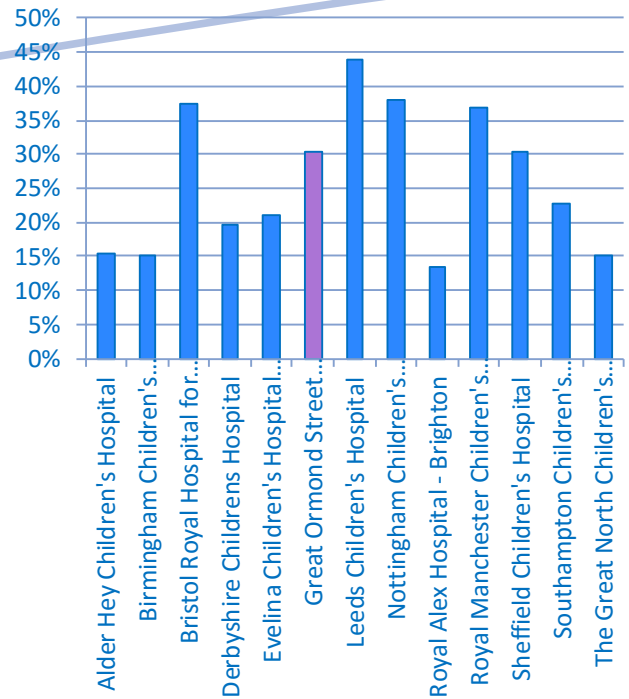


There were no response received for Audiology in July 2017; feedback may have been given via Rhino cards and families may have not specified Audiology on the cards. This has been discussed with the team and will be monitored.

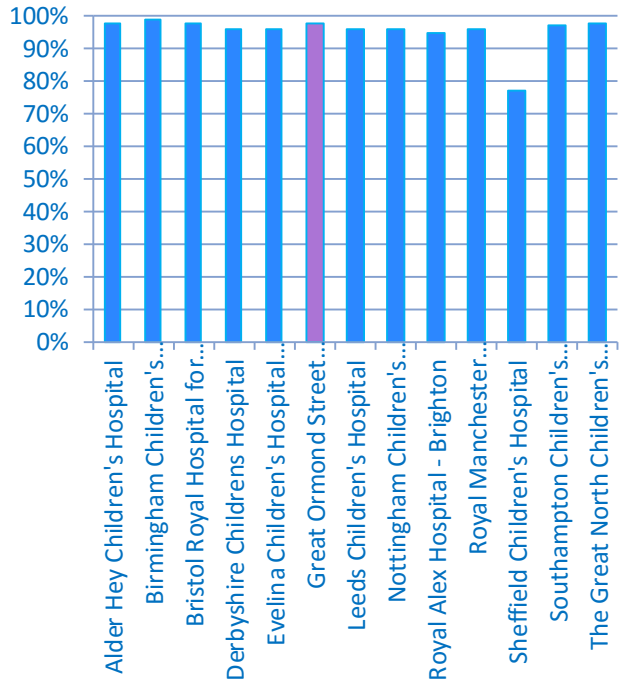
Are we responding and improving?

Benchmarking

Response Rates



Percentage to Recommend



Are we responding and improving?

Learning from Friends and Family Test- Positive Feedback

Great Ormond Street Hospital for Children NHS Foundation Trust

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

Patient Feedback

The nurses and doctors, the play leaders, the ladies that bring the food

The staff are friendly ,they always make sure you don't need anything to eat or drink,

Going home!!

Nothing is bad!

The toys, especially the cars!

Parent/Carer Feedback

Without exception every person we came into contact with was friendly and provided the care that our son needed and reassurance as parents we needed! We couldn't have asked for a better experience. Thank you so much. Such a relief to experience this level of care on a bumpy journey.

Badger ward has amazing people working there, from the domestic staff, play pals to the nurses and doctors, all are so wonderful and caring. Everyone made our stay as comfortable and friendly as possible. Everyone has a smile that has the ability to cheer you up and an ear to listen.

Are we responding and improving?

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

Great Ormond Street Hospital for Children NHS Foundation Trust

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

'You Said'

We did

"Very kind nurses and Drs, very positive experience despite having to have the treatment. Shortage of pillows meant that we had to buy them. It was as good as good can be."

Koala ward has ordered more pillows so that this will not happen again.

Nurses very good. Play specialist helpful - arranged dvd watching would have been helpful to have more explanation of ward procedures - meal times and breakfast arrangments, what to do if child needs help. Had to request parent bedding, wasn't told there was a kitchen. No problems with care of child

Kingfisher Ward Sister is reviewing why the family were not shown around the Ward when the patient was admitted as this is normal procedure ; the Ward tour does include a tour of the kitchen facilities.
With regards to meals etc, the Housekeeper should visit each patient with menu's for the whole day. The Ward currently has agency Housekeepers and therefore patients may have been missed on some occasions. The Ward Sister will ensure that all Housekeepers are aware of this duty as part of their role.
In each bay area there are linen for all parents for beds, the Ward will ensure that a poster is added to explain that parents can take linen to be used for parent beds.

Called and explained about my sons condition but, en-suite room not provided (his weight is 65Kg. He his not standing or walking two people needed to take in to toilet/bath & dress, undress. Only one parent/carer allowed to sleep so, I request en-suite room but not given)Staff helpful & friendly.

The Sleep Unit have contacted the family to discuss the concerns raised. The concerns have been noted by the team.
Currently there are only two rooms available on the Unit which have en-suite facilities and priority for these rooms is given to patients on bi-pap and c-pap.

Are we responding and improving?

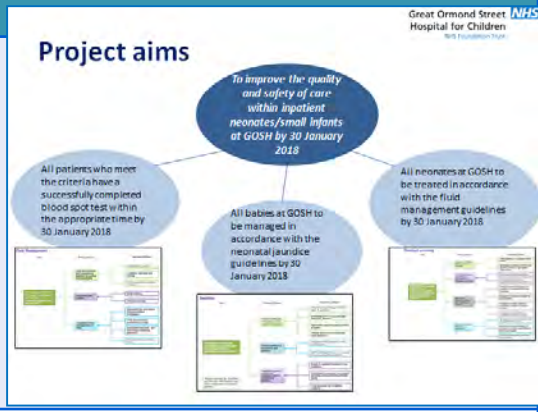
Featured Project: Neonatal care

Great Ormond Street Hospital for Children NHS Foundation Trust

Project aim:
To improve the quality and safety of care within inpatient neonates/small infants at GOSH

This is a trust-wide initiative at GOSH, seeking to improve the quality and safety of care within inpatient neonates/small infants. This work is led by a multi-disciplinary project team, including Medical, Nursing and Quality Improvement leads.
The project was initiated in response to an audit presented to PSOC in November 2016, which detailed the need to decrease the incidence of blood spots classified as avoidable repeats, improve the provision of jaundice identification and treatment and standardise the documentation and management of IV fluids within GOSH's neonatal population. GOSH continues to report quarterly against national neonatal blood spot screening samples.
The high level aim has broken down into three distinct areas of focus, with a separate driver diagram and aim outlined for each workstream, all for completion by 30 January 2018

- All patients who meet the criteria have a successfully completed blood spot test within the appropriate time
- All babies at GOSH to be managed in accordance with the neonatal jaundice guidelines
- All neonates at GOSH to be treated in accordance with the fluid management guidelines



Expected Benefits of the Project:

- Early recognition and timely treatment of neonatal jaundice
- Standardisation of neonatal care – pathways & bundle
- Agreed process for blood spot screening, resulting in fewer avoidable repeats
- Comprehensive neonatal training and resources for staff
- Improved documentation of critical patient information
- Clearly defined guidelines for neonatal IV fluids in order to standardise management across the Trust

Primary Drivers

- **Timely identification and treatment of all patients with suspected jaundice**
- **Bloodspot screening carried out within national guidelines**
- **Competent clinical management of IV fluids**

Measures for Improvement:

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

Outcome measures:

- % of neonates who had bloodspot avoidable repeat
- % of neonates who had bloodspot in the correct timeframe
- % of neonates who were managed as per fluid guidelines
- % of neonates whose jaundice was managed as per guidelines

Process measures:

- Staff confidence in neonatal care (surveys)
- Staff uptake in neonatal training

Progress to date:

- Improved identification of neonates across the Trust
- Developed new neonatal fluid management guideline
- Developed intranet hub and ward folders of standardised neonatal resources and information
- Developed new protocol to enable ward admins to identify and complete missing data for neonatal admissions, including access to NHS Spine national portal
- Developed bloodspot and jaundice e-learning packages
- New neonatal Practice Educators rolling out programme of drop-in, simulation and ward based teaching
- Currently piloting Neonatal nursing and medical documentation to prompt for essential neonatal care and screening
- Currently piloting automated email prompt system highlighting neonates missing NHS# or within the day 5-8 bloodspot window

Next Steps:

- **The data does not currently demonstrate an improvement and on-going work to monitor and assess the impact and sustainability of current interventions will be carried out alongside the roll-out of the remaining interventions**
- Continue pilots of interventions, incorporating learning into subsequent PDSA cycles and rolling out Trust-wide
- Neonatal Practice Educators to develop sustainability plan, including train the trainer package
- Neonatal November – a month of talks, stands, teaching, hot topics and awareness raising
- Reinforce accountability for quality at Matron and Ward Sister level
- Develop neonatal medical education package
- Develop measure for fluid management following the development of the guideline

Are we responding and improving?

Quality Improvement Project Status Update (with Executive sponsorship)

Great Ormond Street Hospital for Children NHS Foundation Trust

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

Are we responding and improving?

Quality Improvement Project Status Update (with Executive sponsorship)

Great Ormond Street Hospital for Children NHS Foundation Trust

Project	Project Aims	Project Leads	Project Timescales and Progress
Transition	Specialties are working on the short-term requirements of the Transition CQUIN and work is on-going on longer-term improvement strategies with specialties to ensure the Trust meets the recommendations of the NICE Transition Guidelines.	Executive Sponsor- Chief Nurse	On-going project Progress to date: • Minimum standards for a Transition Plan agreed (YP) that has 'Generic' and 'Specialty Specific' criteria. This will enable all YP to be started on a plan by 14 yrs even where course of /length of treatment at GOSH is uncertain • Web Ex established to allow young people (YP) to 'attend' Steering Group remotely • HI Team piloting Transition Clinic Next steps: • Agreement to Parent/carer Transition Plan minimum standards • Meeting with Charity to discuss YP & parent/carer education videos and expand Web-presence of transition • Development and pilot of report showing YP on clinic list for following month showing age, number of appointments in previous year and transition status • Development and pilot of eCOF Transition alert tab (pilot with teams currently piloting dedicated PIMS transition tab
Extravasation	To reduce the incidence of extravasation injury at GOSH	Executive Sponsor- **Chief Nurse** Clinical Lead- **Consultant Anaesthetist**	Progress to date: • Six work streams underway • VHP Framework & Tool – • First cohort of test wards in progress (Koala, Eagle, Bumblebee) • Bear, Hedgehog & Walrus - commence Jul 2017 • VHP Tool – Feedback survey completed, report pending • Communication group – agreed format, awaiting final roll out decision. • Training video – Filming completed, under development. • Long lines - Early discussions underway with Neonatal Consultant & Bear ward, potentially pilot to commence in Sep 2017. • Plastic lead – new Cons to take over plastics lead on project

Appendix 1

Methodology for key Trust measures

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

Appendix 2: SPC Frequently Asked Questions

Contents

What is a Dashboard?

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

Where are the Quality Improvement dashboards?

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

What is SPC?

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

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

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

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

SPC charts:

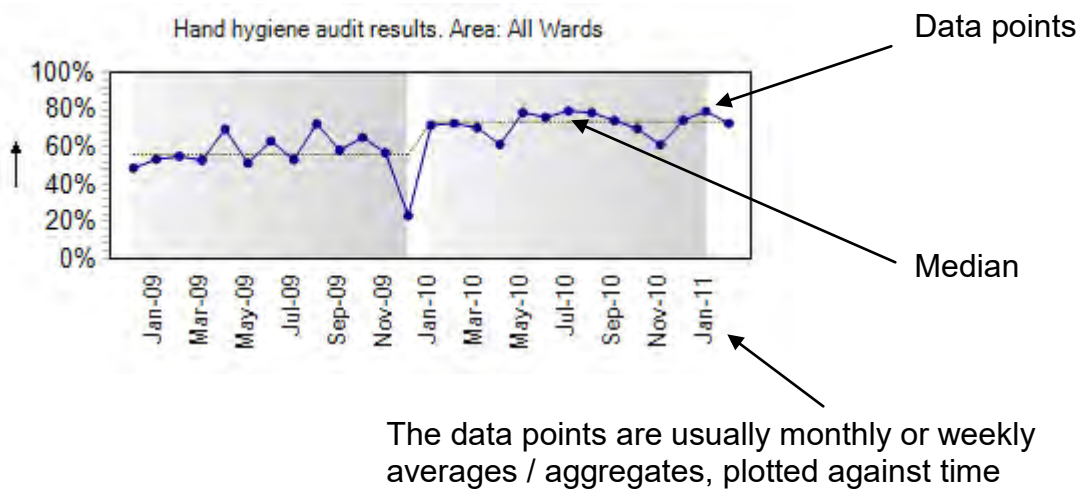
- are an excellent way of **measuring for improvement**
- Use the pattern of events in the past to predict with some degree of certainty where future events should fall.
- distinguish between the natural/common cause variation and special cause variation
- enable you to look for problems when they are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

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

What is a Run Chart?

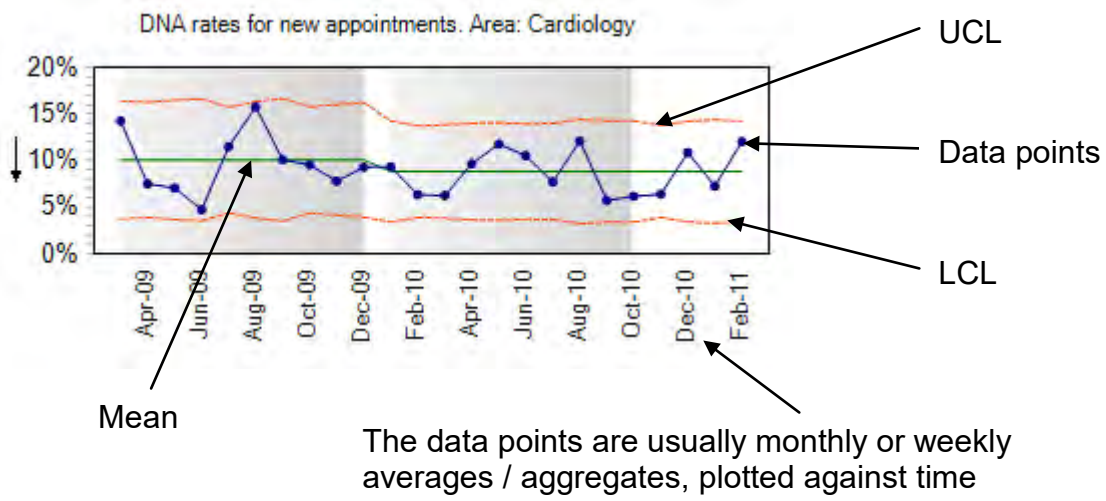
A run chart is used when analysing more than one process, when the data is summed (or aggregated). For instance, if we want to analyse medication errors Trust wide, we would use a run chart - there is more than one process because there are multiple wards in a the Trust with each ward having its own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

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



What is a Control Chart?

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



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

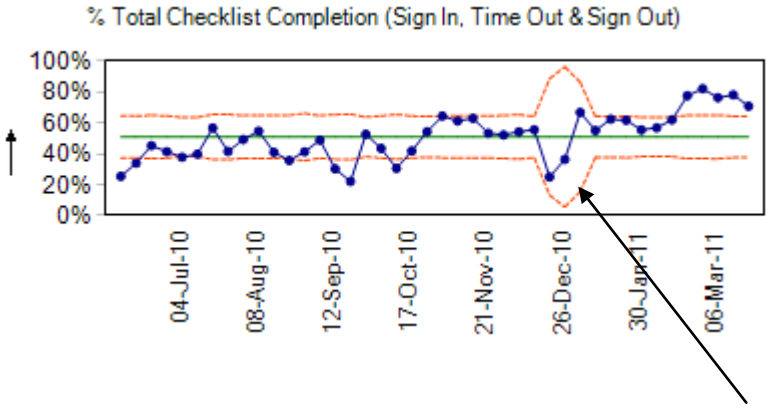
What are the Upper and Lower Control Limits?

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

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

Why are the control limits sometimes wiggly?

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



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

What are the 9 different types of control charts?

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

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

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

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

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

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

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

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

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

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

What is Common Cause Variation?

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

What is Special Cause Variation?

Special cause variation can be spotted using three simple rules:

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

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

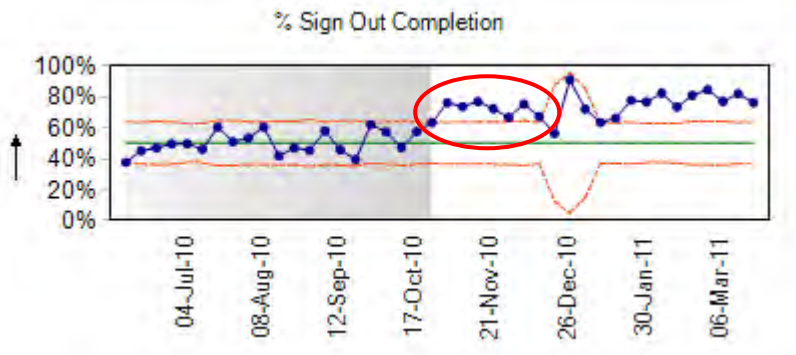
c. **Outliers**. An outlier is a data point which is outside of the control limits.

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

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

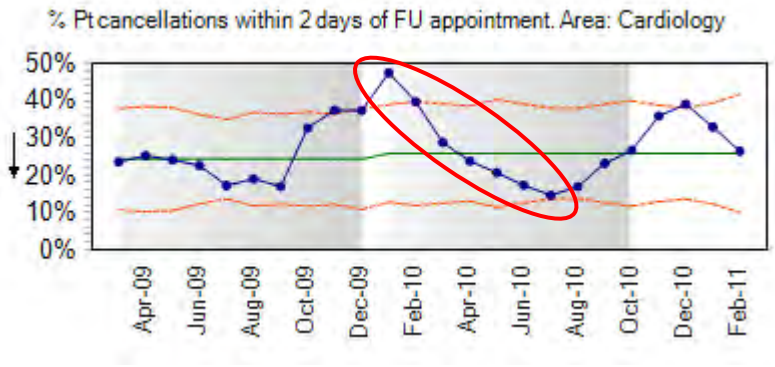
What is a Run?

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



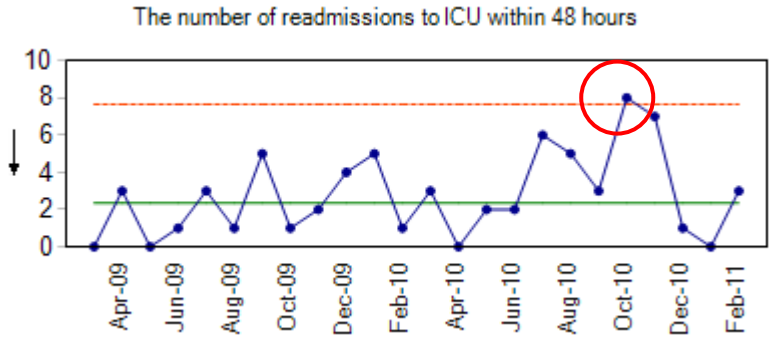
What is a Trend?

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



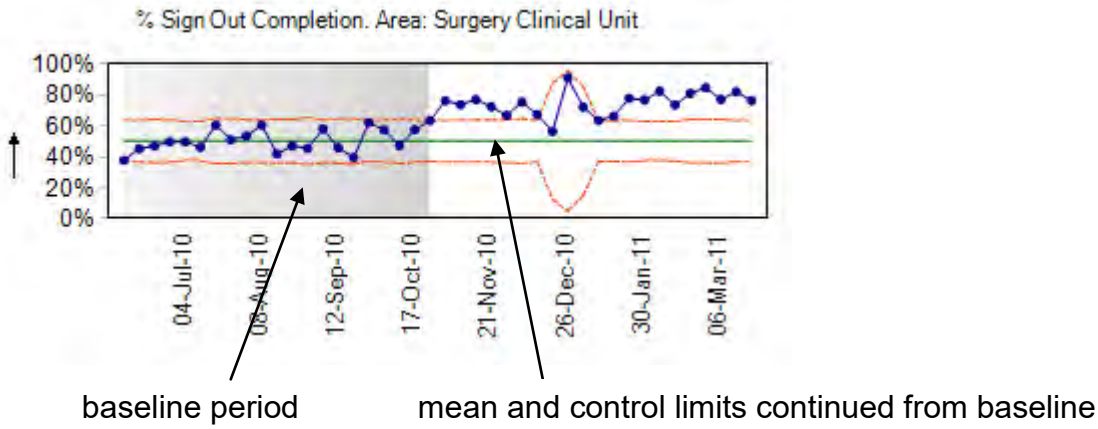
What is an Outlier?

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



What is a Baseline?

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

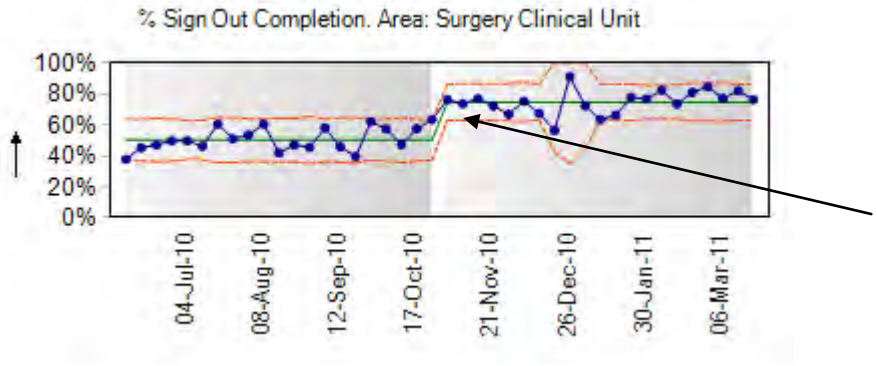


What happens when you have a Special Cause?

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

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

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



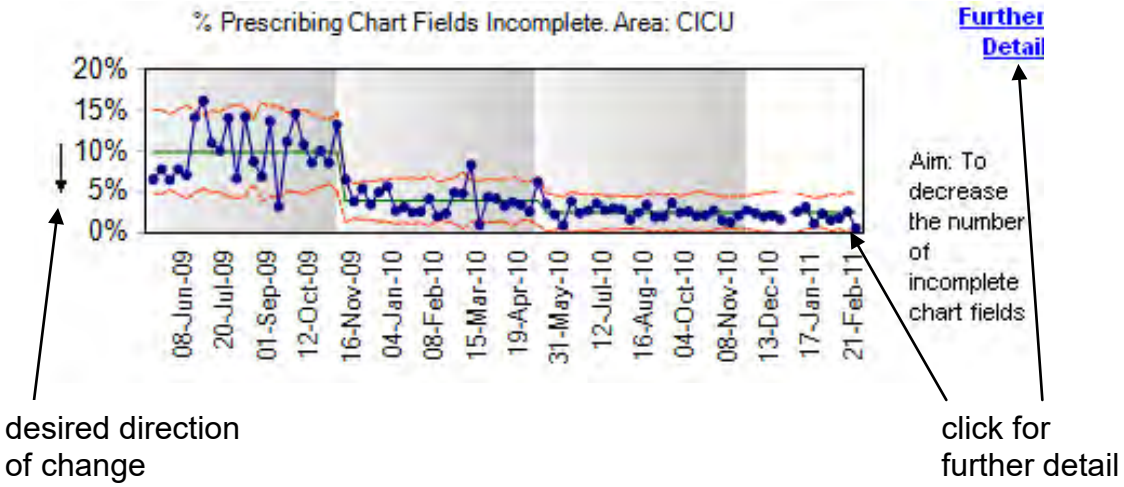
Outliers: If you spot an outlier, it must be investigated. It indicates that something either very good or very bad has happened and action needs to be taken either to correct the problem so that it doesn't happen again, or to learn from the good practice so that it can be applied in future.

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

Any other tips for interpreting SPC at GOSH?

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

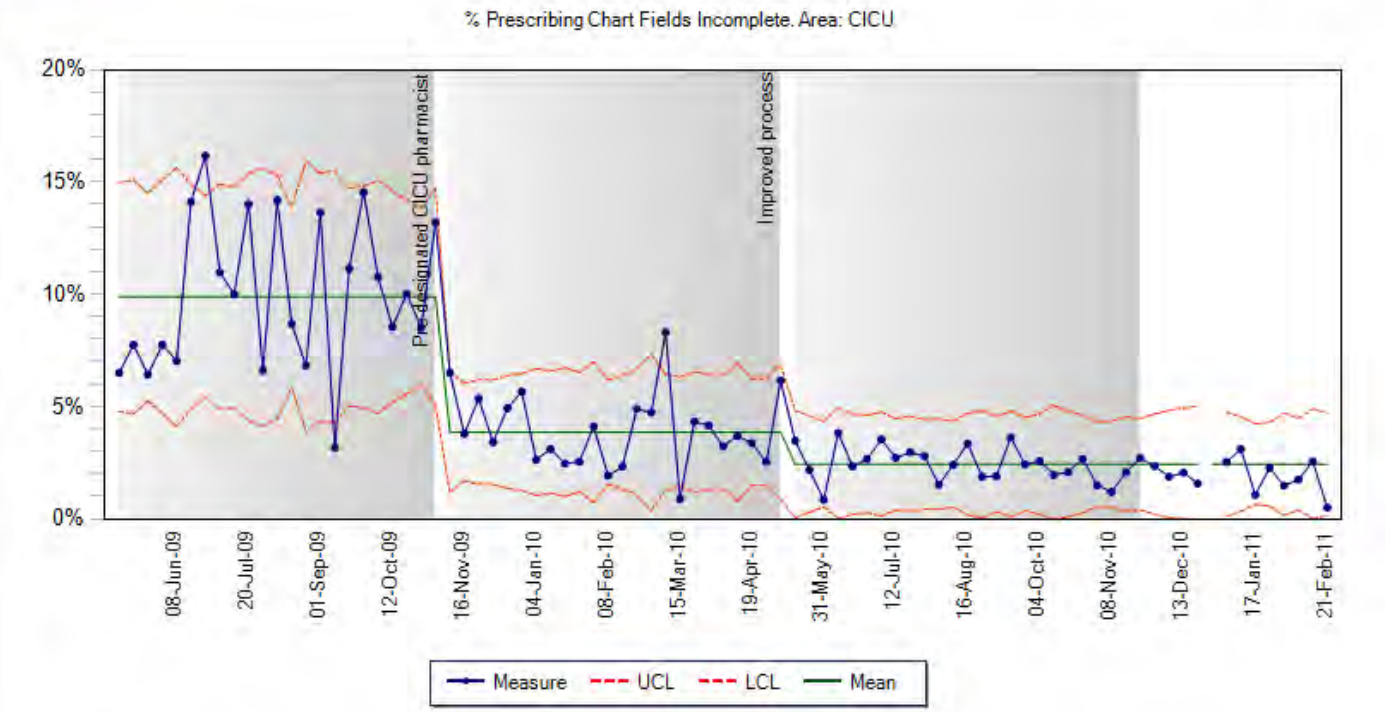
To access **Further Detail and Definitions** for a particular measure on one of the improvement dashboards, either click on a data point or the 'Further Detail' link next to the dashboard charts



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

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

Desired Direction of Change ↓



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

Definition Source: CICU team

Data Source: CICU Prescribing

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

Why is it so important that we measure things?

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

How can you find out more?

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

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

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

Complaints Annual Report

2016/2017

Donna Robinson – Patient Safety and Complaints Manager

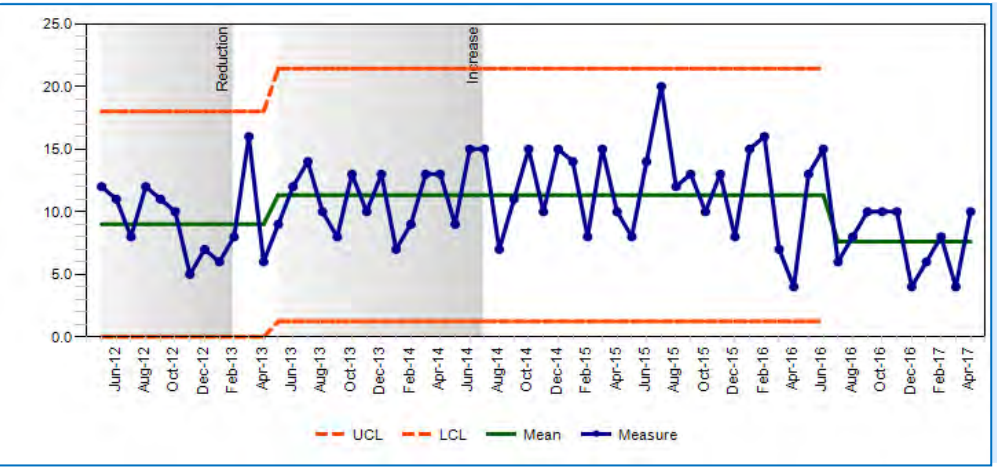
Complaints Summary

Great Ormond Street Hospital for Children NHS Foundation Trust

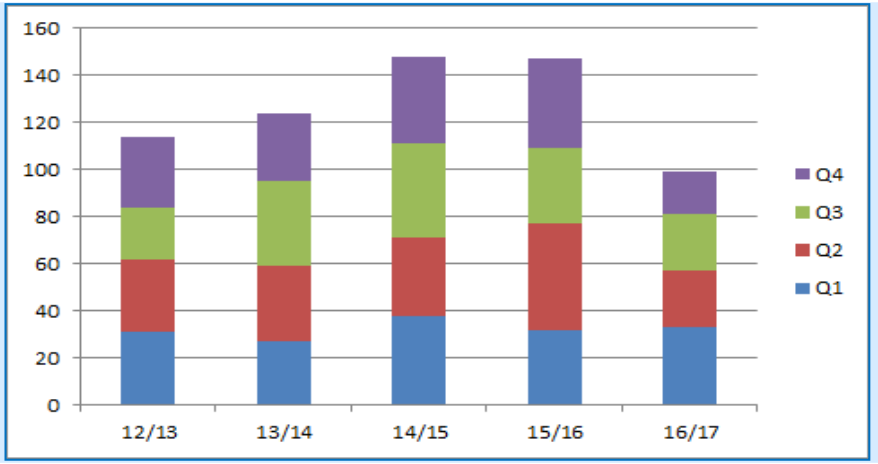
Summary of Key Points:

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

Number of formal complaints received by the Trust:



Trends for the number of formal complaints received since April 2012



Complaints per quarter per financial year

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

Commentary:

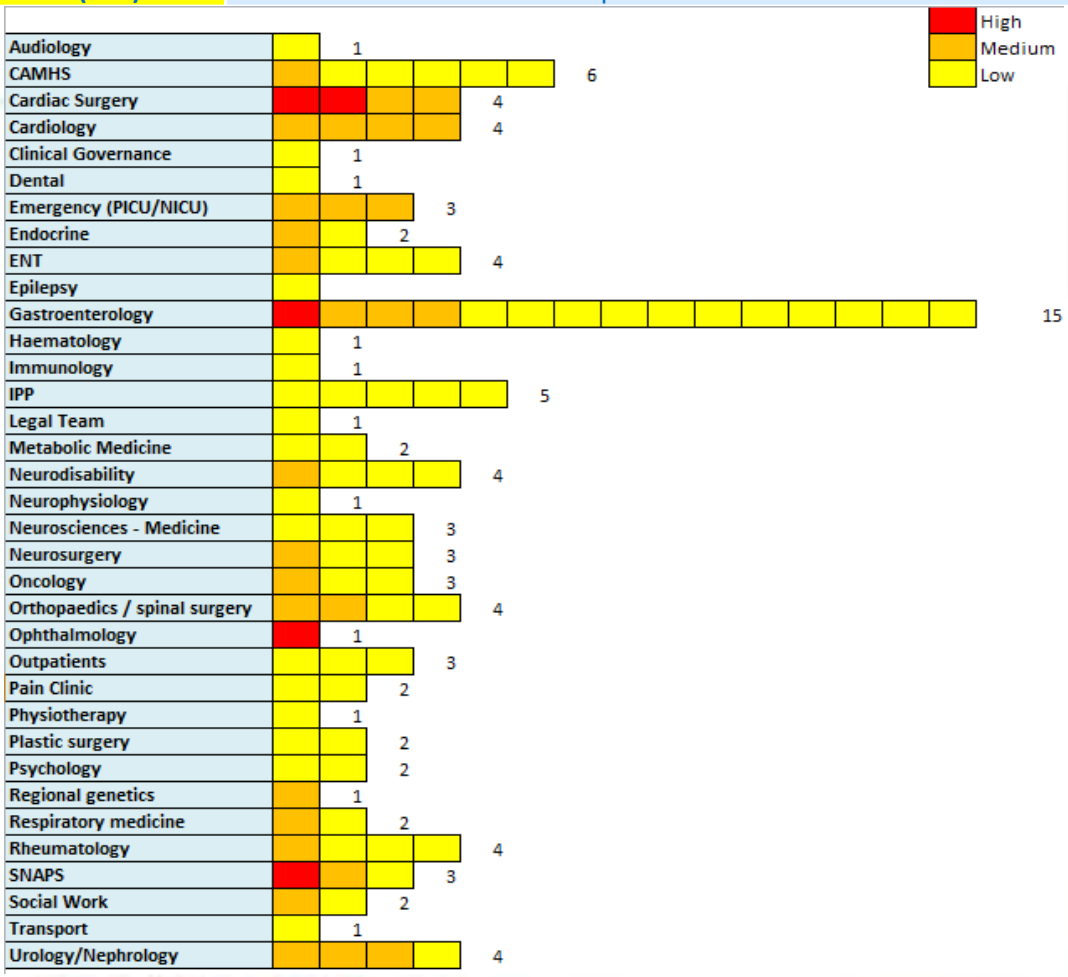
18 new formal complaints were received in quarter four 2016/17. This is the least amount of complaints received in one quarter throughout the year. In addition, it is the least amount of complaints received in one quarter over the last 5 years.

Complaints by Grading & Speciality

Great Ormond Street Hospital for Children NHS Foundation Trust

Complaint grading definitions:

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



Commentary:

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

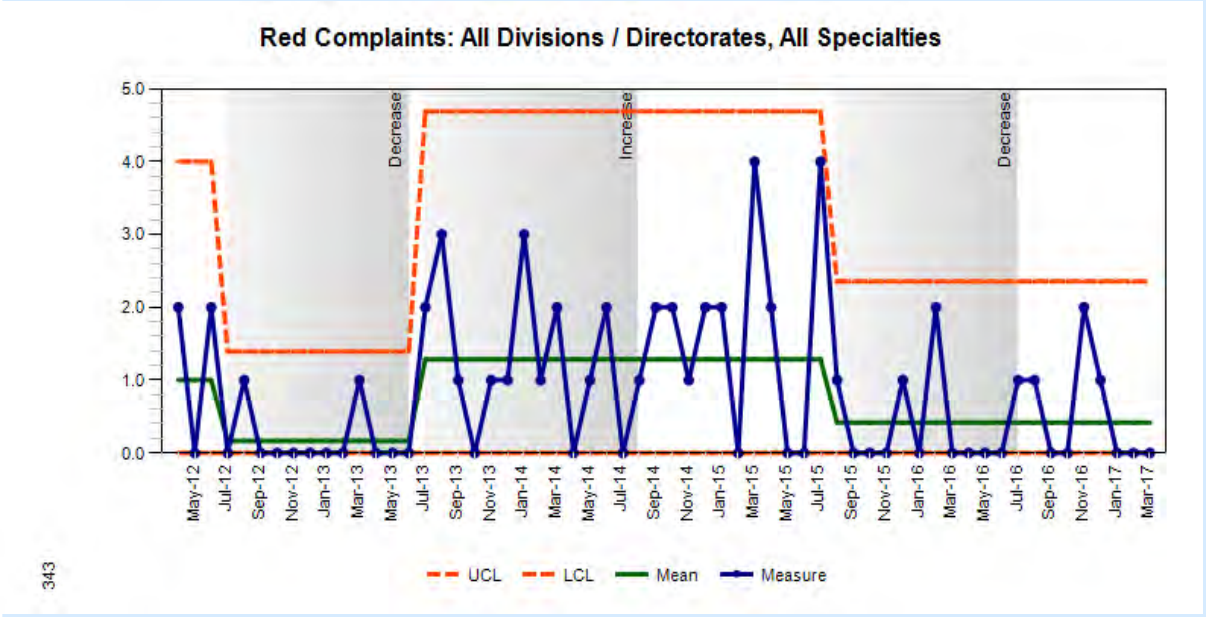
Comparison of complaints grading by year

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

Red Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

Red Complaints



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

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

Q1	Q2	Q3	Q4
0	2	3	0

Subject themes from red complaints (16/17)

There were no reoccurring themes from the 12 red complaints.

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

Complaints by Patient Activity

Great Ormond Street Hospital for Children NHS Foundation Trust

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

combined patient activity = outpatient attendances + inpatient episodes

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

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

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

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

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

Complaints Timescale

Great Ormond Street Hospital for Children NHS Foundation Trust

Complaints closed within the agreed timescales:

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

Yearly comparison of complaints closed within the agreed timescales:

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

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

Complaints timescale monitoring

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

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

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

Disability and Ethnicity Data

Great Ormond Street Hospital for Children NHS Foundation Trust

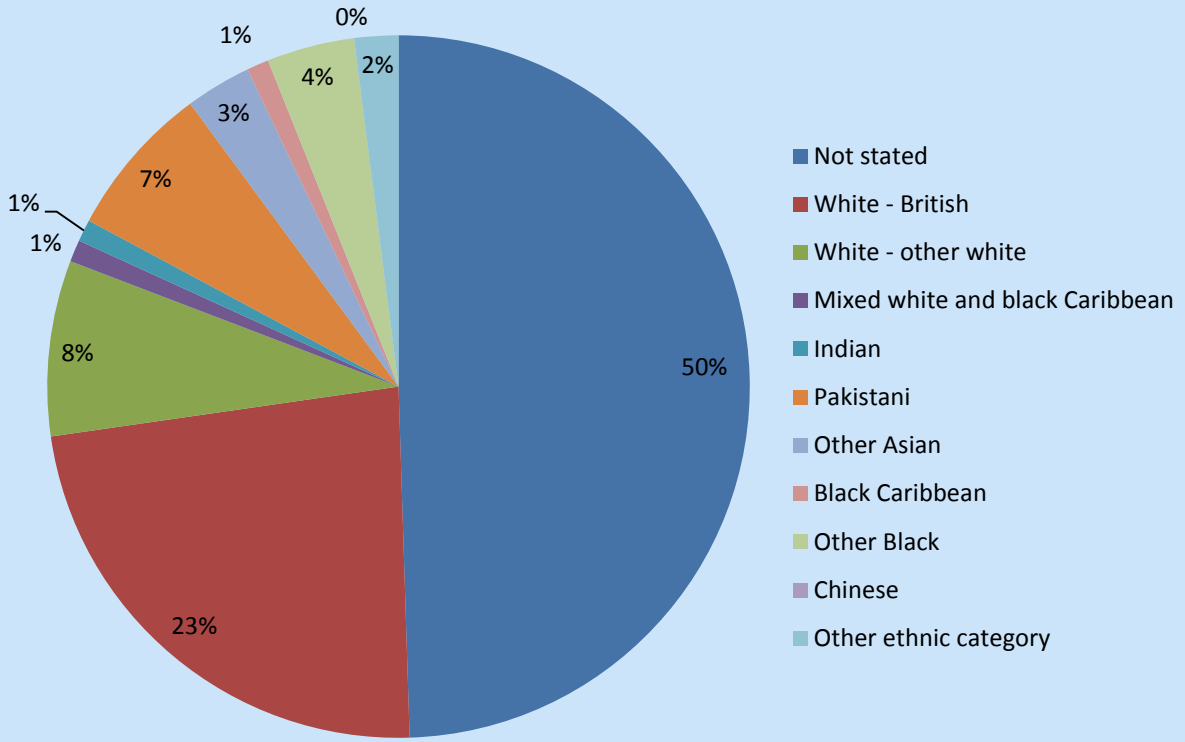
Disability data:

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

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

Complaint Ethnicity Data (16/17)

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



Complaint Trend Analysis

Great Ormond Street Hospital for Children NHS Foundation Trust

Subjects arising in complaints received 2016/17

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

Communication

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

Complaint Trend Analysis

Great Ormond Street Hospital for Children NHS Foundation Trust

Gastroenterology

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

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

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

Delay in Treatment

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

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

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

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

Complaint Trend Analysis

Great Ormond Street Hospital for Children NHS Foundation Trust

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

Complaints and the Trust Always Values 2016/2017:

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

Themes

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

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

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

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

Learning from Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

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

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

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

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

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

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

Learning from Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

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

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

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

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

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

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

Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

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

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

Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

Clinical Records Audit

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

Patient experience and satisfaction surveys regarding the complaints service:

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

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

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

'Well Founded' Complaints:

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

PALS Report

Annual 2016/17 and Q4 2016/17

Luke Murphy
Pals Manager

PALS Summary

Great Ormond Street Hospital for Children NHS

Summary of Key Points:

The key points identified for this report are:

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

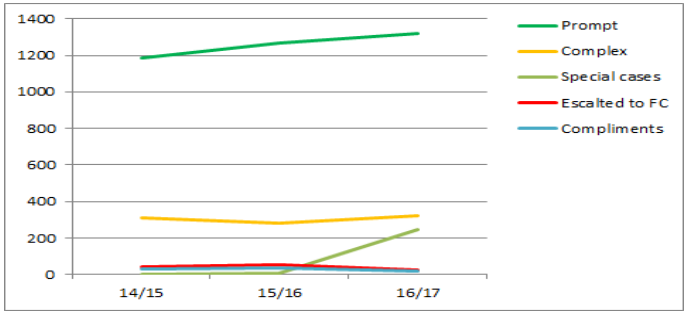
Comparison of PALS cases received by the Trust during financial year 2016/17

PALS grading definitions:

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

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

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



Commentary:

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

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

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

PALS Cases for Q4 2016/17

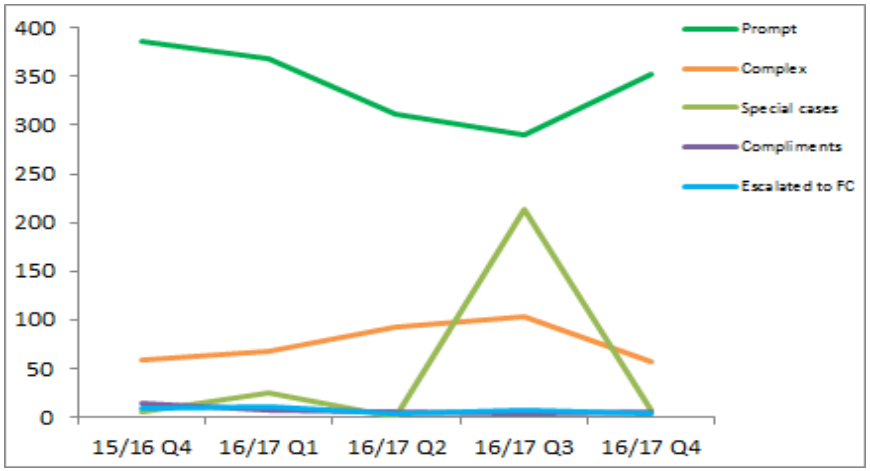
Great Ormond Street Hospital for Children NHS Foundation Trust

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

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

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

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



Commentary

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

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

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

PALS Cases by Speciality 2016/17

Great Ormond Street Hospital for Children NHS Foundation Trust

Annual 16/17 comparison of the top 5 specialities

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

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

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

IPP

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

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

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

Estates & Facilities

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

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

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

PALS Cases by Speciality Q4 16/17

Great Ormond Street Hospital for Children NHS Foundation Trust

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

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

Thematic analysis – Top three themes contributing to speciality in Q4

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

Neurosciences- Poor communication; Outpatient appointment transport concerns; Cancellations

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

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

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

IPP

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

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

The top three themes for IPP queries to Pals were:

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

Estates and Facilities

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

Thematic analysis- top three themes contributing to cases in Q4

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

PALS Thematic Analysis

Great Ormond Street Hospital for Children NHS Foundation Trust

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

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

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

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

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

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

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

PALS Trend Analysis

Great Ormond Street Hospital for Children NHS Foundation Trust

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

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

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

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

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

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

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

Always values, Initiatives and Special cases

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Always year*: 2016/17

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

*Trust values were recorded from Q2 15/16

Thematic analysis- top three themes

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

Themes:

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

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

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

Information about admissions; poor communication; information regarding transport

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

Themes:

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

Poor communication; transport arrangements; cancellations

Cancellations; poor communication; accommodation concerns

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

Poor communication; accommodation concerns and cancellations

Expert

Themes:

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

Lack of communication; Care advice; Delays in treatment

Poor communication; transport delays; access of medical records

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

One Team- one team listening is the highest category

Themes:

Poor communication; cancellations; delays in arranging treatment

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

Poor communication; Cancellations of appointments/admissions and administrative errors

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

Always values, Initiatives and Special cases Q4

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Always year*: Quarter comparison

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

*Trust values were recorded from Q2 15/16

Thematic analysis- top three themes

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

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

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

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

Key Initiatives 2016/17

Pals Outreach Project (Popping)

Commentary: POP stands for Patient Outreach Project

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

Promoting Patient and Family Information

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

Social Media & Other Feedback

Great Ormond Street Hospital for Children NHS Foundation Trust

Social Media and NHS Choices:

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

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

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

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

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

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

Compliments:

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

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27th September 2017

Learning from Deaths. Report of Mortality Review Group 1st January to 30th June 2017 **Submitted by:** Dr David Hicks, Interim Medical Director	**Paper No: Attachment L**

Aims / summary

In March 2017, the National Quality Board published national standards for the reviewing of inpatient deaths and learning from the care provided to patients
The guidance requires that Trusts share information on deaths to be received at a public board meeting.
"*From April 2017, Trusts will be required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public Board meeting in each quarter to set out the Trust's policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards). This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care."*[1]

The Mortality Review Group (MRG) was established in 2012 to review the deaths that occur at Great Ormond Street Hospital (GOSH). The purpose of the MRG is to provide a Trust level overview of all deaths to identify themes and risks, and take action as appropriate to address those risks.

This report meets the requirements of the National Quality Board by

- Outlining the Trusts approach to undertaking case reviews (by end of Q2)
- Including data and learning points from case reviews. (by end of Q3)

NHS England are planning to produce explicit guidance on mortality reviews for the death of children and young people in hospital, expected in Autumn 2017, which will require a review of policy and approach.

A version of this report had previously been reviewed at the Patient Safety and Outcomes Committee in August 2017. Reporting will be required to be shared with Trust Board on a quarterly basis.

Action required from the meeting The board is asked to note the content of the paper.

Contribution to the delivery of NHS Foundation Trust strategies and plans
This report meets the requirements of the National Quality Board to report learning from deaths to a public board meeting.

Financial implications- none.

Who needs to be told about any decision? n/a

[1] National Guidance on Learning from Deaths, National Quality Board, published March 2017

Attachment L

Who is responsible for implementing the proposals / project and anticipated timescales? The Interim Medical Director is the executive lead with responsibility for the learning from deaths agenda .
Who is accountable for the implementation of the proposal / project?

Great Ormond Street Hospital for Children NHS Foundation Trust

Mortality Review Group. Report of reviews 1st January to 30th June 2017

Executive summary

The Mortality Review Group (MRG) was established in 2012 to review the deaths of inpatients at Great Ormond Street Hospital (GOSH). The purpose of the MRG is to provide a Trust level overview of all deaths to identify themes and risks, and take action as appropriate to address those risks to prevent future deaths. This process is linked with case reviews undertaken by specialty teams, and provides an additional oversight of deaths in the Trust. The purpose of the report is to highlight modifiable factors[1] and learning from the reviews undertaken by the MRG.

The group also identifies any processes of care that remain to be completed (e.g. death discharge summary), and any learning for the Trust. Where modifiable factors or other issues are identified at GOSH, the Chairs of the MRG feed these back to the relevant clinical team or Divisional Director for action. Modifiable factors identified outside of GOSH are shared with the Child Death Overview Panel.

The members of the MRG are: Isabeau Walker (Anaesthesia; co-Chair); Stephen Marks (Nephrology; co-Chair); Sophie Skellett (PICU); Timothy Thiruchelvam (CICU); Catherine Downe (CSP); Finella Craig (Palliative Care); Kate Cross (SNAPS); Liina Palm (Pathology); Sam Stuart (Radiology); Jan Baker (Safeguarding); Rachel Cooke (Bereavement Services); Jim Blair (Learning Disabilities); Nicole Douglas (Quality and Safety, Data Analysis and Reporting); Sonia Sinclair (Quality and Safety , Admin support).

This report summarizes the findings from the review of 36 cases that were reviewed by the MRG between 1st January 2017 – 30th June 2017. 34/36 cases reviewed during this time period relate to deaths that occurred in the Trust before January 2017.

Key findings

- The MRG reviews continue to highlight the exemplary care provided by the multidisciplinary teams at GOSH for children, young people and their families, including at the end of life.
- Of the 36 cases reviewed:
    - The MRG felt that there were modifiable factors at GOSH in 3 cases.
    - The MRG felt that there were modifiable factors at GOSH and outside of GOSH in 1 case
    - The MRG felt that there were modifiable factors outside GOSH in 2 cases.
    - In 2 cases there was not sufficient specialist knowledge in the MRG review of the case to reach a conclusion on modifiable factors.
- A full report highlighting modifiable factors and an action plan was presented to the Patient Safety and Outcomes Committee in August 2017. Actions completed include:
    1. The MRG Co-Chair has discussed cases where there were felt to be modifiable factors at GOSH with the relevant Divisional Director.
    2. Cases where there were felt to be modifiable factors outside GOSH have been referred to the relevant CDOP.
    3. The MRG has highlighted the need for accurate completion of the Medical Certificate of Cause of Death in children (MCCD). Targeted training has been delivered for clinicians who are required to complete MCCDs.

[1] Modifiable factors are defined as those which, by means of nationally or locally achievable interventions could be modified to reduce the risk of future child deaths. Department of Education, Child Death Reviews – Year ending March 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/444788/SFR23-2015.pdf (accessed 14.09.2017)

- Learning points from the MRG reviews this quarter include: the important role of palliative care/ parallel planning for long term patients in the intensive care unit; training needs for ECMO cannulation; the importance of timely and accurate decision-making for complex patients; the need to investigate potential harm resulting from refused admissions to GOSH due to bed capacity; the importance of timely recognition of the deteriorating patient on the ward.

- There is currently a backlog of cases for the MRG to review. The MRG terms of reference outline that the MRG review deaths within eight weeks of the date of death. At the time of writing there are 40 cases which have not been reviewed within these timeframes, although this is not a breach of any current external requirement. The main challenge to reviewing is to have quorate monthly meetings. The MRG has been meeting fortnightly where possible since August to reduce the backlog. Additional members of the MRG are being recruited to ensure that all meetings can be quorate.

- The National Guidance on Learning from Deaths was published in March 2017 and reviewed by the members of the MRG in April 2017. The Trust currently meets the recommendations. A further review will take place following the publication of the updated NHS England process to review the death of children and young people in hospital which is expected later in 2017.

14th September 2017

This report has been prepared on behalf of the MRG membership by:
Dr Isabeau Walker, Consultant Anaesthesia and co-chair of the MRG

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **27th September 2017**	
Annual Infection Prevention and Control report **Submitted by: John Hartley** **Director of Infection Prevention and Control**	**Paper No: Attachment M**
Aims / summary To present to the Board the progress and issues in Infection Prevention and Control in 2016/17	
Action required from the meeting Feed back Approval for display on public web site	
Contribution to the delivery of NHS Foundation Trust strategies and plans Prevention and control of health care associated infections prevents harm and reduces cost.	
Financial implications Failure to prevent avoidable infection leads to harm and cost.	
Who needs to be told about any decision? Infection prevention and control is the responsibility of all staff	
Who is responsible for implementing the proposals / project and anticipated timescales? On-going programmes implemented by all Divisions and Corporate units, supported by IPC 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 ANNUAL REPORT
April 16 - March 17

AUTHOR: Dr John Hartley - Director of Infection Prevention and Control

Part A Executive summary

1 Introduction

Great Ormond Street Hospital for Children NHS Trust recognises the obligation placed upon it by the Health Act 2006, (updated 2015) 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.

2) Description of infection control arrangements
Director of Infection Prevention and Control (DIPC) and Infection Control Doctor
Dr John Hartley, Consultant Microbiologist.
Executive lead for IPC - Chief Nurse, Juliette Greenwood.
Lead Nurse for Infection Prevention and Control – 1 wte, Helen Dunn
Deputy Lead Nurse in IP&C 1 wte; IPC nurse 1;
Clinical Scientist in IP&C 1wte (currently 0.4 in place as scientist on NIHR fellowship 0.6)
Other 2 consultant microbiologists – 3 PAs
IPC Administrative support and Data Management **–** 0.6 wte filled May 2017
The CNSs for Tuberculosis and ID lead on Tuberculosis related issues;
ID consultants contribute to the out of hours advice
Antibiotic pharmacist – 1 day of time, post within pharmacy
Quality Improvement team – dashboard development and display

Divisional Responsibility
Under the terms of the Trust IPC Strategy set out previously each Division (CW, JMB and IPP) has a local Divisional group to drive local planning and implementation of IPC actions.

2:3 The Infection Prevention and Control Committee (IPCC) meet every two months in 2016, increased to monthly in 2017. Committee reports to Patient Safety and Outcome Committee.

2:4 Reporting lines
The DIPC is accountable to the CEO and reports to the Board.
The DIPC and Lead nurse for IPC meet bi-weekly with Executive lead.
A report of all significant IPC issues is presented weekly to the Safety Team.
Significant IPC issues are Datix'd, collated and passed through reporting line.
An annual plan is written and included in each annual report.

2:5 **Antimicrobial stewardship**

Antimicrobial Stewardship – in 2016/17 stewardship focused on review and provision of Antimicrobial Policies (Policy group), and audit of consumption and antibiotic review (in line

with the 16/17 CQUIN). In Oct 2016 Chair of the Committee passed from DIPC to ID Consultant (Dr A Bamford). A business case is being developed for additional staff time to enable expansion of AMS activity.

Surviving Sepsis – the Trust established a dedicated improvement project team to lead on implementation of the Surviving Sepsis / Sepsis 6 initiative.

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

3:3 Outbreak Reports
Contemporaneous outbreak reports are written by the IPCT 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 in Department of Microbiology, Virology and IPC, Laboratory Medicine.
Divisions fund own audit and surveillance staff.
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 *2016/17*

5:1 **MRSA bacteraemia =** 3 **episodes**
5:2 MSSA bacteraemia = 36 RCAs showed line infection is the most common cause.
5:3 E. coli bacteraemias = 21 episodes
5:4 ***Glycopeptide resistant enterococcal bacteraemia (GRE)*** = *2*
5:5 Clostridium difficile **associated disease** = 4 reported; 0 lapse in care.
5:7 GOS acquired Central Venous Catheter related bacteraemia = 1.7/1000 line days. This equates to 87 episodes, and is a non-statistically significant Increase from last year's rate of 1.4. We are implementing additional actions to try to reduce further.
5:8 Other bacteraemia episodes and antimicrobial resistance – 660 positive blood cultures, with 777 isolates, from just over 400 clinical episodes.
Review of the antibiotic resistance of the most clinically significant gram negative infection (82 isolates) is the lowest we have experienced.

5:10 Surgical Site Infection Surveillance and Prevention

J M Barrie Surgery (except Neurosurgery) – continuous active surveillance programme. National comparison suggested we were an outlier for spinal surgery, but it is a complex case mix. Active care plan in place. Implementation of One together programme to improve standardisation of pre-, intra- and post-operative care bundle.
J M Barrie Neurosurgery – a continuous surveillance programme VPS infection is maintained at a low rate.
Cardiothoracic – no annual surveillance for 16/17. Continuous surveillance has re-commenced.

5:14 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. There was an increase in admitted and potentially acquired in hospital infection with major outbreaks requiring ward closure for control of enteric viruses.

Respiratory viral infections detected:			
	Total	Community onset	Hospital onset
Total in 2013/14	252	172	80
Total in 2014/15	399	302	97
Total in 2015/16	333	230	103
Total in 2016/17	374	262	112
Enteric viral infections detected			
Total in 2013/14	360	229	131
Total in 2014/15	352	199	153
Total in 2015/16	351	212	139
Total in 2016/17	499	281	218

5:11 MRSA Admission Screening and rates

We continue with a universal admission screening policy, with daily report to wards to facilitate compliance.

MRSA cases of colonisation/carriage at GOSH

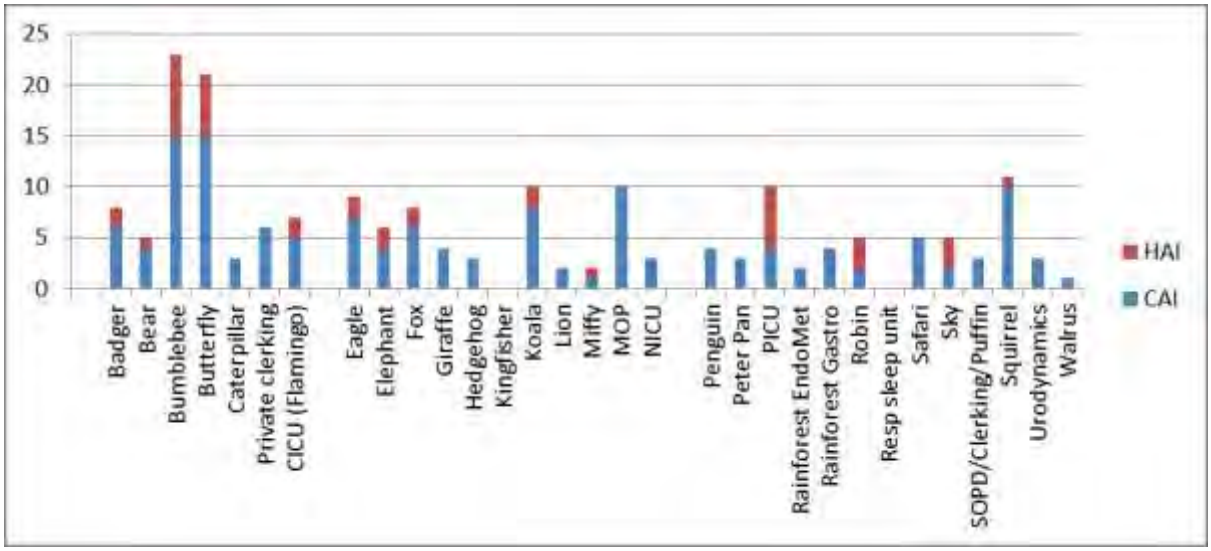
In 2016/17 there were 234 children with first detections, 18 probably or possibly acquired in the hospital. Each case is investigated. There were no outbreaks.

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

Universal admission faecal screening is advocated for standard multidrug resistant isolates and carbapenem resistance.

MDR-GN carriage/colonisation - In 2016/17 testing revealed 186 first detections same as previous years), with 41possible cross infection. These are found across the Trust.

Bar chart showing location of children colonised on admission or subsequently found to be colonised with multiple resistant gram negative bacteria by ward in 2016/17



5.17b Vancomycin resistant enterococci – an increase in carriage has been detected, predominantly associated with sporadic out of hospital acquisition. Surveillance is ongoing.

5:18 Serious Untoward incidents and complaints involving Infection, major outbreaks and threats

Serious Incidents: In the 2016/17 financial year there were no SIs declared involving IPC.As listed under 5.15 Viral Gastroenteritis, ward closures were necessary in the control of 4 outbreaks this year.

6 Hand Hygiene, CVC on going care guidelines

The emphasis on carrying out hand hygiene at the 'point of care' through the '5 moments' campaign has been adopted across the organisation; with regular audit of this and CVC ongoing care. See section 9.

The drop in audit completion continued in 2016/17 and the Divisions have elected to modify the process through focused audit day (JMB) or matron audit (CW).

7) Facilities

Environment

A new Soft FM Services Contract was awarded to the successful bidder Outsourced Client Solutions (OCS). The contract commenced 1 August 2016 with an initial duration until 31 July 2021. Completion of work plans and schedules was slow. Bin and catering reviews are underway.

Decontamination

The Sterile Services provision of service for GOSH will move to a new provider,Steris IMS. from 1 November 2017.
Implementation of NICE IPG 196 for reduction of risk of transmission of Creutzfeldt-Jacob disease (CJD) vie interventional procedures is nearly complete.

8. Estates

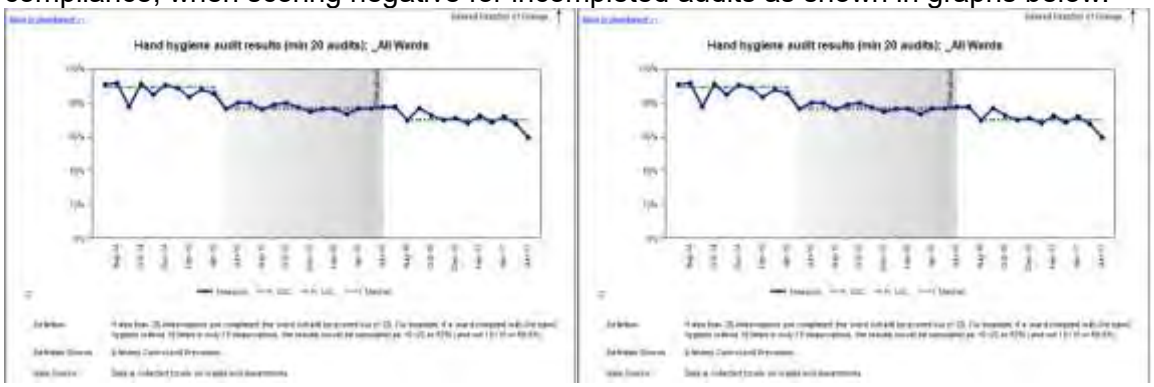
The extensive programme of verification of specialist ventilation was followed in theatres and most areas, but was not able to proceed to schedule in clinical ward areas. This has been prioritised in 2017/18 with ward closures underway to accommodate annual requirements. Water Safety Management Group continues to develop and manage risk associated with water. There is an expanded programme to control risk from *Pseudomonas aeruginosa*. Low temperature hot water system in MSCB operates satisfactorily.
Risk from heater cooler units has been identified as low risk but on going pending manufacture of new equipment (nearly complete).

9 Trust wide audit

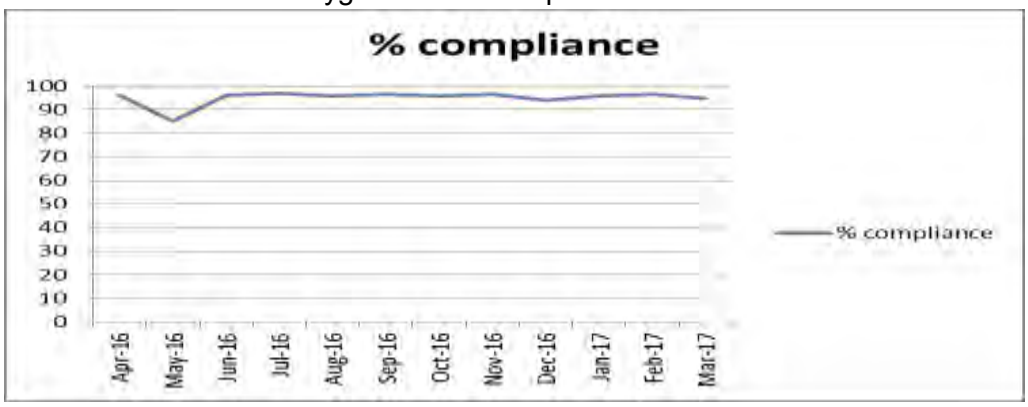
A Trust annual IPC audit programme is followed. Individual ward and 'All Trust' compliance is published monthly on the dashboards and reviewed by Divisional and Nursing boards.

Hand Hygiene and CVL care bundle compliance

Audit completion compliance rates continued to decreased in hand hygiene and CVL bundle compliance, when scoring negative for incompleted audits as shown in graphs below:



Absolute number hand hygiene audit compliance for ward based audit



Developments: Because of the differences between the audit processes and recognition of an audit fatigue, the IPC and Divisional teams have considered these audit reports and elected to modify the process. The J M Barrie Division will be championing a more intense audit day with action plan while C West is asking the senior nurses to undertake the audit themselves.

9:5 Antibiotic prescribing and audit; AMS; Sepsis

Undertook CQUIN 4: antimicrobial resistance and stewardship. We developed definitions, achieved the data requirements and established an excellent surveillance system. 72 hour review compliance review was excellent, but did not achieve the 1% reduction in consumption. The systems have been the foundation for future monitoring and clinical systems. The new AMS committee plans for 17/18 are in the full text.

Surviving Sepsis: A Quality Improvement programme was established in September 2016 under leadership of Ms Claire Rees. This is ongoing. Update in full report.

10 Occupational Health

OH continues to provide 'new entrants' screening ,"Exposure Prone Procedures" clearance, staff immunisation (including influenza, final uptake 62% up again (48% last year) and blood borne virus exposure follow up (74 events, compared to 88 in previous year).

11 Targets and Outcomes	Target	Outcome
MRSA bacteraemia –	0	3
Clostridium difficile infection lapses in care	<14	0
Rate of GOS acquired line infection /1000 days	< 1.3	1.7
Analysis for S. aureus bacteraemias	100%	100%
MRSA colonisation acquisition	0	18
Hand hygiene audits (total audits 16646)	95%	96%
CVL care bundle audits (total audits 2809)	90%	88%
For substantive staff:		
IPC level 1 induction	95%	96%
IPC level 2 update	95%	80%

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, uptake is improving.

New training modules:
The new induction 'game' has almost completed development and will be introduced.
A new online level 2 update training package has now been created and released, with focus on standard precautions, and target to achieve 95% completion.

IPC training days: A popular training day programme continues.

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.

13. Summary

There is a fully functioning Infection Prevention and Control programme established at GOSH with involvement of all staff.

From an infection prevention and control view, overall this year we have continued to provide a safe passage for the majority of the 40 000+ admissions cared for, with provision of clean safe environment and equipment and the avoidance of infection. We have also reduced serious blood stream infections form gram negative antimicrobial resistance organisms to the lowest ever, which represents the outcome of an enormous control effort by patients, families, staff, labs, estates, facilities and all. However, health care associated infections still occur. We had an increase in blood stream infections (from non-resistant organisms) some of which may be explained by case mix. A particular problem was experienced with enteric viruses, including need for ward closures to control. While more children were admitted with infection, subsequent lack of control arises from failure to recognise and contain the risk early. Undertaking of routine hand hygiene audit continued to drop, although compliance during recorded observations by ward staff remained high. The same applies to central venous line care bundles, although compliance was not satisfactory. The two clinical divisions are addressing the non-completion of audit through new audit process; we continue to stress the importance of a full assessment of infection risk and implementation of actions when a patient is symptomatic.

In an effort to understand better the achievable target and gain new perspectives, the IPC Clinical Scientist will be undertaking a sabbatical at Boston Children's Hospital later this year.
J C Hartley DIPC

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27 September 2017

Integrated Performance Report: July & August 2017 (Month 4 & 5 2017/18) **Submitted by:** Nicola Grinstead, Deputy Chief Executive / Peter Hyland, Director of Operational Performance and Information	**Paper No: Attachment N**

Aims / summary

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

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

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

In addition, this report included a deep dive related to improve the Trust theatre utilisation, as well as a report detailing the Kite Marking scores for the Trust Performance Report.

Action required from the meeting

Board members to note and agree on actions where necessary

Contribution to the delivery of NHS Foundation Trust strategies and plans

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

Financial implications

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

Who needs to be told about any decision?

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

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

Each Domain / Section has a nominated Executive Lead

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

As above

Trust Board Dashboard - August 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

Caring

	Jun	Jul	Aug	Trend	Plan	NHS Standard
Access to Healthcare for people with Learning Disability				→		
% Positive Response Friends & Family Test: Inpatients	97.80%	97.12%	97.11%	↓		95%
Response Rate Friends & Family Test: Inpatients	30.29%	23.34%	23.37%	↑	40%	
% Positive Response Friends & Family Test: Outpatients	93.66%	94.33%	90.77%	↓		95%
Mental Health Identifiers: Data Completeness	98.96%	98.86%	0.00%	↓		97%

Safe

		Jun	Jul	Aug	Trend	Plan	NHS Standard
Serious Patient Safety Incidents	In-month	1	2	0			
	YTD	5	7	7	→		
Never Events	In-month	0	0	0	→		0
	YTD	1	1	1	→		0
Incidents of C. Difficile	In-month	0	1	3	↓		1
	YTD	3	4	7	-		15
C.Difficile due to Lapses of Care	In-month	0	0	0	→		1
	YTD	0	0	0	→		
Incidents of MRSA	In-month	0	0	0	→		0
	YTD	0	0	0	→		0
CV Line Infection Rate (per 1,000 line days)		0.63	1.75	1.42	↑	1.6	
WHO Checklist Completion		99.63%	99.87%	98.77%	↓	98%	
Arrests Outside of ICU	Cardiac Arrests	1	0	2	↓	5	
	Respiratory Arrests	1	2	9	↓		
Total hospital acquired pressure / device related ulcer rates grade 3 & above		0	0	1	↓	0	

Responsive

		Jun	Jul	Aug	Trend	Plan	NHS Standard
Diagnostics: Patients Waiting <6 Weeks		97.73%	97.77%	0.00%	↓		99%
Cancer 31 Day: Decision to Treat to First Treatment		100%	100%		→		96%
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Surgery		100%	100%		→		94%
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Drugs		100%	100%		→		98%
Last Minute Non-Clinical Hospital Cancelled Operations		46	40		↑		
Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard		7	3		↑		0
Same day / day before hospital cancelled outpatient appointments		1.24%	1.10%	1.03%	↑		
RTT: Incomplete Pathways (National Reporting)		89.26%	89.84%	0.00%	↓		92%
RTT: Number of Incomplete Pathways (National Reporting)	<18wks	5612	5808	0	↓		-
	>18wks	675	657	0	↑		-
RTT: Incomplete Pathways >52 Weeks - Validated		16	10	0	↑		0
Number of unknown RTT clock starts	Internal Referrals	43	36	0	↑		-
	External Referrals	1755	1580	0	↑		-
RTT: Total Number of Incomplete Pathways Known/Unknown	<18 weeks	7396	7386	0	↓		-
	>18 weeks	689	695	0	↑		-

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

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

People, Management & Culture: Well-Led

		Jun	Jul	Aug	Trend	Plan	NHS Standard
Sickness Rate		2.22%	2.22%	2.25%	↓	3%	
Turnover	Total	19.0%	18.9%	18.4%	↑	18%	
	Voluntary	15.8%	15.8%	15.4%	↑	14%	
Appraisal Rate		88%	87%	85%	↓	90%	
	Consultant	83%	81%	78%	↓		
Mandatory Training		91%	91%	91%	↑	90%	
% Staff Recommending the Trust as a Place to Work: Friends & Family Test		73%				61%	
Vacancy Rate	Contractual	11.5%	8.4%	9.0%	↓	10%	
	Nursing	10.1%	13.7%	0.0%	↑		
Bank Spend		5.7%	5.9%	5.7%	↑		
Agency Spend		2.23%	2.36%	2.22%	↑	2%	

Effective

		Jun	Jul	Aug	Trend	Plan	NHS Standard
Discharge Summary Turnaround within 24hrs		87.22%	88.75%	87.54%	↓		100%
Clinic Letter Turnaround within	7 working days	45.93%	44.50%				
	14 working days	75.89%	76.21%		↑	100%	
Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)		7.72%	7.30%	7.75%	↓	8.36%	

Productivity

			Jun	Jul	Aug	Trend	Plan	NHS Standard
Main Theatres	Theatre Utilisation		73.0%	69.9%	66.5%	↓		77%
	No. of theatres		16	16	16			
Outside Theatres	Theatre Utilisation		57.8%	55.3%	55.4%	↑		77%
	No. of theatres		11	11	11			
Trust Beds	Bed Occupancy		82.5%	84.7%	83.8%	↓		
	Number of available beds		414	413	391	↓		
Average number of trust beds closed		Wards	6.1	5.3	15.6	↓		
		ICU	0.2	0.5	0.4	↑		
Refused Admissions	Cardiac refusals		3	7	1	↑		
	PICU / NICU refusals		2	10	7	↑		

Activity

			Jun	Jul	Aug	Trend	Plan	NHS Standard
Daycase Discharges (YOY comparison)		In-month	2,140	2,044	2,196	↑	2,163	
		YTD	6,058	8,102	10,298		10,575	
Overnight Discharges (YOY comparison)		In-month	1,705	1,663	1,707	↑	1,567	
		YTD	4,853	6,516	8,223		8,005	
Critical Care Beddays (YOY comparison)		In-month	976	1,070	1,111	↑	1,186	
		YTD	3,157	4,227	5,338		5,711	
Bed Days >=100 Days	No. of patients		3	6	6	→		
	No. of beddays		587	1,004	1,004	→		
Outpatient Attendances (All) (YOY comparison)		In-month	22,315	21,543	20,076	↓	20,175	
		YTD	62,860	84,403	104,479		101,446	

Our Money

	Jun	Jul	Aug	Trend	YTD Target	YTD Variance
Net Surplus/(Deficit) v Plan	(1.4)	0.7	(0.1)	↓	1.1	(0.8)
Forecast Outturn v Plan	0.2	0.2	0.2	→	0.2	0.0
Better value	1.0	1.5	1.5	→	6.0	0.0
Pay Worked WTE Variance to Plan	351.5	260.0	300.0	↑	0.0	303.8
Debtor Days (IPP)	201.0	192.0	194.0	↓	120.0	(74.0)
Quick Ratio (Liquidity)	1.83	1.80	1.80	→	1.67	0.1
NHS KPI Metrics	1.0	1.0	1.0	→	1.0	0.0

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

Integrated Performance Report

Nicola Grinstead, Deputy CEO
September 2017
(Month 4 & 5 2017/18)

The child first and always

Index

Great Ormond Street Hospital for Children NHS Foundation Trust

Executive Summary

Great Ormond Street Hospital for Children NHS Foundation Trust

July & August 2017 (Month 4 & 5 2017/18)

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

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

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

The IPR additionally includes further indicators and metrics with regard to Our Money (Finance) and Productivity. These indicators are those that have been recommended by the Trust Board, Clinical Divisions and other relevant parties. The IPR is attached as an appendix to this supporting narrative. As per previously for other elements his report and narrative should continue to be looked at in conjunction with the Quality and Safety Report and Finance Report.

At the time of writing the Trust Board report, not all Month 5 (August 2017) data is available, as this falls prior to a number of key national submissions or the data has not been reviewed in time for inclusion.

Caring

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

Great Ormond Street Hospital for Children NHS Foundation Trust

Friends & Family Test (FFT)

Headlines via the Performance Report for these measures are:

- Continued very positive recommendation responses for those undertaking the Inpatient FFT (97.11% for Aug 2017)

- The rate (%) of those responding (for Inpatients) having seen signs of significant improvement (i.e. 30% plus for May and June) has tailed off over the last couple of months, back to circa 23% (being 23.37% in August Trust wide). There remains variability across the 3 Divisions and the wards. Work in underway assessing the variability and those typically more challenging areas that have frequent attenders during the reporting period. This will be updated on next month,

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

Access to Healthcare for people with Learning Disabilities

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

Safe

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

Great Ormond Street Hospital for Children NHS Foundation Trust

Serious Incidents and Never Events

As confirmed in the Performance Dashboard and in the Quality & Safety Report, there were no reported incidents in August. The YTD positions are:

- Serious Incidents = 7
- Never Events = 1

Further detail is provided in the Quality and Safety Report

Healthcare Associated Infections (HCAIs)

Incidents of C. Difficile

The Trust has now reported 4 additional incidents of C Diff (1 in July and 3 in August), taking the Trust YTD position to 7 (at M5). At this time, none of these have been found to have resulted in lapses of care, and these continue to be reviewed with Commissioners). The Trust total allowance for 2017/18 are 15 cases, as set nationally.

Incidents of MRSA

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

CV Line Infections

There has been an improvement in August to 1.42 (per 1000 line days), All incidents have or will be investigated by the lead nursing staff with involvement from the Infection Control team. As per the Q&S report, the ongoing trend / position over time is within expected levels showing no sustained outlying behaviour.

WHO Surgical Checklist Completion (> 98%)

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

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

A Grade 3 device ulcer has been reported for August, within the IPP Division. The usual processes are being followed to investigate this case by senior nursing staff.

Responsive

Great Ormond Street Hospital for Children NHS Foundation Trust

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

The Trust continues to report improvements in this area, although not delivering to the standard of 99% for patients accessing the 15 diagnostic modalities within 6 weeks of referral / request. As at July (at the time of writing this is the most recent nationally submitted position) the Trust saw 97.77% within 6 weeks. In not delivering the standard this meant that 14 patients were waiting in excess of 6 weeks at the time or the census date for the period. (In order to achieve this the Trust should not have anymore than 6 patients waiting than >6 weeks).

As shown in the table opposite, those modalities reporting patients waiting >6 weeks are: Audiology, Gastroscopy, MRI and US. Of the 14, half of theses can be attributable to process / booking issues which have been investigated by the services and being addressed. The remainder are due to patient specific issues / or patient cancellations.

The areas concerned are being reviewed to ensure that process issues are being addressed sufficiently as possible and that where patients / families cancel, the Trust has been in a position to provide reasonable notice in booking that initial diagnostic appointment. The local team is additionally seeking further clarity nationally regarding the reporting of these types of cancellations.

Contextually when comparing GOSH with other Children's Trust or other London tertiary / specialist providers, the Trust is not an outlier with differential levels of performance. Nationally out of 365 providers reporting against the standard (NHS and Independent sector) 255 in July were delivering 99% or better (it must be noted that 142 of which reported a waiting list of less than 100 and a number are also providers just offering certain specific diagnostics, rather than a full range), 38 providers 98-99%, 15 at 97-98% (of which GOSH was one) and 57 <97%.

DM01 July 2017 Modality:	% <6 Weeks	No. > 6 weeks
Audiology - Audiology Assessments	86.8%	7
Barium Enema	100.0%	
Cardiology - echocardiography	100.0%	
Colonoscopy	100.0%	
Computed Tomography	100.0%	
Cystoscopy	100.0%	
Flexi sigmoidoscopy	100.0%	
Gastroscopy	96.6%	1
Magnetic Resonance Imaging	98.0%	5
Neurophysiology - peripheral neurophysiology	100.0%	
Non-obstetric ultrasound	98.1%	1
Respiratory physiology - sleep studies	100.0%	
Urodynamics - pressures & flows	100.0%	
Trust Total	**97.77%**	**14**

Cancer Wait Times

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

Responsive

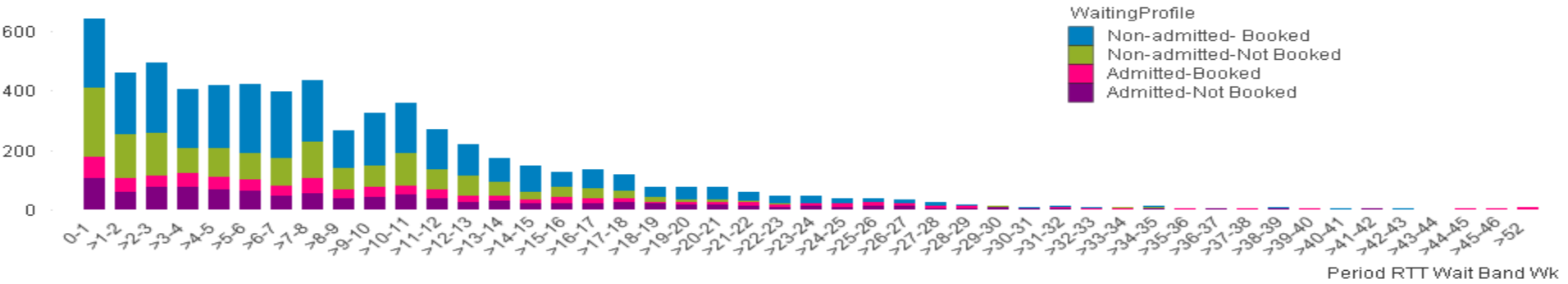
Great Ormond Street Hospital for Children NHS Foundation Trust

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

Whilst the Trust remains below the RTT incomplete standard of > 92% (of pathways waiting no longer than 18 weeks), it continues to be above its improvement trajectory. At the time of writing the most up to date submitted position was for July which was 89.84%, with the trajectory of 89.41%

Benchmarking data available nationally (for July) shows GOSH at 92 (out of 153 Trusts), and with approx. 50% of providers delivering the standard nationally. As stated previously the other children's hospitals (Alder Hay, BHC and Sheffield) are delivering the standard, however there remains variability across specialist and tertiary centres, and throughout London.

The matters reported last time associated with operational issues within the Rheumatology and Genetics service, are improving. In Rheumatology the specialty is on track to be back to compliance by December 2017 and Genetics will be compliant from August 2017 – ongoing work continues to ensure this remains a sustainable position for both services. The other known pressure areas continue to work towards delivery and with the impact of PICB this should improve the position for some key areas. The graph below provides an overview of the distribution of the Trust's RTT wait times (for those with known clock start pathways). As is evident the number of long waiters >52 weeks continues to improve.



52 week waits:
The position has now improved from the slight increase seen over the last couple of months (associated with the specialty level issues flagged previously). Of the 10 reported in July 2017 – these spread across a range of specialties (plastics, spines, rheumatology, neurology and genetics).

Since reporting 6 pathways had clock stop activities in August, and 4 planned for September (with TCIs).

Unknown clocks starts:
The number of pathways with an unknown clock start (i.e. referred to the Trust without confirming the start date of the pathway) has increased over recent months, however in July an improvement was seen off the back of a further push in engaging with referring Trusts and escalating where necessary (reducing it to 20%, and week on week improvements continue to be seen).

Responsive

Great Ormond Street Hospital for Children NHS Foundation Trust

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

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

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

Positively this trend continue into July with the Trust only having 40 last minute non-clinical hospital cancelled operations

Focused work remains on-going within key areas to continue to build on these improvements. Operational teams continue to balance between urgent / emergency cases versus elective with bed capacity remaining a challenge. Certain specialties are additionally being reviewed (e.g. Radiology), and further escalation steps have been put in place with operational senior management teams.

Q1 also reported a significant improvement in rebooking last minute cancelled operations within 28 days of the cancellation, with only 14 (compared to 25 in Q4 16/17). For July this continues with only 3 of the 40 cancellations not able to be booked within the standard (within Cardiac Surgery/Cardiology and Dermatology). All potential 28 days breaches are being escalated and reviewed by the Divisional Operational Directors.

Well-Led

Great Ormond Street Hospital for Children NHS Foundation Trust

Workforce Headlines

- **Contractual staff in post:** Substantive staff in post reduced to 4099.4 FTE (full-time equivalent) in August. This is 218 FTE (5.6%) higher than the same month last year. The Trust has a significant number of new starters in the recruitment pipeline
- **Unfilled vacancy rate:** The Trust's unfilled vacancy rate is currently 9%, which is a slight increase on the previous month, but below target. The rate is expected to reduce in the coming months
- **Turnover** is reported as voluntary turnover in addition to the standard total turnover. Voluntary turnover currently stands at 15.38%; this reported value excludes non-voluntary forms of leavers. Total (voluntary and non-voluntary) turnover has reduced to 18.4% in August 2017.
- **Agency usage** for 2017/18 (year to date) stands at 2.2% of total paybill. The Trust has established a Better Value Scheme scrutinising all agency spend. NHS Improvement (NHSI) have set an agency spend ceiling for all Trusts (3% for GOSH, £6.525 million) and the Better Value Scheme aims to achieve overall savings of £250K. Breaches of the NHSI cap continued to reduce month on month
- **Statutory & Mandatory training compliance:** In August the compliance across the Trust remained at 91%. Currently, all directorates/divisions are meeting the in-year 90% compliance requirement.
- **Sickness absence** remains below target at 2.25% and below the London average figure of 2.8%. Short-term sickness (STS) (episodes of sickness up to 4-weeks) is 1.32%, while long term sickness is at 0.93%
- **PDR completion rates** The appraisal rate has reduced to 85%, which is below target, however the Trust continues to benchmark well and is above it's long term average. The reduction reflects an expected seasonal trend which will be reversed in the next few months.

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

Well-Led

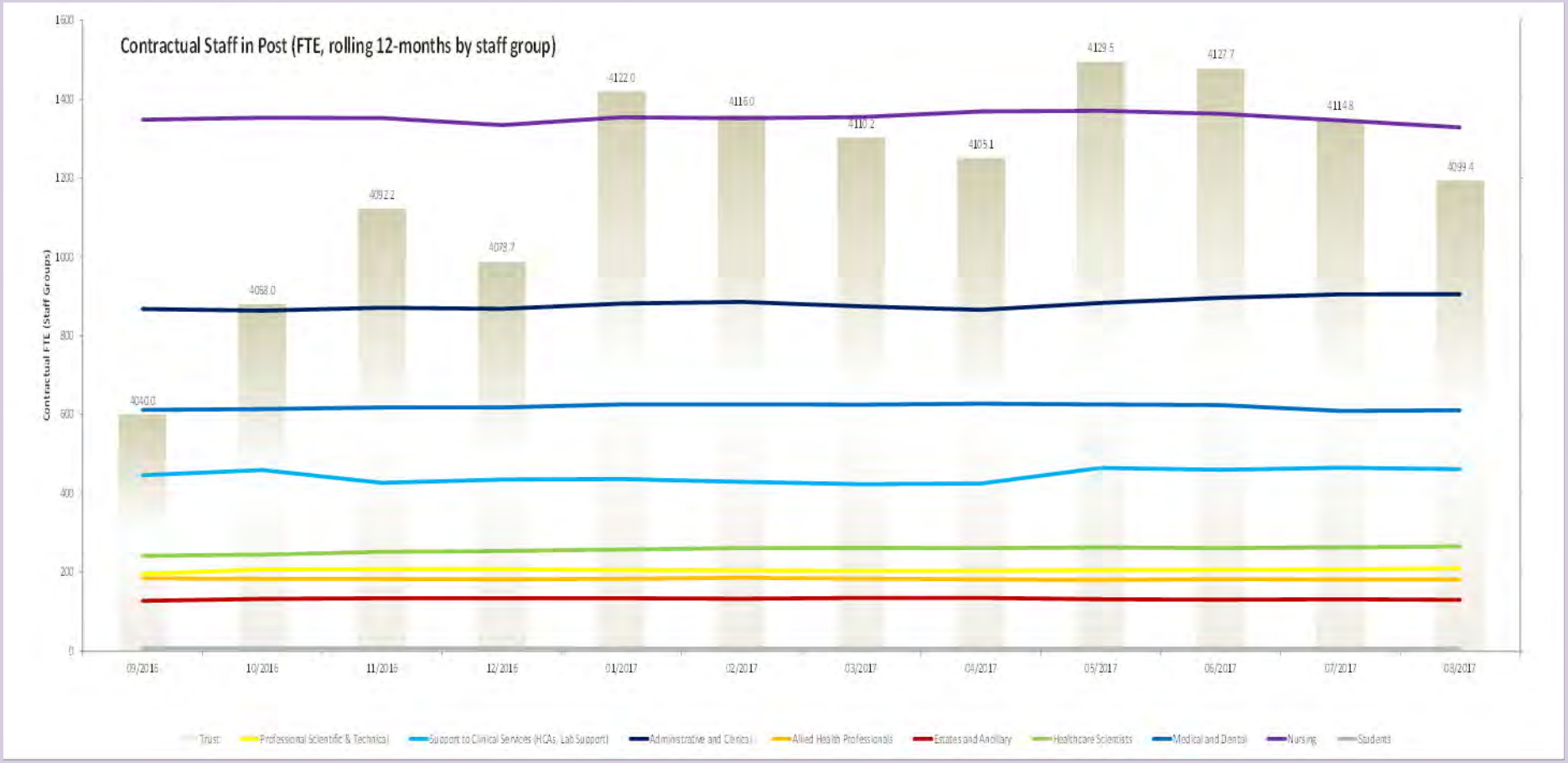
Great Ormond Street Hospital for Children NHS Foundation Trust

Trust KPI performance August 2017

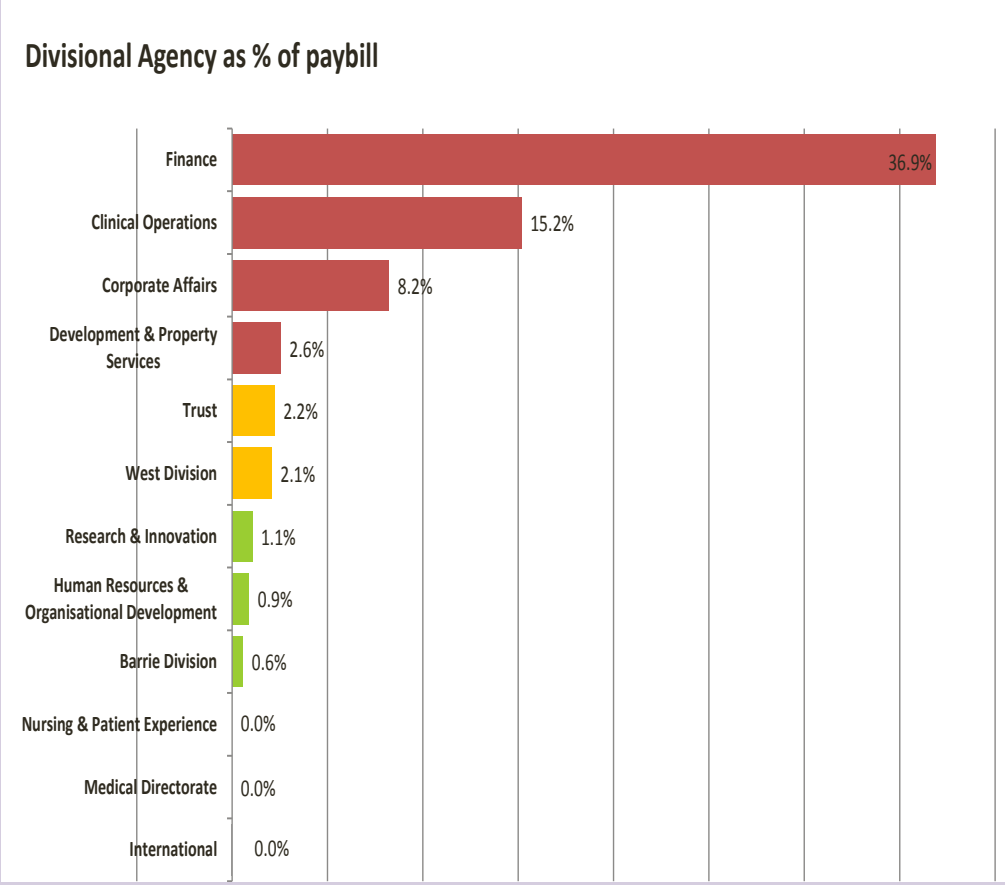
Metric	Plan	Aug-17	3m average	12m average
Voluntary Turnover	14%	15.4%	15.7%	16.1%
Total Turnover	18%	18.4%	18.8%	18.9%
Sickness (12m)	3%	2.3%	2.2%	2.3%
Vacancy	10%	9%	9.6%	8.1%
Agency spend	2%	2.2%	2.3%	3.2%
PDR %	90%	85%	87%	85%
Statutory & Mandatory training	90%	91%	91%	88%

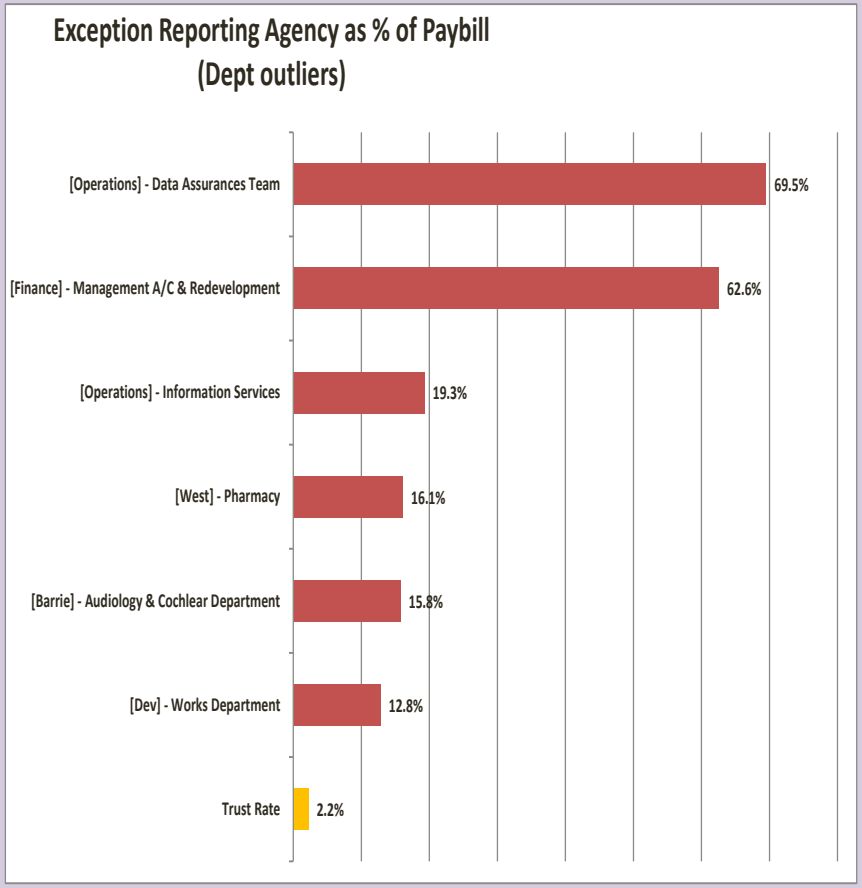
Key:
Achieving Plan **Within 10% of Plan** **Not achieving Plan**

Substantive staff in post by staff group

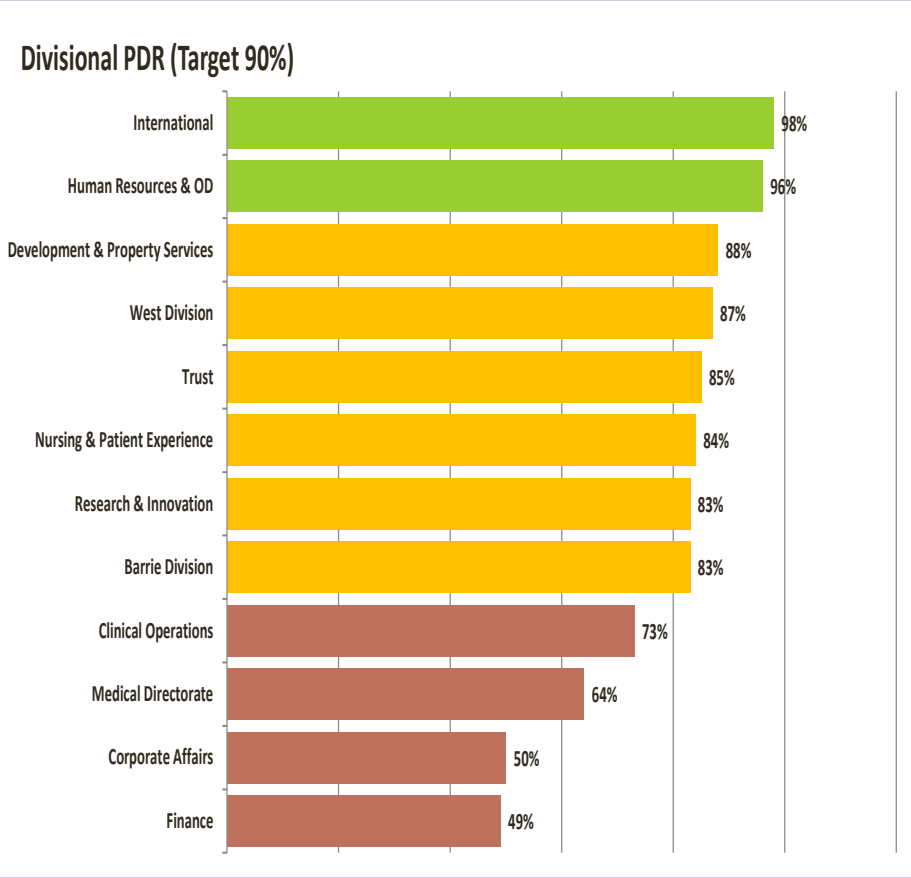


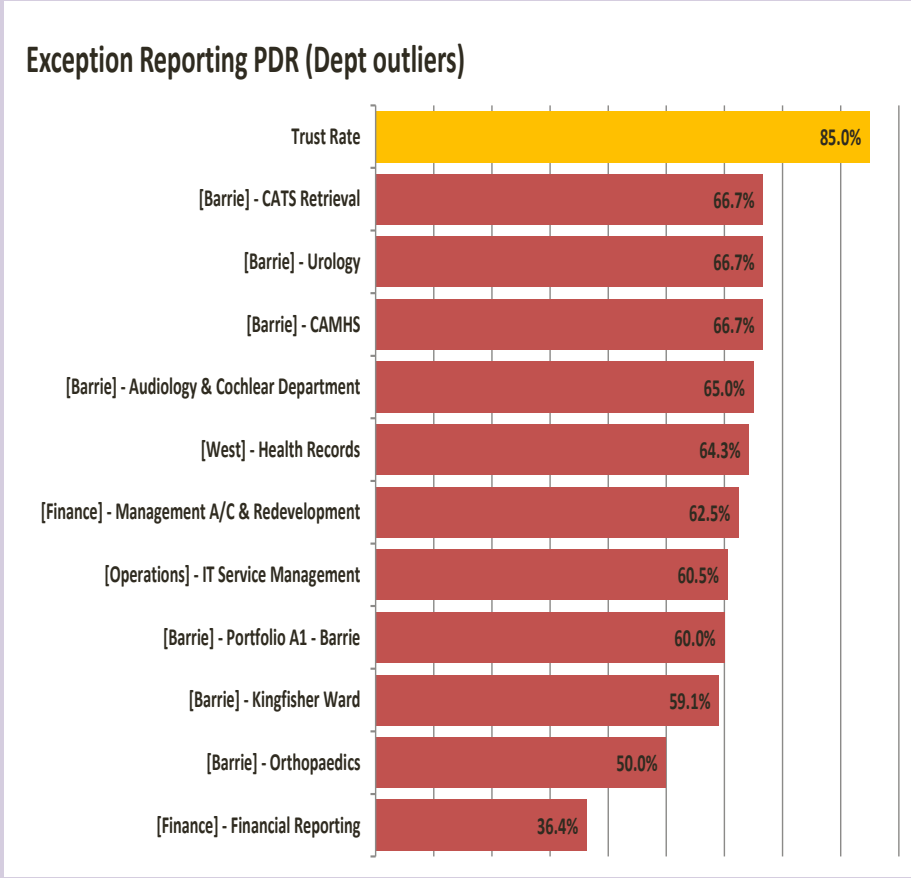
Agency Spend: Exception report





PDR: Exception report





Well-Led

Great Ormond Street Hospital for Children NHS Foundation Trust

Workforce: Highlights & Actions

Sickness %

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

Agency Spend

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

Voluntary Turnover Rate

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

Workforce: Highlights & Actions

PDR Completion

- Simplifying the reporting process of PDRs has supported managers in working towards their PDR targets. The HRBPs are continuing to support managers in identifying the PDRs that are required for completion.
- Performance management via divisional reviews continues.
- PDR rates now regularly reported and accessible via the intranet.
- Continued reminders to individuals and line managers
- HRBP working with Director of Ops to improve PDR performance - now sending out PDRs plans for 17/18 for services in J.M. Barrie.
- HRBP's escalating long term PDR non-compliance with relative managers
- PDR rates are a rolling agenda item for Performance Meetings within the Divisions / Directorates.

Statutory & Mandatory Training Compliance

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

Effective

Great Ormond Street Hospital for Children NHS Foundation Trust

Discharge Summaries

As is evident from the SPC chart and the dashboard, performance in this area continues to fluctuate. For August 2017 the position was 87.54% sent within 24hrs of discharge, which is a slight dip on July

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

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

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

Clinic Letter Turnaround times

For July (as this indicator is reported a month in arrears), improvements have been seen in relation to 14 day turnaround to 76.21%. For those sent within 7 working days, this remains around comparable previous levels of 44.5%. As with the above specific specialties are being targeted by the service management teams to ensure turnaround is improved.

Productivity

Great Ormond Street Hospital for Children NHS Foundation Trust

Theatres

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

As at August utilisation of Main Theatres has dropped to 66.5%. As part of the Better Value work streams this provides increased transparency on theatre productivity in future months, and what is presented here may be updated / improved.

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

Beds

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

Occupancy: For the reporting period of August 2017 occupancy has dropped slightly on previous levels to 83.8%. Further analysis will be required with regard to day and overnight occupancy levels, and what the range of occupancy is across the Trust, whether this can be understood because of the case mix and patients using those beds, and where opportunities exist to improve. For the same period the average number of beds closed are much higher that that the previous 2 months, as a consequence of Fox ward being closed for 17 days (as a consequence of air handling works).

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

Activity

The YTD activity across Day case discharges and critical care bed days are lower than the same reporting period for last year (i.e. up to M5). Inpatient and outpatient attendances are up.

Included for this month is the populated indicator looking at long stay patients. This looks at any patient discharged that month with a length of stay (LOS) greater than 100 days, and the combined number of days in the hospital. For August, the Trust had 6 patients discharged that had amassed a combined LOS of 1004 days. In future reports, further information will be given to provide context behind the stay etc.

Our Money

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary

This section of the IPR includes a year to date position up to and including August 2017 (Month 5). In line with the figures presented, the Trust has a YTD surplus of £0.3m which is £0.8m behind plan. The Trust is currently £0.4m behind the control total.

- Clinical Income (exc. International Private Patients and Pass through Income) is £3.3m higher than plan
- Non Clinical revenue is £0.7m lower than plan
- Private Patients income is £2.3m lower than plan
- Staff costs are £1.0m lower than plan
- Non-pay costs (excluding pass-through costs) are £3.1m higher than plan.

Appendices

Great Ormond Street Hospital for Children NHS Foundation Trust

Appendix I – Integrated Performance Dashboard

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

Appendix II – Definitions

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

Appendix III – Data Quality Kite-Marking

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

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

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

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

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

TRUST BOARD PERFORMANCE DASHBOARD: KPI DEFINITIONS

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

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

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

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

KITE MARKING SUMMARY SEPTEMBER 2017

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

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

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

Background

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

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

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

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

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

Progress made to date

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

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

Domain	Lead	Total Count	Sufficient Assured		Insufficient Assured		Yet to be Assured		Action Plans Reqd	Action Plans Outstanding		Action Plans Over Due	
			Count	%	Count	%	Count	%		Count	%	Count	%
Caring	Juliette Greenwood, David Hicks	49	35	71.4%	0	0.0%	14	28.6%	0				
Safe	Juliette Greenwood, David Hicks	70	61	87.1%	2	2.9%	7	10.0%	2	2	100%	2	100%
Responsive	Nicola Grinstead	98	78	79.6%	20	20.4%	0	0.0%	14	5	25%	4	20%
People, Management & Culture: Well-Led	Ali Mohammed	63	45	71.4%	18	28.6%	0	0.0%	5	0	0%	0	0%
Effective	Nicola Grinstead	28	15	53.6%	13	46.4%	0	0.0%	4	0	0%	4	100%
Productivity	Nicola Grinstead	98	74	75.5%	24	24.5%	0	0.0%	14	4	29%	11	79%
Our Money	Loretta Seamer	49	48	98.0%	1	2.0%	0	0.0%	1	0	0%	1	100%
Grand Total		455	356	78.2%	78	17.1%	21	4.6%	40	9	23%	21	53%

In summary:

- 78.2% of indicators (356) have been assessed as sufficient assurance
- 17.1% of indicators (78) have been assessed as insufficient assurance

- 4.6% of indicators (21) are yet to be assessment..

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

Next Steps

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

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

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

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

    - **Finance KPIs-** October 2017
    - **Quality Improvement Indicators**- October 2017
    - **All other Trust Indicators**- On-going

Appendix V
Theatre Utilisation Update
Trust Board
September 2017

Introduction

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

This paper sets out the following:

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

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

1. Current operating context for theatres

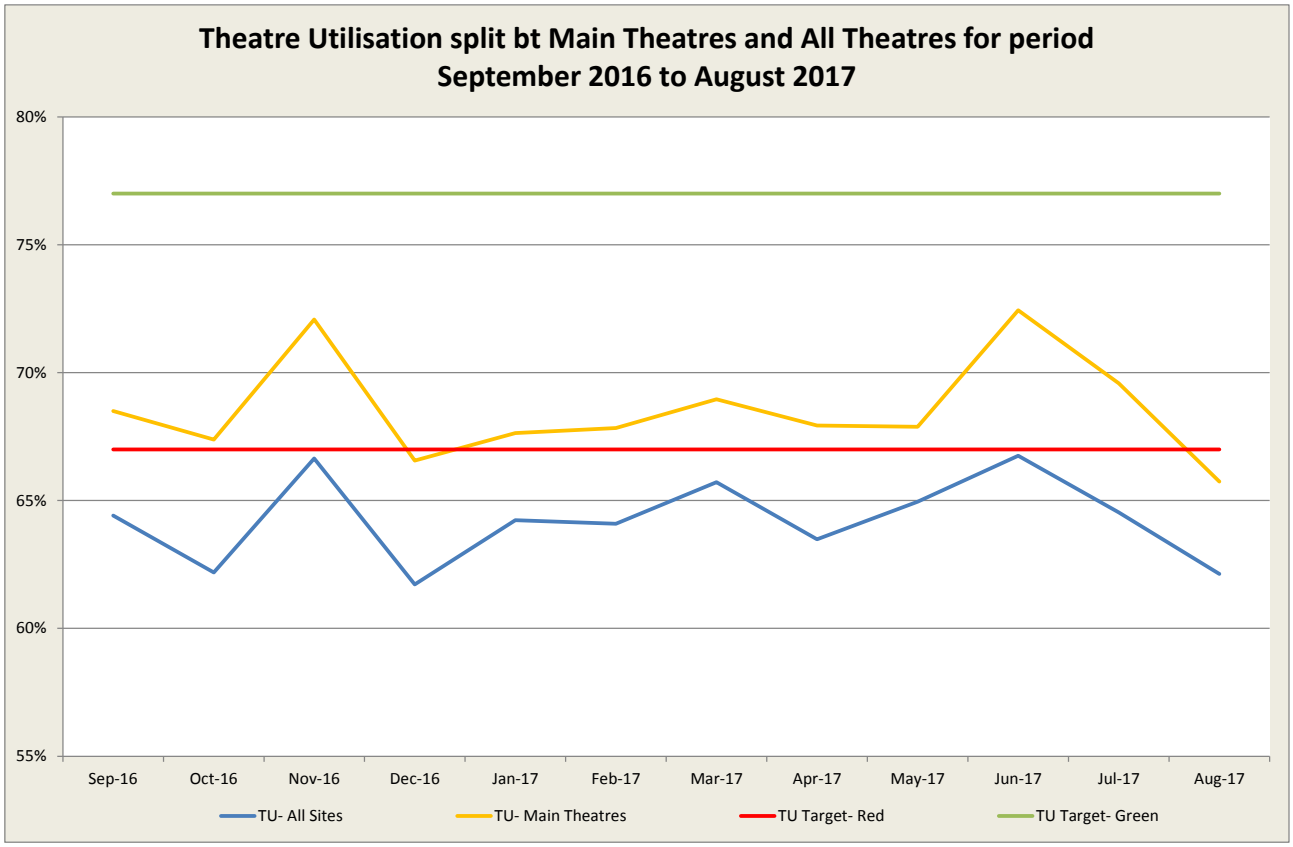
Theatre utilisation has previously been identified as an area where improvement is required to ensure that we maximise the use of resources and improve the quality of experience for our patients by providing more timely care.

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

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

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

For the rolling twelve month period to the end of August 2017, theatre utilisation for all theatres stood at an average of 65.5% for NHS elective care operations (excluding private patients and emergency cases). However the focus of the project has been around the Trust main theatres where theatre utilisation stood at 68.9% on average for the rolling twelve month period. Due to the complexity and specialist nature of the work undertaken at GOSH it may be difficult, in some areas, to regularly achieve 77% utilisation.



2. Detailed update on the Better Value Theatre Utilisation project

The aim of the project is develop more productive and efficient working processes leading to increased throughput, reduced cancellations, improved patient and staff experience and achievement of the Better Value target of £1m. This will be achieved through identification of cash releasing savings in theatres, by way of efficient and effective processes and income generation/absorption of growth through improved list utilisation. This will be delivered in the 2017/18 better value programmes by ensuring that all pass-through non-pay items are billed (£200k) and by creating a number of work streams within specific specialties to enable a higher throughput on existing lists (£800k).

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

ENT and Dental & Max-Fax

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

SNAPs and Ophthalmology

- Reduce hospital cancellations of elective patients for emergency/urgent cases by holding time on each elective list for urgent cases.
- Patients are often cancelled days before surgery due to lack of beds. The aim of this work is to reduce the volume of cancellations, but while advising patients of cancellation risk to ensure that patients are only cancelled if they absolutely have too.
- Review of scheduling 'rules' to ensure that patients requiring pre-meds arrive in the first tranche of staggered arrivals and that an NHS patient from AOD is first on the list (link to 'Golden Patient' project).

- Amend PIMS so that two half day lists are scheduled as an all-day list with flexible lunch allowing more flexibility for longer cases to ensure that utilisation of theatre lists is appropriately reflected (data quality issue) (

Interventional Radiology

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

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

Haem-Onc, Dermatology and Cardiology

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

Spinal Pathway Review

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

- Reviewing the length and wording of the patient surgery confirmation letter
- Working with the patient placement programme regarding earlier confirmation of bed availability
- Scope opportunity to introduce longer session days.

Scheduling

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

Anaesthetic Pre-Operative Assessment (APOA)

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

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

Dedicated Emergency Lists

The two objectives of this group are:

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

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

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

There has been a slight drop in the number of same day cancellations for emergency cases, with performance averaging at 5.4% between April 2016 and December 2016, to 4% between April and June 2017. The monthly average number of emergency cancellations has fallen from 12 to 8 for the same period.

Recruitment of a Clinical Operations Manager in J.M. Barrie

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

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

Due to inconsistencies in the reporting and quality of data used to support theatre reporting, the Trust has developed a new theatre dashboard which went live in August 2017 and has significantly improved the visibility and robustness of theatre information.

New Theatre Dashboard

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

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

An example of the dashboard is provided in appendix 1.

Although the use of the new Theatre Dashboard is in its infancy, it has been extremely well received across the organisation with considerable positive feedback provided by the Operational Teams around the content. The dashboard is now being rolled out across the organisation and has become the principle reporting structure for the monitoring of theatre utilisation and other associated standards across the organisation. The Theatre team now review the reports on a daily basis to ensure robust reporting, correcting any data quality issues that are identified. In addition the dashboard is going to be used to evidence delivery of the Better Value schemes by reviewing the improvement in utilisation. Further details are provided on this in the Better Value report.

In addition the Trust recently attended a Civil Eyes theatre productivity workshop where they presented the theatre dashboard and its content to the group which included representatives from a number of other paediatric hospitals. The feedback received was extremely positive with organisations requesting us to provide more details on the work we have completed. GOSH is exploring how we can share this best practice more widely with other NHS organisations.

Data Quality Assurance

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

The theatre dashboard will provide the following functionality:

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

External Benchmarking Work

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

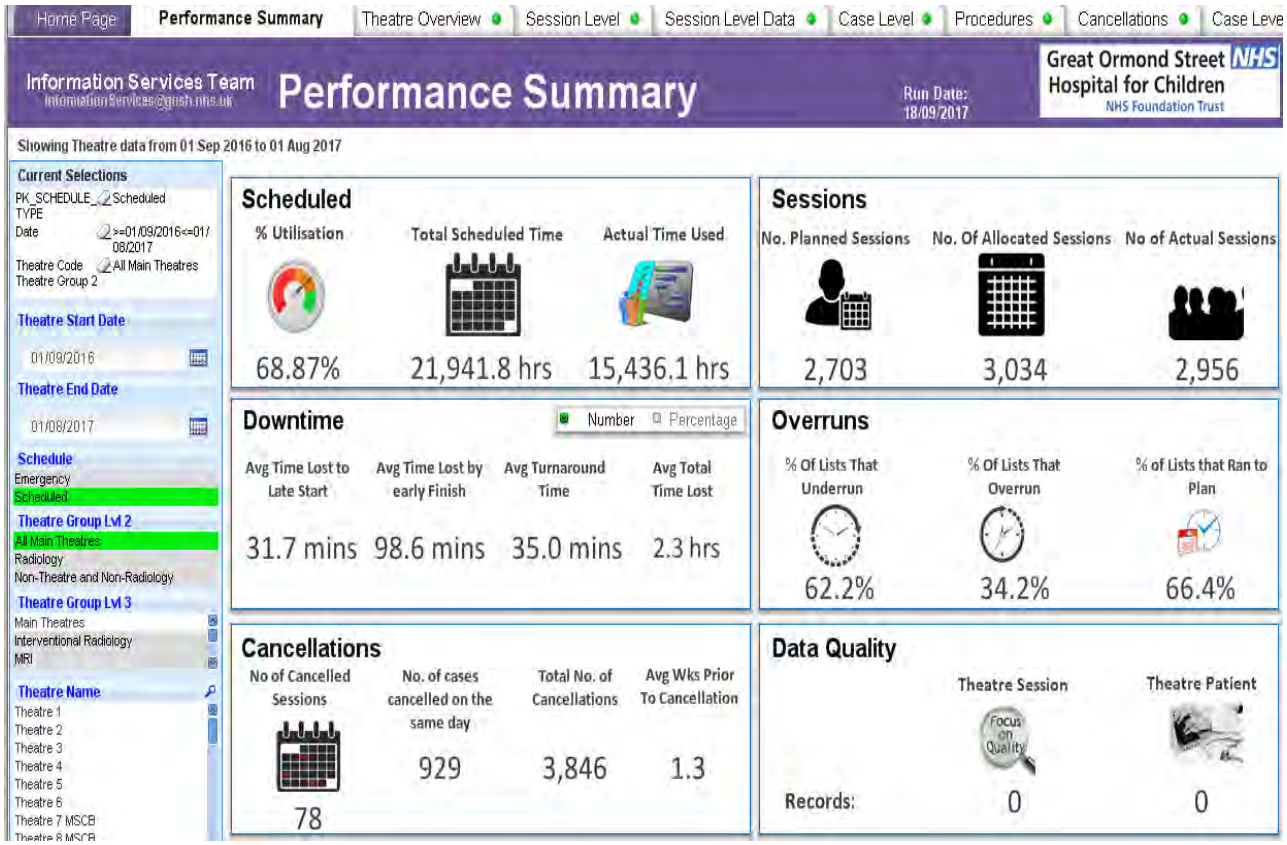
The Trust has also recently implemented and rolled out a 'magic numbers' report which compares the expected number of cases that need to be completed as defined within our NHS contract to actual activity on a monthly and weekly basis. In terms of theatres, this report can be utilised to ensure that procedure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

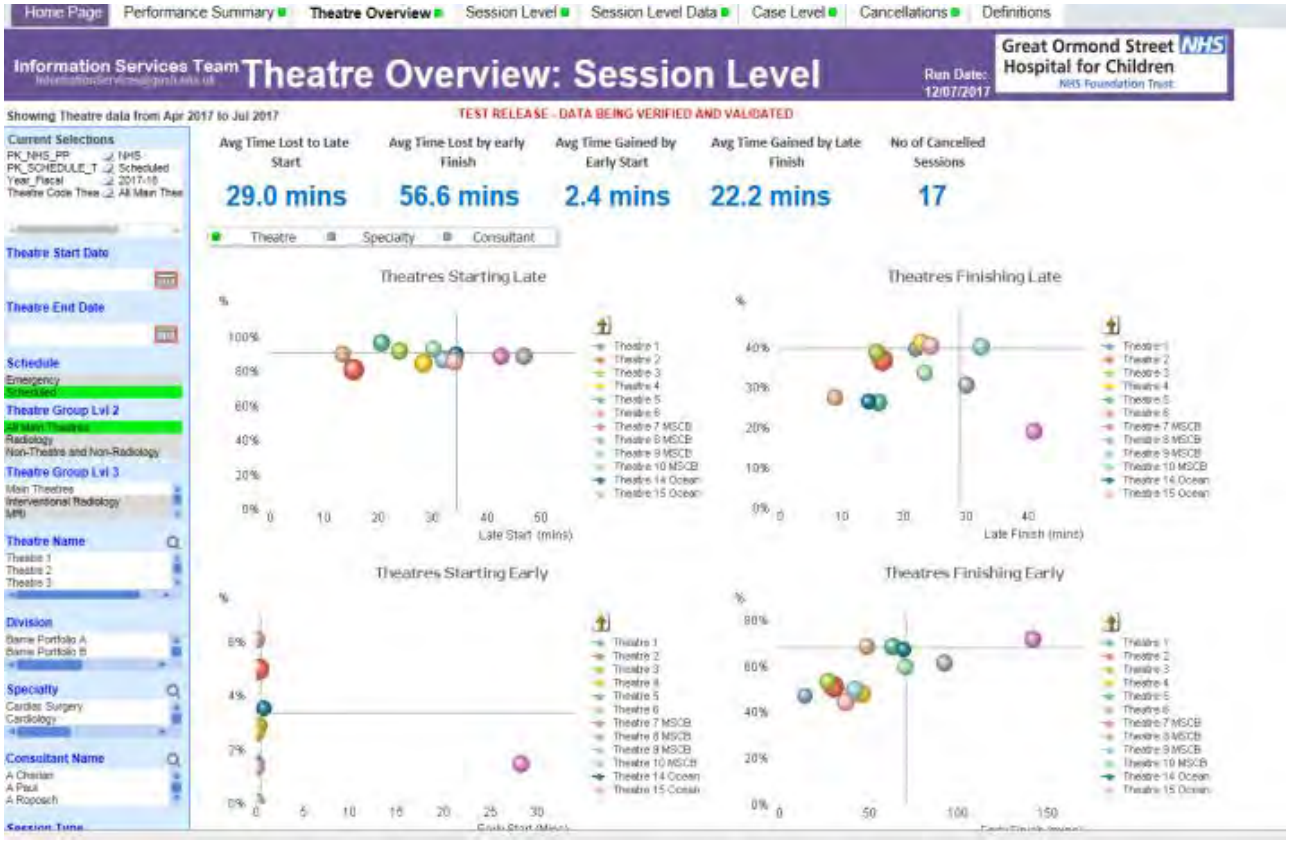
Next Steps

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

Assurance to the Trust Board will be provided regularly through use of the new scorecard which in turn will inform reporting against the Better Value scheme. In addition the Trust is proposing that further details are provided through an annual deep dive to Trust Board which explores the programme of work in more detail.

Appendix 1- Trust Theatre Dashboard- Example Reports





Home Page | Performance Summary | Theatre Overview | Session Level | Session Level Data | **Case Level** | Cancellations | Definitions

Information Services Team — **Case Level** — Run Date: 12/07/2017

Great Ormond Street Hospital for Children NHS Foundation Trust

Showing Theatre data from 10 Jul 2017 to 10 Jul 2017

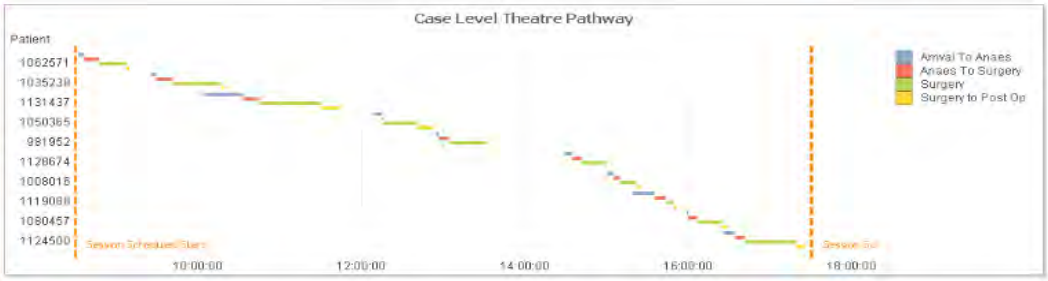
Current Selections: PK_NHS_PP: NHS; PK_SCHEDULE_T: Scheduled; Date: 10/07/2017; Year_Fiscal: 2017-18; MonthYear: Jul 2017; WC: 10/07/2017

Theatre Start Date | Theatre End Date | Schedule: Emergency, Scheduled | Theatre Group Lvl 2: All Main Theatres, Radiology, Non-Theatre and Non-Radiology | Theatre Group Lvl 3: Main Theatres, Interventional Radiology, MRI | Theatre Name: Theatre 3, Theatre 1, Theatre 2 | Division: Barrie Portfolio A, Acute Medical Services Division | Specialty: Ear Nose and Throat, Academic Genetics | Consultant Name: R Hewitt, Radiology Thtr, A Bamford | Session Type: NHS, PP | Clear Selections | Show Further Filters

Number of Active Cases	Number of cancellations	Number of same day cancellations
10	2	1

Drill down to view Case Level flow diagram

Theatre Name	Date	No Of Active Cases	% Utilisation	No Of Sessions	No Of Session Overrun	% Sessions Overrun	No Of Sessions (Underutilised)	Avg Late Start (Mins)	Avg Early Finish (Mins)	% Lost to Late Start	% Lost to Early Finish	Avg Overrun/ Underrun
Theatre 3	10/07/2017	10	0.0%	1	0	0.0%	0	-	-	0.0%	0.0%	0.0 mins
Total	**Total**	**10**	**0.0%**	**1**	**0**	**0.0%**	**0**	-	-	**0.0%**	**0.0%**	**0.0 mins**



Session Schedule: 08:30:00 - 17:30:00

Theatre	Specialty	Consultant	Patient PAS ID	NHS/PP (Case Lvl)	Arrival Time	Anaesthetic Time	Surgery Start	Surgery End	Time Into Post OP	Dept
Theatre 3	Ear Nose and Throat	R Hewitt	1062571	NHS	8:33 AM	8:37 AM	08:48:00	9:08 AM	9:10 AM	9:55 AM
			1035238	NHS	9:26 AM	9:30 AM	09:41:00	10:18 AM	10:20 AM	10:45 AM
			1131437	NHS	10:05 AM	10:34 AM	10:45:00	11:31 AM	11:44 AM	11:44 AM
			1050365	NHS	12:09 PM	12:15 PM	12:16:00	12:42 PM	12:54 PM	1:25 PM
			981952	NHS	12:55 PM	12:57 PM	13:05:00	1:32 PM	1:33 PM	2:00 PM
			1128674	NHS	2:30 PM	2:35 PM	14:42:00	3:00 PM	3:01 PM	3:27 PM
			1008016	NHS	3:01 PM	3:05 PM	15:10:00	3:22 PM	3:24 PM	4:06 PM
			1119088	NHS	3:20 PM	3:36 PM	15:44:00	3:49 PM	3:52 PM	4:39 PM
			1080457	NHS	3:59 PM	4:00 PM	16:07:00	4:25 PM	4:29 PM	5:25 PM
			1124500	NHS	4:26 PM	4:34 PM	16:42:00	5:20 PM	5:26 PM	6:45 PM

Home Page | Performance Summary | Theatre Overview | Session Level | Session Level Data | Case Level | **Cancellations** | Definitions

Information Services Team — **Theatre Cancellations** — Run Date: 12/07/2017

Great Ormond Street Hospital for Children NHS Foundation Trust

Showing Theatre data from Apr 2017 to Jul 2017

Current Selections: PK_NHS_PP: NHS; PK_SCHEDULE_T: Scheduled; Year_Fiscal: 2017-18

Theatre Start Date | Theatre End Date | Schedule: Emergency, Scheduled | Theatre Group Lvl 2: All Main Theatres, Radiology, Non-Theatre and Non-Radiology | Theatre Group Lvl 3: Main Theatres, Interventional Radiology, MRI | Theatre Name: 3TMRI, CT, IR 1 | Division: Barrie Portfolio A, Barrie Portfolio B | Specialty: Audiological Medicine, Cardiac Surgery | Consultant Name: A Barnacle, A Cherian, A G Rao | Session Type: NHS, PP | Clear Selections | Show Further Filters

Number of Active Cases	No Of Cancelled Sessions	No of Clinical Cancellations	No of Non-Clinical cancellations	Number of total cancellations
4,807	37	692	1,065	1,761

Cancellation Metrics: Weeks Prior To Cancellation

Theatre Group 2	Specialty Division Name	Clinical Cancellations	Non-Clinical Cancellations	Total Cancelled Cases	Actual Cases	% Cancelled	Same Day Cancellations	Avg Cancellation Wks Prior to Session
Total		**692**	**1065**	**1,761**	**4,807**	**26.8%**	**562**	**1.1**
All Main Theatres	**Total**	**372**	**598**	**971**	**2,405**	**28.8%**	**209**	**1.3**
	Barrie Portfolio A	282	443	725	1,855	28.1%	138	1.4
	Barrie Portfolio B	19	35	55	186	22.8%	18	1.6
	West Portfolio A	71	120	191	364	34.4%	53	1.1
Radiology	**Total**	**205**	**348**	**556**	**1,589**	**25.9%**	**291**	**0.8**
	Barrie Portfolio B	182	270	455	1,360	25.1%	269	0.4
	West Portfolio A	23	78	101	229	30.6%	22	2.3
Non-Theatre and Non-Radiology	**Total**	**115**	**119**	**234**	**813**	**22.3%**	**62**	**1.3**
	Barrie Portfolio A	24	49	73	156	31.9%	19	1.3
	Barrie Portfolio B	2	2	4	48	7.7%	2	0.5
	West Portfolio A	89	68	157	609	20.5%	41	1.3

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 27 September 2017	
Better Value Programme Update **Submitted by:** Nicola Grinstead, Deputy Chief Executive	**Paper No: Attachment P**

Aims

The attached paper summarises the current position related to the Better Value programme for 2017/18 and describes next steps being taken to secure delivery of the £15m Better Value target over the course of the year.

Summary position

The Trust is reporting it is behind its control total by £0.4m at Month 5 though is reporting recovery to the plan by the end of the Financial Year. Favourable clinical income and pay positions are mitigating some areas of slippage within the Better Value programme, which is currently showing a YTD adverse variance of £2.4m. Mitigating actions are in place to address this variance and ensure the full value of the target will be delivered by year-end. The immediate priority is to assess and sign off schemes on the existing Better Value 'pipeline' to improve the reported position noted above. Further work has been requested by EMT to identify additional cross-cutting opportunities deliverable within the year..

Recommendations

The Board is asked to:

- **Note** the reported position on programme delivery;
- **Note** the immediate priorities for the programme, which are being overseen by the EMT, with assurance on progress to be reported to the Finance and Investment Committee.

Contribution to the delivery of NHS / Trust strategies and plans

The Better Value Programme is a significant contributor to the Trust's overall financial strategy and plans. The £15m Better Value target this year is critical to deliver the Trust's overall control total and move towards a robust ongoing financial surplus. Actions described in this report are being closely monitored and managed by the Programme Office and Executive team.

Financial implications

Included within the overall Trust position

Legal issues

None

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

Deputy Chief Executive & individual project / programme leads with support of Programme Office

Who is accountable for the implementation of the proposal / project

Deputy Chief Executive

Better Value Programme Update
September 2017

Introduction

The Better Value programme is a central contributor to the Trust's refreshed strategy. Activity to deliver efficient care and generate a sustainable surplus allows us to invest and is key to delivering the strategy objective of achieving best possible outcomes through providing the safest, most effective and efficient care. In addition, aspects of the Better Value programme and the work of the Programme Office support the achievement of other priorities and enablers, including:

Strategic priority areas and enablers	Better Value and PMO contribution
We will attract and retain the right people through creating a culture that enables us to learn and thrive	The cross cutting workforce programmes must support delivery of this objective. And Programme Office work to review, share best practice and benchmark will help support GOSH to be a continually learning organisation
We will transform care and the way we provide it through harnessing technology	The Better Value programme includes some immediate ICT- enabled improvement opportunities as well as laying groundwork for more transformational change that will be delivered through EPR implementation
We will secure and diversify funding so we can treat all the children that need our care	The cross cutting Better Value programme to increase commercial and international funding will be an important contributor to this enabler

This paper provides an update on the year to-date position against the Better Value programme agreed within the Trust's Operating Plan and describes actions being taken to mitigate areas of slippage. This complements regular progress reports also provided to the Trust's Finance and Investment Committee (focussing upon financial delivery) and Quality and Safety Assurance Committee (concentrating on quality impact and assessment).

Recommendations

The Board is asked to:

- **Note** the reported position on programme delivery;
- **Note** the immediate priorities for the programme, which are being overseen by the EMT, with assurance on progress to be reported to the Finance and Investment Committee.

Overall composition of the 2017-18 Better Value programme

Through the 2017-19 Operating Plan process, the Board agreed the Trust should deliver £15m through its Better Value programme over the course of the current year. This target is to be achieved through a combination of locally-managed productivity and efficiency schemes led by Divisions plus a small number of larger Trust-wide schemes (and including a contribution from the full-year effects of schemes which started part-way through 2016-17). The £15m programme signed off within the Operating Plan was as follows:

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

Assurance of scheme specification

The Programme Office has undertaken an assurance process for all completed programme documentation - Programme Outline Documents (PODs) and Quality Impact Assessments (QIAs) - to ensure schemes have been appropriately specified with clarity on governance, responsibilities, timescales and deliverables. The QIA process is also subject to assurance led by a QIA Panel, co-chaired by the Medical Director and Chief Nurse, and reporting to the Quality and Safety Assurance Committee. Only those schemes accepted through these processes appear on the live PMO 'tracker'; other proposals currently being worked up and finalised are logged on a separate 'pipeline'.

Assurance of scheme quality impact

As described above, the established QIA processes must be successfully completed before schemes are considered to be 'live'. 43 QIAs have been signed off and the PMO is tracking progress for a further 10 QIAs as schemes are finalised on the pipeline. Progress will be reported to the Quality and Safety Assurance Committee, which also receives a trend

analysis of key quality KPIs and a programme of post implementation reviews to ensure there are no unintended consequence of programme implementation, and that any lessons are shared and learned to inform future scheme development.

Assurance of scheme delivery

The Programme Office and Finance teams work closely together to track in-year delivery, assisted by a single PMO tracker which drives financial reporting and PMO activities, and ensures there is a 'single version of the truth'. A range of additional relevant KPIs have been identified and mapped to the larger cross-cutting schemes, to be tracked and monitored by a joint Finance/PMO review team working with divisions to provide assurance before reporting on programme delivery. Example metrics include:

Cross cutting area	Measures
Flow/patient placement	Length of stay, bed occupancy, cancellations due to bed availability
Flow/theatres	Utilisation, dropped sessions, late starts, early finishes, cancellations
Flow/outpatients	Did not attends, follow up rates, cancellations, clinic utilisation
Medicines management	Time taken to dispense, medication errors
Workforce	Agency spend, management of annual leave, roster completion

Recent progress has been made on the development and launch of a new theatres dashboard and monitoring of additional workforce indicators, e.g. a range of measures to track improvements in rostering performance.

Current reported position against the Better Value programme

During Q1, the Trust's overall financial performance, in particular a favourable income position (due to coding benefits, some increased activity and predominantly favourable price changes from HRG4+), was supporting achievement of the Better Value target. However, the M5 Finance Report to this meeting describes a deterioration in the financial position, with the Trust reporting a £0.4m adverse position to the control total.

Within that overall position, tor the Better Value programme specifically, reporting against live schemes only (excluding pipeline schemes under development as described above) the schemes delivered £3.8m by month 5 – £2.4m behind plan over the year to-date (YTD); £557k of this variance relates to divisional 1% schemes, the remainder is ascribed to the cross cutting programme.

The current year-end forecast outturn for live Better Value schemes is £10.1m; adding in a further £1.9m (in-year effects) of pipeline schemes would improve this position to a potential year-end Better Value year-end forecast of £12m, although some £0.7m of these pipeline schemes have been categorised as higher risk in terms of likely deliverability within the required timescales.

Divisions are continuing to finalise and sign off additional schemes to mitigate slippage within their 1% programmes and have expressed confidence they will be able to achieve the

target in full. Similarly, at the request of EMT, the Programme Office is working with cross cutting executive SROs and divisional colleagues to finalise the attribution of some remaining cross cutting targets into local budgets as well as to identify additional schemes to mitigate slippage where proposals have proven optimistic either in terms of scale or timing. The position against each of the key areas of the programme is described further below.

Carry-forwards from 2016-17

This element of the programme relates to full year effects of schemes started part-way through 2016-17, these already having been specified and signed off last year with brought forward values validated by finance business partners. They have been incorporated into divisional and directorate budgets. Against an anticipated carry-forward of £2.7m when the Operating Plan was prepared last December, the actual carry forward position was confirmed at year-end to be £2.4m, which means a variance of £0.3m against the original plan must be found from other mitigating action either locally (additional to divisional 1% targets) or through a larger cross-cutting contribution.

Divisional 1% programme

Live schemes on the tracker for the 1% programme are forecast to deliver a contribution of £2.4m against an initial target of £3.1m and against live plans amounting to £2.7m. This means there are gaps both in terms of planning (live schemes not yet reaching the target) and of delivery (slippage against signed off plans), summarised as follows:

Division	Target	Live Plan	Forecast year end position	'Planning Gap'	'Delivery Gap'
Charles West	£1,013k	£808k	£609k	(£205k)	(£199k)
JM Barrie	£1,374k	£1,038k	£1,032k	(£336k)	(£6k)
IPP	£150k	£150k	£150k	-	-
Corporate	£601k	£696k	£576k	£95k	(£120k)
Total	£3,138k	£2,692k	£2,367k	(£446k)	(£325k)

This table excludes additional schemes being developed on the pipeline which are expected to improve the position. Taking these into account, the overall variance for the 1% programme against its share of the £15m target would reduce from £771k to £434k. The EMT is overseeing action to address this remaining gap and an update on progress both with signing off pipeline schemes into the live tracker, and on addressing the residual gap, will also be provided to the Finance and Investment Committee.

Cross cutting programme

The cross cutting programme is currently forecast to deliver in-year savings of £5.4m against an initial £9.1m target – a £0.7m improvement on the position reported last month. However, this position excludes pipeline schemes; setting aside those pipeline schemes where delivery confidence is low (valued at £0.7m), the inclusion of these schemes would improve the current year-end forecast position for the cross-cutting programme from £5.4m to £6.2m. This figure is before conclusion of the further work requested by EMT, described above, for SROs to identify additional mitigation plans to ensure in-year delivery of the required Better Value target; these plans are not yet showing on the pipeline.

The table at **annex 1** provides more information on the position against each of the cross cutting enabling work streams, and identifies that areas which currently pose the highest potential risk to financial delivery of the cross-cutting programme are:

- Procurement; and
- The workforce programme.

The Finance and Investment Committee has taken a close interest in both of these areas; it receives regular updates on progress to realise further non-pay savings through working with our procurement partners, and will be reviewing the workforce programme in detail at its November 2017 meeting. In addition for workforce in particular, a recent session with the relevant SROs, divisional, finance and PMO representatives has been held to identify new opportunities for further development. These are now being worked up into more detailed proposals for consideration and oversight by the established workforce steering group chaired by the Director of Human Resources and Organisational Development.

Next steps

The immediate priorities for the Better Value programme are summarised below, this work being overseen by the EMT:

(1) **for divisions to continue to develop and sign off their pipeline schemes and identify further Better Value opportunities** in order to deliver the full value of their targets this year – thereby reducing the need to rely upon fortuitous positive variances (income, pay) elsewhere in order to deliver the control total. Failure to achieve this would result in a requirement to set more challenging Better Value targets next year in order to deliver recurring financial balance;

(2) **for cross cutting scheme SROs to continue work with the programme office and divisional colleagues to firm up pipeline schemes and identify additional proposals** to mitigate the current adverse variance in the cross cutting programme. Significant areas of risk to be addressed described in this report include aspects of the workforce programme and procurement.

Recommendation

The Board is asked to:

- **Note** the reported position on programme delivery;
- **Note** the immediate priorities for the programme, which are being overseen by the EMT, with assurance on progress to be reported to the Finance and Investment Committee.

Annex 1 – Summary of cross cutting programme forecast position as at month 5

(note: figures in the M5 forecast are for live schemes only and do not include potential pipeline schemes)

Scheme	Target	M5 forecast	Comment
Flow – outpatients	£250k	£125k	• New outpatients improvement programme established under leadership of the Charles West Division • But likely £125k shortfall against the original £250k target in the Operating Plan will require new mitigation schemes
Flow – theatres	£1,000k	£811k	• Work is continuing under the leadership of JM Barrie Division to identify schemes to achieve remainder of the target • If pipeline schemes are included, the plan target would be exceeded as schemes valued in excess of £1m have been identified. These are now being finalised for sign off into the live programme • New theatres dashboard launched August 2017
Flow – patient placement (beds)	£1,000k	£225k	• Work continues to evidence delivery and agree KPIs that can be tracked to the financial target • Major work programme underway under leadership of Charles West Division and considered already likely to have had a significant impact – eg securing capacity to undertake a significant increase in CICU activity over the year to-date • If pipeline schemes are included, the plan target of £1m would be met and further work is being undertaken to finalise these for sign off into the live programme
Procurement	£2,000k	£854k	• Figures taken from latest update from our procurement partners and include emerging benefits from the work they commissioned from external consultants to identify new opportunities • If pipeline schemes are included, the forecast outturn would improve to £1.1m but this leaves a significant remaining shortfall requiring new mitigation schemes

Scheme	Target	M5 forecast	Comment
Medicines management	£589k	£381k	• Savings in the forecast outturn relate to cost reductions attributable to individual drugs • Remainder of the medicines management target is held by Charles West division as the host division for the pharmacy directorate • Pharmacy Review recently completed and action plan to be developed
Nursing	£540k	£153k	• Savings in the forecast outturn relate in part to apprenticeships and also to efficiencies expected from improved adherence to the Trust's rostering policy (for example improved management of annual leave reducing the need for additional bank shifts) • Some schemes within the original plan removed following detailed work up and risk assessment • New mitigating schemes now required to make up the significant gap which currently rests with the CNO as SRO
AHPs and Healthcare Scientists	£250k	-	• Following feedback and risk assessment from divisions it has been agreed that there is little scope to pursue rapid opportunities in these areas although an emerging pipeline opportunity is being developed (more likely for 2018-19) • Workforce scheme SROs therefore tasked with identifying alternative proposals to mitigate this gap in the cross cutting programme
Medical staff	£235k	£235k	• Target being allocated out once work complete against individual consultant job plans. Remainder rests with MD as SRO
Back office	£480k	£350k	• Forecast outturn includes contribution from Making Choices programme now unlikely to go ahead • New mitigating schemes required to make up what will be a significant gap, which rests with HRD as SRO
Agency invoice checking	£550k	-	• Agreed that this scheme incorporated in the original plan should not be pursued • New mitigating scheme required to make up significant gap

Attachment P

Scheme	Target	M5 forecast	Comment
Coding	£475k	£475k	• Scheme delivering and to be apportioned to divisional budgets • No further action required
ICT enabled	£275k	£256k	• Some slippage against one scheme (SMS messaging) but other pipeline schemes expected to make up the gap • If all pipeline schemes deliver, the £275k target will be exceeded significantly, with a potential benefit of £336k
Commercial and IPP	£1,495k	£1,495k	• Scheme projected to deliver in full • Overseen by monthly commercial scheme oversight group chaired by the Director of International and Private Patients

Great Ormond Street Hospital for Children NHS Foundation Trust

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

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

1. Purpose

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

2. Background

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

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

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

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

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

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

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

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

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

3. Governance Arrangements

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

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

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

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

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

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

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

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

4. Policy and Guidance

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

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

5. Process of Medical Appraisal and Revalidation

a. Appraisal Performance Data

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

For SAS grades appraisal rates were 100%.

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

Compliance by Division

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

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

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

b. Appraisers

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

c. Quality Assurance

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

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

d. Revalidation and Appraisal Resources

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

6. Revalidation Recommendations

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

7. Recruitment and engagement background checks

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

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

8. Monitoring Performance

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

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

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

10. Monitoring Performance, Responding to Concerns and Remediation

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

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

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

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

11. Risks and Issues

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

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

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

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

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

12. Corrective Actions, Improvement Plan and Next Steps

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

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

13. Recommendation

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

Report Prepared by:
Dr Andrew Long, Associate Medical Director

Appendices

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

Appendix 1

Designated Body Statement of Compliance

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

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

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

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

   Comments: This is undertaken through GMC Connect

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

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

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

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

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

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

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

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

[1,2] Doctors with a prescribed connection to the designated body on the date of reporting

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

Comments: This system in now more robust

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

Comments: This has been implemented during 2017

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

Comments: This is fulfilled

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

Comments: An action plan has been recommended to the Trust Board for implementation

Signed on behalf of the designated body

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

Dr Peter Steer, CEO

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

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

Independent Verification Visit

Great Ormond Street Hospital Meeting room at level 6 old Building, WC1N 3JH		
16th February 2015 9:30am to 16:30pm		
Key Personnel		
Ray Field	Revalidation Lead	NHS England (London)
Ros Crowder	Deputy Director - Revalidation	NHS England (south region)
Dr Ruth Chapman	Regional Lead Appraiser	NHS England (London)
Avinder Grewal	Revalidation Coordinator	NHS England (London)
Dr Catherine Cale	RO and Co-Medical Director	GOSH
TBC	HR/Medical Staffing	GOSH

Agenda Item	
09.30 – 10.00	Pre-Meet with Responsible Officer/Medical Director (and other key personnel)
10.00 – 11.30	Meeting with Revalidation Manager / Team and review of processes and IT systems
11.30 – 12.00	Meeting with Clinical Appraisal Lead
12.00 – 13.00	Meeting with 1 or 2 appraisers
13.00 – 13.30	Lunch
13.30 – 15.00	Review of Appraisal Summaries sample, Revalidation portfolios, case studies for deferrals (or non-engagements)
15.00 – 15.30	Meeting with HR / Medical Staffing
15.30 – 16.30	Meeting with RO and visit summary

Papers	
Item 1: Framework of Quality Assurance for Responsible Officers. Annex A Core Standards (For information purposes)	annex-a-core-standards.xls
Item 2: AOA Report	Great Ormond Street Hospital for Children N
Item 3: AOA Comparator report	NHS England (London region)_Grea
Item 4: Board report	Appraisal revalidation Annual Bo
Item 5: Statement of Compliance	GOSH.pdf
Item 6: Quarterly Reports	Quarterly Report.pdf
Item 7: External Quality Assurance report	N/A
Item 8: Summary of Recommendations	Recommendation Summary .pdf
Item 9: Never Events Summary	ne-prov-data-april-oct-14.pdf ne-prov-q1-q4-data-summ.pdf
Item 10: Care Quality Commission Report	N/A
Item 11: Action plan template	

Great Ormond Street Independent Verification visit from NHS England London Revalidation Team,

16th February 2015

Introduction

The RO and HR lead welcomed the NHS England London team to the hospital and we had an open and helpful meeting that highlighted areas of good practice and developments that the RO is taking forward. The areas of discussion are outlined below. This visit can be considered as an 'external review' and peer review and discussion regarding appraisal practice is recommended as on-going good practice.

Appraisal systems and appraisers

Number of connected doctors to designated body/RO: 485

The RO/lead/MD is also on hospital board and can oversee their statutory responsibility for revalidation. The commitment of board to appraisal and revalidation was described as – 'medium' and needing development. The idea of a NED taking a particular interest in revalidation was raised and will be considered by the RO.

The RO has a good working relationship with the GMC ELA - Tony Americano who has provided helpful advice to the RO.

The RO does not have a formal RO decision making advisory group to calibrate and share the revalidation recommendations.

Appraiser training – Edgecumbe initially, also MIAD and London Deanery (8 x updates a year – topical subjects discussed). Number of appraisers: 99 – each do 3-6 appraisals within April-June. Doctors can choose their appraisers.

Appraisers undertake cross specialty appraisals - not hierarchical. May have three people in room for appraisal.

Use Prep appraisal toolkit for consultants and clinical specialists, but paper based appraisals for trust doctors and fellows. There is an A&R administrator in post.

Appraisal Policy – could add what to do if doctor not following procedure. No QA of appraisal outputs as yet developed. GOS has an appraisal cycle - April-June is when most appraisals are done - with the job plan done beforehand

SI s and Complaints: Not yet feeding in complaints and SIs to appraisal: RO looks at SIs with names of Drs involved. Drs asked in appraisal about SIs. Plan to prompt doctors in future. Look for trends.
Policies are in place. A plan of action relating to appraisal and revalidation has been made - linked to clinical excellence award

Multi-source Feedback (MSF)

Feedback – Edgecumbe tool used for MSF. Sometimes it can be difficult to obtain feedback

Friends and family feedback – not used according to appraiser

Visiting doctors, SAS doctors, bank doctors, trainees, honorary consultants

Many overseas doctors (visiting fellows etc.) – they are assigned an educational supervisor at induction, information about appraisal is on the intranet, HR asks about the date of the last appraisal and revalidation date.

Pre-employment checks on doctors in place

Even if not being revalidated, appraisals are carried out for these doctors if possible – they also do have objective settings and educational supervision. Evidence is accepted from abroad.

GOS does have SAS appraisers. GOS tends to use regular bank doctors rather than unknown locums for extra cover.

Issue of Drs at CCT not being revalidated – to be discussed with Dr Tim Swanick

Honorary consultants - if they see adults, GOS seeks assurance from elsewhere. Vast numbers – 100s. Some are retired. Have uncoupled practise privileges from honorary contracts so will not be connected. Work in progress.

Scope

Academics have joint appraisals.
Private practice – whole scope is included. Appraisers are primed to ask.

Appraiser interview

A doctor will have the same appraiser for 3 consecutive appraisals only
Enough time is allocated to do an appraisal

Asks for portfolio 1 week before, spends an hour preparing, meets for 1-1 ½ hour meeting and writes up summary with appraisee
There is a move towards PREP for non-trainee doctors
No 1:1s or feedback from RO/lead for appraisers
Lead/RO is very approachable and helpful, providing strong leadership.

Academic appraisals are a challenge. Often no reflection with the academic part of the appraisal.

Focus on core standards

Divisional directors nominate doctors to be appraisers. RST spec. Appraisers are not interviewed.

Responding to concerns

After SIs: Look for patterns, discuss and investigate, action plan. Small number of case investigators. RO is the case manager – hasn't done course yet.

Potential Improvements / Actions	
Area	**Action**
Some appraisals are still done on paper	To review and consider MAG and IT retention of appraisal documentation for audit trail and QA, and Information governance purpose
Keeping track of moving trust doctors	RO is considering new manager to monitor movement of doctors.
May have three people in room for appraisal.	Would generally suggest an appraisal is a 1:1 meeting, though as discussed circumstances can require exception
Honorariums and connections	To review – is work in progress
Academics – appraisers and doctors often have little or no reflection on academic element of work	To review and consider Guidance on Reflection, good practice examples, FAQs
Appraiser selection process might be reviewed	To consider selection and interviews
SPAs not specified for appraiser – may need more resource to support appraisers and for their role to be valued QA: varied summaries, PDPs need	We would suggest a formal external/peer review of the appraisal and revalidation process

development and some are long	
QA needs to be addressed: audit of outputs, feedback and 1:1s with appraisers	To be reviewed. We would suggest a formal external/peer review of the appraisal and revalidation process
Appraisal policy – you might like to add a statement to say that there will be a process to follow if appraisals not arranged/completed in time	To consider short addition to policy
The use of the college CPD certificate without more detail relating to the specific CPD event and reflection	To review and ask for more specific reflection that relates CPD with PDP and own professional practice, benefit or not ?

Areas of Good Practice for sharing
Good approach to feedback from patients/clients
Appraisers have updates and cross specialty appraising takes place - not hierarchical
Good doctors' induction and support for appraisal
In house educational supervision feeds into appraisal
Sorting out honorary contracts
RO attends networks, is trained, has good ELA contact, and is considered 'approachable' and helpful by appraisers.

Shared with GOS

Scope of practice list and possible 'no concerns' letter.

Network meeting information and QA resources – info will be available from the revalidation team.

Action plan template

Please complete the below action plan and return to: ENGLAND.revalidation-london@nhs.net

By: (insert date)

Name of designated body	Great Ormond Street Hospital	
Name of responsible officer	Andrew Long	
Area/concern/issue identified at Review Visit	**Action**	**Timescale**
Some appraisals are still done on paper	We have now purchased licences for all doctors employed within the organisation to be enrolled on the PReP system. We are steadily making progress in getting all Associate Specialists/Trust doctors and Fellows however there has been limited HR resource available for this task due to internal pressures. This has been escalated to the Director of HR who has ensured that adequate HR resources will be made available	September 2017
Keeping track of moving trust doctors	We hope to establish a process whereby all non-Deanery doctors have PReP profiles and their movements are recorded and updated through their medical staffing records. PremierIT have informed us that they will be making it easier to transfer information from PReP when doctors move to other organisations	December 2017
May have three people in the room for an appraisal	We have been in discussion with PremierIT about making it a positive decision to include a Secondary Appraiser on the system. As a general rule we have agreed that all those employed on academic contracts will be required to have joint appraisals under the Follett Review Principles and those in senior management	September 2017

	roles may wish to have a senior manager as a secondary appraiser however with those exceptions everyone should have a single appraiser.	
Honorariums and connections	We have recently reviewed our honorary contract procedures and are actively reconsidering every application for honorary contracts. We have therefore removed a number of doctors as connections, although continue to support those in academic posts with global roles as well as those in pure research and public health roles. All are required to participate in annual appraisal	Met
Academics – appraisers and doctors often have little or no reflection on academic element of work	All academics are expected to have joint appraisals with an NHS appointed consultant as well as an academic appraiser undertaking a joint appraisal in line with the Follett Principles.	Met
Appraiser selection process might be reviewed	At the current time we have been engaging with our appraisers to ensure that all have training updates. The RO feels that we may need more appraisers in some areas and there are some appraisers who we feel might be discouraged, either due to inactivity or following a quality assurance review of their performance. We might consider a system of appraiser allocation in the future and encourage a selection process rather than self-nomination	September 2017
SPAs not specified for appraiser – may need more resource to support appraisers and for their role to be valued. QA: varied summaries. PDPs need development and some are long	We are taking a paper to the Trust Board in July 2017 to request more specific resources for appraisal. At the current time there are no defined resource allocations. It is our intention to recommend that there is a recognition for appraisers within the Job Planning process and that there are clearly identified resources for training and updating appraisers. It is our intention to request an external review of the appraisal and revalidation	September 2017

	process and this recommendation will be made to the Trust Board	
QA needs to be addressed: audit of outputs, feedback and 1:1s with appraisers	It is our intention to recommend to the Trust Board that we establish a system of Lead Appraisers within our recently reconfigured Divisional structure	September 2017
Appraisal policy – you might like to add a statement to say there will be a process to follow if appraisals not arranged/completed in time	A new Appraisal and Revalidation Policy was taken to the Policy Approvals Group in January 2017	September 2017
The use of the college CPD certificate without more detail relating to specific CPD event and reflection	We have been in discussion with PremierIT who are the providers both of the GOSH PReP system as well as the RCPCH CPD application. They are actively considering how more information can be drawn from the RCPCH system into the PReP system	September 2017
Follow up meeting / Telecon		
As responsible officer I confirm that the information above has been discussed and agreed with my Board or equivalent	*Signature & Date*	
Date of Board sign-off		

REV6

General Medical Council

Request to send a non-engagement concern letter to a doctor

When to use this form

You have a doctor who is not sufficiently engaging with your local processes and is not meeting the requirements for their revalidation .You want us to send a non-engagement concern communication to them.

You have read the criteria for non-engagement and are satisfied that you are in the process of taking all possible local action to secure the doctor's engagement.

The effect of this form

We will send a non-engagement concern communication to the doctor. This tells the doctor that they must meet the requirements for their revalidation and to contact you.

Next Steps

- Doctor is not under noticeIf they continue not to sufficiently meet the requirements for their revalidation we may bring their revalidation submission date forward so that you can submit a recommendation of non-engagement to us.
- We will contact you shortly after the date you request below to ask if you are satisfied the doctor is now meeting their revalidation requirements.

Doctor is under notice:

- If the doctoris under notice you should make a recommendation by their submission date. You should refer to the recommendation protocol before making your recommendation. If you make a recommendation of non-engagement, we will begin the process to remove the doctor's licence to practise.

How to return this form

Enter the details and click on the 'Submit Form' button in the top right hand corner. Follow the instructions on the screen.

If you have any problems submitting the form please email it to revalidation-support@gmc-uk.org.

This form must be submitted by the Responsible Officer or Suitable Person, or their authorised delegate

Designated body name	Designated body name
Submitted by	Responsible officer name / Authorised delegate name
Date	D D M M Y Y Y Y

Details of the doctor you would like us to send a non-engagement concern letter sent to

Doctor's full name	GMC reference number	Date you want the doctor to comply by
Doctor's full name		D D M M Y Y Y Y

I have read the criteria for non-engagement and confirm that:

- The doctor is not engaging in appraisal or other activities to support a recommendation to revalidate or the level of engagement is not sufficient to support a recommendation to revalidate
- Should this continue, I do not anticipate having sufficient information on which to base a recommendation about the doctor's fitness to practise
- The doctor is being provided with sufficient opportunity and support to engage with revalidation
- Based on the information available to me, there are no extenuating circumstances which account for their failure to engage.
- I will continue local efforts to secure the doctor's engagement.
- I have notified the GMC of any outstanding concerns about the fitness to practise of the named doctor, in accordance with GMC guidance on raising concerns about doctors.
- I would like the GMC to send a revalidation non-engagement concern letter to the named doctor.
- I have advised the doctor of this request

Responsible Officer:	Responsible officer name

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 27 September 2017	
Staff Survey and Listening Events Update **Submitted by:** **Ali Mohammed, Director of HR & OD**	**Paper No: Attachment S**
Aims / summary To provide Trust Board with an update of actions following the 2016 staff survey.	
Action required from the meeting To note the content of the report.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Work supports the Trust strategic objective of creating a culture enabling us to learn and thrive.	
Financial implications Incorporated within current resource allocations and budgets.	
Who needs to be told about any decision? N/A	
Who is responsible for implementing the proposals / project and anticipated timescales? Director of HR&OD Local Divisional and Directorate Management teams	
Who is accountable for the implementation of the proposal / project? Director of HR & OD Local Divisional and Directorate Management teams	

Attachment S

Staff Survey and Staff Listening Events

Introduction

The 2016 GOSH survey saw a return rate of 60% (compared to the average rate of 44%); this was the second highest response rate of any acute specialist trust in England. The survey is due to run again during Sep – Nov 2017.

Headline issues

Key positive areas

One measure relating to feeling unwell due to work related stress in last 12 months showed a statistically significant improvement since 2015. The Trust also compared favourably against the national average for acute specialist trusts.

Our other top ranking scores where we compare most favourably to other acute specialist trusts are:

- Quality of appraisals
- Staff able to contribute to improvements at work
- Quality of non-mandatory training, learning or development
- Satisfaction with level of responsibility and involvement

There were also improvements (although not statistically significant) against the three questions contributing towards the overall measure of recommending the organisation as a place to work or receive treatment.

Top five key concerns

Our top ranking scores where we compare least favourably to other acute specialist trusts are:

- Staff witnessing potential harmful errors, near misses or incidents in last month
- Staff working extra hours
- Staff feeling pressure to attend work when unwell in last three months
- % of staff reporting most recent experience of violence
- % of staff believing that the organisation provides equal opportunities for career progression or promotion

Listening Events

Two listening events were held during May 2017. The aim of these were to engage further with staff around key concerns highlighted by the survey findings and ask staff for ideas of how these could be addressed across the whole of the Trust. The events were well attended by over 40 participants who came from a range of job roles and pay bands.

The events, following the findings of the survey, focused on the following issues:

- Harassment, bullying and violence – mainly from service users, however comments and suggestions we also received around staff on staff behaviours
- Looking after our staff (incorporating working extra hours and attending work when unwell).
- Promotion and progression for all
- Creating a great place to work

Key Themes and Actions Arising

From information gathered at the listening events (Appendix 1) it is apparent that there are opportunities to build on the work already undertaken and support to staff already offered. Any actions taken will be aligned to the Trust's strategic objective of attracting and retaining the right people through creating a culture that enables us to learn and thrive.

Harassment, Bullying and Violence

Numerous recommendations were made by staff around the need to address violence from service users. There were several suggestions made about how the Trust could devise clear messaging around expected parental behaviours. Numerous comments were made about the provision of conflict resolution and mediation training. Issues were raised about the need for a higher profile to be given to encourage staff to report incidents in an appropriate and timely way. It is recognised that issues concerning service users are under the remit of Chief Nurse and information obtained from the listening events will be forwarded as appropriate.

In terms of staff behaviours (harassment & bullying) the following themes consistently came out and will be taken forward:

- Making H&B easier to report
- More communication and information around H&B
- The need for specific H&B training for managers

Actions will include a review of the Freedom to Speak Up Ambassador Service to explore the potential for them to act as another route for staff to discuss H&B concerns; a dedicated communications campaign around behaviours expected from staff, what is (and isn't) acceptable behaviours, how to raise H&B issues etc.; more input for managers around how to recognise and respond to H&B concerns.

Looking After Our Staff

Using information obtained from the listening events a further session, based on the principles of Appreciative Inquiry, was delivered in June 2017 to enable more focussed discussions to take place. The session involved staff side representatives, managers, Occupational Health and HR staff. As a result the following themes will be taken forward:

- Developing a co-ordinated approach to health and wellbeing initiatives
- Increasing communications around staff benefits
- The need to establish a network of health and wellbeing champions
- More training and development for managers
- Reviewing the Sickness and Attendance Policy and the associated documentation

A multi-disciplinary health and wellbeing group has already been established which will concentrate on enhancing the physical and mental health of staff. Other actions proposed include reviewing the training needs of managers to ensure they are able to effectively support staff who suffer ill health, or who are disabled; exploring the provision of mental health first aid training; more bespoke communications and publicity regarding the various benefits available to staff (massage, gym membership, local discounts etc.); a staff health and wellbeing week will take place in January 2018 supported by a roving road show.

Promotion and Progression for All

There were many useful suggestions made and work is already underway including reviewing the inclusion work plan. The HR&OD Directorate is in discussion with relevant individuals to consider the needs of LGBT staff. Actions within this area will be shaped by the Trust's progress against the Workforce Race Equality

Standard, results of will be presented to Trust Board in September 2017, as well as the Trust's staff related equality objectives.

Key themes from the listening events were:

- The need to address behaviours / biases
- Establishing networks to support minority staff
- Reviewing the recruitment and selection processes
- Enhancing diversity across the Trust

Actions to address these will encompass reviewing how and when unconscious bias training happens and the scope for enhancing this or targeting towards specific groups of staff; signing up to the Government's Disability Confident Scheme which will impact on the recruitment & selection processes used; raising the profile of staff diversity in the Trust through events and celebrations. The Trust will also host Project Search interns again from Oct 2017 in conjunction with Camden Council, giving young adults with learning disabilities the opportunity to gain work and life experience.

Creating a Great Place to Work

It is clear from the staff survey results and from the listening events that GOSH staff recognise the Trust as a special place to work.

Key themes from the listening events were:

- Recognising the value of staff and communicating this widely
- The importance of a compassionate workplace culture which promotes mutual respect
- Working as one team
- The importance of living the Always Values

Actions which will be taken forward include supporting the Freedom to Speak Up Ambassadors to promote a speak up culture, developing tools to further embed team working and continuing to develop and embed the Always Values. Following the staff awards ceremony, communications to share award winners' stories will also be developed.

Local Action Plans

HR Business Partners have been working closely with divisional and directorate management teams to support them to develop local actions in response to their particular survey responses.

Action required

Trust Board are asked to note the contents of this report.

Appendix 1

Outputs from the Listening Events

Bullying, Harassment, and Violence: Practical Suggestions

Reporting and Process

- Making the process easier for reporting bullying & harassment
- Create an environment where staff can easily and quickly report issues and create feedback mechanism
- Clearer definitions of H&B
- Give staff the tools to know when enough is enough with aggressive parents and families
- Accessibility to support/debrief local and central. Drop in sessions – clear process to escalate problems
- Evelina project to support staff experiencing conflict
- Clear framework for managing H&B from staff and patients

General Comms

- Positive outcome stories of successful resolution of H&B
- Publish how reported incidences have been followed up

Finding out more

- Ask those who have experienced H&B to talk to HR in confidence to gain greater understanding of issues
- Do a survey to determine more detail about why staff experience H&B. We need to know more about what's going on

Training

- Provide different levels of conflict resolution training (with families) for clinical staff
- Training provided by those who know the topics, to include:
    - Dealing with patients
    - Managing conflict & difficult conversations
    - Manager training skills + communication
    - Managers informed of their responsibilities to support staff – to be trained to be a manager

Culture

- Culture of care
- Trust Board and senior leaders to role model good behaviours
- Develop a coaching conversations culture

Service Users

- Develop rights and responsibilities for patients and families
- Contracts with families regarding behaviours

Attachment S

Place to Work: Practical Suggestions

Communications

- Remind all staff of the value they bring to patient care (2)
- Use promotional videos to see how other departments provide a service to the trust
- Have a dedicated social media platform for staff to share stories

Culture

- Increase values based recruitment
- IHI programme- Joy at work
- Ask the Executive team to shadow a team once a month for them to experience the service
- Try randomised coffee trials
- Staff recognition- not necessarily rewards but a simple thank you card- handwritten.
- Decision making: clarity about responsibility and accountability who can make and are held accountable for decisions
- Quick wins
    - Email culture. Training/top and tail/tone
    - Mindfulness/appreciative input/positive psychology (more useful)
    - Soft skills
        - Reflective time- 'that made me feel'
        - Respectful communication
    - Decisions being made above roles (push back down), culture change

Benefits

- Better communication around benefits available

Teams

- Supporting team such as through away days and other support

Other

- Increase transparency- why we are/are not doing things e.g. vacancy approval forms
- Cutting down mandatory training and ensuring essential for role

Progression and Promotion: Practical Suggestions

Developing career pathways/talent management process

- Look at providing equal progression opportunities for clinical and non-clinical staff
- Consider how would a band 4 clinical assistant can move forward to get new skills
- Recognising that career progression does not (and increasingly will not) link to banding and a pay rise.
- Recognition for more responsibility e.g. health and safety.
- H&OD function to have a stream to look after career progression e.g. L&D team
- Reinstate career development programme
- More bespoke courses for porters, IT, Mechanics etc.

Working with Managers

- Training for managers to draft a career pathway for team roles.
- Provide leadership training for consultants and senior nurses using- role play re: behaviour
- More input required around behaviours including biases

Recruitment Processes

- Advertise vacancies internally before they go external.
- All adverts should include “career progression” routes
- Need to ensure that job applicants’ experience has the same recognition as formal qualifications where possible
- Make it easier for minority to staff to be selected and promoted

Internal Promotions

- Promotion given not depending on a number of fixed years a person has been at the Trust

Other

- More opportunities to network/organised fun during working hours beyond their own department
- Consider identification of rising stars through talent management
- More educational opportunities – training but also coaching, learning new skills.
- More networks required to support minority groups

Taking Care of our Staff: Practical Suggestions

Handovers and paperwork in wards

Lack at staff handovers (nursing) and amount of paperwork – reduce time – staff don’t work late

- QI project

Comms to staff

Monthly forum endorsed by exec team to raise awareness of looking after staff

- Exec talk to cover:
  - Staff wellbeing
  - Work with charity
  - Nutrition
  - Wellbeing Hub

Payments and processes

Staff should get off work on time- should not be the accepted rule that staff work longer

Cross-over of staff for:

- Training
- Work loads
- Annual leave

More consideration of the effect of the application of sickness management procedures on staff with long term illness/conditions and bereavement/carers- can lead to longer period of sickness

Practicing (Athena) which is protected time for meetings to take place. Practiced at UCL

Facilities for staff

Designated staff break area- not healthy to socialize with parents all the time

Support for staff

More opportunities of psychological staff support (PICU do a drop-in)

Manager & staff development and training

Educate managers on managing sickness:

- Educate how staff behaviour affects other behaviour

- HR policies
- How the GOSH absence and support system works
- Explain to employees the purpose of OH referral, some see the OH as a form of punishment.

- Trust Induction to include:
  - Teaching staff responsibility around attendance
  - What happens if they call in sick, what happens if they come in sick
  - More education around consequences of coming in sick

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 27 September 2017	
Update on CQC Action Plan **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment T**

Aims / summary

The Care Quality Commission (CQC) conducted a scheduled acute hospital inspection between 14 and 17 April 2015, with further unannounced inspections occurring between 1 and 3 May 2015.

A Quality Summit was organised by the CQC in February 2016, inviting key stakeholders to discuss the report and actions taken by the Trust. The Trust agreed a final action plan, outlining the actions it will take in response to the CQC's requirement notice and areas for improvement. Accountable leads for each action were identified and responses and timeframes agreed.

The Board is asked to review the summary of actions taken to meet the recommendations.

Action required from the meeting
The Board is asked to note that all the actions are now complete. Work continues in all areas to maintain the standards set by the recommendations.

Contribution to the delivery of NHS Foundation Trust strategies and plans
Safe, effective care that meets regulatory and statutory standards

Financial implications
N/A

Who needs to be told about any decision?
CQC and the Members' Council

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

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

Attachment T

Care Quality Commission Action Plan Update

CQC Action No. and Description	Status
1. RTT – Compliance with Regulation 17 2 (a) (c) and (f). And 4. Ensure that its RTT data and processes are robust and ensure that staff comply with the Trust's patient access policy in all cases.	Completed. Following a successful IST technical review on 31st January 2017, GOSH returned to RTT reporting in February 2017. NHS England Specialised Commissioning has confirmed that the Remedial Action Plan is completed and closed, and as such the contract notice lifted. <u>RTT Incomplete pathways</u> Whilst the Trust remains below the RTT incomplete standard of > 92% (of pathways waiting no longer than 18 weeks), it continues to be above its improvement trajectory. At May 2017 performance was 90.36%, with the trajectory at 88.2% <u>Diagnostics</u> The Trust continues to report improvements in this area, with May 2017 reporting 97.49% against the 99% standard for accessing the 15 diagnostic modalities with 6 weeks of referral / request. This is a marginal improvement on April reporting 97.44%
2. Resume WHO checklist audits in surgery	Completed. WHO checklist audits have taken conducted since the CQC inspection. An observational audit of the WHO checklist was undertaken and the audit showed a good level of performance with the WHO Checklist and an audit conducted in March 2016 showed good engagement in the Team Brief and WHO checklist, and a positive safety checklist culture. The Trust continually monitors compliance with the checklist. The most recent data (June 2017) shows a significant improvement in compliance over the last couple of month, with the Trust reporting Trust-wide delivery of the 98% standard with 98.77%.
3. Ensure that there are clear arrangements for reporting transition care service performance to the Board	Completed. Transition reporting to the Board and the Quality and Safety Assurance Committee commenced in December 2016. Having identified the work required to improve Transition at GOSH for the young people and families, a Quality Improvement Manger for Transition has been appointed. The Assistant Chief Nurse for Patient Experience and Quality is leading this work and a project steering group has been set up to ensure the correct engagement with the patients, families and staff across the Trust. The Board will continue to receive updates on progress with this work.

CQC Action No. and Description	Status
5. Ensure greater uptake of mandatory training relevant to each division to reach the Trust's own target of 95% of staff completing their mandatory training.	Completed. Following the above review, the Trust has revised its own target from 95% to 90% completion requirement for each division. This decision was taken to ensure consistency with other Trusts. In June 2017, the compliance across the Trust was 91%. The improvements to Statutory and Mandatory Training compliance has been driven by: • A Trust-wide focus to drive up compliance at all levels (accessibility of information, publicity via screensavers); • Specific challenge to the appropriateness of training requirements per post within the training needs analysis. • Data collection and quality processes on the GOLD LMS system around Statutory and Mandatory training have been reviewed and refined; data is updated twice weekly and an escalation process is in place for staff where training requirements are outstanding. • Content, relevance and target audience has been reviewed with content owners. Robust systems have been developed to identify and directly address areas of concern around compliance through liaison with HR Business Partners and the Divisions.
6. Ensure that, particularly in critical care, communication between senior nurses and senior medical staff is enhanced and that the contribution of nursing is fully reflected in the hospital's vision	Completed. Key improvements delivered to date include: - Refreshed Divisional leadership team, included an enhanced role for nursing leadership - An external mentorship programme for the Heads of Clinical Service had been introduced. - An away day was held to develop an action plan to address the CQC's recommendation. - New terms of reference for the Critical Care Forum were developed to rotate the Chairing arrangement between nursing and medical leads. - Expanded benchmarking of clinical outcomes with other intensive care units in the UK and internationally and to make these results more visible at our weekly Morbidity & Mortality and critical care forum meetings. Further focused work continues with the teams.
7. Ensure early improvements in the environments of wards	Completed. A number of improvements to the ward environment have been delivered since the CQC inspection, including:

CQC Action No. and Description	Status
which have not been refurbished, rebuilt or relocated.	• In relation to Rainforest ward (which was of particular focus by the CQC), additional toilet facilities had been provided within the area for patients and parents (1 toilet and 1 shower). In addition, Rainforest will be moving to a new/refurbished space as part of the opening of the new Premier Inn Clinical Building (PICB) in 2017 which will significantly improve the environment for the ward. • Mechanisms are in place to monitor the ward environments from patients' and parents' perspectives (Pals, Friends & Family Survey, Patient Family Experience and Engagement Committee walkrounds, etc.) • Executive and non-executive director walk rounds provide an opportunity to monitor ward conditions and provide staff, patients and families with an opportunity to raise concerns with a range of issues including ward environments for them to manage and monitor.
8. Standardise radiation protection training for junior radiologists to overcome inconsistencies caused by short rotations.	Completed. A Radiology Induction Manual has been produced and is now available. A register of radiology trainees that records the date and nature of their most recent radiation protection training is now in place. This allows the Trust to identify any potential deficiencies in training and address them. The Head of Radiology Training reviews the register on a monthly basis and ensures that all trainees have documented their training on the departmental register. Any issues related to radiation protection will be escalated to the Radiation Protection Committee if required.
9. Develop a dedicated advocacy service for CAMHS.	Completed. An advocacy service is now in place. The Advocacy Project (www.advocacyproject.org.uk) provides a customised designed advocacy service relevant to the needs of our patients and their families. A review of the service was conducted 6 months after the contract started and the review concluded that staff and patients were pleased with the service delivery. No problems were reported and communication and reliability was excellent.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **27 September 2017**	
Workforce Race Equality Standard 2017 **Submitted by:** **Ali Mohammed, Director of HR & OD**	**Paper No: Attachment U**
Aims / summary To provide Trust Board with assurance that the Trust is meeting its obligations under the Workforce Race Equality Standard (WRES). This builds on the objectives that were agreed by the Trust Board in January 2016 for the Equality Delivery System.	
Action required from the meeting To note the content of the report and approve the associated action plan	
Contribution to the delivery of NHS Foundation Trust strategies and plans Meeting the statutory duty to report publicly on this activity and meet CQC requirements.	
Financial implications None.	
Who needs to be told about any decision? N/a	
Who is responsible for implementing the proposals / project and anticipated timescales? Staff Equality and Diversity group	
Who is accountable for the implementation of the proposal / project? Director of HR & OD	

Workforce Race Equality Scheme 2017

Introduction

Since 2015 NHS organisations are required to publish data against the NHS Workforce Race Equality Standard (WRES).

WRES data publication is an annual requirement and is included in the 2016/17 NHS standard contract for NHS provider organisations and it also features in the CQC Assessment and Improvement Framework as part of the 'Well Led' domain. All Trusts are also required to develop and publish an action plan based on their data, addressing any issues raised. This plan must be approved by trust boards.

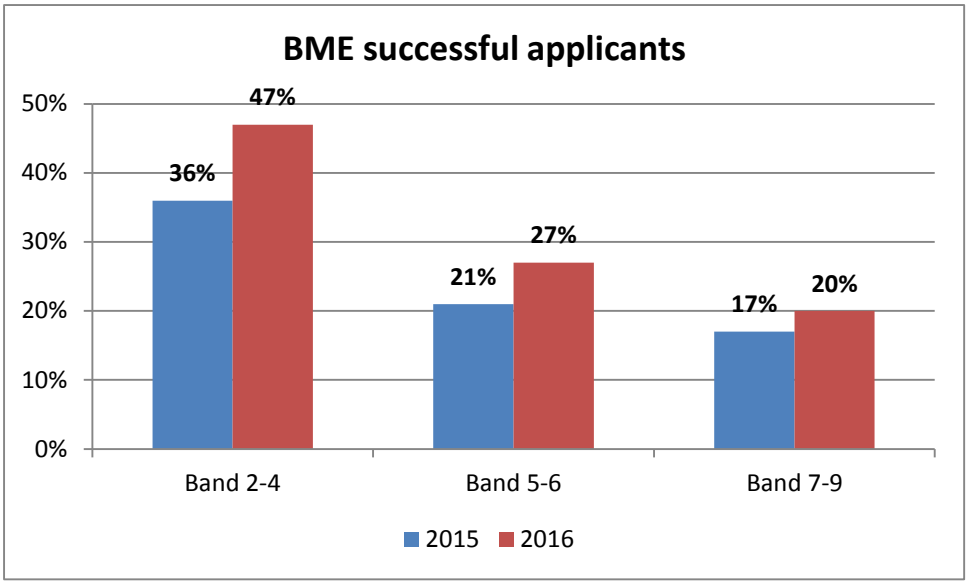
The 2017 WRES Trust data exercise has been completed and will be published with the action plan, following the September Trust Board. These will be available at http://www.gosh.nhs.uk/about-us/equality-and-diversity.

Main findings of the 2017 WRES

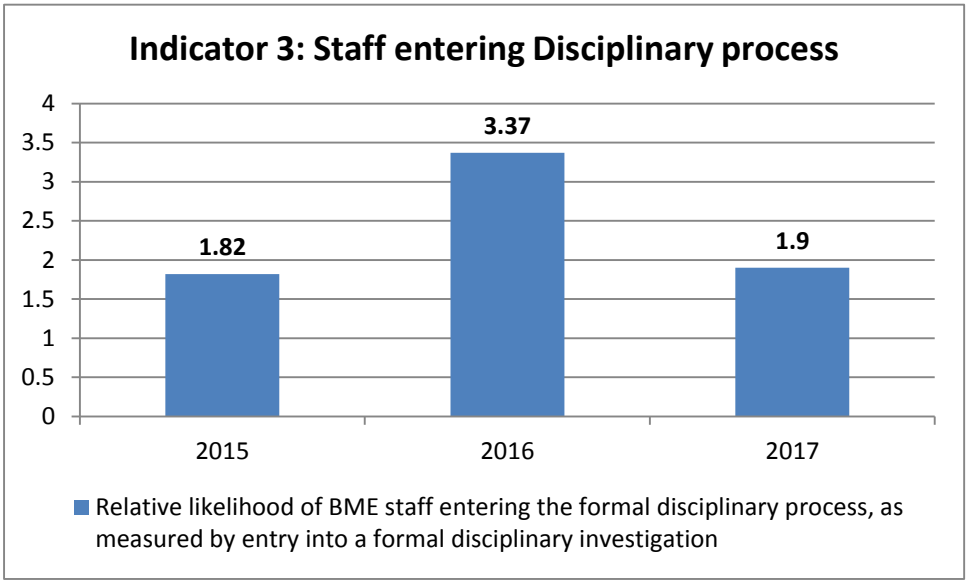
There are nine WRES indicators, four of the indicators focus on workforce data, four from data obtained by the national NHS Staff Survey, and one indicator focusses upon Black and Minority Ethnic (BME) representation on Boards. Further information about these indicators and the Trust data associated with them are given in *Appendix One*.

The main points arising from the Trust data include:

- An overall workforce composition of 29% BME staff.
- The highest representation of BME staff is to be found at lower pay bands, however the data shows that since last year there has been an increase in headcount of the numbers of BME staff in non-clinical Band 8a (+10), in clinical bands 5-7 (+43) and in the number of BME consultants (+12).
- In common with other public sector organisations (NHS England citing "Discrimination by Appointment" report, 2013) Trust data shows that proportionately fewer BME candidates are being appointed into jobs than white applicants (white people are 1.73 times more likely to be appointed). Trust data in this respect, however, continues to improve year on year and the most significant improvement is in bands 2-4. Whilst improvement is less at higher bands, it is noted that progress has been made.

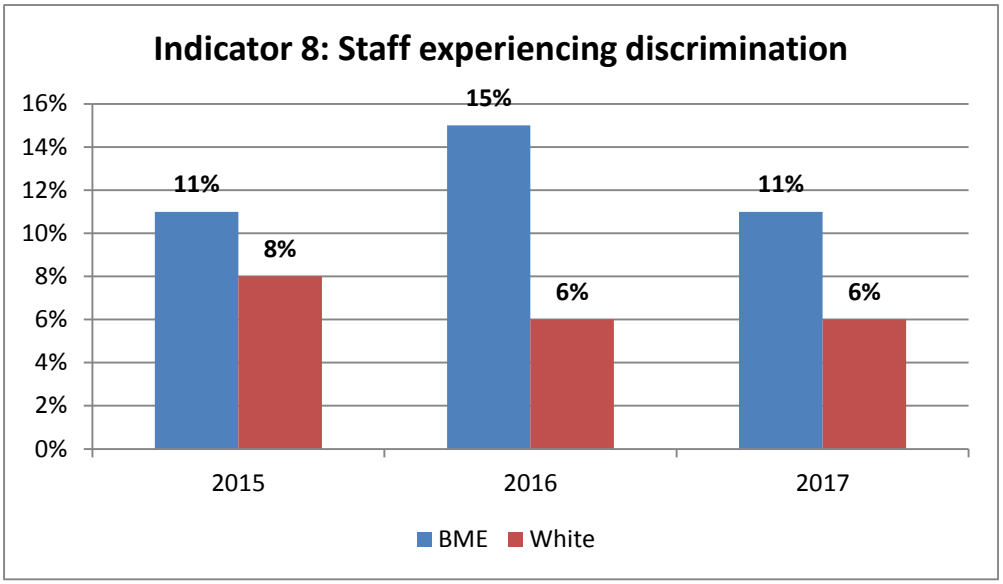


- Conversely, whilst numbers are small overall, proportionately more staff from BME backgrounds at the Trust are involved in formal disciplinary action than white staff (1.9 times more likely). Again, this is a pattern across the NHS (NHS Employers report, 2010). 2017 Trust data reflects an improvement in reaching parity since last year.



- Uptake of non-mandatory training and CPD between BME and white staff is broadly comparable.
- 2017 Trust data shows that race does not appear to be a major factor in whether a member of staff experiences harassment, bullying and abuse from service users (22.9% white, 21.62% BME).
- There has been a slight but continued improvement across the WRES reporting years in BME staff believing that Trust provides equal opportunities for career progression or promotion (BME staff: 79.09% - 2017; 78% - 2016;

77%, 2015) and an improvement since last year in BME staff personally experiencing discrimination at work (11.2% - 2017; 15% - 2016).



Source: NHS Staff Survey 2015 – 17

- Voting membership of the Board has a lower representation of BME staff than is found in the overall workforce (-11.8%).

In January 2016 the Trust Board agreed a set of equality objectives, which were developed using the NHS Equality Delivery System v2. (nb The NHS Equality Delivery System v2 addresses *all* the equality characteristics that are protected in law, for example race, gender, disability; the Workforce Race Equality Scheme focuses *only* on race). These objectives were created following widespread consultation with, and feedback from, staff and other stakeholders about what GOSH's equality priorities should be. The Trust's staffing-related Equality Objectives, which are valid for a period of up to four years, are:

1. Increase overall visibility of the Trust Board and Senior Leaders.
2. Develop the understanding of managers and employees in recognising and managing Harassment and Bullying, with the longer term intention of a reduction in the instances of bullying and harassment concerns raised.
3. To improve the representation of BME staff in senior posts.

The agreed objectives and resultant associated actions will also deliver many of the actions to address the issues highlighted by the data produced for the WRES. The agreed actions arising from the Trust's Equality Objectives were therefore rearticulated in the 2016 WRES action plan. The 2017 WRES action plan also rearticulates these actions as well as including further actions (*see Appendix 2*).

Action required

Trust Board are asked to:

- Note the contents of this paper.
- Re-endorse the actions agreed to progress the Trust's Equality Objectives as part of the WRES action plan.

Appendix One: 2017 WRES Indicators and Trust data

Indicator 1

Breakdown of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) for both clinical and non-clinical workforce

Clinical workforce

Band	White	% of Staff	BME	% of Staff
Under Band 1	0	0.0%	0	0.0%
Band 1	0	0.0%	0	0.0%
Band 2	25	1.0%	36	4.3%
Band 3	112	4.6%	123	14.7%
Band 4	72	3.0%	41	4.9%
Band 5	572	23.7%	145	17.3%
Band 6	500	20.7%	158	18.8%
Band 7	434	18.0%	97	11.6%
Band 8A	146	6.1%	19	2.3%
Band 8B	70	2.9%	12	1.4%
Band 8C	28	1.2%	3	0.4%
Band 8D	10	0.4%	1	0.1%
Band 9	2	0.1%	0	0.0%
VSM	6	0.2%	0	0.0%
of which medical and dental		0.0%		0.0%
Consultant	244	10.1%	80	9.5%
of which senior medical manager	5	0.2%	0	0.0%
Non-consultant career grade	100	4.1%	72	8.6%
Trainee grades	78	3.2%	51	6.1%
Other	9	0.4%	1	0.1%

Non - Clinical Workforce

Band	White	% of Staff	BME	% of Staff
Under Band 1	0	0.0%	0	0.0%
Band 1	0	0.0%	0	0.0%
Band 2	57	9.5%	74	12.3%
Band 3	78	12.9%	79	13.1%
Band 4	147	24.4%	121	20.1%
Band 5	76	12.6%	59	9.8%
Band 6	57	9.5%	30	5.0%
Band 7	70	11.6%	22	3.6%
Band 8A	56	9.3%	19	3.2%
Band 8B	30	5.0%	5	0.8%
Band 8C	14	2.3%	1	0.2%
Band 8D	13	2.2%	0	0.0%
Band 9	1	0.2%	0	0.0%

VSM	4	0.7%	1	0.2%

Indicator	Descriptor	2017	2016	2015
Indicator 2	Relative likelihood of white staff being appointed from shortlisting across all posts	1.73 times	2.02 times	2.57 times
Indicator 3	Relative likelihood of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	1.9 times	3.37 times	1.82 times
Indicator 4	Relative likelihood of white staff accessing non-mandatory training and CPD	1.19	1.07	1.05
Indicator 5 (from Staff Survey)	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White: 22.9% BME: 21.62%	White: 27% BME 21%	White: 25% BME 17%
Indicator 6 (from Staff Survey)	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White: 24.84% BME: 28.34%	White: 23% BME 33%	White: 24% BME 25%
Indicator 7 (from Staff Survey)	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion	White: 86.98% BME: 79.09%	White: 90% BME 78%	White: 93% BME 77%
Indicator 8 (from Staff Survey)	Q17. In the last 12 months have	White: 6.03% BME: 11.2%	White: 6% BME 15%	White: 8% BME 11%

	you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues			
Indicator 9	Percentage difference between the organisations' Board voting membership and its overall workforce	-11.8%	- 4.6%	-5.3%

Appendix 2: Action Plan

EQUALITY OBJECTIVE	RATIONALE	WRES INDICATOR	MEASUREMENT	BASELINE MEASURE	TARGET	ACTION
Increase overall visibility of the Trust Board and Senior Leaders	Enhance communication with staff in light of staff survey results. Enable leaders to demonstrate their commitment to E&D in response to findings from EDS 2 scoring exercise.	1 & 9	Annual staff survey (staff reporting good communication between them and senior managers). Annual WRES	Staff Survey 2015: GOSH score = 30%. Average score for acute specialist trust: 38%.	2017 survey: target of 33%. By the end of 2019, GOSH's score will mirror the average score of acute specialist trusts. Improvements in the EDS 2 (2019) and WRES scores will also be achieved.	Various approaches phased over the life of the objective. These will include: • Strategies to increase the visibility of leadership and enhancement of their communication with staff. • Development of Trust Board and Senior Leaders around equality issues (using patient stories to highlight issues, consideration of unconscious bias training etc.). • Trial of reverse mentoring with a member of the Trust Board and a BME member of staff. • Engaging Senior Leaders with

						celebrations and events throughout the year to further improve visibility.
Develop the understanding of managers and employees in recognising and managing Harassment and Bullying, with the longer term intention of a reduction in the instances of bullying and harassment concerns raised.	EDS 2 survey results and voting showed that it was one of the categories to score highest in the underdeveloped grade.	6 & 8	The number of managers who have undertaken the Harassment and Bullying training The number of employees who have undertaken Harassment and Bullying training Levels of reported harassment and bullying via the staff survey	Staff Survey 2015: Harassment, bullying and abuse from staff: White – 23% BME – 33%	Levels of reported harassment and bullying via the staff survey will have reduced by 5% by 2019	• In 2016 – 2017, we aim to develop the understanding of managers in what constitutes harassment and bullying, recognising when it occurs and how to manage concerns raised by employees. • Develop the understanding of employees in defining what constitutes harassment and bullying behaviours and how they make take action should they believe this behaviour is being aimed at them or their colleagues.

						• Introduce Unconscious Bias training to support the above interventions and to help managers reflect on how they may be managing team members or situations.
To improve the representation of BME staff in senior posts	Data shows that shortlisted applicants from BME groups are less likely to be appointed to senior posts i.e. Band 7-9 jobs at GOSH than people from white groups	1, 2, 7	Annual E&D data report	Shortlisted applicants 2015 bands 7 – 9 64.5% (white), 35.5% (BME) Appointed 2015 bands 7 -9 83% (white) 17% (BME)	By the end of 2019 the proportion of BME senior staff appointed will be more reflective of the number of BME staff shortlisted	• Creating a networking within senior GOSH BME staff and supporting them to apply to National development programmes (Ready Now) • Include 'Understanding Unconscious Bias' in the current recruitment and selection training course which is targeted at new recruiters (the resourcing team

						themselves undertook unconscious bias training in 2016). • In 2018 - 2019 roll out 'Understanding Unconscious Bias' to all managers involved in the recruitment and selection process. • To implement an interview assessment form that is transparent, including a scoring methodology which is reflective of the trusts values. • By the end of 2017 - 2018 we aim to roll out the assessment form to all managers involved in the recruitment and selection process.

In addition to the above associated with the agreed Trust Equality Objectives further actions are planned under other streams of work which will support the improvement of GOSH WRES data and outcomes and these include:

- Implementing actions arising from the staff listening events (held May 2017) regarding harassment & bullying and progression for all
- Review of the staff equality, diversity and inclusion strategy, governance and work plan which will involve engaging with staff including those from BME groups. Work has already started to engage with an LGBT internal interest group and a plan of work has been designed. Senior BME staff have also recently been brought together to discuss their career aspirations and are being supported to apply to the National 'Ready Now' development programme.

Attachment V

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27th September 2017

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

Aims / summary
Under paragraph 39 of the NHS Foundation Trust Standing Orders, the Trust is required to keep a register of the sealing of documents. The attached table details the seal affixed and authorised since end of September 2016.

Date	Description	Signed by
10/02/2017	Lease – 4th Floor, Russell Square House, 10-12 Russell Square, London WC1B 5EH	LS
10/02/2017	License for alterations – mezzanine floor, East, 40 Bernard Street, London, WC1N 1LG	LS, NG
28/02/2017	Lease – 1st Floor (West), 40 Bernard Street, London WC1N 1LG	PS, LS
09/05/2017	FP7 Grant Agreement – Request for accession of a new beneficiary to the grant agreement	Emma Pendleton
13/07/2017	Wayleave agreement relating to 4th floor, 10-12 Russell Sq, London WC1B 5EH.	MT, AF

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