Great Ormond Street Hospital for Children NHS Foundation Trust

Meeting of the Trust Board
Wednesday 28th March 2018

Dear Members

There will be a public meeting of the Trust Board on Wednesday 28th March 2018 at 1:15pm in the Charles West Boardroom, Great Ormond Street.

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

AGENDA

	Agenda Item STANDARD ITEMS	Presented by	Purpose	Attachment
1.	**Apologies for absence**	Chairman		
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 7th February 2018**	Chairman	**Decision**	**A**
3.	**Matters Arising/ Action Checklist**	Chairman	**Discussion**	**B**
4.	**Chief Executive Report**	Chief Executive	**Information**	**Verbal**
5.	**Patient Story**	Interim Chief Nurse	**Information**	**D**
6.	**Update from the Quality and Safety Assurance Committee in January 2018**	Chairman of Audit Committee	**Discussion**	**E**
7.	**Update from the Finance & Investment Committee in March 2018**	Chairman of Finance & Investment Committee	**Discussion**	**Verbal**
8.	**Members' Council Update – February 2018**	Chairman	**Information**	**F**
	STRATEGY AND PLANNING			
9.	**Draft Annual Business Plan 2018/19 including operational and finance plan**	Deputy Chief Executive/ Interim Chief Finance Officer	**Decision**	**G**
10.	**Better Value Update**	Deputy Chief Executive	**Discussion**	**H**
11.	**Strategy Deep Dive: Quality including recruitment and retention update**	Interim Medical Director/ Interim Chief Nurse/ Deputy CEO	**Discussion**	**I**
12.	**Sight and Sound Centre - Full Business Case**	Director of Development/ Deputy Chief Executive	**Decision**	**U**

	PERFORMANCE			
13.	**Integrated Quality Report – 28th February 2018**	Interim Medical Director/ Interim Chief Nurse	**Discussion**	**J**
14.	**Integrated Performance Report (28th February 2018)** **Finance Report (28th February 2018)**	Deputy Chief Executive Interim Chief Finance Officer	**Discussion** **Discussion**	**K** **L**
15.	**Update on Gastroenterology Review (RCPCH report and GOSH response)**	Interim Medical Director	**Discussion**	**M**
16.	**Regular Director of Infection Prevention and Control Report**	Director of Infection Prevention and Control (Dr John Hartley)	**Discussion**	**N**
17.	**Safe Nurse Staffing Report** • **January 2018** • **February 2018**	Interim Chief Nurse	**Discussion**	**O**
18.	**2017 GOSH Annual Staff Survey Results**	Director of HR and OD	**Information**	**P**
	GOVERNANCE			
19.	**Guardian of Safe Working – quarterly report**	Interim Medical Director/ Guardian of Safe Working (Dr Renée McCulloch)	**Information**	**Q**
20.	**Register of Interests and Register of Gifts and Hospitality**	Company Secretary	**Information**	**R**
21.	**Compliance with Emergency Preparedness, Resilience and Response standards**	Deputy Chief Executive	**Information**	**S**
22.	**Equality & Diversity Annual Report and Update against Equality Objectives**	Interim Chief Nurse/ Director of HR and OD	**Information**	**T**
23.	**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.)			
24.	**Next meeting** The next Trust Board meeting will be held on Wednesday 23rd May 2018 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 7th February 2018

Present

Sir Michael Rake	Chairman
Dr Peter Steer	Chief Executive
Lady Amanda Ellingworth	Non-Executive Director
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
Dr Andrew Long	Interim Medical Director
Ms Loretta Seamer	Chief Finance Officer
Ms Nicola Grinstead	Deputy Chief Executive
Mr Ali Mohammed	Director of HR and OD
Ms Polly Hodgson	Interim Chief Nurse

In attendance

Mr Matthew Tulley	Director of Development
Ms Cymbeline Moore	Director of Communications
Professor David Goldblatt*	Director of Research and Innovation
Mr Peter Hyland*	Director of Operational Performance and Information
Ms Emma Pendleton*	Deputy Director of Research and Innovation
Dr Allan Goldman*	Divisional Co-Chair, Charles West Division
Professor Andrew Taylor*	Divisional Co-Chair, Charles West Division
Ms Anne Layther*	Director of Operations
Dr Sophia Varadkar*	Divisional Director JM Barrie Division
Ms Sarah James*	Divisional Director of Operations JM Barrie Division
Dr Elizabeth Jackson*	Divisional Director JM Barrie Division
Ms Trish Evans*	Matron JM Barrie Division
Mr Chris Rockenbach*	General Manager, IPP
Dr Melanie Hirons*	Clinical Director, IPP
Ms Claudia Tomlin*	Interim Head of Nursing, IPP
Dr Anna Ferrant	Company Secretary
Ms Victoria Goddard	Trust Board Administrator (minutes)

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

129	**Apologies for absence**
129.1	No apologies for absence were received.
130	**Declarations of Interest**
130.1	No declarations of interest were received.
131	**Minutes of Meeting held on 28th November 2017**

131.1	The Board **approved** the minutes of the previous meeting.
132	**Matters Arising/ Action Checklist**
132.1	**Action:** Minute 105.8 – It was agreed that Dr Peter Steer, Chief Executive would keep the Board updated on the London consolidation devolution as matters arose.
132.2	Minute 65.8 – to be amended to correct Mr Ali Mohammed's job title.
133	**Patient Story**
133.1	The Board received a patient story by video of Katie, a 13 year old young person who had been treated at GOSH for ten years under the care of Gastroenterology, Respiratory and Surgery.
133.2	Katie highlighted the following points about her visits to GOSH: • Welcome the input from teachers through play. • Play therapy has helped to reduce Katie's fear of hospital stays and procedures. • Katie's parents have always been able to stay with her but there is not enough space for belongings. • Katie stays in a bay on Rainforest Ward which means that she could be next to a baby or a child of a very different age. • Particularly appreciated having access to a specialist nurse for teenagers. • Katie felt that the school caters to very young children or older teenagers rather than young people of her age. • The DVDs and computer games available to play were for younger children. • The food was not always enjoyable.
133.3	Katie made the following recommendations: • Doctors to talk to Katie in language she can understand. • Letters to be improved as those from some teams arrive very close the date of the appointment. This varies by specialty. • Improved food • Improved communication between GOSH teams and external organisations. • Staff being more polite. • Katie emphasised the importance of having access to wi-fi in order to feel connected to friends and family and help keep her occupied during hospital stays. She recommended improvement in this area.
133.4	Mr Akhter Mateen, Non-Executive Director said that many recommendations for improvement were common to a number of patient stories. He highlighted that although action plans had been developed in a number of areas, feedback remained negative. Dr Peter Steer, Chief Executive said he felt that improvements were being made in the hospital food and the wi-fi had been very recently upgraded to the highest specification. Dr Steer added that it was disappointing that the appropriate age entertainment was not available and confirmed that this would be followed up. Ms Nicola Grinstead, Deputy Chief Executive said that there were particular issues around access to wi-fi in outpatients and strict security controls were in place which could be a source of frustration for patients.

133.5	Professor Rosalind Smyth, Non-Executive Director said that the January meeting of the Quality and Safety Assurance Committee had received a paper on progress addressing the actions arising from patient stories and said that she did feel these were being addressed. She said that if similar feedback continued to be received it would be important to speak to the same patients again to see if they had experienced an improvement.
133.6	Ms Grinstead said that face to face communication with patients had been considered as a particular strand in a patient and family listening event and there was a detailed action plan in place. Mr Matthew Tulley, Director of Development said that there were a number of handovers involved in delivering food to wards and work was taking place to look at the scope of the service and receiving input from a hospital food expert.
133.7	**Action:** It was agreed that an update on the issues raised in the patient story would be part of the Chief Executive's report at the next meeting.
134	**Chief Executive Report**
134.1	Genetic Laboratory Consolidation Bid
134.2	Dr Peter Steer, Chief Executive said that GOSH was the lead organisation in a partnership bid for the North Thames geographic area for rare disease and paediatric cancer genetic laboratory work consolidated at the GOSH site. Dr Steer said that negotiations were ongoing and highlighted the significant risks within the bid process particularly around the contract.
134.3	Cognitive Partnership
134.4	The Board had been briefed in January on a cultural change programme in partnership with the Cognitive Institute and a grant proposal for this work would be submitted to the GOSH Children's Charity in March. Feedback from staff who had been involved so far had been positive.
134.5	NHSI Pathology Laboratory Consolidation Strategy
134.6	NHS Improvement had launched a process to consolidate pathology laboratory services into 29 hubs. Chief Executive of the four standalone children's hospitals had written to NHS Improvement to express concern about the lack of consideration for specialist paediatric pathology services and it had been confirmed that a specialist subgroup would be established.
134.7	CQC
134.8	An unannounced CQC inspection in mid-January had focused on outpatients and surgery and an announced well led inspection had also taken place at the end of January. No major concerns had been raised at the exit meeting by the inspection team and the draft report would be provided for factual accuracy checks in March 2018.
135	**Board Committee Updates:**
135.1	Audit Committee Update – January 2018

135.2	Mr Akhter Mateen, Chair of the Audit Committee highlighted the discussed that had taken place around IPP debt provision. He reported that following discussion about the trend in debtor days and total debt at the Finance and Investment Committee a report had been requested on provisioning for the Audit Committee. Following review of potential options for amendments to the provisioning policy it was agreed that the current provisioning methodology was appropriate. The external auditors had been supportive of this agreement and had confirmed GOSH was not an outlier in terms of debtor levels.
135.3	Sir Michael Rake, Chairman said he had noted that all London hospitals that undertook IPP work had a specific issue with debt from one territory. He suggested that the hospitals work together to discuss this. Mr David Lomas, Non-Executive Director highlighted the key part that relationships played in encouraging embassies to pay and suggested that relationships should be developed between Dr Steer, Sir Michael Rake and the middle east.
135.4	Mr Mateen said that the Committee would continue to consider the issue of GDPR readiness and a further update would be received before the go live date in May 2018.
135.5	<u>Quality and Safety Assurance Committee Update – January 2018</u>
135.6	Professor Stephen Smith, Chair of the Quality and Safety Assurance Committee (QSAC) said that the committee had discussed transition and had noted the complexity of the work. Emphasis was placed on the importance of putting timelines on this work.
135.7	Professor Smith said that the CQC had queried the use of language around Never Events in the Integrated Quality Report and the presentation of clinical outcomes to the Committee. Dr Peter Steer, Chief Executive highlighted that the Trust published a significant number of outcomes publically on the GOSH website.
135.8	**Action:** Professor Rosalind Smyth, Non-Executive Director highlighted the important pharmacy review which was taking place and had been discussed by the committee and it was agreed that the Trust Board would receive an update on this work.
135.9	<u>Finance and Investment Committee Update – January 2018</u>
135.10	**Action:** Mr David Lomas, Chair of the Finance and Investment Committee said that the meeting had considered the use of Patient Level Costing to allow patient level data to be cut in many ways giving an insight into the negative NHS contribution. The Committee had also reviewed the drivers of revenue in terms of activity volumes and tariff and it was agreed that both these topics would be discussed by the Board during 2018/19.
136	**Update from the Members' Council in December 2017**
136.1	Dr Anna Ferrant, Company Secretary said that a successful election had taken place which received over 50 nominations for elected seats on the Council of Governors. An induction programme was being developed for the new Council. Sir Michael Rake, Chairman emphasised the importance of a robust induction programme due to the large number of newly elected Governors.

137	**Strategy progress update**
137.1	Research and Innovation
137.2	Professor David Goldblatt, Director of Research and Innovation gave a presentation on the strategic enablers and achievements in terms of research participants, research studies and publications. He said that the challenge in terms of continuing to increase the number of studies was around people and space.
137.3	Mr James Hatchley, Non-Executive Director said that it appeared that the contribution of the GOSH Children's Charity had reduced and Dr Peter Steer, Chief Executive said that work should take place to reflect on some areas of ICH income.
137.4	Charles West Division
137.5	Dr Allan Goldman, Divisional Co-Chair of Charles West Division gave an update on the divisional strategic priorities. Sir Michael Rake, Chairman noted that a recent internal audit had reported a divisional reorganisation had been undertaken to drive out silo working. He asked how far the division believed this objective had been achieved. Dr Goldman said that the reduced number of divisions had a significant impact and enabled better communication and team working.
137.6	Professor Rosalind Smyth, Non-Executive Director welcomed the focus that the division was placing on outcomes but noted that this was far more challenging in specialties where there were no international benchmarks. Professor Smyth highlighted work that was taking place to develop compatible outcome measures internationally and encouraged this work to continue.
137.7	JM Barrie Division
137.8	Dr Sophia Varadkar, Divisional Director for JM Barrie highlighted some of the leading research which was taking place in the division along with the use of specialist technology.
137.9	The division reported that for the first time since the break in reporting, the RTT target of 92% had been achieved. The Board welcomed this.
137.10	International Private Patients
137.11	Mr Chris Rockenbach, General Manager for International Private Patients highlighted the divisional excellent Friends and Family Test response rates and results and the reduction in complaints along with excellent appraisal rates and compliance with statutory and mandatory training. He said that work was taking place to consider whether the billing component of IPP could be built into EPR.
137.12	Sir Michael Rake, Chairman queried the work that was taking place to assess GOSH's competition and consider new markets. Mr Rockenbach said that a review had been undertaken with external consultants to look at relevant territories in terms of accessibility and healthcare needs. Work was taking place to raise the GOSH brand profile in identified new areas. Mr Rockenbach added that technology was key however the Trust did not currently use telemedicine or remote consultations and discussions were taking place around this.

137.13	**Action:** It was agreed that a snapshot of current divisional performance for all divisions and targets which were set but had not been achieved would be circulated outside the meeting.
138	**Draft operational and financial plan**
138.1	Mr Peter Hyland, Director of Operational Performance and Information said that the Trust was moving into the second year of a two year operational plan however no formal national guidance had yet been published for submissions for 2018-19.
138.2	Mr David Lomas, Non-Executive Director noted that analysis of the income statement showed that without contributions from the GOSH Children's Charity the Trust would not be financially sustainable. He suggested that the Board should ask the Executive Team to increase the EBITDA, which was currently decreasing, year on year without impacting the ability to meet the Control Total. He added that he felt a revised target for debtors should also be set.
138.3	Ms Loretta Seamer, Chief Finance Officer highlighted that the Control Total had now been revised to a surplus of £12.065million and recommended that the Board agreed to sign up to this total. Dr Peter Steer, Chief Executive said that this would be challenging target but it was vital that the Trust meet it.
138.4	The Board agreed to sign up to the Control Total and delegate authority to the Chief Executive to sign off the draft submission to NHS Improvement.
139	**Learning from Deaths - Q2 2017/2018**
139.1	Dr Andrew Long, Interim Medical Director presented the report and said that GOSH continue to operate a robust process to review the deaths of inpatients at GOSH. The Board welcomed the update.
140	**Integrated Quality Report – 31st December 2017**
140.1	Dr Andrew Long, Interim Medical Director said that the issues in the report which had been raised by the CQC and noted by Professor Smith earlier in the meeting would be picked up in the report for the next Board meeting.
141	**Integrated Performance Report and Scorecard - 31 December 2017**
141.1	Ms Nicola Grinstead, Deputy Chief Executive presented the report and said that the team continued to validate the data to ensure that the Trust could report a compliant RTT position for the first time since reporting had been paused. She added that it was important that this became a sustained position.
141.2	**Action:** It was agreed that the kitemark would be added to the performance dashboard itself.
141.3	Discussion took place on the Friends and Family Test completion rate which was set at 40% and had been achieved by IPP. Mr James Hatchley, Non-Executive Director asked if there were lessons to be learnt from the division. Ms Grinstead said that the majority of Trusts had a target of 20%, however a significant increase in rates had been achieved when IPP had worked with the other divisions. Dr Peter Steer, Chief Executive highlighted the very different patient stay profile which was likely to impact the completion rate.

141.4	The Board agreed that the target should remain at 40%.
141.5	Theatre Utilisation Programme Overview
141.6	Ms Grinstead presented the overview which gave the Board a sense of the timeline for improvement and the complexity of the work.
141.7	Mr David Lomas, Non-Executive Director suggested amending the targets for each quarter to show that the progress that was anticipated.
141.8	Finance Update – 31 December 2017
141.9	The Board noted the update.
142	**Safe Nurse Staffing Report – November 2017 and December 2017**
142.1	Ms Polly Hodgson, Interim Chief Nurse presented the report and confirmed that no unsafe shifts had been declared in the period. She highlighted that care hours per patient day had increased however agency usage had decreased.
142.2	Turnover had reduced to 16% with minimal vacancies and a number of newly qualified nurses were in the pipeline to begin in post.
142.3	Sir Michael Rake, Chairman noted the large number of newly qualified nurses who had recently joined the Trust and suggested that this would place a burden on training for these individuals. Ms Hodgson said that although it had been challenging, feedback had been positive.
142.4	**Action:** It was agreed that a future meeting would consider a retention analysis of the nursing workforce, the bands of staff who were leaving and after how long. Data produced should enable the Board to follow a trend. Dr Peter Steer, Chairman said that there was a new support and education process in place for newly qualified nurses and the impact of this as a trend should also be identified.
143	**Scheme of Delegation**
143.1	Ms Loretta Seamer, Chief Finance Officer presented the paper and confirmed that discussion had taken place at the Audit Committee and the requested amendments made. Mr Akhter Mateen, Audit Committee Chair confirmed he was satisfied with the amendments.
143.2	The Board **approved** the scheme of delegation.
144	**Medical Revalidation Annual Board report and statement of compliance**
144.1	Dr Andrew Long, Interim Medical Director presented the paper which was an update on the report received at the last meeting. This was noted by the Board.
145	**Board Assurance Framework**
145.1	Dr Anna Ferrant, Company Secretary said that the Board had been involved in updating and scrutinising the risks at the assurance committees. She added that an internal audit report into management of the BAF had provided a rating of

	'significant assurance with minor improvement potential'. The Board noted the report and the update to the risks.
146	**Any other business**
146.1	There were no items of other business.

ATTACHMENT B

Attachment B

TRUST BOARD – PUBLIC ACTION CHECKLIST
March 2018

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
108.3	28/11/17	Mr James Hatchley, Non-Executive Director said that outside the meeting he would welcome further information about DRIVE and the scope of the relationships being formed and GOSH's obligations under these relationships.	Ward Priestman	March 2018	Will be actioned outside of meeting
110.1 110.2	28/11/17	GOSH Learning Academy: It was agreed that a refreshed paper would be considered by the Board at the next meeting which would include information about funding mechanisms. Board members should contact the Chief Executive or Company Secretary to feed their questions into the project. Professor Rosalind Smyth, Non-Executive Director and Director of the UCL GOS Institute of Child Health requested that discussion took place between the two organisations to capitalise on work that could be done collaboratively.	Andrew Long and all Board members	March 2018	Not yet due: To be brought to the May 2018 Trust Board
132.1	07/02/18	It was agreed that Dr Peter Steer, Chief Executive would keep the Board updated on the London consolidation devolution.	PS	On-going	Noted
133.7	07/02/18	The Board would receive an update on the issues raised in the patient story as part of the Chief Executive's report at the next meeting.	PH	March 2018	Updates on progress with matters raised in patient stories are reported to the Quality,

Attachment B

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
					Safety and Assurance Committee. The Committee will update the Board on any outstanding matters following each meeting.
135.8	07/02/18	Professor Rosalind Smyth, Non-Executive Director highlighted the important pharmacy review which was taking place and had been discussed by the Quality and Safety Assurance Committee and it was agreed that the Trust Board would receive an update on this work.	Andrew Long/Matthew Shaw	June 2018	Not yet due
135.10	07/02/18	Mr David Lomas, Chair of the Finance and Investment Committee said that the meeting had considered the use of Patient Level Costing to allow patient level data to be cut in many ways giving an insight into the negative NHS contribution. The Committee had also reviewed the drivers of revenue in terms of activity volumes and tariff and it was agreed that both these topics would be discussed by the Board during 2018/19.	HJ	November 2018	Not yet due
137.13	07/02/18	It was agreed that a snapshot of current divisional performance for all divisions and targets which were set but had not been achieved would be circulated outside the meeting.	NG	March 2018	In progress for end of year
141.2	07/02/18	The kitemark to be shown on the performance dashboard itself rather than a separate paper.	NG	March 2018	Unfortunately this is not possible to report the information on the dashboard due to the amount of data involved. Kite marking information is provided as a

Attachment B

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
					separate report alongside the dashboard
142.4	07/02/18	It was agreed that a future meeting would consider a retention analysis of the nursing workforce, the bands of staff who were leaving and after how long. Data produced should enable the Board to follow a trend. Dr Peter Steer, Chairman said that there was a new support and education process in place for newly qualified nurses and the impact of this as a trend should also be identified.	PH	TBC	On agenda under Deep Dive Quality Report

ATTACHMENT C to follow

Attachment D

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
28 March 2018

Patient Story **Submitted on behalf of** Polly Hodgson, Interim Chief Nurse	**Paper No: Attachment D**

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 for the Trust Board. Each story includes information on actions which were taken to improve aspects of a service, if applicable. Stories which are selected represent a range of families' experiences across a variety of wards and service areas spanning divisions and ensuring that families' experiences are captured.

This story has been pre-recorded and details a patient's (Devan) and parent's (Sanjay) experiences at Great Ormond Street Hospital over the past six years (Devan is 10 years old). There are examples of his past and recent experiences (he still visits GOSH regularly). Devan and his dad Sanjay share their thoughts on the staff they have met, making appointments, what happens when they visit the hospital for their appointments and catering in the Lagoon.

Devan has been under the care of Ophthalmology and his last stay was on Nightingale Ward.

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– Interim Deputy Chief Nurse also covering ACN Quality and Patient Experience

Author and date

Emma James – Patient Experience and Engagement Officer – March 2018

ATTACHMENT E

Great Ormond Street Hospital for Children NHS Foundation Trust

Update from the Quality and Safety Assurance Committee meeting held on 5th February 2018

Matters arising

The Committee discussed 7 day-working and patient safety out of hours. It was confirmed that Trusts had been asked to look at weekend working and safety during this time and GOSH had been satisfied that there were no concerns. The Committee requested information that could be triangulated to reach a view about safety out of hours such as PALS reports, serious incident reports and claims.

The Committee requested an update on sharps at the next meeting to include assurance that the Trust was compliant with the safer sharps regulations.

Update on Transition

Significant progress had been made in this complex area and a consultation had taken place with young people, families and staff. Patients with complex conditions were transitioned to several organisations for their adult care. The Committee requested that any learning was gathered from other paediatric hospitals and it was agreed that an update would be provided on progress against the milestones set out in the Quality Report.

Integrated Quality and Safety Update

Discussion took place about the wording that had been used in the report around Never Events and it was agreed that this would be reviewed. The Committee discussed the way in which trend data was presented and it was noted that the CQC had done work on this and had a suggested list of ways to present the data. It was confirmed that GOSH used Statistical Process Control (SPC) which was considered best practice.

Compliance with Risk Management Framework

The Committee noted that the number of risks of the Trust Wide Risk Register had reduced from 70 to 40 in quarter three as a result of scrutinising the risks' descriptions and the progress made. Work was taking place to ensure there was a standardised process for reviewing risks across the Trust. The Committee agreed that red risks that had been open for some time were the priority for the QSAC.

Whistle blowing update - Quality related whistle blowing cases

A lead Freedom to Speak Up (FTSU) Guardian had been appointed and work was taking place to look at reporting on a more regular basis to the Senior Independent Director and the Board. As part of the work taking place with the Cognitive Institute, two patient safety champions would be appointed and consideration was being given to how they would interact with the FTSU ambassadors.

Quarterly Safeguarding Report (October 2017 – December 2017)

The updated safeguarding policy had been approved by the Policy Approval Group and there had been additional resources put into the team; it was anticipated that the new posts would be filled by March 2018. Work was taking place to expand general paediatrics' cover of safeguarding out of hours which currently fell under the remit of the Clinical Site Practitioners. Patients on child protection protocols were being flagged on PIMS in advance of the implementation of the Electronic Patient Record.

Board Assurance Framework Update

An internal audit report on the Board Assurance Framework had provided a rating of 'significant assurance with minor improvement potential'. Recommendations had been around reporting to assurance committees and the work had been started prior to the report. Discussion took place around the way in which the BAF and the Trust Wide Risk Register (TWRR) worked together and it was confirmed that executive director risk owners were responsible for ensuring they were aware of anything on the TWRR which would impact a BAF risk. The importance of being responsive in this area was emphasised.

Compliance Framework Update

Substantial work was taking place to reduce the number of out of date policies. Processes around national safety standards for invasive procedures (NatSSIPs) were being developed and a governance process would be rolled out to divisions.

Update on implications for GOSH from national guidance on learning from deaths (Trust Board action May 2017)

The Committee noted that GOSH's processes around learning from deaths benchmarked well against other organisations' with the mortality review group having been in place since 2012. The CQC had been positive about GOSH's processes.

Update on learning from patient stories

The Committee noted the update and it was confirmed that a project was taking place around the patient menu.

Pharmacy Review

It was reported that recommendations arising from the review were covered under six themes and the committee welcomed the excellent work that had taken place. A number of positives had also been highlighted around the commitment of staff and their level of expertise. Discussion took place around the anticipated outcome of the work on the recommendations which included a reduction in medication errors. The Committee requested a further update in six months' time.

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

The Committee welcomed the reduction in the use of agency staff and requested an update on the work that was taking place around a theatre utilisation data issue. Two better value scheme post implementation reviews were noted which did not show any negative impact in terms of quality and safety.

Internal Audit Progress Report (October 2017 – December 2017)

The Committee noted the internal audit report on business continuity which had provided a rating of significant assurance with minor improvement opportunities.

Clinical Audit update October 2017 – December 2017

It was noted that the report made reference to an under resourcing in the Clinical Audit team and the committee emphasised the important of this function.

Matters to be raised at Trust Board

It was agreed that the following matters would be raised at Trust Board:

- Freedom to Speak Up
- Pharmacy review
- Actions arising from patient stories
- Compliance with the risk management framework.

ATTACHMENT F

Great Ormond Street Hospital for Children NHS Foundation Trust

Update from the Council of Governors meeting held on 7th February 2018

Update from the Membership Engagement, Recruitment and Representation Committee

It was reported that all Governor seats had been filled in the recent election and communication with new Governors was beginning.

It had been agreed that the 2018 AGM would be held in the staff side lagoon with a theme of 70th anniversary of the NHS.

Update from the Young People's Forum (YPF)

The number of young people in the forum had grown substantially and two groups could be formed for older and younger members to ensure activities could be directed appropriately. A number of current and former YPF members had been elected to the Council of Governors.

Update from the Patient and Family Experience and Engagement Committee (PFEEC) including Q3 2017/18 PALS Report

The Trust had met the target of 95% likely to recommend GOSH for both inpatients and outpatients in the Friends and Family Test and the key positive themes were around 'Always helpful'. Negative themes were around staffing levels, transfer and discharge. An increased number of PALS cases in quarter 3 had resulted in a reduced number of matters being escalated to formal complaints.

NED reappointment

The Council approved the reappointment of Mr Akhter Mateen, Non-Executive Director to the Board. The extension of Mr David Lomas, Non-Executive Director's appointment until 31st March 2018 to support transition to Mr Chris Kennedy (starting on 1 April 2018), was also approved.

Draft Lead Governor Job Description

The draft job description had been reviewed by DAC Beachcroft LLP bearing in mind role descriptions used by other Trusts, best practice and the Code of Governance. Discussion took place around the length of the document and possible simplification. The Council requested that consideration be given to whether the role of Lead Governor could be shared by more than one Governor. It was noted that the Constitution Working Group, comprised of governors and senior managers would take the work forward.

Reports from Board Assurance Committees

- Quality and Safety Assurance Committee (January 2018 agenda)

The Trust had agreed to amend the wording around Never Events in the Integrated Quality Report to be clear that GOSH was responsive and learnt from these events. The Committee had discussed transition and its complexities and welcomed an update on the pharmacy review.

- Audit Committee (January 2018 agenda)

The Committee considered the process of reviewing the risk scores on the Board Assurance Framework and agreed to look at the processes used by other Trusts for potential learning. Deep

dives had taken place on four risks. The committee discussed IPP debt which remained an area of risk. A tender would be conducted for an External Auditor, the contract for which ended in March 2019. The Council of Governors would be involved in this as an area of statutory responsibility.

- Finance and Investment Committee Summary Report (January 2018 and agenda

The year to date results were noted to be equal to, or better than, budget with revenue having increased by 9% based on the same point in the previous year.

Selection by Councillors of a Local Quality Indicator for external data testing and inclusion in the Quality Report 17/18

The Council received an update on the local quality indicators which could be chosen for data testing by the external auditors. It was confirmed that although the decision was not being made to improve the performance of the indicator, the areas were all part of transformation projects with assurance being provided on performance as part of this work.

Chief Executive Report (Highlights and Performance) including integrated quality report

It was reported that the Trust had engaged the Cognitive Institute to undertake a cultural change programme and this had been well received by both clinical and non-clinical leaders.

The Trust had achieved the 92% target for RTT for the first time since reporting had been paused which was amongst the best national performance. Discussion took place around vacancy rates that were within target and the triangulation with the responses to the Friends and Family Test which had raised concerns about staffing. It was noted that GOSH had a large number of newly qualified nurses in post who required additional support and following the opening of the Premier Inn Clinical Building where patients were in cubicles, the perception of staff presence on wards was likely to have changed.

The Council discussed last minute cancelled operations and highlighted the impact on patients and families. It was confirmed that significant work was taking place around patient flow and ensuring all possible options had been explored before it was possible to cancel a patient.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
28th March 2018

Draft Annual Business Plan 2018/19 including operational and finance plan **Submitted by:** Nicola Grinstead, Deputy Chief Executive Helen Jameson, Interim Chief Finance Officer	**Paper No: Attachment G** **Attachments:** **1- Finance Narrative** **2- Operational Plan Narrative**

Purpose

The purpose of this paper is to indicate the highlights that have been submitted to NHSI as part of the 2018-19 annual planning round and to request delegated authority to finalise plans for submission on 30th April. The required submissions are in line with prior year's requirements and consist of a number of returns, namely:

- Annual financial plan in line with the control total notified to us in February
- A summary of efficiencies (our Better Value Programme)
- A workforce return that reconciles to the financial plan in respect of WTE's
- Activity planning assumptions

Draft versions of these were submitted on 8th March in line with NHS improvement's national timetable. The submissions are very large documents and contain a great deal of detail. In order to summarise the documents and highlight key points, two narratives were submitted that detail the specifics of the reports (broadly following the format required by NHSI). These have been grouped into:

- Draft Finance Narrative; this principally covers the first two documents above
- Draft Operational Plan Narrative; this principally covers the last two documents above
  Note, there is naturally some crossover within each.

Draft Finance Narrative – Summary points

The Trust has indicated that it will meet its overall control total subject to delivery of the £15m better value programme and assuming that the overall contract offer that is received from NHS England is aligned with our projected budget. The negotiations remain on-going in respect of this at the time of the submission and clear reference is made in the narrative to the differences between our perspective and the offers that we have received. The return includes an analysis of our variance from the **Month 9 forecast** and our original control total; this is set out below:

Year	Control Total / Outturn	Adjustment for Depreciation on Charity Funded Assets	Net Surplus (Deficit) including Dep'n for charity funded assets
2017/18	£9.7 m Surplus	£9.5 million	£0.2 million Surplus
2017/18 FOT	£11.4 m Surplus	£9.6 million	£1.8 million Surplus
2018/19	£12.1 m Surplus	£11.6 million	£0.5 million Surplus

As covered in the finance report for Month 11, the forecast position has been revised down for Month 11. As part of the return, the budgeting approach undertaken within the Trust is set out and demonstrate how we have moved from our original 2017-18 full-year outturn control total to the 2018-19 plan control total. The movements from the original forecast to our current position are covered in the report; for the final submission of the plan (due end of April 18), the narrative will be updated once again.
The Trust process is described in the draft finance narrative.

There is an additional summary of the Capital Programme for 2018-19; £29.1m has been earmarked from Trust reserves (including £15.7m of schemes agreed in prior years). A proposal has been included at £51m of charity funded capital.

The initial draft Better Value programme is included as a high level summary detailing the £15m of schemes that will need to be delivered in year to achieve the control total. Naturally these are subject to considerable scrutiny and change while detailed budgeting is completed.

Note: The Trust has agreed in principle a settlement for the 2018-19 contract with NHS England though has not formally signed an agreement with them at the time these papers were submitted. The contract that has been proposed is £314m which is in line with 2017-18 outturn and £8m more than the updated contract value agreed in 2017-18. Full details will be submitted to future boards to update on the agreed overall funding envelope for 2018-19 once final budgeting has been completed.

Draft Operational Plan Narrative
This is a refresh for 2018/19 of the narrative required by NHSI originally in December 2016 to cover 2017/18 and 2018/19.

Key updates include:

- **Activity:** revised activity assumptions to reflect latest view of activity required to maintain compliance with the RTT target and growth assumptions based on approved business cases.
- **Quality:** revised priorities for quality improvement in 2018/19, including the early warning scores project.
- **Workforce:** revised workforce numbers to align with latest planning assumptions, and update to focus of workforce initiatives in 18/19 including, for example, work with the Cognitive Institute.

The Board reviewed a version of this refreshed narrative in February 2018. Since then, further refinements have been made to the activity assumptions, reflecting ongoing discussions with commissioners, and workforce assumptions. The financial plan aligns with the activity levels established within this plan.

Action required from the meeting

- **Note** the draft Financial Plan and assumptions and risk assessment of assumptions used in the development of the two year plan.
- **Continue to support the recommendation** that the Trust should agree to the Control Total set for next year, based on the assumptions outlined in the draft financial plan.
- **Note** the draft operational plan narrative including latest activity and workforce assumptions (aligned to the Financial Plan).
- **Indicate** that the Board is satisfied that adequate governance measures are in place to ensure the accuracy of information included within the plans.
- **Delegate** authority to CEO to sign off the final version of these submissions on 30th April

2018, following any further refinements required (e.g. following finalising of contract negotiation).
Contribution to the delivery of NHS / Trust strategies and plans The delivery of the financial plan is a key strategic objective to ensure we have sufficient funding to meet the needs of our delivery of care.
Financial implications Not delivering the Control Total would have led to the Trust losing the S&T Fund. Other affects include the NHSI ratings of the Single Oversight Framework.
Legal issues None
Who is responsible for implementing the proposals / project and anticipated timescales Deputy Chief Executive and Chief Finance Officer / Executive Management Team
Who is accountable for the implementation of the proposal / project Deputy Chief Executive and Chief Finance Officer

Attachment G

Great Ormond Street Hospital for Children NHS Foundation Trust

Revised 2nd Year of NHSI 2 Year Financial Plan

2018-19

Financial narrative to accompany the 2018-19 plan

1. Executive Summary

The NHS planning and contracting process for 2017-18 and 2018-19 required GOSH to submit an initial two-year plan. Following the revised guidance in line with the updated control totals, the trust has now submitted a revised financial plan.

Following the publication of the guidance, the initial phase of the financial planning that has been undertaken is considered a 'top-down' approach and will provide the bridge and key assumptions between the current year forecast outturn and 2018/19. The targeted control total for 2018-19 is as follows:

	£ million
Current 2018/19 control total (including allocated STF)	**11.005 Surplus**
Net impact of CNST income and spend changes	1.214
Risk Reserve (available for deployment)	-1.060
Additional STF allocation	2.187
2018/19 control total (including allocated STF) before flexibility	**13.346 Surplus**
CT flexibility changes made if 2017/18 control total (excluding STF) is delivered	-1.281
Revised 2018/19 control total (including allocated STF) after flexibility	**12.065 Surplus**

Current STF allocation (from the £1.6 billion STF General Fund)	5.384
Additional STF allocation (from the additional £650 million STF)	2.187
Total allocated STF – the enhanced provider sustainability fund (included in revised 2018/19 control total above)	**7.571**

Agency ceiling for 2018/19	**6.123**

The Trust proposes to meet its proposed control total for 2018-19 subject to the following assumptions:

- The NHSE Contract for 2017/18 includes the impact of the Local Price Review, demographic growth, high cost drugs and devices growth, tariff inflation, activity to maintain RTT performance, commissioner QIPP of £7.6m and business cases. The initial contract value that was proposed for 2018/19 was £295.8 million with NHSE, the revised contract at the time of submission (including CQUIN) for 2018-19 is £309.8m. The current expectation of GOSH included within the plan at present is for a contract value of £318.4m in 2018-19; negotiations remain on-going with NHSE over the gap.
- The Better Value Programme from which CIP's are governed and undertaken will need to deliver £15m of tangible savings for 2018-19.
- Inflation is funded for pay, non-pay and income (where appropriate) in line with OBR forecasts. This amounts to £6.3m for pay and £2.2m for non-pay.
- A separate contingency of £5m has been set aside to account for cost pressures arising in year, and fund any developments arising.

2. Background

The control total numbers can be found in the table below and show the 2017/18 control total, 2018/19 control total and the 2017/18 forecast outturn as at Month 9 in line with the submitted return. The 2018/19 plan is to hit the control total that was set within the submission of the two-year plan and adjusted per the revised control totals target set by NHSI in February 2018.

The forecast outturn includes over performance on the NHSE contract and the current assumption is that this continues into 2018/19. There is risk around this as the current over performance remains to be agreed for 2017/18 and the current contract offer for 2018-19 is significantly below the projected outturn (though it is anticipated that NHSE will submit a more robust offer in due course).

Year	Control Total / Outturn	Adjustment for Depreciation on Charity Funded Assets	Net Surplus (Deficit) including Dep'n for charity funded assets
2017/18	£9.7 m Surplus	£9.5 million	£0.2 million Surplus
2017/18 FOT	£11.4 m Surplus	£9.6 million	£1.8 million Surplus
2018/19	£12.1 m Surplus	£11.6 million	£0.5 million Surplus

3. Approach to financial forecasts/planning

Initial Submission Phase

The initial phase of the financial planning is considered a 'top-down' approach and will provide the bridge and key assumptions between the current year forecast outturn and the 2018/19 plan.

The Trust's draft financial plan for 2018/19 has been derived from in principle, a roll forward of the 2017-18 budgets, relative to a forward projection of the forecast out-turn for 2017/18. Additional adjustments were made for:

- non-recurring income and expenditure;
- changes in proposed contract activity and tariff, private income, other income and assumptions for CQUIN;
- known changes to costs for future years;
- cost inflation, productivity and efficiency targets and unavoidable cost pressures;
- any business cases approved in year in line with the Trust mandated approval process; and specifically;
- annualised cost pressures from the opening in 2017-18 of Phase 2b of the Trust's Capital Masterplan (Premier Inn Clinical Building).

Detailed Budget Development Phase

The development of the detailed budgets by cost centre will be based on a rolled budget from the 2017/18. The detailed allocations to divisions will happen over the next few weeks in line with the NHSI planning window for the second submission i.e. the fully allocated budgets derived from the divisional envelopes will be fully allocated ahead of the 30th April 2018 deadline.

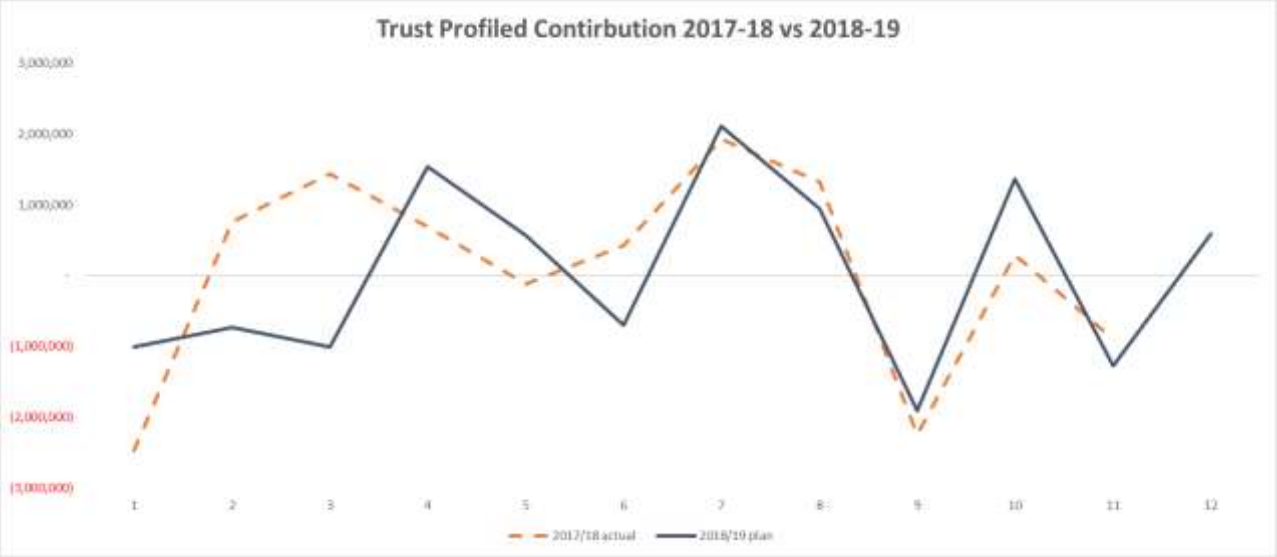
Note: it is not anticipated that the Trust will amend its overall control total.

Profiling

The Trust has aligned the 2018-19 plan in line with an agreed proposal that in summary assumes:

- Elective income is driven by working days.
- Non elective income is driven by calendar days in month.
- Controllable non-pay is linked to activity when there is a demonstrable link to activity.
- Business Cases and Pay / Non-Pay etc. are phased according to each case.
- Specific seasonality has been incorporated for Christmas and an allowance has been made for Eid and Ramadan which have specific effects on delivery of IPP income.

The net effect of the proposed changes indicates a plan that is comparable with prior years:



4. Summary Financial Statements 2018/19

Control Total Targets

Year	Control Total	Adjustment for Depreciation on Charity Funded Assets	Net Surplus (Deficit) including Dep'n for charity funded assets
2017/18	£9.7 million Surplus	£9.5 million	£0.2 million Surplus
2018/19	£12.1 million Surplus	£11.6 million	£0.5 million Surplus

Income Statement

The statement below lays out the original 2017/18 plan, the forecast outturn as at month 9, the 2018/19 plan submitted last year and the new revised plan incorporating the forecast outturn.

Statement of Comprehensive Income	Initial Submission		
£m	2017/18 Plan	2017/18 FOT	2018/19 Revised plan
NHS & Other Clinical Revenue	276.6	278.5	284.6
Pass Through	63.5	65.7	63.4
Private Patient Revenue	60.7	63.4	65.3
Non-Clinical Revenue	53.3	56.4	62.7
Total Operating Revenue	**454.1**	**464.0**	**476.0**
Permanent Staff	(225.5)	(229.7)	(239.7)
Agency Staff^	(6.4)	(4.4)	(4.4)
Bank Staff^	(17.0)	(16.7)	(16.8)
Total Employee Expenses	**(248.8)**	**(250.8)**	**(260.9)**
Drugs and Blood	(13.1)	(11.9)	(12.3)
Other Clinical Supplies	(46.4)	(44.1)	(41.2)
Other Expenses	(54.1)	(64.1)	(69.4)
Pass Through	(63.5)	(65.7)	(63.4)
Total Non-Pay Expenses	**(177.1)**	**(185.8)**	**(186.3)**
Total Expenses	**(425.9)**	**(436.6)**	**(447.2)**
EBITDA	**28.2**	**27.4**	**28.8**
Depreciation on Trust-funded assets	(11.2)	(8.5)	(9.3)
Interest	0.2	0.1	0.1
PDC	(7.5)	(7.5)	(7.5)
Net (Deficit)/Surplus (exc Cap. Don. & Impairments)	**9.7**	**11.5**	**12.1**
Depreciation on Donated Assets	(9.5)	(9.6)	(11.6)
Impairments	(8.0)	(8.0)	0.0
Net (Deficit)/Surplus after adj for dep on donated assets)	**(7.8)**	**(6.1)**	**0.5**
Capital Donations	72.1	30.4	41.9
Net Result	**64.3**	**24.3**	**42.5**

Statement of Financial Position

Statement of Financial Position			
£m	2017/18 Plan	2017/18 FOT	2018/19 Revised plan
Non-Current Assets	536.7	451.3	500.8
Inventory	7.3	8.9	9.5
Debtors	67.2	75.7	77.3
Cash	53.8	50.1	39.1
Creditors	(70.5)	(67.2)	(66.2)
Provisions & Non-Current Liabilities	(5.1)	(5.1)	(4.5)
Total Assets Employed	**589.4**	**513.7**	**556.0**
PDC Reserve	126.0	126.7	126.7
I&E Reserve	353.6	301.9	344.2
Revaluation Reserve	106.7	82.0	82.0
Other Reserves	3.1	3.1	3.1
Total Taxpayers' Equity	**589.4**	**513.7**	**556.0**

Statement of Cashflow

Statement of Cash Flows

£m	2017/18 Plan	2017/18 FOT	2018/19 Revised plan
Cash flows from operating activities			
Operating (deficit) / surplus - excluding charitable capital expend	9.0	10.9	7.9
Impairment and Reversals	(8.0)	(8.0)	0.0
Charitable capital expenditure contributions	33.8	30.4	41.8
Operating surplus	34.8	33.3	49.8
Non-cash income and expense			
Depreciation and amortisation	17.7	18.1	20.9
Impairments and Reversals	0.0	8.0	0.0
Gain on disposal	0.0	0.0	0.0
Increase in trade and other receivables	(22.3)	(9.3)	(1.1)
(Increase) / Decrease in inventories	(0.2)	(0.7)	(0.6)
Increase in trade and other payables	6.9	9.1	0.9
Decrease in other current liabilities	(0.4)	0.4	0.0
Decrease in provisions	(0.1)	(0.3)	(0.2)
Net cash inflow (outflow) from operating activities	1.6	25.3	19.9
Cash flows from investing activities			
Interest received	0.1	0.1	0.1
Purchase of property, plant and equipment and Intangibles	(50.4)	(43.5)	(73.2)
Net cash used in investing activities	(50.3)	(43.4)	(73.1)
Cash flows from financing activities			
Public Dividend Capital received	0.0	0.0	0.0
PDC dividend paid	(7.5)	(7.5)	(7.5)
Net cash outflows from financing activities	(7.5)	(7.5)	(7.5)
Increase/(decrease) in cash and cash equivalents	**(21.4)**	**7.7**	**(10.9)**
Cash and cash equivalents at period start	**63.7**	**42.4**	**50.0**
Cash and cash equivalents at period end	**42.4**	**50.0**	**39.1**

Annual Plan 2018/19

The plan assumes a reduction in cash of £11m; £9m relates to Trust funded capital schemes slipped from 2017/18 and £2m relates to an increase in IPP debtors. NHS debtors is planned to increase at the beginning of the year before improving in November once over-performance invoices begin to get settled. The effect of inflation on the value of trade payables is planned to be offset by improvements in processes as part of the AP transformation work that was commissioned in 2017-18.

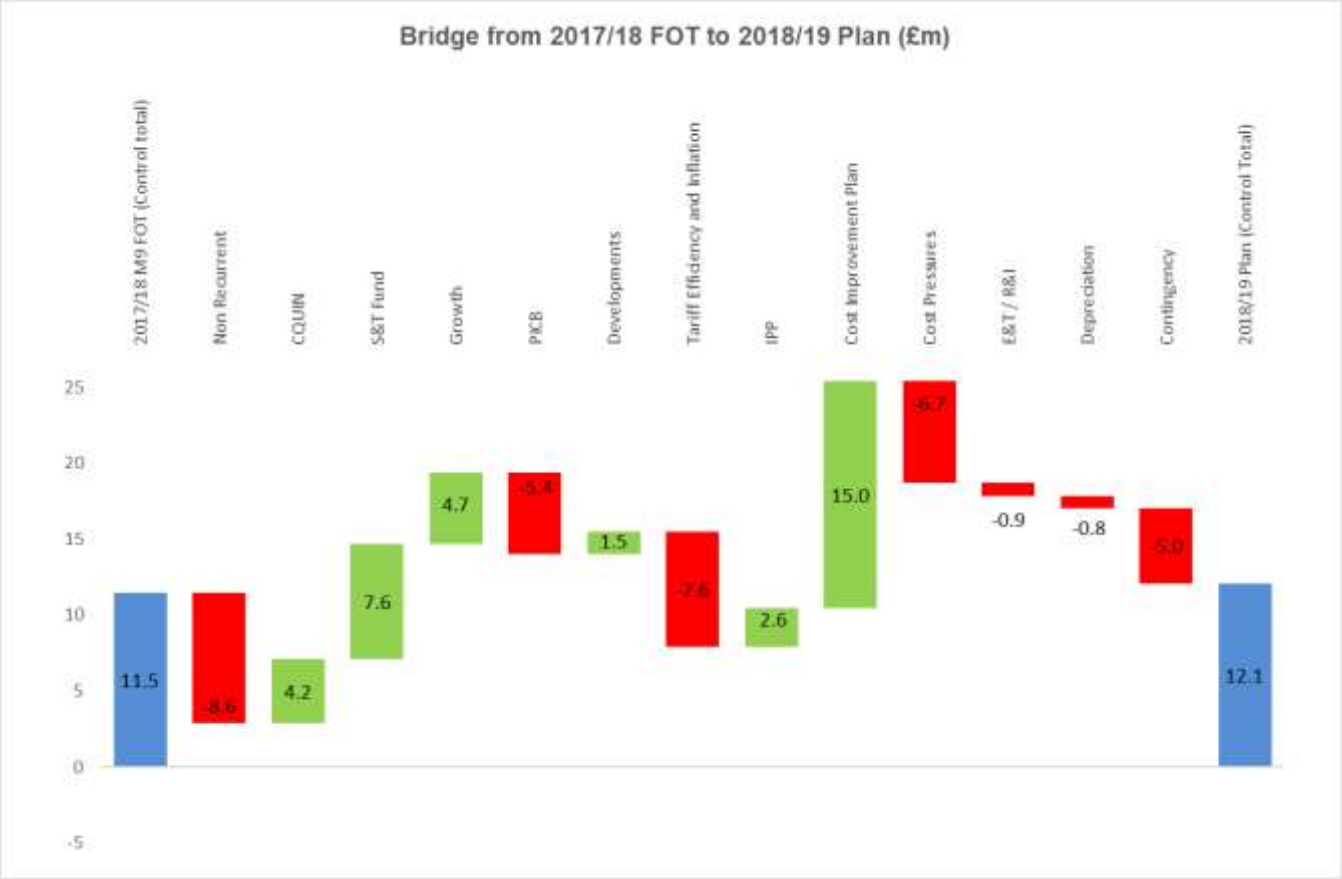
Template Reclassifications (technical changes)

- Other Non-Current Financial Assets has been reclassified into Trade and other receivables (NHS and Non-NHS)
- Other Financial Assets has been reclassified into Trade and other receivables
- Other Financial Liabilities has been reclassified into Trade and other payables - non capital

Please note that the accounts have been prepared excluding any impact associated with Revenue Recognition under IFRS15.

5. Bridging/Planning Assumptions

Refer to Appendix 1 for the bridge that is included within the NHSI return; the assessment including bridging adjustments from out-turn to plan 2017/18 and 2018/19 is presented below.



The plan includes the following assumptions.

2017/18 M9 FOT (Control total)	**£11.5m**	This was in line with the Trust's Month 09 Forecast Outturn including the base STF assumptions i.e. excluding any bonus for over delivery. No adjustments for any of the adjustments made to the forecast after Month 9 have been included here.
Non Recurrent Adjustments	**(£8.6m)**	STF of £5.4m was removed along with CQUIN of £4.2m, RTT delivery of £2.5m and the £3.5m contingency set aside at the start of the year to fund in year initiatives. Equivalent items for 2018-18 are set out below.
CQUIN	**£4.2m**	This has been added back at £5.2m with an adjustment of £1m to account for non-delivery in 2018-19. *Note: this assumes 80% delivery of plan.*
S&T Fund	**£7.6m**	In line with the revised NHSI plan, this has been set in line with the revised control totals at £7.6m.
Growth	**£4.7m**	The income associated with the outturn from 2017-18 has been factored into our recurrent plans net of cost.
Premier Inn Clinical Building (PICB)	**£5.4m**	PICB was opened in 2017-18 and the part year effects of opening the facility were included in the 2017-18 outturn. There are additional recurrent costs of staffing and running the new building which are factored into the 2018-19 plans.

Developments	**£1.5m**	There were a number of initiatives arising in 2017-18 that were agreed as changes to the provision of services via the Trust's Business Case approval process that have been funded in 2018-19.
Tariff Efficiency and Inflation	**(£7.6m)**	These were increased in line with OBR and NHS forecasts for Income, Pay and Non-Pay. These were set at £0.9m for income, £6.3m for pay and £2.2m for non-pay.
International private patients (IPP)	**£2.6m**	The Trust has delivered year on year growth associated with its increased IPP capacity. There are a number of stretch targets agreed for 2018-19 and subsequent years and these have been reflected appropriately in the plan.
Cost Improvement Plan	**£15.0m**	The Better Value Programme for the Trust has been set to 2017-18 levels. The breakdown of savings in the indicative plan is: Non-NHS Income £3.5m, Pay £5.3m, Non-Pay £6.2m.
Cost Pressures	**(£6.7m)**	Cost pressures have only been funded where the position has been deemed unavoidable. There have been a number of estates costs incurred by the Trust due to increased rent and rates and a number of other corporate pressures arising in year.
E&T / R&I	**(£0.9m)**	Reductions in HEE funding have been assumed at 10% and a revised reduction of £0.1m for grant income.
Depreciation	**(£0.8m)**	This is assessed only on Trust owned assets and the level of spend has increased by £0.8m within the plan due predominantly to equipment purchases.
Contingency	**(£5.0m)**	£5m contingency has been included for 2018-19; this is an increase of £1.5m from 2018-19 and adds further resilience to the Trust for issues arising in year.

6. NHS England Contract

NHS Improvement and NHS England published the NHS Operational Planning and Contracting Guidance 2017-19 on 22 September 2016. Joint NHS England/NHS Improvement guidance setting out the expectations for updating operational plans for 2018/19 was published on 2 February 2018.

The joint guidance stipulates that contract variations to the existing 2017/19 contract should be signed no later than 23 March 2018. Local decisions to enter into mediation for 2018/19 contract variations were required by 2 March 2018. Due to the significant and material financial difference between the Trust and NHS England on 2 March 2018, a mutual agreement to enter mediation has been undertaken with expectations that NHS England would provide an updated contract value offer during the week commencing 5 March 2018.

Principles and Assumptions

The following principles and assumptions have been applied in arriving at the proposed Trust contract value for 2018/19.

1. National Pricing

The 2017/18 and 2018/19 National Tariff Payment system was published on 22 December 2016. The Trust has grouped activity using the current tariff grouper and priced PbR activity according to the 2018/19 national prices. Local prices are uplifted by 0.1% in line with the net tariff inflator outlined by NHS Improvement.

2. Starting Baseline

The baseline activity is the 2018/19 activity plan, prior to RTT activity requirements, with local knowledge from individual specialties on any changes for 2018/19.

3. Growth

Specific growth has been applied in line with local knowledge from individual specialties, an overall adjustment for demographic growth for children has not been undertaken. Non demographic growth on pass through drugs costs has been applied at 10% based on the growth levels over the past two financial years,

4. Other adjustments

The baseline has been adjusted for the full year effect of the outcome of the pricing review jointly undertaken in 2016/17. Both NHS England and the Trust now need to work to agree the revised prices and activity levels for those services already reviewed.

Achievement of commissioner QIPP is increasingly difficult. The Trust has included 2.75% or £8.6m for 2018/19 as this is the current contractual requirement.

The Trust has included internally agreed business cases, including the potential impacts of changes arising from the CHD review, within the NHS England contract proposal for 2018/19.

5. CQUIN

2.0% has been included on all points of delivery apart from pass-through costs. The current local GOSH specific schemes are expected to continue from 2017/18 where appropriate and proposals for alternative schemes are under development. The current expectation is that approximately 80% of the CQUIN contract value will be achieved.

Comparison of NHSE Contract Value, NHSI Plan and GOSH Proposal

The Month 9 forecast outturn for 2017/18 is £315.4m. This is £9.4m above the current contract value of £306.0m for both 2017/18 and 2018/19 (after contract variations). The NHSI plan submitted in March 2017 for NHSE was £317.0m for 2018/19.

The activity and pass through growth above both contract and planned levels has not yet been agreed for 2017/18. NHSE is expected to propose a without prejudice formal offer for full and final settlement of the 2017-18 position by the middle of March 2018.

This represents a current risk for 2017/18 and a future risk as the 2017/18 over performance is compounded in 2018/19 with additional activity and pass through growth, tariff inflation and business cases assumed within the GOSH proposal.

The table below summarises the variances:

	2017/18			2018/19	
	NHSE Contract £'m	NHSI Plan £'000	GOSH Forecast £'000	NHSI Plan £'000	GOSH Proposal £'000
Activity	243.1	244.0	248.6	249.6	253.1
Pass through	65.6	69.9	70.2	70.9	68.8
CQUIN	4.9	4.0	3.9	4.1	5.1
QIPP	-7.6	-7.6	-7.3	-7.6	-8.6
TOTAL	**306.0**	**310.3**	**315.4**	**317.0**	**318.4**

In march 2018, NHS England made a contract offer based on a contract value of £309.8m. This was not accepted and negotiations on a mutually acceptable total remain on-going.

NHS E Contract Offer March 2018	Activity £'000	Pass through £'000	TOTAL £'000
Contract value 2017/18	248,000	58,000	306,000
RTT	-2,500		-2,500
Inflation	5,156		5,156
Efficiency	-4,543		-4,543
Growth	8,614	2,195	10,809
Impact of HRG 4+	250		250
QIPP	-7,012	-1,655	-8,667
Other Drugs allocation issue		4,000	4,000
Other balancing line	-705		-705
TOTAL	**247,260**	**62,540**	**309,800**
M9 17/18 Forecast outturn	**252,536**	**62,896**	**315,432**
Difference	**-5,276**	**-356**	**-5,632**

Great Ormond Street	Activity £'000	Pass through £'000	TOTAL £'000
GOSH 2018/19 opening baseline	247,894	62,962	310,856
RTT	5,167		5,167
Inflation	5,206		5,206
Efficiency	-4,958		-4,958
Growth	4,197	5,891	10,088
Impact of HRG 4+	606		606
QIPP		-8,608	-8,608
TOTAL	**258,112**	**60,245**	**318,357**
M9 17/18 Forecast outturn	**252,536**	**62,896**	**315,432**
Difference	**5,576**	**-2,651**	**2,925**

The revised submission for the end of April 2018 will contain the updated income plan number agreed with NHSE and other commissioners as required.

7. Capital plan

Capital is funded by a combination of charity funds which are almost exclusively donated by the Great Ormond Street Hospitals Children's Charity (GOSHCC) and Trust funds. Charity funding assumed in this plan has been allocated based on grants committee approvals on final business cases and specific known schemes.

The budget for Trust-funded capital is set at the level of forecast depreciation for the year plus any agreed slippage brought forward from the previous year.

The Trust has undertaken significant charity funded capital investment in prior years following the implementation of the Trust's Masterplan which has included the opening of Phase 2a (Morgan Stanley Clinical Building), Phase 2b (the Premier Inn Clinical Building opened in 2017) and a number of significant capital projects are forecast for this and future years to enable the delivery of Phase IV of the Master Plan which encompasses the redevelopment of the frontage of the hospital and the subsequent enabling works required before then. For 2018-19, there are additional capital costs associated with these projects.

The Trust is also mid-way through the implementation of the Electronic Patient Records (EPR) Project and there are significant Trust and Charity funded drawdowns required in this and future years to support that scheme of work. These are included within the capital plan.

A summary of the capital plan is provided in Appendix 2.

Trust Funded Schemes

Following this initial review of capital budgets, the following notional allocations have been agreed to be put forward:

- Schemes already approved in prior years (£15.7m)
- Additional funding required for schemes approved in prior years (£1.1m)
- New schemes, including Phase 4 (£12.3m)

Donated funding

Capital funding from the charity is defined according to projects that have been agreed at the Grants committee to cover multiple years or for which an annual allocation of funding is made.

Projects funded by the GOSHCC for 2018-19 are estimated at £51m and currently fall into the following groups:

- EPR (£14.9m)
- Major construction projects for which funding has been agreed, including, Italian Hospital, Southwood Courtyard (IMRI), Nursery (£22.5m)

- Major imaging equipment refresh programme agreed in principle (£2.5m)
- Other medical equipment. The timing in each of the next five years for this will be determined by the Equipment Replacement Plan which is in progress. (£2.0m).

8. The Better Value Programme (CIP's)

The Trust takes a thematic approach to risk profiling around the development of CIP's. The approach is et out below:

Learning from experience and feedback from divisions in 2017/18, we have rebalanced the programme for 2018/19, with an increased (2.5%/£8.3m) target for local schemes and reduction of the target (£6.7m) for cross-organisational initiatives. This more closely reflects what has been found to be realistic and deliverable over the course of the current year.

The following are the targets for the cross-organisational initiatives, and SROs are now working up the detail of how these will be delivered and evidenced. Each cross-organisational scheme has an executive SRO supported by a senior implementation lead and nominated PMO input. The majority of the schemes will also be supported by a named clinical lead with dedicated sessional time allocated to the delivery of savings programmes.

Cross organisational area	Target 2018/19
Outpatients flow	£0.6m
Patient placement	£0.8m
Theatres	£0.8m
Non pay and waste reduction	£1.3m
Medicines management	£0.4m
Workforce – medical	£0.4m
Workforce – nursing	£0.3m
Workforce – other	£0.4m
ICT enabled (non EPR)	£0.3m
Commercial – IPP	£1.0m
Commercial – other	£0.4m
Total	**£6.7m**

Schemes under final development include:
Flow
Three major flow programmes have been established, each comprising several workstreams and individual projects. Work currently in train to identify how these will result in evidenced and measurable productivity and efficiency gains is currently under way. The schemes (in common with all the larger schemes in the Better Value programme) will be presented for final input and recommendation for sign off at a major event for senior managers, clinical leads and the executive team, to be held on 19 March (in advance of the updated operating plan being presented to the Board at its March meeting).
Some of the flow activities anticipated to form larger features of the Better Value flow programme for next year include:

- **Outpatients** – improvements to referral management, outpatient letters and the text reminder system; rollout of self service kiosks and systems to improve patient flow and movement within the hospital; revised outpatient space utilisation policy; and actions to reduce staff turnover;

- **Theatres** – increased rollout of pre-operative assessment, installation of automated scrubs dispensing, improved list utilisation including focus upon on-time start for first cases of the day, conversion of some sessions to full day lists, improved list booking arrangements;

- **Patient placement** – establishment of new control hub/visual management; increased early focus on discharge through rollout of DART round pilot; improved use of data analytics eg on ward dynamics and load and bank shift fill predictions; development of nursing pools.

Non pay and waste reduction

In addition to continued rollout of inventory management and improved stock control arrangements, plus ongoing work to negotiate the best prices, work over the coming year will focus on minimising unnecessary practice variation and increasing product standardisation (led by newly established clinician led reference groups). There will also be a new focus on diagnostics and investigations – with the development of updated test order sets and avoidance of unnecessary and/or repeat testings.

Workforce

A wide range of workforce schemes are under development, including focus on reducing time to hire coupled with more rapid induction programmes; a review of additional pay and overpayments; review of supernumerary periods; focus on management of sickness absence and annual leave; programme to improve retention; review of shift patterns; increased use of the apprenticeship levy; and benefits from the introduction of a new eRostering system (building upon this year's work to improve adherence to rostering rules).

Local schemes

All areas of the Trust are working to finalise their local Better Value schemes to deliver their 2.5% target, with schemes such as (a small sample): partnering arrangements for cochlear care, care pathway redesigns, improved maintenance contracts, reductions in blood product wastage, condensed GIU lists, non-NHS incomes schemes and IPP growth.

Better Value governance and next steps:

Governance and reporting
Progress on development of the programme is overseen by the weekly business planning working group chaired by the deputy CEO and delivery of the programme will be overseen by a newly-established executive level Better Value Programme Board. Quality Impact Assessment will continue to be overseen by the QIA Panel chaired by the Chief Nurse and the Medical Director. Assurance to the Board is provided through regular reports on the programme, both to the Board itself and to its committees – Audit and Risk, Quality and Safety Assurance and Finance and Investment.

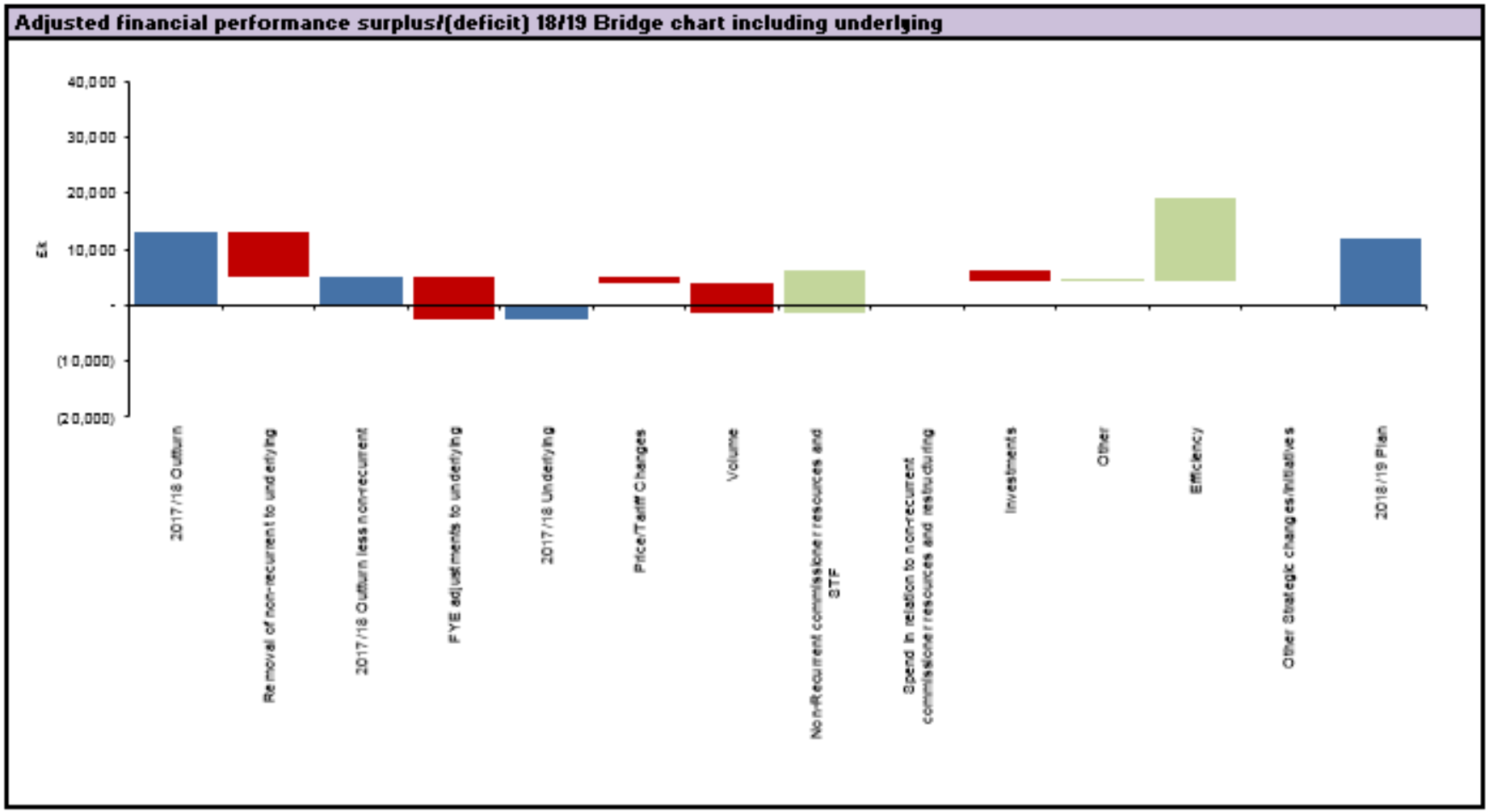
Approach to delivery risk
In addition to the QIA process, before schemes are signed off within the programme, they will be risk-assessed with projected financial benefits adjusted as a result. Where this results in reductions to savings, divisions will need to work either to improve likelihood of full delivery of their schemes, or to find additional projects to fill the gap. The approach to be adopted is summarised as follows:

Level of confidence of delivery	Description	Risk adjustment when counting planned savings
Certain	• Plan already fully developed and all actions taken to give assurance of full delivery of the full projected value	**100%**
High	• Plans to deliver the scheme are running to schedule, or have not yet started but there are no material concerns • Milestones are understood and preparatory work on track • There are no major risks that could affect scheme delivery • There is a low level of scheme complexity • There is high confidence of the scheme being delivered in full and on time • There is clarity on how financial benefits will be evidenced and delivered	**90%**
Medium	• Plans are broadly on track or not yet started but there are no significant concerns • There are some risks/unknowns to delivery but manageable with strong mitigations • Moderate level of scheme complexity within	**75%**

	divisional control • Milestone delivery is on track or missed milestones are not mission critical • There is reasonable confidence of the scheme being delivered in full and on time or with only minimal slippage • There is a high level of confidence that an approach to evidencing financial delivery will be achieved	
Low	• Plans are behind schedule or not started and there are concerns that will require close management • There are significant risks to delivery which could cause delays • Milestones have been missed or preparatory work to deliver the scheme is not complete • There is a high level of complexity with multiple stakeholders or external factors • There is belief the scheme can be delivered but there are material concerns about timing and scale • Measurement of financial benefits is unclear	**30%**

Timescales
The immediate priority is to confirm final values at a granular level for each component of the Better Value programme, including how delivery will be evidenced during the year, and associated KPIs to track benefits. The internal deadline set by the Trust for a full first-cut plan is 12 March, feeding in to a senior leadership (clinical and managerial) all day business planning event and challenge session on 19 March. After that, the plan will be finalised for recommendation to the Trust Board.

Appendix 1 – 2017-18 Outturn to 2018-19 Plan (from NHSI return)



Appendix 2 – Draft Capital Plan

Funding	Scheme category	2018/19	2019/20	2020/21	2021/22	2022/23
Trust	Fire safety	630	700	530	490	335
	Information technology (IT)	4,411	2,511	1,781	2,831	1,736
	Routine maintenance (non-backlog) – land, buildings and dwellings	6,116	6,896	9,440	9,499	10,345
	New build – land, buildings and dwellings	8,476	1,467			
	Other – intangible assets	9,453	7,926	8,249	7,680	8,584
Trust Total		**29,086**	**19,500**	**20,000**	**20,500**	**21,000**
Donated	Routine maintenance (non-backlog) – land, buildings and dwellings	3,800				
	New build – land, buildings and dwellings	18,687	32,121	17,707	43,014	57,868
	Other – intangible assets	14,898	2,178			
	Plant and machinery/equipment/transport/fittings/other	4,487	6,087	3,500	4,500	5,300
Donated Total		**41,872**	**40,386**	**21,207**	**47,514**	**63,168**
Grand Total		**70,958**	**59,886**	**41,207**	**68,014**	**84,168**

Attachment G

Great Ormond Street Hospital for Children NHS Foundation Trust Operational Plan 2018/19 refresh - DRAFT

Introduction

Strategic context

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

Since the two year Operational Plan (2017/18 to 2018/19) was set in December 2016, the Trust has been undertaking a programme of work to update and embed its strategy, with this mission and vision as its starting point. The revised strategy is formed around the framework set out in the diagram below.

In 2017 more than 260,000 patients from all over the country attended GOSH, around half from outside London – so our population is not local. We provide over 50 different specialist and sub-specialist paediatric services – the widest range on any one site in the UK. 90% of our funding is from NHS England specialised commissioning. These factors do set us apart from other providers, but they do not hide us from the very challenging environment across the NHS. GOSH continues to experience pressures such as increasing operating costs; rising demand across core services like cardiac, neuroscience, and cancer; staff shortages; and a requirement to find a place in the new structures and reforms and wider-NHS strategies.

However, the environment also presents exciting opportunities. We are committed to becoming a hospital where research is integral and drives treatment and outcomes. We have seen some exceptional research outcomes this year, many of which have immediately improved children's lives. During treatment patients and their families might be going through the toughest times of their lives, so great importance is put on creating nurturing environments, and high-quality facilities for providing specialised and highly-specialised care, so our estates and facilities are critical. The opening of the new Premier Inn Clinical Building, for example, brings a number of services into one brand new facility from across the current estate. We will use technology to move towards a digital future, to access information and share information, make decisions, engage patients and partners and drive safety. In the context of decreasing real-term funding for specialised and highly specialised services as well as the high costs associated with providing specialised and highly specialised services, funding and financial stability remains critical. It helps us to continue to grow our portfolio of research grants and research posts, fund infrastructure funding for our Somers Clinical Research Facility, while the GOSH charity helps to fund buildings and equipment. Private patient work is also key to providing financial support for our NHS paediatric services.

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

Key achievements in 2017/18 and plans for 2018/19

Teams across the Trust have made significant progress and achievements in the first year of the operational plan 2017-2019, in line with these key areas of focus. These achievements include:

- Opening of the new Premier Inn Clinical building
- Achieving the national RTT target
- Forecast delivery of £10.9m 'Better value' schemes
- Establishing of the work programme to design and build the new EPIC Electronic Patient Record (EPR) system
- Ongoing progress in developing the business case for construction of 'Phase 4' in line with the trust's master plan

In 2018/19, these key areas will continue to be developed – with a plan to:

- Continue to deliver the national RTT target
- Deliver a £15m Better Value programme
- Complete work on EPR for 'go live' in April 2019
- Continue progress on 'Phase 4' development
- We will also continue work with the Cognitive Institute to deliver a Safety & Reliability Improvement Programme that will improve the culture of safety and accountability within the Trust

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

Attachment G

Great Ormond Street Hospital for Children NHS Foundation Trust

Operational Plan

2018/19 Refresh

1 Approach to activity planning

1.1 Activity plan

The two year Operational plan for 2017/18 to 2018/19 was set in December 2016. The 2018/19 activity plan within this has now been reviewed and updated.

The table below sets out the revised assumptions for the trust's activity plan for NHS England and CCG activity – subject to negotiation with commissioners:

	17/18 forecast outturn	18/19 Plan (before reporting change)	Growth	Original plan assumption	Impact of reporting changes	Final 18/19 plan
Consultant led first outpatient attendances	33,788	34,162	1.1%	1.4%	(75)	34,087
Consultant led follow up outpatient attendances	171,691	172,994	0.8%	1.4%	(5,940)	167,054
Elective admissions	34,746	35,608	2.5%	2.7%	0	35,608
Non-elective admissions	2,283	2,316	1.4%	1.4%	0	2,316

Impact of reporting changes:

- An adjustment is being made to the recording of outpatients in national reporting, which has an impact on the plan for outpatient activity. This is shown separately above in the right hand columns in order to present the true growth assumptions in the left hand columns.

Key assumptions for 2018/19:

- First and follow up outpatient growth is predominantly due to two factors: additional activity required to deliver national access targets (see section 1.2 below) and the impact of specific areas of identified growth mainly relating to cardiac, and particularly inherited cardiovascular disease (ICVD).
- Elective (including day case) growth relates to additional activity required to deliver national access targets (see section 1.2) and cardiac growth.
- Based on review of activity trends, and given the nature of services at GOSH, material impacts of activity change have been identified for specific services only – for example, for ICVD and other cardiac services. A generic demographic assumption has not been applied.

Changes from original 2018/19 plan:

- As presented in the table above, the refreshed activity assumptions are not significantly different from the original plan submitted for 2018/19 in December 2016. The reductions in outpatients and elective admissions relate to refreshed assumptions for RTT, and more specific allocation of demographic growth assumptions.

The following sections set out further detail in relation to activity changes, in terms of activity and physical capacity.

1.2 Access targets

Delivering the activity changes required for sustainable delivery of access targets has continued to be a focus throughout 2017/18, and the Trust has worked closely with its specialist commissioner, NHS England, the CQC and NHSI, to address the associated challenges and requirements. The 2018/19 plan

has been updated to reflect the most recent expectations around this – particularly the impact of the delay of opening additional capacity to meet access targets.

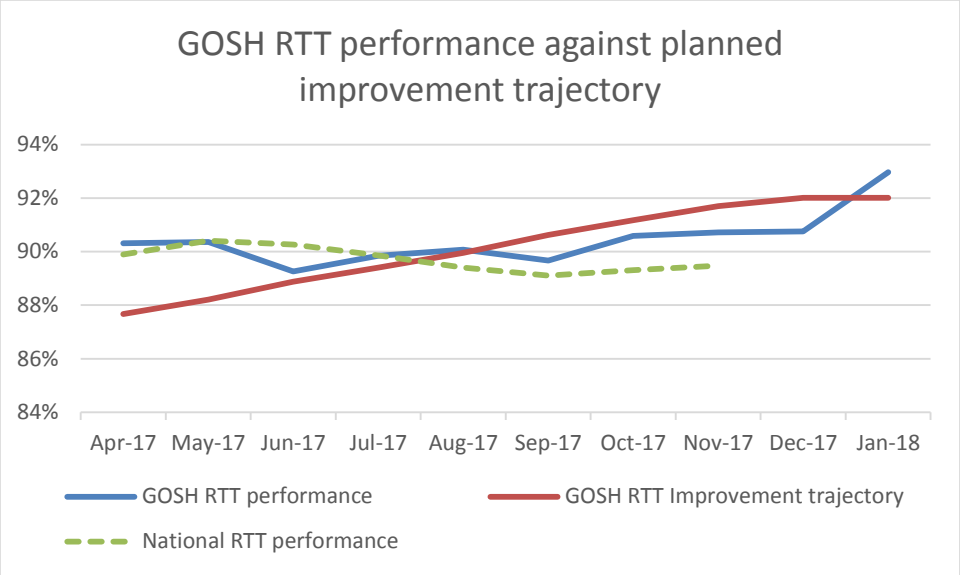
Referral to Treatment target (RTT)

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

- Orthopaedics
- Spinal
- Urology
- Specialist neonatal and paediatric surgery (SNAPS)
- Plastic Surgery
- Neurology

For each speciality, these models have been used to determine the level of activity and the associated capacity needed to support delivery.

As of January 2018, the Trust is now achieving the national RTT target. This was later than the improvement trajectory planned as part of the original two year operational plan for 2017/18 to 2018/19. This was due to the delayed opening of additional capacity, a number of staffing issues in highly specialised areas, and also partly due to the resolution of some additional data quality issues, now resolved.



The additional capacity was opened in November/December 2017 (delayed from August 2017) – this will enable the sustainable delivery of increased levels of activity in challenged specialties, and thereby support the ongoing achievement of the RTT target in 2018/19.

Diagnostics target

Significant work has taken place to improve performance against the diagnostics target during 2017/18, with the Trust achieving the target in November, missing by 1 breach in December and achieving again in January. However, this continues to be a challenge, partly due to the very small margin allowed in terms of number of patients breaching (the target will be failed if there are c. 5 breaches in a month). The plan is to achieve this target throughout 2018/19 – however, this will continue to be at risk on a monthly basis, due to the small numbers involved.

Cancer target

The Trust has delivered against the applicable cancer targets throughout 2017/18 and this is expected to continue throughout 2018/19.

1.3 Expansion of PICU and NICU

The original operational plan for 2017/18 to 2018/19 set out the intention to open two additional NHS PICU/NICU beds (and one further bed relating to private patient activity) in 2017/18, following on from the an increase of two beds at the end of 2016/17. This would bring the total number of staffed beds to 29. The aim was to support the delivery of additional activity required to meet the RTT target, and to meet demand for emergency referrals (in 15/16 190 referrals were refused).

During 2017/18 there have been a number of challenges in implementing this plan, both in terms of lower than expected demand (replicated across other London paediatric centres) and in our ability to staff the beds. Further work is being undertaken for 2018/19 to reassess demand and the appropriate level of resource required in this area to deliver the plans.

1.4 Premier Inn Clinical Building

The Premier Inn Clinical Building (PICB) opened in November 2017 (delayed from the original planned date of August 2017). Further detailed work continued to take place after the setting of the original two year operational plan which led to a number of changes regarding plans for relocating beds and opening new beds.

Under the final plans, this will allow 77 beds to be relocated to the brand new facilities, and the potential to open an additional 64 beds in future. Of these, the 2017/18 and 2018/19 plans involve opening an additional 27 beds, principally focused in RTT challenged specialties and cardiac.

The impact of PICB on the trust's overall capacity is set out below:

Inpatient and day case available bed spaces			Staffed inpatient and day case beds		
16/17	Impact of PICB	18/19	16/17	Impact of growth assumptions	18/19
437	64	501	428	27	455

1.5 Other significant assumptions – transfer of congenital heart disease patients

At the time of setting the Operational Plan for 2017/18 to 2018/19, the Trust was in ongoing discussion with NHS England regarding the transfer of an estimated 150 congenital heart disease patients to GOSH, as a consequence of a national review of congenital heart disease services. The transfer had not yet been agreed, and therefore was excluded from the plan at that stage.

On 30 November 2017, NHS England published initial conclusions from its review, which did not recommend that the transfer take place at that stage. However, it set challenging requirements on those trusts from which activity would have been transferred. It remains uncertain whether the trusts will be able to meet these requirements in the set timeframe, and therefore the transfer of this activity continues to remain uncertain. Given this ongoing uncertainty, no assumption regarding this transfer has been assumed in the plan at this stage.

However, in 17/18 (and prior to this) the Trust has had insufficient capacity to meet the demand for non-elective cardiac activity – this is being addressed in 18/19 and will lead to an increase non-elective activity.

2 Quality planning

2.1 Approach to Quality Governance

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

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

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

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

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

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

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

2.2 Summary of Quality Improvement plan

The Quality Improvement specialists work to support, enable and empower teams to continuously improve the quality of care provided to patients across GOSH. In the past year the teams have successfully completed the Neonatal Card project which had two stands: one was improving the care of neonatal jaundice the other being a reduction in repeated newborn screening tests. Both of these projects have seen a sustained improvement in the care that is provided to our patients.

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

The team continue to focus on the following projects:

- Improvement activities requested as part of Commissioning for Quality and Innovation (CQUIN)
- Transition
- Intensive Care Unit flow (focussing on Respiratory and Spinal Pathways)
- Safety Huddles and Electronic Patient Status at a Glance (EPSAG)
- Extravasation project
- Early Warning Scores project

In addition there are a number of locally led quality improvement projects which may receive mentorship and guidance from the Quality Improvement specialists.

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

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

The Trust has historically defined a range of clinical outcome measures for each specialty and published them on our website. In order to ensure continuing improvement with outcome measurement and reporting we will:

- refocus outcome development on value and patient reported outcome measures as well as clinical outcomes;
- bring outcome data sources into the reporting infrastructure to facilitate timely reporting;
- develop resources for validation and benchmarking of outcomes; and
- publish outcome measures in a way that incentivises quality and allows choice.

2.2.3 Recognition of the deteriorating child

Through the process of reviewing respiratory and cardiac arrests across the Trust it was identified that some children were having unplanned admissions to Intensive Care Units (ICU) yet this was not predicted or reflected in the patient's Early Warning Score. A systematic review of different scores was conducted and found the predictive performance of PEWS to be greater than the current CEWS score in this respect. Plans are now underway to roll this change out across the Trust for completion during 2017. The Trust continues to emphasise the importance of clinical observations, nurses "global professional judgement" and parental observations for identifying the deteriorating child.

The Trust is progressing a number of work streams to review its other processes and ensure they are effective. In particular we have completed the role out of ePSAG (electronic Patient Status at a Glance) boards into every inpatient ward and bespoke ambulatory areas and will complete the roll-out of the use of clinical safety huddles across all inpatient ward areas to increase situational awareness by 31 December 2016.

2.2.4 Cognitive Institute

The Trust is committed to and signed up to the Cognitive Institute's safety and reliability improvement partner programme which include:

- Emerging leaders' development
- Leaders' collaborative
- Safety Champions

The Trust is about to embark on this new partnership and will be investigating in a robust training package to ensure success.

2.2.5 Quality Improvement

The priorities of our Quality Improvement Programme are as follows:

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

- **Facilitate continuous improvement in clinical outcomes and the experience of our children, young people and families**
    - Have a direct impact on outcomes, safety and the experience of patients and staff
    - Design and implementation of a Real Time Patient Experience system
    - Strengthen partnerships through co-leadership with patients and families
    - Transform operational management and business intelligence through the use of data

- **Transform the culture of Great Ormond Street Hospital so that everyone is looking for ways to improve patient care every day**
    - The programme is overseen by the QIC and is currently supporting various projects to improve patient flow (ICU & Outpatients), improving clinical processes through automation, e.g, e-Patient Status at a Glance.

2.2.6 Annual publication of avoidable deaths

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

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

2.2.7 Seven day services

GOSH does not have an A&E department and the majority of its inpatient admissions are on an elective basis. Certain services such as paediatric critical care, acute transport and non-elective surgery are staffed by consultants all days of the week. We have comprehensive on call arrangements, in some cases shared with other Trusts in order to ensure the Trust can access specialised skills at all times. We will continue to participate in NHS England's national audits of emergency admission throughout this planning period.

The Trust now offers some outpatient and diagnostic appointments on Saturdays and extended a daycase ward to admit patients over six days. All new medical staff are recruited on flexible contacts. International Private Patients Division already offers a wide range of services on Saturdays and Sundays.

2.3 Summary of Quality Impact Assessment

The Trust has continued the work described in the 2016/17 business plan to enhance and embed its approach to Quality Impact Assessment (QIA). Following the input and advice from an external consultancy partner, a new Programme Management Office (PMO) has been established to oversee the Trust's CIP (and other major) plans for the next 3 years, and business partners have been recruited to support divisions with the scoping and delivery of their contributing projects.

The PMO has a well-developed integrated system to scope each plan and assess its quality impact. The PMO - working with the Medical Director, Chief Nurse and QI Team - has substantially revised the QIA process in line with Internal Audit recommendations from 2015/16. In support of the new divisional structure with its reinforcement of greater divisional responsibility, development of QIAs has been devolved to Divisional (Clinical) Chairs and Corporate Directors, subject to a related QIA scheme of delegation, with:

- Proposals likely to have more significant potential impact (including for example those of a cross-cutting nature) always requiring formal assessment and sign off by the QIA panel (co-chaired by the Medical Director and Chief Nurse);
- The QIA panel to be kept informed of the approval status of all schemes including those signed off at divisional level, and to oversee a regular audit process including those approved locally.

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

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

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

2.4 Summary of triangulation of quality with workforce and finance

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

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

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

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

The Board intend to use this data:

- to identify emerging linked risks and issues across domains (and therefore provide opportunity to quickly address quality and operational issues in a balanced way)
- to identify and provide challenge over areas of potential productivity improvement (e.g. theatre utilisation)

- as part of assurance over the impact of change processes (for example, the impact of CIPs and QI programmes on quality, workforce and finances together)

3 Workforce planning

3.1 Workforce plan summary

	17/18 forecast outturn	18/19 Plan	% change
Medical	636	666	4.7%
Non-medical clinical	3,218	3,258	1.2%
Non-clinical	734	709	-3.4%
Total	4,589	4,632	1.0%

Growth in WTEs mainly relates to activity growth, particularly in cardiac activity. This is offset by efficiencies, particularly focused on non-clinical WTEs.

3.2 Workforce planning methodology and alignment to integrated plans

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

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

The key changes to local workforce plans for the period of this operational plan are due to the implications at a service level of the opening of PICB and the reconfiguration of services as a result. A model of care document has been produced by service management for each affected service, which includes the current and planned workforce model. This has been reviewed centrally by corporate clinical and workforce staff, and the impact of each of these has then been included in the overarching trust plan.

The Trust recognises the challenging financial environment it must adapt to and, as such, stresses quality and workforce risk as an integral part to its productivity and efficiency programme. Proposed schemes, during scoping and revisited throughout the programme, have an associated Quality Impact Assessment (QIA) undertaken to address consequence and likelihood of risk occurring (described in section 2.4 above).

3.3 Workforce strategy and staff involvement

During 2017, the Trust refreshed its strategy "Fulfilling our Potential" which, working with staff at all levels of the trust and the Members Council, identified the priorities for the Trust in the coming years

The proposals were tested widely with staff who influenced the design, process and future development, including a Trustwide strategy "Open House" series of events to engage and inform staff about how we will deliver the strategy.

Our workforce will be key to delivering all of the priorities identified and in particular the **People** priority *(We will attract and retain the right people and through creating a culture that enables us to learn and thrive)*

In 2018-19, our emphasis will be on:

- Standardisation of processes and roles where possible (including roll out of Standard Operating Procedures associated with patient flow);

- Roll out of development programmes for leaders;
- Ensuring we can respond to national challenges, via recruitment, retention and education of staff;
- Continuation of the programme to embed Our Always Values, which underpins both patient and staff safety, experience and satisfaction.
- Work with the Cognitive Institute to deliver a Safety & Reliability Improvement Programme that will improve the culture of safety and accountability within the Trust.

3.4 Workforce governance

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

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

As part of its workforce planning processes and safe staffing assessments, the Trust also uses PANDA (the paediatric acuity and nurse dependency assessment tool), which the Trust co-designed, as an acuity tool for inpatient paediatric services.

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

3.5 Workforce efficiencies

In 2017/18, the Trust rolled out a new e-rostering system for medical staff, and established plans to replace its current nursing rostering system, and roll out a single integrated rostering system during 2018. The new system will improve the quality of rota management across individual specialties and the Trust more generally, as well as facilitating much greater multi-professional working and supporting integrated clinical care. In addition, we will launch a new e-job planning module which will enable staff such as Clinical Nurse Specialists to record their job plans in a single system, facilitating demand and capacity planning. Nurse rosters are based upon agreed establishments with the Assistant Chief Nurse (Workforce) and finance representatives and reviewed on a regular six-month basis. The Trust also complies with the publication of the safe staffing monthly report which includes:

- fill rate assessments by ward, shift time and staff type;
- divisional reporting of unsafe shifts (including assessment of vacancies and recruitment pipeline, temporary staffing usage and staffing flexibility across services);
- recruitment and retention issues and recommendations;
- linkage to infection control, safety incidents, family concerns and Friends and Family Test (FFT) data.

Recommendations and actions are taken to Board to address workforce issues and in turn update the workforce plans for the organisation (http://www.gosh.nhs.uk/about-us/our-corporate-information/publications-and-reports/safe-nursing-staffing-reports).

In relation to temporary staffing, the Trust has undergone a dramatic profile change over the previous six years. The Trust continues to have low agency spend on clinical staff. The Trust has made good progress on reducing its usage of non-clinical Agency workers during 2017, and is currently spending significantly below its NHS I mandated cap. Further work will be undertaken in 2018/19 to reduce this spend further and support Divisions to move Agency staff to bank or terminate arrangements with the Trust where appropriate.

The Trust implemented the changes to the Junior Doctors contract in 2017/18 without the need for additional staff to achieve compliance.

The Trust is implementing a comprehensive state of the art Electronic Patient Record (EPR) system in 2018/19, which will deliver improvements to the patient experience, which in turn may lead to changes in how we deliver care, with potential changes to the workforce.

3.6 Workforce initiatives and staff development

The Trust has developed an ambitious multi-year Leadership programme focussed on the delivery of a Safety culture with the organisation. This programme will involve working together to develop our leadership capability, deliver improvement projects and improve our accountability practices across the Trust. This will ensure that we are in line with the ambitions articulated in our strategy – we always deliver the safest, most reliable treatment and care for our patients, from the moment they come into contact with GOSH and throughout their patient journey.

The development of new roles and our education strategy are integral to delivering our workforce requirements. We will continue the development of Talent for Care to build our band 2-4 clinical support workforce, and scope the role of Physicians Assistant to allow our registered clinical workforce to focus on direct patient care and deliver greater productivity and quality. We are the host Trust for a North Central London pilot of the new Nursing Associate and we will also review the role, education requirements and frameworks for development of Advanced Nurse Practitioners with the aim of developing nurse-led services where clinically appropriate.

Our Education and Workforce Development Plan reflects the Trust's increased emphasis on multi-professional education and recognises the criticality of education in meeting the Trust's current and future workforce needs. It also responds to the challenges of changes to funding, including maximising our income-generating capability as a leader in paediatric education. Work is underway to ensure that the Trust has suitable space available for delivery of its education plans.

Following the removal of the student bursary from 2017, the Trust refreshed it's attraction strategy for newly qualified nurse (NQN) recruits, concentrating upon providing an excellent, high-quality interactive learning environment including simulation training and welcomed it's largest ever cohort of NQNs in September 2017. Through earlier student recruitment, we are able to offer regular contact and education opportunities giving them a GOSH identity prior to starting their academic education. Our aim is to recruit our student nurses for their career here at GOSH from the day they first apply online to study. In addition we will continue to explore the opportunities around clinical apprenticeships, ensuring full use of our Trust Levy, to support both undergraduate training and post graduate Clinical Professional development for our workforce. We have been successful in our bid to become a pilot site for the Child and Young Person Nursing Associate role in response to the Shape of caring review. The Trust has developed and implemented targeted development plans for Band 5 (NQN) and Band 6 Nursing staff to improve their experience and improve retention rates at the Trust.

Once again in 2016/17 we exceeded our apprenticeship target and we are currently on plan to achieve our Government set 2017/18 public sector apprenticeship starts target. GOSH is working in partnership with other trusts in the STP footprint to implement a new joint policy for apprenticeships. We have now achieved the status of a supporting provider – this has allowed us to introduce and start the delivery of our first clinical apprenticeships. We continue to be involved in a number of trailblazer employer groups to develop new apprenticeship standards including nursing, nursing associate, advanced clinical practitioner and clinical coding, as well as the new national pilot for a paediatric Nursing Associate role.

3.7 Workforce resourcing

We continue to deliver structured fixed term International Fellowship roles which provide outstanding clinical experience for overseas medics, allow us to recruit to service delivery roles in a planned way, and bring in income. These roles are filled from outside the European Union. We are and will continue to review our approach to recruitment from overseas in the light of the Brexit vote. Whilst timescales and impact on EU nationals in UK employment remain unclear, we will continue to use overseas recruitment tactically, whilst minimising the impact of changes should changes in labour market regulation occur.

The ability to recruit and retain nursing staff in particular remains a critical challenge, and is recognised as a risk to our activity plans. Activity on recruitment will include: ensuring we market the Trust as a provider of outstanding employment and education; actively participating with other employers as part of Capital Nursing (for example to promote career pathways within London) and; identifying greater opportunities for safely appointing adult-trained nurses with high quality paediatric experience, which will expand our potential applicant pool. Equal emphasis will be given to retaining staff, with new leadership

programmes for ward and senior managers recognising the critical role they play in shaping the employment experience of staff.

The Trust has developed a retention plan to deliver improvements to retention rates and has already registered a reduction in reported turnover at the Trust. During 2018, these plans will be developed further, ensuring progress is maintained and improved upon.

The Trust has a strong record in controlling temporary staffing costs and will continue to monitor all long term agency usage (more than 6 months) with the intention to convert these staff to bank roles or recruit substantively if there is no planned end date.

The Trust is a signatory to the London Procurement Partnership pan London Agreement, to agree bank rates lower than the NHSI Agency capped rates, and work collaboratively to further reduce agency spend.

The improvements in rostering systems outlined above will allow for increased efficiency in the management of clinical resource allocation. As part of the rostering system implementation, the Trust will implement improved patient acuity monitoring tools, and continue to use its patient dependency tool to identify appropriate nurse staffing levels based on acuity. New divisional structures, including revised Matron roles, will enable more effective resource utilisation across specialisms, with nurse staffing levels continuing to be monitored at Board level in Safe Staffing reports.

4 Financial Planning

See separate financial planning narrative

5 Membership and Elections

6.1 Members' Council elections in previous years and plans for the coming 12 months

There are 27 elected and appointed councillors on the GOSH Members' Council.

Members' Council representation by constituency

Patient and Carer	**Councillors**
Patients from London	2
Patients from outside London	2
Parents and Carers from London	3
Parents and Carers from outside London	3
Public	
North London and surrounding areas	4
South London and surrounding areas	1
Rest of England and Wales	2
Appointed	5
Staff	5

The Trust has held five Members' Council elections to date:

- November 2011 (in readiness for FT authorisation on 1 March 2012) - 22 seats in Patient and Carer, Public and Staff constituencies.
- November 2013 - Staff By-election for 1 seat.
- February 2015 - 20 seats in Patient and carer, Public and Staff constituencies. (2 uncontested seats in Patients from outside London constituency).
- December 2016 – Public By-election for 1 seat: North London and surrounding areas class
- February 2018 - 22 seats in Patient and Carer, Public and Staff constituencies.

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

Councillor Recruitment: Pre election information sessions are held for councillor recruitment alongside a dedicated election page on the Trust website, including podcasts etc. Membership communication tools such as the Membership Newsletter (Member Matters) and monthly membership emails are used to keep members informed of upcoming elections.

Training and development: On appointment, councillors receive mandatory Trust training and continued development by attending tailored information sessions delivered by key Trust staff. Councillors are also encouraged to attend NHS Providers events and Deloitte Governor Workshops. Councillors access GOLD on-line training during their appointment.

Membership and public engagement: The monthly Members' Council eBulletin offers a variety of opportunities for councillors to engage with their members including:

- regular "meet your councillor" engagement sessions in the hospital
- visits to schools and universities including the Hospital School and Activity Centre
- hosting membership stalls at community events, GOSH Children's charity events, and key Trust events
- attending Trust committees and Patient forums

- writing personalised letters and articles in *Member Matters* Membership Newsletter, *Roundabout* Staff Newsletter and Welcome Pack for new members
- online link to contact a councillor is included in all eCommunications on the Trust website and in all printed membership publications and on the Annual Plan surveys to membership
- councillors also have the opportunity to send personalised emails to their constituent members to engage with them around elections and for key trust events such as the AGM.

The Trust held a Listening Event in November 2016 to which patients, carers and councillors were invited.

Some of the world's leading architects took part in a competition to design a new clinical building for the fourth phase of our ongoing redevelopment programme. Staff, patients, families, carers, councillors and neighbours were invited to an exhibition showcasing their design ideas

6.3 Membership Strategy

An updated Membership Strategy 2015-18 was approved at the September 2015 Members' Council meeting.

It sets out the methods that will be used to continue to develop and grow, engage and involve our membership, taking into account our geographical spread.

The Trust has moved to a new specialist provider of membership databases. This has enabled a more detailed reporting system to analyse membership data and map under representation in constituencies so we will be able to target our future recruitment and engagement activities.

This strategy will be subject to review in 2018.

6 Link to the local sustainability and transformation plan

The Trust is located within the footprint for North Central London. Although the Trust is fully supportive of a joined up local planning process to deliver transformational change, the STP model is not directly meaningful for the Trust's tertiary and quaternary services which extend both across London but also throughout England. However, the Trust continues to engage with local plans to improve processes and deliver efficiencies – for example, taking part in an STP-wide benchmarking exercise of back office services and are working in partnership with other trusts in the STP footprint to develop a joint status as an Apprenticeship Provider.

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

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 28 March 2018	
Better Value Update **Submitted by:** Nicola Grinstead, Deputy Chief Executive	**Paper No: Attachment H**
Aims / summary This paper summarises the latest position on Better Value programme delivery for 2017/18 and describes the work being undertaken to confirm the programme for 2018/19.	
Action required from the meeting The Board is asked to note the latest position on Better Value programme delivery and receive assurance that arrangements are in place to confirm a robust Better Value programme, learning from 2017/18 experience, as part of the 2018/19 Trust Operating Plans.	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Better Value Programme is a significant contributor to the Trust's overall financial strategy and plans. Delivery of the £15m Better Value target this year is important in the context of the Trust's overall control total and requirement to move towards delivering a robust ongoing financial surplus. For this reason, the actions described in this report are important and their successful delivery is being closely managed by the Programme Office and Executive team.	
Financial implications Included within the overall Trust financial position.	
Who needs to be told about any decision? N/A	
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.	

SUMMARY
The Better Value Programme is forecasting a year-end outturn of £10.7m. Although this is an underperformance against the target of £15m set in the Trust's Operating Plan, it nevertheless represents the highest delivery of efficiency contribution achieved by the Trust in recent years. Following the completion of current validation work to evidence delivery in two cross-organisational areas, it is anticipated that the final year-end reported position may further improve. Slippage against the Better Value target has been mitigated by other savings not incorporated within the original programme, and by additional income contribution largely related to price changes resulting from the implementation of the new national (HRG 4+) tariff.

SECTION 1 – PROGRESS DURING PERIOD				
Programme RAG Status	This Reporting Period:	A	Last Reporting Period:	A
RAG Reason	▪ Positive progress has been made in month 11 resulting in an increased delivery and forecast outturn, but the programme is still reporting an adverse variance against its YTD plan.			
RAG Recovery Action Plan	▪ On-going work is taking place to maximise local scheme delivery as well as validate delivery against the cross organisational schemes. For example, further work to evidence delivery of non-pay savings in theatres is in progress and anticipated to result in an improved year end position.			
Progress Summary	▪ Over the past month, the Charles West division has been able to fully mitigate a £132k adverse variance in their local Better Value programme because of increased contribution from the CICU.			

SECTION 2 – FINANCIALS (Month 11)		
Better Value Programme 2017/18	**Financial RAG:**	**A**
Total Planned Programme Value	£15m	
Planned YTD Programme value	£13.7m	
Actual YTD Programme Value	£9.8m	**A**
Variance against YTD	-£3.8m	
Forecast Outturn (FYE)	£10.7m	**A**

SECTION 3 – KEY PROGRAMME AREA STATUS

CARRY FORWARDS FROM 2016/17 — RAG

The carry forward element of the programme relates to full year effects of schemes started part-way through 2016-17, with brought forward values validated by finance business partners.

Against an expected carry-forward of £2.7m when the Operating Plan was prepared last December, the actual carry forward position remains as previously reported to the Board and Finance and Investment Committee, at **£2.3m** for the full year.

£2.3m FYE

LOCAL SCHEMES - DIVISIONAL "1%" PROGRAMME — RAG

The 1% programme is currently forecasting to deliver a contribution of **£2.89m** against an initial target of £3.14m.

Division	Target	Forecast year end position	Variance
Charles West	£1,013k	£1016k	(£3k)
JM Barrie	£1,374k	£1,182k	(£192k)
IPP and Corporate	£751k	£692k	(£59k)
Total	**£3,138k**	**£2,890k**	**(£248k)**

The largest variance in the programme, for JM Barrie division, has been raised for urgent action at monthly divisional performance management meetings. The division has been working on addressing this gap in its 1% programme as part of its wider financial recovery plans; delivery against these has been scrutinised by the Finance and Investment Committee.

£2.9m FYE

CROSS ORGANISATIONAL PROGRAMME — RAG

The cross organisational programme is currently forecasting to deliver in-year savings of **£5.5m** against an initial £9.1m target, a position which has improved through the year as work to evidence delivery of these longer-term schemes has been undertaken.

The table at appendix 1 provides further information on the position against each of the cross cutting enabling work streams, and shows the areas which currently pose the highest risk to financial delivery of the full value of the cross-organisational programme remain:

- procurement (£1.3m adverse); and
- the combined workforce programmes (£1.6m adverse in total).

These areas of slippage have been mitigated through other non-recurrent benefits not included within the plan (for example unplanned vacancies) and through additional income largely resulting from price changes introduced with the new national HRG 4+ tariff.

The Finance and Investment Committee has taken a close interest in both areas of slippage; it receives regular updates on progress to realise further non-pay savings through working with our procurement partners, and has undertaken a deep dive into the workforce programme.

£5.5m FYE

SECTION 4 – NEXT STEPS

The PMO continues to work with Divisions to secure the highest achievable contribution from Better Value schemes over the remainder of 2017/18 and, in addition, is focusing on finalising the scoping and sign-off for a robust programme for 2018/19. Learning from experience and feedback from divisions in 2017/18, the programme for the coming year has been rebalanced with an increased (2.5%/£8.3m) target for local schemes and reduction of the target (£6.7m) for cross-organisational initiatives. This more closely reflects what is considered to be deliverable, especially in the context that cross-organisational initiatives by definition tend to have longer timescales to realise benefits.

Each cross-organisational work stream has an executive SRO supported by a senior implementation lead and nominated PMO input. Many schemes will also be supported by a named clinical lead with dedicated allocated sessional time. Wide engagement of local staff and clinical teams has been prioritised and facilitated through dedicated sessions, including the "GOSH Date" workshop held in February and follow-up dedicated business planning day held in March. A summary of the ideas generated at the GOSH Date workshop has been circulated to the Board for information, and these are now being prioritised for incorporation into the future Better Value programme. Schemes under final development include:

Continuation of the three major flow programmes (outpatients, theatres, patient placement) with initiatives including:

- *Outpatients - improvements to referral management, outpatient letters and the text reminder system; rollout of self-service kiosks; and revised space utilisation policy;*
- *Theatres – increased rollout of pre-operative assessment; improved list utilisation including focus upon on-time start for first cases of the day; conversion of some sessions to full day lists; improved booking;*
- *Patient placement – establishment of control hub/visual management; increased focus on discharge through rollout of DART round pilot; improved use of data analytics eg ward load, bank shift fill predictions; development of nursing pools.*

Non-pay and waste reduction schemes. In addition to continued rollout of inventory management and improved stock control arrangements, plus ongoing work to negotiate the best prices, work will focus on minimising unnecessary practice variation and increasing product standardisation (led by newly-established clinician led reference groups). There will also be a renewed focus on diagnostics and investigations with the development of updated test order sets and avoidance of unnecessary and/or repeat testings.

A wide range of workforce schemes including: reducing time to hire coupled with more rapid induction programmes; review of additional pay and overpayments; review of supernumerary periods; review management of sickness absence and annual leave; review of shift patterns; increased use of the Apprenticeship Levy; and benefits from introducing the new eRostering system (building on this year's work to improve adherence to rostering rules).

Quality Impact Assessment will continue to be overseen by the QIA Panel chaired by the Chief Nurse and the Medical Director. In addition, schemes will be risk-assessed based on level of confidence about delivery, with reductions to planned values of higher delivery-risk schemes before incorporation into the programme – which means divisions will need then to work to improve the likelihood of full achievement of their schemes or to find additional projects to fill the resulting gap.

Progress on programme development is overseen by the business planning working group chaired by the Deputy CEO and delivery of the programme will be overseen by the executive level Better Value Programme Board. Assurance to the Board will continue to be provided through regular reports both to the Board itself and to its committees, in particular Audit and Risk, Quality and Safety Assurance, and Finance and Investment.

Recommendation

The Board is asked **to note** the latest position on Better Value programme delivery and **receive assurance** that arrangements are in place to confirm a robust Better Value programme, learning from 2017/18 experience, as part of the 2018/19 Trust Operating Plans.

Attachment H

Attachment

Appendix 1

2017/18 Better Value CROSS-CUTTING schemes

	CURRENT MONTH			YEAR TO DATE			FULL YEAR - 2017/18				
Division	Target Feb-18	Actual Feb-18	Variance	Target	Actual	Variance	Target	Forecast Outturn (FOT)	Variance	RAG	FOT % of Target
Flow - Outpatients	20,833	10,417	(10,417)	229,167	114,583	(114,583)	250,000	125,000	(125,000)	R	50%
Flow - Theatres	83,333	-	(83,333)	916,667	675,924	(240,743)	1,000,000	675,924	(324,076)	A	68%
Flow - Beds	83,333	91,669	8,336	916,667	502,329	(414,338)	1,000,000	594,000	(406,000)	R	59%
Non-pay - Procurement, inventory, supply chain	166,667	86,859	(79,808)	1,833,333	644,618	(1,188,716)	2,000,000	731,477	(1,268,523)	R	37%
Non-pay - Medicines Management	49,083	33,218	(15,866)	539,917	348,018	(191,899)	589,000	381,235	(207,765)	R	65%
Non-pay - Demand Man, Tests & Investigations	-	-	-	-	-	-	-	-	-		-
Workforce - Nursing, HCAs, S&T & AHPs	65,833	18,750	(47,083)	724,167	93,750	(630,417)	790,000	112,500	(677,500)	R	14%
Workforce - Medical	19,583	7,500	(12,083)	215,417	82,500	(132,917)	235,000	90,000	(145,000)	R	38%
Workforce - Back Office, Admin & Managerial	40,000	3,333	(36,667)	440,000	141,667	(298,333)	480,000	145,000	(335,000)	R	30%
Other - Coding	39,583	245,583	206,000	435,417	641,416	206,000	475,000	681,000	206,000	G	143%
Other - ICT Enabled Efficiency	22,917	40,213	17,296	252,083	336,275	84,192	275,000	376,488	101,488	G	137%
Other - Agencies & VAT	45,833	12,500	(33,333)	504,167	137,500	(366,667)	550,000	150,000	(400,000)	R	27%
Other - SLR & PLICS	-	-	-	-	-	-	-	-	-		-
Commercial & IPP	124,583	130,694	6,111	1,370,417	1,364,306	(6,111)	1,495,000	1,495,000	-	G	100%
TOTAL	761,583	680,736	(80,848)	8,377,417	5,082,885	(3,294,532)	9,139,000	5,557,623	(3,581,377)	R	61%

RAG	DESCRIPTION
RED	The programme has issues that are not being sufficiently managed and as such the programme will not deliver the planned value without immediate remedial actions
AMBER	The programme has some issues that are being managed but may impact on the successful delivery of the programmes identified value
GREEN	The Programme is on track against the identified value and there are no foreseeable issues at present that will impact on the delivery

ATTACHMENT I

Quality

Dr Andrew Long, Interim Medical Director and Responsible Officer

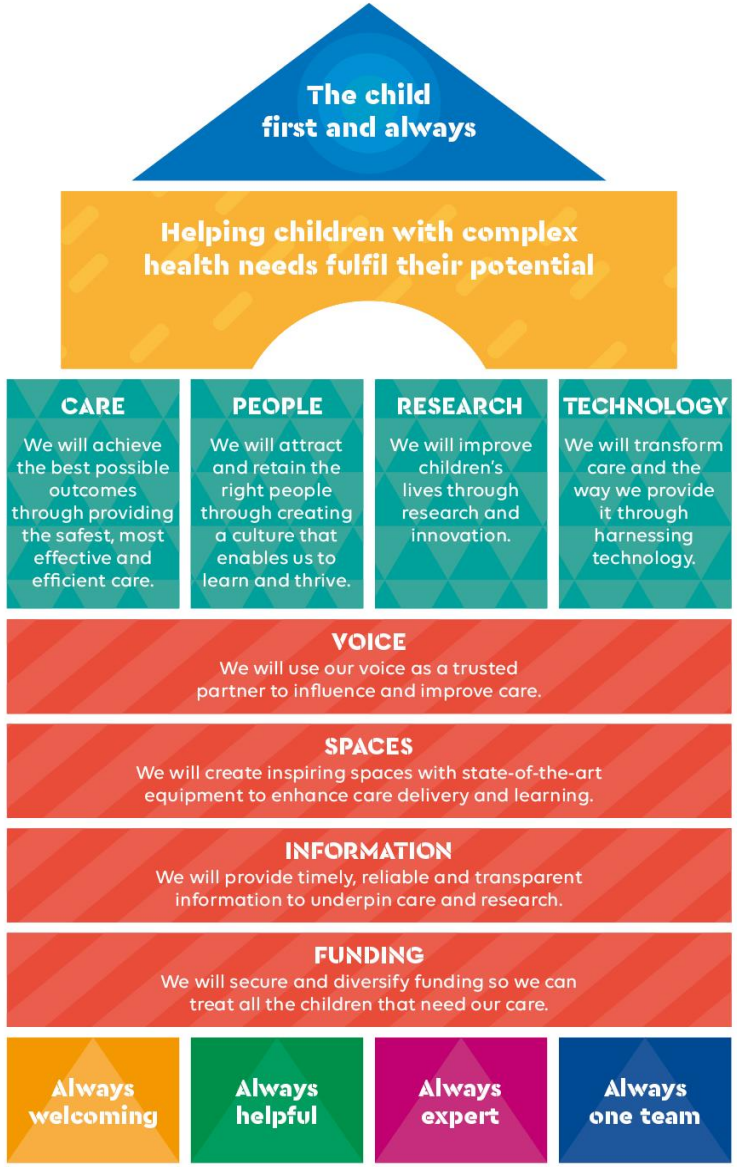
Polly Hodgson, Acting Chief Nurse

QUALITY

Be recognised for our quality of care expertise and clinical innovation in developing, delivering and leading specialised paediatric services

Four areas of quality

1. Safety and reliability improvement programme
2. Comparative outcomes data
3. Recruitment and retention
4. Learning from deaths



Safety and Reliability Improvement Programme

In January 2018 we partnered with the Cognitive Institute as the first UK partner in their Safety and Reliability Improvement Programme (SRIP). This demonstrates our commitment to achieving zero preventable harm and delivering the best possible outcomes through providing the safest, most effective and efficient care

Key activities to date

- Contract signed with Cognitive Institute (Jan 2018)
- Programme mobilised (Jan 18)
- Board and Executive Briefings completed (Jan 2018)
- Five Leaders Orientation Workshops completed (Jan 18)
- Programme Governance in place with SRO assigned and Project Board established with clinical leadership (Feb 18)
- Study Tour completed by Chief Executive and Interim Medical Director (Feb 18)
- Application for funding submitted including KPI's for measuring success (Mar 18)

Next stage

- Application for funding reviewed and funding decision provided (Mar 18)
- "Speaking up for Safety" TM programme launch with selection of 18 Safety Champions (April 18)
- Communications launch to support the Safety Champion selection stage (April 18)
- Safety Champions "Train the Trainer" training (Jun 18)
- Two further Leaders Orientation Workshops for Leaders that were unable to attend in January (May 18)

Key Risks	Mitigation
GOSH does not have the capacity to manage the significant changes through a number of large programmes being implemented during the same period	EPR lead for workforce appointed to Programme Board for SRIP to enable dependencies to be managed.
Insufficient internal resources to manage the programme throughout its duration	SRO reviewing internal options for next phase of implementation
Unable to select sufficient Safety Champions to meet timelines and projected costs	Support the launch with a communications plan and implement soft and hard launch

Comparative Outcomes Data

Many of our clinical services provide outcomes data to national or international registries/audits. These registries monitor incidence of disease, clinical management of conditions and treatment outcomes. Over time, national and international collection of data enables comparison with other paediatric centres on quality of services and the effectiveness of care.

Cleft Lip and Palate

Cleft Registry and Audit Network (CRANE) 2016 data shows:

- **A high proportion of children now aged five who were treated by our teams had good facial growth and development and are unlikely to need further surgery as young adults.**
- the proportion of children at each region/unit with scores for all 16 CAPS-A speech parameters. All centres fall within the expected range of results, **with GOSH achieving high levels of normal speech in our patients.**

Cardiology and Cardiac Surgery

The 30-day survival rate for paediatric cardiac surgery is a nationally accepted benchmark that is used to judge outcomes.

- In the three years 2014 to 2017, there were over 2000 cardiothoracic operations performed in our unit, of which 99.2% of patients survived to 30 days.
- When these outcomes are benchmarked using the Partial Risk Adjustment in Surgery (PRAiS2) model, **our results are better than expected based on the confidence limits selected by the National Congenital Heart Audit (NCHDA).**

Neurosurgery

GOSH has the largest paediatric neurosurgery unit in the UK. On average, GOSH's neurosurgery volume is approximately double that of other UK centres.

- The Neurosurgical National Audit Programme (NNAP) was established by the Society of British Neurological Surgeons in 2013 to publish outcomes data and drive quality improvement.
- **In the three years 2013 to 2016, there were over 3000 neurosurgical procedures performed by our unit, with a risk-adjusted mortality rate of 0.65% - well within the confidence limits selected by the NNAP.**

Recruitment and Retention (part 1/2)

GOSH might be unable to recruit and retain sufficiently high-skilled staff with specific experience to meet its objectives. Amongst the issues: higher than average turnover rates, ongoing 1% pay restraint, London's high-cost living, Brexit, and Immigration rule changes.

Question	Domain	Evidence/Reference
What number of both Registered and unregistered Nurses required?	**Internal** - Annual review of all ward establishments - Monthly review of vacancies and turnover rates. - Plan for changes in services delivery or service expansion - Map the number nurses where retirement age is within the next 2/3 years and include in future turnover estimates. **External** - Effect of removal of NHS bursary for student nurses and now confirmed removal of funding for second degree nurses. - Plan for policy changes and recommendations e.g. National Quality Board, RCN guidance, NICE safe staffing. - Brexit	- Workforce intelligence and attrition reports; Chief Nurse reports to QSAC. - Monitor changes in patient acuity (Panda) and Bank usage, working with Matrons and divisional ACNs. - OH roll out of improving working lives. Indications for concern outside GOSH remit. - Work in collaboration with Redevelopment and Divisional teams. - Highlighted in the Capital Nurse over 50's report indicates flexible hours/incentives: GOSH WFT response - Pick and Mix initiative - Continue funding for the nurse recruitment marketing piece of work to make GOSH the place nurses what to train and work. - Work with feeder universities to gather student feedback including working while training, repayment of student loans, supplementary incomes.

Recruitment and Retention (part 2/2)

GOSH might be unable to recruit and retain sufficiently high-skilled staff with specific experience to meet its objectives. Amongst the issues: higher than average turnover rates, ongoing 1% pay restraint, London's high-cost living, Brexit, and Immigration rule changes.

Question	Domain	Evidence/Reference
Skillset?	- Reviewing Nurse Associate pilot – success/future plans. - Possible Nursing Apprenticeship route changes to NMC Registered nurse Curriculum – need to prepare our current workforce. - Caring for children with rare and complex illnesses	- Nursing Associate and Apprentices – continue assessing and reviewing with Lead for Apprentices to obtain measurable data. - Nursing workforce team – work closely with nurse education team to ensure nursing skills and competencies align to workforce requirements. - Recognise additional teaching and training needs to take place with longer supernumary time required in some specialities
Retention Approximately 250 nurses leave the Trust each year	- Monthly review of Exit Surveys results and results from deep dive events held in 2017 - Generational differences "Mind the Gap" and "Narrowing the gap" research - Identify potential 'flight' risk	- Greater visibility of training and development opportunities. Leadership training for senior nurses to work with HR and OD - Mandatory 3 monthly 1:1s for all staff - Stream lined internal transfers - External secondment opportunities
Available population?	- We can do a number of applications vs posts offered. - We report on Equality Data yearly which has number of applications received each year.	- Consider student numbers applying for nursing – have fallen nationally since bursary removed. Numbers and trends can be reviewed and equated with details from LSBU/other Universities. - Broken down into staff group to compare numbers of applications and if there has been a reduction (year on year comparison)

Learning from Deaths: NHS requirements to report on and learn from deaths

In March 2017, the National Quality Board published guidance aiming to initiate a standardised approach to reviewing and learning from deaths.

The Mortality Review Group been in place since 2012, and is responsible for reviewing the deaths of all inpatients who die at GOSH. These reviews provide oversight of learning from deaths, and take place in addition to local specialty case reviews.

The Trust currently meets the recommendations for reporting on learning from deaths via reporting to Trust Board.

The National Guidance on Learning from Deaths requires trusts to have a policy for reviewing and learning from deaths. The GOSH policy will be written once NHS England's process to review the death of children and young people in hospital has been published. This process is being driven through a national consultation of 'Working Together to Safeguard Children' that includes new 'Child Death Review Statutory Guidance'.

Once the Child Death Review Statutory Guidance is published (due April 2018) the Trust will be able to review changes required and publish a policy.

How learning from the MRG is shared inside and outside of GOSH

- Internally facing issues and actions that arise from individual cases are shared directly with the specialty leads & teams
- Externally facing issues and actions that arise from individual cases are shared and fed back via the Child Death Overview Committee
- The MRG provides a quarterly report to the Patient Safety and Outcomes Committee and Trust Board, which outlines the key analysis and learning from deaths occurring during the quarter

Next steps

1. To develop and implement a Trustwide Policy on learning from deaths
2. To review and implement necessary changes to processes following publication of Child Death Review Statutory Guidance
3. Implementing mechanisms to share learning in an open and constructive way with clinical staff with support from education

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
28 March 2018

The Sight and Sound Centre	**Paper No: Attachment U**
Submitted by Matthew Tulley, Development Director and Nicola Grinstead, DCEO	**For approval**

Aims: The FBC for the Sight and Sound Centre follows the OBC which was approved by the Trust Board in July 2017. The aim of the project is to deliver an exemplar scheme to support the delivery of clinical care and research for a group of patients with special environmental needs. The project looks to expand the boundaries of what a clinical care environment looks and feels like supporting the health and well-being of all who use and work in the centre. The FBC was approved by FIC 20th March 2018.

Summary:

The Sight and Sound Centre will provide a high quality patient environment for a group of patients that often have specific sensory needs and for whom a visit to a busy low quality environment can be stressful. The case supports the qualitative improvement in the care we will provide along with the opportunity to enhance our services and meet increasing demand. The centre also supports improved research opportunities. Finally the development offers the services the chance to be located in new facilities. In the period following the OBC approval the design has been finalised. We have a revised project cost of between £22.2m and £22.7m. This is over the original budget of £21.6m and the Trust and Charity are discussing the best way to address this gap. There is a small revenue cost to the Trust £419k pa. The Trust wide outpatient model of care is being reviewed and the role of the S&SC in supporting the delivery of outpatient services is to be finalised as a part of this review. Our Charity partners Whitbread have agreed to fund a major element of the capital cost of the S&SC as part of their on-going commitment to the GOSH. The Charity has already approved £4.6m of capital spend to acquire Long Yard and provide GOSH with a new nursery facility.

FIC raised a number of questions which were addressed. Specifically:

1) Demand. Is the service at risk from competition elsewhere. The DCEO confirmed this was not considered likely. We are anticipating growth and with the new facility there may be opportunities to expand the service.
2) If Phase 4 was delayed would we still undertake this project. The CEO confirmed that we would the major reason being that we are delivering services in unacceptable conditions.
3) Have the project costs been assessed in terms of value for money. The Development Director confirmed the costs are within expected benchmarks. The Charity's Property Director has also reviewed costs and confirmation will be provided to the Charity's Property and Development Committee prior to final approval of the capital support.

Contribution to the delivery of NHS Foundation Trust strategies and plans

Creates inspiring spaces, contributes to the research hospital mission, supports providing access for patients.

Financial implications The capital support is being provided by the GOSH Charity. Note there is a revenue impact of £419k pa.
Legal issues None
Who is responsible for implementing the proposals / project and anticipated timescales Development Director
Who is accountable for the implementation of the proposal / project CEO

Great Ormond Street Hospital for Children
NHS Foundation Trust

Full Business Case

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

Great Ormond Street Hospital for Children NHS Foundation Trust

Version: 2.0

8 March 2018

Version Control

Trust	Great Ormond Street Hospital for Children NHS Foundation Trust
Document Title	Full Business Case for Refurbishment of the Italian Hospital Building to develop a “Sight and Sound Centre ”
Version	V2
Status	Final
SRO	Matthew Tulley
Contact	Bryony Freeman

Version	Date of Revision	Key Changes	Status
0.1	07/07/2017	Draft	Draft
0.2	10/07/2017	Draft	Draft
0.3	10/07/2017	Draft	Draft
0.4	11/07/2017	Draft with revised financials for review by EMT	Draft
0.5	13/07/17	Draft responding to feedback from EMT	Draft
0.6	19/07/2017	Draft supplemented following presentation to Trustees	Draft
1.0	21/07/2017	Version for Trust Board July 2017	Final
2.0	08/03/2018	Full Business Case update	Final
2.1	14/03/2018	FBC update post EMT	Final
2.2	21/03/2018	FBC update post FIC	Final

GOSH Stakeholders Consulted

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

Name	Role	Division	Version Reviewed	Date of Review
Sarah Metson	General Manager	Barrie	V0.1	31/03/2017
Andrew Smith	Finance Manager	Finance	V0.1	31/03/2017
Aaron Shah	Finance manager	Finance	V0.1	31/03/2017
Tom Burton	Deputy Director, Finance	Finance	V0.3	31/03/2017
Keith Norris	Head of Facilities	DPS	V0.3	31/03/2017 and during February 2018 to refresh Soft FM costs
Jeff Legge	Head of Estates	DPS	V0.2	31/03/2017
Linda Martin	Director of Estates & Facilities	DPS	V0.2	31/03/2017
Crispin Walking-Lee	Head of Healthcare Planning	DPS	v0.3	10/07/2017
Loretta Seamer	Chief Finance Officer	Finance	V0.4	11/07/2017
Matt Tulley	Director of Development	DPS	V0.4	11/07/2017
Stephanie Williamson	Deputy Director of Development (and Chair of the Project Steering Group)	DPS	V0.4	11/07/2017
Kiki Syrad	Deputy Director, Grants & Information	GOSHCC		
Paul Mills	Director of Property & Redevelopment	GOSHCC		
	Speech and Language Therapy team	GOSH		
Project Groups				
Katherine Joel	JM Barrie General Manager (Deputy Chair)	JM Barrie		
Emma Hau	Healthcare Planner	DPS		
Helen Dunn	Lead Nurse, Infection Prevention & Control	Charles West		
Liam Southern	Matron: Outpatients	Charles West		
Fiona Duncan	Lead Audiologist	JM Barrie		
Bronwen Walters	Orthoptist	JM Barrie		
Ben Hartley	Consultant (ENT)	JM Barrie		
Colin Simpson	Head of Decontamination	DPS		
Chris Ingram	Head of Health & Safety	DPS		
Fire officer (TBC)	Fire Officer	DPS		
	Scientist	JM Barrie		
	Audiologist	JM Barrie		
		Charles West		
		Charles West		

Contents

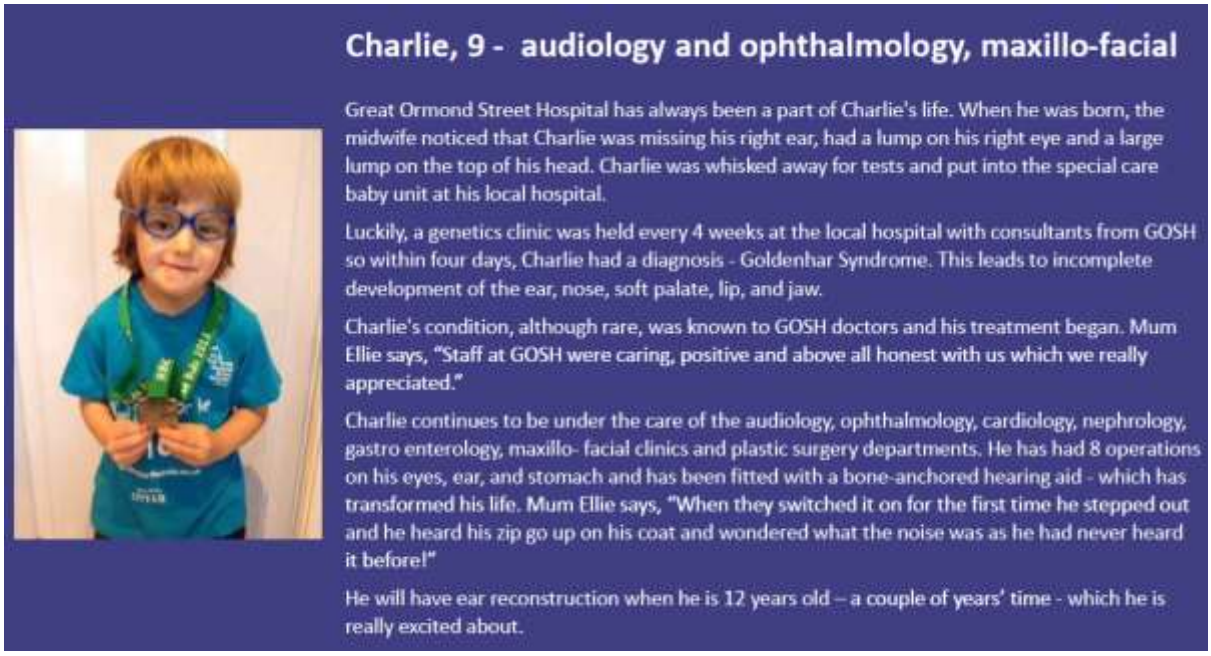
1 Executive Summary

Background

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

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

The vision that developed was the establishment of a **'Sight and Sound Hospital at GOSH'** with existing services in the building to be rehoused as part of the refurbishment and decant plan. Therefore this business case outlines an opportunity to redevelop the Italian Hospital within the Great Ormond Street Hospital precinct into an outpatient clinical building, to provide a 'sight and sound' model of care for ophthalmology, audiology, cochlear implant, ENT, SLT, craniofacial and cleft palate outpatient services. In March 2018 the name of the building was agreed as 'The Great Ormond Street Hospital Sight and Sound Centre' (hereafter referred to as Sight and Sound Centre).



Options

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

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

Model of Care

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

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

Other Benefits:

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

Trust Demand and Capacity Requirements

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

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

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

Financial

The Italian Building project (including the purchase and fit-out of the new property to accommodate the staff crèche) is £26.8-27.3 million. The creation of the Sight and Sound Centre is supported by the Charity who have already received a £10m commitment from a corporate partner.

On the basis of the assumptions outlined in this case, the capital investment required for the preferred option provides value for money for capital investment, will significantly enhance the patient experience and support new models of care. It also avoids expensive and disruptive decants for this service as per the original Phase 4 option planning when Phase 4 commences. The refurbishment also provides additional capacity in the Italian building for either NHS or IPP outpatient services and makes best use of current building stock. The use of the available space in the Phase 4 programme that would otherwise be utilised by the outpatient services will be assigned for other use (the current proposition being the space is used to address our pharmacy requirements). This will be assessed as part of the separate business case.

The more detailed income and expenditure impact is evaluated as part of this full business case but assumes that any service growth is accounted for in the current two year financial plan or future plan baseline demographic growth built into contracts with any demand over and above these baseline assumptions would form part of specific negotiations for additional growth with commissioners. The cost assessment assumes that the service will move with no change in service volumes. An assessment of the Italian Building operational costs compared to the Frontage Building space has been based on cost per m2. Overall this initial assessment indicates a cost increase of £419k pa to operate in the new building.

2 Introduction

2.1 Background

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

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

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

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

2.2 Purpose of this Business Case

The outline business case was prepared to support the investment decision by EMT and the Trust Board. It set out the overall best offer for the Trust, documented the proposed contractual arrangements, confirmed funding and affordability and set out the detailed management arrangements and plans for successful delivery and post implementation evaluation. It was approved in August 2017 with the request that a full business case was developed to answer particularly the following questions:

- Detailed description of the model of care
- More detailed analysis and scrutiny of the revenue impact
- Final GMP

This is now presented in this case.

As per the NHS Improvements' guidance relating to transactions for NHS Foundation Trusts, GOSH is required to report transactions that meet specific criteria to NHS Improvement. The investment in

the Refurbishment of the Italian Hospital does not trigger NHS Improvement reporting requirements (as outlined in the supplementary document '*Reporting Guidance'*).

This full business case updates the cost review conducted at the outline business case stage to confirm the preferred option.

2.3 Structure of Business Case

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

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

3 Strategic Case

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

3.1 Strategic Alignment

3.1.1 Supporting Trust strategic objectives

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

3.2 Scope Services

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

3.2.1 Review of GOSHCC property assets.

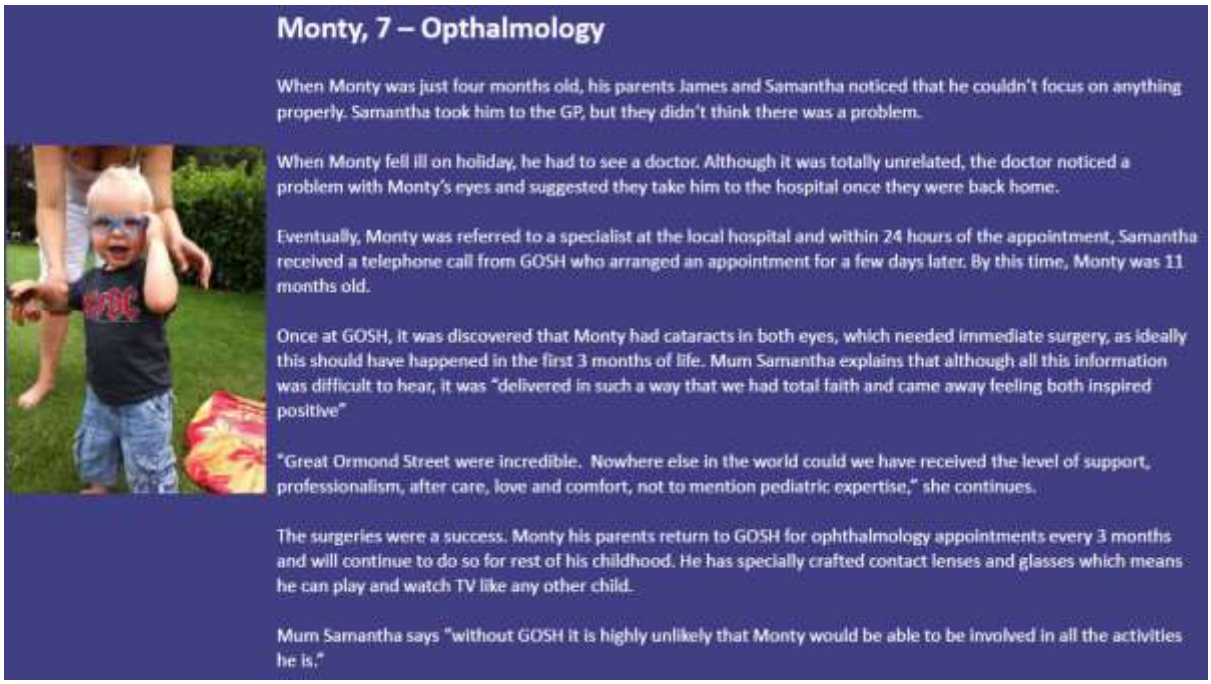
In 2015 GOSH and the Charity agreed to undertake a strategic review of the GOSHCC property portfolio to examine if the assets are being used effectively to support the strategic aims of the hospital as well as maximising the benefit of these assets in the delivery of the Charity's objectives. As the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

3.2.2 Current outpatient space for audiology and ophthalmology is poor and provides a low quality experience for this patient group.

The specialties currently intended for the Sight and Sound Centre are housed in generic outpatient rooms, designed for flexible use across multiple specialties. The space is viewed by the clinical, management and redevelopment teams as unsuitable accommodation. This cohort of mostly well but sensory impaired children currently access our services through the main entrance of an acute hospital site. The volume of traffic and activity and the complex reception activity is not conducive to a great patient experience for visually impaired or hearing impaired individuals.

These specialties would benefit from tailored-designed rooms which could incorporate blackout blinds/ specialised lighting for ophthalmology and support changing models of care. These patients check in at main reception, then at Cheetah reception and again at Rhino reception. An exemplar, dedicated 'sight and sound' building would allow specific design for this patient cohort, including signage and lighting solutions to support those with visual or auditory impairments. It would also provide new opportunities for co-location of these services as many patients and families are seen on the same day in multiple clinic appointments. Furthermore, the layout of the building and the single point of entry and exit represent an opportunity to introduce a new arrival experience for patients and families.

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



3.2.3 Phase 4 decant requirements

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

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

3.3 Clinical Infrastructure Capacity

3.3.1 Change in Outpatient Infrastructure Capacity

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

The additional outpatient services on Level 3 will initially be for new growth in services related to either NHS or IPP.

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

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

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

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

3.3.2 NHS Activity

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

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

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

3.3.3 NHS Demand

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

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

3.4 Benefits Summary

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

The potential benefits of the Italian Hospital development include:

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

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

3.5 Strategic Risks

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

Table 6: Key Risks and Mitigations

Key Risks	Mitigations
The site is designated as a heritage asset and therefore, town planning may be difficult to achieve without potential compromise to the design and therefore functionality of the building	• Planning consent granted September 2017. • Early engagement with neighbours and community • Commitment to engage with external stakeholders throughout the construction management planning process
The site is constrained and so construction planning may be difficult	• Careful engagement by Kier in the construction management process • Careful co-ordination with other projects both at GOSH and NHNN • Effective working with Camden Transport Team
It is possible that due to the impact on neighbouring buildings during planned construction there may be party wall disputes (e.g., with the Mary Ward Centre)	• Engagement with neighbours commenced with on-site presentation and meeting • Communication routes outlined • Party Wall advisor appointed
Section 106 negotiations may be protracted, leading to a delay starting construction on site	• Section 106 agreed
There may be limited opportunities to maximise physical connections to the wider Trust site for heating and cooling (which will impact the BREAAM scores)	• Feasibility study carried out which led to agreement to install chillers and boilers in the new centre • Camden asked to support any future town planning implications although standalone building does not require any digging work to the road • Alternative solution for standalone approach fully developed with independent chiller and boiler.

Key Risks	Mitigations
Delay to nursery project programme may impact start on site for both IH Project and Phase 4	• The Long Yard nursery scheme is designed and funding approved by the Charity. The contractor is ready to start on site

4 Economic Case

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

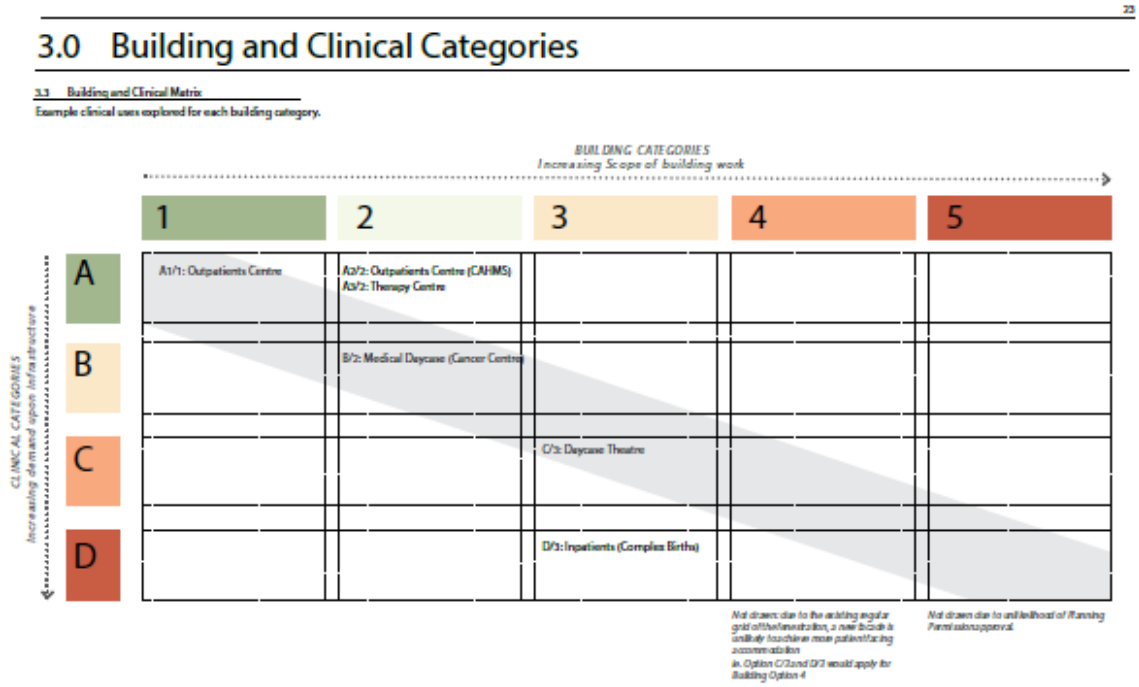
4.1 Options Development

There are two key elements to the economic case:

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

4.1.1 Italian Hospital redevelopment Options

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



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

4.1.2 Options Appraisal Clinical Specialty Location

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

Table 7: Options Appraisal

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

4.2 Shortlisted Options

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

Based on the analysis the following two options were identified.

Option	Advantages	Disadvantages
A) Southwood decant for P4 and final reprovision on island site. **(masterplan 2015 plan)**	• No decant of Italian Building required	• Audiology soundproof booths to be relocated to Level 9 Southwood building and then re-provided in Phase 4 • This is costly due to the complex engineering required and also impacts Safari service delivery • Outpatient clinics would move into Southwood areas vacated when PICB opens (which would require significant investment) • The double decant is disruptive to service and costly.
B) Redevelop Italian Hospital into a 'sight and sound' hospital	• Enables audiology soundproof booths to have a long-term relocation, single decant. • Overall Phase 4 benefits as space on Levels 2 and 3 would be freed up, allowing integration of therapies/ pharmacy/ imaging into the building	• Requires town planning approval • Capital investment of c£26.8m • • Revenue impact of c£419k

4.3 Options Value Review

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

The refurbishment of the Italian building option will:

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

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

Option A – Total Capital Costs £30.6 million

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

   — refitting the Southwood Building £4.4 million; and

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

Option B – Total Capital Cost £26.8 million

.

4.4 Preferred Option

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

4.5 Decant Strategy for the Sight and Sound Centre

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

- Staff nursery –
- Parent accommodation.
- Offices for volunteers and psycho-social

The Charity acquired a long-lease on a property in Long Yard for refurbishment.

The current provision of parent accommodation is 72 rooms. This rises in September 2017 to 87 rooms with the addition of the newly acquired Sandwich Street accommodation. When the Italian building closes in May 2018 there will be a loss of 34 rooms reducing the total provision to 53 rooms. 15 of the rooms lost with redevelopment of the Italian Building will be re-provided in Sandwich Street. 30 rooms are being re provided in Grenville Street which takes the Trust total number of rooms to 83. This number will meet the projected demand for parent accommodation based on our current policies.

The offices will be decanted into other Trust accommodation.

5 Commercial Case

5.1 Procurement Approach

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

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

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

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

5.2 Agreed Services

5.2.1 Design and Construction Team

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

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

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

5.2.2 Design Principles

The design principles for this project are as follows:

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

The Draft plans are provided as Appendix 1.

5.3 Contract Management

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

The Italian Hospital project will use the following contract;

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

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

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

5.4 Implementation Timescales

Completed Tasks to date:

- The design team was appointed in January 2017 and the P22 construction partner (Kier) was selected in March 2017.
- The trust received town planning approval in September 2017 and the GMP will be received in March 2018

The project Timetable is set up below:

Task	Month
Business case approval EMT and Trust Board	Jul 2017
Charity Grant funding Approval	Jul 2017
Town planning application approved	Sept 2017
GMP received and updated in March 2018	Nov 2017
Update Business Case with final GMP for Board Update and Approval. Full Business Case to be submitted March 2018	Dec 2017
Decant current occupants	May 2018
Construction Commences on site	September2018
Construction completion	January 2020
Occupation	April 2020

6 Financial Case

6.1 Overview

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

The costs to operate the Italian Hospital are more than the current space, but this includes additional capacity for growth for which no additional margin for growth in income has been included in this initial assessment. At the OBC stage the increase in costs was projected at £350k pa. At FBC stage this cost increase is now project at £ 419k.

Expenditure	Base Year Nominal Costs 2018
Staffing	£28,000
Hard FM	£146,027
Soft FM	£158,725
Rates	£200,000
Utilities	£41,200
Security/ Materials Management/ Porter	£50,000
Waste	£45,000
Building Insurance	£14,500
Total Direct & Indirect Costs	**£683,452**
Savings -Frontage Reduction Costs:	
- Hard FM costs	£25,061
- Soft FM costs	£120,325
- Rates	£76,800
Savings - Ceased annual re-charge from Charity	£42,000
	£264,186
Net Expenditure Cost	**£419,266**

The capital option indicates value for money but there will be a cost pressure to relocate the services and to operate the services in the new facility. This has been completed for this Full Business Case.

6.1.1 Income and Expenditure Assumptions

The financial case is based on a number of elements:

1 Services

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

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

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

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

2 Facility cost implications for running the Italian Hospital.

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

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

c) The cost model indicates there will be a cost pressure for an increase in Hard and Soft FM costs (425k).

3 Building Rent/Rates Costs

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

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

c) Council rates is now included as previously covered by the funded family accommodation and nursery services (£200k).

4 Operational Costs

It is currently assumed that all existing sight and sound clinical services will move from the main GOSH site into the Sight and Sound Centre. The operating model for the Sight and Sound Centre is still being finalised as part of a site wide review of our outpatient services to create a GOSH generic outpatient model of care and a final revenue budget for the centre will be developed once this review has concluded. The Deputy Chief Executive (DCEO) is the Senior Responsible Officer for this work which is being led by the Divisional Director of Operations Charles West Division. There is no assumption regarding activity growth beyond those outlined in this case and as such it is recognised there will be excess capacity in the building initially. Currently there is no final decision regarding the best use of this additional high quality consulting rooms created in the Sight and Sound Centre.

6.2 Capital Costs

The estimated cost of the project is £26.8-£27.3mmillion. This includes the costs of the enabling works to provide a new home for the GOSH nursery. To accommodate the GOSH nursery the Charity has purchased a long leasehold of a property in Long Yard which provides a long term asset. The funding for the Long Yard scheme has been approved by the Charity.

The fit-out cost for the S&SC was approved at £21.6m. The Guaranteed Maximum Price for the scheme was received from Kier on 12th March and is still being reviewed and finalised. Analysis of the return suggests the final cost of the fit-out works will be in the range of £22.2-£22.7m. These figures have been discussed with the Charity and we are working through the Kier return with the Charity. We are engaged with the Charity to agree what the appropriate cost of the scheme is and the additional funding requirement. This will be discussed at the March GOSHCC Grants Committee with review by the Property and Development Committee.

The total capital commitment for the scheme including enabling works are:

Capital Expenditure	Base Year Nominal Costs 2018
Purchase and fit-out of Long Yard	£4.6m
Design and construction of S&SC	£22.2m-£22.7m
Total Capex	**£26.8-£27.3m**
Funding source	
Long Yard Charity funding committed	£4.3m
GOSH contribution to Long Yard	£0.3m
Approved Charity funding for S&SC	£21.6m
Funding under discussion with GOSHCC	£0.6-£1.1m
Total	**£26.8-£27.3m**

6.3 Charity Capital Funding Support

The Charity approved the OBC for the project in July 2017. Final approval is programmed for the May meeting of the Charity Trustees.

Our PICB corporate partners Whitbread have signed up to support the Sight and Sound Hospital and have commenced the fund raising campaign.

7 Management Case

7.1 Introduction

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

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

7.2 Programme Management Arrangements

GOSH has a strong track record of delivering major capital schemes, from the Phase 1 development which became operational in 2006 to the Premier Inn Clinical Building, which opened for patients in November 2017. The Trust evaluates its projects and refines its management approaches accordingly; the "lessons learned" from Phases 1, 2 and the early lessons from Phase 3 will be applied to the Italian Hospital Project to ensure best practice in delivering major healthcare capital projects is achieved.

The Phase 2A lessons learned summary document was circulated with the OBC. Key lessons include:

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

7.3 Project Management Arrangements

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

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

The project organisational structures and roles are summarised below

7.4 Project Management Roles

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

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

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

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

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

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

7.5 Risk Management Plan

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

The risk management strategy will incorporate the following activities:

- Risk identification and reporting
- Evaluation of proximity, probability and impact of the risk occurring
- Allocation of risk owner
- Development of risk mitigation responses including prevention, reduction, transference, acceptance of reduction
- Identification of escalation procedures
- Planning and resourcing of responses to risks
- Monitoring and reporting of risk status
- The risk register will be reviewed and updated on a regular basis

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

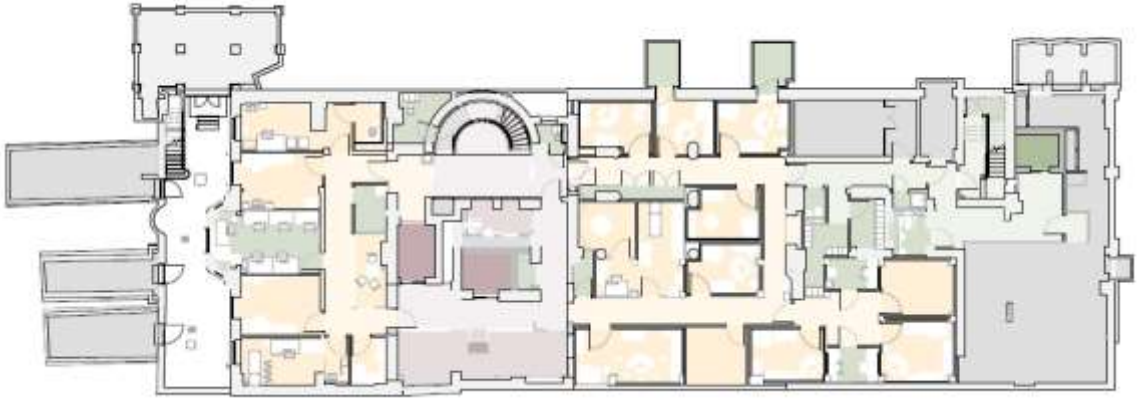
7.6 Stakeholder Engagement and Communication Plan

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

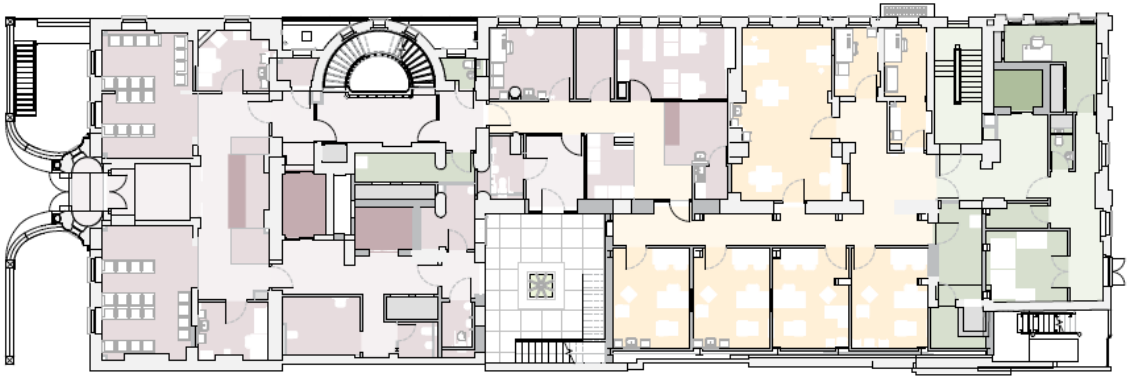
In keeping with its motto 'The Child First and Always', the Trust also includes children and their families in this process. It is important to gain their perspective on what they feel does not currently work well at GOSH and what the future of the hospital looks like for them. The Trust uses a number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

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

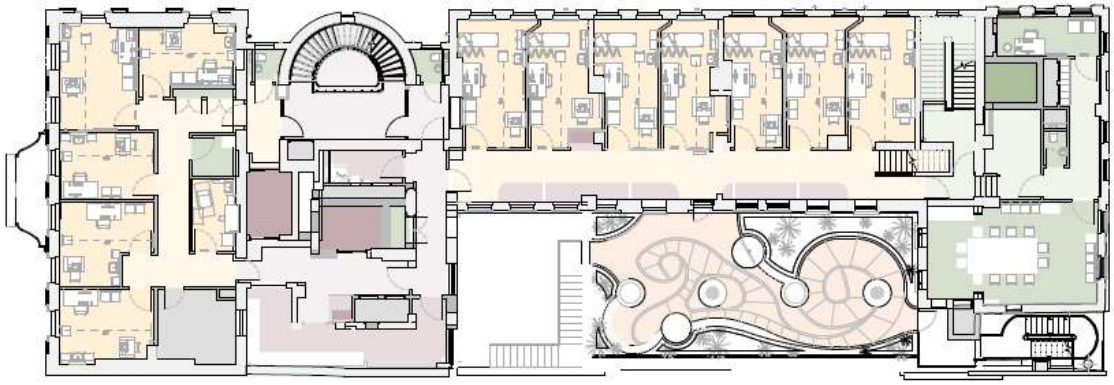
Appendix 1 Draft plans



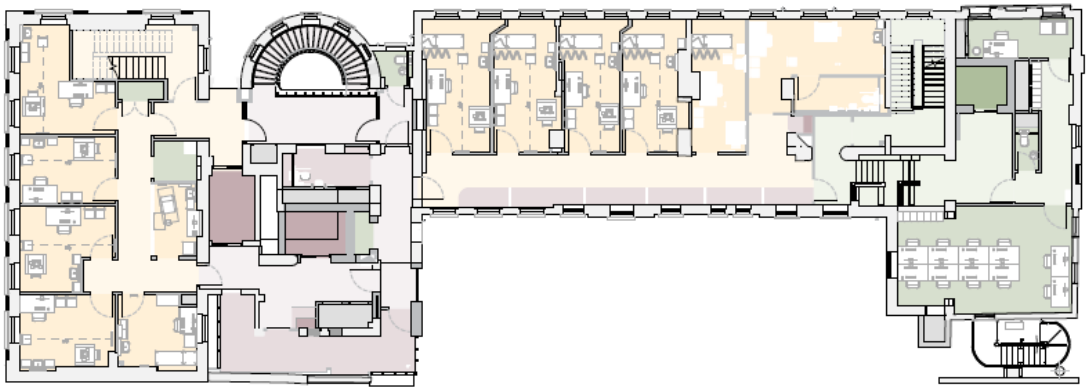
Basement



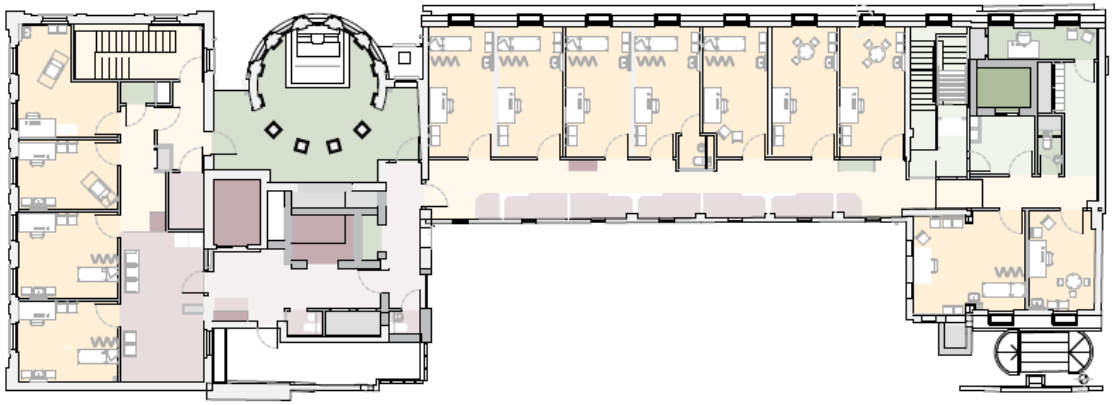
Ground Floor



First Floor



Second Floor



Third Floor

Attachment J

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **28 March 2018**	
Integrated Quality Report – February 2018 **Submitted by:** Dr Andrew Long, Interim Medical Director Polly Hodgson, Interim Chief Nurse	**Paper No: Attachment J**

Aims / summary

The Integrated Quality Report will 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 Trust Board's request

Action required from the meeting

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

Contribution to the delivery of NHS Foundation Trust strategies and plans

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

Financial implications

No additional resource requirements identified

Who needs to be told about any decision?

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

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

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

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

Medical Director and Chief Nurse

Great Ormond Street Hospital for Children NHS Foundation Trust

Integrated Quality Report

Dr Andrew Long, Interim Medical Director
Polly Hodgson, Interim Chief Nurse

March 2018

(covering January- February 2018)

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.	The data remains stable, with a current process mean of 7 patients transferred to ICU per month by CSPs. There were 9 such incidents in January, and 12 in February – both within expected limits. The process is currently in normal variation; there have been no runs, trends or recent outliers identified.
	**Cardiac arrests****	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. There were 2 cardiac arrests outside ICU in both January and February 2018. The process is currently in normal variation at GOSH; there have been no runs, trends or recent outliers identified.
	**Respiratory arrests**** **The figures within the Integrated Quality Report includes arrests within all areas outside of ICUs (including day case Wards, day units, outpatient areas and non-clinical areas e.g. main reception) whilst the Safe Staffing Report arrest data only refers to arrests on in-patient Wards . The data will therefore differ between the two reports as the Integrated Quality Report includes additional areas.	The data remains stable for this measure at 3 respiratory arrests per month; this has remained stable since June 2015 (when there was a decrease) with the exception of an outlier in November 2015 and August 2017 (both high). The most recent 3 months indicate no change – there were 2 respiratory arrests outside ICU in January and 1 in February. The process is currently in normal variation at GOSH; there have been no runs, trends or recent outliers identified, though there has recently been a reduction in the number of respiratory arrests classified as preventable.
	Cardiac arrests outside of ICU	**Respiratory Arrests outside of ICU**
January 2018	2 (IR and Theatres)	2 (Panther ENT and Chameleon)
February 2018	2 (IR and Kangaroo)	1 (Panther Urology)

Has patient care been safe in the past?

Measures where we have no concerns

Great Ormond Street Hospital for Children NHS Foundation Trust

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

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

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

Data Quality Kite-Mark	Measure	Comment
	**Never Events**	The last Never Event was on 20th October 2017. The mean time between never events is unchanged at 220 days. The baseline for this data is from 2010 until 2014. The Never Event declared in October 2017 is for wrong site surgery while the previous Never Event was due to a retained object.
	**Serious Incidents**** ****by date of incident not declaration of SI**	The number of serious incidents remains stable, with a mean of 0.76 per month. This mean is based on a baseline between September 2016 and January 2018, and is a statistically significant reduction compared to the previous mean (taken from a baseline ending in August 2016, which was also a reduction compared to the previous baseline). There were no SIs reported in January or February. If we look at a more sensitive measure (days since previous SI) then we see that SIs have become less frequent. Before August 2016 we would expect an SI to be reported every 13 days, since then we have had an SI reported every 33 days
	**Mortality**	The data remains stable at 6.3 deaths per 1000 discharges; the process is in normal variation and has been since 2014. The rate for January was 6.25 per 1000 discharges, and 5.35 per 1000 discharges in February. There have been no runs, trends or outliers identified. Over 80% of GOSH inpatient deaths are on ICU, and ICU deaths must be risk adjusted to properly determine a trend. Raw survival/mortality rates do not take account of severity of illness and case mix so outcome data needs to be adjusted to take these factors into account. All ICU data is submitted, after risk adjustment, to the national Paediatric Intensive Care Audit Network (PICANET). This process will allow any trends or outlier performance to be determined. Internal monitoring of Variable Life Adjusted Plots (VLAD) from January – June 2017 showed an increase in the number of deaths on PICU compared to expected. A comprehensive internal review of cases did not suggest any obvious patterns or concerns about the quality of care in PICU/NICU, and no single cause that could explain the trend. GOSH has been informed by PICANET it will not be a statistical outlier for 2017 and the full PICANET data for the calendar year 2017 is due to be published on 31 March 2018. The most recent VLAD data suggests that the negative trend has not continued.

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	
	**Hospital acquired pressure ulcers reported (grades 2+)**	Performance remains within normal variation at 6.67 per month.	
		January 2018	**February 2018**
	Grade 2 hospital acquired pressure ulcers	**6**	**4**
	Grade 3 hospital acquired pressure ulcers	**0**	**0**
	Grade 4 hospital acquired pressure ulcers	**0**	**0**
	**GOSH-acquired CVL infections**	We have identified a reduction in the measure of CVL infections per 1000 line days. This reduction started in January 2017 and has been sustained – the current baseline mean from January 2017 to January 2018 shows a rate of 1.38 CVL infections per 1000 line days, compared to a previous mean of 1.42 CVL infections per 1000 line days. (The figures for January and February 2018 are 1.27 and 1.38 CVLS per 1000 line days respectively.)	
	**The number of PALS cases**	The number of PALS cases reported per month remains stable, with an average of 149. Since the outliers in summer 2017 (June and July), the process is currently in normal variation; there have been no runs, trends or recent outliers identified. There were 193 cases in January 2018 and 195 in February 2018, but despite being higher than the mean these are both within expected limits based on previous baseline data.	

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

Serious Incidents and Never Events January - February 2018			
No of new SIs declared in January - February 2018:	0	No of new Never Events declared in January - February 2018:	0
No of closed SIs/ Never Events in January - February 2018:	1	No of de-escalated SIs/Never Events in January - February 2018:	0

Learning from closed/de-escalated SIs/Never Events in January – February 2018 (1):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
2017/ 26155	**A patient was electively admitted for extraction of six teeth. During this procedure, an incorrect molar tooth was extracted.** The patient had an incorrect molar tooth removed. It has not been necessary for the tooth originally planned for removal to be removed at this time and the patient has not needed an additional procedure. The patient will be monitored to observe the progress of this tooth which may need to be removed at a later stage.	The root cause was identified as a failure to identify the correct tooth for removal by the maxillofacial SpR. This failure was due to the retention of the LRE which was confused with the LR6	A dedicated surgical safety checklist for maxillofacial surgery will ensure that a second check of all teeth for removal is implemented as well as identifying which equipment is necessary for the tooth removal. This will reinforce the use of imaging during team brief and the procedure itself. a) Implementation of a safety checklist for use prior to maxillofacial procedures. b) Use of checklist to be audited to ensure this is embedded for use by the maxillofacial and theatres teams. **Action Update: Checklist devised.** It is necessary to raise awareness to all dental, maxillofacial and theatres staff of this type of incident and actions which need to be taken to prevent recurrence. a) Internal safety alert to be devised and disseminated to staff. **Action Update: Complete.** Whilst the responsibility of identifying and removing the correct tooth lies with the surgical team, education of the theatre nurses regarding tooth counts and types of equipment required will empower them to query surgical decisions should this be necessary. a) Education sessions to be organised for relevant theatres nurses. Please note this action isn't due for completion until 01/04/2018, however we have requested an update and are awaiting details.	There may be a need for dedicated safety checklists for specific types of surgery to improve planning and communication amongst surgical teams.

Are we responding and Improving?

Patient and Family Feedback: Red Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

Red Complaints in January - February 2018

No of new red complaints declared in January-February 2018:	1	No of re-opened red complaints in January-February 2018:	0
No of closed red complaints in January-February 2018:	2		

New red complaints (1)

Ref	Opened Date	Report Due	Description of Complaint	Divisions Involved	Exec Lead	Division Lead
17/069	23/01/18	27/02/18	Father raises concerns regarding the nursing care provided to his child on Eagle Ward prior to the child's death. He believes that had certain symptoms been further investigated it may have prevented his child's deterioration. The complaint is currently under investigation, led by JM Barrie division	JM Barrie	Interim Medical Director	General Manager- JM Barrie

Are we responding and Improving?

Patient and Family Feedback: Learning from Red Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

Learning from closed red complaints in January – February 2018 (2):

Ref:	Summary of complaint:	Outcomes/Learning:
17/002	During cardiac surgery a needle was left inside the patient, which necessitated the patient's chest being reopened to remove it. The patient did not leave the theatre between the two procedures. This was investigated as a Serious Incident. The Social Worker on behalf of the local authority raised concerns, and the outcome is identified in the Outcomes/Learning section.	There were a number of actions from this complaint: - A review has taken place of the surgical count policy to ensure the first surgical count is completed and signed before the chest is closed - The way information is recorded in the peri-operative careplan will be reviewed by the Theatres matron and the learning disseminated via newsletter, email, staff meetings and noticeboard In addition it is noted that the planned Trust partnership with the Cognitive Institute may lead to the implementation of a universally recognised safety language to improve safety culture within theatres.
17/040	Patient raises concerns that a complication during renal surgery as a teenager may have had an effect on her fertility and ability to conceive as an adult.	The investigation found that there was a complication during surgery in 2005, however it is unlikely that this would have any effect on the patient's long term fertility. Her underlying condition and the medicine used to manage it can reduce fertility and this was the likely cause. Due to the time that has passed processes have changed a great deal and there was no change to practice as a result of the complaint.

Are we responding and improving?

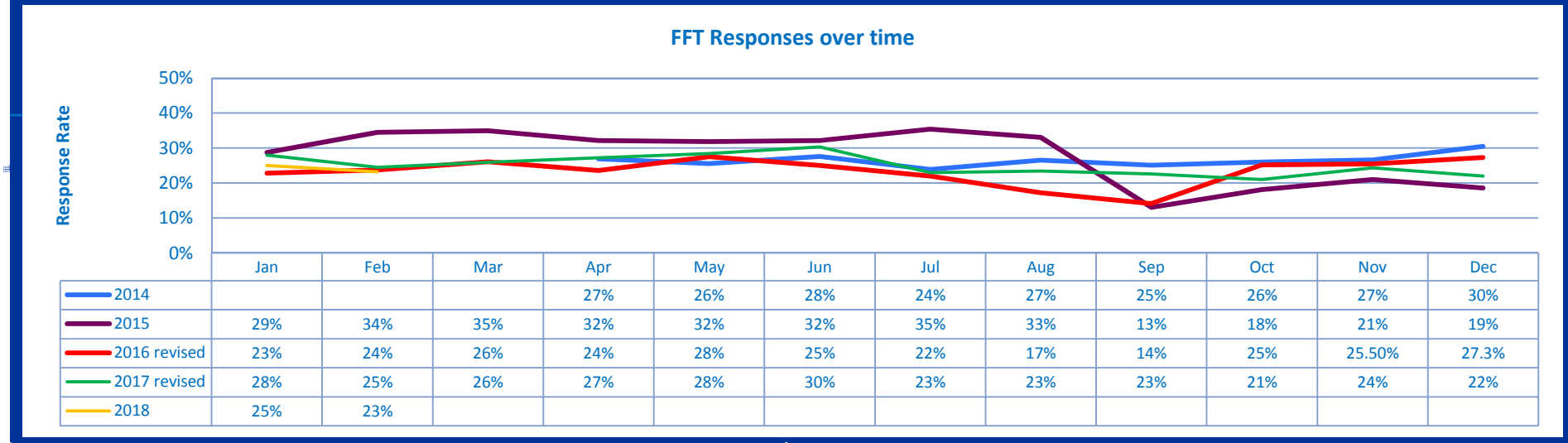
Learning from Friends and Family Test- Inpatient Data

Great Ormond Street Hospital for Children NHS Foundation Trust

Data Quality Kite-Mark	Inpatient Results January 2018	Inpatient Results February 2018

January 2018
Overall FFT Response Rate = 25.1%
Overall % to Recommend = 97.4%

February 2018
Overall FFT Response Rate = 23.2%
Overall % to Recommend = 97.0%



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2014				27%	26%	28%	24%	27%	25%	26%	27%	30%
2015	29%	34%	35%	32%	32%	32%	35%	33%	13%	18%	21%	19%
2016 revised	23%	24%	26%	24%	28%	25%	22%	17%	14%	25%	25.50%	27.3%
2017 revised	28%	25%	26%	27%	28%	30%	23%	23%	23%	21%	24%	22%
2018	25%	23%										

January 2018 Top 3 Themes (by %)

Positive Themes:	No +ve comments	Total comments
Always Helpful	291	298
Always Expert	191	204
Always Welcoming	177	189
Negative Themes:	**No -ve comments**	**Total comments**
Staffing Levels	11	12
Access / Admission / Discharge / Transfer	20	23
Always One Team	9	29

February 2018 Top 3 Themes (by %)
(Not all comments had been themed a time of report production, however the order will not be affected)

Positive Themes:	No +ve comments	Total comments
Always Helpful	288	294
Always Welcoming	125	135
Always Expert	61	75
Negative Themes:	**No -ve comments**	**Total comments**
Access / Admission / Discharge / Transfer	5	5
Staffing Levels	4	4
Catering / Food	6	18

Are we responding and improving?

Learning from Friends and Family Test- Outpatient Data

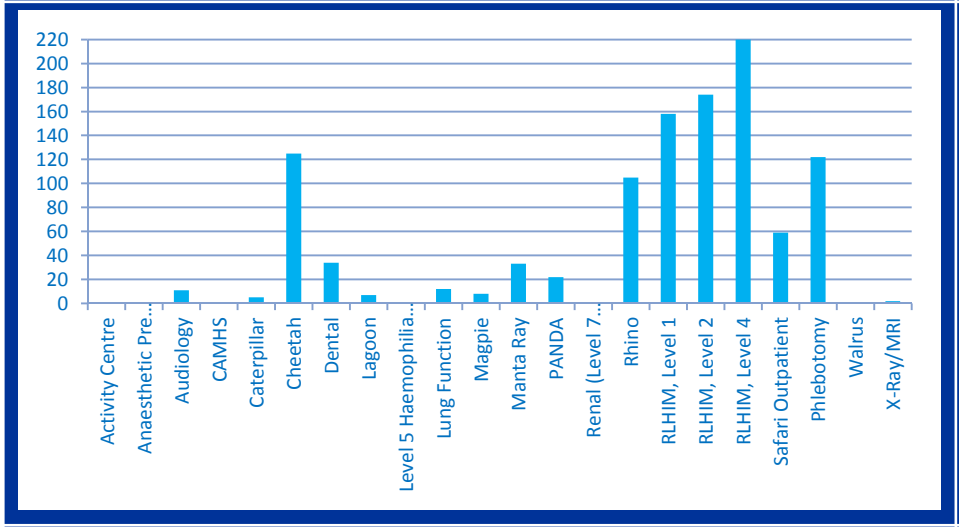
Great Ormond Street Hospital for Children NHS Foundation Trust

Data Quality Kite-Mark	Narrative:
	**The average percentage to recommend for Outpatients reduced to 92.4% in February. The total number of cards collected within Outpatients was significantly lower for this month (n= 566) but there were also 2881 fewer attended appointments due to the severe weather conditions.**

Outpatient Results January 2018

January 2018

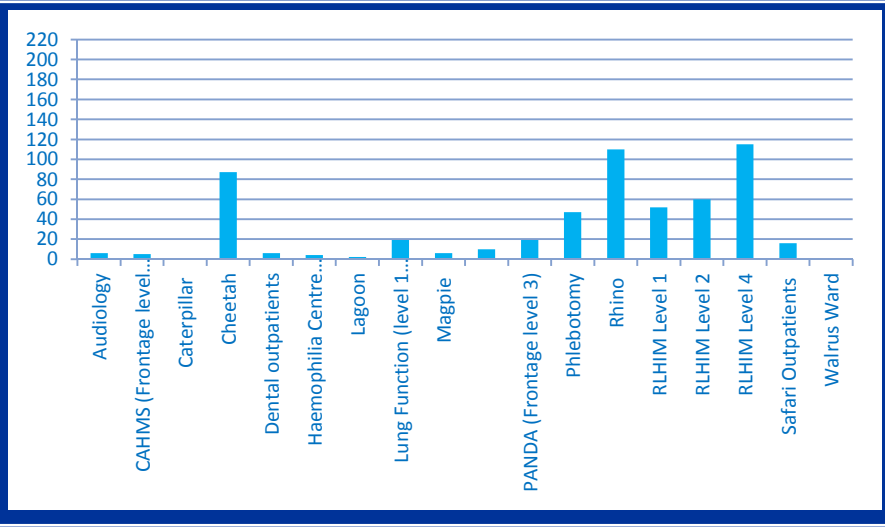
Overall % to Recommend = 93.7%



Outpatient Results February 2018

February 2018

Overall % to Recommend = 92.4%



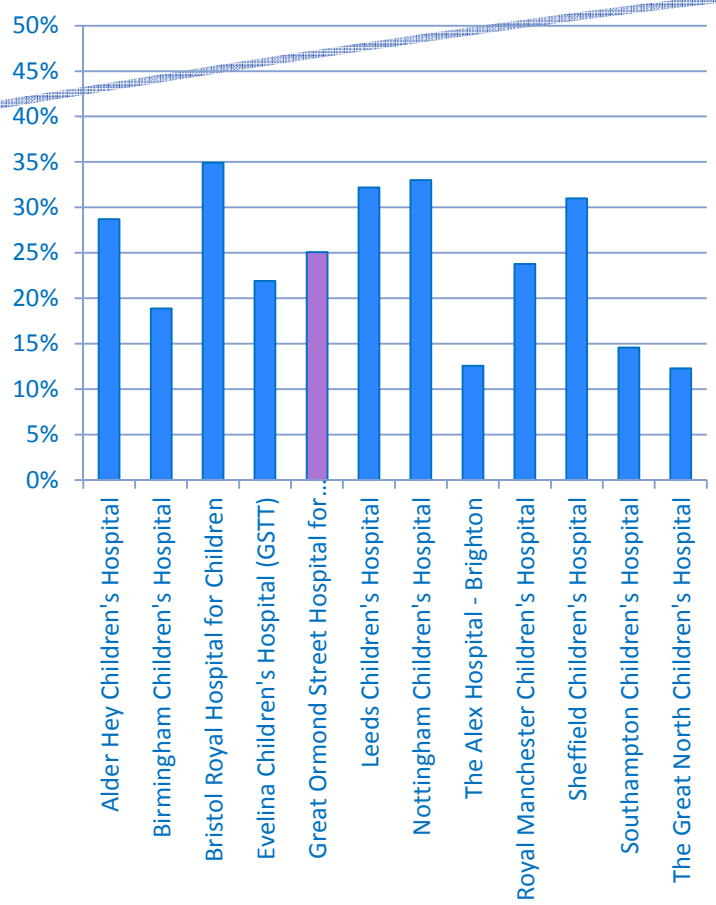
Are we responding and improving?

Benchmarking

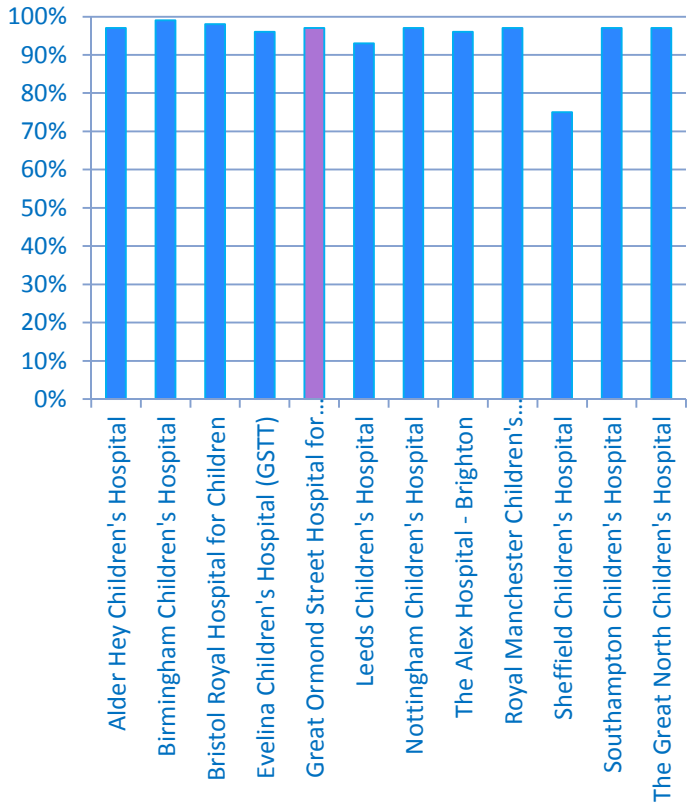
Great Ormond Street Hospital for Children NHS Foundation Trust

Data from NHS Choices – January 2018

Response Rates



Percentage to Recommend



Are we responding and improving?

Learning from Friends and Family Test

Great Ormond Street Hospital for Children NHS Foundation Trust

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

Patient Feedback

All the nurses on elephant ward are lovely. They look after me very well! :-)

I liked the team that came to look after me and that they are very happy, smiley and friendly. I hope to see this friendly team again on my next visit. I like the team a lot.

The Care, professional and thoughtful nursing team do an incredible job. Miracle workers.

My room is really nice and comfy!

Parent/Carer Feedback

I would just say a couple of small issues - we were initially left for 4 hours in our room, weren't shown around despite a list in the room that should be ticked saying we've been told everything.

The staff can be the best and most professional individuals but unless there is enough of them, they are unable to do a good job. There needs to be more clinical staff on the wards for care to be good.

I was disappointed by the poor communication from the consultant. There was no discussion on the day regarding on-going follow up and then a week later we received an appointment in the post for follow up in 1 year! This should have been discussed face to face.

However seems to be an ongoing communication problem between the departments - phones are unanswered and delays occur - this is probably due to a shortage of staff.

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

All different professionals played their part extremely well such as nurses and anaesthetic. However everyone, including ourselves, were let down by the first doctor that came to assess my child. Very unprofessional of her to fail to get the consent form completed, causing a 4-hour delay and leaving my child to the back of the queue when he was meant to be the first one. No need to mention that he didn't have food for several hours, causing more distress. She was chased quite a few times unsuccessfully and at the end they had to get a different doctor to complete her job. As a doctor she should have a duty of care. Also a little bit more communication if she was going to skip my child in the queue. Please ensure that she doesn't do it to other families.

Ward Manager for Nightingale responded:
This patient was under the audiology team and the ENT team are responsible for getting these patients ready for their procedure.
We often have difficulties in getting these patients clerked and consented and I have brought this up many times with these teams.
Patient Experience have sent the comment to the ENT Team, currently awaiting a response.

No food menu all over the weekend. Some amount of food suppled of the trolley. Out of what was left. I had to provide food for my son while he was in hospital.
Feel forgotten with no consistent care, no bed bath, clean sheets etc.

Ward Manager for Sky Ward responded:
To try and ensure that patient menus aren't forgotten about, we are going to introduce a system whereby on Thursdays the menus for pre op patients are taken to the pre op ward and completed there as this has been a previous issue. We have had recent study days on the ward with the staff and basic care has been highlighted as key area for development and staff are being reminded that this needs to happen.

PEWS (Paediatric Early Warning System)

Great Ormond Street Hospital for Children NHS Foundation Trust

Project aim:

To implement PEWS across all inpatient wards at GOSH by April 2018.

Project Initiation and Leadership:

Project Initiated in May 2017, currently led by Interim Chief Nurse (Polly Hodgson)

Background:

Professor Mark Peters presented research comparing the predictive performance of 18 paediatric track and trigger systems to the Out of Hours Steering Group in 2017. On the basis of the research, the Steering Group chaired by the Medical Director, recommended that the Trust change to PEWS.

THE PEWS TOOL

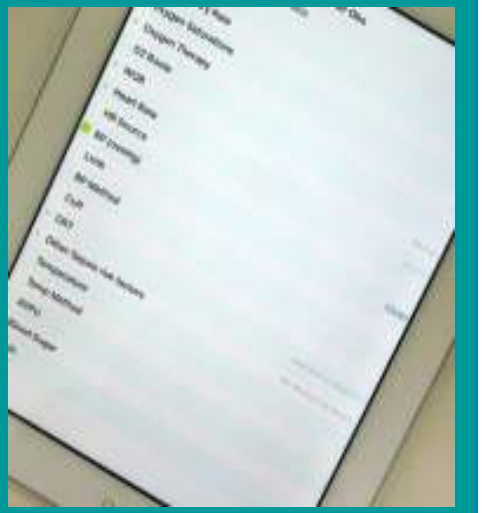
CEWS	PEWS
Temperature	X
Respiratory rate	✓
Sp02	✓
Heart rate	✓
Systolic blood pressure	✓
AVPU	X
	Oxygen
	Capillary Refill
	Work of Breathing
Additional Elements: (no score attached)	Sepsis Criteria Watcher Status

PEWS is a validated scoring system designed to identify potential deterioration in children and young people using a combination of factors such physiological findings, escalation responses and a strong communication framework.

- There are **7** PEWS parameters . All of which must be recorded **every time** an observation is required, for every patient.

There are Four Special Circumstance charts (Nervecentre);

1. **Non-acute monitoring -** For patients who do not require constant monitoring
2. **End of Life Care** – Observations to be agreed between the child's nursing / medical teams and with the child and family.
3. **PCA / NCA Chart** - For CYP on an NCA or PCA
4. **Doppler Chart** - This chart has BP split into systolic and diastolic pressure, with diastolic as a non-mandatory field



Measurements

- The 'Deteriorating Patient Dashboard' combines the measures for cardiac / respiratory arrests, 2222 calls and unplanned ICU transfers across the Trust, broken down by ward / location. http://qst/dashboards#/dashboards/dashboard/GetDashboards/125

Project Milestones

- 7th March 2018 — PEWS launch
- 26th March 2018 — Post PEWS implementation review
- 1st June 2018 — Project closure

Next Steps

• Continuing to embed the new scoring system within GOSH to support the detection and escalation of the deteriorating child.

• Listening to staff feedback regarding the recent Nervecentre and CareVue PEWS changes and making any appropriate adjustments.

• To conduct a post project review to identify any key learnings that could support future Trust -wide projects .

Are we responding and improving?

Quality Improvement Project Status Update (with Executive sponsorship)

Great Ormond Street Hospital for Children NHS Foundation Trust

Project	Project Aims	Project Leads	Project Timescales and Progress
Neonates	To improve the quality and safety of care within inpatient neonates/ small infants* at GOSH by January 2018[*<28 days or 4kg]	Executive Sponsor- **Chief Nurse** Nursing Lead- **Neonatal Nurse Advisor** Medical Lead- **Head of Clinical Service**	Progress to date: • Project closure and sustainability recommendations due to be presented at February QIC
PEWS	To replace the Children's Early Warning System (CEWS) with the Paediatric Early Warning System (PEWS) for wards across GOSH by January 2018	Executive Sponsor- **Chief Nurse** Medical Lead- **Consultant Intensivist** Nursing Lead- **Clinical Site Practitioner**	Progress to date: • PEWS is set go live on 7th March 2018 • Nervecentre have completed the configuration of PEWS into the test system – currently with GOSH for software testing. • Clinical testing is due to be signed off Friday 23rd February • CareVue have completed the changes required to enable PEWS scores to be calculated and flagged as per the algorithm. • Sepsis alerts have been added to both systems, but there will be no automatic alert from the calculations – clinicians will need to observe for amber and red flags and escalate accordingly. • PEWS Nursing Education package currently being rolled out • The PEWS communication strategy being rolled out • GOLD Training has been updated

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	To enable clinicians to start all young people a Transition Plan by the age of 14 in line with NICE recommendations 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: • Growing Up, Gaining Independence (GUGI) programme developed and being presented to teams to ensure works with all specialties • SOPs developed for 4 main outcome pathways • Link between PiMS and eCOF in test phase • Developing/refining process for Medical Director/Chief Nurse approval to accept referral/admit patient ≥ 16 yrs • Audit of ages of subspecialties are transferring majority of patients to adolescent, adult or Primary Care services to be repeated due to lack of engagement Next steps: Currently under development : • Getting feedback on YP/parent/carer information produced • 1st session to film YP for information videos 22.2.18 (joint project with NHSE) • Letter templates for over 16s (as part of OPD Improvement)
Extravasation	To reduce the incidence of extravasation injury at GOSH by 31st July 2018	Executive Sponsor- **Chief Nurse** Clinical Lead- **Consultant Anaesthetist**	Progress to date: • VHP Framework & Tool - now in use on Eagle, Bumblebee, Koala, Bear, Walrus, Butterfly, Giraffe, Lion, Hedgehog wards. • Implementation plan developed for roll out Trust-wide by July 2018 • Adaptions made to Arezzo and Endoscopy Care Pathway to incorporate vein grade and cannulation attempts information. • Completed testing phase of 'new' IV record chart, incorporating sticker elements - going to IP&C Committee for final sign off. • Training video incorporated into IV Study Day & Cannulation/ Venepunture Course • Planning underway for awareness event in May 2018. • Comparison work underway between plastics referrals and Datix. • Development underway of VAF system to log referrals to VAF team and enable prioritization and oversight from CSP team. • Acyclovir study now supported by QI data analyst using data from EP.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **28th March 2018**	
Integrated Performance Report: March 2018 **(Reporting Month 10 & 11 2017/18)** **Submitted by:** Nicola Grinstead, Deputy Chief Executive	**Paper No: Attachment K**

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

Great Ormond Street Hospital for Children NHS Foundation Trust

Integrated Performance Report

Nicola Grinstead, Deputy CEO

March 2018

(Month 10 & 11 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

December 2017 (Month 9 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, Month 11 (February 2018) data was available, with key national submissions deadlines being met and data 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 positive recommendation responses for those undertaking the Inpatient FFT (97.39% in January and 95.68% in February)

- The rate (%) of those responding (for Inpatients) has seen fluctuation over the last six months with average response rate of 23.04%, and January performance at 25.11% and February 23.24%. There remains variability across the three Divisions and the wards. The IPP division returned to compliance in January, and sustained performance in February at 56.9%. The West division has improved from the December position of 19.60%, however, not sustained the performance seen in January (24.83%) with February being 21.15%. Barrie division has continued to improve its position since December (24.02%), achieving 25.53% and 26.30% in January and February respectively. An action plan is in place in both divisions to improve the response rate. Following the discussion regarding the target response rate being reviewed to assess if it can be more in line with other Trusts and Peers it has been agreed that a target will be set for non-frequent flyer wards and frequent flyer wards shown separately.

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 serious incidents reported in January and February. The YTD positions are:

- Serious Incidents = 12
- Never Events = 2

Further detail is provided in the Quality and Safety report.

Healthcare Associated Infections (HCAIs)

Incidents of C. Difficile

The Trust has reported five additional incidents of C Diff during January (one) and February (four), taking the Trust YTD position to 18 (at M11). Eleven out of the eighteen cases of C Diff were trust acquired i.e. they occurred on or after the fourth day of the patients' admission. At this time, none of these have been found to have resulted in lapses of care, and these will be reviewed with Commissioners. The Trust's total allowance for 2017/18 is 15 cases, as set nationally.

Incidents of MRSA

The Trust reported one incident of MRSA in January on Butterfly ward, and RCA is being produced and further details will be provided in the Quality & Safety Report. It should be noted that three cases were reported in 2016/17.

CV Line Infections

The Trust has improved compliance against the standard in January and February (1.27 and 1.38 respectively against 1.6 per 1000 line days). All incidents have or will be investigated by the lead nursing staff with involvement from the Infection Control team. As per the Quality & Safety report, the ongoing trend / position over time is within expected levels showing no sustained outlying behaviour.

WHO Surgical Checklist Completion (> 98%)

The Trust continues to not deliver against the 98% standard as seen from November (97.45%) compliance in January and February was 97.81% and 93.33%, respectively. Work continues within divisions to understand reasons as to why checklists aren't fully completed for some specialties.

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

The Trust reported one grade 3 pressure ulcer in February, which occurred in Sky ward. An RCA is being completed to understand why this occurred.

Responsive

Great Ormond Street Hospital for Children NHS Foundation Trust

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

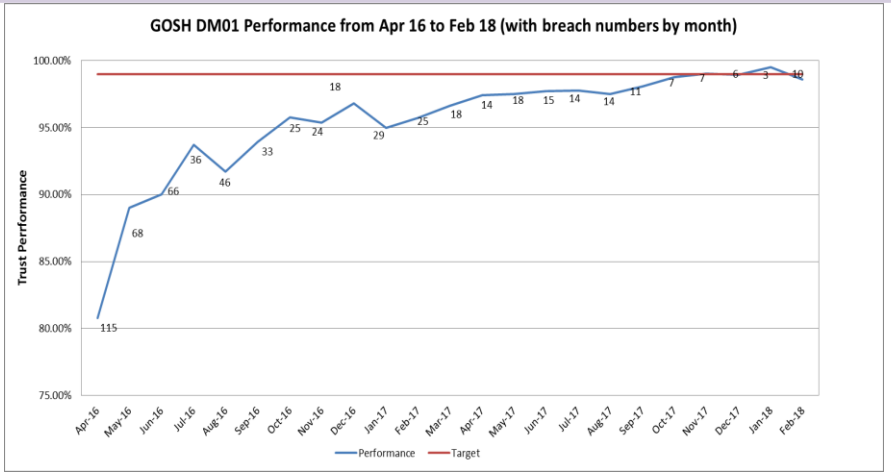
In February, the Trust underachieved against the standard of 99% for patients accessing the 15 diagnostic modalities within 6 weeks of referral / request at 98.60%. Unfortunately, the Trust was unable to sustain the performance in January having achieved 99.51%, which illustrates the volatility in the denominator and breach numbers. Despite the Trust aiming to continue to reduce the number of patients waiting in excess of 6 weeks, February has seen an increase to ten patients.

As shown in the table opposite, the overall number of breaches for February was ten (increase of seven from January). Breaches occurred in MRI (4), Non Obstetric Ultrasound (5) and CT (1).

Five of the ten breaches could potentially have been prevented: four breaches were due to process / booking issues and one remaining breach occurred due to delay in request form. Three breaches occurred due to failed sedation and two patients are only the BBS highly specialised pathway that has limited capacity.

The breach reasons are currently undergoing a deep dive and any resulting actions will be addressed by the services.

Contextually when comparing GOSH with other Children's Trusts or other London tertiary / specialist providers, the Trust is not an outlier with differential levels of performance. Nationally out of 362 providers reporting against the standard (NHS and Independent sector) 261 in January were delivering 99% or better (it must be noted that 98 of these trusts reported a waiting list of less than 100 and a number are also providers just offering certain specific diagnostics, rather than a full range). 31 providers reported 98-99%, 16 at 97-98%) and 54 reported <97%.



Diagnostic Test	Breach	No Breach	Grand Total	Performance
Audiology - Audiology Assessments		34	34	100.00%
Barium Enema		9	9	100.00%
Colonoscopy		2	2	100.00%
Computed Tomography	1	62	63	98.41%
Cystoscopy		6	6	100.00%
DEXA Scan		12	12	100.00%
Gastroscopy		27	27	100.00%
Magnetic Resonance Imaging	4	246	250	98.40%
Neurophysiology - peripheral neurophysiology		37	37	100.00%
Non-obstetric ultrasound	5	154	159	96.86%
Respiratory physiology - sleep studies		91	91	100.00%
Urodynamics - pressures & flows		23	23	100.00%
Grand Total	**10**	**703**	**713**	**98.60%**

Cancer Wait Times

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

Responsive

Great Ormond Street Hospital for Children NHS Foundation Trust

Referral to Treatment Time (incomplete standard > 92%) – February 2018

For the months of January and February the Trust has met the RTT 92% standard submitting performance of 92.96% and 93.54% respectively. January was the first time since returning to reporting that the Trust has met the standard. Significant improvements have been made across a number of specialties with Orthopaedics, ENT and Neurology meeting 92% standard. Specialties which continue not to meet the standard are Plastic Surgery (sub-specialisation within the service), SNAPS (bed capacity) and Urology (complex patients and capacity).

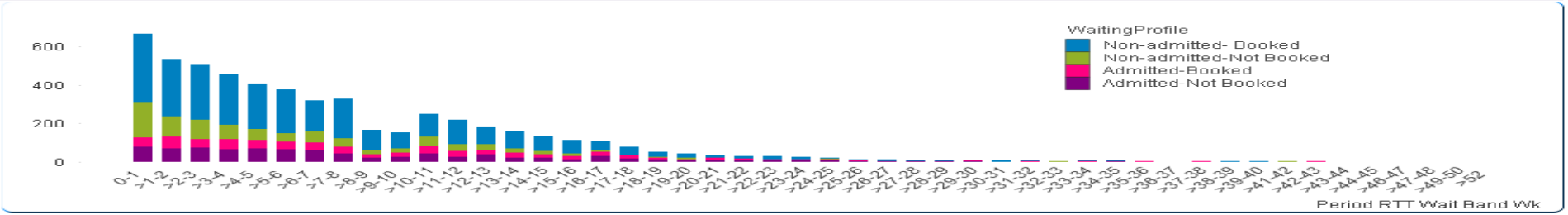
Revised improvement trajectories have been submitted by specialty and these continue to be monitored weekly via the Deputy Chief Exec led Weekly RTT Meeting which is attended by Director of Operations, General Managers, Heads of Clinical Service and Performance Team. The meeting enables in depth discussion to be undertaken on challenged specialties, early warning of potential risks to delivery and plans in place to meet the agreed trajectory.

The number of patients waiting 40 weeks+ has further decreased since the start of the financial year. We reported 43 patients waiting over 40 weeks in April and in February, there were 13 patients waiting over 40 weeks.

Contextually when comparing GOSH with other Children's Trusts or other London tertiary / specialist providers, the Trust is not an outlier with differential levels of performance. Nationally out of 145 providers reporting against the standard (NHS Trusts only) 53 in January were delivering 92% or better. 22 providers reported 90-92%, 62 at 80-90% and 8 reported <80%.

Nationally, GOSH is ranked as the 26th best performing Trust out of 145 providers. In London, GOSH is the 7th best performing Trust out of 21 Providers reporting RTT performance.

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.



The Trust reported three waiting 52+ weeks in January 2018, two of the three patients have been treated during February. One 52+ week wait will be reported at the end of February 2018, a Urology patient who has a treatment date in March. A full RCA and action plan has been developed by the division to mitigate any future instances of this error.

Unknown clocks starts:

The number of pathways with an unknown clock start (i.e. referred to the Trust without confirming the start date of the pathway) has decreased in January and February, in comparison to what we reported in December. Divisions have been asked to further push in engaging with referring Trusts and escalate where necessary.

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 January 2018, the trust reported an improvement in performance in this area. There were 41 last minute non-clinical hospital cancelled operations, compared to 54 in December 2017, and 69 in November 2017. The areas contributing most to this are Radiology, Cardiac Surgery, Dermatology, General Surgery and ENT. Some of the reasons for cancellations were theatre lists overrunning, and cancellations due to emergency patients.

The Trust reported a deterioration in rebooking last minute cancelled operations within 28 days of the cancellation, 14 (compared to 11 in December 2017 and 9 in November 2017). There are plans to set up a joint working group for both divisions on cancelled operations where processes around cancelling and rebooking operations will be reviewed.

Well-Led

Great Ormond Street Hospital for Children NHS Foundation Trust

Workforce Headlines

- **Contractual staff in post:** Substantive staff in post reduced to 4458.29 FTE (full-time equivalent) in February. This is 342.2FTE (8.3%) higher than the same month last year.
- **Unfilled vacancy rate:** The Trust's unfilled vacancy rate has reduced to 2.63% from 4.6% in December. The vacancy rate remains below target and lower than February (8.5%)
- **Turnover** is reported as voluntary turnover in addition to the standard total turnover. Voluntary turnover currently stands below target at 13.9%; this reported value excludes non-voluntary forms of leavers. Total (voluntary and non-voluntary) turnover reduced further to 17.4%, which is below target and is lower than the same month last year (18.8%)
- **Agency usage** for 2017/18 (year to date) stands at 1.8% of total paybill, which is below the local stretch target, as well as below the NHS I target for GOSH 2017/18 of 3% (£6.5 million). Spend is also well below the same month last year (3.78%). The Trust has established a Better Value Scheme scrutinising all agency spend.
- **Statutory & Mandatory training compliance:** In February the compliance across the Trust was 90%. Currently, three directorates/divisions are not meeting the in-year 90% compliance requirement.
- **Sickness absence** remains below target at 2.3% and below the London average figure of 2.8%. During 2018, the Trust will implement an integrated rostering system. The system will support improvements in the accuracy of absence reporting, which may lead to fluctuations in reported rates.
- **Appraisal/PDR completion** The non-medical appraisal rate has reduced to 88% which is below the Trust target, however the Trust continues to benchmark well and is above it's long term average. Consultant appraisal rates have increased in recent months and now stands at 87%.

Well-Led

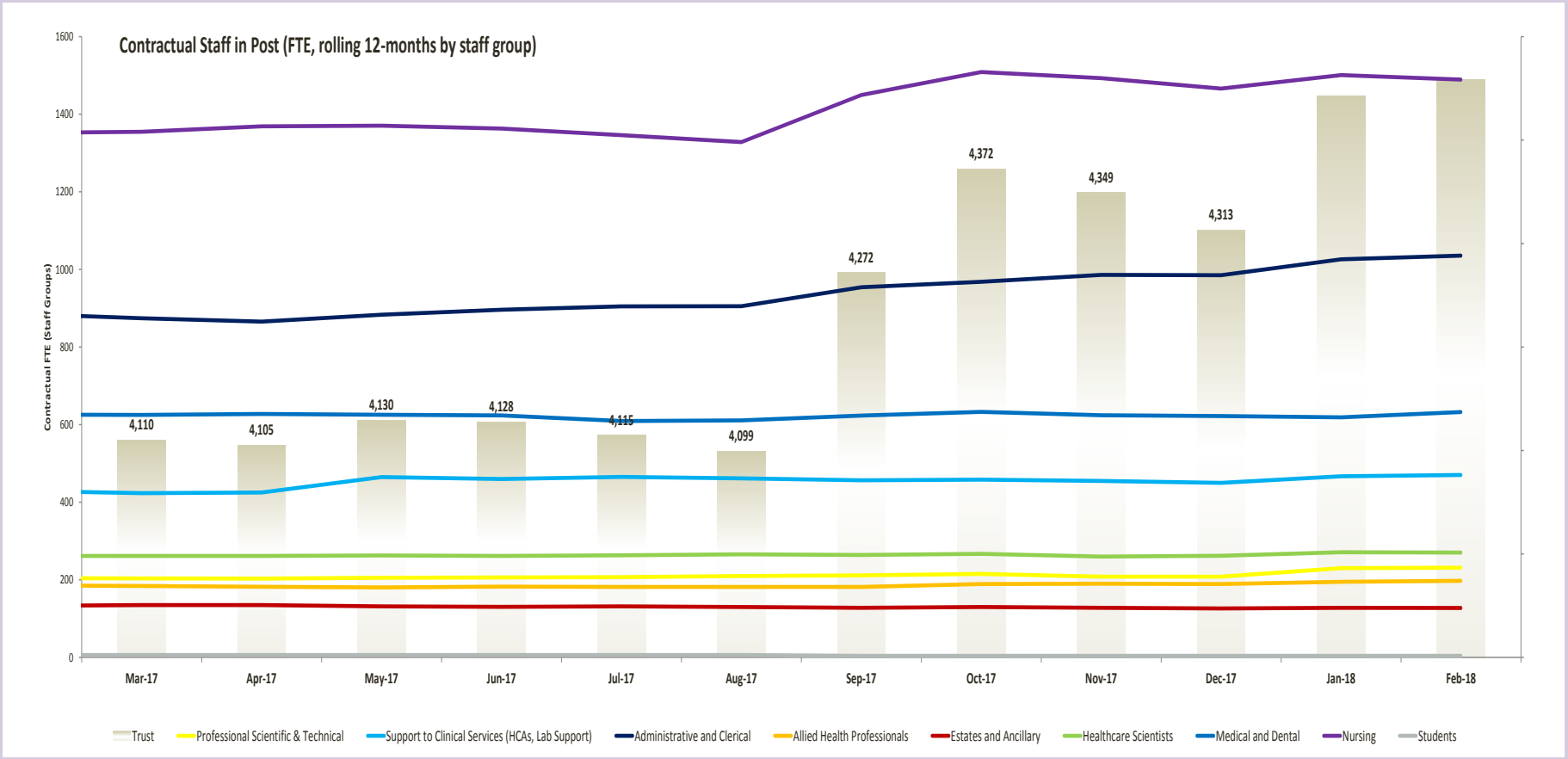
Great Ormond Street Hospital for Children NHS Foundation Trust

Trust KPI performance February 2018

Metric	Plan	Feb 2018	3m average	12m average
Voluntary Turnover	14%	13.9%	14.1%	15.0%
Total Turnover	18%	17.4%	17.7%	18.4%
Sickness (12m)	3%	2.3%	2.3%	2.3%
Vacancy	10%	2.6%	3.4%	6.2%
Agency spend	2%	1.8%	1.8%	2.3%
PDR %	90%	88%	89%	88%
Statutory & Mandatory training	90%	90%	90%	90%

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

Substantive staff in post by staff group



Workforce: Highlights & Actions

Sickness %

- Monthly sickness absence reports distributed to managers from the HR Advisors to encourage a proactive approach to managing sickness absence.
- Regular meetings are held with Ward Sisters, service leads and departmental managers to discuss and provide support for sickness absence management.
- Health and wellbeing; a number of initiatives have been launched in order to support employees at work such as mental health awareness and healthy activities. Nutrition and Hydration week at GOSH is taking place between 12th – 16th March 2018;
- HRBP working with management teams in Finance and ICT to ensure sickness absence is being logged using the correct system so reporting can be accurate.

Voluntary Turnover Rate

- There has been a significant amount of work undertaken to better understand the broader turnover position - with specific focus on areas of low stability and high turnover. There have been developments in also understanding the reasons why people leave and where they go. In addition, the work around nurse recruitment and retention is now a focused project under the Nursing Workforce Programme Board.
- Developing B5s into vacant B6 roles helps to decrease turnover of B5s
- All Nurses within R&I on fixed term contracts have been transitioned over to permanent contracts to support retention of Nurses

Workforce: Highlights & Actions

Agency Spend

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

PDR Completion

- PDR rates now regularly reported and accessible via the intranet with continued reminders to individuals and line managers
- Simplifying the reporting process of PDRs has supported managers in working towards their PDR targets.
- HRBPs are continuing to support managers in identifying the PDRs that are required for completion, this includes consultant appraisals.
- PDR rates are a rolling agenda item for Performance Meetings within the Divisions / Directorates.

Statutory & Mandatory Training Compliance

- Improved visibility through LMS - staff encouraged to check their own records on GOLD
- Learning and Development & ER team work with managers to identify those who are non-compliant including further developments to the Trust GOLD LMS
- Simplicity in reporting process to improve compliance
- StatMan rates are a rolling agenda item for Performance Meetings within the Divisions / Directorates.

Effective

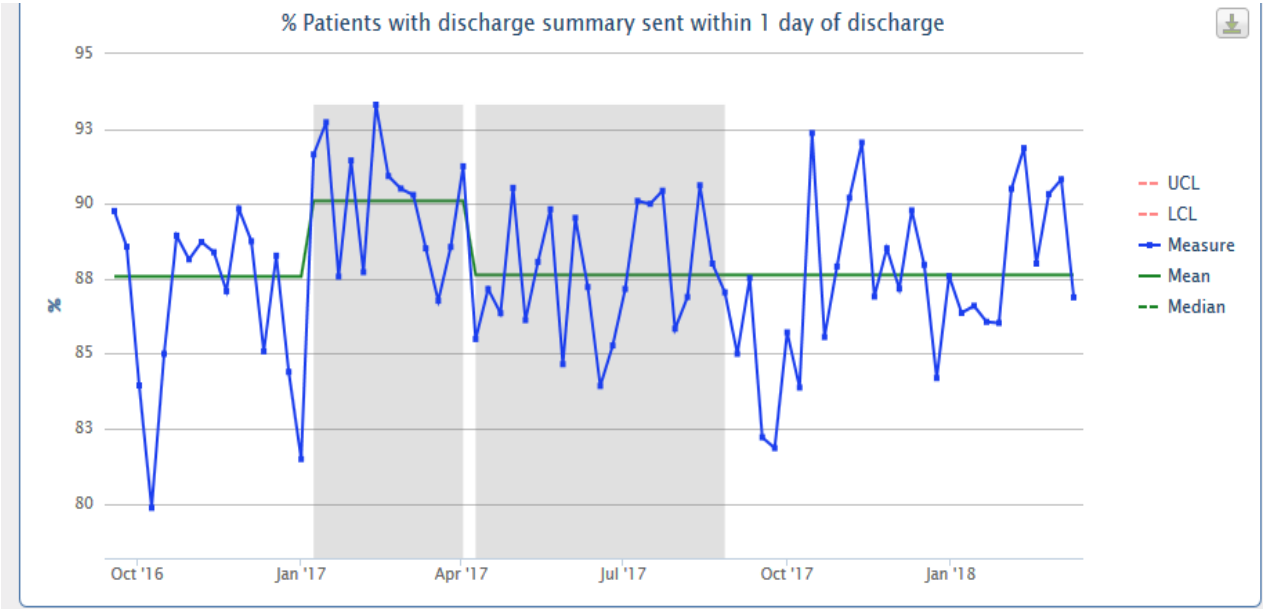
Great Ormond Street Hospital for Children NHS Foundation Trust

Discharge Summaries

As is evident from the SPC chart and the dashboard, performance in this area continues to fluctuate. For January and February 2018, the position was 87.00% and 89.26% sent within 24hrs of discharge, which is a slight improvement from December's performance. As per definitions of this metrics, the expectation for the Trust is to send all discharge summaries within 24 hours.

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

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



Clinic Letter Turnaround times

For January (as this indicator is reported a month in arrears), there has been some deterioration in performance in relation to 14 day turnaround, 72.2% from 74.0% in December. For those sent within 7 working days, performance has also deteriorated, 42.5% from 43.2% in December. As with the above, specific specialties are being targeted by the service management teams to ensure turnaround is improved. Some of the actions in place in divisions include weekly reminders for clinical teams to sign of letters, providing remote access to clinicians so they can sign off letters electronically, create and administer a robust monitoring system for administrators to be used on a weekly basis to check the upload and downloading of letters, weekly reminders for clinical team to sign off letters and extra admin time to work through the backlog of letters in specific areas.

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.

The identification of the data anomaly reported in January has now been rectified. Utilisation of main theatres has dropped in February to 67.6% from 70.6% (January). Contributing factors to the decrease in utilisation are the adverse weather conditions seen in February, along with a high number of procedures cancelled on the day due to contraindication. JM Barrie division has maintained 70% utilisation across both months, whilst Charles West has seen a dip in performance to 57.4% (February) from 61.1% (January). Particularly affected specialties are Craniofacial (57.6%), Urology (67.3%), Cardiology (47.6%) and Cardiac Surgery (57.1%).

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 periods of January and February occupancy has increased from the previous levels to 84.8% and 84.6% respectively, this is expected following the Christmas and New Year period.
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.

Bed closures: There has been a significant increase in the average number of beds closed in February (20) compared to 14 in January. This was mainly due to staffing shortages, Norovirus outbreak on Rainforest for 4 days with 3 beds closed per day and emergency works. Sky, Fox, Mildred Creek and Robin wards have had bed closures for the whole of February.

Productivity

Great Ormond Street Hospital for Children NHS Foundation Trust

PICU Metrics

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

PICU/NICU Refusals: The number of CATS referral refusals into PICU/NICU from other providers during February has decreased to seven from a January position of nineteen. The YTD position for refusals during 17/18 is 172 compared 238 in 16/17, a reduction of 66 (-27%) refusals.

PICU Delayed Discharges: Delayed discharges over 8 hours from PICU can demonstrate the challenges being faced internally and externally with regards to capacity issues on accessing beds. February saw an improvement in the total number of delays with 19 reported compared to 35 in January. Over the last 5 months 47% of patients have been delayed due to accessing another Provider, and 53% accessing a bed internally within the hospital.

PICU Emergency Readmissions: Readmissions back into PICU within 48 hours remains low with only 1 patient in February and zero patients in January. This indicator illustrates patients being safely discharged from the unit by the clinical teams.

Activity

YTD activity across day case discharges, overnight discharges, outpatient attendances critical care bed days are below the same reporting period for last year (i.e. up to M11). Further details will be provided within the Finance Report.

Long stay patients: This looks at any patient discharged that month with a length of stay (LOS) greater than 100 days, and the combined number of days in the hospital. For February, the Trust had nine patients discharged that had amassed a combined LOS of 1656 days. Most of the long stay patients were Bone Marrow Transplant patients. As reported previously, the West division looked at a sample of patients who had an excess stay of > 100 days, and found the reasons for their stay were clinically appropriate due to many having complex conditions and comorbidities warranting that LOS.

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 February 2018 (Month 11). In line with the figures presented, the Trust has a YTD surplus of £0.2m which is £0.4m ahead of plan. The Trust is currently £0.3m ahead of the control total.

- Clinical Income (exc. International Private Patients and Pass through Income) is £4.8m higher than plan
- Non Clinical revenue is £4.0m higher than plan
- Private Patients income is £3.0m lower than plan
- Staff costs are £1.8m higher than plan
- Non-pay costs (excluding pass-through costs) are £6.3m higher than plan

Appendices

Appendix I – Integrated Performance Dashboard

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

Appendix II – 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.

Appendix III – Definitions

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

Trust Board Dashboard - February 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

Caring

		Dec	Jan	Feb	Trend	Plan	NHS Standard
Access to Healthcare for people with Learning Disability					→		
% Positive Response Friends & Family Test: Inpatients		95.48%	97.39%	95.68%	↓		95%
Response Rate Friends & Family Test: Inpatients		21.95%	25.11%	23.24%	↓	40%	
% Positive Response Friends & Family Test: Outpatients		95.14%	93.72%	92.40%	↓		95%
Mental Health Identifiers: Data Completeness		99.11%	99.19%	99.16%	↓		97%

Safe

			Dec	Jan	Feb	Trend	Plan	NHS Standard
Serious Patient Safety Incidents		In-month	2	0	0	→		
		YTD	12	12	12	→		
Never Events		In-month	0	0	0	→		0
		YTD	2	2	2	→		0
Incidents of C. Difficile		In-month	0	1	4	↓		
		YTD	13	14	18	-		
C.Difficile due to Lapses of Care		In-month	0	0	0	→		
		YTD	0	0	0	→		15
Incidents of MRSA		In-month	0	1	0	↑		0
		YTD	0	1	1	→		0
CV Line Infection Rate (per 1,000 line days)			1.78	1.27	1.38	↓	1.6	
WHO Checklist Completion			95.87%	97.81%	93.33%	↓	98%	
Arrests Outside of ICU	Cardiac Arrests		3	2	2	→	5	
	Respiratory Arrests		3	2	1	↑		
Total hospital acquired pressure / device related ulcer rates grade 3 & above			1	0	1	↓	0	

Responsive

		Dec	Jan	Feb	Trend	Plan	NHS Standard
Diagnostics: Patients Waiting <6 Weeks		98.93%	99.51%	98.60%	↓		99%
Cancer 31 Day: Referral to First Treatment							85%
Cancer 31 Day: Decision to Treat to First Treatment		100%	100%	TBC	→		96%
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Surgery		100%	100%	TBC	→		94%
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Drugs		100%	100%	TBC	→		98%
Cancer 62 day: Consultant Upgrade of Urgency of a referral to first treatment		100%	100%		→		
Last Minute Non-Clinical Hospital Cancelled Operations		54	40		↑		
Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard		11	14		↓		0
Same day / day before hospital cancelled outpatient appointments		1.30%	1.09%	1.37%	↓		
RTT: Incomplete Pathways (National Reporting)		90.75%	92.96%	93.53%	↑		92%
RTT: Number of Incomplete Pathways (National Reporting)	<18wks	4992	5127	5154	↑		-
	>18wks	509	388	356	↑		-
RTT: Incomplete Pathways >52 Weeks - Validated		1	3	1	↑		0
RTT: Incomplete Pathways >40 Weeks - Validated		31	22	14	↑		0
Number of unknown RTT clock starts	Internal Referrals	1	2	0	↑		-
	External Referrals	1005	941	842	↑		-
RTT: Total Number of Incomplete Pathways Known/Unknown	<18 weeks	5970	6063	5986	↓		-
	>18 weeks	537	395	366	↑		-

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

		Dec	Jan	Feb	Trend	Plan	NHS Standard
Sickness Rate		2.25%	2.30%	2.28%	↑	3%	
Turnover	Total	18.2%	17.6%	17.4%	↑	18%	
	Voluntary	14.5%	13.8%	13.9%	↓	14%	
Appraisal Rate		90%	90%	88%	↓	90%	
	Consultant	80%	85%	87%	↑		
Mandatory Training		91%	90%	90%	↑	90%	
% Staff Recommending the Trust as a Place to Work: Friends & Family Test						61%	
Vacancy Rate	Contractual	4.6%	3.1%	2.6%	↑	10%	
	Nursing	1.1%	1.1%	1.1%	→		
Bank Spend		5.9%	5.9%	5.9%	↓		
Agency Spend		1.89%	1.85%	0.21%	↑	2%	

Effective

		Dec	Jan	Feb	Trend	Plan	NHS Standard
Discharge Summary Turnaround within 24hrs		86.83%	87.00%	89.26%	↑		100%
Clinic Letter Turnaround within	7 working days	43.18%	42.54%				
	14 working days	73.99%	72.16%		↓	100%	
Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)		8.18%	8.34%	7.32%	↑	8.36%	

Productivity

			Dec	Jan	Feb	Trend	Plan	NHS Standard
Main Theatres	Theatre Utilisation		66.3%	70.6%	67.6%	↓		77%
	No. of theatres		14	14	14			
Outside Theatres	Theatre Utilisation		53.7%	57.6%	54.2%	↓		77%
	No. of theatres		7	7	7			
Trust Beds	Bed Occupancy		80.3%	84.8%	84.6%	↓		
	Number of available beds		412	411	406	↓		
Average number of trust beds closed		Wards	13.8	14.7	20.2	↓		
		ICU	1.9	0.5	1.3	↓		
Refused Admissions	Cardiac refusals		7	6	7	↓		
	PICU / NICU refusals		36	19	7	↑		
Number of PICU Delayed Discharges	Internal 8 - 24 hours		4	6	7	↓		
	Internal 24 hours+		3	17	6	↑		
	External 8 - 24 hours		6	4	1	↑		
	External 24 hours+		14	8	5	↑		
	Total 8 - 24 hours		10	10	8	↑		
	Total 24 hours+		17	25	11	↑		
PICU Emergency Readmissions < 48 hours			1	0	1	↓		

Activity

			Dec	Jan	Feb	Trend	Plan	NHS Standard
Daycase Discharges (YOY comparison)		In-month	1,889	2,319	1,978	↓	1,949	
		YTD	18,534	20,853	22,841		24,729	
Overnight Discharges (YOY comparison)		In-month	1,381	1,457	1,390	↓	1,355	
		YTD	13,190	14,647	15,854		16,884	
Critical Care Beddays (YOY comparison)		In-month	1,082	1,113	1,004	↓	990	
		YTD	9,664	10,777	11,770		12,467	
Bed Days >=100 Days	No. of patients		5	2	9	↓		
	No. of beddays		737	268	1,656	↓		
Outpatient Attendances (All) (YOY comparison)		In-month	17,811	22,688	19,701	↓	21,167	
		YTD	190,557	213,245	234,145		253,717	

Our Money

	Dec	Jan	Feb	Trend	YTD Target	YTD Variance
Net Surplus/(Deficit) v Plan	2.3	0.3	(1.8)	↓	1.7	0.3
Forecast Outturn v Plan	1.9	0.4	0.0	↓	0.2	0.2
Better value	1.3	1.3	1.2	↓	12.6	0.0
Pay Worked WTE Variance to Plan						
Debtor Days (IPP)	216	219	205	↑	120	(85.0)
Quick Ratio (Liquidity)	1.70	1.70	1.70	→	1.60	0.1
NHS KPI Metrics	1.0	1.0	1.0	→	1.0	0.0

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	65	66.3%	33	33.7%	0	0.0%	14	3	21%	4	29%
People, Management & Culture: Well-Led	Ali Mohammed	63	45	71.4%	9	14.3%	9	14.3%	5	0	0%	0	0%
Effective	Nicola Grinstead	28	16	57.1%	12	42.9%	0	0.0%	4	0	0%	4	100%
Productivity	Nicola Grinstead	98	65	66.3%	33	33.7%	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	335	73.6%	90	19.8%	30	6.6%	40	9	23%	21	53%

*To be reviewed December 2017

Domain	Metric	Accuracy	Validity	Reliability	Timeliness	Relevance		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	2	2	1	1	2	1	Y	Y	On-going through DQ Dashboard
Responsive	RTT: Incomplete Pathways >52 Weeks (Unvalidated)	2	2	2	1	1	2	1	Y	Y	On-going through DQ Dashboard
Responsive	RTT: Incomplete Pathways	2	1	2	1	1	2	1	Y	Y	On-going through DQ Dashboard
Responsive	RTT: Number of Incomplete Pathways (Over 18 Weeks)	2	1	2	1	1	1	1	Y	Y	On-going through DQ Dashboard
Responsive	RTT: Number of Incomplete Pathways (Under 18 Weeks)	2	1	2	1	1	1	1	Y	Y	On-going through DQ Dashboard
Responsive	Number of unknown RTT clock starts (Internal Referrals)	1	1	2	1	1	1	1	Y	Y	On-going audits
Responsive	Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard	1	1	2	1	2	2	2	Y	N	
Responsive	Number of unknown RTT clock starts (External Referrals)	1	1	2	1	1	1	1	Y	Y	On-going audits
Responsive	Same day / day before hospital cancelled appointments	1	1	1	1	1	2	1	Y	Y	Audits not yet started
Responsive	Diagnostics: Patients Waiting >6 Weeks	1	1	1	1	1	2	1	Y	N	
Responsive	Cancer 31 Day: Decision to Treat to First Treatment	2	1	2	1	1	1	1	Y	Y	Audits not yet started
Responsive	Cancer 31 Day: Decision to Treat to Subsequent Treatment - Surgery	2	1	2	1	1	1	1	Y	Y	Audits not yet started
Responsive	Cancer 31 Day: Decision to Treat to Subsequent Treatment - Drugs	2	1	2	1	1	1	1	Y	Y	Audits not yet started
Responsive	Last Minute Non-Clinical Hospital Cancelled Operations	1	1	2	1	2	2	2	Y	N	
People, Management & Culture: Well-Led	Sickness Rate	2	2	1	1	1	3	1	Y	Y	01-Jul-18
People, Management & Culture: Well-Led	Turnover - Total	1	1	1	1	1	3	1	NK	NK	
People, Management & Culture: Well-Led	Turnover - Voluntary	1	1	1	1	1	3	1	NK	NK	
People, Management & Culture: Well-Led	Appraisal Rate	2	1	1	2	1	3	1	Y	Y	01-Jul-18
People, Management & Culture: Well-Led	Mandatory Training	1	1	1	1	1	3	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	3	1	NK	NK	
People, Management & Culture: Well-Led	Vacancy Rate	2	1	1	1	1	3	1	Y	Y	31-Mar-18
People, Management & Culture: Well-Led	Bank Spend	2	1	1	2	1	3	1	Y	Y	01-Jul-18
People, Management & Culture: Well-Led	Agency Spend	2	1	1	2	1	3	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	1	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	2	2	1	2	2	2	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	2	2	1	2	2	2	Y	Y	31-Jul-17
Productivity	Bed Occupancy	1	2	2	1	2	2	2	Y	Y	31-Jul-17
Productivity	Number of Beds	2	1	2	1	1	1	1	Y	Y	31-Aug-17
Productivity	Cardiac Refusals	1	1	2	1	1	1	1	Y	N	
Productivity	PICU/NICU Refusals	1	1	2	1	1	1	1	Y	N	
Our Money	Net Surplus/(Deficit) v Plan	1	1	1	1	1	1	1	N	N/A	N/A
Our Money	Forecast Outturn v Plan	1	1	1	1	1	1	1	N	N/A	N/A
Our Money	P&E Delivery	1	1	1	1	1	1	1	N	N/A	N/A
Our Money	Pay Worked WTE Variance to Plan	2	1	1	1	1	1	1	Y	Y	01-Apr-17
Our Money	Debtor Days (IPP)	1	1	1	1	1	1	1	N	N/A	N/A
Our Money	Quick Ratio (Liquidity)	1	1	1	1	1	1	1	N	N/A	N/A
Our Money	NHS KPI Metrics	1	1	1	1	1	1	1	N	N/A	N/A

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
28th March 2018

Trust Finance Position - Month 11, 2017/18 **Submitted by:** Helen Jameson, Interim Chief Finance Officer	**Paper No: Attachment L**

Purpose
The purpose of this paper is to report the Trust Financial Position as at the end of February 2018 (Month 11).

Financial Position – Summary points
In February 2018 there was a net deficit (before capital donations and impairments) of £1.8 million which is £0.1 million better than plan, which has in part been due to a number of non-recurrent benefits on non-pay including anticipated rebates associated with energy charges incurred in year. The year to date position is a net surplus of £0.2 million, which is £0.4 million better than plan

As at month 9 the Trust's forecast outturn position was a £1.8m surplus. This has been reviewed at both month 10 and 11 to ensure it reflects the latest run rate. As a consequence of this it has been revised down due to lower than expected activity within IPP across the Trust and some slippage within clinical divisions. The Trust is still expecting to hit its control total.

At the end of Month 11, NHS income (excluding pass through) is 1.9% (£4.8 million) ahead of plan which is due in part to a more complex case mix and the new tariff and activity being above plan in a number of areas. Though NHS income remains strong, the position on IPP income has deteriorated in Month 10 and 11, therefore reducing the overall forecast across the Trust.

Pay expenditure is worse than plan by £0.4 million in month and £1.8m year to date, due to the increased workforce costs associated with PICB including some double running costs associated with opening up the new capacity. Additionally, a number of targets for Better Value were allocated to pay lines within budget setting and delivery against the overall programme has meant that this is achieved within other areas causing some of the overspends on pay.

Non-pay expenditure is on budget in month and £2.4 million overspent YTD (both excluding pass through) due to the IPP Debt provision, CIP not being delivered exactly in line with the profile set out within the budget and activity related pressures in certain areas. There have been concerns raised previously that there has been a degree of 'stocking up' associated with opening up PICB. Yearend stock counts have now begun, and any additional stock will be included as inventories, thereby potentially reducing the in year spend.

Year to date income for capital donations is now £41.6 million less than plan due to lower capital expenditure on donated assets associated with the redevelopment project, medical equipment programme and ICT. Depreciation, Interest and PDC is lower than plan by £2.4m, due in part to the capital slippage detailed above. This continues to support the Trust's overall bottom line.

The better value programme remains under delivered at Month 11 due principally to slippage across a number of cross cutting schemes though is offset by the favourable variances set out above, principally income over delivery driven in part by the new tariff within HRG4+.

The performance against the control total (which excludes capital donations and depreciation from charitable funded assets) year to date was in line with plan it is forecast that the Trust will achieve the control total .

Financial Forecast – Summary points

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

Division	Forecast	Notes
Charles West	£3.1m	Predominantly achieved through over delivery of income within cardiac, haematology and across IPP. Activity remains favourable to plan, predominantly in high margin areas and within IPP, initial strong delivery ensures that Charles West's income position remains favourable to plan for the year.
JM Barrie	(£13.1m)	JM Barrie's position has deteriorated significantly from the previous forecast; this is predominantly due to pressures in delivering NHS income within PICU and Spinal, along with continued under performance of PICU / NICU activity.
IPP	(£4.8m)	The IPP division has revised down its forecast; as activity and income has been below plan in January and February. There are a number of complex cases anticipated within the division in the second half of March ensuring there financial position is in line with budget in Month 12.
R&I	£0.9m	R&I remains in line with prior forecasts.
Corporate and Central	£13.7m	The forecast position has been improved from the previous forecast due in principle to delivery of QIPP schemes against plan which are held centrally, the release of unused provisions and the release of a number of aged accruals relating to historic maintenance contracts.

Other Key Financial Indicators at Month 11

Indicator	Comment
NHSI Financial Rating	All KPI ratings are Green.
Cash	The closing cash balance was £59.9m, £13.1 higher than the previous month. This includes £10.1m received from GOSH Charity; £5.8 received for various IPP debtors; £2.0m received for over-performance invoices and £4.4m paid to Epic for the EPR project.
NHS Debtor Days	NHS Debtor days decreased in month to 12 days, which remains within target. This is mainly due to the reduction of NHS debtors in month. The Trust received circa £2.0m in respect of over-performance invoices from NHSE; in addition, there was a reduction in activity for the period.
IPP Debtor Days	IPP debtor days decreased in month from 219 days to 205 days; this was predominantly due to the settlement of a number of invoices relating to aged debt.

Creditor Days	Creditor days increased slightly from 29 days to 30 days; however, this remains within target. The value of unpaid invoices in month increased slightly; however, this is in line with planned payables. Large value invoices received in month relating to Cleft contracts (M1-M10), salary recharges (M8-M10) and Genomics remained outstanding at the period end.
Inventory Days	Drug inventory days remained the same as previous month at 8. Non-Drug inventory days increased in month from 69 days to 78 days. The methodology for calculating inventory days is based upon stock level and stock usage in month so, despite the stock level remaining broadly in line with previous month, the lower than average usage results in a higher number of inventory days.

Risks

Risk/Assumption	Comment
£15m delivery of P&E savings	The full Better Value programme has not identified schemes for the full target and it is forecast that the original plan will not be delivered in full. A number of schemes centrally held by the SRO's responsible for delivery have been allocated to the relevant Division, but there remains an overall balance of schemes to be identified and it is becoming less likely that these will deliver by year end. While delivery of the control total remains of paramount importance, the reliance on delivery of additional income cannot be assumed recurrently due to payment risk and it is essential that a recurrent programme is developed in the future. There is a heavy focus on delivery of recurrent cost out schemes in 2018-19 and future years to remediate the position.
Achievement of CQUIN Income	The negotiation of CQUIN schemes is not yet complete for 2017/18 with the commissioner; 85% delivery is assumed but there remains risk around delivering all aspects of the current plans. There is 1 scheme that GOSH has withdrawn from valued at £1.m. The CUR scheme is a national scheme and the commissioners are indicating that this cannot be replaced with a local scheme. The AMR/Sepsis scheme valued at £378k is now included in the list of schemes and underassessment as to the level of achievement. To date £3.3m of the £4.73m has been agreed with commissioners. It is anticipated that the year-end delivery will be c. £4m.
IPP Income / Debt	IPP is down against plan year to date due to a drop in referrals. It is anticipated that some of this is due to external factors though the trend has continued into Month 11. Part of the stabilising of the forecast fro Month 12 centres on additional delivery of IPP income for complex cases. Overall the IPP debt remains high but to date there has not been any debt written off. The income includes a BV scheme for commercial income and several new projects have now been approved to contribute to this target.

Action required from the meeting

- **Note** the financial position at 28 February 2018
- **Note** the residual risks to the 2017/18 outturn
- **Note** the forecast position for 2018/18.

Contribution to the delivery of NHS / Trust strategies and plans

The delivery of the financial plan is a key strategic objective to ensure we have sufficient funding to meet the needs of our delivery of care.

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

Great Ormond Street Hospital for Children NHS Foundation Trust

Board
Finance and Activity Performance Report

Month 11 - 2017/18

(February 2018)

Summary Reports

Great Ormond Street Hospital for Children NHS Foundation Trust

Finance Scorecard

TRUST Our Money	December	January	February	Trend	YTD Target	Variance
Net Surplus/(Deficit)	(2.3)	0.3	(1.8)	↓	(0.2)	0.4
Forecast Outturn	1.9	0.4	0.0	↓	0.2	(0.2)
P&E Delivery	1.3	1.3	1.2	↓	13.8	0.0
Debtor Days (IPP)	216	219	205	↓	120	(85)
Quick Ratio (Liquidity)	1.7	1.7	1.7	→	1.6	0.1
**NHSI KPI Metrics	1	1	1	→	1	0

Key Performance Indicators

KPI	Annual Plan	M11 YTD Plan	M11YTD Actual	Rating
Liquidity	1	1	1	G
Capital Service Cover	1	1	1	G
I&E Margin	1	1	1	G
I&E Margin Distance from Plan	1	1	1	G
Agency Spend	1	1	1	G
Overall	**1**	**1**	**1**	G
Overall after Triggers	**1**	**1**	**1**	G

Key Highlights

- In February 2018 there was a Net deficit (before capital donations and impairments) of £1.8m which was £0.1m favourable to plan. Year to date the Trust has a Net surplus of £0.2m which is £0.4m favourable to plan.
- The Trust is reporting year to date a £0.3m favourable position against the control total.
- The overall weighted NHSI rating for Month 11 is Green (Rating 1) which is on plan.
- The debtor days for IPP decreased from last month by 14 days.
- Cash is £6.7m below plan, liquidity remains strong with cash on hand of £59.9m.
- The Trust is forecasting to be £0.2m (before capital donations and impairments) adverse to the annual plan and on target at Control Total level.

Trust Income and Expenditure Performance Summary
Year to Date for the 11 months ending 28 February 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

2017/18											Notes	2016/17	CY vs PY	
Annual Budget	Income & Expenditure	Month 11				Year to Date				Rating		YTD Actual	Variance	
		Budget	Actual	Variance		Budget	Actual	Variance		Current Year Variance				
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%			(£m)	(£m)	%
272.4	NHS & Other Clinical Revenue	21.75	22.31	0.56	2.57%	249.09	253.89	4.80	1.93%	G	1	232.50	21.39	9.20%
67.80	Pass Through	5.36	5.44	0.08	1.49%	62.17	60.21	(1.96)	(3.15%)			58.20	2.01	3.45%
60.67	Private Patient Revenue	4.89	3.52	(1.37)	(28.02%)	55.53	52.52	(3.01)	(5.42%)	R	2	49.90	2.62	5.25%
53.26	Non-Clinical Revenue	4.41	5.37	0.96	21.77%	48.66	52.69	4.03	8.28%	G		45.30	7.39	16.31%
454.13	**Total Operating Revenue**	**36.41**	**36.64**	**0.23**	**0.63%**	**415.45**	**419.31**	**3.86**	**0.93%**			**385.90**	**33.41**	**8.66%**
(244.42)	Permanent Staff	(20.47)	(19.68)	0.79	3.86%	(223.64)	(210.34)	13.30	5.95%			(195.60)	(14.74)	(7.54%)
(1.68)	Agency Staff^	(0.14)	(0.27)	(0.13)	(92.86%)	(1.54)	(4.11)	(2.57)	(166.88%)			(8.30)	4.19	50.48%
(2.68)	Bank Staff	(0.25)	(1.33)	(1.08)	(432.00%)	(2.71)	(15.25)	(12.54)	(462.73%)			(15.60)	0.35	2.24%
(248.78)	**Total Employee Expenses**	**(20.86)**	**(21.28)**	**(0.42)**	**(2.01%)**	**(227.89)**	**(229.70)**	**(1.81)**	**(0.79%)**	R	3	**(219.50)**	**(10.20)**	**(4.65%)**
(12.35)	Drugs and Blood	(1.03)	(1.22)	(0.19)	(18.45%)	(11.32)	(11.23)	0.09	0.80%	G		(11.40)	0.17	1.49%
(38.92)	Other Clinical Supplies	(3.24)	(2.99)	0.25	7.72%	(35.68)	(39.72)	(4.04)	(11.32%)	R		(36.70)	(3.02)	(8.23%)
(58.05)	Other Expenses	(5.25)	(5.13)	0.12	2.29%	(53.08)	(55.42)	(2.34)	(4.41%)	R		(45.80)	(9.62)	(21.00%)
(67.80)	Pass Through	(5.36)	(5.44)	(0.08)	(1.49%)	(62.17)	(60.21)	1.96	3.15%			(57.60)	(2.61)	(4.53%)
(177.12)	**Total Non-Pay Expenses**	**(14.88)**	**(14.78)**	**0.10**	**0.67%**	**(162.25)**	**(166.58)**	**(4.33)**	**(2.67%)**	R	4	**(151.50)**	**(15.08)**	**(9.95%)**
(425.90)	**Total Expenses**	**(35.74)**	**(36.06)**	**(0.32)**	**(0.90%)**	**(390.14)**	**(396.28)**	**(6.14)**	**(1.57%)**	R		**(371.00)**	**(25.28)**	**(6.81%)**
28.23	**EBITDA (exc Capital Donations)**	**0.67**	**0.58**	**(0.09)**	**(13.43%)**	**25.31**	**23.03**	**(2.28)**	**(9.01%)**	R		**14.90**	**8.13**	**54.56%**
(28.01)	Depreciation, Interest and PDC	(2.54)	(2.38)	0.16	6.30%	(25.46)	(22.83)	2.63	10.33%		6	(22.80)	(0.03)	(0.13%)
0.22	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**(1.87)**	**(1.80)**	**0.07**	**3.74%**	**(0.15)**	**0.20**	**0.35**	**233.33%**	G		**(7.90)**	**8.10**	**102.53%**
6.22%	**EBITDA %**	**1.84%**	**1.58%**			**6.09%**	**5.49%**					**3.86%**	**1.63%**	**42.25%**
(8.00)	Impairments	0.00	0.00	0.00	0.00%	0.00	0.00	0.00	0.00%			0.00	0.00	0%
72.11	Capital Donations	8.31	0.65	(7.66)	(92.18%)	63.79	22.16	(41.63)	(65.26%)		5	31.00	(8.84)	(28.52%)
64.33	**Net Result**	**6.44**	**(1.15)**	**(7.59)**	**(117.86%)**	**63.64**	**22.36**	**(41.28)**	**(64.86%)**			**23.10**	**(0.74)**	**(3.20%)**

Footnotes:

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

Notes

1. NHS & other clinical revenue (excluding pass through) year to date is favourable to plan by £4.8m. This was mainly driven by increases in complex cases, increased tariffs and coding benefits.

2. Private Patient income year to date is £3.0m adverse to plan due to under-delivery in IPP, JM Barrie and the Trust Better value commercial scheme. The recent trend in IPP income has been for a significant downturn in income and this continues in M11.

3. Pay is adverse to plan year to date by £1.8m with agency spend of £4.1m which is below the cumulative NHSI notified agency cost ceiling of £6.0m.

4. Non pay (excluding pass through) year to date is £6.3m adverse to plan.

5. Year to date income for capital donations is £41.6m less than plan due to lower capital expenditure on donated assets.

6. Depreciation YTD is favourable to plan due to reduced capital expenditure, predominately due to slippage against large scale projects including PICB.

Trust Income and Expenditure Performance Summary
Year to Date for the 11 months ending 28 February 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

Full Year Actual 2016/17 (£m)	28 February 2018 Income & Expenditure	Annual Budget (£m)	Internal Forecast Full-Yr (£m)	Variance to Plan (£m)	Variance to Plan %	Rating Current Year Variance	Notes
259.60	NHS & Other Clinical Revenue	272.40	277.40	5.00	1.80%	G	1
63.80	Pass Through	67.80	65.70	(2.10)	-3.20%		
55.10	Private Patient Revenue	60.67	57.00	(3.67)	-6.44%	R	2
47.00	Non-Clinical Revenue	53.26	55.80	2.54	4.55%	G	
425.50	**Total Operating Revenue**	**454.13**	**455.90**	**1.77**	**0.39%**		
(213.10)	Permanent Staff	(244.42)	(228.70)	15.72	-6.87%		
(9.30)	Agency Staff	(1.68)	(4.40)	(2.72)	61.82%		
(17.00)	Bank Staff	(2.68)	(16.50)	(13.82)	83.76%		
(239.40)	**Total Employee Expenses**	**(248.78)**	**(249.60)**	**(0.82)**	**0.33%**	R	3
(11.50)	Drugs and Blood	(12.35)	(13.60)	(1.25)	9.19%	R	
(41.20)	Other Clinical Supplies	(38.92)	(42.10)	(3.18)	7.55%	R	
(49.50)	Other Expenses	(58.05)	(59.40)	(1.35)	2.27%	R	
(63.80)	Pass Through	(67.80)	(65.70)	2.10	-3.20%		
(166.00)	**Total Non-Pay Expenses**	**(177.12)**	**(180.80)**	**(3.68)**	**2.04%**	R	4
(405.40)	**Total Expenses**	**(425.90)**	**(430.40)**	**(4.50)**	**1.05%**	R	
20.10	**EBITDA (exc Capital Donations)**	**28.23**	**25.50**	**(2.73)**	**-10.71%**	R	
(25.00)	Depreciation, Interest and PDC	(28.01)	(25.50)	2.51	-9.84%		5
(4.90)	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**0.22**	**0.00**	**(0.22)**	**-633.33%**	R	
4.72%	**EBITDA %**	**6.22%**	**5.59%**		**0.00%**		
(12.10)	Impairments	(8.00)	(8.00)	0.00	0.00%		
32.00	Capital Donations	72.11	27.28	(44.84)	-164.38%		6
15.00	**Net Result**	**64.33**	**19.28**	**(45.06)**	**-233.75%**		

Summary

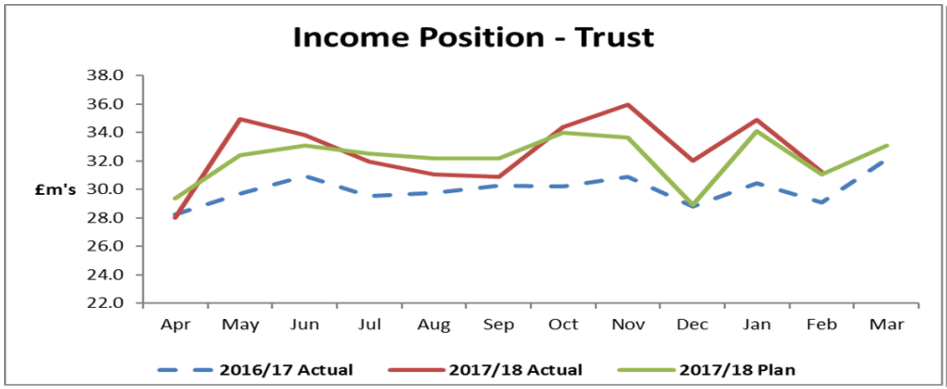
- The Trust is forecasting to be £0.2m adverse to plan though the Trust is forecasting to be on plan against the control total. This represents a reduction in Month 11 from prior months due principally to a downturn in IPP activity assumed in the previous forecast. A detailed review has been undertaken of the IPP year to date and FOT and we are comfortable the revised FOT is realistic.

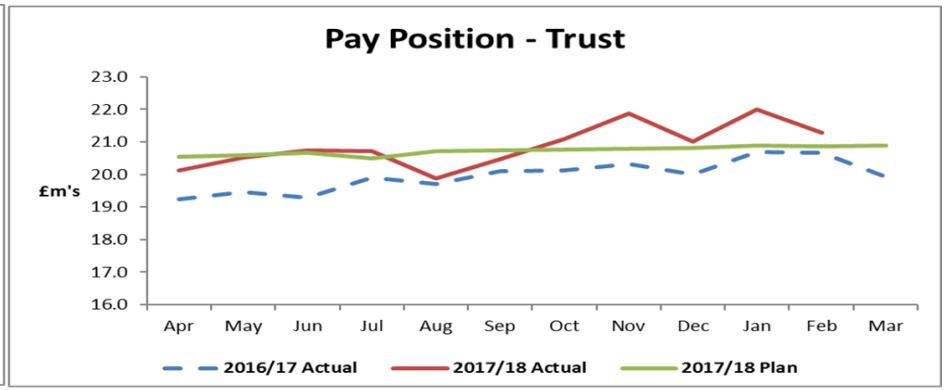
Notes

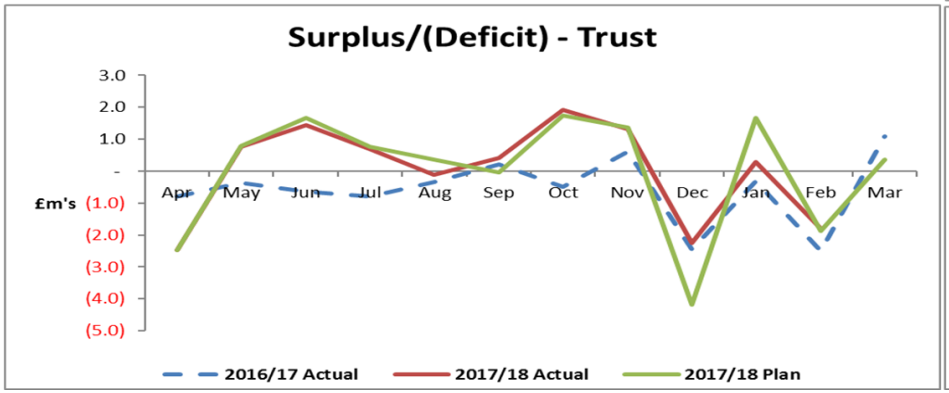
1. NHS & other clinical revenue (excluding pass through) based on forecast outturn will be £5.0m favourable to plan. The favourable variance is due to higher tariffs associated with more complex cases and strong performance against plan in recent months expected to continue to year end.
2. Private patient income based on forecast outturn will be £3.7m adverse to plan. Key drivers are low activity in Butterfly, temporary closure of Hedgehog ward in Month 6 and lower activity in PICU across large parts of the year.
3. Pay based on forecast outturn will be £0.8m adverse to plan due to bank and agency staff being used to cover vacancies in the Trust at a premium. There is increased pay spend in the second half of the year due to PICB opening and newly qualified nurses who needed additional support and training.
4. Non pay (excluding pass through) is forecast to be £6.0m adverse to plan to match the increased activity forecast and additional cost of premises.
5. Depreciation is forecast to be £2.5m favourable to plan. This is due to slippage in the capital programme and the reduction in the opening carrying value of assets driven by the annual revaluation exercise.
6. Capital donations are forecast to be £44.8m adverse to plan due to slippage in the capital programme and therefore a reduction in the charitable donations funding in the programme is forecast.

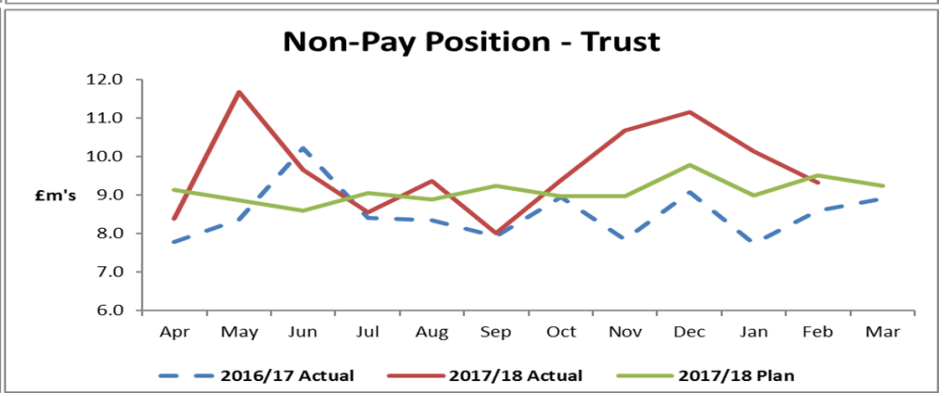
Trust Income and Expenditure Trends
Year to Date for the 11 months ending 28 February 2018

Great Ormond Street Hospital for Children NHS Foundation Trust









Financial Position and Capital Expenditure
Year to Date for the 11 months ending 28 February 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

The following table summarises the net assets and liabilities:

31 Mar 2017 Audited Accounts £m	Statement of Financial Position	YTD Plan 28 Feb 2018 £m	YTD Actual 28 Feb 2018 £m	YTD Variance £m
431.56	Non-Current Assets	537.60	449.19	(88.41)
75.64	Current Assets (exc Cash)	83.24	84.48	1.24
42.49	Cash & Cash Equivalents	53.20	59.93	6.73
(56.09)	Current Liabilities	(80.13)	(78.10)	2.03
(5.81)	Non-Current Liabilities	(5.15)	(5.34)	(0.19)
487.79	**Total Assets Employed**	**522.20**	**510.16**	**(78.59)**

Annual Plan £m	Capital Expenditure	YTD Plan 28 Feb 2018 £m	YTD Actual 28 Feb 2018 £m	YTD Variance £m
37.76	Redevelopment - Donated	33.30	5.59	27.71
19.09	Medical Equipment - Donated	17.51	7.83	9.68
0.00	Estates - Donated	0.00	0.00	0.00
15.26	ICT - Donated	12.99	8.75	4.24
72.11	**Total Donated**	**63.80**	**22.17**	**41.63**
11.06	Redevelopment & equipment - Trust Funded	12.56	6.34	6.22
3.70	Estates & Facilities - Trust Funded	2.07	1.75	0.32
7.18	ICT - Trust Funded	6.72	3.89	2.83
1.00	Contingency	0.85	0.00	0.85
22.94	**Total Trust Funded**	**22.20**	**11.98**	**10.22**
95.05	**Total Expenditure**	**86.00**	**34.15**	**51.85**

Capital Expenditure Update

Redevelopment donated

- £1.0m Bernard St 1st floor to be funded by the Trust
- £7.7m Southwood Courtyard (IMRI) slippage
- £2.0m Mortuary project paused
- £12.3m Phase 4 project slippage
- £1.2m Italian Hospital slippage
- Phase 2B £0.2m underspend
- £2.5m CICU donated equipment included in Phase 2B.

Redevelopment trust funded

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

- £0.9m Barclay House office refurb slippage
- £1.5m chillers slippage
- £1.3m CICU slippage

Medical Equipment – Donated

Expenditure was less than plan due to the following:

- Phase 2B equipment procurement delayed due to delays in construction £3.2m
- IMRI equipment £1.4m (to be procured later)
- Other equipment £1.7m (awaiting outcome of full replacement review)
- £1.5m Cath lab equipment delivery awaiting building works completion

ICT – Donated

- £4.2m EPR implementation costs less than planned schedule.

Estates and Facilities – Trust Funded

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

- Decontamination washer suite £1.5m

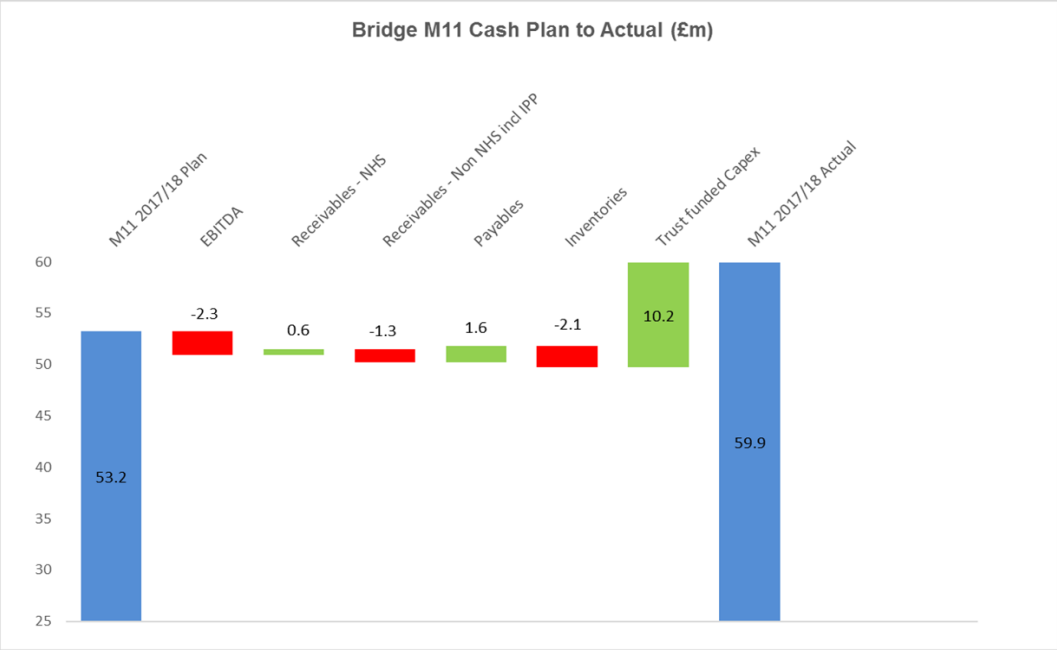
ICT – Trust Funded

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

- Vendor neutral archive and network hardware £1.0m
- GMC infrastructure £0.2m
- E-rostering £0.4m
- £0.5m Cybersecurity additional spend

Cash and Working Capital Summary
Year to Date for the 11 months ending 28 February 2018

Great Ormond Street Hospital for Children NHS Foundation Trust



31-Mar-17	Working Capital	31-Jan-18	28-Feb-18	RAG
19.40	NHS Debtor Days (YTD)	15.0	12.4	G
182.00	IPP Debtor Days	219.0	205.0	R
22.50	IPP Overdue Debt (£m)	27.7	26.5	R
4.00	Inventory Days - Drugs	8.0	8.0	G
63.00	Inventory Days - Non Drugs	69.0	78.0	R
34.50	Creditor Days	29.4	30.0	G
0.82	BPPC - Non-NHS (YTD) (number)	83.7%	83.6%	A
0.88	BPPC - Non-NHS (YTD) (£)	88.0%	88.5%	A

Cash
The closing cash balance was £59.9m, £13.1 higher than the previous month. This includes £10.1m received from GOSH Charity; £5.8 received for various IPP debtors; £2.0m received for over-performance invoices and is offset by £4.4m paid to Epic for the EPR project.

NHS Debtor Days
Debtor days decreased in month to 12 days which remains within target.

IPP Debtor Days
IPP debtor days decreased in month from 219 days to 205 days.

Creditor Days
Creditor days increased in month to 30 days which is broadly in line with last month.

Inventory Days
Drug inventory days remained the same as previous month at 8. Non-Drug inventory days increased in month from 69 days to 78 days. The methodology for calculating inventory days is based upon stock level and stock usage in month so, despite the stock level remaining broadly in line with previous month, the lower than average usage results in a higher number of inventory days.

Workforce Summary
For the 11 months ending 28 February 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

2016/17 Actual (£m)	2017/18 Annual Plan (£m)	£m including Perm, Bank and Agency Staff Group	2017/18 Month 11 Budget (£m)	Month 11 Actual (£m)	Month 11 Variance (£m)	Month 11 Variance %	2017/18 Year to Date Budget (£m)	Year to Date Actual (£m)	Year to Date Variance (£m)	Year to Date Variance %
38.05	48.24	Admin (inc Director & Senior Managers)	4.04	3.66	0.38	9.36%	44.20	38.38	5.82	13.17%
46.62	47.44	Consultants	3.98	4.10	(0.12)	-3.11%	43.44	44.36	(0.92)	-2.12%
3.59	3.99	Estates & Ancillary Staff	0.34	0.27	0.07	19.17%	3.65	3.19	0.46	12.66%
8.83	9.46	Healthcare Assist & Supp	0.86	0.71	0.15	17.14%	8.66	8.04	0.61	7.06%
24.19	25.73	Junior Doctors	2.19	2.10	0.09	4.12%	23.53	22.67	0.86	3.67%
69.54	73.61	Nursing Staff	6.15	6.50	(0.36)	-5.79%	67.39	68.39	(1.00)	-1.48%
0.28	0.36	Other Staff	0.03	0.02	0.01	28.78%	0.33	0.27	0.06	17.26%
39.52	43.70	Scientific Therap Tech	3.72	3.54	0.19	5.01%	39.98	39.52	0.47	1.17%
230.60	**252.52**	**Total substantive and bank staff costs**	**21.31**	**20.91**	**0.40**	**1.86%**	**231.19**	**224.83**	**6.36**	**2.75%**
9.32	1.68	Agency	0.14	0.27	(0.13)	-92.05%	1.54	4.10	(2.56)	-166.14%
239.92	**254.21**	**Total substantive, bank and agency cost**	**21.44**	**21.18**	**0.26**	**1.20%**	**232.67**	**228.94**	**3.75**	**-163.39%**
0.00	(6.04)	Better Value Scheme	(0.50)	0.00	(0.50)	100.00%	(5.54)	0.00	(5.54)	100.00%
(0.48)	(0.26)	Reserve	(0.07)	0.10	(0.17)	240.31%	(0.13)	0.76	(0.89)	693.73%
0.00	0.87	PICB reserves	(0.01)	0.00	(0.01)	100.00%	0.88	0.00	0.88	100.00%
239.44	**248.78**	**Total pay cost**	**20.86**	**21.28**	**(0.42)**	**-2.01%**	**227.89**	**229.70**	**(1.81)**	**-0.79%**

2016/17 Average WTE	2017/18 Annual Plan Average WTE	WTE Including Perm, Bank and Agency Staff Group	2017/18 Month 11 Budget WTE	Month 11 Actual WTE	Month 11 Variance WTE	Month 11 Variance %	2017/18 Year to Date (average WTE) Budget WTE	Year to Date Actual WTE	Year to Date Variance WTE	Year to Date Variance %
948.53	1,080.04	Admin (inc Director & Senior Managers)	1,081.68	1,022.31	59.37	5.49%	1,079.89	997.59	82.30	7.62%
305.38	346.39	Consultants	346.15	318.14	28.01	8.09%	346.41	313.95	32.46	9.37%
117.95	132.36	Estates & Ancillary Staff	132.56	102.97	29.59	22.32%	132.34	108.77	23.57	17.81%
295.84	314.70	Healthcare Assist & Supp	316.54	284.46	32.08	10.13%	314.53	292.29	22.24	7.07%
311.29	333.18	Junior Doctors	333.18	319.51	13.67	4.10%	333.18	317.32	15.86	4.76%
1,405.15	1,542.61	Nursing Staff	1,543.87	1,601.68	(57.81)	-3.74%	1,542.50	1,516.30	26.20	1.70%
5.46	7.60	Other Staff	7.60	5.12	2.48	32.63%	7.60	5.20	2.40	31.64%
736.59	826.96	Scientific Therap Tech	827.01	790.44	36.57	4.42%	826.96	755.30	71.65	8.66%
4,126.19	**4,583.84**	**Total substantive and bank staff**	**4,588.59**	**4,444.63**	**143.96**	**3.14%**	**4,583.41**	**4,306.72**	**276.69**	**8.66%**
105.20	33.90	Agency	33.90	68.07	(34.17)	-100.80%	33.90	85.61	(51.71)	-152.54%
4,231.40	**4,617.74**	**Total substantive, bank and agency**	**4,622.49**	**4,512.70**	**109.79**	**2.38%**	**4,617.31**	**4,392.33**	**224.97**	**-143.88%**
0.00	(116.08)	Better Value Scheme	(112.79)	0.00	(112.79)	100.00%	(116.37)	0.00	(116.37)	100.00%
0.00	0.00	Reserve	0.00	0.00	0.00	0.00%	0.00	0.00	0.00	0.00%
0.00	0.00	PICB reserves	0.00	0.00	0.00	0.00%	0.00	0.00	0.00	0.00%
4,231.40	**4,501.66**	**Total Staff**	**4,509.70**	**4,512.70**	**(3.00)**	**-0.07%**	**4,500.93**	**4,392.33**	**108.60**	**2.41%**

Summary

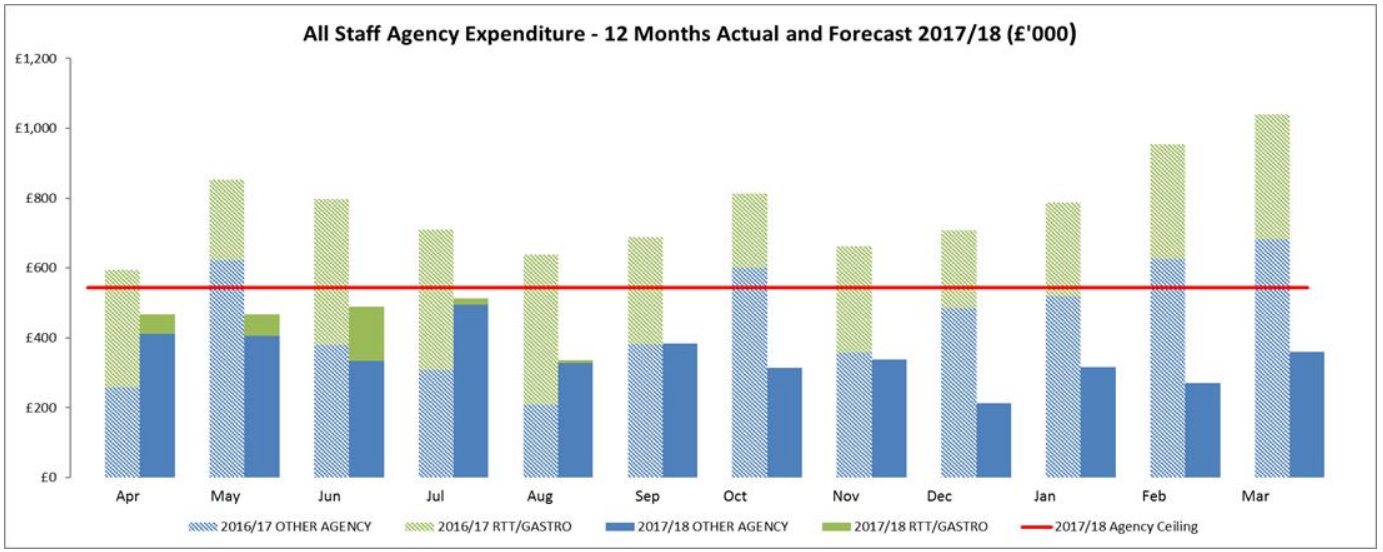
- In Month 11 pay spend is £21.3m which is £0.4m adverse to plan.
- Year to date, pay spend for substantive and bank staff is £6.4m favourable to plan due to numerous vacancies across the Trust.
- In Month 11, agency workers covered 68 of the in month vacancies. The agency spend in Month 11, £0.3m is below the NHSI monthly notified cost ceiling of £0.5m.
- Year to date, the Trust has spent £4.1m on agency workers. This is below the cumulative NHSI notified cost ceiling of £6.0m.

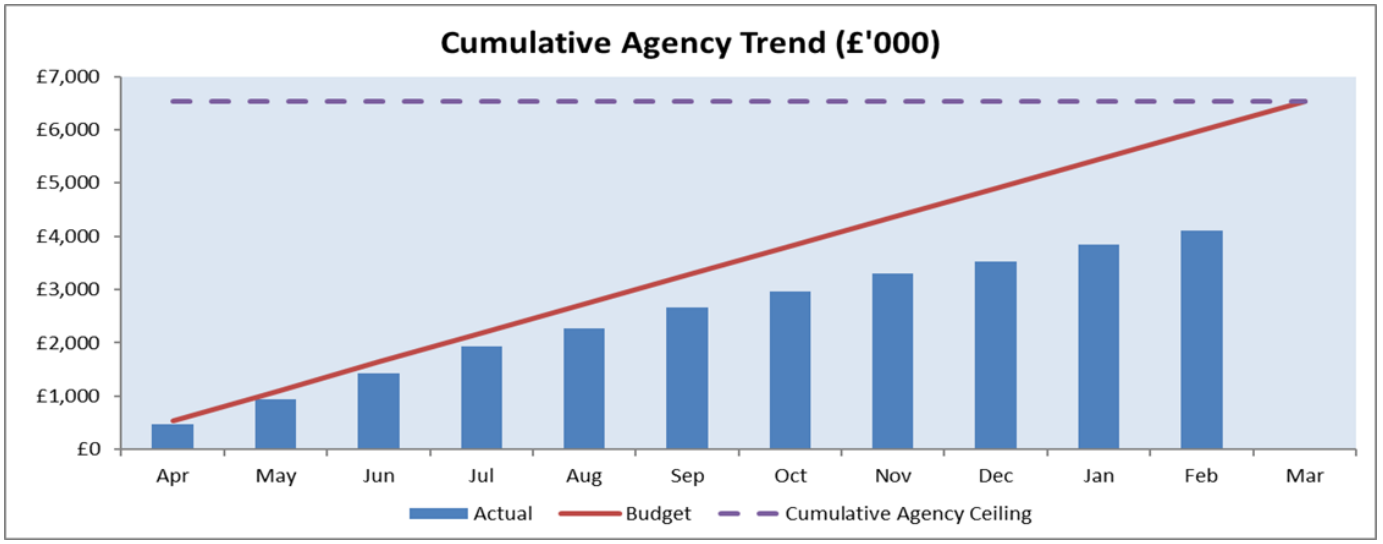
The Better Value Scheme annual plan £6.0m is made up of the following:

Cross Cutting Scheme	
Theatres	£1.0m
Bed Flow	£1.0m
Outpatients	£0.2m
Workforce	£1.3m
ICT Enabled	£0.3m
Agencies & VAT	£0.6m
Local Schemes/Vacancy Factor	
JM Barrie	£1.0m
Charles West	£0.6m
Total	**£6.0m**

Agency Expenditure Summary
Year to Date for the 11 months ending 28 February 2018

Great Ormond Street Hospital for Children NHS Foundation Trust





- In Month 11 the Trust is currently running below its NHSI cost ceiling for agency staff.

Trust NHS and Other Clinical Income Summary
Year to Date for the 11 months ending 28 February 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

	2017/18 YTD								2016/17 YTD					
	Income				Activity				Income			Activity		
	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan	Actual *	Variance	Variance %	Actual £'000	Variance 17/18 to 16/17 £'000	Variance 17/18 to 16/17 %	Actual	Variance 17/18 to 16/17	Variance 17/18 to 16/17 %
Day case	**22,945**	**22,644**	**(301)**	**-1.3%**	**19,170**	**18,829**	**(341)**	**-1.8%**	**21,353**	**1,291**	**6.0%**	**16,265**	**2,564**	**15.8%**
Elective	57,990	54,413	(3,577)	-6.2%	12,868	12,577	(291)	-2.3%	49,633	4,780	9.6%	11,790	787	6.7%
Elective Excess Bed days	2,699	2,421	(278)	-10.3%	4,793	4,327	(466)	-9.7%	2,983	(563)	-18.9%	5,970	(1,643)	-27.5%
Elective	**60,689**	**56,834**	**(3,855)**	**-6.4%**					**52,616**	**4,217**	**8.0%**			
Non Elective	15,565	16,866	1,301	8.4%	1,476	2,540	1,065	72.1%	12,327	4,540	36.8%	1,451	1,089	75.1%
Non Elective Excess Bed Days	1,853	2,445	592	32.0%	3,202	4,078	876	27.4%	1,619	826	51.0%	3,244	834	25.7%
Non Elective	**17,418**	**19,312**	**1,894**	**10.9%**					**13,946**	**5,366**	**38.5%**			
Outpatient	**35,899**	**36,202**	**304**	**0.8%**	**145,003**	**146,026**	**1,023**	**0.7%**	**35,698**	**504**	**1.4%**	**139,568**	**6,458**	**4.6%**
Undesignated HDU Bed days	4,641	5,063	422	9.1%	4,444	4,844	400	9.0%	4,306	757	17.6%	4,126	718	17.4%
Picu Consortium HDU	3,520	2,865	(655)	-18.6%	3,698	2,902	(796)	-21.5%	3,183	(318)	-10.0%	3,297	(395)	-12.0%
HDU Beddays	**8,161**	**7,928**	**(233)**	**-2.9%**	**8,141**	**7,746**	**(395)**	**-4.9%**	**7,489**	**439**	**5.9%**	**7,423**	**323**	**4.4%**
Picu Consortium ITU	32,126	29,087	(3,039)	-9.5%	11,093	10,110	(983)	-8.9%	25,117	3,970	15.8%	10,300	0 (190)	-1.8%
PICU ITU Beddays	**32,126**	**29,087**	**(3,039)**	**-9.5%**	**11,093**	**10,110**	**(983)**	**-8.9%**	**25,117**	**3,970**	**15.8%**	**10,300**	**(190)**	**-1.8%**
Ecmo Bedday	889	1,048	159	17.9%	162	196	34	20.7%	704	344	48.9%	129	67	51.9%
Psychological Medicine Bedday	1,040	942	(99)	-9.5%	2,576	2,332	(244)	-9.5%	1,115	(173)	-15.5%	2,763	(431)	-15.6%
Rheumatology Rehab Beddays	1,377	1,645	268	19.5%	2,421	2,755	334	13.8%	1,236	409	33.1%	2,176	579	26.6%
Transitional Care Beddays	2,650	2,106	(545)	-20.5%	1,828	1,452	(376)	-20.5%	2,363	(257)	-10.9%	1,631	(179)	-11.0%
Total Beddays	**5,956**	**5,741**	**(215)**	**-3.6%**	**6,987**	**6,735**	**(252)**	**-3.6%**	**5,418**	**323**	**6.0%**	**6,699**	**36**	**0.5%**
Packages Of Care Elective	**6,760**	**7,621**	**862**	**12.7%**					**6,863**	**759**	**11.1%**			
Highly Specialised Services (not above)	27,614	27,304	(310)	-1.1%					27,189	114	0.4%			
Other Clinical	22,070	30,627	8,557	38.8%					33,858	(3,231)	-9.5%			
Outturn adjustment	0	(119)	(119)	0.0%					(808)	688	-85.2%			
STF Funding	4,756	4,756	0	0.0%					0	4,756	0.0%			
Pricing Adjustment	6,510	6,510	0	0.0%					0	6,510	0.0%			
Non NHS Clinical Income	2,945	4,202	1,258	42.7%					3,715	488	13.1%			
NHS and Other Clinical Income	**253,849**	**258,648**	**4,800**	**1.9%**					**232,454**	**26,194**	**11.3%**			

*Activity = Billable activity

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

Day case

Day case is behind plan YTD by 341 which is primarily driven by reduced activity in Urology due to having lower staff numbers than plan to perform activity and a lower than anticipated demand level in 2017/18 against 2016/17.

Elective

Elective YTD is below plan due to lower activity in a number of specialty areas but particularly within Urology (for the same reason as above) and Haematology/Oncology (activity significantly ahead of plan in Other NHS clinical, Non-Elective and Outpatients).

Outpatients

YTD there has been an increase in outpatient activity due to Cardiac (cross cover between consultants to ensure avoidance of clinic cancellation due to annual leave), ENT (telephone clinics) and Psychosocial Services.

HDU beds

HDU activity is behind plan in Cardiac services driven by the cancellation of the Chest Wall service. This is partially offset by higher than plan HDU activity within Medical Metabolic due to complex long stay patients.

ITU Bed Days

PICU/NICU activity YTD remains broadly on trend from 16/17 levels. The year to date adverse variance is due to the PICU business case to open 4 additional beds that has been built into the 2017/18 annual plan, not delivering to the original planned levels.

Trust Inpatient and Outpatient Activity
Year on Year trend analysis

Great Ormond Street Hospital for Children NHS Foundation Trust

NHS and IPP Activity (Combined)													
Prior Year 2016/17				Current Year 2017/18				NHS Activity			IPP Activity		
Mth 11 Feb	Total 16/17	YTD Mth 11 16/17	Activity Type	Feb	Total YTD	Change YOY	% Change YOY	NHS YTD 17/18	Change YOY	% Change YOY	IPP YTD 17/18	Change YOY	% Change YOY
			Inpatients										
			Number of Discharges										
1,949	24,729	22,526	Day Case	1,978	22,841	315	1.4%	21,833	214	1.0%	1,008	101	11.1%
189	2,156	1,952	Regular Attenders	169	2,023	71	3.6%	2,019	78	4.0%	4	(7)	-63.6%
			Inpatient:										
1,141	14,010	12,741	Elective	1,151	13,021	280	2.2%	11,979	78	0.7%	1,042	202	24.0%
51	800	727	Non Elective	78	836	109	15.0%	738	110	17.5%	98	(1)	-1.0%
163	2,074	1,914	Non Elective (Non Emergency)	161	1,997	83	4.3%	1,966	95	5.1%	31	(12)	-27.9%
3,493	43,769	39,860	Total Discharges	3,537	40,718	858	2.2%	38,535	575	1.5%	2,183	283	14.9%
			Beddays										
704	9,178	8,403	Day Case	526	7,112	(1,291)	-15.4%	6,747	(1,316)	-16.3%	365	25	7.4%
0.36	0.37	0.37	Day ALOS	0.27	0.31	(0.06)	-16.5%	0.31	(0.06)	-17.1%	0.36	(0.01)	-3.4%
121	1,313	1,195	Regular Attenders	103	1,190	(5)	-0.4%	1,188	(1)	-0.1%	2.0	(4.0)	-66.7%
			Inpatient:										
5,197	66,583	60,635	Elective	5,354	61,540	905	1.5%	48,787	(543)	-1.1%	12,753	1,448	12.8%
622	6,842	5,984	Non Elective	444	6,152	168	2.8%	5,281	308	6.2%	871	(140)	-13.8%
1,854	25,639	23,732	Non Elective (Non Emergency)	1,996	24,594	862	3.6%	23,600	651	2.8%	994	211	26.9%
7,673	99,064	90,351	Total Overnight Beddays	7,794	92,286	1,935	2.1%	77,668	416	0.5%	14,618	1,519	11.6%
5.66	5.87	5.87	Overnight ALOS	5.61	5.82	- 0.05	-0.9%	5.29	- 0.08	-1.4%	12.5	- 0.9	-6.4%
8,498	109,555	99,949	All bed days	8,423	100,588	639	0.6%	85,603	- 901	-1.0%	14,985	1,540	11.5%
6,045	81,559	74,683	All bed days with LOS < 90 days	7,211	78,297	3,614	4.8%	69,898	1,609	2.4%	8,399	2,005	31.4%
			Midnight Census (ON Bed days)										
4,241	54,697	49,807	Elective	4,400	50,899	1,092	2.2%	39,204	(165)	-0.4%	11,695	1,257	12.0%
559	6,022	5,271	Non Elective	384	5,486	215	4.1%	4,693	338	7.8%	793	(123)	-13.4%
1,687	23,310	21,577	Non Elective (Non Emergency)	1,842	22,531	954	4.4%	21,586	745	3.6%	945	209	28.4%
0	1	1	Regular Attenders	2	1	0	0.0%	2	1	100.0%	1	1	100.0%
6,487	84,030	76,656	Total	6,628	78,917	2,261	2.9%	65,485	919	1.4%	13,434	1,344	11.1%
209	230	279	Average ON Beds Utilised	214	287	8	2.9%	196	3	1.4%	41	5	13.8%
			Critical Care Beddays (NICU|PICU|CICU)										
413	4,610	4,112	Elective	351	4,114	2	0.0%	3,141	89	2.9%	973	(87)	-8.2%
162	1,453	1,220	Non Elective	84	948	(272)	-22.3%	908	(192)	-17.5%	40	(80)	-66.7%
415	6,404	5,979	Non Elective (Non Emergency)	569	6,708	729	12.2%	6,469	563	9.5%	239	166	227.4%
990	12,467	11,311	Total CC Beddays	1,004	11,770	459	4.1%	10,518	1,290	14.0%	1,252	(1)	0.0%
31.9	34.2	41.1	Average CC Beddays	32.4	42.8	1.7	4.1%	31.5	3.9	14.0%	3.7	(0.0)	0.0%
			Outpatients										
21,167	253,717	229,552	Outpatient Attendances (All)	19,701	234,145	4,593	2.0%	217,312	3,818	1.6%	16,833	775	4.8%
3,976	47,751	43,362	First Outpatient Attendances	3,788	43,300	(62)	-0.1%	36,547	(258)	-0.7%	6,753	196	3.0%
17,191	205,966	186,190	Follow Up Outpatient Attendances	15,913	190,845	4,655	2.5%	180,765	4,076	2.3%	10,080	579	6.1%
4.3	4.3	4.3	New to Review Ratio	4.2	4.2	(0.1)	-1.5%	4.9	0.1	2.1%	1.5	0.0	3.0%

Comments on key changes to prior year:

Day Cases

Overall Day cases show an increase of 1.4% compared with the same period in 16/17, with a proportionately greater increase in IPP activity (11.1%). Urology continues to report a reduction compared to 16/17 (378 cases; 16%) - due to a combination of staff sickness and a reduction in waiting list initiatives compared to 16/17. Radiology has also decreased mainly due to allocation changes resulting from the new National tariff arrangements (119 cases; 15%). The YTD decrease caused by these is being offset by increases in other areas - for example, Haematology & Oncology (338 cases; 12%), due to some increase in demand but also linked to the allocation changes in relation to Radiology, and Rheumatology (223 cases; 6%), due to utilisation of additional rehab capacity to clear a backlog.

Inpatient

Inpatient spells YTD have increased by 472 (3.0%) compared to 16/17 with the most significant factors being NHS non-elective (increase of 110; 17.5% change) and IPP elective activity (increase of 202). The NHS non-elective increase mainly relates to Nephrology (increase of 42) and Cardiology (increase of 115). IPP elective activity has increased in a number of area, but particularly Respiratory, Haematology/Oncology and Neurology.

Critical care

Critical care bed days YTD have increased by 4.1% compared to 16/17. This represents activity below planned levels - 4 additional PICU/NICU beds were planned to be opened but there have been issues with both demand and staffing.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **28 March 2018**	
Gastroenterology service review **Submitted by:** Dr Andrew Long, Interim Medical Director	**Paper No: Attachment M**
Aims / summary This update marks the completion of the comprehensive review into the Trust's Gastroenterology Service. It includes: a brief summary of action to date being mindful that updates have been shared with the Board throughout the process; the Follow-Up Report from the Royal College of Paediatrics and Child Health (RCPCH) and our action plan to address recommendations made.	
Action required from the meeting To note the content of the report and actions under way in response to the recommendations	
Contribution to the delivery of NHS Foundation Trust strategies and plans	
Financial implications None	
Who needs to be told about any decision? Divisional Team	
Who is responsible for implementing the proposals / project and anticipated timescales? Divisional Teams – progress will be monitored via the Divisional Board and Executive Management Team	
Who is accountable for the implementation of the proposal / project? Deputy Chief Executive	

The Review Process

The Royal College of Paediatrics and Child Health (RCPCH) Follow-Up Review is the final stage of a comprehensive set of reviews and improvement work that has taken place since 2015 in order to ensure an improved service and improved care for our patients.
The improvement work was initiated by the Trust after we had seen a disappointing and sustained number of complaints about the service. It comprised of: an initial RCPCH Service Review; case note reviews by national and international experts; care package reviews in clinic; and the RCPCH Follow-Up report.

Throughout the process we have shared all the key findings of reviews with the Care Quality Commission, NHS Improvement and our commissioners, NHS England. Most recently they have received a copy of our the RCPCH Follow-Up Report and our action plan.

We have had in-depth dialogue with the patients whose care packages were reviewed and ensured all gastroenterology patients were aware of the review and the steps being taken to improve the service, through letters, a listening event and updates on our website.

The RCPCH Follow-Up Review (the Review)

We are pleased that the Review recognises the journey undertaken by the Gastroenterology Department and the progress that has been made since the Trust first invited the RCPCH to review the service in 2015.

In particular, it is pleasing to read that the reviewers were assured by:

- Very good senior clinical and operational leadership;
- Significant improvements in administration of patient communications and clinic organisation;
- New governance meetings and reporting pathways which ensure that any new referrals are appropriately reviewed, investigated and managed in conjunction with their local referring paediatrician and according to agreed, externally validated, care pathways; and
- Improved team working and engagement with multidisciplinary colleagues.

This has been a complex and thorough review process throughout the entire scope of the Gastroenterology Service and our staff have worked with commitment and skill to deliver important changes.

We are confident that patients and families are already seeing the tangible benefits of these improvements, with a significant reduction in the number of issues and complaints raised.

We are however disappointed that some anecdotal information has been included in the report which is unsubstantiated and not adequately triangulated. While it is important to reflect feelings that individuals may have about the service and the review process, it is also imperative that the progress the department has made over the past two years detailed in the review is not undermined by unverified information.

We are aware that there is still room for further improvement, and we have carefully considered the RCPCH's findings and recommendations to formulate a robust Action Plan, which will inform our strategy for our Gastroenterology Service.

The Trust believes that the organisation's programme of improvement to date – and the clear Action Plan initiated for future development – is indicative of how seriously the organisation has engaged with the issues identified and evidence of our continued commitment to take steps to resolve them.

A number of specific areas noted in the Follow-Up Review are worth particular attention:

- The Trust is in agreement that the gastroenterology ward environment at the time of the RCPCH visit was not appropriate and, since then, the Trust has moved the inpatient service. It will be moving again in the near future to new, improved facilities. Ward staff and parents have been involved in on-going discussions throughout the relocation plans and will continue to remain involved.
- Patients under the Service will be subject to governance meetings and reporting pathways that ensure they are appropriately reviewed, investigated and managed in conjunction with their local referring paediatrician and according to agreed, externally validated, care pathways.
- The team are committed to the yearly NHS monitoring process for highly specialised services and take part in the annual review process led by NHS England with commissioners and stakeholders. In addition, they have begun the process of the Joint Advisory Group (JAG) for GI Endoscopy accreditation, newly in place for paediatric gastrointestinal endoscopy and comprising of an annual process of independent assessment against national standards for endoscopy.
- Continuing to foster a climate of openness to ensure that staff feel confident any concerns will be handled with appropriate action and

candour is a priority across the Trust. The Trust has recently appointed a 'Freedom to Speak Up (FSU) Guardian' to support the seven FSU Ambassadors that have been in place for some time; and regular staff attitude surveys and feedback will be used to determine success in this area.

- The Trust agrees that there is an enhanced role for general paediatricians to play in the management of complex patients including the referral meetings and MDTs. They have already been involved in pathway development (e.g. motility, food allergy) and will provide additional support to all multidisciplinary team working. The Trust is keen to invest in the development of general paediatricians with specialist interests to support the Gastroenterology Service as well as the care needs (including repatriation) of patients requiring complex care. Increased general paediatric support for the safeguarding service is already being addressed.
- The RCPCH's recommendations concerning the development of a regional network for gastroenterology services require consideration and leadership in the first instance by the responsible commissioning bodies. The Trust is keen to work with partner organisations to deliver the best possible service for patients at both a local and national level and is very supportive of proposals to develop closer and more collaborative networks.

Next steps

The full action plan resulting from the RCPCH's revisit in 2017 is attached. Progress on this action plan will be monitored through the Trust's existing governance structures to ensure improvements are delivered in a timely manner.

We will continue to monitor and act upon feedback from patients and listening events will continue to be scheduled on a biennial basis.

We are now in active discussion with our commissioners about opening up the service to an increased number of referrals as part of the nationwide system of care for these patients.

RCPCH Invited Reviews Programme

Follow-Up Review

Great Ormond Street Hospital NHS Foundation Trust
Gastroenterology Service

Visit date July 2017
Final report December 2017

Royal College of Paediatrics and Child Health
Leading the way in Children's Health

RCPCH Invited Reviews Programme
December 2017

Published by:
Royal College of Paediatrics and Child Health
5-11 Theobalds Road
London WC1X 8SH
Tel: 0207 092 6000
Email: enquiries@rcpch.ac.uk
Web: www.rcpch.ac.uk

The Royal College of Paediatrics and Child Health (RCPCH) is a registered charity in England and Wales (1057744) and in Scotland (SC038299)

Contents

Note 1: Our review has not looked specifically at clinical outcomes or individual case management. Our recommendations and the plans for network and governance development should facilitate systemic improvements in these areas.
Note 2: This report reflects the evidence and interviews considered by the Review team during the visit in June and July 2017. We acknowledge that in the time taken to agree the final report the Trust has made progress but the report stands as a 'snapshot' of the position in July 2017

Executive Summary

This review report examines progress against the recommendations of the RCPCH Invited Review of gastroenterology service at Great Ormond Street Hospital in 2015. It provides a fresh view of the current service with recommendations that encourage sustainable, achievable and integrated service provision for children and young people with gastroenterological conditions.

The review team recognises that the gastroenterology service had faced a difficultperiod following the 2015 review. The service had significantly reduced activity whilst investigations were carried out including a detailed programme of case review and a thorough overhaul of administration and governance systems.

By the end of 2016 the service was considered by the Trust to be in a positive position and the RCPCH was approached in spring 2017 to carry out a follow up review. The review team comprised two experienced paediatricians and a lay reviewer supported by an RCPCH manager. Terms of reference were agreed and the team interviewed almost 100 people and examined a similar number of documents to the 2015review

The review team found very good senior clinical and operational leadership which needs to be sustained and embedded. There have been significant improvements in administration of patient communications and clinic organisation and a suite of new governance meetings and reporting pathways which ensure that any new referrals are appropriately investigated and diagnosed in conjunction with their local referring paediatrician. The consultants were working better as a team and engaging more with multidisciplinary colleagues, particularly the more recently appointed and locum consultants.

Many of the consultants and other staff were embracing the new ways of working. There had been significant investment in nursing, and improved involvement of multidisciplinary colleagues including psychology and dietetics. Strong nursing leadership on the wards and investigations unit was embedding the governance and quality programme with improved morale and a clear career structure for staff.

However, the new approach has not been universally accepted by all gastroenterology consultants and some remained sceptical about the need for change. Some concerns were expressed that the Trust and team had not yet fully learned from the consequences of the 2015 review, when further detailed case review work was required urgently to ensure all children were on appropriate care plans. Whilst the original report had been shared with regulators and commissioners, who had monitored the action planning and progress of the Trust against the recommendations, some staff working in the service had not seen it and told the review team that they were not yet confident that their concerns could be raised and responded to in a climate of openness.

Further encouragement is needed for the gastroenterologists to fully embrace external peer review. Some consultants see their service as only ‘quaternary’ or highly specialised and are selective about accepting their fair share of specialist (‘tertiary’) referrals in the London catchment; this approach has been supported by the Trust and specialist service commissioners during the period since the initial review report but the continued limitation is causing friction with other providers. It is important going forward that specialist services and the specialist commissioners work closely together with clarity about expertise and referral pathways across London and the South East.

The service is currently working at around half of its previous activity and needs to step back up to manage a similar workload to peer units. There are some efficiency savings which could be made to achieve this and subsequently some investment in staffing and robust job planning may be needed to ensure that the gains made in governance and safety are embedded and continue with the changeover of the Medical Director. We would recommend involvement in a networked Quality Improvement programme and/or appointment of an externally-facing senior clinical leader – equivalent to a Chair or professorship appointed by the NHS with an interest in translational research-- to support the development of a strong gastroenterology network in London.

The full report sets out the findings which are wide ranging but reflect the impact of the 2015 report and the extent of turnaround that has been achieved. There has been good progress in dealing with the immediate issues of concern and implementing practical systems but the next stage is ensuring this culture remains embedded to focus on the best interests of the child.

Safeguarding systems and processes have improved since the previous review with strengthening of the safeguarding team, improved focus on training and reporting and better links with patients’ local children’s services. The appointment in February 2017 of a respected, experienced Named Doctor will enable this improvement to continue.

Involvement of families and management of transition are areas which still require improvement but again the Trust is aware of this and striving to bring the gastroenterology service to the standards of other teams in the Trust and other gastroenterology centres. There is a wide selection of material and support readily available for these schemes and no reason not to move forward more swiftly with this to build healthy trusting relationships with families and other units.

In summary, the Trust is making good progress on the significant transformation identified as necessary in the 2015 report but now needs to broaden its activity to play a full part in the regional network. There are some areas of very good practice, but there is still more to do to complete the assurance process, embed the change of culture and restore the confidence of peers and families that the service has truly turned around.

1 Introduction

1.1 Since the RCPCH's review of GOSH Gastroenterology services in summer 2015 the review team maintained contact with the Medical Director at the Trust, as the detailed recommendations from the review were implemented. The actions taken by the Trust as a result of the review involved significant change to internal team function and staff roles as well as investment in new governance systems and restrictions on referrals until the concerns raised by the review had been dealt with.

1.2 Two years on the Trust formally invited the RCPCH to return and review progress against the recommendations, and provide a fresh steer as to what was needed to embed sustainable change and build a service that was confident and respected as part of a wider gastroenterology network. GOSH has an extremely strong reputation for managing the most complex paediatric conditions and there was ambition that the gastroenterology service could be safely restored to fulfil its role as a specialist level provider with world-class expertise in some aspects of its care.

2 Terms of reference

The terms of reference for the review were agreed by the leadership team at the Trust and the gastroenterology team as follows:

"The RCPCH will conduct a follow up review of the paediatric gastroenterology service at GOSH focusing specifically on:

a) What progress has been made against the recommendations from 2015 in terms of
   - Leadership and management
   - Concerns arising from MDT work
   - Strategic positioning and external referral pathways
   - Safeguarding
   - Communications and administrative support
   - Clinical activity and job planning
   - Governance, guidelines and audit
   - Training and supervision
   - Patient and family Involvement?

b) Are the current protocols, pathways and guidelines fit for purpose and working effectively?

c) Are there any areas of notable practice or achievement?

d) The priorities and strategy for development of the service."

3 Background and Context

The current service

3.1 The gastroenterology service at GOSH is managed as three divisions, each hosting one NHS England Highly Specialised Service as well as managing specialist referrals from other centres and limited referrals from other departments within GOSH. The conditions managed by each unit are:

- Neuro-Gastroenterology and Motility Unit (Drs Borelli. Lindley, Thapar and a locum)

Chronic Intestinal Pseudo-obstruction (CIPO NHS England HSS); Refractory / intractable Constipation; Cyclic Vomiting Syndrome (CVS); Gastro-oesophageal reflux disease, Oesophageal Motility Disorders (Achalasia, Oesophageal atresia etc.); Gastric motility disorders (gastroparesis); Feeding and eating disorders (working closely with feeding team and Mildred Creak Unit and Functional Gastrointestinal Disorders

- GI Mucosal Immunology (Drs Kiparissi, Shah and two locums)

Inflammatory Bowel Disease (IBD) early and late onset, (Crohn's Disease, Ulcerative Colitis, unclassified), Coeliac disease, Eosinophilic Oesophagitis, Immunodeficiency, Autoimmune GI diseases, Epidermolysis Bullosa.

- Nutrition and Intestinal Rehabilitation (Drs Koeglmeier and Hill)

Congenital Diarrhoea (Tufting Enteropathy, Micro-villous atrophy, etc.), Short gut with intestinal failure, Faltering growth, Intestinal failure assessment, Shwachman-Diamond Syndrome, Acute and chronic pancreatitis.

3.2 There are seven permanent consultants, and three locum appointments pending a decision on the future configuration of the service. There are ten 'middle grade' doctors working as clinical fellows or registrars. Two matrons (who also cover other areas), 9.5 clinical nurse specialists (an increase since 2015) a ward sister and 6.5 Band 7 nurses / nurse practitioners complete the senior clinical team.

3.3 Day case attendees and elective/non-elective admissions for less than 5 days are admitted to Kingfisher ward which has 10 inpatient beds (3 assigned to gastroenterology patients) and 6 day case beds and closes at weekends. Inpatients staying for longer are accommodated in the 8-bedded Rainforest ward which is not fit for purpose and at the time of the visit there remained uncertainty as to the plan for relocation.

Actions since the previous review

3.4 Completion of the RCPCH's review in July 2015 coincided with the appointment of a new medical director at the Trust. On 20th July, the RCPCH raised immediate concerns about, some aspects of the service which were followed up in a letter dated 22nd July. These concerns related to allegations of

- Over investigation of some children
- Over diagnosis of certain conditions without consistent criteria or thresholds

- Poor flow of safeguarding and contextual information from local clinicians and children's services
- A concern about how patients are selected for research projects.

3.5 The letter recommended that "*a swift but thorough review is undertaken of the diagnosis and management of 40 of the children currently being treated for eosinophilic colitis to determine whether the overall best interests of the child are being met, and if not devise a strategy for resolution. This review should be completed within three to six months and depending upon the findings of the first 40, more cases may need to be examined*" .

3.6 The Trust responded swiftly to this notification and advised the RCPCH on 24th July that from Monday 27th July all new referrals to the service were to be reviewed by an intake multidisciplinary team (MDT), all procedures were to be agreed in advance against written justification, the cohort of 40 cases for review was being established and consensus –based diagnostic criteria and guidelines for investigation and treatment were to be developed.

3.7 The full review report was sent to the Trust in draft on 7th August and. following receipt of factual accuracy comments, in its final form on 4th September 2015. It defined the external review caseload to "*children without IBD on immune-modulation; enteral feeds and elemental diets"* and made 24 further recommendations.

3.8 During autumn 2015 the Medical Director established the expert panel to conduct the external casenote review, comprising four consultant paediatric gastroenterologists and a consultant allergist. Initial attempts to convene international experts delayed establishment of the panel and the original suggestion of an independent lay chair was not implemented. A list of 40 cases was drawn up for review selected from those who had specifically received any of the following interventions:
1. Exclusion or elimination diet; 2. Presence of gastrostomy or use of NG/J tube; 3. Steroids; 4. Other immune suppressants (eg MMF, azathioprine) or monoclonal antibody treatments. Once established with terms of reference in November 2015 the panel carried out a rapid casenote review and agreed that fourteen of the first 18 cases gave the panel significant cause for concern over the diagnosis and treatment regime. This was formally reported to the Medical Director in December 2015, recommending a more detailed expert review of these same cases including histology, plus a wider clinical review of patients across the service. The panel's report and recommendations were presented in January 2016.

3.9 From January 2016 major restrictions were put on referrals into the service, including significant reduction in endoscopy work, and other specialist centres were asked to increase their activity 'on a temporary basis' to accommodate these referrals

and also conduct follow up reviews of some of the existing GOSH patients. This course of action was agreed with NHS England. An investigation was carried out and there were changes to the management team and a major overhaul of governance, procedures, administration and safeguarding arrangements in line with the recommendations of the RCPCH report, with fortnightly meetings of a task and finish group chaired by the Medical Director.

3.10 The Trust Board was kept fully appraised of the findings and recommendations of the review and the progress being made to address them.

3.11 In parallel with these changes, in March 2016, 42 patients were identified within the gastroenterology service on immunosuppression and/or steroid therapy without another comorbidity or diagnostic rationale. These patients were re-examined by independent expert paediatric gastroenterologists together with the remaining 24 cases in the initial sample. Where appropriate the patient was seen and changes to treatment regime discussed. In line with the panel's recommendations, independent assessment of treatment plans in clinic were undertaken for a sample 20% of gastroenterology patients and two consultant gastroenterologists were seconded into the Trust for three days a week during 2016 to assist with assessing these patients in clinic. Their care was discussed with the GOSH gastroenterologist and where appropriate their treatment regime was amended and and/or they were discharged them to the care of their local service. This was completed by June 2016. For each patient a summary was completed and scored using the NPSA harm definition and the Trust Risk Matrix: "Has harm been done?", "What is the risk of harm?" and "Likelihood of harm"

3.12 The Care Quality Commission (CQC) was involved at an early stage and supported the sampling review of 20% of all gastroenterology patients. In total the Trust estimated that care and treatment of around 300 patients was reviewed. During 2016 the CQC held fortnightly meetings with the Trust but these reduced as the Trust demonstrated more secure governance systems. There was joint oversight with NHS England and NHS Improvement but this moved to operational oversight by the end of 2016. Slide sets presented to the September 2016 Members Council and January 2017 Senior Management team were shared with the RCPCH Review Team but they did not see a formal report for the completion of this process.

3.13 The Specialist Commissioning team at NHS London was made aware of the review and agreed to the changes in referrals and other steps being taken by the Trust to address the concerns raised by the RCPCH. NHS Improvement was also updated.

3.14 By December 2016 the Trust considered it had made significant progress in addressing the clinical concerns raised by the RCPCH and wrote to a number of stakeholders, including specialist centres who had taken its referrals, commissioners, RCPCH and the CQC summarising the concerns and action taken. A summary

statement was posted on the Trust website which set out the steps that had been taken, and included the commitment to invite the RCPCH to conduct a follow up review.

3.15 Both the detailed and the summary statements from the Trust contained the phrase: “the review did not find evidence of long term consequences of over investigation or overtreatment”. This, the review team were told, was justified by the Trust from consideration of the cases examined in detail and review of the statements made by the visiting consultants in response to the questions set out in 3.11. There was recognition by the Trust that for some children there had been lost school days, side effects and disruption.

3.16 Some staff in the Trust, and some clinicians in other specialist centres who had not been fully apprised about the process, inferred that this ’no consequences’ statement had arisen from the RCPCH 2015 review report since most staff had not seen it. Those who expressed concern felt the statement may not have taken into account other patients still undergoing similar treatment for many years whose care had not been reviewed, nor the psychosocial impact on patients who had been on treatments for many years.

3.17 Formal communication with the families whose children’s care was being reviewed by the team at GOSH was carefully planned, and NHSE was involved in this planning. Following the initial casenote review, families were told the conclusions drawn about their child’s care. The letters explained that the child’s care was being reviewed as part of ongoing quality approach and that as a result in some cases changes needed to be made to the treatment regime. The wording used aligned with that on the Trust website and was sent to stakeholders and referring units. In December 2016, the Divisional Director wrote to all children and young people whose care had been reviewed and their parent/carer explaining that the review was complete and that further actions were being addressed including the request for external review.

3.18 The Medical Director left the Trust in December 2016 and Dr David Hicks, a respected former medical director who had been appointed earlier in 2016 to assist with the service overhaul, took over in an interim role and formalised the arrangements for the RCPCH to revisit the service.

4 The Review Process

4.1. The review team comprised three of the four members who conducted the previous review.The team's gastroenterology expert had retired so was replaced by a BSPGHAN Council member who had contributed to the development of the recent 2017 joint standards.

4.2 Members of the review team attended a helpful pre-visit meeting with the Interim Medical Director, Deputy Chief Executive and other colleagues in May 2017. There was agreement that this review should be as open as possible and involve all those who contributed previously (if still in post) as well as others who are new to working with the service. A range of documentation was provided to the team before and during the review period and information requested was provided, where available, swiftly and without hesitation.

4.3. The review was conducted over five individual days to maximise the availability of the review team. The visit programme was put together by the Trust and alongside this the RCPCH made contact with other stakeholders and arranged for written submissions or telephone or face-to-face interviews with one or more members of the team. In all 94 individuals contributed to the review.

4.4 A survey seeking the views of patients and families was made available through the Trust and relevant social media and a member of the review team attended an engagement morning for patients and families on 15th July 2017. The survey generated just 18 responses which was surprisingly low. The RCPCH uses surveys on its reviews to provide an opportunity for patients and families to contribute their views. However it is more important to assess how a service is itself gathering and acting upon the views of patients and families and this is considered in section 5.9.

4.5 Throughout the review the Interim Medical Director and staff across the service have been helpful, open and accommodating and the review team did not feel there was any restriction on access to information. Those contributing from outside the Trust have been open and honest in their opinions and almost all those who participated had noticed an improvement in the service and were keen to continue to work with the Trust to embed the changes.

5 Findings

The findings from the review have been grouped under the headings of the terms of reference.

5.1 Leadership and management

5.1.1 Most of those interviewed recognised that it had been a very difficult two years for the gastroenterology service; particularly for the consultants who had undergone investigation but also for nursing and other staff who recognised that treatments they had been administering may have been inappropriate. The impact of the changes to the service had been far-reaching in some teams whilst others had seen little change beyond temporary disruption. Some of the external experts who agreed to support the Trust through casenote reviews and taking referrals had found the team unwelcoming and the process and communications unsatisfactory.

5.1.2 At Trust Board level the arrival of the new Medical Director in July 2015, alongside a new Chief Nurse catalysed the change, enabling the Trust to start to tackle longstanding concerns raised by the RCPCH and others about the service. An interim general manager was appointed for a year in February 2016 who gained respect and ensured the casenote review work was delivered and documented systematically. Actions were completed and clear policies began development. A new Divisional Director and replacement General Manager alongside the appointment of a new clinical lead from within the team has enabled swift and positive change in the governance systems, referral pathways, administration of clinics and communication with patients and families.

5.1.3 Although improved processes and systems are now in place there were still some concerns expressed that more time is needed, with clear and confident leadership to tackle deep-seated attitudes amongst some of the consultants.

5.1.4 A consistent theme amongst almost all staff interviewed, was frustration at the absence of clear communication from senior management about the 2015 RCPCH review report and how and why the changes during 2016 were implemented. Whilst the Board, CQC, commissioners and external reviewers had seen the report it had not been shared with the consultants, even in summary form and there was much unhelpful speculation and frustration at the report's content and the reason for the imposition of changes by the Trust management. Staff received a brief announcement just before Christmas 2015 explaining that as a consequence of the RCPCH report, activity would be significantly restricted but there was too little information for them to understand and plan for the consequences or advise families what was happening. Some of the staff interviewed had inferred a lack of trust and a sense of isolation from the Board and senior management, which could have been mitigated through greater visibility, briefings

and a programme of organisational development to build and retain trust and recognise the efforts of those working with and within the service.

5.1.5 Whilst staff felt it was important to share their frustrations at how the process had been handled, in order that lessons could be learned, most interviewees did recognise, with hindsight, that the events of 2016 had been necessary and helpful in the longer term. They appeared to understand that given there were personnel issues to deal with, it had been important to be careful with information, sure-footed in managing potential trigger points, particularly around media interest, and to maintain control to make the service safe as swiftly as possible. They recognised the positive medical and operational leadership of the Trust, division and service and were hopeful that the 2017 RCPCH review would trigger sustainable restoration of an open, fully functioning service. The General Manager is well respected and has built a good level of trust. The Interim Medical Director is well respected and has provided a positive influence on the team but is scheduled to leave in December; the Divisional Director is highly respected and has a clear vision of how to manage the consultant team and encourage the best from the service and important that the new Medical Director engages swiftly to maintain the confidence of the team and its stakeholders.

Recommendation: Take steps to ensure there is stability of clinical and operational management to embed the positive developments

5.1.6 Amongst the consultants there is a more positive approach to service deliveryand governance systems. Following case reviews all consultants underwent individual and team coaching sessions to address the issues highlighted in the previous review and build greater interpersonal .and team-working skills. This has had some impact although several interviewees were concerned that the changes made around multidisciplinary working, consistent protocols and peer review may not be sustained once the service gets busier so continued management vigilance to ensure the new processes are embedded is important.

5.1.7 Whilst the clinical lead has worked hard to bring the team together, support the governance changes and develop, with colleagues, a shared vision for the service, there is an opportunity to establish the service more formally as a centre of excellence, building momentum and respect externally amongst specialist and research colleagues. By creating an NHS based senior clinical leadership post in gastroenterology, high calibre applicants would be attracted to the opportunity to develop and influence the clinical service. This was a recommendation in the 2015 review. The right appointee would bring gravitas, credentials, excellent networking capability and constructive challenge to lead and develop the GOSH team further in regional, national and international circles. Strategically GOSH being based in London has a responsibility to equitably contribute alongside other paediatric GI units to the care of children in the region. They should encourage greater external collaboration and peer engagement

amongst the consultant team to develop and demonstrate excellence alongside providing opportunities for critical challenge and enhanced research capability.

Recommendation – Appoint a respected NHS based external clinical leader to the post of senior clinical lead - equivalent to a chair - in gastroenterology to develop the service, working together with other units on London-wide GI network collaboration (see also section 5.8 about networks)

Recommendation - GOSH should become part of this London network to equally contribute to the care of the regional population alongside other GI units. In addition, GOSH may wish to also agree on their unique focus and to ensure appropriate communications between GOSH and all hospitals in this network

5.1.8 Other teams in the Trust have risen to the challenge and continued to support families and the gastroenterology team, recognising that they have been undergoing significant difficulties. Surgeons have seen a more systematic approach to pathways but are concerned that the systems may have become 'over bureaucratic' and inefficient, with little cross-department representation at team meetings.

5.1.9 The dietetics team were very enthusiastic about the changes since the 2015 review, with much greater MDT involvement in clinics, development of protocols and pathways and rigorous follow up of children following exclusion diets. However, there is more to do to embed the changes and ensure that children with complex needs always receive appropriate observation, management and review.

5.1.10 Nursing leadership within gastroenterology has improved significantly with a new matron and ward sisters/nurse practitioner on the wards and investigations unit. Staff turnover has reduced, morale is good, staff have defined career pathways and speak positively about the service outside the Trust. Stronger links have been forged with mental health staff so ward nurses feel better equipped to manage and support complex families.

5.2 Concerns arising from MDT work

5.2.1 The 2015 RCPCH report recognised the intention of the complex cases MDT to identify and review the care of patients with challenging presentations, where there may be a more functional / psychological / factitious cause to symptoms and treatment may need to be revised. This was chaired by a consultant child psychologist, but the 2015 report commented that it was not being robustly supported to work as swiftly and effectively as it should. Since the review the complex case MDT had increased its activity and attendance, and the review team were told of a database of complex cases numbering around 180 of which 70% were perplexing presentations. The chair retired late in 2016; the new chair was reported to be well-respected and the meetings are continuing to work effectively with increasing engagement of most of the consultants.

The local paediatrician for a child whose case is under review is usually invited to telephone in and provide context to the discussions, and the Named Doctor for safeguarding also attends when her diary permits.

5.2.2 Despite the improvement and changes to functioning of the complex case MDT, there remain concerns amongst some staff that whilst the process continues to improve it is insufficiently effective or thorough at the moment. They told the review team that a higher proportion of children may benefit from reduced or delayed intervention where the indicators of disease are unclear, but that even as clinicians they did not feel confident to raise concerns. They explained that in some areas they still perceived a culture that suppressed challenge from colleagues which made them fearful of speaking out. The published phrase stating, “no evidence of long term consequences” as referenced in 3.15-3.16 further exacerbated their concerns although the Trust had received approval from NHS England for all communications. Several indicated that there appeared not to have been any organisational learning or remorse from the situation or focus on actually what happened to those children and families.

5.2.3 These continuing concerns need to be tackled systematically and transparently by the Trust so that all staff understand the process for raising concerns and feel confident that these will be properly investigated and, most importantly, responded to genuinely and honestly with due care and support for the families involved. Specific cases brought to the attention of the RCPCH team were raised swiftly with the Medical Director in July and the review team has been advised that the matter is being addressed.

5.2.4 Under the 2016-7 NHS Contract all Trusts were required to appoint a “Freedom to Speak Up Guardian” to support whistleblowing and reporting of concerns. GOSH appointed seven FTSU Ambassadors across a diversity of job roles to ensure they were approachable. The team meet regularly, are engaged in an ongoing development programme supported by the Human Resources and Organisational Development department and link with the National Guardian’s office. The initiative is being reviewed but was reported to be working well.

Recommendation – Clinical management should satisfy the Board that an investigation of historical gastroenterology cases has been completed in full, specifically the care of all children on long term interventions without a clear validated diagnosis.

Recommendation - There should be a demonstrated climate of openness in addressing concerns raised by staff to provide assurance that appropriate action and candour has been exercised.

Recommendation - There should be a further clinical review of the service and approach to cases 12 months after the lifting of referral restrictions

5.2.5 The review team recognises the challenges faced by clinicians and families in discussing changes of treatment or discharge from the service, particularly when families have become familiar with one consultant and the service at GOSH. The two consultants seconded into the service in 2016, as well as gastroenterologists in other specialist units were expected skilfully to manage an unenviable task in explaining to patients and families why the changes had been made and helping them to adapt to a different care plan.

Recommendation - Ensure the effectiveness of complex cases MDT to encourage the lead clinician to discuss cases in a forum with other GI consultants, general paediatrician[1], safeguarding lead (when appropriate), nursing staff and clinical psychologists. All staff should be empowered to contribute.

5.2.6 Every clinic is now preceded and followed by an MDT which reviews the cases and agrees the clinical management. This shared decision-making improves patient safety, provides a teaching and learning opportunity and reassures patients that there is more than one clinician advising on their care. This assurance and consistency of approach has been welcomed by almost all staff involved. There are some consultants who find it burdensome and others noted the additional clinical and administrative time required for reporting and uploading all discussions to casenotes. The universal MDT approach still needs to be fully embedded but will also need to be risk assessed and streamlined so it is sustainable and remains effective once the service has opened up to a wider range of referrals. As a minimum, there must be the consultant on take and the lead consultant for the clinic.

Nuclear Medicine and diagnostics

5.2.7 The 2015 report highlighted poor communications between the gastroenterologists and the diagnostic team, with inadequate information for and about patients, a lack of clarity over the purpose and need for some investigations and concerns that children were being over-investigated. The pre-procedure information about patients available to the diagnostic team was reported to have improved, but the review team was told that sometimes patients are still being referred with insufficient justification or checks, or requests for procedures that are unusual, which generates tension between the teams. Regular meetings between the teams should be facilitated to address these concerns and ensure that all procedures are carefully considered in terms of the best interests of each child with a climate of equality and discussion.

Gastroenterology Investigations Unit (GIU)

5.2.8 Following the review there has been a transformation in the GIU and endoscopy service. Activity had dropped significantly; each referral requires detailed supporting information and is now robustly assessed by an MDT to identify where symptoms may be functional. A bid for replacement of the endoscopy stack was successful with the new

[1] Section 5.5 on safeguarding explores the role of the general paediatricians

equipment coming into use at the time of the visit. This investment in the service has been much welcomed and improved morale in the unit as well as significantlyreducing risk; the previous stack was not fully compatible with the Trust's information systems. Nurses are receptive to doing more investigations and an in house specialist training course is being established

5.2.9 Children and families are much better prepared for the diagnostic procedures in the GIU than two years ago, when communications and administration was very poor and staff felt unsupported. There is reasonably good information on the Trust website and patient leaflets and a newly appointed staff member will focus on pre-admission arrangements and further improve communication and patient/family experience. The nursing leadership has been strengthened, including the recent appointment of a nurse practitioner which has improved morale and reduced turnover.

5.3 Clinical activity and job planning

5.3.1 Following the restriction on accepting referrals, total activity has dropped significantly (Fig 1) yet the consultant staffing numbers remain unchanged, enabling much more time to be spent on MDTs and governance activity. However even with reduced referrals from July 2015 and further reductions six months later the department only succeeded in meeting the 18 week RTT targets in December 2016. It has since remained compliant.

Activity (Source = Qlikview)	2014/15	2015/16*	2016/17	Commissioned 17/18
Outpatient - New	902	1,237	207	263
Outpatient - Follow-Up	2,395	3,922	2,934	2,646
Total Outpatient	*3,297*	*5,159*	*3,141*	*2,909*
Outpatient (Telephone)	1,762	389	617	594
Day Case	1,319	1,344	881	725
Elective	1,190	961	859	840
Non-Elective	41	50	77	46

Fig 1 Gastroenterology Activity *Whilst additional consultants were seeing extra patients

5.3.2 There is a referral MDT every Monday morning which all consultants are expected to attend. The MDT was reported to work well with good agreement.

5.3.3 The criteria for accepting referrals were finalised in May 2017 and include all referrals from other specialist centres, plus selective referrals from secondary care in a district general hospital (DGH), and limited in-Trust referrals. These criteria are too limited; they were imposed in 2015-6 when the service was being reviewed and some staff were not available for a period. Now the review is complete and all are working again it is important that the service 'steps up' to deliver at least as efficiently as peer units contributing effectively to paediatric GI care in the region.

5.3.4 The general manager for gastroenterology had drafted a comprehensive service position statement as a basis for future planning, which included a demand and capacity analysis and assessment of the administrative and clerical workforce restructure. It reflected that the current workload is unsustainable in the long term which is also the view of the specialist commissioner given the increased pressure on other units which previously referred to GOSH. Of course, families who have been waiting a considerable time for their appointment and travelled a long way for it expect plenty of time with the doctor or others at the hospital but this is inefficient use of medical time.

5.3.5 The review team concur that the service should be able to see 6-8 patients per clinic including appropriate MDT review. With nursing backup and efficient administration this should be feasible and is more in line with other specialist services nationally.

Recommendation - Review the acceptance criteria, pre-and post clinic MDT, and job plans carefully to enable greater throughput of patients without compromising governance or increasing risk

Nutrition/intestinal failure

5.3.6 The nutrition service/intestinal failure was reported to be very stretched with two consultants and three nurse specialists with up to 52 inpatients on PN across up to ten wards in the hospital. They struggle to meet the RCPCH/BSPGHAN standards that every child on PN should be seen weekly and have seen reduction in clinical fellow support since 2015, which impinges on the consultant job plans. The issue is on the Risk Register and the team are seeking an additional consultant post to enable cover for leave and sickness.

5.3.7 It is suggested that a review of patients on PN is conducted to ensure that all are requiring the intervention, and comparison with network and European standards as conducted in 2015 may again provide useful benchmarks. However the current situation is unsustainable and there is a realistic case for increased senior medical cover.

Recommendation – Increase medical support for the intestinal failure team

5.3.8 Concerns were also raised to the review team from regional centres about the local management of children with feeding tubes. A typical cited example is of children with displaced Jejunal tubes, with no clear pathway with regards to point of referral or contact in GOSH to replace these tubes. Presently these referrals may be accepted by either the surgical or gastroenterological teams, partly depending on which unit may have a bed.

Recommendation – Strengthen the pathway and links with local units for support for children with feeding tubes

Managing patient diets

5.3.9 Given the cohort of families that are referred to the department seeking advice, the oversight and management of exclusion diets needs to be robust. The review team heard reports that some children had been kept on strict dietary regimes for over 6 months without review and others had been recommended exclusions even before a first appointment, which may not have been necessary and could have affected self-esteem and quality of life. It was reported to have been in some cases hard to reintroduce foods even following inpatient stays, as compliance at home can be patchy.

.

5.3.10 Although there is a fortnightly steering group for allergy, and the dietitians have a higher profile within the MDT, there is no currently paediatric allergy consultant in the Trust.

5.3.11 Whilst the review team was told there are now better explanations about special diets and improved expectation management, including written diet sheets, just two consultants sign off multiple exclusion diets which can cause delays. Clarity is required about what allergy service should be offered and its governance, and there is scope for the general paediatricians to have greater involvement.

Rotas, ward rounds and team working

5.3.12 There has been considerable progress made in rostering and visibility of the consultants. Job plans have been drafted by the clinical lead and general manager but have not been agreed yet pending the recommendations of this review and any consequent changes to service activity.

5.3.13 Nine of the consultants cover a fortnight on 'take' including availability on-call overnight and at weekends. Although this technically risks breaching the Working Time Regulations[2] in terms of compensatory rest for periods on call in the hospital the workload is not acute or excessive (there is of course no emergency department) and all consultants are content with the arrangement, in effect working seven weeks a year on-call.

5.3.14 The on-take doctors conduct a ward round at least daily and sometimes twice, and others were reported be more visible on the ward seeing their patients and liaising with the nursing staff on Wednesdays and Fridays. Following the Monday morning referral MDT there is a Grand Round at which each inpatient is presented by their consultant to the consultant on-take for the week. Although there were still reports of the on-take consultant changing the management plan of an inpatient there was a greater tendency to discuss the approach with the child's consultant and the increased profile of the specialist nurses has improved consistency of care and involvement of patients and parents in understanding why changes were being made.

[2] Statutory requirements adopted in the UK based on the European Working Time Directive limiting the number of hours spent on site at work. https://www.gov.uk/maximum-weekly-working-hours/overview

5.3.15 Team working amongst the consultants was reported to have improved and some have risen very well to the challenge of new opportunities since the 2015 review. All have undertaken four team-coaching sessions to assist this, but teamworking remains relatively fragile and continued vigilance around behaviours and attitudes by the General Manager and Strategy/research lead is likely to be required for some time yet. It was suggested that further teambuilding work would be helpful and as we suggest elsewhere, the appointment of a senior clinical leader to the department could provide that. There is more to do to fully involve other disciplines; although the consultants have begun to engage better with managers, nurses and dietitians through multidisciplinary teams, others such as pharmacists struggle to be heard. (see Section 5.10.8). The paediatric gastroenterology team has three divisions and it is important for these units to not only communicate and work cohesively together but also to come across as a unified paediatric GI team when working with other specialities and hospitals.

5.3.16 There were still no scheduled weekend ward rounds despite the service accommodating extremely sick children. The consultants were reported to often 'pop in' and see their patients or catch up on paperwork, but the surgeons would not involve them for post-surgery review at a weekend. The review team support the BSPGHAN/ RCPCH standards that specialist advice should be available round-the-clock and children should not be in hospital for any longer than absolutely necessary. Development of an efficient seven-day service, as happens in paediatric services around the country will increase throughput and make best use of limited inpatient beds.

Recommendation – Finalise job plans, including weekend ward presence, appoint to permanent positions and consider additional recruitment to provide cross-cover and manage activity.

Outliers

5.3.17 Whilst most patients are accommodated on Rainforest and Kingfisher wards, the gastroenterology and nutrition team also visits those recovering from surgery or receiving parenteral nutrition but under a different department. There was some confusion as to which doctors have overall responsibility and the role of the gastroenterology team and general paediatricians which needs to be addressed.

Recommendation - Clarify the responsibilities between gastroenterology and general paediatrics for patients on non-gastro wards

Ward environment

5.3.18 All interviewees agreed that although nursing leadership and culture had improved, the physical environment on Rainforest Ward remained at the time of the visit wholly unfit for purpose. There have been numerous reports and business cases highlighting insufficient cubicles, toilets and space resulting in excessive waits for admission, high numbers of complaints, inappropriate outliers and concern aboutpatient

safety. This has also been highlighted by the CQC and despite the construction of new ward space elsewhere in the Trust there was still no definitive plan. This isunacceptable.

5.3.19 At the time of the visit relocation had been proposed to Sky ward once the space has been vacated by other specialties which would enable the three locations in which the team works to be closer together, but there were concerns about privacy and dignity for adolescents. Many staff expressed anxiety that the new ward space may need to be shared with metabolic and endocrine teams due to risk of 'patient overflow' and other risks to patients. Some expressed concerns that the nursing approach is very different and considerable training and team building would be required in such an arrangement, but the senior nurses did not consider that to be significant orinsurmountable.

5.3.20 The plans still offer insufficient beds to manage patients needing stabilisation of long term nutrition needs; they cannot be accommodated on Rainforest, making their care inefficient and potentially delaying discharge. Some patients requiring long term observation or two-week pre-transplant assessment before transferring to King's cannot be accommodated to meet the timescale required for the procedure.

5.3.21 Neither the ward sister nor Matron appeared to have been consulted over the practical requirements of a new ward. Their involvement at an early stage is important when planning use of space and practical operation, alongside the benefits of proximity of the three clinical services (inpatients, day-case and endoscopy).

Recommendation – Prioritise improvement of the ward environment as a matter of urgency and involve ward staff in discussions about relocation.

5.3.22 If a move is not approved then the service will need to further restrict those referrals that can be accepted. This is not feasible given the pressure on other services and the continued presence of a full complement of paediatric gastroenterologists so it is essential that a move to an appropriate location is expedited.

Recommendation - Plan realistically to ensure the appropriate number of beds so that children with "perplexing presentations" can be admitted, observed and managed, cohesively with general paediatrics, local paediatric teams and safeguarding where necessary.

<u>Mental health CAMHS and psychological support</u>

5.3.23 There is increased awareness, through the MDT and the clinical lead of the importance of psychological input to the gastroenterology service. In November 2016 a band 8b Clinical Psychologist was appointed on a two year fixed term 0.8 wte contract in order to embed psychology within the gastroenterology service. A clinical fellow from the gastroenterology team has been allocated one session a week to link with the feeding team resulting in swift resolution of queries, and much improved pathways for children moving between the services. The clinical fellow and administration team have inrecent

months built much more effective communication channels with the child's local paediatrician and CAMHS service to smooth referrals between the specialist teams, and discharge to integrated local care.

5.3.24 Whilst there have been significant improvements in the approach to children presenting with complex conditions, including advising parents that a psychologist will be present at the initial MDT, and earlier involvement in review, some consultants were reported to focus on medical investigations before considering functional /psychological causes for symptoms. The review team was told of inconsistency and confusion over who is responsible for a child, once physical investigations have been completed and no clear diagnosis made. This appeared to be a deep-seated view and requires firm and consistent challenge to recognise 'normality' and a more holistic approach to the child and family. Other clinical specialties at GOSH have moved much further forward with this approach for which psychology is well embedded, delivering improved health outcomes. A psychologist should attend every gastroenterology referral assessment meeting and psychosocial assessment should be completed for every patient for whom surgery is proposed.

5.3.25 A business case has been drafted for provision of universal mental health screening as a CQuIN[3] for all children and young people with long term conditions at their first appointment in four specialties, including gastroenterology. However there remains insufficient capacity in the CAMHS team (0.8WTE, 8b Clinical Psychologist fixed term to November 2018) to support the gastroenterology team properly. A business case for two additional Band 7 roles and permanency for the psychologist is awaiting approval.

Recommendation - Invest in building sufficient clinical psychology input to meet identified demand and increase mental health screening /support.

5.4 Communications and administrative support

5.4.1 Since the 2015 review there has been improved leadership and investment in administration systems and personnel, which has reduced turnover and improved morale. A skill-mix review resulted in some posts being regraded to provide a clearer career progression, and each department having a similar administrative support structure. The medical secretaries have clear processes for managing and responding to contacts from families, arranging call-back on telephone calls and monitoring letter turnaround times. Appointment letters were increasingly being sent on time with better templates for patient letters, discharge notes and other notifications. There is a single departmental number for queries, with a rota for taking enquiries enabling the others to concentrate on other duties.

[3] Commissioning for Quality and Innovation – Indicators which enables release of funding.

5.4.2 A monthly performance dashboard is prepared by the clinical service lead and general manager to ensure administrative improvements remain a priority for support. In May the gastroenterology RAG meeting noted a plan to address the issues that had been raised around discharge summaries.

5.4.3 Communication within the gastroenterology team was reported to be better – there is less changing of patient regimes when on take and grand round care plans seem to last the week more frequently.

5.5 Safeguarding

5.5.1 There has been good progress in addressing the arrangements for safeguarding across the Trust since 2015. The RCPCH had previously expressed serious concerns about the isolation of the safeguarding (social work) team from the problems in gastroenterology, and the frequent absence on admission of any local data on the child and family in terms of safeguarding or fabricated or induced illness (FII) issues. These issues had been identified in a serious case review in 2013 and a number of changes have been made including the appointment in February 2017 of an experienced Named Doctor for child protection to the General Paediatric team which has been widely welcomed as a further positive step.

5.5.2 The safeguarding annual report 2016-7 also highlights the strengthening of the safeguarding nursing team, development of social work function and increased involvement of staff in child protection conferences as well as plans for updating the safeguarding policy and improving safeguarding training quality and compliance. Following an internal report in response to the Lampard Report prepared by the interim named doctor in 2015-6, a review was commissioned from an external expert in March-April 2017 following the arrival of the new Named Doctor. The report recognised that progress had been made and provided a number of helpful recommendations.

Recommendation - Ensure continued support for the safeguarding programme with all clinical staff in gastroenterology safeguarding trained to Level 3

5.5.3 The 2017 review team was told of patients requiring extensive psychological therapy who had undergone many years of invasive treatment thought to have been based on functional or fabricated symptoms. Although the families may have accessed several teams, the Trust is moving towards a culture of systematic, sustained organisational learning from these cases and proactive case review for others in similar situations. Some staff remain unconvinced that this is embedded. Such cases are complex and may require involvement of many clinicians and agencies to ensure that case reviews are thorough and complete and those patients and their families are supported through the process.

Social work team

5.5.4 As a result of the previous reviews the social work team has been strengthened and started to link more closely with local units. The social work team can provide a range of therapeutic support to families, helping them cope with the challenges of a sick child and also exploring issues that may relate to functional problems or psychological need. Some staff were concerned that some of the doctors feel that involving social care may be stigmatising for a family, although work is under way to improve MDT working and level 3 face to face training is delivered by members of the social work team. Work continues to strengthen these relationships with a new training programme to help clinicians communicate with families about managing functional illness where there is no physiological reason for a child's symptoms.

Recommendation - Continue to improve liaison and understanding between the gastroenterology consultants and the social care team.

General paediatrics

5.5.5 The role of the general paediatricians in supporting the gastroenterology service is undervalued and should have a higher profile. General paediatricians can bring objectivity to complex and perplexing cases, particularly motility patients awaiting surgery where it is important that all possible child protection issues or alternate treatments are considered carefully. They should be fully integrated within the department to advise on 'normality' of cases, liaise effectively with local referring clinicians and provide an experienced opinion around safeguarding concerns.

5.5.6 Currently the general paediatricians cover many specialties, offering continuity of advice and support for families navigating several teams within GOSH including surgery, TPN and gastroenterology. They also have an important role in the international and private patients division, ensuring that the principles of the Trust are upheld for these families and the restrictions on accepted referrals and approaches to treatment are consistent with the NHS work carried out in the Trust. They do not of course have oversight of the approach to patients and families who choose private investigations, diagnosis and treatment in other centres but these services are registered with the CQC.

5.5.7 The general paediatricians have worked hard since the 2015 review to identify those children whose diagnosis and treatment may have been inappropriate in order to move them more towards 'normality' where possible, reducing interventions and tackling psychosocial issues. They reported that whilst there have been massive improvements in safety and protecting children from harm they do not use the escalation process to raise or discuss cases of concern, learn from findings and focus on making the child better.

5.5.8 It is essential that a general paediatrician provides regular input to the referrals meeting and complex MDT, that they take lead responsibility for patients as part of the MDT and it is suggested that they have access to observation and rehabilitation beds.

These could be used for children recovering from major surgery, requiring observation before diagnosis or those with a residual disability.

Recommendation – Involve a named general paediatrician in the referrals meeting and any gastroenterology subspecialty case with a perplexing presentation, including current cases where a child has a significant disability after receiving treatment or investigations, without a proven cause.

5.6 Governance, guidelines and audit

5.6.1 The improvements to governance and administrative processes since the 2015 review have been positive and were remarked upon by several interviewees. During 2016 the Medical Director chaired a fortnightly Improvement Group meeting to address the report's recommendations.

5.6.2 Since November 2016, with a new general manager and completion of the case reviews, these meetings have migrated to a more sustainable structure and the following have been introduced:

- Monthly Report showing activity, incidents, risks, feedback, finance, various KPIs
- Monthly Risk Action Group with multi-disciplinary representation
- Fortnightly Quality Improvement Group that include the following work-streams
  - Improving Outpatient Clinics
  - Improving Communications
  - Improving Pathways for procedures in the GIU
- Weekly Consultants Meeting
- Monthly Administration & Clerical Team Meeting
- Weekly PTL and planning meeting to assess capacity for GIU admissions
- Quarterly Guidelines and Protocols Review Meeting (from July 2017)

5.6.3 This is a strong system, with good feedback about how the Risk Action Group, chaired by the Clinical Lead supported by the Divisional Director and General Manager with cross-service medical and nursing attendance is driving improvements such as the GIU Stack replacement. Some concerns were raised that a 'spike' in medication errors was not on the risk register but the systems have been refined with routine double-checking. The review team heard that nurses raise issues more readily with doctors and incidents are more formally approached and dealt with in a more open way.

5.6.4 Some of these new work streams are in their early stages, driven by the general manager and will need continued support, encouragement and review to maintain commitment and demonstrate sustainable impact amongst the consultant team. This is particularly important should there be any changes to the management team, and/or if the activity increases in line with the recommendations of this report.

IBD service

5.6.5 This service operates under an international benchmarking collaborative 'Improve Care Now' or ICN which has had pre and post clinic peer review and outcome measures for many years. The department has continued to accept all new referrals aged under 6 years from specialist centres, although referrals for older children have been restricted since late 2015 and are sent elsewhere. The team was reported to have made good progress with the MDT, virtual IBD clinics, regular ward rounds and improved governance with plans for an improved patient database for specialist clinics and a swifter pathway enabling more patients to be seen. The team is apparently keen to increase its networking with peers in this relatively limited field, and they are planning an open day for DGH paediatricians and the development of shared guidelines with local settings. Guidance for the diagnosis and management of eosinophilic disease are being developed through the European Society for Paediatric Gastroenterology, Hepatology and Nutrition, (ESPGHAN).

5.6.6 The IBD unit also subscribes to Patient Knows Best scheme (PNB), a UK-social enterprise-developed patient-controlled online medical records system and tool to help patients better manage their care. GOSH is one of the first UK hospitals to use the scheme and reported positive benefits.

5.6.7 The review team did not examine these schemes in detail but recognise the importance of quality improvement and benchmarking, the enthusiasm of the IBD team and the Trust's international reputation. It is of note that although the service was reported to be respected, it is very selective about the age range covered and few interviewees outside the IBD team mentioned the schemes or the international status of the service, and evidence of Quality Improvement initiatives outside IBD was slim. Many interviewees reflected that a priority should be establishing a stronger presence and benchmarking within UK gastroenterology peer networks but there is scope to use the learning from these schemes in other divisions and indeed departments in the Trust.

Recommendation - Maintain current safeguards, governance and QI programmes and consider rolling out the benefits and principles of PNB and ICN across the service

Patient experience and quality

5.6.8 There are three Assistant Chief Nurses responsible for workforce, patient experience and quality.

5.6.9 The service was proud of the reduction in complaints to zero since January 2017 from 2-3 per month during 2015, which comprised around 15% of overall complaints in the Trust. In the year to April 2016 there were 152 informal comments/concerns, with most of the negative ones being about the Rainforest ward environment. However, it is

important to acknowledge that the activity has dropped by around half in the period so a proportionate reduction in complaints is to be expected.

5.6.10 The number of reported incidents fell between June and November 2016 but since then has increased – probably reflecting increased reporting - then plateaued as they are being dealt with, peaking at 33 per month in April 2017. There were no serious incidents reported to NHSE between June 2016 and May 2017; of the comments analysed resulted in minor or no harm but 91% were patient safety and 9% were health and safety issues. The multidisciplinary Risk Action Group monitors and acts on incidents which is good practice.

5.7 Training and supervision

5.7.1 Within the Trust the last 18 months has seen a strengthened process to allocation and support for trainees, with refreshed College Tutor roles linking with Divisional Educational leads and better join-up between departments. The Trust has begun to run College membership training courses and exams and has a positive feel about future developments of teaching and training.

5.7.2 The Medical Director temporarily suspended its training posts in November 2015 but the Trust has indicated to the Head of School that they would like to accept them from September 2017. One grid trainee and two SHO posts will be established in the context of a department that is now better furnished with juniors to contribute to the overall out of hours rota. It is important that the new posts are suitably attractive in terms of experience and innovation as recruitment in the past has previously been difficult. Most of the non-consultants working in the department (and Trust) are clinical fellows including international graduates.

5.7.3 The GMC report and other intelligence indicated that junior doctors previously experienced few opportunities to participate in practical procedures – the Trust now has a simulator facility but this is under-utilised and could be better co-ordinated.

5.7.4 Not all the consultants had been enthusiastic teachers which was surprising to hear for a team that considers itself to be offering “quaternary care”. Consultant attendance at the educational meeting can be poor but the College Tutor plans to improve that. There were however no concerns about the consultants’ competence. Trainees reported that much of their learning had been from peers, and they were sometimes asked themselves to teach beyond the scope that they were comfortable with.

5.7.5 It is important if the Tier 1 trainees are returned to the department that they are offered protected time for training. The College Tutor was willing to support the reintegration of trainees if the issues above can be sustainably improved.

5.7.6 For Clinical Fellows there has been considerable improvement since 2015, with more time for teaching and learning with the reduced activity and introduction of the pre- and post-clinic MDTs. Some come from overseas with no gastroenterology experience so can struggle a little initially. The timing of the Grand Round after the complex MDT means some registrars find it difficult to attend the first meeting but they see patients regularly and discuss with colleagues. The teaching afternoons are appreciated and feedback about those consultants who regularly attend was very positive.

5.7.7 Consultant compliance with appraisal is monitored. All appeared to be up to date.

5.7.8 There has been considerable improvement in career opportunities for nurses within the gastroenterology service with the increased profile of the clinical nurse specialists, but there is still no nursing practice educator. It is a priority for teaching to include a more structured approach to manage total parenteral nutrition (TPN) and double-checking prescriptions so patients can leave hospital sooner.

Recommendation - Consider appointment of a nursing practice educator

5.8 Strategic positioning and external referral pathways

5.8.1 Following the 2015 review a restriction was placed on new referrals which was still in place when the review team revisited. The lead consultant and a colleague had developed a positive and clear strategy for the future of the service which concentrated on development of the highly specialised work and providing opportunities for specialist consultants from other units to conduct joint clinics at GOSH. Whilst it is logical and straightforward, the strategy perhaps underestimates the capability of the service. It does not recognise the expertise that has over several years developed in other centres from which the GOSH team may themselves learn. Most of the work commissioned from GOSH is relatively routine specialist work and the three ‘highly specialist’ elements are very low volume.

5.8.2 Relationships with other specialist providers were mixed; whilst individual consultants worked well with external teams (Luton and Dunstable and UCLH were specifically mentioned) there was continued unease about poor communications from GOSH management and lack of recognition from both GOSH and the NHS England commissioners that the ‘temporary’ redirection of referrals had placed considerable strain on other teams. Seven specialist providers were asked to support GOSH on a short term basis in November 2015 when the service closed to new referrals as investigations were in progress. During 2016 only selective referrals from other specialist centres were accepted. In December 2016, GOSH wrote to all units explaining that their internal investigations were complete and that they were asking the RCPCH to revisit but without providing further information about outcomes or anticipated timescales for completion and resumption of normal services. This resulted in increasing frustration at other units which were facing pressure on waiting lists, frustrated families and additional cost which

was not covered by the payable tariff, which had been proportionately withdrawn from GOSH

5.8.3 The review team was told that this whole process had been ‘utter chaos’ with no details about pathways and protocols, alternative specialist centres being overwhelmed and unable to offer shared care to DGH referrers. The consultants were unable to advise as they were not driving the process. There were concerns that children and families were unsupported and confused and that GOSH was perceived to be practising ‘defensive medicine’ with the consultants becoming too afraid to practise and being ‘micromanaged’. There were concerns about patients who had missed several appointments due to the confusion and a lack of clarity and communication from commissioners as to how these patients and the ongoing situation should bemanaged.

5.8.4 During the course of the review team’s visits a joint letter was sent to the London Specialist Commissioner from seven specialist units requesting urgent intervention to rebalance the patient flows and require GOSH accepting more specialist referrals. The letter highlighted the implications for patients of the reduced activity at GOSH, which included long waiting lists to be seen at other centres and no attempt by GOSH or the Commissioners over the 18 months of restrictions to proactively liaise with the specialist centres and plan the capacity required to manage the additional workload. The specialist commissioner had confirmed that he was awaiting confirmation from the MD at GOSH that the service was fit to restore activity.

5.8.5 Across London there has over recent years been an expansion in provision of specialist gastroenterology with many expert services developing their own preferred catchment areas and building enviable reputations. The RCPCH 2013 census[4] showed a considerably greater proportion of specialists in London (there are 25 paediatric GI consultants for a population of 8-9 million where Department of Health guidance suggests 1 per million. See Fig 1 overleaf.

5.8.6 Although proud of its three small highly specialised elements of its services the GOSH team is not providing leadership to other units and the struggle to appoint to permanent posts whilst the review was ongoing stimulates questions about how these services are provided. There is no formal network or opportunity for co-ordinated referral pathways and peer support between specialist units for development of highly specialised expertise and mutual teaching and learning. There appeared to be no formal monitoring of outcomes or quality of the highly specialised (and expensive) services nor whether they offer the NHS value for money as provided.

[4] RCPCH 2013 census – specialist services.

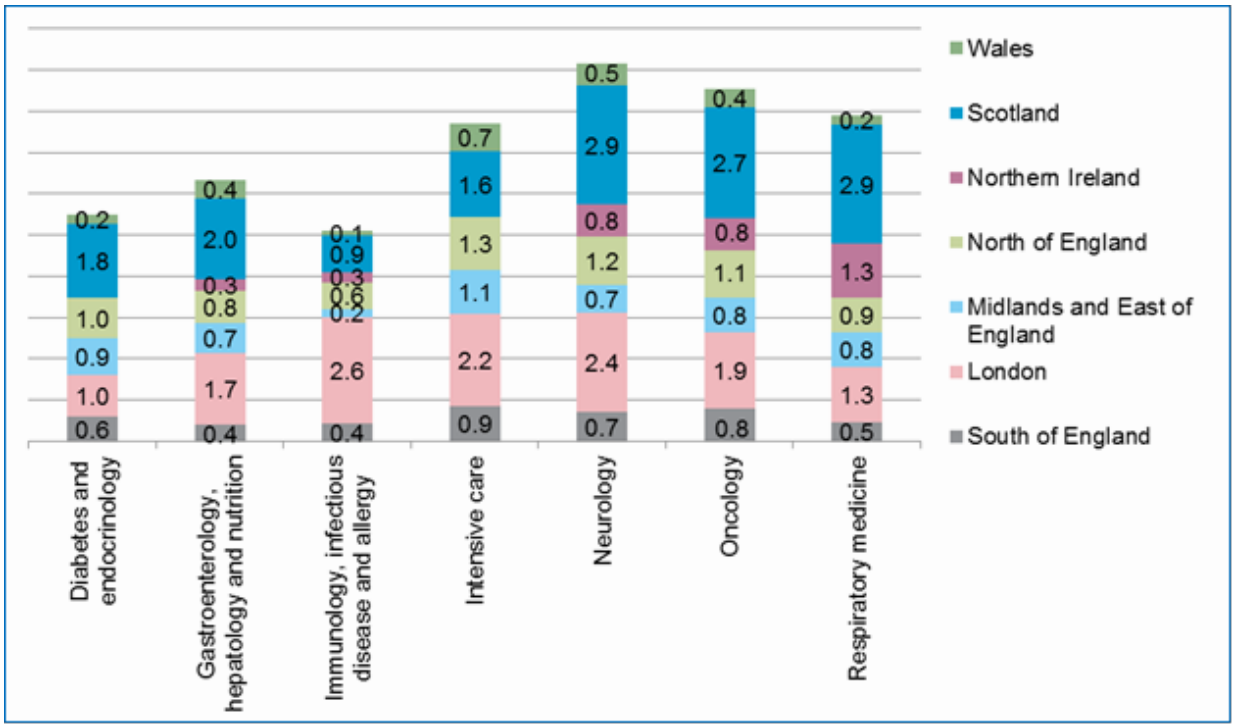


Fig 1 Ratio of headcount of where specialty consultants are based to 100,000 children aged 0-15 for the largest seven subspecialties (excluding neonatal medicine and community child health) by UK region.

5.8.7 The Specialist Commissioning team are minded to establish a London network for specialist paediatric gastroenterology services and there is a role for GOSH (or indeed another unit) to take the lead on establishing and administering the network, developing agreed pathways of care and quality indicators. It is important that GOSH plays a full part in that network, managing a specialised service as well as the small elements of highly specialised work, learning from others and restoring relationships following the problems outlined above.

Recommendation – As commitment to the proportion of its catchment from Greater London, working alongside other paediatric gastroenterology units, GOSH should agree and publish a defined specialist geographically based catchment area alongside its national specialisms. This would encourage development of stronger relationships, better networking with provision of services close to patients' homes.

Recommendation: Develop a proactive programme of quality Improvement and engagement with management and other specialist teams. The team should aim to develop clear service pathways and build a QI/safety dashboard across the London GI Network.

5.9 Patient and family involvement (see also 5.6.8)

5.9.1 This is an area where there is scope for more proactive activity, partially due to the focus necessarily having been on ensuring the service is operating safely and dealing with those families who have longstanding concerns. It was reassuring that the number of complaints has dramatically fallen in recent months in response to improved administration processes and better communication between the clinicians.

5.9.2 Although there is scope and aspiration amongst some of the clinicians to improve engagement with families several do not see this as a priority and were cautious about the RCPCH team seeking patient input. There was mention of an engagement event some years previously that had gone badly and alongside previously high levels of complaints this appears to have restricted the approach of the consultant team to seeking feedback. However the Friends and Family test is operating in the Trust with monthly feedback and a 'you said, we did' noticeboard and there are opportunities for engagement work being developed elsewhere in the Trust to be proactively developed within the gastroenterology service including patient reported outcome (PROM) or experience (PREM) measures.

5.9.3 Families whose child(ren)'s care had been reviewed during 2016 had been invited to talk to the PALS service if they had concerns or questions about the care and treatment of their child. They and their children were invited to an engagement event which was very effectively facilitated by an external agency in July 2017. Disappointingly there were several no-shows but those that attended provided a rich source of material and feedback from which the service can build an engagement strategy for all children and families as well as an action plan to resolve the concerns raised. Given these were generally families with considerable experience of the service it was a good place to start, but the review team noted that some of these families whose child's medication had been appropriately decreased expressed discontent at the intervention.

5.9.4 Feedback received by the review team indicated that many parents were not satisfied with the communication from the Trust following the 2015 report, and complaints continue around the lack of family-focus and integration when organising appointments. Many families still don't know what the situation is for their child. The listening event provided a clear message that although things appear to be improving, more must be done to build confidence amongst the families and listen meaningfully to, and act upon their concerns and suggestions.

5.9.5 Across the wider Trust the level of engagement of parents and families was reported to vary between teams. The hospital has a Young People's Forum to support involvement of Children and Young People who are or have been patients in their care and service planning. Individual departments have developed other schemes and tools and the gastroenterology team could learn techniques from colleagues. The 'Patient

Knows Best' scheme (see 5.6.6) helping individual IBD patients manage their condition was a good model and its principles could be extended to other divisions

5.9.6 In practical terms there were complaints about the lack of parent facilities on Rainforest ward and children on special diets being sent from the catering team foods they were not allowed. Involvement of parent groups in designing information leaflets /webpages and perhaps representation on risk or guidelines groups would begin to demonstrate a desire to listen and respond to the views of patients and families. The RCPCH "&Us" team can provide sources of advice and assistance in establishing such schemes.

5.9.7 The RCPCH was keen to hear from any patients or families who wished to share their views with the review team and a short qualitative online survey was prepared and distributed through the ward (leaflets and posters), via Facebook social media groups and face to face contact at the engagement event. Eighteen responses were received, almost all heard of the survey through social media despite leaflets and posters being provided by the RCPCH to put on the wards.

Recommendation - Consider developing leaflets and web guides for patients and parents to support and improve their experience of using the service.

5.10 Protocols pathways and guidelines

5.10.1 Since the review a considerable number of internal guidelines and protocols have been redrafted and there was positive feedback from multidisciplinary colleagues that that the approach to care was more consistent and relationships had improved under the new clinical lead. All consultants were now reported to work within the guidelines and the MDT arrangement supports that. Some pathways are still required such as GI Food Allergy, (see 5.10.11) led by dietetics but the guidelines group is in place to oversee that.

5.10.2 International and private patient activity carried out at GOSH was also reported to be compliant with the guidelines used for NHS patients.

5.10.3 Guidelines will be drafted and reviewed in future through the quarterly guidelines and protocols meeting, approved by the Trust-wide multidisciplinary Guidelines and Protocols Approvals Committee (GAPAC). The terms of reference for this gastroenterology group mention international links but not liaison with other specialist services within a network; it is important to share learning amongst peers particularly where presentations are rare or complex, and to be sure the protocol enables clinicians to "recognise normal". Including this element in the approval cycle will enable the service to better serve patients and external peers through clear agreed pathways.

Recommendation – Ensure a UK peer network is involved with development and agreement of guidelines, perhaps through BSPGHAN, not just international partners.

5.10.4 The tendency for local DGH's to refer complex families to GOSH for a second opinion when a local DGH is capable of managing the case had reduced since the 2015 restrictions on referrals. Consequently, more patients were reported to be being managed confidently by the 'local' paediatrician, which can result in improved school attendance, social relationships and a sense of normality. All guidelines and protocols should be based upon this close to home principle, with commissioner support. For example, 2-week observations currently based on Rainforest and some diagnostic tests may be possible in local units prior to admission with properly supported local staff. This is already being explored by the IBD team and benefits the patients and frees ward space at GOSH.

Compliance with national standards

5.10.5 The RCPCH/BSPGHAN standards published in 2017 provide nine criteria which apply to all gastroenterology units, and one of the consultants was on the advisory group. The service is striving to comply with them all but needs additional resource to meet standards

Standard		Compliance
1	Work in a network	Not yet. See recommendation
2	Access to advice/transfer 24/7	Advice possible 9-5, Phone response 24/7t. No beds for transfers
3	Transition policies and pathways	Patchy. See below
4	Endoscopy facilities and emergencies	Not compliant for emergencies – Business case for an interventional endoscopist
5	Specialist service IBD	Compliant
6	Specialist diets need paediatrician and MDT	All have named consultant but not necessarily a paediatrician – no regular round
7	Inpatient PN are reviewed weekly by consultant led MDT	Risk – not compliant due to insufficient clinical staff. See recommendation
8	Home PN patients have a dedicated team	Compliant
9	The service has links to a hepatology specialist centre	Compliant – linked to King's

Adolescence and Transition

5.10.6 Transition arrangements for gastroenterology patients were reported to be patchy in practice although the Trust is in year 2 of a three-year improvement project for transition with a bespoke CQUIN and priority in the Quality Account. There is a good relationship with University College London Hospitals (UCLH) for IBD patients but the links for PN are less assured, and the transition arrangements outlined to the review

team appeared to lack flexibility, being based on the medical relationships rather than patient choice. The motility service is relatively new so some patients are only just approaching transition and it was not clear what plans are in place. Concerns were expressed that UCLH would not take new patients under 18 years and GOSH policy at the time of the visit was reported to be transition at 16 so this needs to be addressed.

5.10.7 At the time of the visit the webpage outlining the transition process was out of date but this has been improved with helpful information and a video. The Trust has a Clinical Nurse Specialist for adolescent patients but some staff were unaware of her role within gastroenterology and identified a need for exploration with gastroenterology patients issues around transition and any psychosocial concerns, as well as practical discussion about sexual health and pregnancy.

Recommendation- Continue the roll out of the Transition improvement project to gastroenterology. Pathways should be patient based rather than be clinician's choice and require better networking. The design of such a programme should involve young people and include a suite of communications materials suitable for patients, parents and families.

Pharmacy

5.10.8 The relationships between the gastro team and the pharmacy department still had room for improvement. The pharmacists work with a range of teams across the Trust providing advice on new drugs, checking and administering prescriptions and supporting the treatment of patients alongside the medical team. In particular, they support patients on Parenteral Nutrition (PN) who number 45-50 inpatients and around 50 at home which is one of the highest levels in the UK.

5.10.9 The pharmacists are keen to work more closely with the consultants but consider the importance of their service in the MDT is not respected by the consultants– in marked contrast to the engagement of other teams. For example, gastro consultants do not provide input to the development of new protocols, sending a junior doctor who is unable to contribute sufficiently. Consultants refuse to sign prescriptions immediately without full consideration. Although there are regular meetings between the gastro consultants and the pharmacists, agreements made at the meeting were reported not to be followed through. A protocol is needed about joint working with pharmacy and accountability and governance arrangements, perhaps nominating a liaison clinician in each team

Recommendation – Strengthen links with and feedback from the pharmacy team within the overall governance reporting arrangements

5.11 Are there any areas of notable practice or achievement?

5.11.1 A number of positive actions and good practice are covered throughout the sections above but are drawn together in this section to recognise progress since 2015 and encourage further work going forward. For example

- Investment in clinical leadership
- Positive, engaged general management with informed, useful monthly dashboards.
- Improved ward leadership and better links to mental health expertise.
- A systematic governance and reporting structure although this needs to be embedded.
- A comprehensive set of guidelines agreed and monitored.
- Better equipped endoscopy suite with reduced turnover and improved morale.
- Administration – managing telephone calls and response times
- The rapid response service for medication review which was reported to have made big changes to children's' quality of life.
- Positive attitudes in the IBD service– engaging outside the Trust, PNB and ICN
- Development of the Risk Action Group – resulting in tight governance and action.
- Much greater involvement of dietetics.
- Improved clinical nursing leadership and confidence to speak out

5.12 The priorities and strategy for development of the service.

This is covered in the sections above and the recommendations for the service.

6 Recommendations

We recommend sharing this report with the GI team who have contributed to the review process and the full report or a summary should be shared more widely amongst contributors to demonstrate transparency.

Leadership, Strategy and external focus

Appoint a respected NHS based external clinical leader to the post of senior clinical lead - equivalent to a chair - in gastroenterology to develop the service, working together with other units on London-wide GI network collaboration. (5.1)

GOSH should become part of this London network to equally contribute to the care of the regional population alongside other GI units. In addition, GOSH may wish to also agree on their unique focus and to ensure appropriate communications between GOSH and all hospitals in this network. (5.1)

As commitment to the proportion of its catchment from Greater London, working alongside other paediatric gastroenterology units, GOSH should agree and publish a defined specialist geographically based catchment area alongside its national specialisms. This would encourage development of stronger relationships, better networking with provision of services close to patients' homes. (5.8)

Review the acceptance criteria, pre-and post clinic MDT and job plans carefully to enable greater throughput of patients without compromising governance or increasing risk (5.3)

There should be a further clinical review of the service and approach to cases 12 months after the lifting of referral restrictions. (5.2)

Management and Governance

Clinical Management should satisfy the Board that an investigation of historical gastroenterology cases has been completed in full, specifically the care of all children on long term interventions without a clear validated diagnosis. (5.2)

There should be a demonstrated climate of openness in addressing concerns raised by staff to provide assurance that appropriate action and candour has been exercised. (5.2)

Take steps to ensure there is stability of clinical and operational management to embed the positive developments. (5.1)

Ensure a UK peer network is involved with development and agreement of guidelines, perhaps through BSPGHAN, not just international partners. (5.10)

Finalise job plans, including weekend ward presence, appoint to permanent positions and consider additional recruitment to provide cross-cover and manage activity. (5.3)

Increase medical support for the intestinal failure team. (5.3)

Prioritise improvement of the ward environment as a matter of urgency and involve ward staff in discussions about relocation. (5.3)

Consider appointment of a nursing practice educator. (5.7)

Strengthen links with and feedback from the pharmacy team within the overall governance reporting arrangements. (5.10)

Safeguarding and Patient centred care

Maintain current safeguards, governance and QI programmes and consider rolling out the benefits and principles of PNB and ICN across the service. (5.6)

Involve a named general paediatrician in the referrals meeting and any gastroenterology subspecialty case with a perplexing presentation including current cases where a child has a significant disability after receiving treatment or investigations without a proven cause. (5.5)

Strengthen the pathway and links with local units for support for children with feeding tubes. (5.3)

Clarify the responsibilities between gastroenterology and general paediatrics for patients on non-gastro wards. (5.3)

Continue the roll out of the Transition improvement project to gastroenterology. Pathways should be patient based rather than be clinician's choice and require better networking. The design of such a programme should involve young people and include a suite of communications materials suitable for patients, parents and families. (5.10)

Invest in building sufficient clinical psychology input to meet identified demand and increase mental health screening /support. (5.3)

Plan realistically to ensure the appropriate number of beds so that children with "perplexing presentations" can be admitted, observed and managed cohesively with general paediatrics local paediatric teams and safeguarding where necessary. (5.3)

Ensure the effectiveness of complex cases MDT to encourage the lead clinician to discuss cases in a forum with other GI consultants, general paediatrician, safeguarding

lead (when appropriate), nursing staff and clinical psychologists. All staff should be empowered to contribute. (5.2)

Ensure continued support to the safeguarding programme with all clinical staff in gastroenterology safeguarding trained to Level 3. (5.5)

Consider developing leaflets and web guides for patients and parents to support and improve their experience of using the service**.** (5.9)

Develop a proactive programme of quality Improvement and engagement with management and other specialist teams. The team should aim to develop clear service pathways and build a QI/safety dashboard across the London GI Network. (5.8)

Continue to improve liaison and understanding between the gastroenterology consultants and the social care team. (5.5)

The Review team

Dr David Shortland MD FRCP FRCPCH DCH has been a paediatrician for 25-years in Poole, Dorset, including ten years as neonatal lead and twelve as clinical director. David was the lead clinician for the rebuild of the paediatric department in 2005 and currently leads on Clinical Quality for the paediatric department.

Following five years as member, then Chair, of the Clinical Directors Special Interest Group, in 2006 David was elected as the National Workforce Officer for the RCPCH leading the 2007 national workforce census and designing a cohort study of trainees to provide a clearer understanding of the current and future workforce, helping to define how the role of paediatricians can evolve to provide consultant delivered care and hence safe and sustainable services. David was elected Vice President (Health Services) in 2009 and played a central role in developing strategy for Child Health Services in the United Kingdom supporting paediatricians through the challenges of radical reform tothe health service, working time legislation and service re-design. During David's five years in post he developed a national template for the resident paediatrician and was lead author for "Facing the Future". This document defined 10 quality standards for acute paediatric services and is widely quoted as a template for good practice. David led a national audit of these standards in 2013 and currently chairs a steering group extending the standards approach to care outside hospitals. Since 2014 David has been clinical adviser to the RCPCH Invited Reviews programme and has led a number of high profile reconfiguration, individual and service reviews.

Dr Nadeem Ahmad Afzal MBBS, MRCP, MRCPCH, MD is an Expert Adviser for the NICE Centre for Guidelines and has recently served as Honorary Secretary of the British Society of Paediatric Gastroenterology Hepatology and Nutrition (BSPGHAN). Dr Afzal is a Consultant in Paediatric Gastroenterology, Hepatology and Nutrition at University Hospital Southampton. As Honorary Senior Clinical Lecturer at Southampton University he runs an active research programme. Dr Afzal has established paediatric hepatology services at University Hospital Southampton, is the paediatric endoscopy lead and helps to run the Wessex Paediatric Gastroenterology Network. Dr Afzal is an Invited lecturer to the MSc in paediatric gastroenterology at Barts, London and MSc in Allergy in Southampton University. Dr Afzal has served as Editor in Chief for World Journal of Gastrointestinal Endoscopy and has contributed to the gastroenterology section of the RCPCH Paediatric Care Online.

Claire McLaughlan is an independent consultant and former Associate Director of the National Clinical Assessment Service with a particular interest in the remediation, reskilling and rehabilitation of healthcare professionals. As a former registered (intensive care) nurse, educationalist and non-practising barrister Claire developed the NCAS Back on Track services for dentists, doctors and pharmacists in difficulty. Over the last 10 years Claire has worked with over three hundred organisations and practitioners to 'make a difference' before irreparable damage was done to patients and the public,

practitioners, and organisations. Before joining NCAS Claire was Head of Fitness to Practise at the Nursing and Midwifery Council.

Sue Eardley joined RCPCH as Head of Health Policy in January 2011 and established the Invited Reviews programme for the College, conducting over 70 reviews in five years. An engineer by training, Sue spent 13 years as a non-executive and then Chairman of an acute Trust in London, alongside a range of voluntary activities including national and local involvement in maternity services and the NHS Confederation. Sue led groups contributing to the Maternity NSF and chaired her local MSLC forfour years. Before joining the RCPCH Sue spent six years full time leading the maternity and children strategy team at the Healthcare Commission and then Care Quality Commission, overseeing strategy, design and delivery of all inspections and reviews in England of maternity, child health and safeguarding.

List of Abbreviations

BSPGHAN – British Society for paediatric gastroenterology, hepatology and Nutrition CAMHS – Child and Adolescent Mental Health Services
CQC – Care Quality Commission
CQUIN – Commissioning for Quality and Innovation DGH – District General Hospital
GI – Gastro Intestinal
GIU – Gastro Intestinal Unit
GOSH – Great Ormond Street Hospital for Children HEE – Health Education England
IBD – Irritable Bowel Disease ICN – Improve Care Now scheme
MHPS – Maintaining High Professional Standards MDT – Multi Disciplinary team
NHSE- HSS - NHS England Highly Specialised Services NICE – National Institute for Health and Care Excellence (P)ICU – (Paediatric) Intensive Care Unit
QI – Quality Improvement
RCPCH – Royal College of Paediatrics and Child Health TPN /PN - Total parenteral nutrition
UCLH – University College London Hospitals

Great Ormond Street Hospital for Children NHS Foundation Trust

GOSH Response to the Follow-Up Review by RCPCH

January 2018

We are pleased that The Royal College of Paediatrics and Child Health (RCPCH) Follow-Up Review recognises the journey undertaken by the Gastroenterology Department at Great Ormond Street Hospital for Children (GOSH) and the progress that has been made since the Trust first invited the RCPCH to review the service in 2015.

This review is the final stage of a comprehensive set of reviews and improvement work that has taken place since 2015, in order to ensure an improved service and improved care for our patients.

In particular, it is pleasing to read that the reviewers were assured by:

- Very good senior clinical and operational leadership;
- Significant improvements in administration of patient communications and clinic organisation;
- New governance meetings and reporting pathways which ensure that any new referrals are appropriately reviewed, investigated and managed in conjunction with their local referring paediatrician and according to agreed, externally validated, care pathways; and
- Improved team working and engagement with multidisciplinary colleagues.

This has been a complex and thorough review process throughout the entire scope of the Gastroenterology Service and our staff have worked with commitment and skill to deliver important changes.

We are confident that patients and families are already seeing the tangible benefits of these improvements, with a significant reduction in the number of issues and complaints raised.

We are however disappointed that some anecdotal information has been included in the report and is unsubstantiated and not adequately triangulated. While it is important to reflect feelings that individuals may have about the service and the review process, it is also imperative that the progress the department has made over the past two years detailed in the review is not undermined by unverified information.

We are aware that there is still room for further improvement, and we have carefully considered the RCPCH's findings and recommendations to formulate a robust Action Plan, which will inform our strategy for our Gastroenterology Service. This Action Plan can be found below, including clear timelines.

The Trust believes that the organisation's programme of improvement to date – and the clear Action Plan initiated for future development – is indicative of how seriously the organisation has engaged with the issues identified and evidence of our continued commitment to take steps to resolve them.

A number of specific areas noted in the Follow-Up Review are worth particular attention:

- The Trust is in agreement that the existing gastroenterology ward environment was not appropriate and, since the time of the RCPCH's visit, the Trust has moved the service from its original, unsatisfactory Rainforest location. It will shortly be moving again to new, improved facilities. Ward staff and parents have been involved in on-going discussions throughout the

relocation plans and will continue to remain involved.

- Patients under the Service will be subject to governance meetings and reporting pathways that ensure they are appropriately reviewed, investigated and managed in conjunction with their local referring paediatrician and according to agreed, externally validated, care pathways.
- The team are committed to the yearly NHS monitoring process for highly specialised services and take part in the annual review process led by NHS England with commissioners and stakeholders. In addition, they have begun the process of the Joint Advisory Group (JAG) for GI Endoscopy accreditation, newly in place for paediatric gastrointestinal endoscopy and comprising of an annual process of independent assessment against national standards for endoscopy.
- Continuing to foster a climate of openness to ensure that staff feel confident any concerns will be handled with appropriate action and candour is a priority across the Trust. The Trust has appointed seven 'Freedom to Speak Up Ambassadors', and regular staff attitude surveys and feedback will be used to determine success in this area.
- The Trust agrees that there is an enhanced role for general paediatricians to play in the management of complex patients including the referral meetings and MDTs. They have already been involved in pathway development (e.g. motility, food allergy) and will provide additional support to all multidisciplinary team working. The Trust is keen to invest in the development of general paediatricians with specialist interests to support the Gastroenterology Service as well as the care needs (including repatriation) of patients requiring complex care. Increased general paediatric support for the safeguarding service is already being addressed.
- The RCPCH's recommendations concerning the development of a regional network for gastroenterology services require consideration and leadership in the first instance by the responsible commissioning bodies. The Trust is keen to work with partner organisations to deliver the best possible service for patients at both a local and national level and is very supportive of proposals to develop closer and more collaborative networks.
- Finally, it is important to be clear that (i) the Trust Board has been provided with updates throughout the review process and (ii) thorough investigations into relevant gastroenterology cases have been completed.

The full action plan resulting from the RCPCH's revisit in 2017 is attached below. Progress on this action plan will be monitored through the Trust's existing governance structures to ensure improvements are delivered in a timely manner

Action Plan for Discussion and Development with Gastroenterology Team

RCPCH gastroenterology service review – January 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

	RCPCH Recommendation	Response	Led By	Reporting to (governance/group)	Due date
A		**Leadership, strategy and external focus**			
A1	Appoint a respected NHS based external clinical leader to the post of senior clinical lead – equivalent to a chair – in gastroenterology to develop the service, working together with other units on London-wide GI network collaboration	**This recommendation, rather than being unilaterally considered by GOSH, must be agreed jointly with partner organisations**, the way forward being developed within the context of networked service models overseen and signed off by commissioners. The Trust has invested in developing and appointing a clinical leader for gastroenterology from its existing team. It has focused particularly on achieving high and sustained standards of service delivery and judged that investment in clinical leadership of the service was an essential enabler for this. The Trust does not consider that appointing a Chair for the service at the current time is appropriate given such a post is likely to be primarily academic. The Trust is, however, very supportive of proposals to develop closer and more collaborative networks, and would be keen to participate in a London-wide collaboration. It would not be appropriate for this to be GOSH-led, except where particular sub-specialty expertise is required but the Trust would be very happy to work with those responsible for setting up such networks.	NHS England Dep CEO to agree next steps with Med Director for NHS England Specialised Services Commissioning	NHS England	tbc
A2	GOSH should become part of this London network to equally contribute to the care of the regional population alongside other GI units. In addition, GOSH may wish to also agree on their unique focus and to ensure appropriate communications between GOSH and all hospitals in this network	**Agreed and should be developed with partners and led by commissioners** as described above. GOSH fully supports strengthening of such arrangements and would wish to play a full part in a London wide gastroenterology network, focusing on working together to provide the services that enable children across London – and nationally - to fulfil their potential. This would include potentially taking on additional tertiary work as long as that is supported by adequate resource and capacity. The Trust is keen to work with network colleagues, led by specialised commissioners, to achieve this aim.	NHS England Dep CEO to agree next steps with Med Director for NHS England Specialised Services Commissioning	NHS England	tbc
A3	As commitment to the proportion of its catchment from Greater London, working alongside other paediatric gastroenterology units, GOSH should agree and publish a defined specialist geographically based catchment area alongside its national specialisms. This would encourage development of stronger relationships, better networking, with provision of services close to patients' homes	**Agreed and should be developed with partners and led by commissioners** as described above. GOSH fully supports this proposal and is keen to work with commissioners and neighbouring units to agree how to define and organise the network to achieve these aims. Although we recognise that geographically based catchment areas would work well for some sub-specialist work, it is the opinion of GOSH that working alongside provider units that meet an appropriate standard of care and agreed referral guidelines is critical to the success of a managed network.	NHS England Dep CEO to agree next steps with Med Director for NHS England Specialised Services Commissioning	NHS England	tbc

Action Plan for Discussion and Development with Gastroenterology Team

RCPCH gastroenterology service review – January 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

	RCPCH Recommendation	Response	Led By	Reporting to (governance/group)	Due date
A4	Review the acceptance criteria, pre-and post clinic MDT and job plans carefully to enable greater throughput of patients without compromising governance or increasing risk	**Agreed. This work is underway**, with a review of acceptance criteria complete, pre and post clinic MDTs now established and work continuing on job planning to reinforce delivery of a safe, sustainable and secure service.	Clinical Lead for Gastroenterology	Divisional Management Team	April 2018
A5	There should be a further clinical review of the service and approach to cases 12 months after the lifting of referral restrictions	**GOSH fully supports the need for continued review and learning, and considers this must be part of 'business as usual'**. The Trust has already undertaken a significant journey with this service and is now working to embed sustainable high quality care; it will therefore deliver this objective through its improved internal governance processes, which are externally scrutinised. It will consider the requirement for further clinical review if that process and scrutiny suggests there is such a need.	Divisional Director of Operations	Operational Performance and Delivery Group	April 2019
B		**Management and governance**			
B1	Clinical management should satisfy the Board that an investigation of historical gastroenterology cases has been completed in full, specifically the care of all children on long term interventions without a clear validated diagnosis	**Complete**. GOSH has kept the Board regularly informed of progress on this work and this action has been completed. Additional assurance about all patients currently within the service will be provided from a newly-launched database now rolled out, which will enable the Trust to identify and review care and outcomes of all children treated by the department.	Clinical Lead for Gastroenterology	Divisional Management Team	Complete
B2	There should be a demonstrated climate of openness in addressing concerns raised by staff to provide assurance that appropriate action and candour has been exercised	**Agreed and ongoing**. The Trust has appointed seven Freedom to Speak Up Ambassadors and is committed to ensuring openness and candour are embedded across all of its services including gastroenterology. Regular staff surveys and feedback will be used to determine success in this area.	Clinical Lead for Gastroenterology	Divisional Management Team	Ongoing
B3	Take steps to ensure there is stability of clinical and operational management to embed the positive developments	**Ongoing**. The Trust has taken, and continues to deliver, a considerable organisational development programme with particular focus on the development and improvement of clinical and operational leadership and management, embedding mutual trust and support and ensuring clear and robust oversight of its service delivery.	Clinical Lead for Gastroenterology	Divisional Management Team	Ongoing
B4	Ensure a UK peer network is involved with development and agreement of guidelines, perhaps through BSPGHAN, not just international partners	**Agreed and ongoing**. There is a limit to UK only peer networks for some of these services, as there are no UK peers who provide some of the more specialised gastroenterology services available at GOSH. For that reason, the Trust relies upon international expertise and is currently engaged in such peer reviews and networks, including representation at the highest level on ESPGHAN and BSPGHAN. For IBD and nutrition the guidelines have been peer-reviewed by two external paediatric gastroenterologists.	Clinical Lead for Gastroenterology	Divisional Management Team	Ongoing

Action Plan for Discussion and Development with Gastroenterology Team

RCPCH gastroenterology service review – January 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

	RCPCH Recommendation	Response	Led By	Reporting to (governance/group)	Due date
B5	Finalise job plans, including weekend ward presence, appoint to permanent positions and consider additional recruitment to provide cross-cover and manage activity	**Agreed and ongoing**. This is something the Trust does for all consultants (not just gastroenterology). Appropriate consultant 24/7 cover is already provided for the service, with consultant ward rounds undertaken on Saturdays and clear consultant on-call arrangements to support the on-site registrar on Sundays. Every emergency admission to the Trust is reviewed for how long they wait for consultant opinion, and the gastroenterology service has not been raised as an area of concern from those reviews.	Clinical Lead for Gastroenterology/ Divisional Director	Medical Director	April 2018
B6	Increase medical support for the intestinal failure team	**Agreed and to be considered as part of the broader London-wide system noted above**. Business case under development.	Clinical Lead for Gastroenterology	Divisional Management Team	September 2018
B7	Prioritise improvement of the ward environment as a matter of urgency and involve ward staff in discussions about relocation	**Complete**. Initial moved has happened. The service has already been decanted from its original unsatisfactory Rainforest location and will shortly be moving again to new, improved facilities. Ward staff and parents have been involved in ongoing discussions throughout the relocation plans and will continue to remain involved.	Clinical Lead for Gastroenterology	Divisional Management Team	Complete
B8	Consider appointment of a nursing practice educator	**The Trust is committed to effective and appropriate levels of practice educator support** (for all of its services)	Assistant Chief Nurse	Divisional Management Team	April 2018
B9	Strengthen links with and feedback from the pharmacy team within the overall governance reporting arrangements	**Agreed**. The team will take forward this recommendation and ensure it has excellent working arrangements with the pharmacy team. This recommendation will also be taken forward through the existing programme to review the Trust's pharmacy service.	Chief Pharmacist/ Clinical Lead for Gastroenterology	Divisional Management Team	July 2018
C	**Safeguarding and patient centred care**				
C1	Maintain current safeguards, governance and QI programmes and consider rolling out the benefits and principles of PNB (as referred to in report, but usually known as PKB) and ICN across the service	**Agreed and ongoing**. The Trust is taking this forward through the ICN database which enables international benchmarking (see also the answer to recommendation B1 above). The service also partakes in the broader ongoing safeguards, governance and QI approach overseen by the patient experience team	Clinical Lead for Gastroenterology	Quality Improvement Committee	Ongoing
C2	Involve a named general paediatrician in the referrals meeting and any gastroenterology subspecialty case with a perplexing presentation including current cases where a child has a significant disability after receiving treatment or investigations without a proven cause	**The Trust has taken steps to encourage the role of general paediatricians within the service** including, for example, allergy, complex care, and the dysmotility pathway. GOSH is keen to invest in development of general paediatricians with specialist interests to support the gastroenterology service as well as the needs (including repatriation) of patients requiring complex care.	Clinical Lead for General Paediatrics/ Clinical Lead for Gastroenterology	Divisional Management Team	July 2018

Action Plan for Discussion and Development with Gastroenterology Team

RCPCH gastroenterology service review – January 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

	RCPCH Recommendation	Response	Led By	Reporting to (governance/group)	Due date
C3	Strengthen the pathway and links with local units for support for children with feeding tubes	**Agreed**. GOSH has invested in additional Interventional Radiology and agrees there is need for a clearer pathway to be developed jointly between IR, Gastroenterology and local units, for children who have been repatriated with complex needs requiring long term feeding tubes.	Clinical Leads for Radiology, Surgery and Gastroenterology	Divisional Management Team	July 2018
C4	Clarify the responsibilities between gastroenterology and general paediatrics for patients on non-gastro wards	**Agreed**. The Medical Director will take responsibility for taking forward this recommendation with the general paediatrics service.	Medical Director	Divisional Management Team	March 2018
C5	Continue the rollout of the Transition improvement project to gastroenterology. Pathways should be patient based rather than be clinician's choice and require better networking. The design of such a programme should involve young people and include a suite of communications materials suitable for patients, parents and families	**Agreed and ongoing**. The Trust has an existing Transitional Care Policy with a project addressing these points is being overseen by a dedicated transitional care lead within the QI team.	Transition Improvement Manager/Clinical Lead for Gastroenterology	Quality Improvement Committee	September 2018
C6	Invest in building sufficient clinical psychology input to meet identified demand and increase mental health screening/support	**Agreed. A business case for a new psychologist has been approved** with the post-holder starting in January 2018. An additional business case for further psychology input into gastroenterology is currently under development, as well as care pathways specifically addressing the inclusion of psychological and other CAMHS support.	Clinical Lead for Psychology/ Clinical Lead for Gastroenterology	Divisional Management Team	September 2018
C7	Plan realistically to ensure the appropriate number of beds so that children with 'perplexing presentations' can be admitted, observed and managed cohesively with general paediatrics local paediatric teams and safeguarding where necessary	**Agreed and ongoing** – the Trust's gastroenterology service is committed to ensuring that it has the right capacity to enable it to offer specialist investigation, advice and support, including support to clinical networks aiming to ensure patients are cared for as close to home as possible and appropriate (see recommendation A3).	Divisional Management Team	Operational Performance and Delivery Group	Ongoing
C8	Ensure the effectiveness of complex cases MDT to encourage the lead clinician to discuss cases in a forum with other GI consultants, general paediatrician, safeguarding lead (where appropriate), nursing staff and clinical psychologists. All staff should be empowered to contribute	**Agreed and ongoing**. The team has put much focus on ensuring that these meetings are happening regularly and functioning well as part of ongoing work to develop an open culture and give staff the freedom to speak up. Much positive feedback has been received on the progress that has been made and the Trust will follow up with an internal survey to see how people are finding the new arrangements, and obtain their views on what more we could do to encourage and embed an open culture.	Clinical Lead for Gastroenterology	Divisional Management Team	Ongoing
C9	Ensure continued support to the safeguarding programme with all clinical staff in gastroenterology safeguarding trained to Level 3	**Agreed and complete**. These are the current requirements already operating within the service.	Clinical Lead for Gastroenterology	Divisional Management Team	Complete

Action Plan for Discussion and Development with Gastroenterology Team

RCPCH gastroenterology service review – January 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

RCPCH Recommendation		Response	Led By	Reporting to (governance/group)	Due date
C10	Consider developing leaflets and web guides for patient and parents to support and improve their experience of using the service	**Agreed. Listening event has been held and work on guides is under way**.	Clinical Lead for Gastroenterology	Divisional Management Team	July 2018
C11	Develop a proactive programme of quality improvement and engagement with management and other specialist teams. The team should aim to develop clear service pathways and build a QI/safety dashboard across the London GI Network	**GOSH fully supports the suggestion that this should be done on a London-wide/network basis and would be keen to participate in such a proposal**. The Trust would be happy to work with those responsible for establishing the network to achieve this. The team are committed to the NHS monitoring process for highly specialised services, take part in the annual review process led by NHS England and have started the process of JAG review, newly in place for paediatrics and comprising of an annual process of independent assessment against national standards for endoscopy. The team also engages actively with the Trust's QI initiatives, including – for example - focus currently being given to work to support the transition to adult services.	NHS England Medical Director to agree next steps with Med Director for NHS England Specialised Services Commissioning	NHS England	tbc
C12	Continue to improve liaison and understanding between the gastroenterology consultants and social care team	**Agreed and ongoing**.	Social Care Team Lead/Clinical Lead for Gastroenterology	Divisional Management Team	Ongoing

Attachment N

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 28th March 2018	
Regular Director of Infection Prevention and Control Report **Submitted by:** Dr John Hartley, DIPC	**Paper No: Attachment N**
Aims / summary: To update the Board on Infection Prevention and Control issues and current plans	
Action required from the meeting Board support for actions and feedback.	
Contribution to the delivery of NHS Foundation Trust strategies and plans: Minimising infection is a central component of the Trust goal of zero harm	
Financial implications Failure to prevent or control infections leads to harm and cost.	
Who needs to be told about any decision? Infection prevention and control is responsibility of all staff.	
Who is responsible for implementing the proposals / project and anticipated timescales? Clinical and Corporate Divisions Infection Prevention and Control Team. On-going.	
Who is accountable for the implementation of the proposal / project? Director of Infection Prevention and Control	

Attachment N

Great Ormond Street Hospital for Children NHS Foundation Trust

Regular Director of Infection, Prevention and Control (DIPC) Report to Trust Board
2017 - 2018
Update at 28/03/2018

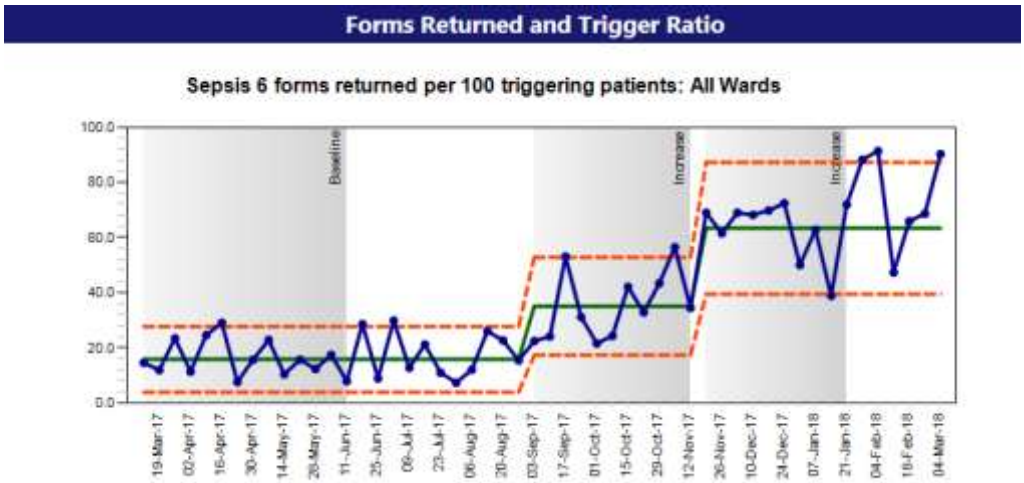
1. **Infection Prevention and Control (IPC) team -**

Administration, data and electronic infection prevention management system
Issue: electronic management system outdated and unsupported.
Assurance – Contract recently signed for RL Solutions infection surveillance module for implementation alongside EPIC; transitional data programming support employed.
Difficulty – Time requirements to work with implementation team will detract from activity.

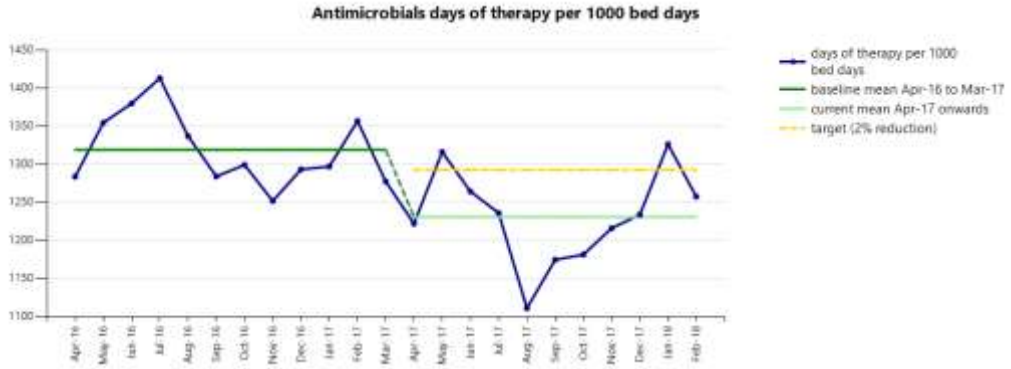
Issue: Difficulty maintaining input in to DPS projects without reducing core service.
There has been an ever increasing requirement for IPC Team input into development projects. While endeavouring to meet this, it has resulted in reduced time available to fulfil core function in hospital, and we have not always contributed to the satisfaction of DPS.
Potential resolution: Additional funding proposed by DPS for IPC nurse time but agreement has not been reached how to deploy this.

2. **Antibiotic stewardship** –

Funding approved for additional staff time in Infectious Diseases, and Microbiology, and Pharmacy. Recruitment process is underway.
CQUIN – achieving (sections on sepsis (led by Claire Rees) and antibiotic consumption (A Bamford), with examples of dashboard data below.



Attachment N



3. Health care associated infection (HCAI) statistics

HCAI Mandatory national reporting:

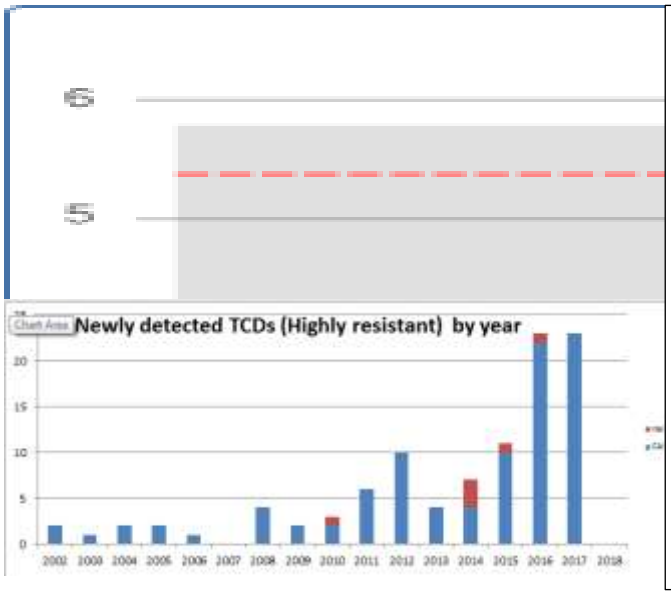
	2017/18 after 11 months		Last financial year Apr 16/ Mar 17	
	Developed while in hospital	**Admitted with**	**Developed while in hospital**	**Admitted with**
MRSA bacteraemia	**1**	**1**	**1**	**2**
MSSA bacteraemia	**11**	**9**	**21**	**12**
E. coli bacteraemia	**10**	**5**	**17**	**4**
P. aeruginosa bact	**6**	**7**	**Not mandatory in**	**16/17**
Klebsiella sp. bact	**17**	**1**	**Not mandatory in**	**16/17**
C. difficile infection	**11**	**7**	**1**	**3**

HCAI non-mandatory internal reporting:

	2017/18 after 11 months		Last financial year Apr 16/ Mar 17	
Infection:				
GOS acquired CVC related bacteraemia	**1.43 / 1000 line days (73 episodes)**		**1.65 / 1000 line days(87 episodes)**	
	Developed in	**Admitted with**	**Developed in**	**Admitted with**
Respiratory viral infection	**160**	**354**	**112**	**262**
Enteric viral infection	**219**	**273**	**218**	**281**
Colonisation:				
MRSA colonisation	**13**	**189**	**18**	**216**
MDR GN (non CPO) colonisation	**53**	**162**	**41**	**145**
Carbapenemase producing (CPO) GN		**21**	**1**	**17**
Vancomycin resistant enterococci	**31**	**30**	**15**	**14**
MDR GN = Multi antibiotic resistant gram negative 'alert' organism ; CPO = carbapenemase producing organism				

This season has seen the greatest number of respiratory viral infections, which remain difficult to control.

Surveillance for VRE (for which we did not routinely screen until Jan 2017) has shown a higher than expected background colonisation and there is evidence of episodes of cross infection.



Since the last report there has been a reduction in GOSH acquired line infections.

The threat from an increase in admission of children colonised with CPO was maintained from 2016 and we continue to work hard to successfully control this.

4. Major outbreaks or preventable high risk exposure events 2017/18

Date	Organism and issue	Ward	Outcome
2017/18	VRE	Pan trust	Additional cleaning methods to be introduced
2017/18	Norovirus / Astrovirus	3 wards restricted	Controlled; re-introduction is continuous threat
2017/18	Respiratory viruses	Pan trust	Transmissions but no closures

Common theme: control difficult due to continuous re-introduction but worsened by non-recognition of cases with delayed implementation of transmission based precautions; and variable environmental control.

5. Infection prevention and control regular audits and data display

Audits undertaken by ward staff, according to a monthly schedule:

Attachment N

Audit data is a composite of two parameters: recorded audits (with a negative score if ward undertake less than a minimum) and compliance.

Audit results are reviewed locally, in divisional meetings and at the Trust IPC committee.

Last year there was a fall in audit undertaken and a reduction in confidence of audit accuracy and value. This prompted a review of methodology.

Retraining and focus took place and further audit initially demonstrated a further fall in compliance (which was felt to be a truer reflection of situation) but now input has led to improvement.

6. Surgical site infection prevention

J.M Barrie Division - Surgery

Surgical Site Surveillance Monthly Report – December 2017 (Data from Leo Morgan, SSIS officer)

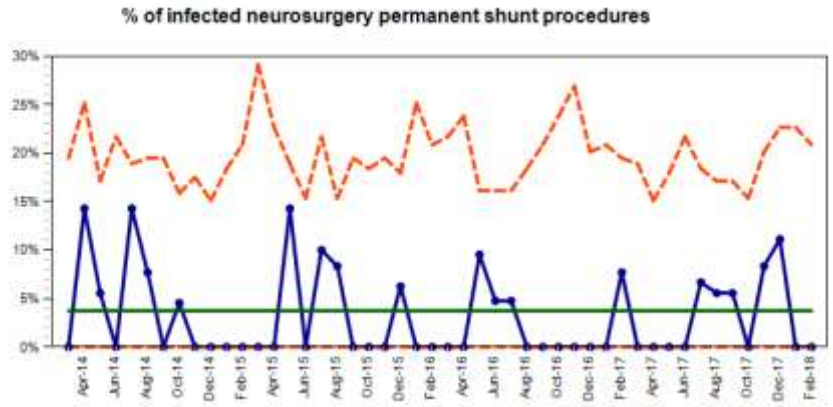
Procedure		Annual Combined*	Annual Combined*
	2017 Total **(2016 Total)**	Infection with parent reported % **(2016 %)**	Infection without parent reported **(2016 %)**
Spinal surgery:			
All Spines	**231 (189)**	**4.3 % (7.4%)**	**2.1 % (3.2%)**
Orthopaedic:			
8 plates	**30 (36)**	**0 (14%)**	**0 (0%)**
Open # Reduction	**24 (18)**	**0 # (5.5%)**	**0 # (0%)**
ENT:			
Cochlear Implant	**38 (47)**	**0 (4.2%)**	**0 (2.1%)**
LTR Graft	**18 (9)**	**5.5 (11%)**	**0 (11%)**
Thyroglossal Cysts	**12 (7)**	**0 (0%)**	**0 (0%)**
Urology:			
Open Pyeloplasty	**26 (30)**	**0 (0%)**	**0 (0%)**
Nephrectomy	**28 (24)**	**0 (0%)**	**0 (0%)**
Cleft:			
Cleft Lip	**52 (53)**	**0 (1.8%)**	**0 (0%)**
General Surgery:			
Laparotomy	**70 (79)**	**7.1 (10%)**	**5.7 (8.8%)**
Neuroblastoma	**10 (8)**	**0 (0%)**	**0 (0%)**
Plastic Surgery:			
Non-buried K wires	**38 (24)**	**0 (4.2%)**	**0 (0%)**
Tissue Expander	**10 (4)**	**10 (20%)**	**10 (20%)**
Tongue Reduction	**30 (21)**	**0 (0%)**	**0 (0%)**
Dental/Maxillofacial			
ABG	**47 (65)**	**4.2 % (6.1%)**	**0 % (1.5%)**

Attachment N

	Numbers		Number and %		Number and %	
	2017	2016	2016	2017	2016	2017
Total	646	(614)	19 (3%)	37 (6%)	10 (1.5%)	17 (2.8%

One Open Reduction Organ Space SSI in IPP not captured. Final figures not ratified yet.

The Divisional and specifically Theatre infection control groups have focused more on SSI prevention. Excellent systematic surveillance has been undertaken. The number of infections detected in 2017 compared to 2016 has reduced. Review of procedures to survey is underway. Continuous audit of some key control points is undertaken during surveillance. Data below. Work continues in particular on temperature control and adequate data collection for antibiotic prophylaxis. Continuous surveillance is undertaken in neurosurgery; and has now been successfully re-established for cardiothoracic services. Data not shown.



The annual rate is low (now around 3%) with a dedicated infection prevention protocol.

7. Estate and facilities – issues

a. Cleaning – there have been difficulties this year (see IPC committee report) with an improvement action plan currently in place.
b. Water Safety Management

- Heater cooler units for cardiac bypass - mycobacterium infection risk has been significantly reduced with change of machines. Water surveillance continues.
- Delay in appointing Authorising Engineer (Water), now appointed, and shortage of responsible persons
- Low temperature silver/copper control system in PICB has not been commissioned adequately. There is no legionella present, but currently risk of control failure.

b. Ventilation systems –Verification schedule has improved compliance. Good process with theatres.
- Verification of specialist ventilation in PICB not completed before occupancy. Further work necessary.

c. Decontamination – risk due to age of endoscopy decontamination unit and mattress cleaning. This was hoped to be mitigated through the business case for new endoscopy unit and MEDU, but this has not progressed.
- Risk will arise from shortage of staff with specialist knowledge to fulfil Head Decontamination.

It was reported to the Patient Safety and Outcome Committee in January 2018 that there is concern that there is/may be insufficient capacity and knowledge to ensure the estate is always maintained and used safely.

Since this time: a new Director of Estates and Facilities has started and a senior estates officer has been appointed as Head of Estates.

8. Infection, Prevention and Control Training - At	**15/03/2018**	**20/03/2017**
Trust compliance with level 1 training	98%	96%
Trust compliance with level 2 training	82%	79%

Actions: Compliance has increased but not reached target yet. Divisions need to monitor and continue to improved compliance.

9. Infection Prevention and Control Committee – Some items of discussion and developments from recent meetings

1. Major modification in use of face masks for personal protection (moving from FFP2's to FFP3's and surgical masks) – progressing, but requires additional support for procurement and fit testing regimen.
2. Divisional audit methodology, including hand hygiene audit tools and 'bare-below-the-elbows' policy – JM Barrie audit day model was successful. Other division to observe at next day, with view to adoption.
3. Cleaning (Facilities/OCS) Service level agreements and work plans finally agreed 'in place in all areas' on 15/3/2018
4. Joint cleaning audits – programme in place now.
5. Cleaning failures (Item added 21/09/2107) when increase in Datix noted. More significant variation from expected in practice and cleanliness reported in Feb 18 and Facilities / OCS required to formulate an improvement action plan. This is underway.
6. VRE epidemiology reveals concern regarding transmission and higher colonisation rate. Not under control. Modification in specialist cleaning to be implemented.
7. Implementation of new isolation strategy in outpatients – due to recognition of general increase in risk from antimicrobial resistance (present in children who have not been screened) and acute infections (present in children on arrival), and finite number of isolation cubicles in outpatients, it was agreed to make a fundamental change to isolation in outpatients. Use of rooms to enable isolation will be reserved for higher risk children with acute infections (e.g. respiratory, chicken pox, D&V) and known colonisation with highly resistant or transmissible organisms. Risk from other children with antimicrobial resistant

organism alerts will be reduced by environmental modification (including modification of toy policy, replacement of curtains with cleanable screens, and cleaning policy).
Policy being developed, capital bid for modifications submitted.

8. Vaccination of student nurses – Falling under a number of Universities, standards were not uniform. They will be brought in line with GOSH staff requirement.
9. Reduction of glove use – we will be launching the national programme, to save hands (from dermatitis) and improve infection control and save cost.

J C Hartley
Consultant Microbiologist and DIPC

17/03/2018

Attachment O

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
28 March 2018

Safe Nurse Staffing Report for January and February 2018 **Submitted by:** Polly Hodgson, Interim Chief Nurse	**Paper No: Attachment O**

Aims / summary

This paper provides the required assurance that GOSH has safe nurse staffing levels across all in-patient ward areas and appropriate systems in place to manage the demand for nursing staff. In order to provide greater transparency the report also includes appropriate nurse quality measures and details of ward safe staffing reports. The paper includes a brief summary of nursing vacancies, nurse turnover and patient acuity data.

Action required from the meeting

To note the information in the report on safe staffing, the continued improvement in retention and the progress of the recruited newly qualified nurses and the effect on the staffing numbers.

Contribution to the delivery of NHS Foundation Trust strategies and plans

Safe levels of nurse staffing are essential to the delivery of safe patient care and experience.

Compliance with *How to ensure the right people, with the right skills, are in the right place at the right time – A guide to nursing, midwifery and care staffing and capability'* (NHS England, Nov 2013) and the *'Hard Truths Commitments Regarding the Publishing of Staffing Data'* issued by the Care Quality Commission in March 2014. In July 2016 there was further guidance – '*Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time' (National Quality Board, July 2016).* This guidance provides an updated set of NQB expectations for nurse staffing to help Trust boards make local decisions that will deliver high quality care for patients within the available staffing resource.

Financial implications
Already incorporated into 17/18 Division budgets

Who needs to be told about any decision?

Divisional Management Teams
Finance Department
Workforce Planning

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

Acting Chief Nurse; Assistant Chief Nurses and Head of Nursing

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

Acting Chief Nurse; Divisional Management Teams

GOSH Safe Nurse Staffing Report

Great Ormond Street Hospital for Children NHS Foundation Trust

Capacity:

- Bed closures continued throughout the month of January and February this is due to patients high level of acuity and sickness . However the activity in the Cancer wards has been less during the month of February
- Ad hoc bed closures across a number of wards due to staffing numbers. The main area affected were in the surgical wards and IPP.

Staffing:

- There were no unsafe shifts reported in January or February although there has been "tight" shifts reported but staff were utilised and allocated accordingly to ensure areas are safely staffed.
- Care hours per patient day have generally been higher in January and February compared to the previous 2 months. The trend in patient acuity requiring a nurse to patient ratio of 1:1or 1:2 level of care has been consistently in the mid 60% for the period of this report. Turnover rate has remained static for the period of this report and the vacancy rate has also reduced for registered nurses but remained static for unregistered nurses. The Pipeline figures are, at present, being reviewed. Sickness figures were lower in January than February, this is a slight difference to the trend experience last year.

Temporary Staffing:

- Overall shift request numbers were slightly up for January but still lower than the trend at the end of 2017. The fill rate was 91% in January and 89% in February and 16 hours were filled by using Agency. When reviewing year on year the requests are reducing, this should further reduce over the next month as the junior Band 5's Staff Nurses recruited last year increase their skills and competences.

Month	UNIFY * Actuals vs plan	CHPPD** Trust average	PANDA Acuity (weighted for cubicle and complexity)				Maternity leave (RN)	Sickness (RN)	Turnover FTE (RN)	Vacancies (RN)	Vacancies (un-registered)	Pipeline recruits (RN)	Pipeline recruits (un-registered)
			WIC (1:1)	HD (1:2)	Normal under 2 (1:3)	Normal over 2 (1:4)							
Nov	101.2 %	14.5	49.5%	17.3%	11.9%	21.3%	2.06%	2.97%	14.6 FTE (15.8%)	5 FTE (0.3%)	56.9 FTE (17.9%)	16.6	7
Dec	98.61 %	14.5	46.8%	17.5%	12.7%	22.3%	1.76%	2.99%	26.1 FTE (16%)	16.4 FTE (1.1%)	62.8 FTE (19.8%)	87.1	13
Jan	108%	15.5	43.9%	19.9%	11.3%	24.7%	3.3%	2.93%	15.9 FTE (15.8%)	110 FTE (6.9%)	57.7 FTE (17.9%)	65.9	7
Feb	91%	15	45.28%	18.41%	10.75%	25.56%	3.56%	2.9%	13.2 FTE (15.95%)	47 FTE (2.9%)	59 FTE (18.3%)	82.9	14

Glossary

UNIFY - Unify is an online collection system used for collating, sharing and reporting NHS and social care data.

Care Hours Per Patient Day (CHPPD) - CHPPD is calculated by adding the hours of registered nurses and healthcare support workers available in a 24 hour period and dividing the total by the number of patients at midnight. CHPPD is reported as a total and split by registered nurses and HCAs to provide a complete picture of care and skill mix. CHPPD data is uploaded onto the national Unify system and published on NHS Choices on a monthly basis.

Care hours per patient day =	Hours of registered nurses and midwives alongside Hours of healthcare support workers
	Total number of inpatients

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

Defining Staffing levels

- **Normal dependency Under 2 Years - 1 Nurse: 3 Patients**
- **Normal dependency Over 2 Years - 1 Nurse: 4 Patients**
- **Ward High Dependency (HD) - 1 Nurse: 2 Patients**
- **Ward Intensive Care (WIC) - 1 Nurse: 1 Patient**

Defining staffing levels for Children's and Young People's services (Royal College of Nursing, July 2013)

January 2018

Great Ormond Street NHS Hospital for Children

Ward	Nursing Staffing Actual vs Planned					CHPPD			Key Indicators						
	Registered Day	Care Staff Day	Registered Night	Care Staff Night	Comments	Registered	Care Staff	Total	Pressure Ulcer, Grade 2	Cardiac Arrest	Respiratory Arrest	PALS	Complaints	Datix	Unsafe shift
Charles West Division															
Bear	134.0%	135.1%	117.7%	63.7%	The acuity of the patients on Bear Ward remained high for the duration of January; this instigated a need for a higher level of staffing. The figures for the Ward also indicate an under-establishment on Band 4 and over-establishment on Band 5 staff – this will be corrected in the new budget.	10.8	1.6	12.4	0	0		0	0		0
Flamingo	119.1%	51.7%	114.9%	57.4%	Unit safely staffed	28.3	0.5	28.9	3	0	0	0	0		0
NICU	124.4%	0.0%	108.2%	-	Unit safely staffed	26.9	0.0	26.9		0	0	0	0		0
PICU	112.6%	33.6%	97.1%	6.7%	Unit safely staffed	29.9	0.3	30.2		0	0	0	0	1	0
Elephant	116.6%	73.6%	112.3%	30.3%	There was considerable deficits in IV Givers across the ICI Division during January, the actuity of the patients was very high and there was consistantly busy wards throughout this period. This was mitigated	10.2	1.1	11.2	0	0	0	0	0	1	0
Fox	110.9%	78.5%	96.9%	85.7%	Please see Elephant Ward	14.5	2.0	16.4	0	0	0	0	0		0
Giraffe	147.4%	74.6%	108.0%	41.6%	Please see Elephant Ward	12.4	1.9	14.3	0	0	0	0	0		0
Leopard	106.2%	102.2%	101.8%	79.7%	Ward safely staffed	12.0	1.6	13.6	0	0	0	0	0		0
Lion	112.0%	86.6%	109.2%	65.9%	Please see Elephant Ward	10.6	1.7	12.3	0	0	0	0	1		0
Pelican	138.4%	174.4%	100.9%	52.4%	There was considerable deficits in IV Givers across the ICI Division during January, the actuity of the patients was very high and there was consistantly busy wards throughout this period. This was mitigated	11.1	4.4	15.5	1	0		0	0		0
Kangaroo	184.2%	90.7%	129.9%	102.9%	Over- recruitment of nursing staff	11.4	8.7	20.1	0	0	0	0	0		0
Robin	110.4%	79.4%	103.5%	72.0%	Band 3 vacancies and please see Elephant Ward	13.1	1.7	14.9	0	0	0	0	0		0
International Private Patients Division															
Bumblebee	106.4%	183.5%	95.5%	65.3%	To ensure safe and appropriate staffing level and skill mix, including HCA's to cover specials, staff were moved across the Division	9.3	2.2	11.5	0	0	0	0	0		0
Butterfly	84.3%	142.2%	72.7%	73.6%	Increase in both acuity and activity levels over the month, requiring additional qualified and unqualified nursing staff and in some circumstances requiring 1:1 care. . High acuity of patients and bank shifts not filling led to any empty beds being closed for 12-24 hours. Through these measures and the movement of staff across the division to cross cover, the ward remained safe.	7.8	1.5	9.3	0	0	0	0	0		0
Hedgehog	129.2%	62.1%	91.0%	61.8%	Please see Butterfly Ward	13.1	2.4	15.5	0	0	0	0	0		0
JM Barrie Division															
Eagle	109.4%	56.7%	110.8%	85.6%	Ward safely staffed	11.9	2.1	13.9	0		0	0	0		0
Kingfisher	89.4%	37.7%	121.1%	-	Ward safely staffed	9.3	2.5	11.8	0	0	0	0	0		0
Rainforest Gastro	162.6%	48.5%	149.8%	71.6%	Have had a 1:1 special since December 2017 which has required extra nurses. Since the relocation to old Badger they have also had to have increased numbers day and night to accommodate the fact that the ward layout means the children are no longer co located. The new environment is also all cubicles which	10.5	3.4	13.9	0	0	0	0	0		0
Rainforest Endo/Met	144.8%	49.6%	91.3%	124.8%	Acuity high for January, extra staff needed for cover due to a court case requiring multiple staff to attend. Ward also moved and extra staff needed for the new area due to lay out and environment.	11.5	3.6	15.1	0	0	0	0	0		0
Mildred Creak	134.8%	84.9%	121.2%	41.4%	Have had an influx of new staff there high numbers reflect supernumery period which should look different on next months numbers. They also have 2 patients requiring 15 min checks which requires and increase in numbers	8.5	2.8	11.3	0	0	0	0	0		0
Koala	104.7%	100.0%	92.4%	43.9%	Both Sky ward and Koala ward are a true reflection of the staffing requirements for these specialities. There were a significant number of staff off sick, necessitating an increase in the number of staff required to fill vacant shifts. There is a slightly higher fill rate for days vs nights, as fewer staff are required for the night shift, as indicated by the numbers used this was due potentially to increased daytime discharges and unavoidable cancellations . Beds were closed ossasionally during the month of Januarydue to staffing issues. Additionally, neither ward was able to completely reduce to weekend bed numbers, necessitating	11.2	0.9	12.1	0	0	0	0	0		0
Panther ENT	136.8%	98.2%	117.0%		Multiple Isolated patients and outliers requiring specialing. Staff sickness and acuity high	12.2	1.9	14.0	0	0	0	0	0		0
Sky	117.9%	164.2%	101.6%	-	Please refer to Koala Ward	9.2	2.7	11.9	1	0	0	0	0		0
Panther Urology	197.0%	115.7%	141.8%	29.9%	Ward safely staffed	14.9	2.4	17.3		0	0	0	0		
Chameleon	173.6%	82.4%	219.2%	58.5%	Squirrel (SNAPS) had its establishment reviewed with the numbers provided after the split of Squirrel. Chameleon was found to be under established significantly to be able to safely run and provide a 4 bedded HDU area. There still a lack of clarity in the establishment, leading to inaccurate statistics being reported. This situation is being monitored locally, ensuring that the Wards are safely staffed.	10.9	1.3	12.2		0	0	0	0		

February 2018

Great Ormond Street NHS Hospital for Children

Ward	Nursing Staffing Actual vs Planned				Comments	Care Hours per Patient Day			Key Indicators						
	Registered Day	Care Staff Day	Registered Night	Care Staff Night		Registered	Care Staff	Total	Pressure Ulcer, grade 2	Cardiac Arrest	Respiratory Arrest	PALS	Complaints	Datix	Unsafe shift
Charles West Division															
Bear	131%	127.4%	105.6%	64.6%	There has been a consistant workload of HDU Patients both in the ward and cubicles which has not diminshed since November. All practical solutions have been utilised including the use of other clinical resources.	10.4	1.5	11.9	0	0		0	0		0
Flamingo	104.0%	38.8%	97.4%	41.9%	Unit Safely staffed during this period	25.1	0.4	25.5	0	0	0	0	0		0
NICU	108.9%	0.0%	87.9%	-	Unit Safely staffed during this period	28.4	0.0	28.4	1	0	0	0	0		0
PICU	89.9%	30.4%	80.8%	0.0%	Unit Safely staffed during this period	29.7	0.3	30.0		0	0	0	0		0
Elephant	91.5%	17.5%	87.7%	41.0%	Lower average fill rates in care staff (HCA) category due to vacancies that have been offset by the number of new and junior staff nurses. Several occasions patient dependency/ acuity in Giraffe Ward were quite high (e.g patient requiring 1:1care during infusion of mediation/ antibodies) during the	10.7	0.8	11.4	0	0	0	0	0		0
Fox	70.5%	67.3%	63.3%	41.5%	There are B5 vacancies in Fox Ward, however as necessary, staff were moved from Robin Ward to assist. Clinical workload evenly spread across both wards. There has been a reduction in activity over the last three weeks..	13.1	1.8	14.9	0	0	0	0	0		0
Giraffe	107.5%	76.0%	73.5%	44.3%	See Elephant ward	10.7	2.4	13.0	0	0	0	0	0		0
Leopard	89.4%	98.6%	80.6%	71.0%	There are B5 & B6 Vacancies in Leopard Ward but the ward was safely staffed	11.4	1.8	13.1	0	0	0	0	0		0
Lion	99.5%	84.4%	88.0%	50.9%	See Elephant ward	10.4	1.7	12.1	0	0	0	0	0	1	0
Pelican	119.3%	113.7%	97.3%	54.1%	Long term sickness nursing staff, one to one care required, dependency of patients, nursing cross cover ICI wards, HCA trialling new role within the dept, Less HCA's on night shifts, bank shifts filled	8.2	2.6	10.8	0	0		0	0	3	0
Kangaroo	150.0%	73.8%	112.9%	79.5%	There is still a over recruitment in Kangaroo Ward and a level of HCA sickness which account for these figures but the ward was safely staffed.	11.3	8.2	19.5	0	0	0	0	0	1	0
Robin	68.4%	51.8%	67.9%	70.6%		11.9	2.0	13.8	0	0	0	0	0		0
International Private Patients Division															
Bumblebee	91.8%	160.6%	86.8%	82.0%	Increased qualified and unqualified staffing vacancies/deficits and associated risks were mitigated by additional bank HCA's and careful allocation. Reduction in patient numbers requiring 1:1s this month, which were previously covered by HCA usage. A number of beds closed on an ad hoc basis for night shifts where staffing reduced across the division due to sickness to maintain safety of all areas.	12.8	3.6	16.4	0	0	0	0	0		0
Butterfly	66.9%	139.7%	62.2%	111.1%	Increased qualified and unqualified staffing vacancies/deficits and associated risks were mitigated by additional bank HCA's and careful allocation. Reduction in patient numbers requiring 1:1s this month, which were previously covered by HCA usage. A number of beds closed on an ad hoc basis for night shifts where staffing reduced across the division due to sickness to maintain safety of all areas. Hedgehog ward closed for 2 weeks so additional staff moved across the division accordingly. Dragonfly (4 day care beds) closed regulary and patients accomodated on Bumblebee due to staffing. 3 BMT cubicles closed for last 2 weeks of month for annual revalidation programme.	8.1	2.2	10.8	0	0	0	0	0		0
Hedgehog	106.8%	84.0%	70.2%	75.6%	Some reduced patient numbers especially at nights, due to some day cases, has allowed for staff to move across the division and still ensure safe staffing levels on the ward. Increased patient acuity and change in the patient cohort group requiring increased bank usage and staffing cover. Staff moved across the division to Bumblebee and Butterfly at some points accordingly. No beds closed.	9.9	3.0	12.9	0	0	0	0	0	1	0
JM Barrie Division															
Eagle	92.7%	56.5%	88.6%	92.5%	Ward safely staffed	11.2	2.4	13.6	0		0	0	0		0
Kingfisher	71.2%	37.5%	98.3%	-	Ward safely staffed	9.8	2.5	12.7	0	0	0	0	0		0
Rainforest Gastro	132.0%	41.5%	126.6%	40.7%	Qualified numbers are high, due to new ward environment of old badger having to nurse 2 completely separate areas, and having a 1:1 special. We have 2 HCA vacancies and like MCU have used bank on nights as these fill much better	9.8	2.9	12.7	0	0	0	0	0		0
Rainforest Endo/Met	111.8%	64.1%	79.8%	113.3%	Ward safely staffed	11.0	4.6	15.7	0	0	0	0	0		0
Mildred Creak	109.8%	94.0%	98.4%	57.4%	3 HCA vacancies. Staff requested as appropriate to ensure safe staffing	6.5	3.2	9.7	0	0	0	0	0		0
Koala	92.6%	101.0%	77.7%	59.2%	Both Sky and Koala ward are a true reflection of the staffing requirements for these specialities. During the month of February there were a significant number of staff off sick and sometimes the ability to fulfil the outstanding shifts necessitated bed closures to reflect staffing issues. Additionally neither ward was able to completely reduce to weekend bed numbers necessitating an increase in staff.	10.0	1.0	11.0	0	0	0	0	0	1	0
Panther	110.6%	125.6%	106.9%		Panther ENT had a significant number of staff off sick during February. In addition to this they had a number of children requiring additional specialist case due to infection however the Ward was safely staffed	11.8	2.8	14.6	0	0	0	0	0		0
Sky	106.4%	133.8%	89.8%	-	see Koala Ward	10.1	2.8	12.8	2	0	0	0	0		0
Panther Urology	159.0%	67.8%	102.2%	31.1%	Ward safely staffed	11.5	13.6	13.1		0	0	0	0		
Chameleon	145.3%	75.6%	177.4%	63.2%	The situation on the ward remains under review. The ward was safely staffed.	10.0	1.0	11.4		0	0	0	0		

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **28th March 2018**	
2017 Annual Staff Survey Results **Submitted by:** Ali Mohammed, Director of HR&OD	**Paper No: Attachment P**
Aims / summary To provide the Trust Board with a high level summary of results and key areas of action.	
Action required from the meeting To note the results and proposed actions	
Contribution to the delivery of NHS Foundation Trust strategies and plans The results provide evidence of areas of strength and for development in staff experience, allowing improvement plans to be developed in a range of areas. CQC and commissioners review our results and action plans.	
Financial implications No direct financial implications	
Who needs to be told about any decision? The results and actions are being communicated to staff.	
Who is responsible for implementing the proposals / project and anticipated timescales? Executive Management Team	
Who is accountable for the implementation of the proposal / project? Ali Mohammed, Director of HR&OD	

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of the 2017 Staff Survey Results

Background

NHS England have now published the results of the 2017 Annual Staff Survey. A full copy of the GOSH results are available to view at the end of March on GOSHWeb. A summary of all key findings is appended.

Copies of the survey went out to a random sample of 1,250 staff, and our overall survey response rate was 45.8% (536 respondents), which is lower than recent years.

The staff survey is an important indicator of our staff experience, which is vital to our ability to attract and retain staff, deliver the Trust's strategy, Fulfilling Our Potential, and ensuring that high quality leadership and safe care delivery are achieved.

Headline issues

The survey is grouped into 32 Key Findings (KF) under nine themes:

- Equality and Diversity
- Errors and Incidents
- Health and Wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care & experience
- Violence, harassment and bullying

When benchmarked against other Acute Specialist trusts:

- 1 KF was better than average
- 10 KFs were average
- 21 KFs were worse than average
- 4 KFs improved from 2016
- 2 KFs remained the same
- 26 KFs deteriorated from 2016

Overall our staff engagement score was average when compared to our benchmark acute specialist trusts. Our score has reduced to 3.90 from 3.98 in 2016 (the closer the score is to 5 the more positive the result) but compared to other London Trusts this year we have performed relatively favourably against this measure.

In relation to the highest and lowest performance areas:

Key positive areas

The five most favourable GOSH results are:

- Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse: GOSH 54%, national average for acute specialist trusts is 47%.

- Quality of appraisals: GOSH 3.18, national average for acute specialist trusts is 3.16.
- Percentage of staff appraised in last 12 months: GOSH 88% which is also the national average of acute specialist trusts.
- Percentage of staff able to contribute to improvements at work: GOSH 73% which is also the national average of acute specialist trusts.
- Staff motivation at work: GOSH 3.94 which is also the national average of acute specialist trusts.

Top five key concerns

The five scores in which GOSH compares least favourably to our comparator acute specialist trusts are:

- Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month: GOSH: 36% as opposed to the acute specialist trust average of 27%. Underlying this, there was no reported change since 2016 in the percentage of staff witnessing errors etc. which could have hurt patients, but there was an increase in witnessing those which could have hurt staff.
- Support from immediate managers: GOSH: 3.7 as opposed to the acute specialist trust average of 3.81.
- Staff confidence and security around reporting unsafe clinical practice: GOSH: 3.57 as opposed to the acute specialist trust average of 3.71. The most confident staff group to report issues were maintenance & ancillary and the least confident were adult / general nurses.
- Effective team working: GOSH: 3.69 as opposed to the acute specialist trust average of 3.79. This was lowest for Nursing/Healthcare Assistants.
- Percentage of staff reporting errors, near misses or incidents witnessed in the last month: GOSH: 88% as opposed to the acute specialist trust average of 92%. This was lowest amongst Allied Health Professional Staff.

For the first time GOSH asked survey respondents about the Always Values. Our results showed that over 99% of respondents to this question were aware of the Values and 60% said that managers demonstrated the values at work always or often; 66.9% said that their colleagues also displayed them always or often.

Next Steps

A number of initiatives are currently being progressed that will address the themes, including:

- Safety and Reliability Improvement Project (Cognitive)
- Trust-wide leadership Learning Needs Analysis
- Development of an Equality, Diversity and Inclusion strategy
- Management development refresh
- Bullying & Harassment refresh
- Health and wellbeing actions

In addition the following are being undertaken:

- Results will be communicated to the Trust in conjunction with internal communications and divisional/corporate leaders, including a focus on the results in an Executive open briefing session.

- Results are being discussed at SMT and ODG. Themes from local action plans will be discussed to help inform the inclusions into the Trust-wide action plan.
- To ensure localities are fully supported in accessing and acting on their data, they have been provided, for the first time, with an electronic data pack which contains their results and allows them to drill down into specific questions and themes.
- All localities will be expected to use their data to identify their local issues, and produce plans to address these.
- HR Business Partners will support divisional and directorate teams in analysing their local results and developing action plans with their staff.
- Staff Side will be engaged in order to help support actions where appropriate.

Action Required

Trust Board are requested to note the contents of this report.

Appendix 1: Summary of Key Factors

3.4. Summary of all Key Findings for Great Ormond Street Hospital for Children NHS Foundation Trust

KEY

✓ Green = Positive finding, e.g. better than average, better than 2016.

! Red = Negative finding, e.g. worse than average, worse than 2016.

'Change since 2016 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2016 survey.

-- No comparison to the 2016 data is possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

	Change since 2016 survey	Ranking, compared with all acute specialist trusts in 2017
Appraisals & support for development		
KF11. % appraised in last 12 mths	• No change	• Average
KF12. Quality of appraisals	! Decrease (worse than 16)	• Average
KF13. Quality of non-mandatory training, learning or development	• No change	• Average
Equality & diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	! Increase (worse than 16)	! Above (worse than) average
KF21. % believing the organisation provides equal opportunities for career progression / promotion	• No change	! Below (worse than) average
Errors & incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	! Above (worse than) average
KF29. % reporting errors, near misses or incidents witnessed in last mth	• No change	! Below (worse than) average
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	! Decrease (worse than 16)	! Below (worse than) average
KF31. Staff confidence and security in reporting unsafe clinical practice	! Decrease (worse than 16)	! Below (worse than) average
Health and wellbeing		
* *KF17. % feeling unwell due to work related stress in last 12 mths*	! Increase (worse than 16)	! Above (worse than) average
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	• No change	! Above (worse than) average
KF19. Org and mgmt interest in and action on health and wellbeing	• No change	! Below (worse than) average
Working patterns		
KF15. % satisfied with the opportunities for flexible working patterns	• No change	! Below (worse than) average
* *KF16. % working extra hours*	• No change	• Average

3.4. Summary of all Key Findings for Great Ormond Street Hospital for Children NHS Foundation Trust (cont)

	Change since 2016 survey	Ranking, compared with all acute specialist trusts in 2017
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	• No change	• Average
KF4. Staff motivation at work	• No change	• Average
KF7. % able to contribute towards improvements at work	• No change	• Average
KF8. Staff satisfaction with level of responsibility and involvement	• No change	! Below (worse than) average
KF9. Effective team working	! Decrease (worse than 16)	! Below (worse than) average
KF14. Staff satisfaction with resourcing and support	• No change	• Average
Managers		
KF5. Recognition and value of staff by managers and the organisation	! Decrease (worse than 16)	! Below (worse than) average
KF6. % reporting good communication between senior management and staff	• No change	! Below (worse than) average
KF10. Support from immediate managers	• No change	! Below (worse than) average
Patient care & experience		
KF2. Staff satisfaction with the quality of work and care they are able to deliver	• No change	• Average
KF3. % agreeing that their role makes a difference to patients / service users	• No change	! Below (worse than) average
KF32. Effective use of patient / service user feedback	• No change	! Below (worse than) average
Violence, harassment & bullying		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	! Above (worse than) average
* *KF23. % experiencing physical violence from staff in last 12 mths*	• No change	! Above (worse than) average
KF24. % reporting most recent experience of violence	• No change	• Average
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	! Above (worse than) average
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	! Above (worse than) average
KF27. % reporting most recent experience of harassment, bullying or abuse	• No change	✓ Above (better than) average

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 28 March 2018	
Guardian of Safe Working – quarterly report **Submitted by:** Dr Renée McCulloch, Guardian of Safe Working	**Paper No: Attachment Q** **Attachment plus Appendix 1: Results from Exception Report Survey**

Aims / summary

This report is the second report to the Board regarding the mechanisms within the new Junior Doctor contract for monitoring safe working practices. This report covers the period October 2017 to February 2018 inclusive.

Action required from the meeting

The board is asked to note the report and continue to monitor compliance with the TCS 2016.

Contribution to the delivery of NHS Foundation Trust strategies and plans

The Guardian of Safe Working works to enable a safe and positive working and training environment for junior doctors. This contributes to the Trusts strategic objective relating to providing safe patient care and an excellent place to work and learn.

Financial implications

n/a

Who needs to be told about any decision?

n/a

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

Dr Renee McCulloch, Guardian of Safe Working
Dr Sanjiv Sharma, Deputy Medical Director for Medical & Dental Education
Sarah Ottaway, Head of Medical HR & PGME Services

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

Matthew Shaw, Medical Director

Attachment Q

Guardian of Safe Working – Quarterly Board Report

1. Purpose

1.1 To inform the board on issues arising relating to the junior doctors 2016 contract and the work of the Guardian of Safe Working (GOSW).

2. Background

2.1 In August 2016 the new Terms & Conditions (TCS) were introduced for doctors in training. The TCS clearly indicate the importance of appropriate working hours and attendance at training and education. Both issues have a direct effect on the quality and safety of patient care.

2.2 Aligned to the 2016 contract, is the development of the role of a 'Guardian of Safe Working'. Responsibilities include overseeing the safeguards outlined in the 2016 contract and ensuring that issues of compliance with safe working hours are addressed by the doctors and/or the employer. The role of the GOSW at GOSH is evolving and includes facilitating the reporting structures and supporting the wellbeing of the junior doctors.

3. High level data (as at 12th March 2018)

3.1

Number of doctors / dentists in training	141
Number of doctors / dentists in training on 2016 TCS	141
Number of doctors on local (non-training) TCS	178

4. Implementation Progress

4.1 Rota redesign

As of 2nd October 2017, all junior doctors in training have transferred to the new TCS. There are 45 different rota patterns currently in place within the Trust. All are compliant with the 2016 TCS. Issues arise with rota gaps (due to unfilled positions and sickness)

5. Exception Reports

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

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

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

5.4 The GOSW is required to regularly provide reports to Trust board regarding exception reporting.

From May 2017:

- **Total number of Exception Reports received** = 92
- **Number of Exception Reporting Episodes** = 139

(When submitting an Exception Report doctors can enter different episodes, relating to exceptions occurring on different dates)

5.5 Number of Exception Reports received by quarter:

- May; June; July 17 = 20
- Jun,; July; Aug 17 = 29
- Sep; Oct; Nov 17 = 27
- Dec; Jan; Feb 18 = 16

5.6 **30 ER Submissions by Trust Doctors from June 2017 (34 Episodes)**

5.7 **Number of Exception Reports closed / complete**

Many ER logged within the first six months were not closed due to lack of familiarity with system requirements

- May to September 34/ 62
- October to February 29/ 30

GOSW has been working closely with educational supervisors to improve understanding and response time to ERs.

5.8 **Exception Report Themes**

Exception reports 1st Oct 17 to 28th Feb 2018 Details by specialty; grade and reason for ER					
Specialty	**Rota grade**			**Exceptions relating to hours of work**	**Exceptions relating to educational opportunities**
	SHO	SpR	Fellow		
Neurology	7	3		10	
HaemOnc	5			5	
CICU			5	4	1
Imm/ID	3	3		6	
Audiology			1		1
ICON			1	1	
PICU/ NICU			1	1	
Respiratory		1			1
Total	**15**	**7**	**8**	**27**	**3**

The predominant themes behind the extra hours being worked were:

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

5.9 **Exception Report Outcomes:**

Exception Report Outcomes 1 October 17 to 28 February 18				
Compensation with payment	TOIL	No further action	Further information	Pending ES meeting
13	8	7	1	1

6 Fines and Payments

6.1 GOSW has ensured all trainees remaining in post at GOSH with outstanding ERs related to working overtime from May 2017 to date have received financial compensation.

6.2 Awarding time off in lieu seems to be practically challenging on some rotas. GOSW has requested educational supervisors to consider the likelihood of the doctor achieving TOIL when awarding compensation.

6.3 The existing reporting system makes it very difficult to work out whether the 'higher' fines against a department should be levied (and given to the junior doctors' forum). This has been fed back to the software designers who are working on several of the issues reported by GOSH.

.

7 Exception Reporting Survey

Please see appendix 1: Exception reporting survey Jan 2018

- Achieved a 48% response rate

7.1

- Results showed:
  - Few junior doctors are exception reporting despite working over their contracted hours, missing breaks and not getting to educational opportunities
  - Junior doctors are aware of that they can exception report for hours worked but less aware that this is also the route for reporting missed educational opportunities
  - Issues regarding the process – it is arduous and involves education supervisors input which deters junior doctors.
  - Reluctance to exception report due to concerns about negative impact on career, exceptions being 'part of the normal work of a doctor' and not having any belief that the ER will change anything.
  - A lack of encouragement to ER by consultants (comments) however junior doctors report feeling supported by the consultant body.

7.2

- Actions:
  - Survey has been circulated to all junior doctors and education leads.
  - GOSW has been visiting all departmental meetings to improve consultant understanding of the system and encourage ER support.
  - GOSW is at all junior doctor inductions to discuss and encourage ER.
  - Results from the GOSH experience regarding exception reporting process are being presented at the RCPCH meeting and at an open meeting JDF in April.
  - A work plan is being developed to address issues raised.
  - Website development is under way.

7.3

- Of note:
  - National picture reflects more junior trainees (foundation and core level) reporting more readily.

- GOSH has more senior level trainees which may be influencing results.

8. Junior Doctors' Forum

8.1 The 2016 TCS required the establishment of a Junior Doctors Forum (JDF) to serve as a key point of liaison between junior doctors, the GOSW and Director of Medical Education. The 2016 TCS mandates attendance by junior doctor representatives from every department across the Trust, in addition to representatives from the trust Local Negotiating Committee and the BMA.

8.2 The JDF has been meeting monthly since December 2016. Focus has been on projects surrounding exception reporting and rest facilities.

8.3 The JDF and DocsReps Committee are merging to form one group, maintaining the JDF title. It is hoped that this will improve attendance and focus more effective representation of the junior doctors within the Trust.

9. Vacancies

9.1 As of 12th March 2018 the following junior doctor posts were vacant:

Specialty	Rota grade	Rota establishment	Vacant posts	Vacancy rate %
Orthopaedic Surgery	SHO	3	1	33.3
Urology	SHO	4	2	50
Plastic Surgery	SHO	3	1	33.3
ENT	SHO	2	1	50
Gastroenterology	SpR	5	0.4	8
Gastroenterology	SHO	3	1	33.3
Metabolic	SpR	3	1	33.3
Metabolic	SHO	2	1	50
Rheumatology	SpR	4	0.4	10
Megga 2 Metabolics	SpR	7	1	14
Immunology	SpR	6	1	17
PICU	SpR	16	2	32
ICON	SpR	8	4	50
ECMO	SpR	7	1	14
Cardiothoracic Surgery	SpR	8	4	50
International Private Patients	SpR	14	7	50

The overall vacancy rate across junior doctor rotas is 10% with 28.8 FTE vacant out of a total of 284 rota slots.

10. Locums - Bank and Agency use

10.1 Below is a breakdown of locum (bank and agency) usage across junior doctor rotas, for the period 2nd October 2017 to 28th February 2018.

Specialty	Number of shifts	Cost
BMT	0	0

Cardiology SHOs	2	£623.87
Cardiology SpRs	1	£202
Cardiothoracic SpRs	22	£13,458.26
CATS	19	£9,503.70
CICU	111	£79,062.22
Dermatology	9	£2,515.91
Haematology/Oncology	119	£62,953.81
MEGGA SpR	96	£45,473.62
MEGGA SHO	106	£32,265.95
Neurology SpR	34	£17,616.10
Neurology SHO	33	£13,167.79
NICU PICU ICON	175	£132,011.96
Neurosurgery	15	£5000.50
IPP	351	£458,305.84
Spinal/Orthopaedics SpR	12	£3,549.81
Surgery SHOs	517	£189,414.90
Surgery SpRs	1	£1161.50
Symptom Care Team	0	0
Total		**£766,381.79**

10.2 Of the 1623 shifts covered as locums, 1614 were covered by doctors directly engaged via the GOSH in-house bank, with 9 shifts covered by locums via agencies. This represents a significantly lower reliance on premium rate agency locum staff to cover rota gaps, when compared with other trusts.

11. Summary

11.1 All junior doctors in training within the Trust have moved onto the 2016 contract. (from October 2017)

11.2 All junior doctors, including Trust Fellows (non-training grades) can exception report at GOSH although with differing compensation. GOSH is the only Trust nationally to implement this.

11.3 Rotas are compliant however rota gaps can put significant pressure on the system.

11.4 The exception reporting system has been implemented to allow working hours and training issues to be expressed and addressed in real time however there are significant issues with implementation and process. These include the culture of an exception reporting system in medicine, understanding and acceptability of the ER process across junior and senior medical workforce and the accessibility of the reporting system.

11.5 The GOSH experience regarding ER has been presented at the national RECPCH annual meeting and was received extremely well. It has led to invitations for GOSH to present findings to other national groups.

11.5 The junior doctor's forum is being represented in a new form from April 2018 to improve attendance and engagement. JD representative roles and responsibilities will be formalised.

11.6 GOSW is continuing to work to support the junior doctors at GOSH.

GOSH Junior Doctor

Exception Reporting Questionnaire

Thursday, February 15, 2018

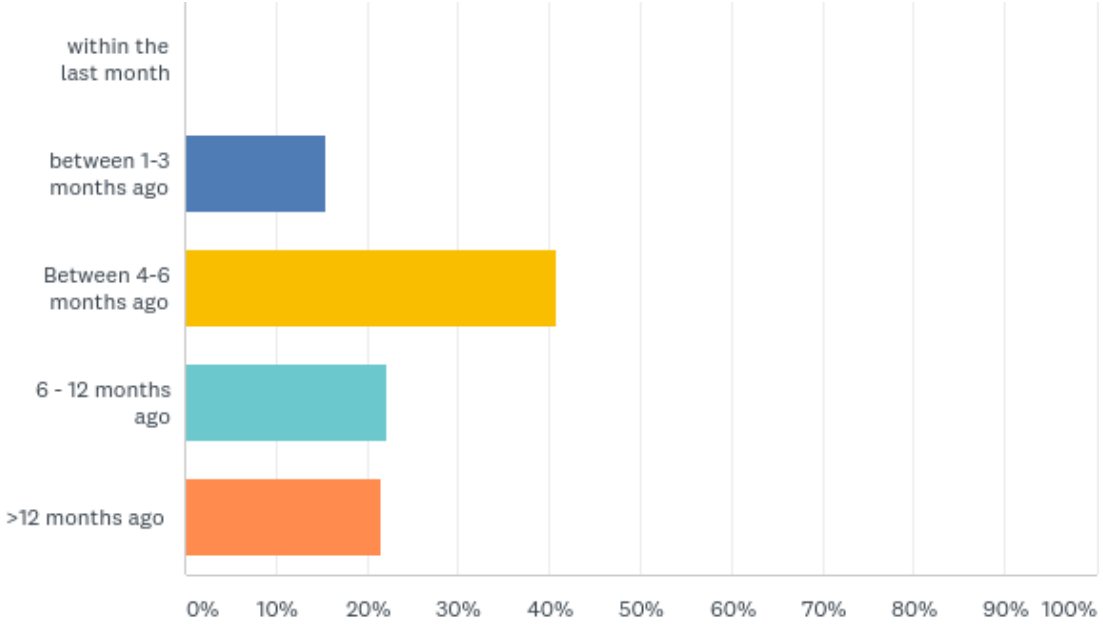
135

Total Responses

48% response rate = fantastic – thanks all!

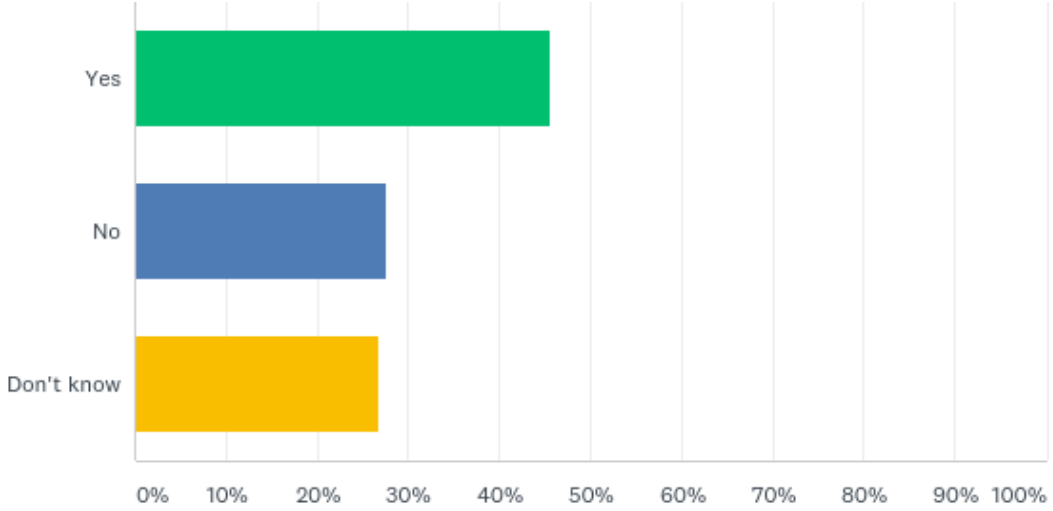
Q1: When did you start working at GOSH? (If you have worked at GOSH before please answer relating to your current rotation).

Answered: 135 Skipped: 0



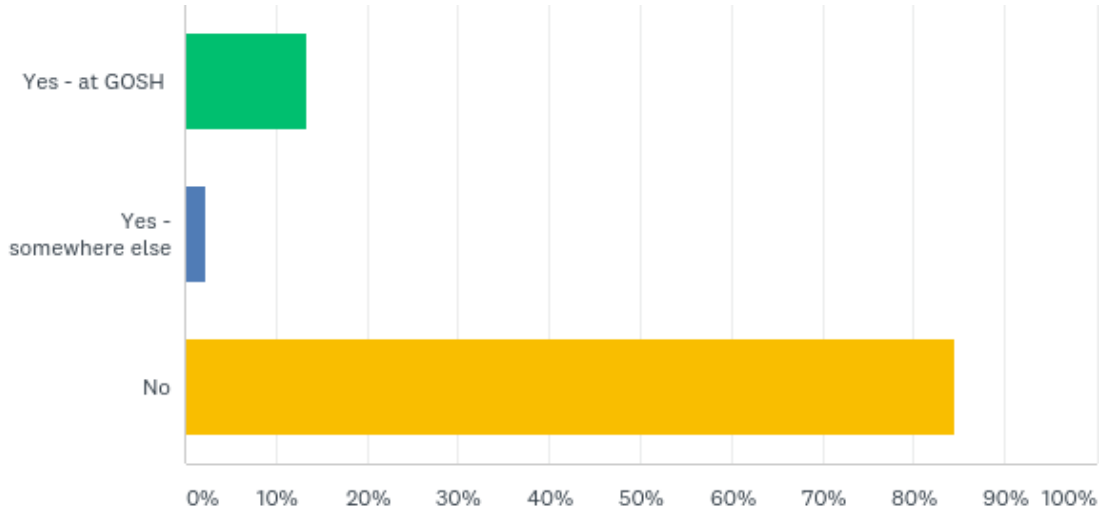
Q2: Are you employed on the new Junior Doctor's contract?

Answered: 134 Skipped: 1



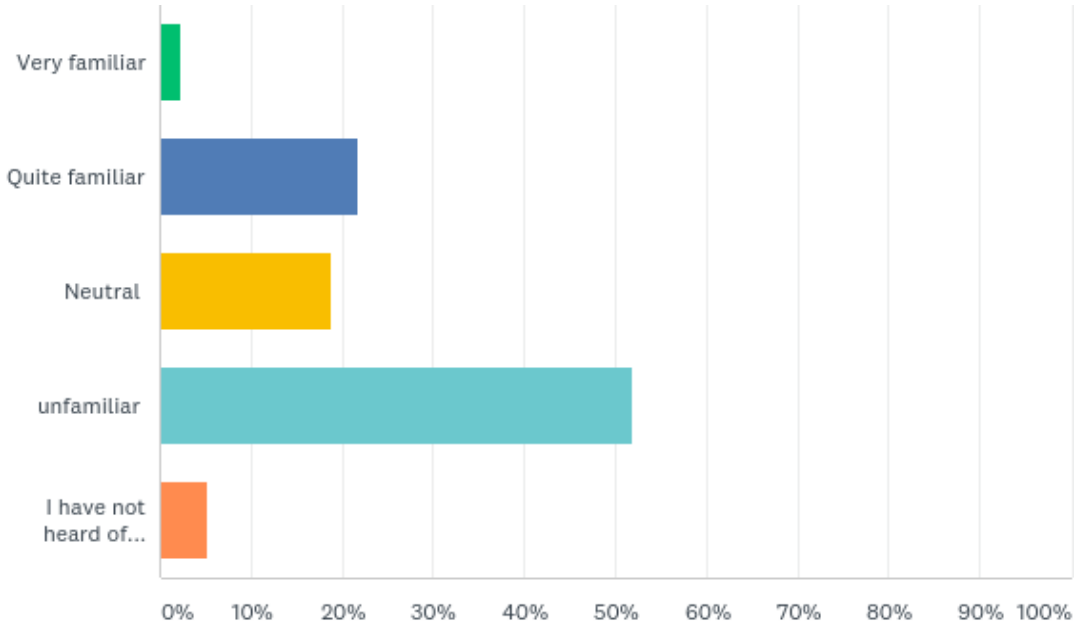
Q3: Have you ever completed an exception report?

Answered: 135 Skipped: 0



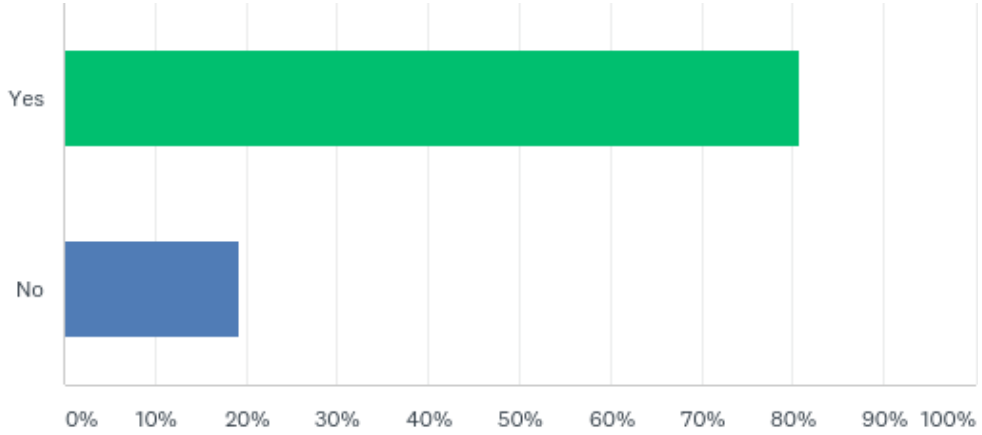
Q4: How familiar are you with the process of exception reporting (ER)?

Answered: 133 Skipped: 2



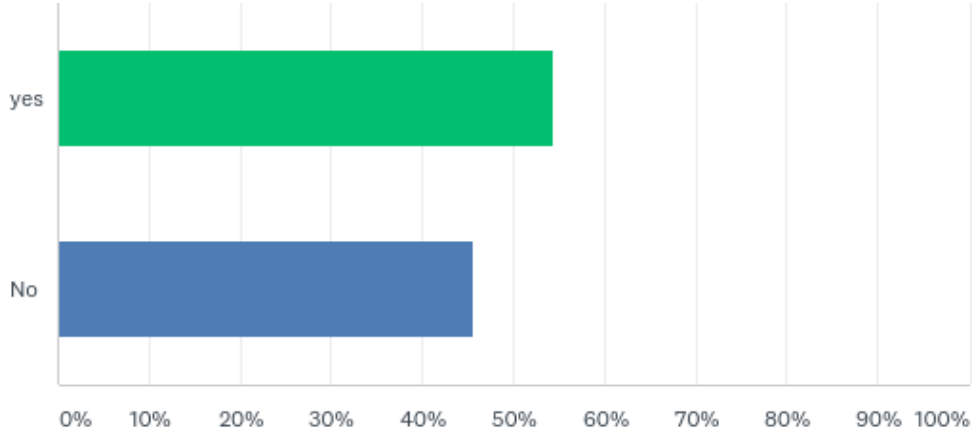
Q5: Are you aware that you can exception report when your actual work varies from your agreed rota?

Answered: 135 Skipped: 0



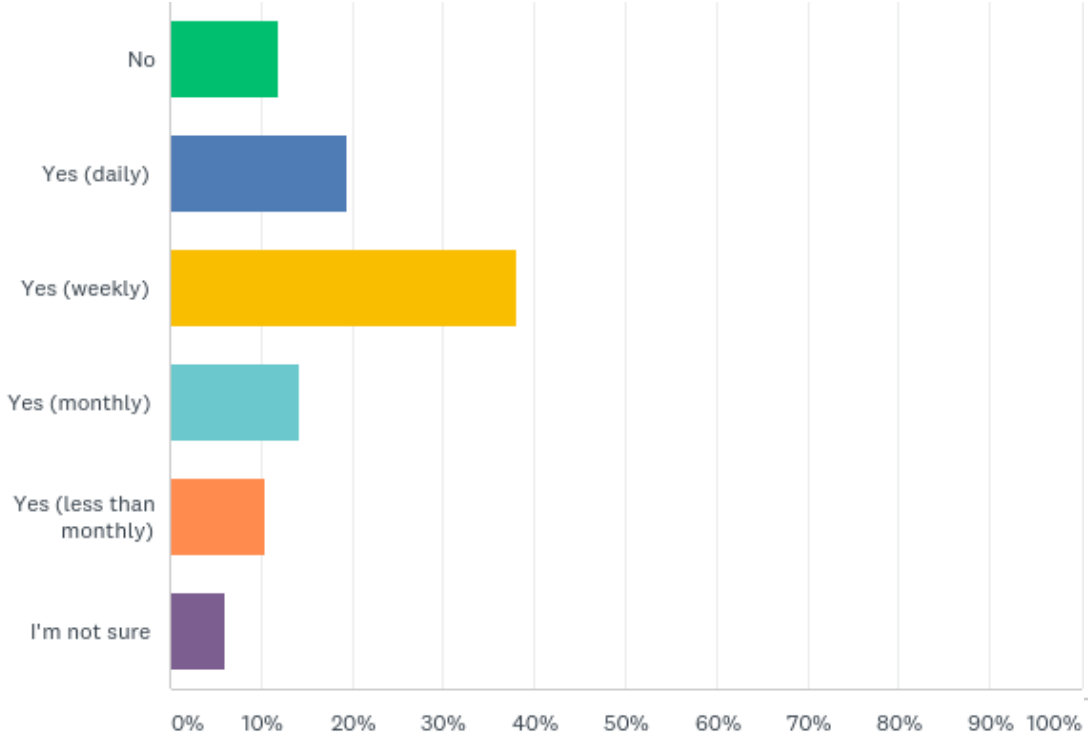
Q6: Are you aware that you can exception report missed or disrupted educational or training opportunities?

Answered: 134 Skipped: 1



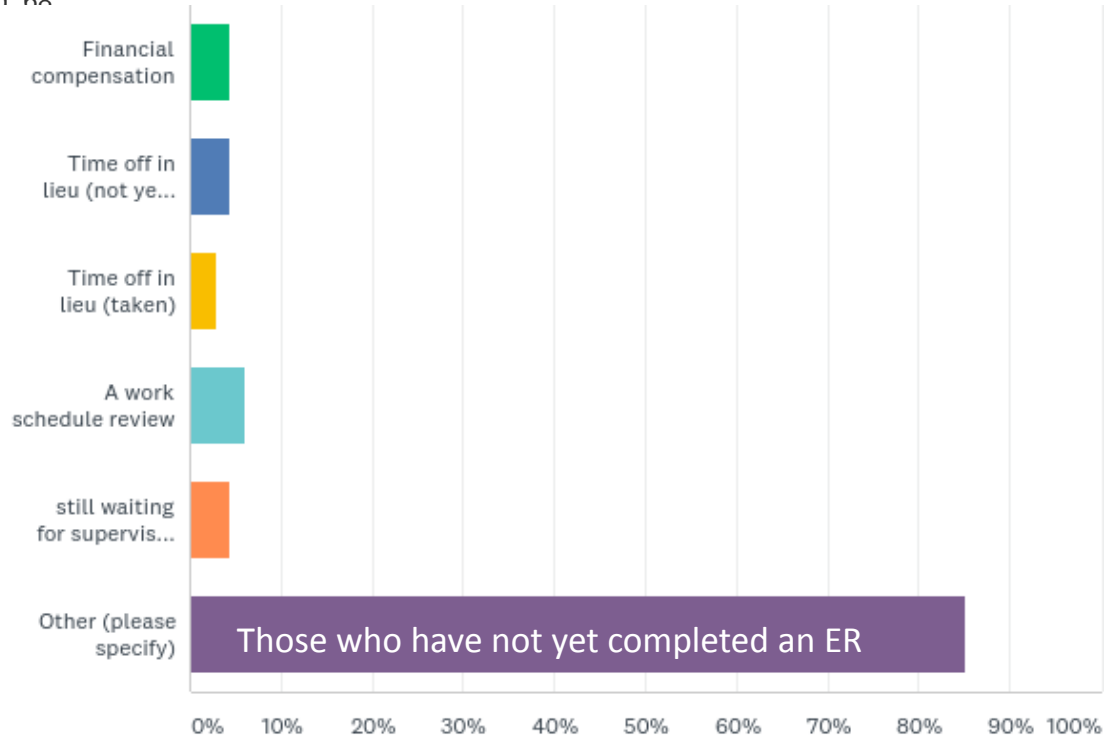
Q7: While at GOSH, have you worked outside of your agreed working patterns and not filled in an exception report?

Answered: 134 Skipped: 1



Q8: If you have completed an exception report, what was the outcome?

Answered: 67 Skipped: 68



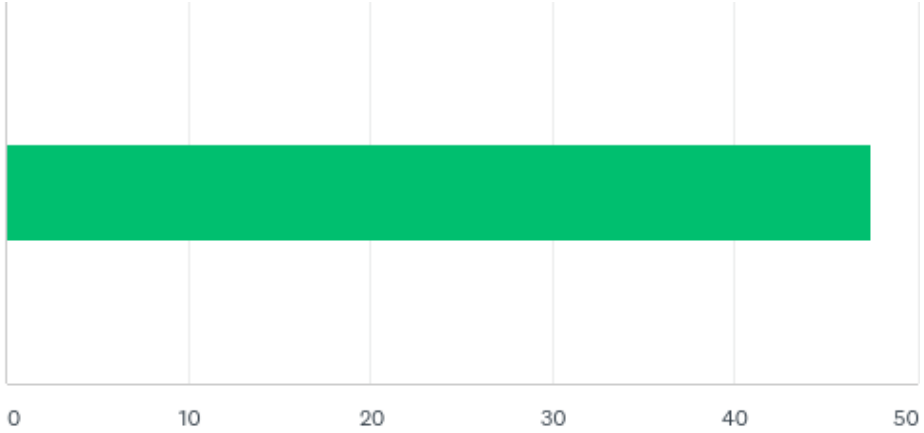
Q8: If you have completed an exception report, what was the outcome?

Answered: 67 Skipped: 68

ANSWER CHOICES	RESPONSES	
Financial compensation	4.48%	3
Time off in lieu (not yet taken)	4.48%	3
Time off in lieu (taken)	2.99%	2
A work schedule review	5.97%	4
still waiting for supervisor meeting	4.48%	3
Other (please specify)	85.07%	57
Total Respondents: 67		

Q9: How did you feel about this outcome?

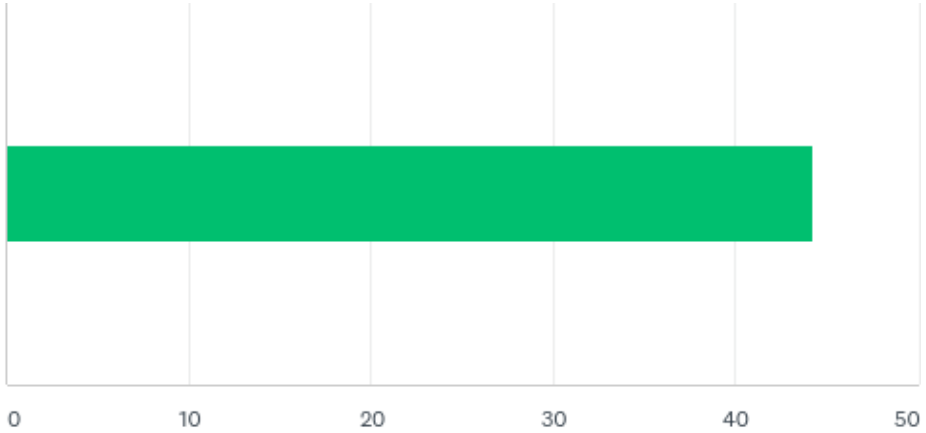
Answered: 59 Skipped: 76



Scale 0-100%: rated as very unsatisfied- unsatisfied- satisfied-very satisfied
Average score of 59 respondents 48% = unsatisfied with ER outcome

Q10: How likely do you think it is that you can get time of in lieu if offered this as an outcome?

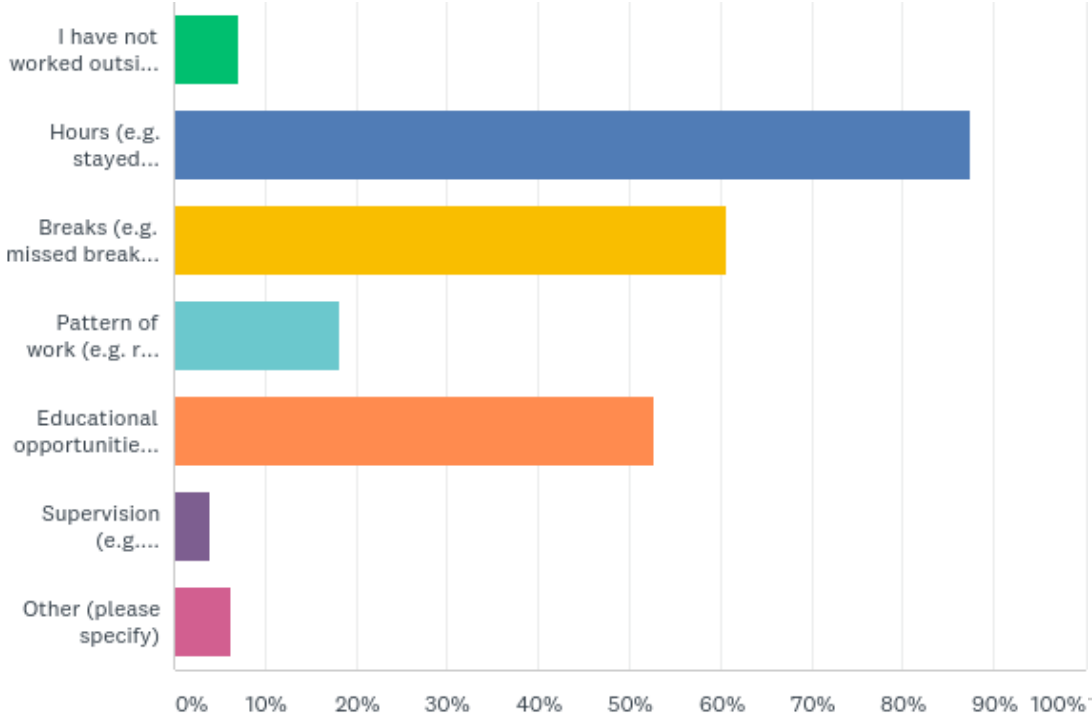
Answered: 81 Skipped: 54



Scale 0-100%: rated as very unlikely-unlikely- likely- very likely
Average score of 81 respondents 44% = unlikely to get TOIL if offered

Q11: In what ways have you worked outside your agreed working conditions? (tick as many as apply)

Answered: 127 Skipped: 8



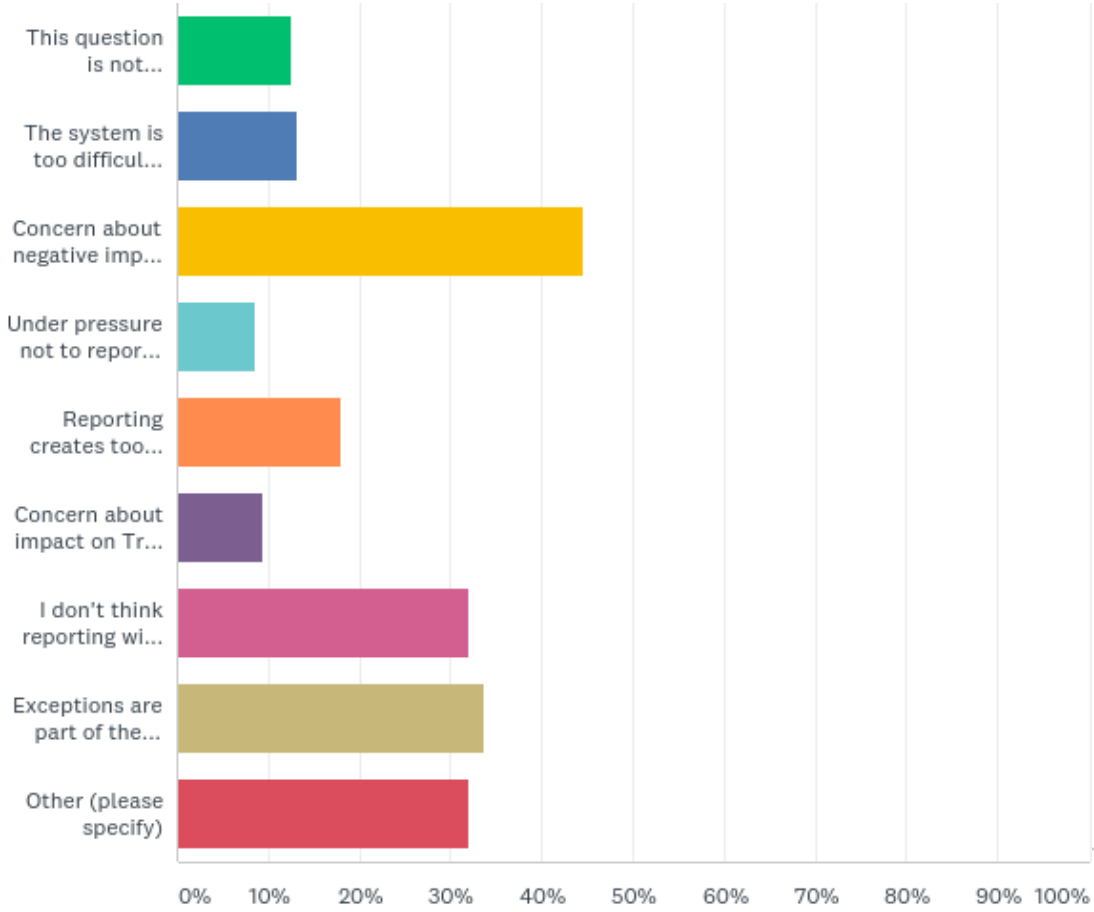
Q11: In what ways have you worked outside your agreed working conditions? (tick as many as apply)

Answered: 127 Skipped: 8

ANSWER CHOICES	RESPONSES	
I have not worked outside my agreed working conditions	7.09%	9
Hours (e.g. stayed late/came in early)	87.40%	111
Breaks (e.g. missed breaks, short breaks, breaks not evenly spaced throughout day)	60.63%	77
Pattern of work (e.g. rota doesn't match expected working pattern)	18.11%	23
Educational opportunities (e.g. missed teaching, teaching session cancelled)	52.76%	67
Supervision (e.g. Supervisor not available)	3.94%	5
Other (please specify)	6.30%	8
Total Respondents: 127		

Q12: What, if anything, has stopped you from filling out an exception report? You may select more than one answer.

Answered: 128 Skipped: 7



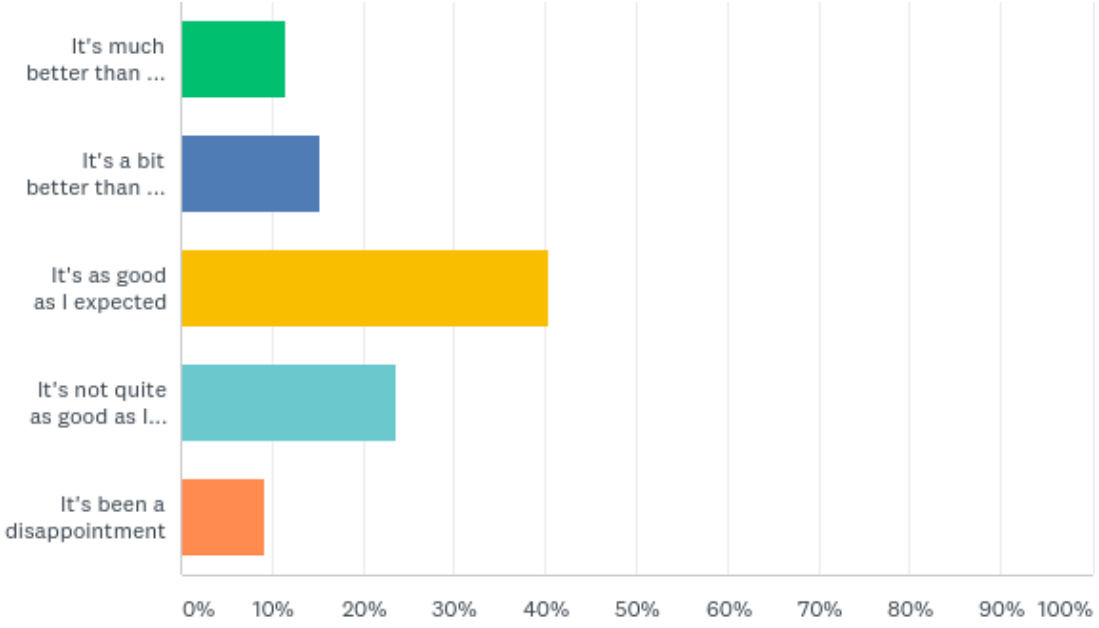
Q12: What, if anything, has stopped you from filling out an exception report? You may select more than one answer.

Answered: 128 Skipped: 7

ANSWER CHOICES	RESPONSES	
This question is not applicable to me	12.50%	16
The system is too difficult to navigate	13.28%	17
Concern about negative impact on career or reputation	44.53%	57
Under pressure not to report by others	8.59%	11
Reporting creates too much work for others in the team	17.97%	23
Concern about impact on Trust or Departmental finances	9.38%	12
I don't think reporting will lead to any changes	32.03%	41
Exceptions are part of the expected everyday work of a doctor	33.59%	43
Other (please specify)	32.03%	41
Total Respondents: 128		

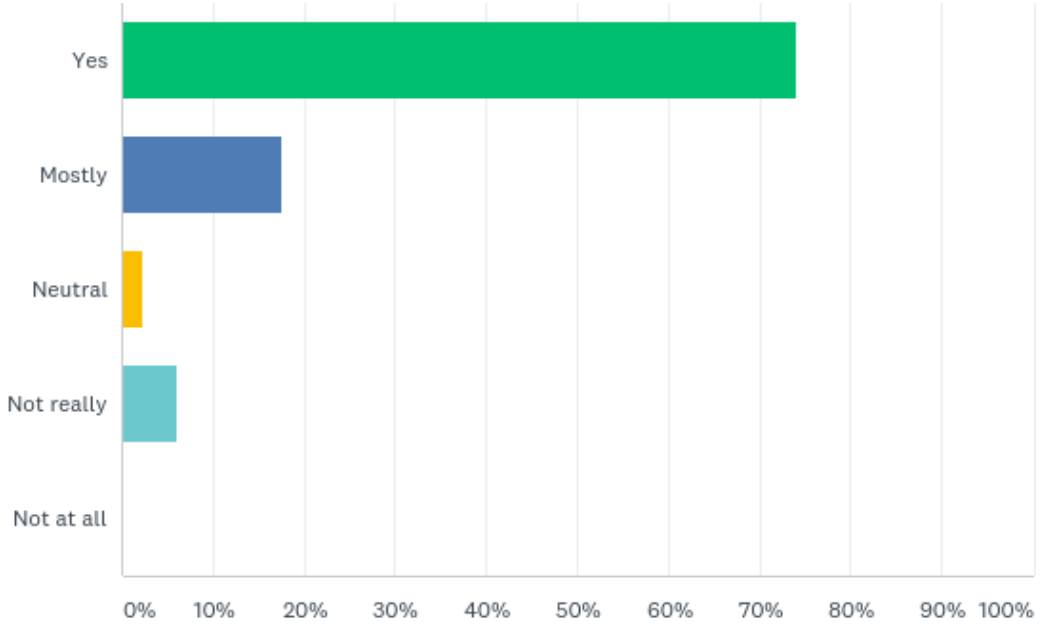
Q14: How satisfied are you with your current role?

Answered: 131 Skipped: 4



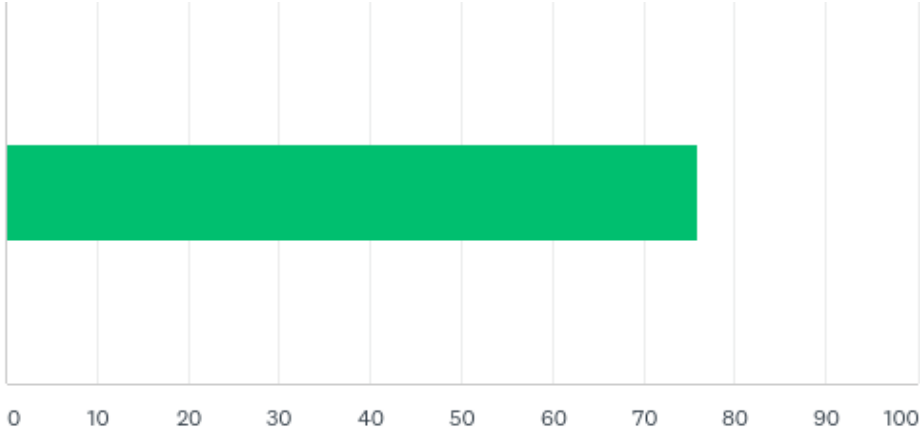
Q15: Do you understand what is expected of you in your current role?

Answered: 131 Skipped: 4



Q16: How supported do you feel in your current role by the consultants in your department?

Answered: 131 Skipped: 4



Scale 0-100% rated as very unsupported- unsupported- supported- very supported
131 respondents: 76% felt supported by consultants

How could we make exception reporting easier and more accessible for you?

Selected responses: CULTURE

- ‘We should not feel worried about exception reporting and our consultants should encourage us. If our consultants do not support us it is very difficult’

- ‘The culture, however, is what is problematic. In order to achieve fairness again, there needs to be a strong message from consultant heads of department to encourage and reassure us that we will not be thought badly of if we ask to be paid for the work we actually do’.

- ‘We are climbing "career ladders" and aspire to show our supervisors that we are hard working, conscientious and may even like to one day ask for references or even apply for a consultant job in the same department. Our seniors grew up in an environment where there was no such thing as exception reporting and I think there is a belief that to get far in medicine we have to go "above and beyond" just like they had to. Creating a system where we have to report our department in a "name-and-shame" kind of way seems too much to ask. I believe that if real change is going to happen about doctors' hours, the onus needs to be on hospital management and our seniors to take a more pro-active role in ensuring we keep to our working hours, not the other way around. this I believe requires culture change and leadership from the top’.

- ‘I would report it if it was just an ‘exception’, but in our department it is a daily occurrence that we registrars stay on much longer than our contracted hours’

How could we make exception reporting easier and more accessible for you?

Selected responses: CULTURE

- ‘Consultants know the flaws in system. They must address it’
- The new contract working hours regulations are completely incompatible with the department requirements.
- ‘It is such an ingrained culture that we are expected to stay past our rostered hours that I am not sure how this will change. It has been especially disappointing over the past 2 rotas that we have been short on the rota and this has impacted our educational and training opportunities (and we have just been expected to cover the gaps without complaint)’
- ‘Many trainees not doing exceptional reporting because of the hassle and (they are) worried it may cause negative impact. There is a need to change this culture.’
- …Another team I cross cover work ridiculously out of their rostered hours and it seems to be an accepted thing. I don't think its fair. GOSH is a good hospital but works on most medical teams working well beyond rostered hours/not having breaks/ not having supervision or teaching
- ‘It is very difficult for a junior to report against their dept knowing that the dept is under staffing and financial pressure already’.

Regarding outcomes of Exception Reporting

Selected responses: Outcomes

- ‘A discussion with my educational supervisor where I was encouraged not to take the matter further’

- ‘From other colleagues that have done some of the reporting the outcome has been multiple meeting with educational supervisor and then been told that as no further exception reports filed things have improved although there has not been any change’.

- One set of reports - my educational supervisor talked to my clinic team and made them aware of educational meetings, so that they would allow me to leave clinic promptly to get there Another set of reports - essentially nothing happened. I reported loss of educational opportunities due to pressures of service due to lack of junior staff; I also came in early and worked through lunch breaks for 2 weeks.

- I spoke to the consultant to exception report and they said don't do it unless you want to get paid and it causes too much hassle and paperwork. It puts people in a very difficult situation. …. At Gosh I work out of my rostered hours at least on a weekly basis but do not feel confident enough to exception report.

COMMENTS ON THE ER PROCESS

- ‘Make it an icon you can click on on every trust computer that takes you to a generic log in so you don't have to remember a log-in but requires you to fill out all details - not dissimilar to a datix incident report -make it a zero tolerance culture about missing training days, currently it is still just "part of the job" that you are on-call for deanery training days at GOSH whilst in many other trusts ALL trainees are rostered to be on SL for these deanery training days without exception.....’

- ‘1. Phone app 2. ER does not go to Ed Sup - ideally a system where individual trainee ERs are not shared with the consultants in the dept so as not to negatively impact on how we are judged 3. If pay not offered, then automatic TOIL to be added to e-roster leave allocation so it is clear to all that this is owed. I would prefer cumulative TOIL leading to an extra half/full day off...’

- ‘Email an electronic template link every Monday to all junior doctors for that week to be filled out.’

- ‘Email a reminder on the Friday to remind everyone to fill it out. At the end of each month or quarter email us a report by sub-speciality of the number of exception reports and their outcomes’.

COMMENTS ON THE ER PROCESS:

- ‘Promote it regularly, put easy-to-access link on GOSH Homepage; make access to log in details more straightforward’
- ‘Weekly reminder with link to the form’
- ‘Allow it to be completed via a mobile app’.
- ‘If it is available from outside the hospital. Part of EOL for instance ‘
- ‘Add to rostering system. Weekly reports to be sent’.
- ‘Mobile apps for everybody. Just a click away, can do it on the way home instead of spending extra time in the Trust to fill up the form’
- ‘The 7 day time limit is a bit challenging - while I see it's purpose, the entire reason I need to exception report is because that day/week has been too busy for me to be able to leave work so adding an extra task in is difficult. Which tends to mean my reports are done a little later when rotating to a less busy area!’
- ‘needs to create less work for our consultant’

Thank you everyone for filling in the survey

Plan:

1. JDF meeting March 8th @ 12.30 Doctor's Mess Seminar Room: presentation, feedback and discussion.

2. Circulate Action Plan based on ER survey results and feedback

3. JDF meeting April 12th @12.30 with senior colleagues to discuss ER survey and any related issues within the Trust.

Sandwich lunch available at JDF

For any queries or concerns contact: guardianofsafeworking@gosh.co.uk OR renee.mcculloch@gosh.nhs.uk

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
28th March 2018

Register of Interests (Directors and Staff) and Register of Gifts and Hospitality **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment R**

Aims / summary

Declarations of Interest

Great Ormond Street Hospital's Declaration of Interest and Gifts and Hospitality Policy requires that all members of staff (including temporary and agency staff) and directors of the Board declare any potential or actual conflict on joining the organisation or when the potential for conflict arises.

Paragraph 31 of the Board of Director's Standing Orders outlines the requirements for directors to disclose any pecuniary, personal or family interest, whether that interest is direct or indirect, in any proposed contract or other matter that is under consideration or is to be considered by the Board

A conflict of interest occurs when the private or personal interests of a member of staff/ member of the Board could affect their role at the Trust in terms of bringing some possible advantage to them or close relatives.

Any declared interests are reconfirmed annually until such time as either the member of staff/ member of the Board leaves GOSH or the potential for a conflict of interest no longer exists.

In some cases, complex declarations of interest are considered by the Declaration of Interest Oversight Group. Staff are asked to complete a declaration of Interest management plan where an actual, perceived or potential conflict (of interest) has been identified. The purpose of the plan is to support staff in managing or reducing actual, potential or perceived conflicts that may develop as they engage for example in entrepreneurial activities while simultaneously remaining an employee (substantive or honorary) of the Trust.

The Company Secretary is required to draw up a register of interests declared by members of staff and members of the Board and to report on this annually in the public part of a Trust Board meeting. The returns are maintained in a register which is open for inspection. The registers for Trust Board members (Appendix 1) and staff (Appendix 2) are attached with this report.

Gifts and Hospitality

The Trust is directly responsible for ensuring that staff and board members are impartial and honest in the conduct of their official business, and that they do not abuse their official positions for personal gain or to the benefit of their family and friends

The Trust complies with the requirement in the Constitution that board members and members of staff are required to declare hospitality and sponsorship offered by and accepted from contractors, suppliers and others.

The Company Secretary holds and maintains the Trust's 'Register of Gifts, Hospitality and Sponsorship'. The Register for 2017/18 is attached to this report at Appendix 3.

Revision of Policy

The Trust is in the process of refreshing its Declaration of Interest and Gifts and Hospitality Policy, taking account of the guidance published by NHS England in 2017. The purpose of the guidance is to ensure that staff understand what an interest is and when they should declare. The guidance requires that 'decision making staff' should, at least annually, be prompted to declare their interests or make a nil return. The following non-exhaustive list describes who these individuals are likely to be:

- Executive and non-executive directors who have decision making roles which involve the spending of taxpayers' money;
- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services;
- Those at Agenda for Change band 8d and above;
- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation;
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of good, medicines, medical devices or equipment, and formulary decisions.

Upon consideration of the interest, if it presents an actual or potential conflict of interest then management action is required which may include:

- deciding that no action is warranted
- restricting an individual's involvement in discussions and excluding them from decision making
- removing an individual from the whole decision making process
- removing an individual's responsibility for an entire area of work
- removing an individual from their role altogether if the conflict is so significant that they are unable to operate effectively in the role.

The Trust has purchased a web-based system which provides an easy-to-use tool that guides staff through the different types of declarations (Gifts, Hospitality, Outside employment, Shareholdings and other ownership interests, Patents, Loyalty interests, Donations, Sponsored events, Sponsored research, Sponsored posts, Clinical private practice), registers their declarations and publishes them at least annually (the web based tool supports regular uploads to the GOSH web). This system will be rolled out in the next few months.

Action required from the meeting
To note the content of the registers for 2017/18 and the guidance on revising the Trust policy.

Contribution to the delivery of NHS Foundation Trust strategies and plans
Transparency

Financial implications
None

Who needs to be told about any decision?
N/A

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

Who is accountable for the implementation of the proposal / project?
The Company Secretary

Attachment R

Register of Interests 2017-18
Great Ormond Street Hospital for Children NHS Foundation Trust
Directors
Non – Executive Directors (Voting)

Name	Declared Interests
Sir Michael Rake	Chairman, Worldpay PLC Vice President, Royal National Institute of Blind People Director, S&P Global Inc Chairman, Majid Al Futtaim Holdings (UAE) Adviser, Teneo Holdings LLC Senior Advisor, Chatham House Member of Oxford University Centre for Corporate Reputation Global Advisory Board Member of International Business and Diplomatic Exchange Advisory Board Chair of Advisory Council for A Blueprint for Better Business. Chairman of the Advisory Board, Engie Ltd Chairman, Phoenix Global Resources Chairman of the International Chamber of Commerce UK Director, (owner) MDVR Services Ltd
Mr Akhter Mateen	NED – Centre for Agriculture and Biosciences International Trustee – Developments in Literacy (DIL) UK Trustee – Malala Fund UK
Mr David Lomas until 31st March 2018	Interim Chief Finance Officer at Spire Healthcare Group (from 21st March 2018).
Professor Rosalind Smyth CBE	Director, UCL Great Ormond Street Institute of Child Health (GOS ICH) As Director of GOS ICH, I have overall responsibility for all research funding applications and awards to staff in GOS ICH. Honorary Consultant, Great Ormond Street Hospital for Children NHS FT Trustee, Charitable Incorporated Organisation UCL Great Ormond Street Institute of Child Health. Chair of the MRC Clinical Training and Careers Panel. Governor, The Health Foundation Member of the Reform Club Trustee, Cystic Fibrosis Trust
Professor Stephen Smith	Non-Executive Director Netscientific PLC Trustee Pancreatic Cancer Draper and Dash United Medicine Ltd Biotechspert Ltd Signum Health Ltd.
Mr James Hatchley	Group Strategy Director 3i Member of the 3i Group plc investment committee
Lady Amanda Ellingworth from 1st January 2018	Chair, Plan International UK International UK Director, Plan International UK International Inc Deputy Chair, Barnardo's Lay Adviser Royal Collage Emergency Medicine

Attachment R

Register of Interests 2017-18
Great Ormond Street Hospital for Children NHS Foundation Trust
Directors

Name	Declared Interests
Chris Kennedy from 1st April 2018	Chief Financial Officer, Micro Focus Non-Executive Director, Whitbread PLC Non-Executive Director, The EMI Archive Trust
Baroness Tessa Blackstone until 30th April 2017	Member, House of Lords Chair, British Library Board Director of UCL Partners Chair Orbit Group Co-Chair of the Franco-British Council
Mrs Mary MacLeod OBE until 31st October 2017	Deputy Chair, Cafcass (Child and Family Court Advisory and support service) (until 30th April 2017) Chair, Internet Watch Foundation Ethics Committee Non-Executive Director, Video Standards Council Trustee, Columba 1400 Trustee, Refugee Trauma Initiative

Executive Directors

Name	Declared Interests
Dr Peter Steer, Chief Executive	Director – University College London Partners (UCLP) Director – Children's Hospital Group Board, Ireland
Ms Nicola Grinstead, Deputy Chief Executive	Director of World Association of Girl Guides and Girl Scouts Europe Region – a not for profit (L'association internationale sans but lucrative) in Belgium. Resigned September 2017 but this is not yet reflected on the Belgian public registry.
Mr Ali Mohammed, Director of HR and OD	None
Mrs Juliette Greenwood, Chief Nurse until 31st October 2017	None
Dr David Hicks, Interim Medical Director until 31st December 2017	None
Mrs Polly Hodgson, Interim Chief Nurse from 1 January 2018	None
Dr Andrew Long, Interim Medical Director (from 1 January 2018 until 31 March 2018)	Vice President, Royal College of Paediatrics and Child Health Lead Assessor, National Clinical Assessment Service
Mrs Loretta Seamer, Chief Finance Officer until 28	None

Attachment R

Register of Interests 2017-18
Great Ormond Street Hospital for Children NHS Foundation Trust
Directors

Name	Declared Interests
February 2018	
Ms Helen Jameson, Interim Chief Finance Officer from 5 March 2018	UCL Partners Board member

Other Directors (Non-Voting)

Mr Matthew Tulley	None
Professor David Goldblatt	Department of Health JCVI subcommittees: meningococcal and pneumococcal. UCL-ICH laboratory performs contract research with GSK, Merck, Sanofi. Occasional expert member of panels for WHO, GSK, Sanofi and Merck. Treasurer, International Society of Pneumococci and Pneumococcal Disease (ISPPD) Chair, Scientific Advisory Board, LimmaTech Biologics AG Chair, International Scientific Advisory Board, Malawi-Liverpool-Wellcome Trust Clinical Research Programme, Blantyre, Malawi Chair, External Advisory Board, NIHR Health Protection Research Unit, London School of Tropical Medicine and Hygiene.
Ms Cymbeline Moore	None

Name	Role	Declaration	Declared/Renewed
ANDERSON, John	Honorary Consultant Oncologist	I lead a research group at UCL ICH developing novel immunotherapies for childhood cancer. I am honorary consultant oncologist at GOSH with responsibility for several clinical trials including a CAR T cell trial based on the technology developed at UCL. Autolus Autolus is a UCL spin out company with a vision to develop CAR T cell therapies for cancer, through R+D and the running of early phase clinical trials based at UCL and UCL hospitals.I was allocated founder shares at its inception based on my share in a patent held by myself and others for a chimeric antigen receptor (CAR) targeting neuroblastoma. This CAR is now being evaluated in a phase I study at GOSH sponsored by CRUK (1RG-CART), for which I am chief investigator. [Managment Plan in place] TC Biopharm A patent (40% co-lead inventor) held through UCLB and based on work coming from my research group has recently been licensed from UCLB to TC-Biopharm, a company based in Glasgow. Standard UCLB terms are included in the licensing, with a proportion of future revenues coming to the inventors. TCB have asked me to be their medical director, paid on a consultancy basis, to oversee an initial clinical trial in adult actute myeloid leukaemia, and to develop other trials in paediatric cancer based at GOSH or other UK centres. [Managment Plan in place]	Feb-18
ASHWORTH, Michael	Consultant, Histopathology	I pay my private earnings into a private company known as 'Repath' of which I am a director. The income is derived entirely from the International Private Patients Wing, which is managed by the NHS. The fees are for expert opinion. The Company is essentially a handling mechanism for the consultants' private fees. The accounts are audited and subjected to company tax. The fees are used to pay for expenses in the Histopathology Department, e.g. training fees for non-medical staff. The remainder is paid to the consultants as annual dividends. I declare these earnings in my own income tax return. This is a longstanding arrangement of which managers are aware, and it has been suggested as a model for others. However, it has come to my attention that a formal declaration should be made to the Trust, and this I now do.	Feb-17
BARNACLE, Alex	Consultant Paediatric Radiologist	I have practising privileges at the Portland Hospital for Women and Children. I undertake diagnostic imaging sessions at the Portland Hospital averaging 3 hours per fortnight, which is done in my own time. I now also run a regular interventional radiology (IR) operating list in my own time at the Portland Hospital, which takes place approximately once per month and is almost exclusively for the treatment of vascular malformations. I do occasional ad hoc IR procedures for other clinical teams at the Portland Hospital when referred specific patients. I am currently the lead clinician for the Radiology department at the Portland Hospital and represent the department on the Portland Hospital Medical Advisory Committee. I have no involvement in any financial institutions that would cause a conflict of interest.	Feb-16

BLADEN, Melanie	Clinical Specialist Physiotherapist	I have received £600 for organising and presenting on the National Haemophilia Physiotherapy conference that is sponsored by Bayer February 2015 and February 2016 (annual leave taken). I have also received research funds from Pfizer totally £35,000 to date - processed through R&D	Mar-16
BRIERLEY, Joe	Consultant Paediatric Intensivist	I undertake private practice at the Portland Hospital PICU. This is undertaken outside my GOSH hours and I do not personally perceive a conflict as I also undertake private practice within GOSH itself.	Feb-16
BROWN, Caroline	Childcare Services Manager	I have recently set up a limited company providing HR management and leadership training. I am a Director in this company.	Feb-18
CALDER, Alistair Duncar	Consultant Paediatric Radiologist	Undertakes sessions at the Portland Hospital in paediatric Radiology, averaging 3 sessions per month. These do not occur during scheduled NHS sessions, are included in my job plan and do not otherwise conflict with work at GOSH.	Feb-18
CALE, Catherine	Consultant Immunologist	My husband is a corporate accounts manager for Thermo Fisher Scientific who supply GOSH with laboratory equipment and consumables.	Feb-17
CHUGH, Deepti	Highly specialist physiotherapist (NDS&SDR service)	I provide domiciliary physiotherapy services (2-3 hours/wk). This work is conducted outside of the NHS contracted hours.	Feb-18
CLARK, Elaine	Consultant Paediatrician in Neurodevelopment	Once I week I undertake private practice with a Clinical Psychologist to offer joint neurodevelopmental assessments for Autism Spectrum Disorder	Feb-18
CLEARY, Maureen	Consultant Metabolic Paediatrician	Membership of IEM CRG NHS England Member Sanofi Genzyme Expert Advisory Group Member Biomin Expert Advisory Group	Jan-17
COLLINS, Richard	EPR Programme Director	I am Director of Integris Solutions which is a deployment services company which provides support to NHS Trusts and EPR system suppliers in regard to deploying clinical systems. I am currently employed by the Trust in the role of EPR Programme Director, a role that I have held for since October 2016. Prior to my appointment at GOSH, Integris was contracted to review elements of the Trust information systems and subsequesntly delivered a reporting soltuion to support the development of the Trust data quality dashboard. [Management Plan in place] In 2017 Integris was awarded the contract to deliver the data migration services for the EPR Programme. [Management Plan in place]	Jan-18

CLOUTMAN-GREEN, Elaine	Clinical Scientist, Infection Control	Participation in an Advisory Board for Baxter Healthcare Corporation in October 2017 and ICAN (International Conference for Advancing Nutrition) Paediatrics Advisory Board December 2017 with further meetings in 2018.	Jul-15
DUNAWAY, David	Consultant Plastic Surgeon, Craniofacial Department	I am a Trustee of Facing Africa (a charity providing care to children in Africa). I am a Director and 25% shareholder of 152 Harley Street Ltd (A registered day hospital providing consulting facilities, radiology and local anaesthetic and sedation operating facilities and also registered for paediatric care). I am a Director and 50% shareholder of the London Craniofacial Unit Ltd (a company co-ordinating local, private and overseas craniofacial care).	Feb-18
DUNN, Helen	Lead Nurse for Infection Control	I will be undertaking ad hoc consultancy work for Infection Prevention Solutions for approx 20 hours a month. It will not be carried out in GOSH time. This does not represent a conflict of interest	Nov-15
EASTY, Marina	Consultant Paediatric Radiologist	Takes sessions at the Portland Hospital, performing ultrasound scans, screening, general reporting and MRI. Also GOSH in-house private patient work, as requested by the referring clinicians. There is no conflict of interest because the work is done out of NHS time.	Feb-18
FANE, Andrew	Lay Chair for Advisory Appointments Committee	I hereby declare that with effect from Thursday, 10 July 2014 my wife became President of Royal College of Surgeons of England. I will make this declaration briefly at the outset of all future AACs making a surgical appointment.	Feb-16
FORZANO, Francesca	Locum Consultant, Clinical Genetics	Member of the Professional and Public Policy Committee (PPPC) of the European Society of Human Genetics (ESHG) since 2008 Board Member of the ESHG 2014 - 2019 Liaison Member (as a Board Member of ESHG and member of the PPPC) of the SPC (Scientific Programme Committee) for the organisation of the annual conference of the ESHG since 2015 Co-Director (since 2008) and faculty member (since 2006) of the international course of the European Schol of Genetic Medicine (ESGM) in collaboration with the ESHG 'Genetic Medicine Practice'. Co-Director has been Prof. Heather Skirton until 2014, since 2015 is Prof Aad Tibben Honorary Professor of the Specialisation School in Medical Genetics of Genova University since 2015 (chair Prof. Paola Mandich)	Feb-17
GASPAR, Bobby	Honorary Consultant in Paediatric Immunology	Research work that I have undertaken on gene therapy has been licensed to a new spin-out company, Orchard Therapeutics. I am a consultant to the company and am Chief Scientific Officer. I hold equity in the company and receive a consultancy fee. Note:UCL Business PLC (UCLB), the technology transfer company of University College London (UCL), and F-Prime Capital Partners launched Orchard Therapeutics, a biotechnology company in 2016. It is dedicated to bringing transformative gene therapies to patients with serious and life-threatening orphan diseases	Jan-18
GILMOUR, Kimberly	Clinical Lead Immunology and Director of Cell Therapy	I am a Board member of the charity UKPIN. The United Kingdon Primary Immunodeficiency Network is the professional body for the United Kingdom Immunologists, Specialist Nurses and Healthcare/Academic Scientists in the UK. UKPIN is a registered charity and a registered company. UKPIN has the overall aim of advancing care in Primary Immunodeficiency.	Feb-17

GOLDMAN, Allan	Divisional Co-Chair, West Division	1. I can confirm that I still run a ventilator course jointly with a colleague for 2 days in the year for which I receive an income. I always take these two days as annual leave. I have been doing this for at least 16 years now. 2. I am one of four equal shareholders in a limited liability company called Risky Business Courses and Consultancy (the other three shareholders do not work at GOSH). We have not to date earned any income or traded and have audited accounts showing that. As an update, we have now shut down this company and are in the process of setting up a new company along the same lines called Risky Business Events. I will be one of a number of Directors in this company. We have not as yet traded with this company and I have not earned any income from this new company as of this time.	Feb-18
HARTLEY, Benjamin	ENT Consultant	I do private practice at the Portland Hospital	Feb-18
HEALES, Simon	Head of Clinical Service, Laboratory Medicine	I have received honoraria, travel grants and consultancy fees from the following commercial organisations: Amicus, Audentes, Genzyme and Vitaflo. This work is carried out under the time allocated for research and academic work.	Feb-18
HEMINGWAY, Cheryl	Consultant Neurology	I served on a Novartis funded Expert Advisory on paediatric MS from 3:00pm-7:00pm Saturday 9th October. I was remunerated £1080 which will be transferred into my UCL research fund. I have received a DVLA cheque for £42 for completing a medical form which is made out to me personally, so will be paid into my private account and declared for tax purposes.	Oct-17
HILL, Robert	Consultant Orthopaedics Surgeon	I am a part time NHS consultant and have a paid role as Medical Director for the Portland HCA Hospital. I have not been involved in any financial negotiations in relation to NHS work taking place within the HCA hospitals and my position at the Portland is not dependent on turnover or financial targets. I undertake paid Consultancy work on an occasional basis for Smith and Nephew, an orthopaedic devices company with whom the trust do business. This is in connection with development of new devices and nothing the Trust uses at present.	Feb-17
HILL, Susan	Gastroenterology and Nutrition Consultant	Participation in an Advisory Board for Baxter Healthcare Corporation in October 2017 and ICAN (International Conference for Advancing Nutrition) Paediatrics Advisory Board December 2017 with further meetings in 2018. Shire advisory role and lecturing	Oct-17
HINDMARSH, Peter	Professor of Paediatric Endocrinology	I receive payment as member of Medtronic Diabetes Medical Advisory Board of £600 per annum	Feb-18
HIORNS, Melanie	Consultant Radiologist, Radiology	I do some radiology scanning/reporting sessions at the Portland Hospital.	Feb-18
HUDSON, Lee	Consultant General Paediatrician	I work occasionally on an ad hoc basis in a private capacity, outside of my contracted NHS hours, for Ellern Mede Eating Disorder Unit as a paediatric consultant. I also work privately in GOSH IPP Outpatients outside of NHS contracted hours	Feb-18

JACKSON, Elizabeth	Consultant Anaesthetist/Divisional Director, Surgery	I have practicing privileges and undertake private anaesthetic practice at HCA hospitals in London within the times stated in my job plan.	Feb-18
JACQUES, Thomas	Honorary Consultant in Paediatric Neuropathology	I am an executive editor at the journal, Neuropathology and Applied Neurobiology. This is a medical and scientific journal and is the journal of the British Neuropathological Society. I am paid a fee for each manuscript I handle at the journal and have the potential to access travels funds from the journal. I derive some income from royalties from authoring medical books or chapters thereof. I pay my private earnings into a private company known as 'Repath Ltd' of which all the consultant histopathologists, including myself are directors and shareholders. I am the Company Secretary. The Company is a mechanism for handling the consultants' private fees. I undertake reports for HM courts as an expert witness. The fees for this work is paid to Neuropath Ltd for which I am also a director and shareholder. My wife is also a shareholder and director at Neuropath Ltd. I am the chair of the Clinical Practices Committee of the British Neuropathological Society. This is the committee of my professional society responsible for leading on clinical matters. There is no remuneration for this work. I am the chief investigator and chair of the scientific committee of the Children's Cancer Leukaemia Group (CCLG) national tissue bank. There is no remuneration for this work. I am an elected committee member and trustee of the Pathological Society of Great Britain and Ireland. There is no remuneration for this work.	Feb-17
KHAIR, Kate	Consultant Nurse, Haemophilia	<u>Research funding:</u> Haemnet, Octapharma, Shire. <u>Consultancy/speaker fees:</u> NovoNordisk, Pfizer, Roche, Shire, Sobi That I am a Trustee of two Charities: The Haemophilia Society (to November 2017) Haemnet	Feb-18
LYON, Susan	Organisational Development Manager	I am a Director in a registered company providing HR, management and leadership training	Dec-15

MCALLISTER, Eve	Clinical Psychologist	I work at Great Ormond Street Hospital in the Psychological Medicine Team in the Department of Child and Adolescent Mental Health (DCAMH). This role includes provision of specialised assessment and treatment packagesfor individuals with mental health difficulties in the context of physical and neurological illness. I also undertake a small amount of private work. This is undertaken in accordance with local GOSH trust policy and the Department of Health's Code of Conduct for Private Practice. I would like to emphasise that there is a clear distinction and separation between the private work offered and the work undertaken by the NHS as part of my role. In particular: - Private work is not offered or discussed with patients who are attending/actively open to the NHS services I work in. - I do not refer private patients to the NHS services I work in. - If there are cases I have met with on a private basis, I do not see these when they are open to the NHS service I work in. - My line manager is informed (as soon as I am aware) of any situation in which a private patient I have seen is referred to the NHS service I work in.	Apr-17
MCHUGH, Kieran	Consultant Paediatric Radiologist	Occasionally reports MRIs, x-rays and ultrasounds at the Portland Hospital.	Feb-18
MELLERIO, Jemima	Constultant Dermatologist	I undertake private dermatology clinics at The London Skin and Hair Clinic, 19 Cavendish Square, London. I have a limited company Mellerio Dermatology Ltd	Feb-17
MORRIS, Samantha	Endocrine Nurse Specialist	Novo Nordisk have paid for me to attend the Novo Nordisk Endocrine Nurse Workshop on 21st April 2016. This includes train fares and hotel accommodation.	Mar-16
MUNTONI, Francesco	Professor and Honorary Consultant Paediatric Neurology	In 2017 I have provided ad-hoc consultations at Scientific Advisory Board meetings for the following companies: Sarepta Therapeutics, Biogen, PTC Therapeutics, Roche, Servier, Avexis, Santhera, Summit. Meetings or consultancies that have taken place during UCL or GOSH working hours are administered via UCL Business. I have served as chair of the Data Safety Monitoring Committee of Santhera (Omigapil trial) I have served in the SAB of the Pfizer Rare Disease unit I am the Chairman of the Scientific Advisory Board for the Myotubular Trust I have provided lectures (and recieved compensation) at Industry Symposium as part of Scientific International and National meetings for the following companies: Biogen, Sarepta I am involved in the following clinical trials for which GOSH and UCL receive funding from industry or grant giving bodies: Audentes, Summit, British Heart Foundation, MRC, Association Francaise Myopathies, Pfizer, Wellcome Trust, NIH, Sarepta, Ionis, Roche, PTC, Esperare, Muscular Dystrophy UK, NIHR, Genethon, SMA Trust, SMA Europe, GOSH Charity.	Feb-18

MUSHTAQ, Imran	Consultant Urologist	I participate in private practice both within this Trust and outside	Feb-17
OLSEN, Oystein	Consultant, Radiology	I have admission rights at The Portland Hospital for Women and Children where, along with colleagues in Radiology I provide an average of 3 hours per fortnight of paediatric plain film reporting, ultrasound, fluoroscopy and MRI reports. This does not conflict on either a financial or a time basis with any of my work at GOSH. I therefore have no conflict of interest.	Feb-18
ONG, Juling	Locum Craniofacial Plastic Surgeon	That I hold an honorary consultant appointment at the Chelsea & Westminster Hospital and that from time to time will be required to provide clinical sevices are required. These will only be provided in the time outside of my clinical commitment at Great Ormond Street Hospital. Remuneration will be on an ad hoc basis. That I will be seeing private patients on occasion outside Great Ormond Street Hospital. These clinical commitments will only be provided in the time outside of my commitment at Great Ormond Street. Remuneration will be on a private patient basis.	Mar-16
OWENS, Catherine	Consultant Radiologist	Employed at the Portland Hospital where, along with her colleagues in Radiology, she provides an average of 3 hours per fortnight of paediatric plain film reporting, ultrasound and fluoroscopy, and occasional MRI/CT reports. Not perceived as a conflict to GOSH Practice as declared in job plan	Feb-17
PETERS, Mark	Senior Lecturer in Paediatric and Neonatal ICU	I provide occasional medical expert witness reports for a variety of legal cases including medical negligence cases within my expertise. I undertake private practice as a Paediatric Intensivist at the Portland Hospital as one of a team of 5. This work is conducted entirely outside of my contracted time to ICH/Great Ormond Street and does not conflict with my University/NHS work and is not detrimental to it.	Feb-18
QASIM, Waseem	Professor of cell & gene therapy, & Hon consultant Immunology	Between April 2017- March 2018, I have held active funding from the following commercial entities: Bellicum, Autolus, Cellmedica, & Servier I have no financial interest in trials in which I have a clinical investigator role. I declined personal fees for the following work and arrangements were made with UCL for waived fees to be paid to a UCL account: Bellicum advisory boardDuring the same period I received or was eligible to receive payments from organisations where I have no investigator role: i. Consulting fees via UCLC and revenue from Orchard Therapeutics as part of licencing arrangements with UCLB (see management plan) ii. Consulting fees via UCLC and holder of founder stock in Autolus Ltd iii. Possible future revenue eligibility following licencing of WT1-TCR to Catapult-TCR and subsequently licenced to Cellmedica iv. Advisory board meeting fee from Novartis (CAR therapy logistics) v. Consulting fee from Altrica via UCLC (Vector applications) [Management Plan submitted]	Mar-18

PETROS, Andy	Consultant PICU	I undertake private practice intensive care and anaesthesia at the Portland Hospital and private anaesthesia at the Harley Street Clinic. This work forms part of my new job Plan and I do not believe there to be any conflict of interests in these roles. I am very careful to be as open and transparent as possible in separating out my various activities to avoid any conflict of interests. This work is conducted outside of the time I am contracted to Great Ormond Street Foundation Trust. It does not conflict with my NHS work and is not detrimental to it.	Feb-18
RAGLAN, Ewa	Consultant Audiovestibula	I have private practice, I consult my patients at GOSH, London Hearing and Balance Centre, Parkside Hospitals and St Anthony's Hospital	Feb-18
RAJPUT, Kaukab	Consultant, Audiovestibular	I have been invited to speak at the 7th EROC Conference from 17th - 19th of January.	Oct-16
RAMNARAYAN, Padmanabhan	Consultant, CATS	I act as a part-time Medical Advisor for Isabel Healthcare Ltd, a diagnostic software system I have begun private practice at the Portland Hospital PICU. This will be entered on my Zircadian Job Plan. This work is conducted outside of the time I am contracted to Great Ormond Street Foundation Trust. It does not conflict with my NHS work and is not detrimental to it.	Feb-17
SAMUELS, Martin	Locum Consultant in Respiratory Paediactrics, Paediatric Respiratory Medicine	I am a Trustee for the charity Advanced Life Support Group, based in Manchester. This organisation provides hospital and community trusts around the UK with educational courses for staff. I receive no financial remuneration from the charity. I am medical advisor to two other UK charities: Breathe On (a charity for children receiving long term ventilation) and the UK CCHS Family Support Network. I do not receive any financial remuneration from these organisations. I have no other declarations of interest.	Feb-18
SEBIRE, Neil	Consultant, Histopathology	I pay my private earnings into a private company known as 'Repath' of which all the consultant histopathologists, including myself are directors and shareholders. The Company is essentially a mechanism for handling the consultants' private fees, which are requests for opinions regarding reporting of specimens. The income is primarily derived from the International Private Patients Wing of GOSH, which is managed by the NHS. I also perform occasional reporting work to cover for colleagues in other centres who may be off-work, for which I also get paid on a case by case basis. The accounts are audited and subjected to company tax. The fees are used to pay for expenses in the Histopathology Department, such as training fees for non-medical staff. The remainder of the income is paid to the consultants as annual dividends. I declare these earnings in my own income tax return. This is a longstanding arrangement of which managers are aware, and it has been suggested as a model for others. However, it has come to my attention that a formal declaration should be made to the Trust, and this I now do.	Feb-18
SHAH, Neil	Consultant, Gastroeneterology	I have done Unrestricted lectures/Consultancy work for AbbVie, Mead Johnson, Nutricia and Nestle	Feb-18
SHARMA, Sanjiv	Consultant Paediatric Intensivist	I continue to do private work at the Portland Hospital PICU and this has been recorded on my job plan. The work continues to be done outside of the time I am contracted to Great Ormond Street Hospital NHS Foundation Trust. It does not conflict with my NHS work and is not detrimental to it.	Feb-15

SIRIMANNA, Tony	Consultant Audiological Physician	That I have private practice privileges at The Portland Hospital, 234 Great Portland Street, London where I hold a clinic on a few Monday mornings. I do not do any NHS clinics there. This is in my free time outside my 10PA contract. Similarly I see private patients at GOSH but this again is outside the NHS time. I do not think there is anything that I do will have any conflict with my NHS work	Feb-16
SKELLETT, Sophie	Consultant Paediatric Intensivist	I have begun private practice at the Portland Hospital PICU. The work has been entered on my new Job Plan. This work is conducted outside of the time I am contracted to Great Ormond Street Foundation Trust. It does not conflict with my NHS work and is not detrimental to it.	Feb-18
SMITH, Gillian	Consultant Plastic Surgeon	I have taken up a part-time substantive post in Chelsea and Westminster starting on 28th September 2015 in Plastic Surgery with an interest in Adult and Paediatric Hand surgery. Two thirds of the work there is in adult practice.	Feb-18
STARK, Daniel	Clinical Psychologist	I work at Great Ormond Street Hospital in the Psychological Medicine Team in the Department of Child and Adolescent Mental Health (DCAMH). This role includes provision of specialised assessment and treatment packagesfor individuals with mental health difficulties in the context of physical and neurological illness. I also undertake a small amount of private work. This is undertaken in accordance with local GOSH trust policy and the Department of Health's Code of Conduct for Private Practice. I would like to emphasise that there is a clear distinction and separation between the private work offered and the work undertaken by the NHS as part of my role. In particular: - Private work is not offered or discussed with patients who are attending/actively open to the NHS services I work in. - I do not refer private patients to the NHS services I work in. - If there are cases I have met with on a private basis, I do not see these when they are open to the NHS service I work in. - My line manager is informed (as soon as I am aware) of any situation in which a private patient I have seen is referred to the NHS service I work in.	Apr-17
STEPHENSON, Terence	Nuffield Professor of Child Health, ICH	01/01/2015 - 31/12/2018 GMC reimburse UCL £110,000 p.a. for my secondment 01/01/2016 - 31/12/2016 Excellence in Congress and Communications UK ltd paid ICH/UCL 6,000 Euros last year for my academic input to their Editorial Board.	Mar-17
THRASHER, Adrian		Research work that I have undertaken on gene therapy has been licensed to a new spin-out company, Orchard Therapeutics. I am a consultant to the company and hold equity.I am a consultant to Rocket Pharmaceuticals Note:UCL Business PLC (UCLB), the technology transfer company of University College London (UCL), and F-Prime Capital Partners launched Orchard Therapeutics, a biotechnology company in 2016. It is dedicated to bringing transformative gene therapies to patients with serious and life-threatening orphan diseases. [Management Plan in place]	Feb-18

VAN'T HOFF, William	Consultant Paediatric Nephrologist and Head of Clinical Research Facility	I have entered into a consultancy agreement, contracted by Dr Vanshree Patel, R&D Office, to contribute to the Scientific Advisory Board (SAB) for Ultragenyx, related to the development of a new treatment for X linked rickets, and am leading contracted clinical research in the Trust with that drug. I receive no personal reward for the SAB, having asked for any funding through the agreement to be passed to R&I for support for research in the Trust (agreed through Emma Pendleton, Deputy Head of R&I). My role in the trial is fully costed and contracted through the Trust. I have received hospitality (flights, hotel accommodation) to attend 2 meetings (one day Dublin September 2014, two days Salzburg summer 2015) on this new trial drug development. I am undertaking contracted (through standard Trust processes) commercial research with other innovative drugs in renal disease: Raptor: a trial of a new delayed release drug ProCysbi, in cystinosis AINylam: forthcoming trial in new therapy for hyperoxaluria Participating as co-investigator in trials on hyponatraemia (Otsuka), immunosuppression for renal transplant (Astellas). I have not receievd any hospitality from these companies.	Feb-18
WALKER Isabeau	Consultant Anaesthetist	I am a trustee of Lifebox Foundation registered as a Charity in England & Wales (1143018). Registered as a complany limited by guarantee (companies house registration 7612518). I am the Principle Investigator for a study to design a robust and reliable pulse oximeter for use by frontline healthcare workers caring for children with pneumonia in low-income countries. This study is funded by the Bill and Melinda Gates Foundation. The Lifebox Foundation is the sponsor of this study. The study has now been completed and the pulse oximeter probe is undergoing further field testing before going for manufacture; I don't have any financial interests in this and do not receive any consultancy fees.	Feb-18
WELLESEY, Hugo	Consultant Anaesthetist	I undertake some private practice on an ad hoc basis at The Portland Hospital in my spare time	Feb-18
WILLIAMS, Emma	Genetic Counsellor	I undertake private work as a genetic counsellor. I work through a company providing genetic counselling services called Genehealth UK	Feb-17
WYATT, Michelle	Consultant ENT Surgeon	I hereby declare that I undertake private practice at the Portland Hospital, London W1W 5QT	Feb-18

Register of Gifts and Hospitality 2017-18

Name of recipient	*Name of Authoriser*	*Host*	*Event (for sponsorship/ hospitality)*	*Accepted/ declined*	*Date*
Allaway, Rachel	Claire Waller	Hartmann	Wounds UK Conference, hotel stay and travel to Harrogate	Accepted	13/11/2017-15/11/2017
Allaway, Rachel	Claire Waller	Coloplast	Tissue Viability Advisory Board meeting and remuneration cost £250 to go into Tissue Viability funds. (Awaiting confirmation of special purpose fund.)	Accepted	Feb-18
Broxholme, Catherine	Kaukab Rajput	Advanced Bionics UK	Advanced Bionics UK have offered sponsorship for me to attend the European Symposium on Paediatric Cochlear Implantation (ESPCI) from 24/5/17 - 28/5/17. Sponsorship will cover cost of travel conference registration, travel and hotel. Advance Bionics are the main supplier for cochlear implants at GOSH following successful tender in 2012.	Accepted	May-17
Calder, Alistair Duncan	Derek Roebuck	Synergy Medical Communications ltd on behalf of Sanofi/Genzyme and Biomarin Synergy Medical Communications ltd on behalf of Sanofi/Genzyme and Biomarin	Speaker at satellite symposium at Paediatric Rheumatology European Society Annual Meeting. Travel and accommodation expenses covered by host. Honorarium of £1000 received and transferred to GOSHCC (fund SR04) Speaker at satellite symposium at British Society for Paediatric and Adolescent Rheumatology. Travel and accommodation expenses covered by host. Honorarium of £1000 paid directly to GOSHCC (SR04).	Accepted, honorarium transferred to GOSHCC SR04 Accepted, honorarium paid directly to GOSHCC SR04	29/09/2016 29/11/2016
Cloutman-Green, Elaine	Helen Dunn	Proeconomy	Thank you gift for presenting at the LEAP one day conference - Fortnum and Mason hamper	Accepted	Jul-17

Emmett, Anne	Ali Wood	JACIE inspectorate	EMBT invited lecturer at a conference, travel and accommodation paid.	Accepted	Feb-18
Evans, James	Shelly Cleghorn	Vitaflow	International paediatric dietitians conference	Accepted	Nov-16
Gomes, Michaela	Deborah Cairns	Patient's family	A purse (Ted Baker)(gift) from family	Accepted	Jun-17
Hallam, Paula	Vanessa Shaw	Vitaflow	BIMDG/Vitaflow metabolic meeting - travel expenses and hotel fee covered by Vitaflow	Accepted	24/11/16-25/11/16
Hedges, Emma	Chris Rockenbach	Patient's family	Bulgarian bracelet. To be returned at next appointment.	Declined	Jan-18
Hyland, Peter	Nicola Grinstead	Teletracking	Leaders lunch with Lord Carter - London Olympia	Accepted	Apr-17
Jackman, Lucy	Sarah MacDonald	Nutrica	Nutrica Food Allergy Study Day. Accepted flights to Dublin and a place on the course (which Nutrica are running)	Accepted	Feb-18
Lavia, Lisa	Chris Rockenbach	Parents of patient	Bouquet of flowers under £25	Accepted	Feb-18
Liesner, Ri	Paul Gough	Bayer	Travel/accommodation and fee for attending global advisory board	Accepted	30/01/2017
		Roche	Consultancy fee for advisory board	Accepted	23/03/2017
Liesner, Ri	Paul Gough	Bayer	Travel/accommodation and fee for attending global advisory board (2 days)	Accepted	2/2/2016
		Octapharma	Travel/accommodation and lecturing fee (1 day)	Accepted	19/02/2016
		SOBI	Fee for lecturing at symposium (1 day)	Accepted	19/02/2016
		Baxalta	Travel/accommodation to HRSU meeting (2 days)	Accepted	11/03/16
		NovoNordisk	Travel/accommodation and lecture fee for Malaysian summit (5 days)	Accepted	10/04/16
		Roche	Travel/accommodation for investigators meeting (2 days)	Accepted	07/07/16
		Octapharma	Travel/accommodation for world federation of haemophilia (7 days)	Accepted	21/07/16
		Bayer	Travel/accommodation for PEDNET meeting (2 days) Travel to ACHIEVE lecturing (1 day)	Accepted	08/09/16
		Bayer	Travel/accommodation to American Society of	Accepted	21/11/16
		Octapharma	Haematology (6 days)	Accepted	2/12/16

Martin, Linda	Matthew Tulley	Bywaters	NHS Sustainability Award dinner	Accepted	May-17
McAlister, Louise	Vanessa Shaw	Vitaflow	4th International Paediatric Renal Dietitians meeting in Manchester (paid to attend meeting)	Accepted	3/11/16-4/11/16
Mitchell, Carol	Matthew Tulley	Bywaters (Leyton) Ltd	NHS Sustainability Awards	Accepted	May-17
Mutogo, Juliet	Deborah Cairns	Patient's family	Ted Baker purse	Accepted	Jun-17
Oslizlok, Aisling	Joanne Price	Nutrica	Nutrica Food Allergy Study Day. Accepted flights to Dublin and a place on the course (which Nutrica are running)	Accepted	Mar-18
Phillips, Jez	Salina Parkyn	Suffolk University	Healthcare travel seminar	Accepted	May-17
Skellett, Sophie	Simon Hannam	Zoll Belgium	Asked to moderate a symposium at PREM May 18th-19th 2017 in Ghent, Belgium speaking about current quality audit improvement at GOSH (international collaboration). We had dinner the night before to discuss the programme of events at Het Fakhuis in Ghent which one of the Zoll reps paid for. Symposium - unpaid and not about 2011 products, but quality CRP in children.	Accepted	May-17
Stafford, Jacky	Vanessa Shaw	Vitaflow Vitaflow	Society for the study of Inborn Errors of Metabolism, Rome 8th Vitaflow Dieticians meeting Liverpool (speaker)	Accepted Accepted	6/9/16-9/9/16 25/12/16
Summerville, Sophie	Deborah Cairns	Patient's family	Ted Baker purse	Accepted	Jun-17
Thaci, Eneida	Deborah Cairns	Patient's family	A purse (Ted Baker)gift from family	Accepted	Jun-17
Thaci, Eneida	Deborah Cairns	Patient's family	Perfume from family as a gift	Accepted	Jun-17
Tulley, Matthew	Peter Steer	Bywater	NHS Sustainability Awards	Accepted	Sep-17
Williamson, Stephanie	Matthew Tulley	Director for Healthcare WSP (engineers)	Lunch for women in construction at Somerset House	Accepted	Mar-18

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 28th March 2018	
Compliance with Emergency Preparedness, Resilience and Response standards **Submitted by:** Nicola Grinstead, DCEO and Emergency Accountable Officer	**Paper No: Attachment S**

Aims / summary

NHS England run an annual assurance process to measure Trust compliance with Emergency Preparedness, Resilience and Response standards.

For 2017/18 across 66 standards, 63 were rated green, 2 amber and 1 red giving the Trust a 'substantial' rating from NHSE.

The Trust Board is asked to note the outcome of the 2017/18 assurance process and to note the associated action plan.

Action required from the meeting

The action plan will be implemented across the Trust, led by the Emergency Planning Liaison Officer with support from the DCEO.

Contribution to the delivery of NHS Foundation Trust strategies and plans

Contributes to the Safe, People and Spaces objectives in the Trust Strategy.
Ensures Trust compliance with the Civil Contingencies Act (2004) and NHSE Emergency Preparedness, Resilience and Response (2015)

Financial implications

None

Who needs to be told about any decision?

Emergency Planning Liaison Officer

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

Emergency Planning Liaison Officer

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

DCEO and Emergency Accountable Officer

1. Introduction and background

1.1. The Civil Contingencies Act (2004) and the NHSE Emergency Preparedness, Resilience and Response Framework (20115) set out specific responsibilities with which acute Trusts much comply.

1.2. Within Great Ormond Street Hospital for Children NHS Foundation Trust, Emergency Preparedness, Resilience and Response (EPRR) governance oversight is the responsibility of the Audit & Risk Committee with accountability to the Trust Board. Akhter Mateen is the NED lead for EPRR

1.3. Operationally EPPR is managed through the Emergency Planning Group which reports to the Operational Performance and Delivery Group. Nicola Grinstead is the Trust's Emergency Accountable Officer and Chris Ingram is the Interim Emergency Planning Liaison Office.

1.4. Each year the Trust self-assesses its EPRR performance against a national set of criteria. In addition, NHSE facilitate an assessment process with a combination of NHSE staff and a peer review team testing the Trust's self assessment scores and rationale.

1.5. This paper details the outcome of the 2017-18 annual assessment process. The Trust Board is asked to note the outcome of the assessment and confirm its agreement with the next steps identified.

2. Annual NHSE Assurance Process and Outcomes

2.1. The 2017-18 NHSE Assurance Process was broadly similar to that followed in 2016-17. The focus of the meetings was primarily to review those areas where the organisation scored red or amber last year. However, in light of several major incidents in London over the last year, the process also maintained a broad oversight to ensure plans and arrangements were being updated as appropriate with relevant learning and guidance.

2.2. For acute trusts, additional site visits were arranged to review specific requirements regarding Chemical, Biological, Radiological, Nuclear and Explosive (CBRNe).

2.3. Across a total of 66 standards for GOSH, 63 were scored green, 2 amber and 1 red. The NHSE assurance rating for GOSH is 'substantial'. The full list of standards and assessment details can be found in appendix 1.

2.4. The amber scores relate to the Trust need to finalise its mass casualty plan and to develop a mass vaccination action card. The Mass Casualty Plan was signed off by the Major Incident Planning Group on Thursday 15th March and so this action is now complete. The mass vaccination plan requires further development before sign off.

2.5. The red score relates to the non-attendance of the Trust at the Local Health Resilience Partnership meeting in 2017. Attendance has now been resumed.

2.6. Since the 2016/17 review the Trust has improved performance in several specific areas including particularly in relation to strengthening its Business Continuity Plans.

2.7. For the 2017/18 review it was specifically noted that an area of good practice at GOSH is the programme of live ward evacuation exercises.

3. Actions and next steps

3.1. The Emergency Planning Liaison Officer has an operational plan detailing the Trust will stay compliant with the nationally defined standards. This is overseen by the Major Incident Planning Group and is reviewed regularly with NHSE.

3.2. In addition, the Emergency Planning Liaison Officer has a development plan in place to ensure the further strengthening of the Trust's business continuity plans.

3.3. In April 2019 the Trust will implement the EPIC system. The Emergency Planning Liaison Officer is now prioritising a work plan to ensure the Trust has resilient plans in place to support go-live and also future scenarios such as 'down-time' periods.

4. Key decisions/action

4.1. The Trust Board is asked to note the outcomes of the NHSE Assurance Process and to note the planned actions and next steps.

	Core standard	Clarifying information	Evidence of assurance	Organisation's 2016 agreed RAG scores	2017 Self assessment RAG Red = Not compliant with core standard and no evidence of progress. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Post Assurance Review 2017 RAG
Governance						
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		• Ensuring accountaable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergeny Preparedness Resilience and Response, and Business Continuity Management agendas • Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an appropriate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.		Deputy Chief Executive is accountable for EPRR	AEO has been in post for 18 months.
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy			EPRR 2017/18 work plan in place. Managed by the EPO and monitored by Major Incident Planning Group	The AEO and EPLO come together once a year to discuss the workload.
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology. • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation			EPRR Policy in place.	The policy was reviewed in June 2017, follow up with trust to ensure that this reviewed.
4	The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.			Trust Board updated on EPRR progress and recent events - March 2017.	This takes place annually post assurance.
Duty to assess risk						
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver its functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages; • surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites) There is a process to consider if there are any internal risks that could threaten the performance of the organisation's functions in an emergency as well as external risks eg. Flooding, COMAH sites etc.	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages • Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed		EPO monitors external risks via the LRF community risk register and Camden Borough risk register. Department / service BC plans complete individual risk assessments as part of the BIA process.	Each department risk assess their own services.
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.				EPO adds external risks to the EPRR work plan (2017/18) which is RAG rated. Significant risks identified in the work plan are included in the Estates and Facilities or relevant directorate risk register. If required, these are escalated to the BAF.	
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.			Estates and Facilities risk register links into the BAF and is monitored by the Risk Compliance Group. The Board review the Trust risk register.	This is shared internally.
Duty to maintain plans – emergency plans and business continuity plans						
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity.	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.		Critical and Major Incident plan in place (2017/18)	Ratified by Major Incident Planning Group. The SitRep process on page 9 will change going forward as soon as an alternative tool is found.
9	Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	corporate and service level Business Continuity (aligned to current nationally recognised BC standards)			Corporate BC plan updated (2017/18). Clinical and non-clinical BC plans updated, as required.	Divisional Directors are responsible for plan sign-off.
10		HAZMAT/ CBRN - see separate checklist on tab overleaf			HAZMAT action card as part of un-booked attendees policy (annex 1)	
11		Severe Weather (heatwave, flooding, snow and cold weather)			Heatwave plan reviewed and evoked (2017). Flood plan in place (Estates lead).	
12		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)			Influenza plan in place and exercised (Pandemia - 2016). Received a compliant score in last years 'deep dive' assurance process.	
13		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)			Mass vacianation action card under development.	This work is being led by Judith Cope and is due to complete April 2018.
14		Mass Casualties			Mass casualty plan under development.	This is due to complete December 2017.
15		Fuel Disruption			Fuel disruption action card added to corporate bc plan.	
16		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)			Winter pressures programme 2017/18	
17		Infectious Disease Outbreak			Activate Ebola work / procedures, if required.	
18		Evacuation			Live ward evacuation exercises scheduled for Aug / Sept / Oct 2017	Share Good Practice.
19		Lockdown			Security refresher training completed Spring 2017. Partial Lockdown as a result of a number of incidents.	
20		Utilities, IT and Telecommunications Failure			Documented in Estates and ICT BC plan (2017/18)	
21		Excess Deaths/ Mass Fatalities			Emergency procedures in place but limited additional capacity on a daily basis. BC covered in Redevelopment prog.	A Funeral Director has been approached should the trust have capacity issues.
22		having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme) - see HART core standard tab		N/A	N/A	
23		firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab		N/A	N/A	
24	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed • Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including acknowledgement of multi-agency working) • Stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • Contact details of key personnel and relevant partner agencies • Plan maintenance procedures (Based on Cabinet Office publication Emergency Preparedness, Emergency Planning, Annexes 5B and 5C (2006))	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors • References and list of sources • Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).		Critical and Major Incident repsonse plan follows NHSE guidance.	
25	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.		Alerting and escalating procedures are clearly documented in all plans.	
26	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities			Critical and priority services are listed in individual departments / service level BC plans.	
27	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management			VIP policy (2018) in place	Share VIP patient policy with NHS England - London team.
28	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		• Specifiy who has been consulted on the relevant documents/ plans etc.		Key stakeholders invited to relevant planning meetings and comments included in revised plans.	
29	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold) at the end of an incident.			The need to debrief after all incidents is documented in the EPRR policy and relevant plans.	
Command and Control (C2)						
30	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Explain how the emergency on-call rota will be set up and managed over the short and longer term.		On-call arrangements in place 24/7	
31	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England publised competencies are based upon National Occupation Standards .	Training is delivered at the level for which the individual is expected to operate (ie operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.		Training needs analysis in place.	

	Core standard	Clarifying information	Evidence of assurance	Organisation's 2016 agreed RAG scores	2017 Self assessment RAG Red = Not compliant with core standard and no evidence of progress. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Post Assurance Review 2017 RAG
32	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and scope of the organisation.	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/co0ordination centre and manage any events required.		The mananagement and incident control room is documented in the relevant plans.	
33	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.				Record keeping is covered in on-call training sesssions and documented in plans.	Arrangement in place for a pool of 14 loggists to come on site out of hours.
34	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.				Details for reporting are located in the relevant plans.	
35	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials		N/A	N/A	
36	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident			24HR support is via UCLH via security team or CSPs	
Duty to communicate with the public						
37	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of future campaigns • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'. • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work.		Communication action card (annex incident response team) supported by Comms / Press BC plan.	The trust can set up a deidicated line but GSTT control the phone messages for GOSH. It would take over 24 hours to make changes to a voicemail message.

	Core standard	Clarifying information	Evidence of assurance	Organisation's 2016 agreed RAG scores	2017 Self assessment RAG Red = Not compliant with core standard and no evidence of progress. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Post Assurance Review 2017 RAG
38	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.		Runners action card supoorted by the use of radios. SnapComms and all user email, if operational.	
Information Sharing – mandatory requirements						
39	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and inclue DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supercedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	• Where possible channelling formal information requests through as small as possible a number of known routes. •Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience Forum(s) / Borough Resilience Forum(s). •Social networking tools may be of use here.		Information Governance policy in place supported by relevant training.	
Co-operation						
40	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and memebership is quorat. • Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups •Taking lessons learned from all resilience activities • Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements •Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to share them with colleagues •Having a list of contacts among both Cat. 1 and Cat 2. responders with in the Local Resilience Forum(s) / Borough Resilience Forum(s) area		Attend Camden borough meeting	
41	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA				Attend multi-agency Camden borough mmeting and NENC network meetings	
42	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	NB: mutual aid agreements are wider than staff and should include equipment, services and supplies.			Documented in business continuity plans	
43	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.			N/A	N/A	
44	Arrangements outline the procedure for responding to incidents which affect two or more regions.			N/A	N/A	
45	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.			Complete requests as required e.g. during cyber attack	
46	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared			N/A	N/A	
47	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months			N/A	N/A	
48	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level					
Training And Exercising						
49	Arrangements include a curent training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • A training needs analysis undertaken within the last 12 months • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate •Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective •Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice •Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs.		Training and exercise programme in place supported by a training needs analysis.	
50	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. •Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. •If possible, these exercises should involve relevant interested parties. •Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective	• Developing and documenting a training and briefing programme for staff and key stakeholders •Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidentshave been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate) • Communications exercise every 6 months, table top exercise annually and live exercise at least every three years		As above.	The Trust have completed 12 live exercises and 55 table tops in the last 12 months.
51	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises				NHS England Mass casualty exercise, 2017. Exercise Audacious (NHS England, Counter Terrorism, CATs)	Representatives from the trust attended Exercise Seacole II.
52	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation. - Do not RAG rate core standard 52, this should be considered as part of core standard 31 (formerly 16).	**Core standard to be considerd as part of core standard 31 (Formerly 16)**		N/A	N/A	

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)				Organisation's 2016 agreed RAG scores	2017 Self assessment RAG Red = Not compliant with core standard and no evidence of progress. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Post Assurance Review 2017 RAG
Q	**Core standard**	**Clarifying information**	**Evidence of assurance**			
	Preparedness					
53	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access control • emergency / contingency arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements • Version control		Dedicated annex (unbooked attendees policy)	The main door to the hospital is not currently under access control.
54	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	• Site inspection • IT system screen dump		Policy is stored on a shared drive and EPRR intranet page	Training currently takes place with partners.
55	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)		Risk assessments and safe systems for working are documented in the waste contract.	Suits are available but no decontamination suits.
56	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		• Resource provision / % staff trained and available • Rota / rostering arrangements	N/A	N/A	
57	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	• For example PHE, emergency services.	• Provision documented in plan / procedures • Staff awareness		CSPs have received necessary training. Procedures for specialist advice is documented in the annex.	This is achieved by an in house alerting protocol known to staff.
	Decontamination Equipment					
58	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	• completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))		The CSP grab box is reviewed on a regular basis.	A small grab bag will be placed with Security office to bring with them when called.
59	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable)	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017		N/A	N/A	
60	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment	There is a named role responsible for ensuring these checks take place		N/A	N/A	
61	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment			N/A	N/A	
62	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)		N/A	N/A	
	Training					
63	The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training			N/A	N/A	
64	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme		Training based on primary care guidance.	
65	The organisation has sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.			N/A	N/A	

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)				Organisation's 2016 agreed RAG scores	2017 Self assessment RAG Red = Not compliant with core standard and no evidence of progress. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Post Assurance Review 2017 RAG
Q	**Core standard**	**Clarifying information**	**Evidence of assurance**			
66	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)			Training programme includes reception staff and security.	

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **28 March 2018**	
Equality & Diversity Annual Report and Update against Equality Objectives **Submitted by:** Polly Hodgson, Interim Chief Nurse and Ali Mohammed, Director of HR & OD	**Paper No: Attachment T**
Aims / summary To provide Trust Board with assurance that the Trust continues to meet its statutory obligations under the Equality Act 2010.	
Action required from the meeting To note the content of the report and the activity delivered.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Meeting statutory duties to report publically on Equality, Diversity and Inclusion. Promotes fairness and equity in service delivery and employment.	
Financial implications Incorporated within current resource allocations and budgets.	
Who needs to be told about any decision? N/A	
Who is responsible for implementing the proposals / project and anticipated timescales? Family Equality and Diversity Group (patient and families). HR&OD Directorate (staffing)	
Who is accountable for the implementation of the proposal / project? Acting Chief Nurse (families and patients) and Director of HR & OD (staff).	

Equality and Diversity Annual Report 2017/18

Introduction

The Equality Act came into force on 1st October 2010, simplifying existing equalities law into one single source of Statute. In addition to the Act, the statutory Equality Duty came into force in April 2011 which is applicable to all public sector bodies. As a Trust, we are legally required to demonstrate that we comply with the Equality Act and are meeting the Equality Duty through the work we do, the involvement we have of the Trust Board in this work and through publishing a range of equalities data on an annual basis.

To comply with the first specific duty of the Act, the Trust is legally required to annually publish equality data relating to both service users and staff. A copy of the latest edition of this report is available on the GOSH website at **www.gosh.nhs.uk/about-us/equality-and-diversity/**. The second part of the specific duty requires the Trust to prepare and publish specific and measurable equality objectives, setting out how progress towards these objectives should be measured. This paper provides an update against the six objectives as agreed by the Trust Board in January 2016. The Trust also reports annually on the Workforce Race Equality Standard and the action plan associated with this reflects our equality objectives to provide congruency and consistency in approach.

As with all other employers the Trust is required to report data relating to the Gender Pay Gap for the first time in 2018. This will be presented to Trust Board under separate cover.

Equality objectives for period 2016 to 2020/21

Six objectives were agreed; three relating to patients and families and three relating to staff.

Objective 1: Achieve Accessible Information Standard within timescale

This objective was time-limited as NHS England had required the Standard to be met by the end of July 2016. We can now supply information in alternative formats on request. The inclusion of the additional needs tab on the Patient Information Management System (PiMS) finally allows staff to record communication need and preferred information format centrally. It is now feasible to advertise our capacity to provide information in alternative formats more widely and this will be a continued priority in 2018.

Measurement: Having the facility to record additional need, enables the Trust to monitor completion rates for these fields as well as any requests for communication and information support received.

Progress against objective: The 'additional needs' tab on PiMS has had great impact to date, with records being updated as part of routine clinical contact. The Quality Improvement team have also developed a mechanism for monitoring the number of records updated and which additional needs are selected, which can now be reported to the Family Equality and Diversity Group. Revision of Trust-wide data collection paperwork is underway to enable all staff to collect data about additional need.

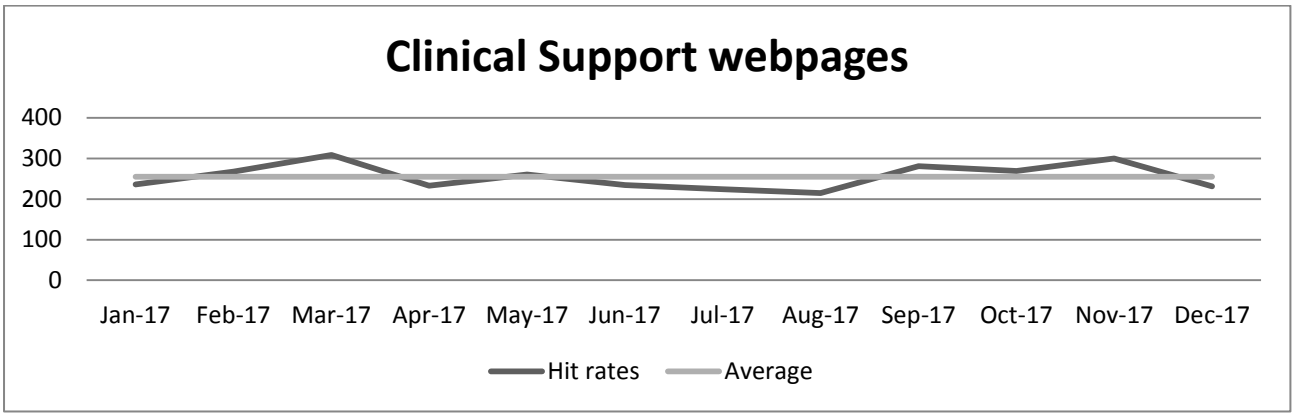
The range of Easy Read information has also increased and draft versions are now available for each diagnostic procedure used at GOSH. As part of radiology patient experience improvements, the sheets are now being checked for accuracy by clinicians. A small selection is currently being evaluated with Project Search students.

Next steps: The Family Equality and Diversity group will continue to monitor compliance with this standard, in terms of usage levels of the additional needs tab and provision of communication and information support on request.

Objective 2: Publicise support for families including support organisations

There are a wide range of support mechanisms for families both within and outside GOSH but families tell GOSH, in surveys and other encounters, that these are not always promoted as well as they could be. While many excellent support organisations exist, families may not always be aware of their existence so promoting them in the course of our clinical contact is important.

Measurement: Number of hits for support services webpages at http://www.gosh.nhs.uk/parents-and-visitors/clinical-support-services.



The average number of hits to the clinical support services pages has remained steady at average of 255 hits per month. This is an increase on the baseline measure from December 2015 which was 210 hits.

Progress against objective: Provision of information trolleys outside the Pals Office, supplying information sheets about support, details of organisations that can help and benefits advice, continues to be popular with the number and titles of information sheets supplied monitored monthly. The associated costs of stocking the trolleys are also being monitored.

Next steps: It is unclear how the current re-organisation of the GOSH website will impact on progress. It is clear that the information will remain but the level of visibility on the site may increase or decrease depending on the location chosen by the Web team.

Objective 3: Support on-going work to improve transition to adolescent or adult services

Following publication of NICE guidelines on transition, work has continued at GOSH by the Transition Improvement Manager with the aim that all applicable young people should have a Transition Plan in place to support their move from children's to adolescent or adult services.

Measurement: Documented evidence of transition planning. In addition, the release of NICE guidelines as above will enable us to measure GOSH against the associated standards and highlight areas for improvement in the future.

Progress against objective: This year has seen the development of the Growing Up Gaining Independence (GUGI) pathway which clearly shows what tasks need to be completed as part of transition planning. A major component of this is to enable the young person to become as independent as possible in managing their health, for instance, taking medicines, preparing for appointments and understanding the impact of lifestyle issues on their particular conditions.

Next steps: To continue to work with clinical services to advise introduction of the GUGI pathway, developing information for young people to enable them to understand their health. Adaptations to the pathway for young people with a learning disability are also being developed, alongside specific information for parents and Easy Read information for the young person.

Objective 4: **Increase the overall visibility of the Trust Board and Senior Leaders**

This outcome was chosen to form an equality objective as the EDS2 consultation showed that this scored the highest of all outcomes in the underdeveloped grade, albeit whilst still receiving an overall grade of 'developed'. Through this objective, various approaches will be considered and will be phased over the life of the objective.

Measurement: Staff reporting good communication between senior management and staff – as measured annually by the National NHS Staff Survey and at the end of year four via the EDS 2 scoring system.

Baseline measure: Staff Survey 2014: GOSH score = 29%. Average score for acute specialist trust: 37%.
Current measure: Staff Survey 2017: GOSH score = 29%. Average score for acute specialist trust: 35%.

Target: By end of 2017, GOSH will score in the region of 33%; by the end of 2019, GOSH's score will mirror the average score of acute specialist trusts; improvements in the EDS 2 score will also be achieved.

The 2017 target has not been met despite the following actions being achieved / implemented:

- CEO all staff monthly briefing sessions and Executive visibility walk rounds continued to be well established. These briefings are used to present GEMS winners with their awards thus providing an opportunity for the CEO and other Directors to visibly celebrate outstanding staff.
- Breakfast with the CEO launched.
- GOSH open house event (however this was after the survey had closed)
- The CEO and other Executives attended a staff inclusion interactive session as part of the GOSH Open House event (again after survey had closed).
- The HR&OD Director hosted an event for women in leadership at GOSH.
- The HR&OD Director supported BAME staff in their application to NHS-wide leadership development programmes.
- Senior Trust leaders supported Black History Month.
- CEO has met with specific staff groups (e.g. ICU staff and theatre staff)

Activities will continue across 2018 and will also include introducing the new Chief Nurse and Medical Director to the staff community.

Objective 5: To develop the understanding of managers and employees in recognising and managing Harassment & Bullying (H&B) in the workplace, with the longer term intention of a reduction in the instances of bullying and harassment concerns being raised by staff.

Measurements & Target:

- Measurement of the number of managers who have undertaken training in areas linked to H&B.
- Measurement of the number of employees who have undertaken training in areas linked to H&B.
- Levels of reported H&B via the staff survey will have reduced by 5% by 2019 (24% in 2014).

Update on 2017 progress:

- Unconscious Bias has now been included in manager PDR training. During 2017 60 members of staff attended these sessions.
- H&B explored in staff listening events (May 2017), as a result a strategy to address H&B is being developed.
- THE GOSH FTSU Ambassador service has been well established and has been used by staff to raise H&B concerns.
- The Employee Relations (ER) team continued to provide training on Managing Difficult Conversations to support managers with their approach to raising issues with members of their team in a constructive manner and Dignity at Work training (part of the HR bite-sized courses).

Objective 6: To improve the representation of BME staff in senior posts.

Measurement & Target: By the end of 2019 the proportion of BME senior staff appointed will be more reflective of the number of BME staff shortlisted.

2017 data shows an improvement across two pay bands (Bands 2-4 and Bands 7-9), in that proportionally more BME staff are being shortlisted and appointed than was the case in 2016:

	Shortlisted bands 2 - 4	Appointed bands 2 - 4	Shortlisted bands 5 - 6	Appointed bands 5 - 6	Shortlisted bands 7 - 9	Appointed bands 7 - 9
BME	68% 2017 [65% 2016]	45% 2017 [44% 2016]	48.7% 2017 [43% 2016]	25% 2017 [27% 2016]	41.7% 2017 [40% 2016]	23% 2017 [20% 2016]
White	32% 2017 [35% 2016]	46% 2017 [48% 2016]	51.3% 2017 [57% 2016]	71% 2017 [69% 2016]	58.2% 2017 [64.5% 2016]	71% 2017 [74% 2016]

Progress during 2017:

- During 2017 Black and Minority Ethnic staff were supported to apply for both Step Up and Ready Now programmes resulting in some GOSH staff commencing on the courses.
- Since October 2017 Unconscious Bias has been included in recruitment and selection training and is now weaved into the Recruitment and Selection Process.
- The Resourcing team have focussed on collating improved recruitment data in relation to recruitment and selection decisions. This will enable a deep-dive analysis of data to be completed.
- The Resourcing team have reviewed the Trust's interview assessment form against ACAS best practice. They have also ensured that the Trust's Always Values have been included to provide assurance that selection decisions are value-congruent.
- The Trust has signed up to be a member of the Government's Disability Confident Committed Scheme (replaces the Governments two tick symbol) which influences recruitment and retention processes.
- The Resourcing team have updated the Recruitment Policy as well as recruitment documentation in order to ensure that recruiting managers score each candidate independently and then moderate the collective scores. This is known to be effective in reducing unconscious bias when making selection decisions.

Family Equality and Diversity (FED) Group

The Family Equality and Diversity Group has continued to meet during 2017. In September, the group welcomed members of the Learning Disabilities Steering Group – as the aims and objectives of both groups are so similar, it was felt to be more efficient for all equality and diversity issues affecting children,

young people and families to be considered by one working group. As part of this, the Terms of Reference were revised with members feeling that they are still working effectively and delivering against objectives.

Highlights of the previous year include:

- Presentations received from Redevelopment and GOSH Arts
- Launch of revised Disabled Go information about GOSH
- Support of improving Muslim prayer facilities
- Development of teaching and information resources around equality data
- Reviewed several nationally published reports for consideration of issues at GOSH

The group is looking forward to new initiatives at GOSH such as the Electronic Patient Record and the Real Time Feedback systems – both of which have received representation to include equality and diversity issues – so should enable greater analysis and improvement in future.

GOSH is now represented on the Pan London NHS Equality and Diversity Leads Network, with the aim of learning from successful initiatives at other Trusts and sharing what has been learnt at GOSH. The two GOSH Operational Leads for Equality and Diversity also meet more regularly to plan joint working such as improvement of equality analysis and coordination of reporting.

Staff Equality, Diversity & Inclusion

Other points of note:

- The Trust's Freedom to Speak Up Ambassador service continues to be utilised by staff. A dedicated Freedom to Speak Up Guardian was appointed in January 2018
- Five Project Search interns graduated in July 2017 and a further eight commenced in October 2018. The Scheme allows the Trust to connect in a meaningful way with its local community and support people with learning disabilities obtain work and life skills
- A pre-disciplinary investigation checklist has been implemented by the Employee Relations team. This requires completion before a decision to formally investigate under the Disciplinary Policy is made and aims to ensure consistency and fairness in decisions. This is particularly important as the GOSH WRES data, in common with many other trusts in the London region, shows disparity between the disciplinary rates between white and BAME staff.
- Following on from the Listening events we aim to 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.
- The Trust will be walking at Pride 2018 for the first time.
- HR&OD are supporting staff with an interest in LGBT+ issues to progress key pieces of work. A social event with interested staff was held in March 2018 and another event is planned.
- Work will be undertaken during 2018 to pull together the various data sources available (staff data, WRES, gender pay gap, staff survey etc.) to produce an organisational narrative around EDI. This will be used to help inform future actions and the EDI strategy.

Future Actions

Objectives 1, 2 & 3 will continue to be formally monitored by FED and objectives 4, 5 & 6 by HR&OD. Progress against each objective will be reviewed by the appropriate group every year. Progress against all objectives will be formally reported to Trust Board annually.

Action required

Trust Board is asked to note the contents of this report.