Great Ormond Street Hospital for Children NHS Foundation Trust

Meeting of the Trust Board
Wednesday 24th July 2013

Dear Members

There will be a public meeting of the Trust Board on Wednesday 24th July 2013 at 3:00pm in the **Charles West Room,** Great Ormond Street, London, WC1N 3JH.

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

AGENDA

	Agenda Item **STANDARD ITEMS**	Presented by	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** • **24th May 2013** • **26th June 2013**	Chairman	**F** **G**
3.	**Matters Arising/ Action Checklist**	Chairman	**H**
4.	**Chief Executive Report**	Chief Executive	**Verbal**
	STRATEGIC ISSUES		
5.	**Offering More Elective Activity Outside Traditional Hours**	Director of Planning and Information	**I**
6.	**Assessment of 2A Benefits Realisation**	Director of Planning and Information	**J**
7.	**Update on response to the report of the public inquiry into Mid Staffordshire NHS Foundation Trust**	Co-Medical Director	**K**
	PERFORMANCE		
8.	**Summary of performance for the period:** • **Targets and indicators including update on workstreams for quarter 1 2013/14** • **Finance and Activity for quarter 1 2013/14** • **Quality and Safety**	Chief Executive Chief Operating Officer Chief Finance Officer Co-Medical Director	**L** **Li** **Lii** **Liii**
9.	**Patient Experience & PALS Annual Report 2012/13**	Chief Nurse and Families' Champion	**M**
10.	**2013 Annual Infection Prevention and Control Report – Executive Summary**	Chief Nurse and Families' Champion/ Director of Infection, Prevention and Control	**N**
11.	**Annual Health and Safety Report**	Director of HR and OD	**O**

	GOVERNANCE		
12.	**Quarter 1 Monitor Return (3 months to 30 June 2013)**	Chief Finance Officer	**Q**
13.	**Trust Board terms of reference and workplan**	Company Secretary	**R**
14.	**Summary reports from Board committees** • **Audit Committee June 2013** • **Clinical Governance Committee June 2013** • **Finance and Investment Committee May 2013**	Chairman of the Audit Committee Chairman of the Clinical Governance Committee Chairman of the Finance and Investment Committee	**S** **T** **U**
15.	**Members' Council update – June 2013 meeting**	Company Secretary	**Anna Ferrant**
16.	**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.)		
17.	**Next meeting** The next Trust Board meeting will be held on Wednesday 25th September 2013 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London, WC1N 3JH.		

ATTACHMENT F

Attachment F

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT Minutes of the meeting of Trust Board on Friday 24th May 2013

Present

Baroness Tessa Blackstone	Chairman
Mr Jan Filochowski	Chief Executive
Ms Mary MacLeod**	Non-Executive Director
Ms Yvonne Brown	Non-Executive Director
Mr John Ripley	Non-Executive Director
Mr Charles Tilley	Non-Executive Director
Mr Robert Burns	Acting Chief Operating Officer
Dr Barbara Buckley	Co-Medical Director
Professor Martin Elliott	Co-Medical Director
Mrs Liz Morgan	Chief Nurse and Director of Education
Mrs Claire Newton	Chief Finance Officer
Mr Ali Mohammed	Director of Human Resources and OD

In attendance

Dr Anna Ferrant	Company Secretary
Mr Matthew Tulley	Director of Redevelopment
Ms Rachel Williams	Newly appointed COO (from July 2013)

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

25.	**Apologies for absence**
25.1	Apologies were received from Professor Rosalind Smyth, Non-Executive Director.
26.	**Declarations of interest**
26.1	No declarations of interest were received.
27	**Minutes of the meeting held on 24th April 2013**
27.1	The minutes of the meeting of 24th April 2013 were approved with no amendments.
28.	**Matters Arising/Action Checklist**
28.1	Minute 12.2: The Chief Executive reported that a letter had been received from Monitor asking what action the Trust had taken in response to members of staff being paid through a company.
28.2	Mrs Claire Newton, Chief Finance Officer confirmed that the Annual Report included a disclosure about individuals who were paid in this way. She reported that this referred to five members of staff throughout the year, mainly in the corporate area.
28.3	**Action:** It was agreed that Mrs Newton would follow up individuals to ensure that there would be no adverse reputational affects.

28.4	Minute 12.4: Dr Anna Ferrant, Company Secretary confirmed that she was working with the Head of Operational HR to follow this up.
28.5	Minute 9.4:**Action:** It was agreed that this action would become part of the 2A project.
28.6	Minute 14.4:**Action:** The paper on why Trusts fail to be circulated to the Board prior to the next meeting.
28.7	**Action:** Mr David Lomas, Non-Executive Director expressed some concern that there had been no actions carried over from previous meetings. It was agreed that he would confirm with Dr Ferrant if any actions had been omitted.
29.	**Chief Executive Report**
29.1	The Chief Executive reported that nationally there was pressure on acute services which would indirectly affect GOSH when patients are not able to be discharged due to a shortage of ICU beds in local hospitals.
29.2	Mr Filochowski confirmed that the themes from the Francis report had been mapped and actions were being developed.
29.3	It was reported that the Trust had been shortlisted for two HSJ National Patient Safety awards along with around six other Trusts.
29.4	**Action:** It was agreed that the Board would be notified if the awards were won and a note of congratulations would be sent to those involved on behalf of the Board.
29.5	Mr Filochowski confirmed that the Muscular Dystrophy Campaign had designated the Trust a paediatric centre for research and clinical excellence. He reported that the Trust was the only centre in the country which had received both designations.
29.6	The Board noted a number of other successes by members of staff at GOSH
29.7	**Action:** The Chairman to send a note of congratulations to the teams involved.
29.8	Mr Ripley stressed the importance of a distribution strategy to enable the good work innovated by GOSH to be used in other Trusts.
29.9	The Board **noted** the verbal report.
30.	**Electronic Document and Record Management System (EDRMS) Business Case**
30.1	Professor Martin Elliott reported that the EDRMS was the first stage in moving towards Electronic Patient Records. He confirmed that the preferred supplier would be Kainos with a system called Evolve.
30.2	It was reported that initial capital investment would be £4.3m which was projected to be returned over 5 years. Non cash benefits were anticipated to be over £1m. Mr Lomas confirmed that the business case had been discussed at Finance and Investment Committee and that the proposal had been recommended for Board

	approval.
30.3	Mr John Ripley, Non-Executive Director stressed that many of the benefits delivered by the project were 'soft' and therefore a project team would be required to ensure they were delivered. He added that the project would place further demands on existing infrastructure so it was vital to ensure the network was fast and reliable.
30.4	Ms Newton confirmed that work was ongoing with Kainos to gain an understanding of what optimal infrastructure would look like and compare it to what was currently in place. She added that changes would be made as a result of this comparison.
30.5	Professor Elliott confirmed that site visits had provided assurance that the system was working well and was well supported.
30.6	The Trust Board **approved** the business case.
31	**Chief Executive's Report**
31.1	Summary of performance for the period:
31.2	**Targets and indicators including update on workstreams for quarter 4 2012/13**
31.3	Mr Robert Burns reported that the Trust had met the waiting time target for April but cautioned that long waits would need careful management. He added that 24hour discharge summary rate had gone above 80% for the first time for a year.
31.4	Mr Burns said that a team had visited Chelsea and Westminster Hospital NHS Foundation Trust who achieved 80% compliance against the Clinic Letter Turnaround sent within 5 working days. He reported that the target at Chelsea and Westminster was measured differently and confirmed that GOSH would not be redefining the target.
31.5	The Board was informed that Meridian would be employed to work with the Outpatient department to identify efficiencies. It was confirmed that the cost for this service was £160,000.
31.6	The Chairman asked whether a tender process had been used to appoint Meridian in view of the costs involved.
31.7	The Chief Executive reported that a tender process had not gone ahead however Meridian were part of a national framework and theirs was a specialist skill.
31.8	**Action:** It was agreed that Meridian would be asked to present their findings to the Board when the project was more advanced.
31.9	Mr Burns confirmed that the Trust had a reported a 99.3% return against CQUIN targets which was an excellent result.
31.10	**Action:** This information to be used in hospital publicity and to be given to GOSH Children's Charity for their use.

31.11	Mr Lomas asked for an update around capacity constraint in terms of nurses in intensive care.
31.12	The Chief Nurse said that she was anticipating nurses from Ireland and Portugal starting employment at the Trust in June. She reported that there had been delays due to a lengthy process to confirm compliance with national standards in their home countries. Mrs Morgan reported that a programme was in place to induct the nurses once they arrived.
31.13	Mr Lomas asked for a steer on the level of patient refusals.
31.14	Mr Burns said that of the current refusals (43) almost all were Children's Acute Transport Service (CATS) patients and it would be difficult to reduce this number without increasing the number of intensive care beds.
31.15	Baroness Blackstone, Chairman asked whether, given the delay in Safe and Sustainable, the Trust would be increasing the number of cardiac beds.
31.16	Mrs Morgan reported that she would be meeting with the newly appointed Head of Nursing to discuss how further beds could be filled through an increase in nursing staff.
31.17	The Board stressed the importance of being innovative whilst remaining objective. **Action:** It was agreed that trends in mortality rates would be included in future updates.
31.18	**Finance and Activity**
31.19	The Chief Finance Officer reported that she was still yet to receive clinical activity fully priced and there were no indicators on CRES delivery. She confirmed that this
31.20	information would be available in the coming weeks. **Action:** A full update to be provided at the next meeting.
31.21	**Quality and Safety**
31.22	Professor Martin Elliott, Co-Medical Director highlighted that no red complaints had been received for 65 days. He added that there had been an increase in the
31.23	number of complaints which were being referred to the Ombudsman but this was likely to be as a result of change in reporting criteria. Analysis had shown that there had been no changes to the type or severity of complaints received.
31.24	Professor Elliott highlighted the spinal and Arvind Jain pathways which had been well received and successful and the International Health Improvement conference hosted by the Trust which had been well attended and reviewed. **Action:** It was agreed that the transformation document which summarised the work of the team would be circulated to the Board.
31.25	The Board **noted** the report.

32	**Compliance with Monitor's Code of Governance**
32.1	Dr Anna Ferrant, Company Secretary said that work was ongoing on a schedule of matters and reported a number of actions which were being taken for three other criteria.
32.2	The Board **confirmed** that the actions reported were sufficient to determine compliance with Monitor's Code of Governance.
33	**Corporate Governance Statement**
33.1	Mrs Claire Newton, Chief Finance Officer explained that the Corporate Governance Statement would be submitted to Monitor alongside the annual plan,
33.2	Mrs Newton recommended to the Board that confirmation be given on each point of the Governance Statement.
33.3	Mrs Newton highlighted that representatives from the Members' Council had asked the Board whether there was sufficient evidence to be able to confirm each point. She added that the Deloitte review had made recommendations which the Trust had followed up and a report had been submitted to the Board confirming progress that had been made.
33.4	The Board **approved** the confirmation of each point of the Corporate Governance Statement.
34	**Annual Risk Report 2012-13**
34.1	Mr Robert Burns, Acting Chief Operating Officer reported that the number of incidents had increased by 14% on the previous year which was due to an increased culture of reporting. He added that there was a downward trend of harm causing incidents but an increase in serious harm which would be investigated further.
34.2	**Action:** It was agreed that a paper would come to the Board in September about the timeliness of reviews of risks.
34.3	**Action:** It was agreed that the percentages of incidents when split by level of harm would be rounded to one decimal place rather than integers.
34.4	The Board **noted** the report.
35	**Safeguarding Annual Report 2012-13**
35.1	The Chief Nurse reported that the safeguarding team had been restructured to ensure there was an appropriate skills mix. She reported that the Trust had achieved all national and North Central London training requirements at all levels and had received positive Camden Ofsted inspections. It was confirmed that priorities for the year had been identified.
35.1	The Board **noted** the update.

36	**CQC Compliance Update**
36.1	The Company Secretary reported that an initial review against the CQC essential standards had indicated that the Trust was fully compliant.
36.2	Dr Ferrant confirmed that a new process and dashboard was in place for documenting compliance. She added that CQC standards were reviewed at the Clinical Governance Committee and were monitored by the Risk, Assurance and Compliance Group.
36.3	Mr Burns reported that outcome 6 which was rated high yellow was caused by the Trust being marked against a national specialty database. He confirmed that he would be writing to the CQC who would determine if this was an appropriate standard.
36.4	**Action:** Dr Ferrant to provide an update following the June CGC meeting.
37	**Update on local action planning in response to 2012 national Staff Survey**
37.1	Mr Ali Mohammed, Director of Human Resources and Organisational Development reported that a more detailed paper had been discussed at the Overall Management Group (OMG). He confirmed that the majority of divisions and directorate management teams had succinct action plans in place.
37.2	The Board **noted** the update.
38	**Any Other Business**
38.1	Dr Ferrant provided an update on advice received from Deloitte around the Quality Account.
39	**Next meeting**
39.1	The next Trust Board meeting will be held on Wednesday 24th July 2013 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London WC1N 3JH
39.2	The Trust's Staff awards will be held on 6th June in the Kennedy Lecture Theatre, Institute of Child Health.

ATTACHMENT G

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT Minutes template of the meeting of Trust Board on Wednesday 26th June 2013

Present

Baroness Tessa Blackstone	Chairman
Mr Jan Filochowski	Chief Executive
Ms Mary MacLeod	Non-Executive Director
Ms Yvonne Brown	Non-Executive Director
Mr John Ripley	Non-Executive Director
Mr Charles Tilley	Non-Executive Director
Prof Rosalind Smyth	Non-Executive Director
Mr Robert Burns	Acting Chief Operating Officer
Dr Barbara Buckley	Co-Medical Director
Mrs Claire Newton	Chief Finance Officer
Mr Ali Mohammed	Director of Human Resources and OD

In attendance

Dr Anna Ferrant	Company Secretary
Mr Matthew Tulley	Director of Redevelopment
Ms Rachel Williams	Newly appointed COO (from July 2013)

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

40.	**Apologies for absence**
40.1	No apologies were received.
41.	**Declarations of interest**
41.1	No declarations of interest were received.
42.	**MRI 3T**
42.1	Mr Robert Burns, Acting Chief Operating Officer presented the paper and reminded the Board that in October 2011 it had approved a business case for a 3-T MRI scanner at a cost of £3.4M. At that time it was proposed to locate the 3-T MRI in the space vacated by our oldest MRI scanner (MR1) in the basement of the Cardiac Wing. In addition the budget for the 2B project, approved by the Board in July 2011, included amounts for putting temporary arrangements in place both for accessing alternative MRI capacity and CT capacity due to the 2B site work reducing access to imaging equipment in the Cardiac wing at certain times of the day.
42.2	Mr Burns explained that further investigation of the plans for alternative imaging provision coupled with unforeseen problems with installing a 3-T MRI in the original location without incurring substantial extra costs, had resulted in a change in plans and the development of this business case.
42.3	This case presented offered a different and significantly lower risk solution for maintaining imaging capacity during the 2B project, involving repositioning of the 3-T MRI and CT scanning capability in the Southwood wing combined with the original project to invest in a "new generation" 3-T scanner. Additional elements

	of the project included a new superior CT scanner within the new imaging suite and the provision of anaesthetic rooms and a recovery area adjacent to the suite.
42.4	The Board was advised that investment in the 3T would provide increased epilepsy service capacity; enabled the Trust to meet waiting targets; reduced the number of scans needing to be sent externally and increased capacity for research income. It would also provide an opportunity for development of an MRI post mortem service. Investment in a new CT would significantly reduce potential safety issues as it used a lower dose of radiation (academic research demonstrates that CT scans increase a child's risk of cancer later in life).
42.5	The revised business case greatly reduced risk in terms of sustainability of phase 2B and provided a space for a 5th scanner in 2017 without seriously impacting capacity of the remaining 4 scanners.
42.6	The Board was advised that the GOSH Charity had committed £3.4m to fund a 3-T MRI. The Trust was in discussion with the Charity in terms of funding the remaining balance. Any remaining amounts not funded by the Charity would be funded directly by the Trust by deferring other items within the Trust's capital plan for 1314 or 1415. Plans for an integrated theatre had been deferred following discussions with Divisional Directors and agreement that the replacement of the MRI scanner be prioritised.
42.7	Mrs Mary MacLeod, Non-Executive Director asked if there were any future plans to replace other MRI scanners. Mr Burns stated that there could be an option to upgrade some of the existing scanners rather than full replacements.
42.8	The Board was advised that by the end of the calendar year, all four scanners would be used every evening of the week until 9:00pm extending to use at the weekends. Further work was underway to extend the use of the machines by 5-10% increase in patients per day.
42.9	Mr Burns advised the Board that the scanner will be selected through a tender process.
42.10	**Action**: Mr Charles Tilley, Non-Executive Director asked that a pro forma be agreed with Board members for presentation of future business cases.
42.11	Mr David Lomas, Non-Executive Director asked whether the Trust could delay the purchase of the scanner. Mr Burns advised that this was not possible due to the fact that the scanner required replacement and upgrade and that any alternative solution would delay the phase 2B redevelopment programme.
42.12	The Trust Board asked Mr David Lomas, Chairman of the Finance and Investment Committee and Mr John Ripley, Non-Executive Director and Finance and Investment Committee member to review the business case in detail in the next week and report back to the Chairman. The Board agreed that Chairman's action would be taken on final approval of the business case.
43.	**Annual Order for Blood Products**
43.1	Mrs Claire Newton presented the request for approval for a series of annual orders for blood products. The total value of all major orders for the year from 1st June 2013 was £20.5M.

43.2	Mr Newton explained that under the current SFIs orders of budgeted expenditure valued at £1m or more are required to be authorised by the Trust Board. She proposed that when the SFIs and SOs are updated later in this financial year, approval of the blood orders be delegated to executives on the basis that the amounts are recurring purchases and within the approved budget. The Board agreed.
43.3	Mr David Lomas asked whether the Trust received discounts for these large orders and whether the Trust is optimising its commercial position or should it buying in partnership with others. Mrs Newton advised that the products were purchased under a national framework which was set up to ensure that the Trust achieves the best available price for such products.
43.4	The Board **approved** the annual order.
44.	**Any Other Business**
44.1	There were no items of any other business.
45.	**Next meeting**
45.1	The next Trust Board meeting will be held on Wednesday 24th July 2013 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London WC1N 3JH

ATTACHMENT H

Attachment H

TRUST BOARD - ACTION CHECKLIST
24th July 2013

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
12.4	24/04/2013	Dr Ferrant was asked to look at the possibility of asking all senior clinical staff to complete a nil return.	AF	May 2013	The Conflict of Interest Policy has been updated to reflect this and is in the process of being consulted on
14.4	24/04/2013	Mr Ripley asked for the paper on why Trusts fail, to be circulated to all Board members.	AF	May 2013	Actioned on 24th June 2013
28.3	24/05/2013	It was agreed that Mrs Newton would follow up individuals who were being paid through a company to ensure that there would be no adverse reputational affects.	CN	July 2013	Verbal Update
28.5	24/05/2013	It was agreed that this action would become part of the 2A project (Minute 9.4: The Board asked for an update, when available, on the impact of the space and facilities provided for in the Lagoon)	CM	July 2013	Action noted
28.6	24/05/2013	The paper on why Trusts fail to be circulated to the Board prior to the next meeting.	AF	July 2013	Actioned
28.7	24/05/2013	Mr David Lomas, Non-Executive Director expressed some concern that there had been no actions carried over from previous meetings. It was agreed that he would confirm with Dr Ferrant if any actions had been omitted.	DL	July 2013	Discussion between DL and AF confirming that no actions had been omitted
29.4	24/05/2013	It was agreed that the Board would be notified if the HSJ National Patient Safety awards were won	JF	July 2013	The Trust has been awarded the Patient Safety in Paediatrics Award at

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
		and a note of congratulations would be sent to those involved on behalf of the Board.			the HSJ and Nursing Times 2013 Patient Safety and Care Integration Awards Ceremony.
29.7	24/05/2013	The Chairman to send a note to the teams involved in the Muscular Dystrophy Campaign designation and other staff who had won awards.	TB	July 2013	Actioned 7th June 2013
31.8	24/05/2013	It was agreed that Meridian would be asked to present their findings to the Board when the project was more advanced.	RB	September 2013	Not yet due
31.10	24/05/2013	Achievement of 99.3% return against CQUIN targets to be used in hospital publicity and to be given to GOSH Children's Charity for their use.	RB	July 2013	Action noted
31.18	24/05/2013	It was agreed that trends in mortality rates would be included in future performance updates.	RB	July 2013	On agenda – performance report
31.21	24/05/2013	A full finance and activity update to be provided at the next meeting.	CN	July 2013	On agenda – performance report
31.25	24/05/2013	It was agreed that the transformation document which summarised the work of the team would be circulated to the Board.	ME	July 2013	To be circulated
34.2	24/05/2013	It was agreed that a paper would come to the Board in September about the timeliness of reviews of risks.	RB	September 2013	Not yet due

Attachment H

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
34.3	24/05/2013	It was agreed that the percentages of incidents when split by level of harm would be rounded to one decimal place rather than integers.	RB	Ongoing	Action noted
42.10	26/06/13	Mr Charles Tilley, Non-Executive Director asked that a pro forma be agreed with Board members for presentation of future business cases.	RB	September 2013	Not yet due

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **24th July 2013**	
Offering More Elective Activity Outside Traditional Hours **Submitted by:** **Robert Burns, Director of Planning & Information**	**Paper No: Attachment I**
Aims / summary The paper assesses the realisation of the benefits outlined in the 2A Business Case. It reviews the funding sources of other major redevelopments of children's hospital services and recommends revised measures for assessing the benefits of 2B.	
Action required from the meeting To approve the recommendations for each resource area To agree the forum and timescales for a discussion and decision on the issue of consultant availability, which is fundamental to offering more than a limited range of services outside core hours.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Patient experience and financial stability	
Financial implications The running of services outside of core hours will present a cost pressure to the Trust	
Legal issues Potential need to change staff contracts	
Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place? Divisions and staff effected	
Who needs to be told about any decision? NA	
Who is responsible for implementing the proposals / project and anticipated timescales? Divisional Directors	
Who is accountable for the implementation of the proposal / project? Robert Burns, Director of Planning & Information Rachel Williams, Chief Operating Officer	

1. Introduction

The aim of this paper is to explore the need, benefits and challenges of extending working times for elective activities beyond the traditional Monday – Friday office hours.

NHS England outlined five 'offers' in the 'Everyone counts – planning for patients 2013/14'[1] document.

Whilst there are no specific targets set, from the inclusion of the offer of "NHS services: 7 days a week" it is evident that the NHS England has prioritised that the NHS offer more routine services at the weekend, in addition to emergency services.

2. Current Elective Extended Hours Services

Delivery of more routine clinical services out of hours or at the weekend is currently implemented in certain areas across the Trust;

- Weekend operating for private patients
- Physiotherapy and Dietetic cover over weekends (in addition to on call therapy services)
- Saturday morning Pharmacy
- Cardiac theatres extend into evenings 4 days per week
- MRI lists run most weekday evenings
- IR extend lists into early evening
- Saturday Sleep studies
- Saturday Haemodialysis
- Audiology clinics

3. Scope of this Paper

In May 2013 Trust Board expressed a desire to drive forward further extended working in order to make best possible use of the physical assets of the organisation and improve choice and access for patients and families.

This exercise considers the key resources of theatres, MRI scanners and outpatients.

For each of these resource areas this paper reviews the following to determine which service extensions to pursue;

- Current sessional utilisation in traditional hours
- Family / patient preferences
- Service demands
- Affordability
- Workforce issues

[1] NHS Commissioning Board, December 2012. *Everyone Counts: Planning for Patients 2013/2014*.

4. Current Use of Resources

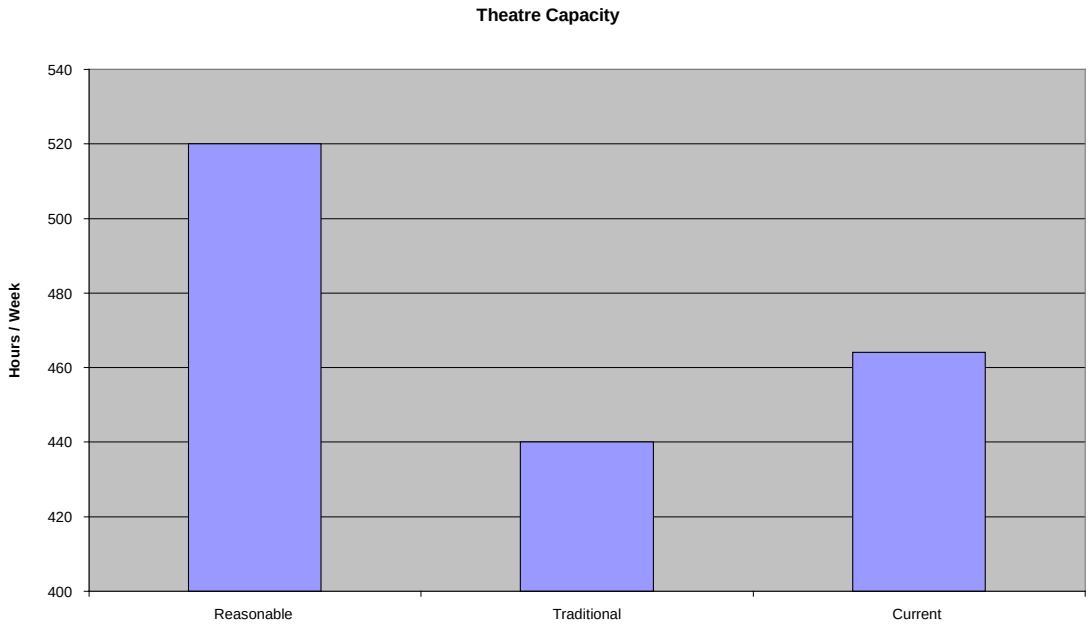
For each resource area the theoretical maximum capacity is calculated, along with the capacity delivered for traditional elective working hours, the current utilisation and what is termed a “Realistic maximum for a children’s hospital”. This figure has been established by placing the needs of the patient and their family first ensuring that service delivery meets their preferences and care is delivered in a safe manner. Patients who are going home following their appointment or test should have 7.30pm as the latest appointment time. For patients that are staying in hospital transfers back to the ward following a procedure should not occur outside of day time ward shifts unless the transfer is back to an ITU. Weekend services are established in services where they do not significantly compromise the continuity of patient care and recognise that the general hospital staffing levels are at a lower level.

Theatres

GOSH currently has 11 theatres which are predominantly used during the traditional working week but access is always available 24 hours per day 365 days of the year. They are used about 28 hours per week for emergency patients outside of scheduled sessions.

In theory 1,848 hours theatre capacity is available each week (11 theatres * 7 days * 24hours). The traditional theatre capacity would be 440 hours per week (2 four hour sessions Monday to Friday).

However, a more realistic maximum for a children’s hospital is 520 hours per week. This is two theatres extended by 2 hours each day for patients that go directly to ICU plus 5 theatres running Saturday morning, Saturday afternoon and Sunday morning.



Currently we open the theatres for approx 464 hours per week (excluding emergencies) this is made up of 96% utilisation of scheduled weekday lists, extended cardiac hours, scheduled weekend slots and list overruns.

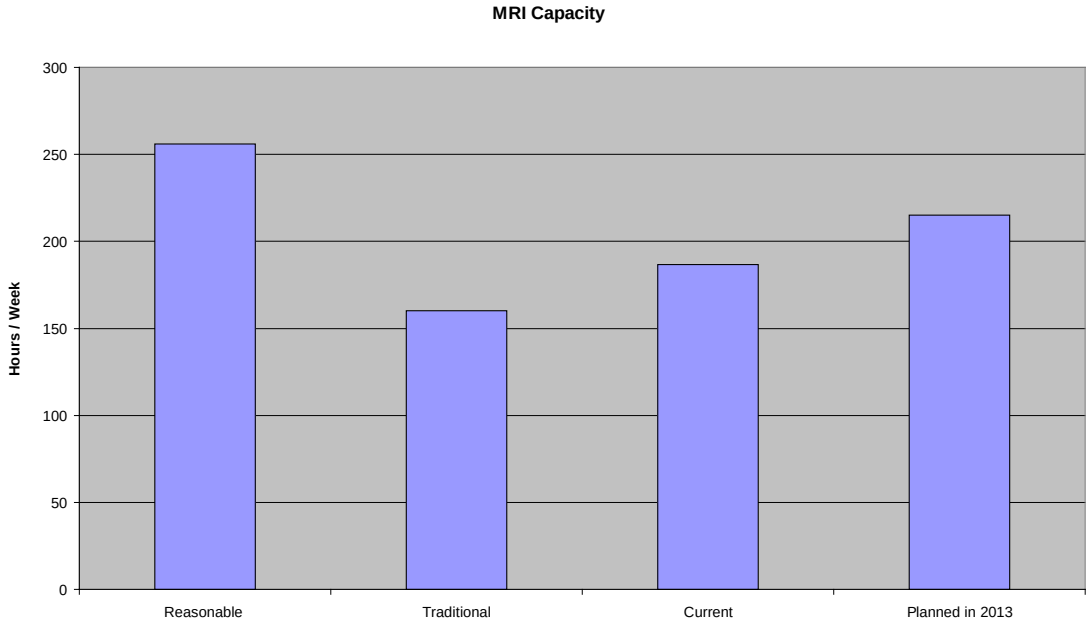
Summary – sessional utilisation is good within traditional hours and some extended hours practice currently exists. There is still some scope (4% of sessions) to improve in hour output.

MRI Scanners

We have 4 MRI scanners within GOSH which are extensively used between Monday and Friday and increasingly in the weekday evenings. 2.5 of these scanners are currently designated for clinical use and 1.5 are for research use, although there is some degree of flexibility in these arrangements. They are currently not routinely used at weekends, although in the past we have done some ad hoc lists on a Saturday morning to try and manage demand but these have not been entirely successful. We provide an on call service at weekends (which is mainly for acute neurological conditions), and we have a 'goodwill' service on weekday nights.

In theory, 672 hours MRI capacity is available each week (4 scanners * 7 days * 24 hours). The traditional MRI capacity would be 160 hours per week (2 four hour sessions Monday to Friday).

However, a more realistic maximum for a children's hospital is 256 hours per week. This is 11 hours per weekday plus 3 MRIs running Saturday morning, Saturday afternoon and Sunday morning. To safely deliver 11 hour days the evening sessions would need to be unsedated patients as patients requiring general anaesthetic are better served during conventional working hours when full support services are available. There is some uncertainty as to whether there are sufficient numbers of suitable unsedated patients to take advantage of these potential hours and Radiology are currently modelling this.



We currently utilise approx 187 hours per week and have definitive plans to increase this to over 215 hours during 2013/14. We will need to utilise all the realistically available capacity to cope with additional demand over the coming 3 years.

Summary – virtually all sessions in traditional hours run and some extended hours practice currently exists. Expansion can only be out of traditional hours and this is currently ramping up and will eventually lead to the full realistic capacity being used.

Outpatients

There are currently 72 consulting rooms across the Trust which are open for 10 hours during weekdays (8.30am to 6.30pm). The clinic rooms are in several locations;

- VCB Level 2
- Frontage Building levels 1 and 2
- Royal London Hospital for Integrated Medicine levels 1,2 and 4 (rented from UCLH)
- OBW level 2 (IPP)
- Safari (Haem / Onc / BMT)

The realistic maximum duration of clinic times is 8.30am to 7.30pm Monday to Friday and Saturdays 8.30am to 5.00pm. Additionally using clinic rooms over the weekend at the Royal London Hospital for Integrated Medicine would require negotiation with UCLH and additional infrastructure charges.

We do not currently have accurate data on the use of clinic rooms but have commissioned an external consultancy (Meridian) to improve our utilisation. Part of their work will be to produce a template to monitor future utilisation. Using clinic rooms effectively is often more complex than theatres or MRI scanners as in almost all scenarios several rooms are required to be collocated concurrently and often with certain diagnostic services (e.g. sonography, phlebotomy, X Rays etc)

Currently, there is a waiting list of additional clinics to accommodate and a strong perception across the Trust that we are short on clinic room capacity.

Summary – whilst we do not have accurate figures of clinic room utilisation, it is believed that we could generate additional activity and hence income from out of hour usage.

5. Patient Survey

We undertook a survey of 250 families to gather their views on whether we should offer extended hours / weekends for elective hospital treatments.

The headline survey results are shown in Appendix 1, but in summary families do not see being able to attend appointments in the evenings or at weekends as being as important to them as consultant continuity. Other key messages we have gathered from the results and hence include in our decision making;

- We should not aim to work beyond a maximum of 7.30pm in the evening as most patients travel for over 1 hour to the hospital and only 9% of families would choose evenings with a free choice
- A reasonable proportion of patients would like Saturday to be an option, and is preferable to evenings
- Outpatient services should be the priority for evening working / weekends
- Caution should be taken with evening or weekend working in other areas

- We need to be mindful of the family preference of consultant continuity over out of hours options and thus it may be best to develop services which are generic in nature i.e. families have the option of in week if their circumstances dictate.

6. Service Demands

The demand requirements are assessed by each of the resource domains;

Theatres

Whilst there are some specialties that have longer waiting times we consistently deliver within the national targets for 18 week admitted pathways. We do not currently use all the sessions during the traditional working week with on average 16 hours of operating not utilised each week. These sessions have funded theatre staff and anaesthetists.

MRI Scanners

We currently use 99.8% of weekday in hour sessions and demand is greater than supply. Currently we use the scanner on several evenings and have recently approved a plan to increase this extensively. Further extensions into the evening and weekend working must be delivered to meet demand. Within about 3 years we will exhaust all realistic opportunities to further expand into evening and weekend working.

Outpatients

There is currently a waiting list for additional clinic sessions and a need to decant Cardiac Wing prior to 2B. As such we need to use Saturday sessions to cope with demand.

7. Affordability

We have reviewed the following cost implications of Saturday working for each of the key resource areas;

- Increased cost of running a session at the weekends rather than in the week
- Potential reduced cost if we could run resources for longer in the week and hence require less of them
- Impact on contribution of running sessions at the weekend over weekdays

Detailed costings and assumptions are shown in Appendix 3

Theatres

Consultant T & Cs	Increased direct revenue cost (£)	Potential reduced fixed costs (£)	Net Revenue Impact (£)	Approx average annual income (£)	Revised Contribution %
On Contract	18,159	(15,833)	2,326	300,000	24%
£500 / 4 hours	50,350	(15,833)	34,517	300,000	13%

The first column shows the approx revenue impact of running a theatre session on a Saturday rather than in the week. If the activity is a straight transfer then this value would be a cost pressure.

The second column is the potential fixed cost benefit of 1 session if we could reduce our need by 1 whole theatre through more weekend working, it should not be considered a direct cash benefit. Whilst this can't be realised at present as we already have the theatres, in theory we could decrease the theatre requirement in 2B and move a whole week's theatres work to the weekend. This would be approximately cost neutral if we could do so on the basis of the consultant contract but would be significant cost pressure if the weekend sessions were paid at a £500 rate.

The last two columns show the approx annual income associated with a year's worth of activity in one session and the revised contribution (assuming a baseline of 70% marginal costs) of the work being delivered at the weekend rather than a weekday. We always ensure that increased activity has a 30% contribution so on contractual terms the impact would be manageable but on the £500 rate there would be a significant decrease in contribution

MRI Scanners

Consultant T & Cs	Increased direct revenue cost (£)	Potential reduced fixed costs (£) (1)	Net Revenue Impact (£)	Approx average annual income (£)	Revised Contribution %
On Contract	7,881	(25,750)	(17,869)	300,000	27%
£500 / 4 hours	23,976	(25,750)	(1,774)	300,000	22%
No Consultant	3,780	(25,750)	(21,970)	300,000	29%

The first column shows the approx revenue impact of running a MRI session on a Saturday rather than in the week. If the activity is a straight transfer then this value would be a cost pressure.

The second column is the potential fixed cost benefit of 1 session if we could reduce our need by 1 whole MRI scanner through more weekend working, it should not be considered a direct cash benefit. This cannot be realised as we have 4 scanners which are being extensively used. However, this analysis does confirm that we are financially better on all the above calculated aspects of workforce cover and remuneration to extend the working hours of the current scanners before we consider a 5th scanner.

The last two columns show the approx annual income associated with a year's worth of activity in one session and the revised contribution (assuming a baseline of 70% marginal costs) of the work being delivered at the weekend rather than a weekday. We always ensure that increased activity has a 30% contribution so on all contractual terms the impact would be manageable but it is clearly best for activity that does not require a consultant radiologist being present.

Outpatients

Consultant T & Cs	Increased direct revenue cost (£)	Potential reduced fixed costs (£) (1)	Net Revenue Impact (£)	Approx average annual income (£)	Revised Contribution %
On Contract	4,678	NA	NA	120,000	26%
£500 / 4 hours	20,773	NA	NA	120,000	13%

The first column shows the approx revenue impact of running an outpatient session on a Saturday rather than in the week. If the activity is a straight transfer then this value would be a cost pressure.

It is difficult to quantify the potential benefit of having less outpatient rooms and would be challenging to convert this into a revenue benefit.

The last two columns show the approx annual income associated with a year's worth of activity in one clinic and the revised contribution (assuming a baseline of 70% marginal costs) of the work being delivered at the weekend rather than a weekday. We always ensure that increased activity has a 30% contribution so on contractual terms the impact would be manageable but at £500 payment this would considerably reduce the contribution

8. Workforce Issues

a) Agenda for Change Staff

Agenda for Change staff, band 4 and above are paid a 30% enhancement for working from 8pm to 6am and all day Saturday and 60% for all day Sunday and Bank Holidays.

AfC terms and conditions recognise the need – and allow for – evening, night and weekend working. Current GOSH contracts specify working hours per week that is, 37.5 for full-time staff; working days are not specified. However, given working hours and arrangements currently in place, it would be necessary to undertake a formal exercise to change contracts in order to insert contractual requirement to work evenings and/or weekends. In practice this would involve consulting on the reasons for change, attempting to reach agreement on the change to contract and – if agreement is not secured – 'dismiss and re-engage' on new contractual terms which include evening/weekend working.

In recognition of the desire to expand the working days some recently appointed staff on AfC contracts have explicitly outlined that weekend working may be required (e.g. radiographers). Also many staff may be willing to work on the weekends and the financial recognition for them is significant on AfC contracts.

b) Bank Staff

Bank staff can be offered evening and/or weekend work but are under no obligation to accept the offer of work.

c) Consultant Staff

However, the greatest challenge will be with consultant staff. The consultant contract states core hours as being between 7am and 7pm Monday to Friday and work outside these hours receives a 33% enhancement. Additionally the contract gives consultants the right to refuse to work outside core hours.

- "Consultants will have the right to refuse non emergency work at such times. Should they do so there will be no detriment in relation to pay progression or any other matter" (Schedule 3, Para 6)
- "For the purposes of Schedule 3, Para 6, non emergency work shall be regarded as including the regular, programmed work of consultants whose specialty by its nature involves dealing routinely with emergency cases e.g. A & E consultants" (Consultant Contract, Definitions)

HR have undertaken a small benchmarking exercise to ascertain what other organisations are doing with regards to weekend working, this is shown in Appendix 2.

Based on this and other information the majority of Trusts undertaking weekend work are doing so with a consultant remuneration rate above the standard Consultant Contract Terms and Conditions.

We have a few anaesthetists undertaking Saturday sessions at the GOSH agreed rate of £500 per session, but it is reasonably difficult to cover sessions and any increase in the amount of sessions would not have sufficient consultant interest.

It is highly unlikely any surgeon would choose to work at the weekend for anything other than private rates or a significant local premium rate.

The majority of the Radiologists have made it clear that they do not wish (but have not actually refused) to work at the weekends, although they absolutely accept that extended hours scanning is now necessary. They are currently fully engaged in trying to find an interim solution that selects appropriate patients (whose scans can be fully protocollised) for unsupervised lists in these extended scanning hours.

Outpatient sessions are being arranged on the basis of Consultant Contract rates but at present the clinicians involved are doing so voluntarily.

Options we have to deliver a consultant workforce able to undertake extensive elective weekend working are the following;

- Cover weekend work with newly appointed consultants only i.e. appoint consultants on local contracts excluding Para 6.
- Offer an attractive weekend remuneration package for weekend working or offer other incentives such as flexible working, SPA allocation, reduced on call, productivity payments etc.) This would still be entirely voluntary
- Renegotiate the contract for current staff, excluding Para 6.

- Only offer APAs at weekends. This would still be entirely voluntary

Each has challenges and gives different benefits.

9. Summary & Recommendations

For each of the resource areas we have summarised the position with regard to each of the 5 considerations;

- Current sessional utilisation in traditional hours
- Family / patient preferences
- Service demands
- Affordability
- Workforce issues

These are shown in the tables below and followed by recommendations

Theatres

Issue Considered	Summary
Current resource usage	Some capacity still exists in traditional hours
Family / patient preference	Some caution over extending hours
Service demands	More operating space would be useful but some exists in traditional hours
Affordability	Transfer activity would present a cost pressure Additional activity affordable at consultant contract rate
Workforce issues	Currently highly unlikely to be deliverable

Recommendation: Focus on better utilisation of day time sessions as current need is limited and deliverability is highly unlikely until a strategy is agreed on tackling the consultant availability and remuneration.

MRI Scanners

Issue Considered	Summary
Current resource usage	All traditional hour capacity is used and service extends already
Family / patient preference	Some caution over extending hours
Service demands	Clear demand for additional capacity
Affordability	Additional activity affordable especially that which does not require a consultant Realise full working potential of scanners before purchasing a 5th
Workforce issues	Radiologists are very reluctant to work weekends (and some may refuse) and we need to run weekend sessions that do not require a consultant

Recommendation: Continue to expand out of traditional hour services for cases that do not require a radiologist present. Radiologists have given a clear message that they would not choose to work weekends (although they have not said categorically that they won't; they are exploring other solutions in the first instance).

Outpatients

Issue Considered	Summary
Current resource usage	Lack accurate data on current resource usage
Family / patient preference	Family preference for extended hours, especially at weekends
Service demands	Demand for more clinics – current waiting list
Affordability	Additional activity affordable at contractual consultant rates
Workforce issues	Consultants currently offering on a voluntary basis

Recommendation: Develop a routine Saturday outpatient service, commencing with the volunteer specialties of Audiology, Genetics and Cardiology. Encourage other specialties to opt in. Remuneration should only be at consultant contractual rates.

Other Specific Developments

Whilst undertaking this review of the potential to extend elective activities we have encountered a few services which have specific demands or other reasons why they are planning to extend working hours. These are shown in Appendix 4.

Longer Term Plans

Going forward we need to strategically review if extensive extended elective working is the right direction of travel for the Trust. We will only be able to offer a limited range of services until a strategy is agreed to tackle consultant availability and remuneration. This is a pivotal decision and one which requires careful consideration.

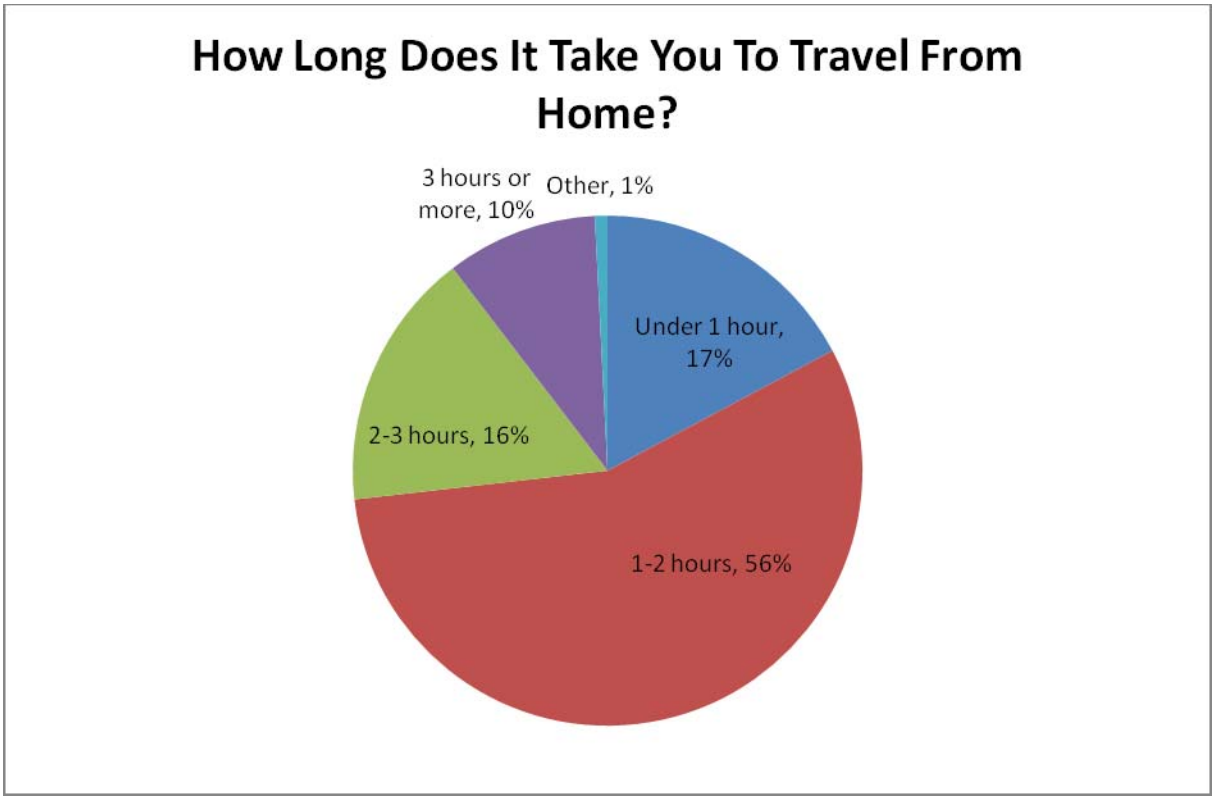
Attachment I

Appendix 1 – Patient & Family Survey

We randomly surveyed 250 families. These were mostly made up of families visiting GOSH for an appointment or MRI scan but also a few surveys were completed on line by our members. There was no significant difference between the 2 groups.

Results

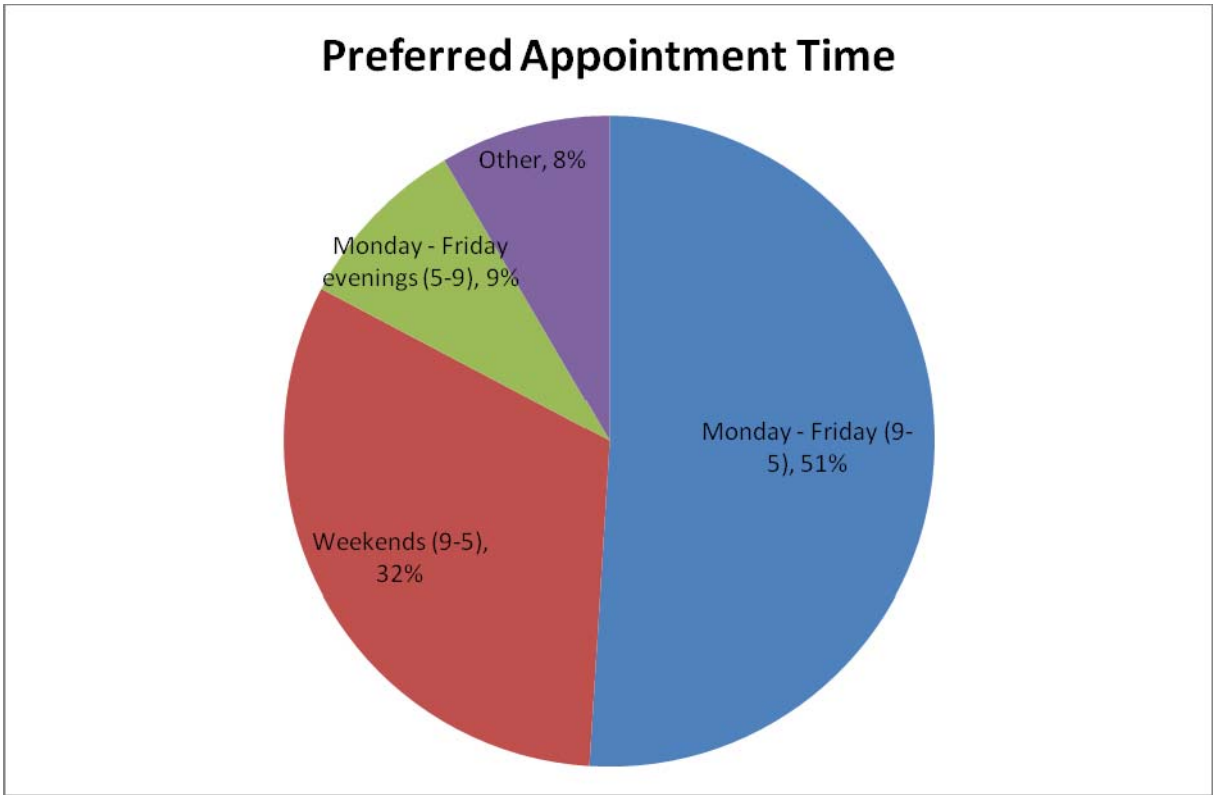
1. We gathered information on the travel time to GOSH;



Key Message

Over 80% of our patients travel for over 1 hour.

2. We asked the question of when families would prefer their appointment to be in the context of all the options being available

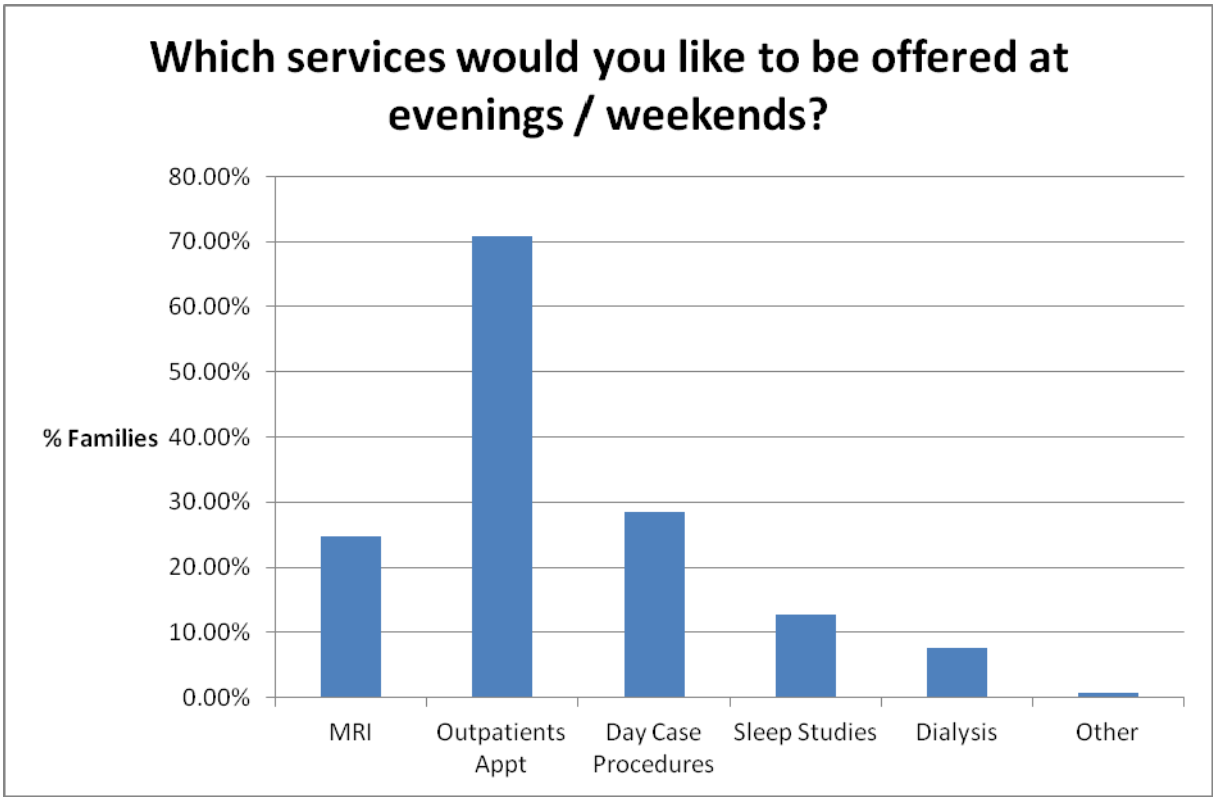


Key Message

Over half preferred “traditional hours” with a significant proportion being keen on weekends but evenings were less popular.

The most common reasons given for preferring “traditional hours” were general convenience and care of other children and to enable family time away from school and other commitments.

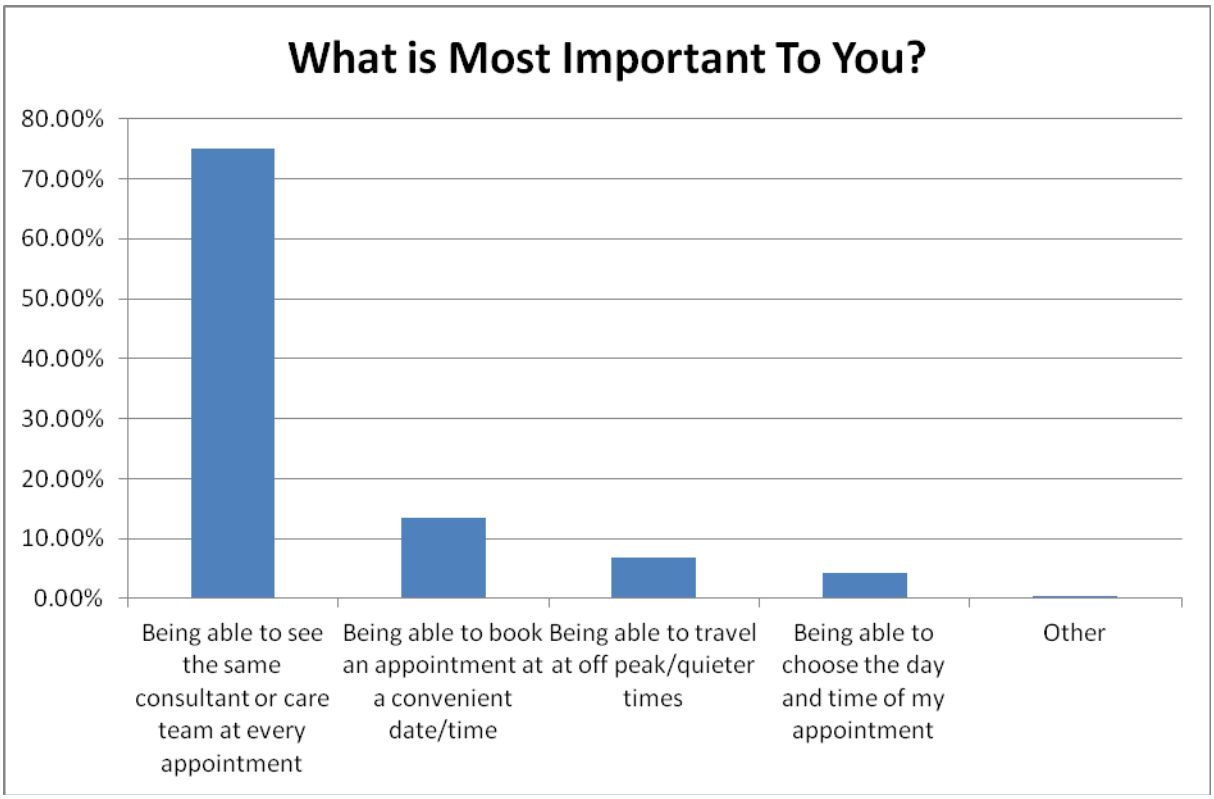
3. We asked families which services they would like to be available in the evening or weekend;



Key Message

Outpatients were the only area where a significant proportion of families would like to see services being offered outside standard hours.

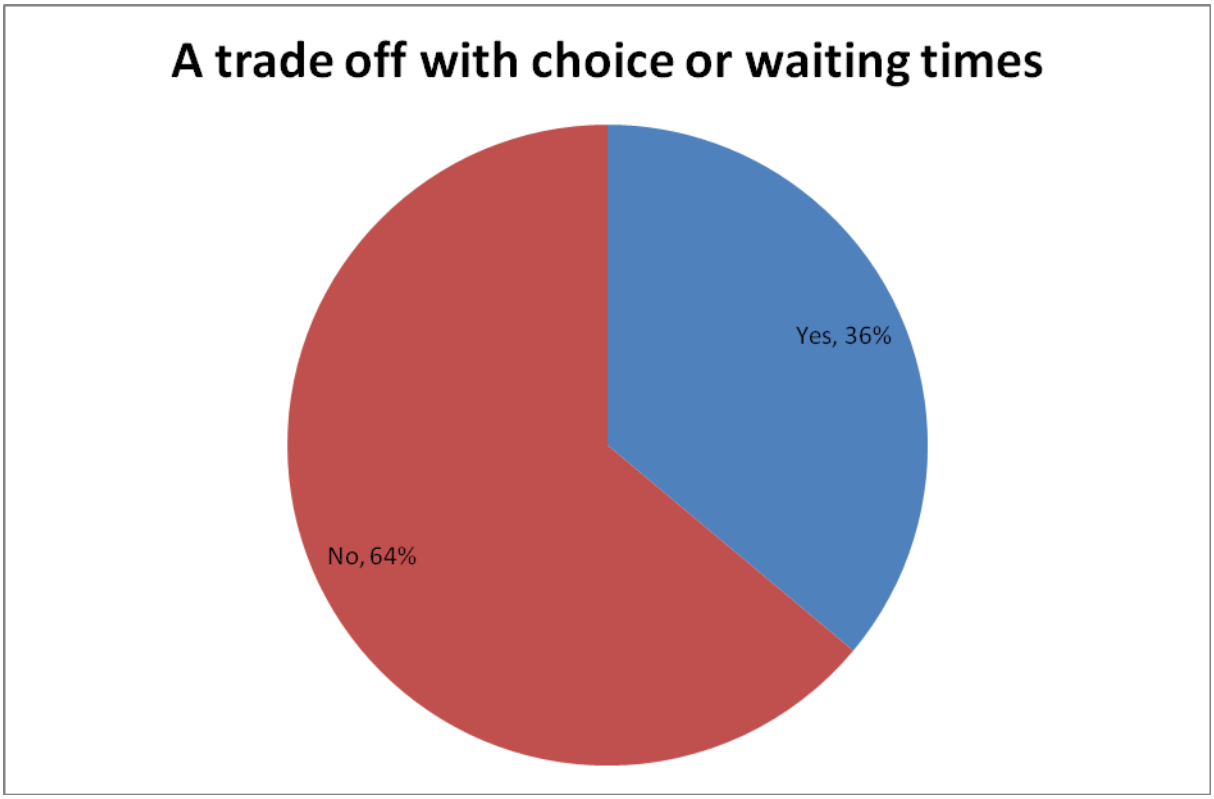
4. We asked families what was the most important factor to them when arranging a hospital appointment



Key Message

A clear message that clinician continuity was the important factor with families

5. We asked families if they would prefer to be seen in hours outside of traditional hours if it meant that they had reduced choice in other ways (e.g. a different clinician)



Key Message

These results confirm the opinion that offering appointments outside of traditional hours does not outway other trade offs (e.g. only having Saturday as the option if you wish to see the same consultant)

Appendix 2 - Weekend Working – Other Trusts

UCLH: Do weekend working. Have a number of separate arrangements in place. As a general rule, most elective surgery taking place at weekends is remunerated at a rate higher than national entitlements. Typical remuneration is £650 for a four hour session.

Moorfields: Do weekend 'periodically' i.e. not a regular feature. Have an agreed rate of £80 per hour for consultant work undertaken over a weekend. Consultants cover weekend work on a locum basis; consultants are not job-planned to do routine weekend work.

Derby Hospitals FT: Consultants do weekend elective work. Have a 'productivity agreement' in place whereby consultants only receive enhanced rates (£450 per four hour session) once productivity targets have been achieved. Currently under review.

Christie FT: No weekend work.

Southampton FT: Do elective work at weekends, consultant contract rates (Premium Time PA) rates paid.

Newcastle-Upon-Tyne FT: Have a range of consultants working at weekends on emergency activity (Emergency Medicine, Trauma and Orthopaedics, A&E) paid at standard consultant contract rate. Waiting List Initiative work paid at £200 per hour.

Royal Free FT: Little elective work done at weekends. Consultants paid on national contract rates. Bank consultants who do Independent Assessments in Renal get paid £80 per hour irrespective of day of the week. In the past have paid Waiting List Initiative payments of £400 per four hour session.

Appendix 3

Change in direct staff costs of running 1 theatre sessions on a Saturday as opposed to a weekday

Consultants on CC

	Weekday		Saturday		Movement	
	WTE	Annual Cost £	WTE	Annual Cost £	WTE	Annual Cost £
Rostered Non Medical Staff	1.03	41,371	1.03	51,328	0.00	9,957
Medical Staff:						
Consultant Surgeon		12,304		16,405		4,101
Consultant Anaesthetist		12,304		16,405		4,101
Registrar						0
Total		**65,978**		**84,138**		**18,159**

Consultants at £500/session

	Weekday		Saturday		Movement	
	WTE	Annual Cost £	WTE	Annual Cost £	WTE	Annual Cost £
Rostered Non Medical Staff	1.03	41,371	1.03	51,328	0.00	9,957
Medical Staff:						
Consultant Surgeon		12,304		32,500		20,196
Consultant Anaesthetist		12,304		32,500		20,196
Registrar						0
Total		**65,978**		**116,328**		**50,350**

Change in direct staff costs of running one extra MRI session on a Saturday as opposed to a weekday

Consultants on CC

	Weekday		Saturday		Movement	
	WTE	£	WTE	£	WTE	£
Radiographer	0.13	6,650.00	0.13	8,190.00	0.00	1,540.00
Radiographer	0.13	5,660.00	0.13	6,950.00	0.00	1,290.00
Admin Support	0.13	3,440.00	0.13	4,390.00	0.00	950.00
Consultant		12,303.72		16,404.96		4,101.24
Total		**28,054**		**35,935**		**7,881**

Consultants at £500/session

	Weekday		Saturday		Movement	
	WTE	£	WTE	£	WTE	£
Radiographer	0.13	6,650.00	0.13	8,190.00	0.00	1,540.00
Radiographer	0.13	5,660.00	0.13	6,950.00	0.00	1,290.00
Admin Support	0.13	3,440.00	0.13	4,390.00	0.00	950.00
Consultant		12,303.72		32,500.00		20,196.28
Total		**28,054**		**52,030**		**23,976**

No Consultant

	Weekday		Saturday		Movement	
	WTE	£	WTE	£	WTE	£
Radiographer	0.13	6,650.00	0.13	8,190.00	0.00	1,540.00
Radiographer	0.13	5,660.00	0.13	6,950.00	0.00	1,290.00
Admin Support	0.13	3,440.00	0.13	4,390.00	0.00	950.00
Consultant						0.00
Total		**15,750**		**19,530**		**3,780**

Change in direct staff costs of running one outpatient clinic on a Saturday as opposed to a weekday

Consultants on CC

	Weekday		Saturday		Movement	
	WTE	£	WTE	£	WTE	£
Consultant		12,304		16,405		4,101
Clinic Assistant		1,602		2,082		481
Admin Support		320.35		416.46		96.11
Total		**14,226**		**18,904**		**4,678**

Consultants at £500/session

	Weekday		Saturday		Movement	
	WTE	£	WTE	£	WTE	£
Consultant		12,304		32,500		20,196
Clinic Assistant		1,602		2,082		481
Admin Support		320.35		416.46		96.11
Total		**14,226**		**34,999**		**20,773**

Key Assumptions

Theatre Capital Cost	£2million
Theatre Lifespan	15 Years
MRI Capital Cost	£1.5million
MRI Lifespan	8 Years
Annual Theatre Maintenance	£25k
Annual MRI Maintenance	£70k

Assume that increased usage does not effect lifespan or maintenance costs

Theatre Activity Per Session	2
Sessions Per Year	50
Income Per Case (£)	3,000
MRI Activity Per Session	4
Sessions Per Year	50
Income Per Case (£)	1,500
Outpatient Activity Per Session	12
Sessions Per Year	50

Income Per Appointment (£)	200

Appendix 4 – Other Extended Hour Developments

Service	Expansion	Reasons	Status
Psychology	Weekday evenings	Lack of clinic room space during the day To accommodate school age children	In planning
Speech & Language Therapy	Weekday evenings	Lack of clinic room space during the day To accommodate school age children	In planning
Neuro Telemetry	Weekends	Currently a Mon to Friday service Most patients have a planned block of treatment Some activity is outsourced due to capacity constraints Saturday only was considered and dismissed as the benefits of one extra day would be minimal for block treatments, hence expansion of 2 days is being considered	Being scoped
Haemodialysis	Sundays	Currently run 6 day a week service. Clinical and capacity benefits with 7 days.	Project approved and staff being trained, will be in place during 2013/14
Sleep Studies	Sundays	Currently run 6 day a week service. Capacity constraints	Business Case in development

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
July 2013

Assessment of 2A Benefits Realisation **Submitted by:** **Robert Burns, Director of Planning & Information**	**Paper No: Attachment J**

Aims / summary
The paper assesses the realisation of the benefits outlined in the 2A Business Case. It reviews the funding sources of other major redevelopments of children's hospital services and recommends revised measures for assessing the benefits of 2B.

Action required from the meeting
To note

Contribution to the delivery of NHS Foundation Trust strategies and plans
Maximising the benefits from the redevelopment programme will contribute to all the Trust's strategic plans

Financial implications
The benefits from the redevelopment programme include growth and delivering cost effective healthcare.

Legal issues
NA

Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place?
The paper is also being presented to the GOSHCC Special Trustee Meeting

Who needs to be told about any decision?
NA

Who is responsible for implementing the proposals / project and anticipated timescales?
Robert Burns, Director of Planning & Information

Who is accountable for the implementation of the proposal / project?
Robert Burns, Director of Planning & Information

Assessment of the Impact of the 2A Development

1. Background & Scope

In 2007 the Trust Board approved the development of the Morgan Stanley Clinical Building (MSCB) which is Phase 2A of the extensive Phase 2 redevelopment programme to replace aging clinical accommodation with modern 21st Century facilities.

The approved business case outlined a number of benefits this would give to GOSH in terms of;

- Improved Building Stock
- Improved Facilities for Families & Staff
- Enable New Model of Care
- Effective Use of Staff
- Additional Physical Capacity

This paper will assess the realisation of these benefits for the GOSHCC Trustees and GOSH Trust Board.

It will also analyse the activity and financial position of the Trust in 2012/13 in comparison to that set out within the 2A Business Case.

Additionally the paper will review other major redevelopments of children's hospitals across the UK and worldwide to compare their funding sources and overall costs.

The paper will not assess the current direct incremental financial impact of 2A nor assess the management of the redevelopment project.

The paper will conclude with a recommendation of the metrics that should be measured to assess the benefits of the upcoming 2B Business Case

2. 2A Benefits Realisation

Appendix F of the approved 2A Business Case sets out a number of expected benefits from the development with specific measures and targets. These are assessed in the table below;

In the right hand column, green indicates that the target has been achieved, amber improvement has been made but the target not reached, red no improvement has been realised.

Improved Bed Stock

Specific Benefit	Suggested Measurement	Comments	Target	Achievement
Greater comfort and more patient-centred approach to accommodation	Pre & post feedback from children, families and staff within 12 months of operation	This has been assessed by a patient / family survey of space, privacy & noise, comfort and play	% of patients / families satisfied with building standards is 10% higher than previous estate	Overall satisfaction score across all measures for all inpatient wards risen from 65% to 84%
Lower infection rates because facilities easier to clean and manage	Infection rates for specified infections	The best measure is the rate of Central Venous Line (CVL) Infections. But it should be noted that accommodation is likely to only play a small factor in this performance	Infection rate for specified infections in the new building is 5% lower than previous infection rate	Rate has reduced by 27% from 2.2 per 1,000 line days to 1.6 per 1,000 line days
Cleaner building because facilities are easier to clean	Successful passes of hygiene audits based on NHS Estates cleaning standards	This measure is no longer undertaken	NA	NA
Safer buildings for staff, patients and families	Number of health & safety incidents	This is not a great measure as other factors have a much larger influence on the raw numbers, notably the culture and ease of incident	No of Health & Safety incidents relating to the new building is lower than previous estate	The number of H & S Incidents on the related wards has increased by 39% from 49 to 68 annually pre and post MSCB

Specific Benefit	Suggested Measurement	Comments	Target	Achievement
		reporting		
Safer buildings for staff, patients and families	Levels of backlog maintenance	This is good measure as it gives a financial value to the remaining estate that requires improvement	At the opening of the buildings the overall level of backlog maintenance across the estate has reduces by 8% compared to before	Backlog maintenance has decreased by 23% from £4.8million pre MSCB to £3.7million currently
Buildings more accessible for staff, patients and families	Compliance with DDA	A reasonable measure but would question any major development that doesn't achieve this	Buildings fully compliant with DDA	MSCB is fully compliant

Improved Facilities for Families & Staff

Specific Benefit	Suggested Measurement	Comments	Target	Achievement
Provide improved facilities for staff	Pre & post feedback from staff within 12 months of new building operational	This is a good measure unfortunately we did not undertake the survey before transfer	Staff satisfaction with the facilities has increased by 10% pre and post working in the new environment	NA
Provide improved facilities for staff	Turnover and vacancy rates for staff	This is not a good measure as physical facilities are generally considered to be a small factor in	5% reduction in turnover rates for the teams working in the new facilities	Turnover has increased in the following specialties as follows; Nephrology from

Specific Benefit	Suggested Measurement	Comments	Target	Achievement
		staff recruitment and particularity retention. Culture and team working is a much bigger factor. Additionally when staff move facilities it is known to temporarily adversely impact on turnover even if the facilities are improved. Vacancy rates are difficult to compare as the bed numbers and hence ward establishments have changed		11.8% to 16.6% Cardiac Intensive Care from 12.2% to 20.3% Neurosciences from 4.9% to 16.8% Turnover has decreased in the following specialty; Cardiac Ward from 21.7% to 13.3%
Provide improved facilities for children and families	Pre & post feedback from children and families using new facilities	This is essentially the same question as the first one under Improved Bed Stock	% of patients / families satisfied with building standards is 20% higher than previous estate	Overall satisfaction score across all measures for all inpatient wards risen from 65% to 84%

Enable New Model of Care

Specific Benefit	Suggested Measurement	Comments	Target	Achievement
Treat more children as day cases or in	Day Case Rates	This is an important measure for the	Increase of 5.7% in day case rate to a	Day Case rates have increased to 57.45%

Specific Benefit	Suggested Measurement	Comments	Target	Achievement
ambulatory care settings		whole of Phase 2 and is relevant when specific day case and ambulatory care facilities become operational	Trust average of 57.44%	
Treat more children as day cases or in ambulatory care settings	Length of Stay	The difficulty with this measure is that length of stay is multi-factorial and often these factors are outside the direct control of GOSH. For example increasing acuity rates, changes in clinical protocols and provision of services at other providers	Reduction in average length of stay by 0.25 days to 5.05 days	Average length of has reduced by 1 day from 5.3 to 4.3 days

Effective Use of Staff

Specific Benefit	Suggested Measurement	Comments	Target	Achievement
Staff are used more effectively in the new building	Ward based staff costs per unit of activity	This is a good measure but it should be noted that other factors such as patient acuity and nationally agreed pay rates will influence this. A	For specialties in the new building, ward based staffing costs per bed day reduce by 3%	The fully absorbed average bed day cost has reduced by 2.8% from £1,081 to £1,051

Specific Benefit	Suggested Measurement	Comments	Target	Achievement
		better measure is the fully absorbed cost per bed day as this also represents other cost impacts such as estate and facility revenue costs.		
Staff are used more effectively in the new building	Staff attitudes about how the building supports their effective working	This is not a measure we collect	NA	NA
Staff are used more effectively in the new building	Staff intentions to stay at the Trust	This is not a measure we collect	NA	NA

Additional Physical Capacity

Specific Benefit	Suggested Measurement	Comments	Target	Achievement
Provide additional physical capacity for the delivery of services needed by stakeholders	Number of beds available	This is a really key measure	An increase of 7 beds	Beds have increased by 23 (See Appendix 1)
Provide additional physical capacity for the delivery of services needed	Theatre sessions available	This is a really key measure	No increase in theatres (Note the spec changed during the project to convert one	1 Additional theatre provided

Specific Benefit	Suggested Measurement	Comments	Target	Achievement
by stakeholders			angiography suite to a theatre)	
Provide additional physical capacity for the delivery of services needed by stakeholders	Measure activity levels for relevant specialties before and pre and post opening	This is a really key measure	Increase activity from 2005/06 by 8% to 28,966 episodes	Activity has increased by 57% to 42,140 episodes
Provide additional physical capacity for the delivery of services needed by stakeholders	Theatre utilisation	This measure has many factors which affect its performance	Improves in the new building by 10%	Theatre utilisation dropped from 76% to 69% in the specialties that transferred theatres
Provide additional physical capacity for the delivery of services needed by stakeholders	Refused referrals and admissions	This measure is important but should be considered in the context of many other factors influencing this figure, notably the capacity in other centres	Reduction in the number of refused referrals	Refusals have increased by 79% from 291 to 520 in the year post opening over the previous year

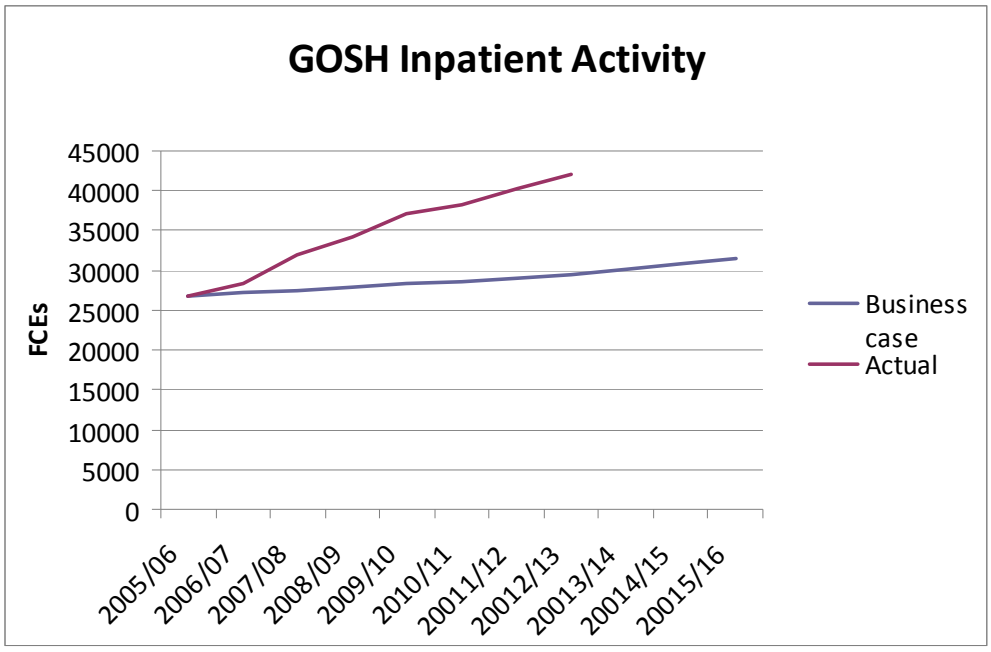
In conclusion over half of the measured benefits outlined in the 2A Business Case have been achieved. On reflection, whilst some of the benefits outlined are good measures, this is not the case for all. The paper concludes with a revised set of measures which cover a range of issues. These are all measurable and it is recommended are utilised to assess the impact of 2B.

3. Activity and Financial Comparison

The 2A Business Case clearly sets out an expected level of activity that the Trust would be undertaking in the year post 2A opening and an associated financial plan.

The graph below shows the actual inpatient activity levels at GOSH compared to those predicted in the 2A Business Case. As can be seen activity levels have growth substantially more than those predicted and current levels are already considerably above those predicted post 2B.

It is worth noting that the 2A business case predicted activity to grow in uniform way and not in steps associated with the addition of new facilities (e.g. 2A and 2B). This is logical as increased additional physical capacity will not immediately convert into the equivalent growth of patient numbers. Factors such as recruitment, the ability to train a growing workforce, referral patterns, and commissioned activity will also influence the phasing of growth. 2A provides an example of this in that growth is continuing post the opening of the MSCB, but it will be several years before we realise the full activity potential of the building (and the decanted space it creates).



The table below shows the actual GOSH Income & Expenditure for 2012/13 against that forecast within the 2A Business Case. As can be seen the total income and expenditure of the Trust has grown significantly more than predicted and is also in line with the overall activity growth in the same period (57%)

	2012/13 GOSH Income & Expenditure Position		
	Forecast in		
Income	**2A Business Case (£k)**	**Actual (£k)**	**% Variance (£k)**
Clinical	171,822	266,928	55%
Private Patients	15,480	41,294	167%
R & D	19,800	19,682	-1%
Education & Training	6,391		53%

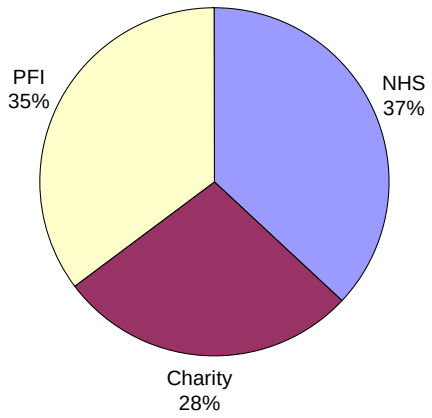
		9,802	
Other Income	19,305	34,128	77%
Total Income	**232,798**	**371,834**	**60%**
Expenditure	**220,432**	**353,871**	**61%**
Operating Surplus	**12,366**	**17,963**	**45%**

4. Other Children's Hospital Redevelopments

Over the past decade and upcoming in the next few years a significant number of specialist children's hospital facilities have been or are being upgraded, including Chelsea & Westminster, University College London Hospitals, Barts Health, Guy's & St Thomas', Southampton, Newcastle, Sheffield, Glasgow, Dublin, Manchester, Edinburgh, Alder Hey and Oxford. These are shown in Appendix 2.

For those in England the approx. breakdown of funding sources is shown in the pie chart below.

Funding Source



Charitable contributions play a significant role in the capital funding for many children's hospital developments but overall the percentage is much higher at GOSH with 77%. The Evelina redevelopment at Guy's Hospital was 83% charitably funded. The two developments that are most similar in size to that of the whole GOSH phase 2 programme are;

- New Children's Hospital Dublin (2017/18) (slightly bigger) – 484m-660m Euros
- Alder Hey Children's Health Park (2015) (slightly smaller) - £237m

- GOSH Phase 2 Redevelopment - £321m

5. 2B & Future Metrics

Many of the measures suggested in the 2A Business Case are appropriate; however, some are not the best measures for objectively assessing the direct impact of new facilities. The below table recommends the measures that should be measured as a quantative assessment of future major developments such as 2B.

Benefit being measured	Measurement	Suggested Targets for 2B
Patient and parent experience of facilities	Pre & post feedback from children and families within 12 months of operation	Satisfaction rates are 10% higher
Staff experience of facilities	Pre & post feedback from staff within 12 months of operation	Satisfaction rates are 10% higher
Safer buildings for staff, patients and families	Levels of backlog maintenance	At the opening of the buildings the overall level of backlog maintenance across the estate has reduces by 15% compared to before
Treat more children as day cases or in ambulatory care settings	Day Case Rates	This depends on the exact facilities being planned – baselines and targets should be established nearer the time
Cost effective use of resources	Fully absorbed cost per bed day	Reduction of 4% per bed day (in line with current NHS efficiency requirements)
Provide additional facilities as required by the demand and activity projections	No of operational beds & theatres	Provide 35 additional bed spaces Provide 1 additional theatre

Benefit being measured	Measurement	Suggested Targets for 2B
		(net) and beds
Provide capacity as required by the demand and activity projections	Actual activity levels meet demand projections Reduction in refused referrals	Activity levels in line with Trust projections (should be determined nearer the time) The Trust does not refuse any clinically appropriate referrals for inpatient care
Safe ward medical care	Reduction in the % of bed days managed as outliers	Reduce the percentage of outlier bed days from 12% to 9%

6. Summary

Undertaking this exercise and in particular referring back to the development's original aims has been an enlightening and worthwhile exercise.

The hospital has grown considerably more than had been planned and reflects both continuous improvements in the efficiency of healthcare delivery and the constant investment in the expansion of facilities by both GOSHCC and GOSH.

The redevelopment of children's hospital services has been widespread across England, and nearly 1/3 of this has been charitably funded. Without the significant proportion of funding from GOSHCC it is likely that the only viable funding route would have been PFI.

Some of the metrics outlined in the Business Case have not been measured and some are not particularly relevant. It is thus recommended that the proposed list is formally reviewed annually prior to 2B opening to continually validate their relevance.

A final point worth noting is that opening new and expanded facilities will not deliver an immediate consummate increase in activity, but rather support the continuous growth of activity levels.

Appendix 1

Impact of 2A on Beds

Specialty	Physical Bed Spaces 2011/12	Physical Bed Spaces 2012/13	Change	Operational Beds – July 2013
Nephrology	16	15	-1	15
CICU	16	21	+5	17
Ward Cardiac	20	24	+4	22
Neurosciences & Craniofacial	25	24	-1	24
Vacated CICU (Now NICU)	0	16	+16	0
Total	**77**	**100**	**+23**	

Impact of 2B on Beds

Specialty	Physical Bed Spaces 2012/13	Physical Bed Spaces 2017/18	Change
ICI	24	22	-2
Surgical Unit	66	70	+4
Level 2 (Respiratory)	0	24	+24
Neurosciences & Craniofacial	24	33	+9
Total	**114**	**149**	**+35**

Appendix 2

Hospital Name	Location	Completion Date	Total Capital Cost	Funding Source	Facilities Received	Contact Details	Notes
Chelsea & Westminster	UK	Dec-13	£41,200,000	Financed by the hospital from its surplus, no PFI involved - £40,000,000 Charity - £1,200,000 (see breaksown in faciities received column in red)	**Phase I of the hospital is now open and features:** •Four new children's operating theatres – the first of their kind in the UK -Hospital •A 12-bed children's High Dependency Unit, and a sensory room -core build hospital but art/design, sensory room, parents room facilities and ambient lighting charity funded. •A state-of-the-art simulation unit to train paediatric surgeons from all over the UK -charity •Two treatment rooms and five examination rooms - core build hospital but art/design, ambient lighting, distraction aids and therapy services charity funded. •Interactive design features and visual arts to stimulate the imagination, provide distraction from treatment and humanise the environment -Charity **We are seeking to raise the remaining £287,000 to fund:** •Children's Outpatients' enhancements (sensory play, design features etc) -core build hospital but enhacements all charity funded •Chill Out area for teenagers complete with games, music and social media -charity funded •Elephant info kiosks - charity funded •Parental accommodation - charity funded	Kerry Huntington, Fundraising Manager, Chelsea and Westminster Health Charity on 0203 315 6619 or at kerry.huntington@chelwest.nhs.uk	http://www.chelwestcharity.org.uk/Chelsea-Childrens-Hospital_13595.html
Southampton Children's Hospital	UK	2020	£70,000,000	Capital Budget - £40,000,000 Fundraising - £30,000,000	The children's hospital will be linked to Southampton General Hospital but will be purpose built with a separate entrance to provide a worthy home to our specialist, internationally renowned children's services. These include cardiac surgery, neuroscience, oncology and a world-leading paediatric intensive care unit. One of only a handful of UK specialist hospitals for young people, the state-of-the-art facility will include: • Its own dedicated children's accident and emergency department. •An exclusive child-friendly entrance to the children's hospital. •The Ronald McDonald House, which will have 60 rooms for families of sick children. •An expansion of Southampton General Hospital's already world-class paediatric intensive care unit.	023 8079 6972	http://www.childrenshospital.uhs.nhs.uk/Home.aspx http://www.dailyecho.co.uk/news/10030628.Southampton_s_new___70m_children_s_hospital_revealed/
Evelina	UK	2005	£60,000,000	Charity - £50,000,000 Government - £10,000,000	The Evelina Children's Hospital moved to a stunning new purpose-built hospital at St Thomas' in 2005. It includes: •140 inpatient beds, including 20 intensive care beds • 3 operating theatres • a full children's imaging service with MRI scanner, x-ray and ultrasound • a kidney dialysis unit • an outpatients department • a medical day care unit • a hospital school	020 7188 7188	http://www.guysandstthomas.nhs.uk/our-services/childrens/childrens-services.aspx
UCLH	UK	2008	£250,000,000	PFI	The state-of-the-art facility brings together all the NHS acute care facilities that are currently provided by The University College Hospital, The Middlesex hospital, The Elizabeth Garrett Anderson Hospital and the Hospital for Tropical Diseases. It comprises of three interconnected blocks all with two basement levels. Block one including plant rooms is a five-storey Podium Building. Block two including plant rooms is an eighteen-storey tower accommodating the Accident and Emergency department on the ground floor. Block three, which is Phase two, is the five-storey Elizabeth Garrett Anderson Wing which is a women's hospital with direct access to the main hospitals operating theatres, intensive care and specialist units.	ian.lloyd@uclh.nhs.uk	http://construction.morgansindall.co.uk/uploads/project_sheets/210/hospital_redevelopment_uclh_foundation_trust_250m_08.pdf?1256555832
UCLH Cancer Centre	UK	2012	£100,000,000	Charity - £40,000,000 NHS - £60,000,000	The centre will provide patients, families and carers with excellent educational, social psychological and complementary therapy support alongside clinical treatment. The main focus of the centre will be on daycare and outpatient based treatment such as chemotherapy. There will also be a strong emphasis on research with the cancer centre linked to the recently opened University College London Cancer Institute immediately opposite. This will allow for close collaboration between the institute and centre and support UCLH's aim to transform laboratory research into treatments that directly benefit patients.		http://www.uclh.nhs.uk/aboutus/Campaignsandcharities/UCLHCF/Fundraising%20news/UCLH%20fundraising%20news%20-%20Winter%202008.pdf
Oxford Children's Hospital	UK	Jan-07	£30,000,000	NHS - £15,000,000 Fundraising by the community – aided by an Oxford Mail campaign - £15,000,000	Provide a wide range of specialty services for children from throughout the Thames Valley and beyond. Services are largely provided by paediatricians and surgeons with particular paediatric specialist interests, but who also provide the general paediatric service.	01865 741166	Part of a £135m redevelopment of the West Wing, which includes the children's hospital. http://www.oxfordmail.co.uk/news/headlines/3932783.Queen_officially_opens_hospital/ http://www.ouh.nhs.uk/children/
Sick Kids	Toronto	1993	$232,000,000	Taxpayers and contributors to the Hospital's capital campaign SickKids Foundation Other donors and bequests.	Most patients now have their own room, with a washroom, storage, and a day bed so a parent can stay at night. With the addition of the new wing, SickKids now fills an entire city block.The Atrium houses exciting facilities to help provide enhanced care and improve the treatment and diagnosis of childhood disease. The Critical Care Unit, where children with life threatening illness and injury receive care, almost doubled in size to 36 beds. The Emergency Department has two trauma rooms and a six-bed observation room	General inquiries: 416-813-1500	http://www.sickkids.ca/AboutSickKids/History-and-Milestones/Our-History/

Newcastle Children's Hospital	UK	2010	£100,000,000	PFI Bond scheme	Services and Facilities •Spacious and airy environment for our inpatients - there are 246 beds - 75% of which are single rooms with en-suite facilities. •The purpose built Teenage Cancer Unit with its 'Penthouse'. •One large centralised Children's Outpatient Department. •Five dedicated paediatric theatre suites - two of these are state of the art laparoscopic theatres - all allowing children to benefit from modern techniques thereby aiding recovery, as well as reducing the length of stay. •Broad range of staff including medical, nursing, hospital play specialists and nursery nurses, dieticians, pharmacists, occupational health and physiotherapy staff. •First class facilities to allow parents to stay overnight. •An 'Amazing Interactives' 3D system. The Burns and Plastic Surgery unit is the first to benefit from this system which aids distraction therapy (and gives fun) to children. •MediCinema - a new 50 seat cinema is sited within the RVI that will benefit children - blockbuster movies can be viewed with nursing staff in attendance. •The Bridges School will have new accommodation within the Great North Children's Hospital including a classroom to support education of children within the hospital environment. •Our CANI Nursing Team - this Community Acute Nursing Initiative is an outreach team which helps support early discharge in children by offering nursing care and support in the local community.	robin.smith@nuth.nhs.uk	Part of a £300,000,000 development project
Sheffield Children's Hospital	UK	2015	£40,000,000	Government £20,000,000 The Children's Hospital Charity - £20,000,000	The new build will include: •new modern wards and facilities •priority car parking •a new Outpatient Department •a new main reception area •a stunning iconic play tower •a high percentage of single rooms providing en-suite facilities for parents staying with their child •an inner court yard play area •a drop off point outside.	support@tchc.org.uk 0114 271 7203	http://www.tchc.org.uk/makeitbetter http://www.sheffieldchildrens.nhs.uk/about-us/hospital-redevelopment/ http://spractis.wordpress.com/2012/11/06/avanti-architects-children-hospital-in-sheffield/
NHS Greater Glasgow and Clyde	UK	2015	£751,950,000 (for the integrated adults and children's hospital)	Publically funded	This will provide A&E services and a comprehensive range of inpatient and day case specialist medical and surgical paediatric services on a local, regional and national basis. The new development will also have outpatient facilities. The care strategy is that all of Glasgow's Children's Services (up to the age of 16 and up to 18 years where appropriate) will be provided at the New Children's Hospital. Of the 256 beds planned, around 20% of the beds will be for day patients and the balance for in-patient requirements. Key components of the facility include: a) Outpatient Accommodation - Full range of Children's outpatient clinics including audiology, general paediatrics, orthopaedics, ENT etc b) Day Services - Circa 10 medical day beds; 4 dialysis stations and circa 15 day surgery beds c) Treatment & Diagnostic - Emergency Department, Imaging, 9 theatres, rehabilitation d) Clinical Support Services - Aseptic unit, pharmacy, medical physics, medical illustration (laboratory services linked to hospital by underground route and pneumatic tube system and e) Non Clinical Support Services - Facilities, ancillary services, administration, spiritual services, medical records, staff change, main entrance,	Mairi Macleod 0141 245 5700 Mairi.Macleod@ggc.scot.nhs.uk	Children's Hospital part of a £842m project to fund new Laboratory Building, and integrated children's and adult hospital. http://www.nhsggc.org.uk/content/default.asp?page=home_southerngeneralcampus
New Children's Hospital, Dublin	UK	2017/2018	484m-660m euros	National Lottery - 200m euros Capital budget - 360m euros 50m euros will be available in relation to ambulette care development.	The hospital will accommodate 445 beds, including in-patient and day care beds, which will meet the healthcare demands of the child population which is projected to peak in 2021. The configuration of these beds reflects current international best practice with more critical care and day care beds within the overall bed complement. The hospital, combines with its Ambulatory and Urgent Care Centres, will also provide out-patient, day care and emergency services to children and young people.	T: +353 1 6424720 E: info@nph.ie	http://www.rte.ie/news/2012/1106/344459-decision-on-new-childrens-hospital-due/ http://www.newchildrenshospital.ie/
Central Manchester	UK	2009	£500,000,000 (see notes)	Private Finance Initiative £400,000,000 Government Funding	The new children's hospital provides: - An integrated paediatric service to Greater Manchester and beyond - Latest medical equipment and information technology. - Play centre, schooling, family accommodation and adolescent facilities to cater for the needs of the whole family.	New Hospitals Development Office on 0161 276 4363	Part of a £500m redevelopment programme to redevelop 4 hospitals: manchester Children's Hospital, Manchester Royal Infirmary, St Marys Hospital for Women and Children, and Royal Eye Hospital
Alder Hey Children's Health Park	UK	2015	£237,000,000	Cash surpluses generated by Alder Hey NHS trust's Charity Private finance initiative - £104,000,000	The new hospital will have 270 beds, including 48 critical care beds. There will be six standard wards with 32 beds. Each ward will have two four-bed bays and 24 single rooms on each ward so the majority of children will have their own room with en-suite facilities. The development will also include a multi-storey car park with 1,200 spaces, 200 more than the current site.	0151 252 5367	http://www.placenorthwest.co.uk/news/archive/11703-new-alder-hey-to-open-in-2015.html http://www.ahchp.com/
Edinburgh Sick Kids	UK	2017	£150,000,000	Part of the NPD and hub initiative pipeline, supported by the Scottish Futures Trust, which will see £750 million of investment in health facilities across Scotland.	This new building will add to the existing facilities at Little France to create a centre of excellence, bringing paediatric care, specialist neonatal care, neurosciences and A&E together		The project is part of a £750m package to improve hospital and community health facilities across Scotland.

CHOP	USA	2017	£2 billion	£270 million bond sale	More than a million square feet of new space Plans unveiled today call for: -- Expansion of the Hospital's main inpatient facility at 34th Street and Civic Center Boulevard to include a new South Tower designed for expanded bed capacity. -- Major expansion on the west side of the main hospital facility to include space for operating rooms, clinical laboratories, a new pediatric imaging center, and additional diagnostic and support space. -- Ten additional floors on one wing of the Leonard and Madlyn Abramson Pediatric Research Center, adjacent to the Hospital. -- A new 450,000-square-foot building on the former Civic Center site that will house expanded capacity for ambulatory care and clinical research.		http://www.prnewswire.com/news-releases/the-childrens-hospital-of-philadelphia-issues-a-270-million-bond-sale-to-fund-future-expansion-projects-131876118.html

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
July 2013

Update on response to the report of the public inquiry into Mid Staffordshire NHS Foundation Trust **Submitted by:** Professor Martin Elliott, Co-Medical Director	**Paper No: Attachment K**

Aims / summary
This paper outlines the GOSH response to the Francis Report, and presents the Trust's action plan for approval.

Action required from the meeting
The board is asked to:

1. Note the approach outlined in this paper
2. Approve the action plan that is given in appendix A
3. Approve the Trust's response to the recommendations outlined in appendix B
4. Note that the progress against the action plan will be monitored by the Clinical Governance Committee, and that the Trust board will receive an annual report on progress.

Contribution to the delivery of NHS Foundation Trust strategies and plans
This action plan supports the trust's plans to deliver the best quality care, safely and effectively.

Financial implications
There are no specific financial implications of agreeing the action plan set out in this paper. The actions will be delivered within existing budgets.

Legal issues
We await further information on any legislative changes that may be adopted nationally in response to Francis.

Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place?
In the development of this action plan there has been consultant with: the members council, clinical divisions, PALS, Complaints, Legal and Finance teams.

Who needs to be told about any decision?
Divisional Directors, General Managers and Department Heads.

Who is responsible for implementing the proposals / project and anticipated timescales?
Each action in the plan has been assigned to a member of the executive team.

Who is accountable for the implementation of the proposal / project?
Professor Martin Elliott, co-Medical Director

The response to the report of the public inquiry into

Mid Staffordshire NHS Foundation Trust, chaired by Robert Francis QC.

1. Background:

1.1. In February 2013 the Report of the Public Inquiry into Mid Staffordshire NHS Foundation Trust was published. This was the second public inquiry into the care provided at the hospital, and it focused on the failings of the whole healthcare system which did not appropriately detect or act upon evidence of failure. In his letter accompanying the report, Sir Robert Francis QC, explains that the key aims of his recommendations are to:

- Foster a common culture shared by all in the service of putting the patient first;
- Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated;
- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff who have to provide the service;
- Ensure openness, transparency and candour throughout the system about matters of concern;
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards;
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service;
- Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field;
- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do;
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units, and provider organisations for the patients, the public and all other stakeholders.

1.2. The theme of the report is that patients, not numbers should be at the heart of how we provide, manage and oversee healthcare.

1.3. The report made 290 detailed recommendations for the NHS, the first of which was that: “All commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply

them to their own work; Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions." (Francis, rec 1)

1.4. This paper outlines the response of Great Ormond Street Hospital for Children NHS Foundation Trust to the Francis Report, and sets out the actions the Trust plans to take to ensure that learning from the public inquiry is embedded within the organisation. The paper will also explain the government's response to the recommendations, and how these will impact upon GOSH.

2. The Government's response to the Francis Report

2.1. The Department of Health (DoH) published a response to the Francis report in March 2013, in a paper entitled 'Patients first and foremost'. The paper makes it clear that policies will be made to ensure that providers, commissioners and oversight organisations spend more time focusing on patient care and patient experience, rather than financial performance or activity measurement. The government has made it clear that all those within the NHS need to consider how they can use the lessons from the public inquiry to improve patient care. This improvement must come through openness, transparency and listening to patients and families.

> "Every individual, every team and every organisation needs to reflect with openness and humility about how they use the lessons from what happened at Mid Staffordshire NHS Foundation Trust to make a meaningful difference for people who use their services and their staff, and on how they are transparent and honest in demonstrating the progress they make to the public."[1]

2.2. In the response to Francis, the DoH identifies four groups of people who are important in healthcare delivery. The report explains that patients and families are best placed to know when services are failing, and that frontline staff have individual responsibilities for building a positive culture and promoting high quality care. The DoH also outlines how leadership teams within hospitals have a responsibility for ensuring care is safe, and external organisations have a duty to measure what is truly important to patients. Having identified these four groups of people (patients, frontline staff, leadership teams and external organisations) the DoH outlines policies and changes that will respond to the Francis recommendations across the four layers. As an NHS organisation, GOSH will have to ensure that the Trust response to Francis takes into account the roles of these four groups in improving care.

2.3. The DoH response outlines a five point plan for improving care. These five areas are:

[1] 'Patients First and Foremost', Department of Health, published March 2013, p5. Available at: https://www.gov.uk/government/publications/government-initial-response-to-the-mid-staffs-report

A. Preventing problems
B. Detecting problems quickly
C. Taking action promptly
D. Ensuring robust accountability
E. Ensuring staff are motivated and trained

2.4. The key details within this plan are the appointment of a Chief Inspector of Hospitals, the streamlining of performance data collection and review, and placing more importance of patient complaints and feedback. The paper also outlines changes to nurse-training, and sets an expectation that Trust's will make progress with the implementation of the national nursing vision 'Compassion in Practice – 6 Cs'. The paper advocates for zero tolerance of 'avoidable harm', and that this will be embedded within all layers of the NHS.

2.5. 'Patients first and foremost' does not provide much detail on the specific actions Trust's should take in the wake of Francis, and there are likely to be further announcements regarding inspection, data and outcomes that will require attention from GOSH.

2.6. The Cavendish Review[2] into the role of Health Care Assistants (HCAs) and Support Workers was published in July 2013. The review makes 18 recommendations that aim to strengthen and codify the role of HCAs. At GOSH we have already published a code of conduct for HCAs and are working to improve training for this important group of staff.

3. GOSH approach to responding to the recommendations of the Francis Report

3.1. It is our intention to ensure that in everything we do, across every department at GOSH, for every patient, we provide the quality of care that we would want for our own family. This is implied in our Trust motto 'The child first and always', and the Francis working group aims to build upon the passionate commitment of our staff to ensure that we consistently deliver this aim.

3.2. An executive working group was established to co-ordinate GOSH's response to the Francis report. The group is chaired by Professor Martin Elliott, Co-Medical Director. The group consists of Liz Morgan, Chief Nurse, Cathy Cale, Divisional Director for ICILM, Anna Ferrant, Company Secretary, Lesley Miles Director of Communications, Ali Mohamed, Director of HR, Sarah Dobbing, General Manager for Neurosciences. The group reports to the Chief Executive.

3.3. The working group has completed the following actions:

- Reviewed the Francis report, and recommendations made.

[2] 'The Cavendish review: an independent review of healthcare assistants and support workings in NHS and social care settings' Department of Health, July 2013. Available at: https://www.gov.uk/government/publications/review-of-healthcare-assistants-and-support-workers-in-nhs-and-social-care

- Identified the recommendations which apply directly to GOSH, and categorised these. These can be seen in appendix B.
- Engaged with departments and individuals across the trust who are already working on issues related to the recommendations and involve them in taking forward any actions (thereby preventing duplication).
- Undertaken a workshop with the Trust members council to consider the lessons from the Francis report.
- Drafted an outline action plan to improve GOSH performance and processes in light of the recommendations.
- Reviewed the current information available (parents survey, staff survey, complaints information) that indicates how GOSH performs and where we need to focus attention.

3.4. The working group also ensured that any work being undertaken across the Trust that had a potential impact upon the quality of patient care and patient experience, or the themes highlighted by Francis, was aligned with the work of the group. The group has noted the divisional action plans which have been put in place in response to the staff and patient surveys, and also the listening event which took place on 22nd June.

4. GOSH performance against Francis priorities

4.1. The public inquiry showed that it is vital that NHS organisations listen to the opinions of staff and patients. The DoH response to Francis also emphasises the need to use the views of patients, relatives and frontline staff in analysing the performance of an organisation and identifying areas for improvement. The GOSH working group felt the Trust has access to many sources of feedback from patients, parents and staff. The group prioritised reviewing this information rather than gathering more information, as it was felt that we should focus on taking action on what we have already been told.

4.2. The key issues highlighted through this work were:

- Both parents and staff report high levels of general satisfaction with the service provided by GOSH;
- there is sometimes poor communication or co-ordination of care between different specialties at GOSH, and this causes problems for families;
- parents of children with special needs are likely to be more dissatisfied with the service they receive from GOSH;
- there is a feeling amongst staff that communication between senior managers and staff is not good, and that senior managers do not always act upon information;
- satisfaction with patient food is just 57%;
- parents felt unable to complain if they had a concern, or felt that GOSH did not encourage feedback.

4.3. A summary of the feedback and analysis of the results of surveys can be found in appendix C. This information has now been supplemented by further feedback from the listening

event, which brought together patients, families and staff to think about how we can improve services.

5. Interpreting the recommendations and making an action plan

5.1. As the Francis report and recommendations are very detailed, the working group felt it was important to organise the response by theme. This would enable the trust to communicate coherently with staff, patients, families and the public about our response to the Francis report and our planned actions.

5.2. The themes identified by the working group are:

- Values, culture and compassion.
- Listening.
- Candour.
- Quality and excellence
- Monitoring and measuring

5.3. Values, Culture and Compassion

5.4. Francis highlighted how important the culture of an organisation is to providing high-quality care. He also made it clear that culture plays a pivotal role in addressing problems when they have been identified. It is vital for GOSH to have a culture that promotes the best interests of the patients, respects and values staff and encourages openness and reporting of concerns. In the Francis action plan the working group has prioritised the implementation of the Trust's nursing vision which incorporates the national nursing strategy (published by DoH) that focuses on 6 Cs – care, compassion, competence, communication, courage and commitment. The Trust will also redevelop appraisal training for all staff groups that focuses on compassion and listening. The values-based-recruitment that is already used for nursing recruitment, and has been acclaimed by DoH, will be rolled out to other staff groups.

5.5. At the listening event staff, patients and parents were asked to contribute to the creation of the GOSH promise, which will encapsulate our commitment to patients, families and staff.

5.6. We recognise that we have many very dedicated and hard-working staff at GOSH. Their passion is reflected in the staff survey results. It is important that we foster and support their commitment, and never take it for granted. The Trust is introducing monthly staff awards to recognise and celebrate excellence. This will complement the annual awards.

5.7. Listening

5.8. As 'Patients first and foremost' points out, patients, families and frontline staff are in the best position to judge the quality of the service we provide. We have seen from our patient survey and from the research into the complaints process that parents of GOSH patients

are sometimes unwilling to complain or offer feedback even when they are dissatisfied with something. This may be because they are satisfied with other elements of the care, or because they do not want to alienate staff. It is imperative that the Trust finds more ways to elicit feedback from patients and parents, so that staff and families can work together to make improvements. As the Trust provides treatment in very stressful situations, it is important that staff are trained to deal with difficult conversations, and accept negative feedback in a positive manner.

5.9. It is also important that GOSH values its staff by listening to what they say, and then acting upon what it hears. If action is not possible, either in response to a patient complaint or staff feedback, it is imperative that the organisation is clear about why action cannot be taken.

5.10. Openness

5.11. Candour or being open is the most common theme in the Francis recommendations. Through the zero harm programme GOSH has tried to promote openness in reporting harm and incidents. It is important to take this work further now to ensure patients and families are engaged in investigating and understanding incidents. The staff survey highlighted that staff do not feel there is good communication across the organisational hierarchy, and this must be improved if the organisation is to consider itself open and transparent.

5.12. It is important that when there are problems or difficulties within the hospital, that this is discussed openly, and that clear decisions are made in a timely fashion. This helps to support staff morale, and ensures that staff and families know where they stand.

5.13. Quality and excellence

5.14. The Francis report highlights the need to well trained staff who are able to provide a quality service. It is important that the organisation understands it's capacity to deliver a safe service in each division, and that when there are fluctuations in activity or staffing levels then action is taken to ensure the service is safe. This can be difficult to assess, but it must be a constant consideration for divisional management and corporate teams. In the absence of simple rules which dictate how many staff are required per patient, GOSH will use best practice guidance and agree staffing levels with front-line staff. The organisation must listen to staff, and monitor indicators of safety to understand how staffing numbers affect patient care.

5.15. The working group identified that the co-ordination of care for patients who are seen by several specialities at GOSH can be problematic. There will be a renewed focus of running pilot projects to try to understand how we can improve care for these complex patients. The lead clinician project will aim to identify how we can that complex patients have one lead, co-ordinating their care.

5.16. The Francis report highlights that failings can occur when information indicating poor standards is not understood and acted upon swiftly. The Trust board and executive team must be mindful of the lessons of Francis, ensuring that when problems occur decisive action is taken swiftly, and communicated effectively to staff.

5.17. Monitoring

5.18. Both Francis and DoH make it clear that there need to be changes in the way performance of NHS organisations is monitored. We await further information on the details, but it is likely that there will increased focus on clinical outcomes. At GOSH we will continue to use outcome measures to review performance. The Trust is seeking to benchmark performance against other specialist children's hospitals both internationally. We have also redeveloped Key Performance Indicators and how these are reported to the board to ensure that they are transparent, and meaningful.

5.19. The Trust's response to the Francis report will be audited by the Internal Audit team, and progress against the action plan will be monitored at the Clinical Governance Committee.

6. Conclusions

6.1. The Francis working group has considered the recommendations from the Public Inquiry, and the response from the Department of Health. The recommendations that are relevant to GOSH, or those which might have an impact upon how we are regulated and inspected, have been assessed. In Appendix B we have set out our response to these recommendations.

6.2. The working group has also reviewed information about GOSH's current performance in light of Francis. The group has developed an action plan to embed the key issues of compassions, listening, openness and transparency in the running of the hospital. The action plan is given in appendix A.

7. Recommendation

7.1. The board is asked to:

- Note the approach outlined in this paper
- Approve the action plan that is given in appendix A
- Approve the Trust's response to the recommendations outlined in appendix B
- Note that the progress against the action plan will be monitored by the Clinical Governance Committee, and that the Trust board will receive an annual report on progress.

	Theme	using current information to improve services	additional information gathering	objective one	objective two	Objective three
A	Culture and compassion	1) staff survey - high engagement, staff report bullying and harassment in line with national average 2) patient survey - reduction in some areas - professionals taking concerns seriously. MDTS + neuro perform worse	1) listening event to gain information from patients, parents and staff	Implement nursing vision that focuses on 6 Cs (including compassion). Embed this vision across the hospital. **Liz Morgan**	Develop appraisal refresher training that focuses on compassion, listening and openness. Focus on understanding feelings around bullying. Ensure line-managers attend every 2 years. **Ali Mohamed**	Roll-out values-based recruitment to all staff groups. **Ali Mohamed**
B	Listening	1) complaints review - parents do not feel able to complain 2) patient survey - professionals taking concerns seriously.	1) listening event to gain information from parents and staff.	All divisional SMTs to perform weekly 'walkabouts' of their areas to listen to staff and patients concerns. **Rachel Williams**	Introduce 'real time' feedback for parents and patients, and ensure there are mechanisms in place to act on information swiftly. **Liz Morgan / Cym Moore**	Develop framework and training on 'active listening' for staff. Consider how we can use and evaluate 'what matter's most to you?' into daily clinical care. **Liz Morgan**
C	Openness	1) patient survey - professionals not taking concerns seriously		Develop guidelines and training for clinicians to support communication when families give feedback, or when errors have been made. **Martin Elliott**	Publish feedback, complaints and incident information on the GOSH website. **Martin Elliott / Cym Moore**	Introduce team brief to share information and encourage engagement with staff. **Cym Moore**
D	Quality and excellence	1) staff survey - staff report high level of risk.	1) clinical outcomes measurement - move to reviewing results, not just counting outcome measures.	Ensure all teams and departments include items on all meetings agenda's to discuss openness, listening (to staff and parents), and compassion. **Rachel Williams**	Pilot 'lead clinician' model for complex patients in one specialty and evaluate how this could be rolled out across the Trust. **Martin Elliott**	
E	Monitoring	1) monitoring of action plans for patient and staff surveys - not previously integrated with unit plans. Now needs to be integrated.		Implement monthly performance reviews that review performance against key quality indicators. Ensure specialties have meaningful metrics for quality and safety. **Robbie Burns**	Redevelop board KPI reports to ensure transparency. **Robbie Burns**	

This document outlines the GOSH response to a selection of the relevant Francis recommendations

Rec Num.	Recommendation	GOSH Response	GOSH Theme					
			Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
1	It is recommended that:All commissioning, service provision regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work; Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions; In addition to taking such steps for itself, the Department of Health should collate information about the decisions and actions generally and publish on a regular basis but not less than once a year the progress reported by other organisations; The House of Commons Select Committee on Health should be invited to consider incorporating into its reviews of the performance of organisations accountable to Parliament a review of the decisions and actions they have taken with regard to the recommendations in this report	We have complied with this recommendation by forming a working group and reviewing the Francis report						
2	It is recommended that:The NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in everything done. This requires: y A common set of core values and standards shared throughout the system; y Leadership at all levels from ward to the top of the Department of Health, committed to and capable of involving all staff with those values and standards; y A system which recognises and applies the values of transparency, honesty and candour; y Freely available, useful, reliable and full information on attainment of the values and standards; y A tool or methodology such as a cultural barometer to measure the cultural health of all parts of the system.	We accept this recommendation and will ensure that we focus on building and supporting a strong culture and set of values.						
3	The NHS Constitution should be the first reference point for all NHS patients and staff and should set out the system's common values, as well as the respective rights, legitimate expectations and obligations of patients.	We note this recommendation and the updated NHS constitution.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
4	The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.	We note this recommendation and that it is reflected in the GOSH motto 'The child first and always'.						
5	In reaching out to patients, consideration should be given to including expectations in the NHS Constitution that: y Staff put patients before themselves; y They will do everything in their power to protect patients from avoidable harm; y They will be honest and open with patients regardless of the consequences for themselves; y Where they are unable to provide the assistance a patient needs, they will direct them where possible to those who can do so; y They will apply the NHS values in all their work.	We note this recommendation.						
7	All NHS staff should be required to enter into an express commitment to abide by the NHS values and the Constitution, both of which should be incorporated into the contracts of employment.	We will review our recruitment and employment requirements, and assess how this can be incorporated into contracts for new members of staff.						
8	Contractors providing outsourced services should also be required to abide by these requirements and to ensure that staff employed by them for these purposes do so as well. These requirements could be included in the terms on which providers are commissioned to provide services.	We note this recommendation and will consider how it can be implemented in our contracts with outside providers.						
11	Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work. Their managers need to ensure that their employees comply with these requirements. Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manager within the trust, with external support where necessary. Professional bodies should work on devising evidence-based standard procedures for as many interventions and pathways as possible.	We note this recommendation. At GOSH we will continue to support clinicians to be involved in developing local and national standards and policies.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
12	Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.	At GOSH we already encourage staff to report incidents through DATIX and staff response to the annual survey indicates a high level of understanding of risk.						
13	Standards should be divided into: y Fundamental standards of minimum safety and quality – in respect of which non-compliance should not be tolerated. Failures leading to death or serious harm should remain offences for which prosecutions can be brought against organisations. There should be a defined set of duties to maintain and operate an effective system to ensure compliance; y Enhanced quality standards – such standards could set requirements higher than the fundamental standards but be discretionary matters for commissioning and subject to availability of resources; y Developmental standards which set out longer term goals for providers – these would focus on improvements in effectiveness and are more likely to be the focus of commissioners and progressive provider leadership than the regulator. All such standards would require regular review and modification.	We note this recommendation						
17	The NHS Commissioning Board together with Clinical Commissioning Groups should devise enhanced quality standards designed to drive improvement in the health service. Failure to comply with such standards should be a matter for performance management by commissioners rather than the regulator, although the latter should be charged with enforcing the provision by providers of accurate information about compliance to the public.	We note this recommendation and will strive to meet any standards that are set.						
36	A coordinated collection of accurate information about the performance of organisations must be available to providers, commissioners, regulators and the public, in as near real time as possible, and should be capable of use by regulators in assessing the risk of non-compliance. It must not only include statistics about outcomes, but must take advantage of all safety related information, including that capable of being derived from incidents, complaints and investigations.	We note this recommendation and will strive to provide helpful and honest information to all necessary organisations.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
37	Trust Boards should provide, through quality accounts, and in a nationally consistent format, full and accurate information about their compliance with each standard which applies to them. To the extent that it is not practical in a written report to set out detail, this should be made available via each trust's website. Reports should no longer be confined to reports on achievements as opposed to a fair representation of areas where compliance has not been achieved. A full account should be given as to the methods used to produce the information. To make or be party to a wilfully or recklessly false statement as to compliance with safety or essential standards in the required quality account should be made a criminal offence.	We note this recommendation and wil ensure our quality account meets a national format if this is provided.						
40	It is important that greater attention is paid to the narrative contained in, for instance, complaints data, as well as to the numbers.	We note this recommendation. At GOSH we already provide detailed narrative and qualitative analysis of the issues raised by complaints.						
45	The Care Quality Commission should be notified directly of upcoming healthcare-related inquests, either by trusts or perhaps more usefully by coroners.	We note this recommendation. We do not currently do this, but could do so if we were given guidance on the type of information and format required.						
62	For as long as it retains responsibility for the regulation of foundation trusts, Monitor should incorporate greater patient and public involvement into its own structures, to ensure this focus is always at the forefront of its work.	We note this recommendation.						
74	Monitor and the Care Quality Commission should publish guidance for governors suggesting principles they expect them to follow in recognising their obligation to account to the public, and in particular in arranging for communication with the public served by the foundation trust and to be informed of the public's views about the services offered.	We will await this guidance and will support the members council in meeting their obligations.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
75	The Council of Governors and the board of each foundation trust should together consider how best to enhance the ability of the council to assist in maintaining compliance with its obligations and to represent the public interest. They should produce an agreed published description of the role of the governors and how it is planned that they perform it. Monitor and the Care Quality Commission should review these descriptions and promote what they regard as best practice.	We note this recommendation. We have a terms of reference which explains the role of the council, and are working to redevelop this to ensure it is more descriptive.						
76	Arrangements must be made to ensure that governors are accountable not just to the immediate membership but to the public at large – it is important that regular and constructive contact between governors and the public is maintained.	We note this recommendation. The GOSH members council are aware of the requirement to consider how to represent the public at large. However, we believe as a national hospital it is difficult for members to be effectively accountable to the whole area we serve.						
79	There should be a requirement that all directors of all bodies registered by the Care Quality Commission as well as Monitor for foundation trusts are, and remain, fit and proper persons for the role. Such a test should include a requirement to comply with a prescribed code of conduct for directors.	The board has noted this recommendation, and will comply with any process that is implemented.						
86	A requirement should be imposed on foundation trusts to have in place an adequate programme for the training and continued development of directors.	We note this recommendation and will continue to provide development and training to directors.						
88	The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations should be made available to healthcare regulators through the serious untoward incident system in order to provide a check on the consistency of trusts' practice in reporting fatalities and other serious incidents.	We note this recommendation.						
89	Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive.	We note this recommendation and will await further guidance on whether this is adopted nationally and how we should provide the information.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
91	The Department of Health and NHS Commissioning Board should consider what steps are necessary to require all NHS providers, whether or not they remain members of the NHS Litigation Authority scheme, to have and to comply with risk management standards at least as rigorous as those required by the NHS Litigation Authority.	We note this recommendation. GOSH achieved level 3 in 2012 and will continue to prioritise compliance with NHSLA standard to support patient safety.						
93	The NHS Litigation Authority should introduce requirements with regard to observance of the guidance to be produced in relation to staffing levels, and require trusts to have regard to evidence-based guidance and benchmarks where these exist and to demonstrate that effective risk assessments take place when changes to the numbers or skills of staff are under consideration. It should also consider how more outcome based standards could be designed to enhance the prospect of exploring deficiences in risk management, such as occurred at the Trust.	We note this recommendation and will await guidance on how this will be applied. We will continue to review staffing levels to ensure they meet best practice requirements.						
95	As the interests of patient safety should prevail over the narrow litigation interest under which confidentiality or even privilege might be claimed over risk reports, consideration should also be given to allowing the Care Quality Commission access to these reports.	We note this recommendation and will comply with information sharing as instructed.						
98	Reporting to the National Reporting and Learning System of all significant adverse incidents not amounting to serious untoward incidents but involving harm to patients should be mandatory on the part of trusts.	We note this recommendation and will continue to share learning with the paediatric risk management forum. We will await further guidance on how we can comply with reporting requirements.						
109	Methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its conclusion, although all such methods should trigger a uniform process, generally led by the provider trust.	We note this recommendation and will ensure we have more diverse methods for receiving feedback, and acting appropriately upon what we hear. This forms part of the Francis action plan.						
110	Actual or intended litigation should not be a barrier to the processing or investigation of a complaint at any level. It may be prudent for parties in actual or potential litigation to agree to a stay of proceedings pending the outcome of the complaint, but the duties of the system to respond to complaints should be regarded as entirely separate from the considerations of litigation.	We note this recommendation, and will continue to ensure that we are providing information to families regardless of litigation.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
111	Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints; constant encouragement should be given to patients and other service users, individually and collectively, to share their comments and criticisms with the organisation.	We note this recommendation and will ensure we have more diverse methods for receiving feedback, and acting appropriately upon what we hear. This forms part of the Francis action plan.						
112	Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as a formal complaint, whether or not the informant has indicated a desire to have the matter dealt with as such.	We note this recommendation. At GOSH we are already reviewing complaints, PALS concerns and patient feedback and conduct RCA reviews if appropriate.						
113	The recommendations and standards suggested in the Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS.	We note this recommendation and await further guidance on how this might be implemented.						
114	Comments or complaints which describe events amounting to an adverse or serious untoward incident should trigger an investigation.	At GOSH we already comply with this recommendation as all complaints that contain serious concerns are reviewed to consider whether they should be investigated as RCA or SI.						
115	Arms-length independent investigation of a complaint should be initiated by the provider trust where any one of the following apply: y A complaint amounts to an allegation of a serious untoward incident; y Subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion; y A complaint raises substantive issues of professional misconduct or the performance of senior managers; y A complaint involves issues about the nature and extent of the services commissioned.	We note this recommendation and will consider how it can be complied with. We do occasionally use external organisations or individuals to review complaints or incidents, where this is considered helpful. However we note that it can be difficult for external experts to understand services they do not work in, and it takes time to develop this understanding. It is therefore important that sufficient time is devoted to reviews.						
116	Where meetings are held between complainants and trust representatives or investigators as part of the complaints process, advocates and advice should be readily available to all complainants who want those forms of support.	We note this recommendation and will continue to ensure parents and patients are supported when attending meetings.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
118	Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response should be published on its website. In any case where the complainant or, if different, the patient, refuses to agree, or for some other reason publication of an upheld, clinically related complaint is not possible, the summary should be shared confidentially with the Commissioner and the Care Quality Commission.	We note this recommendation and are working towards meeting this.						
119	Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality.	We note this recommendation and await further guidance on how this might be implemented.						
121	The Care Quality Commission should have a means of ready access to information about the most serious complaints. Their local inspectors should be charged with informing themselves of such complaints and the detail underlying them.	We note this recommendation and await further guidance on how this might be implemented.						
122	Large-scale failures of clinical service are likely to have in common a need for: y Provision of prompt advice, counselling and support to very distressed and anxious members of the public; y Swift identification of persons of independence, authority and expertise to lead investigations and reviews; y A procedure for the recruitment of clinical and other experts to review cases; y A communications strategy to inform and reassure the public of the processes being adopted; y Clear lines of responsibility and accountability for the setting up and oversight of such reviews. Such events are of sufficient rarity and importance, and requiring of coordination of the activities of multiple organisations, that the primary responsibility should reside in the National Quality Board.	We note this recommendation.						
125	In addition to their duties with regard to the fundamental standards, commissioners should be enabled to promote improvement by requiring compliance with enhanced standards or development towards higher standards. They can incentivise such improvements either financially or by other means designed to enhance the reputation and standing of clinicians and the organisations for which they work.	We note this recommendation and await further guidance on how this might be implemented.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
129	In selecting indicators and means of measuring compliance, the principal focus of commissioners should be on what is reasonably necessary to safeguard patients and to ensure that at least fundamental safety and quality standards are maintained. This requires close engagement with patients, past, present and potential, to ensure that their expectations and concerns are addressed.	We note this recommendation and await further guidance on how this might be implemented.						
132	Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis during the contract period: y Such monitoring may include requiring quality information generated by the provider. y Commissioners must also have the capacity to undertake their own (or independent) audits, inspections, and investigations. These should, where appropriate, include investigation of individual cases and reviews of groups of cases. y The possession of accurate, relevant, and useable information from which the safety and quality of a service can be ascertained is the vital key to effective commissioning, as it is to effective regulation. y Monitoring needs to embrace both compliance with the fundamental standards and with any enhanced standards adopted. In the case of the latter, they will be the only source of monitoring, leaving the healthcare regulator to focus on fundamental standards.	We note this recommendation and await further guidance on how this might be implemented.						
139	The first priority for any organisation charged with responsibility for performance management of a healthcare provider should be ensuring that fundamental patient safety and quality standards are being met. Such an organisation must require convincing evidence to be available before accepting that such standards are being complied with.	We note this recommendation and await further guidance on how this might be implemented.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
143	Metrics need to be established which are relevant to the quality of care and patient safety across the service, to allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed.	We note this recommendation. As a specialist hospital we understand that it difficult to use metrics on safety which are meaningful. We believe the best way to take this forward is through networks of specialist providers on a specialty specific level. We are taking this forward through an international benchmarking exercise.						
144	The NHS Commissioning Board should ensure the development of metrics on quality and outcomes of care for use by commissioners in managing the performance of providers, and retain oversight of these through its regional offices, if appropriate.	We note this recommendation and await further guidance on how this might be implemented.						
152	Any organisation which in the course of a review, inspection or other performance of its duties, identifies concerns potentially relevant to the acceptability of training provided by a healthcare provider, must be required to inform the relevant training regulator of those concerns.	We note this recommendation and await further guidance on how this might be implemented.						
153	The Secretary of State should by statutory instrument specify all medical education and training regulators as relevant bodies for the purpose of their statutory duty to cooperate. Information sharing between the deanery, commissioners, the General Medical Council, the Care Quality Commission and Monitor with regard to patient safety issues must be reviewed to ensure that each organisation is made aware of matters of concern relevant to their responsibilities.	We note this recommendation and await further guidance on how this might be implemented.						
156	The system for approving and accrediting training placement providers and programmes should be configured to apply the principles set out above.	We note this recommendation and await further guidance on how this might be implemented.						
158	The General Medical Council should amend its standards for undergraduate medical education to include a requirement that providers actively seek feedback from students and tutors on compliance by placement providers with minimum standards of patient safety and quality of care, and should generally place the highest priority on the safety of patients.	We note this recommendation and will respond to any change in the requirements of the GMC.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
159	Surveys of medical students and trainees should be developed to optimise them as a source of feedback of perceptions of the standards of care provided to patients. The General Medical Council should consult the Care Quality Commission in developing the survey and routinely share information obtained with healthcare regulators.	We note this recommendation and will respond to any requirements from the GMC and CQC.						
160	Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.	We note this recommendation and will continue to support the junior doctor representive committee, and all trainees to raise concerns.						
161	Training visits should make an important contribution to the protection of patients: y Obtaining information directly from trainees should remain a valuable source of information – but it should not be the only method used. y Visits to, and observation of, the actual training environment would enable visitors to detect poor practice from which both patients and trainees should be sheltered. y The opportunity can be taken to share and disseminate good practice with trainers and management. Visits of this nature will encourage the transparency that is so vital to the preservation of minimum standards.	We note this recommendation and await further guidance on how this might be implemented.						
162	The General Medical Council should in the course of its review of its standards and regulatory process ensure that the system of medical training and education maintains as its first priority the safety of patients. It should also ensure that providers of clinical placements are unable to take on students or trainees in areas which do not comply with fundamental patient safety and quality standards. Regulators and deaneries should exercise their own independent judgement as to whether such standards have been achieved and if at any stage concerns relating to patient safety are raised to the, must take appropriate action to ensure these concerns are properly addressed.	We note this recommendation and await further guidance on how this might be implemented.						
173	Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.	We note this recommendation and will endeavour to embed it within the Trust-wide work on culture, openness and values.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
174	Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.	We note this recommendation. The Trust has a 'Being Open' policy and will continue to ensure that incident investigations include patients and parents where they wish to be included. We understand that some patients and families will not wish to be included, but will ensure that if they change their minds.						
175	Full and truthful answers must be given to any question reasonably asked about his or her past or intended treatment by a patient (or, if deceased, to any lawfully entitled personal representative).	We note this recommendation.						
177	Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.	The board has noted this recommendation, and will comply with it.						
178	The NHS Constitution should be revised to reflect the changes recommended with regard to a duty of openness, transparency and candour, and all organisations should review their contracts of employment, policies and guidance to ensure that, where relevant, they expressly include and are consistent with above principles and these recommendations.	We note this recommendation and await further guidance on how this might be implemented.						
179	“Gagging clauses” or non disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.	We note this recommendation. We do not believe we have ever 'gagged' a member staff to prevent them from raising patient safety concerns. There may be confusion with confidentialty clauses.						
180	Guidance and policies should be reviewed to ensure that they will lead to compliance with Being Open, the guidance published by the National Patient Safety Agency.	We note this recommendation and will continue to ensure that incident investigations include patients and parents where they wish to be included. We understand that some patients and families will not wish to be included, but will ensure that if they change their mind in the future they are entitled to full details of the investigation.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
181	A statutory obligation should be imposed to observe a duty of candour: y On healthcare providers who believe or suspect that treatment or care provided by it to a patient has caused death or serious injury to a patient to inform that patient or other duly authorised person as soon as is practicable of that fact and thereafter to provide such information and explanation as the patient reasonably may request; y On registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable. The provision of information in compliance with this requirement should not of itself be evidence or an admission of any civil or criminal liability, but non-compliance with the statutory duty should entitle the patient to a remedy.	We note this recommendation and await further guidance on how this might be implemented.						
182	There should be a statutory duty on all directors of healthcare organisations to be truthful in any information given to a healthcare regulator or commissioner, either personally or on behalf of the organisation, where given in compliance with a statutory obligation on the organisation to provide it.	The board has noted this recommendation, and will comply with any process that is implemented.						
183	It should be made a criminal offence for any registered medical practitioner, or nurse, or allied health professional or director of an authorised or registered healthcare organisation: y Knowingly to obstruct another in the performance of these statutory duties; y To provide information to a patient or nearest relative intending to mislead them about such an incident; y Dishonestly to make an untruthful statement to a commissioner or regulator knowing or believing that they are likely to rely on the statement in the performance of their duties.	We note this recommendation and will act upon any guidance or process that is implemented.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
184	Observance of the duty should be policed by the Care Quality Commission, which should have powers in the last resort to prosecute in cases of serial non-compliance or serious and wilful deception. The Care Quality Commission should be supported by monitoring undertaken by commissioners and others.	We note this recommendation and await further guidance on how this might be implemented.						
185	There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires: y Selection of recruits to the profession who evidence the: – Possession of the appropriate values, attitudes and behaviours; – Ability and motivation to enable them to put the welfare of others above their own interests; – Drive to maintain, develop and improve their own standards and abilities; – Intellectual achievements to enable them to acquire through training the necessary technical skills; y Training and experience in delivery of compassionate care; y Leadership which constantly reinforces values and standards of compassionate care; y Involvement in, and responsibility for, the planning and delivery of compassionate care; y Constant support and incentivisation which values nurses and the work they do through: – Recognition of achievement; – Regular, comprehensive feedback on performance and concerns; – Encouraging them to report concerns and to give priority to patient well-being.	We note this recommendation and already practice 'values based' recruitment for nursing staff. We plan to extend this to other staff groups.						
190	There should be national training standards for qualification as a registered nurse to ensure that newly qualified nurses are competent to deliver a consistent standard of the fundamental aspects of compassionate care.	We note this recommendation and await further guidance on how this might be implemented.						
191	Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates' values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements.	We note this recommendation and already practice 'values based' recruitment for nursing staff. We plan to extend this to other staff groups.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
194	As part of a mandatory annual performance appraisal, each Nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio an up-to-date knowledge of nursing practice and its implementation. Alongside developmental requirements, this should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients, evidenced by feedback from patients and families on the care provided by the nurse. This portfolio and each annual appraisal should be made available to the Nursing and Midwifery Council, if requested, as part of a nurse's revalidation process. At the end of each annual assessment, the appraisal and portfolio should be signed by the nurse as being an accurate and true reflection and be countersigned by their appraising manager as being such.	We note this recommendation and will respond to any national guidance on how to implement it.						
195	Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal.	We note this recommendation and are considering this requirement within our review of nursing establishments that is being undertaken in 2013. We note that in small clinical areas it is sometimes necessary for ward managers to work clinically, however this should not prevent them from meeting the requirements of being available to patients and families.						
197	Training and continuing professional development for nurses should include leadership training at every level from student to director. A resource for nurse leadership training should be made available for all NHS healthcare provider organisations that should be required under commissioning arrangements by those buying healthcare services to arrange such training for appropriate staff.	We note this recommendation and will continue to provide leadership training for nurses.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
198	Healthcare providers should be encouraged by incentives to develop and deploy reliable and transparent measures of the cultural health of front-line nursing workplaces and teams, which build on the experience and feedback of nursing staff using a robust methodology, such as the “cultural barometer”.	We note this recommendation and will await further information and instruction on whether this will be applied nationally.						
199	Each patient should be allocated for each shift a named key nurse responsible for coordinating the provision of the care needs for each allocated patient. The named key nurse on duty should, whenever possible, be present at every interaction between a doctor and an allocated patient.	We note this recommendation and believe that we already comply with this requirement.						
202	Recognition of the importance of nursing representation at provider level should be given by ensuring that adequate time is allowed for staff to undertake this role, and employers and unions must regularly review the adequacy of the arrangements in this regard.	We note this recommendation.						
205	Commissioning arrangements should require the boards of provider organisations to seek and record the advice of its nursing director on the impact on the quality of care and patient safety of any proposed major change to nurse staffing arrangements or provision facilities, and to record whether they accepted or rejected the advice, in the latter case recording its reasons for doing so.	We note this recommendation and await further guidance on how this might be implemented.						
207	There should be a uniform description of healthcare support workers, with the relationship with currently registered nurses made clear by the title	We note this recommendation. We already have a plan for training HCA's here that is becoming increasingly embedded. In 2013 we launched a Code of Conduct for all HCA's to guide them in their role.						
208	Commissioning arrangements should require provider organisations to ensure by means of identity labels and uniforms that a healthcare support worker is easily distinguishable from that of a registered nurse.	We note this recommendation and already comply with it as we have a clear uniform policy which differentiates staff of different professionals and qualifications.						
210	There should be a national code of conduct for healthcare support workers.	We note this recommendation and already have in place a GOSH code of conduct for HCAs. If there is national guidance on what this should include we will endeavour to include it.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
214	A leadership staff college or training system, whether centralised or regional, should be created to: provide common professional training in management and leadership to potential senior staff; promote healthcare leadership and management as a profession; administer an accreditation scheme to enhance eligibility for consideration for such roles; promote and research best leadership practice in healthcare.	We note this recommendation and if such a system is implemented will support our managers and leaders to engage.						
215	A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it.	We note this recommendation and will await further guidance on whether this is adopted nationally and how we should comply.						
216	The leadership framework should be improved by increasing the emphasis given to patient safety in the thinking of all in the health service. This could be done by, for example, creating a separate domain for managing safety, or by defining the service to be delivered as a safe and effective service.	We note this recommendation and will await further guidance on whether this is adopted nationally and how we should comply.						
217	A list should be drawn up of all the qualities generally considered necessary for a good and effective leader. This in turn could inform a list of competences a leader would be expected to have.	We note this recommendation and await further guidance on how this might be implemented.						
218	Serious non-compliance with the code, and in particular, non-compliance leading to actual or potential harm to patients, should render board-level leaders and managers liable to be found not to be fit and proper persons to hold such positions by a fair and proportionate procedure, with the effect of disqualifying them from holding such positions in future.	We note this recommendation and await further guidance on how this might be implemented.						
221	Consideration should be given to ensuring that there is regulatory oversight of the competence and compliance with appropriate standards by the boards of health service bodies which are not foundation trusts, of equivalent rigour to that applied to foundation trusts.	We note this recommendation and await further guidance on how this might be implemented.						
222	The General Medical Council should have a clear policy about the circumstances in which a generic complaint or report ought to be made to it, enabling a more proactive approach to monitoring fitness to practise.	We note this recommendation and will await further guidance on whether this is adopted nationally and how we should comply.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
229	It is highly desirable that the Nursing and Midwifery Council introduces a system of revalidation similar to that of the General Medical Council, as a means of reinforcing the status and competence of registered nurses, as well as providing additional protection to the public. It is essential that the Nursing and Midwifery Council has the resources and the administrative and leadership skills to ensure that this does not detract from its existing core function of regulating fitness to practise of registered nurses.	We note this recommendation and will await further guidance on whether this is adopted nationally and how we should comply.						
230	The profile of the Nursing and Midwifery Council needs to be raised with the public, who are the prime and most valuable source of information about the conduct of nurses. All patients should be informed, by those providing treatment or care, of the existence and role of the Nursing and Midwifery Council, together with contact details. The Nursing and Midwifery Council itself needs to undertake more by way of public promotion of its functions.	we note this recommendation.						
236	Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care.	We note this recommendation and in 2013-14 we will conduct an improvement project to assess how we can improve the identification of 'lead clinicians' for complex patients.						
237	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	We note this recommendation and will consider how it can be applied to our patient group, or although not elderly, are vulnerable.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
238	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds: y All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors. y Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients. y The NHS should develop a greater willingness to communicate by email with relatives. y The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered. y Information about an older patient's condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled.	We note this recommendation. We are working to implement and embed Trust Nursing Vision which embraces national 6C's Nursing vision. The hospital is working to improve the process of writing discharge summaries that are meaningful for referrers and families.						
239	The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provide continued care to the patient.	We note this recommendation and will continue to work with referrers and network partners to ensure care is safe after discharge from GOSH.						
240	All staff and visitors need to be reminded to comply with hygiene requirements. Any member of staff, however junior, should be encouraged to remind anyone, however senior, of these.	We note this recommendation and will continue to promote good hygiene standards.						
241	The arrangements and best practice for providing food and drink to elderly patients require constant review, monitoring and implementation.	We note this recommendation and will consider how it can be applied to our patient group, or although not elderly, are vulnerable. We will continue to monitor nutrician for patients, and strive to improve food for patients.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
242	In the absence of automatic checking and prompting, the process of the administration of medication needs to be overseen by the nurse in charge of the ward, or his/her nominated delegate. A frequent check needs to be done to ensure that all patients have received what they have been prescribed and what they need. This is particularly the case when patients are moved from one ward to another, or they are returned to the ward after treatment.	We note this recommendation and will continue to monitor medication processes to improve safety.						
243	The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded.	We note this recommendation and will continue to investigate how this can be implemented.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
244	There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems: y Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way. y Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to accurate recording of information on first entry. y Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered. y Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input. y Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements. Systems must be capable of reflecting changing needs and local requirements over and above nationally required minimum standards.	We note this recommendation and will comply with information sharing as instructed. We already seek to benchmark our performance against other specialist childrens hospitals nationally and internationally.						
245	Each provider organisation should have a board level member with responsibility for information.	We already comply with this recommendation.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
246	Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality accounts should be required to contain the observations of commissioners, overview and scrutiny committees, and Local Healthwatch.	We note this recommendation and will comply with any guidance published.						
248	Healthcare providers should be required to have their quality accounts independently audited. Auditors should be given a wider remit enabling them to use their professional judgement in examining the reliability of all statements in the accounts.	We note this recommendation and will await further guidance on whether this is adopted nationally and how we should comply.						
249	Each quality account should be accompanied by a declaration signed by all directors in office at the date of the account certifying that they believe the contents of the account to be true, or alternatively a statement of explanation as to the reason any such director is unable or has refused to sign such a declaration.	We note this recommendation and will comply with any guidance published.						
250	It should be a criminal offence for a director to sign a declaration of belief that the contents of a quality account are true if it contains a misstatement of fact concerning an item of prescribed information which he/she does not have reason to believe is true at the time of making the declaration.	The board notes this recommendation.						
251	The Care Quality Commission and/or Monitor should keep the accuracy, fairness and balance of quality accounts under review and should be enabled to require corrections to be issued where appropriate. In the event of an organisation failing to take that action, the regulator should be able to issue its own statement of correction.	We note this recommendation and await further guidance on how this might be implemented.						
255	Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near “real time” as possible, even if later adjustments have to be made.	We note this recommendation. The Francis action plan includes a commitment to collect real time patient feedback and seek information from patients and parents in a variety of ways.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
256	A proactive system for following up patients shortly after discharge would not only be good “customer service”, it would probably provide a wider range of responses and feedback on their care.	We note this recommendation and will consider how it can be applied to our developing processes for receiving patient feedback in real time.						
260	The standards applied to statistical information about serious untoward incidents should be the same as for any other healthcare information and in particular the principles around transparency and accessibility. It would, therefore, be desirable for the data to be supplied to, and processed by, the Information Centre and, through them, made publicly available in the same way as other quality related information.	We note this recommendation and await further guidance on how this might be implemented.						
262	All healthcare provider organisations, in conjunction with their healthcare professionals, should develop and maintain systems which give them: y Effective real-time information on the performance of each of their services against patient safety and minimum quality standards; y Effective real-time information of the performance of each of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction. In doing so, they should have regard, in relation to each service, to best practice for information management of that service as evidenced by recommendations of the Information Centre, and recommendations of specialist organisations such as the medical Royal Colleges. The information derived from such systems should, to the extent practicable, be published and in any event made available in full to commissioners and regulators, on request, and with appropriate explanation, and to the extent that is relevant to individual patients, to assist in choice of treatment.	We note this recommendation and the Trust has already improved it's performance reporting. We will continue to review this and will implement guidance as it is published.						
263	It must be recognised to be the professional duty of all healthcare professionals to collaborate in the provision of information required for such statistics on the efficacy of treatment in specialties.	We note this recommendation. At GOSH we will continue with the programme of clinical outcomes, and bench-marking of outcome information.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
264	In the case of each specialty, a programme of development for statistics on the efficacy of treatment should be prepared, published, and subjected to regular review.	We note this recommendation. GOSH has already developed clinical outcomes for each specialty and is seeking to benchmark these with other specialist hospitals.						
265	The Department of Health, the Information Centre and the Care Quality Commission should engage with each representative specialty organisation in order to consider how best to develop comparative statistics on the efficacy of treatment in that specialty, for publication and use in performance oversight, revalidation, and the promotion of patient knowledge and choice.	We note this recommendation.						
266	In designing the methodology for such statistics and their presentation, the Department of Health, the Information Centre, the Care Quality Commission and the specialty organisations should seek and have regard to the views of patient groups and the public about the information needed by them.	We note this recommendation and will ensure we meet any new requirements.						
267	All such statistics should be made available online and accessible through provider websites, as well as other gateways such as the Care Quality Commission.	We note this requirement and will continue to publish information online.						
268	Resources must be allocated to and by provider organisations to enable the relevant data to be collected and forwarded to the relevant central registry.	We note this recommendation and will continue to resource data collection.						
269	The only practical way of ensuring reasonable accuracy is vigilant auditing at local level of the data put into the system. This is important work, which must be continued and where possible improved.	We note this recommendation.						
270	There is a need for a review by the Department of Health, the Information Centre and the UK Statistics Authority of the patient outcome statistics, including hospital mortality and other outcome indicators. In particular, there could be benefit from consideration of the extent to which these statistics can be published in a form more readily useable by the public.	We note this recommendation and will continue to engage with the national debate on outcome measures.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
271	To the extent that summary hospital-level mortality indicators are not already recognised as national or official statistics, the Department of Health and the Health and Social Care Information Centre should work towards establishing such status for them or any successor hospital mortality figures, and other patient outcome statistics, including reports showing provider-level detail.	We note this recommendation and will await further guidance on how this might be implemented and what will be required of GOSH.						
273	The terms of authorisation, licensing and registration and any relevant guidance should oblige healthcare providers to provide all relevant information to enable the coroner to perform his function, unless a director is personally satisfied that withholdingthe information is justified in the public interest	We note this recommendation and will continue to use our 'Being Open' policy.						
274	There is an urgent need for unequivocal guidance to be given to trusts and their legal advisers and those handling disclosure of information to coroners, patients and families, as to the priority to be given to openness over any perceived material interest.	We note this recommendation. The Legal Team at GOSH wish to promote a culture of openness, and support clinicians to provide helpful and honest information to coroners and families. We will review how we can best develop guidance for staff for this. We note that it can be difficult for clinicians to be open when patient care spans different hospitals, as clinicians do not want to comment on care provided in other hospitals when they do not have full access to facts.						
278	It should be a routine part of an independent medical examiners's role to seek out and consider any serious untoward incidents or adverse incident reports relating to the deceased, to ensure that all circumstances are taken into account whether or not referred to in the medical records.	We note this recommendation.						
279	So far as is practicable, the responsibility for certifying the cause of death should be undertaken and fulfilled by the consultant, or another senior and fully qualified clinician in charge of a patient's case or treatment.	We note this recommendation. We plan to develop further guidance for professionals in this area.						

Rec Num.	Recommendation	GOSH Response	Values and compassion	Candour	Listening	Quality excellence	Monitoring	other must do
280	Both the bereaved family and the certifying doctor should be asked whether they have any concerns about the death or the circumstances surrounding it, and guidance should be given to hospital staff encouraging them to raise any concerns they may have with the independent medical examiner.	We note this recommendation and will consider how we can provide appropriate guidance and advice to staff.						

Francis Working Group – what we already know about GOSH

Key messages from Patients

The Francis Report made it clear that Trusts should spend more time listening to patients, relatives and the public. It was highlighted that engagement with patients and the public should result in real change. The report emphasises the need to look beyond the figures from patient surveys, and spend more time understanding the narrative:

" *... the reaction was to look at the results as numbers to be improved if possible rather than to examine the underlying causes."*
"An approach to this sort of survey that accepts AVERAGE as acceptable or takes comfort from a majority of positive responses when the proportion of negative ones indicates a significant number of substandard episodes of treatment is likely to leave large numbers of patients being cared for badly."

(Par 6.451)

The Francis working group reviewed the information available from the national inpatient and staff surveys. It also looked at information coming from reviews of complaints, concerns raised with PALS and clinical incidents. The aim of this work was to understand the narrative of concerns raised by staff, patients and families. This work fed into the creation of the Francis action plan.

Key messages coming out of the GOSH inpatients survey

What's really positive

1. Patient and family satisfaction rates remain very strong, despite a small year on year decrease (93% 2013 vs 96% 2012)
   This is in the context of the overall NHS satisfaction rates which currently stands at 61% (see the King's Fund British Social Attitudes survey data for 2012)
   http://www.kingsfund.org.uk/press/press-releases/public-satisfaction-nhs-stabilises-after-record-fall
2. Patient and family advocacy rates (friends and family test) are very high at 96%. This is complemented by a 90% score from Trust staff in the staff survey.
3. Confidence in doctors (97%) and nurses (94%) remains extremely high- in previous work to identify the most important criteria for parents and young people, this was the most important driver of satisfaction.

What we need to think about/find out more about

1. In some questions there has been a reduction in the very highest scores given to the Trust although the overall scores are still very high. We need to consider why this has happened. In particular there was a reduction in respondents who 'strongly agree' that they have confidence in doctors and nurses, and also in the number of respondents saying that staff were 'very good' at taking concerns seriously and spending enough time with patients.

2. The Medicine Unit has been shown to be the lowest performing unit in a number of key indicators and we need to investigate this further to establish whether this is more marked in individual specialties in the unit. Patients and parents in MDTS were less likely than average to say:
    a. They knew how to offer feedback or complain
    b. That health professions were very good at spending time with them
    c. They feel doctors and nursing were very good at asking how they were feeling
    d. That doctors and nurses were very good at explaining why they needed tests and treatment
3. A significant proportion of respondents say they were kept awake at night by noise (27%). There has been previous work done looking at this, and it showed that most noise was related to medical and nursing tasks which had to be carried out, or noisy equipment.

What we need to improve

1. Parents of children with special needs are less satisfied than others. This is shown across a number of different questions.
2. We need to increase awareness amongst parents/patients about how to complain, the availability of PALS and also increase their confidence in complaining and giving feedback. There were reductions in the respondents who said:
    a. They felt they could complain and it would be taken seriously fell from 83% to 75%
    b. They knew how to complain and offer feedback (74% to 67%)
    c. They knew abut PALS (61% to 53%)
3. Satisfaction levels with food have improved slightly but are still low (just 57% are satisfied with the quality and variety of the food).
4. Handwashing awareness has decreased by 6% to 83% and should be higher

How does GOSH handle complaints

In 2012 GOSH commissioned an independent research company to conduct a survey and focus groups about our complaints process. This included both questions to those who had made a complaint to GOSH, and FT members who volunteered to take part.

Key findings from this work were:

- 75%+ of survey respondents who had complained felt that their complaint was taken seriously and they had known who to contact.
- More than two-thirds agreed that the complaints staff were fair and that they were kept informed on progress.
- the emphasis on communications and feedback can be seen as 89% of respondents agreed that ‘often complaints can be avoided if someone just talks to me first or explains things’

- People report that GOSH's reputation deters them from complaining - 65% of respondents agreed they would be less likely to make a complaint because of the service the hospital provides and 38% said they would be less likely to complain because of the hospital's reputation.
- A criticism from the focus groups was around a lack of change on the back of the complaints.
- There was a perception from several attendees that there was not a culture of listening and encouraging feedback within GOSH and that it needed to be given a higher priority and level of importance within the organisation.

Key Messages from Staff survey

Positive messages:

1. Staff advocacy rates (if a friend or family member needed treatment I would be happy with the standard of care provided by my organisation) is high – 90% This benchmarks very well against other Trusts in the UK. (only 8 trusts had staff advocacy scores of 90%+) http://www.telegraph.co.uk/health/healthnews/9901354/Doctors-dont-trust-their-own-hospitals.html
2. The overall staff engagement score (aggregated from responses to a number of questions was 3.99 out of 5. This compares to a national average of acute specialist trusts of 3.92/5, and the GOSH score for 2011 which was 3.77/5.
3. Staff report positively about being able to contribute towards improvements at work.

What we need to think about/find out more about

There were a number of areas where GOSH scored worse than other acute specialist trusts, and these require more thinking:

1. percentage of staff witnesses potentially harmful errors, near misses or incidents in the last month (38% v 30% national score)

Although this may relate to focus on Zero Harm, which means more staff of aware of safety. It could be an indication of a high level of harm in the Trust. It should also be noted that of those who witness errors, only 92% report it compared to 98% nationally.

2. percentage of staff receiving health and safety training in last 12 months (60% v 76% national score)
3. percentage of staff agreeing that their role makes a difference to patients (88% v 91% national score)
4. percentage of staff saying hand washing materials are always available (51% v 61% national score).

5. percentage of staff working extra hours (76% v 72% national score).

Other interesting results:

1. 24% staff say they have experienced bullying and harassment from patients / families in the last 12 months,
2. 23% of staff say they have experienced bullying and harassment from other staff in the last 12 months.
3. Only 29% of staff say they have had training on how to handle or prevent violence and aggression (compared with 39% nationally)
4. 40% of staff feel communication between senior management and staff is effective – our score in 2011 was just 27%.
5. 32% of staff feel senior management act on staff feedback – this is the same as the national score and similar to the GOSH 2011 score.

Key messages from quarter 4 Aggregated Analysis (Jan – March 2013)

This is a quarterly report that provides and overview of the main issues identified through the aggregated analysis of incidents, complaints, PALS concerns and clinical claims across the Trust.

Common themes identified were:

1. communication between clinical teams and either parents, patients or other healthcare professionals cause problems.
2. communication between and within GOSH clinical teams also causes issues to clinical care. This can cause delays or confusion to parents.
3. Patients being lost to follow-up caused delays and concerns to families.
4. Data protection – the loss or mishandling of sensitive personal data. This resulted in complaints and incidents.

Key messages from annual review of complaints 2012-13

1. Communication is key issue – families have highlighted poor communication with families. Communication between specialties is also a problem.

2. Information governance concerns have been raised as families report us sharing information inappropriately.

3. Gastroenterology continue to receive a very high level of complaints.

Key messages from PALS quarterly report – Jan – April 2013

1. Cancellation of appointments at short notice
2. Families also report difficulties getting through to secretaries to get information or results.
3. Problems with transport not being booked.
4. Waiting times in clinics

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
24 July 2013

Performance Summary Report **Submitted by:** Jan Filochowski, Chief Executive	**Paper No: Attachment L**

Aims / summary

Targets and Activity

- The Trust reported a significant rise in the number of patient spells, an increase of 700 against the previous month. This is largely attributable to an increase in day cases within Haematology following improvements to the coding of Financial SLAM data.
- ITU bed days are additionally reported at their highest level since October 2012.
- 18 week referral to treatment, diagnostic and cancer waits continue to be achieved.

Finance and CRES

Revenue account

- NHS Clinical income is 1.4% below plan; Inpatient and Outpatient activity is ahead of plan but critical care activity is below plan.
- Private patient income is 8.3% above plan.
- Non clinical income is 6% below plan but a high proportion of this variance is offset by matched expenditure variances.
- Pay in all areas other than Junior Doctors is within plan, as is non-pay
- EBITDA is £6.2m (6.8%) against a plan of 6.2%.
- There are positive variances on non-operating expenditure, chiefly on depreciation.

Statement of Financial Position

- Cash levels at £39.9m are ahead of plan although there remain some delays in receiving funding from some CCGs.
- Total capital expenditure is close to plan.
- Working capital at the end of Q1 is showing negative performance trends; private patient debts and the BPPC have deteriorated. Action is being taken to address both these items which should be reversible within the month.

CRES delivery

- The risk adjusted value of CRES schemes is below the level included in the financial plan by 24%.
- CRES delivery in the quarter represented 12% of the annual planned value.
- Weekly meetings are taking place with all divisions at present to identify options for filling the gaps and a major Trust review of the CRES process, including determining projects to fill the gaps, is also taking place.

Quality/Safety

- Year to date the Trust has reported 2 cases of C Difficile and 1 case of MRSA. Both measures remain within contractual/Monitor target limits.
- There has been a significant increase in the number of Information Governance incidents reported in the last year (120 from 67 in the previous 12 month period). This has led to 4 reportable Serious Incidents since April 2013.
- Higher reporting of incidents is thought to be result of increased staff awareness e.g. Information Governance training, QST Newsletter and shared learning through risk action groups.

Action required from the meeting Trust Board to note performance for the period.
Contribution to the delivery of NHS Foundation Trust strategies and plans To assist in monitoring performance across external and internal objectives.
Financial implications Failure to achieve contractual performance measures may result in financial penalties.
Legal issues N/A
Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place? The Members' Council receive a copy of the performance report and Commissioners receive a sub-section of the performance report monthly.
Who needs to be told about any decision? Executive Directors.
Who is responsible for implementing the proposals / project and anticipated timescales? Executive Directors.
Who is accountable for the implementation of the proposal / project? Executive Directors.

Attachment L

Great Ormond Street Hospital for Children NHS Foundation Trust

Targets and Indicators
Report to Trust Board July 2013

Activity
The Trust reported a significant rise in the number of patient spells, an increase of 700 against the previous month. This is largely attributable to an increase in day cases within Haematology following improvements to the coding of Financial SLAM data. ITU bed days are additionally reported at their highest level since October 2012.

Referral to Treatment waiting times
The Trust continues to meet all the national 18 week referral to treatment standards for admitted, non-admitted and incomplete pathways. The proportion of patients waiting no more than 6 weeks for a key diagnostic test remains within the tolerance of 1%.

Discharge summaries (completed within 24hours)
The overall discharge summary completeness rate has improved to 81% from a previous month position of 76%. Improvements are seen across all Divisions with the exception of ICI-LM. Surgery remain static but with a high rate of 85%.

The most significant improvements are seen within Medicine who report a rate of 93% against a previous month position of 72% and CCCR who report a rate of 80%, an increase over 10% against the previous month.

A group of clinical and operational staff, supported by the Transformation Team, have been brought together to address service issues and identify good practice both within GOSH and elsewhere with the aim of developing and rolling out a gold standard by September 2013.

Clinic letter turnaround (within 5 days)
The percentage of clinic letters sent within 5 working days following clinic attendance has improved marginally to 19% from a previous month position of 15%. Progress also continues to be been made in reducing the average number of days in which letters are sent. The project team continue to progress performance with the aim of achieving the 50% target by September 2013.

Mortality rate
The mean mortality rate has remained consistent since July 2011 at a rate of 3.4 per 1000 discharges. The rate remains well within statistical process control limits.

Staff turnover
Staff turnover is reported at 17% against a London benchmark rate of 13%. Services reporting highest turnover rates include: R&I (49%), Surgery Orthopaedics (37%), CCCR (34%). The Director of Human Resources will provide a verbal update to Trust Board following further investigation across these areas.

Great Ormond Street Hospital for Children NHS Foundation Trust

Targets & Indicators Report

	Indicator	Graph	YTD Target	YTD Performance	Monthly Trend														
					Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Activity & Use of Resources	Number of patient spells	1	6,845	**7,522**	2,545	2,010	2,452	2,237	2,325	2,960									
	Number of outpatient attendances	2	35,646	**35,692**	12,010	10,887	10,742	12,058	11,905	11,729									
	DNA rate (new & f/up) (%)		<10	**8.5**	9.5	8.7	8.8	8.5	8.6	8.4									
	Number of ITU bed days	3	2,464	**2,243**	791	664	802	712	717	814									
	Number of unusued theatre sessions		61	**58**	14	16	8	26	25	7									
Patient Access	18 week referral to treatment time performance - Admitted (%)	4	90	**90.4**	91.1	90.1	92.0	90.4	90.3	90.7									
	18 week referral to treatment time performance - Non-Admitted (%)	4	95	**95.2**	95.4	97.1	95.7	95.3	95.9	95.2									
	18 week referral to treatment time performance - Incomplete Pathways (%)	4	92	**92.2**	93.7	92.8	92.9	92.5	92.8	92.9									
	Cancer patients waiting no more than 31 days for second of subsequent treatment (%)		98	**100**	100	100	100	100	100	100									
	Proportion of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests (%)	5	<=1	**0.54**	0.57	0.28	0.75	0.54	0.36	0.65									
Patient / Referrer Experience	Number of complaints		28	**28**	5	9	17	6	10	12									
	Number of complaints - high grade		<5	**0**	0	0	1	0	0	0									
	Discharge summary completion (%)	6	85	**78.6**	77.4	76.3	72.7	77.1	77.1	81.4									
	Clinic Letter Turnaround, % letters on CDD - sent within 5 working days	7	50	**19.4**	19.0	17.6	15.2	19.4											
	Clinic Letter Turnaround, letters on CDD - average no. working days sent	8	To reduce	**15.6**	20.6	19.1	17.5	15.6											
	Patient refusals		130	**128**	37	43	35	43	36	49									
Workforce Measures	Sickness Rate (%)		3.15	**2.8**	3.0	2.9	2.9	2.9	2.8	2.7									
	Trust Turnover (%)		13.1	**17.1**	16.3	16.5	16.7	16.8	17.0	17.4									
Quality & Safety	Combined Harm Index**	9	Within Tolerance	**22.8**	20.9	23.7	22.8	20.7	23.8	23.9									
	Number of serious patient safety incidents	10	Within Tolerance	**5**	3	2	3	2	1	2									
	Hospital mortality rate (per 1000 discharges)		Within Tolerance	**2.9**	2.2	3.4	3.8	3.1	2.9	2.8									
	Incidence of C.difficile		7	**2**	0	0	0	0	1	1									
	Incidence of MRSA		0	**1**	0	0	1	0	0	1									
	CV Line related blood-stream infections (per 1,000 line days)	11	1.5	**2.6**	1.9	2.0	3.2	2.2	3.3	2.4									
	Number of patient acquired CV Line related blood stream infections		TBC	**35**	8	8	14	10	15	10									
	Number of arrests outside ICU (cardiac or respiratory)	12	Within Tolerance	**16**	8	6	7	5	0	11									

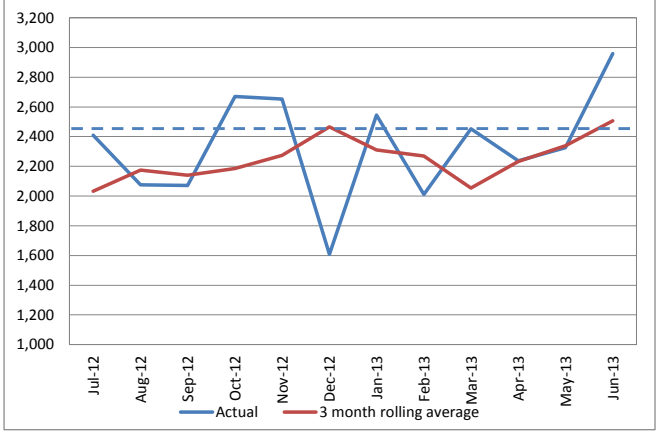
*N/D - No Data for month 1

**Harm index comprised of hospital acquired infections, serious incidents, non-ICU arrests, medication errors, falls, and pressure ulcers

Activity and Use of Resources

1. Patient spells

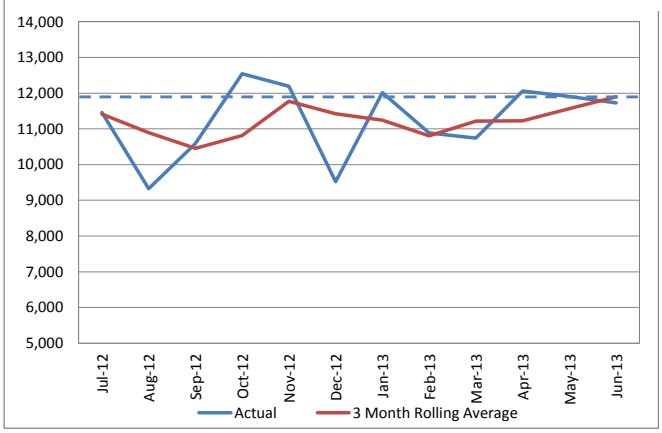
Desired direction of travel ↑



Description: **The total number of patient spells (including day case, elective and non-elective)**
Target: *Contractual target:* 2507 spells per month
Trend: Increasing
Comment: increase in activity (700) against the previous month. This is largely attributable to an increase in day cases within Haematology following improvements to the coding of Financial SLAM data

2. Outpatient Attendances

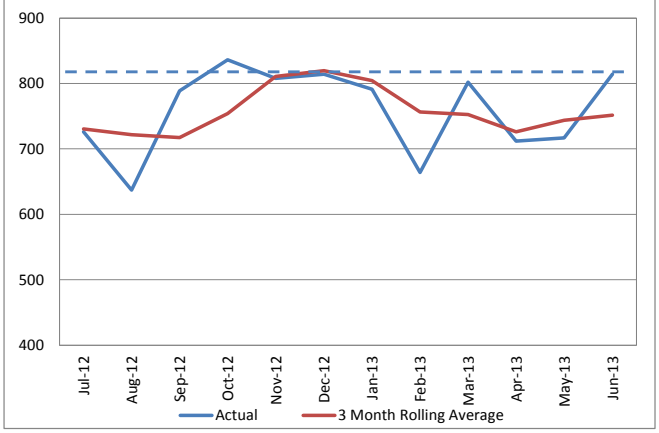
Desired direction of travel ↑



Description: **Total number of new & follow-up consultant-led chargeable appointments**
Target: *Contractual target:* 11,882 attendances per month
Trend: Performance remains relatively stable
Comment: Performance sustained since April 13

3. ITU Bed Days

Desired direction of travel ↑

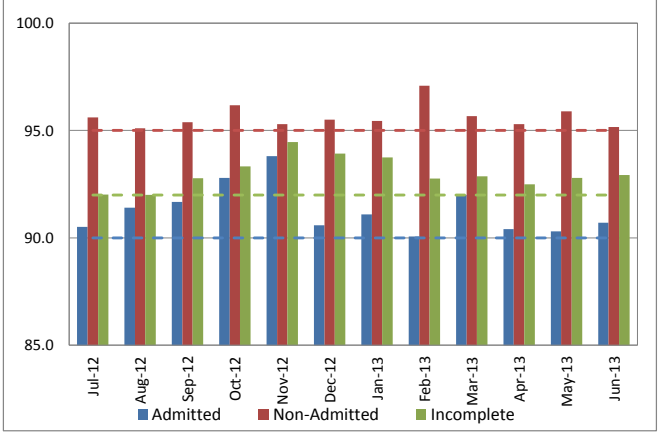


Description: **Total number of ITU bed days used per month**
Target: *Contractual target:* 821 bed days per month
Trend: Significant upward trend against previous month
Comment: ITU bed days are reported at their highest level since October 2012

Patient Access

4. Referral to Treatment Waiting Times

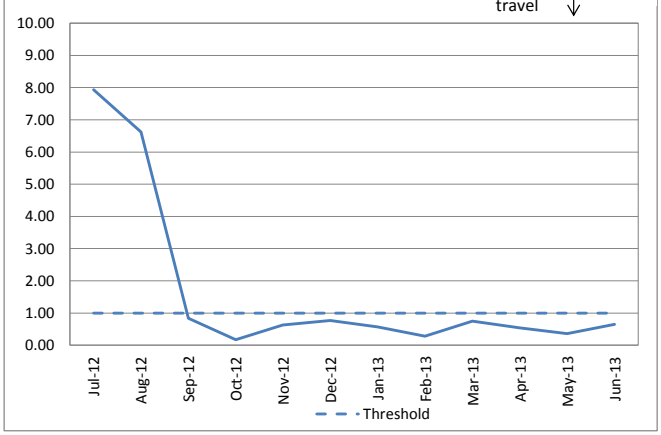
Desired direction of travel ↑↑↑



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

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

Desired direction of travel ↓

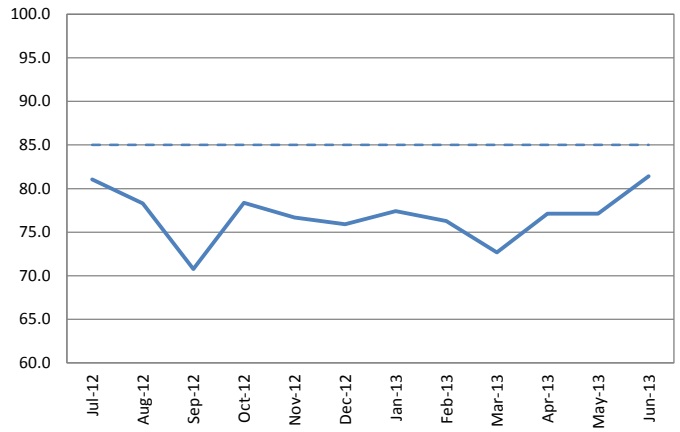


Description: **The proportion of patients waiting no more than 6 weeks for diagnostic test (across 15 national key diagnostic areas)**
Threshold: *Contractual target* <1%
Trend: Small negative movement against previous month
Comment: Performance sustained under 1% threshold

Patient / Referrer Experience

6. Discharge Summary Completeness

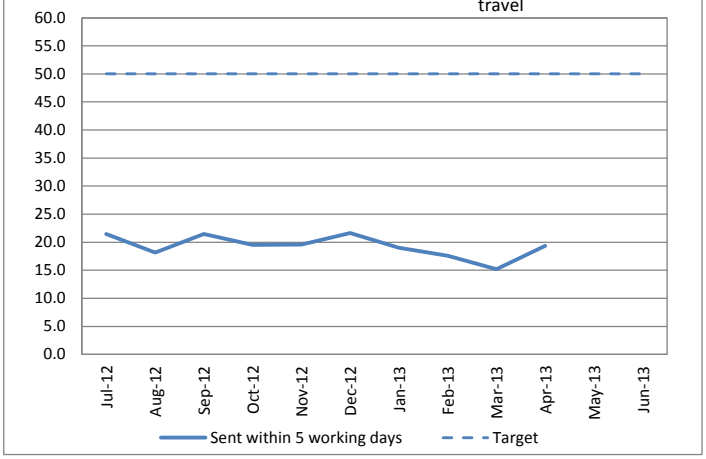
Desired direction of travel ↑



Description:	**The percentage discharge summaries completed and sent within 24 hours of patient discharge**
Target:	*Internal target:* 85%
Trend:	Positive movement in month
Comment:	The overall discharge summary completeness rate has improved to 81% from a previous month position of 76%. Improvements are seen across all Divisions with the exception of ICI-LM

7. Clinic Letter Turnaround - % sent within 5 days

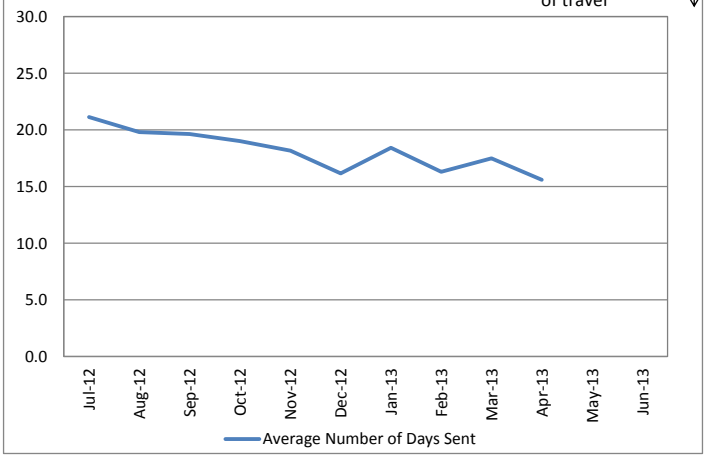
Desired direction of travel ↑



Description:	**The percentage of clinic letters sent within five working (and average days) following patient clinic attendance & recorded on the Clinical Document Database (CDD)**
Target:	*Internal target:* 50%
Trend:	Small improvement on previous month
Comment:	The project team continue to progress performance with the aim of achieving the 50% target by September 2013

8. Clinic Letter Turnaround - Average Number of Days sent

Desired direction of travel ↓

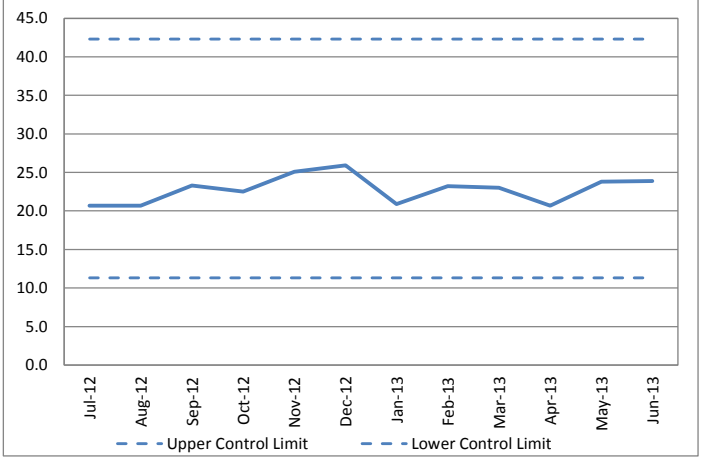


Description:	**The percentage of clinic letters sent within five working (and average days) following patient clinic attendance & recorded on the Clinical Document Database (CDD)**
Target:	*Internal target:* 50%
Trend:	Positive trend
Comment:	Progress also continues to be been made in reducing the average number of days in which letters are sent. A working group in place to progress performance

Quality and Safety

9. Combined Harm Index

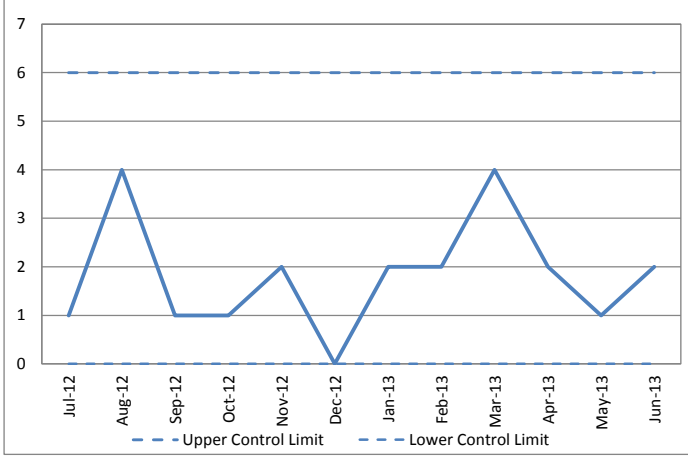
Desired direction of travel ↓



Description:	**Harm index comprised of hospital acquired infections (CVL, serious incidents, non-ICU arrests, medication errors, falls, and pressure ulcers**
Target:	*Internal target:* Year on year reduction
Trend:	Performance sustained
Comment:	Performance remains within statistical tolerance

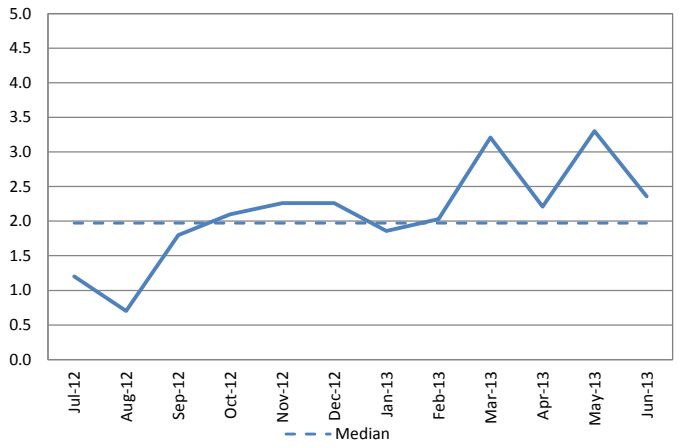
10. Serious Patient Incidents

Desired direction of travel ↓



Description:	**Defined as either - Unexpected/avoidable death of patient(s), staff visitors or members of public. Serious harm to patient(s), staff, visitors or members of public. Allegations of abuse. One of the core sets of 'Never Events'**
Target:	*Internal target:* To remain within control limits
Trend:	Negative trend - 2 SIs reported in month
Comment:	Performance remains within statistical tolerance

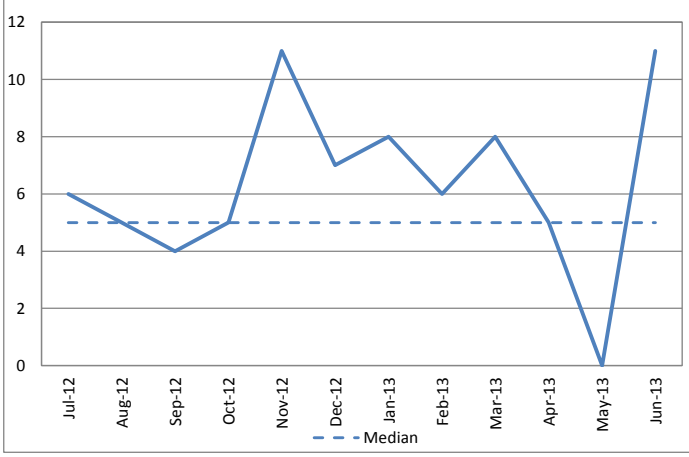
11. Central Venous Line (CVL) Infections (Per 1000 Line Days) ↓



Description:	**The number of CVLInfections for every 1000 Bed Days acquired at the Trust**
Target:	*Internal target:* <=1.5
Trend:	Positive movement in performance against previous month
Comment:	Performance remains within tolerance

12. Arrests Outside ICU

Desired direction of travel ↓



Description:	**The monthly number of arrests (cardiac or respiratory) outside of ICU wards (recorded from calls made to the 2222 Clincal Emergency Team)**
Target:	*Internal target:* 50% reduction
Trend:	Negative trend in month
Comment:	Incidents of arrests being investigated. Performance remains

Monitor Governance Risk Rating 13/14

Targets - weighted (national requirements)		Threshold	Score Weighting	Score Weighting Q1			
				M1	M2	M3	Q1
1	MRSA - meeting the MRSA objective *	0	1	0	0	0	0
2	Clostridium difficile year on year reduction (to fit with trajectory for the year as agreed with PCT)**	7	1	0	0	0	0
3	All cancers: 31-day wait for second or subsequent treatment comprising either:		1	0	0	0	0
	Surgery	94%		0	0	0	0
	Anti cancer drug treatments	98%		0	0	0	0
	Radiotherapy (from 1 Jan 2011)	94%		0	0	0	0
4	Non Admitted within 18 weeks	95%	1	0	0	0	0
5	Admitted within 18 weeks	90%	1	0	0	0	0
6	92% - 18 week referral to treatment time Incomplete Pathways Performance	92%	1	0	0	0	0
7	Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96%	0.5	0	0	0	0
8	Certification against compliance with requirements regarding access to healthcare for peopl e with a learning disability	N/A	0.5	0	0	0	0
			Total	**0**	**0**	**0**	**0**
			Overall governance risk rating	**Green**	**Green**	**Green**	**Green**

Monitor governance rating matrix	
Green	from 0 to 0.9
Amber-green	from 1.0 to 1.9
Amber-red	from 2.0 to 3.9
Red	4.0 or more

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

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

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

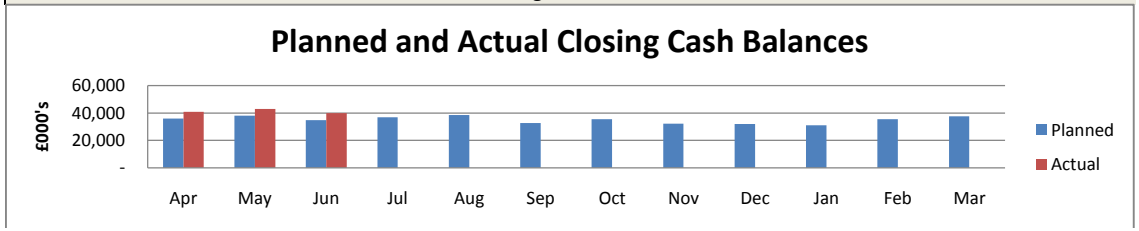
Great Ormond Street Hospital for Children NHS Foundation Trust
Financial Performance Report 3m to Jun 13

Commentary:

* NHS Clinical income is 1.4% below plan - the major adverse variance is in critical care
* Total staff costs remain within plan but junior doctor pay is over plan and admin agency rates remain high
* EBITDA at 6.7% is above plan of 6.2%
* FRR at 4 is on plan
* IPP debtor days has deteriorated due to high levels of current debt (not overdue) and a delayed payment from a major customer
* BPPC has deteriorated due to payment issues on 2 large invoice categories which have now been remedied

I&E	Current Month			Year to Date			RAG
	Budget (£m)	Actual (£m)	Variance (£m)	Budget (£m)	Actual (£m)	Variance (£m)	Rating
NHS Clinical Revenue	18.4	18.4	0.0	56.5	55.7	(0.8)	A
Pass Through	3.7	3.3	(0.4)	11.4	10.8	(0.6)	
Private Patient Revenue	3.6	4.0	0.4	10.8	11.7	0.9	G
Non-Clinical Revenue	4.4	4.8	0.4	13.3	12.5	(0.8)	A
Total Operating Revenue	30.1	30.5	0.4	92.0	90.7	(1.3)	
Permanent Staff	(17.0)	(15.5)	1.5	(51.8)	(47.1)	4.7	G
Agency Staff	0.0	(0.3)	(0.3)	(0.1)	(1.1)	(1.0)	R
Bank Staff	(0.1)	(1.0)	(0.9)	(0.2)	(2.9)	(2.7)	G
Total Employee Expenses	(17.1)	(16.8)	0.3	(52.1)	(51.1)	1.0	
Drugs and Blood	(1.2)	(1.2)	0.0	(3.6)	(3.9)	(0.3)	A
Other Clinical Supplies	(1.8)	(2.1)	(0.3)	(5.7)	(5.8)	(0.1)	G
Other Expenses	(4.4)	(4.8)	(0.4)	(13.5)	(13.0)	0.5	G
Pass Through	(3.7)	(3.3)	0.4	(11.4)	(10.8)	0.6	
Total Non-Pay Expenses	(11.2)	(11.4)	(0.3)	(34.2)	(33.5)	0.7	
EBITDA (exc Capital Donations)	**1.8**	**2.3**	**0.4**	**5.7**	**6.1**	**0.4**	
Depreciation, Interest and PDC	(2.7)	(2.4)	0.3	(8.0)	(7.4)	0.6	G
Net Surplus (exc Capital Donations)	(0.9)	(0.1)	0.7	(2.3)	(1.3)	1.0	
EBITDA %				6.2%	6.7%		
Capital Donations	2.2	1.6	(0.6)	5.2	4.5	(0.7)	

Closing Cash Balance



Statement of Financial Position	31-Mar-13 £m	31-May-13 £m	30-Jun-13 £m
Non-Current Assets	336.5	336.0	336.2
Current Assets (exc Cash)	39.9	45.1	48.0
Cash & Cash Equivalents	38.4	43.2	39.9
Current Liabilities	(43.9)	(51.8)	(50.1)
Non-Current Liabilities	(7.8)	(7.7)	(7.7)
Total Assets Employed	**363.1**	**364.8**	**366.3**

Capital Expenditure	Annual Plan £m	Actual YTD £m	Forecast Outturn £m
Redevelopment - Donated	24.2	3.5	24.4
Medical Equipment - Donated	9.1	0.8	9.1
Estates - Donated	1.2	0.2	1.2
Total Donated	34.5	4.5	34.7
Estates & Facilities - Trust Funded	6.2	0.7	6.2
IT - Trust Funded	5.3	0.5	5.3
Medical Equipment - Trust Funded	3.5	0.0	3.5
Total Trust Funded	15.0	1.2	15.0
Total Expenditure	**49.5**	**5.7**	**49.7**

	31-Mar-13	31-May-13	30-Jun-13	RAG Rating
NHS Debtor Days (YTD)	9.87	8.31	7.55	G
IPP Debtor Days	130.92	128.46	135.54	A
Creditor Days	29.88	31.21	28.5	A
BPPC (YTD) (number)	83.9%	86.3%	84.0%	A
BPPC (YTD) (£)	83.4%	88.2%	85.9%	A

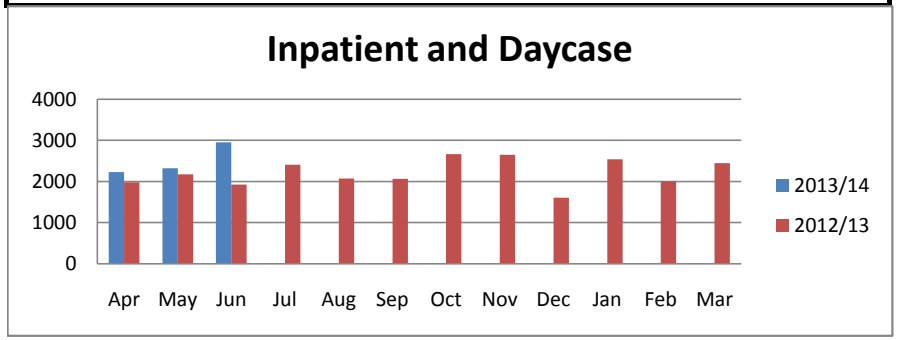
Financial Risk Rating	2013/14 Plan	31-May-13	30-Jun-13	RAG Rating
Underlying Performance	3	3	3	G
Achievement of Plan	5	4	5	G
Return on Assets	2	2	2	G
I&E Margin	5	4	5	G
Liquidity	4	4	4	G
Overall	4	3	4	G

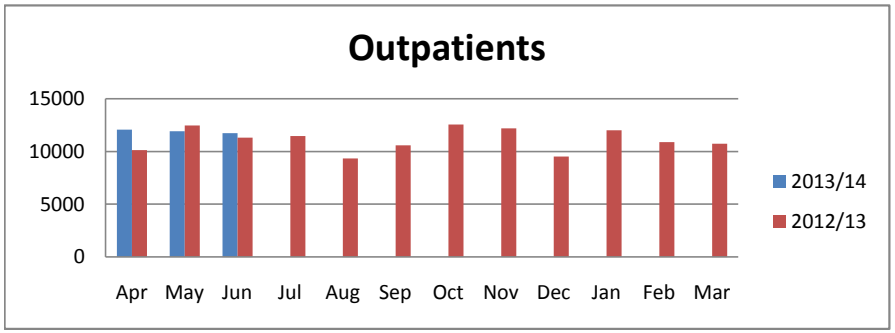
Financial Performance Report 3m to Jun13 — ACTIVITY AND INCOME

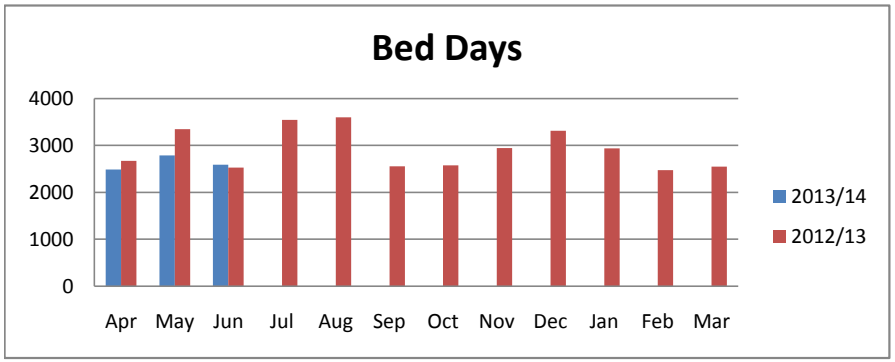
	Income from NHS clinical activity £M year to date				
	YTD 13/14 Actual	Var v plan		Var v LY	
Inpatients/ Daycases	**21.8**	0.3	1.6%	2.5	13.2%
Bed days	**10.0**	(1.0)	-10.5%	(0.4)	-4.0%
Outpatients	**8.8**	0.2	2.0%	0.2	2.7%
Other eg Highly Specialised	**15.1**	(0.3)	-2.0%	0.4	2.7%
Total	**55.7**	**(0.8)**	**-1.5%**	**2.8**	**5.2%**

Activity				
YTD 13/14 Actual	Var v plan		Var v LY	
7,522	677	9.0%	1,423	23.3%
7,869	(1,449)	-18.4%	(711)	-8.3%
51,083	(726)	-1.4%	1,831	3.7%

PATIENT ACTIVITY







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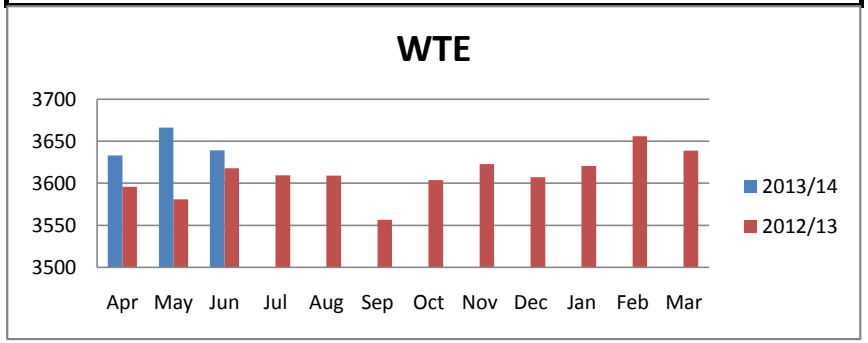
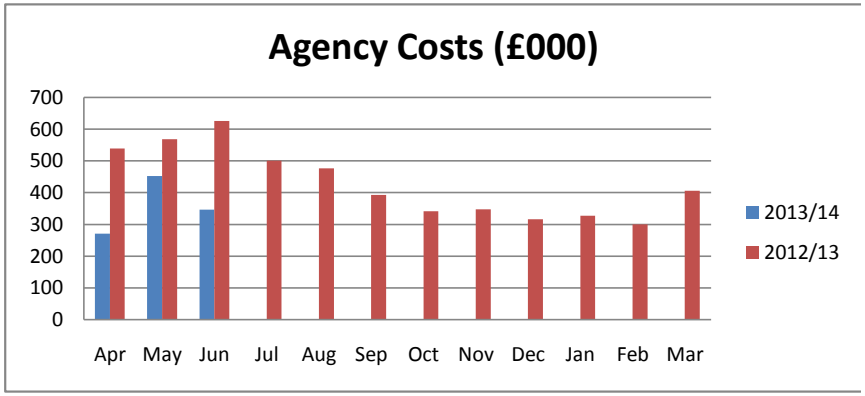




Agency % by Staff Category	Current Month	Year to Date
Junior Doctors	1.1%	1.0%
Admininstration & Estates	7.5%	8.4%
Healthcare Assist & Supp	0.6%	0.7%
Nursing Staff	2.0%	1.5%
Scientific Therap Tech	2.1%	2.6%

Attachment L

Great Ormond Street Hospital for Children NHS Foundation Trust

Quality and Safety
Report to Trust Board July 2013

Safety
Since April 2013 there have been 12 serious incidents declared, 10 of which are still under investigation. It has been 23 days since the last serious incident.

There has been a significant increase in the number of Information Governance (IG) incidents reported in the last year (120 from 67 in the previous 12 month period). This has led to 4 IG serious incidents (reportable to the Information Commissioner's Office) since April 2013.

It is likely that the rise in reported incidents is due to an increase in staff awareness, following a number of interventions:

- Increased number of staff trained in IG with 88% of staff currently trained (up from 51% in January)
- Quality Safety & Transformation Newsletter and staff email Newsletter have regularly promoted better IG compliance.
- Risk Action Group teams have been encouraged to share learning more widely

The Assistant Head of QST is working with the Head of Information Governance, Data Protection Officer and Head of Education and Training to review and improve content of training.

The Learning from Experience Group will facilitate and monitor action plans identified through investigations.

There are no notable trends among the other open serious incidents.

Complaints
The last Red Complaint was received on 11 July 13.

The number of complaints received to date is consistent with previous years.
Communication (with families) continues to be the biggest trend raised in complaints.

The roll out of the People's Strategy will contribute to improving issues around communication. The strategy will focus on 8 key themes, one of which will address the kind of issues raised in complaints, for example staff attitudes and behaviours. A work stream is being set up to take this forward.

Delays in treatment and incorrect information being given to families have both been the subject of complaints this quarter. Relevant Action plans have been created and monitored via the complaint action log. These have mainly related to changes in process, for example, the way referrals are dealt with for a particular team or the way procurement of nuclear medicine is managed.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **24th July 2013**	
Patient Experience, Patient & Public Involvement (PPI) and PALS Annual Report 2012/13 **Submitted by: Liz Morgan, Chief Nurse & Families' Champion**	**Attachment M**
Aims / summary To update the Board on Trust-wide patient experience, PPI and Pals activity and achievements in 2012/13.	
Action required from the meeting None	
Contribution to the delivery of NHS Foundation Trust strategies and plans This work is central to Trust objectives which recognises that a positive patient experience is as important as patient safety and clinical excellence in providing a quality service, and listening and responding well to all stakeholders is key to improving services.	
Financial implications None	
Legal issues None	
Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place? This work is monitored by the Trust's Patient and Public Involvement & Experience committee (PPIEC) which includes both parent representatives, and Members Council representation. Pals work was also monitored in 2012/13 by the Trust's Quality & Safety Committee.	
Who is responsible for implementing the proposals / project and anticipated timescales? Grainne Morby, Head of Pals & PPI	
Who is accountable for the implementation of the proposal / project? Liz Morgan, Chief Nurse and Families Champion	

Attachment M

Patient Experience, Patient & Public Involvement and Pals
Annual Report 2012/2013

1. Summary

'What happened to me and how I feel about it', GOSH's definition of patient experience, is broad and deliberately subjective as every single staff member in every service area can make a difference to the way in which a family experiences their visit, as do the expectations and past experiences brought with every visitor.

This report brings together highlights of some of the work done in 2012/13 at a Trust-wide level on improving patient experience, engaging patients, parents and membership and in listening to, and responding to the concerns voiced by users of GOSH services. This report no longer includes details of divisional or specialty patient and public involvement and experience work as this is are now firmly embedded in divisional plans and reports.

This report also draws on the Pals Annual Report 2012/13 by including the key themes identified by Pals from its casework, and the Trust's response.

2. Trust-wide highlights

2.1. A new 3 year Patient & Public Involvement & Experience strategic plan

This was approved by Trust Board and Management Board in January 2012 and positive results for Year One's Action Plan were received, reviewed and monitored by the Patient and Public Involvement & Experience Committee (PPIEC). The following was achieved:

2.2. Young People's Forum

A key focus of the strategic plan was to place the voices of children and young people at the heart of involvement work. We knew that previous attempts to sustain children's and young people's participation had proved short-lived. We wanted young people to create their own agenda and work programme but to also advise clinical divisions and its specialties in improving services.
The first meeting of the Young People's Forum took place in August 2012 and three further meetings took place in-year. The enthusiasm and commitment of the members has been overwhelming and a work programme focussing on helping the Trust improve transition to adult services, and a decision to set up a Facebook site were agreed. The Trust is being assisted by Changemakers to ensure that the young people learn skills of leadership, participation and teamwork in recognition of their contribution to improving services.

2.3. Real Time Patient Experience

The Transformation Board discussed the evaluation of a pilot using volunteers and i-pads to collect 'real-time ' parent/patient views on four wards in June 2012. It decided then that it did not require a 'clinical dashboard' approach to the collection and reporting of patient experience and would favour a more face-to-face 'ward tailored' approach using other media such as focus groups, regular teas/meetings, comment cards and the '15 Step' approach piloted by the Nursing Team's Visible leadership programme. However, this strategy has been reviewed to take account of the need to publish Friends and Family' test data for all in-patients, out-patients and day case patients from April 2014 and the recognition that this would be more easily achieved with a trust-wide IT supported patient feedback system. Funding for a dedicated project worker was successfully achieved by year end.

2.4. Main reception refurbishment and front of house service standards

Bespoke customer service training workshops have been delivered following a volunteer-aided participant observation survey of main reception, accommodation and transport reimbursement services. Service standards have been developed taking into account family and staff feedback and work has started to roll them out. This includes the feasibility of promoting them during

Induction and having bespoke sessions with staff other than those who work on main and Outpatients receptions.
A consultation exercise took place in December 2012 to obtain views and preferences about the refurbishment plans for reception. The feedback was largely positive, however, there was some concern that there needs to be space and quiet zones and textures for those with special needs and learning disabilities. Also older patients wanted space and facilities. Parents were keen to point out that the reception area should allow and facilitate way finding and navigation to the rest of the hospital. The project team working on the refurbishment has welcomed the feedback and will continue to work with the PPI team to ensure feedback is acted on.

2.5. The needs of Orthodox Jewish families
To gain a deeper insight into the issues faced by or those from another culture or language, we started a programme of focus groups. In 2012/13 we concentrated on the needs of Orthodox Jewish families. Topics covered include communication and information, the time and attention received, how involved patients and families were in decisions about care and treatment, how well personal and spiritual needs were met, food and general comments on staying with us. A task and finish group for one year (2013/14) will prioritise issues and work on implementing the findings.

2.6. The needs of patients and families living with Autism
To gain a deeper insight into the issues faced by families with children with special needs, a targeted focus group was held with parents and young people living with autism.
Findings and recommendations have been reflected in and will be implemented through the Trust's Learning Disabilities Action Plan and Charity funding for a part time Learning disability Nurse Consultant was obtained.

2.7. Response to Survey of Nationally Commissioned Services (NCS) by Picker Institute
A patient survey, commissioned by the Department of Health from Picker, of specialist services nationally included five services offered at GOSH (lysomal storage disorder, heart & lung transplantation, epidermis bullosa, rare neuromuscular disorder and Bardet Biedl). Overall the results were clinically positive although families need better information and support on social care. A response from GOSH, including action plans for each service was put in place.

2.8. Patient Experience Project with UCL Partners
GOSH collaborated with UCL Partners in new project called 'Listening to Patients' which involves a series of short seminars for junior (S/CT1) trainees to meet patients and listen to their stories. Over 150 trainees will attend the seminars and each will undertake a project in their own workplace to improve patient experience. The first seminars took place in February 2013.

2.9. Outpatient Survey
The bi-annual patient and family outpatient experience survey, drawn from patients who used Outpatients in June and July 2012, was commissioned from Ipsos Mori and the results were presented to Trust board. Once again we achieved very high levels of satisfaction generally, sustaining the 95% overall satisfaction achieved in the 2010 survey**.** Key areas highlighted for improvement are appointment arrangements, knowing how to complain, ensuring that the needs of patients with special needs are better catered for and giving young people the opportunity to talk to a doctor or nurse on their own during a consultation, as well as with their parents. Action plans have been put in place to address these issues.

2.10. Inpatient Survey
Ipsos Mori was commissioned to undertake the annual inpatient survey for 2012 with field work completed in January/February 2013. The results were presented to Trust Board and an action plan to address the findings has been put in place. Patient and family satisfaction rates remain very strong, despite a small year on year decrease (93% 2013 vs 96% 2012). Patient and family advocacy rates (friends and family test) are very high at 96%. This is complemented by a 90% score from Trust staff in the staff survey and this benchmarks very well against other Trusts in

the UK (only 8 trusts had staff advocacy scores of 90%+). Confidence in doctors (97%) and nurses (94%) remains extremely high - in previous work to identify the most important criteria for parents and young people, this was the most important driver of satisfaction. Improvements are needed generally for patients with special needs, the provision of play and activities, the quality of food, discharge processes and information. We also need to increase awareness amongst parents/patients about how to complain, give feedback, the availability of Pals, and hand washing.

2.11. Focus Groups on use of Patient experience outcome measures (PROMs) and Patient Experience measures (PREMs)

Two focus groups were organised, one with young people who are currently GOSH patients, the other with their parents/carers to capture service users' views on PROMs and PREMs, on how best to use these in a clinical setting and how to engage effectively with parents and patients so they understand the importance of completing these questionnaires as part of routine clinical care. These focus groups were funded by an MRC Public Engagement fund.

2.12. Patient led inspections of the care environment (PLACE)

There was a very positive response from patients and parents to participate in PLACE inspections of ward environments and food. Training took place in March 2013 prior to the first inspection due to take place in June 2013. The inspections will comprise 5 teams of 6 people and there is a requirement for 50% of the team to be made up of patients.

2.13 Support to divisions

The PPIE Officer provided advice and practical help to all divisions in 2012/13. Highlights included research to improve the care pathway for Duchenne Muscular dystrophy patients, support to the Complaints teams in making the process more 'patient and family friendly', support for a surgery workflow survey, the Panda daycentre playroom refurbishment, a parent reporting adverse events project, patient focus groups in Cardio-Respiratory and help to develop a measurement tool to assess the patient experience of being treated for conditions within Endocrinology.

3. Patient Advice and Liaison Service

3.1. Activity 2012/13

Pals helped over 2.800 families and patients during the course of the year and its casework provides the Trust with a useful barometer of patient experience. Pals recorded 1,139 cases and overwhelmingly these were parents who had problems, concerns or complaints that needed to be resolved.

A separate and more detailed Pals Annual Report for 2012/13 is available. However the following 'themes/issues' were identified in year and reported to both the Trust's Quality & Safety Committee and the Patient and Public Involvement and Experience Committee.

4. Key Issues for Improvement identified by Pals in 2012/13

4.1. Clinical units not following MRSA policy on removal of alerts

Pals provided evidence that there was 'confusion' as to whose responsibility it is to remove an MRSA alert from the patient information system. In addition many families find isolation to be a distressing and humiliating experience, however sensitively this is done by staff. Parents do not always accept the necessity for isolation, and many GOSH patients are frequent attendees at local hospitals and therefore find it hard to meet the criteria for removal of the alert.
It was clarified that clinical divisions are responsible for alerting infection control to when MRSA alerts should be removed and The Head of Infection Control agree to highlight this element of long-standing policy again at relevant committee meetings.

4.2. Eligibility for NHS treatment (and the consequences of giving wrong advice)

Three cases were highlighted in–year which showed the need for staff to seek the advice of Legal services when interpreting guidance, and for Legal Services to take a proactive role in ensuring that clinical managers understand their responsibilities and have accessible guidance.

Case	Experience	Outcome
Cardiac Cardiac surgery 8796	Pals was contacted by an MP's office asking why a referral to GOSH for urgent treatment agreed with clinical team had taken 4 weeks to date to process. Transpired that family were being given advice by GOSH that a new-born baby born whilst visiting relatives abroad and in an overseas hospital was 'not ordinarily resident in UK' so was not therefore entitled to NHS treatment despite the parents being –ordinarily resident.) Advice being quoted from the DOH was that child needed to be brought to the UK to register with the NHS and then wait for a referral to GOSH from local services, or for the child to have an E112 transfer. The former would have been clinically unsafe and the latter could take weeks and would classify the baby was 'not ordinarily resident in the UK'	Pals liaised with the family who was able to demonstrate to GOSH (again) that they were ordinarily resident in the UK. Pal liaised with unit management, the Overseas Visitor Manager at GOSH and Legal and it was agreed to seek further advice from DOH. GOSH now advised the family that the patient could be registered at GOSH and that transfer could be arranged. Meeting arranged with Consultant to review whether treatment at GOSH remained clinically appropriate.
ICI Rheumatology 8797	Very distressed family to Pals for support and advice reporting that they had been told by GOSH staff that they owed 15k which they had no way of paying and that it would impact adversely on their immigration status if they did not pay. Pals sought legal advice which was that although the child had not been eligible for NHS treatment this was not an enforceable debt.	A meeting was arranged with the manager to reverse the previous advice. This case is was subject to a root cause analysis by clinical governance staff and senior management.
Neurosciences Neuromuscular 8682	Angry family arrived with independent health advocate to Pals as they felt that they had no option but to take their son abroad for monthly infusions as these had not been arranged by GOSH to take place in the UK where the family are 'ordinarily resident'. This was causing them distress and financial hardship.	Service Manager called a meeting with Pals, Consultant and CNS to agree care plan and identify why family were taking child abroad. Meeting arranged with family to agree a treatment plan that would begin at GOSH and transfer to local hospital.

4.3 Communications between staff, patients and families in Rheumatology/ Physiotherapy

Pals provided details of several cases brought to Pals by families who were unhappy/'felt intimidated' with service communications in order to evidence the complexity of some of the issues that families raised and that staff grapple with. This provided a good example of the many services at GOSH that provide care for complex patients, some with family psycho-social issues, where expectations need to be managed with care and where pre-admission information and continuing clear communication needs to be of the highest order.

4. 4. Problems caused for families as a result of the move of the Fares Reimbursement Desk to a main hospital corridor

The temporary relocation of the desk to the busy Lagoon corridor which took place over the Christmas period was never going to be popular but could have been better planned. However, since the move the installation of a ticket machine and a defined, dedicated waiting area, the queue management system works. Installation of informative signage was installed following feedback from families and Volunteer Services identified GOSH Guides who now provide both directional support to our families on the location of the office, and further information on the process of obtaining a fares reimbursement. It is reluctantly accepted that there was not a better alternative available at the time but Pals is still recommending a location that allows more privacy and dignity.

4.5. Problems caused for families as a result of the move of the Family Accommodation Office

The temporary relocation of the Family Accommodation Office from the ground floor to an upstairs office in the Cardiac wing is also not popular with families. All Trust wayfinding was updated for Accommodation's new location and the Trust's Manual Handling Trainer produced a risk assessment on the layout of the office. However it remains inconveniently sited for families with buggies and suitcases and breast-feeding mothers attending for vouchers. There is no plan to move the office until the new main reception area opens.

4.6. Problems with making clinic appointments and availability of clinic slots

Since raising family concerns the appointment lines have relocated from the various locations of reception areas in Outpatients (OPD) to one designated location following the opening of the new OPD area in the Frontage Building in January 2013. This has provided a quiet environment for calls to be received. The volume of calls continues to be monitored on a daily basis and during busy times an additional member of staff provides support from the level 1, Frontage Building reception. All receptionists are fully trained in covering the appointment lines in order to ensure flexibility of cover and consistency of service. Demand and capacity for clinic appointments continues to be a concern that will be addressed by an Outpatients Improvement Project which will include two parent representatives on its Stakeholder Board.

4.7. Problems caused for families by GOSH cancelling clinic appointments in many specialties at short notice

There has been an increase in families raising this as a concern, occasionally having arrived at GOSH to find the appointment has been cancelled. Families have usually booked tickets in advance to get cheaper deals which they cannot always get refunded; they often take time off work not always paid, and some have made considerable efforts to organise transport, occasionally overnight accommodation and sibling care. A family can be many hundreds of pounds out of pocket, the overwhelming costs of which are borne by the family.

Cancelling appointments is wasteful of families' time and creates logjams for the future. This will be addressed in more detail as part of an Outpatients Improvement project for 2013/14 which includes two parent representatives on its Stakeholder Board.

4.8. Gastroenterology service

Pals has raised a range of family concerns with many aspects of the gastroenterology service over the last three years. Although the service continued to attract a disproportionate number of concerns in 2012/13 it has become apparent that the improvement project and new referral and admission processes and criteria that have been put into place are beginning to have a positive effect. An analysis of recent gastroenterology service enquiries to Pals shows that there has been a marked decrease in complex and long-term cases and a corresponding increase in promptly resolved cases – suggesting that the service as a whole is becoming increasingly responsive. Pals continues to actively support the improvement plan (which is available on GOSH web), monitor enquiries closely and ensure relevant managers are kept informed.

5. Concluding Remarks

Overall the Trust is making good progress in ensuring that a positive patient experience is seen as complementary to keeping patients safe and providing clinical excellence. There is greater

commitment than ever before to engage Members, patients, parents, public and staff, particularly at Divisional and specialty level. It is anticipated that as the Members Council begins to settle in, extend its knowledge base and councillor involvement, it will help us to ensure that we focus on what matters most to our users and how we can listen better to improve more.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
24th July 2013

2013 Annual Infection Prevention and Control Report – Executive Summary **Submitted by:** Liz Morgan, Chief Nurse and Families' Champion and Director of Infection Prevention and Control Dr John Hartley Deputy DIPC/ Lead Nurse Deirdre Malone	**Attachment N**

Aims / summary
To assure Board that there is a functioning IPC programme. To inform Board of achievements and targets in Infection Prevention and Control and Annual Plan

Action required from the meeting
Note and Approve (for public access – Full report is a public document)

Contribution to the delivery of NHS / Trust strategies and plans
Essential to achieve zero harm; minimising risk of infection is a central trust goal

Financial implications
Failure to prevent or control infections leads to harm and cost.
Failure to meet CQUIN targets will result in financial penalties.

Legal issues
Compliance with the Health and Social Care Act 2008 Code of Practice for health and adult social care on the prevention and control of infections and related guidance (from 1 April 2010) is a Statutory requirement for registration with the Care Quality Commission

Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?
Report and Annual plan need to be discussed at Infection Prevention and Control Committee

Who needs to be told about any decision
Infection prevention and control is responsibility of all staff.
All Clinical and Corporate staff

Who is responsible for implementing the proposals / project and anticipated timescales
Clinical and Corporate Divisions and all staff – in conjunction with the Infection Prevention and Control Team,

Who is accountable for the implementation of the proposal / project
Director of Infection Prevention and Control

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST

INFECTION PREVENTION AND CONTROL ANNUAL REPORT

April 12 - March 13

AUTHORS: Dr John Hartley - Director of Infection Prevention and Control
Deirdre Malone – Lead Nurse in Infection Prevention and Control

Executive summary: Activity in 2012/13

Overview of infection prevention and control activities in the Trust during 2012-13
(numbers related to sections in full report)

2) Infection control arrangements

Infection Control Team:
Dr John Hartley continues as DIPC (since Aug 2009) and ICD (0.3 wte); other Consultant Microbiologist time allocated for IPC, 0.3 wte.
Deirdre Malone continues as Lead Nurse Infection Prevention and Control..
One full time Deputy Lead Nurse and 0.4 wte clinical scientist
Administrative support - Administrator and Data Analyst appointed September 2011.
Part time (0.2 wte) antibiotic pharmacist support was present through the year.
Surgical site infection prevention and surveillance (SSIP&S) team, funded for three years, started November 2009, fully disbanded Jan 2013.
Practice Educator IPC – funded through Transformation process – in post Nov 2011 to July 2012, following resignation. Reappointment to the post not supported by Transformation Team.
IPC team have been unable to undertake all planned activities due to this staff restraint.
Executive lead: Chief Nurse and Families Champion
Infection Control Committee: the committee meet bi-monthly

Divisional Directorate local IPC structure:
A key component of Trust policy is the delegation to and acceptance of responsibility by all clinical staff, starting with formation of Divisional IPC groups and plans. All Divisions, except MDTS, had regular IPC meetings during this financial year. MDTS have subsequently commenced. Surgery and Cardiorespiratory IPC groups have been very active.

3) DIPC reports to trust board

Apr 2012 - Regular DIPC report to Board Apr 2012 - Assurance framework on HCAI – update presented to Clinical Governance Committee
July 2012 – Presentation of 2012 Annual report to Board
Nov 2012 – Regular DIPC report to Board
April 2013 – Regular DIPC report to Board

4) Budget allocation to infection control activities

Main funding for IPC Team lies with Department of Microbiology, Virology and Infection Prevention and Control.
Full time funding had been made available through the Transformation Process, to provide a second experienced IPC practitioner (Clinical Nurse Specialist/Practice Educator) to enhance the Trust IPC activity towards the strategic goal of no avoidable infections. This

post was filled 29/11/2011 to13/07/2012 but became vacant and funding into this post has been withheld by Transformation.

SSIP&S team – this was supported by Special trustees until end of project. Responsibility for surveillance was handed to the Divisions, but this has been slow to be established.
Excellent Trust support is provided for emergency supplies of personal protective equipment as required.
Extensive routine and specialist laboratory support was provided by the Department of Microbiology/Virology and Infection Prevention and Control, GOSH

5) HCAI Statistics

GOSH complied with all mandatory HCAI surveillance schemes as well as completing a number of specific local surveillance programmes. This report does not include all local Speciality surveillance covering infection, which may be in Specialty reports.

5a Mandatory reporting

MRSA bacteraemia - total Trust apportioned cases during year = 3
(National target = 0) (One line related, one spontaneous, one contaminant)

Glycopeptide resistant enterococcal bacteraemia – total during year = 5 (No target)

Clostridium difficile - Trust apportioned cases in national surveillance scheme (cases aged greater than 1 and in for 3 or more days when tested) = 7.
National target for 2012/13 was less than or equal to 8.

Orthopaedic SSI: The trust does not carry out the procedures with mandatory nationally surveillance. (Surveillance is performed in other areas – see GOSH surgery figures)

MSSA - S. aureus (methicillin sensitive) bacteraemia
Episodes of MSSA bacteraemia = 29 (No National target in 2012/13)
13 detected on admission/less than 48 hours; 16 on set after 48 hours
(11 central line related, 2 peripheral line, 1 spontaneous and 2 contaminants)

E. coli bacteraemia
Episodes of E. coli bacteraemia = 19 (No National target)

5b GOSH specific (non-mandatory) HCAI statistics

Central Venous Line related bacteraemia acquired at GOSH
= 2.1 per 1000 line days.
This equates to a slight increase year on year (episodes per 1000 line days 07/08 – 4.4; 08/09 - 3.7; 09/10 3.2; 10/11 2.6; 11/12 2.0) however we continue to aim to reduce this further.

Surgical site infection prevention and surveillance
The SSI Surveillance team data
The SSIS team performed inpatient and post discharge surveillance in line with the Health Protection Agency protocol. Surveillance was performed in orthopaedic spinal implant, cardiac (open and closed heart), craniofacial, neurosurgery, thoracic surgery, general and neonatal surgery, orthopaedic ‘8 plates’ and plastic surgery patients for periods between 3 and 12 months.

(This data may not be directly comparable with other Trusts as surveillance and case mix varies.)

1554 procedures were surveyed – 'all procedure' results for deep and organ/space infection show rates of 0.5 and1.2%. With the inclusion of superficial (2%) and patient reported infections (2.8%) the overall infection rate was 6.4%.

Specialty surveillance data
- Urology continued specialty based SSI surveillance of all procedures and detected the same low number of cases as last year (4 in a 1008 procedures compared to 6 in previous year).
- Cochlear implant
Local service report 103 surgeries with no infections, although one implant removed for infection possible not related to original surgery.

SSI Root cause analysis
Divisions have not yet established a robust system for investigating and reporting all serious infections.

Other GOSH surveillance

Viral infections acquired while in hospital

There was an increase in the number of episodes of viral respiratory (104 cases, 15 on set in hospital) and viral gastroenteritis (151 cases, 79 onset in hospital) infections present in children when admitted or developed while in hospital. This had a greater impact on patient flow than last year. One ward was closed.

These infections transmit readily between patients, staff, parents and visitors. Continuous application of standard infection prevention and control precautions and high levels of cleanliness are required to maintain control.

Antimicrobial resistance

MRSA
123 newly colonised or infected children were detected on admission in 2012, with 4 probably or possible acquisitions within the trust in (compared to 9 previous year).
There were no MRSA outbreaks. This was a reduction from 156 in 2011.

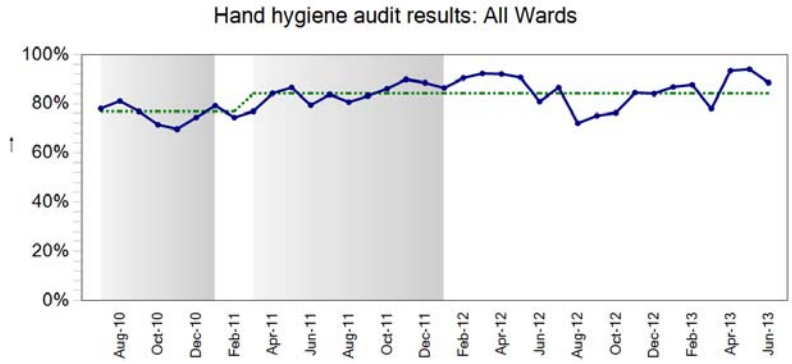
Multiple resistant 'gram negative' organism colonisation or infection
(E coli, Pseudomonas and other related organisms as defined in admission screening policy)

Screening/testing in 2012 revealed 183 first detections, of which 137 definitely came in colonised and 46 were either cross infection or detected as result of antibiotic selection with previous negative or not screened. This is similar to last year (180 detections in 2011, up from 124 first detections in 2010) and is likely to reflect the continuing national and international increase in antimicrobial resistant organisms.

Serious incidents (SI) involving infection
In 2012/13 there were no Sis principally on HCAI.

6) Hand Hygiene, Aseptic Protocols and care bundles (Saving Lives High Impact Interventions and other relevant bundles e.g. WHO, NICE)

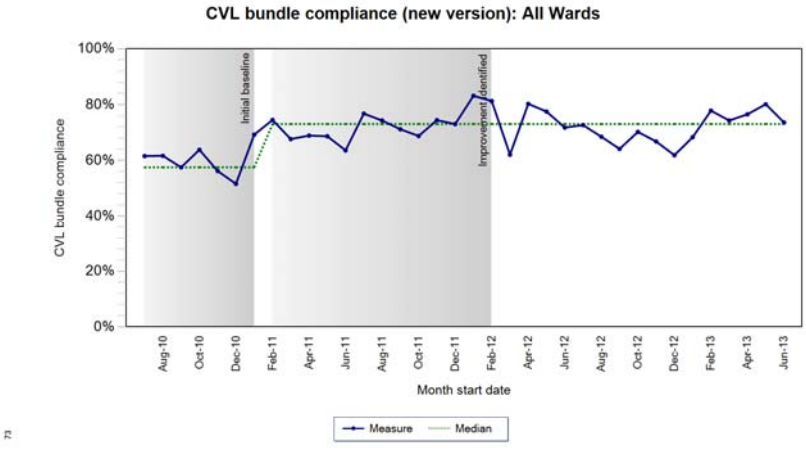
The practice educators are continuing to provide training on hand hygiene for staff within their Divisions. The IPC team provides induction IPC to all groups of staff but face to face annual update has been curtailed by the Trust. Each division has now incorporated infection prevention & control into their divisional plans and this also includes hand hygiene.



The time point for June 2013 represents 2503 satisfactory observations out of 2632 performed, giving a rate of 95%.

The national staff survey again reported lower than desired satisfaction with availability of facilities for all staff at all time. An in house survey confirmed that this mainly involved staff working in non clinical areas. Facilities are working on ensuring hand cleaning material is always available, but local areas need to take some responsibility on requesting replacement when needed..

CVL care bundle – each ward / department conducts monthly compliance audits with the CVL care bundle. This data is displayed on the Trusts transformation dashboard and wards / departments are encouraged to print off and display their own data, this should also be discussed with staff at their ward meetings.



Time point for June 2013 represents 265 satisfactory observations out of 302 performed, with a rate of 87%.

Divisions need to ensure improvement in these areas. Additional staff in the IPC Team would be able to assist with this process.

7) Corporate Facilities

Decontamination

The Trusts Decontamination services maintained accreditation in all three aspects: Sterile Services, Endoscopy and Medical Equipment to ISN standards. However, off site sterilisation has commenced due to cessation of local capacity and full service will move off site Sept 1st 2013.
Progress has been made towards full compliance with the vCJD control guidance as approval was given to purchase new neurosurgical instruments. Assurance must be given by any external provider that the integrity of these instruments will be maintained.

Facilities

Services remain outsourced to MITIE. A number of concerns were raised during the year regarding the standard of cleanliness by the senior nursing team, and as a result MITIE have implemented an internal transformation team to rectify these.

8) Estates

A rolling programme of validation of critical ventilation systems has commenced. All Theatres are verified, however, the programme has not yet covered all areas and there may still be hidden risks.
Legionella in domestic water supplies in all buildings is now monitored through a single service contract. No significant legionella counts were detected in high risk clinical areas. Remedial works have been carried out in some areas in the Frontage Building.

The MSCB was handed over to Estates in December 2011. The low temperature copper/silver system has been implemented for legionella control, no legionella has been detected, however, modification of the water supply system is still required to ensure the active agents are delivered to all outlets.

An initial response to the DoH alert on *Pseudomonas aeruginosa* has taken place, with satisfactory results from screening of the ITU's. Isolated detections have occurred but not linked to any patient isolates. Implementation of the full programme will require funding and a full business case is under way.

9) Audit

A regular IPC audit programme is followed throughout the year. The audits are undertaken by the link practitioners on their respective wards/departments. Audit data is displayed on the dashboards, discussed at Board and Unit meetings.

In addition to auditing hand hygiene compliance and compliance with the CVL care bundle (see graphs above) the following areas are covered as part of the 'Saving Lives' programme:
- Peripheral line care bundle (insertion and maintenance)
- Urinary catheter care bundle (insertion and maintenance) audited annually
- Renal dialysis care bundle audited annually
- Isolation precautions audited annually

Antibiotic prescribing – Antimicrobial stewardship committee agreed and commenced audit of three performance indicators.

Independent IPC Team audits and monitoring of practice have not been carried out as intended due to insufficient staff time.

10) Occupational Health

The Staff immunisation policy was updated. Influenza immunisation was provided.

11) Targets and outcomes

See HCAI statistics and Hand hygiene (sections 5 and 6)
CQUIN targets linked to IPC (CVC infections, SSI and blood stream infection audit) were mostly met.
Completion of an RCA for all appropriate *S. aureus* bacteraemia was achieved.

12) Training activities

A short session is provided for all clinical and nonclinical staff on induction in IP&C; antimicrobial prescribing is provided for medical induction and annual update.
Face to face annual IPC update has been curtailed. Local induction should provide additional training.
Role out of local training and competency assessment in aseptic non-touch technique and line insertion protocols has not been achieved Trustwide. Further work is required by Training and Education regarding assurance of medical competencies.

The annual infection control link network training was held in Oct 2012, and 14 people attended. Further training session were held as part of the bi-monthly infection control link network meetings.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
24th July 2013

Health and Safety Annual Report 2012-13 **Submitted by:** Ali Mohammed, Director of HR and OD	**Paper No: Attachment O**

Aims / summary

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

Action required from the meeting

To note the content of the report

Contribution to the delivery of NHS Foundation Trust strategies and plans

Contributes to the zero harm agenda

Financial implications

None of note

Legal issues

None of note

Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place?

N/A

Who needs to be told about any decision?

Aidan Holmes, Health and Safety Advisor

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

Aidan Holmes, Health and Safety Advisor

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

Trust Executive through Director of HR and OD and Chief Operating Officer

Health and Safety Annual Report 2012 -2013 (Trust Board)

1.0 Introduction

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

2.0 Context

- The team is made up of two, an advisor and an assistant, whose role is to advise the entire Trust on all health and safety matters.
- The Health and Safety Team sits within the Quality and Safety Department.
- There is no specific budget for health and safety within the department.
- Health and safety issues are reported to the Health and Safety Committee with appropriate issues being escalated to the Overall Management Group.
- The Director of Human Resources and Organisational Development is the new executive director responsible for Health and Safety (with effect from June 2013).

3.0 Achievements

- The number of incidents reported remains steady after the introduction of the online reporting system in 2011

- The Trust must be compliant with the EU Safer Sharps Directive by May 2013. The Trust is currently compliant with this

- The Health and Safety intranet site is complete and will be overseen by the Health and Safety Team

- The Health and Safety Team now benchmark the Trust's health and safety data against other Paediatric Trusts. This will continue in the future with a view to increasing the number of Trusts and data compared.

- The annual audit has been improved and simplified to reduce the workload on the local teams and buttress safety culture.

- The process for assessing the risks associated with the COSHH has been simplified and individual assessments will be placed on the intranet sites for corresponding wards or departments.

4.0 Issues

- A need to introduce *mandatory* risk assessment training for some staff groups has been identified and a plan for implementation is being agreed.

- The on-going redevelopment work will place a strain on the day to day workings of the Trust. All construction work must have a Risk Impact Assessment in place to mitigate the risks associated with patient care and any significant impact on the Trust.

- The permit to work system is being reviewed by the Estates Department as there is a need for the Trust to have greater control of the work undertaken across the Trust.

4.0 Priorities

4.1 Incident Reporting: Regular incident reporting throughout the Trust allows the Health and Safety Team to investigate incidents and accidents and identify themes that may be prevalent. GOSH employees reported 919 Health and Safety incidents from the 1st of April 2012 to the 31st of March 2013 including 100 patient safety incidents. To help the learning process; the Health and Safety Team contact the reporter of incidents to ascertain the wellbeing of those involved in the incident and to establish whether there is an opportunity for learning. Subsequent learning is then spread to the relevant individuals/groups either through the Risk Action Groups, QST Times, Safety Alerts or training sessions/tool box talks.

4.2 Training: Over the past two years, the staff survey has shown that only 60% of staff perceived that they received health and safety training over the last 12 months. The national average was 78%. In response to this there is an aim to make Risk Assessment Training mandatory for relevant groups of staff across the Trust. The groups will be formalised by the 1st of August 2013.

Greater emphasis has been placed on enhancing the safety culture within the whole of the Estates Directorate. Part of this has been an increase in safety training. Staff are openly encouraged to undertake relevant courses incorporating safety aspects which include: Conflict Resolution training, Institute of Occupational Safety and Health training, Ladder training, Site Specific Generator training, Release of Trapped Person training, Asbestos Training, High Voltage Authorised Person training, Power Electronics Generator training, Authorised Person LV (Healthcare) training and Eclipse training (Building System Management).

4.3 Control of Substances Hazardous to Health: COSHH issues within the Trust continue to evolve as newer, safer substances become available. COSHH folders have been implemented for staff on the Wards for a number of years and are a source of knowledge relating to substances and processes. COSHH information is in the process of being ported onto the intranet where each individual Ward has a site contained within the health and safety site. This will allow the Health and Safety Team to update information as and when necessary.

4.4 Redevelopment Work – Phase 2B: Further redevelopment work will take place over the next financial year. It is important that the Health and Safety Team continue to build constructive relationships with our primary contractors and that safety information is acted upon. This should help to keep accidents to a minimum and ensure that any accidents that do occur are investigated thoroughly and openly.

5.0 Progress

5.1 Successes:

- Positive evolution of the Estates department safety culture. This has continued to progress.
- The building of the MSCB with limited health and safety issues.
- Close working relationship with Mansells contractors.

- Achieving Level 3 NHSLA.
- Zero severe incidents reported over the timeframe.
- Overall, the results of the audit improved on the previous year particularly with regards to the Estates Department.
- The Health and Safety Team currently facilitate 17 monthly Risk Action Groups across the corporate areas of the Trust.
- A new Trust Fire officer was appointed further to the previous long standing post holder leaving.

5.2 Concerns:

- Concerns regarding the lack of system for implementing widespread changes in Departments which have a direct impact on safety. Systems need to be in place to assess the validity of changes which may affect the safety of patients/staff and visitors. The Laboratories are an example of good practice in this regard.
- Communication: this is a trend throughout every RCA and SI. This is not exclusively a Health and Safety issue. There are still some issues and incidents that are not always communicated or reported to the Safety Team.
- Some of the buildings on the site are too hot in summer and too cold in winter. There is often a reactionary response to these issues which are re-occurring and yet fail to adequately plan for.
- Accidents reported under RIDDOR have increased from 7 to 9. The prevention of serious incidents is a priority for the Health and Safety Team.
- The hospital has recently (late June 2013) discovered shortcomings in its fire response capability and these will remain the subject of senior management attention and action until resolved.

6.0 Conclusions

The HSE state that if an organisational reporting profile does not comprise of at least 70% near misses/no harm events, there is a need to raise awareness of the importance of reporting near misses. Near misses and no harm events are free safety lessons. The percentage of all health and safety incidents at GOSH comprising of near misses and no harm events is 96.5%. This would seem to indicate that GOSH has a positive reporting culture and staff are aware of their health and safety responsibilities. During a benchmarking session with some of the other Paediatric Trusts in the United Kingdom, our incident reporting rates were found to be very high, particularly the proportion of near misses that we received. The number of incidents reported under RIDDOR has increased however, which highlights there is no room for complacency.

Events over the time period have also highlighted issues relating to a change in a procedure which has caused a great deal of confusion. A major factor in this has been a lack of communication. This is also a factor in the vast majority of safety investigations undertaken by the Safety Team. A more robust approach is required to improve communication and also to put checks in place to prevent people from making wholesale changes that affect safety.

Overall, the Trust was compliant with its statutory requirements during the reporting period, had no health and safety incidents classified as severe and has had a small increase in the amount of health and safety incidents reported. This has been achieved whilst a brand new clinical building has been completed within a working

hospital. There are some areas of concern outlined above that can be improved but overall the Health and Safety performance of the Trust has been good.

7.0 Recommendations

Recommendation	Action Required	Lead for Action	Due for Completion	Date Completed	Plan for on-going monitoring of compliance
Publicise the Trusts Incident Reporting system Datix and continue to encourage an open no blame culture. This allows the maximum amount of data and information to be collected and investigated	Work with the Datix Administrator to continue to allow Datix to evolve to make reporting easier and more accessible.	Chris Ingram	31/8/13		Monitored via the Trust H&S Committee. Local risk registers.
Raise the profile and improved branding of the health and safety training available to staff.	Work with the Education and Training Department to implement new training courses and materials and help staff to recognise the training that they do receive.	Aidan Holmes	31/8/13		Monitored via Health and Safety Committee.
Introduce new COSHH assessments and re-audit the Trust to investigate what hazardous substances are in the Trust at the present time. Try to substitute hazardous substances where possible.	COSHH Audit 2013	Aidan Holmes	31/8/13		Monitored via Health and Safety Committee. All information fed back to senior nursing staff.
Continued communication and engagement with the Redevelopment team particularly regarding Phase 2B.	Continued attendance at Project meetings. Auditing of Risk Impact Assessments. On-going communication with Redevelopment team	Aidan Holmes / Chris Ingram	2013 / 14		Monitored via Projects Health and safety Committee and the Trust Health and Safety Committee.
Annual Health and safety Audit of the whole Trust due August 2013.	Audit of Trust	Aidan Holmes / Chris Ingram	31/8/13		Monitored via Health and Safety Committee.
Further benchmarking of health and safety issues and incidents with other paediatric trusts.	Renewed communication and sharing of information with other Trusts	Chris Ingram	31/8/13		Monitored via Health and Safety Committee and Audit Committee.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
24th July 2013

Quarter 1 Monitor Return (3 months to 30 June 2013) **Submitted by:** Claire Newton, CFO	**Attachment Q**

Aims / summary
This paper summarises the Trust's 2013/14 Quarter 1 (Q1) Return to Monitor, the independent regulator of NHS Foundation Trusts.

The Trust is reporting a Financial Risk Rating of **4** and a Governance Risk Rating of **green**for the period 1 April to 30 June 2013.

Key points:

Finance

- The financial information included in the template is entirely consistent with the Month 3 Board report.
- There are no financial risk indicator warnings resulting from the information included in the template.
- The Trust is forecasting a Financial Risk Rating of 4 for the remaining quarters of the financial year 2013/14.

Governance

- The Trust is reporting that it has met all relevant governance targets in Q1.
- The Trust has plans in place to ensure on-going compliance with all relevant governance targets and is committed to comply with all known targets going forward.

Other

- No governors' elections have taken place in the period.
- There are no matters arising in the quarter requiring an exception report to Monitor.

Action required from the meeting
The Board is asked to approve the Quarter 1 'In-Year Governance Statement' prior to submission to Monitor.

Contribution to the delivery of NHS Foundation Trust strategies and plans
Financial Stability and Health

Financial implications The Trust is meeting its planned financial targets

Legal issues N/A

Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place? N/A

Who needs to be told about any decision? Monitor

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

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

Worksheet "Finance Risk Indicators"

Finance Risk Indicators for Great Ormond Street Hospital for Children

Please respond "True" or "False" in the yellow cells below to statements 3 to 7 inclusive

	Finance Risk Indicators	Response
1	**Unplanned decrease in (quarterly) EBITDA margin in two consecutive quarters**	**FALSE**
2	**Trust is unable to certify that Board anticipates that the Quarterly FRR will be at least 3 over the next 12 months (from Governance Statement)**	**FALSE**
3	**Working capital facility (WCF) was used at any point in the quarter ending 30 Jun 2013**	**FALSE**
4	**Debtors > 90 days past due account for more than 5% of total debtor balances**	**FALSE**
5	**Creditors > 90 days past due account for more than 5% of total creditor balances**	**FALSE**
6	**Two or more changes in Finance Director in a twelve month period**	**FALSE**
7	**Interim Finance Director in place over more than one quarter end**	**FALSE**
8	**Quarter end cash balance <10 days of *(annualised)* operating expenses**	**FALSE**
9	**Capital expenditure < 85% of Latest Plan for the year to date**	**FALSE**
10	**Capital expenditure > 115% of Latest plan for the year to date**	**FALSE**
	Note: Once your financial results are entered in SoCI, SoFP and SoCF the "?" cells will be calculated	0

Notes: *As set out in Monitor's Compliance Framework 2013-14, Monitor will separately consider this limited set of indicators to highlight the potential for any future material financial risk. Where Monitor believes that one or more of these indicators are present at an NHS foundation trust, Monitor will consider whether an earlier meeting with the trust to discuss them is appropriate. Following this meeting, Monitor may request the preparation of plans, or the provision of other assurances as to an NHS foundation trust's capacity to mitigate any potential risk. The use of these indicators will not form part of the formal regulatory framework or Monitor's approach to the potential use of its statutory powers of intervention.*

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 24th July 2013	
Trust Board terms of Reference **Submitted by: Anna Ferrant, Company Secretary**	**Attachment R** For approval
Aims / summary The terms of reference have been reviewed and updated. A revised version of the terms of reference is attached at appendix 1. Amendments are shown in red text. The Board Calendar has also been reviewed and update and this is attached here.	
Action required from the meeting To note the report and ratify the amendments to the terms of reference.	
Contribution to the delivery of NHS / Trust strategies and plans This report demonstrates that the Committee has complied with its Terms of Reference and adequately demonstrated its accountability to the Trust Board.	
Financial implications No direct financial implications.	
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? N/A	
Who needs to be told about any decision N/A	
Who is responsible for implementing the proposals / project and anticipated timescales? All members of the Committee.	
Who is accountable for the implementation of the proposal / project Clinical Governance Committee Chairman	

Great Ormond Street Hospital for Children NHS Foundation Trust

BOARD OF DIRECTORS' TERMS OF REFERENCE

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

1. Constitution

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

~~1.~~2. Role

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

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

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

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

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

- Audit Committee
- Clinical Governance Committee
- Finance and Investment Committee
  ~~Management Board~~
  ~~Claims Group~~

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

~~2.~~3. Membership

The Board of Directors shall comprise 12 directors excluding the C~~c~~hairman.

There shall be 6 non-executive directors.~~, one of whom shall be appointed by the Institute of Child Health, University College London~~. The Deputy Chairman may deputise for the Chairman. No other person will be authorised to deputise for a non-executive director.

There shall be 6~~5~~ executive directors ~~(authorised deputies are shown in brackets)~~:

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

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

The Board may approve ~~other~~ deputies with formal acting up status.

~~3.~~4. Attendance at meetings

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

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

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

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

- Director of Planning and Information
- Director of Redevelopment
- Director of Research and ~~Development~~Innovation

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

These invited individuals do not hold a vote.

~~4.~~5. Quorum

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

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

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

~~5.~~6. Frequency of meetings

The Board of Directors shall normally hold formal Board meetings on the ~~last~~ fourth Wednesday of the ~~month except in February, August, October and December~~follows:~~.~~

- January
- March
- May
- July
- September
- November

~~The Board of Directors shall normally hold strategic review days in February and October of each year.~~

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

Executive directors and non-executive directors are expected to attend a minimum of 5~~7~~ meetings per year including strategic review days.

~~6.~~7. Performance evaluation

The Board of Directors will undertake an evaluation of its own performance on an annual basis.

~~7.~~8. Secretariat

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

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

Signed minutes shall be maintained by the Secretariat.

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

~~8.~~9. Review of the terms of reference

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

Draft - July 2013

TRUST BOARD CALENDAR

Area of Work	Responsible Executive/Director/ Company Secretary	January	February	March	April	May	June	July (AGM)	August - NO MEETING	September	October	November	December - NO MEETING
CONFIDENTIAL ITEMS													
Legal Report including claims	BB	√						√ Annual					
Serious Incident Report	ME	√		√		√		√		√		√	
Employment Report including claims	AM							√ Annual					
Remuneration Committee Summary of Minutes	JC	√				√							

TRUST BOARD CALENDAR

Area of Work	Responsible Executive/Director/ Company Secretary	January	February	March	April	May	June	July (AGM)	August - NO MEETING	September	October	November	December - NO MEETING
PUBLIC ITEMS													
Assurance framework	RB	Summary				√				Summary			
Performance Report -Targets and indicators & CRES - Finance and activity - Quality and Safety - Pt Experience	RB	√ PE		√		√ PE		√PE		√		√ PE	
Clinical Presentation	RW	√		√		√		√		√		√	
Trust wide risk register summary	ME					√							
Redevelopment Update	MT	√ - sustainable								√			
Update on research activities	DG	√								√			

TRUST BOARD CALENDAR

Area of Work	Responsible Executive/Director/ Company Secretary	January	February	March	April	May	June	July (AGM)	August - NO MEETING	September	October	November	December - NO MEETING
Annual Reports													
Child Protection and Safeguarding Report	LM					√ (annual report							
Annual H and S report	ME							√					
Annual PPI and PALS report	LM							√ Annual					
Trust Annual Report	AF					√							
Annual Fire Strategy	RB	√											
Equality and Diversity Annual Report	BB	√											
Strategies and corporate policies													
Annual Plan Strategic Objectives (and mid year update)	RB		√								√		
Quality Strategy	ME	√				Quality Report							

TRUST BOARD CALENDAR

Area of Work	Responsible Executive/Director/ Company Secretary	January	February	March	April	May	June	July (AGM)	August - NO MEETING	September	October	November	December - NO MEETING
Governance													
Trust Board ToR and Board Calendar	AF							✓					
Clinical Governance Committee Summary of meeting	AF			✓		✓		✓				✓	
Finance and Investmant Committee Summary of meeting	CN			✓		✓		✓				✓	
Audit Committee Summary of meeting	AF			✓		✓		✓				✓	
Members' Council Report including update on membership	AF			✓		✓		✓				✓	
Risk Management Training/ Code of Conduct update	AF			✓ - Conduct				✓ - Risk					
Register of Interests and gifts	AF			✓									
Register of Seals	AF	✓		✓		✓		✓		✓		✓	

TRUST BOARD CALENDAR

Area of Work	Responsible Executive/Director/ Company Secretary	January	February	March	April	May	June	July (AGM)	August - NO MEETING	September	October	November	December - NO MEETING
Compliance													
External Auditor Management Letter	CN											✓	
CQC registration overview - QRP (CGC reviews)	AF			✓						✓			
Infection Control Report including HoN input	ME			✓				√ and annual DIPC report				✓	
Monitor self-certification statements	RB/CN	✓			√			√			√		
Board evaluation	AF										✓		

ATTACHMENT S

Great Ormond Street Hospital for Children NHS Foundation Trust

Report from the Audit Committee – 24th May 2013

Risk

It was noted that the Board Assurance Framework format had changed to take into account the Board's risk appetite. This had resulted in a larger number of amber risks which was deemed appropriate. In future, risks with a catastrophic impact score would also be reviewed by the committee.

The committee reviewed two risks at its May meeting:

- Funding: It was reported that a downside mitigation programme for the continuity of funding streams would be reviewed on a six monthly basis and the action plan would be reviewed at the next committee meeting.
- CRES: It was reported that GOSH was benchmarked at the mid-point for delivery of CRES when compared with other Trusts. It was agreed that it was important to establish clarity around messaging about CRES to staff and to distinguish between the target the Trust aims for and the bottom line target that had to be met.

The committee noted that work was underway to map incidents to risks on the trust wide risk register.

Update on NHSLA assessment

It was reported that the NHSLA inspectors had reviewed the outstanding 8 criteria and confirmed that the Trust would retain its level 3 assessment.

Update on level of insurance for Trust

The committee heard that the Trust was conducting a process to purchase a comprehensive insurance programme. Since authorisation as a Foundation Trust, the Trust had taken out property insurance and also additional professional indemnity and travel insurance. The process was expected to conclude by the end of July with all necessary insurances in place.

It was agreed that the Trust should conduct credit checks on existing critical suppliers.

Work was underway to review the inter relationship between GOSH and ICH with respect to insurance responsibilities.

Draft Internal Audit Annual Plan 2013-14

The Committee approved the plan subject to the IT strategy review being replaced with an operational IT review.

Counter Fraud Progress Report and 2013/14 Work Plan

The Committee approved the plan.

Foundation Trust Final Accounts (1st April 2012 – 31st March 2013)

The Committee approved the accounts and recommended them to the Board.

Draft Annual Report (1st April 2012 – 31st March 2013) including annual governance statement

The Committee approved the annual report and recommended it to the Board.

Chief Finance Officer's Review of the annual accounts for 2012-2013

The Chief Finance Officer informed the Committee that the increase in non-pay was due to the commissioning of the Morgan Stanley Building resulting in a direct increase in costs including estates and facilities, as well as the cost associated with additional investment in IT.

Quality Report 2012-13

The report was approved for submission to the Board subject to minor clarifications.

Report on the financial statement audit for the 12 month period ended 31 March 2013

The external auditor (Deloitte) confirmed that they would issue an unmodified opinion on the financial statements, taking account of issues presented in the report.

The auditors confirmed that they were satisfied with the content of the representation letter and with the management responses to audit reports and the monitoring of these recommendations and actions.

The report would be sent to Monitor and the Members' Council.

The committee agreed to recommend signing of the representation letter and the statement on disclosure of information to the auditors.

2012/13 Quality Report External Assurance Review

The Committee was reminded that the auditors gave a limited opinion because the focus of the audit was restricted to the content and consistency of reporting only. The Committee was informed that the Trust had scored green across all measures, and was the only Trust that had achieved this level of assurance.

The Committee recommended the auditor's statement to the Board.

Working capital

It was reported that cash and creditors were in a good position and levels of overdue debtors were being closely monitored. There had been some improvements in IPP debtor days.

ATTACHMENT T

Great Ormond Street Hospital for Children NHS Foundation Trust

Clinical Governance Committee Summary of Meeting

19th June 2013

The Committee received an update on the Arvind Jain Action Plan. It was reported that the Neuromuscular team was engaging with the King's Fund on a programme of improvements and the committee agreed that ongoing work around time between referral and gastrostomy could be tasked to the surgical team.

The Committee reviewed their terms of reference and stressed the importance of avoiding a formulaic agenda and that time should be allowed to review the items on which assurance was required and to perform deep dives where necessary.

It was agreed that a meeting would take place with the Chief Executive, the CGC Chair, Audit Committee Chair and the Company Secretary would take place to ensure risks were refined and joined up with the activity around the hospital.

The Committee reviewed 3 CRES schemes and agreed that there no adverse effects had arisen.

The Head of Nursing report confirmed that there had been particular focus placed on CVL compliance and the poor documentation in the area. It was reported that new documentation had been rolled out Trust wide and that a number of areas had achieved 100% compliance.

The Committee noted that an internal audit of consent to treatment had provided reasonable assurance based on a follow up review. Significant assurance had been provided in the area of CQC compliance monitoring.

The Committee chairman stressed the importance of sharing and following up the learning which had come from clinical audits.

It was reported that the Pressure Ulcer Improvement Project had led to a 35% reduction in GOSH acquired grade 2+ pressure ulcers and the reduction had continued during 2013-14.

A presentation on the play therapy service was provided and the committee stressed that play was fundamental to providing a service to sick children and saving costs in terms of avoiding cancelled procedures.

It was agreed that the Francis Report would be a standing item on the CGC agenda.

The committee stressed the importance of tackling the issues with timeliness of discharge summaries in relation to the 2013 referrers' survey results. It was noted that the survey results were disappointing given the improvement programme which had been ongoing since 2010.

The Committee noted that the Trust had achieved the necessary levels of training for both information governance and safeguarding.

It was highlighted that the Trust achieved 99.3% of CQUIN targets which was excellent.

ATTACHMENT U

Great Ormond Street Hospital for Children NHS Foundation Trust

Update from the Finance and Investment Committee meeting held on 20th May 2013

Review of Financial Performance 2012/13

The Committee reviewed the Trust's financial performance for 2012/13 and discussed activity currencies and the increase in cost growth for the financial year.It was agreed that clinical unit financial performance and activity reports will be further developed with the aim of improving the allocation of support costs; removing distortions in activity information caused by changes in activity measures, and the development of a strategy to address activities where costs exceed available funding.

CRES delivery

It was noted that the Trust was reporting full CRES delivery whereas in March there had been a forecast shortfall. It was agreed that the finance team would review systems for reporting CRES achievement in year

Segmental Reporting

The Committee discussed the reasons for the increased deficit of the NHS activity and agreed to review in further detail at the next meeting.

EDRMS Business Case

The Committee supported the business case going to the Trust Board.

CG Proposal

The Committee discussed the CG proposal. The non-executive directors supported the concept in principle and the Committee agreed that further due diligence should be carried out and independent advice sought before progressing.

Proposal to Increase Treasury Deposits Limit

The Committee approved an increase to the level of deposits the Trust can make with the National Loans Fund from £10m to £25m.

ATTACHMENT V

Attachment V

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council Update

A meeting of the Members' Council was held on 26th June 2013.

Councillors received a presentation on the results of the IPSOS Mori inpatient survey. The Council agreed the importance of patients and families knowing how to complain and access the PALS service and discussion took place around ensuring visibility of these services.

It was reported that the Auditor opinion on the financial accounts and quality report had been received. It was noted that recommendations had been provided and would be monitored.

The Members' Council noted the Quality Report 2013 and received an update about consultation plans for the 2014 report. It was confirmed that the Council would be required to select from the service improvement projects which had taken place during 2013, those that should be included in the Quality Report for 2014.

A report from the Membership and Engagement Committee was received which set out the priority areas the Committee had agreed to pursue: membership numbers and membership composition; ensuring councillors have a link to their constituencies; how to engage with the hospital and events that councillors can get involved with.

Feedback from the Listening Event was discussed and the Council stressed the importance of providing timely feedback to those who had attended the event.

The Council discussed the questionnaire which would be used for the purpose of self-evaluation. It was agreed that the survey would be conducted in July/ August for reporting to the September meeting.

A verbal report was provided by the Chief Executive who updated the Council on a number of news stories of achievements and awards won by staff at GOSH. Discussion took place around the national pressure on intensive care beds and the affect this had on GOSH.

Councillors noted reports from the May meeting of the Audit Committee and June meeting of the Clinical Governance Committee.

The Members' Council raised the matter of wi-fi internet access being available to patients and families and agreed to receive a report on issues with this at the next meeting.