Great Ormond Street Hospital for Children NHS Foundation Trust

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST

MEETING OF THE MEMBERS' COUNCIL

Wednesday 28th January 2015
4:00pm – 6.30pm
Charles West Room, Paul O'Gorman Building

NO.	ITEM	ATTACHMENT	PRESENTER	TIME
1.	**Welcome and introductions**		Chairman	4:00pm
2.	**Apologies for absence**		Chairman	
3.	**Declarations of interest**		Chairman	
4.	**Chief Executive Update**	**Verbal**	Interim Chief Executive	
	PRESENTATIONS			
5.	**Update on implementation of the IPP Strategy**	**A**	Director of Planning and Information	4:10pm
6.	**Apprenticeships at GOSH**	**B**	Geoff Speed, Assistant Director of Medical Education	4:20pm
	ITEMS FOR DISCUSSION			
7.	**Genomic Medicine Centre**	**C**	Maria Bitner-Glindzicz, Honorary Consultant, Clinical Genetics	4:30pm
8.	**Annual Plan 2015/16**	**D**	Director of Planning and Information – Robert Burns	4:45pm
9.	**Update on CQC Inspection at GOSH**	**E**	Anna Ferrant, Company Secretary& Kelly Stevens, Compliance and Governance Manager	4:55pm
10.	**Update on the Members' Council Development**	**F**	Geoff Speed, Assistant Director of Medical Education	5:05pm
	ITEMS FOR APPROVAL			
11.	**Appointment of a non-executive director at Great Ormond Street Hospital for Children NHS Foundation Trust**	**G**	Company Secretary	5:15pm
12.	**Process for appointment of the Lead Councillor**	**H**	Company Secretary	5:25pm

	PERFORMANCE REPORTS			
13.	**Chief Executive's Report including** • **Quality and Safety (including infection rates)** • **Activity (including discharge summary performance)** • **Workforce** • **Finance**	**I**	Interim Chief Executive Co-Medical Director – Martin Elliott Chief Operating Officer – Rachel Williams Director of HR and OD – Ali Mohammed Chief Finance Officer – Claire Newton	5:35pm
14.	**Update on Patient Experience** • **Patient Advice & Liaison Service Report - Quarter 3 2014/15** • **Complaints**	**J**	Chief Nurse – Liz Morgan Chief Operating Officer	5:50pm
15.	**Update on election and report from the Membership Engagement Committee**	**K**	Membership and Governance Manager - Deirdre Leyden and Lisa Chin-A-Young, Chair of the MEC	6:00pm
16.	**Young People's Forum Update**	**Verbal**	Chair of the YPF - George Howell, Councillor	6:10pm
	GOVERNANCE & REPORTS FROM BOARD COMMITTEES			
17.	**Minutes of the meeting held on 24 September 2014** **Minutes of the meeting held on 26th November 2014**	**M** **R**	Chairman	6:15pm
18.	**Matters Arising and action log**	**N**	Chairman	
19.	**Reports from Assurance Committees** • **Audit Committee (January 2015)** • **Clinical Governance Committee Summary Report (January 2015)** • **Finance and Investment Committee Summary Report (January 2015)**	 **O** **P** **Q**	 Chairman of the Audit Committee – Charles Tilley, NED Chair of the CGC – Mary MacLeod, NED Chairman of the F&I Committee – David Lomas, NED	6:20pm
20.	**Any Other Business**		Chairman	6:30pm
21.	**Meeting closes**			

Attachment A

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

28th January 2015

International and Private Patients Strategy Group Sub Committee

Summary & reason for item:

To NOTE the International and Private Patients Strategy recommendations.

Councillor action required:

To NOTE the recommendations for plans for IPP strategy noting that all developments will be progressed in accordance with the Trust's Business Case process.

To NOTE specifically that plans to develop IPP services will not adversely affect NHS services.

To NOTE that the current plans for IPP development do not exceed the growth limits as set down in legislation and therefore do not require explicit Governor approval.

Report prepared by:

Trevor Clarke, Director International Private Patients Service

Item presented by:

Rachel Williams COO

Attachment A

Great Ormond Street Hospital NHS Foundation Trust

Members Council Meeting

28 January 2015

Introduction

This document is a summary of the view of the previous IPP strategy and provides recommendations for the next five years.

Along with other acute trusts, GOSH is already feeling the impact of a significant, and growing, gap in funding for NHS services. Financial pressures on NHS activities at the Trust are expected to increase and NHS income is forecast to fall over the strategic plan period. This will increase the importance of the contribution of IPP activity to the Trust's overall financial position.

Capacity in Octav Botnar private wards is now maxed out. Last year, the Trust responded to impending IPP capacity constraints by agreeing a strategy to increase usage of outlier beds. However, divisions failed to meet income targets for outlier beds and were only able to partially mitigate the loss of income by increasing OBW activity. Growth in IPP income therefore effectively 'topped out' in 2013/14.

For the foreseeable future, most IPP income will continue to be derived from the treatment of patients at GOSH in London. Increasing treatment capacity in London is therefore a major priority for the strategic period and IPP income is unlikely to grow significantly until this occurs.

Background

The IPP strategy and future strategy was reviewed at two workshops, the notes of these meetings and presentation slides are attached. The main areas of growth considered were:

- Treatment in London
- Partnerships
- Options for growth outside of OBW

Treatment in London

Treatment in London will continue to deliver the vast majority of IPP income. It has been considered in two phases.

Phase 1, years 1 - 2, short to medium term.

Phase 2, medium to long term, that is after phase 2b becomes operational.

Several options were considered to provide an increase in bed capacity, ideally OBW would become the 'private wing' of the hospital. Future growth following the opening of Phase 2b could be contained in this wing. It was recognised careful consideration needs to be given to the relocation of NHS activity.

10% growth per annum requires an additional 21 IPP beds.

All options require additional supporting resources in terms of theatres, ICU beds, MRI scans and IR. There are plans in all areas to accommodate IPP growth.

Theatres, MRI scan, Interventional radiology (IR) and PICU have all been modelled and there are solutions.

A new theatre (theatre 10) is scheduled to open late next year and this will accommodate some IPP growth. . It is anticipated there will also be planned overruns on NHS lists and Saturday lists to accommodate private surgical patients and there is a commitment from the surgeons to provide this.

For MRI / IR there are business cases being developed to open currently unused capacity for NHS emergency cases and private cases. This would provide capacity to reduce the current practice of GOSH IPP patients being transferred elsewhere for MRI and to will also ensure current NHS lists are not disrupted with emergency activity.

In PICU there is available bed capacity, staffing has increased recently and recruitment will continue. 21 additional IPP beds would require less than 1 additional PICU bed.

Overview of options considered:

1. Build upon the 7th Floor of OBW. Planning and height restrictions would prevent this option.

2. Sky ward, this option would deliver 11 beds, however the location of NHS orthopaedic beds would be difficult.

3. Kingfisher ward, relocation of NHS activity to Island Short Stay, Puffin and Woodpecker was possible. However, the relocation of the gastroenterology scope suite made this option unaffordable, the cost was estimated to be in the region of £19 million and would be open in 2 years' time.

4. IPP beds to be provided in a combination of adjacent areas in Southwood, Island Short Stay, Puffin and the wing in between. This option would deliver 10 beds which would open in 1 year, the cost is estimated at £8 million.

5. Convert OBW outpatient facility (Caterpillar) into an inpatient ward. Relocation of IPP OPD would be either in level 1 OBW or the frontage. Both options would prevent future expansion of NHS activity.

The option felt to be most appropriate to deliver phase 1 would be option 4, although 21 beds would not be delivered, future phases would be available following the opening of 2b.

Partnership

Partnership with another NHS provider or the Private Sector has been considered as a way to facilitate growth. The main issue with partnerships would be the delivery of care off site and the critical mass of support services needed to treat a GOS case mix of complex patients. It is therefore likely that less complex work could be considered for off-site treatment and unfortunately this does

not fit with the longer term strategy of increasing quaternary service provision and therefore attracting more complex patients for treatment London. . The consultants providing private services at GOSH are reliant upon the clinical support services for their complex patients. They also value private facilities on site without having to travel, this has featured highly with those consultants indicating they would repatriate their work to GOSH.

In the light of this Partnership will only become attractive if capacity to increase activity cannot be found on the GOSH site,

Options for growth outside of Treatment services

Consideration will be given to growth other than treatment in London and a range of products education, training and consultancy products will be developed building upon work undertaken in Kuwait. Accreditation has been discussed with the Education and Training Team but has been discounted.

The range of international offerings and products will include;

- International Faculty of GOSH staff to deliver education
- Development of a lower cost model for the provision of education and training using on line resources e.g. Gold

Other products will include 'training needs assessment, Curriculum development, tools for individual assessment and performance and service consultancy and review

Deloitte have been reviewing these commercial opportunities (amongst others) and will shortly make recommendations.

Quality and customer Experience

The concept of mixed speciality wards is different from the model of GOSH wards and IPP has had to demonstrate that clinical practice is the same as in the rest of the Trust. IPP has had the benefit of a stable and very focused senior team which has driven safety and best practice in line with the Trusts Safety and Quality programmes. This will continue.

Given the nature of the International patient base IPP will continue to focus on improving customer experience for patients and families visiting London from abroad. This includes further development of cultural support and of interpretation services working with the clinical teams to ensure all patients receive adequate support.

Marketing

The marketing approach has been to segment territories and establish a framework to assess territories. The main focus is Referrals to London for Treatment and Education and Training. A 'mixed economy' of referrals from different territories would help to alleviate the reliance upon the Middle East. Self- pay patients from different territories are fraught with potential debt issues, however there is more we can do to encourage packages of care with the risk element taken by the

Trust. GOSH provides many estimates currently but currently only a small percentage of these result in a referral to GOSH.

The Middle East media thrives in Facebook and Twitter; there are also many patient and family on line groups. GOSH web sites in Arabic and English have been launched in Kuwait and UAE. These and the use of appropriate social media need to be further developed.

Consultants need support, they are in the main very loyal but the lack of beds and theatres recently has been difficult. The growth strategy is underpinned by consultant repatriating work to GOSH and they need to be kept on board.

The Charity team have been very helpful to IPP and work closely to provide marketing services. Plans have been established to increase capacity and capability and these will produce benefit I the second half of 2015.

Next steps

1. Continue to progress plans to formalise the project plan for option 4 which delivers 10 beds by January 2016.

2. Progress the business plan for the above option.

3. Progress plans for phase 2 to deliver the remaining 11 required IPP beds.

4. Partnerships not to be considered in phase 1 and 2.

5. Continue to review services in UAE and Kuwait (known territories) supported by Education and Training. Consider other territories as the opportunities arise.

6. Continue to ensure parity of clinical services.

7. Continue to develop marketing of IPP services.

8. Continue to monitor NHS activity and the effect of IPP upon NHS activity.

<u>Action Requested</u>

Members' Council are asked to note:

-the intention to expand treatment capacity in London as suitable capacity becomes available beginning with 10 further beds in 2015/16

-the further development of education and training products for international use

-the development of marketing capability to secure referral flows and introduce new services to international referrers in the light of increasing international competition.

Trevor Clarke

Director of International and Private Patients

January 2015

Attachment B

Great Ormond Street Hospital for Children NHS Foundation Trust

HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT

Members' Council

28th January 2015

Apprenticeships at GOSH

Summary & reason for item: This paper provides an update on the progress made in relation to the employment of Apprenticeships at GOSH

Councillor action required: For information and comment

Report prepared by: Geoff Speed

Item presented by: Geoff Speed

1. Introduction

The following paper provides Members Council with an update on the progress GOSH has made with their Apprenticeship Scheme.

2. Background

Apprenticeships are work-based training programmes designed around the needs of employers which lead to national recognised qualifications. GOSH currently uses apprenticeships to train both new and existing employees and the Trust receives government funding to train many of the apprentices.

The majority of the training is 'on the job' but any remaining training requirements are provided by a local college or by a specialist learning provider. GOSH have an on-going partnership with Hawk Training to provide support for admin based roles and more recently have begun exploring child healthcare qualifications to support opportunities within the Staff Nursery and the hospital Play Service.

The benefits to both managers and apprentices are numerous from a simpler shortlisting process to salary savings made during the first year of the apprenticeship for managers and real work experience opportunities for apprentices, a number of whom have gone onto take up permanent roles within the Trust.

3. Activity

There have been 27 apprenticeship appointments at GOSH since April 2012 (12 in 2012-13, 7 in 2013-14 and 8 so far in 2014-15). These apprenticeships have been appointed at both band 2 (15 appointments)

and band 3 (12 appointments). Of these, 19 have completed their qualification - 70% of whom are still working at GOSH - 5 have recently started and 3 are currently undergoing their pre-employment checks.

4. Estimated Savings

When apprenticeships are used to replace the conventional recruitment process there are cost savings related to:-

1. Salary savings (including basic pay, NICs and superannuation) as the apprentices are paid at a rate of 60% of the top of banding for the first six months and 75% of the top of the banding for the final six months of their 1 year appointment. This is opposed to the assumption that a conventional staff appointment would be made at 100% of the bottom of the banding.
2. Time savings in relation to the removal of the need for Line Managers to shortlist suitable candidates as this task is undertaken by the training provider (Hawk). It is estimated that this would be and average of 4 hours per appointment.
3. A reduction in the work required from the HR Recruitment Team as some of the recruitment task are undertaken by the training provider. It has been estimated that this would again be an average of 4 hours per appointment.

The estimated saving for each apprenticeship amounts to £3,257 for a band 2 appointment and £4,213 for a band 3 appointment. It is important to note these savings are non-recurrent (one-off). After 12 months the apprenticeship should lead to permanent employment. For the savings to be recurrent a level of staff turnover or progression through bands 2 and 3 is required to maintain the apprenticeship role(s).

5. Taking apprentices to the next level

The Trust is ambitious in terms of our drive to increase the number of apprentices and also become properly recognised as a strong, caring local employer. To support us, HENCEL have awarded the Trust £50,000 that will be used to support the following areas:

- communicate the expansion of our programme;
- develop the competencies and assessment programmes required;
- train managers and supervisors required for an expansion on this scale and;
- measure and evaluate the success of the programme through the development and implementation of a set of tailored metrics.

6. On-going support and future plans

6.1 Apprenticeship Lead Roles

Earlier this year, GOSH was successful in a bid to host two new roles – Apprenticeship Leads – to work in close partnership with HENCEL (Health Education North Central and East London). The post holders are based at GOSH but funded by HENCEL with a remit to support NHS Trusts within NCEL to expand their apprenticeship numbers across the area in 2014 and 2015. It is hoped that by providing this valuable extra capacity, Trusts will be able to collaborate further, share examples of best practice and continue building strong cases for apprenticeship schemes.

6.2 National Apprenticeship Week (NAS) taking place 9th - 13th March 2015)

GOSH will be promoting Apprentices throughout this week. Activity will include:

- The release of three videos on apprenticeship; two small podcast style videos for intranet (managers discussing apprenticeship for new staff and existing) and one longer video for internet (interviews with staff, managers, footage of GOSH etc)
- Drip feed marketing to organisation about NAS week (Roundabout and Newsletter and emails to targeted managers nearer the time)
- Marketing of existing apprenticeship learning
- Certification ceremony celebrating completed Apprenticeship qualifications over 14-15.
- Develop an Apprentice newsletter
- Marketing to source mentors for apprentices

7. Summary

Members Council is asked to acknowledge the on-going work with increasing the number of apprenticeships across the Trust and offer its continued support to the scheme.

Attachment C

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

28th January 2015

Genomic Medicine Centre

Summary & reason for item: For Information

Councillor action required: To outline GOSH's involvement in the initiative to sequence 100,000 genomes of patients with rare diseases and cancer.

Report prepared by: Prof Maria Bitner-Glindzicz.

Item presented by: Prof Maria Bitner-Glindzicz and Prof Lyn Chitty.

Attachment C

Genomic Medicine Centre

Background

In 2012 the Prime Minister announced an initiative to sequence 100,000 genomes of patients with rare diseases and cancer. Consequently NHS England set up a company - Genomics England - to deliver the project by the end of 2017. In August 2013 competition began to designate Genomic Medicine Centres (GMCs) to recruit patients for the study. GOSH was the lead organization for the application for a GMC in the North Thames area (6 Trusts in all) and was successful in becoming one of 11 GMCs in England.

The aims of the project are

- to enable new scientific discovery and medical insights into rare diseases and cancer by linking genome data to clinical information, with informed consent. The clinical information is anonymised but linked to the patient's genetic information.
- to bring benefit to patients, with faster and more accurate diagnosis than is currently possible, and to set up a genomic medicine service for the NHS ensuring that genomics becomes part of everyday care and clinical management
- to promote the development of a UK genomics industry (new diagnostic tests and treatments)
- to increase public knowledge and support for genomic medicine and science by demonstrating improved diagnosis and treatment

The role of GMCs in the 100,000 Genomes Project

- To give patients and families information about the project and recruit them
- To take blood samples (and tumour), prepare and store them for transport to Genomics England lab for whole genome sequencing
- To participate in the interpretation and validation of the genomic data, along with scientists in our NHS genetics laboratory and to feedback clinically significant information to patients.
- To establish consortia of researchers to work with the data to improve our understanding of the underlying genetic aetiology of diseases.

The additional role of GOSH as Lead Organisation

As lead, in addition to the roles above, GOSH will receive patient samples from *all* of the partner trusts, ensure that Information Systems are in place to collect all of the necessary clinical data for each participant recruited with a rare disease or cancer, and upload this to the Genomics England database. Our NHS Regional Genetics Service will work towards integrating findings into the appropriate patient care pathway.

What is unusual about the project

The timescales involved and the numbers of patients with rare diseases and cancer who will participate in the project and ultimately benefit from it (up to 7,000 per year)
The 'transformational nature' of the project (not just genomics but also informatics and industrial collaboration) so that the NHS ultimately works in a better and more advanced way.
The consent issues, as patients and their parents agree to provide clinical information on a lifelong basis, available to Genomics England-approved researchers and to Industry.

Impact

GOSH has the lead role in a flagship national project working in partnership with trusts across the North Thames region to embed genetic medicine within all areas of clinical medicine. It establishes us as a Genomic Medicine Centre for rare diseases and paediatric cancer and dovetails with the strategy to build the first Centre for Research into Rare Diseases in Children. The designation as a GMC will assure the future of the Genetics Laboratory at GOSH in the current national reconfiguration of laboratory services. Our Information Systems will be

updated and refined so that we are able to store and use our patient data more easily and efficiently in the future.

Attachment D

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

28th January 2015

Developing the Annual Plan

Summary & reason for item:

To provide an update on the annual plan for 2015/16, outline progress so far, the context within which GOSH are operating and to progress the sub-group engagement group in early February,

Overview

The report provides further clarity and update as to the development of the Trust's annual plan to deliver to the timetable below outlined by Monitor:

- Draft Operational Plan - 27th February 2015 (midday): Summarised financial template, and a brief narrative setting out key assumptions, as well as the basis and degree of confidence in them

- Final detailed Operational Plan – 10th April 2015 (midday): Operational Narrative, redacted summary of the operational plan narrative (suitable for external publication) and full, final financial template (which requires the completion of one year of detailed financial forecasts)

Item presented by:

Robert Burns, Director of Planning & Information

Councillor action required:

- To note the progress and process of engagement on the Annual Plan, as outlined above;
- To note meeting to be scheduled for early February

Great Ormond Street Hospital for Children NHS Foundation Trust: Annual Plan 2015/16

1. 2015/16 Monitor Annual Plan Requirement

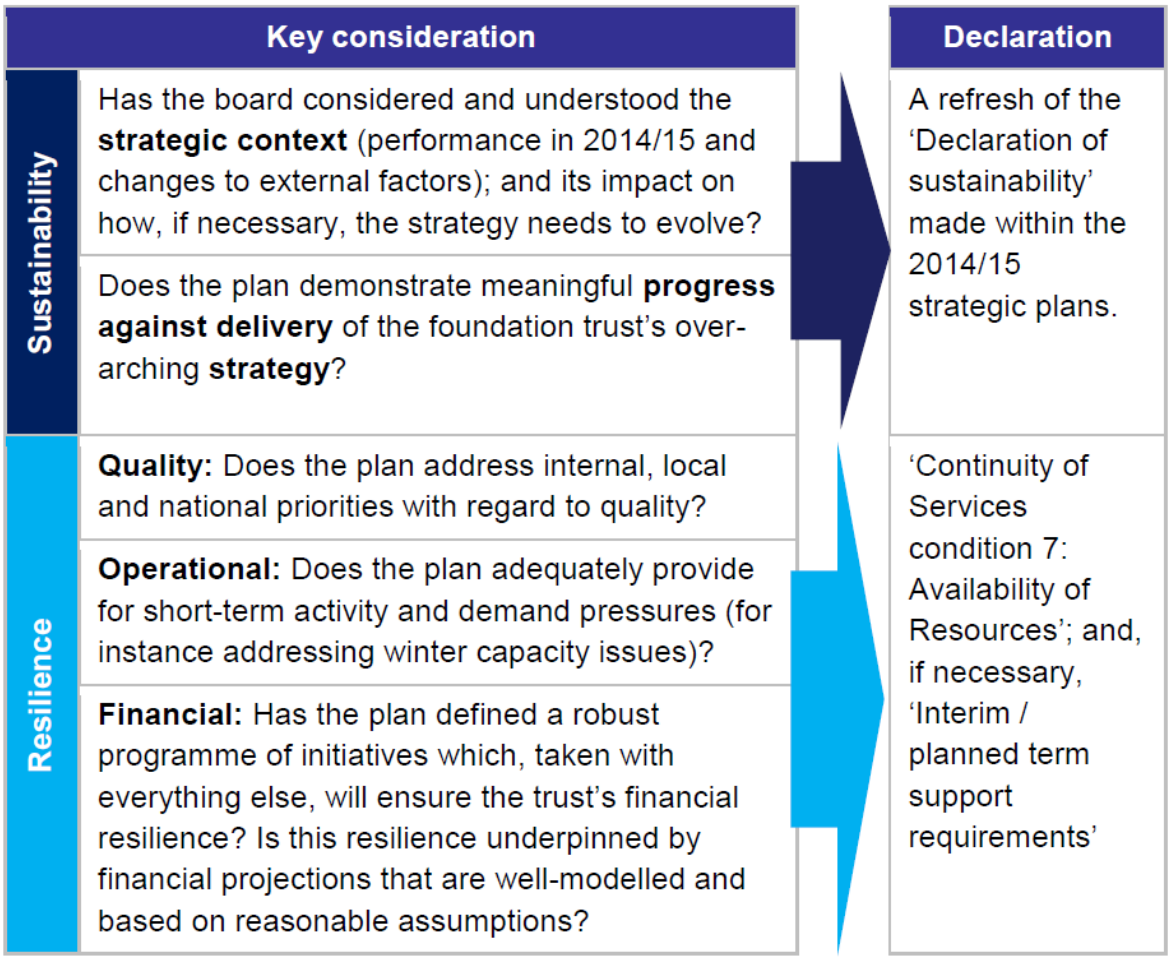
External Timetable (as per Monitor Annual Planning Guidance 2015/16)**:**

- Draft Operational Plan - 27th February 2015 (midday): Summarised financial template, and a brief narrative setting out key assumptions, as well as the basis and degree of confidence in them

- Final detailed Operational Plan – 10th April 2015 (midday): Operational Narrative, redacted summary of the operational plan narrative (suitable for external publication) and full, final financial template (which requires the completion of one year of detailed financial forecasts)

Operational Plan Guidance

Monitor requests that NHS FTs Operational Plans address the key considerations as set out below.



Source: Guidance on the 2015/16 annual planning review for NHS foundation trusts. Monitor.

2. Internal Timetable

We have already commenced work on the annual plan submission for 2015/16. A first draft of key issues to include in the plan was presented to the Investment & Planning Group on 20 January 2015 and we have drafted most of the strategic objectives for the year.

Budget setting is in full swing, cost pressures are being assessed, P & E schemes are being developed and predicted activity and capacity plans for 2015/16 have been fully modelled.

However, the delay from NHS England and Monitor in publishing the outcome of the commissioning consultation has inhibited the ability to complete our financial planning or commence in detail contract discussions.

Our next steps will be to continue to develop a draft annual plan narrative during January and February 2015, with the aim to share with Trust Board remotely for comment by the end of February 2015. This will be further refined during March 2015 for approval at the March Trust Board.

Additionally it is crucial for the involvement with our Member's Council and as such a process was shared in late November, and agreement sought to meet with a dedicated sub-group to support the development of the Annual Plan.

In the early part of February 2015, once we have received further information on the commissioning arrangements we will meet with the agreed Members' Council sub group to share our key themes and objectives for 2015/16.

Monitor's suggested structure is logical to test both a Trust's appreciation of the impact of the changing environment on their strategies and to articulate the organisations operational priorities for the year. These have been badged as "sustainability" and "resilience" and it is recommended that this structure is followed.

Below outlines the areas the Annual Plan will be focusing on.

- **Strategic Context**
  What has changed internally &/or externally which would change our strategy?

- **Progress against delivery of the strategy**
  What will we do in 2015/16 towards delivery of our overall strategy?
  Is it on track, what objectives have we set for the year?

- **Quality Priorities**
  What are our quality priorities for 2015/16? What is the rationale and what do we aim to achieve?

- **Operational Requirements**
  What operational resources will we use during the year and what key risks are there to the delivery of core standards?

- **Financial Forecasts**
  This section must link to the one year financial forecasts submitted and be based on reasonable assumptions.

Strategic Plans
The diagram below outlines the strategic plans within the organisation and how these then fit to the overarching strategy and the values of the organisation.

We would update on each of the following core strategies outlining any significant changes to the 2014-19 strategic plan and what the specific objectives are for 2015/16, incorporate any key suggestions from our Members' Council:

- Clinical Services Strategy
- Productivity & Efficiency
- Quality
- Patient Experience
- People / Workforce
- Transformation through IT and Information
- Research
- Education
- Commercial
- Estates

3. Actions for the next period
The table below provides a summary of the actions undertaken so far in order to meet the timescales as outline above, notwithstanding the impact of the on-going tariff consultation.

Date	Committee	Action
Early Jan 2015	Investment and Planning Group	Initial draft of the skeleton plan for Monitor
Early Jan 2015	Senior Management Team	Draft Proposed Trust Priorities shared, as developed through the sequence of meetings throughout December
Late Jan / Early Feb 2015	Members Council sub-group	Draft priorities presented and reviewed by a nominated MC sub group.
Early Feb 2015	Senior Management Team	2015/16 Priorities re-drafted and presented to SMT including MC input and feedback.
27th February 2015	Draft Operational Plan submission to Monitor: Summarised financial template, and a brief narrative setting out key assumptions, as well as the basis and degree of confidence in them	

Attachment D

Date	Committee	Action
End Feb / early Mar 2015	Feedback to Members Council	Either via the sub-group or another mechanism, provide update on 2015/16 Annual Plan
End of Mar 2015	Trust Board	Present 2015/16 Annual Plan for approval
Apr 2015	Members' Council	Present Annual Plan 2015/16
10th April 2015	Final detailed Operational: Operational Narrative, redacted summary of the operational plan narrative (suitable for external publication) and full, final financial template (which requires the completion of one year of detailed financial forecasts)	

Attachment E

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

Wednesday 28th January 2015

New CQC Inspection regime

Summary & reason for item: To inform the Members' Council of the new Inspection regime (published September 2014) in preparation for the Trust's scheduled CQC inspection in April 2015.

Councillor action required: to note the new CQC inspection regime and the date of the CQC inspection at GOSH.

Report prepared by: Kelly Stevens, Compliance and Governance Manager

Item presented by: Anna Ferrant, Company Secretary

Attachment E

Great Ormond Street Hospital for Children NHS Foundation Trust

CQC Summary Report - Members' Council January 2015

Introduction

The Trust has been advised by CQC that a scheduled inspection will take place in April 2015.

Background and inspection framework overview

The Trust is registered as one location with services delivered on the Great Ormond Street Hospital main site for the provision of the following regulated activities:

- Diagnostic and screening procedures
- Surgical procedures
- Surgical procedures
- Transport services
- Treatment of disease, disorder or injury

The Trust expects approximately 30-50 inspectors on site for the inspection over a number of days for an announced and unannounced inspection.

The CQC inspection team will include a national team of expert hospital inspectors and clinical and other experts, including service users and those with experience of receiving care, or caring for someone who uses services (Experts by Experience).

Inspectors will use professional judgement, supported by objective measures and evidence to assess services against the 5 key questions:

No.	Question	What this means
1	**Are services safe?**	Are people protected from abuse and avoidable harm?
2	**Are services effective?**	Does care, treatment and support achieve good outcomes, promote a good quality of life based on the best available evidence?
3	**Are services caring?**	Do staff involve and treat people with compassion, kindness, dignity and respect
4	**Are services responsive?**	Are services organised so that they meet people's needs?
5	**Are services well- led?**	Does the leadership, management and governance of the Trust assure the delivery of high quality person centred care, support learning and innovation and promote an open and fair culture?

The Inspection team will collate evidence as follows:

a) Gathering the views of people who use services:

The team will seek out and listen to the experiences of the public, people who use services and those close to them, including the views of people who are in vulnerable circumstances or those

who are less likely to be heard.

The CQC will gather people's views through a range of activities, including:

- Speaking to people who use services (individually and in groups)
- Holding public listening events.
- Holding focus groups with people who use services and those close to them.
- Holding drop-in sessions.
- Placing comment cards in reception areas and other busy areas to gather feedback. Comment cards will also be available at listening events and focus groups.
- Using posters to advertise the inspection to allow people an opportunity to speak to the inspection team.
- Using the information gathered from the team's work looking at complaints and concerns.
- Promoting the 'share your experience' form on the CQC's website

Experts by Experience will talk to people who use services, as many people will find it easier to talk to an Expert by Experience rather than an inspector. They will also talk to carers and staff, and observe the care being delivered.

b) Gathering the views of staff

The inspection team will interview individual directors and staff at all levels within the Trust.

The team will hold focus groups with separate groups of staff. These will be peer to peer focus groups involving the clinical experts on the inspection team, and will normally include:

- Consultants and other medical staff
- Junior doctors
- Registered nurses and midwives / sisters and matrons
- Student nurses and healthcare assistants
- Allied health professionals
- Administrative and support/other staff
- Foundation trust councillors.

The views of staff may also be sought through an online survey or email.

The CQC is therefore likely to seek to the views of Members' Council representatives as part of their enquiries into ascertaining the views of patient and public representatives of the Trust.

Other inspection methods/ information gathering:

- Observing care
- Pathway tracking people through their care
- Inspecting care environments
- Reviewing and copying records where required
- Reviewing and gathering policies and documents.

Feedback following the inspection

At the end of visit, the Inspection Chair and Head of Hospital Inspection/team leader will hold a high

level initial feedback only meeting with the chief executive, the chair and other members of the provider's board.

Initial feedback will also be communicated to all staff across the Trust.

GOSH Communications Plan

Communications about the impending inspection are being cascaded to all staff via the GOSH Newsletter and senior management team.

The Executive Team will monitor the preparations for the inspection.

The Trust's Compliance and Governance Manager has previously presented the CQC's new inspection framework to the Senior Management Team and is in the process of cascading it to all divisional board meetings and specialist services management teams, to ensure senior clinicians and managers have the necessary knowledge of the framework.

Collation of evidence in preparation for a CQC visit

Divisions are being asked to populate a centralised CQC database with evidence of controls and assurances, any gaps for remedy against the 5 key CQC questions outlined above.

The Compliance and Governance Manager is working with the divisions and corporate teams to collate local information and populate the evidence database.

CQC judgement and ratings

The CQC inspection team will base their judgement on the available evidence and will use their professional judgement. The CQC will use the following rating scale:

Outstanding	Good	Requires improvement	Inadequate

They will rate the Trust's performance at the following four levels:
Level 1: Rate each core service for every key question
Level 2: An aggregated rating for each core service
Level 3: An aggregated for each key question
Level 4: An aggregated overall rating for the Trust as a whole

Where Organisations are found not to be meeting the requirements, the CQC have the following powers:

- Requesting an action plan for improvements
- Issues a warning notice
- Restrict the services
- Suspend the registration
- Cancel the registration
- Prosecute the care provider.

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

28th January 2015

Title: Update on Members Council Development Programme

Summary & reason for item: This paper provides a summary of the Member Development Programme run throughout 2014

Councillor action required: For information and comment

Report prepared by: Geoff Speed

Item presented by: Geoff Speed

1. Introduction

A programme of development events was run for the Trust's Member's council throughout 2014. This paper provides a brief summary of activity, feedback from Members and plans for 2015 onward.

2. Summary of Activity

In April 2014 Geoff Speed and Dee Leyden facilitated a workshop that:

1. Provided a summary of the 2014 Members Council skills assessment results and introduced a matrix profiling the skills mix of the Members' Council

2. The key development areas identified through that piece of work were:
   - Leadership
   - Team working & engaging with Others
   - Chairing Meetings
   - Presentation Skills
   - Business Planning
   - Project management
   - Assertiveness – Contribute to Meetings
   - Experience of working with Children, Parents & carers
   - Quality & Risk Management
   - Communication & Conflict Resolution
   - Regulatory Knowledge
   - Equality & Diversity
   - NHS Structure
   - Handling Data and Information Governance.

3. Instigated a group discussion where we received comment and feedback on the results of the skill assessment. One of the key themes to come out of this discussion was the

need for the matrix to reflect skills and experiences that members bring to the Trust (other than the core ones identified in matrix)

There followed a 30 minute introduction to Human Factors. The session was designed to provide members with an overview of a key learning topic that has been blended into a significant amount of learning at GOSH.

Further sessions ensured the council developed their mandatory training knowledge. Sessions was designed to meet the Trust's compliance needs whilst ensuring the topics were delivered in a way that was relevant for the Member's Council. Topics covered included Fire, Information Governance, Safeguarding Children, Infection Control, Health & Safety and Equality & Diversity. A variety of learning techniques were used including digital learning and traditional presentations provided by appropriate subject matter experts. The level of energy and interest was very high.

We also ran a debrief session looking at supporting active contribution by all involved in the Members Council. Three questions were asked:

i) What does active contribution look like?
ii) What are the bocks to active contribution at Members Council meetings?
iii) How can we make the meetings more interactive?

The outputs from this session are set out in appendix A.

We also ran a session covering the current structure of the NHS – looking at Andrew Lansley's original plans and how these have been modified and changed over the lifespan of the coalition government.

4. Moving Forward

1. It is proposed that we continue to run a development programme for the Members Council post-election. The content will be reviewed but new members will be required to complete the mandatory topics delivered in 2014.

Following feedback from the member council it is proposed that more work is done to utilise the knowledge & skills that each member may bring to the Trust from their own work/life experiences.

Geoff Speed

Assistant Director for Medical Education & Leadership
Great Ormond Street Hospital for Children NHS Foundation Trust
London WC1N 3JH

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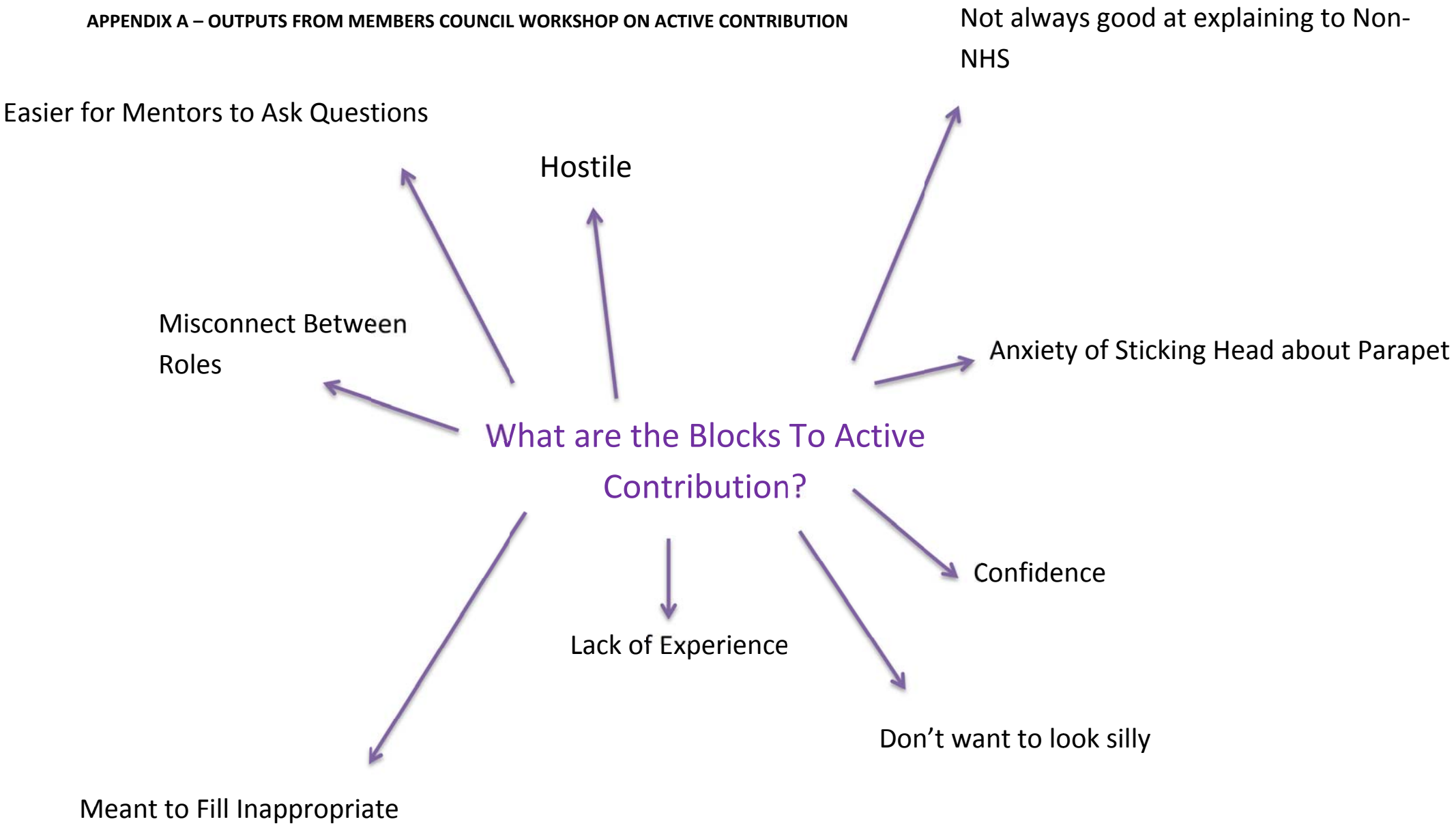
geoff.speed@gosh.nhs.uk

APPENDIX A – OUTPUTS FROM MEMBERS COUNCIL WORKSHOP ON ACTIVE CONTRIBUTION



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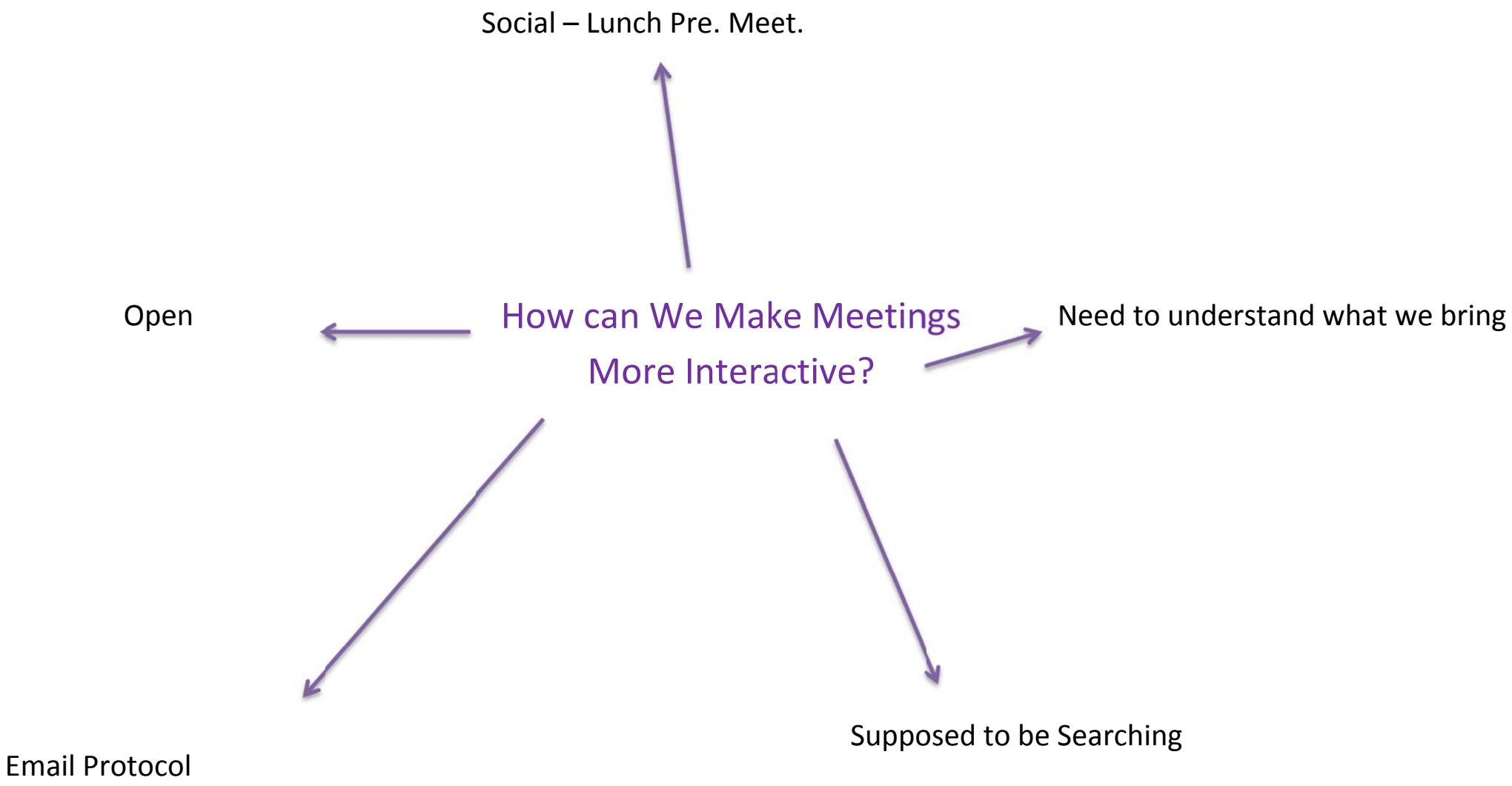

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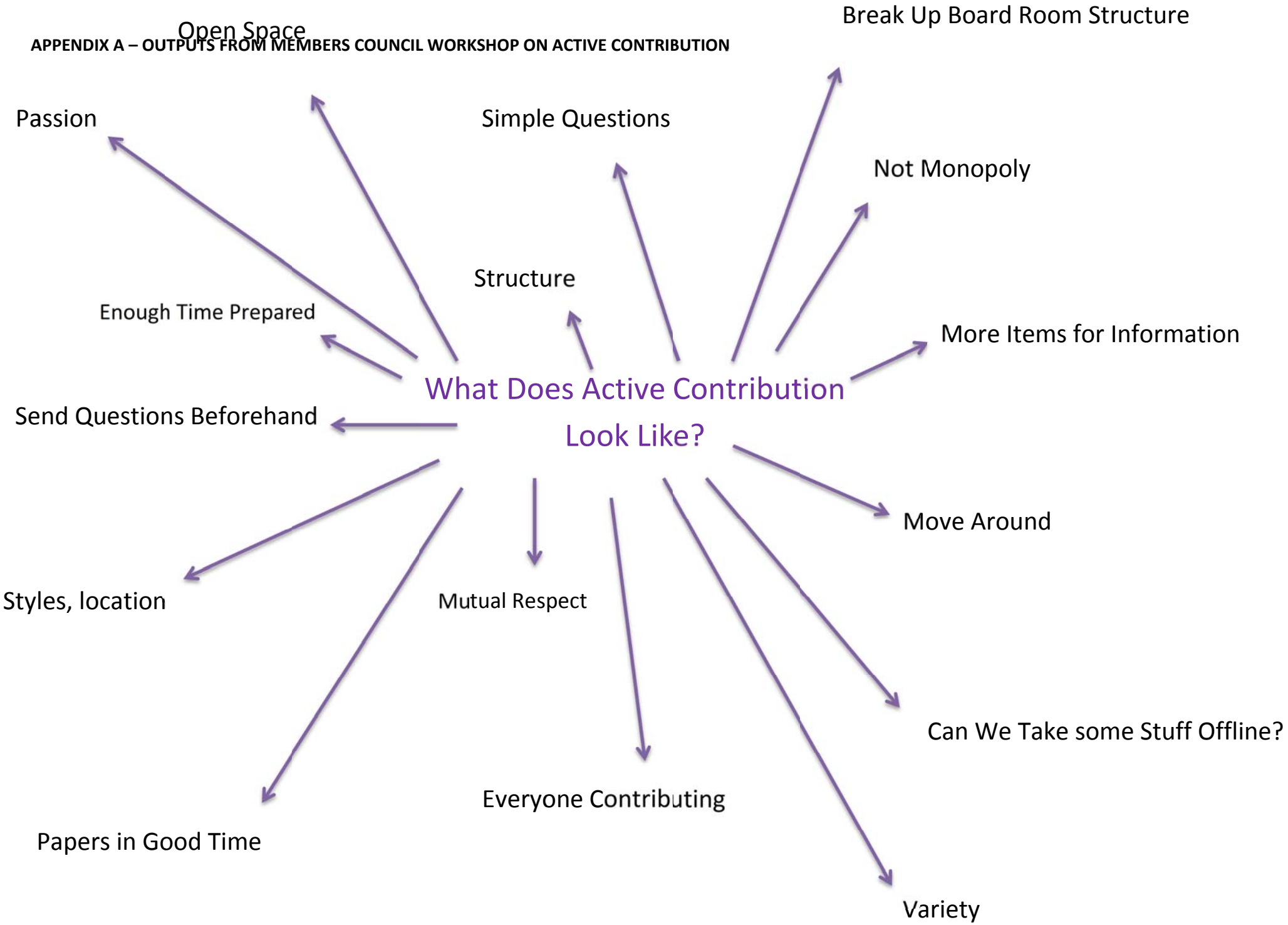


Confidential
Attachment G

Great Ormond Street Hospital for Children NHS Foundation Trust

CONFIDENTIAL

Members' Council

28th January 2015

Appointment of a non-executive director at Great Ormond Street Hospital for Children NHS Foundation Trust

Summary & reason for item:

To seek approval of the appointment of a new non-executive director at Great Ormond Street Hospital.

Councillor action required:

The Members' Council Nominations and Remuneration Committee recommend approval by the Members' Council of the appointment of a non-executive director at Great Ormond Street Hospital.

The Council is asked to note the process for the appointment and approve the appointment.

Author: Dr Anna Ferrant, Company Secretary

Presented by: Dr Anna Ferrant, Company Secretary

Confidential
Attachment G

APPOINTMENT OF A NON-EXECUTIVE DIRECTOR ON THE BOARD OF DIRECTORS OF GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST

1. PURPOSE

This paper seeks approval for the appointment of [redacted] as a non-executive director on the Board of Directors of Great Ormond Street Hospital for Children NHS Foundation Trust.

2. BACKGROUND

2.1. Appointment process

The appointment process followed the process approved at the Members' Council meeting in November 2014:

- the appointment process was conducted by the Trust's HR department and the Company Secretary and included development of an advert, website copy, information pack and application form. The information pack included the amended and Job Description, Person Specification (taking account of the findings of the Board evaluation results) and Terms and Conditions of Service as approved at the November 2014 Council meeting.

- The role was advertised on the Cabinet Office website and NHS Professionals website for a Non-Executive Director with strong business and financial acumen and Board level experience in a complex and changing organisation. Reference was made to it being highly desirable that the candidate has expertise in the management, implementation or funding of IT programmes. Experience with a service-based organisation was agreed to be of value, but not essential.

- The position was advertised from 28th November to 18th December 2014. Candidates were asked to provide a CV with a covering letter outlining why they are interested in the role and how they fit the person specification for the role. The Trust received 48 applications.

- The interview panel consisted of:
  - Tessa Blackstone (Chairman)
  - David Lomas (NED and Chairman of the Finance and Investment Committee)
  - Matthew Norris (Parent Councillor)
  - Edward Green (Patient Councillor)
  - Christine Kinnon (ICH Appointed Councillor)
  - Anna Ferrant, Company Secretary (advice)

- The panel met on Friday 9th January to conduct shortlisting. An initial sift of applications was considered by the interview panel. The panel agreed that it would interview five candidates who met the essential and desirable criteria in the person specification.

- One candidate was subsequently unable to attend the interview. Prior to the interview, the four shortlisted candidates were invited to discuss the non-executive director role with the Deputy Chairman of the Board. As agreed by the Council, the Chairman sought two telephone references for each candidate.

- The interview took place on Friday 16th January 2015. Prior to the interviews the Interview Panel agreed a set of questions to put to each candidate to ensure that the interviews were consistent, fair and transparent. Documentation was provided to panel members to ensure all agreed criteria were fairly assessed.

- As agreed by the Council, each short-listed candidate was invited to speak for 5 minutes at the start of the interview to outline why they are interested in the role and what they will bring to the role. Candidates were then asked questions to assess their skills and expertise for the post.

- The interview panel agreed that [redacted] should be recommended for appointment as a NED. A summary of his experience and skills is mapped against the person specification for the advertised role below:

Requirements of the post	Evidence
Board level experience in a large/complex/changing organisation (Essential) Strong business and financial acumen with an ability to understand complex strategic issues (Essential) A commitment to NHS values and principles of NHS foundation trusts (Essential)	[redacted]
Highly developed interpersonal, communication and leadership skills (Essential) Sound, independent judgement, political astuteness and diplomacy (Essential) Clear understanding, and acceptance, of the legal duties, liabilities and responsibilities of non-executive directors (Essential)	[redacted]

Requirements of the post	Evidence
	[redacted]
Sufficient time and commitment to fulfil the role (Essential)	[redacted]
Understanding/ experience of management, funding and/or implementation of IT programmes (Highly Desirable)	[redacted]
Experience of working in service-based organisation (of value but not essential).	[redacted]

- The Members' Council Nominations & Remuneration Committee agreed with the recommendation.
- The offer is subject to approval by the Members' Council, the appropriate checks (including a DBS check and assessment against the Fit and Proper Person assessment criteria) and validation as a public or parent/ carer foundation member of Great Ormond Street Hospital for Children NHS Foundation Trust.
- If approved, [redacted] will commence his appointment from 28th March 2015.

The Members' Council is asked to approve the appointment of [redacted] to the role of non-executive director on the Great Ormond Street Hospital for Children NHS Foundation Trust.

Attachment H

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

28th January 2015

Process for appointment of the Lead Councillor

Summary & reason for item:
Foundation Trusts are required by Monitor to appoint a 'Lead Councillor'. The current Lead Councillor, Mr Ian Lush is stepping down from the Members' Council at the end of his tenure on 28th February 2015. A new appointment will need to be made. The role and process for nominating and appointing the Lead Councillor is attached.

Action required:
The Council is asked to approve the proposed process for appointment to the Lead Councillor role and the revised role description.

Report prepared by:
Anna Ferrant, Company Secretary

Item presented by:
Anna Ferrant, Company Secretary

Attachment H

Appointment of a Lead Councillor

Foundation Trusts are required by Monitor to have in place a nominated 'Lead Governor' (referred to as a Lead Councillor at GOSH).

Monitor's Code of Governance (July 2014) outlines the role:

The lead governor has a role to play in facilitating direct communication between Monitor and the NHS foundation trust's council of governors. This will be in a limited number of circumstances and, in particular, where it may not be appropriate to communicate through the normal channels, which in most cases will be via the chairperson or the trust secretary, if one is appointed.

It is not anticipated that there will be regular direct contact between Monitor and the council of governors in the ordinary course of business. Where this is necessary, it is important that it happens quickly and in an effective manner. To this end, a lead governor should be nominated and contact details provided to Monitor, and then updated as required. The lead governor may be any of the governors.

The main circumstances where Monitor will contact a lead governor are where Monitor has concerns as to board leadership provided to an NHS foundation trust, and those concerns may in time lead to the use by Monitor's board of its formal powers to remove the chairperson or non-executive directors. The council of governors appoints the chairperson and non-executive directors, and it will usually be the case that Monitor will wish to understand the views of the governors as to the capacity and capability of these individuals to lead the trust, and to rectify successfully any issues, and also for the governors to understand Monitor's concerns.

Monitor does not, however, envisage direct communication with the governors until such time as there is a real risk that an NHS foundation trust may be in significant breach of its licence. Once there is a risk that this may be the case, and the likely issue is one of board leadership, Monitor will often wish to have direct contact with the NHS foundation trust's governors, but at speed and through one established point of contact, the trust's nominated lead governor. The lead governor should take steps to understand Monitor's role, the available guidance and the basis on which Monitor may take regulatory action. The lead governor will then be able to communicate more widely with other governors.

Similarly, where individual governors wish to contact Monitor, this would be expected to be through the lead governor.

The other circumstance where Monitor may wish to contact a lead governor is where, as the regulator, we have been made aware that the process for the appointment of the chairperson or other members of the board, or elections for governors, or other material decisions, may not have complied with the NHS foundation trust's constitution, or alternatively, whilst complying with the trust's constitution, may be inappropriate.

In such circumstances, where the chairperson, other members of the board of directors or the trust secretary may have been involved in the process by which these appointments or other decisions were made, a lead governor may provide a point of contact for Monitor. Accordingly, the NHS foundation trust should nominate a lead governor, and to continue to update Monitor with their contact details as and when these change.

Further information about the role is documented in Monitor's document '*Statutory Duties: A Reference Guide for NHS Foundation Trust Gover*nors' in Appendix 1.

Additional responsibilities

In line with the NHS Act 2006, the Trust's Constitution states that the Chairman will chair the Members' Council (or in her absence, the Deputy Chairman of the Trust). However, there will be certain occasions when the Trust Chairman and/or Deputy Chairman will be absent, or, it will be inappropriate for them to preside at meetings of the Members' Council or members' meetings (due to a conflict of interest, for example, when councillors are considering the remuneration and appointment of these individuals). Under these circumstances, the Lead Councillor will preside at these meetings. This should rarely occur.

The Lead Councillor will be asked, in a limited number of circumstances to act as a conduit between the Council, the Chairman and the Board. Examples include:

- seeking the views of councillors on the performance of the Chairman for the purposes of the appraisal;
- leading Members' Council discussions when, for example, only members are present before Council meetings to discuss agenda items
- coordinating Councillor responses to a consultation.

Councillor constituency and length of appointment

Whilst the Code of Governance now states that any councillor can be appointed to the role, the Chairman recommends that the Council continues to limit nominations to the public and patient/ parent/ carer constituencies in order to avoid any possible conflicts of interest for staff or appointed councillors.

The Council asked to approve this recommendation.

It is proposed that the Lead Councillor will continue to be appointed every three years.

The Council asked to approve this recommendation.

The role description and person specification for the Lead Councillor is attached at appendix 2.

Nomination/appointment process

The following nomination/appointment process is proposed. This process takes into account the date of the announcement of the results of the Members' Council election (19th February 2015):

a. Following announcement of the results of the Council election the Trust will write to all public and patient/parent/carer councillors (week of 23rd February) outlining the nomination and appointment process and the role description and inviting self-nominations for the position of Lead Councillor;
b. Councillors will be asked to record their interest in the role by submitting a short statement (250 words maximum) by email to the Company Secretary on how they are suited to the role;
c. The deadline for nominations will be **Monday 2nd March 2015**.
d. Voting will be conducted using the alternative voting system (see appendix 3 for further information);
e. Statements from nominees will be circulated to all councillors including instructions on accessing the electronic voting system (using SurveyMonkey). This system enables a secret ballot to be conducted;
f. Voting will open on **Thursday 5th March** and close on **Thursday 12th March**

The successful candidate will be announced by email on **Friday 13th March 2015**.

Members' Council Action Required:

Councillors are asked to approve:

- The proposed nomination, voting and appointment process;
- The revised role description and person specification for the Lead Councillor;
- The recommendation that the Council continues to limit nominations to the public and patient/ parent/ carer constituencies in order to avoid any possible conflicts of interest.
- The recommendation that the Lead Councillor will continue to be appointed every three years.

Appendix 1 – 'Statutory Duties: A Reference Guide for NHS Foundation Trust Governors'

Lead governor

Monitor has asked all NHS foundation trusts to nominate a "lead governor". This individual will liaise between Monitor and the council of governors where, for example, we have concerns about the leadership provided to an NHS foundation trust or in circumstances where it would be inappropriate for the chair to contact us, or vice versa (for example, regarding concerns about the appointment or removal of the chair). However, the term "lead governor" has created some confusion. Monitor did not intend the person holding this role to "lead" the council of governors or assume greater power or responsibility than other governors. We recognise that many NHS foundation trusts have broadened the original intention of this role and given greater responsibility or power to their lead governor. Every trust can decide how best to structure its own council; we continue to require only that the lead governor act as a point of contact between Monitor and the council of governors when needed. Directors and governors alike should always remember that the council of governors as a whole has the responsibilities and powers in statute, and not individual governors.

Where NHS foundation trusts choose to broaden the lead governor's role, directors and the council of governors should agree what it should and should not include. The council of governors should vote on or otherwise decide who the lead governor will be; directors (including the chair) should not be involved in this process.

Having a lead governor does not, in itself, prevent any other governor from making contact with Monitor directly if they feel this is necessary. The Independent Panel for Advising Governors can provide advice if the council approves the submission of a question to it.

Communication from Monitor to governors will, as a matter of course, be disseminated by trust secretaries.

Great Ormond Street Hospital for Children NHS Foundation Trust

Role description for Lead Councillor

Appointment as Lead Councillor will be for a three-year term.

1. **Main duties and responsibilities**

1.1. Act as a point of contact for Monitor should the regulator wish to contact the Members' Council on an issue for which the normal channels of communication are not appropriate.

1.2. Be the conduit for raising with Monitor any councillor concerns that the Foundation Trust is at risk of significantly breaching the terms of its authorisation, having made every attempt to resolve any such concerns locally.

1.3. Chair such parts of meetings of the Members' Council which cannot be chaired by the Trust Chair or Deputy Chair due to a conflict of interest in relation to the business being discussed.

1.4. Be the link between the Council and the Board, liaising regularly with the Chairman and Company Secretary and coordinating councillor responses to Board reports, plans and consultations.

1.5. Work with the Senior Independent Director in collating the input of councillors to the annual performance of the Chairman.

1.6. Co-ordinate councillor pre meetings to Members' Council meetings.

1.7. Work with the Company Secretary to develop systems for evaluating the effectiveness of the Members' Council.

2. Person Specification

To be able to fulfil this role effectively the Lead Councillor will:

1. Be a public councillor or patient, parent and carer councillor;

2. Have the confidence of councillors;

3. Have the experience and ability to influence and negotiate at a senior level;

4. Be able to present well-reasoned argument;

5. Have experience of chairing meetings;

6. Be committed to the success of the Foundation Trust and have a good understanding of NHS Foundation Trust Governance.

7. Understand Foundation Trust councillors' Statutory Responsibilities.

8. Understand the role of Monitor and the basis on which Monitor may take regulatory action.

Appendix 3

Alternative Voting System

The Alternative Vote (AV) is a preferential system where the voter has the chance to rank the candidates in order of preference.

The voter puts a '1' by their first choice a '2' by their second choice, and so on, until they no longer wish to express any further preferences or run out of candidates.

Candidates are elected outright if they gain more than half of the first preference votes. If not, the candidate who lost (the one with least first preferences) is eliminated and their votes are redistributed according to the second (or next available) preference marked on the ballot paper. This process continues until one candidate has half of the votes and is elected.

Attachment I

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

28th January 2015

Chief Executive's Report

Summary & reason for item:
Council members are provided with a performance summary report outlining key issues and assurance of action being taken.

Quality and Safety
In December, the Trust reported no cases of C.Difficile, leaving our year to date total of assigned cases in patients aged two and over, tested on third day or later, to 11 cases.

The number of cases of C.difficile remains a significant risk to achieving the Monitor quality governance risk rating throughout 2014/2015; however we remain within Monitors de minimis limit of 12 cases and continue to closely monitor this indicator as a key priority.

No cases of MRSA were reported in December, which continued the year to date position.

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

Discharge summary completion rates decreased to 78.8% in December. This decrease has been attributed to the impact of seasonal leave.

In response to the national drive for Trusts to focus on their longest waiting RTT Patients, and as a conscious decision by the Trust, we have increased the proportion of long waiting patients admitted which prompted a reduction in the Admitted RTT metric for November and continued into December. The high volume of long waiting patients is almost exclusively in our Surgical Clinical Division.

The Trust maintained compliance against all other service performance measures including cancer and incomplete RTT waiting times.

Complaints
The Trust received 17 complaints in December.

Communication continues to be a key theme featuring in complaints along with a lack of information or incorrect information being given to families. The Complaints team monitor all open complaints in order to ensure responses are sent in a timely manner. When actions are identified as a result of complaints the Complaints team also monitor these to ensure they are completed and learning is shared across the Trust.

A detailed quarterly report of complaints, trends and action plans is presented to the Learning, Implementation and Monitoring Board in addition to ad-hoc reports as issues arise for example as a result of recommendations from the Health Service Ombudsman.

Workforce
GOSH decreased its contractual FTE (full-time equivalent) figure by 8 in December to 3700. This change is within anticipated levels and is 150 FTE higher than the same point in 2013.

Sickness absence continues to decrease to 2.43% following a very slight downward trend and remains significantly below the London average figure of 2.99%.

Turnover is broadly stable; currently at 17.67% (+0.23%) in December; this remains lower than the same point in 2013 where turnover was 17.87%. The (unadjusted) London benchmark figure is 13.63%.
The reported vacancy rate has decreased to 3.62% in December.

Agency usage (as a percentage of pay bill) stands at 2.64% in December, this is a slight decrease from the previous month (of 2.73%). Bank usage is increasing year-on-year and now stands at 6.51% (as percentage of pay bill).

PDR completion rates The Trust overall appraisal rate stands at 78.30% - a significant increase from the previous month of 73.50%. Only one directorate (HR & OD) is currently meeting the target of 95% however most divisions/directorates have shown a slight increase to their PDR rates since November.
Inclusion of 'CQC Intelligent Monitoring' measures to the sickness, turnover and vacancy reports. These are consistent with the calculations used by the CQC as a measure of risk. Comparison of month-on-month changes to made from next report.

Statutory and mandatory training compliance rates are reported below against a number of key mandatory training subjects (this is the first time training data has been reported in 12-months and represents in-depth training reporting, please note that this may be subject to some delay between training completion and reporting – data validation to be completed by March 2015). The required training compliance for any of the courses is 95%; currently the Trust is compliant with one (safeguarding children level 1) of the reported eight topic areas. Compared to November safeguarding adults has improved (+15%); counter fraud (+8%); equality and diversity (+26%); Health, Safety and Welfare (+9%); Infection, Prevent & Control (level 1) (+8%); however, Information Governance has decreased (-4%) as has Safeguarding children (level 1) (-1%).

Executive level scrutiny of all posts continues. The executive vacancy panel meets on a weekly basis to review jobs requesting to be recruited to (this excludes some key roles e.g. rostered nursing roles).

Finance and Productivity & Efficiency (Chief Finance Officer)
The Trust is reporting a net surplus of £2.2M, £(2.8)m worse than Plan. EBITDA of £18.7m (7.3%) is £3.0m below the planned EBITDA of £21.7m (8.4%). Total income excluding pass through is £-5.8m below plan principally due to doubt over the receipt of £3.1m of specialist funding from NHSE and £1.3m lower private patient activity. In month private patient income was £0.1m above plan. Overall NHS patient activity is in line with plan but NHS elective, & non-elective activity is below plan

Cash levels are £2.9m higher than plan due a higher starting point at the beginning of the year and delays in Trust funded capital expenditure. NHS debtor levels improved in month.

Productivity & Efficiency scheme values do not yet reach the annual target although short

term cost savings are partly mitigating this. Agency cost levels continue to be higher than in the previous year.

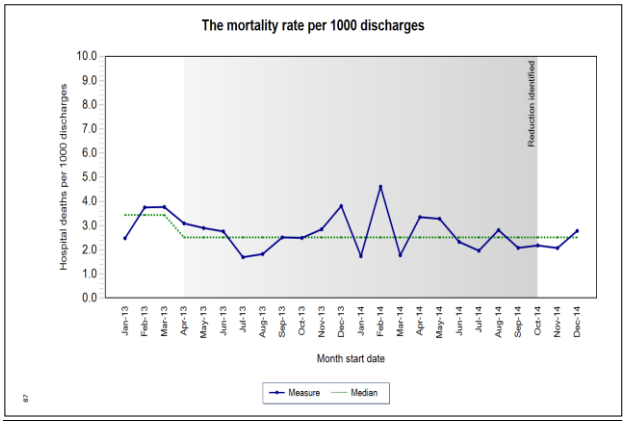
Although private patient debt levels have increased in the month for the second month running, this is due to a significant increase in activity relative to prior months.

Item presented by:
Peter Steer, CEO

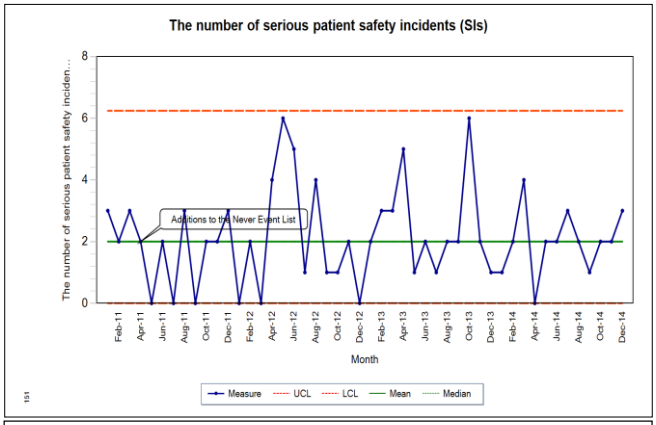
Councillor action required:
To note the content of the report

Quality and Safety report

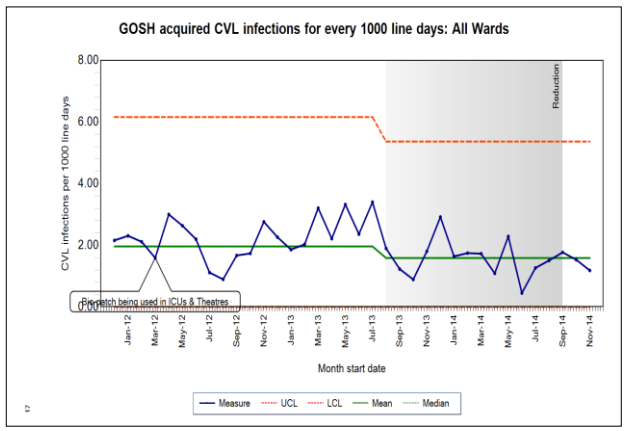
Quality and Safety Indicators



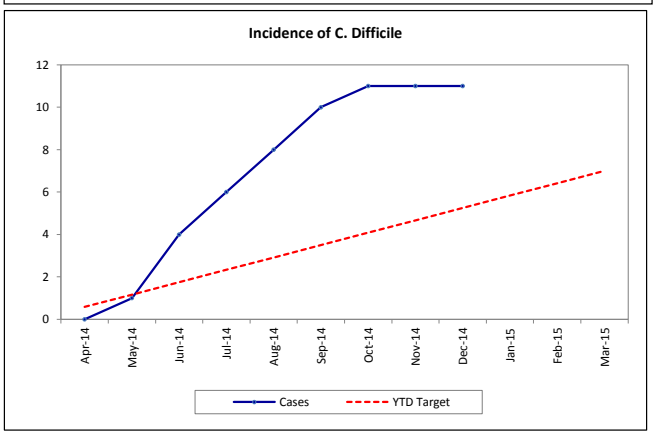
Description: The mortality rate per 1000 discharges
Target: Internal target: Year on year reduction
Trend: The current rate is 2.5 deaths per 1000 discharges.
Aim: To make statistically significant reductions in the mortality rate.
Comment: We will continue to measure, looking for a further reduction in the mortality rate.



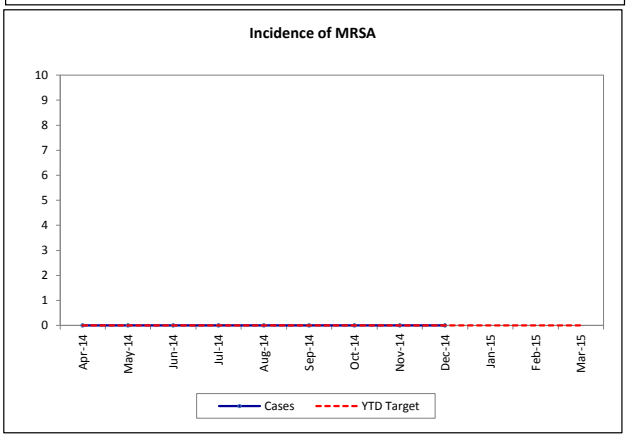
Description: Defined as either - Unexpected/avoidable death of patient(s), staff visitors or members of public. Serious harm to patient(s), staff, visitors or members of public. Allegations of abuse. One of the core sets of 'Never Events'
Target: Internal target: To remain within control limits
Trend: Performance sustained
Comment: There has been no statistical change in the number of SIs – we are still running at 2 per month.



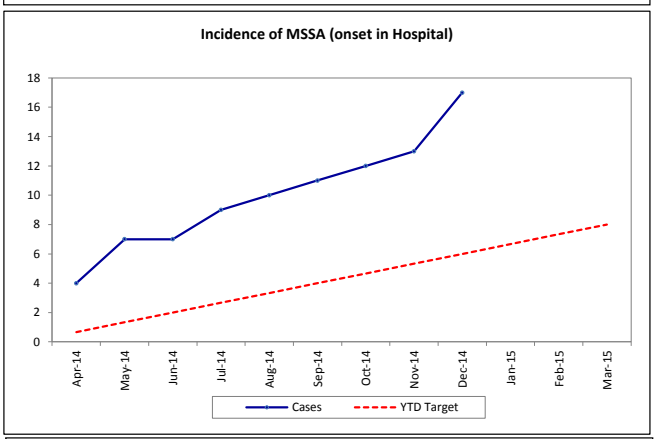
Description: The number of CVLInfections for every 1000 Bed Days acquired at the Trust
Target: Internal target: <=1.5
Trend: Performance sustained.
Comments: There has been no statistical change in the number of CVL infections – we are still running at 1.6 per 1000 line days



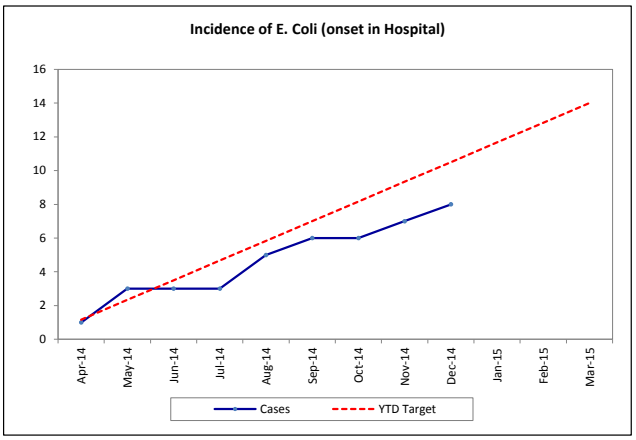
Description: **Cases detected after 3 days (admission day = day 1) are assigned against trust trajectory**
Target: No more than seven cases per year
Trend: Trend above trajectory
Comment: 11 cases reported at M7. The number of cases of C.difficile remains the most significant risk to achieving the Monitor quality governance risk rating throughout 14/15. The Trust remains within Moniotrs De Minimis Limit of 12 cases.



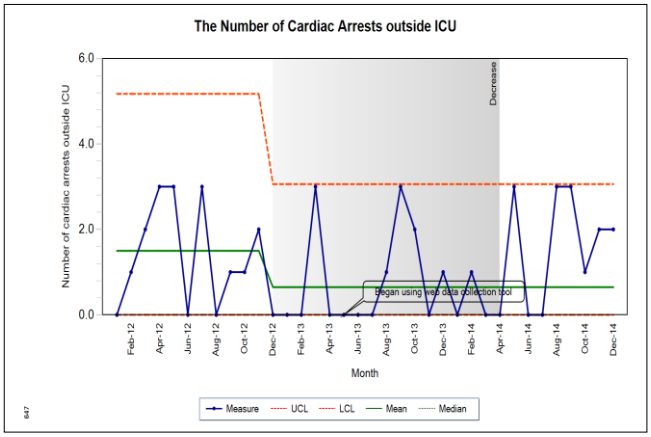
Description: MRSA bacteraemias
Target: Zero cases
Trend: 0 cases reported to date
Comment: Performance sustained at zero cases



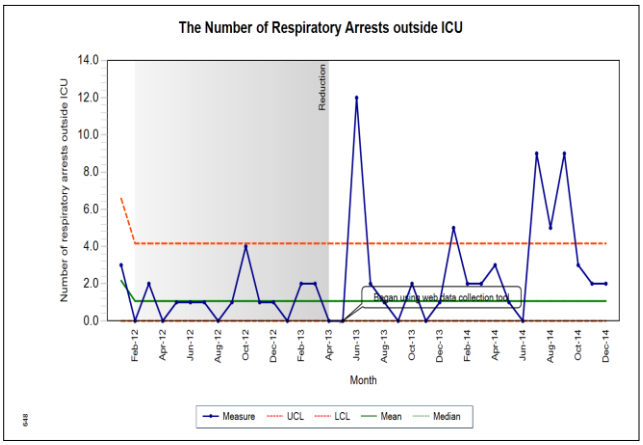
Description: Cumulative incidence of MSSA bacteraemia episodes (Methicillin sensitive S. aureus)
Target: Internal Target no more than eight cases
Trend: Performance continues above trajectory
Comment: Performance being monitored closely



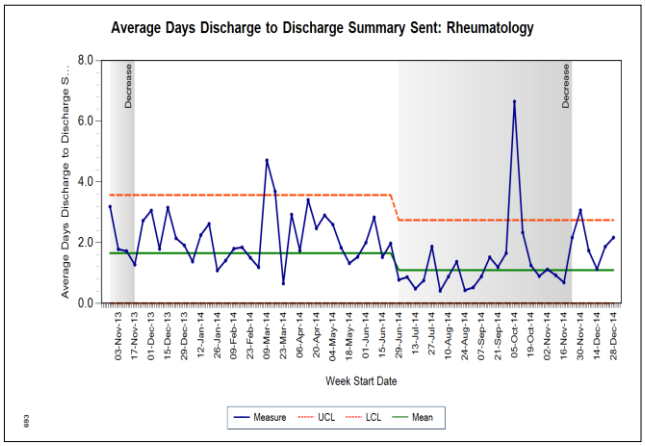
Description: **Cumulative incidence of E. coli bacteraemia**
Target: Internal Target no more than fourteen cases
Trend: Performance reported below trajectory at M7
Comment: Performance being monitored closely



Description: The monthly number of arrests (cardiac) outside of ICU wards (recorded from calls made to the 2222 Clincal Emergency Team)
Target: Internal target: 50% reduction
Comment: There has been no change in the number of cardiac arrest outside the ICU since December 2012. The current rate is less than 1 per month. Throughout 2014 respiratory arrests have remained low although it is noted that there were 3 months where the number of respiratory arrests were more than expected and a total of 6 consecutive months where respiratory arrests were more than the average for the current process.



Description: The monthly number of arrests (respiratory) outside of ICU wards (recorded from calls made to the 2222 Clincal Emergency Team)
Target: Internal target: 50% reduction
Trend: Performance sustained
Comment: RECALL (Rapid Evaluation of Cardio-respiratory Arrests with Lessons for Learning) takes place for every 2222 call and lessons for learning are identified and fed back to the team to improve detection and management of deteriorating patients and prevent cardio-respiratory arrest.



Description: Harm index comprised of hospital acquired infections (CVL, serious incidents, non-ICU arrests, medication errors, falls, and pressure ulcers
Trend: Performance sustained
Comment: For Rheumatology the time taken from discharge to completing the discharge summary was reduced back in September 2013 and has remained steady at less than 2 days. It should be noted that the high data points in September were the result of something exceptional - a backlog of discharge summaries being completed.
More specialties have joined the project with plans to spread further.

Targets & Indicators Report

	Indicator	YTD Target	YTD Performance	Monthly Trend											
				Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Activity & Use of Resources	Number of patient spells	24,491	**24,786**	3,001	2,755	2,643	2,672	2,763	2,666	2,863	2,625	2,540	3,052	2,854	2,751
	Number of outpatient attendances	112,605	**116,233**	14,130	12,867	13,467	12,224	12,475	13,333	14,409	11,548	13,771	14,468	11,719	12,286
	DNA rate (new & f/up) (%)	<10	**8.1**	7.5	7.8	8.0	8.1	7.5	7.7	8.7	8.6	8.3	7.6	7.5	8.6
	Number of ITU bed days	7,415	**8,100**	1031	738	789	798	831	1,017	871	820	979	946	1019	819
	Number of unused theatre sessions	190	**174**	11	13	21	14	17	15	14	19	10	15	11	59
	Average number of beds closed - Total Ward	-	**19**	34.0	28.7	30.4	26.3	18.8	18.0	20.7	21.1	16.8	11.7	10.7	24.2
	Average number of beds closed - Total ICU	-	**1**	1.3	2.9	3.0	1.9	1.3	0.9	0.2	0.1	0.3	0.3	0.7	1.0
Patient Access	18 week referral to treatment time performance - Admitted (%)	90	**88.7**	91.0	90.0	90.3	92.0	91.2	90.3	87.8	90.3	89.8	81.8	86.4	
	18 week referral to treatment time performance - Non-Admitted (%)	95	**95.0**	95.8	95.6	96.0	95.5	97.0	95.5	95.3	95.2	95.0	92.3	94.5	
	18 week referral to treatment time performance - Incomplete Pathways (%)	92	**92.3**	92.6	93.5	94.6	92.6	92.2	92.7	92.3	92.1	92.2	92.0	92.0	
	Cancer patients waiting no more than 31 days for second of subsequent treatment (%)	98	**100**	100	100	100	100	100	100	100	100	100	100	100	100
	Proportion of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests (%)	<=1	**0.51**	0.70	0.00	0.22	0.82	0.65	0.19	0.98	0.00	0.43	0.75	0.55	0.20
Patient / Referrer Experience	Number of complaints	92	**113**	7	9	12	12	12	16	13	8	12	15	8	17
	Number of complaints - high grade	8	**12**	3	1	1	0	2	2	0	0	2	3	0	3
	Discharge summary completion (%)	85	**81.7**	88.2	87.2	88.5	82.2	81.1	85.1	84.9	77.7	80.6	83.4	81.2	78.8
	Clinic Letter Turnaround, % letters on CDD - sent within 5 working days	50	**27.1**	29.7	27.9	24.8	23.5	24.4	27.0	30.2	28.2	26.6	29.6		
	Clinic Letter Turnaround, Average Days Letter Sent	-	**13.4**	16.8	17.6	17.2	14.7	13.9	12.9	11.1	14.0	15.4	11.9		
Work - force	Sickness Rate (%)	2.99	**2.5**	2.7	2.6	2.6	2.5	2.5	2.5	2.6	2.5	2.5	2.6	2.5	2.4
	Trust Turnover (%)	14.13	**17.2**	17.6	17.7	17.4	17.3	17.5	17.1	16.8	16.5	17.1	17.5	17.4	17.7

Monitor	YTD Target	YTD Performance	Quarter 4			Quarter 1			Quarter 2			Quarter 3		
Monitor governance risk rating 14/15	0 - 0.9	0	0	0	Green	0	0	Green	0	0	Green	0	0	Green

Monitor Governance Risk Rating

Targets - weighted (national requirements)		Threshold	Score Weighting	Reporting Frequency	Score Weighting Q1				Score Weighting Q2				Score Weighting Q3			
					M1	M2	M3	Q1	M4	M5	M6	Q2	M7	M8	M9	Q3
1	MRSA - meeting the MRSA objective *	0	1	Quarterly	0	0	0	0	0	0	0	0	0	0	0	0
2	Clostridium difficile year on year reduction (to fit with trajectory for the year as agreed with PCT)**	0	1	Quarterly	0	0	0	0	0	0	0	0	0	0	0	0
3	All cancers: 31-day wait for second or subsequent treatment comprising either:	100%	1	Quarterly	0	0	0	0	0	0	0	0	0	0	0	0
	Surgery	94%			0	0	0	0	0	0	0	0	0	0	0	0
	Anti cancer drug treatments	98%			0	0	0	0	0	0	0	0	0	0	0	0
	Radiotherapy (from 1 Jan 2011)	94%			0	0	0	0	0	0	0	0	0	0	0	0
4	Admitted within 18 weeks	90%	1	Quarterly	0	0	0	0	1	0	1	2	1	1	1	3
5	Non-Admitted within 18 weeks	95%	1	Quarterly	0	0	0	0	0	0	0	0	1	1	1	3
6	Referral to treatment time Incomplete Pathways Performance	92%		Quarterly	0	0	0	0	0	0	0	0	0	0	0	0
7	Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96%	0.5	Quarterly	0	0	0	0	0	0	0	0	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	Annual	0	0	0	0	0	0	0	0	0	0	0	0
				Total	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**2**	**2**	**2**	**2**	**6**
				Overall governance risk rating	**Green**	**Green**	**Green**		**Green**	**Green**	**Green**		**Green**	**Green**	**Green**	

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

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

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

TRUST BOARD WORKFORCE METRICS & EXCEPTION REPORTING – DECEMBER 2014

Introduction
This suite of workforce reports includes:

- Turnover;
- Sickness absence;
- Vacancy rates;
- PDR rates;
- Agency usage as a percentage of paybill;

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

Headlines
GOSH decreased its contractual FTE (full-time equivalent) figure by 8 in December to 3700. This change is within anticipated levels and is 150 FTE higher than the same point in 2013.

Sickness absence continues to decrease to 2.43% following a very slight downward trend and remains significantly below the London average figure of 2.99%.

Turnover is broadly stable – currently at 17.67% (+0.23%) in December; this remains lower than the same point in 2013 where turnover was 17.87%. The (unadjusted) London benchmark figure is 13.63%.

The reported **vacancy rate** has decreased to 3.62% in December.

Agency usage (as a percentage of pay bill) stands at 2.64% in December, this is a slight decrease from the previous month (of 2.73%). Bank usage is increasing year-on-year and now stands at 6.51% (as percentage of pay bill).

PDR completion rates The Trust overall appraisal rate stands at 78.30% - a significant increase from the previous month of 73.50%. Only one directorate (HR & OD) is currently meeting the target of 95% however most divisions/directorates have shown a slight increase to their PDR rates since November.

Inclusion of 'CQC Intelligent Monitoring' measures to the sickness, turnover and vacancy reports. These are consistent with the calculations used by the CQC as a measure of risk. Comparison of month-on-month changes to made from next report.

Statutory and mandatory training compliance rates are reported below against a number of key mandatory training subjects (this is the first time training data has been reported in 12-months and represents in-depth training reporting, please note that this may be subject to some delay between training completion and reporting – data validation to be completed by March 2015). The required training compliance for any of the courses is 95%; currently the Trust is compliant with one (safeguarding children level 1) of the reported eight topic areas. Compared to November safeguarding adults has improved (+15%); counter fraud (+8%); equality and diversity (+26%); Health, Safety and Welfare (+9%); Infection, Prevent & Control (level 1) (+8%); however, Information Governance has decreased (-4%) as has Safeguarding children (level 1) (-1%).

Training Topic	Trust Training Compliance (%)	Surgery	Neurosciences	Medicine	International	ICI-LM	DTS	CCCR
Information Governance - current	87	91.9	91.1	89.5	90.7	92.8	87.9	90
Safeguarding Children – level 1	95	94.1	96.2	93.4	98.6	96.8	100	96.8
Safeguarding Adults	48	46.3	50.4	54.1	45.3	48	49	51.6
Fire Safety Overall	59							
Counter Fraud	76	71.9	86.5	76.7	80	78.3	82.8	72.5
Equality, Diversity and Human Rights	81	79.1	85.8	80.2	79.4	81.1	84	81.4
Health Safety and Welfare	79	75	89.3	78.3	81.6	79.9	83.5	74.4
Infection Prevention and Control Level 1	78	75.4	87.8	78.3	81.6	80.2	83.5	74.8

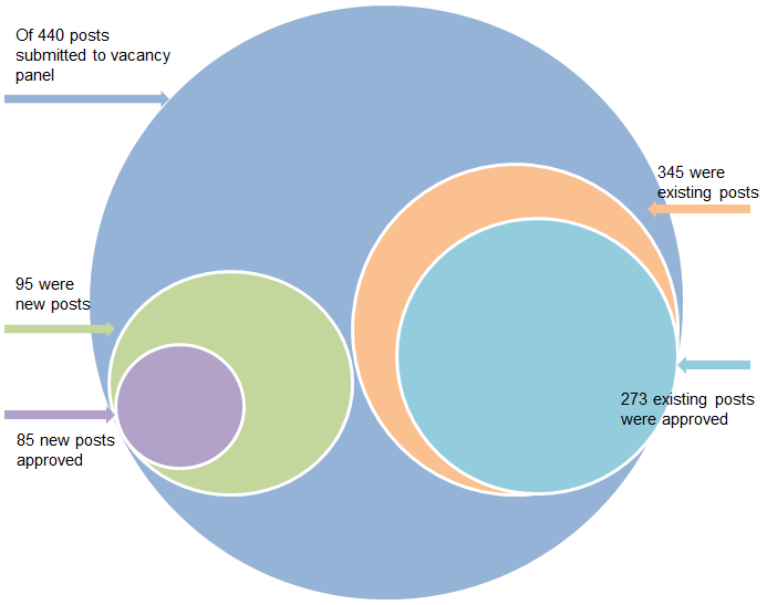
Key issues

Executive level scrutiny of all posts continues.

The executive vacancy panel meets on a weekly basis to review jobs requesting to be recruited to (this excludes some key roles e.g. rostered nursing roles).

The graphic (right) demonstrates the volume and outcomes of roles considered by the vacancy panel from 1 April 2014 to 31 December 2014.

A total of 82 roles were not approved from the 440 submitted.



Vacancy control period	Approval rate
April 14 to October 14	92%
Overall April 14 to December 14	81%

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

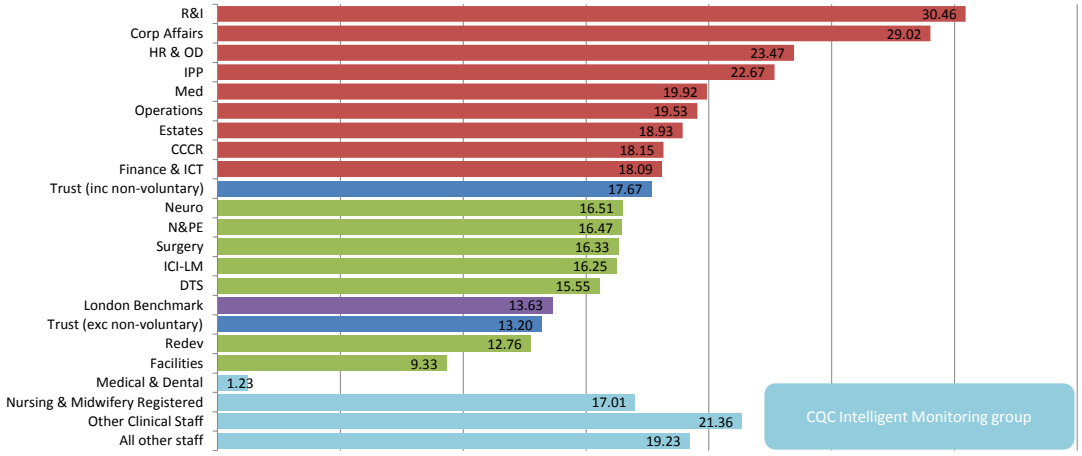
Division	Contractual Staff in Post (FTE)	Turnover Rate (%)	Sickness Rate (%)	PDR Completion (%) (target 95%)	Vacancy Rate (%) (Unfilled vacancies, 0-10% green; overestablished white)	Agency (as % of total paybill)
Critical Care & Cardio-Respiratory	713	18.2	2.7	67.6%	2.9%	1.5%
Diagnostic & Therapeutic Services	453	15.6	2.5	79.6%	5.6%	2.9%
Infection, Cancer & Immunity	676	16.3	2.3	81.2%	4.1%	0.3%
International	152	22.7	4.2	89.1%	7.0%	7.0%
Medicine	263	19.9	3.0	86.5%	1.0%	2.9%
Neurosciences	393	16.5	1.8	81.8%	2.1%	0.1%
Surgery	556	16.3	2.4	86.1%	4.8%	0.5%
Clinical & Medical Operations	58	19.5	0.8	61.1%	5.8%	5.5%
Corporate Affairs	9	29.0	0.1	87.5%	33.6%	6.8%
Corporate Facilities	81	9.3	3.1	63.3%	0.3%	7.6%
Estates	30	18.9	2.6	85.7%	13.4%	16.7%
Finance & ICT	91	18.1	2.3	48.2%	21.0%	29.0%
Human Resources & OD	100	23.5	1.5	100.0%	2.9%	0.3%
Nursing & Patient Experience	28	16.5	1.2	85.3%	11.5%	0.0%
Redevelopment	22	12.8	2.0	73.7%	0.2%	0.0%
Research & Development	64	30.5	1.4	73.8%	0.2%	0.7%
Trust	3700	**17.7▲**	**2.4▼**	**78.3%▲**	**3.6%▼**	**2.6%▼**

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

Division	Red Metrics / DoT	Metric	DoT	Actions & Comments
Estates	5 (previously 5)	Turnover improved from 21.6% to 18.9%		Pending consultation may further impact on turnover.
		Sickness improved from 2.9% to 2.6%		Monthly catch ups with the managers regarding sickness absence.
		PDR improved from 52.4% to 63.3%		There are a number of management vacancies, interim arrangements being established.
		Vacancy worsened from 10.7% to 13.4%		Currently holding vacancies pending consultation.
		Agency% worsened from 15.8% to 16.7%		Pending consultation to address staffing structure.
International	4 (previously 4)	Turnover worsened from 21.9% to 22.7%		Discussions took place in December regarding the importance of exit interviews and the spotting of patterns.
		Sickness unchanged 4.2%		One long term sickness absence returned to work in December. Monthly meetings with managers.
		PDR improved from 78% to 89.1%		Regular reminders by GM at monthly OMG.
		Agency% improved from 7.2% to 7%		
Medicine	4 (previously 4)	Turnover worsened from 18.8% to 19.9%		A number of people not returning to work from maternity leave
		Sickness improved from 3.2% to 3%		Kingfisher 2 Employees returned from LTS in January 2015. Monthly catch ups with both sisters from Kingfisher and Rainforest
		PDR improved from 82.7% to 86.5%		Discussed at MDTS management board
		Agency% improved from 3% to 2.9%		
Corporate Affairs	4 (previously 4)	Turnover improved from 35% to 29%		Small departmental group (9 staff).
		PDR improved from 62.5% to 87.5%		PDR action plan in effect
		Vacancy improved from 34.3% to 33.6%		
		Agency% improved from 7.7% to 6.8%		
Finance & ICT	4 (previously 4)	Turnover worsened from 17.1% to 18.1%		High numbers leaving one department to be addressed with new manager
		PDR worsened from 52.4% to 48.2%		PDR rates due to be discussed with departmental leads.
		Vacancy improved from 21.5% to 21%		Active recruitment episode for multiple posts ongoing.
		Agency% improved from 29.6% to 29%		
Corporate Facilities	3 (previously 4)	Sickness improved from 3.2% to 3.1%		Minimum of monthly catch-ups with the managers regarding sickness absence.
		PDR improved from 53.1% to 63.3%		
		Agency% improved from 8.3% to 7.6%		
Critical Care & Cardio-respiratory	3 (previously 3)	Turnover improved from 18.4% to 18.2%		
		Sickness improved from 2.9% to 2.7%		Monthly meetings with senior representatives from division
		PDR improved from 64.2% to 67.6%		Addressed with GM within regular catch up
Diagnostic & Therapeutic Services	3 (previously 2)	Sickness unchanged 2.5% (Trust improved)		1 employee returned from LTS absence. Monthly catch ups with the service managers to discuss sickness absence.
		PDR improved from 74.8% to 79.6%		
		Agency% improved from 3% to 2.9%		
Clinical & Medical Operations	3 (previously 3)	Turnover worsened from 18.1% to 19.5%		A number of secondments and fixed term contracts concluding
		PDR worsened from 72.2% to 61.1%		To be discussed with senior managers
		Agency% improved from 5.9% to 5.5%		

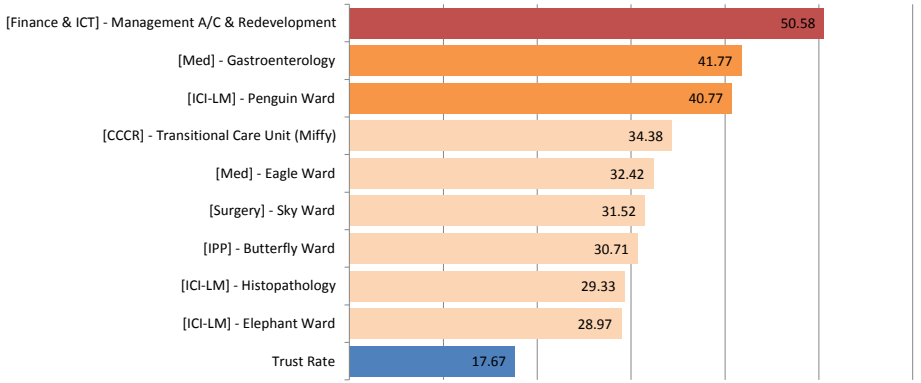
HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - DECEMBER 2014 REPORT

Divisional Turnover



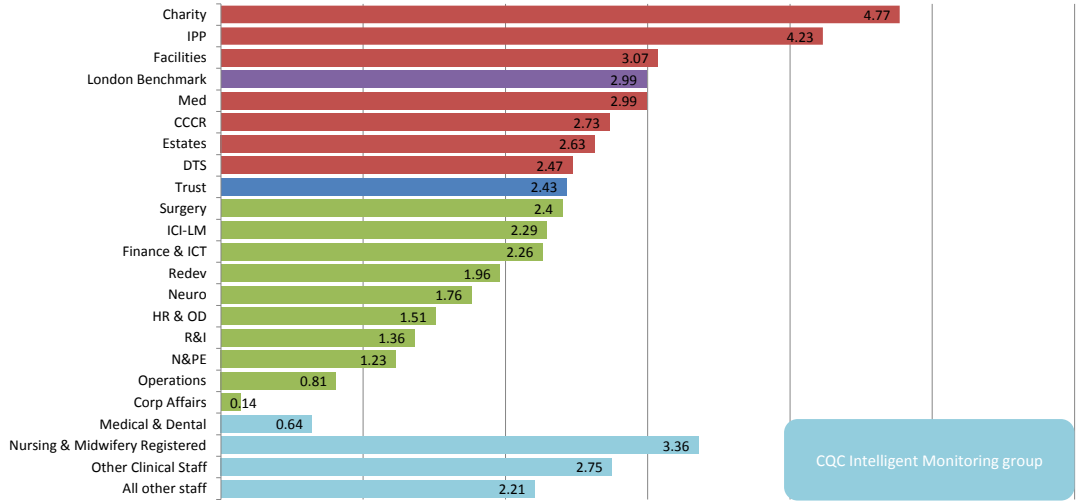
Inclusion of 'CQC Intelligent Monitoring' measures to the sickness, turnover and vacancy reports. These are consistent with the calculations used by the CQC as a measure of risk. Comparison of month-on-month changes to made from next report.

Exception Reporting Turnover

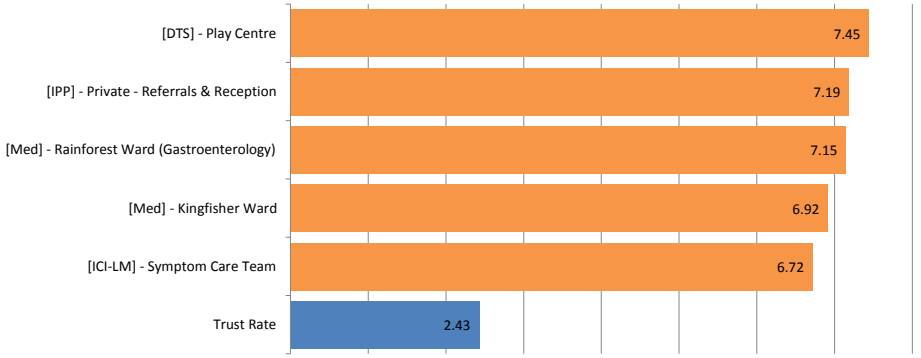


DTS (pharmacy) – pre reg pharmacists are on 12 month fixed term contracts around 20 staff on average; Surgery (Anaesthetic Staff Theatres) – majority of the staff are ODPs come and work at the Trust for 6 months to develop, the band 6 roles have low turnover so they are appointed to band 6 and 7 roles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

Divisional Sickness

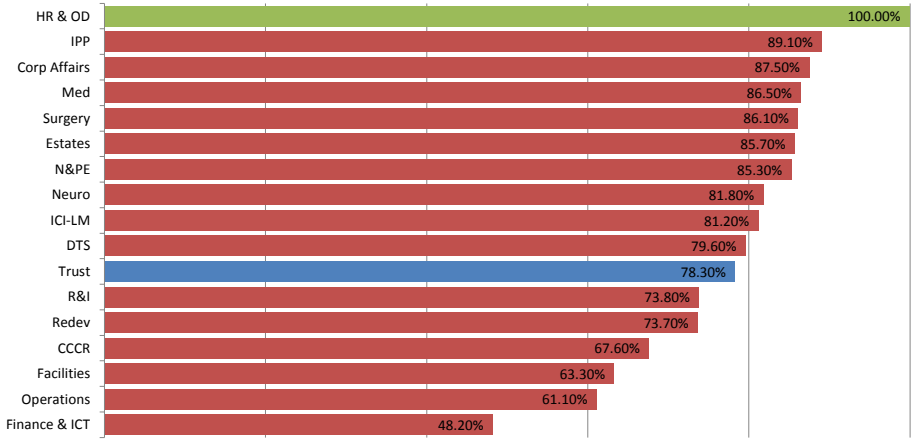


Exception Reporting Sickness

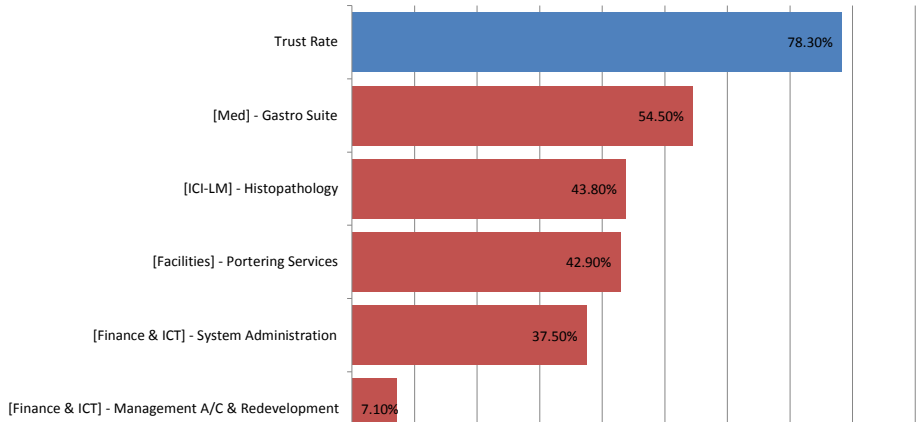


HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - DECEMBER 2014 REPORT

Divisional PDR (Target 95%)

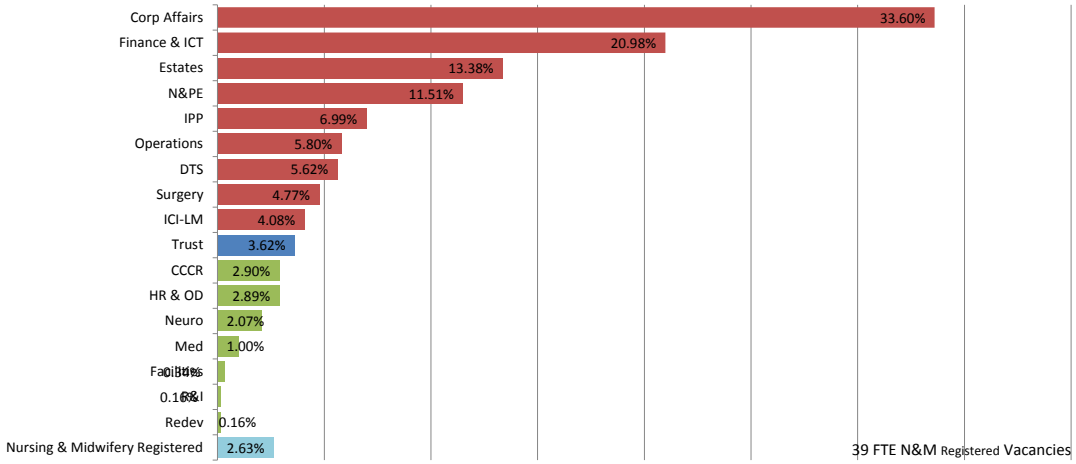


Exception Reporting PDR

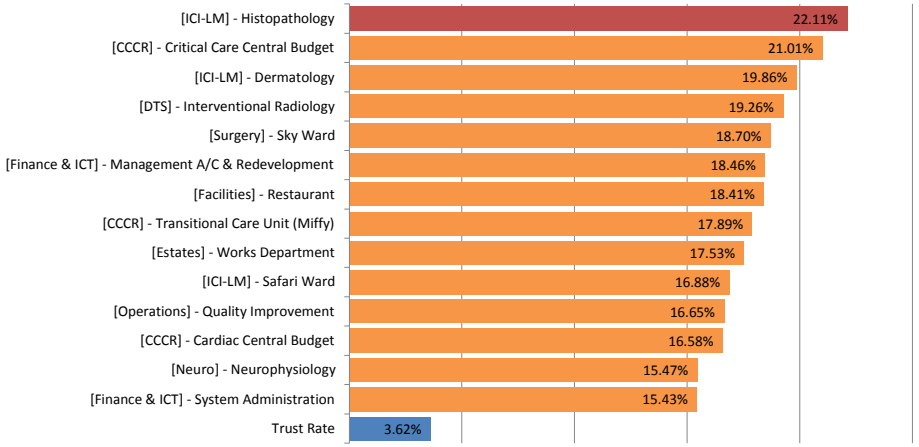


HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - DECEMBER 2014 REPORT

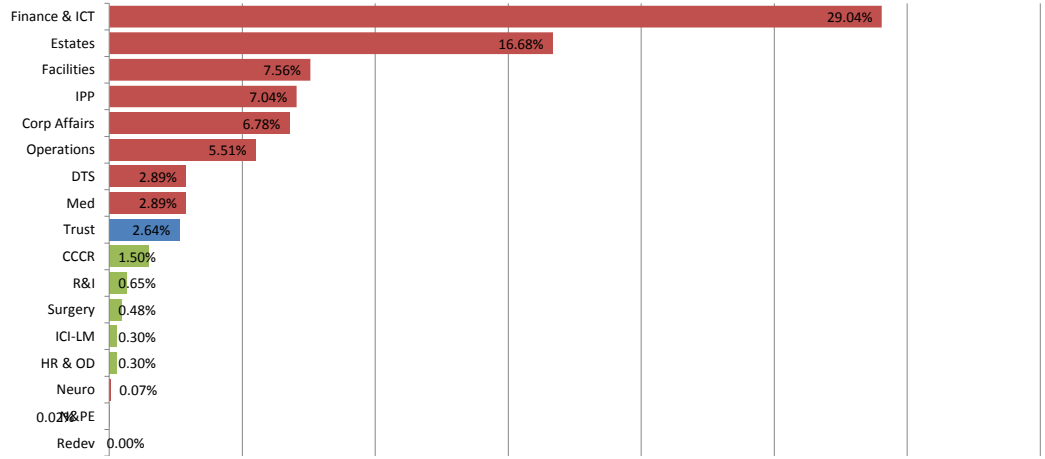
Divisional Vacancy Rate



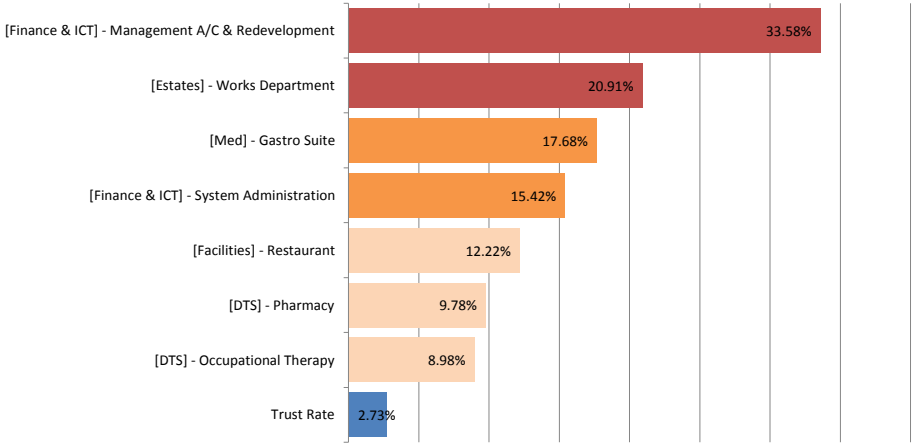
Exception Reporting Vacancy Rate



Divisional Agency as % of paybill



Exception Reporting Agency as % of Paybill



Great Ormond Street Hospital for Children NHS FT - Summary Financial Performance Report. 9 Months to 31 December 2014

Commentary :

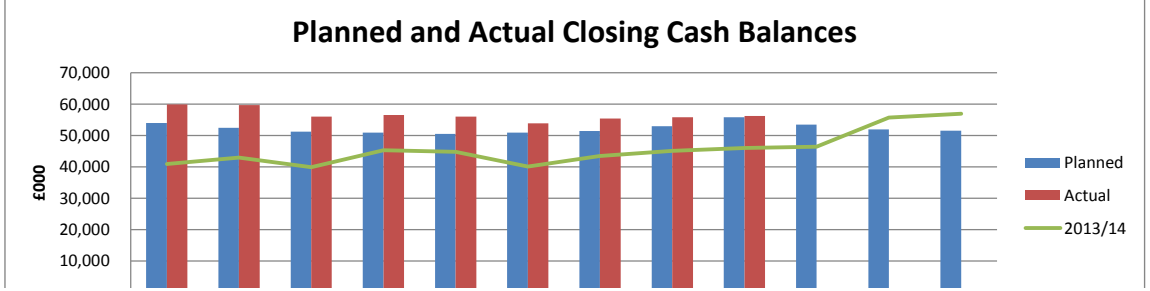
* The Trust is reporting a net surplus of £0.9M , £(3.7)M worse than Plan
* EBITDA of £19.5m 6.8% is £4m below the planned EBITDA of £23.5m (7.9%)
* Total income excluding pass through is £(7.8m) below plan principally due to doubt over the receipt of £3.5m of specialist funding from NHSE and £1.6m lower private patient activity . In month, private patient income was £0..3m above plan.
* Overall NHS patient activity is just below plan but NHS elective, & non-elective activity remain significantly below plan
* Cash levels are now only £0.4m higher than plan , the variance reduced from previous months),due to capital expenditure increasing, the operating deficit in the month and increased NHS debtor levels.

Other Challenges:

Productivity & Efficiency scheme values do not yet reach the annual target although short term cost savings are currently mitigating this.
Agency cost levels are higher than in the previous year

I&E	Current Month			Current Year Year to Date			YTD Prior Year Year to Date		RAG Rating
	Budget (£m)	Actual (£m)	Variance (£m)	Budget (£m)	Actual (£m)	Variance (£m)	Actual 2013/14 (£m)	Variance CY vs PY (£m)	Current Year Variance
NHS & Other Clinical Revenue	20.2	19.5	(0.7)	184.5	183.8	(0.7)	177.7	6.1	A
Pass Through	4.1	4.9	0.8	36.7	36.6	(0.0)	35.5	1.1	G
Private Patient Revenue	3.5	3.2	(0.3)	34.1	32.5	(1.6)	31.2	1.2	A
Non-Clinical Revenue	4.8	3.8	(1.0)	41.0	35.6	(5.5)	34.2	1.4	R
Total Operating Revenue	**32.6**	**31.5**	**(1.1)**	**296.3**	**288.5**	**(7.8)**	**278.6**	**9.8**	
Permanent Staff	(16.7)	(16.3)	0.4	(148.5)	(145.9)	2.7	(141.4)	(4.5)	G
Agency Staff	(0.4)	(0.3)	0.1	(3.7)	(4.1)	(0.4)	(3.7)	(0.4)	R
Bank Staff	(1.0)	(1.0)	0.0	(9.2)	(9.6)	(0.4)	(9.2)	(0.4)	A
Total Employee Expenses	**(18.1)**	**(17.7)**	**0.5**	**(161.5)**	**(159.5)**	**1.9**	**(154.3)**	**(5.3)**	
Drugs and Blood	(1.2)	(1.1)	0.1	(9.2)	(8.7)	0.4	(9.9)	1.2	G
Other Clinical Supplies	(3.0)	(3.1)	(0.1)	(27.0)	(28.0)	(1.0)	(26.0)	(1.9)	A
Other Expenses	(4.4)	(3.9)	0.5	(38.6)	(36.1)	2.5	(32.5)	(3.7)	G
Pass Through	(3.9)	(4.9)	(1.0)	(36.5)	(36.6)	(0.1)	(35.5)	(1.1)	A
Total Non-Pay Expenses	**(12.6)**	**(13.0)**	**(0.4)**	**(111.3)**	**(109.5)**	**1.8**	**(103.9)**	**(5.5)**	
EBITDA (exc Capital Donations)	**1.8**	**0.8**	**(1.0)**	**23.5**	**19.5**	**(4.0)**	**20.4**	**(1.0)**	
Depreciation, Interest and PDC	(2.2)	(2.1)	0.1	(18.9)	(18.5)	0.3	(22.4)	3.8	
Net Surplus (exc Cap. Don. & Impair	(0.4)	(1.3)	(0.9)	4.7	0.9	(3.7)	(1.9)	2.8	
EBITDA %	**5.6%**	**2.6%**		**7.9%**	**6.8%**				
Capital Donations	2.0	0.7	(1.3)	28.3	12.5	(15.8)	12.8	(0.3)	

Closing Cash Balance



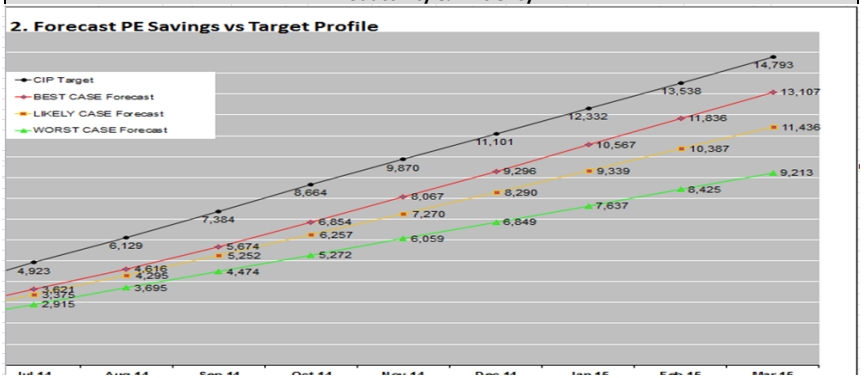
Statement of Financial Position	31 March 2014 Actual £m	31 Dec 2014 Planned £m	31 Dec 2014 Actual £m
Non-Current Assets	371.0	415.7	377.7
Current Assets (exc Cash)	58.2	55.1	57.9
Cash & Cash Equivalents	57.0	55.9	56.3
Current Liabilities	(56.8)	(56.7)	(49.4)
Non-Current Liabilities	(7.3)	(6.9)	(6.9)
Total Assets Employed	**422.1**	**463.1**	**435.6**

Capital Expenditure	Annual Plan £m	31 Dec 2014 Reforecast £m	31 Dec 2014 Actual £m
Redevelopment - Donated	18.8	10.3	10.4
Medical Equipment - Donated	8.9	2.4	2.5
Estates - Donated	1.2	0.0	0.0
ICT - Donated	0.0	0.1	0.1
Total Donated	28.9	12.8	13.0
Redevelopment - Trust Funded	0.0	4.5	4.4
Estates & Facilities - Trust Funded	6.4	2.5	1.7
ICT - Trust Funded	8.5	4.7	2.8
Medical Equipment - Trust Funded	6.6	0.1	0.0
Total Trust Funded	21.5	11.8	8.9
Total Expenditure	**50.4**	**24.6**	**21.9**

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

	31-Mar-14	30-Nov-14	31-Dec-14	RAG Rating
NHS Debtor Days (YTD)	17.35	8.85	15.64	G
IPP Debtor Days	116.40	140.42	135.72	A
IPP Overdue Debt (£m)	5.95	4.85	5.02	A
Creditor Days	35.65	21.95	20.77	G
BPPC - Non-NHS (YTD) (number)	86.8%	88.0%	88.4%	A
BPPC - Non-NHS (YTD) (£)	90.8%	91.1%	91.4%	G

Productivity & Efficiency

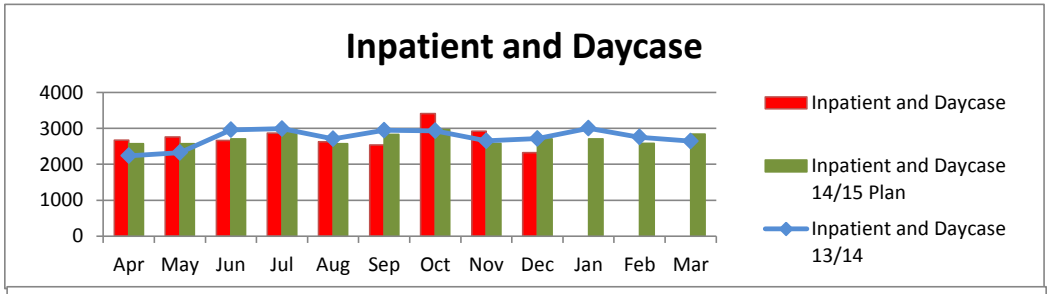


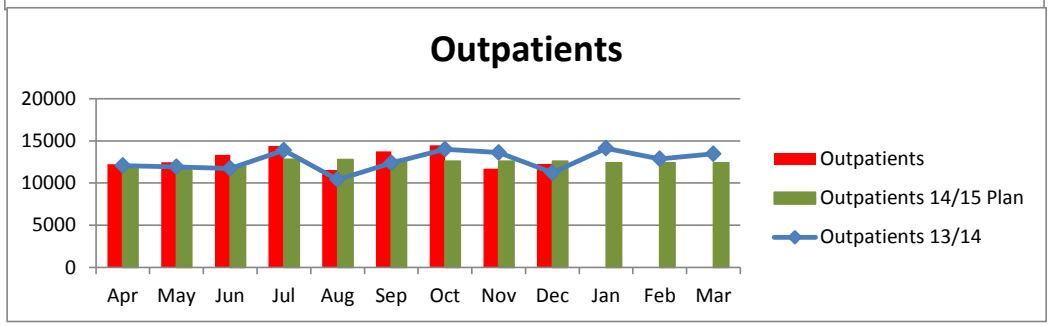
ACTIVITY AND INCOME

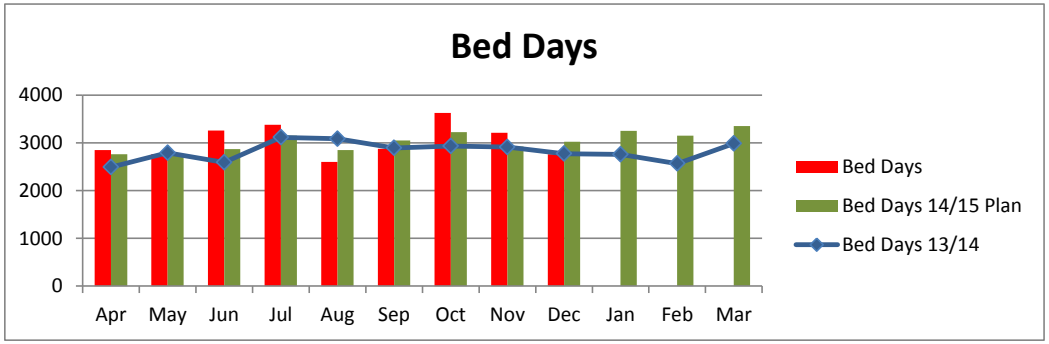
	Income from NHS & Other Clinical Activity £M year to date				
	YTD Actual (£m)	Variance to plan (£m)	Variance to plan (%)	Variance to Prior Year (£m)	Variance to Prior Year (%)
Daycases	**17.3**	(0.8)	-4.8%	0.9	5.3%
Elective Inpatients	**40.7**	(3.4)	-8.3%	(1.5)	-3.6%
Non-Elective Inpatients	**10.3**	(0.5)	-5.3%	(0.4)	-3.8%
Bed days	**33.8**	1.3	3.9%	1.0	3.2%
Outpatients	**28.9**	1.0	3.4%	1.0	3.7%
Other eg. Highly Specialised	**52.8**	1.8	3.4%	5.1	10.7%
Total	**183.8**	(0.7)	-0.4%	6.1	3.4%

Activity				
YTD Actual	Variance to plan	Variance to plan (%)	Variance to Prior	Variance to Prior Year (%)
14,198	1,410	9.9%	834	6.2%
9,294	(1,034)	-11.1%	(175)	-1.8%
1,294	(82)	-6.3%	(61)	-4.5%
27,316	773	2.8%	1,752	6.9%
116,233	3,628	3.1%	5,007	4.5%

PATIENT ACTIVITY

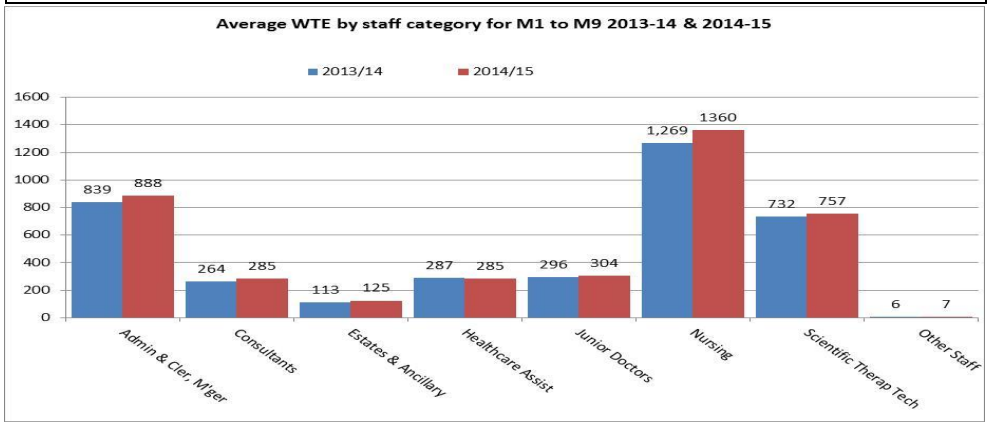


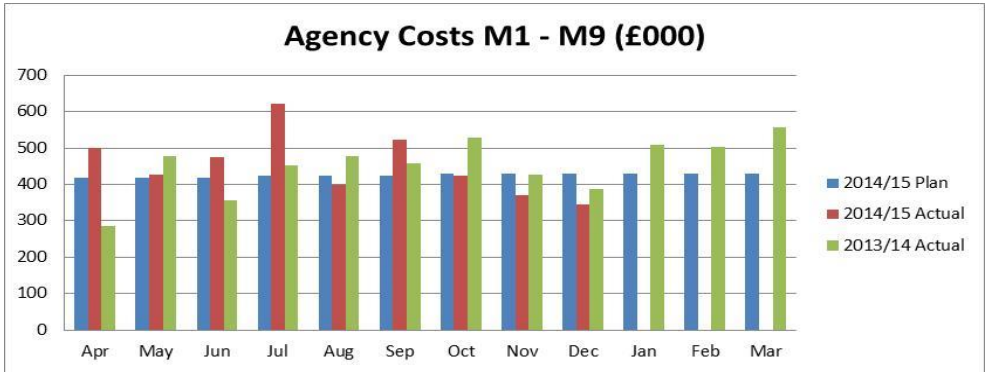




STAFF

Year	WTE Average	YTD Total Pay (£m)	YTD Agency (£m)	Agency as % of Total Pay	YTD Bank (£m)	Bank as % of Total Pay
2014/15	4,010	159.5	4.1	2.57	9.6	6.02
2013/14	3,805	154.3	3.8	2.46	9.6	6.22
Movement	205	5.2	0.3	0.11	0.0	-0.20





Attachment J

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

28th January 2015

Patient Experience Report

Summary & reason for item:

This report provides information on patient experience in the last quarter in relation to friends and family test, PALS referrals and complaints.

Highlights from the reports show that:

PALS

- 986 PALS contacts to PALS were made this quarter
- 8.2 % increase in PALS contacts
- 6 cases escalated to complaints, a fall on the previous quarter
- 12 Compliments received regarding GOSH services

Key themes emerging from PALS referrals this quarter were poor communication between staff leading to delays in communication with families and the provision of inaccurate information, and poor experiences of the discharge process to local services or home.

Complaints

- 40 new formal complaints were received this quarter
- There was an increase of 17.5% in complaints received this quarter compared to last quarter (Q2 2014/2015).
- There were five (5) complaints graded as red in Q3 compared to two (2) in the previous quarter.

Key themes emerging from complaints this quarter were lack of communication with parents/carers and inaccurate information provided regarding timescales for appointments.

Councillor action required:

Members' Council to note the positive experiences of patients and families and the areas that require improvement.

Report prepared by:

Caroline Joyce Assistant Chief Nurse Quality & Patient Experience.

Item presented by:

Liz Morgan Chief Nurse and Families Champion

Great Ormond Street Hospital for Children NHS Foundation Trust

PALS Q3 Report
October-December 2014

1. Key themes of this report

- **986 Pals contacts to Pals were made this quarter**
- **8.2 % increase in Pals contacts**
- **6 cases escalated to complaints, a fall on the previous quarter**
- **12 Compliments received regarding GOSH services**

2. Learning and Patient Experience from Pals Cases in Q3

2.1. Issue: Communication breakdown between clinical/nursing staff and administrators leading to delays in communication with families or inaccurate in communication to families. This was an issue for a range of services at GOSH and identified in 32 cases.

e.g. A letter was requested by the parents to give to the child's school to enable the GOSH patient to receive school transport. This was important to the family because the child was now at an age the parents needed extra assistance in taking the child to school. The absence of the letter is a barrier to the child getting to school with additional support. This was requested in September at the beginning of the school term. By November the parents had still not received the letter, therefore they contacted Pals. The parents' initial thought was that this was an administrative issue for not processing the letter; however the delay was because the medical team had not been able to prioritize this piece of work.

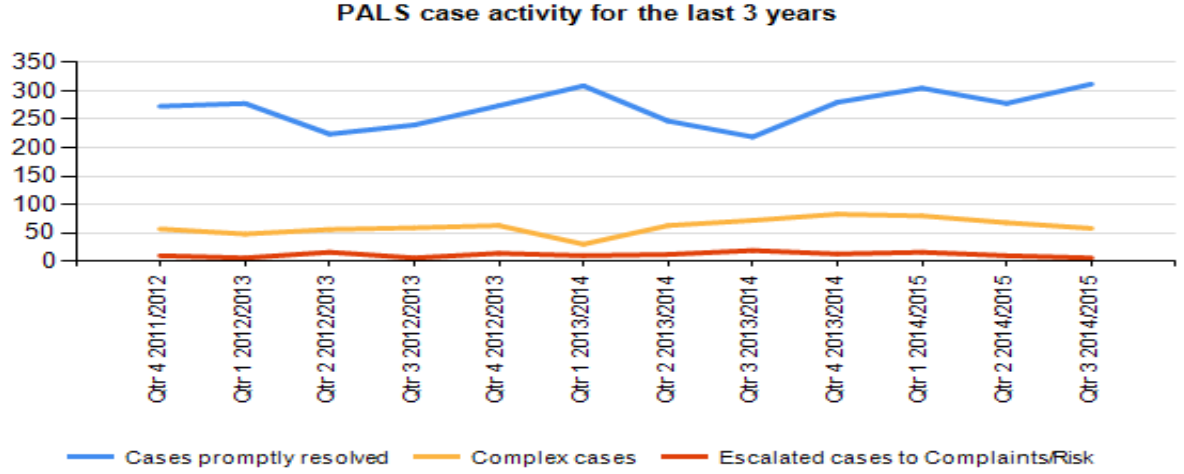
2.2. Issue: Difficulties in discharge from GOSH to local hospital/services or home.

This issue touches many services at GOSH and in Q3 Pals identified 15 cases where families were unhappy with the planning of discharge from GOSH. In many of these cases the families asked if the "Discharge of Patients Policy" was being followed and in some cases it was not. We have highlighted this issue as the time absorbed by some of these cases was significant, including many specialists and in two cases Directors met with the parents. The contact from parents to Pals focused on the lack of their involvement in the discharge planning and subsequently disagreed with or resisted discharge from GOSH.

3. Pals Casework Activity in Q3

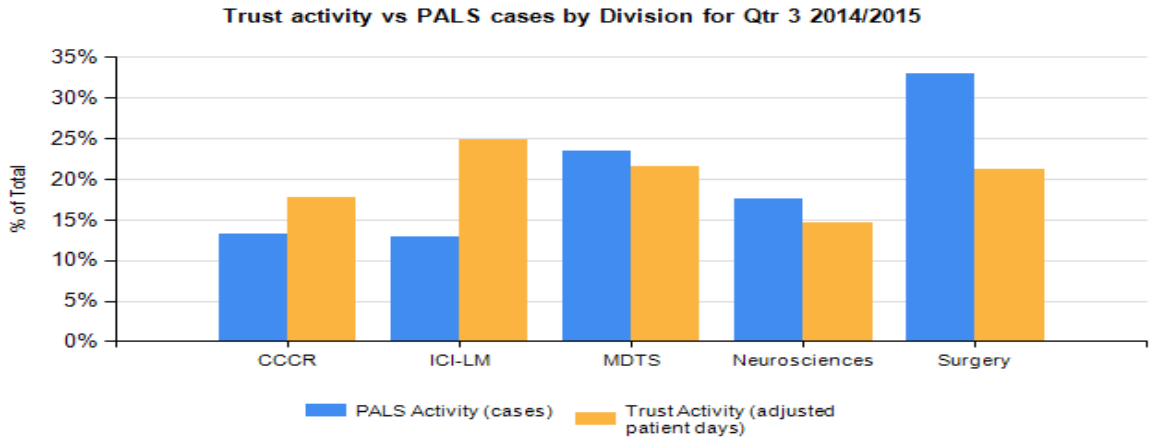
- 610 Information enquiries
- 312 Promptly resolved cases
- 58 Complex cases
- 6 Escalated cases to Complaints

4. Pals case activity for the last 3 years (not including Information inquiries)



For Q3 the chart above shows a marked increase in promptly resolved cases in comparison with the preceding Q3 and a slight decrease in complex cases.

4. Trust activity in comparison with Pals case activity - for clinical divisions for Q2



4.1 Pals "top three" specialty cases by Division and Specialty for Q3

Surgery: 111 cases. Orthopaedics: 35.1%, General Surgery 16.2%, ENT: 11.7%
MDTS: 77 Cases. Gastro 54.5%, Endo: 13%, Radiology: 6.5%
Cardio: 43 cases. Cardiology 41.9%, Respiratory 30.2% Critical Care 20.9%
ICI: 42 Cases. Rheum 35.7%, Dermatology 28.6%, Oncology 9.5%
Neuroscience: 61 cases. Ophthalmology 32.8%, Neurology 23%, Outpatients 11.5%
Facilities: 26 cases. Transport 34.6%, Catering 15.4%, Medical Records 15.4%

5. Pals promptly resolved cases analysed by theme (313 cases)

Surgery: Communication/letters 44.1%, Cancellations 11.8%, Care Advice 8.6%
MDTS: Communication/letters 38.9%, Cancellation 11.1%, Care Advice 9.3%
Cardiac: Communication/letters 20%, Care Advice 13.3%, Cancellations 13.3%
ICI: Communication/letters 42.4%, Cancellations 12.1%, Care Advice 9.1%
Neurosciences: Communication/letters 35.9%, Care Advice 20.5%, Cancellations 10.3%
Facilities: Catering 22.7%, Medical Records 13.6%, Rude Staff 13.6%
"Care Advice" is not provided by Pals. These queries about medication or equipment are promptly responded to by CNS's or the Clinical Team.

6. Pals Complex Cases Analysed by theme for Q3 (57 cases)

Surgery: Communication (delay in responses) 27.3%, Outpatient experience (delay in OPA dates) 27.3%, Admission/Discharge 27.3%
MDTS: Outpatient experience 55.6%, Admission/Discharge 16.7%, Communication 9%
Cardiac: Inpatient experience 50% (one family contacted Pals many times), Admission issues (cancelations) 16.7%, Admission/Discharge problems 33.3%
ICI: Admission/Discharge 50%, Inpatient experience 20%, Parental responsibility (5 complex cases) 20%
Neuroscience: Outpatient experience 53.8% (OPA communication), Inpatient Experience 23.1% (cancelations), Parental Responsibility 7.7% (only one case)
Facilities: Transport (unsafe driving) 50%, Medical records (Info. to be sent to international hospital) 50%

7. Same Sex Accommodation: There have been no cases this quarter.

8. Update on key issues from Q2 July- September 2014

Issue	Update
Unanswered/unreturned phone calls and emails.	The numbers of Pals cases that are initiated because of this issue have not fallen. Pals have started to meet on a weekly basis with the Office Managers where these numbers are highest to improve communication and identify patterns in such cases.
	Pals agreed to look deeper in to such cases and found (please see 2.1) that a number of the cases result from administrators not having sufficient information to reply to a family. There is some concern amongst junior staff that incomplete plans might cause greater anxiety for families.

9. Cases formally escalated to Complaints or Risk teams

Pals escalated 6 cases to the Complaints Team in Q3. This is a reduction on the preceding quarter. These cases are managed and reported via the Complaints Q3 Report.

10. Compliments

Location (exact)	Directorate (primary)	Specialty	Description	Outcome
KOALA	NEUROS	NEUROL	Mother wanted Christmas presents delivered to Koala Ward as a thank you as her daughter had been an inpatient previously.	Presents delivered to Koala Ward accepted by Ward Sister
PUFFIN	NEUROS	OUTPAT	Mother wanted to give positive and feedback on a recent stay at GOSH.	Pals fed this back to the ward sister.
	SURGER	AUDIO	Father would like to praise consultant for her effort in treating her child.	Pals fed this back the relevant team who have acknowledged this.
ISS	MDTS	RADLGY	Father wanting to thank consultant who was involved in treating his son.	Pals fed this to the relevant teams to deal with.
KOALA	NEUROS	NSURG	Comment Card complementing the koala team for their care.	Shared with team and senior management
PICU	Cardiac	PICU	Pals received a comment card: praising the doctors and the nurses.	Pals to feed this back to the team
OUTPAT	SURGER	PLAST	Pals received positive comments on recent OPA experience.	Pals have fed this back to outpatient team. Pals to write a letter to the family.
	NEUROS	NSURG	Former patient wanting to give her thanks to consultant who treated her at GOSH.	Pals have fed this to the relevant team.
	MDTS	Play	Member of public donating toys to GOSH.	Pals have given the toys to a play worker, who will contact the person who donated them.
OUTPAT	NEUROS	OUTPAT	Comment Card complimentary of SWAN outpatients.	Feedback to lead nurse, ward sister and service manager
ISS	SURGER	UROLOG	Father wanted to give positive feedback. Child was on Island short stay.	Pals have forwarded this to the relevant manager to deal with.
PPAN	SURGER	ENT	Family wanting to give their praises to the staff that were involved in treating their child whilst she was an inpatient on GOSH.	Pals to forward this feedback to management.

Great Ormond Street Hospital for Children NHS Foundation Trust

Complaints Report
Quarter 3, 2014/15

Summary of key points

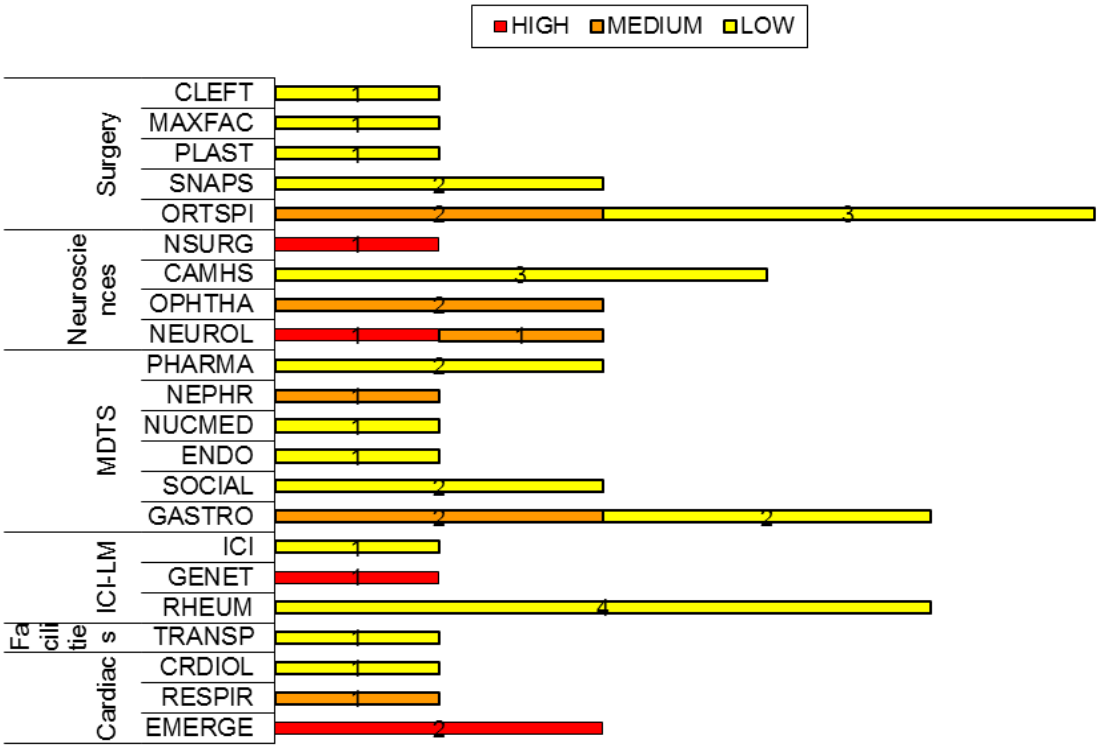
The key points identified from this report are:

- 40 new formal complaints were received this quarter
- There was a increase of 17.5% in complaints received this quarter compared to last quarter (Q2 2014/2015).
- There were five (5) complaints graded as red in Q3 compared to two (2) in the previous quarter.

Number of formal complaints received by the Trust

The Trust saw the number of formal complaints received increase by 17.5% in quarter 3 this year compared to quarter 2. This is also a small increase of 5% in comparison to quarter 3 in 2013/2014.

Number of complaints received by division, speciality and grading



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

Percentage of complaints received compared to patient activity for each division

Directorate	Total # of Complaints	Adjusted patient activity	Amount of Complaints per 1000 Adjusted Patient Days	% of Complaints per 1000 Adjusted Patient Days
MDTS	11	3242.37	3.39	26.4%
Surgery	10	3376.10	2.96	23.1%
Neurosciences	8	2293.93	3.49	27.2%
ICI-LM	6	3815.01	1.57	12.2%
Cardio-respiratory Services	4	2822.96	1.42	11.1%
Totals:	39*	15550.37	2.51	100.0%

*During Q3 2014-15, there was one complaint concerning Facilities which is not counted in this table as there are no comparable bed days.

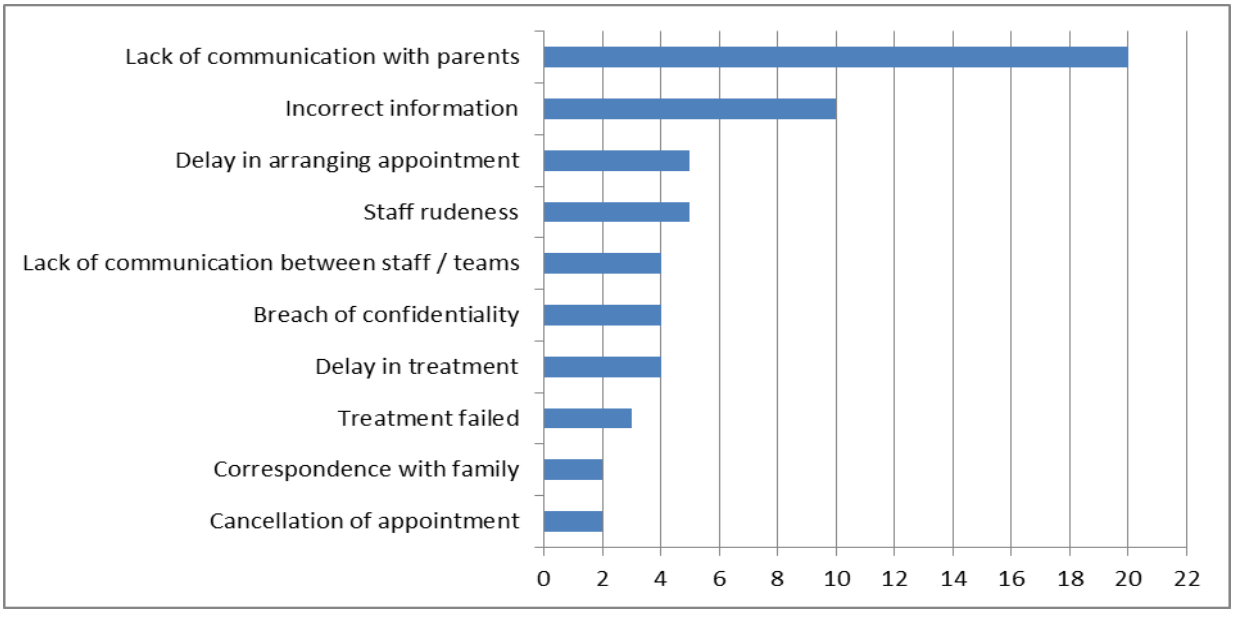
Adjusted Patient Activity is a measure which weights outpatients, inpatients and critical care bed days into a combined figure representative of overall healthcare resource activity.

Complaints closed within the agreed timescale

92% of all complaints closed this quarter were responded to on time which is an improvement from quarters 1 and 2. However, the Complaints Team only received 53% of draft responses on time from the divisions which is a decrease from the last two quarters.

Trend analysis of complaints received in Q2

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



Themes in complaints

The following themes have been apparent this quarter:

- Lack of communication with parents/carers

- Inaccurate information regarding timescales for appointments

Learning from complaints

An update on learning following the themes identified in the quarter 1 report follows:

- Inaccurate information in letters – each of the issues raised was addressed by the relevant division and appropriate apologies given to the families. The causes of the mistakes have largely been due to human error and a failure to check accuracy. While mistakes will sometimes be made these complaints highlight the importance of accurately checking information which has been communicated to relevant staff. In one case the division agreed to reimburse the patient for loss of earnings as he had been given the wrong date on which to attend the hospital and this money would not have been needed to be spent had the error not occurred.
- Referrals to social services/sharing information with other organisations – the responses to these complaints have all explained that the Trust has a legal obligation to share information as required and a duty of care to the child which includes sharing information with other organisations when this is in the best interests of the patient. In addition to this the possibility of producing a short leaflet explaining this which could be given to parents is being explored.
- Communication – this is a recurrent theme within complaints. Issues are addressed with individual staff, departments and divisions as needed and any action identified is monitored by the complaints team. The complaints team also monitor for specific areas of concern or recurrent issues with specific teams.

Re-opened complaints from dissatisfied complainants

Five complaints were reopened this quarter as a result of the complainants being dissatisfied with the response to their initial complaint. For three of these a further response has been sent to the family, in one a response is currently being drafted and in the other a meeting has been offered to the family.

Health Service Ombudsman

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

- **New cases**

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

- **Update on cases with the Ombudsman**

In one case currently under investigation the Ombudsman requested some further information. This was provided where possible but we were unable to supply all the information requested which was explained to the Investigator.

- **Cases closed this quarter**

Two cases was closed by the Ombudsman this quarter. One of these concerned communication with the family following the patient's death and communication with another Trust during the patient's care. The complaint was partly upheld and following the Ombudsman's report we have written to the family apologising for the failings identified and updating them on the actions taken as a result. The other complaint concerned care and treatment provided to a patient throughout the course of their illness and was not upheld by the Ombudsman.

ATTACHMENT K

Great Ormond Street Hospital for Children NHS Foundation Trust

Update on Election and Report from the Membership and Engagement Committee

Summary & reason for item: To provide the committee with an update on:

1. Members' Council Election 2014/15
2. Membership Statistics and Report

Report prepared by: Deirdre Leyden & Kirsty Woodbridge.

Item presented by: Deirdre Leyden, Membership and Governance Manager
Lisa Chin- A-Young on the work of the Membership Engagement Committee

1. Members' Council Election 2014/15

Election Timetable

The Trust is now in the final stage of the election. The election is run on the Trust's behalf by an independent election company, Electoral Reform Services. The election conforms to model election rules recently updated and adopted by the Trust.

A breakdown of the candidates by constituency is below:

Constituency	Number of Nominations	Seats to elect
Parent and Carer- Patients from outside London	2	2
Parent and Carer- Patients from London	4	2
Parent and Carer- Parents or carers from outside London	6	3
Parent and Carer- Parents or carers from London	7	3
Public- North London and Surrounding Area	5	4
Public- South London and Surrounding Area	8	1
Public- Rest of England and Wales	7	2
Staff	6	5

The revised model election rules enable online nominations and voting. The Trust has used this method of nominating and will use it for voting in addition to paper based voting.

Of note is that 34 members opted to use the electronic nomination option.

Voting will open on 27th January 2015. To view the nominated candidates statements visit www.gosh.nhs.uk/ftelection . Voting closes on 19th February 2015 with results announced on 20th February 2015.

The Members' Council 2015-2018 will receive a comprehensive induction and development programme. Those members unsuccessful at election will be offered other opportunities to get involved in Trust activities.

2. Membership Statistics and Report

Summary Position

Active Membership Total

The current membership stands at **8,759.** This shows an increase of **405** members since the last report to the Members' Council in November. The 2013/2014 Annual Membership report to Monitor estimated a projected target of 8,449.

Membership Profile

Membership is increasing. The profile of the active membership compared against England and Wales is however still under-represented by men, and people from lower socio economic groups. However there has been an increase in men joining (63 since last report) and we aim to continue with face to face recruitment which will help balance this short-fall (although it should be noted typically, more mothers attend hospital with their children.)

ATTACHMENT K

Patient and Carer and Public Membership Recruitment

Eligible membership is open to children over the age of 10.
Public membership is limited to people who live in England and Wales.
Patient members need to have been seen in the hospital within the last six years. Parents or carers of patients seen in the last six years can be members. If a patient or parent / carer member was seen more than six years ago, they are transferred to the public constituency. This is because the Trust wants patient and carer members to be those with more recent experiences of our service.

Membership Publications

Voting letters for the voting process
Voting Booklet and Instructions
Member Matters, Adult and Teen versions
Roundabout Newsletter for staff in December and February feature election
Payslips for staff advertise election
V Focus magazine will feature election

Member Matters - Timetable for spring version:

Editorial Committee meeting- 15 January 2015
Editorial Committee approval on copy(including covering letter),9 - 18 March 2015
Editorial Committee Approval on Final Design, 10 - 17 April 2015
Mailing, 6 May 2015

Design

FT Get Involved teen version included in mail outs for outpatient letters.
Posters and flyers now on display in new out patient's area where membership have been allocated a poster board.
Pop up election banner used for events and in the hospital.
Am Screen ads in Lagoon and at Charity desk advertising election and ' Meet your councillor sessions'

Online communications- Website/Intranet

Membership and Engagement Committee received a presentation on the Social Media Strategy at their November Meeting.
Members' Council receive monthly e bulletin.
Dedicated website page is updated throughout the election.
FT Get Involved email to members gives key dates, opportunities to update membership details and links to dedicated website page.
Website banners for online nominations and voting.
Social media election campaign.
Election Intranet pages updated.
All staff GOSH e Newsletter updated with election news.

Events

Two Election information Sessions in December 2014
Face to face recruitment sessions in the Lagoon
Coram Fields Christmas Fair

Table 1: Patient and Carer and Public membership

Data as of 1 January 2015.

	Number of members as at 1 April 2014	Number of members recruited in year	Number of members leaving in year**	Number of members as at 1 January 2015
Patient and Carer Membership	5884	232	23	5951
Public Membership	2140	544	18	2666
Total	**8024**	**776**	**41**	**8759**

**Note does not show members moving constituency*
*** 'Number of members leaving in year' includes members who have been suppressed i.e. goneaways, general suppressions, deceased since April 2014.*

Table 2: Membership breakdown by constituency

Data as of 1 January 2015.

Breakdown by constituency	Number of members as at 1 January 2015
Patient and carer constituency	
Parent/carer in England and Wales	3126
Parent/carer in London	2053
Patient in England and Wales	483
Patient in London	431
Sub Total	6093
Public constituency	
Public in England and Wales	653
Public in North London	1384
Public in South London	629
Sub Total	2666
Grand Total	8759

Public Membership

Table 3 sets out the Trust's public membership as at 1 January 2015, compared against the eligible membership in England and Wales.[1]

Table 3: Public membership, compared against eligible membership in England and Wales.

Public Constituency	Total number of members	Percentage of membership	Catchment area profile (All of England and Wales (%)*)	Over or under representation (England and Wales)
Number of members	2666	100%		
Gender *				
Male	828	31.06%	48.90%	under
Female	1764	66.17%	51.10%	over
Unknown	74	2.78%	-	n/a
Age Range *				
10-16	81	3.04%	8.26%	under
17-21	267	10.02%	6.59%	over
22+	2093	78.51%	73.32%	over
Unknown	225	8.44%	-	n/a
Ethnicity *				
White	1590	59.64%	85.97%	under
Mixed	76	2.85%	2.18%	over
Asian or Asian British	200	7.5%	7.51%	over
Black or Black British	199	7.46%	3.33%	over
Other	42	1.58%	1.01%	over

[1] *As GOSH is a tertiary hospital providing some national services, the public membership covers the whole of England and Wales.*

Unknown	559	20.97%	-	n/a
Social Group *				
ABC1	**	**	52.96%	over
C2	**	**	22.07%	over
DE	**	**	24.98%	under
Unknown	**	**	-	n/a

*Data true as of 2011 (ONS data).
** We no longer have the Socio Economic Status stored in our database. In the past, this metric had been calculated using the MOSAIC Household Income information we append in to our database. MOSAIC have changed their Household Income bandings, this means that we are unable now to convert this information into the desired Socio Economic Status. Alternative methods are being investigated.

- When percentages don't add up to 100% this is because certain categories are omitted i.e. age range 0-9.

Patient and Carer Membership

Table 4 sets out how the Trust's patient and carer eligible membership by age.

Table 4: Patient and Parent/Carer membership by age

Patient and Parent/Carer Constituency by age range	Total number of members	Percentage of membership
Total number of members	6093	100%
0-16	313	5.14%
17-21	571	9.37%
22+	4876	80.03%
Unknown	333	5.47%

Table 5: Trust's patients and carer breakdown by gender, ethnicity and social grade as compared to the hospital patient database (PIMs)

	Patient & Parent/Carer	%	% of patients	Over or under represented
Gender				
Male	1846	30.3%	50.25%	Under
Female	4218	69.23%	49.75%	Over
unknown	29	0.48%	-	n/a
Social Group				
ABC1	*	*	59.07%	Over
C2	*	*	26.90%	Under
D	*	*	2.95%	Over
E	*	*	10.40%	Under
unknown	*	*	0.67%	n/a
Ethnicity				
Asian or Asian British	464	7.62%	8.57%	Under
Black or Black British	417	6.84%	5.8%	Over
Mixed	198	3.25%	2.16%	Over
Other	134	2.2%	3.06%	Under
Unknown	560	9.19%	34.16%	n/a
White	4320	70.9%	46.25%	Over

* We no longer have the Socio Economic Status stored in our database. In the past, this metric had been calculated using the MOSAIC Household Income information we append in to our database. MOSAIC have changed their Household Income bandings, this means that we are unable now to convert this information into the desired Socio Economic Status. Alternative methods are being investigated.

Summary

Our data is starting to indicate a shift towards a more accurate representation against eligible membership. Numbers of men and ethnic minorities are increasing.

We aim is to increase awareness of FT status in the hospital and be representative of the hospital patient community, with our recruitment focusing on increasing the number of young members. 29 patients were recruited from face to face sessions in the hospital.

We are also continuing to work with the Trust's Volunteer Manager who has supported recruitment. 56 volunteers were recruited face to face. Future induction sessions will include awareness sessions around FT status and the opportunity to join the Trust.

We wish to re-connect with some of our members who have a valid email address but not a postal address so that we can include them within our election communications and for future membership activity. We are 'getting back' a significant number of our suppressions (over 100). This is probably due to the 'update your address' email, and other general updates in the FT Get Involved email.

ATTACHMENT M

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT MINUTES OF THE MEMBERS' COUNCIL MEETING
24th September 2014
Charles West Boardroom

Present:

Baroness Tessa Blackstone	Chair
Mrs Lisa Chin-A-Young	Patient and Carer Councillors: Parents and Carers from London
Mr Matthew Norris	
Mrs Claudia Fisher	Patient and Carer Councillors: Parents and Carers from outside London
Dr Camilla Pease	
Mr John Charnock	
Mr Edward Green	Patients outside London
Mr George Howell	
Mr Trevor Fulcher	Public Councillors: North London and the surrounding area
Ms Rebecca Miller	
Mr Stuart Player	Public Councillor: Rest of England and Wales
Reverend James Linthicum	Staff Councillors
Ms Clare McLaren	
Mrs Jenny Headlam-Wells	Appointed Councillor: London Borough of Camden
Ms Olivia Frame	Appointed Councillor: Expert Patient Programme CIC
Mr Muhammad Miah**	Appointed Councillor: Great Ormond Street Hospital School
Mr Alastair Whitington	Appointed Councillor: NHS England, London Region

In attendance:

Ms Yvonne Brown	Non-Executive Director
Mr David Lomas	Non-Executive Director
Ms Mary MacLeod	Non-Executive Director
Mr John Ripley	Non-Executive Director
Mr Julian Nettel	Interim Chief Executive
Dr Catherine Cale	Interim Co-Medical Director
Ms Rachel Williams	Chief Operating Officer
Mr Robert Burns	Director of Planning and Information
Mr Ali Mohammed	Director of HR and OD
Mrs Claire Newton	Chief Finance Officer
Mrs Liz Morgan	Chief Nurse and Families' Champion
Dr Anna Ferrant	Company Secretary
Ms Deidre Leyden	Membership Relationship and Engagement Manager
Mrs Claire Newton	Chief Finance Officer
Ms Victoria Goddard	Trust Board Administrator
Ms Lisa Dawes	Assistant Chief Operating Officer
Mr Paul Labiche	Director of Estates and Facilities

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

***Denotes a person who was present by telephone*

54	**Apologies for absence**
54.1	Apologies for absence were received from: Jilly Hale, Staff Councillor; Sophie Talib, Patient and Carer Councillor; Lynne Gothard, Patient and Carer Councillor; Lewis Spitz, Public Councillor; Ian Lush, Public Councillor; Christine Kinnon, Appointed Councillor, Dhimple Patel, Staff Councillor; Louise Clark, Public Councillor.
55	**Declarations of Interest**
55.1	No declarations of interest were received.
56	**Update on the implementation of the Always Values**
56.1	Mr Ali Mohammed, Director of HR and OD gave a presentation on the Trust's implementation of the Always Values. He thanked those people who had taken part in the work so far.
56.2	Mr Mohammed said that Directors had presented to each senior management team to share the work and the feedback had been very positive. He added that the outcome of a tender for external expert support would be known on 25th September. Support would be provided for running development sessions to ensure that the message is consistent across the organisation and to embed the work into Trust recruitment process.
56.3	Mr Mohammed told the Council that a number of potential workstreams had been identified to enable broader user involvement.
56.4	The Council **noted** the update.
57	**GOSH Strategy 2014-20**
57.1	Mr Robert Burns, Director of Planning and Information reminded the Council that the strategic review began with a stakeholder day which included representatives from GOSH, GOSH Children's Charity, the Institute of Child Health and the Members' Council. He said that each area of the Trust's work had a strategy along with a resources strategy and people strategy. Mr Burns added that further work was required to ensure the strategies were integrated and to ensure success was measurable. Mr Burns presented performance measures for a number of strategies.
57.2	It was reported that the Members' Council would be kept updated via the presentation of the Annual Plan, a 6 monthly strategic update and updates on the Trust's performance against 5 strategic goals would be presented in public Board meetings.
57.3	**Action:** It was agreed that the presentation would be circulated with the meeting minutes.
57.4	**Action:** It was agreed that a Trust ICT update would be provided in January 2015 with regular briefings thereafter.
57.5	**Action:** It was agreed that the November Members' Council meeting would

	receive an update on the IPP strategy.
57.6	The Council **noted** the update.
58	**Membership engagement and recruitment including an update from the Membership and Engagement Committee (MEC)**
58.1	Ms Deirdre Leyden, Membership and Governance Manager reported that membership numbers had increased since the last report and focus was being placed on engaging with young people. She added that this would be a key focus of the Membership Strategy which was currently under revision.
58.2	Ms Lisa Chin-A-Young, Patient and Carer Councillor said that positive work was taking place and there had been instances of good engagement and recruitment by Councillors.
58.3	Dr Camilla Pease, Patient and Carer Councillor said that the MEC had discussed communication between the Board and Councillors and was reviewing the Monitor guidance document on the subject. She said that following comments from the MEC, amendments had been made to Member Matters to improve the overall tone of the document.
58.4	Dr Pease reported that there would be opportunities to engage with constituents in the hospital before each Members' Council meeting.
58.5	**Action:** It was agreed that the notes from the Freedom of Information seminar session would be circulated to the Council.
58.6	The Council **noted** the update.
59	**Clinical Governance Committee Summary Report – July 2014**
59.1	**Action:** Ms Mary MacLeod, Chair of the Clinical Governance Committee said that the Committee had received its first patient story and three recommendations had been made which would be followed up. An update on these issues would be provided at the next Members' Council meeting.
59.2	The Committee **noted** the update.
60	**Finance and Investment Committee Summary Report**
60.1	Mr David Lomas, Chair of the Finance and Investment Committee outlined the committee's workplan to the end of 2014/15 and invited Councillors to attend meetings. He stressed that the Trust was moving into more challenging financial times and it was vital to focus on productivity and efficiency.
60.2	Dr Pease queried the effect of a change to the GOSH Children's Charity GOSHCC) structure.
60.3	Mr Lomas explained that recent legislation will mean that GOSHCC will be required to change their structure including the liability of their Trustees. He stressed that the change will be around legal status and would not affect the Charity's ability to raise funds.

60.4	The Committee **noted** the update.
61	**Update on Catering Improvement Plan (including Healthwatch Camden Survey results and PLACE results)**
61.1	Mr Paul Labiche, Director of Estates and Facilities said that Healthwatch Camden had visited the Trust in June and produced a report on the Trust's catering. He said that their findings on food provision were generally positive and three key recommendations were made which had been incorporated into the overall Catering Improvement Programme.
61.2	Mr Labiche said that recently published Patient-Led Assessments of the Care Environment (PLACE) scores reflected the improvements that had been made throughout the year. He stressed that continued improvement was vital as was the embedding and monitoring of these changes.
61.3	Mr Stuart Player, Public Councillor said that he felt the Healthwatch report was not as positive as the summary report provided to the Council suggested and cited that during the Healthwatch visit food did not arrive on wards within 30 minutes of leaving the kitchen.
61.4	Mr Labiche agreed that this had been a weakness and stressed that it had been incorporated into recommendations and the Catering Improvement Plan.
61.5	Mr Trevor Fulcher, Public Councillor asked if there was a gap between food arriving on the wards and being served to patients. Mr Labiche said that there had previously been a gap on some occasions due to ward staff not realising the food had been delivered. He said that now ward staff were required to sign to indicate they knew the food had arrived on the ward.
61.6	Mrs Liz Morgan, Chief Nurse said that this was primarily an issue out of normal working hours and work was being done to look at the way the housekeeping service is provided.
61.7	**Action:** It was agreed that the Catering Improvement Action Plan should be RAG rated.
61.8	**Action:** It was agreed that the Food Group would be asked to consider if there was a meaningful metric which could be monitored by the Members' Council.
61.9	**Action:** It was agreed that where external/other reports were referenced in papers, the Council should be directed to the full report where appropriate.
61.10	The Council **noted** the update.
62	**Election to the Members' Council Nominations and Remuneration Committee**
62.1	Dr Anna Ferrant, Company Secretary said that four Councillors had nominated themselves to sit on the Members' Council Nominations and Remuneration Committee for a term of office of one year, subject to re-election.
62.2	The Councillors who had nominated themselves were:

	• Mr Edward Green, Patient and Carer Councillor • Professor Christine Kinnon, Appointed Councillor • Mr Matthew Norris, Patient and Carer Councillor • Ms Jilly Hale, Staff Councillor
62.3	The Council **approved** the above Councillors to sit on the Members' Council Nominations and Remuneration Committee.
62.4	Mr Norris suggesting normalising terms of office across roles and Committees.
62.5	Dr Ferrant said that as this committee carried out statutory duties of the Council she felt it was important for as many Councillors as possible to have the opportunity to take part during their tenure on the Council.
62.6	It was agreed that the term of office would remain at one year and would be reconsidered following the next committee election.
63	**Approval of revised model election rules 2014**
63.1	Dr Ferrant reminded the Council that the Trust had adopted the model election rules from the Department of Health when GOSH was first authorised as a Foundation Trust. She presented the revised election rules which enabled electronic voting (via website, telephone and texting).
63.2	**Action:** Mr John Charnock, Patient and Carer Councillor noted that the 'interpretation' section of the Model Election Rules 2014 defined a lead governor role as having been nominated by the corporation, when it was, in fact, nominated by the Members' Council. It was agreed that this would be amended.
63.3	The Council **approved** the revised model election rules subject to the above amendment.
64	**Chief Executive's Report**
64.1	Mr Julian Nettel, Interim Chief Executive reported on the following points: • PLACE scores: The March scores had been published and all GOSH scores had improved, particularly in the areas of food and privacy and dignity. • 100,000 genome project: GOSH patients have played a major part in the pilot phase of a project to analyse the DNA of 100,000 people with rare diseases and cancers. • Double ear reconstruction of a GOSH patient: Mr Neil Bulstrode, Consultant Plastics Surgeon performed a double ear reconstruction on patient Kieran Sorkin. • Visit of Dr Peter Steer, newly appointed substantive CEO: Dr Steer visited the Trust for two weeks at the beginning of September. He met with senior staff and Members' Council and visited divisions.

64.2	Quality and Safety (including infection rates)
64.3	Dr Catherine Cale, Co-Medical Director reported that the Trust was above the threshold of Clostridium Difficile infections (C. Diff) for the year but below the Monitor di minimis level of 12.
64.4	It was stressed that the Infection Prevention and Control team followed up each case. Dr Cale stressed that C. Diff was not the same in adults as it is in children.
	Activity (including discharge summary performance)
64.5	Mr George Howell, Patient and Carer Councillor queried why data was missing for July and August.
64.6	Ms Rachel Williams, Chief Operating Officer said that there was always a two month lag in data which ensured that the most accurate figures were given.
64.7	It was confirmed that the Trust had achieved the 18 week target in all areas however work was being done on the Trust's admitted targets.
64.8	Mr Player queried the progress that was being made on discharge summaries.
64.9	Dr Cale said that overall a lot of progress had been made in producing discharge summaries more quickly. She stressed that there was strong engagement within divisions.
64.10	**Action:** It was agreed that Dr Clarissa Pilkington, Specialty Lead for Rheumatology would give a presentation on discharge summaries at the next meeting.
64.11	Workforce
64.12	The Council **noted** the update.
64.13	Finance
64.14	The Council **noted** the update.
64.15	
65	**Patient Advice and Liaison Service Report – Quarter 1 2014/15**
65.1	Mrs Liz Morgan, Chief Nurse said that previous patient surveys had shown the families and patients were not clear about how to make a complaint. She said that since work had been done in this area, the number of complaints had increased as people became more aware of the process.
65.2	**Action:** It was agreed that information would be given to the Young People's Forum about what had been done to advertise the complaints service to young people.
65.3	Mrs Morgan said that there were good examples of clinical teams taking ownership of issues with the support of PALS.

65.4	The Council **noted** the update.
66	**Minutes of the meeting held on 25th June 2014**
66.1	The Council **approved** the minutes of the meeting of 25th June.
67	**Matters arising and action log**
67.1	Minute 46.3: Dr Cale reported that the Trust was in the process of rolling out 'My Daily Plan' to include the name of a child's consultant and that this had been taken forward as part of the lead consultant project. She said that the feeling was that it would be unlikely for the Trust to be in a position to have one central telephone number for patients and parents to ring.
67.2	The Board **noted** the update.
68	**Update on the Members' Council development programme**
68.1	Ms Leyden said that four development sessions had taken place so far. She added that a lot of the learning that had taken place in the sessions would be used in the induction of new Councillors.
68.2	The Council **noted** the update.
69	**Young People's Forum**
69.1	Mr George Howell, Chair of the Young People's Forum (YPF) said that focus was being placed on the systems and processes for joining and leaving the forum. He added that he was working with Mr Jamie Wilcox, Head of Volunteer Services to utilise their existing resources.
69.2	Mr Howell said that the teen website pages had been launched and the Forum was pleased with the results.
69.3	Mr Howell expressed sadness at the deaths of Grainne Morby, who had been instrumental in setting up the YPF, and Jade who had been an active Forum member from the beginning and who was featured on a number of Trust teen publications.
69.4	Baroness Blackstone confirmed that a memorial meeting would be held for Ms Morby on 20th November at 5:00pm in the Charles West Room.
70	**Any other business**
70.1	Mrs Claudia Fisher, Patient and Carer Councillor referred to the recent case of Ashya King, who was removed from Southampton General Hospital by his parents and taken overseas. Mrs Fisher asked what measures GOSH had in place to support both medical teams and parents to ensure a similar situation could not arise at GOSH.
70.2	Dr Catherine Cale, Co-Medical Director agreed that it was a difficult situation and stressed that it was appropriate for parents and clinicians to have

	discussions around different treatments. Dr Cale said that clinicians worked closely in multidisciplinary teams to ensure that no one clinician was responsible for making difficult decisions. She added that there Trust had an excellent clinical ethics service and a large social work team.
70.3	Dr Cale said that teams were very willing to seek second opinions and actively sought to have good communication with families.
70.4	Reverend James Linthicum, Staff Councillor reiterated that the Clinical Ethics service was key and families could choose to be involved in this discussion. He added that it was crucial for families to feel listened to.
70.5	It was stressed that complete information was not available to the Trust.
70.6	Mrs Fisher asked what the advised course of action would be for a parent if a clinician had not agreed to a treatment which the parent believed would be beneficial.
70.7	It was emphasised that when a family requested a second opinion, one would be offered and in many cases contact details of a recommended clinician would be provided.
70.8	Mr Matthew Norris suggested putting a footnote on all letters to advise families that a second opinion could be sought. Dr Cale expressed reservations about the use of such a statement and the resource implications it could have for the provision of services.
70.9	Mr George Howell, Patient and Carer Councillor asked what impact the Trust foresaw from the planned healthcare workers strikes taking place on 13th October.
70.10	Mr Ali Mohammed, Director of HR&OD said that a number of unions had balloted its members about public sector pay policy. He said that some members had voted to strike and a number had voted for action short of strike. He said that work was ongoing to see which areas would be most affected but highlighted that teachers were also due to strike and this would have a knock-on effect for staff with children. He stressed that the Trust would be working constructively with the Staff Side and would look at rotas and flexibility of staffing.

ATTACHMENT R

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT MINUTES OF THE MEMBERS' COUNCIL MEETING
26th November 2014
Charles West Boardroom

Baroness Tessa Blackstone	Chair
Mrs Lisa Chin-A-Young	Patient and Carer Councillors: Parents and Carers from London
Mr Matthew Norris	
Mrs Lynne Gothard	
Mrs Claudia Fisher	Patient and Carer Councillors: Parents and Carers from outside London
Dr Camilla Pease	
Mr John Charnock	
Miss Sophie Talib	Patient from London
Mr Edward Green	Patients outside London
Mr George Howell	
Mr Trevor Fulcher	Public Councillors: North London and the surrounding area
Ms Rebecca Miller	
Professor Lewis Spitz	
Mr Ian Lush	
Mrs Louise Clarke**	Public Councillors: South London and surrounding area
Ms Jilly Hale	Staff Councillors
Ms Dhimple Patel	
Reverend James Linthicum	
Ms Clare McLaren	
Professor Christine Kinnon	Appointed Councillor: Institute of Child Health, UCL
Ms Olivia Frame	Appointed Councillor: Expert Patient Programme CIC
Mr Muhammad Miah	Appointed Councillor: Great Ormond Street Hospital School
Mr Alastair Whitington	Appointed Councillor: NHS England, London Region

In attendance:

Ms Yvonne Brown	Non-Executive Director
Mr David Lomas	Non-Executive Director
Ms Mary MacLeod	Non-Executive Director
Mr John Ripley	Non-Executive Director
Mr Julian Nettel	Interim Chief Executive
Dr Catherine Cale	Interim Co-Medical Director
Ms Rachel Williams	Chief Operating Officer
Mr Robert Burns	Director of Planning and Information
Mr Ali Mohammed	Director of HR and OD
Mrs Claire Newton	Chief Finance Officer
Mrs Liz Morgan	Chief Nurse and Families' Champion
Dr Anna Ferrant	Company Secretary
Ms Deidre Leyden	Membership Relationship and Engagement Manager

Mrs Claire Newton	Chief Finance Officer
Ms Victoria Goddard	Trust Board Administrator
Ms Kirsty Woodbridge	Stakeholder Communications and Marketing Manager
Dr Kate Oulton	Research Fellow
Mr Jim Blair	Consultant Nurse Intellectual (Learning) Disability

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

71	**Apologies for absence**
71.1	Apologies for absence were received from: Mrs Jenny Headlam-Wells, Appointed Councillor and Mr Stuart Player, Public Councillor, the rest of England and Wales.
72	**Declarations of Interest**
72.1	No declarations of interest were received.
73	**Chief Executive Update**
73.1	Mr Julian Nettel, Interim Chief Executive provided an update on the following matters: • Interim report on the BRC: positive feedback had been received on the performance of the National Institute for Health Research Biomedical Research Centre • The inquest into the case of four children who died after problems were identified around the processes used in GOSH's stem therapy programme has been completed. The coroner concluded that these children were extremely unwell and in three out of four cases these problems would not have made a difference to the children's chances of survival. In one case the effect was unclear. • Nominations open for the Members' Council Election: Formal Notice of Election was issued on 19th November with a deadline of 17th December. • HSJ Rising Star Award: the award was won by a former GOSH fellow. • Premier Inn Clinical Building: Construction has begun on the Premier Inn Clinical Building • Health Education North Central and East London (HENCEL): The Trust was subject to a Health Education England quality visit at the beginning of November following up on issues raised at a previous visit in April 2014.
73.2	Mr Matthew Norris, Patient and Carer Councillor queried the opportunities that were available to trainees to raise concerns internally. Dr Cale said that there were frequent opportunities for them to do so.
73.3	**Action:** Following a discussion, it was agreed that the Lead Councillor would continue to receive the media updates which were regularly circulated to the Board.

73.4	Mr John Ripley told the Members' Council that he would be stepping down from the Trust Board at the end of his term in March 2015. Baroness Blackstone thanked Mr Ripley on behalf of the Council for his contribution to GOSH.
73.5	The Council **noted** the update.
74	**Reports from Assurance Committees**
74.1	Clinical Governance Committee Summary Report (October 2014)
74.2	Mrs Mary MacLeod, Chair of the Clinical Governance Committee highlighted the patient story discussed at the committee and said that the lessons learnt would be fed into the Trust's Learning, Implementation and Monitoring Board (LIMB) and the resulting messages circulated Trust wide.
74.3	Mrs Claudia Fisher, Patient and Carer Councillor suggested that an alert system similar to the one being trialled to flag patients with a learning disability on PIMS should be extended to cover patients will additional needs of other kinds such as those arising from a fear of procedures.
74.4	Mr Ian Lush, Public Councillor noted the importance of patient stories and suggested that these should be presented at the Members' Council. The Council agreed that it was difficult to ask patients and parents to speak to a group such as the Members' Council but the Trust Board or its committees should hear the stories.
74.5	Mr Trevor Fulcher, Public Councillor highlighted patient stories already on the GOSH Children's Charity Facebook page.
75	**Update on Learning Disability**
75.1	Dr Kate Oulton, Research Fellow and Mr Jim Blair, Consultant Nurse in Intellectual (Learning) Disability gave a presentation on research taking place at GOSH on the experiences of the families of children with a learning disability and the children themselves.
75.2	Dr Oulton reported that people with a learning disability tended to have more hospital admissions, longer hospital stays and more contact overall with health professionals, however little work had been conducted to understand the hospital experience of families of children and young people with a learning disability.
75.3	Mr Blair said that his role was unique to GOSH and explained a number of improvements which were being made to processes which would enable staff to be aware of patients coming to hospital and to make reasonable adjustments to care. Mr Blair added that there were 35 learning disability link leads across the Trust who would be supporting the roll-out of learning disability initiatives and monitoring and evaluating changes in service.
75.4	It was noted that education and training for hospital staff was being improved to include information provided at induction and tailored to a variety of settings.

75.5	Dr Camilla Pease, Patient and Carer Councillor queried whether providing a double appointment for a child with a learning disability was an ethical dilemma. Mr Blair stressed those adjustments which were made must be reasonable and would enable a family to attend an appointment which might otherwise not have been appropriate.
75.6	Baroness Blackstone, Chairman queried how the Trust ensured that patients with a learning disability were provided support following transition.
75.7	Mr Blair highlighted that transition was one of the Trust's Commissioning for Quality and Innovation (CQUIN) targets and confirmed that this would be a priority for the next year.
75.8	Mrs Fisher queried the sustainability of this work given the funding available.
75.9	Mr Blair confirmed that this was a cost effective way of working however the need was currently greater than resources.
76	**Reports from assurance committees**
76.1	Finance and Investment Committee Summary Report (October 2014)
76.2	Mr David Lomas, Chair of the Finance and Investment Committee told the Council that the Committee was responsible for considering the financial results to date and the drivers behind these along with the trajectory for the year. It was reported that the October committee meeting had considered benchmarking data for GOSH when compared to peers and the Committee welcomed the results that GOSH were comparable to, or better than its peers.
77	**Financial overview of the Trust**
77.1	Mr Julian Nettel, Interim Chief Executive gave a presentation on the Trust's finances and future challenges. He explained that expenditure had grown over the last six years and was increasing at a faster rate than income. Mr Nettel stressed that the Trust's NHS activity remained viable only due to the contribution made by International and Private Patients and GOSH Children's Charity.
77.2	The Council noted that analysis of income by inpatient spells had shown that a small number of spells were responsible for a greatly disproportionate level of expenditure. Mr Nettel reported that difficult ethical and health economics discussions must take place. Mr Matthew Norris, Patient and Carer Councillor said that he felt this work was an important and suggested that more should be done to raise awareness of the levels of loss to the Trust created by treating these patients.
77.3	Mr Trevor Fulcher, Public Councillor asked about the Trust's levels of agency staff use and Mr Nettel said that the Trust was actively reviewing this and that GOSH used bank staff wherever possible.
77.4	Mrs Lisa Chin-A-Young, Patient and Carer Councillor queried the implications of the financial environment on the Trust's future investment in IT which was recognised to be a significant driver of productivity and efficiency.

77.5	Mr Nettel emphasised that investment in IT was vital and would be a capital investment in combination with funding from GOSH Children's Charity. He explained that as a Foundation Trust it was important to have cash reserves and this could also be invested in IT.
77.6	Reverend James Linthicum, Staff Councillor welcomed the presentation and stressed that it was vital to work with staff. He added that the letter which had been sent to nurses about their pay was not particularly helpful in this respect.
77.7	Dr Pease asked for an update on actions from the IPP strategy group which had agreed to increase IPP activity.
77.8	Mr Robert Burns, Director of Planning and Information said that the preferred option was for IPP beds to be located in the same area within the hospital and this was proving challenging. He stressed that it was vital to ensure that NHS patients were not disadvantaged by any plans.
77.9	**Action:** It was agreed that the Council would receive an update report on the increase in IPP activity at the next meeting.
77.10	Mr Norris asked for an update on extended working hours.
77.11	Mr Burns said that there had been an agreement from the Trust Board to begin outpatient clinics during weekends and these had been running on Saturdays since the summer. He explained that the national consultant contract made it optional for consultants to work weekends which had slowed progress, however newly appointed consultants' contracts contained an additional clause to cover work at the weekend.
77.12	The Council discussed the view of GOSH Children's Charity (GOSHCC) that it should not fund core NHS activity. Mr Nettel stressed that a range of activity was funded by GOSHCC and it was important to respect the view of the Trustees.
77.13	Baroness Blackstone highlighted the on-going large programme of capital works funded by GOSHCC and said it was important that this funding was not compromised.
77.14	Mr Fulcher queried the Trust's procurement arrangements and suggested that this was often an area where efficiencies could be made. Mr Nettel said that the Trust was currently ensuring that support services were correctly contracted as a number were up for retendering.
77.15	Baroness Blackstone emphasised the need to ensure that the Trust was doing all it could to reduce expenditure and raise additional income wherever possible.
78	**Developing the Annual Plan**
78.1	Mr Burns outlined the way in which the Annual Plan would be developed and requested volunteers to form a subgroup to look at this. The following Councillors volunteered:

	• Mrs Lisa Chin-A-Young • Mrs Claudia Fisher • Mr Trevor Fulcher • Mr George Howell • Mr Muhammad Miah
78.2	The Council **noted** the update.
79	**Quality Strategy Update**
79.1	Professor Martin Elliott, Co-Medical Director emphasised that it was vital to monitor the quality strategy as this was used to demonstrate that the Trust was delivering internationally effective work.
79.2	Mr Fulcher asked for a timeline to complete the next steps required to maintain high levels of medication safety.
79.3	Professor Elliott said that this was an on-going issue as the risk of medication errors was always present. He stressed the importance of continuing to reduce the risk over time and continuing to monitor performance.
79.4	Mr Fulcher asked why it was anticipated that huddles would not be rolled out across the Trust until June 2016.
79.5	Professor Elliott said that huddles were resource intensive and staff required significant training to do this well. He added that IPP had been successful in using huddles and that the learning from this experience was being taken forward.
79.6	Ms Rebecca Miller, Public Councillor asked whether there was a timeline in place for specialties beyond Rheumatology to improve discharge summary performance.
79.7	Dr Catherine Cale, Co-Medical Director said that 10 specialties were currently using the learning gained by rheumatology and a pilot was taking place.
79.8	Mrs Fisher suggested that there should be more information provided about how communication was being improved to support standard 7 – decrease unnecessary delay in all processes in the patient journey.
79.9	Profession Elliott said that the Chief Operating Officer was leading work to rewrite all patient pathways to make them more efficient. It was agreed that this should also ensure equal access to pathways for all children including those with additional needs. Professor Elliott confirmed that all electronic patient records being considered by the Trust included a messaging system which generated automatic alerts and escalation policies which would support this work.
79.10	Professor Lewis Spitz, Public Councillor queried whether the Trust had considered electronic delivery of medications alongside electronic prescribing.
79.11	Professor Elliott said that GOSH was looking at this, however further issues would then be raised about how to convert this investment into real savings

	which was likely to lead to a reduction in nursing staff.
79.12	Mr Fulcher queried why the Friends and Family Test had not yet been rolled out into outpatients.
79.13	Mrs Liz Morgan, Chief Nurse confirmed that the test was currently only in operation for inpatients nationwide and said that the Trust was on target with planning for the roll out to outpatients.
79.14	**Action:** It was agreed that the following revisions would be made to the Quality Strategy Progress Report: • Standard 2 to be amended to read 'Maintain and improve high levels of medication safety' • Lead consultant for complex cases project to be included under standard 4 • Update to the information given about progress with the Always Values under standard 9
79.18	The Council **noted** the update.
80	**Results of the GOSH Board experience and knowledge audit**
80.1	Dr Anna Ferrant, Company Secretary highlighted the importance of IT knowledge amongst the Board.
80.2	It was noted that it had previously been agreed by the Council that there was sufficient in house marketing expertise to allow this skill to be removed from the audit.
80.3	The Council **approved** the results of the audit.
81	**Process for the appointment of a non-executive director at Great Ormond Street Hospital for Children NHS Foundation Trust**
81.1	Dr Ferrant confirmed that the wording of the person specification had been amended following comment from the Members' Council Nominations and Remuneration Committee.
81.2	Mr Lush suggested that it would be prudent to search more widely in order to find an individual with the required IT experience and said that this was likely to be someone from a more commercial background.
81.3	Dr Ferrant confirmed that the advertisement was being placed on the Cabinet Office website and the NHS jobs website both of which were standard for NHS Non-Executive Director jobs.
81.4	**Action:** It was agreed that the eligibility requirements would be extended to include members of the patient constituency.
81.5	**Action:** It was confirmed that Dr Ferrant would inform the Members' Council when the advertisement was published.

81.6	The Council **approved** the process.
82	**Procedure for the Appraisal of the Chairman and Non-Executive Directors**
82.1	Dr Ferrant presented the document which was **approved** by the Members' Council.
83	**Amendment to the Members' Council Nominations and Remuneration Committee Terms of Reference**
83.1	Dr Ferrant reported that the terms of reference had been amended to ensure that the quorum reflected the membership of the committee.
83.2	The Council **approved** the terms of reference.
84	**Chief Executive's Report including:**
84.1	Quality and Safety (including infection rates)
84.2	Professor Elliott said that infection and mortality rates had decreased as had arrests outside the Intensive Care Unit which was positive.
84.3	Activity (including discharge summary performance)
84.4	Ms Rachel Williams, Chief Operating Officer said that the number of complaints had risen and these were being monitored. It was added that work was continuing with the gastroenterology team.
84.5	It was reported that work was on-going with surgery to look at the 18 week to referral target and weekly meetings were taking place. Improvement was anticipated in the coming weeks. Ms Williams said that all she was confident that all specialties would be able to match capacity to activity with the exception of orthopaedics which would run additional Saturday clinics.
84.6	Mr Fulcher queried the Trust's level of staff turnover which was high in comparison to other London Trusts.
84.7	Mr Ali Mohammed, Director of HR and OD said that about 4% of the Trust's turnover was as a result of the expiration of fixed term contracts and when this was removed, the level was more comparable with the London trust average.
84.8	Workforce
84.9	Mr Mohammed said that additional information had been provided about the growth of staff groups over years.
84.10	Mr George Howell, Patient and Carer Councillor asked what was being done to increase the Trust's PDR completion rate.
84.11	Mr Mohammed reported that a recovery plan was in place to ensure the target was met by the end of the year but acknowledged that there was work to do. He said that there was an element of cultural change in that historically PDR results were low and a new appraisal system had recently been introduced which

	needed to be embedded.
85	**Update on election and report from the Membership Engagement Committee**
85.1	Ms Deirdre Leyden, Membership and Governance Manager reported that the nomination period for Members' Council elections was now open and there was daily contact with Electoral Reform Services (ERS) who were running the election on the Trust's behalf.
85.2	Mrs Chin-A-Young provided an update on the last meeting of the Membership and Engagement Committee and said that consideration had been given to the development of the new membership strategy which would give focus on engaging with young people and people outside London.
85.3	**Action:** The Council noted the dates of two election information sessions on 6th and 11th December. It was agreed that any councillors wishing to volunteer to attend the sessions should contact Ms Leyden.
85.4	It was reported that 36 expressions of interest for nominations had been received.
85.5	**Action:** Mr Howell asked Members of the Young People's Forum to contact Ms Leyden to volunteer to get involved in the design of Member Matters.
86	**Update on Patient Experience**
86.1	Patient Advice & Liaison Service Report - Quarter 2 2014/15
86.2	Mrs Liz Morgan, Chief Nurse confirmed that the report had been discussed at both Trust Board and Clinical Governance Committee. She said that approximately 30% of PALS contacts were around lack of, or poor communication and this had highlighted that further work was required to develop guidelines for communicating.
87	**Update on recommendations following a patient story at the Clinical Governance Committee**
87.1	The Committee **noted** the update.
88	**Report on acceptance of non-audit work**
88.1	The Council **noted** the update.
89	**Minutes of the meeting held on 24th September and action log**
89.1	**Action:** It was agreed that the minutes and any outstanding actions would be approved at the meeting in January 2015.
90	**Reports from Assurance Committees**
90.1	Audit Committee (October 2014)

90.2	Mr Charles Tilley, Chair of the Audit Committee highlighted that the Committee continued to work to improve risk management. He added that following the publication of Monitor's well-led framework, the Trust was required to undertake a governance review on a three yearly basis at a time to be determined by the Trust.
90.3	Mrs Fisher expressed some concern about the 'alleged use of unethical fundraising' by the charity.
90.4	Mrs Newton explained that this had arisen following a television programme about a fundraising company which acted for GOSHCC along with a number of other large charities. It was confirmed that the Charity's Trustees had discussed the matter at length and the issue was being proactively managed.
90.5	Mr Norris queried the cost of salary overpayments.
90.6	Mrs Newton confirmed that it was approximately £100,000 which was small, however a number of initiatives were being taken to reduce it further.
90.7	The Council **noted** the update.
91	**Young People's Forum Update**
91.1	Mr George Howell, Chair of the Young People's Forum said that he had attended an event which discussed good practice for engaging with young people and was an opportunity to network with other engaged young people.
91.2	**Action:** It was reported that the forum had been consulted on the lead consultant project and raised the important issue of a consultant's responsibilities in transition. Dr Cale agreed that this must be incorporated into the project as it was a key issue.
91.3	Mr Howell said issues around the operation of the Young People's Forum were in the process of being resolved with the support of other Councillors.
91.4	The Council **noted** the update.
92	**Any Other Business**
92.1	Baroness Blackstone told the Council that this would be the Interim Chief Executive's final Members' Council meeting. She thanked Mr Nettel for his contribution to the Trust and the Members' Council.

ATTACHMENT N

Attachment N

MEMBERS' COUNCIL - ACTION CHECKLIST
November 2014 and January 2015

Checklist of outstanding actions from previous meetings

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
57.4	24/09/14	It was agreed that a Trust ICT update would be provided in January with regular briefings thereafter.	**CN**	**January 2015**	This will be provided at a future Council meeting
61.8	24/09/14	It was agreed that the Food Group would be asked to consider if there was a meaningful metric which could be monitored by the Members' Council as a proxy for the standard of the catering service.	**RW**	**November 2014**	Verbal update
65.2	24/09/14	It was agreed that information would be given to the Young People's Forum about what had been done to advertise the complaints service to young people.	**LM**	**November**	Verbal update
77.9	26/11/14	It was agreed that the Council would receive an update report on the increase in IPP activity at the next meeting.	**TC**	**January 2015**	On agenda
79.14	26/11/14	It was agreed that the following revisions would be made to the Quality Strategy Progress Report: • Standard 2 to be amended to read 'Maintain and improve high levels of medication safety' • Lead consultant for complex cases project to be included under standard 4 • Update to the information given about	**ME**	**January 2015**	Actioned

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
		progress with the Always Values under standard 9			
81.4	26/11/14	It was agreed that the eligibility requirements of the Non-Executive Director post would be extended to include members of the patient constituency.	**AF**	**December 2014**	Actioned
81.5	26/11/14	It was confirmed that Dr Ferrant would inform the Members' Council when the advertisement was published.	**AF**	**December 2014**	Actioned
85.3	26/11/14	The Council noted the dates of two election information sessions on 6th and 11th December. It was agreed that any councillors wishing to volunteer to attend the sessions should contact Ms Leyden.	**ALL**	**December 2014**	Noted
85.5	26/11/14	Mr Howell asked Members of the Young People's Forum to contact Ms Leyden to volunteer to get involved in the design of Member Matters.	**YPF members**	**Dece,ber 2014**	Noted
89.1	26/11/14	It was agreed that the minutes and any outstanding actions would be approved at the meeting in January 2015.	**AF**	**January 2015**	On agenda
91.2	26/11/14	It was reported that the YPF had been consulted on the lead consultant project and raised the important issue of a consultant's responsibilities in transition. Dr Cale agreed that this must be incorporated into the project as it was a key issue.	**CC**	**On-going**	Noted

ATTACHMENT O

Attachment O

Great Ormond Street Hospital for Children NHS Foundation Trust

AUDIT COMMITTEE
Monday 19th January 2015, 9:00am, Charles West (Board) Room, Great Ormond Street Hospital for Children, Great Ormond Street, London WC1N 3JH
AGENDA

	Agenda Item	Presented by	Attachment	Time
1	**Apologies for absence**	Chairman		**9:00am**
2	**Minutes of the meeting held on 1st October 2014**	Chairman	**A**	
3	**Matters Arising and action point checklist**	Chairman	**B**	
	RISK			
4.	**Review of Strategic and Operational Risks (Audit Committee focus):**			**9:10am**
(i)	**Reduction in funding available to NHS organisations (operational risk)**	Chief Finance Officer	**C**	
(ii)	**Productivity and Efficiency Strategy (action 49.10, Oct 2014) including risks to delivering the P&E strategy and as a result of delivery of the strategy**	Chief Operating Officer	**D**	
5.	**Risks identified at last meeting**			**9:30am**
	Update on NHS debtors (action 7.3, April 2014)	Deputy Director of Finance	**F**	
	Business continuity at GOSH (action 29.4, May 2014)	Chief Operating Officer	**G**	
	Update on procurement and contracts (action 50.9)	Chief Finance Officer	**H**	
6.	**Assurance Framework (including Risk Assurance and Compliance Group Actions and overview of risk management and escalation process)**	Director of Planning and Information	**I**	**9:45am**
7.	**Analysis of Top 3 Risks**	Director of Planning and Information	**J**	**9:55am**
8.	**Information Governance and Data Quality Update**	Director of Planning and Information	**K**	**10:05am**
	EXTERNAL AUDIT			

9.	**Sector Update**	Deloitte	**L**	**10:10am**
	INTERNAL AUDIT AND COUNTER FRAUD			
10.	**Internal Audit Progress Report (October 2014 – January 2015) and Technical Update**	KPMG	**M**	**10:20am**
11.	**Internal and external audit recommendations – update on progress**	Deputy Director of Finance	**O**	**10:30am**
	GOVERNANCE			
12.	**Planning for 2014/15 year-end including review of Accounting Policies**	Chief Finance Officer	**P**	**10:40am**
13.	**Proposed Audit Committee Effectiveness Survey**	Chief Finance Officer	**Q**	**10:50am**
	Draft Audit Committee Report to be included in the Annual Report	Chief Finance Officer	**N**	**11:00am**
14.	**Whistle blowing Update**	Director of HR and OD	**R**	**11:05am**
15.	**Counterfraud Update**	Counterfraud Officer	**S**	**11:10am**
16.	**Overview of definition of a significant transaction (action 48.5, Oct 2014)**	Company Secretary	**T**	**11:15am**
17.	**Overview and plans for the Well Led Governance review at GOSH**	Company Secretary	**U**	**11:20am**
	ITEMS FOR INFORMATION			
18.	**Losses and ex-gratia payments**	Deputy Director of Finance	**V**	**11:25am**
19.	**Working Capital Update**	Deputy Director of Finance	**W**	**11:30am**
20.	**Audit Committee Waivers – October 2014 to January 2015**	Chief Finance Officer	**X**	**11:35am**
21.	**Performance Report – Month 9 (2014-15)**	Director of Planning and Information	**Y**	**11:40am**
22.	**Finance and Investment Committee – Summary of meetings (November - 2014)**	David Lomas, Chairman of the F&I Committee	**Z**	**11:45am**
23.	**Clinical Governance Committee – Summary of meeting in October 2014**	Company Secretary/ Yvonne Brown	**1**	**11:50am**
24.	**Any Other Business**			**11:55am**
25.	**Next meeting**	**Wednesday 20th April 2015, 2:00pm – 5:00pm in the Charles West Room**.		
26.	**Audit Committee Terms of Reference and annual work-plan**	**For reference only - 2**		

ATTACHMENT P

Great Ormond Street Hospital for Children NHS Foundation Trust

CLINICAL GOVERNANCE COMMITTEE
Friday 23rd January 2015 at 2:00pm to 5:00pm in the Charles West (Board) Room, Great Ormond Street Hospital for Children NHS Foundation Trust

AGENDA

	Agenda Item	Presented by	Attachment	Time
1.	**Apologies for absence**	Chairman		**2:00pm**
2.	**Minutes of the meeting held on 8th October 2014**	Chairman	**A**	
3.	**Matters arising/ Action point checklist**	Chairman	**B**	
	PRESENTATIONS			
4.	**Patient Story**	Deputy Chief Nurse	**C**	**2:05pm**
	RISK			
5.	**Update on HENCEL and:** **Operational risk overview:** **All patients at all times do not receive safe medical cover (operational risk)**	Interim Co-Medical Director	**D**	**2:25pm**
6.	**Update on review of gastroenterology service**	Co-Medical Director (CC) and Anna Jebb, General Manager, MDTS	**E**	**2:35pm**
8.	**Assurance Framework including actions from the Risk Assurance and Compliance Group** **Risks to implementing the Clinical Services Strategy** **Failure to provide sufficient capacity to meet existing and future demands (operational risk)**	Director of Planning and Information Director of Planning and Information Chief Operating Officer	**F** **G** **H**	**2:45pm** **2:55pm** **3:00pm**
	Update on recent IT issues (impacting on clinical work and issues with server capacity) **and** **the future Digital Strategy (action 66.6)**	Chief Operating Officer/ Michael Bone, Director of ICT	**Verbal Update**	**3:05pm**
	Top Three Risks Analysis	Director of Planning and Information	**V**	**3:15pm**

	Update on quality and safety impact of Productivity & Efficiency (P&E) programme	Chief Operating Officer	**I**	**3:25pm**
	COMPLIANCE			
	CQC Compliance Summary Report	Company Secretary	**J**	**3:35pm**
	Update on NHSLA including premiums	Head of Clinical Governance and Safety	**K**	**3:45pm**
	ASSURANCE			
	Head of Nursing Report	Deputy Chief Nurse	**L**	**3:50pm**
	Staffing Information Report	Director of HR and OD	**M**	**4:00pm**
	Learning Disabilities Annual Report	Deputy Chief Nurse	**N**	**4:05pm**
	Update from Learning, Improvement and Monitoring Board (LIMB)	Head of Clinical Governance and Safety	**O**	**4:15pm**
	Quarterly Safeguarding Report (October - December 2014)	Deputy Chief Nurse	**P**	**4:20pm**
	Internal Audit Progress Report	KPMG	**Q**	**4:25pm**
	Internal and external audit recommendations update	Deputy Director of Finance	**R**	**4:30pm**
	Clinical Audit update October - December 2014	Clinical Audit Manager	**S**	**4:35pm**
	GOVERNANCE			
	Matters to be raised at Trust Board	Chair of the Clinical Governance Committee	**Verbal**	**4:40pm**
	Performance Report – December 2014	Director of Planning and Information	**T**	**4:45pm**
	Audit Committee Summary – October 2014	Yvonne Brown, NED	**U**	**4:50pm**
	Any Other Business	Chairman		**4:55pm**
	Next meeting	**Wednesday 22nd April 2015 2:00pm – 5:00pm**		
	Terms of Reference and Acronyms	**1**		

ATTACHMENT Q

Great Ormond Street Hospital for Children NHS Foundation Trust

Attachment Q

FINANCE AND INVESTMENT COMMITTEE MEETING AGENDA
13th January 2015 by telecom
GOSH staff will take call from Barclay House L4 Meeting room
UK Freefone: 0800 032 8069
Participant passcode: 26650151 then #
10.00-11.00

Members:

David Lomas (DL)	Chair	NED
John Ripley (JR)		NED
Dr Peter Steer (PS)		CEO
Rachel Williams (RW)		COO
Claire Newton (CN)		CFO
Robert Burns (RB)		DP&I

Apologies:
None notified

In attendance:

Andrew Needham	DFD
Neil Redfern	FC & Minute taker
Matt Tulley	Director of Redevelopment
Trevor Clark	Director IPP
Chris Rockenbach	Head of F&I IPP

		Provisional time	Paper Ref	Account able
1	Agenda		**Enc 1.0**	
2	Apologies for absence	**10.00**		**DL**
3	Updated Outline Business Case for the investment in new IPP capacity	**10.05**	**Enc 3.0**	**TC/MT/RW**
4	Brief on 2015/16 financial planning – Context & risks	**10.35**	**Enc 4.0**	**CN**
5	Update on legal advice re Charity restructure	**10.50**	**Verbal**	**CN**