Great Ormond Street Hospital for Children NHS Foundation Trust

Meeting of the Trust Board
22nd July 2015

Dear Members

There will be a public meeting of the Trust Board on Wednesday 22nd July 2015 at 2:30pm in the **Charles West Room**, Great Ormond Street, London, WC1N 3JH.

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

AGENDA

	Agenda Item **STANDARD ITEMS**	Presented by	Attachment
1.	**Apologies for absence**	Chairman	**Verbal**
Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.			
2.	**Minutes of Meeting held on 22nd May 2015**	Chairman	**K**
3.	**Matters Arising/ Action Checklist**	Chairman	**L**
4.	**Chief Executive Report**	Chief Executive	**Verbal**
	STRATEGIC ISSUES		
5.	**Clinical Presentation – Epilepsy Service**	Sarah James General Manager Neurosciences and Sophia Varadkar, Consultant, Neurology	**M and Presentation**
6.	**Update on the scope and progress of the Outpatient project**	Jane Valente, Divisional Director and Sarah James, General Manager for Neurosciences	**N and Presentation**
7.	**Medical Revalidation Annual Board report and statement of compliance**	Medical Director	**O**
	PERFORMANCE		
8.	**Quality and Safety Update**	Medical Director	**P**
9.	**Targets and Indicators Update**	Interim Chief Operating Officer	**Q**
10.	**Workforce Metrics & Exception Reporting – June 2015**	Director of Human Resources &OD	**R**
11.	**Financial Performance 3 months to 30th June 2015**	Chief Finance Officer	**S**

12.	**Research and Innovation Report July 2015**	Director of Research and Innovation	**9**
	ASSURANCE		
13.	**Patient experience Update including PALS annual report 2014/15 and 2015/16 Report**	Chief Nurse	**T**
14.	**Complaints Report Q1 2014/15**	Medical Director	**U**
15.	**Safe Nurse Staffing Report – May and June 2015**	Chief Nurse	**V**
16.	**Nursing Skill Mix and Ward Nursing Establishments**	Chief Nurse	**W**
17.	**Health and safety Annual Report 2014/15**	Director of HR and OD	**X**
18.	**Annual Infection Prevention and Control Report – Executive Summary 2014/15**	Director of Infection, Prevention and Control	**Y**
19.	**Education Annual Report 2014-2015**	Director of HR and OD	**Z**
	GOVERNANCE		
20.	**Quarter 1 Monitor Return (3 months to 30 June 2015)**	Chief Finance Officer	**2**
22.	**Clinical Governance Committee evaluation 2014/15**	Company Secretary	**3**
23.	**Revised Board of Directors' Terms of Reference**	Company Secretary	**4**
	REPORTS FROM COMMITTEES		
24.	**Audit Committee update – May 2015 meeting**	Chair of the Audit Committee	**5**
25.	**Clinical Governance Committee update – July 2015 meeting**	Chair of the Clinical Governance Committee	**6**
26.	**Finance and Investment Committee Update – April and June 2015**	Chair of the Finance and Investment Committee	**7**
27.	**Members' Council Update –June 2015**	Chairman of the Members' Council	**8**

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

Next meeting
The next Trust Board meeting will be held on Wednesday 30th September 2015 in the Barclay House Conference Room, Great Ormond Street, London, WC1N 3JH.

ATTACHMENT K

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT Minutes of the meeting of Trust Board on 22nd May 2015

Present

Baroness Tessa Blackstone	Chairman
Dr Peter Steer	Chief Executive
Ms Mary MacLeod	Non-Executive Director
Ms Yvonne Brown	Non-Executive Director
Mr Akhter Mateen	Non-Executive Director
Mr David Lomas	Non-Executive Director
Mr Charles Tilley	Non-Executive Director
Dr Catherine Cale	Interim Co-Medical Director
Ms Dena Marshall	Interim Chief Operating Officer
Mr Ali Mohammed	Director of Human Resources and OD
Ms Juliette Greenwood	Chief Nurse
Mrs Claire Newton	Chief Finance Officer

In attendance

Mr Robert Burns	Director of Planning and Information
Dr Anna Ferrant	Company Secretary
Ms Victoria Goddard	Trust Board Administrator (minutes)
Ms Meredith Mora*	Clinical Outcomes Development Lead
2 members of the public	

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

23	**Apologies for absence**
23.1	Apologies for absence were received from Professor Martin Elliot, Professor Rosalind Smyth and Mr Matthew Tulley.
24	**Declarations of Interest**
24.1	No declarations of interest have been received.
25	**Minutes of Meeting held on 25th March 2015**
25.1	The minutes of the meeting of 25th March 2015 were **approved.**
26	**Matters Arising/ Action Checklist**
26.1	The actions that had been taken were **noted**.
27	**Chief Executive Report**
27.1	Dr Peter Steer, Chief Executive gave an update on the following areas: • The announced CQC inspection had taken place in the week of 13th April 2015 following which high level feedback had been provided. Dr Steer said that following the announced inspection, inspectors undertook three unannounced inspections focusing on particular areas.

	• Biomedical Research Centre (BRC) Director - Professor David Goldblatt will be stepping down from his role as Director of the BRC and GOSH was working with UCL and the Institute of Child Health (ICH) to appoint a new Director who would take forward the funding renewal application for 2016. • International Nursing Day • Living through research awareness week • No waste week • Children's Hospitals International Executive Forum (CHIEF) conference – Dr Steer met with a number of Chief Executive's from other Children's Hospitals and received case reports.
27.2	The Board **noted** the update.
28	**Annual accounts and annual report 2014/15**
28.1	<u>NHS Foundation Trust Final Accounts</u>
28.2	Mr Charles Tilley, Chair of the Audit Committee gave an overview of discussions which had taken place at the May meeting of the Audit Committee on the Trust's Annual Accounts, Annual Report and Quality Report.
28.3	It was reported that the Trust's External Auditors Deloitte had reviewed the Annual Accounts focusing on receivables and valuation of the estate as well as providing good assurance on levels of debt. Mr Tilley said the committee had discussed the matter of confirming the Trust's position as a going concern and it had been agreed that its definition would be limited to twelve months given the uncertainty around future tariff proposals. It had also been agreed that references to being a going concern 'for the foreseeable future' would be removed.
28.4	Mr Tilley told the Board that Deloitte had confirmed that the accounts were fair, balanced and understandable to external members of the public.
28.5	It was confirmed that on the Quality Report, Deloitte would provide a qualified opinion on the 18 week referral to treatment data; an amber report on discharge summaries and an unqualified opinion on cancer waits.
28.6	Mr Tilley confirmed that the Trust's Internal Auditors had provided a Head of Internal Audit Opinion of 'significant assurance with minor areas for improvement'.
28.7	<u>Annual Governance Statement</u>
28.8	Mr Tilley said that the Audit Committee had agreed that the Chair of the Clinical Governance Committee should be satisfied with the content of the Governance Statement and should also review the Quality Report prior to consideration by the Trust Board.
28.9	The Executive Team confirmed that there was no additional information that should be brought to the attention of the Chief Executive prior to his signing the Annual Governance Statement.
28.10	Mrs Newton said that Dr Steer was also required to sign the Accounting Officer's Statement and she confirmed that she was assured that all points had been satisfied.

28.11	**Action:** It was agreed that any comments on the Annual Report would be provided to the Company Secretary by 26th May 2015.
28.12	Representation Letter
28.13	Mrs Newton reported that the Board was required to approve the letter which confirmed that the annual report and accounts had been properly prepared without the omission of material facts to the best of the Executive Team's knowledge. It was confirmed that the Audit Committee had recommended the letter for approval by the Board.
28.14	The Board **agreed** that all necessary and relevant information had been provided to the auditor.
28.15	The Board **approved** the following documents: • NHS Foundation Trust Annual Accounts • Annual Report 2014-15 • Annual Governance Statement • Head of Internal Audit Opinion. • Representation letter
29	**Quality Report 2014-15**
29.1	Dr Catherine Cale, Co-Medical Director said that feedback on the Quality Report had been provided by the Audit Committee and additional information would be included about a never event that occurred in 2006.
29.2	**Action:** It was agreed that the wording of the section on the identification of patients should be amended to ensure it was clear that there were a number of clinical reasons why patients could not be identified in the way which was set out in the policy.
29.3	The Board **approved** the report subject to the above amendment.
29.4	**Action:** Baroness Blackstone, Chairman said that it was important to ensure that documents were as concise as possible in order to ensure that they were able to be read by the public and asked that an exercise was undertaken prior to the preparation of the 2015/16 documents to reduce the length.
30	**Annual Report of the Audit Committee 2014-15**
30.1	The Board **approved** the report.
30.2	The Board thanked the finance and performance teams for their work to prepare the year end documents and noted Deloitte's comments on the high quality of the teams.
31	**Progress against strategic objectives**
31.1	Mr Robert Burns, Director of Planning and Information said that the aim was to be exceptional in all areas and therefore had considered the best possible benchmarking data.
31.2	Mr Burns said that the Trust had 82 clinical outcome measures which were listed on

	the website and publically available. He added that the quality report highlighted three areas where GOSH's outcomes were world class. He added that good progress had been made however there were some areas which required improvement to demonstrate GOSH's status as a world leading children's hospital.
31.3	**Action:** It was agreed that an opening statement would be included to clarify which organisations the Trust was using as benchmarking comparisons.
31.4	The Board **noted** the update.
32	**Lampard Report**
32.1	Ms Juliette Greenwood, Chief Nurse presented the report and said that Monitor had requested that Trusts report back on the recommendations that were applicable to the Trust and the Charity.
32.2	The Board **supported** the approach set out in the action plan.
33	**Performance Summary Report (Quality and Safety and Targets and Indicators)**
33.1	Dr Catherine Cale, Co-Medical Director said that discharge summary completeness rates had fallen since the last report. She said that there were specific and reasonable reasons for this in some areas and that this was discussed with each division at performance review meetings. It was reported that an electronic solution to increase the ease with which summaries could be completed was being rolled out across the Trust and focus was being maintained.
33.2	Dr Cale said that central venous line (CVL) infections continued at the lowest ever Trust rate and this was being sustained despite a complex mix of patients.
33.3	Ms Dena Marshall, Interim Chief Operating Officer said that ICU bed spells were below plan for April and further work would be done to ascertain the reasons.
33.4	Mr David Lomas, Non-Executive Director noted that 20 beds had been closed during April and asked for an explanation of the reasons for this.
33.5	Ms Marshall said that there had been an issue with plumbing in the Southwood building which had resulted in a ward being closed to ensure a comprehensive fix was implemented. Ms Greenwood added that some beds had been closed due to levels of staff and acuity of patients. Ms Marshall said that a bed management project was being initiated to look at a pan Trust solution.
33.6	Ms MacLeod queried the increase in respiratory arrests outside ICU. Dr Cale said that this had been investigated and was due to wards having moved around the hospital and using different but appropriate systems to reach support.
33.7	The Board **noted** the update.
34	**Workforce Update**
34.1	Mr Ali Mohammed, Director of HR and OD said that there had been a significant reduction in the 'time to hire' metric which had reduced from 14 weeks to 8 weeks. He said it was now clear which areas were within the Trust's control.

34.2	It was reported that data quality for staff sickness had been tested as GOSH reported low levels. It was confirmed that GOSH reported the data in the same way as other Trusts.
34.3	Ms MacLeod asked whether turnover could be shown for nursing workforce by week. She emphasised the pressures faced by staff working with acutely sick children as well as the importance of reducing turnover in the current financial environment.
34.4	**Action:** Mr Mohammed said that work had been done between GOSH and Guy's and St Thomas' NHS Foundation Trust to look at the burnout rate of ICU staff. It was agreed that Mr Mohammed and Ms Greenwood would discuss this outside the meeting.
34.5	Mr Akhter Mateen, Non-Executive Director queried the low rate of fire safety training and Mr Mohammed agreed that it was important to reduce this. He added that the majority of staff had undertaken initial training and required refresher training.
34.6	Ms Yvonne Brown, Non-Executive Director noted the high turnover rate in finance and IT.
34.7	Mrs Claire Newton, Chief Finance Officer said that a number of finance staff had left the Trust within a short period of time which had led to a high turnover rate. She added that some IT work had been outsourced and then brought back in-house.
34.8	The Board **noted** the update.
35	**Finance Update**
35.1	Mrs Newton said that the Trust was within budget for month one of 2015/16 however there were a number of potential issues to consider going forward. It was reported that International Private Patient (IPP) income continued to be below the projected level but with signs that good improvement would be made in coming months.
35.2	Mrs Newton told the Board that staff figures had increased significantly based on the same point in 2014/15. She said that almost half the additional staff were Healthcare Assistants (HCAs) and had been recruited as a result of the initiative to alter the staff mix of nurses to HCAs. Mrs Newton added that 27 of the additional 170 staff were consultants whose recruitment had been directly related to business cases.
35.3	Mr Mateen queried the RAG rating of the current year variance as he noted that it would be possible to continue with spend greater than income, but better than plan. Mrs Newton emphasised that the budget reflected anticipated productivity and efficiency savings as well as other previously agreed reasons for change.
35.4	The Board **noted** the update.
36	**Patient Experience Update including**
36.1	PALS Q4 Report

36.2	The Chief Nurse reported that there had been a steady increase in complex PALS contacts in line with the complexity of patients at the Trust. She said that future reports would look at lessons learnt and would break down PALS contacts within divisions.
36.3	**Action**: The Board discussed the issue of patients and families smoking in front of the hospital in no smoking areas. It was suggested that Camden Council should be approached to consider Great Ormond Street becoming a no smoking road and contacting other Trusts to look at how they managed the issue.
36.4	Friends and Family Test
36.5	It was reported that the Trust had achieved its quarter 4 CQUIN target for survey completion rates which had increased since the last survey.
37	**Annual Complaints Report 2014-15**
37.1	Ms Marshall said that there had been an increase in low grade complaints and the continuing overall theme of complaints was communication. It was reported that in 2014/15, 59% of complaints were about communication.
37.2	Ms Marshall said that learning from complaints was shared at Learning, Implementation and Monitoring Board (LIMB) meetings and high level learning points were disseminated through the Trust.
37.3	The Board **noted** the update.
38	**IPSOS Mori Outpatient survey results**
38.1	Ms Greenwood said that as this was the third time the Trust had taken part in the survey, it was now possible to look at trends. She added that the outpatient improvement project was looking at a number of issues which had arisen from survey results.
38.2	**Action:** It was agreed that an update would be given on the outcomes of the implementation of the outpatient improvement project.
38.3	**Action:** It was agreed that the Co-Medical Director would ensure that procedures were being followed to escalate when consultants were late for clinics.
38.4	Dr Peter Steer, Chief Executive said it was vital to set out standards of professionalism and the consequences for failing to meet these.
38.5	Baroness Blackstone emphasised the importance of ensuring that outpatient clinics began early in the morning to ensure that the Trust's facilities were being used efficiently.
38.6	The Board **noted** the update.
39	**Safe Nurse Staffing Report**
39.1	Ms Greenwood confirmed that there had been no incidents of unsafe shifts or areas of unsafe activity during the period of the report. She said that recruitment was on going and noted the national shortage of children's nurses and the challenging

	market.
39.2	Mr Charles Tilley, Non-Executive Director asked why average fill rate of registered to unregistered staff often exceeded 100%. Ms Greenwood said that in some cases this would be due to 'over-skilling' on a ward but was often due to acuity of patients.
39.3	**Action:** It was agreed that a narrative should be provided in the paper on the meaning behind the figures provided.
40	**Safeguarding Annual Report 2014-15**
40.1	Ms Greenwood presented the report which highlighted the increasing number of complex Serious Case reviews (SCRs) which GOSH was involved in. She said that there was improved compliance with training but further work could be done.
40.2	Ms MacLeod said that a quarterly safeguarding report was reviewed by the Clinical Governance Committee and told the Board that she reviewed all SCRs prior to their submission and was assured that all learning was considered by the Learning Implementation and Management Board to be cascaded throughout the Trust.
40.3	The Board discussed the importance of ensuring that an organisation was taking the lead in a SCR but ensuring that the responsibility did not rest with GOSH for longer than was appropriate. The Chief Executive emphasised that the team were a small resource who did not have the benefit of being confined to the work within a local community.
40.4	The Board **noted** the update.
41	**Annual Risk Report 2014-15**
41.1	Dr Catherine Cale, Co-Medical Director said that there had been an increase in incident reporting and timeliness of reporting.
41.2	Dr Cale said that under the Duty of Candour regulations the Trust had an obligation to inform families when incidents had occurred. She emphasised the importance of recording where families had been given this information and ensuring that families were informed appropriately without placing an undue burden on staff.
41.3	The Board **noted** the update.
42	**Review of Quality Governance Framework**
42.1	Mr Robert Burns, Director of Planning and Information said that the Trust had conducted a self-assessment against available evidence. He added that action plans were in place in the required areas to increase data quality across the organisation.
42.2	The Board **noted** the update and **approved** the findings of the review.
43	**Register of Seals**
43.1	The Board **endorsed** the use of the company seal.

44	**Audit Committee update – April 2015 meeting**
44.1	Mr Charles Tilley, Chair of the Audit Committee said that it had been agreed that a Risk Management Meeting would take place in July and added that he would work with the Audit Committee's independent member and Mr Mateen to look further at the Trust's risk framework.
45	**Clinical Governance Committee update – April 2015 meeting**
45.1	**Action:** Mrs Mary MacLeod, Chair of the Clinical Governance Committee said that a patient story had been received by the Committee which had described a family's frustrations at accessing a number of services within the Trust as well as support services such as transport. It was agreed that the patient story would be circulated to Board members.
45.2	Dr Peter Steer, Chief Executive said that Health Education North Central and East London (HENCEL) had undertaken a further positive visit to the Trust. Dr Cale said that feedback had been largely positive and the written reports were expected in the next few weeks.
46	**Finance and Investment Committee Update – April 2015**
46.1	Mr David Lomas, Chair of the Finance and Investment Committee said that the Committee's areas of attention from the last meeting were productivity and efficiency and the financial plan for 2015/16.
47	**Members' Council Update – April 2015**
47.1	The Board received the update and noted that Claudia Fisher had been elected as Lead Councillor.
48	**Any Other Business**
48.1	**Action:** It was noted that the GOSH BBC Documentary series was scheduled to begin in July 2015. It was agreed that the Director of Communications would send dates to the Board and Members' Council.
48.2	Baroness Blackstone told the Board that it was Dr Catherine Cale's last Board meeting as Co-Medical Director as well as Professor Martin Elliott who had sent apologies. She thanked Dr Cale and Professor Elliott for their great contributions to the Board in many areas and read out a statement that Professor Elliott had provided in his absence.

ATTACHMENT L

Attachment L

TRUST BOARD – PUBLIC ACTION CHECKLIST
July 2015

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
138.2	26/11/14	Baroness Blackstone agreed that play was a very important part of therapy for children and requested a paper to set out the costs of the service, the number of staff, the space involved and therefore opportunity costs. It was agreed that this would be brought to the Board following the completion of work which was being done with Manchester Children's Hospital at the March meeting.	JG	July 2015	This report will be presented to the Board in September 2015
211.8	25/03/15	It was agreed that both a prevalence rate and an incidence rate for discharge summary and clinic letter turnaround times would be considered as part of the targets and activity report as it was recognised that activity and spells were increasing.	DM	July 2015	On agenda
28.11	22/05/15	It was agreed that any comments on the Annual Report would be provided to the Company Secretary by 26th May 2015.	ALL	May 2015	Actioned – the Annual Report is in the process of being laid before Parliament
29.2	22/05/15	It was agreed that the wording of the section on the identification of patients should be amended to ensure it was clear that there were a number of clinical reasons why patients could not be identified in the way which was set out in the policy.	Meredith Mora	May 2015	Actioned – the Quality Report has been published

Attachment L

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
29.4	22/05/15	Baroness Blackstone, Chairman said that it was important to ensure that the Quality Report and Annual Report documents were as concise as possible in order to ensure that they were able to be read by the public and asked that an exercise was undertaken prior to the preparation of the 2015/16 documents to reduce the length.	AF	January 2016	Not yet due
31.3	22/05/15	It was agreed that an opening statement would be included in the progress against strategic objectives document to clarify who the Trust was using as benchmarking comparisons.	RB	September 2015	Not yet due
34.4	22/05/15	Mr Mohammed said that work had been done between GOSH and Guy's and St Thomas' NHS Foundation Trust to look at the burnout rate of ICU staff. It was agreed that Mr Mohammed and Ms Greenwood would discuss this outside the meeting.	AM&JG	July 2015	Verbal update
36.3	22/05/15	The Board discussed the issue of patients and families smoking in front of the hospital in no smoking areas. It was suggested that Camden Council should be approached to consider Great Ormond Street becoming a no smoking road and contacting other Trusts to look at how they managed the issue.	JG	September 2015	Not yet due
38.2	22/05/15	It was agreed that an update would be given on the outcomes of the implementation of the outpatient improvement project.	DM	July 2015	On agenda

Attachment L

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
38.3	22/05/15	It was agreed that the Co-Medical Director would ensure that procedures were being followed to escalate when consultants were late for clinics.	VD	July 2015	Verbal update
39.3	22/05/15	Safe Nursing Report: Mr Charles Tilley, Non-Executive Director asked why average fill rate of registered to unregistered staff often exceeded 100%. Ms Greenwood said that in some cases this would be due to 'over-skilling' on a ward but was often due to acuity of patients. It was agreed that a narrative should be provided in the paper on the meaning behind the figures provided.	JG	July 2015	Actioned from May report onwards
45.1	22/05/15	Ms Mary MacLeod, Chair of the Clinical Governance Committee said that a patient story had been received by the Committee which had described a family's frustrations at accessing a number of services within the Trust as well as support services such as transport. It was agreed that the patient story would be circulated to Board members.	VG	July 2015	Actioned on 13th July 2015
48.1.	22/05/15	It was noted that the GOSH BBC Documentary series was scheduled to begin in July 2015. It was agreed that the Director of Communications would send dates to the Board and Members' Council.	CM	July 2015	Actioned: BBC Two's BAFTA-nominated documentary, *Great Ormond Street*, returns for a third series starting on Tuesday 14 July, at 9pm. For all staff (and councillors and YPF members), there was an exclusive preview screening of the first episode, Fix My Genes, the night before it is transmitted in the Lagoon staff side.

Attachment M

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **22nd July 2015**	
Children's Epilepsy Surgery Service: Clinical Strategy Presentation **Submitted by:** **Sophia Varadkar, Consultant Neurologist**	**Paper No: Attachment M**
Aims / summary To update the board on the clinical outcomes of the current CESS service and planned future advances in surgical intervention and the commissioning landscape	
Action required from the meeting Briefing only	
Contribution to the delivery of NHS Foundation Trust strategies and plans To support the Trust strategy to become the leading children's hospital in the world	
Financial implications Opportunity for additional income through service expansion associated with the proposed commissioning changes	
Who needs to be told about any decision? All CESS stakeholders	
Who is responsible for implementing the proposals / project and anticipated timescales? Sophia Varadkar – Clinical Lead for CESS Trisha Webbe – Service Manager Siobhan Lalor-Mctague – HON Neurosciences	
Who is accountable for the implementation of the proposal / project? Jane Valente – Clinical Director for Neurosciences Sarah James – Divisional Manager for Neurosciences	

UCL - Institute of Child Health

Great Ormond Street Hospital for Children NHS Foundation Trust

UCL

Children's Epilepsy Surgery Service

Clinical Strategy Presentation to Trust Board 22nd July 2015

Dr Sophia Varadkar MRCPI, MSc, PhD

Consultant Paediatric Neurologist and Honorary Senior Lecturer

Specialty Lead for the Epilepsy Unit and the Children's Epilepsy Surgery Service (CESS)

Great Ormond Street Hospital Charity

Outline

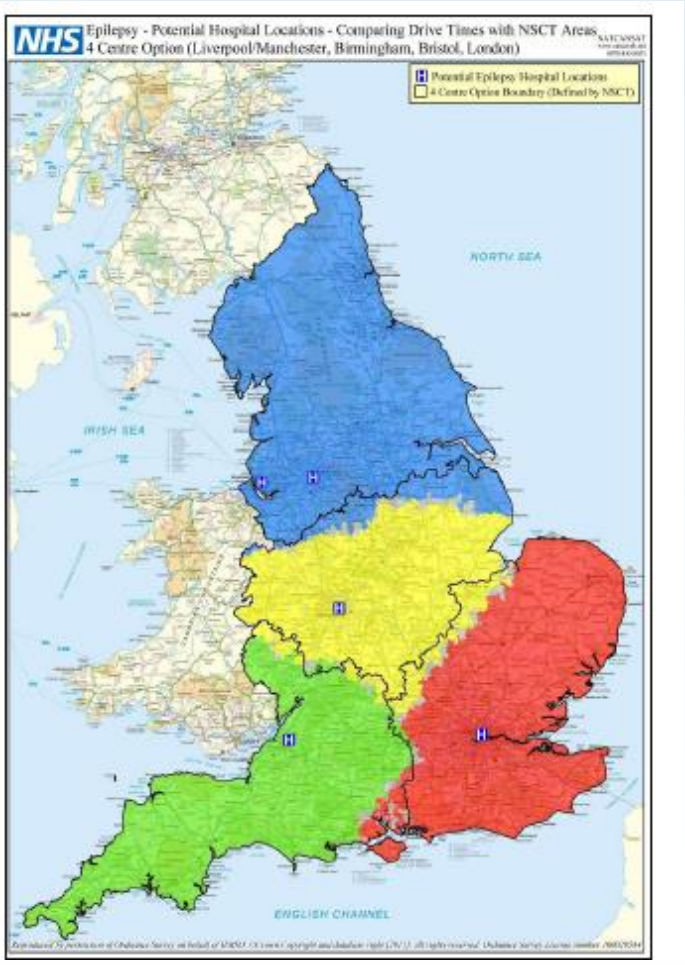
Current Service

1. Introduction to CESS and epilepsy surgery
2. Clinical outcomes

Future Service Provision

3. Clinical strategy
   i. Drivers
   ii. Capacity

1. Introduction to CESS and Epilepsy Surgery



- GOSH service since1990
- From Nov 2012, lead of four NHS England nationally commissioned designated CESS centers
- Work in partnership with King's Health Partners and Young Epilepsy
- Comprehensive Epilepsy Service

Great Ormond Street Hospital Charity

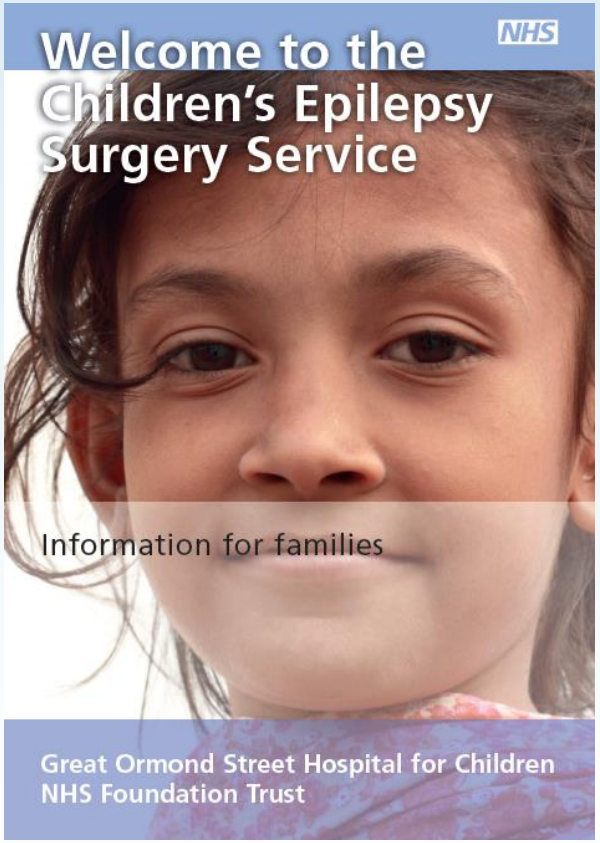
Epilepsy surgery

Definition

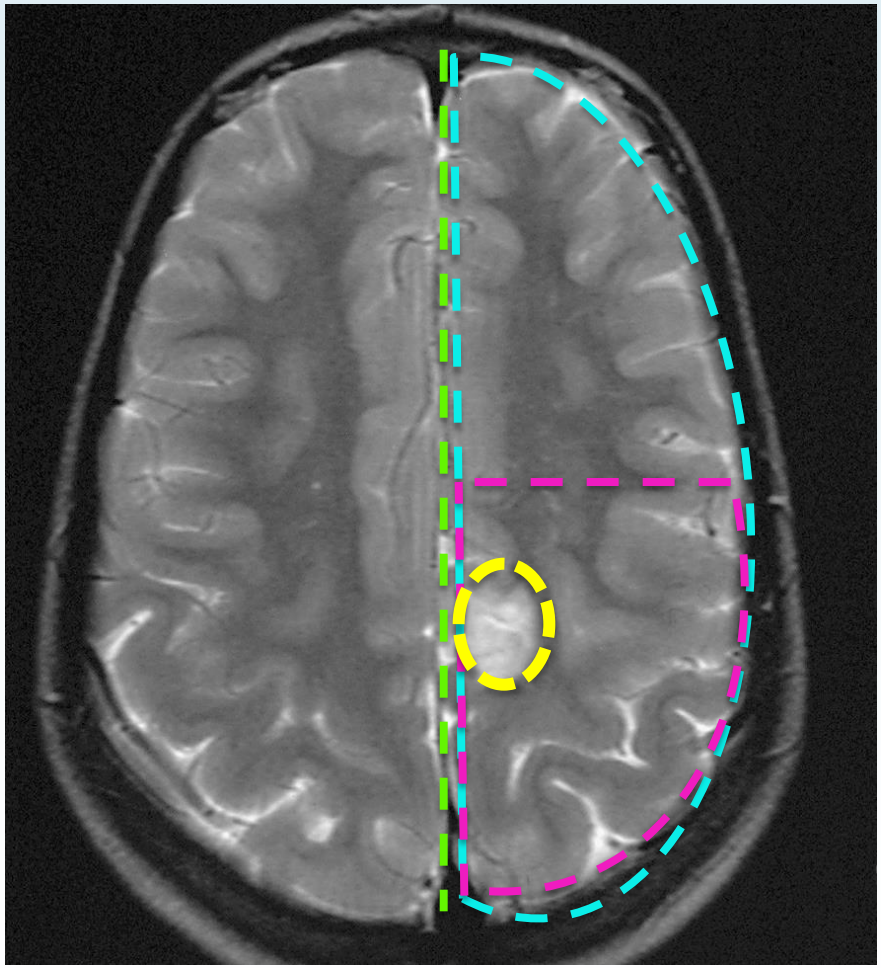
- Removal of an area of the brain with the aim of alleviating seizures

Aims

- Primary: seizure freedom/reduction
- Secondary: neuro-developmental gains, behavioural improvement



Types of surgery



Lesionectomy

Lobectomy

Hemispherectomy

Corpus Callosotomy

2. Clinical outcomes

1st April 2013 – 31st March 2014	NHS England		
Procedure Coded EP	**GOSH**	**KHP**	**Total**
Invasive recording • implant & resect (surgical episodes) • Implant & deplant	6 (12) 3 (6)	1 (2) 5 (10)	14 16
Hemispherotomy (non-NHS)	19 (2)	(2 at GOSH 5-and-under)	19
Temporal resections (non-NHS)	18 (1)	4	22
Frontal resections/disconnection (non-NHS)	3 (1)	2	5
TOP Disconnections	4	0	4
Occipital resections	0	1	1
Lesionectomies (with ECoG)	6	2 (2)	8
Corpus Callosotomy	4	0	4
VNS implant or battery change	16	12	28
(Wound wash-out)	1		1
Total NHS surgeries (excluding VNS)	**88 (72)**	**33 (21)**	**121 (93)**

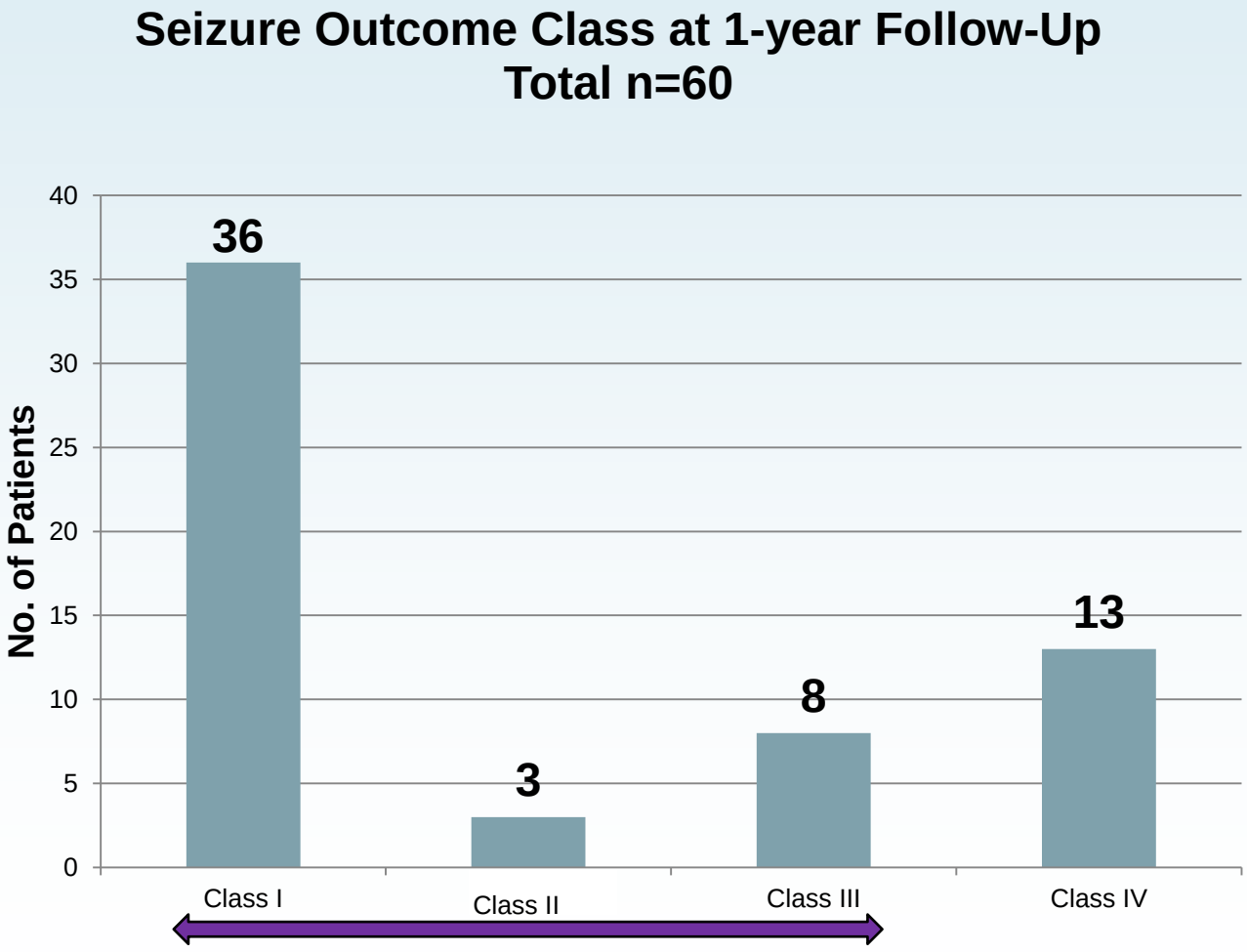
Adverse surgical events at GOSH

1st April 2013 to 31st March 2014

Grade	Criteria	Number
1	Length of stay not increased	4
2	Length of stay increased but GCS not reduced	4
3	Reduced GCS	1
4	Death	0
Total		9

Seizure outcomes - 1 year post-surgery

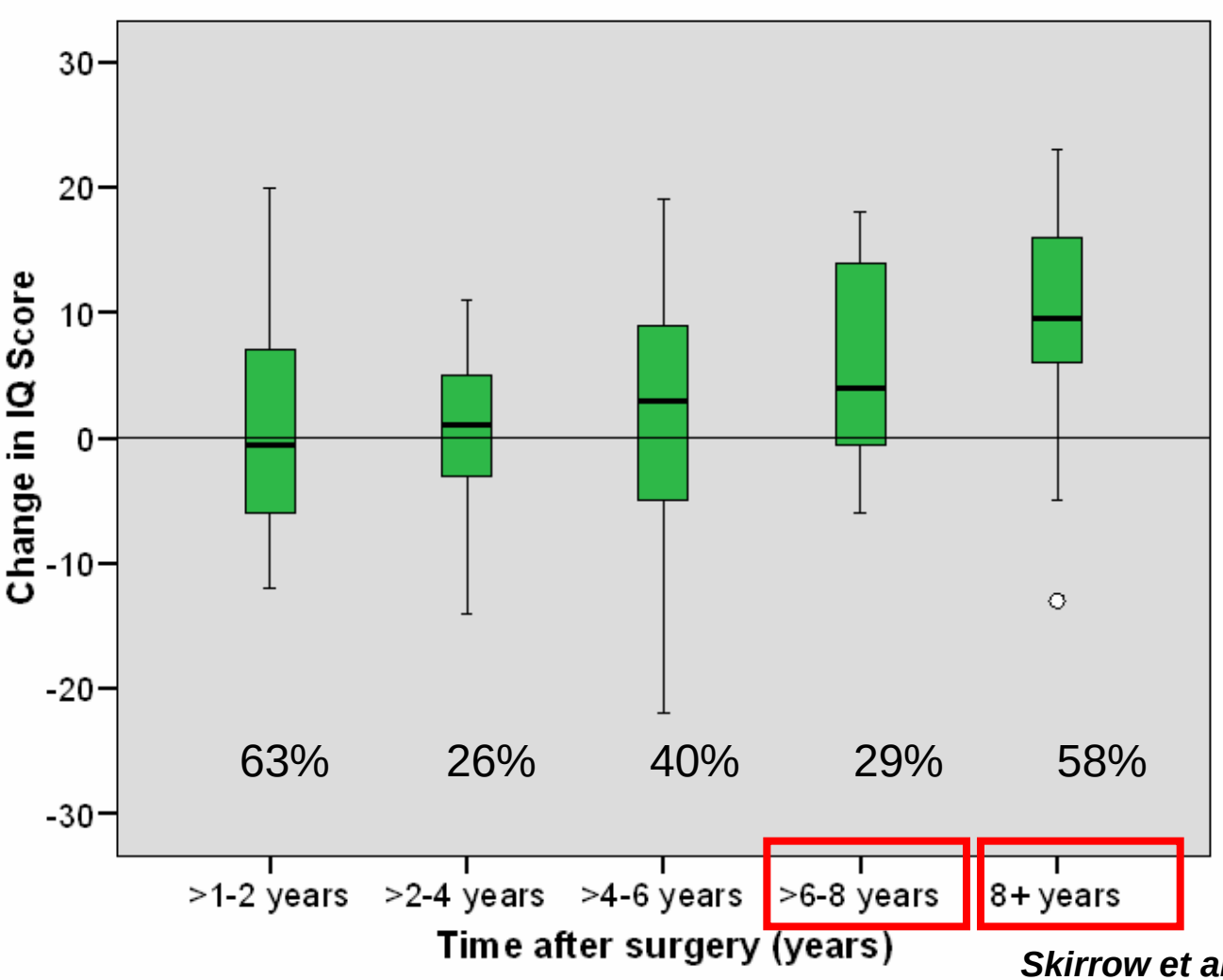
All resective & corpus callosotomy (VNS excluded)



Great Ormond Street Hospital Charity

Cognitive outcome after temporal lobe surgery in childhood

IQ change across the post-op period



- Variability in IQ changes until 4-6 years post-op

- IQ improvements detectable >6 years post-op

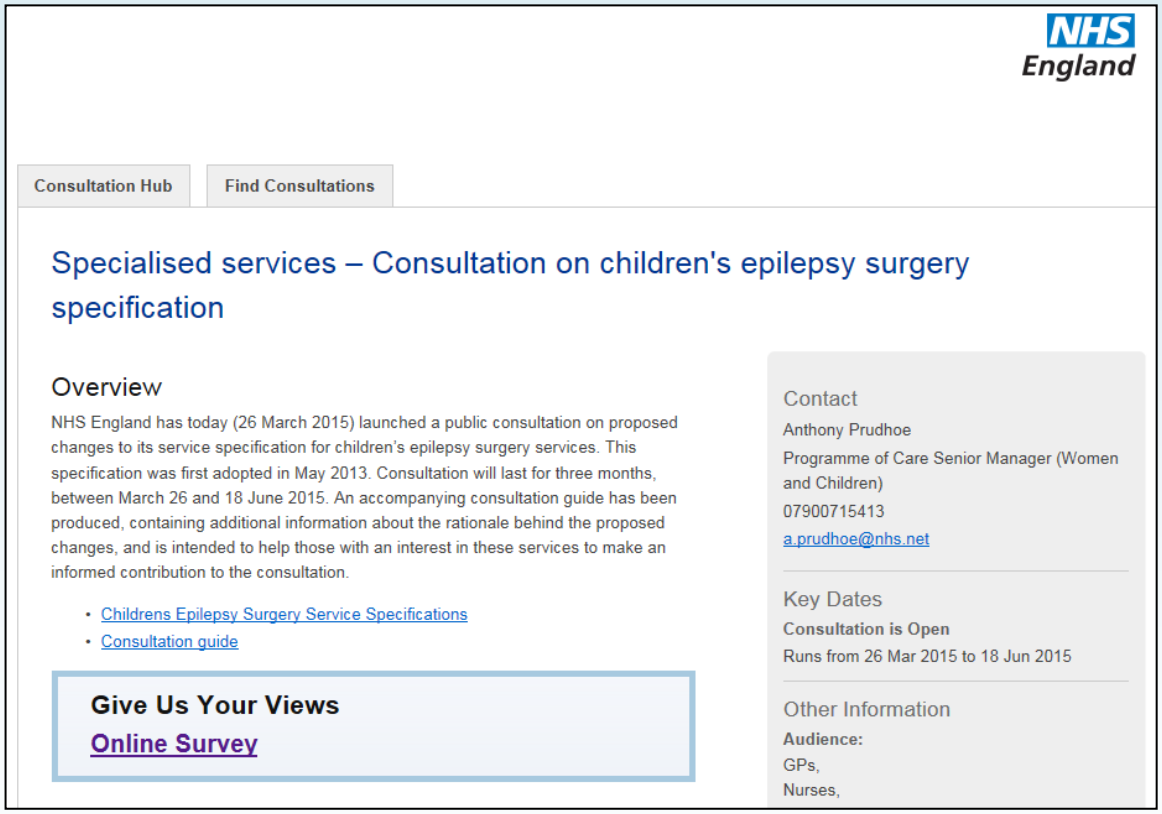
*Skirrow et al Neurology 2011;*76:1330-1337

3. Clinical Strategy

3. Clinical Strategy - Drivers

- Increasing demand
- NHS England Consultation
- New epilepsy surgery approaches
- Parallel growth in medical epilepsy services

NHS England Consultation



NHS England

Consultation Hub | Find Consultations

Specialised services – Consultation on children's epilepsy surgery specification

Overview

NHS England has today (26 March 2015) launched a public consultation on proposed changes to its service specification for children's epilepsy surgery services. This specification was first adopted in May 2013. Consultation will last for three months, between March 26 and 18 June 2015. An accompanying consultation guide has been produced, containing additional information about the rationale behind the proposed changes, and is intended to help those with an interest in these services to make an informed contribution to the consultation.

- Childrens Epilepsy Surgery Service Specifications
- Consultation guide

Give Us Your Views
Online Survey

Contact
Anthony Prudhoe
Programme of Care Senior Manager (Women and Children)
07900715413
a.prudhoe@nhs.net

Key Dates
Consultation is Open
Runs from 26 Mar 2015 to 18 Jun 2015

Other Information
Audience:
GPs,
Nurses,

- Until now, only children aged under six-years of age had to have their surgery performed at one of the four CESS centres
- Key change proposed in this consultation is that all children should now have their surgery at a CESS centre

https://www.engage.england.nhs.uk/consultation/childrens-epilepsy-surgery

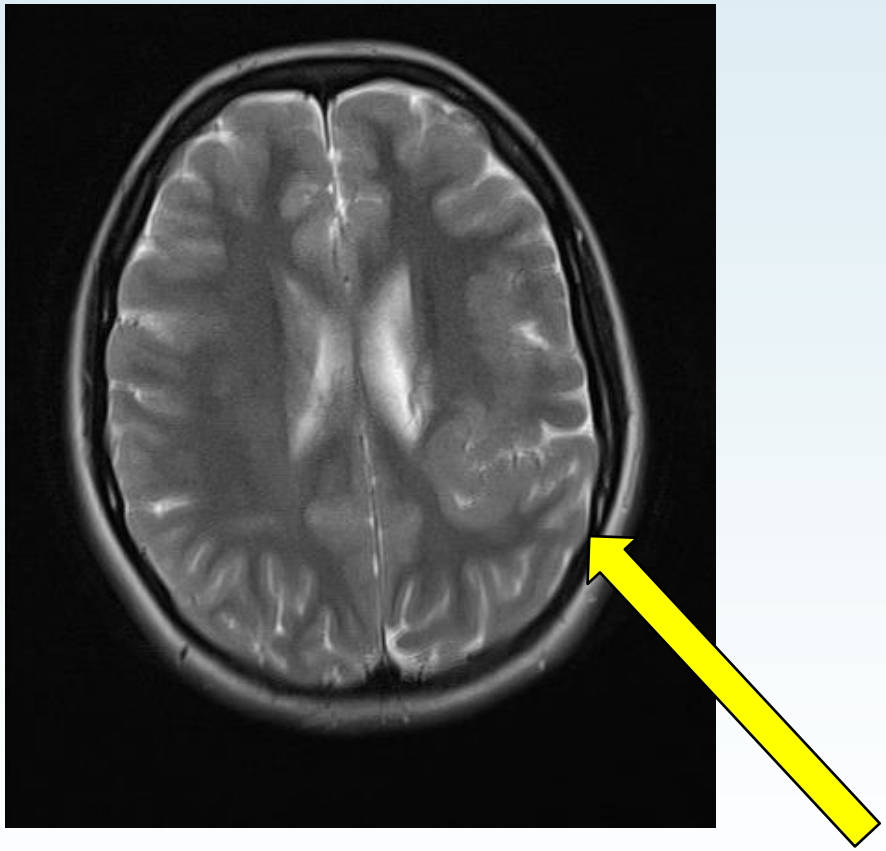
Great Ormond Street Hospital Charity

New approaches

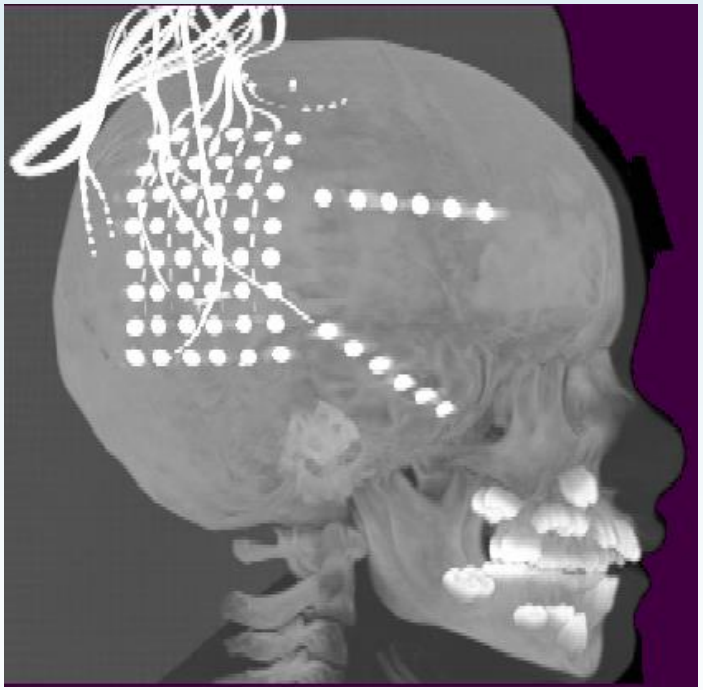
Surgical

- Invasive monitoring
  - Stereo-EEG
- Stereotactic laser ablation for hypothalamic hamartomas
- Intra-operative MRI

Invasive monitoring



Left perisylvian polymicrogyria



Invasive EEG recording

Stereo-EEG – what's different

Slide Courtesy of Charlotte Wilkins, Martin Tisdall

New approaches

Surgical

- Invasive monitoring
  - Stereo-EEG
- Stereotactic laser ablation for hypothalamic hamartomas
- Intra-operative MRI

Medical

- Video-EEG telemetry service
  - Home VT service
  - 7-day VT service
- Medical epilepsy service
  - Ketogenic diet
- Psychological medicine
  - Learning disability neuropsychiatry

Proposed growth

	2012/13	2013/14	2014/15	Proposed
PSE	159	186	148	260
Surgeries	81	88	97	130

- Delivered through
  - 7-day EEG video-telemetry and home telemetry
  - Additional neurosurgical theatre time

Summary

- Primary goal of epilepsy surgery is seizure freedom
- GOSH CESS clinical outcomes are excellent
  - 78% seizure free or worthwhile improvement
  - Surgical morbidity data very good; no mortality
- Increasing demand for the service
  - invasive monitoring expands the number of children in whom surgery is possible and also avoids unacceptable neurological deficit
- Clinical strategy for the programme informed by NHS England consultation and by advances in techniques

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 22nd July 2015	
Update on the scope and progress of the Outpatient project (presentation) **Submitted by:** Sarah James – Divisional Manager for Neurosciences Jane Valente – Clinical Director for Neurosciences Dena Marshall- Interim COO	**Paper No: Attachment N**
Aims / summary To give the Trust Board a brief on the scope and progress of the Outpatient Access Project	
Action required from the meeting None for information only	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Access to Outpatients projects is one of two No Waste Quality Improvement (QI) priority projects. The No Waste agenda is one of GOSH's trust wide three Quality Strategies: No waits, No waste, Zero harm. The objective of this stream is to build a No Waste culture across the trust, enabling staff to recognise waste in their systems, and work towards eliminating it. All No Waste projects report into a single No Waste steering group and then up to the Quality Improvement Committee.	
Financial implications 85k has been identified currently as a P&E target for this scheme for 15/16 through reduction of clinic sessions as a result of improved utilisation and access to ensure effective demand management.	
Who needs to be told about any decision? All outpatient stakeholders	
Who is responsible for implementing the proposals / project and anticipated timescales? Sarah James – Divisional General Manager and Project Lead Jane Valente – Clinical Director for Neurosciences and Outpatients This will require buy in and support from all divisional teams.	
Who is accountable for the implementation of the proposal / project? Claire Newton (Chief Finance Officer) – Executive Sponsor	

Access to Outpatient Project

Trust Board

22nd July 2015

Sarah James

Divisional General Manager for Neurosciences Division

Jane Valente

Clinical Director for Neurosciences Division

Aim

To reduce waste and maximise utilisation of outpatient clinic slots by March 2017, with a resultant improvement in patient access and experience.

Every specialty will agree SMART objectives to deliver the above through baseline data and mapping.

Objectives

- Creation of a central outpatient appointment centre
- Identify and reduce waste in current outpatient pathways
- Standardise appointment booking processes
- Outpatient clinics that start and finish on time
- Improved co-ordination with appointments in other clinical areas (e.g. diagnostics, pathology etc)
- Cancellation process
- Support divisions to:
  - Improve planning of speciality outpatient clinics (demand and capacity)
  - Reduce overbookings
  - Reduce DNAs and Cancellations

Measures

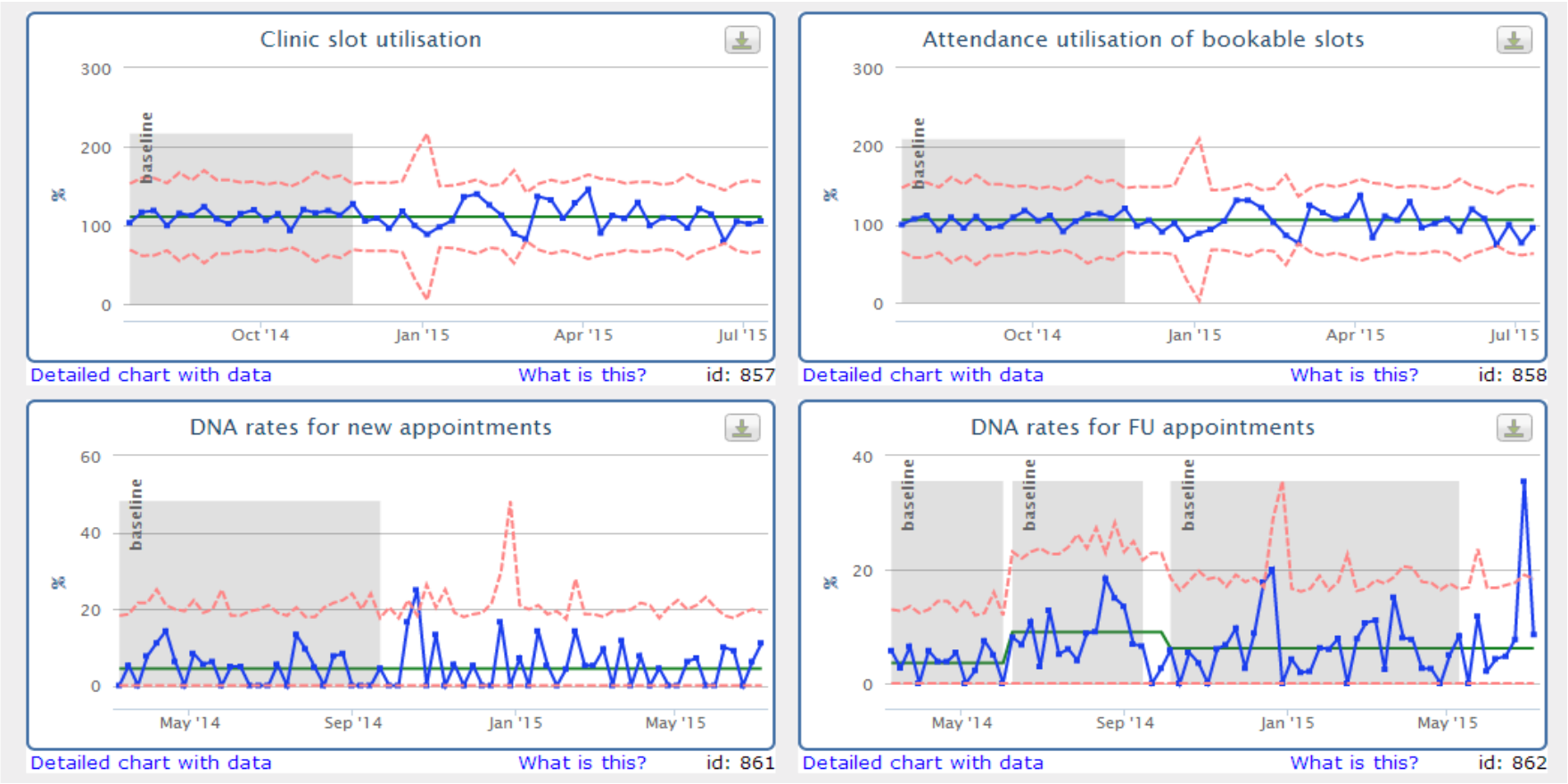
Measure	Name	Description	Source
OUTCOME	Clinic slot utilisation	% booking of available slots *Numerator*: total no. of booked appointments in a clinic *Denominator*: total no. of clinic slots available within that clinic	PiMS
	DNAs	% patients who DNA their booked appt (new and follow up)	PiMS
	Attendance utilisation of bookable slots	% utilisation of available slots *Numerator*: total no. of patients that attended a clinic *Denominator*: total no. clinic slots available within that clinic	PiMS
PROCESS	Patient Cancellations	% of outpatient appointments (new and follow up) cancelled by patient/family	PiMS
	Hospital Cancellations	% of outpatient appointments (new and follow up) cancelled by GOSH	PiMS
	Resolution rates for Clinic cash-up	% of appointments fully outcome within [timeframe tbc]	SPCDI
	Calls handled by appointments line	% of presented calls answered by appointments line	Cisco – SPCDI
	Call centre resolution rates	% of calls handled that are successfully resolved by appointments line	SPCDI
	CBO resolution rates for New appointments	% new referrals successfully booked by CBO	SPCDI
BALANCING	Clinic Overruns	Time (in mins) clinics run past the planned finish time	TBC
	Referral Rates	Weekly count of the number of outpatient referrals accepted by clinic	PiMS
	Incomplete pathways	% of incomplete pathways	PiMS
	Non Admitted Performance	% of Non admitted compliance	PiMS
	New: Follow-up ratios	Number of News and Follow-ups actually seen	PiMS

Progress to Date

- CBO structure redesigned and staff redeployed from Neurosciences
- NDS new referral process (move to CBO)
- Effective check out (Cheetah reception PDSA)
  - Booking appointments on the day
  - Minimal backlog outcome forms
- Waiting times in clinic (Cheetah reception PDSA)
  - process mapping: cut from 5 to 2 steps for check-in
- Appointments line (9-11am extra staff PDSA)
  - Increased % of handled and resolved calls
- Testing new clinic outcome form in SNAPS

Neurodisability Outcome Measures

Neurodisabiltiy aim: By 31st July 2015, Every NDS subspecialty clinic will aim for 100% clinic slot utilisation (with week-to week range of 90-120%) and maintain DNA rate at 3-5% (News and F/up).



Neurodisability Measures

- Backlog of Appointments

	March	April	May	June
Open Pathways	800	309	262	228

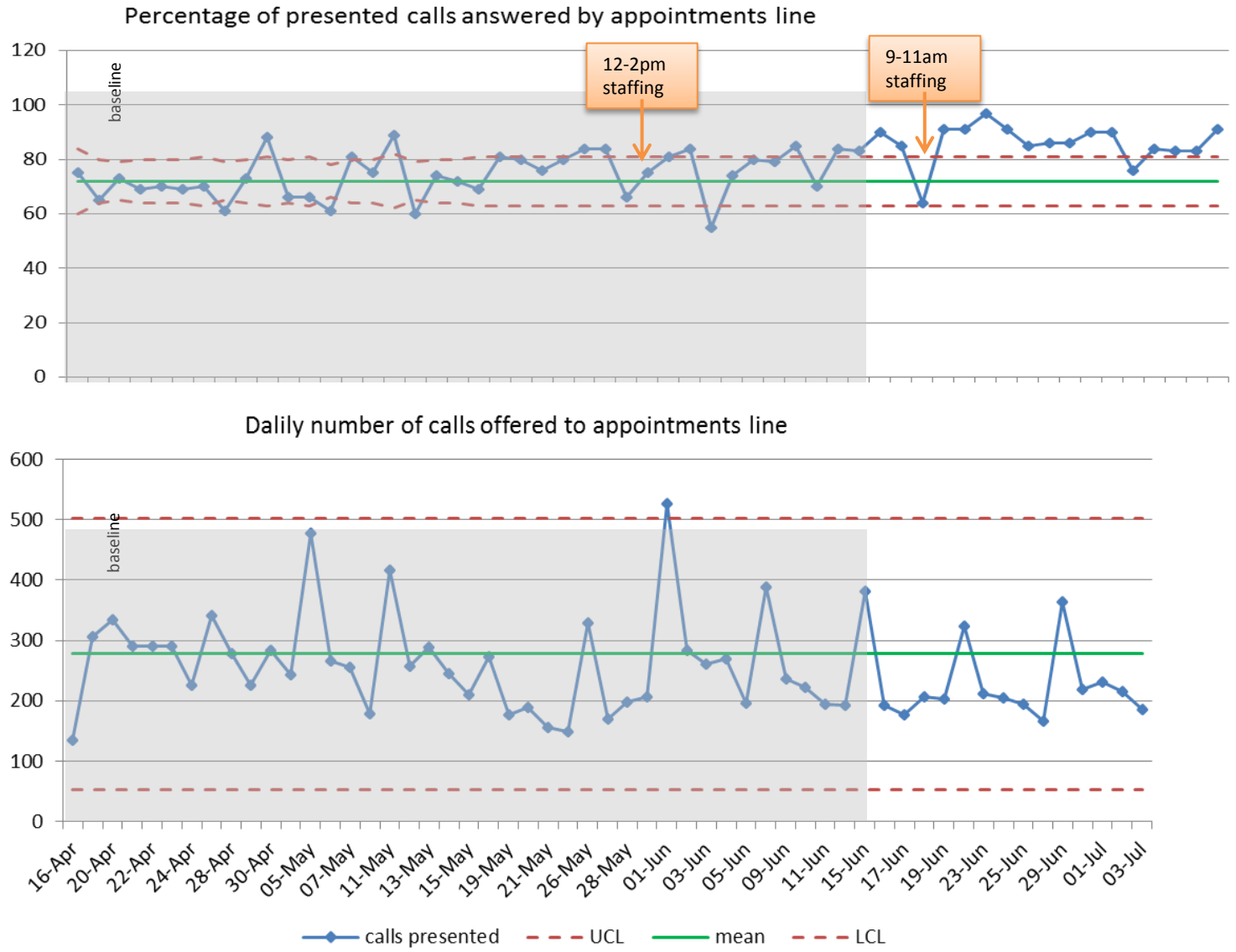
- Incomplete Performance

	March	April	May	June
% Performance	89.32	93.75	100.00	99.00

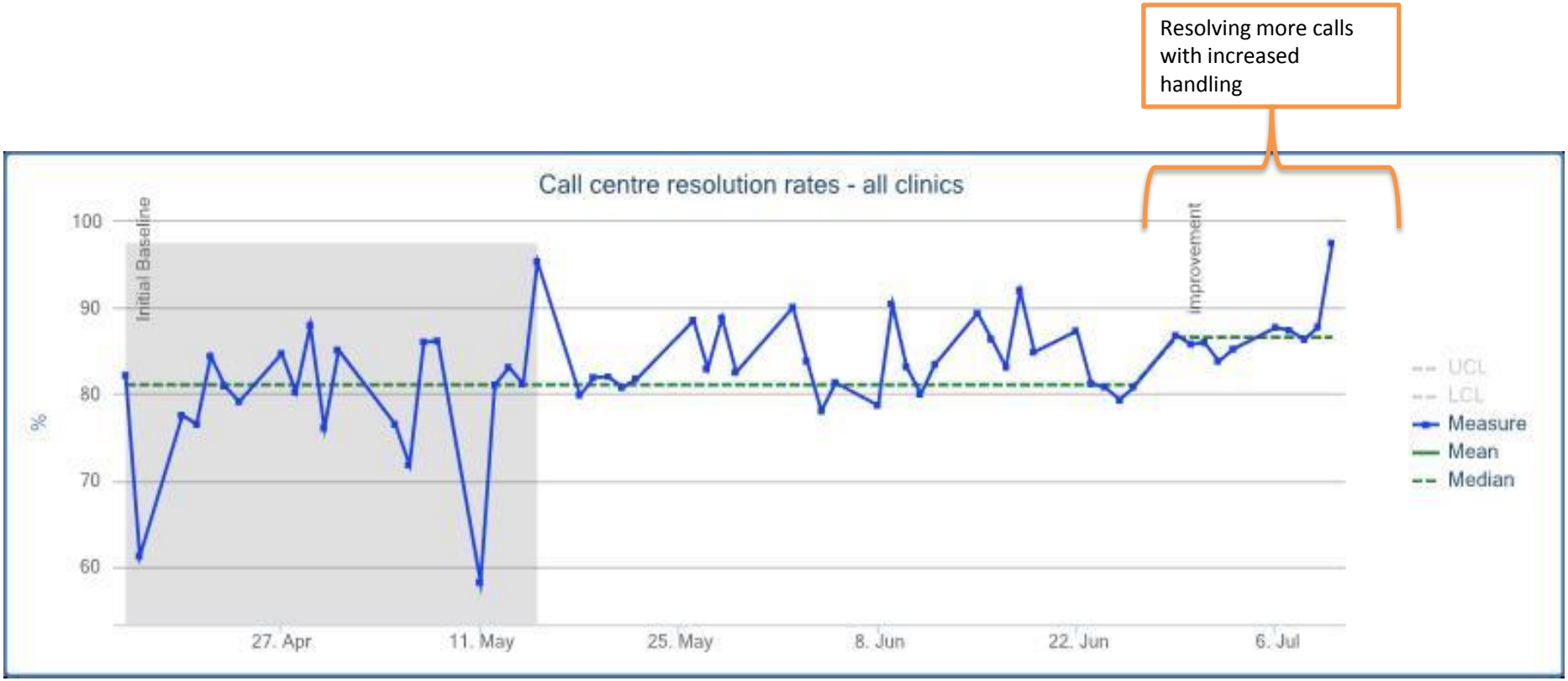
- Non Admitted Performance

	March	April	May	June
% Performance	66.67	76.92	84.00	Has not been finalised yet

Appointment Line Data

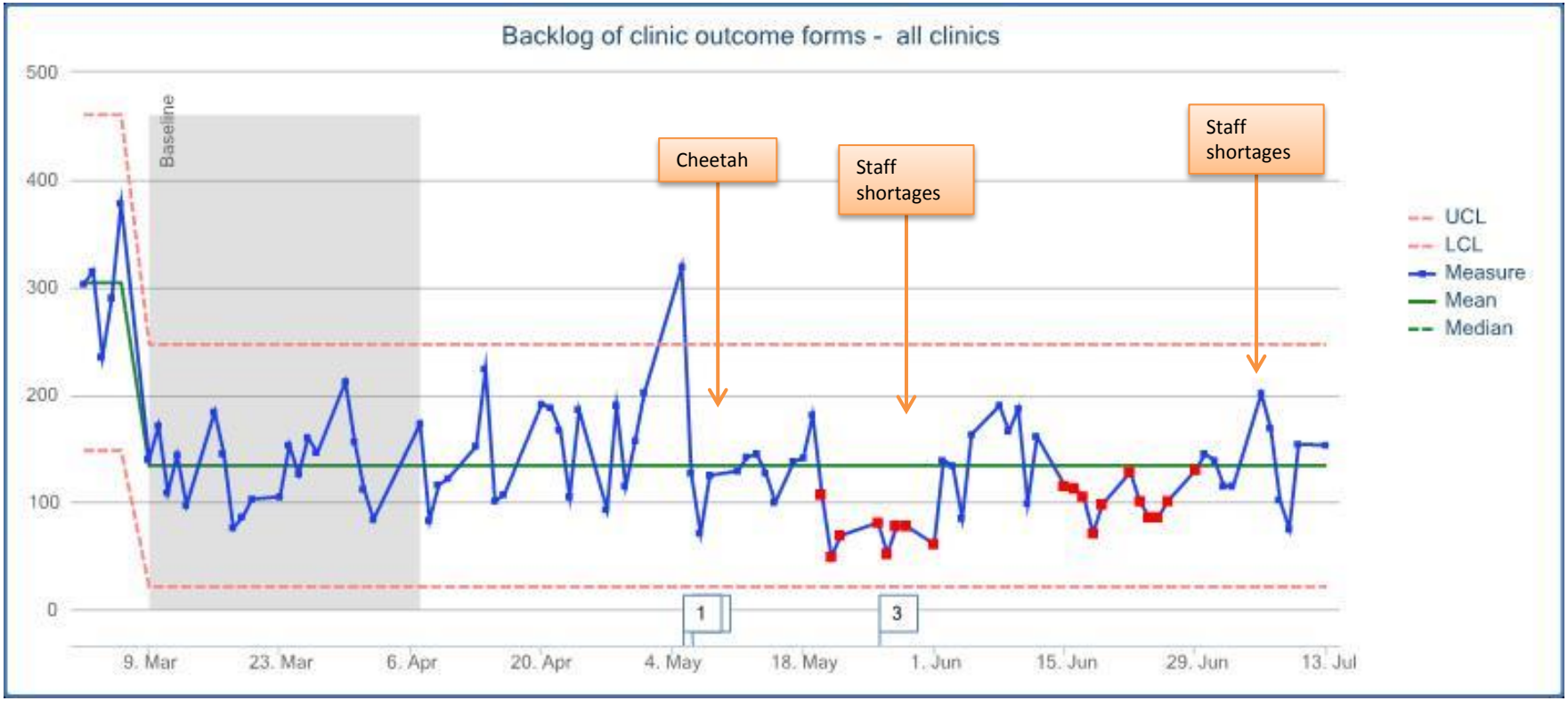


Appointment line Data



Most common reason for not being able to resolve a call: Calls was for another department (Genetics/Dental)

Cheetah Reception



Access to Outpatients - Receptionist in Cheetah PDSA 6/5/15-12/5/15

What has been the feedback over the last week?

Reception Staff

- It has surprisingly worked well
- Booking most f/u appts in Cheetah rather than sending appts in the post
- Reduced backlog of booking appointments at Oscar
- No issues with queues or flow of traffic in Cheetah
- Some Cheetah patients are still checking-in at Oscar
- Quite a few patients asking directions for Rhino, particularly before the volunteers are around

Clinic Assistants

- Don't get rid of the Receptionist in Cheetah – we like it!
- Great to have a point of contact, someone who is available and easy to contact
- Improved communication with outpatients reception
- Noticed less number of patients 'gettting lost'
- Reduction in number of questions by patients, allowing CA more time to do their clinical work

Volunteers

- Nil issues, has been working well
- Able to capture most patients, but regular attending patients will automatically just report to Oscar to check-in
- Signage has been useful – patients are reading the board to see which doctors are running clinics in Cheetah
- Daily list of clinics in Cheetah has been useful

Patients/parents

- Cheetah receptionist has made check- in easier
- More privacy, not as many people around
- Although we checked-in at Oscar, its nice to know there is someone around to ask questions

Contact: chantell.sculfor@gosh.nhs.uk
yalini.vijeyakumar@gosh.nhs.uk

GOSH QI
NO WAITS | NO WASTE | ZERO HARM

Next Steps

- Mapping diagnostics flow and booking processes
- Demand and capacity review
- Design and test new clinic outcome form
- Data collection re: resolution of outcome forms and CBO queries
- Local Receptionist in all clinic areas
- Confirm future location of appointments line
- Complete Neurosciences then commence baseline mapping for Surgery division
- Review of IT infastructure to support operational management of outpatients

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **22nd July 2015**	
Medical Revalidation Annual Board report and statement of compliance **Submitted by:** **Dr Catherine Cale**	**Paper No: Attachment O**
Aims / summary The paper provides a summary of the organisational obligations for medical revalidation as assessed against national requirements and highlights areas of risk and for improvement	
Action required from the meeting The Board is asked to note the contents of the report and approve the recommendation from the clinical governance committee to sign off the statement of compliance.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Appraisal is an important tool in improving quality and outcomes.	
Financial implications The Trust has a statutory responsibility to provide adequate resources so that the responsible officer can discharge their duties appropriately. The costs are of an IT system and licences for this and 360 feedback, support staff and appraisal lead/RO time. To date, although there has been no separate budget, financial resources have been adequate.	
Who needs to be told about any decision? Higher Level Responsible Officer	
Who is responsible for implementing the proposals / project and anticipated timescales? Responsible Officer	
Who is accountable for the implementation of the proposal / project? Dr Catherine Cale, Deputy Medical Director, Responsible Officer	

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

Note: this is an abbreviated report. The full report has been discussed at the Clinical Governance Committee on 8th July 2015.

1. Background

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

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1]

Each Doctor in the UK is linked (via a legally defined algorithm) to a Designated Body who appoints a responsible officer to discharge the duties under the RO Regulations.

2. Governance Arrangements

As a designated body, GOSH submitted an annual organisational audit to NHS England in May 2015. We responded "no" to 3 questions:

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

2.2 Every Doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded.
Actions are in place to better log all appraisals and ensure that reasons for non-completion are fully recorded.

2.5 There is a process in place for the RO to ensure that key items of information (eg SIs) are included in the appraisal portfolio.
Although this information is available to Doctors, and the appraisal form contains questions that prompt inclusion it is not proactively supplied to them. This is addressed in the action plan for this year.

3. Policy and Guidance

The Trust has appropriate policies in place and the Responsible Officer seeks appropriate advice and attends London Region responsible Officer Network meetings.

4. Medical Appraisal

a. Appraisal Performance Data

For consultants (including honorary consultants) appraisal rates for 2014-15 were 90% and meets the national target. This is a further improvement on the 86% rate achieved in 2013-14. For the 33 individuals where an appraisal was not completed, there was a justified reason (eg maternity leave, long term sickness) in 8.

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

For SAS grades appraisal rates were 100%.

Accurate figures are not available for non-consultant grade doctors as data for this staff group is not robustly recorded. However, all non-consultant grades where they were required to provide the RO with evidence of appraisals for the purposes of revalidation were able to do so in a timely manner.

b. Appraisers

For 2014-15 the Trust had 102 trained appraisers. 12 new appraisers were trained, and 34 appraisers attended update training (required every 3 years). Each appraiser receives a summated feedback report each year from feedback provided by appraisees.

c. Quality Assurance

External assessment of appraisal policies and procedures is a requirement, and the hospital was visited by NHS England's (London) revalidation team in February 2015. They did not identify any significant issues with our processes.

Formal quality assurance of the content and output of appraisals was planned to start in 2014-15 but was not undertaken due to lack of capacity in the appraisal team. This will be undertaken this year using templates developed by NHS-England. Discussion at regional Responsible Officer and appraisal lead meetings suggest that most organisations are at a similar point regarding QA.

5. Revalidation Recommendations

For 2014-15 198 revalidation recommendations were made on 182 doctors, with 16 deferral recommendations. This gives a deferral rate of 9% which is in keeping with the national average.

6. Recruitment and engagement background checks

Robust pre-employment checks are conducted on all candidates as per national guidance. A lot of work has been undertaken by HR in 2014 to strengthen the process around honorary contract holders and ensure full checks are made.

7. Monitoring Performance

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

8. Responding to Concerns and Remediation

1 investigation from the previous year was closed during this time period. The recommendations have been completed.

In the period 2014-15, 4 investigations were initiated involving doctors not in training grades,. Only 1 of these has concluded and the recommendations have been implemented.

No remediation or retraining programmes were in place for any individual during this time period.

9. Corrective Actions, Improvement Plan and Next Steps

Issue	Action	Responsible	By
Inadequate admin support	Review admin support (amount and line management) for short and long term	Dep Dir HR/RO	31 08 15
Ensure appraisal lead/RO has sufficient time in job plan	Review with MD	App Lead/RO/MD	31 08 15
Process to ensure key items of information are included in the appraisal portolio	Work with CG team to implement a system of proactive uploading of information by appraisal administrator into appraisal portfolio	App Lead	31 10 15
Recording of non-training grade Dr appraisals	Develop more robust system to prompt appraisals and capture	PGME Manager with DME and RO	31 12 15
Quality Assurance of appraisal content and output	App lead to develop and undertake quality assurance process	RO	30 11 15

10. Recommendation

The Board is asked to note the contents of the report and approve the recommendation from the clinical governance committee to sign off the statement of compliance attached at appendix 1.

Designated Body Statement of Compliance

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

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

   Comments: In this time period the normal capacity of the responsible officer and the support available was reduced. This was due to changes in personnel and sick leave, and has been addressed.

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

   Comments: none

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

   Comments: none

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

   Comments: none

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

   Comments: A small (and decreasing) number of doctors do not have an appraisal and the reason is not known. Drs in this circumstance are informed in writing by the RO, this will be recorded on the appraisal system so there is an accurate record.

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

   Comments: none

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

   Comments: none

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

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

   Comments: none

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

   Comments: none

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

    Comments: a plan is in place, particularly around capacity and quality assurance.

Signed on behalf of the designated body

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

Dr Peter Steer, CEO

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

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

Attachment P

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 22nd July 2015	
Quality and Safety Update **Submitted by:** Dr Vinod Diwakar, Medical Director	**Paper No: Attachment P**

Aims / summary

The purpose of this report is to assure the board that the processes in the organisation are safe and of a high quality. This report is under review and will be redesigned over the next two months. The aim is to report on each of the 12 Quality standards that have been adopted by the Trust. These are:

1. Develop a strong governance structure for Quality and Safety with a Systems approach to quality and safety
2. Maintain high levels of medication safety
3. Decrease and eliminate hospital acquired infections
4. Improve reliability in handover of clinical information at all interactions
5. Eliminate all avoidable pressure injuries occurring in the hospital
6. Recognise and respond to unexpected deterioration of children:
7. Decrease unnecessary delay in all processes in the patient journey:
8. Develop clear measures of clinical outcomes to provide evidence of top 5 children's hospital status
9. Measure and continually improve the experience of children and families:
10. Provide equal access to all children who need our care
11. Accelerate standardisation of clinical care:
12. Develop reliable and accurate documentation of care

Action required from the meeting

For review

Contribution to the delivery of NHS Foundation Trust strategies and plans

The report highlights a number of the quality standards. These will be developed over the next few months with the aim that all standards will have a measure

Financial implications

All QI and safety programmes aim to decrease cost through the standardisation of care. The programmes are funded.

Who needs to be told about any decision?

The Divisions

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

The individual standards are the responsibility of the clinical teams supported by QI and Safety

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

The accountable officer is the Medical Director supported by the Division Directors

Attachment P

Trust Board Data July 2015

Key:

Measure - The data itself.

Median - The middle value in a set of data.

Mean - The mean (or average) of a set of data values is the sum of all of the data values divided by the number of data values.

UCL and LCL - Upper Control Limits (UCL) and Lower Control Limits (LCL). A data point outside of these limits is extremely unlikely to have happened by chance and is therefore considered to be significant and worthy of investigation. They are drawn at 3 standard deviations from the mean.

Standard 1 Serious Incidents:

Aim: To make reductions in the number of Serious Incidents.

Trend: Performance sustained. There has been no statistical change in the number of SIs – we are still running at 2 per month.

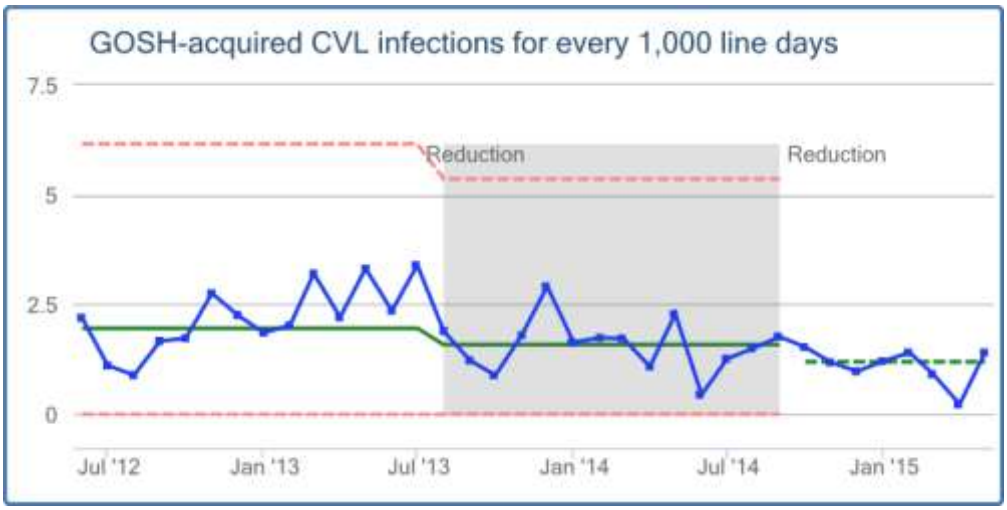
What's going well:

What's not going well:

What action is being taken:

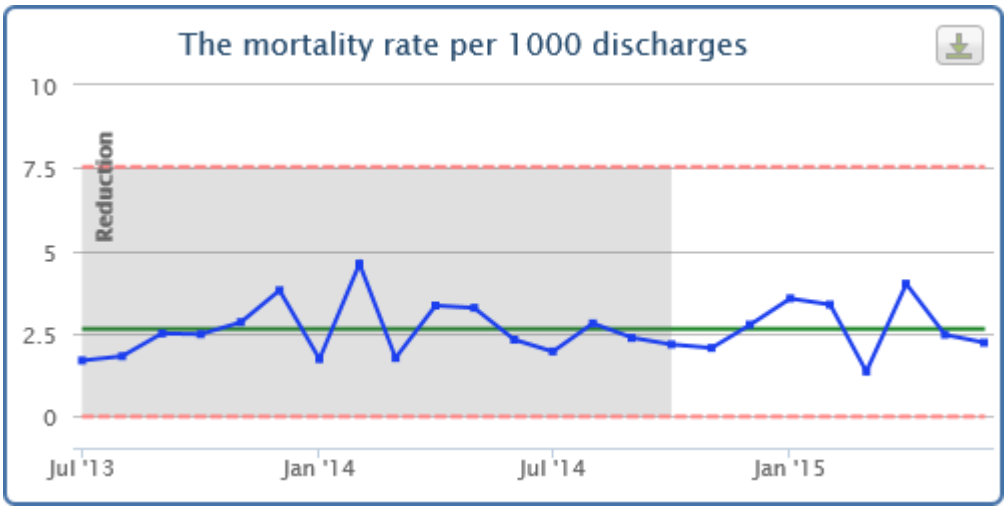
Attachment P

Standard 3 CVL Infections:



Aim:	To make statistically significant reductions in the rate of CVL infections.
Trend:	There has been a reduction in the CVL infection rate. We continue to measure to ensure the new process is sustained.
What's going well:	Achieved lowest ever GOSH acquired CVL infections per 100 line days. We believe that this is due to the introduction of parafilm in IPP & ICI. Both areas previously had high rates of CVL infections.
What's not going well:	Areas that have not introduced parafilm have not seen this same reduction.
What action is being taken:	Rollout of parafilm trust wide.

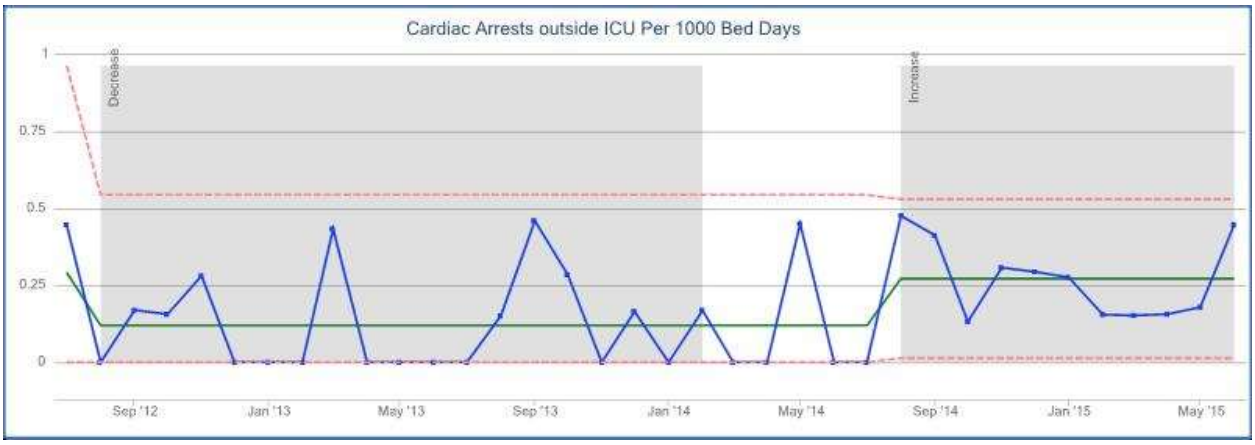
Standard 6 Mortality:

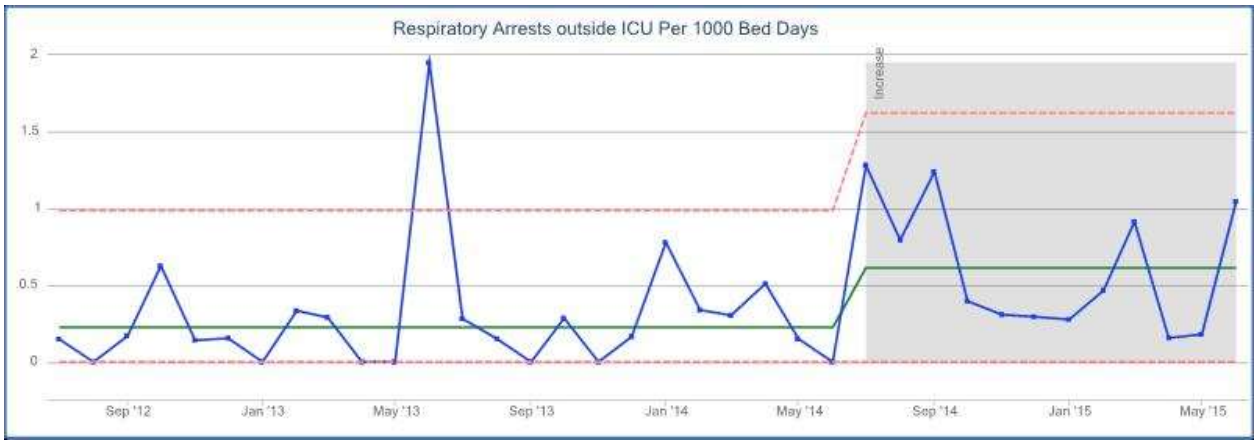


Aim:	To make reductions in the mortality rate

Trend:	The current rate is 2.5 deaths per 1000 discharges with no change. This is to be expected with the current case mix.
What's going well:	We study every death via the mortality review to see if there are specific causes. Unexpected deaths are reviewed.
What's not going well:	-
What action is being taken:	The S.A.F.E programme aims to decrease unexpected deterioration with the potential to reduce mortality.

Standard 6 Cardiac and Respiratory Arrests:





Aim:	To make reductions in the number of cardiac and respiratory arrests outside the ICU.
Trend:	**Please note: these measures have changed and are now reported "per 1000 bed days".** Cardiac arrests – the increase seen since August 2014 has sustained. There are now 0.27 arrests per 1000 bed days, up from a previous mean of 0.12 per 1000 bed days. Respiratory arrests – have shown a sustained increase since July 2014. They are now

0.61 per 1000 bed days, up from a previous mean of 0.22 per 1000 bed days.

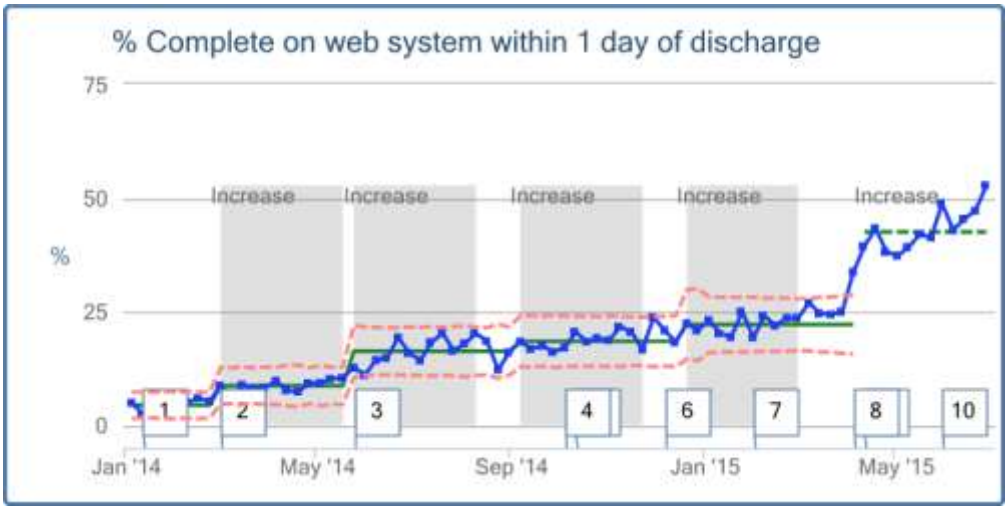
What's going well: Our Cardiac arrest survival to discharge has increased from 68% to 70%. Respiratory arrest: 91% survival to discharge.

What's not going well: We still have a high number of cardiac and respiratory arrests in the ward areas. Most patients are classed as HDU but the number of patients deteriorating on the wards is still too high. Although it is vital patients are cared for within their speciality it is also important they are safe.

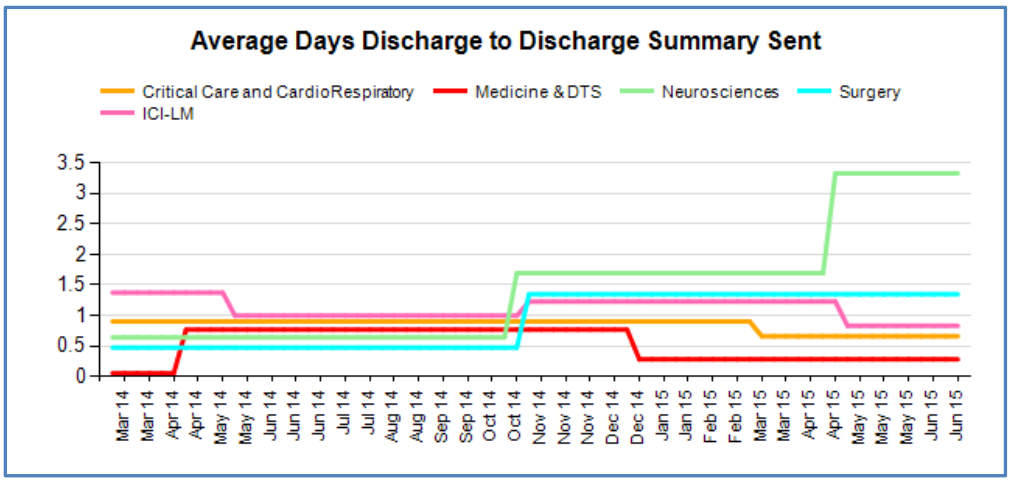
What action is being taken: We have adopted a new Trust-wide escalation policy. We have now launched electronic observations across the Trust with automatic escalation with a CEWS > 3, parental or nurse concern. We have 100% compliance on escalation but it is questionable whether patients are being seen by medical staff and referred to ICU earlier. Further audit is required.

We have commenced the SAFE project on Rainforest as well as IPP areas. This is a project aimed at improving situational awareness and one method being is to introduce safety huddles on the wards. It is too early to assess whether this has improved early recognition and safety of the deteriorating child.

Standard 7 Discharge Summaries:



Attachment P



Aim: To make statistically significant reductions in the time taken to complete a discharge summary.

Trends: There have been recent reductions in the time from discharge to sending the summary for:

- Critical Care and CardioRespiratory from 0.9 to 0.7 days
- Medicine and DTS from 0.8 to 0.3 days
- ICI-LM from 1.2 to 0.8 days

And a recent increase for Neurosciences from 1.7 to 2.7 days

What's going well:

- Spread of the new discharge summary system and associated improvements in process has been completed across 21 clinical specialties
- Engagement from clinical teams has been high, particularly across surgery and ICI.
- In the last couple of months improvements in discharge summary completion within 1 day have been made in cardiac specialties, respiratory medicine, haematology, oncology

What's not going well:

- Some areas have proved trickier to spread to due to having more complex and less efficient current processes. Our work in neurosciences has exposed problems with current processes that we are working to fix. MDTS specialties also have a more complex process we are developing the system to support.

- Engagement from admin teams has been difficult, particularly relating to weekend and leave cover, this means that whilst medics complete discharge summaries quickly, they are not always sent immediately.

What action is being taken:

- Significant development work has been undertaken to ensure that the system is fit for purpose for all clinical specialties
- Mixed Quality Improvement/Operational approach to tackling admin issues
- Focus on giving patients copies of their discharge summaries when they leave rather than relying solely on post/fax transmission
- Sustainability plan in place to ensure long term success, including focus on cultural change and leadership across all specialties

Attachment Q

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
22nd July 2015

Performance Summary Report **Submitted by:** Dena Marshall – Chief Operating Officer, Vinod Diwakar – Medical Director	**Paper No: Attachment Q**

Quality and Safety
In June the Trust reported no cases of C.Difficile, assigned in patients aged two and over, tested on third day or later, leaving the total year to date cases recorded at 1 in 15/16

This case was not attributed to a lapse of care outlined in the assessment criteria from Monitor and agreed with NHS England.

No cases of MRSA or MSSA were reported in June.

Three cases of E. Coli were reported in June following 48 hours of admission, taking the year to date total to 4 cases in 15/16

Targets and Activity
Patient spells were reported above plan, with ITU Bed days remaining above plan during month 3.

The Number of outpatient attendances remained below plan for the year to date.

Discharge summary completion rates increased to 83.3% in June. A Trust wide improvement project for Discharge Summary completion is currently underway and introduction across all Specialties within the Hospital will be completed by the end of July 2015. This is being led by the Quality Improvement team.

In relation to 18 week Referral to Treatment Time measures, the Trust achieved the Admitted, Non-Admitted and Incomplete performance standards in May. The June position is unavailable at the time of reporting.

In addition, the Trust maintained compliance against all other service performance measures including Cancer Wait times and the 1% threshold for the proportion of patients waiting no more than 6 weeks for Diagnostic Testing (within the national 15 key diagnostic tests).

Complaints
The Trust received 16 complaints in June, none of which were attributed to the highest categorisation.

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.

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

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

Attachment Q

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

Targets & Indicators Report

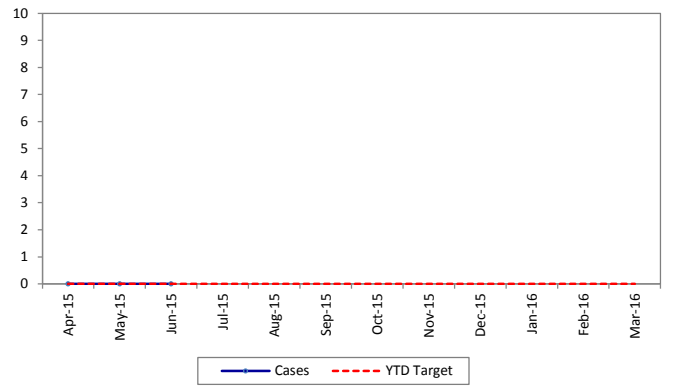
	Indicator	Target	YTD Performance	Monthly Trend					
				Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Activity & Use of Resources	Number of patient spells	8,377	**8,636**	2,829	2,802	3,137	2,847	2,732	3,057
	Number of outpatient attendances	38,731	**36,065**	13,234	12,911	13,733	12,307	10,705	13,053
	DNA rate (new & f/up) (%)	<10	**8.2**	7.3	7.4	6.9	7.7	8.1	8.7
	Number of ITU bed days	2,680	**2,866**	840	774	856	710	1,221	935
	Number of unused theatre sessions	31	**52**	12	5	13	22	9	21
	Average number of beds closed - Total Ward	-	**16.4**	14.1	10.5	13.7	20.2	13.5	15.5
	Average number of beds closed - Total ICU	-	**0.2**	0.0	0.5	0.4	0.4	0.1	0.2
Patient Access	18 week referral to treatment time performance - Admitted (%)	>90	**93.9**	90.4	90.6	93.1	93.9	94.2	
	18 week referral to treatment time performance - Non-Admitted (%)	>95	**95.4**	95.2	95.6	95.5	95.4	95.3	
	18 week referral to treatment time performance - Incomplete Pathways (%)	>92	**93.1**	94.6	93.9	94.7	93.1	94.4	
	Patient Refused Admissions - Trust Total Excluding PICU/NICU & CATS*	90	**17**	4	3	1	8	9	
	PICU/NICU & CATS General refusals	<235	**38**	12	20	21	17	21	
	Cancer patients waiting no more than 31 days for second of subsequent treatment (%)	98	**100**	100	100	100	100	100	100
	Proportion of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests (%)	<=1	**0.7**	0.9	0.0	1.1	0.6	0.82	0.72

	Indicator	Target	YTD Performance	Monthly Trend					
				Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Patient / Referrer Experience	Number of complaints	40	**36**	11	9	13	13	7	16
	Number of complaints - high grade	4	**2**	1	1	3	2	0	0
	Friends & Family Test (% of those Likely & Extremely Likely to recommend)	>95	**98.0**	97.5	97.8	97.4	98.1	96.9	98.9
	Discharge summary completion (%)	85	**81.0**	80.3	79.0	80.2	78.6	80.9	83.3
	Clinic Letter Turnaround, % letters on CDD - sent within 5 working days	50	**33.0**	31.6	34.9	37.8	36.0	30.0	
	Clinic Letter Turnaround, Average Days Letter Sent	-	**10.9**	12.1	11.2	10.0	11.0	10.9	
Work - force	Sickness Rate (%)	2.99	**2.5**	2.6	2.5	2.6	2.5	2.6	2.6
	Trust Turnover (%)	14.13	**18.2**	17.6	17.7	18.9	18.3	18.1	18.3

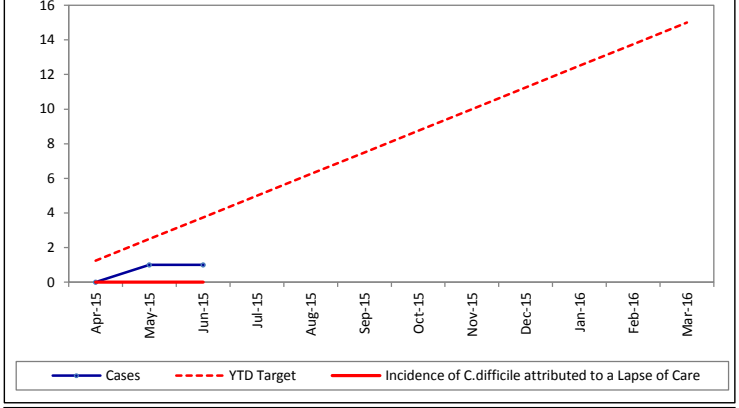
Monitor	YTD Target	YTD Performance	Quarter 4			Quarter 1		
Monitor governance risk rating 14/15	Green	0	0	0	Green	0	0	Green

*Patient Refused Admissions figure is the total received at the time of reporting and may be subject to change as further data is collated

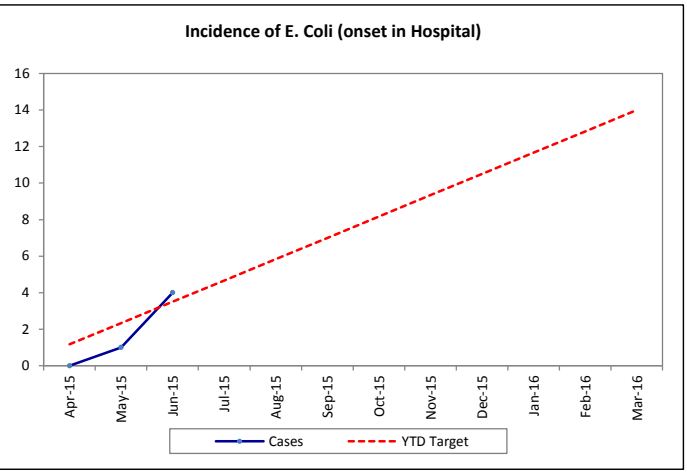
Health Care Associated Infection Indicators



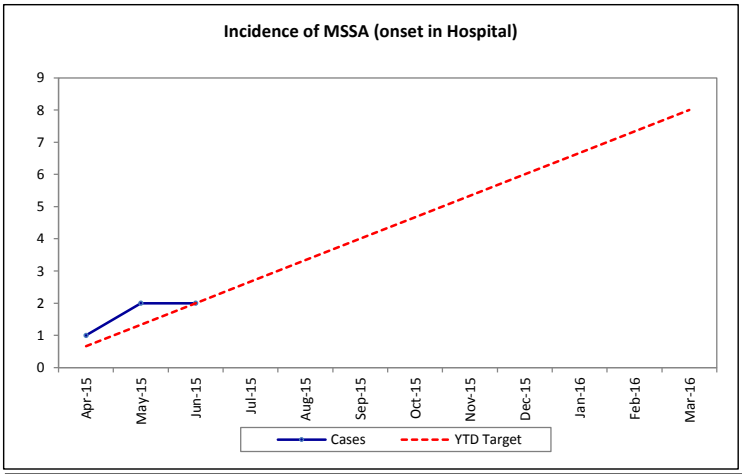
Description: MRSA bacteraemias
Target: Zero cases
Trend: 0 cases reported to date
Comment: Performance sustained at zero cases



Description: **Cumulative Cases detected after 3 days (admission day = day 1) are assigned against trust trajectory**
Target: No more than seven cases per year
Trend: Trend below trajectory in month 1
Comment: **The Trust has attributed no cases to a laspe of care for the YTD.**



Description: **Cumulative incidence of E. coli bacteraemia**
Target: Internal Target no more than fourteen cases
Trend: Performance delivered below trajectory at M2
Comment: Performance being monitored closely



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

Monitor Governance Risk Rating

Targets - weighted (national requirements)		Threshold	Score Weighting	Reporting Frequency	Score Weighting Q1			
					M1	M2	M3	Q1
1	MRSA - meeting the MRSA objective *	0	1	Quarterly	0	0	0	0
2	Clostridium difficile year on year reduction (Against Monitors defined Lapse of Care categorisation)	0	1	Quarterly	0	0	0	0
3	All cancers: 31-day wait for second or subsequent treatment comprising either:	100%	1	Quarterly	0	0	0	0
	Surgery	94%			0	0	0	0
	Anti cancer drug treatments	98%			0	0	0	0
	Radiotherapy (from 1 Jan 2011)	94%			0	0	0	0
4	Admitted within 18 weeks	90%	1	Quarterly	0	0	0	0
5	Non-Admitted within 18 weeks	95%	1	Quarterly	0	0	0	0
6	Referral to treatment time Incomplete Pathways Performance	92%		Quarterly	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
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
				Total	**0**	**0**	**0**	**0**
				Overall governance risk rating	**Green**	**Green**	**Green**	

*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

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **22nd July 2015**	
Workforce Metrics & Exception Reporting – June 2015 **Submitted by:** Ali Mohammed, Director of HR & OD	**Paper No: Attachment R**
Aims / summary This report provides an updated position of a number of workforce metrics, together with a summary of interventions for those areas of concern.	
Action required from the meeting To note the content of the report.	
Contribution to the delivery of NHS Foundation Trust strategies and plans To be sustainable	
Financial implications The report details metrics on a number of areas which have a direct and indirect financial implication; these include absence (sickness) and the percentage of the total paybill spent on agency usage; the report shows that both of these areas have reduced from the previous month.	
Who needs to be told about any decision? Not applicable.	
Who is responsible for implementing the proposals / project and anticipated timescales? Divisional management teams; supported by members of the HR & OD team.	
Who is accountable for the implementation of the proposal / project? Divisional management teams.	

TRUST BOARD WORKFORCE METRICS & EXCEPTION REPORTING – JUNE 2015

Introduction
This suite of workforce reports includes:

- Voluntary turnover and total turnover;
- Sickness absence;
- Vacancy rates
- PDR appraisal rates (based on new PDR framework);
- Agency usage as a percentage of paybill;
- Statutory and mandatory training compliance (at Trust level only).

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 23 in June to 3719. This change is within anticipated levels and is 87 FTE higher than the same point in 2014.

Sickness absence has remained stable at 2.56% and remains significantly below the London average figure of 3%.

Turnover is now being reported as voluntary turnover in addition to the standard total turnover. Voluntary turnover currently stands at 15.8% (decreased from 16.3% May 15) and will be reported and compared on a monthly basis; this new reported value excludes non-voluntary forms of leavers (e.g. dismissals, TUPE, fixed-term and redundancies). Total (voluntary and non-voluntary) has increased slightly – currently at 18.3% (+0.2%) in June. The (unadjusted) London benchmark figure is 14.28% (which includes voluntary and non-voluntary leavers).

The reported **vacancy rate** has increased to 5.3% in June.

Agency usage for 2015/16 (year to date) stands at 1.9% of total paybill; this is significantly below 2014/15 (at 2.5%) outturn. Estates retains high spend on agency as percentage of paybill at 23% (decreasing) with Finance & ICT at 21% (rising).

PDR completion rates The Trust overall appraisal rate stands at 82% - a decrease of 2% since May. This has been calculated using the new PDR framework calculation (linking increments to performance outcomes). Two directorates are meeting the target of 95% (Nursing & Patient Experience, HR & OD). One division is within 2% of meeting target (Estates).

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.

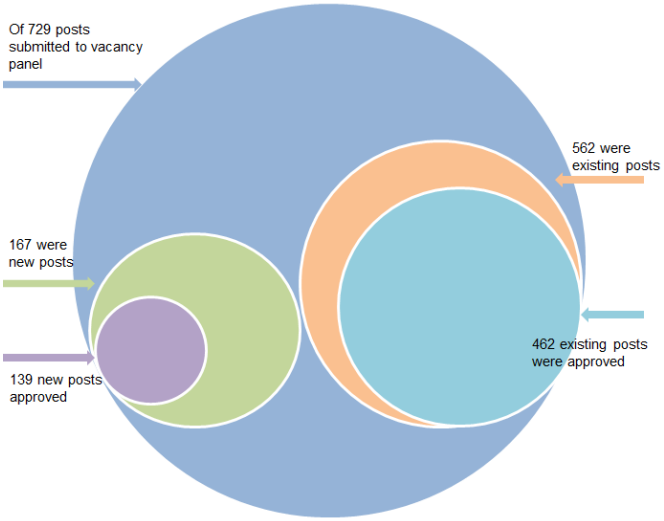
Statutory and mandatory training compliance rates are reported below against a number of key mandatory training subjects. The required training compliance for any of the courses is 95%; currently the Trust is compliant with one (safeguarding children level 1) of the reported seven topic areas. Information Governance and Infection Prevention have dropped slightly by 1% whilst fire safety training has improved by 3%.

Training Topic	Trust Training Compliance (%)
Information Governance – current	90
Safeguarding Children – level 1	96
Fire Safety Overall	81
Counter Fraud	87
Equality, Diversity and Human Rights	90
Health Safety and Welfare	88
Infection Prevention and Control Level 1	87

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 roles). The new Workforce Control processes came into effect late March 2015.

The graphic (right) demonstrates the volume and outcomes of roles considered by the vacancy panel from 1 April 2014 to 30 June 2015.



A total of 128 roles were not approved from the 729 submitted.

Vacancy control period	Approval rate
April 14 to October 14	92%
April 14 to December 14	81%
Year to date (Apr 14 to Jun 15)	82%

Honorary Contract Holders – Safeguarding Update

The table provides an update following Director of HR & OD email to host organisations of non- GOSH/ICH honorary consultants. A follow up email (to 30 Trusts) has been drafted to chase those organisations yet to respond. Since the original email compliance for each level has increased by approx. 10% for this group.

Medical and Dental Staff compliance breakdown	Pre-email Current Training %	Post-email Current Training %
Honorary Consultants Level 1	59.10%	68.10%
Honorary Consultants here less 3 months who already have Level 1	92.30%	95.20%
Honorary Consultants level 2	46.30%	56.10%
Honorary Consultants here less 3 months who already have Level 2	35.10%	41.70%
Honorary Consultants Level 3	29.60%	39.80%
Honorary Consultants here less 3 months who already have Level 3	23.30%	27.90%

HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - JUNE 2015 REPORT

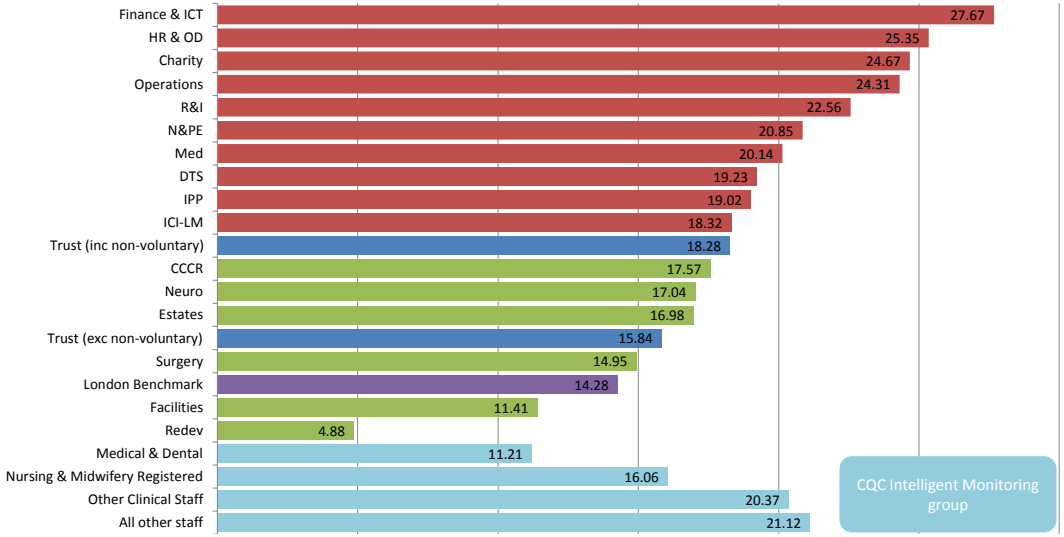
Division	**Contractual Staff in Post (FTE)**	**Voluntary Turnover Rate (%, FTE)** (voluntary leavers in 12-months in brackets, <14% green)	**Total Turnover Rate (%, FTE)** (number of leavers in 12-months in brackets, <18% green)	**Sickness Rate (%)** (0-3% green)	**PDR Completion (%)** (target 95%)	**Vacancy Rate (%, FTE)** (Unfilled vacancies, 0-10% green; overestablished white)	**Agency (as % of total paybill, £)** (Max 0.5% Corporate, 2% Clinical)
Critical Care & Cardio-Respiratory	711	16.7% (103.8)	17.6% (109.3)	2.5	86.0%	6.7%	1.3%
Diagnostic & Therapeutic Services	372	13.9% (53.1)	19.2% (73.5)	2.4	83.0%	8.9%	2.7%
Infection, Cancer & Immunity	667	16.4% (104.5)	18.3% (116.7)	2.7	85.0%	5.3%	0.5%
International	158	17.7% (26.3)	19.0% (28.3)	4.4	89.0%	12.6%	5.2%
Medicine	265	18.4% (42.1)	20.1% (46.1)	3.2	85.0%	6.2%	2.7%
Neurosciences	456	13.8% (57.7)	17.0% (71.4)	2.2	80.0%	1.0%	0.9%
Surgery	569	11.5% (56.1)	15.0% (72.6)	2.4	88.0%	2.5%	0.9%
Clinical & Medical Operations	68	17.7% (10.7)	24.3% (14.7)	0.7	75.0%	15.1%	0.1%
Corporate Affairs	8	24.3% (2.0)	40.1% (3.3)	0.1	86.0%	0.0%	0.0%
Corporate Facilities	85	10.2% (8.5)	11.4% (9.5)	2.5	36.0%	10.7%	1.4%
Estates	30	17.0% (5.0)	17.0% (5.0)	5.3	93.0%	23.6%	25.7%
Finance & ICT	95	26.6% (24.4)	27.7% (25.4)	2.5	54.0%	21.2%	13.8%
Human Resources & OD	103	22.0% (22.0)	25.4% (25.4)	3.1	95.0%	2.8%	
Nursing & Patient Experience	31	16.1% (4.7)	20.9% (6.1)	1.2	100.0%	1.7%	0.0%
Redevelopment	22	0.0% (0.0)	4.9% (1.0)	2.0	86.0%		0.0%
Research & Innovation	74	21.1% (14.7)	22.6% (15.7)	1.7	71.0%		0.5%
Trust	3719	**15.8%▼ (542.8)**	**18.3%▲ (626.2)**	**2.6▲**	**82.0%▼**	**5.3%▲**	**1.9%▲**

HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - JUNE 2015 REPORT

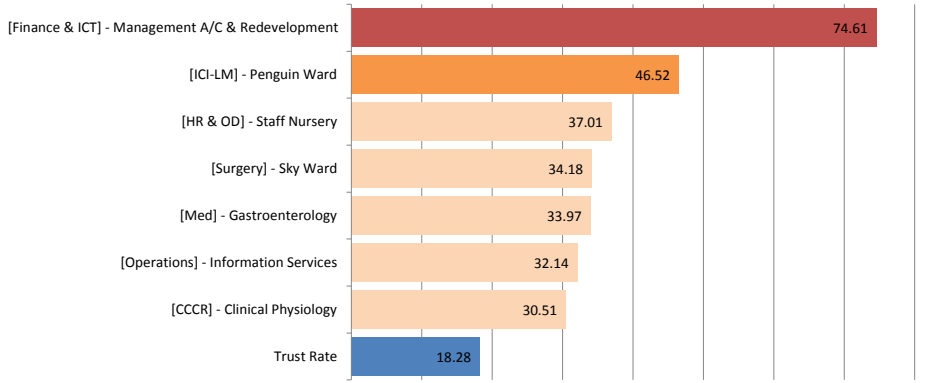
Division	Red Metrics / DoT	Metric	DoT	Actions & Comments
Estates	5 (previously 5)	Voluntary turnover worsened from 16.8% to 17%		Work on-going with the department regarding the structure which should drive a more stable workforce.
		Sickness worsened from 5.1% to 5.3%		Managers being met with to review sickness cases
		PDR rate unchanged at 93%		On-going reminders to complete and submit PDRs
		Vacancy rate worsened from 23.3% to 23.6%		Ongoing recruitment started in June to fill vacant senior posts
		Agency usage improved from 27.1% to 25.7%		Above recruitment should reduce agency spend in coming months
International	5 (previously 5)	Voluntary turnover worsened from 16.4% to 18.3%		Ongoing monthly meetings with managers
		Sickness worsened from 4.3% to 4.4%		Meeting planned in July about sickness and sickness recording
		PDR rate worsened from 91% to 89%		
		Agency usage worsened from 3.3% to 5.2%		
		Vacancy rate improved from 14.5% to 12.6%		Workforce control measures took effect from April 2015
Finance & ICT	4 (previously 4)	Voluntary turnover worsened form 25.7% to 27.7%		Exit Interviews held with HR, themed feedback being provided to department.
		PDR rate improved from 51% to 54%		Department to be reminded of individuals who have not completed PDR
		Agency usage improved from 14.8% to 13.8%		Ongoing recruitment to roles covered by agency staff
		Vacancy rate worsened from 19.7% to 21.2%		Ongoing work with ICT over recruitment to specific roles
Medicine	4 (previously 4)	Voluntary turnover improved from 21.4% to 19.7%		Improved turnover rate
		Sickness unchanged at 3.2%		On-going management with individual managers
		PDR rate worsened from 87% to 85%		Managers to be informed of staff who are outstanding
		Agency usage worsened from 2.5% to 2.7%		Workforce control approvals to be reviewed to identify what has caused the increase
DTS	3 (previously 3)	Voluntary turnover improved form 14.6% to 14.3%		Improved turnover rate
		PDR rate improved from 81% to 83%		Improved compliance rate
		Agency usage worsened from 2.5% to 2.7%		Work to be completed reviewing agency usage in line with workforce controls
Clinical & Medical Operations	3 (previously 3)	Voluntary turnover worsened from 14.5% to 18.1%		Turnover to be analysed for this department
		PDR rate worsened from 77% to 75%		Managers to be informed of staff who are outstanding
		Vacancy rate worsened from 11% to 15.1%		Recruitment to work with the department to identify if vacancies are appropriate based on the workforce control measures

HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - JUNE 2015 REPORT

Divisional Turnover (Voluntary & Non-Voluntary)

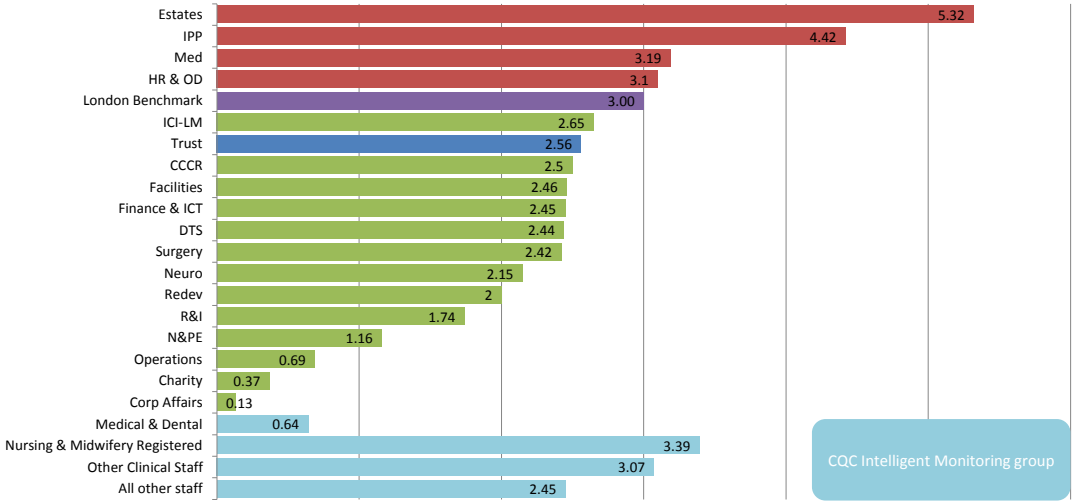


Exception Reporting Turnover

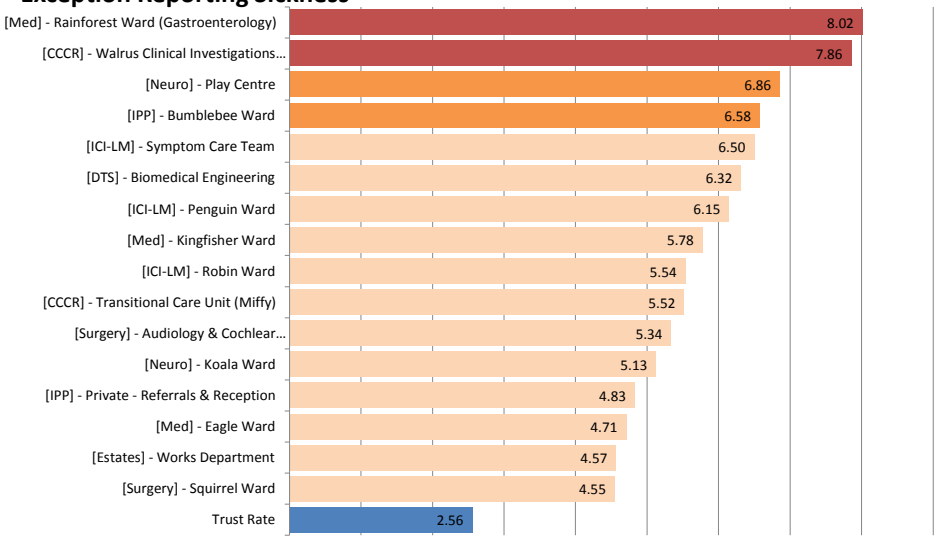


DTS (pharmacy) – pre reg pharmacists are on 12 month fixed term contracts around 20 staff on average; Surgery (Anaesthetic Staff Theatres) – majority of the staff are ODPs come and work at the Trust for 6 months to develop, the band 6 roles have low turnover so they are appointed to band 6 and 7 roles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

Divisional Sickness

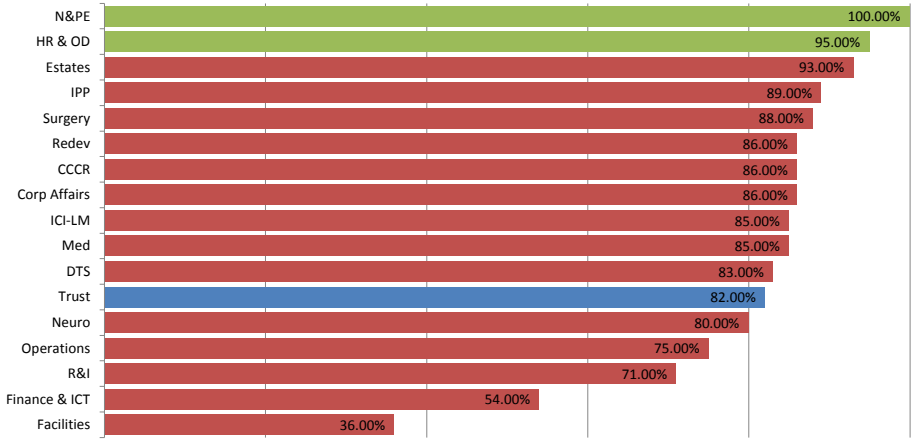


Exception Reporting Sickness

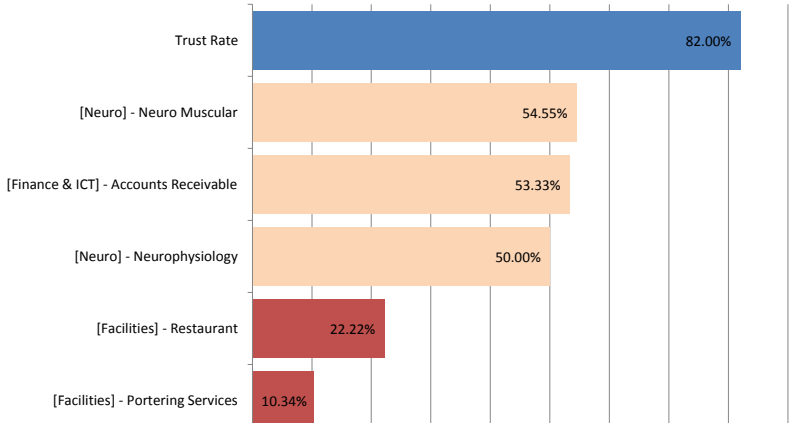


HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - JUNE 2015 REPORT

Divisional PDR (Target 95%)

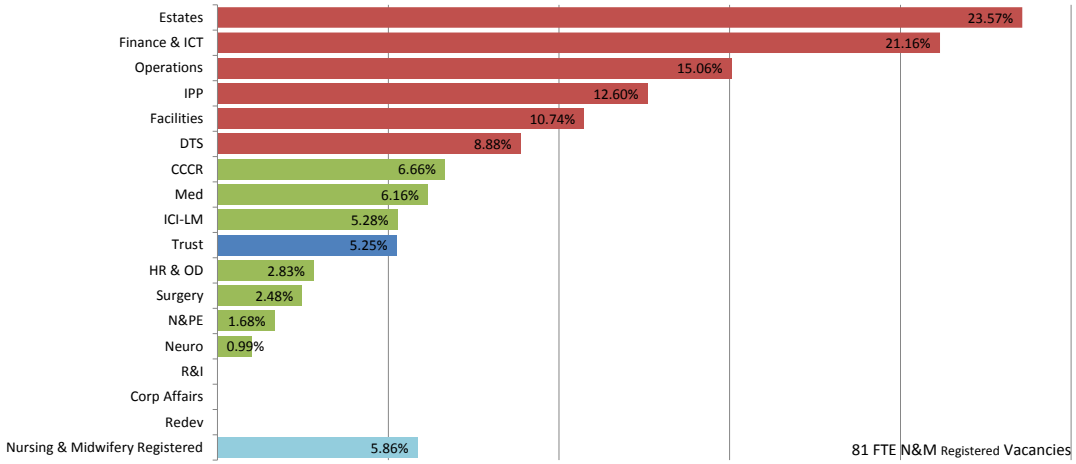


Exception Reporting PDR

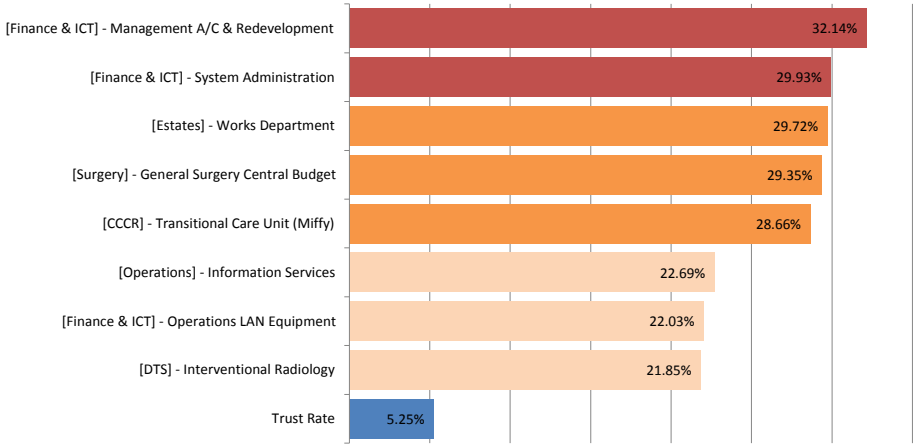


HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - JUNE 2015 REPORT

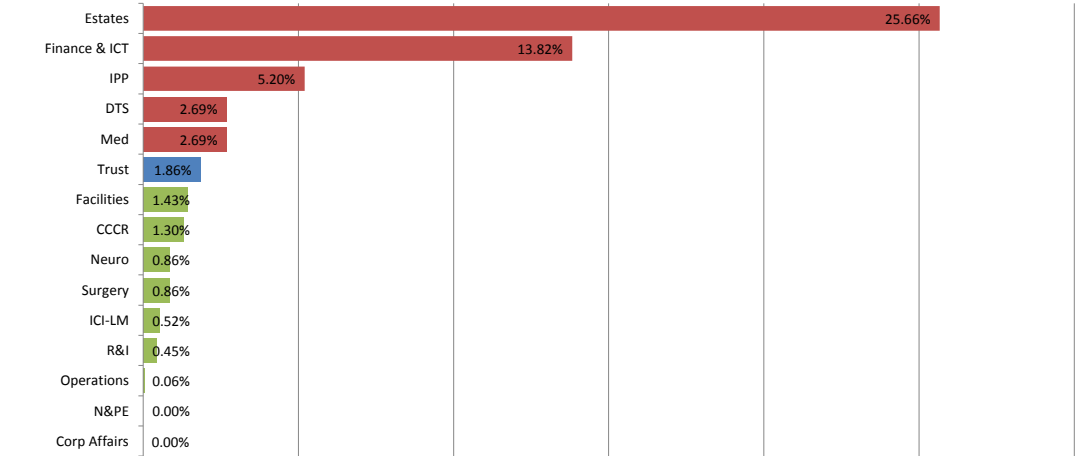
Divisional Vacancy Rate



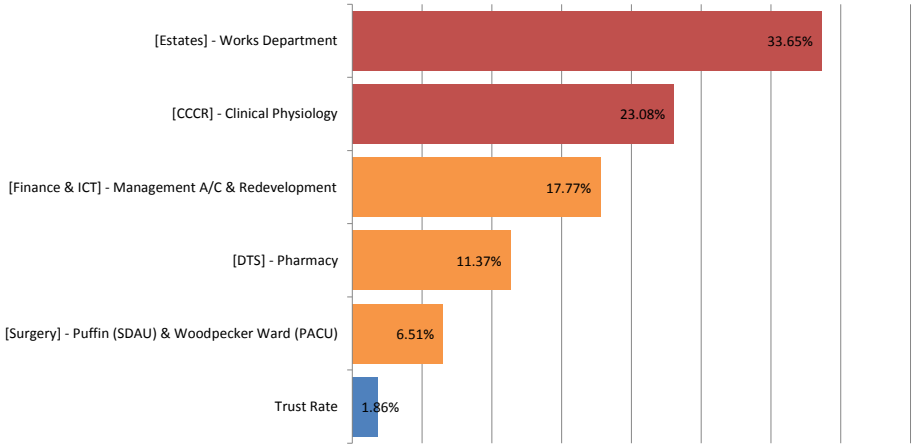
Exception Reporting Vacancy Rate



Divisional Agency as % of paybill



Exception Reporting Agency as % of Paybill



Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
22nd July 2015

Financial Performance 3 months to 30th June 2015 **Submitted by:** **Claire Newton**	**Paper No: Attachment S**

Aims
To brief the Board on the financial performance for the three months to 30th June 2015

Summary

The attached report shows the financial performance for the month and for the year to date position – three months.

The overall position is ahead of plan at both the EBITDA (£1.6M ahead of plan) and at the net surplus/deficit position (£1.6m ahead of plan).

Total operating revenue is behind plan by £2m though £1.7m relates to pass-through.

Pay is in line with plan and non-pay is lower than plan.

There are continuing discussions with commissioners in respect of finalising the 15.16 contract value.

Cash is ahead of plan for the year to date position by £4.5m

PE is around £9.5m at a risk adjusted level and below the target value of £12m.

Action required from the meeting
To note the report

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

Financial implications
Failure to achieve contractual performance measures may result in financial penalties.

Who needs to be told about any decision? N/A

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

Who is accountable for the report
Chief Finance Officer

Great Ormond Street Hospital for Children NHS FT - Summary Financial Performance Report. 3 Months to 30 June 2015

* The Trust is reporting a net deficit of £(3.5)M , £1.6M better than Plan. This is a £0.5M improvement in the month.
* EBITDA of £2.5m (2.7%) is above the planned EBITDA of £(0.9)m by £1.6m. This is a £0.5m improvement from period 2.
* NHS clinical income excluding pass through is £0.4m lower than plan. Pay is in line with plan and non-pay is 3.5m lower than plan of which 1.6M is pass through.
* A proportion of the pay and non-pay position will reflect funding for activity growth and these costs will increase during the year .
* Private patient income was £0.5m above plan and a £0.3m improvement in variance from yts at period 2.

Cash

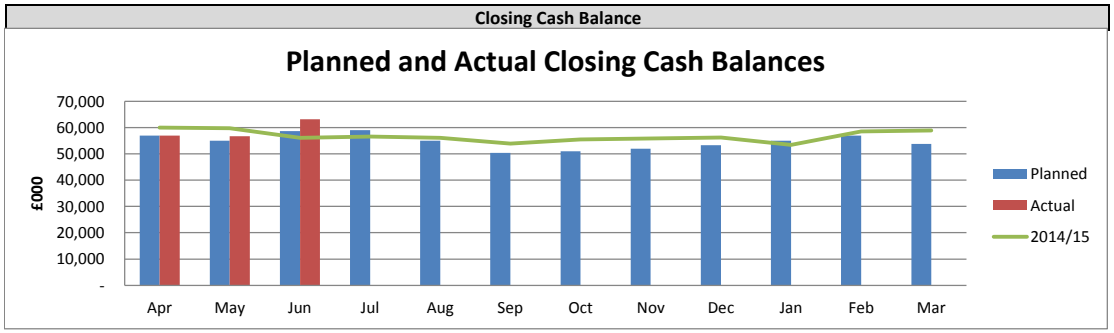
Cash levels are above plan which is £58.6m at £63.1 - £4.5m favourable

Efficiencies

Over £14m of PE schemes exist. These vary in terms of their development and progress and the risk asjusted value is around £9m. A further validation exercise underway which may result in the values decreasing for red/amber

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 2014/15 (£m)	Variance CY vs PY (£m)	Current Year Variance
NHS & Other Clinical Revenue	21.2	21.4	0.2	59.5	59.1	(0.4)	55.7	3.4	A
Pass Through	4.6	4.1	(0.5)	14.1	12.3	(1.7)	10.8	1.6	R
Private Patient Revenue	3.8	4.0	0.2	10.2	10.7	0.5	11.7	(1.0)	G
Non-Clinical Revenue	3.5	3.7	0.2	10.6	10.2	(0.4)	12.5	(2.3)	A
Total Operating Revenue	**33.1**	**33.3**	**0.1**	**94.3**	**92.3**	**(2.0)**	**90.7**	**1.7**	
Permanent Staff	(18.0)	(16.5)	1.5	(53.3)	(49.8)	3.4	(47.1)	(2.7)	G
Agency Staff	(0.0)	(0.4)	(0.3)	(0.0)	(0.9)	(0.8)	(1.1)	0.2	R
Bank Staff	(0.1)	(1.1)	(1.0)	(0.4)	(3.0)	(2.6)	(2.9)	(0.1)	R
Total Employee Expenses	**(18.2)**	**(18.0)**	**0.2**	**(53.7)**	**(53.7)**	**0.0**	**(51.1)**	**(2.6)**	
Drugs and Blood	(0.8)	(1.1)	(0.3)	(7.3)	(6.3)	1.0	(3.9)	(2.4)	G
Other Clinical Supplies	(3.2)	(3.5)	(0.3)	(9.8)	(9.6)	0.3	(7.9)	(1.7)	G
Other Expenses	(4.4)	(4.4)	0.0	(13.2)	(12.2)	1.0	(10.9)	(1.3)	G
Pass Through	(4.8)	(4.0)	0.8	(9.4)	(8.2)	1.2	(10.8)	2.6	G
Total Non-Pay Expenses	**(13.2)**	**(13.0)**	**0.2**	**(39.7)**	**(36.2)**	**3.5**	**(33.4)**	**(2.8)**	
EBITDA (exc Capital Donations)	**1.8**	**2.2**	**0.5**	**0.9**	**2.5**	**1.6**	**6.2**	**(3.7)**	G
Depreciation, Interest and PDC	(2.0)	(2.0)	0.0	(6.0)	(6.0)	0.1	(7.4)	1.5	
Net (Deficit)/Surplus (exc Cap. Don	(0.3)	0.3	0.5	(5.2)	(3.5)	1.6	(1.3)	(2.2)	G
EBITDA %	**5.3%**	**6.8%**		**0.9%**	**2.7%**				
Estimated impairments									
Capital Donations	2.3	2.4	0.1	5.7	4.2	(1.5)			

Closing Cash Balance

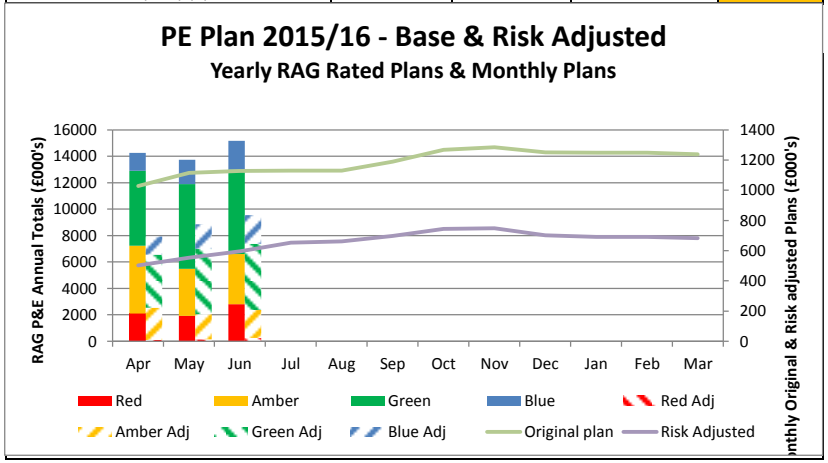


Statement of Financial Position	31 March 2015 Actual £m	30 Jun 2015 Planned £m	30 Jun 2015 Actual £m
Non-Current Assets	372.9	379.3	375.3
Current Assets (exc Cash)	56.3	57.8	56.3
Cash & Cash Equivalents	58.9	58.6	63.1
Current Liabilities	(47.9)	(55.1)	(53.8)
Non-Current Liabilities	(6.7)	(6.6)	(6.6)
Total Assets Employed	**433.5**	**434.0**	**434.3**

Capital Expenditure	Annual Plan £m	30 Jun 2015 Planned £m	30 Jun 2015 Actual £m
Redevelopment - Donated	37.6	4.5	3.2
Medical Equipment - Donated	2.9	0.7	1.0
Estates - Donated	0.0	0.0	0.0
ICT - Donated	2.0	0.5	0.0
Total Donated	42.5	5.7	4.2
Redevelop& equip - Trust Funded	9.8	2.6	0.8
Estates & Facilities - Trust Funded	5.0	0.9	0.5
ICT - Trust Funded	5.0	2.6	1.3
Total Trust Funded	19.8	6.1	2.6
Total Expenditure	**62.3**	**11.8**	**6.8**

Continuity of Service Risk Rating	2015/16 Plan	31-May-15	30-Jun-15	RAG Rating
Liquidity	4	4	4	G
Capital Servicing Capacity	4	4	4	G

	31-Mar-15	31-May-15	30-Jun-15	RAG Rating
NHS Debtor Days (YTD)	25.53	19.40	15.90	G
IPP Debtor Days	130.73	127.10	137.60	A
IPP Overdue Debt (£m)	6.36	6.78	7.06	A
Creditor Days	33.00	27.40	34.50	G
BPPC - Non-NHS (YTD) (number)	88.3%	85.0%	85.2%	A
BPPC - Non-NHS (YTD) (£)	91.8%	91.4%	91.5%	A

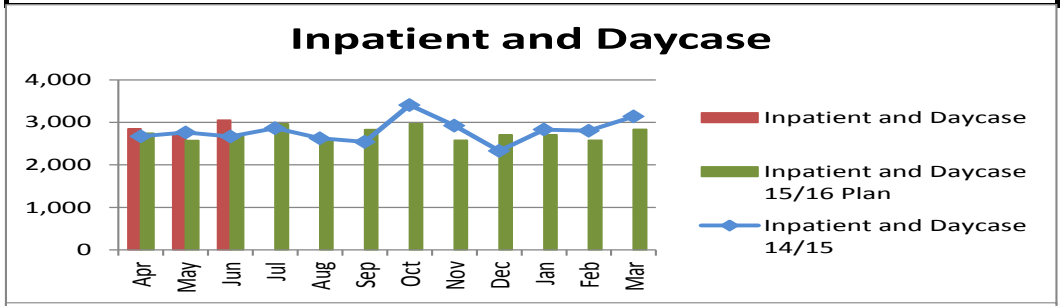


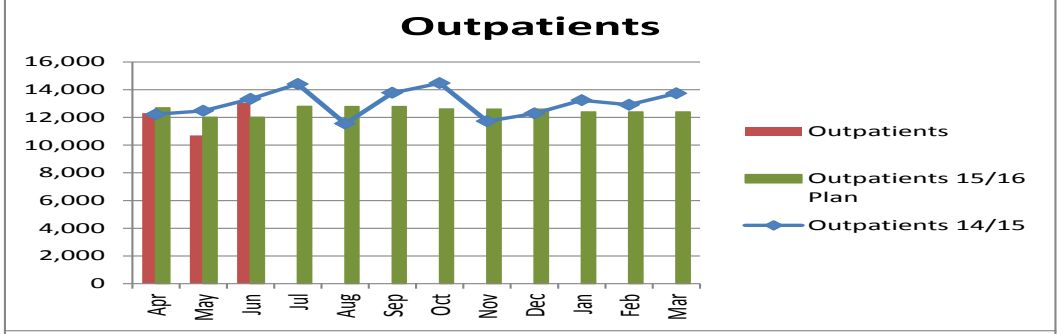
ACTIVITY AND INCOME

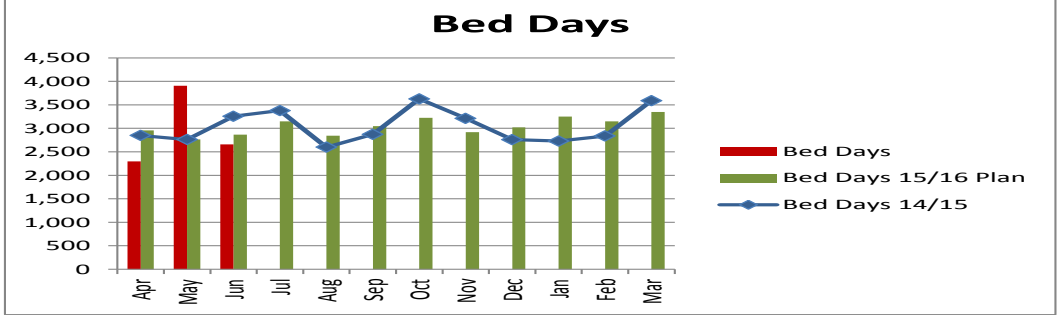
	Income from NHS & Other Clinical Activity £M year to date				
	YTD Actual (£m)	Variance to plan (£m)	Variance to plan (%)	Variance to Prior Year (£m)	Variance to Prior Year (%)
Daycases	**6.9**	0.8	11.2%	1.3	23.6%
Elective Inpatients	**12.8**	(0.5)	-4.1%	(0.3)	-2.6%
Non-Elective Inpatients	**3.4**	0.0	0.8%	0.1	2.1%
Bed days	**11.3**	0.2	1.5%	0.2	1.6%
Outpatients	**9.1**	(0.5)	-5.4%	(0.4)	-3.9%
Other eg. Highly Specialised	**15.6**	0.4	2.8%	(1.8)	-10.5%
Total	**59.1**	(0.4)	-0.6%	(1.0)	-1.6%

	Activity				
	YTD Actual	Variance to plan	Variance to plan (%)	Variance to Prior	Variance to Prior Year (%)
Daycases	**5,258**	452	8.6%	580	12.4%
Elective Inpatients	**2,959**	(166)	-5.6%	(35)	-1.2%
Non-Elective Inpatients	**419**	(27)	-6.5%	(10)	-2.3%
Bed days	**8,859**	(135)	-1.5%	(9)	-0.1%
Outpatients	**36,065**	(2,666)	-7.4%	(1,967)	-5.2%

PATIENT ACTIVITY

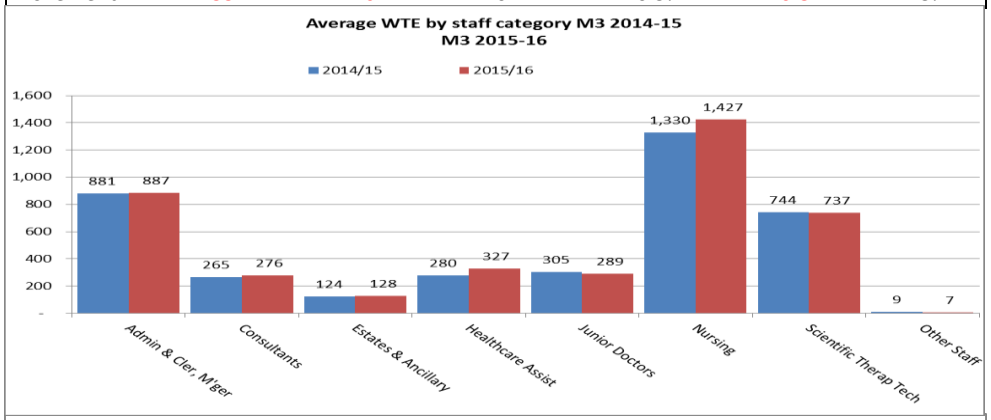


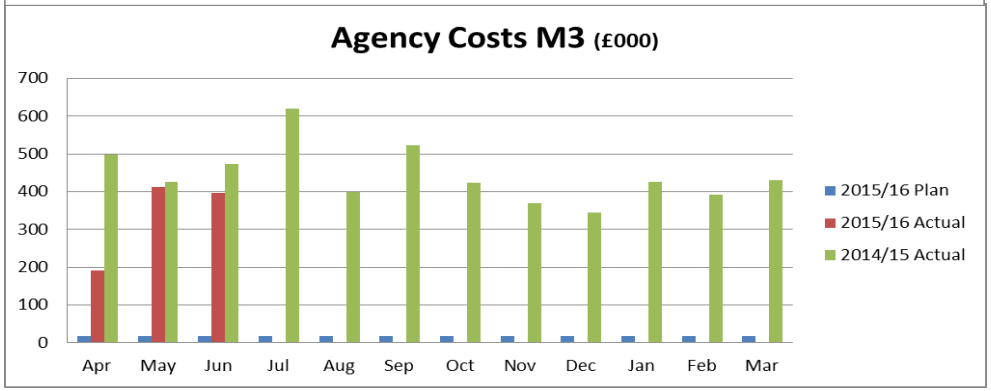




STAFF

Year	WTE M3	YTD Total Pay (£m)	YTD Agency (£m)	Agency as % of Total Pay	YTD Bank (£m)	Bank as % of Total Pay
2015/16	4,073	53.7	0.9	1.6%	3.0	5.5%
2014/15	3,938	51.1	1.1	2.2%	2.2	4.3%
Movement	-135	-2.6	0.2	0.5%	-0.8	-1.3%





Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 22nd July 2015	
Research and Innovation Report: July 2015 **Submitted by**: Professor David Goldblatt, Director of Research and Innovation and Emma Pendleton, Deputy Director of Research and Innovation	**Paper No: Attachment 9**
Aims / summary This report provides Trust Board with an oversight of research activity and performance at GOSH.	
Action required from the meeting Trust Board is asked to note our current research activity data.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Research is one of the Trust's strategic objectives: With partners maintain and develop our position as the UK's top children's research and innovation organisation.	
Financial implications Loss of research income is on the Trust's Risk Register, the Trust needs to ensure there is a strategy and systems in place to retain and increase research income.	
Who needs to be told about any decision? Professor David Goldblatt, Director of Clinical Research and Development	
Who is responsible for implementing the proposals / project and anticipated timescales? Emma Pendleton, Deputy Director of Research and Innovation	
Who is accountable for the implementation of the proposal / project? Professor David Goldblatt, Director of Clinical Research and Development	

Great Ormond Street Hospital for Children NHS Foundation Trust

Research and Innovation July 2015
This report is to provide Trust Board with an oversight of research activity and performance at GOSH.

Research Inputs

1. Research Income: The table below provides details of Trust research income at month 12 14/15 along with income at month 2 15/16, with income at month 2 14/15 provided for direct comparison.

Table 1 Direct Funding to GOSH

Funding Type	Funding Source	Income as at Month 12 14-15 (£000)	Income as at Month 2 14-15 (£000)	Income as at Month 2 15-16 (£000)
A. Centre Grants and Infrastructure, Research Delivery Support				
Biomedical Research Centre	NIHR	7,331	1,355	1,210
Research Capability Funding	NIHR	2,250	375	311
Local Comprehensive Research Network	NIHR	1,833	376	304
B. Programme and Project Grants				
NIHR Programme, Project Grants	NIHR	1,313	232	0
Charity Research Project Grants	Variable*	1,743	331	176
European Union Research Project Grants	EU	30	5	26
Commercial Research Contracts	Variable	1,346	135	172
Other	Variable	633	150	259
Total income		**16,479**	**2,961**	**2,458**
Total budget		**16,655**	**2,747**	**2,688**

1. NHS accounting requires us to only recognise grant income when we have matching expenditure. Although there has been £65k expenditure on NIHR grants an accounting correction has set this to zero. Month 2 figures for programme and project grants do not include accruals.
2. Charity funding is mostly GOSH Children's Charity

2. Directly funded research staff: At month 2 15/16 there are 145 WTE staff directly funded through the research income sources detailed in Table 1 above. The table below provides details at month 2 15/16 with month 2 14/15 shown for comparison.

Table 2: Directly funded research staff

Staff Group	Month 12 14-15	Month 2 14-15	Month 2 15-16
Administration, Data Managers, Trial Coordinators	48	46	46
Consultants	5	11	5
Directors & Senior Managers	7	5	8
Junior Doctors	1	1	0
Nursing Staff	36	33	33
Nursing Staff Bank	0	2	1
Scientific, Therapeutic, Technical	38	40	52
TOTAL	**135**	**138**	**145**

Note**:** This does not include research active clinicians whose substantive employment contract is with UCL, nor the research components of a clinician's job plan where this is not directly funded through the sources in Table 1.

Great Ormond Street Hospital for Children NHS Foundation Trust

Research outputs

3. Research Projects: The table below details the number of projects directly funded by the Programme and Project Grant income detailed above in Table 1B only. Activity is defined by spend on a grant account. Final year figures are provided for month 12 14/15 along with activity at month 2 for 15/16, with activity at month 2 14/15 provided for comparison.

Table 3: Directly funded research projects

Funding Stream (Direct Income to GOSH)	Number Active YTD M12 14-15	Number Active YTD M2 14-15	Number Active YTD M2 15-16
NIHR Programme and Project Grants	14	7	5
Charity Research Project Grants	55	30	51
European Union Research Project Grants	7	2	5
Commercial Research Contracts	103	21	75
Total	**179**	**60**	**136**

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

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

Table 4: Total number of research projects by Clinical Division

The table below details the number of research projects undertaken during 14/15, along with the activity at month 2 15/16, with month 2 14/15 for comparison. These totals include directly funded projects, indirectly funded and own account. Projects are considered active as soon as they receive R&D Approval, these totals include projects that are currently open to recruitment and also those that are in set-up or closed to recruitment but in follow-up.

Division	Total number of projects YTD M12 14/15	Total number of projects YTD M2 14/15	Total number of projects YTD M2 15/16	UKCRN Portfolio projects YTD M2 15/16
Critical Care and Cardio-Respiratory	124	91	95	26
Infection, Cancer and Immunity – LM	246	184	207	75
Medicine, Diagnostic and Therapeutic Services	257	203	201	71
Neurosciences	142	104	128	48
Surgery	48	31	40	11
Other GOSH	15	12	17	2
Total	**832**	**625**	**688**	**233**

4. Research recruitment: Projects in receipt of external funding awarded via open competition and peer review can be adopted to the UK Clinical Research Network (UKCRN) Portfolio and GOSH receives additional income for each patient recruited to these projects.

We are currently working on encouraging more researchers to apply for Portfolio adoption, and updating our systems and processes to record detailed non-Portfolio recruitment.

Please note that although recruitment is listed by Division, recruitment across Divisions is not directly comparable as this will be dependent on the patient base.

Table 5: Patient recruitment to UKCRN Portfolio studies

Division	Patient recruitment YTD M12 14/15	Patient recruitment YTD M2 14/15	Patient recruitment YTD M2 15/16
Critical Care and Cardio-Respiratory	796	151	98
Infection, Cancer and Immunity – LM	552	75	54
Medicine, Diagnostic and Therapeutic Services	1356	256	159
Neurosciences	384	62	124
Surgery	450	41	93
Other GOSH	0	0	0
Total	**3538**	**585**	**528**

5. NIHR performance metrics in initiating and delivering clinical research: All NHS organisations in receipt of NIHR funding are required to report performance against the following two metrics on a quarterly basis:

a) The time it takes high-impact clinical projects to pass from a valid application to recruitment of the first participant (project initiation) – target 70 days; and
b) The number of commercially-sponsored high-impact clinical projects that recruit the agreed number of participants within the agreed timeframe (project delivery).

Table 6 Performance in initiation:

	Trials submitted	Adjusted total	Adj. trials meeting benchmark	% adj. total meeting benchmark	% all orgs' adj. total meeting benchmark	GOSH rank	Mean days
Q3 13/14	33	23	14	61%	52%	20 / 52	91 days
Q4 13/14	33	18	15	83%	57%	13 / 60	67 days
Q1 14/15	37	18	14	78%	65%	21 / 60	47 days
Q2 14/15	36	18	13	72%	66%	24 / 61	53 days
Q3 14/15	47	20	16	80%	80%	31 / 61	40 days

Great Ormond Street Hospital for Children NHS Foundation Trust

Table 7 Performance in delivery:

	Trials submitted	Closed trials	Closed trials meeting target	% closed trials meeting target	% all orgs' closed trials meeting target	GOSH rank
Q3 13/14	58	31	17	64%	43%	12 / 53
Q4 13/14	63	27	18	67%	46%	5 / 61
Q1 14/15	66	32	23	72%	47%	5 / 58
Q2 14/15	68	31	22	71%	47%	4 / 59
Q3 14/15	76	36	24	67%	51%	8 / 59

Research Outcomes

6. Publications: Publication numbers for the last five financial years and the current year to date are shown below. Only publications credited to GOSH and/or UCL Institute of Child Health are identified, and these can then be assigned to Clinical Divisions based on where the authors are employed. This assignment is currently being carried out for completion by the end of this financial year. The numbers include all publication types (articles, reviews, proceedings papers, letters, editorials, book chapters etc.).

Table 8: Number of publications

	09/10	10/11	11/12	12/13	13/14	14/15
GOSH-only and GOSH/ICH	736	876	784	1017	990	885
ICH-only	567	612	610	719	585	467
Total	**1303**	**1488**	**1394**	**1736**	**1575**	**1352**

Table 8b: Number of publications by Clinical Division

Division	Publications YTD M12 13/14	Publications YTD M12 14/15
Critical Care and Cardio-Respiratory	131	98
Infection, Cancer and Immunity – LM	217	238
Medicine, Diagnostic and Therapeutic Services	266	244
Neurosciences	129	95
Surgery	79	72
Other GOSH	300	251

Note: Because papers are often written by authors in different Divisions, the total is less than the sum of all the Divisions. "Other GOSH" papers tend to be written by authors who have given their address as GOSH but we cannot identify their Division (often honorary staff).

Since it can take up to three months for all journals to be fully indexed, we do not yet have data for this financial year. As such, M12 14/15 has been compared with 12 months previously.

Great Ormond Street Hospital for Children NHS Foundation Trust

CASE STUDIES

Case Study 1: Professor John Anderson

Professor John Anderson is Professor of Experimental Paediatric Oncology and a Consultant Oncologist at GOSH. He was appointed as a Clinical Lecturer in paediatric oncology at UCL Institute of Child Health (ICH) in 1998 after completing his PhD, which he had undertaken as a clinical research fellow at the Institute of Cancer Research (1995-1998). His initial 4 year appointment (1998-2002) at ICH was funded by a donation to ICH from the Great Ormond Street Hospital Special Trustees. In 2001 he was awarded a Cancer Research UK (then the Cancer Research Campaign) Clinician Scientist Fellowship (2002-2007) and in 2007 he was awarded a HEFCE Senior Clinical Fellowship. Professor Anderson's research is currently supported by GOSH CC, the Wellcome Trust and Children with Cancer UK.

Survival rates for certain types of cancers have vastly improved over the last 20 years, yet, for some groups of children, such as those with rare childhood cancers, not all treatments lead to cures, while for others, lengthy treatments result in long-term and unpleasant side effects. Radical approaches are urgently needed to develop new and gentler cancer treatments.

Professor Anderson's research underwent a major shift in direction from basic cancer biology to tumour immunology and immunotherapy after joining ICH in 1998. Through his research he seeks to investigate novel immunotherapy approaches for childhood cancers and therapeutic methods for immune modulation. In the last 7 years he has switched the disease specific focus of his clinical and scientific work towards the tumours neuroblastoma and high grade glioma; two childhood cancers with poor prognosis and encouraging data on potential for response to immunotherapy.

The key focus of Professor Anderson's research is to harness the power of the body's immune system to attack the cancer. In cancer, the balance between the growth of the tumour and the immune system's ability to reject the cancer lies in favour of the tumour's growth. Tipping this balance in favour of the immune system is how immunotherapy works. Immunotherapy has the potential to achieve complete, long-lasting remissions and cancer cures, with few side effects. Professor Anderson and his group are focusing on using immune cells – specifically T cells – to recognise and kill cancer cells. In one approach, they are using novel genetic engineering techniques to redirect T cells to recognise tumour cells. This work is particularly focused on neuroblastoma, one of the most aggressive childhood cancers. Neuroblastoma cells express a protein called GD2 on their surface.

Through Professor Anderson's research he wants to engineer T cells taken from a patient's body to specifically express proteins that can recognise GD2 and then kill neuroblastoma cells. As GD2 is not expressed on any other cells, this type of treatment could attack the cancer without damaging healthy cells, resulting in fewer side effects for children. The team are launching an early phase clinical trial, funded by Cancer Research UK, to test the safety and effectiveness of this new treatment for neuroblastoma.

In another approach he is investigating a rarer subset of T cells called gamma delta T lymphocytes as alternate killer cells for childhood cancer immunotherapy.

The work of Professor Anderson and his team is pivotal in trying to create more effective treatments for childhood cancers.

Neuroblastoma killing properties of V-delta 2 and V-delta2 negative gamma delta T cells following expansion by artificial antigen presenting cells. Jonathan P.H. Fisher, Mengyong Yan, Jennifer Heuijerjens, Lisa Carter, Ayda Abolhassani, Jennifer Frosch., Rebecca Wallace, Barry Flutter, Anna Capsomidis, Mike Hubank, Nigel Klein, Robin Callard, Kenth Gustafsson., and John Anderson. Clinical Cancer Research 2014 Nov 15;20(22):5720-32

Effective combination treatment of GD2-expressing neuroblastoma and Ewing's sarcoma using anti-GD2 ch14.18/CHO antibody with Vγ9Vδ2+ γδT cells. Jonathan P H Fisher, Barry Flutter, Florian Wesemann, Jennifer Frosch, Claudia Rossig, Kenth Gustafsson and John Anderson. Oncoimmunology 2015. In press

Great Ormond Street Hospital for Children NHS Foundation Trust

Case Study 2: Professor Khalid Hussain

After completing his medical degree at Glasgow University Professor Khalid Hussain, Professor of Paediatric Metabolic Endocrinology at the UCL Institute of Child Health (ICH) and Honorary Consultant in Paediatric Endocrinology at GOSH, initially trained as a GP. It was during his GP training that he developed a passion for paediatrics and neonatology. He trained at the Monash Medical Centre in Australia to become a fully qualified neonatologist. When he returned from Australia he secured a post at GOSH/ICH working under the mentorship of Professor Sir Albert Aynsley-Green. Professor Hussain's research is funded by the Wellcome Trust, the Medical Research Council, Diabetes UK and The Children's Hyperinsulinism Fund.

Professor Hussain wanted to understand the molecular mechanisms of childhood hypoglycaemia, especially congenital hyperinsulinism. The body's ability to control blood glucose levels through insulin production is absolutely vital for it to function normally. Too much glucose (hyperglycaemia) or too little glucose (hypoglycaemia) in the blood can be detrimental. Through research the GOSH congenital hyperinsulinism centre has been transformed into one of the major centres in the world looking after these complex patients. It is designated by NHS England as one of two centres of excellence in the UK for the diagnosis and treatment of the condition.

As a national referral centre children with the most severe forms of congenital hyperinsulinism are seen; children who do not respond to conventional medical therapy. The only available treatment involves eliminating the source of insulin, through either a complete or partial removal of the pancreas. Professor Hussain's research has completely transformed how doctors make this decision. Working with collaborators in Finland, Professor Hussain's research team have shown that an imaging technique, known as an 18F-DOPA-PET/CT scan, can show more precisely which parts of the pancreas are producing excessive insulin. If a small part of the pancreas is identified then only partial surgical removal is required, preventing hypoglycaemia. The 18F-DOPA-PET/CT scan allows surgeons to better identify the 'hotspots' in the pancreas. It has radically changed the way these children are now managed. This is a significant improvement on previous invasive, technically demanding and non-specific techniques used to make this diagnosis. This approach is now being refined as newer and better imaging technologies become available.

If the entire pancreas is affected then the whole organ needs to be surgically removed. This is not a cure, removing the entire pancreas causes the opposite effect. Children then go on to develop diabetes and require regular insulin injections. They also require enzyme replacement therapy to supply the enzymes responsible for digestion. Professor Hussain's research has also focused on developing a better treatment option for these children. In a landmark study led by Professor Hussain and published in 2014, researchers pinpointed the molecular pathway most likely to be responsible for the overproduction of insulin in children where the whole pancreas was affected. They then searched for an existing drug capable of blocking this pathway, and identified the drug sirolimus, which has been used to treat renal transplant patients. Four GOSH patients who had not responded to conventional medication and whose only remaining option was to have their whole pancreas removed, were offered sirolimus as an alternative treatment. All four patients responded well to sirolimus treatment and were discharged home safely without the need to remove their pancreas. One year on, all the patients are doing well, with stable blood glucose levels and no significant side effects. Identifying the key pathways involved in this disease has helped us to find the most suitable treatment for these patients. The aspiration is that in the long-term, the treatment will lessen the severity of the condition, enabling children to be moved onto more standard medication. This new discovery could change the way children with congenital hyperinsulinism are managed in the future.

Senniappan S, Alexandrescu S, Tatevian N, Shah P, Arya V, Flanagan S, Ellard S, Rampling D, Ashworth M, Brown RE, Hussain K. Sirolimus therapy in infants with severe hyperinsulinemic hypoglycemia. N Engl J Med. 2014 Mar 20;370(12):1131-7. doi: 10.1056/NEJMoa1310967.

Shah P, Arya VB, Flanagan SE, Morgan K, Ellard S, Senniappan S, Hussain K. Sirolimus therapy in a patient with severe hyperinsulinaemic hypoglycaemia due to a compound heterozygous ABCC8 gene mutation. J Pediatr Endocrinol Metab. 2015 May;28(5-6):695-9. doi: 10.1515/jpem-2014-0371.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
22nd May 2015

Patient Experience Report **Submitted by:** Juliette Greenwood, Chief Nurse	**Paper No: Attachment T**

Aims / summary

The purpose of this report is to provide assurance to the board in relation to the experience of children, young people and their families at GOSH. The report includes:

- Initial findings from the results of the first Care Quality Commission (CQC)National children's inpatient and day case survey 2014
- Quarter 1 Friends and Family test results
- Pals annual report and quarter 1 report.
- Other patient involvement and experience activity in 2015/16

CQC Children's Inpatient and day case survey 2014

On the 1st July 2015 the Care Quality Commission published the first national children's inpatient and day case survey results 2014. A full report will be provided to the board in September 2015 but summary results show:-

- Overall response rate of 30% (3% above the national average)
- GOSH were green (amongst the best hospitals) on 4 scores
- GOSH had 0 scores in the red (amongst the worst performing hospitals). Children and young people scored their overall experience as 8.5/10 whilst parents rated their experience as 8.7/10. This is comparable to other children's hospitals but lower than the best performing Trusts who achieved up to 9.4/10 for each.
- Neither GOSH or the other children's hospitals were in the top 5 performing Trusts on the survey.

Friends & Family Test (FFT)

- The inpatient FFT response rate decreased by 2.7% to 32.16% below the quarter target of 40%.
- The inpatient percentage increased by 2% to 99% the highest achievement for GOSH to date.
- The outpatient FFT response rate increased by 141%
- The outpatient percentage to recommend increased by 2% to 96%

Pals annual 2014/15 summary

- 4074 contacts and cases (37% increase from 2518 in 2013/14)
- 2536 Information enquiries (54% increase from 1167 in 2013/14)
- 1186 Promptly resolved cases (10% increase from 1059 in 2013/14)
- 311 Complex cases (23% increase from 238 in 2013/14)
- 41 Escalated cases to Complaints (31% decrease from 54 cases in 2013/14)
- 30 compliments for services across GOSH

Great Ormond Street Hospital for Children NHS Foundation Trust

Pals Quarter 1 summary • 822 Pals contacts to Pals were made this quarter • 7.5% decrease in Pals contacts compared to quarter 4 and a 6.2% increase compared to quarter 1 2014/15. • 16 cases escalated to complaints • 6 Compliments received regarding GOSH services • 3 reviews posted on NHS Choices
Action required from the meeting Trust board to note the positive experiences of patients and families and the areas that require improvement.
Contribution to the delivery of NHS Foundation Trust strategies and plans This contributes to the Trusts strategic objective to be the number 1 children's hospital in the world in relation to patient experience.
Financial implications Not applicable
Who needs to be told about any decision? Caroline Joyce Assistant Chief Nurse Quality & Patient Experience.
Who is responsible for implementing the proposals / project and anticipated timescales? Caroline Joyce Assistant Chief Nurse Quality & Patient Experience.
Who is accountable for the implementation of the proposal / project? Juliette Greenwood Chief Nurse

Great Ormond Street Hospital for Children NHS Foundation Trust

Great Ormond Street Hospital for Children NHS Foundation Trust

Patient Experience and Pals Report July 2015

The purpose of this report is to provide assurance to the board in relation to the experience of children, young people and their families at GOSH. The report includes:

- Initial findings from the results of the first Care Quality Commission (CQC)National children's inpatient and day case survey 2014
- Quarter 1 Friends and Family test results
- Pals annual report and quarter 1 report.
- Other patient involvement and experience activity.

1. Results of CQC Children's Inpatient and day case survey 2014

On the 1st July 2015 the Care Quality Commission published the first national children's inpatient and day case survey results 2014. 137 Trusts participated in the survey including specialist Children's hospital's and paediatric units within general hospitals. Surveys were conducted by a range of suppliers via post and online with GOSH using Picker Institute Europe. The survey sample was taken from August 2014 and questions were asked of

- Children and young people aged 8 – 15 years
- Parents and carers of patients aged 0 – 15 ears
- Some questions were specifically aimed at parents and carers of patients aged 0 – 7 years.

The CQC converted each Trusts survey responses into a scoring system on a scale of 0 – 10 with results standardised to enable fair comparisons to be made.

GOSH achieved an overall response rate of 30% (3% above the national average) with 68% from a white Caucasian background and 31% from a black and ethnic minority (BME) background (10% above the national average for BME responses). GOSH were green (amongst the best hospitals) on 4 scores and had 0 scores in the red (amongst the worst performing hospitals). Children and young people scored their overall experience as 8.5/10 whilst parents rated their experience as 8.7/10. This is comparable to other children's hospitals but lower than the best performing Trusts who achieved up to 9.4/10 for each. Neither GOSH or the other children's hospitals were in the top 5 performing Trusts on the survey.

A full report of the results with benchmarking against other Trusts will be provided to the September board.

2. Quarter 1 Friends and Family Test (FFT) summary

Staff across the Trust continue to be proactive in encouraging patients and families to complete the friends and family test and are increasingly making improvements in response to concerns raised. FFT is also being promoted on GOSH social media and on outpatient letters. Detailed information about FFT results is contained within appendix 1.

2.1 Inpatient FFT summaries

The Trust inpatient response rate as at June 2015 is 32.16% below the original end of year target of 40%, and 2.5% lower than the response rate at the end of the previous quarter. Since the last report the Trust has agreed

to stretch the target to 60% by the end of March 2016. The response rate is expected to increase with the introduction of FFT cards for children and young people. The Patient Experience (PE) team are working proactively with frontline staff and managers to address areas where the required response rate is not being achieved. The team are also reviewing the reports provided to the wards as feedback has identified that improving the way narrative comments are presented could help with engagement with FFT and the response rate.

The Percentage to recommend for inpatient areas has consistently over achieved our target of 95% with our highest score of 99% achieved in June 2015.

Analysis of the narrative comments made continues to demonstrate that staff behaviours, welcoming and care are the most positive areas experienced by parents/patients. Environment and infrastructure are the areas where most improvement is required, along with access, admission, transfer and discharge arrangements. Wards in the Southward building saw a reduction in the numbers of patients very likely to recommend as a result of recent problems with the plumbing and toilets. Estates and Facilities are currently undertaking a full review of the drainage systems within the Southward building to determine the current condition, that all flows are correct and if the system requires upgrading. Consideration is also being given to increasing the frequency of the periodic cleaning of the drainage system. A standard operating procedure has been put in place to improve the responsiveness of the estates and facilities team when events happen to reduce the impact on the wards. Changes are also being made to the cleaning contractor response times.

2.2 Outpatient and day-care FFT summary

The Trust rolled out FFT to 21 outpatient areas and 10 day case areas in Quarter 4 2014/15. Nationally, the guidance for outpatients is different to that of inpatients with the test only required to be offered. No guidance has been provided about the denominator from which to calculate a response rate and there is no agreed target for the response rate within outpatient areas.

Current response rates for outpatients have dramatically increased by 141% from 153 returns in April 2015 to 318 in June 2015 as a result of the Outpatient and Patient Experience (PE) team working well together and promoting the benefits of FFT to the wider team. The Outpatients team have thought of innovate to ways to encourage staff to engage with FFT which the PE team will share with other areas that have lower response rates.

The outpatient team are very responsive to any negative feedback received contacting families to apologise and actively taking action to improve things. As a result the outpatient percentage to recommend has increased by 2% from 94% to 96% in the quarter.

Examples of things that outpatients have done in response to FFT feedback include:-

- Purchase of ear and throat models to enable staff to better explain conditions and operations to patients and families in outpatients.
- Seating covers replaced and seating configuration changed within outpatients.
- Pagers are now provided within outpatients so that families can wait in the café or an alternative area until they are called.
- Refreshments are now provided in outpatients and water machines are available.
- Improved ventilation within the frontage building.
- Improved signage within outpatients.

Day care wards continue to obtain FFT feedback but due to the merger of Puffin and Woodpecker wards in June 2015 there are some short term technical difficulties with reporting this data which will be resolved for future reporting. Day case areas have not yet been included within the overall FFT response rate. This will occur when the new database goes live and the reporting function includes all day case areas.

3.0 Feedback from Pals

Pals traditionally have produced a separate annual report in addition to quarterly reports in future the annual report will be incorporated into the quarter 4 Pals report. This report includes a summary of the annual report 2014/15 (appendix 2) and the Pals quarter 1 report 2015/16 (appendix 3)

3.1 Pals annual report

Pals activity in 2014/15 increased by 38% from 2518 contacts in 2013/14 to 4074 contacts in 2014/15 with a 46% increase in the volume of information requests (1167 to 2536) and a 23% increase in complex cases (238 – 311). However, there was a 31%decrease in the number of Pals referrals that were escalated to formal complaints in year reduced from 54 to 41.

The surgical division saw a significant increase in Pals referrals in 2014/15 and were the Division with the highest number of referrals each quarter. This relates to administrative and clerical issues such as arranging outpatient appointments and with arranging admissions. In this year the Surgery team have had difficulty with administrative staff recruitment/retention but these are now resolved and there are good systems of communication and escalation in place.

The Estates and Facilities Division saw a notable decrease in concerns raised about issues such as catering, transport and accommodation. A verbal update will be provided at the Board to illustrate this.

3.1.1 Themes and actions taken over the year

- Television/entertainment maintenance: Agreement was made to involve the floor managers in basic technical/maintenance support and Pals has not had a recurrence of this issue subsequently. The Estates and Facilities team also agreed to increase the attendance frequency of the professional TV maintenance support

- Lack of space for families own car seats (used on hospital transport) in redeveloped Main Reception: The Reception staff, Pals and volunteers supported family's inconvenienced by a lack of storage at the opening of the new reception. Security later provided space for storage until appropriate provision was made. There is now good communication between transport, the reception staff and volunteers to direct and support parents with car seats.

- Unanswered phones and unreturned messages: The Division where this was most significantly presenting a challenge to our families has implemented a communication strategy clarifying who can help with which calls. The result has been that administrative staff are now aware of who to direct calls to and the numbers of families calling but unable to get through or leaving messages but not getting a reply has significantly fallen. Pals have shared this with other teams with similar though smaller problems which have also been followed by a fall in contacts on this issue.

- Communication breakdown between staff groups impaction of communication to families: This remains a challenge in the more complex cases but with the promptly resolved cases have benefited by the above mentioned communication strategy. Further work needs to take place on this complex issue and Pals have worked with Quality Improvement on the Lead Clinician Project.

- Difficulties in discharge from GOSH to home/local services: The Clinical Audit Team conducted research into discharge and found that across the Trust there is good evidence of the Discharge Checklist. More complex discharge needs to involve a range of specialists and there is also evidence that this takes place but a more simplified way of recording, and evidencing the communication of the Discharge Plan needs to be developed.

Pals are working with Clinical Audit, the Assistant Chief Nurse Quality & Patient Experience to aid teams in this recording.

- Smoking in front of and outside the hospital: The Estates and Facilities team have worked quickly to install a smoke detection machine that once detecting smoke under the canopy outside the Main Reception sets off an automated recording of a child asking the smoker to stop. The Estates and Facilities team are also producing new signage for outside the hospital. There has been a fall in the numbers of Pals contacts from parents unhappy about smoking outside the Main Reception.

3.1.2 Compliments

2014/15 was the first year that Pals received compliments about GOSH care, services and staff behaviours with 30 compliments received this year. The Trust will be doing more work to collect and report compliments in 2015/16.

3.2 Pals quarter 1 report.

822 contacts were made to Pals this quarter, a 7.5% decrease when compared to quarter 4 of 2014/15 and 6.2 % increase compared to quarter 1 2014/15. 6 compliments were received and 16 cases were escalated to formal complaints. 3 reviews were posted on NHS Choices containing a mixture of positive and negative feedback identified in appendix 3. The Trust is currently showing a 4 star rating on NHS Choices.

3.2.1 Key Theme
The key theme from Pals referrals in quarter 1 was the number of families complaining about problems with fares reimbursement both in terms of entitlement, miscommunication and the process of obtaining fares reimbursement.

The Outpatient Service Manager and Main Reception Lead have instigated the following actions in response to the concerns raised:-

- Establishment of weekly meetings with Pals to discuss issues and concerns raised
- Meetings with ward sisters and other staff to educate them about the policy for fares reimbursement and the restrictions around entitlement, particularly focusing on those wards where the most problems arise.
- Reviewing the fares reimbursement forms to make the definitions and guidance clearer to patients, families and staff

Pals will monitor the number of concerns raised and report back on the impact of these actions in the Pals Quarter 2 report.

3.2.2 Thematic Summary by Division.

- **Surgery:** The 100 Pals cases for Q1 included a very slight fall by three cases. Of these ENT had 21% cases, Urology 17% and General Surgery 15%. Nearly half the contacts were about communication regarding admission dates and 12% were about cancellations.
- **MDTS:** There was a fall in case numbers for MDTS from 92 to 81. Gastroenterology remains the most frequent department needing help with families followed by Endocrine with 18% of cases. Half the cases were about communication, mostly the absence of communication. 13% were about cancelations. The RCPCH are currently undertaking a review of the gastroenterology service.
- **CCCR:** There was a fall in cases this quarter from 49 cases to 38 Pals cases. Cardiology itself excluding the other services made up 57% of contacts. 24% were about communication but 21% were about cancelations.

- **ICI:** There was a slight fall in cases from 54 to **5**0 cases, 60% were for Rheumatology, then BMT with 10% and Dermatology with 8%. Communication about appointments and responding to parent contacts were the top issues but over 12% were about cancelations.
- **Neurosciences:** There was an increase from 54 to 70 cases, a third were for Ophthalmology then Neurology then Outpatients. Communication was the top issue for Ophthalmology with contacts about appointment times but overall 8% of Pals contacts for Neurosciences are about cancellations.
- **Facilities**: There was a reduction in cases from 33 to 17 cases for Estates and Facilities. Parent Accommodation and Catering were the two main areas. Accommodation about capacity and the difficult to arrange somewhere for parents to stay. Catering issues included contacts unhappy about our serving "red meat" and the use of Halal products. Both were responded to with the aid of the Communications Team.
- **IPP:** There were only 5 cases in Q1 though Pals are frequently contacted about how to be referred to GOSH IPP. The team have requested that the GOSH website is updated to make this information easier to find. Other contacts about IPP have included queries about payment, services available on the ward and accommodation for private patients. All were resolved promptly and to the family's satisfaction

3.2.3 Update on key theme for quarter 4 2014/15

Concerns raised about parent's smoking outside the hospital and underneath the main reception canopy were the key theme of the last quarter. The number of Pals contacts in relation to this issue has fallen significantly since the introduction of the smoke detector and the activation of the automatic recording of a child asking people to not smoke. Estates and Facilities have put in a number of new signs adjacent to the main reception outside the Paul O'Gorman Building and Powis Place; Estates and Facilities are going to arrange for more signs to be put on the hospital railings. Together these measures ought to further improve communication on this issue.

4.0 Other Patient Involvement and experience activity

4.1 Focus Groups

In April 2015 Ipsos Mori facilitated focus groups with children and young people and their parents in relation to the experiences of younger children in order to develop a set of Patient Reported Experience Measures (PREMS) for the Trust. The outcomes of this work are awaited but will be reported back to the Patient and Public Involvement and Experience Committee.

In May 2015 Ipsos Mori facilitated focus groups, commissioned by the Family Equality and Diversity Group, to understand better the experience of parents of children from the Muslim faith and parents of children with physical disabilities / mobility issues. A number of families identified that they would like to participate but practical constraints made this impossible therefore additional telephone interviews were conducted and one of our survey volunteers spent time in an outpatient clinic with a number of physically disabled children speaking to them about their experiences in order to enhance the feedback obtained. Both groups were very positive about their overall experiences of the care and treatment at GOSH but identified areas for improvement. The report will be taken to the Family Equality and Diversity group and an action plan developed to address areas of concern.

4.2 IHI Experience Day: 21st April 2015

In April 2015 the Quality Improvement (QI) Team hosted an experience day for the Institute of Health Improvement. In partnership with quality improvement leads at GOSH, the Patient Experience team organised the "Person Centred Care" element of the programme for the day. This comprised of three discrete sessions looking at how we offer person centred care at GOSH, approaching it from a duty of care perspective and how we work in partnership to deliver a safe, high quality, positive experience. The day was an enormous success and generated some fantastic feedback including:-

'' *Hearing from patients and families; their experiences and feedback makes for higher impact and strengthens the message of needing to involve them more in discussions moving forward- An inspirational day. Thank you"* Critical to the success was the involvement of our Young People's Forum members, parent representatives, volunteers and key partners from within and outside of GOSH. As a result of this day a European attendant has requested a GOSH staff member and young person present at a conference in Belgium in February 2016 'Patients as partners in healthcare'.

4.3 PLACE Inspection

In May 2015 Parents and Young People led the annual PLACE Inspections of the care environment. Scoring for each category for 2015 will not be published until the scores are collated for all Trusts in August 2015 and it is unclear when the results will be published. However, early indications from facilitator feedback and assessors is that there was good levels of confidence in care and the environment in the ward areas and assessors who have undertaken PLACE before felt that there has been improvement in the cleanliness of wards and the environment, as well as food.

4.4 Parent and Youth Involvement

The Trust continues to have very active involvement and engagement from dedicated and committed parents and young people. In addition the recent Member's Council elections have generated interest from new parents and young people wanting to participate in a range of activities in the Trust. Over the last 6 months parent representatives have been recruited to the new Quality Improvement Committee, and the Always Values steering and operational delivery groups. Our Parent representative on the Always Values operational group is very much a co-partner in the design and development of our programmes of work to implement and embed the Always Values with Young people and other parents consulted via virtual forums.

The Young People's Forum (YPF) continues to grow and develop with over 25 Young Members involved in the forum. Young Members participated in the recent Race for GOSH event to encourage young people to join the Foundation Trust membership and YPF. The YPF are currently working with the redevelopment team on the design brief for the next phase of the redevelopment and are planning a whole day in August with the architects, engineers and GOSH team where children and young people will be feeding in their ideas about what the future hospital and facilities should look like. Key actions the forum are currently working on are their plans for Children's Commissioner Take Over day for later this year; their election process for a new Chair and Vice Chair for the forum and how they raise their profile in the Trust.

Young people from the GOSH , Royal College of Paediatrics and Child Health (RCPCH) and Family Reform Boards Young People's Forum's participated in a panel discussion at the GOSH Clinical Ethics Symposium about their views on children's Rights and how to balance knowledge and consent in decision taking about care and treatment . A panel of parents including those from GOSH also participated reflecting on the balance of parental rights and responsibilities around decision taking for their child. As a consequence BBC Radio 4 approached the Trust to request a young person to speak on their programme 'Inside the Ethics Committee'. This will take place on the 30th July 2015.

Ends

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **22nd July 2015**	
Complaints Report Q1 2015/16 **Submitted by:** Donna Robinson, Patient Safety and Complaints Manager	**Paper No: Attachment U**
Aims / summary This report provides information regarding: • Complaints received by division • Complaint themes • Learning from Complaints • Re-open complaints • Parliamentary & Health Service Ombudsman	
Action required from the meeting This report is for information only, however if further information is required Board Members can contact Donna Robinson Donna.robinson@gosh.nhs.uk or 0207 813 8402	
Contribution to the delivery of NHS Foundation Trust strategies and plans The Trust has processes in places to ensure that patients and their families know how to access the complaints team and to ensure they are listened to and responded to effectively and efficiently.	
Financial implications	
Who needs to be told about any decision? Donna Robinson, Patient Safety and Complaints Manger	
Who is responsible for implementing the proposals / project and anticipated timescales? Donna Robinson, Patient Safety and Complaints Manger	
Who is accountable for the implementation of the proposal / project? Salina Parkyn, Head of Clinical Governance and Safety	

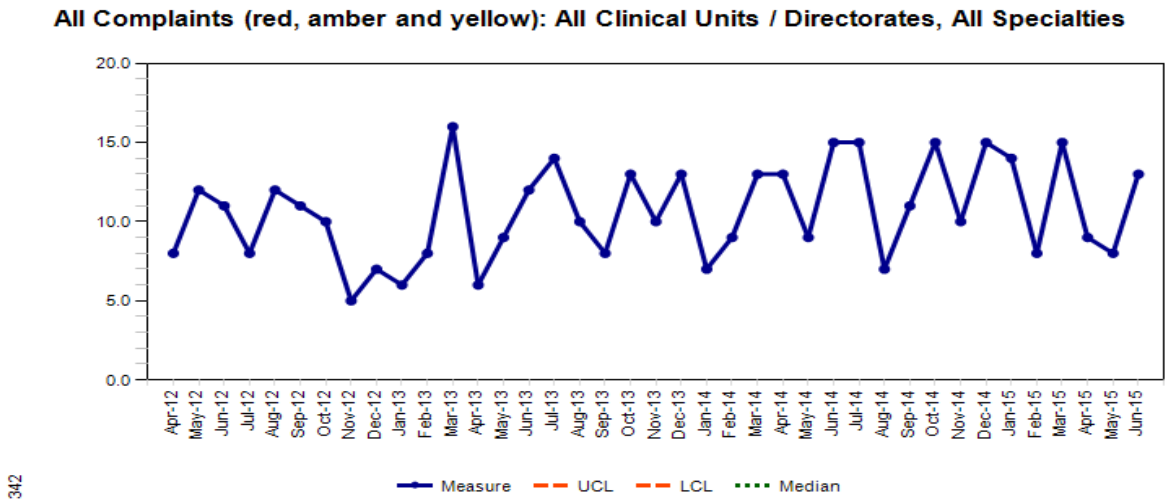
Complaints Report
Quarter 1, 2015/16

Summary of key points

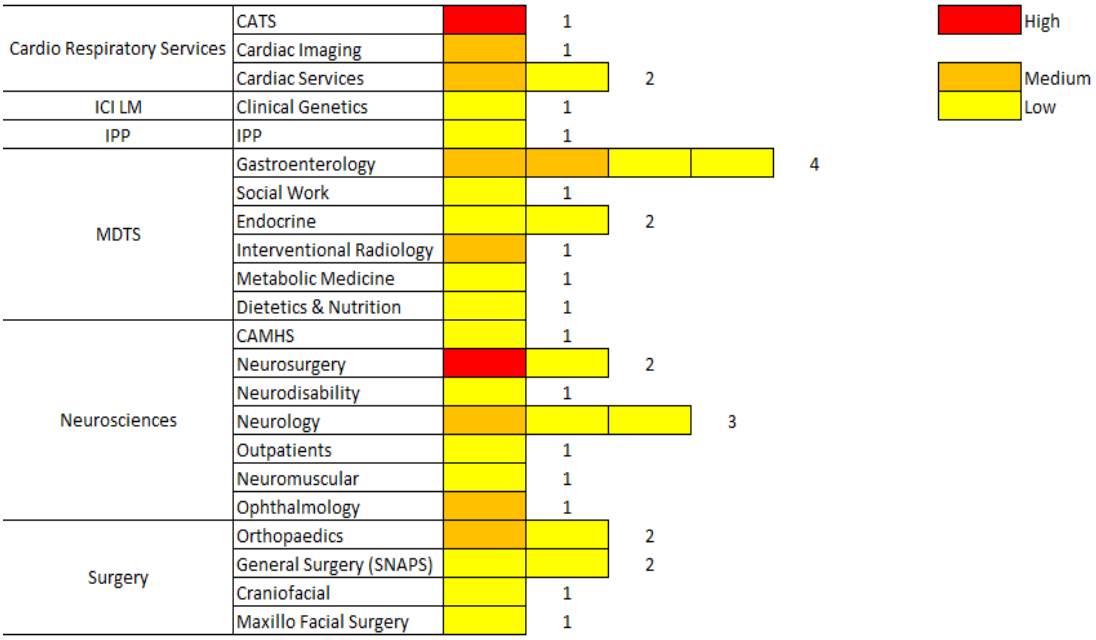
The key points identified from this report are:

- 32 new formal complaints were investigated this quarter. In addition 1 complaint was raised but then withdrawn by the family
- There were 2 new complaints graded as red in quarter 1 compared to 5 in the previous quarter
- Themes relating to communication and delayed diagnosis have featured this quarter

Trends for the number of formal complaints received by the Trust



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	10	42643.94	0.234	32.67%
Surgery	6	53742.25	0.112	15.55%
Neurosciences	10	34737.67	0.288	40.10%
ICI-LM	1	42084.86	0.024	3.31%
Cardio-respiratory Services	4	66632.07	0.060	8.36%
Totals:	31	239840.8	0.81	100%

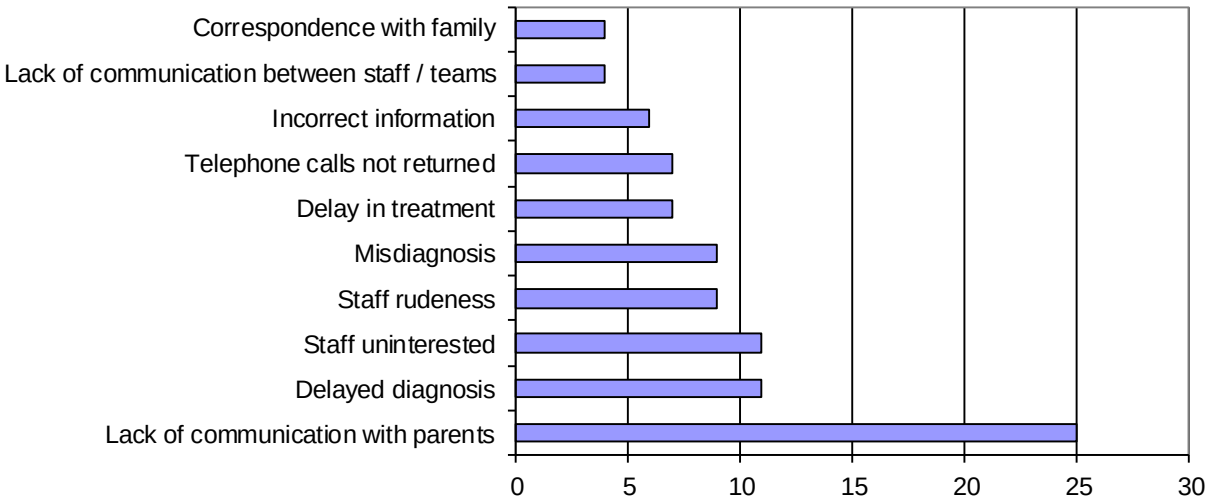
Adjusted Patient Activity is a measure which weights outpatients, inpatients and critical care bed days into a combined figure representative of overall healthcare resource activity.

Complaints closed within the agreed timescale

The Complaints Team received 44% of draft responses on time from the divisions, which has been progressively decreasing over the previous quarters. This impacted the final response timescales and 60% of all complaints closed this quarter were responded to on time.

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
- Delayed diagnosis

Learning from complaints

Example of learning from complaints:

- The surgery ward escalation procedure have been reviewed and changed. An addition to the procedure has been made to ensure that all children who have been deemed unfit for surgery and need to be discharged back to their local hospital for further care should be reviewed by a member of the medical team or general paediatricians within 2 hours before their departure.
  The new surgery ward escalation procedure will ensure that parents are able to raise any clinical concerns with a doctor and a review of the patient would take place before departure.
- The escalation policy regarding failed lumber puncture attempts will now be included in induction for future junior doctors.
- Prior to the complaint the Trust Infection Control team only sent letters out to inform parents of MRSA positive results after they are discharged and they copy in the GP if they are resident in the UK. Since receiving the complaint the Infection Control Team met to undertaken a review of the current process for communicating positive results. It was agreed during this review that the Infection Control Team will be implementing the same process we have for MRSA results by 30 September 2015.

Re-opened complaints from dissatisfied complainants

Two complaints were reopened this quarter as a result of the complainants being dissatisfied with the response to their initial complaint.

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 provided a draft response. A meeting has been arranged with the Chief Nurse, Medical Director and Head of Clinical Governance and Safety to meet with the investigator at the PHSO. The aim of the meeting is to discuss the inaccuracies within the report and to try and come to a final resolution.

- **Cases closed this quarter**

No cases closed this quarter

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
22nd July 2015

Safe Nurse Staffing Report May and June 2015 **Submitted by: Juliette Greenwood Chief Nurse**	**Paper No: Attachment V**

Aims / summary
This paper provides the required assurance that GOSH has safe nurse staffing levels across all in- patient ward areas and appropriate systems in place to manage the demand for nursing staff. In order to provide greater transparency the report also includes appropriate nurse quality measures and details of ward safe staffing reports. The paper includes a brief summary of nursing vacancies and nurse recruitment.

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

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

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

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

Financial implications
Already incorporated into 15/16 Division budgets

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

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

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

GOSH NURSE SAFE STAFFING REPORT

May 2015

1. Introduction

1.1 This report on GOSH Safe Nurse Staffing contains information from the month of May 2015. The report provides information on staff in post, safe staffing incidents, nurse vacancies and includes quality measures which are reported by exception.

2. Context and Background

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

2.2 Monthly nurse staffing updates are submitted to NHS England and the Trust Board with the following information:

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

3. GOSH Ward Nurse Staffing Information for Trust Board

3.1 Safe Staffing

3.1.1 The UNIFY Fill Rate Indicator for May is attached as Appendix 1. The spread sheet contains:

- Total monthly planned staff hours; the Heads of Nursing provide this figure based on the agreed average safe staffing level for each of their wards. These figures are fixed i.e. do not alter month on month. Bed closure information is used to adjust the planned staffing levels. A short term change in acuity and dependency requiring more or fewer staff is not reflected in planned hours but in the actual hours.
- Total monthly actual staff hours worked; this information is taken from the electronic rostering system (RosterPro), and includes supervisory roles, staff working additional hours, CNS shifts, extra staff booked to cope with changes in patient dependency and acuity from the Nurse Bank. This may both exceed or be below 100% to meet the changing occupancy and activity levels as well as the patient dependency and acuity.
- Average fill rate of planned shifts. It must be noted that the presentation of data in this way is open to misinterpretation as the non-registered pool is small in comparison to the registered pool, therefore one HCA vacancy or extra shifts worked will have a disproportionate effect on the % level.
- To comply with previous guidance, this and future returns will exclude Registered Nurses and Care Staff that have worked in a supernumerary capacity on wards.

3.1.2 Commentary:

- Heads of Nursing are asked to comment on percentage scores of less than 90% or greater than 110%, and declare any unsafe staffing situations that have occurred during the month in question including actions taken at the time to rectify and make the situation safe.
- The overall Trust fill rate % for May is:

RN Day	RN Night	HCA Day	HCA Night	Total Fill Rate
106.8%	92.2%	96.3%	76%	99.3%

ICI – No unsafe shifts reported in May

Both Robin Ward and Fox Ward report high levels of sickness and several vacant posts. Several patients have been unable to commence treatment due to their clinical condition, this has resulted in some shifts with lower dependency and acuity, and significantly reduced staffing requirements.

Penguin Ward, HCA requirement on night reduced due to patient numbers. The high percentage of HCAs on day relates to nurses awaiting registration (rostered on HCA grades).

ICI staff are moved across wards to meet the needs of the patient population.

Surgery No unsafe shifts reported in May

Peter Pan Ward was closed for a prolonged period for deep cleaning hence the low number of filled hours.

CCCR – No unsafe shifts reported in May

Badger report having increased numbers of Ward Intensive Care patients requiring 1:1 care. MIFFY have an extra nurse on days undergoing training. Two funded extra beds remain closed on Badger Ward whilst staff are recruited. HCA numbers have increased and are being trained for their new posts hence the high numbers on days.

Flamingo planned staffing for 17 beds, up to 3 additional beds (total 20) are opened when staff available through the Nurse Bank. Three ECMO cases requiring 2:1 care. High HCA numbers account for Nurses awaiting NMC registration

NICU have increased sickness requiring extra staff on shifts whilst inducting new staff to the unit.

MDTS - No unsafe shifts reported in May

Eagle Ward has 2 HCAs absent (20% of total), Rainforest Endocrine/Metabolic has a vacant HCA position registered nurse hours were increased to fill this gap. Rainforest Gastro has closed two beds due to long term sickness and vacancies.

Neurosciences - No unsafe shifts reported in May

Koala has reported high levels of acuity requiring extra staff, beds have been closed at times to accommodate the high patient acuity.

Higher number of HCA hours on day shifts is due to staff training, once competent, staff will move to nights to equalise numbers.

Mildred Creak Unit –increased registered hours for several children requiring 1:1 special, in addition to the overlap between the acting Ward Sister and the current postholder.

IPP - No unsafe shifts reported in May

Bumblebee - increase in HCAs on days to care for several vulnerable neonates requiring supervised care. A number of patients on overnight leave hence reduced night hours. Butterfly has seen a variance in activity resulting in fewer registered staff both day and night shift. Staff worked flexibly across the wards as needed.

3.1.4 The Clinical Site Practitioners (CSPs) report that no wards were declared unsafe during May, however there were 5 occasions in May where staff were moved between wards for part or a whole shift to maintain safe care. A further 8 occasions are noted where wards reported a shift being short of staff, however patient safety was not compromised.

3.2 General Staffing Information

3.2.1 Appendix 2 – Ward Nurse Staffing overview for May. The table provides information on staff in post, vacancies and staff in the recruitment pipeline and includes bed closure information.

3.2.2 18 out of 23 inpatient wards closed beds at various points during May. An average of 12 beds were closed each day, this has reduced from 17 in April. A number of these closures were for both urgent and routine maintenance work. Badger Ward continues to have 2 beds closed whilst staff are recruited and trained, Koala closed up to 4 beds due to increased patient acuity and dependency. Rainforest Gastro has a number of vacancies plus nurses on maternity leave, this has resulted in 2 closed beds whilst these vacancies are filled. Other areas had beds closed at times due to acute staff sickness and fluctuations in dependency and acuity.

3.2.3 For the inpatient wards, registered and non-registered vacancies for May are 109 (11%) and increase of 9 Whole Time Equivalents (WTE) from April, this breaks down to 83 (73 in April) registered nurse (RN) vacancies (10% of RN total). HCA vacancies number 26 (27 in April) non registered vacancies (16% of HCA total). Temporary nurses, mainly from GOSH Nurse Bank, employed on wards totalled 100 WTE, the May position was therefore 9.4 WTE vacant posts slightly down from 11.2 WTE reported in April 2015.

3.2.4 New starters progressing through pre-employment checks total 26 registered nurses and 6 HCAs. There has been delays in obtaining clearance for a number of HCAs from the April Assessment Centre (candidates delay in providing information). HCA recruitment to the ICUs is on currently on hold pending further work on the education pathway. We continue to recruit HCAs to the wards to achieve the target, however high numbers fail to attend the assessment centre or do not meet the requirements of the assessment centre, to compensate we have increased the numbers of candidates invited for the day.

3.2.5 The recent Newly Qualified advertisement received 195 applications, 179 were shortlisted, 139 attended. Candidates participated in 4 assessments, a good standard of numeracy skills is essential, 28 candidates did not meet this standard. 111 candidates have gone through for consideration by wards for employment.

3.2.6 Twelve nurses exiting the Trust General Rotation Programme have secured GOSH employment (100% retention).

3.2.7 The Trust will be represented at the Birmingham RCN jobs Fair in July.

3.2.8 As a Trust we continue to sustain recruitment against a backdrop of well publicised national nurse shortages.

3.2.9 The 6 monthly nurse establishment reviews were completed in June 2015, The Board of Directors will receive the report in July.

4 Key Challenges

- Recruitment of HCAs in the Critical Care areas.
- Recruitment of Band 6 Nurses.
- Retention of Band 5 and 6 Nurses.

5. Key Quality and Safety Measures and Information

5.1 Hard Truths Commitments Regarding the Publishing of Staffing Data (Care Quality Commission, March 2014) states ‘data alone cannot assure anyone that safe care is being delivered. However research demonstrates that staffing levels are linked to the safety of

care and that fewer staff increases the risks of patient safety incidents occurring.' In order to assure the Board of safe staffing on wards the following nursing quality and patient experience information has been collated to demonstrate that the wards were safe during May 2015.

5.2 The following quality measures provide a base line report for the Board. A number are Key Performance Indicators (KPIs) that are regularly monitored, any poor results are reviewed, challenged and investigated through the Nursing quarterly performance reviews led by the Chief Nurse with each Divisional Nursing team.

5.3 **Infection control**

C Difficile	1	Reported as HAI
MRSA Bacteraemias	0	
MSSA Bacteraemias	1	
E Coli Bacteraemia	1	
D & V and other outbreaks	2	1 cluster of parainfluenza – no beds close 4 chicken pox exposures
Carbopenamase resistance	1	Awaiting confirmation

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

5.4 **Pressure ulcers**

	Number	**Ward**
Grade 3	**1**	Discovered on admission to GOSH
Grade 2	**6**	2 Bumblebee, 3 PICU, 1 Flamingo - all considered avoidable

5.5 **Deteriorating patient**

5.5.1 For the month of May, 6 patient related emergency calls were received of which 2 were cardiac arrests (Flamingo and VCB theatres) there was 1 respiratory arrest (interventional radiology). In addition 8 patients had unplanned admissions to Intensive Care (2 Rainforest Endocrine/Metabolic, 1 Elephant, 2 Squirrel, and 3 from Fox Ward.

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

Koala Ward - patient underwent procedure that would require 1:1 nursing care in a cubicle, due to staffing levels the patient was nursed in the High Dependency Bay which may have affected the clinical information from telemetry monitoring.

Badger Ward – poor communication regarding a child with a tracheostomy and the level of care that would be required post anaesthetic, there were 3 tracheostomy patients requiring 1:1 care, this patient was the 4th, putting a strain on nursing resources. Additional staff were allocated to Badger.

5.7 **Pals concerns raised by families regarding nurse staffing - 0**

5.8 **Complaints re nurse safe staffing – 0**

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

- Response rate for May was 31.76%, the target has increased from 25% to 40% by the end of Quarter 2 and up to 60% by the end of Quarter 4.
- The FFT score remains at 82 for May.
- Families that were extremely likely to recommend their friends and family was 82.6% (246) with 14.1% (42) likely to recommend, similar to April results.
- 3 Families provided information praising staff on Elephant Ward, Peter Pan Ward and Squirrel Ward. 1 negative response was received relating to communication on King-fisher.

6. Conclusion

6.1 This paper seeks to provide the Board of Directors with the required overview and assurance that all wards were safely staffed against the Trust's determined safe staffing levels during May, and appropriate actions were taken when concerns were raised. All Trusts are required to ensure the validity of data by triangulating information from different sources prior to providing assurance reports to their Board of Directors, this has been key to compiling the report.

7. Recommendations - The Board of Directors are asked to note:

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

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

7.3 The bi annual establishment review process will be complete in June 2015, the Board will receive the outcome report in July 2015.

7.4 The success of recent advertising and recruitment.

Staffing: Nursing, midwifery and care staff

Org: RP4 Great Ormond Street Hospital For Children NHS Foundation Trust

Period: May_2015-16

Please provide the URL to the page on your trust website where your staffing information is available

(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

Comments

Validation alerts (see control panel)	Only complete sites your organisation is accountable for	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night	
							Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff					
		Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
		RP401	Great Ormond Street Hospital Central London Site - R	Badger Ward	340 - RESPIRATORY MEDICINE		2025	2428.85	303	460	1820	2078.2	303	216.7	119.9%	151.8%	114.2%	71.5%
		RP401	Great Ormond Street Hospital Central London Site - R	Bear Ward	170 - CARDIOTHORACIC SURGERY	321 - PAEDIATRIC CARDIOLOGY	2848	3246.25	597	548.75	2848	2886.4	356	320.95	114.0%	91.9%	101.3%	90.2%
		RP401	Great Ormond Street Hospital Central London Site - R	Flamingo Ward	192 - CRITICAL CARE MEDICINE		5589	7150.8	356	437	5347	6246.9	184	270.7	127.9%	122.8%	116.8%	147.1%
		RP401	Great Ormond Street Hospital Central London Site - R	Miffy Ward (TCU)	340 - RESPIRATORY MEDICINE		709	1002.9	1063	733.75	709	664.4	709	600.7	141.5%	69.0%	93.7%	84.7%
		RP401	Great Ormond Street Hospital Central London Site - R	Neonatal Intensive Care Unit	192 - CRITICAL CARE MEDICINE		2823	3642		207	2470	3207.2		43.2	129.0%		129.8%	
		RP401	Great Ormond Street Hospital Central London Site - R	Paediatric Intensive Care Unit	192 - CRITICAL CARE MEDICINE		6035	6646.4	355	454.75	6035	5515.97	355	216	110.1%	128.1%	91.4%	60.8%
		RP401	Great Ormond Street Hospital Central London Site - R	Elephant Ward	370 - MEDICAL ONCOLOGY	823 - HAEMATOLOGY	1664	1730.5	355	347.5	1423	1345.5	355	302.4	104.0%	97.9%	94.6%	85.2%
		RP401	Great Ormond Street Hospital Central London Site - R	Fox Ward	303 - CLINICAL HAEMATOLOGY	313 - CLINICAL IMMUNOLOGY and ALLERGY	2023	1345.25	303	229.15	1671	1194.7	303	290.9	66.5%	75.6%	71.5%	96.0%
		RP401	Great Ormond Street Hospital Central London Site - R	Giraffe Ward	313 - CLINICAL IMMUNOLOGY and ALLERGY	350 - INFECTIOUS DISEASES	1061	1079	353	282	1061	752.9	353	291.3	101.7%	79.9%	71.0%	82.5%
		RP401	Great Ormond Street Hospital Central London Site - R	Lion Ward	370 - MEDICAL ONCOLOGY	303 - CLINICAL HAEMATOLOGY	1643	1593.85	351	264.5	1405	1241.7	351	233.75	97.0%	75.4%	88.4%	66.6%
		RP401	Great Ormond Street Hospital Central London Site - R	Penguin Ward	330 - DERMATOLOGY	410 - RHEUMATOLOGY	934	1069.66	349	617	698	674.9	349	123	114.5%	176.8%	96.7%	35.2%
		RP401	Great Ormond Street Hospital Central London Site - R	Robin Ward	350 - INFECTIOUS DISEASES	313 - CLINICAL IMMUNOLOGY and ALLERGY	1981	1486.75	348	251.5	1744	1362.45	348	290.9	75.1%	72.3%	78.1%	83.6%
		RP401	Great Ormond Street Hospital Central London Site - R	Bumblebee Ward	171 - PAEDIATRIC SURGERY	420 - PAEDIATRICS	2345	2387.65	335	644	2010	1911.65	670	404.5	101.8%	192.2%	95.1%	60.4%
		RP401	Great Ormond Street Hospital Central London Site - R	Butterfly Ward	370 - MEDICAL ONCOLOGY	420 - PAEDIATRICS	2585	2302.5	323	503.5	1939	1355.3	323	262	89.1%	155.9%	69.9%	81.1%
		RP401	Great Ormond Street Hospital Central London Site - R	Eagle Ward	361 - NEPHROLOGY		2248	2181.25	707	609	1415	1518.1	353	259.2	97.0%	86.1%	107.3%	73.4%
		RP401	Great Ormond Street Hospital Central London Site - R	Kingfisher Ward	420 - PAEDIATRICS		1733	1841.1	895	642	293	303.1		21.6	106.2%	71.7%	103.4%	
		RP401	Great Ormond Street Hospital Central London Site - R	Rainforest Ward (Gastro)	301 - GASTROENTEROLOGY		825	997.15	616	368	616	666.2	616	295.1	120.9%	59.7%	108.1%	47.9%
		RP401	Great Ormond Street Hospital Central London Site - R	Rainforest Ward (Endo/Met)	302 - ENDOCRINOLOGY		1058	1221.95	705	172	1058	767.5	352	305.9	115.5%	24.4%	72.5%	86.9%
		RP401	Great Ormond Street Hospital Central London Site - R	Mildred Creak	711- CHILD and ADOLESCENT PSYCHIATRY		1094	1495.75	586	431	500	442.8	443	464.4	136.7%	73.5%	88.6%	104.8%
		RP401	Great Ormond Street Hospital Central London Site - R	Koala Ward	150 - NEUROSURGERY	421 - PAEDIATRIC NEUROLOGY	3038	3281.5	324	414.3	2934	2891.32	324	129.6	108.0%	127.9%	98.5%	40.0%
		RP401	Great Ormond Street Hospital Central London Site - R	Peter Pan Ward	120 - ENT	160 - PLASTIC SURGERY	1537	842	592	207	1423	729.2			54.8%	35.0%	51.2%	
		RP401	Great Ormond Street Hospital Central London Site - R	Sky Ward	110 - TRAUMA & ORTHOPAEDICS	171 - PAEDIATRIC SURGERY	1926	2030.3	678	796.5	1871	1882.1			105.4%	117.5%	100.6%	
		RP401	Great Ormond Street Hospital Central London Site - R	Squirrel Ward	171 - PAEDIATRIC SURGERY	101 - UROLOGY	2939	3081.56	703	708	2644	2679.6		11.5	104.9%	100.7%	101.3%	

Appendix 2: Overview of Ward Nurse Staffing – May 2015

			Registered Nursing staff			Non Registered							Recruitment Pipeline			
Division	Ward	Established Bed Numbers	Proposed Funded Establishment	Staff in Post	Vacancies	Proposed Funded establishment	Staff in Post	Vacancies	Total Establishment	Total Vacancies	Bank Used	Net Vacant	Registered Starters	Non-registered Starters	Number of unsafe shifts	Average Bed Closures
CCCR	Badger	15	39.5	31.0	8.5	7.5	5.0	2.5	47.0	11.0	3.3	7.8	2.0	2	0	2.2
	Bear	22	47.8	41.0	6.8	9.0	6.0	3.0	56.8	9.8	7.7	2.1	0.0	2	0	0.0
	Flamingo	17	121.0	104.0	17.0	10.8	7.0	3.8	131.8	20.8	16.3	4.5	0.0	0	0	0.0
	Miffy (TCU)	5	14.1	12.6	1.5	7.8	6.0	1.8	21.9	3.3	4.7	-1.4	0.0	1	0	0.0
	NICU	8	51.5	41.0	10.5	5.2	1.0	4.2	56.7	14.7	12.0	2.7	3.0	0	0	0.1
	PICU	13	83.0	94.7	-11.7	8.9	5.0	3.9	91.9	-7.8	9.4	-17.2	7.0	0	0	0.1
ICI-LM	Elephant	13	25.0	25.0	0.0	4.9	4.9	0.0	29.9	0.0	1.8	-1.8	2.0		0	0.0
	Fox	10	31.0	24.0	7.0	5.2	5.0	0.2	36.2	7.2	3.4	3.8	2.0		0	1.5
	Giraffe	7	19.0	18.3	0.7	3.1	3.5	-0.4	22.1	0.3	2.4	-2.1			0	0.1
	Lion	11	22.0	22.0	0.0	4.0	4.0	0.0	26.0	0.0	2.6	-2.6			0	0.2
	Penguin	9	15.5	15.5	0.0	5.5	5.5	0.0	21.0	0.0	2.8	-2.8	1.0		0	0.2
	Robin	10	27.2	23.8	3.4	4.5	4.4	0.1	31.7	3.5	4.4	-0.9	1.0		0	0.2
IPP	Bumblebee	21	38.3	28.7	9.6	9.7	9.0	0.7	48.0	10.3	5.3	5.0	6.0	1	0	1.3
	Butterfly	18	37.2	27.0	10.2	10.5	9.0	1.5	47.7	11.7	2.5	9.2	1.6		0	1.7
MDTS	Eagle	21	39.5	34.6	4.9	10.5	10.0	0.5	50.0	5.4	1.1	4.3			0	0.1
	Kingfisher	16	17.1	16.8	0.3	6.2	4.8	1.4	23.3	1.7	0.7	1.0			0	0.0
	Rainforest Gastro	8	17.0	11.0	6.0	4.0	4.0	0.0	21.0	6.0	3.5	2.5			0	1.1
	Rainforest Endo/Met	8	15.6	17.1	-1.5	5.2	5.0	0.2	20.8	-1.3	2.1	-3.4			0	0.1
Neuro-sciences	Mildred Creak	10	11.8	15.2	-3.4	7.8	7.6	0.2	19.6	-3.2	0.2	-3.4			0	0.1
	Koala	24	48.2	44.8	3.4	7.8	5.5	2.3	56.0	5.7	4.4	1.3				2.1
Surgery	Peter Pan	16	24.5	21.3	3.2	5.0	5.0	0.0	29.5	3.2	0.6	2.6			0	0.2
	Sky	18	31.0	27.4	3.6	5.2	6.0	-0.8	36.2	2.8	3.2	-0.3			0	0.9
	Squirrel	22	43.6	40.6	3.0	7.0	6.0	1.0	50.6	4.0	5.6	-1.6			0	0.3
	TRUST TOTAL:	**322**	**820.4**	**737.4**	**83.0**	**155.3**	**129.2**	**26.1**	**975.7**	**109.1**	**99.7**	**9.4**	**25.6**	**6.0**	**0.0**	**12.5**

Great Ormond Street Hospital for Children NHS Foundation Trust

GOSH NURSE SAFE STAFFING REPORT

June 2015

1. Introduction

1.1 This report on GOSH Safe Nurse Staffing contains information from the month of June 2015. The report provides information on staff in post, safe staffing incidents, nurse vacancies and includes quality measures which are reported by exception.

2. Context and Background

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

2.2 Monthly nurse staffing updates are submitted to NHS England and the Trust Board with the following information:

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

3. GOSH Ward Nurse Staffing Information for Trust Board

3.1 Safe Staffing

3.1.1 The UNIFY Fill Rate Indicator for June is attached as Appendix 1. The spread sheet contains:

- Total monthly planned staff hours; the Heads of Nursing provide this figure based on the agreed average safe staffing level for each of their wards. These figures are fixed i.e. do not alter month on month. Bed closure information is used to adjust the planned staffing levels. A short term change in acuity and dependency requiring more or fewer staff is not reflected in planned hours but in the actual hours.
- Total monthly actual staff hours worked; this information is taken from the electronic rostering system (RosterPro), and includes supervisory roles, staff working additional hours, CNS shifts, extra staff booked to cope with changes in patient dependency and acuity from the Nurse Bank. This may both exceed or be below 100% to meet the changing occupancy and activity levels as well as the patient dependency and acuity.
- Average fill rate of planned shifts. It must be noted that the presentation of data in this way is open to misinterpretation as the non-registered pool is small in comparison to the registered pool, therefore one HCA vacancy or extra shifts worked will have a disproportionate effect on the % level.

3.1.2 Commentary:

- Heads of Nursing are asked to comment on percentage scores of less than 90% or greater than 110%, and declare any unsafe staffing situations that have occurred during the month in question including actions taken at the time to rectify and make the situation safe.
- The overall Trust fill rate % for June is:

RN Day	RN Night	HCA Day	HCA Night	Total Fill Rate
108.7%	95.5%	96.6%	78%	100.7%

ICI – No unsafe shifts reported in June

Fox Ward report high 10 vacancies, staff have been moved within division to cover Fox Ward. 7 vacancies have been filled and staff are in the recruit phase. In tandem there has been a reduction in activity as a number of patient treatments have been delayed due to their clinical condition, this has resulted in some shifts with lower dependency and acuity, and consequently reduced staffing requirements.

Penguin Ward, HCA requirement on night reduced due to patient numbers. The high percentage of HCAs on day relates to nurses awaiting registration (working rostered shifts on HCA grades).

ICI report a high level of short notice sickness, to manage this scenario staff are moved across wards to meet the needs of the care requirements of patients on a shift by shift basis.

Surgery No unsafe shifts reported in June

Squirrel and Sky report an increased staffing requirement for patients requiring High Dependency care.

CCCR – No unsafe shifts reported in June

Miffy – increase in registered nurse hours on days is due to on-going training of staff. Low HCA hours are due to delay in employment of new staff.

Badger report having increased numbers of Ward Intensive Care patients requiring 1:1 care. Two funded extra beds remain closed on Badger Ward whilst staff are recruited. HCA numbers have increased and are being trained for their new posts hence the high numbers on days.

Flamingo planned staffing for 17 beds, up to 3 additional beds (total 20) are opened when staff available through the Nurse Bank. Three beds have been used for ECMO cases requiring 2:1 care. In addition two Berlin hearts were placed requiring initial 2:1 care. High HCA numbers account for Nurses awaiting NMC registration. Four datix reports were received regarding staffing levels see 5.6. below.

NICU report 100% occupancy and opening extra beds when required which accounts for the extra staff.

MDTS - No unsafe shifts reported in June

Eagle Ward report that the low percentages are due to 6 staff are on long term absence, reasons are sickness and maternity leave. Rainforest Endocrine/Metabolic has a vacant HCA position, and has had an increase in PICU transfers requiring addition registered nurse hours. Rainforest Gastro has closed two beds due to long term sickness and vacancies. Kingfisher has had several patients requiring 1:1 registered nurse care whilst undergoing tests impacting on actual registered nurse hours.

Neurosciences - No unsafe shifts reported in June

Koala has report closing up to 4 beds during early June due to high patient acuity. The ward has been fully opened since 10th June.

Higher number of HCA hours on day shifts is due to staff training, once competent, staff will move to nights to equalise numbers.

Mildred Creak Unit – for safety reasons the number of inpatient beds has been reduced to 7 beds overnight, hence the reduction in planned staff on night shift.

IPP - No unsafe shifts reported in June

Bumblebee and Butterfly report an increase in complex patients on day shifts requiring high dependency care, often when nursed in a cubicle they require 1:1 care. A number of patients on overnight leave hence reduced night hours. Staff worked flexibly across the wards as needed.

3.1.4 The Clinical Site Practitioners (CSPs) report that no wards were declared unsafe during June, however there were 7 occasions in June where CSPs moved staff between wards for part or a whole shift to maintain safe care. A further 11 occasions are noted where wards reported a shift being short of staff, however patient safety was not compromised.

3.2 General Staffing Information

3.2.1 Appendix 2 – Ward Nurse Staffing overview for June. The table provides information on staff in post, vacancies and staff in the recruitment pipeline and includes bed closure information.

3.2.2 16 out of 23 inpatient wards closed beds at various points during June. An average of 13 beds were closed each day. Reasons for closure include - four beds were closed in IPP for works, additional beds were 'closed' (reserved) in IPP for following day admissions. Squirrel ward had up to 13 beds closed for the latter part of the month due to an outbreak of Noravirus. Badger Ward continues to have 2 beds closed whilst staff are recruited and trained. Rainforest Gastro has a number of nurses on maternity leave, this has resulted in 2 closed beds whilst these vacancies are filled. Other reasons for closures cited are infectious cleans, awaiting swab results and beds in bays closed as a result of an infectious patient being nurses in that area. There were a small number closed at times due to acute staff sickness and fluctuations in dependency and acuity.

3.2.3 For the inpatient wards, registered and non-registered vacancies for June total 121 Whole Time Equivalents (WTE) up from 109 in May. This breaks down to 92 (83 in May) registered nurse (RN) vacancies (11% of RN total). HCA vacancies number 28 (18% of HCA total) 26 vacancies were reported in May. Temporary nurses, mainly from GOSH Nurse Bank, employed on wards totalled 93 WTE, the June position was therefore 28 WTE vacant posts.

3.2.4 On the 1st July the number new starters progressing through pre-employment checks totalled 87 registered nurses and 1 HCA. There were still a number of job offers pending. The majority of the registered recruits will be newly qualified and will not commence in post until September 2015. The majority of HCA vacancies (15) are within the ICU areas, recruitment has been on hold pending further work on the education pathway due for completion in July. We continue to recruit HCAs to the wards to achieve the target, however high numbers fail to attend the assessment centre or do not meet the requirements of the assessment centre, to compensate we have increased the numbers of candidates invited for the July assessment centre.

3.2.5 The Trust sent representatives to the Birmingham Royal College of Nursing jobs Fair in July.

3.2.6 As a Trust we continue to sustain recruitment against a backdrop of well publicised national nurse shortages.

3.2.7 The 6 monthly nurse establishment reviews were completed in June 2015, The Board of Directors will receive the report in July.

4 Key Challenges

- Recruitment of HCAs in the Critical Care areas.
- Recruitment of Band 6 Nurses.
- Retention of Band 5 and 6 Nurses.

5. Key Quality and Safety Measures and Information

5.1 Hard Truths Commitments Regarding the Publishing of Staffing Data (Care Quality Commission, March 2014) states 'data alone cannot assure anyone that safe care is being delivered. However research demonstrates that staffing levels are linked to the safety of care and that fewer staff increases the risks of patient safety incidents occurring.' In order to assure the Board of safe staffing on wards the following nursing quality and patient experience information has been collated to demonstrate that the wards were safe during June 2015.

5.2 The following quality measures provide a base line report for the Board. A number are Key Performance Indicators (KPIs) that are regularly monitored, any poor results are reviewed, challenged and investigated through the Nursing quarterly performance reviews led by the Chief Nurse with each Divisional Nursing team.

5.3 **Infection control**

C Difficile	0	
MRSA Bacteraemias	0	
MSSA Bacteraemias	0	
E Coli Bacteraemia	3	
D & V and other outbreaks	1	Squirrel Ward (noravirus & rota virus) closed to admissions 26.6.15 – 3.7.15
Carbopenamase resistance	1	

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

5.4 **Pressure ulcers**

	Number	**Ward**
Grade 3	**0**	
Grade 2	**1**	PICU (avoidable)

5.5 **Deteriorating patient**

5.5.1 For the month of June, 14 patient related emergency calls were received of which 3 were cardiac arrests (2 on Bear Ward and 1 on Rainforest), there was 7 respiratory arrests (2 on Squirrel Ward, 2 on Badger Ward, 1 on Butterfly, Peter Pan and Lion Wards). In addition 15 patients had unplanned admissions to Intensive Care. Overall these are some of the highest monthly numbers reported recently.

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

- 4 incidents were raised from Flamingo ward (CICU) due to a range of issues related to volume and dependency of patients, and staff sickness. 2 of these involved young infants on ECMO who require 2 nurses but only one nurse was available for each patient. In all cases staff had been moved from other wards or duties to ensure the ward was safe, however staff report delays in delivering care.
- 1 incident reported on Squirrel ward due to short notice sick leave before and during the shift linked to the infection outbreak. A Health Care Assistant was moved from another ward to assist.

- 1 incident reported on Butterfly due to team work and communication with colleagues on Bumblebee ward during a respiratory arrest. Staff felt unsupported and in need of an additional nurse to care for other patients whilst supporting the arrest team with the sick patient.

5.7 **Pals concerns raised by families regarding nurse staffing**

- Pals referrals were received relating to Puffin ward from parents of patients who had been cancelled because there was no bed available for their child to have their surgery.

- 1 referral from a family on Koala ward about a range of issues relating to the medical and nursing team including staffing issues on the ward.

5.8 **Complaints re nurse safe staffing -**

There was one complaint regarding delays in nursing staff providing care and treatment in the International and private patient unit. Initial investigations suggest that this relates in part to reduced nursing capacity due to staff sickness and other issues.

5.9 All issues noted in 5.6, 5.7 and 5.8 are under investigation by the respective Head of Nursing.

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

- Response rate for June was 32.27% (May 21.76%), the overall target has increased from 25% to 40% by the end of Quarter 2 and up to 60% by the end of Quarter 4.
- The FFT score was 82 for May and June.
- The overall percentage to recommend score is 99%.
- 240 (81.6%) of families were extremely likely to recommend their friends and family compared to 246 (82.7%) in May, with 51 (17.3%) likely to recommend, 42 (14.1%) in May.
- 3 Families provided information praising staff on Puffin, Respiratory Sleep Unit and Sky Wards. 1 negative response was received relating to communication and predicted patient outcomes on PICU.

6. Conclusion

6.1 This paper seeks to provide the Board of Directors with the required overview and assurance that all wards were safely staffed against the Trust's determined safe staffing levels during June, and appropriate actions were taken when concerns were raised. All Trusts are required to ensure the validity of data by triangulating information from different sources prior to providing assurance reports to their Board of Directors, this has been key to compiling the report.

7. Recommendations - The Board of Directors are asked to note:

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

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

7.3 The bi annual establishment review process was completed in June 2015, the Board will receive the outcome report in July 2015.

7.4 The success of recent advertising and recruitment.

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: RP4 Great Ormond Street Hospital For Children NHS Foundation Trust

Period: June_2015-16

Please provide the URL to the page on your trust website where your staffing information is available

(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

Comments

Validation alerts (see control panel)	Only complete sites your organisation is accountable for			Main 2 Specialties on each ward		Day				Night				Day		Night	
	Hospital Site Details		Ward name			Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
	RP401	Great Ormond Street Hospital Central London Site - R	Badger Ward	340 - RESPIRATORY MEDICINE		2009	2356.15	298	372.7	1790	2008.9	298	272.1	117.3%	125.1%	112.2%	91.3%
	RP401	Great Ormond Street Hospital Central London Site - R	Bear Ward	170 - CARDIOTHORACIC SURGERY	321 - PAEDIATRIC CARDIOLOGY	2665	3046.4	577	608.55	2665	2565	333	417.4	114.3%	105.5%	96.2%	125.3%
	RP401	Great Ormond Street Hospital Central London Site - R	Flamingo Ward	192 - CRITICAL CARE MEDICINE		5413	6593.45	344	379.5	5161	6067.18	206	270.7	121.8%	110.3%	117.6%	131.4%
	RP401	Great Ormond Street Hospital Central London Site - R	Miffy Ward (TCU)	340 - RESPIRATORY MEDICINE		686	946.6	1030	649.75	686	700.65	686	492.45	138.0%	63.1%	102.1%	71.8%
	RP401	Great Ormond Street Hospital Central London Site - R	Neonatal Intensive Care Unit	192 - CRITICAL CARE MEDICINE		2720	3452.1	0	184	2380	2829.5	0	129.6	126.9%	-	118.9%	-
	RP401	Great Ormond Street Hospital Central London Site - R	Paediatric Intensive Care Unit	192 - CRITICAL CARE MEDICINE		5865	6447.15	345	276	5865	5476.2	345	248.4	109.9%	80.0%	93.4%	72.0%
	RP401	Great Ormond Street Hospital Central London Site - R	Elephant Ward	370 - MEDICAL ONCOLOGY	823 - HAEMATOLOGY	1630	1770.6	344	322	1377	1036.8	344	324	108.6%	93.6%	75.3%	94.2%
	RP401	Great Ormond Street Hospital Central London Site - R	Fox Ward	303 - CLINICAL HAEMATOLOGY	313 - CLINICAL IMMUNOLOGY and ALLERGY	2090	1420	310	333.5	1738	1237.2	310	270.7	67.9%	107.6%	71.2%	87.3%
	RP401	Great Ormond Street Hospital Central London Site - R	Giraffe Ward	313 - CLINICAL IMMUNOLOGY and ALLERGY	350 - INFECTIOUS DISEASES	1028	1255.8	342	264.5	1028	796.8	342	231.7	122.2%	77.3%	77.5%	67.7%
	RP401	Great Ormond Street Hospital Central London Site - R	Lion Ward	370 - MEDICAL ONCOLOGY	303 - CLINICAL HAEMATOLOGY	1616	1633.05	341	368	1365	1231.6	341	267.6	101.1%	107.9%	90.2%	78.5%
	RP401	Great Ormond Street Hospital Central London Site - R	Penguin Ward	330 - DERMATOLOGY	410 - RHEUMATOLOGY	940	1191	344	671.1	688	682.9	344	75.6	126.7%	195.1%	99.3%	22.0%
	RP401	Great Ormond Street Hospital Central London Site - R	Robin Ward	350 - INFECTIOUS DISEASES	313 - CLINICAL IMMUNOLOGY and ALLERGY	1901	1495	331	176.75	1658	1132.65	331	275.75	78.6%	53.4%	68.3%	83.3%
	RP401	Great Ormond Street Hospital Central London Site - R	Bumblebee Ward	171 - PAEDIATRIC SURGERY	420 - PAEDIATRICS	2281	2564.05	325	584.75	1955	1958.65	651	454	112.4%	179.9%	100.2%	69.7%
	RP401	Great Ormond Street Hospital Central London Site - R	Butterfly Ward	370 - MEDICAL ONCOLOGY	420 - PAEDIATRICS	2449	2346.5	306	468	1837	1307.2	306	276.55	95.8%	152.9%	71.2%	90.4%
	RP401	Great Ormond Street Hospital Central London Site - R	Eagle Ward	361 - NEPHROLOGY		2212	1946.95	684	345	1368	1278.6	342	185.7	88.0%	50.4%	93.5%	54.3%
	RP401	Great Ormond Street Hospital Central London Site - R	Kingfisher Ward	420 - PAEDIATRICS		1748	1868.4	897	718.75	331	444.2	0	10.8	106.9%	80.1%	134.2%	-
	RP401	Great Ormond Street Hospital Central London Site - R	Rainforest Ward (Gastro)	301 - GASTROENTEROLOGY		712	897.2	521	345	521	592.95	521	231	126.0%	66.2%	113.8%	44.3%
	RP401	Great Ormond Street Hospital Central London Site - R	Rainforest Ward (Endo/Met)	302 - ENDOCRINOLOGY		1008	1349.6	672	241.5	1008	907.2	336	331	133.9%	35.9%	90.0%	98.5%
	RP401	Great Ormond Street Hospital Central London Site - R	Mildred Creak	711- CHILD and ADOLESCENT PSYCHIATRY		1087	1312.7	606	476.05	494	410.4	448	336.2	120.8%	78.6%	83.1%	75.0%
	RP401	Great Ormond Street Hospital Central London Site - R	Koala Ward	150 - NEUROSURGERY	421 - PAEDIATRIC NEUROLOGY	3126	3320.52	330	572.15	3038	2998.25	330	156.8	106.2%	173.4%	98.7%	47.5%
	RP401	Great Ormond Street Hospital Central London Site - R	Peter Pan Ward	120 - ENT	160 - PLASTIC SURGERY	1512	1466.25	586	414	1422	1375.1	0	56.8	97.0%	70.6%	96.7%	-
	RP401	Great Ormond Street Hospital Central London Site - R	Sky Ward	110 - TRAUMA & ORTHOPAEDICS	171 - PAEDIATRIC SURGERY	1903	1861	663	766	1858	1696	0		97.8%	115.5%	91.3%	-
	RP401	Great Ormond Street Hospital Central London Site - R	Squirrel Ward	171 - PAEDIATRIC SURGERY	101 - UROLOGY	2715	3053.76	641	807.5	2437	2489.9	0		112.5%	126.0%	102.2%	-

Appendix 2: Overview of Ward Nurse Staffing – June 2015

			Registered Nursing staff			Non Registered							Recruitment Pipeline			
Division	Ward	Established Bed Numbers	Proposed Funded Establishment	Staff in Post	Vacancies	Proposed Funded establishment	Staff in Post	Vacancies	Total Establishment	Total Vacancies	Bank Used	Net Vacant	Registered Starters	Non-registered Starters	Number of unsafe shifts	Average Bed Closures
CCCR	Badger	15	39.5	34.4	5.1	7.5	4.9	2.6	47.0	7.7	3.7	4.1	4.0		0	2.0
	Bear	22	47.8	40.2	7.6	9.0	8.0	1.0	56.8	8.6	6.0	2.6	8.6	1	0	0.8
	Flamingo	17	121.0	98.5	22.5	10.8	4.0	6.8	131.8	29.3	16.0	13.3	8.0		0	0.1
	Miffy (TCU)	5	14.1	10.1	4.0	7.8	6.0	1.8	21.9	5.8	4.5	1.3	1.0		0	0.0
	NICU	8	51.5	40.4	11.1	5.2	1.0	4.2	56.7	15.3	10.1	5.2	5.0		0	0.1
	PICU	13	83.0	91.8	-8.8	8.9	5.0	3.9	91.9	-4.9	8.8	-13.7	10.0		0	0.0
ICI-LM	Elephant	13	25.0	24.7	0.3	5.0	5.1	-0.1	30.0	0.2	4.4	-4.2	2.0		0	0.0
	Fox	10	31.0	21.9	9.1	5.0	4.9	0.1	36.0	9.2	2.8	6.4	7.0		0	1.0
	Giraffe	7	19.0	18.1	0.9	3.1	3.5	-0.4	22.1	0.5	1.6	-1.1	2.0		0	0.0
	Lion	11	22.0	22.8	-0.8	4.0	3.5	0.5	26.0	-0.3	2.5	-2.8	1.0		0	0.1
	Penguin	9	15.5	15.3	0.2	5.8	6.0	-0.2	21.3	0.0	1.8	-1.8	0.0		0	0.0
	Robin	10	27.2	23.7	3.5	4.5	4.4	0.1	31.7	3.6	2.1	1.5	3.0		0	0.4
IPP	Bumblebee	21	38.3	34.8	3.5	9.7	8.6	1.1	48.0	4.6	4.5	0.1	6.0		0	1.2
	Butterfly	18	37.2	28.4	8.8	10.5	11.0	-0.5	47.7	8.3	2.9	5.4	2.0		0	2.0
MDTS	Eagle	21	39.5	34.9	4.6	10.5	10.0	0.5	50.0	5.1	1.6	3.5	5.0		0	0.1
	Kingfisher	16	17.1	17.2	-0.1	6.2	5.0	1.2	23.3	1.1	0.4	0.7	0.0		0	0.0
	Rainforest Gastro	8	17.0	11.0	6.0	4.0	4.5	-0.5	21.0	5.5	2.9	2.6	4.0		0	2.0
	Rainforest Endo/Met	8	15.6	16.4	-0.8	5.2	4.5	0.7	20.8	-0.1	1.1	-1.2	0.0		0	0.2
Neuro-sciences	Mildred Creak	10	11.8	14.2	-2.4	7.8	6.3	1.5	19.6	-0.9	0.4	-1.3	0.0		0	0.0
	Koala	24	48.2	44.2	4.0	7.8	5.0	2.8	56.0	6.8	6.8	0.0	9.0		0	1.0
Surgery	Peter Pan	16	24.5	23.3	1.2	5.0	5.0	0.0	29.5	1.2	2.1	-0.9	2.0		0	0.3
	Sky	18	31.0	24.0	7.0	5.2	5.0	0.2	36.2	7.2	2.2	5.0	3.0		0	0.7
	Squirrel	22	43.6	37.4	6.2	7.0	6.0	1.0	50.6	7.2	3.8	3.4	4.0		0	1.6
	TRUST TOTAL:	**322**	**820.4**	**727.7**	**92.7**	**155.5**	**127.2**	**28.3**	**975.9**	**121.0**	**93.0**	**28.0**	**86.6**	**1.0**	**0.0**	**13.6**

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
22nd July 2015

Nursing Skill Mix and Ward Nursing Establishments **Submitted by:** **Juliette Greenwood** **Chief Nurse**	**Paper No: Attachment W**

Aims / summary

The publication of guidance from NHS England – '*How to ensure the right people, with the right skills, are in the right place at the right time – A guide to nursing, midwifery and care staffing and capability'* (NHS England, Nov 2013) and the *'Hard Truths Commitments Regarding the Publishing of Staffing Data'* issued by the Care Quality Commission in March 2104 sets out the requirement for all NHS organisations to undertake a nurse staffing establishment review every 6 months which must be reported to the Trust Board.

This report is the third such report submitted to Trust Board since the publication of the above guidance and provides an update on the required ward nursing establishments at GOSH.

Action required from the meeting

To discuss the findings and note the changes in establishment in response to safety requirements and changes in occupancy, acuity and dependency.

Contribution to the delivery of NHS Foundation Trust strategies and plans

Safe levels of nurse staffing are essential to the delivery of safe patient care and experience.

Financial implications

Already incorporated within the 15/16 Division budgets.

Who needs to be told about any decision?

Division Management Teams
Finance Department

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

Chief Nurse; Assistant Chief Nurse – Workforce; Heads of Nursing

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

Chief Nurse; Division Management Teams

Attachment W

Nursing Skill Mix and Ward Nursing Establishments at

Great Ormond Street Hospital for Children NHS Foundation Trust

1. Introduction

1.1 Following the publication of the Francis Report 2013 and the Chief Nurse for England vision: Compassion in Practice there is greater focus on ensuring that Trusts have the right nursing workforce with the right skills to meet the needs and expectations of patients and their families. The publication of guidance from NHS England – '*How to ensure the right people, with the right skills, are in the right place at the right time – A guide to nursing, midwifery and care staffing and capability'* (NHS England, Nov 2013) and the *'Hard Truths Commitments Regarding the Publishing of Staffing Data'* issued by the Care Quality Commission in March 2014 sets out the requirement for all NHS organisations to undertake a nurse staffing establishment review every 6 months which must be reported to the Trust Board of Directors. The Board received the last report for the period May to October 2014 in November 2014.

2. Context/Background

2.1 Determining the skill-mix between registered and non-registered staff is not an exact science, it requires a very good understanding of the patient population and the nursing requirements for each ward and department before deciding how many staff are required on each shift. There is evidence that a reduction in registered nurses has an adverse effect on nurse's physical and mental health, with work related stress being reported by approximately 55% of the nursing workforce nationally (2014 NHS Staff survey). National and International evidence clearly demonstrates that poorly staffed wards increase staff sickness, burnout and reduce staff well-being all of which have direct consequences on outcomes of care and the patient experience. Ahead of the recommendations from Francis etc. the Chief Nurse and Assistant Chief Nurse met in 2013 with Unit General Managers and Heads of Nursing to review nursing establishments and skill-mix, this was the first of such meetings.

2.2 In order to plan safe nurse establishments for the future the review took into consideration a number of sets of information including data on staffing and clinical incidents as well as bed closures.

2.3 One of the aims was to bring uniformity to the staffing approach at GOSH e.g. Band 5:6 ratios and registered:non registered ratios, ultimately ensuring establishments were able to meet the proposed funded activity, patient acuity, dependency, and acknowledging the increasing complexity of care and treatment GOSH provides. A further set of meetings were held to agree the detail, these included local finance managers.

2.4 Work to determine the appropriate balance of registered to non-registered nursing staff to meet the needs of the service and ensure the delivery of safe patient care has been fundamental to the introduction of Health Care Assistants (HCAs) into the wards.

2.5 The National Institute for Health and Care Excellence (NICE) developed a number of Safe Staffing Guidelines. The plan to develop further guidance to include Acute Paediatric and Neonatal Wards has ceased.

2.6 In the absence of any nationally determined mandated guidelines for the staffing of childrens wards, the Royal College of Nursing Standards for Children's and Young People's Nurse Staffing (2013) are used as the best national speciality specific guidance available. Nurse staffing in Intensive Care adhere to the Paediatric Intensive Care Society Guidance (2010). In addition PANDA (Paediatric Acuity and Nurse Dependency Assessment Tool) is widely used across GOSH to assist in determining safe staffing, the use of these tools is comparable to approaches in use in children's environments across the UK. The RCN categories are:

- Normal dependency Under 2 Years - 1 Nurse : 3 Patients
- Normal dependency Over 2 Years - 1 Nurse : 4 Patients
- Ward High Dependency 1 Nurse : 2 Patients
- Ward Intensive Care 1 Nurse : 1 Patient
- Intensive Care - 1.5 Nurses: 1 Patient (this includes ventilated children on vasoactive drugs with multiple system problems.

- Intensive Care - 2 Nurses: 1 Patient (this includes children requiring ECMO or renal replacement therapies).

3. Bi annual review of nursing establishments and skill mix

3.1 During April/May 2015 the in-patient ward nursing establishments were reviewed and agreed by each Divisional Head of Nursing, General Manager and the Assistant Chief Nurse for Workforce. As part of the review quality measures such as complaints, datix reports and PALS reports received on safe staffing were reviewed alongside ward incidents. Projected activity, dependency, occupancy and PANDA data underpinned by professional judgement informed and determined safe establishments on GOSH wards. Table 1 provides a breakdown of PANDA data for the previous 9 months, this shows a consistent level of dependency and acuity over this period e.g. approx. 36% of GOSH Ward patients are Ward Intensive Care requiring 1:1 Care, approx. 65% of all GOSH patients require either Ward Intensive Care and/or High Dependency Care during their admission.

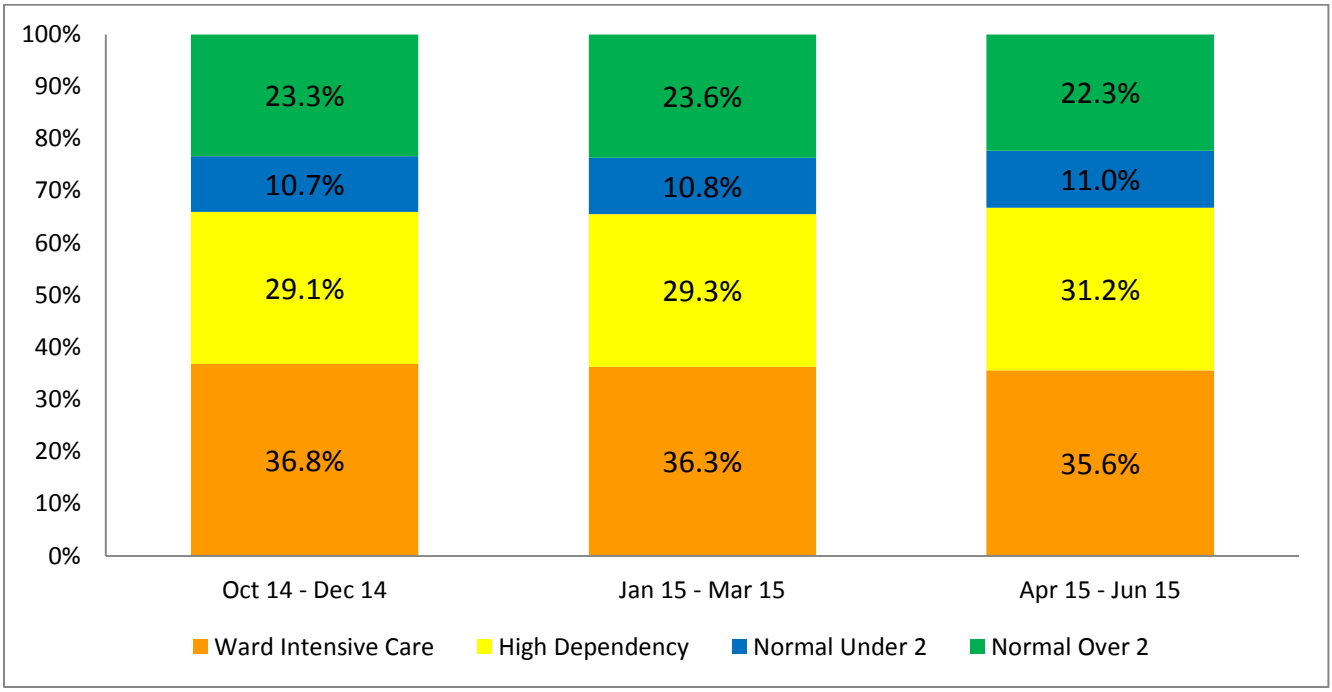


Table 1 – Quarterly PANDA data by Category

3.2 Appendix 2 details the agreed establishments from June 2015 by in-patient ward. The majority of establishments agreed in October 2014 and reported to the Board in November 2014 were carried forward the exceptions are:

- Koala Ward - increase in Registered Staff numbers by 4.2 Whole Time Equivalents (WTE), 3.5 Band 5, and 0.7 Band 3, this is to accommodate the increase in bed occupancy to 90%, acknowledging the extra operating lists and the higher patient dependency.
- In November 2014 a further review of Rainforest Gastro identified safety concerns on night shifts, as a result the Registered Nurse complement was increased by 2 WTE Band 5 taking effect in December 2014.

3.3 Progress on implementation of the skill-mix ratios on wards was also reviewed, the Intensive Care areas have not as yet fully achieved their target ratios. Initial recruitment to these areas was successful, however staff turnover and lack of uniformity in the deployment of HCAs in the ICUs has prompted a review of the HCA role. The review is now complete and a phased re introduction of the HCA role will commence initially on CICU and PICU. Progress will be monitored directly with Head of Nursing, it is anticipated the target ratios will be achieved by the end of 2015.

3.4 Core principles used to determine nursing establishments are outline in Appendix 1 these were presented to the Clinical Governance Committee in January 2014 and Trust Board.

3.5 Although 3 establishment reviews have taken place and establishments agreed with Heads of Nursing and General Managers, not all ward staffing budgets have been adjusted accordingly, also some elements of the pay budget have not been included or underestimated e.g. unsocial hours payments. To gauge the extent of the problem an exercise will be undertaken with each Division and will include Finance, Workforce Planning and the Assistant Chief Nurse, aiming to identify the extent of any discrepancy, and ensure that the full cost of staffing is clear and transparent. Ultimately matching budget and establishments including the appropriate uplift and unsocial hours payments.

3.6 Given the increased requirements for training and updating of staff an uplift of 22% may be insufficient, some NHS organisations have increased this to 25%. In addition the constant turnover and training of staff means for example a new nurse to intensive care will require 3 months supernumerary in addition to the 22% for annual leave, sickness and study leave. Therefore almost 50% of their first year will not be in rostered practice. Further analysis will be undertaken to consider an appropriate uplift for ward establishments.

4. Summary of Recruitment, Staff Turnover and Sickness

4.1 Nurse sickness on inpatient Wards for the year to June 2015 is 3.6%, sickness of less than 21 days accounts for 1.7% of total, long term sickness i.e. greater than 21 days accounts for 1.89% of total, for all registered nurses in the Trust the average is 3.2%. The average for all staff groups is 2.63%. The national sickness rate for nurses and midwives is reported as approx. 5%.

4.2 Turnover for the year to June 2015 is reported as 18.5% (17.2 % Trust nurse average). Maternity Leave is at 6.2% for inpatent wards (4.5% Trust nurse average). Appendix 3 provides a table to summarise turnover, sickness and maternity leave by inpatient ward.

4.3 All specialist children's hospitals are reporting difficulties in nurse recruitment and retention. There continues to be a challenge to recruit and retain Band 6 nurses, there is a disproportionately high level of maternity leave associated with this group and turnover has increased by 3% in the last year. To encourage band 5s into the role and aid transition a Band 6 development programme was introduced in 2014.

4.4 During 2013/14 156 Band 5 and 6 nurses were recruited to inpatient wards, a target of 200 nurses was set for 2014/15 (an increase of 44 staff - 28%), 207 (an increase of 51 staff - 33%) have actually been recruited to wards with an additional 50 Health Care Assistants. The impact of these additional posts has been reduced by an increase in turnover and new posts. Table 2 shows the increase in staff in post from 827 in May 2014 to 872 in April 2015. Table 3 shows vacancies by Band in WTE and percentages.

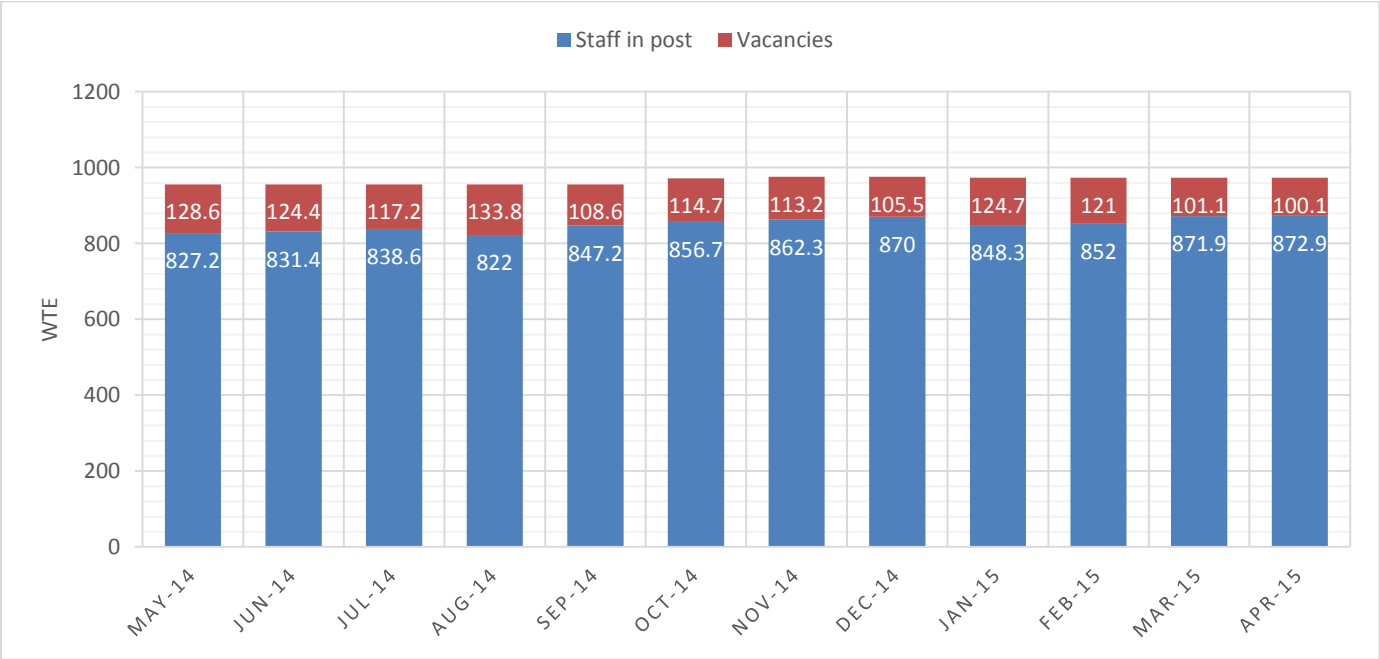
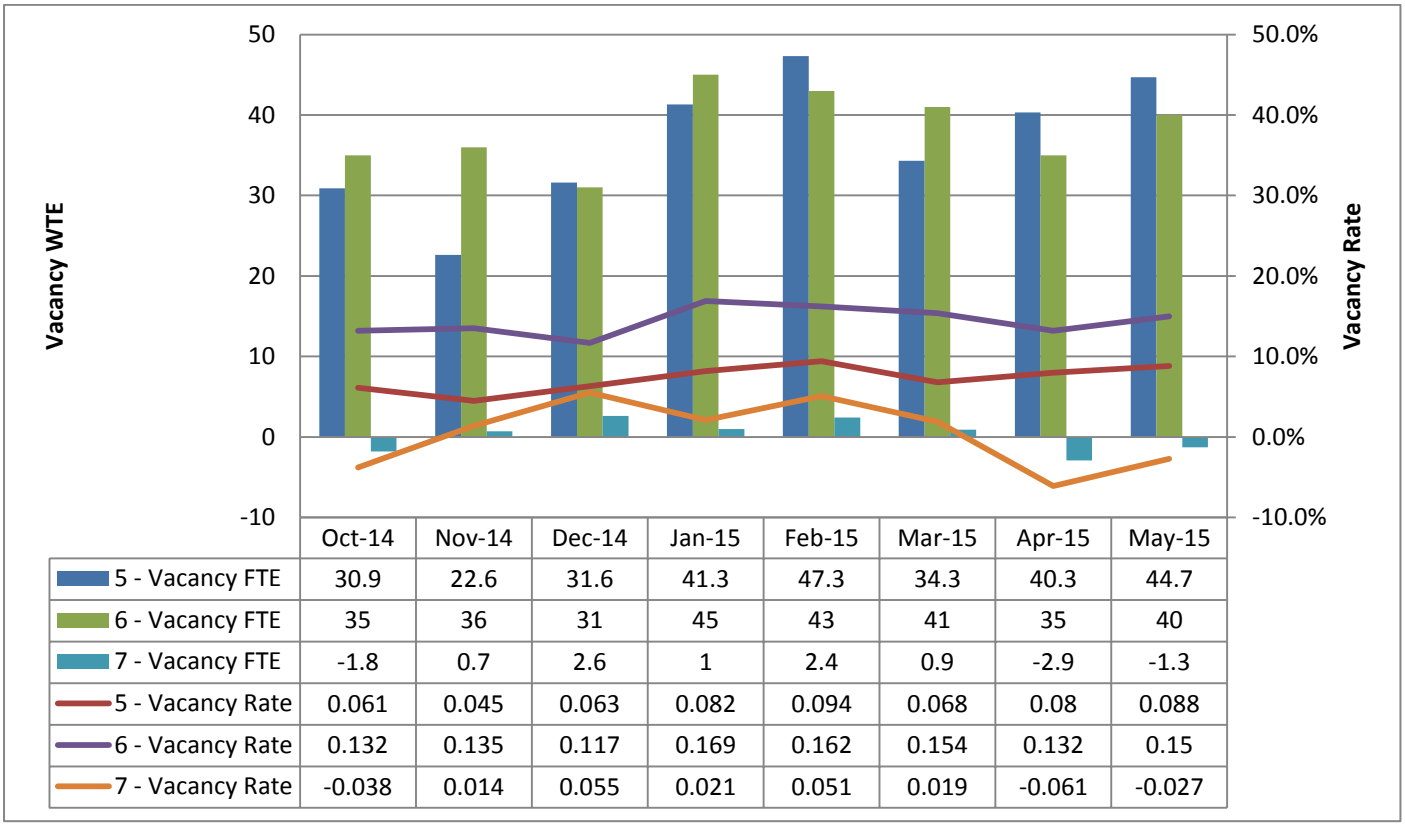


Table 2. Inpatient ward staff: Registered Staff in post and vacancies

Attachment W



	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
5 - Vacancy FTE	30.9	22.6	31.6	41.3	47.3	34.3	40.3	44.7
6 - Vacancy FTE	35	36	31	45	43	41	35	40
7 - Vacancy FTE	-1.8	0.7	2.6	1	2.4	0.9	-2.9	-1.3
5 - Vacancy Rate	0.061	0.045	0.063	0.082	0.094	0.068	0.08	0.088
6 - Vacancy Rate	0.132	0.135	0.117	0.169	0.162	0.154	0.132	0.15
7 - Vacancy Rate	-0.038	0.014	0.055	0.021	0.051	0.019	-0.061	-0.027

Table 3: The Number and % of In Patient Ward Vacancies by Band.

4.5 Band 6 vacancies have been consistently high for several years, some divisions convert Bands 6s to 5s flexibly, the impact of permanent regrading of these posts will be explored with the Heads of Nursing.

5. Health Care Assistants (HCA)

5.1 Following agreement on the introduction of HCAs onto wards in 2013 progress in divisions to achieve their target was slow, some areas did not have vacant registered nurse posts to convert or were uncertain of the impact of such a change. Cohorted recruitment of HCAs commenced in November 2014 to drive this process. To aid the transition and speed up implementation of the role, current recruitment has been focussed on experienced Band 3 HCAs, to date three assessment centres have taken place, determining the candidates levels of literacy, numeracy, communication and ensure their values align to Trust values. Our experience to date with recruiting HCAs has been variable. Although large numbers of applications are received there is significant fall out throughout the recruitment process. Once an established cohort of HCAs have been recruited and trained we will explore recruitment at Band 2.

5.2 In line with the national employment requirements of the *'Cavendish Review; an independent review into Health Care Assistants and support workers in the NHS and social care settings'* (2013); GOSH has implemented the 'Certificate of Fundamental Care' training. The certificate must be completed with 12 weeks of commencement of employment, and until complete HCAs must be supervised. Two cohorts have received the training and a further two cohorts are planned for 2015. A Practice Educator is employed for HCAs.

5.3 This group requires significant investment in education, training and support. Turnover has been a concern in the ICUs alongside the burden this extra supervisory role places on the registered workforce. However once competent HCAs become a valuable asset to ward teams, feedback from registered staff and families supports this.

6. Clinical Nurse Specialists

6.1 We have further developed and improved the activity recording for Clinical Nurse Specialists (CNS). Individuals record their activity on a bespoke CNS system 'Great Ormond Street Nursing Activity Tool' (GNAT). CNSs have for a number of years been required to work 2 clinical shifts (23 hours) on a ward as part of the nursing numbers each month, this equates to 15% of their time (Whole Time Equivalent). This rule was once more endorsed in July 2014 following a review of CNS activity with Divisional General Managers and Heads of Nursing, the shifts are included in the Divisional Productivity and Efficiency plans.

7. Nurse Bank

7.1 In addition to the substantive workforce the Trust Bank currently has over 1316 nurses and Health Care Assistants on its books (1062 substantive staff, 254 non substantive staff). These staff work extra shifts to support the delivery of care in times of higher than expected patient acuity and staff sickness. The current fill rate of requests is circa 90%. Our reliance on third party agencies has significantly reduced over recent years to between 3% and 5%, agency nurse are mainly employed in satellite recovery areas, it is anticipated that this number will reduce further as the management of these areas has been centralised under theatres.

8. Safe Staffing Reports (UNIFY)

8.1 The Trust submits monthly safe staffing data to NHS England, statistics are published on NHS Choices, Trust Board receives these figures monthly as part of the Safe Nurse Staffing Report. Table 4 shows the analysis of data submitted between May 2014 and May 2015. The Trust monthly overall fill rate i.e. hours worked expressed as a % of planned hours for this period falls between 96% - 102%. Many of the wards actual hours are now falling within the 90% – 110% bracket however there are several wards that repeatedly fall outside of this threshold. With robust data we will investigate further with Heads of Nursing.

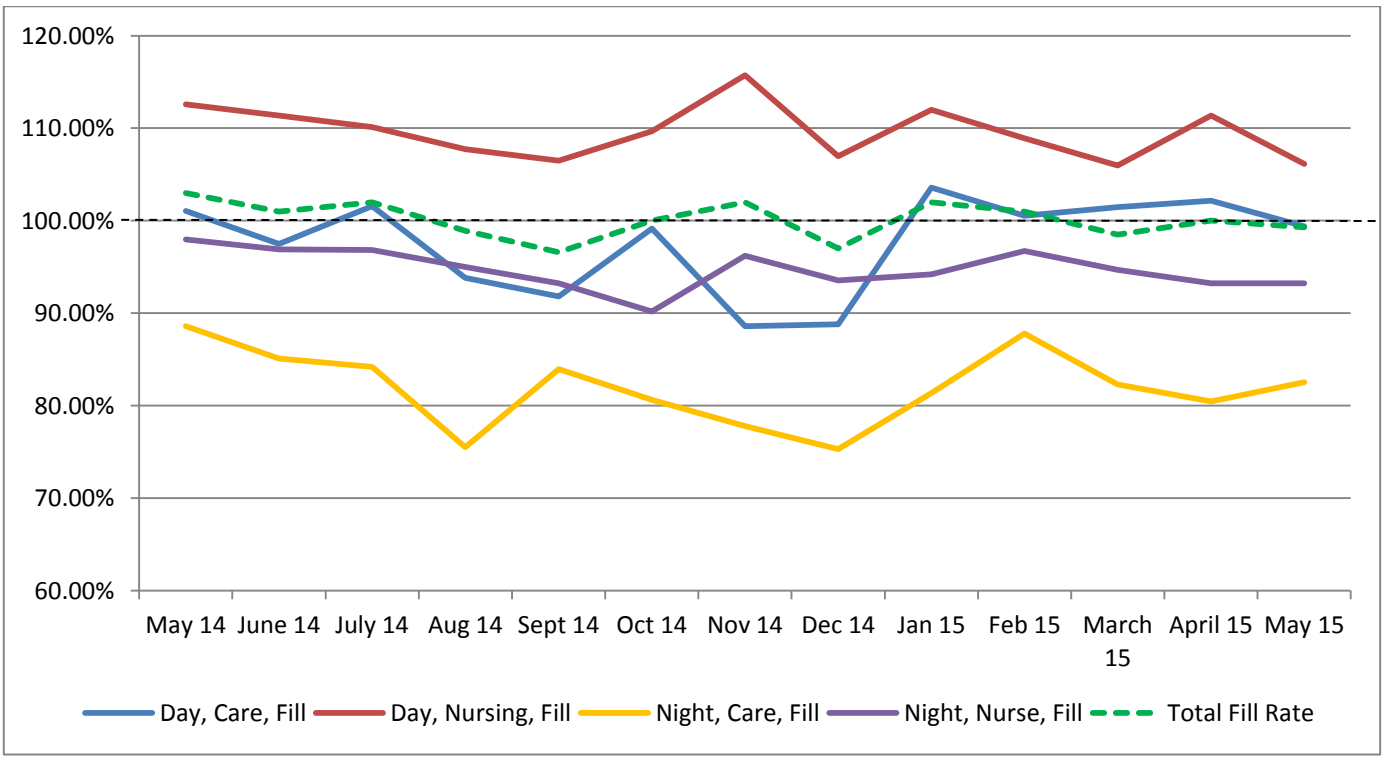


Table 4: Analysis of Nurse Safe Staffing UNIFY Return

9. PANDA

9.1 PANDA has been purchased by 6 NHS Trusts, and is on trial in a further 3. A PANDA User group meets quarterly, presenting an ideal opportunity to benchmark practice and agree how PANDA

could be developed further. A review of PANDA categories is under way, a more comprehensive suite of reports has been commissioned, and in addition we are exploring ways of incorporating actual staffing data to compare against PANDA predicted staffing data.

10. Electronic Rostering

10.1 Rosterpro is the electronic rostering system utilised by nurses. To assure the Trust that nurses are deployed effectively and appropriately a short term project will commence in July 2015. This will involve in-depth analysis of three consecutive monthly rosters, information will be cross referenced against a number of criteria. Feedback will be provided to managers commencing August 2015. Unfortunately we cannot merge data from PANDA and Rosterpro.

11. Conclusion

11.1 We have undertaken a comprehensive ward by ward review of staffing levels to ensure ward establishments are robust and able to meet the national recommendations to ensure safe, quality care is provided. Following this review 21 Ward establishments remain unchanged, Rainforest Gastro introduced 2 posts in December 2014, Koala 4 posts from April 2015. There is a need to continue with the drive to recruit Health Care Assistants, in addition the need to explore further the recruitment and retention of the Band 6 cohort or seek alternative routes to ensure we meet the ward establishment requirements. This paper can assure the Board of Directors that the Trust has safe staffing levels and systems in place to manage the demand for nursing staff, however there is no room for complacency and there is a need to stabilise the workforce by continuing with the current recruitment drive and strategies to improve deployment of nursing staff and overall retention.

12. Recommendation:

It is recommended Trust Board note this report

Note the work and robustness of the review process

Note the further work, recommendations and associated implications

For the Board to support the decision and rationale to amend the establishments on Koala and Rainforest (Gastro) Wards.

Attachment W
Appendix 1

Principles for Calculating Nursing Establishments

1. On wards with one Band 7 Sister/Charge Nurse - do not include uplift/head room.

2. On ICUs Band 7 Sister/Charge Nurse work shifts and there is a requirement for, 24/7cover therefore head room is included.

3. Band 7 Supervisory to Practice time i.e. not in rostered numbers. The RCN propose that Ward Sister/Charge Nurses are totally supervisory to practice, recognising the pivotal role played in maintaining quality, managing patient experience and being leaders, these views are echoed in the Francis report. GOSH will implement as follows; wards with 13 beds and over 70% of time will be supervisory, Wards with 12 beds and under 50% of the time will be supervisory.

4. Agreement on forecasted activity, planned dependency and occupancy levels - establishments can be reviewed and adjusted accordingly, accepting variability between weekdays and weekends.

5. If basing establishments on out turn, then a clear understanding of what outturn means, how are refused, cancelled or delayed admissions to services incorporated to give the anticipated level of activity and occupancy.

6. Projected occupancy needs to be based on activity and growth, including impact of growth or reduction in other related services e.g. increase in PICU capacity and knock on effect of discharges from PICU to GOSH wards.

7. Increased ICU throughput and expansion leads to increased pressure on wards, the patient pathway must be factored into activity forecasts and discharges areas staffed appropriately.

8. Admissions are blocked due to pressures on beds electives v emergencies, ICU discharges v local emergency admissions. Need to ensure the planning model has sufficient capacity for emergencies.

10. Acknowledging Education and Training Requirements as an essential element of calculating establishments, therefore a 22% uplift on rosters is the accepted norm when calculating establishments, this is exclusive of maternity leave.

11. Uplift includes a percentage for sickness but does not include other types of leave, General Managers and Heads of Nursing to proactively manage staff sickness to achieve a target of under 3%.

12. The main bulk of uplift is annual leave, to maximise staff utilisation and meet activity levels managers must allocate, manage and monitor annual leave.

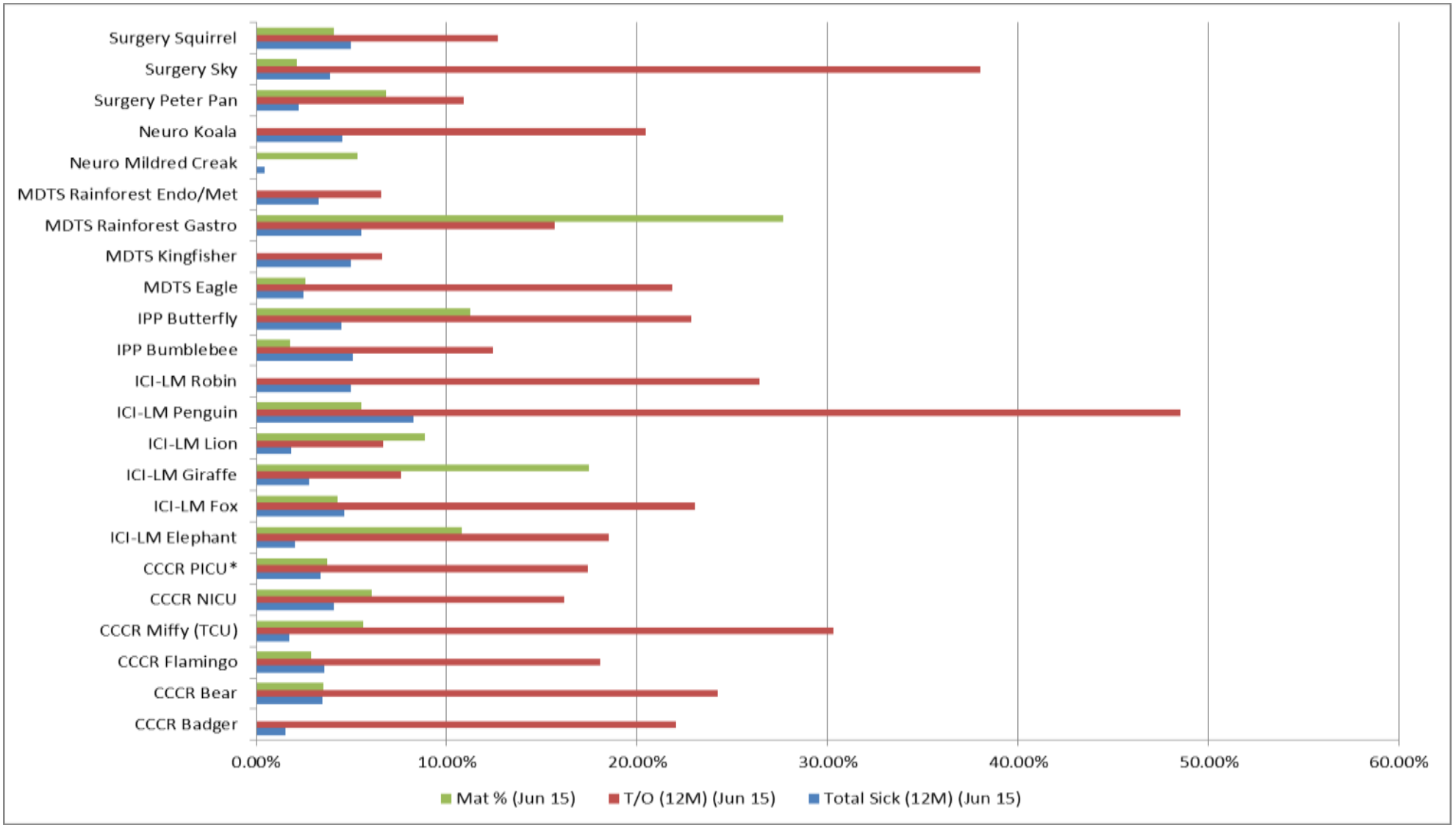
Attachment W

Appendix 2: Nursing Establishment by In-Patient Ward at 1st June 2015

Division	Ward	Established Bed Numbers	Target Registered: Non-registered ratio	Target Band 5:6 ratio	Ward sister supervisory time	Nursing Establishment (incl, registered & Non-registered 1st Nov 2014)	Nursing Establishment (incl, registered & Non-registered) 1st June 2105	June 2015 Registered	June 2015 Non-Registered
CCCR	Badger	15	85:15	70:30	70%	47.0	47.0	39.5	7.5
	Bear	22	85:15	70:30	70%	56.8	56.8	47.8	9.0
	Flamingo	17	90:10	60:40	n/a	131.8	131.8	121.0	10.8
	Miffy (TCU)	5	65:35	70:30	50%	21.8	21.8	14.0	7.8
	NICU	8	90:10	60:40	n/a	56.7	56.7	51.5	5.2
	PICU	13	90:10	60:40	n/a	92.3	92.3	83.4	8.9
ICI-LM	Elephant	13	85:15	70:30	70%	30.7	30.0	25.0	5.0
	Fox	10	85:15	70:30	50%	36.2	36.0	31.0	5.0
	Giraffe	7	85:15	70:30	50%	20.0	22.0	19.0	3.0
	Lion	11	85:15	70:30	50%	27.2	26.0	22.0	4.0
	Penguin	9	80:20	70:30	50%	20.7	21.3	15.5	4.8
	Robin	10	80:20	70:30	50%	32.4	31.7	27.2	4.5
IPP	Bumblebee	21	80:20	70:30	70%	48.0	48.0	38.3	9.7
	Butterfly	18	80:20	70:30	70%	47.7	47.7	37.2	10.5
MDTS	Eagle	21	80:20	70:30	70%	50.0	50.0	39.5	10.5
	Kingfisher	16	80:20	70:30	70%	24.5	23.3	17.1	6.2
	Rainforest Gastro	8	80:20	70:30	50%	19.0	21.0	17.0	4.0
	Rainforest Endo/Met	8	80:20	70:30	50%	20.9	20.8	15.7	5.2
Neuro-sciences	Mildred Creak	10	60:40	62:38	50%	19.6	19.6	11.8	7.8
	Koala	24	85:15	70:30	70%	51.8	56.0	48.2	7.8
Surgery	Peter Pan	16	80:20	70:30	70%	29.5	29.5	24.5	5.0
	Sky	18	80:20	70:30	70%	36.2	36.2	31.0	5.2
	Squirrel	22	85:15	70:30	70%	50.6	50.6	43.6	7.0
TRUST TOTAL June 2015:		322			TRUST TOTAL:		976.1	820.8	154.4
TRUST TOTAL Nov 2014		322			TRUST TOTAL:	971.4		815.6	155.0
TRUST TOTAL April 2014		320			TRUST TOTAL:	965.9		813.3	152.6

Attachment W

Appendix 3 – Matrernity Leave, Sickness and Turnover for Inpatient Wards



Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **22nd July 2015**	
Health and safety Annual Report 2014/15 **Submitted by:** **Ali Mohammed, Director of HR and OD**	**Paper No: Attachment X**
Aims / summary To provide the Trust Board with an overview of the issues and risks faced over the previous financial year and give some insight into what can be expected of 2015/16.	
Action required from the meeting None	
Contribution to the delivery of NHS Foundation Trust strategies and plans: Zero Harm	
Financial implications None.	
Who needs to be told about any decision? Health and Safety Committee / Director of Estates and Facilities / Health and Safety and Fire Manager	
Who is responsible for implementing the proposals / project and anticipated timescales? Aidan Holmes	
Who is accountable for the implementation of the proposal / project? Aidan Holmes	

Health and Safety Annual Report 2014 – 15

The Health and Safety and Fire Team at GOS assist the departmental managers in adhering to health and safety legislation and facilitate the Trust's commitment to controlling risks and precluding the chance of harm to patients, visitors and staff. The Trust has a systematic audit process in place with department types having bespoke audits for the type of work they undertake. Checklists are used in conjunction with the audits as a means of a reminder for staff to help them, and the Trust, meet its statutory targets and facilitate a process of continual improvement. In the past year the team have become the Health and Safety and Fire Team

The following work has been undertaken by the team during the year:

- All clinical areas have had a fire and health and safety risk assessment undertaken in using a tool devised by the health and safety and fire safety team. See appendix for example of risk assessment produced.
- An electronic audit toolkit which covers both health and safety and fire risk assessments makes most of the obvious synergies in the roles. Any remedial actions coming out of the audits are emailed to the relevant departments to remedy in a timely fashion and monitored by the Health and Safety and Fire Team. The Health and Safety Committee will receive reports on all aspects of fire and health and safety, including evidence of statutory and mandatory compliance, holding all parties to account and promoting continuous improvement.
- Closer working relationship forged with the Projects Team. A new Protocol for Risk impact Assessments was introduced in conjunction with the Projects Team.
- Generic Control of Substances Hazardous to Heath (COSHH) assessments have been undertaken for all substances used across the Trust. Local areas can then use these as the basis their own bespoke assessments.
- Introduction of a new Control of Substances Hazardous to Health assessments and protocol.
- Improved access to all health and safety risk assessments through the creation of local health and safety intranet sites with follow up nudge reminders for action plans/risk assessment reviews.
- The team aim to respond to all incidents within one working day of reporting (100% compliance following audit of random sample incidents).
- Taking over the responsibilities for fire safety. Increasing statutory fire training compliance from 49% to over 80% and maintaining an upward trajectory.
- Estates and Facilities risks are discussed at a monthly Risk Action Group and a paper is then presented to the Director outlining areas of any concern and subsequent mitigation. At eth start of the year the Group had 47 risks but this has been reduced to 28 risks on the Estates and Facilities Risk Register due to some risks being resolved and some being merged or accepted. The Health and Safety Team are deeply involved in both arms of the directorate and safety is a core part of their daily work.
- Closer working ties have been forged with the Commissioning Team to make the process of project management and handover smoother in the present and future.
- Visit from the LFB to the Italian Building on the 26th of June gave no recommendations and a clean bill of health.

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

Aims for the New Financial Year

The team will be changing in the coming quarter with the addition of a new fire advisor and some additional administrative support.

The team have worked assiduously to increase the numbers of staff undertaking mandatory fire training. The rise from 49% to 80% compliance since the team took over the responsibilities is testimony to that. The team are aiming to have at least 95% of the Trust receiving the mandatory training in both fire and health, safety and welfare training (health, safety and welfare currently stands at 87.6% coverage).

All staff who have not received their training within the allotted timescale are being written to in order to remind staff of their obligations to attend. Sessions have been arranged either locally or in the Weston House training suite.

All areas will receive a fire risk assessment and health and safety assessment in the coming months. This will be helped in part by employing an additional Fire Advisor who will help maintain the improvements whilst bringing their expertise to bear in respect of future projects.

The Team are aiming to have at least two members of staff trained as fire marshalls in every clinical and non-clinical area in the Trust. Currently there are just under 100 staff trained but this figure will rise considerable in the first quarter of 2015/16.

We wish to forge closer ties with the London Fire Brigade (LFB) in 2015/16. In February 2015 the LFB visited the Trust and were shown all of the areas that were considered to pose a greater hazard than others and have grab packs containing information pertinent to the fire brigade.

Each non-clinical building will receive at least 1 fire drill in the next 12 months Fire.

CAPITEC will be re-auditing in July 2015 and the results will be presented to the next Clinical Governance Committee.

Number and severity of incidents reported (Pan Trust)

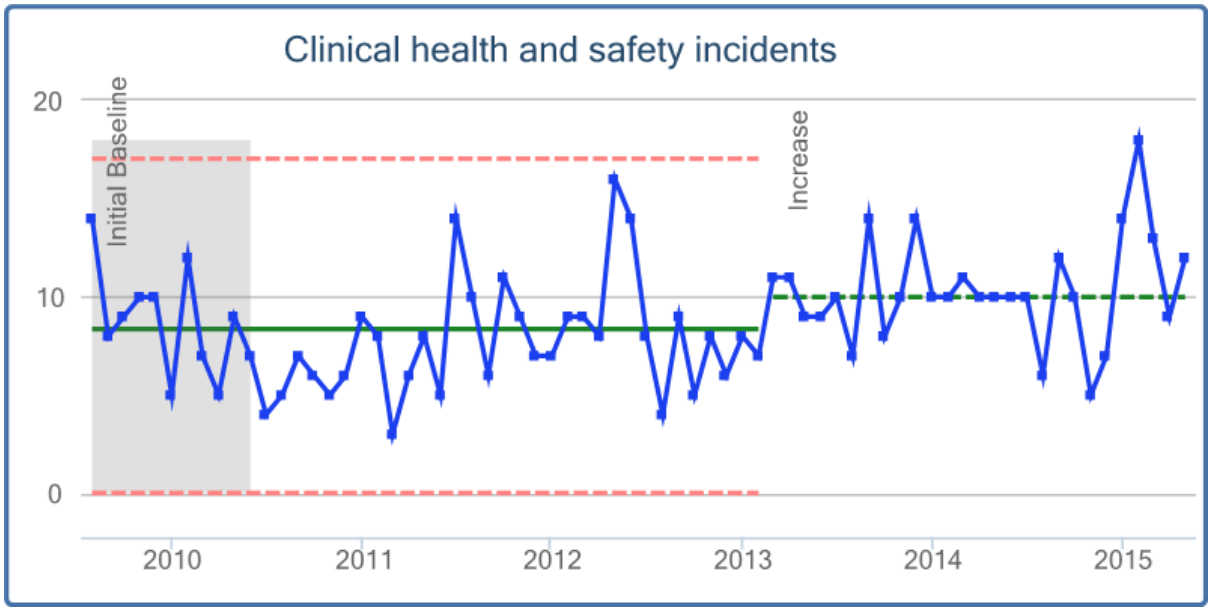
GOSH employees reported 822 health and safety incidents in the year from April 2014. These included including 125 patient safety incidents.

During the period, there were:

- 3 RIDDOR reportable incidents (0 reported as severe)
- There was one incident graded as severe (parent self-harming)

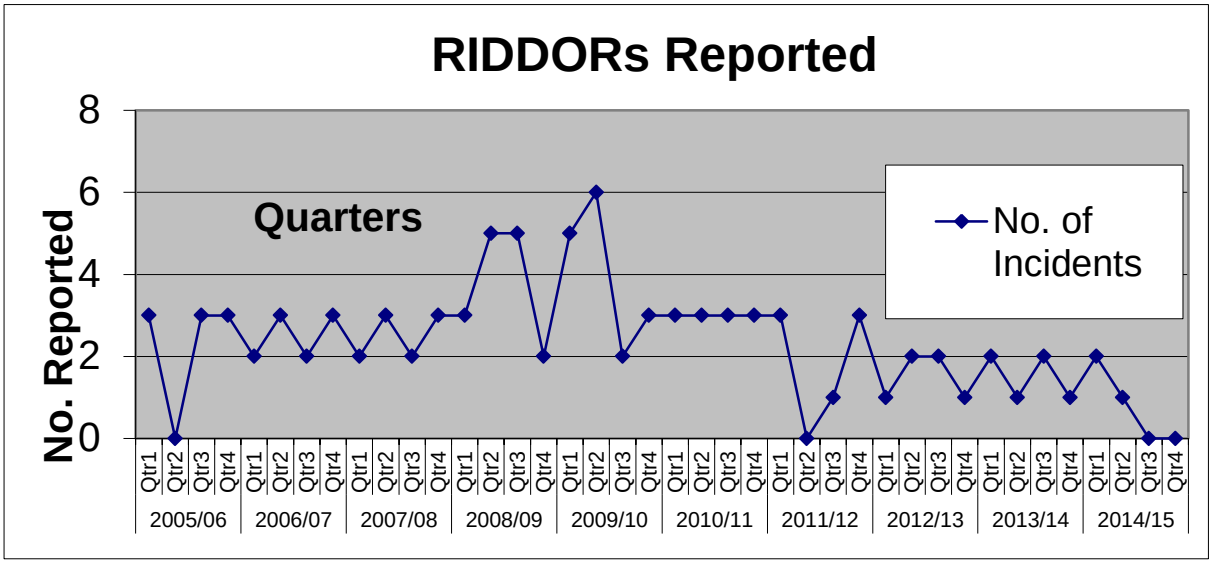
- 27 incidents reported as moderate severity.
- 330 incidents reported as low harm, and
- 464 incidents reported as no harm.

2014-15 was characterised by a drop in non-clinical incident reporting. Clinical health and safety incident numbers have remained stable. The Trust's health and safety management arrangements continue to function effectively.



Reporting of Injuries, Diseases and Dangerous Occurrence Regulations

The Trust is required by law to report specified workplace incidents, such as work-related deaths, major injuries, over 7-day injuries, work related diseases, and dangerous occurrences (near miss accidents). (Previously the reporting threshold was over-3-days, now it is over-7-days off work or unable to do normal duties. This change occurred in April 2012).



Conclusion

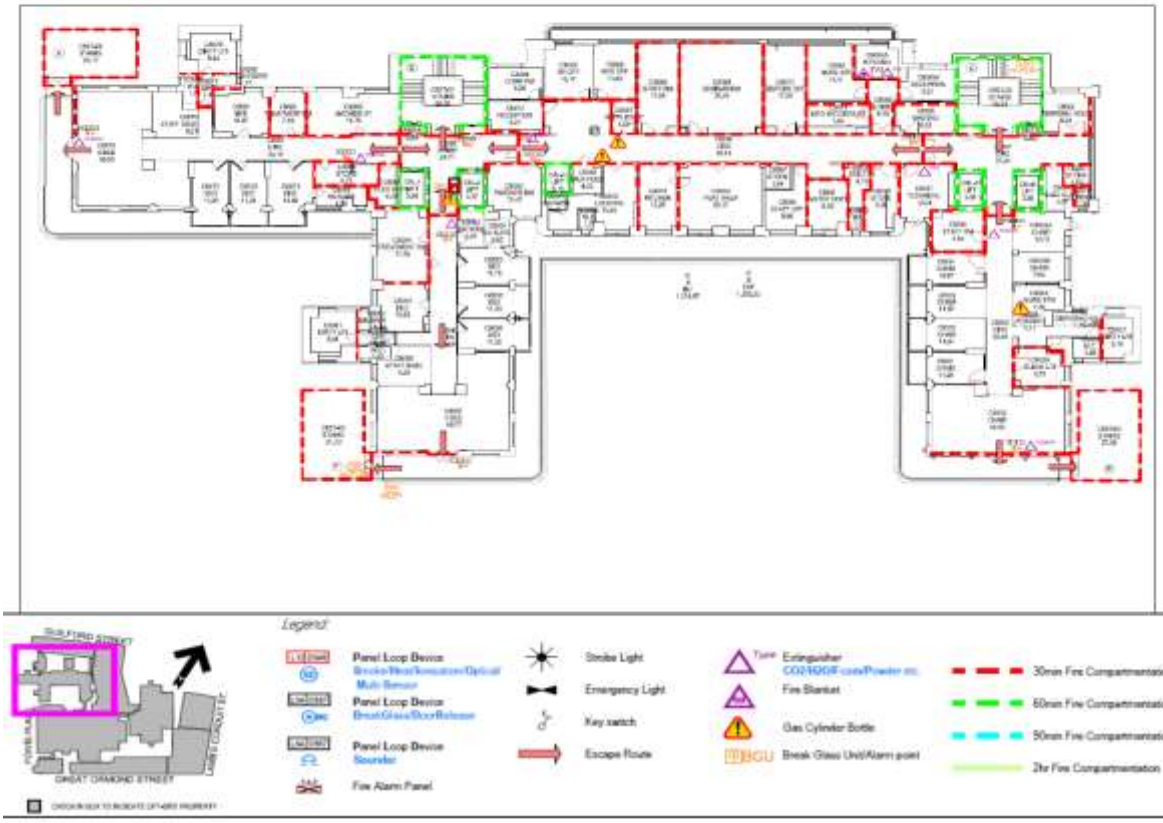
There was 1 serious health and safety incident reported during the year. In conjunction with the incident reporting system the Trust uses proactive means of identifying and subsequently mitigating risks. These include auditing the entire Trust using a tool which monitors compliance against statutory regulations (COSHH/PUWER/LOLER etc.) and measures performance against any safety critical alerts or Trust/paediatric specific criteria. The governance structure ensures that any statutory compliance is undertaken within stated legislative guidelines.

The Trust has a multimillion pound building/redevelopment program underway which brings with it inherent problems especially when juxtaposed with the clinical environment. There are measures in place which put additional controls on the construction work and ensures this work fits around the delivery of the clinical care rather than vice versa. The Trust is in a good position at present from a health and safety and fire perspective.

Appendix 1 (Example of a GOS Fire risk assessment)

Great Ormond Street NHS Hospital for Children
NHS Foundation Trust

Ward/ Department Fire Risk Assessment:	Badger
Description of Location:	Southwood, level 8
Responsible Person:	Ana Marote



Department Information:

Name of Department/Ward:	Badger
Building:	Southwood
Floor:	8
Usage:	Clinical
Responsible Person:	Ana Marote
Number of people using each room:	
• Patient	15
• Staff	20
• Visitor	20
• Contractor	0

Great Ormond Street NHS Hospital for Children
NHS Foundation Trust

Describe the risk, controls and actions required and assess the risk level.

Type:

- Combustible materials - Bio/flam substances
- Combustible Materials - Flam Solids Class A
- Combustible Materials - Flam.Gases-compressed
- Combustible Materials - Textiles and Furniture
- Compartmentation - Fire Door(s)
- Extra-departmental risks - adjacent area(s)
- Extra-departmental risks – below floor
- Extra-departmental risks – overhead
- Ignition Sources – Chemicals
- Ignition Sources - Equip't – Electrical
- Means of Escape - Fire Escape Route
- Oxygen – Portable
- Oxygen - piped under pressure
- People – Contractors
- People – Disabled
- People – Visitors
- People - Young People

Existing Controls:

- Compartmentation – Complete
- Compliance - Planned Preventive Maintenance
- Compliance - Reactive maintenance
- Compliance – Training
- Compliance - Training - Fire Team
- Compliance - Organisational Policy
- Compliance - Organisational Procedures
- Compliance - Local Procedures
- Electrical Supply - Adequate sockets
- Electrical Supply - Fixed Wire Test In date
- Emergency Lighting provided
- Fire Alarm & Detection system to L1 standard
- Fire Brigade Access provided
- Fire Plans compliant
- Fire Evacuation plans in place
- Fire Hazard Plans - Site compliant
- Fire Fighting Equip't - Manual Exting'rs/blankets provided
- Means of Escape - Alternative Routes provided
- Means of Escape - Protected, provided
- Means of Escape - Travel Distance compliant
- Refuge(s) Relative or Temporary Safety provided
- Refuge(s) - stairwell(s) – provided
- Signs - Fire Action Notice provided
- Signs - Fire Door(s) provided
- Signs - Fire Exit provided
- Training in date - Fire Team

Action (s) required:

- Sign to stairwell on West balcony above door requires changing. New exit sign (running man). Reported to Works 3/04/2015
- Fire exit sign required in C8006 pointing towards Southern balcony exit. Works contacted 3/04/2015
- Arrange bed evac training for staff email sent to Catharine Spreckley 3/04/2015
- Remove lockers and cabinet from C8014 obscuring the fire exit. Removed immediately. 02/04/2015
- Additional lights on south eastern balcony required. Works contacted 3/04/2015

Date:

To be completed	04.03.15
Consequence:	4 Major
Likelihood:	2 Unlikely

Attachment Y

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **22nd July 2015**	
Annual Report on Infection Prevention and Control **Submitted by: Dr John Hartley, DIPC**	**Paper No: Attachment Y**
Aims / summary To present to the Board the progress and issues in Infection Prevention and Control in 2014/15	
Action required from the meeting Feedback from Board. Approval for display on public web site	
Contribution to the delivery of NHS Foundation Trust strategies and plans Essential to achieve zero harm; minimising risk of infection is a central Trust goal	
Financial implications Failure to prevent or control infections leads to harm and cost. Individual penalties may follow specific HCAIs in future.	
Who needs to be told about any decision? Infection prevention and control is responsibility of all staff.	
Who is responsible for implementing the proposals / project and anticipated timescales? Divisional and Corporate Units and all staff Infection Prevention and Control Team.	
Who is accountable for the implementation of the proposal / project? Director of Infection Prevention and Control	

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST
INFECTION PREVENTION AND CONTROL ANNUAL REPORT
April 14 - March 15

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

Part A Executive summary

1 Introduction

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

Standard 3 Decrease and eliminate hospital acquired infections

The aim of this programme is to focus on

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

The IPC programme is described in the Trust Policy 'Infection Prevention and Control Assurance Framework and Operational Policy'. This report lists the IPC team structure (and team plan) and some aspects of the policy but mainly reports the results of process (control) and outcome (infection) surveillance and audit.

The data shows that a great effort is employed to reduce HCAI (such as 23,568 hand hygiene audits or 23,274 MRSA screens) but they still occur (such as 330 bacteraemias, with 76 acquired line infections, or 250 hospital onset respiratory and enteric virus infection) and some are preventable.

Health care associated infection is an ever present risk for patients and staff and requires constant application of best practice to reduce to a truly unavoidable minimum. In recognition of the ever growing needs for IPC input the Trust funded a new IPC nurse (started June 2014) to increase the team's capacity to develop, educate, encourage and enforce best practice.

2) Description of infection control arrangements

Director of Infection Prevention and Control (DIPC) **-** Dr John Hartley, Microbiologist
Executive lead for IPC -The Chief Nurse, Liz Morgan during this year.
Lead Nurse for Infection Prevention and Control – 1 wte, Helen Dunn from June 2014

Deputy Lead Nurse in IP&C 1 wte; New IPC nurse 1 wte commenced June 2014; 0.4 wte Clinical Scientist in IP&C
Other consultant microbiologists – 3 PAs
IPC Administrative support and Data Management **–** 1 wte band 4; part vacant due to career break
(The CNSs for Tuberculosis and ID lead on Tuberculosis related issues;
ID consultants contribute to the out of hours advice.)
Antibiotic pharmacist - Part time post within pharmacy
Quality Improvement team – dashboard development and display

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

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

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

2:4 Reporting lines
The DIPC is accountable to the CEO and reports to the Board and Sen. Management Team.
The DIPC and Lead nurse for IPC meet weekly with Executive lead.
A highlight report of all significant IPC issues is presented weekly to the Safety Team.
An annual plan is written and included in each annual report.
***2:5 Links to Drugs and Therapeutics Committee,* Antimicrobial stewardship**
A Consultant Microbiologist and Infectious Disease Physician are members of the Drugs and Therapeutics Committee. There are antimicrobial working and stewardship groups.

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

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

4 Budget allocation to IP&C activities

4:1 Staff
Staff budget in Department of Microbiology, Virology and IPC, Laboratory Medicine, ICI-LM
4:2 Support
IT Support and hardware: is supplied within the departmental budget.
There is no separate IPC budget, but emergency outbreak funding is provided by the Trust.

5 HCAI Statistics ***2014/15***
5:1 **MRSA bacteraemia =** 0
5:2 MSSA bacteraemia = 25 RCAs showed line infection is the most common cause.
5:3 E. coli bacteraemias = 19 episodes
5:4 ***Glycopeptide resistant enterococcal bacteraemia (GRE)*** *= 2*
***5:5 Clostridium difficile* associated disease** = 15 reported; 2 judged as lapse in clinical care (against objective of less than 8).
5:7 GOS acquired Central Venous Catheter related bacteraemia = 1.3/1000 line days. Lowest rate ever, although still 76 episodes. Effort is underway to reduce further.

5:8 Other bacteraemia episodes and antimicrobial resistance – 330 episodes (so potentially 254 non GOSACVCRB bacteraemias).
Review of the antibiotic resistance of the 20 coliforms in haematology/oncology/immunology/BMT children still shows a high level of resistance:

	Amikacin	Gentamicin	Ciproflox	Ceftaz	P/Taz	Carbaepnem
% resistant	5	15	45	35	30	5

5:9 PICU recommenced a period of ventilator related pneumonia and is reviewing how further surveillance may proceed.

5:10 Surgical Site Infection Surveillance

Surgical division – has established a regular SSIS programme including at least one procedure from each specialty. Reports at Surgical IPC Board.
Critical care and cardiorespiratory – an intermittent surveillance programme has been possible. Reports to the CCCR weekly M&M and the SSI prevention group.
Neurosciences – continuous audit is performed for permanent shunt procedures, and displayed on the dashboard. RCAs are performed for each infection and a separate audit is performed of compliance with the shunt insertion protocol.
2014/15 - 5 infections from 157 procedures at rate of 3.2

5:14 Viral infections detected while at hospital

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

Respiratory viral infections detected:			
	Total	Community onset	Hospital onset
Total in 2013/14	252	172	80
Total in 2014/15	399	302	97
Enteric viral infections detected			
Total in 2013/14	360	229	131
Total in 2014/15	352	199	153

Over all there has been an increase in detection of viruses in children admitted to the trust. One wards was on restricted admission in 14/15.

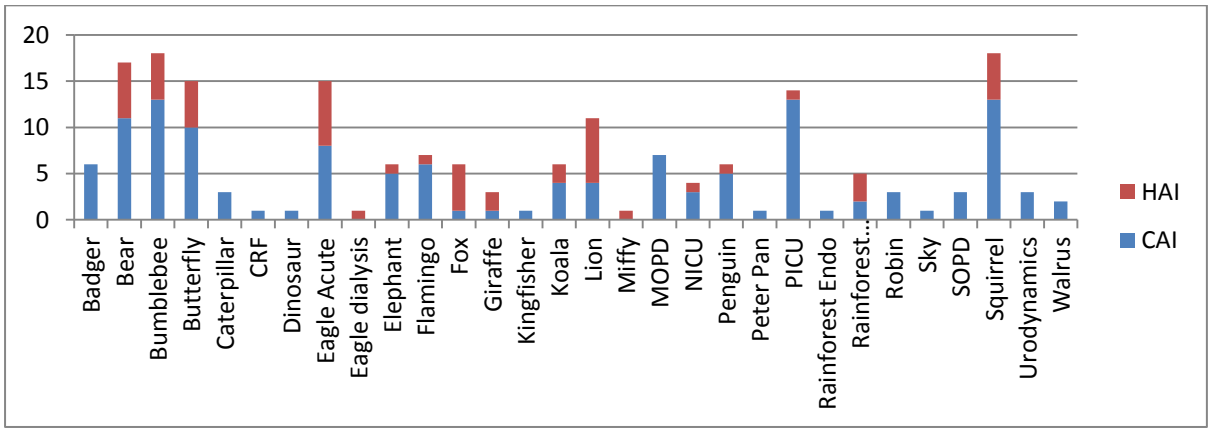
5:11 MRSA Admission Screening and rates
Nose and throat swab screening rate at 48 hours for inpatient admissions remaining in for > 48 hours, all patients. Target > 95%: 2014 screen compliance = 98%

MRSA cases of colonisation/carriage at GOSH
In 2014 there were 154 children with first detections,9 probably or possibly acquired in the hospital. Each case is investigated.

5:12 Multiple resistant 'gram negative' (MDRGN) organisms screening and rates
Faecal screening for inpatients remaining in for > 48 hours; target >75%: 2013 rate = 88%

MDR-GN carriage/colonisation - In 2014 testing revealed 186 first detections, 132 came in colonised, 54 were possible cross infection. These are found across the Trust.

Bar chart showing location of children colonised on admission or subsequently found to be colonised with multiple resistant gram negative bacteria by ward in 2014



Three cross infections clusters were confirmed, Including a serious outbreak of a carbapenemase producing *K. pneumoniae*

5:18 Serious Untoward incidents and complaints involving Infection, major outbreaks and threats (including Ebola virus)

2 SIs involving risk from *M. tuberculosis* with failure to implement appropriate control and recognise risk from symptomatic adult.
Major outbreak - transmission of a carbapenemase producing *Klebsiella pneumonia*.
Ebola – major preparation, risk assessment and education programme undertaken.
One significant cluster of infections in spinal surgery was investigated.

6 <u>Hand Hygiene, CVC on going care guidelines, National Staff Survey</u>

The Trust clinical practice guidelines are available on the GOSH Web within the Infection Control link. Alcohol gel hand hygiene products are placed inside all ward areas to encourage staff, visitors and patients to decontaminate their hands within the clinical area. Compliance with the CVL ongoing care bundle is essential for the prevention of line infections. Regular audit is undertaken.
National Staff survey scored low on the infection control question (training) and we need to understand this better to respond.

7) <u>Facilities</u>

Estates and Facilities became one Directorate from April 2014.

Environment

Additional measures have been put in place to monitor the cleanliness of the environment. External cleaning contract is up for renewal.

Decontamination

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

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

8. Estates

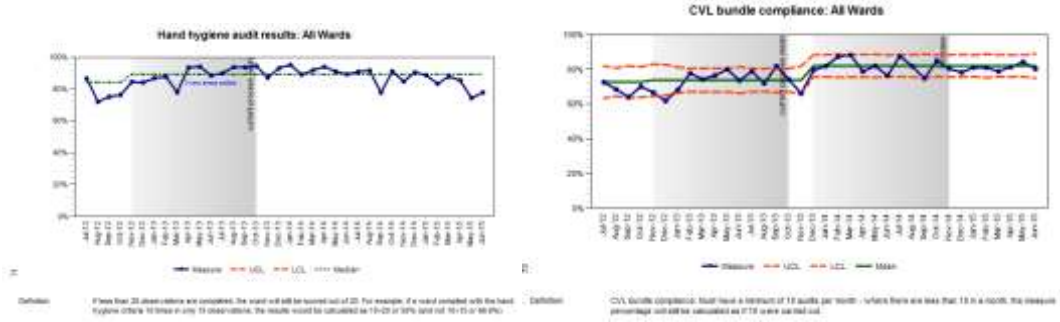
Authorised Engineers are in place for Ventilation and Water.
Verification of specialist ventilation proceeds to schedule.
Water Safety Management Group continues to develop and manage risk associated with water, with an expanded programme to control risk from *Pseudomonas aeruginosa*.

9 Trust wide audit

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

Audit completion compliance rates have decreased in hand hygiene, although not in audits completed (97% of 26,568 observations were actually satisfactory).

Hand hygiene and CVC care bundle audit:



Central Venous Line Ongoing Care

Compliance remains static, as shown above. This is 88% compliance in 3844 audits (89% last year) so we aim to improve.

This audit process represents a lot if time in its own right.

9:5 Antibiotic prescribing and audit

Antimicrobial stewardship was included as a CQUIN target for 14/15, and this was achieved. A new plan is being developed for 2015/16.

10 Occupational Health

OH continues to provide 'new entrants' screening, "Exposure Prone Procedures" clearance, staff immunisation (including influenza, final uptake 40%, same as last year)) and blood borne virus exposure follow up (74 events, compared to 84 in previous year).

11 Targets and Outcomes	Target	Outcome
MRSA bacteraemia –	0	0
MRSA Screening for children admitted > 48 hours (total screens done = 23,274)	95%	98%
Faecal screens for children in > 48 hours	> 75%	88%
Clostridium difficile infection lapses in care	<8	2
Rate of GOS acquired line infection /1000 days	<2.1	1.3
Root cause analysis for S. aureus bacteraemias	100%	100%
MRSA colonisation acquisition	0	7
Hand hygiene audits (total audits 26,568)	95%	97%
CVL care bundle audits (total audits 3844)	90%	88%
IPC level 1 induction	95%	85%
IPC level 2 update	95%	<50%

12. Training activities

Basic IPC training and update is provided for all staff through either e-learning, face to face teaching from the IPC team or both. Update is now only through e-learning, including assessment questions. Attendance is monitored and records are maintained by the Training Department, but uptake is not satisfactory.

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

IPC training days: A popular training day programme continues.

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

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

Training and competency assessment for intravascular catheter insertion is provided locally and all divisions should be working towards a standard policy. This is not yet completed but ICUs are just introducing a new bundle.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board Meeting
22nd July 2015

Education Annual Report 2014-2015 **Submitted on behalf of:** Ali Mohammed, Director of HR and OD	**Paper No: Attachment Z**

Aims / Summary
This Annual Report provides an overview of education activity in the period from April 2014 to March 2015. It addresses the Trust's responsibilities for education and training, including national undergraduate and postgraduate professional training programmes, continuing professional development (CPD), and leadership development.

Action required from the meeting
The Board are asked to note the contents of this report and make any recommendations as necessary.

Contribution to the delivery of NHS / Trust strategies and plans
The report addresses key domains of the DoH Education Outcomes Framework, LETB strategic aims, and the Trust's strategic priority to 'recruit, train, and retain the very best staff'.

Financial implications
There are some financial implications regarding reduced workforce development funding in 2014 and changes to medical funding tariff for 2014-2015.

Legal issues
There are no direct legal implications.

Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?
Key relationships are detailed within the report.

Who needs to be told about any decision
Geoff Speed, Assistant Director Medical Education and Leadership
Louise Morton, Assistant Director Clinical and Professional Education
Education teams, internal and external partners as indicated.

Who is responsible for implementing the proposals / project and anticipated timescales
Geoff Speed, Assistant Director Medical Education and Leadership
Louise Morton, Assistant Director Clinical and Professional Education

Who is accountable for the implementation of the proposal / project
Ali Mohammed, Director or HR and OD

Author and date
Louise Morton, Assistant Director Clinical and Professional Education
Geoff Speed, Assistant Director Medical Education and Leadership
July 2015

EDUCATION ANNUAL REPORT
2014-15

Louise Morton, Assistant Director Clinical and Professional Education
Geoff Speed, Assistant Director Medical Education and Leadership

July 2015

EXECUTIVE SUMMARY

Background

Education, learning, and development underpin our Trust mission to deliver world-class clinical care and innovative clinical research, and this is reflected in the Trust strategic aim, 'to be an excellent place to work and learn'.

The period to which this report relates (April 2014 to March 2015) has seen the publication of the NHS Five Year Forward View, which outlined how NHS services must change to move towards the care models required for the future. The challenge for education is to ensure that commissioning, design, and delivery are aligned to and keep pace with that change. National education commissioning structures have been subject to further change as the 13 Local Education and Training Boards (LETB) in England, formed in 2013, have been re-configured into 4 geographical regions with a more streamlined structure. The Health Education England (HEE) mandate was refreshed in April 2014 to reflect an increasing focus on integrated care but also included a welcome focus on the needs of children and young people. For GOSH, there is a risk of a mismatch between Trust priorities as a tertiary centre and national/LETB priorities for impact across the health economy. The Trust's approach, to date, has been to make the case for specialist education but also seek opportunities to collaborate on generic child health education, network education, or areas such as leadership and quality improvement.

The Trust has developed an effective working relationship with the LETB, Health Education North Central and East London (HENCEL), and continues to work closely with London South Bank University (LSBU), UCL Partners, and other key partners to ensure the Trust continues to offer a high standard of education, training, and development to staff and also that education keeps pace with Trust strategic priorities, service demands, workforce change, and the needs of children, young people, and families.

Education at GOSH

The core principle of education at GOSH is to ensure staff have the skills, knowledge, attributes, and confidence to provide a high quality, safe, and effective care and that learning is effective without compromising efficient service delivery.

The education priorities for 2014-2015 were determined as follows:

- Work with colleagues across the Trust to develop education activity to support and embed the Trust Always Values
- Implement and evaluate the University Certificate of Competence, Principles of Caring for Children and Young People (Level 3 academic qualification)
- Introduce a Care Certificate in line with the HEE requirements for Bands 2-4
- Develop and deliver a work-based learning module for high-dependency nursing
- Introduce a monitoring system for triennial review and action plan to ensure and sustain compliance with NMC mentorship requirements.
- Embed the new PDR process
- Support the Heads of Clinical Service recruitment process through the design and delivery of an HOC Assessment Centre
- Introduce a new Learning Management System (LMS) which will pull together GOLD and the existing training database. This will provide a self-service one-stop-shop, allowing staff to access on-line learning, course information, tutorials, and training records.
- Expand medical education activity, improving communications, and working in partnership with Specialities.

The Trust has made good progress against these priorities. Key successes include:

- Significant improvement in compliance with mentorship update training
- Successful introduction of the University Certificate of Competence for Healthcare Assistants
- Development of the children and young people's Care Certificate for Bands 2-4
- Launch of new PDR process, updating paperwork and moving PDR windows to be in line with AfC terms & conditions
- Increase in Apprenticeships across Trust
- Expansion of the medical education prospectus (see medical education section of this document)
- Increase of mandatory training compliance through innovative delivery

Key areas for on-going development have been some areas of medical training, on-going improvement in mandatory training compliance, and the final implementation of the new Learning Management System which has been delayed due to (now resolved) data migration issues.

Next steps

Key priorities for the forthcoming year are:

- Approve and implement the Education Strategy
- Develop and launch a Leadership Development Strategy, supporting all levels of leadership
- Use new Leadership Development Strategy to support the development of Heads of Clinical Service & other senior leadership
- Implement and evaluate the Care Certificate
- Build upon the actions resulting from HENCEL trainee review
- Review of nursing preceptorship, in line with emerging national standards
- Expand the number of Apprenticeships at GOSH
- Ensure education commissioning supports the development of advanced nursing practice and other roles which will support alternative workforce models, in line with workforce and clinical strategy
- Establish a quality review process for placement learning across nursing and non-medical health professions in line with HENCEL multi-professional quality review procedures and standards.
- Realise the benefits of the new Learning Management System

1. SCOPE OF THIS REPORT

1.1. This report relates to the period from April 2014 to March 2015 and addresses Great Ormond Street Hospital for Children NHS Foundation Trust's (the Trust's) responsibilities for education and training, including national undergraduate and post graduate professional training programmes, continuing professional development (CPD), and leadership.

2. STRATEGIC OVERVIEW

2.1. National and regional context

2.1.1. The implications of the Health and Social Care Act (2012) have been significant for education, as for all areas of healthcare. The NHS Five Year Forward View[1] sets some clear challenges for the commissioning and education of a workforce that can deliver transformational change. In line with this agenda HEE strategic priorities will inevitable focus on the integrated care agenda seeking to promote workforce redesign that will support New Models of Care. Commissioning priorities within the LETBs will follow suit, which is likely to see a further challenge to limited workforce development funding (that is, funding streams to support the current workforce). There are clear implications here for GOSH as there is a risk of a mismatch between national/LETB priorities and those of the Trust, as the very nature of GOSH business makes an integrated/collaborative approach across the LETB geography hard to achieve. The Trust's approach, to date, has been to continue to make the case for specialist education but also seize opportunities relating to key HEE mandate priorities with regard to developing apprenticeships and development pathways for healthcare assistants. Other initiatives have been collaboration on generic child health education, network education, or areas such as leadership and quality improvement. Going forward, education activities which support workforce redesign represent the most likely area of opportunity in terms of commissioning and funding support.

2.1.2. The quality of practice learning and education is likely to be a key element within the Learning Development Agreement for 2015-2016. HENCEL is developing a practice learning quality toolkit which is based upon a self-reporting process with external review and validation which aims to identify and promote good educational practice in the clinical setting. The Trust will be expected to use this to demonstrate quality of placement learning and progress against the key quality requirements outlined in the LDA.

2.1.3. This report anticipates the publication of the Shape of Caring Review in the first quarter of 2015-2016. The Shape of Caring Review was commissioned by HEE and led by an independent Chair, Lord Willis of Knaresborough. The aim of the review is to ensure that nurses and care assistants receive consistent high quality education and training throughout their careers. The report will bring together findings from recent major reports and an extensive engagement programme. It is expected that a period of consultation will follow the publication of the report and that, once agreement has been sought on which recommendations should be prioritised, further development work will take place before these are finalised.

[1] NHS England, The Five year Forward View (2014)

3. GOSH EDUCATION STRATEGY

3.1. A key priority for 2014-2015 has been the development of the Trust's education strategy. This section of the report provides a summary of progress to date. The strategy was originally developed as a result of two stakeholder events: a 'world café' to scope the vision with internal stakeholders to and a strategic conversation with a wider group of Trust staff from across the professions and representatives from key partners to determine strategic goals and priorities.

3.2. A draft was discussed at Trust Board in October 2014 further to which the strategy was revised and a document providing an overview of the core objectives written. This overview has been widely circulated and commented upon. The strategy sets out, at a high level, the proposed strategic goals and priorities for education at GOSH for the next five years. The core strategic goals are:

1. **Fulfilling the Trust's role as an employer and education provider**
2. **Supporting the Trust's mission as a world leader in paediatrics and child health**
3. **Meeting the Trust's mandatory requirements**
4. **Building a financially sustainable education function which identifies and acts upon commercial opportunities**

3.3. Further to feedback, the strategy is currently being amended to include more specifics regarding key drivers for change, current versus future state in terms of demand and required resourcing, and a clearer statement of the first year's delivery plan. The timescale for further development of the education strategy is contingent on the development of other strategies, such as workforce, clinical, and research with which the education strategy shares key inter-dependencies.

3.4. The stakeholder engagement events helped shape the immediate priorities for 2014-2015. These were determined as follows:

- Introduce a new Learning Management System (LMS) which will pull together GOLD and the existing training database. This will provide a self-service one-stop-shop, allowing staff to access on-line learning, course information, tutorials, and training records.
- Work with colleagues across the Trust to develop education activity to support and embed the Trust Values
- Implement and evaluate the University Certificate of Competence, Principles of Caring for Children and Young People
- Introduce a Certificate of Care in line with the HEE requirements for Bands 2-4.
- Develop and deliver a work-based learning module for high dependency nursing
- Introduce a monitoring system for triennial review and action plan to ensure and sustain compliance with NMC mentorship requirements
- Responding to HENCEL recommendations post "From the Coalface" report.
- Expansion of Apprenticeships – both from a recruitment perspective and existing staff undertaking qualification.
- Leadership development

3.5. Progress against these priorities is summarised in the Appendix 1. Key areas of activity are discussed in detail later in this report.

4. OPERATIONAL OVERVIEW

4.1. The education team has three core functions: Postgraduate Medical Education (PGME), Learning and Development (L&D), and Nursing and Non-Medical Education. A schematic of the teams and reporting structure, the teams' core functions, and key relationships are outlined in Appendix 2.

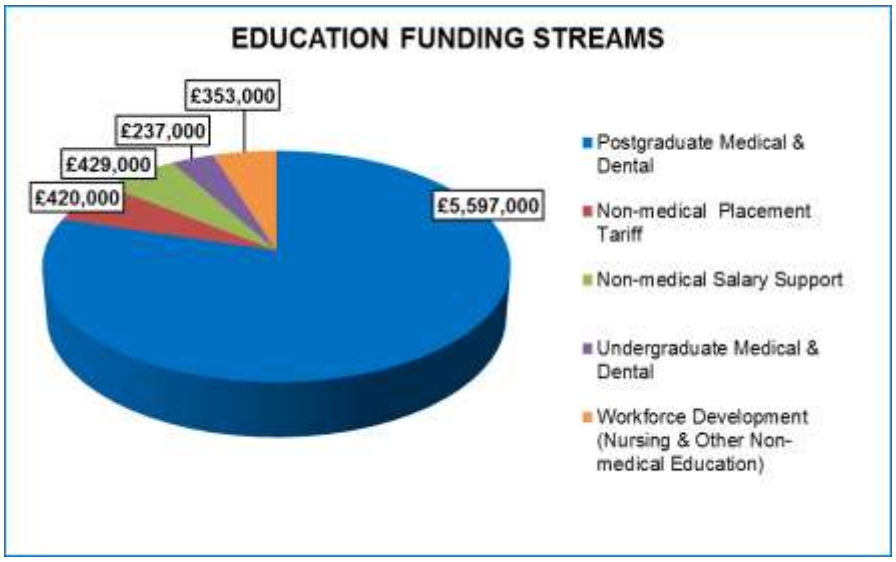
5. COMMISSIONING AND FUNDING OF EDUCATION AND TRAINING

5.1. Education Funding for 2014-2015

5.1.1. The Learning and Development Agreement (LDA) between the Trust and HENCEL sets out the Trust's responsibilities in relation to funding streams for non-medical education and training (NMET), undergraduate medical and dental, postgraduate medical and dental, and workforce development funding for Bands 1-9. The LDA requires compliance with performance and quality monitoring procedures as determined by HENCEL/HEE. The Trust is asked to account to HENCEL for spend against each funding stream, and the Trust is expected to show progress against national and LETB priorities as well as Trust priorities. Funding is released on a quarterly basis, dependant on compliance.

5.1.2. The current funding streams are outlined in Figure 1 below. HEE introduced a tariff based system for healthcare education within higher education and for placement learning in provider institutions. The Trust receives salary supported places on core training programmes in nursing (predominantly the shortened children's nursing programme for adult trained nurses), pharmacy, operating department care, and healthcare science.

Figure 1: Education Funding Streams



5.1.3. Changes to the medical funding tariff in the 2014-15 financial year will result in a reduction in the funding GOSH can expect to receive, as the Trust will only receive

50% salary-support for those trainee posts, where previously we received 100% of said funding. Continuing Professional Development (CPD) is commissioned by the LETB. The Trust receives an allocation with local Higher Education Institutions (HEI), chiefly our partner HEI, London South Bank University (LSBU). The Trust also receives an allocation for Workforce Development Funding.

5.1.4. In addition to our allocated LDA funding streams, GOSH secured HENCEL funding though bids for specific workforce development projects in line with HENCEL's strategy. In 2014-2015 this resulted in additional funding as shown below:

Project	Allocation
Crossing Boundaries – Addressing Care Fragmentation	£39,850
Apprenticeship Development	£50,000
Communication with Medical Trainees	£30,000
Developing Skills in Clinical Teaching	£16,000
Cavendish Care Certificate	£9,743
Total	**£145,593**

5.1.5. Although the Trust sustained a loss of workforce development funding (WDF), additional funding from HENCEL for mentorship and preceptorship allowed for release of workforce development funding to support other areas of CPD, which limited the impact of the WDF shortfall. Non-recurrent funding was released mid-year for mentorship and preceptorship for nursing, which was supplemented in a response to an additional successful bid submitted by the Trust. This enabled the development of the Professional Development Programme for newly qualified nurses and improvements in mentorship training and compliance with NMC requirements for mentor updates and triennial reviews.

5.1.6. Further information on education commissioning can be found at Appendix 3.

5.2. Charity Funding Streams

5.2.1. The Trust is fortunate to receive significant support for educational activity from the GOSH Charity. Activity against these funding streams is outlined in Appendix 4 and can also be found in the 2014-15 impact reports submitted to the Charity.

5.3. Education and Training Reference Cost Exercise

5.3.1. In January 2014, all NHS Trusts were required by the Department of Health to calculate the costs of providing training programmes for all salaried and non-salaried staff over a period of 6 months (April to September 2013). The rationale for calculating the costs of education and training was to support the development of education tariffs and ensure that the costs of educating staff are separated from the costs of delivering clinical services which are collected annually to inform the development of the national tariff. A further exercise covering a twelve-month period was submitted in August 2014. A summary of the outcome from this costing exercise is seen below:

Type	Data	
	Activity (Hours)	Costs (£m)
Salaried	251,447	15.23
Non-Salaried	168,510	4.38
Total	**419,957**	**19.61**

5.3.2. A summary of the guidance provided by the DoH to calculate these costs was included in the 2013-14 Annual Report. However, as a reminder of the key points:

- For medical training, the costing exercise covered all staff in training posts, even those where there is no funding received from Health Education England (approx. 50% of staff).
- For the purposes of costing clinical placements, training programmes had to be categorised as salaried and non-salaried training.
- Non-salaried training programmes included programmes such as undergraduate medical and dental, pre-registration nursing, and Allied Health Professions.
- Salaried training programmes included programmes such as specialty medical training programmes, pre-registration pharmacy, and STP healthcare scientist training.
- Costs were required to be analysed at the level of:
    - *Salaried and non-salaried training programmes*
        1. Pre-placement
        2. Direct teaching
        3. Training for teaching staff
        4. Teaching while delivering patient-care
        5. Facilities
        6. Administration
        7. Central educations
        8. Overheads
    - *And for salaried training programmes*
        1. Checking trainees' work
        2. Trainee courses and examinations
        3. Trainee staff costs
        4. Proportion of trainee time in training

5.3.3. The August 2014 submission built upon the initial January work clarifying some of the assumptions and ensuring training costs for all staff were included in the non-salaried programme. Further guidance is anticipated from the DoH on the implications of this work. An annual return will now be required.

6. CORE EDUCATION ACTIVITY

6.1. Post Graduate Medical Education

6.1.1. The Postgraduate Medical Education Design team reviewed the challenges of accessing education for Junior Doctors at Great Ormond Street Hospital as highlighted in the Trainees' report "At the Coalface". The report highlighted that one of the areas that worked well was the "support from PGME and the teaching and variety of courses". Building on this strength PGME worked with the Co-medical Director, Director of Medial Education (DME) and education leads to create a strategy aimed at improving the culture of education at GOSH and introduced initiatives designed to address the training issues raised in the report.

6.1.2. The PGME Newsletter was launched on 21st March 2014 and continues to be distributed weekly. The target audience has grown and the newsletter distribution list includes Consultants, Sisters, Charge Nurses, Specialty Leads, Nurse Consultants, Heads of Nursing, Learning and Development, Practice Facilitators, Junior Doctors, and Practice Educators. The concept of the Newsletter is to have valuable sources

of training opportunities available in an interesting and reliable format. Positive feedback for the Newsletter continues to be received. Recognised areas of development including the establishment of an editorial board and circulating responsibility between specialties to ensure the material remains useful and relevant to all.

6.1.3. Specialty teaching: Integration with the clinical specialties in the communication of teaching activities has been successful. This initially started with advertising the teaching of one specialty (paediatric cardiology) and quickly spread, attracting more specialties into the initiative. Building on this engagement, PGME now issues a weekly bulletin of specialty teaching that takes place across the Trust, with the aim of making high quality teaching more widely accessible. The hosting specialties have also appreciated the opportunity to deliver teaching to a wider audience.

6.1.4. Guidebook: Building on the original communication strategy of increasing information regarding cross-Trust teaching activities, funding was secured from HENCEL for a communication project. There was a demand for information about teaching to be widely distributed with integration between the clinical departments. Working alongside an external application design company 'Guidebook' a bespoke interactive teaching communication guide has been developed which is due to launch in July 2015. The guide will be accessible across all platforms, including Trust and personal devices. Instant and clear information will be provided about training events with the option to categorise according to areas of interest and also to create a personal teaching schedule. The app provides users with the options to create and share teaching notes and also provide feedback to trainers, supporting our quality assurance strategy.

6.1.5. The PGME website was redeveloped and launched 22nd May 2014. It remains an up-to-date, reliable, and user-friendly resource.

6.1.6. Developing Educators**:** July 2014, saw the launch of a six-month training programme in educational leadership for junior doctors, 'Developing Leadership through Simulation and Practice'. The aim was to empower junior doctors to lead on improving education within their department. The quality of the projects was very high. This pilot programme demonstrated great potential for faculty development, and building on this, the Education teams were successful in securing funding for an Inter-Professional Faculty Development programme in October 2014. Following consultation with the medical and non-medical educators across the Trust, the programme has developed into an Inter-Professional Education Network which launched on 3rd June 2015. The aim of the Network is to provide a foundation and sustainable source of support for educators across the Trust to continue to develop their skills and come together to support one another.

6.1.7. Having identified within the Coalface Report the need for further training and support of consultants and senior trainees to provide teaching, funding was secured from

HENCEL to create two new courses: 'Leading Learning', which explores education culture, approaching barriers to education and development of clinical teaching skills and 'Coaching and Mentoring', which equips trainers with vital skills to support trainees in their development.

6.1.8. Coaching and Mentoring Course: This introductory course has been designed to develop knowledge, skills, and attitudes to enable participants to coach colleagues, trainees, and supervisees.

6.1.9. The PGME Team continues to work alongside the Docs Rep committee to support trainees across the Trust. This has been especially important during significant organisational events over the last 6 months: HENCEL visit and removal of oncology trainees (November 2014) and also support through the HR & OD/PGME reconfiguration (September 2014).

6.1.10. Since March 2014, there has been representation of trainees at the London School of Paediatrics, with increased integration with the College Tutors.

6.1.11. In May 2014, a weekly Paediatric Teaching programme commenced and ran successfully until October 2014.

6.1.12. Inter-Professional integration: the Senior Education Team have been meeting on a regular basis over the last year, giving the opportunity of understanding and supporting one another's activities. Joint initiatives have been successful including the joint application for funding for the Inter-Professional Faculty Development Programme (see right). The team continues to work together on the establishment of an Education Network for GOSH. There is great potential for further integration within the education faculty.

6.1.13. PGME have continued to develop a wide portfolio of courses covering areas such as leadership development through 'Clinical Leadership in Action' and 'Leading Learning'; technical skills through 'Improving Communication Skills', 'Educational Supervision', 'Time Management' and addressing care fragmentation through the 'Crossing Boundaries' programme.

6.1.14. The team has also provided administrative support for the successful delivery of a number of other programmes including 'End of Life Care', 'Non-Invasive Ventilation', and 'EQUIP Quality Improvement Programme for Doctors". The team commissioned 'Train the Trainer', 'Courtroom Skills', and 'Politics, Power and Persuasion' from external providers.

6.1.15. In total 567 places were taken on these centrally run programmes. The more multi-professional audience now attending PGME activity is reflected in the profile of

attendees: 101 Consultants, 245 Doctors (Trainees, Trust Grade, Fellows), 74 Nurses, 52 AHP's, 64 Admin, 31 external fee paying delegates.

6.1.16. Educational Supervision: PGME have given full support to the accreditation of educational supervisors through the regular provision of Educational Supervision training courses and one-to-one support for portfolio completion. The accreditation rate has increased from 35% to 92% from October 2014 to June 2015.

6.1.17. PGME have continued to support to the community of educators around the Trust and the range of education initiatives they offer, including introduction of a Neuroradiology teaching programme, introduction of oncology teaching, creation of a critical care app, and the provision of surgical simulation skills training equipment. New projects include: Level 1-2 paediatric cardiology training programme, orthopaedics revision programme, simulated deteriorating child project, and junior surgical induction.

6.2. Nursing and Non-Medical Education

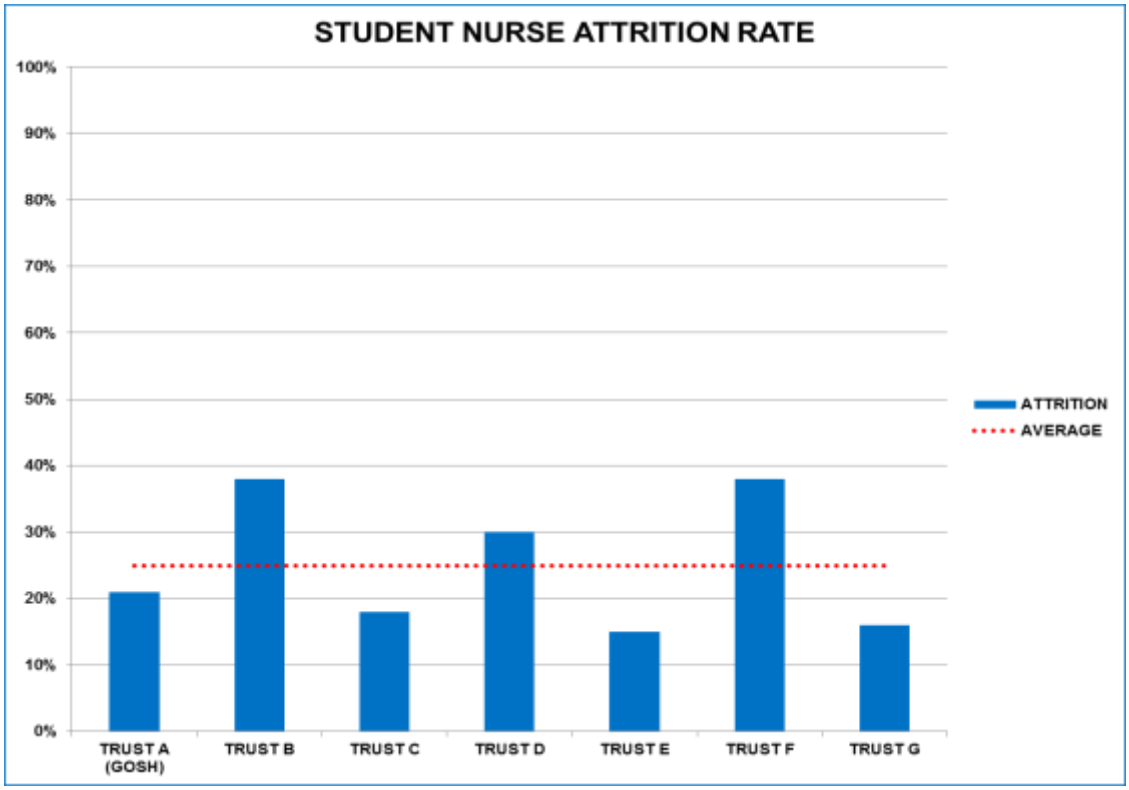
6.2.1. Pre-Registration Nursing

6.2.1.1. GOSH hosts between 300 and 400 pre-registration nursing students per year, totalling approximately 4-5,000 placement weeks. Students are supported in practice by designated mentors based in the clinical area and the Practice Educator and Student Practice Facilitators (SPFs) from the NNMET. In 2014-2015, GOSH commissioned 116 places on mentoring courses for registered nurses to ensure the Trust is able to continue to deliver a high quality placement learning environment and meet the NMC requirements for support of students.

6.2.1.2. Student nurses continue to evaluate their placement experience at GOSH positively (see Appendix 7 for a summary of recent evaluations). Students provide feedback via formal evaluations initiated by the university, by informal feedback at student forum to NNMET staff, and via a Survey Monkey questionnaire administered by NNMET. Evaluation is fed back to the ward areas via NNMET. The Practice Educator for Pre-Registration Nursing meets with the ward sister if there are any ward specific issues to address. Unfortunately the completion rate for evaluation is low and numbers therefore small. LSBU has introduced measures to address this. In addition, the student practice facilitators (SPFs) now contact students on the wards towards the end of their placements to ask them to complete the aforementioned questionnaire. The SPFs have recently introduced 'business cards' to give to students with details on how to submit an evaluation. They have also ensured that feedback to students, in response to their evaluations, is posted on the student intranet at LSBU. It is anticipated that these measures will see a higher return for evaluations in the next quarter.

6.2.1.3. Student attrition at GOSH is comparable to that at other Trusts where LSBU students are placed (see Figure 4 below). GOSH has by the far the largest cohorts of students (80-100 students compared with 5-25 at other trusts). The predominant reasons for attrition across all cohorts and Trusts are academic failure and personal reasons.

Figure 4: Student children's nurse attrition at GOSH (Trust A) and other trusts where LSBU students are placed



6.2.1.4. In 2014-2015, the education annual report reported compliance with annual nursing mentorship updates and triennial review as a risk. It was evident that a number of areas were not compliant with annual updates but also that the Trust mentorship database was not up-to-date. The NNMMET worked closely with Heads of Nursing, ward managers, PEs, and the Workforce Planning Team to address the compliance issues and ensure the mentor database is now up-to-date. As of March 2015, compliance with annual mentorship update stands at 96%. Compliance is regularly monitored by the NNMET and emails sent to alert staff and managers as mentors are approaching their update deadline.

6.2.1.5. The Nursing and Midwifery Council (NMC) requires that all mentors of nursing students must produce, at a formal review held every three years, evidence that they have mentored at least two students within the previous three years, completed an annual mentorship update, and had the opportunity to consider, in a group setting, the validity and reliability of judgements made when assessing practice in challenging circumstances. The NNMET have been working with Nursing Education Working Group (NEWG) members to agree a new proforma and process to ensure all mentors undertake this triennial review in accordance with NMC requirements. This went live in January 2015 with the aim of achieving 80% compliance within 3 months. As of March 2015 compliance stands at 83%. Compliance with mentorship update and triennial review is reported to Nursing Education Working Group.

6.2.1.6. The Trust continues to support adult nurses working at GOSH to undertake a shortened children's nursing programme in order to register as a children's nurse. Four nurses completed this programme this year, and another four are currently in training. The Trust has secured salary support for nine nurses to undertake the programme in September 2016. The Trust commissioned two salary-supported

places for support staff to enter an undergraduate professional training programme. These staff are now in their first year of training, one as a children's nurse and the other as an Operating Department Practitioner. Salary support has been secured for a further place on each programme in 2016.

6.2.2. Preceptorship for newly registered nurses (NRNs)

6.2.2.1. HENCEL have developed standards for nursing preceptorship, which will form part of the multi-professional quality monitoring review in which GOSH will be expected to participate in 2015-2016. The Trust received an invitation to bid for additional funding from HENCEL to support preceptorship and the implementation of the quality standards.

6.2.2.2. The NNMET conducted a review of preceptorship across the Trust, involving focus groups with staff and newly registered nurses, and some 'field work' to determine compliance with the preceptorship policy and quality of preceptee experience across the Trust. This found that preceptorship policy was not being implemented consistently across the Trust. Whilst a number of preceptees were receiving a positive experience, this was not true for all. In response, and with funding support from a HENCEL, a formal preceptorship programme has been established which incorporates Trust and local induction, clinical skills development, and professional development. Trust Values, quality improvement, and patient experience are key tenets of the programme. The programme addresses the areas identified in the HENCEL standards and brings GOSH in line with other major Trusts in London. The programme also provides a structure through which to implement more effective monitoring of preceptorship and to enable early intervention where staff need additional support. The programme has incorporated training for a group of nurses (B5-7) to act as facilitators/coaches to deliver the programme going forward. The first cohort has successfully completed the programme and the second commenced in March 2015. Evaluation form the first cohort is positive and has allowed adaptation of content for the second cohort. NRNs particularly highlighted the value of time spent with their immediate peers to learn, reflect, and seek support.

6.2.2.3. HEE is consulting across its LETBs with a view to adopting HENCEL preceptorship standards nationally. The GOSH programme has been highlighted as an example of good practice. With support from workforce development, a database is being created to support the development of a key data set for preceptorship and enable quality/performance monitoring and reporting.

6.2.3. Nursing CPPD

6.2.3.1. It has also allowed for additional mentorship places to be requested this year in order to secure on-going mentor support. The education team worked with internal stakeholders to ensure all available educational funding streams were used to best advantage. Heads of Nursing, lead nurses, and Practice Educators determined the key principles by which divisions were asked to commission post-registration nursing courses. This ensures that training requests are closely aligned to clinical and service priorities. Priority is given to education programmes which are deemed 'clinically essential', i.e. considered as providing the essential knowledge and skills to care for children and young people in the speciality/clinical area, e.g. PICU course, cancer course, etc.

6.2.3.2. Every year the initial 'bids' made by divisions for CPPD modules exceed funds available and have to be adjusted according to the budget available, using the

principles outlined above. The identified demand for 'clinically essential' modules accounted for approximately 50% of the indirect CPPD budget. Despite the funding limitations GOSH commissioned 468 places on post-registration specialist nursing courses, in addition to supporting staff on a variety of Masters programmes. The latter contributes to the expansion of advanced practice/nurse led roles and services and supports the Trust's aspirations for academic development of senior nursing staff.

6.2.3.3. In partnership with LSBU, the Trust has developed a new model for work-based learning which delivers accredited specialist education at degree or masters level. These programmes are taught at GOSH by GOSH staff, which allows for content and teaching to be tailored to need. These programmes require less time away from the work environment, incorporate competencies demonstrated in practice and are subject to significantly reduced fees. The Trust now delivers specialist renal, cardiac, and high dependency care (HDC) education via this route with the HDC pathway having been successfully introduced this year.

6.2.3.4. Between September 2014 and July 2015 (2014/15 academic year), students have undertaken 396 nursing modules at LSBU. At the time of this report, approximately 37% of students have received their results with the remaining to be reported by the end of August 2015. Of these students the majority have passed at first submission with only a small number needing to re-sit (referred). No students have failed at final submission to date.

6.2.4. Healthcare assistants

6.2.4.1. All trusts were mandated by Health Education England (HEE) to fully implement a Care Certificate by April 2015. The Care Certificate is a national education certificate, the aim of which is to provide clear evidence to employers and patients that healthcare support workers have been trained to a specific set of standards. Every Band 2-4 employed to provide direct care in health and social care settings must successfully complete a Care Certificate on commencement, as of April 2015. The Nursing and Non-Medical Education Team (NNMET) were approached by HENCEL to develop a children and young people's (CYP) Care Certificate, applying the generic competencies to the CYP workforce and outcomes for CYP.

6.2.4.2. Working alongside the nursing workforce team, new recruitment and selection procedures have been introduced enabling cohort recruitment of HCAs via an assessment centre. This incorporates standardised numeracy and literacy assessments, a group communication exercise, and a values-based interview. Successful candidates will then proceed directly to the Care Certificate on commencement. The first cohort commenced in April 2015. It is anticipated that the Care Certificate will need to run 3 times a year with an estimate of 10-20 candidates per cohort, although this may need to be adjusted to keep pace with workforce redesign and recruitment initiatives.

6.2.4.3. Further information of the Care Certificate can be found in Appendix 5.

6.2.4.4. The NNMET has, together with London South Bank University, developed an accredited programme for Healthcare Assistants based on the Trust's highly successful Foundation Development Programme. This was formally validated in April 2014. This will provides a unique paediatric specific programme for Bands 2-4 staff and the first step on a pathway towards entry to professional training. At time of writing, the first cohort is nearing completion of the course. All students

have passed their assignments to date. Student evaluations at the first Course Board were very positive, with students highlighting, in particular, their increased understanding of compassion in practice and what it really means to 'put yourself in someone else's shoes' and their increased confidence to recognise a deteriorating child and escalate this appropriately.

6.2.4.5. In 2014, LSBU approved the creation of the University Foundation Certificate in Principles of Healthcare Practice (UFC). This is a 120 credit bridging award that allows candidates to meet the entry requirements for a pre–registration professional degree. GOSH has been working with the Institute of Vocational Learning at LSBU to design and deliver a children and young person's pathway for the UFC. This ensures there is a full CYP specific pathway for HCAs working in this field and a route of entry into children's nursing. Validation of the above course is scheduled for June 2015.

6.2.4.6. A schematic of the education pathway for clinically-facing Bands 2-4 staff can be found at Appendix 6.

6.2.5. AHPs, Pharmacy, and Healthcare Scientists

6.2.5.1. AHP leads employ a similar process to that used within nursing to identify CPD requirements based on service development needs. A number of services are very proactive in engaging in education activity which brings in income from which the department can support study leave. This, and funding from the GOSH charity, is essential to augment limited workforce development funding and ensure on-going education provision. This year, CPD activity has included masters awards in advanced clinical practice, specialist courses essential for clinical practice in therapies, and train-the-trainer programmes. The Trust also supported a member of the play team to complete a Foundation Degree to become a qualified hospital play specialist. Charity funding has enabled staff to attend and share their work at national and international conferences. Particular highlights include a number of poster prizes awarded to GOSH psychologists at a national/international conferences, successful application for an NIHR funded MRes place in dietetics and the introduction of an experiential teaching group for physiotherapy students to improve the learning experience within the practice placement setting. Last year, the Trust initiated a foundation family therapy training course delivered in-house by GOSH family therapists. A second cohort was recruited for September 2014 and is now nearing completion. The course has evaluated very positively and has enabled some staff to access year 2 family therapy training where relevant for their role. The programme is currently being considered for accreditation by the Institute of Family Therapy.

6.2.5.2. The NNMET have been working with healthcare scientists to establish an education working group for healthcare scientists. This was initiated with a networking event in the autumn of 2014 to bring scientists together to consider their education needs, share and identify areas of good practice, and consider how to co-ordinate education activity across healthcare science. Healthcare scientists are an under-represented group and yet provide a significant amount of training for doctors and scientists in training. The event was attended by the Scientific Projects Lead NHS England (London Region) who commended the group for being amongst the first of its kind.

6.2.5.3. Last year the Sleep/Lung function service supported their first PTP student. This student has since been successfully recruited into a substantive post within the service, on qualifying. In addition to hosting a number of Scientific Training

Programme (STP) trainees (funded via salary support from Health Education England), the Trust also supports the Higher Specialist Scientist Training Programme (HSST) which is a five-year workplace-based training programme supported by an underpinning doctoral-level academic programme. The genetics service successfully applied to the LETB to support an internal candidate for this training programme active from September 2014. HSST applications for 2015 have been submitted by genetics and immunology (one place respectively).

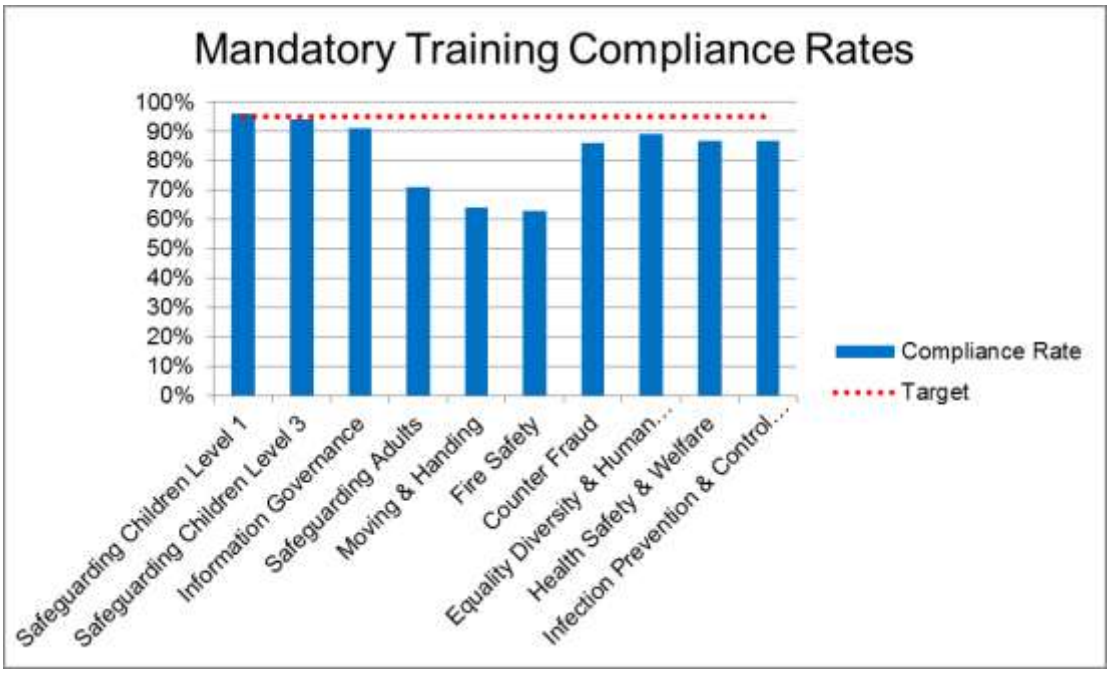
6.3. Learning and Development

6.3.1. Mandatory Training

6.3.1.1. The Trust has continued to innovate to support staff maintain compliance, this year introducing an "Update Booklet" providing staff with a simple tool for confirming their understanding of mandatory topics. This combined with Trust Induction, teaching, and e-learning, provides a varied prospectus of training options.

6.3.1.2. In March 2015, compliance rates for core mandatory topics (as set by the national Core Skills Framework) are shown below in Figure 2:

Figure 2: Mandatory Training Compliance Rates, March 2015



6.3.1.3. Further progress can be seen in the current compliance figures shown in Figure 3:

Figure 3: Mandatory Training Compliance Rates, July 2015

6.3.1.4. Education Services work in partnership with all Subject Matter Experts to formulate action plans for raising compliance. This work will be on-going throughout 2015-16.

6.3.1.5. The 14-15 staff survey showed that 88% of staff had been appraised in previous 12 months, however the actual figure at March 2015 stood at 79% (a 1% drop from March 2014). It should be noted that on 1st April 2015 the Trust moved PDR dates to tie-in with increment dates (allowing the implementation of AfC terms and conditions around holding staff at increment if underperforming). This has resulted in a 2% increase in PDR rates as set out below in Figures 4 and 5:

Figure 4: PDR Appraisal Rates as of 18th June 2015

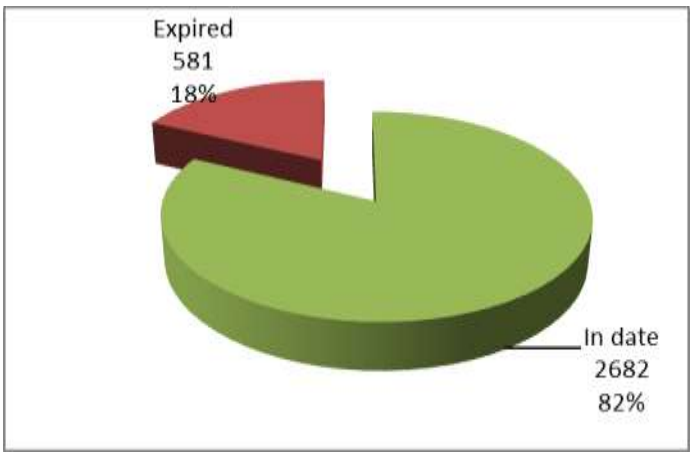
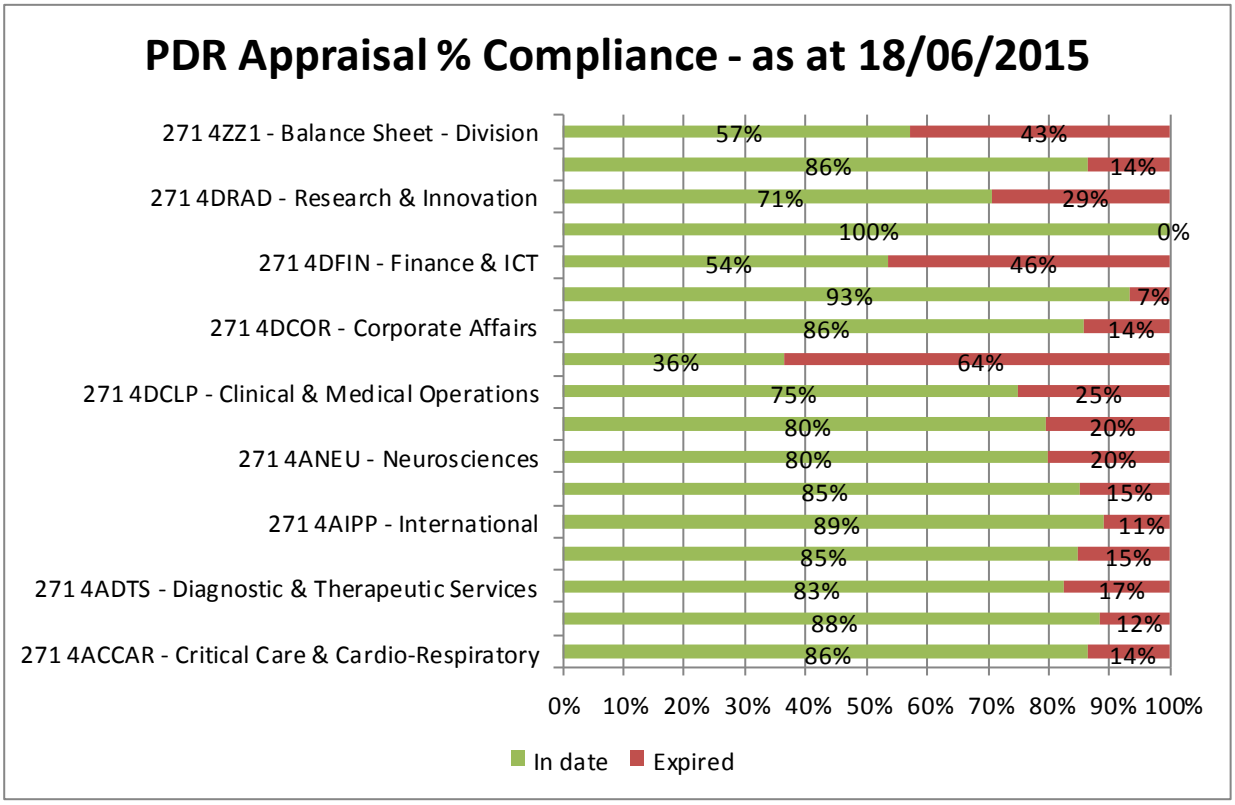


Figure 5: PDR rates broken down further into Divisions



6.3.2. Leadership

6.3.2.1. The Trust's "Leadership Pathway" continues to offer a wide range of development opportunities, supporting staff to access the right leadership support at every stage in their career. February 2015 saw the annual Gateway to Leadership Assessment Centre converted to support the recruitment of the new Heads of Clinical Service role. 34 clinicians undertook this process, receiving structured feedback on their leadership strengths and development needs. This event included assessment exercises and feedback built around the Trust's Always Values.

6.3.2.2. 266 Trust Leaders were trained in the Trust Always Values. The delegates were encouraged to take the learning back to their teams and discuss how the values can be reflected in the service. The Values are now a core element of the PDR paperwork and will be further blended into the Trust's Leadership development and mandatory training programmes,

6.3.2.3. In addition, 80 delegates went through the Gateway to Leadership Assessment Centre (GtoL) in early 2014 to help them identify their leadership development needs. Delegates assesses against five key leadership qualities:

1. Emotional maturity
2. Drive for improvement
3. Collaborative team working
4. Effective communication
5. Ability to understand and engage with the broader healthcare context

6.3.2.4. The top 20, out of the 80 candidates are selected to go on the Leadership Excellence Programme (LEP) which consists of six Action Learning Set days, four skills workshop days, a showcasing event, and 10 personal phone coaching sessions. In addition, each participant is expected to undertake some improvement work. A summary of feedback against the measurements of success for this programme are set out below:

How was there an increase in the confidence of those participating in the intervention?

- Better understanding of how the NHS and GOSH work.
- Improved networking within organisation.
- Increased confidence in tackling difficult conversations.
- Success in changing/managing sub-optimal staff performance.
- Increased knowledge of the organisation within which I work.
- Confidence in my own leadership skills and clarity of where I could focus further.
- Outlook as a leader has been transformed. Feel much more equipped to tackle tricky situations.
- Better leader for my team, provide regular support and feedback.
- LEP has enabled me to think about vision, rather than just working operationally.
- I have become clearer on how and when to plan for certain important conversations that I need to have.
- Increased confidence in leadership abilities/capabilities. Coaching has helped me to reflect on my leadership style and grow in confidence.
- Learnt strategies to deal with everyday management issues.
- Empowered to drive change and lead.
- Greater confidence as a leader and in challenging status quo when it doesn't meet current needs of our service or team.
- Feel more measured and considered as a leader.
- Better service through applying leadership skills.
- Increased commitment to working at GOSH and understanding of how to deliver within parameters of "high quality but cost-effective".
- Increased efficiency within service as a result of improving people management, specific project work and networking within the organisation.
- In many cases this could be translated into a financial saving.
- Budgeting and invoicing project will save one person's work for 12 weeks/year.
- More effective in my job role with better understanding of what and how to influence people.
- Better skills will be kept in the Trust.
- Will work towards passing on skills to other staff—help retention.
- Improvement project work progressing has already achieved improved patient satisfaction, increased revenue for the Trust and improved waiting times means less waste as patients are seen quicker.
- Networking has been invaluable and allowed a bigger picture of Trust-wide issues, encouraged a move away from no longer tempted to think in silos.
- Being able to disseminate and share learning from LEP to the wider team

- LEP has been invaluable in personal development which has had an immediate benefit for the children and staff. It has given confidence to carry out innovative reforms.
- The people managed are being more effective in their roles and feel more empowered…leadership potential has been recognised and that I could take on a bigger leadership role within the Trust.
- Improvement project could mean more efficiency of staff time and resources and a better patient/family experience at GOSH.
- Very good investment in terms of developing leaders with the confidence and ability to lead and drive improvement across the NHS.

What return on investment did GOSH get from the investment in LEP? What improvement projects were delivered or are in process of being delivered?

- Speed blood samples from ward to lab.
- Plan staffing levels appropriately.
- Play service improvement plan.
- Centralising Speech & Language Therapy appointments and waiting lists in order to increase efficiency around admin and clinical resources, reduce waiting times, reduce complaints.
- Develop electronic tracking system for FISH probes within the department—to improve efficiency and savings
- Improving discharge summary completion rate within 24 hours.
- To improve morale, by improving knowledge of team working and team working days, to improve sickness, lower levels of stress and provide more consistent communication with patients and families.
- Improve the quality, equity of access, and consistency in how managers appraise staff. Improved appraisal experience can lead to improved outcomes for the individual and therefore the service/patient = improved safety, retention, morale, relationships between managers and teams
- Streamlining the Botulinum Toxin service; examining patient journey/experience. Looking at the process of service delivery. Aim is to decrease waiting times between referral into the service and injection. To minimise delay in accessing injections as a long waiting list for treatment once recognised as clinically indicated may result in further long term problems which will require extra interventions (such as more orthopaedic surgery) and a poorer outcome for the child with Cerebral Palsy.
- Developing a template to evaluate service improvements across TDPFS based on pilot focusing on outpatient services in cleft/craniofacial services.
- Centralising information for families who visit the cranio-facial unit

6.3.2.5. 15 candidates went onto the Stepping up To Senior Leadership programme. This programme is aimed at middle management and covered nine core leadership areas with the programme ending with the delegates presenting their ideas for improving the service to the Trust's senior team. The topics covered were:

- Session 1 – the NHS Leadership model; latest developments in leadership theory; being a senior leader in the NHS; the NHS post-Francis report
- Session 2 – the leader's role in developing and maintaining a strong patient safety culture; human factors
- Session 3 – coaching staff for higher performance

- Session 4 – people management; building rapport; managing diversity; managing stress/mental wellbeing
- Session 5 – effective time and organisational management
- Session 6 – financial management; commissioning; strategic management; workforce planning
- Session 7 – effectively evaluating information
- Session 8 – presenting yourself and your ideas effectively
- Session 9 – pitching your vision; keynote speaker

6.3.2.6. Other Leadership programmes run included the Trust's HR Skills Pathway, the PGME Leadership programmes (covered in this document under the Medical Education section), Fundamentals of Leadership for staff new to leadership, Pitch Perfect Presentation Skills, Productive Leadership techniques.

6.3.2.7. In total 1019 places were taken across all leadership development programmes (including both L&D and PGME activity). This equates to approximately 45% of the workforce where it could be assumed leadership responsibility is a core requirement (i.e. medical or band 6 and above). However, this is an approximation as the figure does not factor in staff attending more than one programme.

6.3.2.8. Moving forward a new leadership development strategy is currently in development and will be launched in autumn 2016 to coincide with Heads of Clinical Service posts going live. As part of this strategy the Trust will be looking at creating further measurements on uptake v demand and impact.

6.3.3. Apprenticeships

6.3.3.1. The GOSH apprenticeship scheme has continued to grow. Upon successful completion of their apprenticeship, apprentices are converted automatically into a substantive position, enabling progression into full-time employment. During the year, 27 apprenticeship places have been commissioned for existing staff and 7 new Apprentices have commenced. Since the programme began in 2012, 32 new Apprentices have joined GOSH, which is recognised as an exemplar trust, having embedded the scheme across a variety of services. GOSH were "Highly Commended" for this work at the 2015 Camden Business Awards.

6.3.4. International Education

6.3.4.1. Following completion, in 2013, of the initial three-year contract with the Kuwait Ministry of Health, negotiations for a new contract continue and, it is hoped, could conclude by the autumn. In the interim, the experience gained in delivering the initial contract has enabled the International Practice Development team to undertake an extensive review of the existing programme, with a specific focus on three areas:

1. *Faculty*
    - Developed and implemented selection criteria, consistent with Our Always Values, to identify and quality assure a core multi-professional faculty for international education programmes
2. *Monitoring and evaluation*
    - Developed electronic systems to monitor and report candidate attendance and progress
    - Developed robust systems for evaluating programmes
3. *Curriculum*

- Reviewed and redesigned existing programme content
- Developed a prospectus for International Education
- Developed library of potential modules and associated learning and teaching tools, to enable bespoke design of education curriculum for future programmes
- Worked with LSBU to design five module descriptors for additional core modules that could be used across a variety of programmes.

7. QUALITY AND ASSURANCE

7.1. Nursing placement learning is audited according to Nursing Midwifery Council requirements. The Trust is required to audit all ward areas that offer student places every two years. In practice, 50% of such areas are audited each academic year. The audits are conducted jointly with ward staff, members of the Nursing and Non-Medical Education Team (NNMET), and LSBU link tutors. All of the audits for the 2014-2015 academic year have been completed. No issues of concern have been identified as a result of these audits.

7.2. The Nursing Education Working Group (NEWG), which includes a student representative, receives reports on student nurse evaluations and compliance with mentorship update and triennial review. The trust returns data annually via LSBU on mentorship update and triennial review compliance against Nursing Midwifery Council requirements. Senior staff from the Trust and LSBU conduct quarterly contract performance monitoring meetings to review all aspects of the partnership regarding pre and post-registration nursing. Trust representatives also contribute to the HEE Quality Contract Performance Review process for LSBU. The regulators of the non-medical professions conduct reviews of curriculae and placement learning environments via the relevant university.

7.3. The Trust is required to submit a workforce development plan to the LETB, detailing intended spend in regard to workforce development funding. The plan for 14/15 was submitted within timescale in April 2014 and approved in Q2. The year end reports were submitted, within timescale, in March 2015. Where the Trust is conducting HENCEL funded projects, progress is reported quarterly.

7.4. Internally, quality and performance are managed through the Nursing Education Working Group (reporting to the Nursing Board), Postgraduate Training Committee, and Nursing Quarterly and Divisional Performance Meetings. Individual academic programmes report to Course Boards established for this purpose and chaired by one of the Assistant Directors. The Assistant Directors (ADs) meet monthly with the Senior Education Team (senior members of all three core teams) and the ADs meet weekly with the Senior HR and OD team and the Director of HR and OD. Reviewing the governance and reporting structure for education will be key tenet of the education strategy.

7.5. Exceptions & Risks

7.5.1. <u>Operational Activity vs. Education Delivery</u>

7.5.1.1. As the Trust increases operational activity, it will be important to remain vigilant that this does not impact upon the ability of staff to access learning. As already discussed, the “From the Coalface” report highlighted concerns that medical trainees are not able to access the required learning to ensure their placement is of educational benefit. In addition, “DNA” rates for centrally run education activity

continue to be an issue. For 01/04/14-31/03/15 there were 783 no-shows out of 17,287 bookings made for centrally-coordinated courses, equating to a 4.5% no-show rate; in the same period, there were 859 cancellations out of 17,287 bookings, a 5% cancellation rate.

7.5.1.2. The introduction of the Care Certificate for healthcare assistants brings with it a significant increase in education activity both in terms of the taught content and the supervision and assessment required in clinical practice. The nursing workforce and education teams have worked with the Heads of Nursing and others to implement cohort recruitment of HCAs to ensure efficiency in terms of recruitment processes and delivery of the Care Certificate. Currently 3 cohorts are planned, but the workforce demands are such that additional cohorts are likely to be needed in the next year.

7.5.2. Ability to Generate Income

7.5.2.1. With the reductions in LDA funding streams (as noted elsewhere in this report), it is key that the GOSH education team develops the capacity to be able to generate additional income through:

a. Continuing to respond quickly and effectively to invitations to bid for external funding.
b. Identify opportunities to market education programmes both nationally and internationally

7.5.2.2. As the Education Strategy is further developed further consideration should be given to the working up a commercial strategy for education. It will be important to ensure that the Trust has sufficient capacity to undertake further commercial activity without adverse impact on the delivery of learning to staff at GOSH.

7.5.3. Nursing student placement capacity

7.5.3.1. The Trust has a maximum placement capacity for pre-registration student nurses of 140 student placements at any time and operates at or just over capacity for much of the year. It is anticipated that the Trust will continue to need to operate at full placement capacity to meet workforce demands and commissioned numbers. Clearly, working consistently at full capacity places pressures on clinical areas. This is augmented by additional requirements to supervise and assess healthcare assistants undertaking training.

7.5.3.2. The NNMET Pre-registration staff work closely with ward staff to support students in practice and their mentors, frequently offering clinical time to allow for mentors and students to meet to review progress. Capacity and demand is reviewed at the quarterly performance review with LSBU. In 2015-2016, the Trust, in partnership with other trusts within HENCEL, will be supporting a Darzi Fellow to undertake a project to identify opportunities for expanding placements in children's nursing, particularly in community settings and promoting a more collaborative approach to managing placements. This is in tandem with work being undertaken by HENCEL to explore opportunities for maximising placement opportunities across the patch.

7.5.4. Access to 2nd registration programmes

7.5.4.1. At GOSH the main thrust of recruitment is for registered children's nurses. However, it is recognized that in highly specialist areas, the expertise required to work in the specialty may usurp the children's nursing expertise, e.g. Theatres, Intensive Care, and Mental Health, and so, the Trust has a cohort of non-

children's trained nurses working in these areas. As part of the commitment to ensure that the GOSH has 'the right staff, with the right knowledge and skills', the Trust is supporting this group of staff to obtain second registration as children's nurses. At present, this is through a shortened (up to one-year) pre-registration children's nursing course. The Trust receives salary support from HEE/LETB (equivalent to 0.9WTE bottom of Band 5) for commissioned places. To date, the Trust has been able to commission sufficient places to meet demand. However, any increased demand due to proactive recruitment of specialist staff could exceed available commissions in future years. In addition, the pressures on placement capacity mean that any increase in 2nd registration student numbers would require the Trust to re-negotiate commissions with the LETB for three-year pre-registration students in order to accommodate all the students without compromising placement quality.

7.5.5. Funding

7.5.5.1. In 2014 the LETB indicated that trusts should expect up to 40% reduction in workforce development funding (WDF) over the next five years.

7.5.5.2. Whilst the Trust received funding to develop the pilot for a children and young people Care Certificate, the Trust has not received any additional funding to account for the costs of running the Care Certificate at GOSH.

8. **MOVING FORWARD**

8.1. GOSH is committed to ensuring that learning at work for all students and staff reflects he Trust's values and objectives and supports delivery of the highest standard of care for children, young people, and families. Whilst the next year will not be without its challenges, the education team will continue to work in partnership with internal and external stakeholders to ensure that students and trainees have an excellent experience at GOSH and that education meets the needs of the current workforce, providing innovative approaches to support workforce redesign.

8.2. **Next Steps**

8.2.1. The Trust's emerging education strategy sets out a clear vision of 'Education in All That We Do', supporting greater integration of education with the clinical, workforce and research strategies. The overarching goals for 2015/16 are to ensure:

1. GOSH is an excellent place to train and learn for students/trainees in all professions.
2. Education and development equips staff with the skills, knowledge, aptitudes, and values they need to deliver world-leading care.
3. GOSH is the provider of choice for specialist education programmes in paediatrics and child health, national and internationally.
4. GOSH's Education Service is financially sustainable.

8.2.2. Key priorities for the forthcoming year are:

- Approve and implement the Education Strategy
- Develop and launch a Leadership Development Strategy, supporting all levels of leadership

- Use new Leadership Development Strategy to support the development of Heads of Clinical Service & other senior leadership
- Implement and evaluate the Care Certificate
- Build upon the actions resulting from HENCEL trainee review
- Review of nursing preceptorship, in line with emerging national standards
- Expand the number of Apprenticeships at GOSH
- Ensure education commissioning supports the development of advanced nursing practice and other roles which will support alternative workforce models, in line with workforce and clinical strategy
- Establish a quality review process for placement learning across nursing and non-medical health professions in line with HENCEL multi-professional quality review procedures and standards
- Realise the benefits of the new Learning Management System

APPENDICES

APPENDIX 1

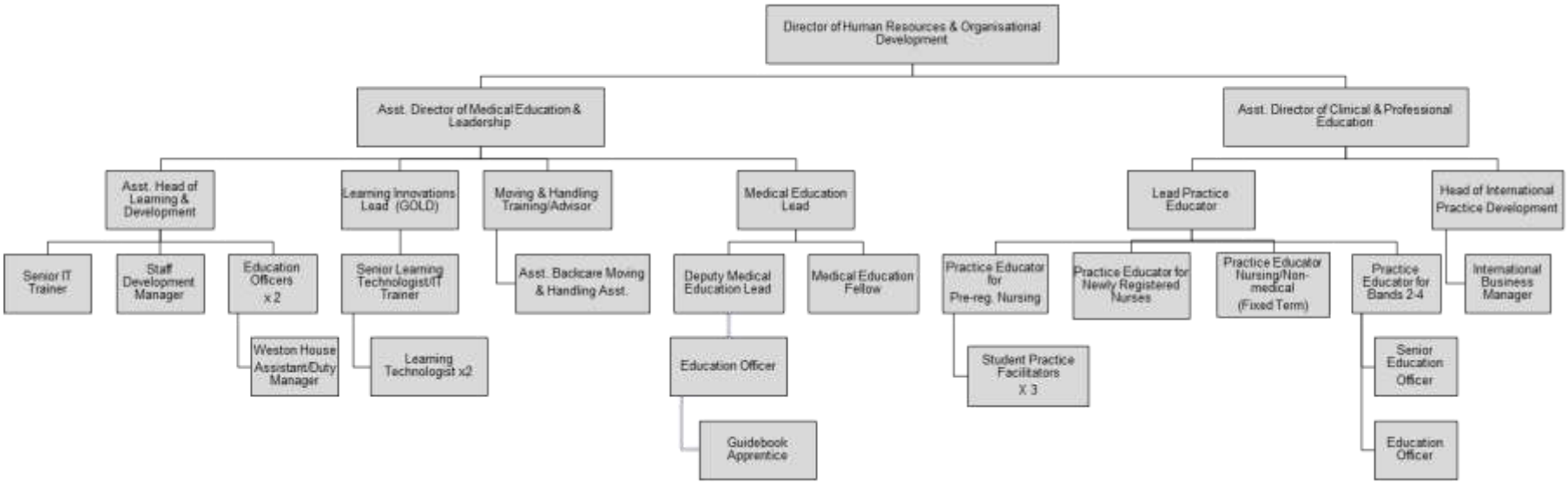
Summary of Progress against Education Objectives 2014-2015

Introduce a new Learning Management System (LMS) which will pull together GOLD and the existing training database	There was some delay with extracting old data from the current training database provider; this was resolved and data migration is complete. The L&D team quality checked and configured 15 years' worth of data (equating to approx. 1,500,000 individual records). Now in process of building and testing reporting functionality. On target for autumn go-live date.
Work with colleagues across the Trust to develop education activity to support and embed the Trust Always Values	266 Trust leaders were trained in Trust Always Values and charged with going back to their teams to disseminate learning and good practice. Values now reflected in Trust induction. Trust prospectus being reviewed to ensure it how learning supports/reflects Always Values.
Implement and evaluate the University Certificate of Competence, Principles of Caring for Children and Young People	Course commended at validation for focus on values and learning from Francis/Cavendish reviews. First cohort nearing completion. Initial reports to Course Board very positive. Students reporting impact on care delivery.
Introduce a Certificate of Care in line with the HEE requirements for Bands 2-4	Children and Young People's version developed by GOSH as part of HENCEL pilot. To commence April 2015 in line with national guidance.
Develop and deliver a work-based learning module for high-dependency nursing	20 credit module designed for L6 or L7 award. Validated in Oct 2014, first cohort commenced Nov 2014. 100% pass rate at final assessment.
Introduce a monitoring system for triennial review and ensure sustained compliance with NMC mentorship requirements	Mentor database up to date. Action plan reviewed monthly by NNMET and reported to NEWG. Monthly email reminders to staff due mentor update and updated compliance data circulated to Divisions. Pre-reg team follows up all triennial reviews.
Embed the new PDR process	Paperwork updated, PDR windows reviewed, process launched

APPENDIX 2

Education Teams Structure, Core Functions, and Key Relationships

Education Team Structure



Attachment Z

Education Teams' Core Functions

Post Graduate Medical Education	Learning & Development	Nursing & Non-medical Education
Continuing professional development for doctors, including leadership Training and registering accredited Educational Supervisors Assurance of training standards Design & delivery of medical education programmes Commissioning of external learning	Statutory and mandatory training Digital learning design Management of the Trust's online campus (GOLD) Organisational development support Design and facilitation of team interventions Design & delivery of leadership pathway & HR skills training IT systems training Development of LMS Vocational learning	Pre-registration nursing contract, placement learning, and mentorship Preceptorship and newly qualified nurse Rotation Programme Nursing continuing professional development (CPD) Undergraduate education/professional training and CPD for AHPs/Scientists Bands 2-4 clinical education International education
Design & delivery of multi-professional education		

Key relationships

Internal: The education teams work closely with the Chief Nurse, Medical Director, Divisional Directors, Heads of Nursing, Practice Educators, and service leads to ensure that education provision meets the needs of staff and services. Education staff work in partnership with subject matter experts (SMEs) from clinical services to develop high quality, clinically relevant educational materials and courses.

External: The Trust continues to work in close partnership with ICH, LSBU, and UCLP. Members of the education, finance, and workforce teams work closely with HENCEL in regard to delivering the LDA and reporting arrangements and the workforce commissioning process. GOSH is the host trust for the Lead Apprenticeship role for the HENCEL sector.

APPENDIX 3

Commissioning and Funding of Education

Medical Training

Funding to support medical training follows the trainee with the Trust funded via the LDA for the salary and study leave for each placement. In addition, GOSH receives received funding to support the infrastructure required to deliver medical education (i.e. PGME activity and resources) and to support the ICH Library Service. PGME administer the level of study leave funding accessed and use the infrastructure funding to support the delivery of innovative programmes of activity and the redevelopment of the Doctor's Mess.

Nursing and Non-medical Education

Pre-registration student numbers for nursing and allied health professionals are determined and funded by HEE via HENCEL. HENCEL leads an annual workforce commissioning process with its partner trusts to establish demand within the sector. The Trust receives funding to support quality placement learning for these students via the Placement Support Tariff.

Healthcare Commissioning for healthcare scientists is co-ordinated by the lead LETB for Healthcare Scientists, Health Education West Midlands.

Continuing Professional Development (CPD) is commissioned by the LETB. The Trust receives an allocation to access programmes offered by local Higher Education Institutions (HEI), chiefly our partner HEI, London South Bank University (LSBU). This is termed 'Indirect CPD Funding'. This is allocated within the Trust according to training needs analyses conducted with and by the Divisions. The Trust also receives an allocation for Workforce Development Funding which can be used to fund non-HEI activity or that which doesn't fall within the indirect allocation. This is allocated in tandem with Indirect CPD through the same process.

APPENDIX 4

Education Activity Supported by GOSH Charity

Clinical & Non-clinical Support Fund	CPD support for AHPs, pharmacy, healthcare scientists, and non-clinical staff groups in accordance with priorities identified by service leads.
Development Fund for Clinical Fellows, Trust & Specialty Doctors	Enables these groups, who provide the same level of medical service as Trainees, an opportunity to maintain and develop their skills.
Nurses' Study Leave Fund	Supports nurses to train in advanced paediatric life support, undertake a degree at undergraduate or masters level, or present at national/international conferences.
Library Fund	Supports front-line clinical decision making and patient care through the provision of timely information for evidence-based practice.
Leadership Development	Used for multi-professional groups to support 80 delegates to undertake our Gateway to Leadership Assessment Centre (GtoL), to help them identify their leadership development needs. In Feb 2015 this was also used to support Heads of Clinical Service Assessment centre.
GOLD	The on-line campus, GOLD, continued to use the funding to support the development of blended/online learning content for all staff and, in doing so, underpin our goal to provide high quality, innovative, and accessible learning.

APPENDIX 5

The Care Certificate

Background

In 2013 The Francis Report identified a lack of standardised training for Health Care Assistants (HCAs). The subsequent Cavendish Review recommended the need for structured education programmes with opportunities for progression into pre-registration nursing. This review also recommended the development of a Certificate of Fundamental Care—the 'Care Certificate'—to prepare HCAs for their roles within care settings.

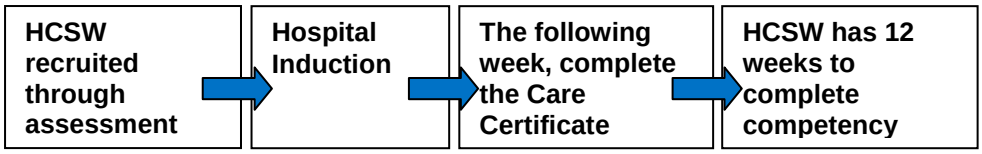
In October 2014, the Government announced that the Care Certificate would be introduced. Health Education England (HEE) identified 11 sites to pilot it over Spring/Summer. All trusts were then mandated by HEE to ensure full implementation of the Care Certificate by April 2015. The Care Certificate was developed jointly by Skills for Care, Health Education England and Skills for Health, and it applies across health and social care. It is a national education certificate. The aim is to provide clear evidence to employers and patients that HCAs have been trained and developed to a specific set of standards and also that the worker has been assessed for the skills, knowledge, and behaviours requisite to compassionate and high-quality care.

The Care Certificate will replace the National Minimum Training Standards (NMTS) and the Common Induction Standards (CIS) and provides a new framework for these within Health and Social Care. The Care Certificate builds on these two frameworks and sets out explicitly the learning outcomes, competences and standards of behaviour that should be expected of a HCA in both sectors. There are 15 standards which cover the areas that are common to this workforce and meet the legal requirement for providers of regulated activities to ensure that their staff are suitably trained. Each standard is underpinned by full learning outcomes and assessment criteria. The Care Certificate is a key component of the overall induction which an employer must provide, legally and in order to meet the essential standards set out by the Care Quality Commission.

The Care Certificate at GOSH

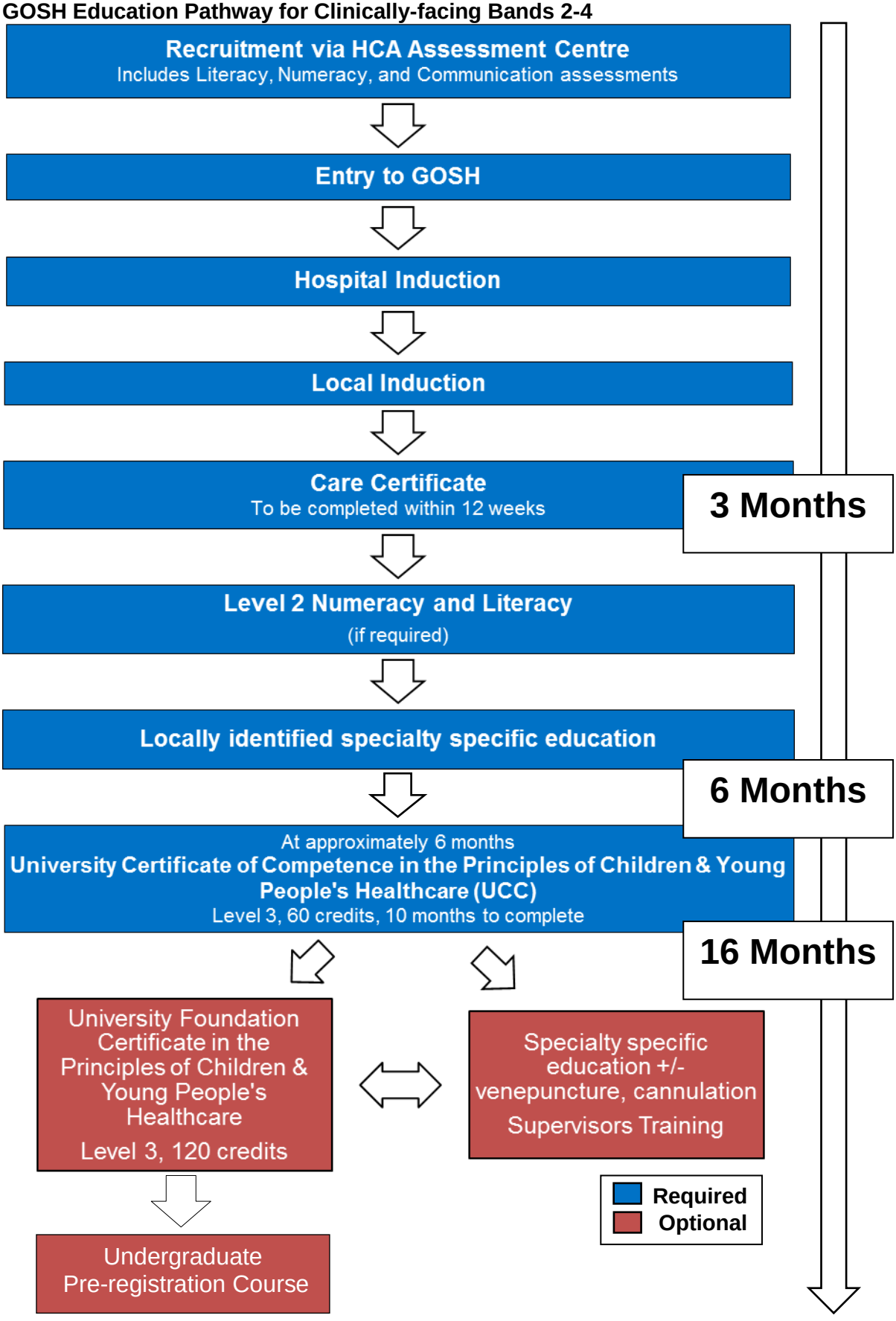
The Nursing and Non-Medical Education Team at GOSH were approached by HENCEL to review the Care Certificate and make recommendations as to how the generic competencies could be meaningfully applied to children and young people (CYP). Two scoping events were held with staff at GOSH, ranging from HCSWs to Heads of Nursing to determine what staff wanted from a CYP Care Certificate. The HEE standards were mapped against GOSH's current induction and e-learning. Using findings from both these processes, a bespoke taught programme was designed to deliver educational outcomes not covered via induction/e-learning. An assessor's guide was developed to show how the competencies relate to CYP using exemplars to demonstrate how each competency can be achieved in practice.

The Care Certificate at GOSH must be completed within 12 weeks. It will incorporate both knowledge and clinical competence outcomes. There will be four days of face-to-face teaching, e-learning, and a competency assessment document to be completed in practice. The first cohort of the Care Certificate at GOSH will run from April 2015 and will have a slightly higher number of candidates (25 candidates).



APPENDIX 6

GOSH Education Pathway for Clinically-facing Bands 2-4



APPENDIX 7

Summary of Student Nurse Evaluation of Practice Placements, March 2015 (N=20)

Question	% students answered 'Yes'
When you commenced the placement, did you feel welcomed?	100%
The NMC recommends that you have access to your Practice Mentor for 40% of your total time in Practice. Do you feel this was achieved for you?	90%
Do you feel that you were suitably supervised by your Practice mentor/Practice Staff throughout your placement?	100%
Would you recommend this placement to other students?	100%
Did you find the staff friendly and approachable?	100%

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
22nd July 2015

Quarter 1 Monitor Return (3 months to 30 June 2015) **Submitted by:** Claire Newton, CFO	**Paper No: Attachment 2**

Aims / summary
This paper summarises the Trust's 2015/16 Quarter 1 (Q1) Return to Monitor, the independent regulator of NHS Foundation Trusts.

Key points:

Finance

- The financial information included in the Monitor template for Q1 is entirely consistent with the Month 3 Board report.
- The Trust is forecasting a Continuity of Service risk rating of at least 3 for the next 12 months.

Governance

- The Trust reported one case of C.Difficile in Quarter 1, leaving our year to date total of assigned cases in patients aged two and over, tested on third day or later, at 1 case. This case was not attributed to a lapse of care outlined in the assessment criteria from Monitor and agreed with NHS England.
- No cases of MRSA were reported in Q1, leaving the cumulative position at 0 cases for 2015/16.
- In relation to 18 week Referral to Treatment Time measures, June figures are not available at the time of reporting. However the Trust has achieved the standards for the first 2 months of the quarter and is expected to so for month 3 (and as such for the quarter).
- The Trust remained 'green' against Monitor's governance risk rating in the fourth quarter.

Other

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

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

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

Financial implications
An unqualified return is important for on-going sustainability

Who needs to be told about any decision?
Monitor

Who is responsible for implementing the proposals / project and anticipated timescales? CFO re the submission
Who is accountable for the implementation of the proposal / project? CEO re the good governance of the Trust

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

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

For finance, that:	**Board Response**
The board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.	**CONFIRMED**

For governance, that:	
The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.	**CONFIRMED** As Monitor is aware, and as reported in the Annual Governance Statement, an internal review of the Trust's waiting list data revealed two data quality issues: a relatively high proportion of patients within the incomplete pathways did not have clock starts, and potentially, due to the complexity of pathways, inconsistencies in the records of incomplete pathways. Support was requested from the national response team who have carried out a review and an action plan has been put in place to address these issues.

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

Consolidated subsidiaries:

Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds.	**NONE**

Signed on behalf of the board of directors

Signature		Signature	
Name	Baroness Tessa Blackstone	**Name**	Dr Peter Steer
Capacity	Chair	**Capacity**	Chief Executive
Date	22 July 2015	**Date**	22 July 2015

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

Attachment 3

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
22nd July 2015

Assessment of the Clinical Governance Committee's effectiveness 2014-2015 **Submitted on behalf of:** Chairman of the Clinical Governance Committee	**ATTACHMENT 3** *For discussion and approval*

Aims / summary

A desk-top evaluation of the Clinical Governance Committee's effectiveness against the terms of reference has been conducted for the period April 2014 – March 2015. A self-assessment review of the effectiveness of the committee was conducted in June 2015

From analysis of the minutes and agendas throughout the period and the findings from the survey, the Clinical Governance Committee has adequately discharged its duties in accordance with its terms of reference.

A summary of the recommendations accepted by the Committee to enhance its effectiveness is summarised here:

Recommendation 1: Committee members challenge accountable risk owners on the adequacy of the assurance that controls are working and that any proposed gaps will be closed by the stated deadline.
Recommendation 2: Accountable risk owners are reminded to provide sufficient information to the committee on the adequacy of controls and assurances in place and a clear indication of how and when any gaps will be closed.
Recommendation 3: The CGC summary reports are reviewed and revised so as to provide:

- A summary of the matters discussed at the committee
- An assessment of the adequacy of the controls and assurances for key strategic and operational clinical risks discussed at the committee; and,
- The findings of the quality focused audits discussed at the committee

The Committee reviewed the findings of the evaluation and survey and agreed that different methods of evaluation (desk top analysis, surveys etc.) would be used annually on a rotational basis in order to use different methods of securing the full engagement of members and attendees on the effectiveness of the committee.

The Committee agreed that the NEDs should be circulated with the dates of the executive walkrounds for them to attend when convenient. The executives also offered to take them around the Trust for ad hoc walkrounds.

The Board is asked to note that following the self-assessment evaluation of the Trust Board in May 2015, a recommendation was agreed for a review of the workload of the Trust Board to be conducted during 2015/16.

This will focus on the balance of quality and financial items on the Board agenda and will involve consideration of the workload of the Clinical Governance Committee and its assurance remit. This work will be conducted at the same time that the clinical and quality focused management committees are being reviewed so as to ensure that there is full alignment of the quality governance reporting framework. In light of this work, the Clinical Governance Committee's work programme will be considered at its October meeting and presented to the Board in November 2015.

Following the results of this evaluation, at the present time, there are no amendments to the terms of reference of the Clinical Governance Committee.

Action required from the meeting

To note the findings of the desk top evaluation and survey of the Clinical Governance Committee and ratify the recommendations approved by the Committee. To note the work underway to review the quality governance reporting framework.

Contribution to the delivery of NHS / Trust strategies and plans
This report demonstrates that the Committee has complied with its Terms of Reference and work programme.

Financial implications
No direct financial implications.

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

Who needs to be told about any decision
Not applicable

Who is responsible for implementing the proposals / project and anticipated timescales?
All members of the Committee.

Who is accountable for the implementation of the proposal / project
Clinical Governance Committee Chairman

ATTACHMENT 3

1. Introduction

The Clinical Governance Committee is a standing subcommittee of the Trust Board and is made up of three Non-Executive Directors and executive directors/ senior managers. It has delegated authority from the Trust Board to be assured that the correct structure, systems and processes are in place within the Trust to manage clinical governance and that these are monitored appropriately.

It is accountable to the Trust Board and required to assure the Board that work being undertaken by the clinical divisions, corporate departments, standing committees and any sub groups in respect of quality, safety and improvement is co-ordinated and prioritised to meet the Trust's objectives.

The duties of the Clinical Governance Committee are set out in the Terms of Reference. This report comments on compliance with the Terms of Reference and gives an overview of the work carried out by the Clinical Governance Committee Between April 2014 and March 2015.

2. Membership during the financial year

The Committee met five times in the financial year (four scheduled meetings and one extraordinary meeting to discuss a strategic risk). The members of the Clinical Governance Committee are expected to attend at least 3 meetings a year and all members attended a minimum of this number of meeting during 2014/15.

The terms of reference require a quorum of at least one non-executive director and two executive directors. This was achieved at every meeting.

3. Key functions of the committee

A summary of the work conducted by the committee during the year against its key requirements is outlined below:

Principal responsibilities of the committee	Key areas formally reviewed during 2014/15
Review of the framework to support an environment in which excellent clinical care will flourish Review of implementation of Quality Strategy	• Implementation of the Trust's Quality Strategy • Learning arising from patient stories and sought assurance of actions taken • Reports from the Clinical Ethics Committee
Review of the controls to mitigate clinical risk within a regulatory and legislative framework	Summary reports on the relevant risks on the Board Assurance Framework - Senior managers were invited to report on the controls in place to manage the risks and the assurances available to determine the effectiveness of these controls. The following risks were reviewed during the year: • Loss of key services which are critical to GOSH remaining a credible tertiary paediatric centre. • Risk that all patients at all times don't receive safe medical cover. • Failure to have reliable processes for booking the follow up care of patients

Principal responsibilities of the committee	Key areas formally reviewed during 2014/15
	• Failure to recognise and respond to patient deterioration in a timely manner. • Lack of a systematic approach to development of organisation and people may compromise our effectiveness of service and compromise our ability to deliver a compassionate and effective service. • Failure to safeguard children and young people from maltreatment and neglect. • Failure to provide a quality education (environment, support and expertise). • Difficulties in recruiting and retaining highly skilled staff with specific experience which prevent efficient use of resources i.e. beds, theatres, ICU. • Failure to provide an environment and service which minimises the risk of medication errors. • Lack of local paediatric in-patient and community services to facilitate repatriation or discharge of patients to local services. • Risks to implementing the Clinical Services Strategy • Failure to provide sufficient capacity to meet existing and future demands Patterns and themes arising from analysis of the high level risks reported across the Trust. Summary of actions taken following reviews of clinical and support services Reports received on key risk areas: • Quality review of high cost efficiency savings • Health and Safety • Head of Nursing Report • Child Protection and Safeguarding • Research Governance • Summary from the Learning, Improvement and Monitoring Board (LIMB) covering complaints, PALS, incidents and claims • Workforce Information • CQC compliance An extraordinary meeting of the committee was held in November 2014 to discuss the findings from HENCEL about clinical training and medical cover out of hours.

Principal responsibilities of the committee	Key areas formally reviewed during 2014/15
Review of findings and recommendations from Internal audit, clinical audit and learning from external investigations and reports	The Internal Audit annual plan was presented to the committee in January 2014, with update on progress with the plan covered at subsequent meetings Findings and recommendations of clinical focused internal audit reports are presented to every committee meeting. The following internal audit reports were discussed during the year: Incident reporting Whistle blowing arrangements Health and Safety Governance arrangements HR arrangements – employment checks Implementation and status reports on audit recommendations Findings from clinical audits and recommendations and work programmes arising from these results
Other	Reviewed and updated the committee terms of reference and annual workplan Reviewed the Freedom of Information Act annual report The Clinical Governance Committee gave an account of the committee's work in the Trust's annual report 2014/15.

4. Escalating matters with the Trust Board

A summary of the matters arising at the Clinical Governance Committee were reported to the Trust Board following every meeting and assurances given. On occasions, matters were escalated to the Trust Board for consideration or information, such as risks around the findings of the HENCEL visit and the gastroenterology service.

5 Other matters pertinent to compliance with the Terms of Reference

It is recognised that Corporate Governance and Clinical Governance should be closely linked. The terms of reference required that the duties of the Clinical Governance Committee have synergy and convergence with the Audit Committee. This is achieved by:

- an unambiguous division of all Assurance Framework risks between the respective committees and standardisation of approaches of each Committee to monitoring the assurance available to the Trust Board on such risks.
- ensuring that the internal audit and clinical audit plans are aligned; and
- a member of the Clinical Governance Committee being a member of the Audit Committee (in 2014/15 this was Yvonne Brown).
- A summary report of the work of the CGC is reported to the Audit Committee following each meeting (and vice versa).

ATTACHMENT 3

6 Self-assessment tool

Monitor's Code of Governance requires the Board of Directors to "*undertake a formal and rigorous annual evaluation of its own performance and that of its committees …".*

A survey was conducted in June 2015 using Survey Monkey. Members of the Committee, attendees at the Committee and Trust Board members were asked to respond to a range of different questions.

The following responses were received:

- Clinical Governance Committee members: 5 out of 8
- Clinical Governance Committee attendees 7 out 9
- Trust Board members 5 out of 7
- Total = 17/ 24

The results were analysed using the percentage of responses reviewed against the following possible answers:

- Strong agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Responses to each question are presented in Appendix 1.

Appendix 1

Question	Overall Analysis (out of 17)
The Committee effectively monitors the clinical strategic risks of the organisation	Strongly agree: 6 respondents Agree: 7 respondents Neither agree nor disagree: 4 respondents Disagree: 0 respondents Strongly disagree: 0 respondents
The Committee actively considers the full range of risks relating to quality and safety across the Trust	Strongly agree: 5 respondents Agree: 6 respondents Neither agree nor disagree: 5 respondents Disagree: 1 respondent Strongly disagree: 0 respondents

Question	Analysis (out of 12)
The chairman facilitates the effective contribution of all staff and non-executive directors and allows adequate time for discussion and decision-making on all agenda items.	Strongly agree: 7 respondents Agree: 4 respondents Neither agree nor disagree: 1 respondent Disagree: 0 respondents Strongly disagree: 0 respondents
Owners (i.e. those accountable) of risks are held to account through a process of overview and challenge	Strongly agree: 3 respondents Agree: 6 respondents Neither agree nor disagree: 2 respondents Disagree: 1 respondent Strongly disagree: 0 respondents
The Committee seeks assurance from both internal and external sources.	Strongly agree: 5 respondents Agree: 5 respondents Neither agree nor disagree: 2 respondents Disagree: 0 respondents Strongly disagree: 0 respondents

Question	Analysis (out of 11)
The Committee champions continuing improvements in quality and safety	Strongly agree: 4 respondents Agree: 6 respondents Neither agree nor disagree: 1 respondent Disagree: 0 respondents Strongly disagree: 0 respondents
Question	**Analysis (out of 5)**

The Committee champions the patient voice and experience	Strongly agree: 3 respondents Agree: 2 respondents Neither agree nor disagree: 0 respondents Disagree: 0 respondents Strongly disagree: 0 respondents
The Committee effectively monitors audit results and recommendations	Strongly agree: 4 respondents Agree: 1 respondent Neither agree nor disagree: 0 respondents Disagree: 0 respondents Strongly disagree: 0 respondents

Question	**Analysis (out of 10) – committee and Board members**
The reports made by the Clinical Governance Committee to the Board and the Audit Committee are: focused and intelligible summaries of the work carried out	Strongly agree: 3 respondents Agree: 6 respondents Neither agree nor disagree: 1 respondent Disagree: 0 respondents Strongly disagree: 0 respondents
Clear in terms of the adequacy of controls and assurance or the weaknesses found.	Strongly agree: 3 respondents Agree: 5 respondents Neither agree nor disagree: 1 respondent Disagree: 1 respondent Strongly disagree: 0 respondents

Question	**Analysis (out of 5) – committee members only**
The Committee's agendas allocate sufficient time for discussion of the major risks facing the Trust	Strongly agree: 2 people Agree: 2 people Neither agree nor disagree: 0 people Disagree: 1 person Strongly disagree: 0 people
The committee receives sufficient information within the reports presented to enable it to be assured of the safety of patients	Strongly agree: 2 people Agree: 3 people Neither agree nor disagree: 0 people Disagree: 0 people Strongly disagree: 0 people
The committee receives sufficient information within the reports presented to enable it to be assured of patients' experiences at the hospital	Strongly agree: 2 people Agree: 3 people Neither agree nor disagree: 0 people Disagree: 0 people Strongly disagree: 0 people
The Committee is supplied in a timely manner with information in a form and of a quality	Strongly agree: 3 people Agree: 2 people

appropriate to enable it to discharge its duties.	Neither agree nor disagree: 0 people Disagree: 0 people Strongly disagree: 0 people
The Clinical Governance Committee gains value and assurance from the work of the Risk Assurance and Compliance Group.	Strongly agree: 2 people Agree: 3 people Neither agree nor disagree: 0 people Disagree: 0 people Strongly disagree: 0 people
Question	**Analysis (out of 10)**
Are there sufficient processes in place to avoid duplication or prevent gaps in assurance with the Audit Committee	Strongly agree: 3 Agree: 5 respondents Neither agree nor disagree: 2 respondents Disagree: 0 respondents Strongly disagree: 0 respondents
Question	**Analysis (out of 11)**
Committee members possess the necessary skills and experience required to conduct the work of the committee	Strongly agree: 5 respondents Agree: 6 respondents Neither agree nor disagree: 0 respondents Disagree: 0 respondents Strongly disagree: 0 respondents

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 22nd July 2014	
Revised Board of Directors' Terms of Reference **Submitted by:** Dr Anna Ferrant, Company Secretary	**Paper no: Attachment 4** For approval

Aims / summary

The Board of Directors' terms of reference have been reviewed and updated. The terms of reference have been reviewed against Monitor's revised Code of Governance (July 2014) and Monitor's Well Led Assessment (April 2015).

Monitor's revised Code of Governance (July 2014)

The Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. The Board of Directors considers that from 1 April 2014 to 31 March 2015 it was compliant with the provisions of the NHS Foundation Trust Code of Governance.

Monitor's Well Led Assessment (April 2015).

Monitor's well led assessment framework has been developed to support NHS foundation trusts to gain assurance that they are well led. Its aim is to help them continue to meet patients' needs and expectations in a sustainable manner under challenging circumstances. Following a review of the four domains and ten questions under the framework (see Appendix 1), the terms of reference has been reviewed and the wording revised to align it with the framework.

A revised version of the terms of reference is attached at appendix 2 and amendments are shown in highlighted text. These include changes to the titles of executive directors on the Board.

In light of the review of the structure and reporting arrangements between management committees, assurance committees and the Board, the Board Calendar is under review and an updated version presented as soon as the work has been completed.

Review of compliance with the Board terms of reference in 2014-15

Attendance at meetings

There have been a number of changes to the Board membership during 2014/15 (as documented in the Trust's annual report):

- The departure of Julian Nettel, Interim Chief Executive in December 2014
- Dr Peter Steer joined the Trust as substantive Chief Executive in January 2015
- The retirement of Mrs Elizabeth Morgan, Chief Nurse in March 2015
- The departure of John Ripley, Non-Executive Director in March 2015

- The appointment of Juliette Greenwood as Chief Nurse, commencing employment on 1 May 2015
- The appointment Dr Vinod Diwakar as Medical Director, commencing employment on 1 June 2015
- The appointment of Akhter Mateen as Non-Executive Director in March 2015

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

Publication of papers

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

Board evaluation

In 2014/15 the Board conducted a self-assessment evaluation against specific areas of the four domains and ten questions outlined in the Monitor guidance and agreed recommendations to review the balance and format of information presented at Board throughout the year.

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

The Board has planned to undergo an independent evaluation against the Well Led Criteria in the fourth quarter of 2015/16.

Action required from the meeting

To approve the amendments to the terms of reference and note that the Board Calendar will be presented at a meeting later in the year (September or November 2015).

Contribution to the delivery of NHS / Trust strategies and plans
The terms of reference provide a written framework of how the Board operates.

Financial implications
No direct financial implications.

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

Who needs to be told about any decision
N/A

Who is responsible for implementing the proposals / project and anticipated timescales?
The Board of Directors and Company Secretary.

Who is accountable for the implementation of the proposal / project
The Board of Directors

Great Ormond Street Hospital for Children NHS Foundation Trust

BOARD OF DIRECTORS' TERMS OF REFERENCE

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

1. Constitution

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

2. Role

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

- To provide leadership in establishing and promoting the vision, values and standards of conduct and ethical behaviour for the Trust and its staff;
- To establish a clear strategic direction, by setting ~~strategic~~ objectives that are supported by quantifiable and measurable outcomes ~~reflected in an explicit set of key deliverables~~ and performance indicators;
- To seek and receive assurance on the quality and sustainability of the Trust's services, promoting high standards of effectiveness, patient safety and patient experience;
- To be accountable for the Trust's performance, ensuring that the necessary financial and human resources are in place for the organisation to meet its objectives and deliver its business plans; and that systems are in place to minimise the risk of adverse performance; and, to take account of independent scrutiny of performance.
- ~~To monitor the Trust's performance, ensuring that the necessary financial and human resources are in place for the organisation to meet its objectives and deliver its business plans; that systems are in place to minimise the risk of adverse performance; and, to take account of independent scrutiny of performance including scrutiny from councillors, regulators and other external stakeholders;~~
- To ensure the Trust develops and implements appropriate risk management strategies and policies to identify, monitor and address current and future risks on the quality and financial sustainability of services and comply with regulatory and statutory requirements. ~~deliver its Annual Plan and comply with its Care Quality Commission registration and Monitor's Terms of Authorisation and licence conditions, systematically assessing and managing its clinical, financial and corporate risks.~~

~~To ensure the Trust develops and implements appropriate risk management strategies and policies to deliver its Annual Plan and comply with its Care Quality Commission registration and Monitor's Terms of Authorisation and licence conditions, systematically assessing and managing its clinical, financial and corporate risks.~~

- To ensure that strategic development proposals have been informed by open and accountable consultation and involvement processes with staff, patients and their representatives, councillors, members, the wider community and other key external stakeholders, as appropriate.

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

- To ~~demonstrate a commitment to~~ support continuous learning and improvement and ensure the development of extensive internal and external feedback systems.

- To ~~demonstrate a commitment to~~ encourage and promote openness, honesty and transparency in the Trust's relationships with, patients and their representatives, the public, staff, councillors, members and other stakeholders;

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

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

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

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

3. Membership

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

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

There shall be 6 executive directors:

- the Chief Executive
- Chief Finance Officer
- Chief Operating Officer
- Medical Director ~~Co-Medical Directors~~
- Chief Nurse ~~and Families Champion~~
- Director of Human Resources and Organisational Development

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

The Board may approve deputies with formal acting up status or interim directors.

4. Attendance at meetings

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

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

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

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

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

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

These invited individuals do not hold a vote.

5. Quorum

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

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

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

6. Frequency of meetings

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

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

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

7. Performance evaluation

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

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

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

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

Appropriate action will be taken where recommendations are highlighted.

8. Secretariat

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

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

Signed minutes shall be maintained by the Secretariat.

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

9. Review of the terms of reference

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

July 2015

ATTACHMENT 5

Great Ormond Street Hospital for Children NHS Foundation Trust

Update from the Audit Committee meeting held on 22nd May 2015

The agenda for the May Audit Committee meeting focussed on year end reports and risk processes.

Year-end reports

The Committee welcomed the Head of Internal Audit Opinion for 2014/15 which had provided 'significant assurance with minor improvements required' for the year.'

The Committee discussed the timing of the internal audit of the discharge process including discharge summary completion. The committee noted the importance of this area to families and agreed that as a lot of work was on-going in this area, the audit would take place in January and February 2016 to allow time for changes to be made and embedded.

The Committee discussed the key accounting policy of preparing accounts on a going concern basis and noted that this was particularly pertinent given the uncertainty around tariff. It was agreed that the definition of 'going concern' would be tightened to cover the period of the next 12 months. It was confirmed that Deloitte had conducted sensitivity analyses on the productivity and efficiency programme and other key assumptions and had concluded that the Trust would be a going concern for the next twelve months.

The Trust's external auditors' report focused on recoverability of receivables, valuation of the estate and value for money. It was confirmed that testing had been carried out on revenue and debtors in a number of ways and that Deloitte was satisfied that the position taken overall was materially correct. It was noted that the debtors level overall was increasing throughout the NHS.

It was reported that Deloitte had tested the valuation of the estate made by the District Valuer who had reported that despite additional expenditure of £22.9million, the portfolio had only increased by £7.8m as a result of significant expenditure on enabling works which did not increase the value of the property. Ms Bygrave confirmed that, following testing of the data, Deloitte was satisfied with the valuation.

It was reported that the productivity and efficiency programme was below plan however Ms Bygrave confirmed that GOSH was not an outlier from other Trusts in this area.

It was confirmed that a qualified opinion would be issued by Deloitte on the 18 week referral to treatment pathway data due to issues with unknown clock start times. The Committee discussed clock start times and agreed that this was a complex issue and it was unlikely that all the required information would be found for each patient even with the input of significant resources. It was noted that the Trust had invited the intensive national support team to give advice in this area.

Deloitte confirmed that an unqualified opinion would be provided on cancer waiting times in which 100% had been achieved against an 80% target. An amber evaluation would be provided on the local indicator which had been chosen by the Members' Council: discharge summaries as a result of difficulties in ascertaining the dates on which many of the summaries were produced.

The Committee discussed the Quality Report and agreed that in future years it should be signed off by the Clinical Governance Committee prior to being considered by the Audit Committee.

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

- Annual Report 2014/15
- Annual Accounts 2014/15
- Annual Governance Statement
- Representation letter
- Quality Report

Risk Management

The Committee discussed the following high level risks

- Risk 3: Delivery of Productivity & Efficiency targets and plan

It was noted that there was currently a £4m gap in schemes identified. Additional schemes were being offered to bridge the gap but were likely to deliver only a part year effect. The Committee agreed that a large culture change would be required to deliver £12m based on efficiencies rather than income growth.

- Risk 4: Delivery of IPP Income Targets (2015-16)

The Committee agreed that it was vital to ensure that there was rigorous monitoring and tracking of income, activity and the way this was affected by the referrals being made.

Review of non-audit work conducted by the external auditors

The Committee noted that two linked assignments have been carried out on a pro bono basis for the Trust during the year. The Audit Committee members were consulted before each assignment commenced and were provided with the planned scope of each assignment. The Committee concluded in each case that they did not believe the independence of the auditor would be compromised by the work and prior to both assignments the Committee members were advised that the audit partner had also concluded this.

Update on whistleblowing

The Committee noted an update on the whistleblowing cases which were currently in progress and those which had been completed since the last meeting. It was noted that there had been a process review to ensure that all cases raised through all teams were captured and reported. It was reported that a route map for raising concerns which had been circulated around the Trust.

ATTACHMENT 6

Great Ormond Street Hospital for Children NHS Foundation Trust

Update from the Clinical Governance Committee meeting held on 8th July

Clinical Governance Effectiveness Review

The Committee noted the outcome of the Clinical Governance Effectiveness Review. The Trust's internal auditors provided advice around the required frequency of reviews and suggested that different categories of respondents i.e. committee members, committee attendees and Board members should be surveyed in alternating years.

The Committee discussed Executive Safety Walkrounds and noted that since the structure of the walkrounds had changed it had been difficult for Non-Executive Directors to take part. It was agreed that the Chief Nurse would conduct informal walkrounds with Non-Executive Directors in the coming months.

Social Work practice

A presentation was given on Social Work practice within the Trust. The Committee discussed the number of ways in which the team received referrals and expressed some concern about the informal way in which this could be conducted. It was agreed, however, that receiving referrals informally encouraged staff to highlight all concerns. The Committee emphasised the importance of empowering front line staff to use their own judgement and assessment rather than having an over-reliance on the social work team.

Productivity and Efficiency Programme Quality Assurance Process

The Committee received a presentation on the quality assurance process for productivity and efficiency schemes. The Committee expressed concern at the number of operations which had been cancelled as a result of the closure of Island Short Stay and the loss of Woodpecker space. It was noted that a proposal was being considered at the Senior Management Team meeting which would aim to create available beds and reduce cancellations. It was confirmed that no adverse data had been received in terms of morbidity and mortality rates or rates of infection to indicate that the productivity and efficiency programme was having an adverse effect on quality and safety.

Medical staffing out of hours

An update was provided on medical staffing out of hours. It was noted that the Trust was working with HENCEL to reduce dependence on Junior Doctors at night by looking at alternative strategies for staffing and potentially developing new roles with HENCEL's support. It was reported that HENCEL had queried the Trust's education strategy and facilities for education provision.

Gastroenterology review

The Committee noted that a learning event had been held by an external senior gastroenterologist around a recent Serious Case Review. It was reported that recommendations had been made following the external review of the gastroenterology service and these were being considered.

The Committee considered that following high level risks:

- Risk 10: Failure to adequately schedule and track patients

It was reported that an external Intensive Support Team had been invited to review the Trust's Referral to Treatment (RTT) processes and data. It was noted that their report was being finalised and would be considered by the Trust Board along with an impact assessment to show how many patients were being affected by the issues highlighted. It was added that a waiting list management expert had been invited to work with the Trust for two weeks.

- Risk 12: Commissioner's role in strategic decision making regarding service provision

It was reported that progress was being made in getting active engagement with commissioners and meeting with relevant key people to facilitate discussions.

CQC Update

The Committee noted that the Quality Summit to receive the outcome report of GOSHs CQC inspection had been set in August. The Trust would be given the opportunity to review the report and make factual accuracy comments prior to the Summit and the report's publication. The Committee agreed it was important to consider how the work from the report would be delegated to ensure it was considered by the Trust Board and Clinical Governance Committee as appropriate. It was noted that the communications team were developing an action plan to react to any press interest.

Medical revalidation and appraisal

An update was provided on medical revalidation and appraisal. It was reported that a gap existed around the population of clinical fellows in the Trust who were often present for short employment periods at GOSH.

Head of Nursing report

The Head of Nursing report was received and the committee welcomed the detailed work which had taken place to look at reasons for nurses leaving GOSH. It was reported that some negative messages had been received which had not previously been picked up through other means. It was noted that work was on-going to consider how these views could be captured prior to the point at which staff members had resigned. It was reported that recommendations and an action plan would be developed from the feedback which would be considered at the Senior Management Team meeting.

Child Protection and Safeguarding Update

The Committee noted the imminent publication of two Serious Case Reviews including one which was expected to be high profile. It was confirmed that the team were working with the Communications team.

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

- Social work practice and the identification of child protection practices
- Publication of two SCRs
- Waiting list management action plan
- Work with commissioners
- Work on nurses leaving GOSH and broader work on retention
- CQC update
- Revised approach to quality assurance of productivity and efficiency programme.

ATTACHMENT 7

Attachment 7

Great Ormond Street Hospital for Children NHS Foundation Trust

Update from the Finance and Investment Committee meeting held on 27th April 2015

2014/15 Financial Performance

The Committee reviewed 2014/15 finance and activity and segmental reporting. The non-executive directors questioned the rise in WTE and pay costs in the year and the Trust's productivity for the year.

2015/16 Financial Plan

The Committee reviewed the assumptions that were feeding into the 2015/16 annual plan. The non-executive directors challenged the forecast levels of paycosts and questioned the achievability of productivity and efficiency targets.

2015/16 Operational Plan

The non-executive directors suggested that the narrative document should highlight the research work done in the hospital and the Trust's links to the Charity.

Productivity Report

The Committee discussed the productivity report and staff productivity.

2015/16 Productivity and Efficiency Programme Update

The Committee was given an update.

IPP Review of Activity, Capacity and Demand

The Committee review the paper provided. The non-executive directors questioned price increases and price elasticity.

Education Business Model

The Committee discussed the paper. The non-executive directors questioned standardisation of study leave for trainee doctors between funded and non-funded posts.

Cash Management Update

The Committee was given an update.

Results of Review of Effectiveness

The Committee discussed the results of the effectiveness review. The non-executive directors suggested that there should be an alignment to the Trust's strategy. The non-executive directors also suggested that the Committee spends more time reviewing productivity metrics, pay costs and headcount.

Review of Terms of Reference and 2015/16 Work Programme

Terms of reference and the workplan for 2015/16 were agreed.

Attachment 7

Great Ormond Street Hospital for Children NHS Foundation Trust

Update from the Finance and Investment Committee meeting held on 15th June 2015

Capital budgets

The committee reviewed reconciliation between medical equipment and redevelopment

EPR Business case – OBC

The committee reviewed the draft OBC and a discussion took place with regard to the mapping of clinical systems to processes. The committee felt that there were benefits from doing the same for business systems and that an overarching ICT strategy should be produced. Questions were raised as to the trust's ability to deliver the project and a discussion took place as to the resources available and what else would be put in place. The committee considered and discussed the procurement processes and timescales to deliver the project.

Supplementary Budget Information

The committee reviewed a detailed paper showing the finances of the Trust over a three year period and this included analysis of pay, non-pay and income as well as divisional information, cost pressures, WTE and productivity. There were concerns raised about the degree of completion of the PE program and the risks to delivery though there was some mitigation available.

IPP Business case

The committee reviewed the business case and it was discussed that additional space was needed prior to the move to the PICB and this additional capcity would then be freed up for NHS activity. A discussion with regard to theatre 10 and MRI business cases took place and the suitability of the proposed accommodation. It was confirmed that this business case was in the 2015/16 capital plan.

GS1 Implementation plan

The GS1 implementation plan was discussed and the committee were advised that there may be a considerable overlap with the EPR which would need to be fully integrated. The committee were advised that this would largely meet the requirements of the DH but that timescales would need to be finalised.

Tariff

.A discussion took place with regard to the 2015/16 tariff.

ENDS

ATTACHMENT 8

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council update

A Members' Council meeting was held on Wednesday, 24th June 2015

The Council welcomed the new Chief Nurse and Medical Director to their first meeting.

The Council received a presentation on the results of the 2014 Outpatient Experience Survey. It was noted that there had been a reduction since the last survey in the percentage of respondents who felt that they and their child was involved in decisions about care and emphasised the importance of ensuring that patients and their families felt involved. The Council also stressed the importance of ensuring that children with fears or anxieties were supported appropriately.

The Council welcomed the Quality Report and the continuing low levels of Central Venous Line infection. It was agreed that future letters from the Trust's auditors would be circulated to the Council as soon as they were available.

An update on overall financial performance for 2014/15 and the two months to May 2015 was noted. The Council expressed concern that a number of operations on NHS patients had been cancelled following the closure of Island Short Stay in order to increase capacity for IPP beds despite falling IPP activity at the end of 2014/15. The Interim Chief Operator confirmed that a robust capacity plan would be developed which would mitigate the risk of further cancellations.

It was confirmed that IPP activity had been lower than anticipated. It was emphasised that there was no direct correlation between IPP expansion and cancellation of operations. It was agreed that the IPP group including Councillor representatives would be re-established.

The Council noted the annual operating plan that had been submitted to Monitor.

The Council approved the re-appointment of two Non-Executive Directors as recommended by the Members' Council Nominations and Remuneration Committee. They noted the Committee's request to plan recruitment processes so that high calibre candidates are attracted to any vacant posts.

It was noted that the Trust's membership had now exceeded 9,000 and would continue to focus on engaging with members. The Council received an update on the outcome of the Members' Council elections and welcomed the number of candidates who had self-nominated.

Councillors reported that the food group was now moving forward with meetings planned on a monthly basis until December 2015. It was added that some Councillors had taken part in a discussion at the Clinical Ethics Symposium.

The Council noted that there continued to be an issue with the high number of PALS contacts related to the Gastroenterology team and it was confirmed that work was on-going with the team particularly around communication which was the most frequently reported concern.

The Council suggested that it should be easier to give compliments to members of staff and suggested that compliment cards should be placed throughout the Trusts with returns boxes to facilitate this.

The annual complaints report was received and it was noted that communication continued to be the most frequently occurring theme. It was reported that Medical Director and Chief Nurse would be looking at the way the complaints and PALS information was used for learning. The importance of learning from examples of good patient experience and care was also emphasised.

The Council discussed the work that was being undertaken with the Nurse Consultant for Intellectual (Learning) Disabilities and suggested that this could be expanded to support children with a range of additional needs but which did not meet the criteria for a learning disability. It was agreed to consider the way in which the hospital passport could be expanded for use with older patients who did not have a learning disability.