Great Ormond Street Hospital for Children NHS Foundation Trust

Meeting of the Trust Board
Wednesday 27th January 2016

Dear Members

There will be a public meeting of the Trust Board on Wednesday 27th January 2016 at 1:30pm in the **Charles West Room, Paul O'Gorman Building** Great Ormond Street, London, WC1N 3JH.

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

AGENDA

	Agenda Item STANDARD ITEMS	Presented by	Attachment
1.	**Apologies for absence**	Chairman	
Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.			
2.	**Minutes of Meeting held on 25th November 2015**	Chairman	**N**
3.	**Matters Arising/ Action Checklist**	Chairman	**O**
4.	**Chief Executive Report**	Chief Executive	**Verbal**
	STRATEGIC ISSUES		
5.	**Annual Planning Process**	Interim Director of Strategy and Planning	**8**
6.	**Update on access improvement work**	Interim Chief Operating Officer	**Q**
7.	**CQC Inspection Report**	Company Secretary	**R**
8.	**Research and Innovation Update**	Director of R&I	**S**
9.	**Equality and Diversity Annual Report 2015**	Chief Nurse/ Director of HR and OD	**T**
	PERFORMANCE		
10.	**Summary of performance for the period:** • **Quality and Safety** • **Targets and Indicators** • **Workforce** • **Finance**	Chief Executive Medical Director Interim Chief Operating Officer Director of HR and OD Interim Chief Finance Officer	 **U** **V** **W** **X**
11.	**Monitor Self Certification Q3 2015/16**	Chief Finance Officer	**Y**

12.	**Patient Experience Report**	Chief Nurse	**9**
13.	**CQC Inpatient Survey Results**	Chief Nurse	**3**
14.	**Safe Nurse Staffing Report – November 2015 and December 2015**	Chief Nurse	**4**
15.	**Redevelopment Update**	Director of Development	**5**
	GOVERNANCE		
16.	**Responsible Officer**	Medical Director	**7**
17.	**Members' Council Update** • **September 2015** • **November 2015**	Company Secretary	**6**
18.	**Update from the Audit Committee in January 2016**	Chair of the Audit Committee	**Verbal**
19.	**Update from the Finance & Investment Committee in January 2016**	Chair of the Finance and Investment Committee	**Verbal**
20.	**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.)		
21.	**Next meeting** The next public Trust Board meeting will be held on Friday 1st April 2016 in the Charles West Room, Great Ormond Street, London, WC1N 3JH.		

ATTACHMENT N

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT Minutes of the meeting of Trust Board on 25th November 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
Professor Rosalind Smyth	Non-Executive Director
Mr Charles Tilley	Non-Executive Director
Dr Vinod Diwakar	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 Matthew Tulley	Director of Redevelopment
Ms Cymbeline Moore	Director of Communications
Dr Anna Ferrant	Company Secretary
Ms Victoria Goddard	Trust Board Administrator (minutes)
Dr John Hartley*	Director of Infection Prevention and Control

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

158	**Apologies for absence**
158.1	Apologies for absence were received from Mr Robert Burns, Director of Planning and Information.
159	**Declarations of Interest**
159.1	No declarations of interest were received.
160	**Minutes of Meeting held on 30th September 2015**
160.1	The minutes were **approved**.
161	**Matters Arising/ Action Checklist**
161.1	The actions taken were **noted.**
161.2	Play at GOSH
161.3	Ms Juliette Greenwood, Chief Nurse presented a summary of a paper which had been considered by the Clinical Governance Committee. She said that work had begun to look at areas of work by the play service, GO-Create! and the activity centre to assess any gaps or areas of overlap.

161.4	Ms Greenwood said that it was difficult to benchmark the GOSH play service with other services provided elsewhere as it was not possible to identify whether data for other providers included work in outpatients. In addition, other organisations operated an Emergency Department.
161.5	Baroness Blackstone, Chairman said that it was clear that play was important and of value for the organisation but said that the report should be clear about the service's value for money including opportunity costs in terms of the space used for playrooms.
161.6	Mrs Mary MacLeod, Non-Executive Director said that the Clinical Governance Committee had recommended that an internal review of the service may be helpful.
161.7	**Action:** It was noted that play had been considered by the Trust Board a number of times at recent meetings. It was agreed that opportunity costs in terms of the space used for playroom would be considered and brought back to a future meeting.
161.8	The Board **noted** the update.
162	**Chief Executive Report**
162.1	Dr Peter Steer, Chief Executive provided an update on the following items: • Tariff negotiations – The Chief Finance Officer had been engaging in the continuing negotiations. The Board had expressed concerns about the potential outcome of the discussions. • Junior Doctor Strike: Meetings had taken place with Junior Doctors and the Consultant body as well as discussions with service managers in preparation for the strike. The Director of HR and OD said that there was some confusion as to what constituted 'action short of strike action' and clarification was being sought. It had been agreed that Junior Doctors would be asked if they would be striking, although it was noted that they were not obliged to tell the Trust, and teams would be agreeing how their services would be organized locally. • The Trust continued to liaise with the Care Quality Commission (CQC) and an update had been provided to the regulator on the current RTT issues. The draft CQC report had not yet been released.
163	**Update on access improvement work**
163.1	Ms Dena Marshall, Interim Chief Operating Officer presented the report and said that all Trusts in London had challenges in relation to their cancer or referral to treatment data in either data or performance terms.
163.2	It was reported that an Interim Director of Information had been recruited on secondment from the Intensive Support Team and good progress was being made with a lot of work to be done. Ms Marshall said that he would be leading work to look at demand and capacity by specialty which would feed into business planning for 2016/17.
163.3	A number of regular meetings were taking place and reports were being provided to the Clinical Governance Committee and Audit Committee as well as the Trust Board. It was confirmed that good evidence was in place to provide assurance to the Board around actions being taken. It was noted that the Audit Committee would

	consider the outcome of the data review being conducted by KPMG at its January meeting.
163.4	The Board **noted** the update.
164	**Update on Education and Development Quarter 1&2 2015/16**
164.1	Mr Ali Mohammed, Director of HR and OD said that work was taking place to look at shaping the structure and responsibilities for education going forward. He highlighted that all external contractual requirements had been met and new requirements had been introduced to introduce care certificates and more adults trained nurses.
164.2	The Board discussed the work that had taken place to recruit adult trained nurses and it was noted that although this was going well within Cardiac Intensive Care, there had not been high numbers recruited in the rest of the hospital. Ms Juliette Greenwood, Chief Nurse said that the work would be valuable when recruiting nurses from overseas, a number of whom were likely to be adult nurses.
164.3	**Action:** It was agreed that future reports would be more 'outcomes based' and include information about return on investment.
164.4	It was confirmed that a priority over the next six months was to recruit a substantive Director of Medical Education.
164.5	Ms Greenwood said that one of the reasons given for nurses leaving the Trust was about access to education and training with more specialist training requested. Ms Greenwood said it would be important to review what was required to deliver the service against the perceptions of the team.
164.6	Dr Vinod Diwakar, Medical Director told the Board that Health Education North Central and East London (HENCEL) had confirmed that training posts for national trainees would be returned to GOSH in 2016. He said that discussions were on going about the issue of trainee general paediatricians who had found work at GOSH to be too specialised. Dr Diwakar said that it would be difficult to manage rotas without these juniors due to national restrictions in the number of specialist trainees so discussions were focusing on potentially placing generalists in other, more suitable areas.
164.7	The Board **noted** the update.
165	**Progress against Trust Objectives for 2015/16**
165.1	Mrs Claire Newton, Chief Finance Officer said where progress had been RAG rated as red, in most cases the Board had been previously briefed on the issues. It had been proposed at the Trust Board Strategy meeting in October that a time limited committee be convened to discuss the commercial strategy which had been RAG rated red for progress.
165.2	Professor Rosalind Smyth, Non-Executive Director said that the Institute of Child Health also had a commercial strategy and recommended that the organisations work together on this.
165.3	Mrs Mary MacLeod noted that a number of clinical outcomes were published on the

	GOSH website and suggested that these should be highlighted to the Trust Board and Members' Council.
165.4	**Action:** It was agreed that the strategic priorities document would be considered by the Board at the January meeting following the incorporation of feedback provided by Non-Executive Directors at the Strategy workshop in October.
165.5	The Board discussed the difficulties of approving a strategy given the current environment and financial uncertainty. Mr David Lomas, Non-Executive Director suggested that before the Board could endorse the strategy it would be important to look at a view of the likely resource requirements notwithstanding the uncertainties.
165.6	The Board **noted** the update.
166	**Quality and Safety Update – as at 31st October 2015**
166.1	Dr Vinod Diwakar, Medical Director said that he proposed to integrate the quality and safety and patient experience reports into one document and to make reporting more proactive, giving assurance that the Trust is currently safe and that practices are in place ensure safety going forward.
166.2	It was reported that mortality had remained constant over the last few years and the Mortality Review Committee had undertaken excellent work on deaths at GOSH which would be taken to the Clinical Governance Committee.
166.3	The Board noted that the number of cardiac and respiratory arrests had been slowly rising over recent months. Following a review, it had been found that 75% of arrests had not triggered the children's early warning score. He said that a national study on early warning systems was due to be published from which the Trust would take recommendations in the absence of an internationally recommended system.
166.4	The mean time from writing a discharge summary to sending it had been reduced to 0.8 days and learning was being gathered from divisions as this had been achieved in varying ways. Learning would also be applied to the work being undertaken to reduce the time taken for clinic letters to be sent.
166.5	The Board **supported** the new report layout and **noted** the update.
167	**Targets and Indicators Update – as at 31st October 2015**
167.1	Ms Dena Marshall, Interim Chief Operating Officer said that there had been a significant increase in theatre productivity with unused sessions being at their lowest in a number of months. In a number of areas utilisation was over 70 per cent.
167.2	The Board **noted** the update.
168	**Workforce Metrics & Exception Reporting – as at 31st October 2015**
168.1	Mr Ali Mohammed, Director of HR and OD said that agency spend, although generally low had been increasing in some areas. He said more stringent controls had been put in place as the how much the Trust was able to pay for agency staff and by May 2016 it would not be possible for a member of agency staff to earn

	more than a substantive member of staff.
168.2	Following good work undertaken on the time to hire metric it had become clear that delays were often being caused by the police checks part of the DBS check which had in some cases taken an average of 13-14 weeks to complete. Mr Mohammed reported that this was an issue across London.
168.3	Baroness Blackstone, Chairman said it was important to be proactive on this issue and to raise awareness of the delays and the impact. Mr Mohammed agreed to keep the Board updated as necessary.
168.4	The Board **noted** the update.
169	**Financial Performance – as at 31st October 2015**
169.1	Mrs Claire Newton, Chief Finance Officer said that similarly to previous months, October had finished slightly above plan due to strong IPP activity in month which offset lower NHS activity and lower than plan non-pay expenditure.
169.2	It was reported that some of the changes in activity to address access issues may impact on IPP activity and affect the above plan trend; this had been taken into account in the forecast submitted to Monitor.
169.3	**Action:** It was agreed that discussion would take place between Mrs Newton and Mr Charles Tilley, Non-Executive Director outside the meeting to look at the relationship between non-elective inpatient activity and income.
169.4	Mr Charles Tilley, Non-Executive Director queried whether there was any indication that GOSH was losing market share.
169.5	Mrs Newton said that she had recently received market share information for quarter 1 there had been no indication of any particular issues. She added that a number of London Trusts were reporting a reduction in elective activity.
169.6	It was reported that in general, surgical specialties had been underperforming throughout the year although additional activity as a result of the access improvement work was addressing some of this shortfall.
169.7	The Board **noted** the update.
170	**Update on patient experience at GOSH**
170.1	<u>Update on Friends and Family Test</u>
170.2	Mrs Juliette Greenwood, Chief Nurse said that the Trust had previously been excluding some families from the data set of those eligible to complete the Friends and Family Test. As a result of the increase in eligible families, the response rate had reduced from an average of 33%-35% to 14%. Mrs Greenwood confirmed that the data had now been corrected and significant work was taking place to increase completion rates.
170.3	Baroness Blackstone, Chairman expressed concern about the ability to rely on feedback provided given the low response rate.
170.4	Mrs Greenwood said that the 14% response rate was disappointing against a

	national average of 20%. She said that at the point of discharge all families were given the necessary information however the rules were clear that the Trust must not directly ask for responses to be provided. In parallel it was important to drive other work on engagement with families and ensure that real time information was available.
170.5	PALS report Q2 2015/16
170.6	An increase had been noted in the number of patients and families providing feedback through social media. Mrs Greenwood said the Trust did encourage this but it was important to track comments and follow them up where necessary.
170.7	The primary theme of PALS contacts continued to be around communication which was mirrored in complaints.
170.8	It was reported that positive results had been received in three of four themes in the Patient-led Assessments of the Care Environment (PLACE) and a significant increase in the score received for food.
170.9	Complaints Report Q2 2015/16
170.10	The complaints report was presented and Ms Greenwood said that timeframes for complaint resolution were being benchmarked with those of other organisations.
170.11	The Board **noted** the updates.
171	**Safe Nurse Staffing Report – September and October 2015**
171.1	Mrs Juliette Greenwood, Chief Nurse said that in September the average fill rate dropped with a lower fill rate of qualified nurses on night shifts and there were six ward areas where day and night fill rates fell below 90%. The fill rate improved to an average of 96% during October.
171.2	It was reported that there had been an unexpected increase in the number of grade 2 pressure ulcers with 11 reported in September and 6 in October. The Tissue Viability Team were investigating the increase.
171.3	Mrs Greenwood said that the vacancy rate significantly improved during September as due to an intake of newly qualified nurses however challenges remained around recruitment of Health Care Assistants, recruitment of band 6 nurses and retention of band 5 nurses.
171.4	The Board welcomed the lowest ever reported number of bed closures.
171.5	It was confirmed that there were no unsafe shifts during September or October 2015.
172	**Infection Control Report**
172.1	Dr John Hartley, Director of Infection Prevention and Control said that infections did continue to occur as a result of the failure to prevent cross infection. Dr Hartley emphasised the importance of continuing to reinforce standard precautions.
172.2	**Action:** Dr Hartley raised the issue of control of critical ventilation systems and the

	importance of having the ability to manage rooms, closing them where necessary for verification. Dr Hartley also raised the issue of having sufficient space to clean equipment. It was agreed that these issues would be taken forward outside the meeting.
172.3	The Board discussed the 'bare below the elbow' policy and it was noted that GOSH operated a policy of bare below the elbows by the bedside. Dr Hartley said he believed this strategy allowed focus to be placed on infection prevention and control measures where they have been shown through research to be most effective.
172.4	The Board **noted** the update.
173	**Update of Standing Financial Instructions and Delegated Financial Limits**
173.1	Mrs Claire Newton, Chief Finance Officer presented the report and said that it had been recommendation to the Board for approval by the Audit Committee.
173.2	The Board **approved** the amendments to the documents.
174	**Update from the Audit Committee in November 2015**
174.1	Mr Charles Tilley, Chair of the Audit Committee provided an update on the Committee's last meeting. He said that the Committee had asked the Chief Executive whether independent oversight was required for the important Electronic Patient Record Programme as it goes forward. He added that work to look at the Board Assurance Framework (BAF) was being led by Mr Akhter Mateen, Non-Executive Director and Executive Directors outside of Audit Committee meetings.
175	**Update from the Clinical Governance Committee in October 2015**
175.1	Ms Mary MacLeod, Chair of the Clinical Governance Committee presented the update and confirmed that all items the committee had agreed to escalate to the Board had been discussed within the meeting.
176	**Update from the Finance & Investment Committee in November 2015**
176.1	Mr David Lomas, Chair of the Finance and Investment Committee said that the latest financial forecast showed that the Trust was likely to end the year approximately on plan. He said that this would be a considerable achievement given the significant pressures on the Trust.
177	**Any Other Business**
177.1	There were no other items of business.

ATTACHMENT O

Attachment O

TRUST BOARD – PUBLIC ACTION CHECKLIST
January 2016

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
118.2	30/09/15	Reduction in activity levels: Ms Dena Marshall, Interim Chief Operating Officer said that a full update would be provided in January 2016 on some systemic gaps which were being identified between activity and capacity.	DM	January 2016	On agenda under update on access improvement
120.2	30/09/15	It was reported that risk appetite had been reviewed and would be brought back to the Board to be agreed.	AF	Postponed to February 2016	Not yet due
121.3	30/09/15	Baroness Blackstone, Chairman said that it was important to discuss the redevelopment of the frontage building as set out in the masterplan as this would involve significant additional funds being raised by the GOSH Children's Charity.	MT	January 2016	Redevelopment report on agenda
161.7	25/11/15	It was noted that play had been considered by the Trust Board a number of times at recent meetings and it was therefore agreed that work would be done on the paper which would be brought back at a future meeting.	JG	March 2016	Not yet due
164.3	25/11/15	It was agreed that future education reports would be more outcomes based and include information about return on investment.	AM	May 2016 and on-going	Noted

Attachment O

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
165.4	25/11/15	It was agreed that the strategic priorities document would be considered by the Board at the January meeting following the incorporation of feedback provided by Non-Executive Directors at the Strategy Board meeting.	AF	January 2016	Verbal update on progress with the strategy
169.3	25/11/15	It was agreed that discussion would take place between Mrs Newton and Mr Charles Tilley, Non-Executive Director outside the meeting to look at the relationship between non-elective inpatient activity and income.	CN & CT	January 2016	Actioned
172.2	25/11/15	Dr Hartley raised the issue of control of critical ventilation systems and the importance of having the ability to manage rooms, closing them where necessary for verification. Dr Hartley added that it was important to have space to clean equipment and this was currently not available. It was agreed that these issues would be taken forward outside the meeting.	JG and MT	January 2016	The Chief Nurse discussed the matter with the DIPC and is undertaking active engagement with key teams to ensure that maintenance of equipment is appropriately planned for.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27th January 2016

Annual Planning Process **Submitted by**: Claire Newton, Interim Director of Strategy and Planning	**Paper No: Attachment 8**

Aims
To brief the Board on the NHS Planning requirements for 2016/17

Summary

The Planning Guidance was released by NHS England and Monitor just before Christmas and requires a first draft submission of the annual Operating Plan, including financial information, by February 8th with a final version by April 11th.

We will be submitting our three year strategy to the Board at the March Meeting and this will be aligned with the plans required to be submitted to NHS Improvement (formerly Monitor). At the February Board workshop, further elements of the three year strategy will be considered.

This paper sets out the overall requirements for the draft submission on February 8th. ***An update will be provided of the completed planning templates before the Board meeting.***

Organisations are also expected to prepare five year planning information and work with other providers and their commissions to submit a combined five year plan. For GOSH, it is unclear which other organisations we should work with to submit a combined plan.

Action required from the meeting
To note the planning process and approve the submission of the DRAFT annual operating plan and financial plan

Contribution to the delivery of NHS Foundation Trust strategies and plans

The paper concerns the development of the Trust's plan

Financial implications
None

Who needs to be told about any decision?
All staff involved in developing the annual plan

Who is responsible for implementing the proposals / project and anticipated timescales?
CFO & Interim Director of Strategy and Planning

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

Attachment 8

Brief for Trust Board on NHSE Planning Guidance 2016/17 and Draft Submission due 8th February 2016

A What has to be submitted and when?

DRAFT One year operational plan

- required by 8th February 2016
- FINAL One year operating Plan, aligned with commissioners and approved by the Board **11 April 2016**
  A declaration of sustainability is required for the final plan

Five year Sustainability and Transformation Plan "STP" aligned with commissioners and other relevant Providers by end of June

B Key elements of the one year operational plan

- A full set of finance, activity and workforce plan data collections required at draft as well as final.
- A detailed Productivity &Efficiency plan showing in what areas the Trust is intending to deliver cost savings and efficiencies
- The predicted financial "Outturn" for 2015/16 based on the current forecast.
- Monthly phasing of the income and expenditure within the plan is highlighted as critical.

Challenges in assumptions required for the the Draft Plan financial submission

- The Board is aware that we are currently developing a robust Demand and Capacity model which will link to Capital Developments. This will be used to determine the Trust's bed and resource requirements
- Medical equipment – we are currently developing a short and long term replacement strategy which will inform our capital programme
- Access improvement – the activity profile for 2016/17 will include additional activity focussed on the areas with long waiting lists
- There will be additional non-recurring costs associated with data validation etc
- Staffing – the structural changes in Divisions and Support Departments will need to be fully costed
- The plan should include the additional funding which has just been notified by NHSI but which the Trust (in common with other Trusts) is challenging the basis

Additional issues:

- The Trust's Clinical Negligence premium is increasing by £1.5m which creates a significant additional cost pressure
- We are only just starting discussions with our Commissioners in relation to the 2016/17 contract and we have not yet commenced the review of local prices which commissioners agreed would influence the prices in 2016/17
- No discussions have yet taken place on CQUIN schemes for which there will be costs to deliver the schemes to offset against the performance linked income
- The national tariff has been issued but is not yet finalised

C Operating Plan Narrative Contents

A draft version of the submission due in February will be circulated subsequent to this paper ahead of the Board meeting.
The key components are based on the NHSE Targets for 2016/17 which relate to delivery of theNHS's 2020 Strategy

Operational

- Plan to achieve the targets within the NHS Seven day service plan (4 clinical standards in all relevant specialties)
- Publish avoidable deaths
- Reduction in emergency admission rates?
- New models of care
- Reduction in delayed transfers of care
- Plan to improve patient choice (incls end of life care)

Governance:

- Improve NHSI governance rating /achieve access & treatment targets
- Improve no of staff who feel their organisation acts on concerns raised

Quality and Safety

- Measurable improvement in antimicrobial prescribing

Service Specific:

- Specific objectives for Cancer, diabetes, LDs
- Deliver GMC targets
- Increase diagnostic capacity?

Innovation:

- Expand and trial promising interventions to support people with long-term health conditions and disabilities
- Increase uptake in research and innovation

Information governance:

- Robust data security standards
- Progress data sharing where relevant
- Increase patient access to health record

Staff:

Deliver targets to improve health and wellbeing of staff

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **27th January 2016**	
Update on RTT/ Access Improvement **Submitted by:** **Dena Marshall, Interim Chief Operating Officer**	**Paper no: Attachment Q**
Aims / summary To update Trust Board on progress regarding RTT/ Access Improvement.	
Action required from the meeting • To note the report	
Contribution to the delivery of NHS Foundation Trust strategies and plans Delivery of the RTT standard is part of the NHS Constitution.	
Financial implications There are significant costs associated with implementing the RTT Improvement Plan.	
Who needs to be told about any decision? All relevant internal and external stakeholders are being consulted.	
Who is responsible for implementing the proposals / project and anticipated timescales? COO	
Who is accountable for the implementation of the proposal / project? CEO	

Attachment Q

GREAT ORMOND STREET HOSPITAL FOR CHILDREN

REFERRAL TO TREATMENT (RTT) UPDATE

JANUARY 2016

Introduction

Good work continues across the whole organisation in respect of rectifying our RTT data quality issues, improving our operational systems and processes and treating our longest waiting patients. We continue to have excellent engagement from all the clinical and corporate teams.

This report updates the Trust Board on key activities over the last eight weeks and performance against key milestones.

Patient Tracking Lists (PTL)

Our interim Director of Information & Performance is continuing to work on ensuring that our active waiting list is accurate.

The Trust now has a robust PTL in place with total visibility of all patients who have been referred since 1st October 2015. This has increased the overall size of the PTL to c.9,000 pathways (from c6,200).

We continue to work on reducing waiting times for our patients, through treating the longest waiting patients.

Excellent progress is being made to reduce waiting times in radiology.

Validation

The validation of the open pathways commenced on 30th November 2015.

A validation plan with trajectories, plan assumptions and milestones for validating each identified cohort has been developed and submitted to NHSE and Monitor.

Owing to the delays to recruitment (previously reported) it is unlikely that the validation will be completed before September 2016.

Clinical Review

The internal clinical review panel (CRP) process is now well established. This group has the primary role of overseeing the review of patients who have waited longer than the nationally required wait times to provide assurance and rigour that the length of time any patient has waited has not been clinically disadvantageous to her/ him.

The panel has been meeting weekly for four months. No moderate/high harm has been identified via the panel.

The commissioners have established an external clinical review panel. Two meetings have been held (November, December 2015). The processes and outcomes of the internal panel are discussed at this meeting. The commissioners have been satisfied that our processes are robust, and panel decisions appropriate.

Performance against plan

The clinical teams have worked very hard to accommodate their longest waiting patients.

All of these actions mean that for all long waiting patients identified on the PTL as at 1 November 2015 will have been treated by end of February 2016, with the exception of those patients waiting for services which we have highlighted to the Commissioners require pausing owing to capacity constraints at GOSH, and those patients who have chosen a date outside the 30 week milestone standard.

Capacity

We have transferred a small number of patients to alternative providers where this is clinically appropriate to do so.

The initial outputs of the work we have been undertaking on demand and capacity will be available for presentation to the Board at the end of January 2016 and with other stakeholders in February 2016.

Data Quality Review

The data quality review is underway and we expect to receive the final report in February 2016. An interim update has been provided to Audit Committee in January 2016.

Communications Plan

We have agreed with Monitor and NHS England, a comprehensive communications plan use with internal and external stakeholders. This plan has been approved by our local Access Improvement Board and shared with NHS England and Monitor.

Training

The Trust is implementing its training strategy which includes the roll out e-learning for staff. The roll out has commenced and will be completed by April 2016.

Governance and assurance

Our internal Access Improvement Board meets fortnightly to track progress against our Improvement Plan. This chaired by the interim Chief Operating Officer and includes Executive Directors, Clinical Directors and General Managers.

The clinical review panel meets weekly, chaired by the Medical Director.

We continue to update Monitor and NHS England of progress against our improvement plan and the key milestones via the fortnightly tripartite meetings, chaired by the interim Chief Operating Officer.

IST Review

Given that it is approximately eight months since the original RTT diagnostic review was completed, the Trust has invited the IST to undertake an 'interim review' of progress related to RTT recovery.

Whilst the Trust is fully aware there is still much work to do, this interim review will provide assurance of the progress, as well as highlighting if the future direction of the recovery programme is appropriate. This has been planned for mid-February.

Summary

Significant progress is being made on a number of fronts.

The key risks that we continue to work on are:

- the completion of the validation of the open referrals
- the capacity (beds and theatres) required to continue to maintain the 18

week access standard

A further update on RTT improvement will be available at the next meeting.

Dena Marshall
Interim Chief Operating Officer
January 2016

Attachment R

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **27th January 2016**	
CQC Report Update **Submitted by:** Anna Ferrant, Company Secretary	**Paper No: Attachment R**

Aims / summary

To provide the Board with an update on the findings of the 2015 scheduled CQC inspection and on the actions underway to address the formal findings and informal opportunities for improvement identified in the report.

A summary report is provided at Attachment 1. The report has been circulated to all Board members and is also available on the CQC website:
http://www.cqc.org.uk/sites/default/files/new_reports/AAAE1574.pdf

A Quality Summit will be organised by the CQC in February 2016, inviting key stakeholders to discuss the report and actions taken by the Trust. The Trust must finalise a plan outlining the actions it will take in response to the CQC's requirement notice and areas for improvement and send this to the CQC within one month of the quality summit date (once this takes place). Accountable leads for each action have been identified and responses and timeframes are being reviewed and agreed. It is intended that a final draft of the action plan will be taken to the February Trust Board meeting for approval.

Action required from the meeting

To note the update provided.

Contribution to the delivery of NHS / Trust strategies and plans

Registration with the CQC and compliance with their fundamental standards is a critical requirement to provide services and therefore, achieve the Trust's strategies and plans.

Financial implications

Not applicable.

Legal issues

Not applicable.

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

Executive Leads will be identified and assigned for each action.

Who is accountable for the implementation of the proposal / project

Dr Peter Steer, Chief Executive is the accountable lead. Anna Ferrant, Company Secretary is the CQC's Nominated Individual and will lead the response to the CQC report.

Attachment R

Care Quality Commission Report Update

Background:
The Care Quality Commission (CQC) conducted a scheduled acute hospital inspection between 14 and 17 April 2015, with further unannounced inspections occurring between 1 and 3 May 2015.

Results and Recommendations
A summary report is provided below and the full quality report is available online – http://www.cqc.org.uk/sites/default/files/new_reports/AAAE1574.pdf

Based on evidence collected at the inspection, information provided by the Trust and the CQC's own intelligence, the Trust was rated as 'Good' overall. The overall rating is calculated based on consideration of the CQC's five questions, as outlined in the diagram below.

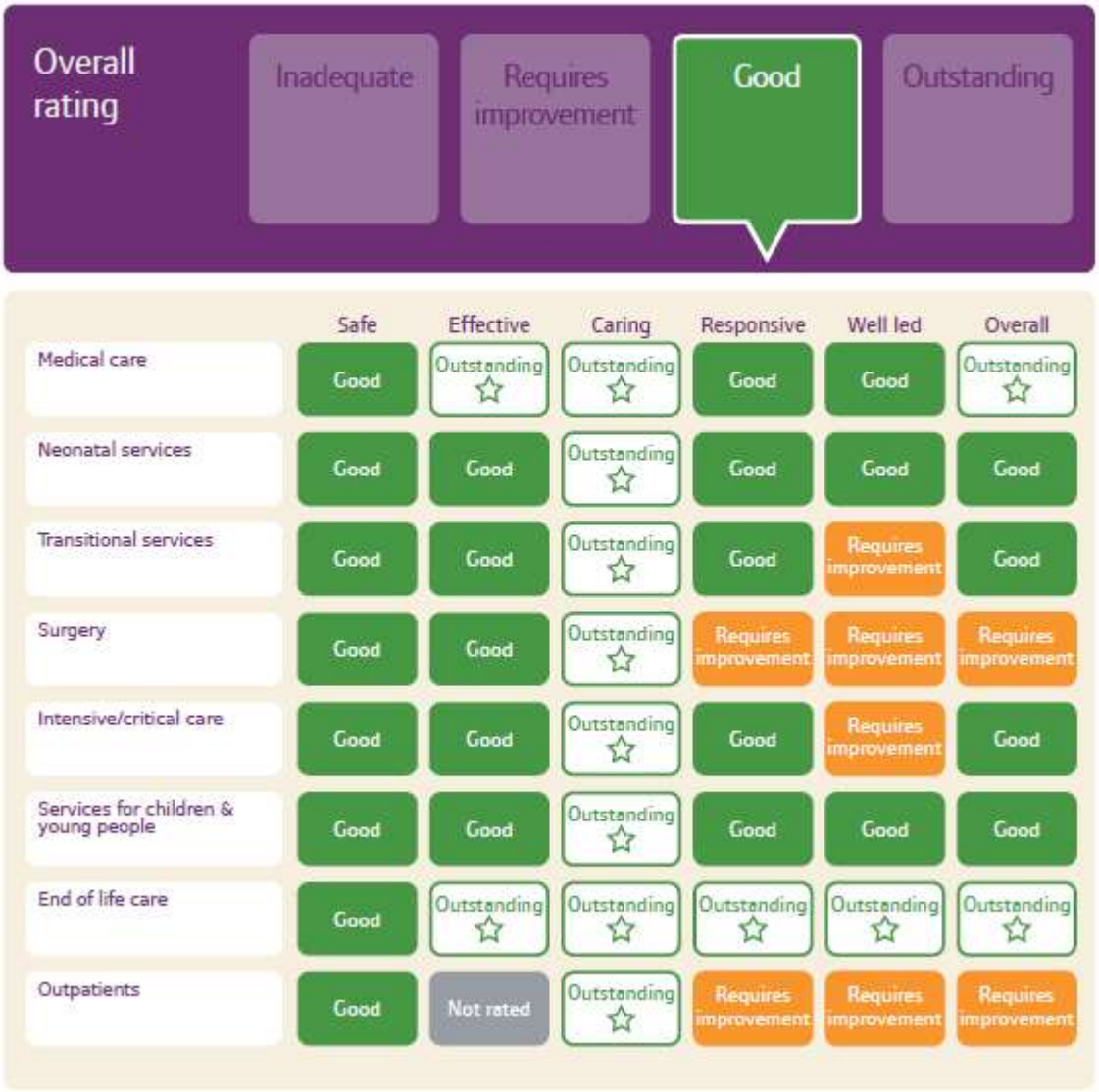
Overall rating for this trust	Good
Are services at this trust safe?	Good
Are services at this trust effective?	Outstanding
Are services at this trust caring?	Outstanding
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

The CQC assessed eight 'core services' across the Trust. As demonstrated by the diagram below, two services were rated as 'Outstanding' (medical care and end of life care), four services were rated as 'Good' (critical care, neonatal services, child and adolescent mental health services and transitional services) and two services were rated as 'Requires Improvement' (surgery and outpatients and diagnostic imaging).

The report identified a number of areas of outstanding practice including:

- Patient and parent involvement and the degree of compassion and respect demonstrated by staff.
- Commitment to continually improve the quality of care and innovate.
- An open and transparent culture including good duty of candour. This approach was seen with parents and patients when apologies and support were offered and corporately through the reporting and investigation of incidents.
- The refurbished or rebuilt facilities. These were seen as modern, extremely child friendly and conducive to excellent patient care.

Attachment R



While there were areas of outstanding performance, areas for action and improvement were also identified in the report as follows:

- One formal requirement notice was issued, to address a fundamental (governance) standard not currently being met around the Trust's capacity to effectively assess, monitor and mitigate risks, which was prompted by the RTT issues identified since the inspection (please see Attachment 2, item 1 for this action).
- The report also identified areas for improvement that the Trust 'must' and 'should' action (please see Attachment 2 , items 2 – 9), including information management (which is linked to the RTT data issues already being worked through), staff training and redevelopment.
- To ensure the Trust considers all opportunities for improvement, the Trust is also considering all negative comments or observations included in the report for management consideration and action, as required.

The Executive team has circulated the final report to all staff across the Trust. A series of internal communication initiatives are underway to acknowledge the many areas of outstanding practice highlighted in the report and note the areas for improvement.

Inspected trusts are required to display CQC ratings at premises where services are being provided. As required, posters have been erected in all main entrances to the hospital and a link included on the homepage of the GOSH website. The internal communications team has been working with General Managers and Services' clinical leaders to ensure they are prepared to respond to any questions or concerns raised by patients, families and staff around the impact of the report and what it means for patient care.

Next Steps:
A Quality Summit will be organised by the CQC in February 2016, inviting key stakeholders to discuss the report and actions taken by the Trust.

The Trust must finalise a plan outlining the actions it will take in response to the CQC's requirement notice and areas for improvement and send this to the CQC within one month of the quality summit date (once this takes place). Accountable leads for each action have been identified and responses and timeframes are being reviewed and agreed. It is intended that a final draft of the action plan will be taken to the February Trust Board meeting for approval.

DRAFT - Preliminary responses to CQC Report (as at 19 January 2016)

No	Chapter	Page ref	Theme	Action/ Statement in CQC report	Initial response and action taken by the Trust	Overseeing Assurrance Committee/s
1	Requirement notice	Pg 130	Other - risk and governance	Below outlines the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards. The provider was not complying with Regulation 17 2 (a) (c) and (f). Systems were not sufficiently established or operated effectively to ensure the provider was able to assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk, which arise from carrying on of the regulated activity because: 1) Irregularities were discovered in the trust's management and recording of referral to treatment practice and data over several years meaning that the data was unreliable. This affected mainly but not uniquely the surgical and outpatient and diagnostic divisions. 2) The trust and also local divisions had not managed referral to treatment efficiently and the inefficiencies had not formally been picked up and managed and remedied at both local division and trust level. 3) At the same time the trust had not managed access to treatment for all patients in a consistent way in accordance with its own access to treatment policy.	The Trust has embarked on a significant transformation programme related to the delivery of elective care across the organisation. This includes both the RTT and cancer standards. This programme of work is being lead by the Chief Operating Officer (COO), with nine specific workstreams related to the requirements of the IST reports received by the organisation to address the findings. These workstreams have their own dedicated leads who report to the COO (as SRO) for the project through the fortnightly internal Access Improvement Board that has been established, as well as a fortnightly Tripartite meeting with external stakeholders, including Monitor and NHS England. The nine dedicated workstreams are Training, Data Systems & Processes, Validation, Clinical Review Group, Operational Delivery & Waiting List Management, Radiology, Policies & Procedures, Communications and Cancer. Each of these workstreams has multiple actions which are then monitored through a centrally held Action Plan. The timeframe for the completion of these actions vary considerably based on the actions required, however the Trust anticipates that the work to correct the issues identified and embed change into the organisation will be on-going throughout the remainder of 2016 and onwards. For example, the Trust is undertaking a considerable validation exercise related open referrals on its patient administration system (PAS) and this will not be completed until September 2016 at the earliest. As such the Trust will not be able to recommence reporting against the RTT standards until after this date.	AC and CGC
2	Areas for improvement - Actions that MUST be taken	Pg 128	Other	Resume WHO checklist audits in surgery	This has been completed. WHO checklist audits have taken place since the CQC inspection. An observational audit of the WHO checklist was undertaken and the results shared with the Theatres and Risk Action Group in October 2015 . The audit showed a good level of performance with the WHO Checklist. The key findings are outlined below. • Components of the checklists were completed in 100% of the surgeries observed, and was completed entirely in 17/40 (43%) surgeries. • The average percentage of the checklist completed was 92.98%. • The most poorly performed component of the Surgical Safety Checklist was checking for any new members since team brief, which only 29 of the 40 surgeries did. The reasons for this may be that no new members of staff were present since the team brief, although this should still be verbalised during time-out. A meeting has arranged with the Clinical Audit Manager, head of Nursing and key clinicians to plan a meaningful way of auditing the quality of the WHO checklist in 2016-17.	CGC

DRAFT - Preliminary responses to CQC Report (as at 19 January 2016)

No	Chapter	Page ref	Theme	Action/ Statement in CQC report	Initial response and action taken by the Trust	Overseeing Assurrance Committee/s
3	Areas for improvement - Actions that MUST be taken	Pg 128	Transition	Ensure that there are clear arrangements for reporting transition care service performance to the Board	The Chief Nurse is leading work to respond to the CQC's 'must do' action to implement arrangements for transition care services reporting to the Board, along with a number of other comments about transition services included in the report. A comprehensive plan will be provided to Trust Board in due course, but is expected to include: 1. Work to define what the 'transitional care' service is / will be at GOSH and agree and set our minimum standards through to best practice (informed by external & peer work). For example by age 14 all eligible young people will have commenced on the transition pathway / all young people over the age of X will be offered the option of meeting with their consultant / CNS / AHP at their outpatient appointment without their parent / carer 2. Undertake internal scoping with the HoCS / CNS / AHP to confirm the current status of each individual speciality against a minimum data set & ultimately the GOSH standards (point 1) 3. Identify and agree key metrics to report against from 'Ward to Board' 4. Establish a robust process for reporting of key metrics from 'Ward to Board' that demonstrate current status and progress of improvements 5. Establish a Programme of Care to lead on the delivery of our quality service improvement work for adolescent care. This will be sponsored by the Chief Nurse as the Executive Lead for 'Transition', but delivered through the planned Divisional Programme of Care approach (under development) 6. Through the Young People's Forum we will support and enable work to scope out best practice with other Young People's Forums (across the Children's Hospital Alliance) to inform & delivery of the programme of care	CGC
4	Areas for improvement - Actions that MUST be taken	Pg 128	Work processes, access and flow	Ensure that its RTT data and processes are robust and ensure that staff comply with the trust's patient access policy in all cases.	The Trust has embarked on a considerable programme of work to improve the data systems and processes in place to support RTT delivery. The IST review completed highlighted that the reporting solution in place related to RTT was not in-line with guidance. The Trust has embarked on a considerable work to re-write the scripts related to RTT reporting and these went live at the end of December 2015, with further testing required in early January. The Trust will now move to the new reporting solution from 22nd January 2016 and therefore the Trust is then confident that the reporting solutions in place are robust going forward. This logic will apply to all referrals received by the organisation from 1st October 2015 onwards, with any referrals that pre-date this point will need to be managed through the validation process. An interim Access Policy was redrafted following the review in October 2015, with a further one due in February 2016.	AC and CGC

DRAFT - Preliminary responses to CQC Report (as at 19 January 2016)

No	Chapter	Page ref	Theme	Action/ Statement in CQC report	Initial response and action taken by the Trust	Overseeing Assurrance Committee/s
5	Areas for improvement - Actions that MUST be taken	Pg 128	Staffing and Training	Ensure greater uptake of mandatory training relevant to each division to reach the trust's own target of 95% of staff completing their mandatory training.	In relation to mandatory training, the following actions have been agreed. • Implement the changes in the refresher training schedule agreed by the Trust's Executive Team in October 2015 which reschedules a number of updates from 2 yearly to 3 yearly. • Establish a multidisciplinary task-and-finish group, co-chaired by the Assistant Director of Organisation Development and the Director of Medical Education and consisting of representatives from main staff groups to oversee work on review and compliance. • Through this group, which will report to a newly convened Education Board jointly chaired by the Director of HR&OD, Chief Nurse and Medical Director, agree a risk-based matrix to establish priority areas for improved compliance in existing training. This may include, for example, identifying key staff groups/departments/subjects in which there is greatest risk in non-compliance. Consider implementing a RAG rating for compliance, and incremental targets to build to 95%. • Over a 6-12 month period, review all subjects which currently make up the GOSH statutory and mandatory training programme. In conjunction with subject matter experts, develop clear criteria that set out the reason for the training and frequency (for those subjects which are GOSH-specific); content and delivery mechanisms; quality indicators; outcome and audit; regular review. • Establish a clear set of responsibilities and escalation mechanisms to ensure compliance is sustained.	CGC
6	Areas for improvement - Actions that MUST be taken	Pg 128	Trust Culture (CC, nursing)	Ensure that, particularly in critical care, communication between senior nurses and senior medical staff is enhanced and that the contribution of nursing is fully reflected in the hospital's vision.	Whilst recognising the issues raised in the CQC report, it should be noted that since the review, the Divisional Head of Nursing has been established (was in post for <2 months at the time of the review), two of the four Lead Nurses (PICU and NICU) are new in post and there are now have 4 Heads of Clinical service (PICU, NICU, CICU and CATS) in post as well. To strengthen the relationships between all the teams and improve communications between teams the following actions have occurred: strengthened the critical care board with all new leaders meeting monthly, have a monthly critical care forum with consultants, senior nurses and allied professionals and a strong parent representative, the Head of Nursing meets the lead nurses monthly, the general manager is meeting the lead nurses and heads of clinical service for each area monthly. The Divisional Director will meet the Heads of Clinical service on a one to one every 2nd month. In response to this report an extra-ordinary Critical Care Board Meeting (with all new leaders) was held on 14 Jan 2016 to discuss this issue. This group is intended to focus their away day on 5 Feb 2016 (with the senior nursing and medical teams) to discuss these issues raised by the CQC and to come up with an action plan. The key items on the agenda for this day are to discuss communication and relationships between senior nurses and doctors as well as to relook at the vision for the critical care division, including the nursing vision. A more detailed plan will be able to be provided after this away day. An external mentorship programme for the Heads of Clinical service has also been introduced. The incoming Head of Leadership for GOSH will be tasked with working with nursing and medical leaders in critical care to support senior team development using diagnostic and OD techniques to build on existing approaches.	CGC

DRAFT - Preliminary responses to CQC Report (as at 19 January 2016)

No	Chapter	Page ref	Theme	Action/ Statement in CQC report	Initial response and action taken by the Trust	Overseeing Assurance Committee/s
7	Areas for improvement - Actions that SHOULD be taken	Pg 128	Redevelopment and Environment	Ensure early improvements in the environments of wards which have not been refurbished, rebuilt or relocated.	The CQC report specifically commented on the need to consider the small treatment rooms on Starfish ward, and the subsequent challenges associated with manoeuvring a hoist or a resuscitation trolley in the case of an emergency. In response, a review has commenced of the treatment areas to explore any environmental changes within the areas or if there are any other suitable areas for storage to improve the circulation space for manoeuvring equipment within the treatment rooms. This review is expected to be completed by April 2016. The report also referenced the environment on Rainforest ward, including the cramped area, challenges around ensuring privacy and the number of toilets available. In response, an additional toilet and shower facility has been provided within the area for patients/parents (1 toilet and 1 shower). However, Rainforest will be moving to OBW as part of the moves associated with the opening of the new PICB building in 2017, this will significantly improve the environmental condition for the Rainforest ward	AC and CGC
8	Areas for improvement - Actions that SHOULD be taken	Pg 128	Staffing and Training	Standardise radiation protection training for junior radiologists to overcome inconsistencies caused by short rotations.	A register of radiology trainees will be created to record the date and nature of their most recent radiation protection training. This will allow the Trust to identify any potential deficiencies in training and address them. A process of compiling a printed induction manual for rotating radiology trainees is also underway, which will include radiation protection information. This will reinforce the existing training for these junior doctors. This is anticipated to be completed by the end of March 2016. The Head of Radiology Training will regularly review the register and ensure that all trainees have documented their training. The induction manual will be reviewed annually.	CGC
9	Areas for improvement - Actions that SHOULD be taken	Pg 128	Other	Develop a dedicated advocacy service for its Child and Adolescent Mental Health service (CAMHS).	The CAMHS team have commenced investigating options to identify the most appropriate response to this action. Possible advocacy organisations are being approached and work to finalise a budget to pay for the potential services is underway. An alternative option being considered is to identify an 'advocate' from another unit (eg a nurse from another child's psychiatric unit) and a GOSH nurse to provide 'advocacy' for their unit. The effectiveness and affordability of both options are being explored fully and it is intended the preferred response will be in place by March 2016.	CGC

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 27th January 2016	
Research and Innovation Update **Submitted by: Professor David Goldblatt, Director of Research and Innovation, Emma Pendleton Deputy Director of Research and Innovation**	**Paper No: Attachment S**
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, in particular our increase in commercial research income, our continued performance in recruiting to NIHR portfolio studies and the contribution GOSH is making to and the benefits our patients are receiving from the 100,000 Genomes project. Annex 1a and b have been provided for information to evidence our performance as a NIHR Biomedical Research Centre. Each year the NIHR analyse BRC performance based on the annual report we submit, within the NIHR document GOSH BRC is number 10, we have also completed our own analysis normalising for BRC award value.	
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 Research and Innovation	
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 Research and Innovation	

Great Ormond Street Hospital for Children NHS Foundation Trust

Research and Innovation January 2016

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 for 14/15 and month 8 for 15/16, with income at month 8 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 814-15 (£000)	Income as at Month 8 15-16 (£000)
A. Centre Grants and Infrastructure, Research Delivery Support				
Biomedical Research Centre	NIHR	7,331	5,407	5,306
Research Capability Funding	NIHR	2,250	1,500	1,429
Local Comprehensive Research Network	NIHR	1,833	1,283	1,495
B. Programme and Project Grants				
NIHR Programme, Project Grants	NIHR	1,313	744	416
Charity Research Project Grants	Variable*	1,743	1,239	1,088
European Union Research Project Grants	EU	30	16	37
Commercial Research Contracts	Variable	1,346	851	1,465
Other	Variable	633	453	565
Total income		**16,479**	**11,494**	**11,802**

*Charity funding is mostly GOSH Children's Charity

2. Directly funded research staff

As at month 8 15/16 there are 138 WTE staff directly funded through the research income sources detailed in Table 1 above.

Table 2: Directly funded research staff

The table below provides details of directly funded staff at month 8 for 15/16 with month 8 14/145 shown for comparison.

Staff Group	Month 12 14-15	Month 8 14-15	Month 8 15-16
Administration, Data Managers, Trial Coordinators	48	44	47
Consultants	5	6	12
Directors & Senior Managers	7	5	10
Junior Doctors	1	1	0
Nursing Staff	36	36	33
Nursing Staff Bank	0	0	1
Scientific, Therapeutic, Technical	38	38	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

1. 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 8 for 15/16, with activity at month 8 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 M8 14-15	Number Active YTD M8 15-16
NIHR Programme and Project Grants	14	14	19
Charity Research Project Grants	55	55	54
European Union Research Project Grants	7	7	6
Commercial Research Contracts	103	95	72
Total	**179**	**175**	**151**

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 to month 8 15/16, with month 8 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.

2. Research recruitment

Division	Total number of projects YTD M12 14/15	Total number of projects YTD M8 14/15	Total number of projects YTD M8 15/16	UKCRN Portfolio projects YTD M8 15/16
Critical Care and Cardio-Respiratory	123	108	109	31
Infection, Cancer and Immunity – LM	250	228	237	81
Medicine, Diagnostic and Therapeutic Services	260	245	235	82
Neurosciences	147	131	152	59
Surgery	47	42	51	12
Other GOSH	16	14	25	4
Total	**843**	**768**	**809**	**269**

Great Ormond Street Hospital for Children NHS Foundation Trust

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.

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 M8 14/15	Patient recruitment YTD M8 15/16
Critical Care and Cardio-Respiratory	797	528	335
Infection, Cancer and Immunity – LM	568	334	345
Medicine, Diagnostic and Therapeutic Services	1453	948	802
Neurosciences	422	270	405
Surgery	450	275	404
Other GOSH	0	0	4
Total	**3690**	**2355**	**2295**

North Thames Clinical Research Network is the top recruiting network for children and 3rd for genetics nationally. GOSH is the top recruiting Trust in the NT network for both of these specialties.

3. 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
Q4 14/15	51	26	19	73%	72%	96 / 209	48 days
Q1 15/16	51	24	19	79%	75%	104 / 210	46 days
Q2 15/16	56	29	22	76%	78%	112 / 208	47 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	55%	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
Q4 14/15	86	42	32	76%	53%	22 / 187
Q1 15/16	88	38	26	68%	50%	15 / 185
Q2 15/16	89	42	28	67%	52%	34 / 183

Research Outcomes

4. 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. 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	737	876	783	1016	1014	1013
ICH-only	566	612	611	724	607	556
Total	**1303**	**1488**	**1394**	**1740**	**1621**	**1569**

Table 8b: Number of publications by Clinical Division

Division	Publications YTD M12 14/15	Publications YTD M8 14/15	Publications YTD M8 15/16
Critical Care and Cardio-Respiratory	113	74	57
Infection, Cancer and Immunity – LM	277	177	86
Medicine, Diagnostic and Therapeutic Services	272	174	117
Neurosciences	106	71	54
Surgery	82	55	29
Other GOSH	286	207	131
Total	**1013**	**679**	**410**

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).

Great Ormond Street Hospital for Children NHS Foundation Trust

100,000 Genomes Project

In October 2013 GOSH, UCLH and Moorfields were approached to participate in the Genomics England 100,000 Genomes pilot; the project was established to deliver on the government's commitment to sequencing 100,000 genomes by the end of 2017 in order to aid diagnosis and management in patients with rare Disease, Cancer and Infectious Diseases.

GOSH worked in partnership with UCLH and Moorfields to deliver over 1000 samples during the pilot phase, 22 per cent of the samples. The pilot was led by Professor Phil Beales (Head of Genetic and Genomic Medicine at ICH-UCL and Director of GOSgene) and was supported by Biomedical Research Centres and Clinical Research Facilities across the three sites. The GOSH Somers Clinical Research Facility opened at weekends during the pilot phase and many families travelled long distances to take part in this rare genetic disease pilot. Patients from the other partner hospitals could also attend the weekend clinics at the GOSH Clinical Research Facility.

Following the pilot a call for designation as Genomic Medicine Centres was launched in 2014, enabling recruitment to the main 100,000 Genomes Programme. Led by GOSH, six hospital trusts in north London successfully formed the North Thames Genomic Medicine Centre (NTGMC). The partnership includes GOSH, Barts Health NHS Trust, London North West Healthcare, Moorfields Eye Hospital NHS Foundation Trust, the Royal Free London NHS Foundation Trust and University College London Hospitals NHS Foundation Trust (UCLH). Professor Lyn Chitty (GOSHCC Professor of Genetics and Fetal Medicine) is the Clinical Lead for NTGMC and Professor Maria Bitner-Glindzicz (GOSHCC Professor of Clinical and Medical Genetics and honorary consultant in clinical genetics at GOSH) is the lead for Rare Diseases across the GMC.

By collecting and analysing DNA samples on a large scale and matching them with the symptoms and the long-term outcome associated with these conditions, the genome project aims to position the UK as the first country in the world to sequence 100,000 whole human genomes. This will help researchers and clinicians better understand, and ultimately treat, rare and inherited diseases and common cancers. The programme is now well established across the country with 13 GMCs now inaugurated. The NTGMC has been recruiting more than 100 families a month and to date has contributed 22 per cent of the national total. Patients receiving care at all hospitals in the Centre are identified and asked with consent to provide blood samples for genetic analysis and future biochemical and metabolic tests.

The first children to receive a genetic diagnosis through the 100,000 Genomes Project are patients recruited at GOSH.

The results, which pinpoint changes in different single genes as the cause of two previously undiagnosed conditions, come from the first wave of families recruited as part of the pilot phase of the project. As well as removing a large amount of uncertainty for the families, the results stand to have a major impact on many areas of their lives including future treatment options, social support and family planning. They also have the potential to help many more children with undiagnosed conditions who may be tested for these genetic mutations early on and be offered a diagnosis to help manage their condition most effectively.

The hope is that the positive results will help to encourage more clinicians to refer patients to the project so that a greater number of families can be tested and helped.

The 100,000 Genomes Project has put the NHS at the forefront of science, expanding on medical diagnosis and providing a personalised medical treatment plan based on the information that comes from their genome.

Great Ormond Street NHS Hospital for Children
NHS Foundation Trust

Case Study 1: Professor Waseem Qasim

Professor Waseem Qasim is Professor of Cell and Gene Therapy at UCL ICH and consultant Immunologist at GOSH. Waseem joined GOSH in 1996 as a junior doctor and then undertook PhD studies with the Molecular Immunology Unit at ICH. He secured clinician scientist fellowships in 2002 and completed paediatric speciality training, before leading his own research group developing gene therapies in relation to bone marrow transplantation . In 2015 Waseem was awarded a prestigious NIHR Professorship (£1.7m) having previously held a GOSH CC Leadership award. Waseem holds a number of large research grants and contracts including Autolus (£1.1m), Technology Strategy Board (£662K), Cellectis (£762k) Catapult (£250k) and Leukaemia and Lymphona Research (£245k). Waseem is also a member of the GOSH NIHR BRC Faculty and his research is supported by our BRC 5 year award, including a joint industry award with Miltenyi Biotec (total value £1.4m) to automate cell engineering.

Waseem's research is centred on diagnosing and treating immune disorders, improving immune recovery after haematopoietic stem cell transplantation and gene based therapies. He has a special interest T lymphocytes and how they can be used to control virus infections and treat malignant conditions. His laboratory projects are developing and testing viral vectors derived from HIV and new gene editing reagents including TALENs and CRISPRs.

Waseem is leading 'first in man' clinical trials for antivirus cell therapies in conjunction with CellMedica and a trial of suicide gene engineered cells with Bellicum at GOSH. He is also coninvestiagtor responsible for manufacturing T cells for trials at RFH (WT1-TCR study) and UCLH (CAR19 Cobalt trials). Last year saw the first use of T cells engineered to express a recombinant receptor against a Hepatitis B antigen in a patient with hepatocellular carcinoma in Italy.1

More recently a new highly experimental treatment that uses 'molecular scissors' to edit genes and create designer immune cells programmed to hunt out and kill drug resistant leukaemia was used under the MHRA Special's Licence at GOSH. The treatment, previously only tested in the laboratory, was used in one-year-old, Layla, who had relapsed acute lymphoblastic leukaemia (ALL) to achieve a complete remission ahead of transplantation. This was the first ever use of this new technology anywhere in the world and generated extensive media interest. The team at GOSH / UCL ICH and biotech company Cellectis, are now planning a clinical trials for 'off-the-shelf' banks of engineered T-cells for other patients in a similar situation.

In addition to studies in his own speciality, Waseem has collaborations in Infectious Diseases, Neurology and Metabolic medicine has led development and initiation of two gene therapy trials for inherited skin diseases. A trial of lentiviral gene modified skin grafts in the rare skin condition Netherton Syndrome is open at GST and has treated its first subject. In addition a trial of gene modified fibroblasts for patients with Epidermolysis Bullosa has just opened using vectors developed at ICH2 and the first adult patient treated

Publications:
1. Immunotherapy of HCC metastases with autologous T cell receptor redirected T cells, targeting HBsAg in a liver transplant patient.
Qasim W, Brunetto M, Gehring AJ, Xue SA, Schurich A, Khakpoor A, Zhan H, Ciccorossi P, Gilmour K, Cavallone D, Moriconi F, Farzhenah F, Mazzoni A, Chan L, Morris E, Thrasher A, Maini MK, Bonino F, Stauss H, Bertoletti A.; J Hepatol. 2015 Feb;62(2):486-91. doi: 10.1016/j.jhep.2014.10.001.
2. Lentiviral Engineered Fibroblasts Expressing Codon Optimized COL7A1 Restore Anchoring Fibrils in RDEB.
Georgiadis C, Syed F, Petrova A, Abdul-Wahab A, Lwin SM, Farzaneh F, Chan L, Ghani S, Fleck RA, Glover L, McMillan JR, Chen M, Thrasher AJ, McGrath JA, Di WL, Qasim W.; J Invest Dermatol. 2015 Sep 22. doi: 10.1038/jid.2015.364

Case Study 2: Professor Helen Cross

Professor Helen Cross is the Prince of Wales Chair of Childhood Epilepsy and Honorary Consultant in Paediatric Neurology at GOSH. Helen trained in medicine and paediatrics in Birmingham and then joined GOSH as a registrar to train in paediatric neurology. Helen became an NHS consultant in 1996, transferred to Senior Lecturer in 2000, and was promoted to Reader in 2004 and a Professor in 2007, appointed as the Prince of Wales Chair of Childhood Epilepsy in 2008.

Helen has been successful in attracting European Union funding (over £1m) along with a NIHR EME (Efficacy and Mechanism Evaluation) award of £1.04m. Helen's research has also been funded by Action Medical Research and Vitaflo amongst others.

The typical treatment pathway for children with epilepsy is anti-epileptic drugs. Around 60-70% of children have their seizures controlled this way but it is the 30-40% of children where the drugs do not work which is Helen's research area of interest. Surgery has become an option for these children and Helen's early research looked at developing imaging techniques with the aim of pinpointing the area in the brain where the seizures start and ultimately remove that part of the brain. This research on the use of MRI and other techniques such as single photon emission computerised tomography (SPECT) are now part of standard pre-clinical surgical evaluation at GOSH.

Helen's research has now moved into the development of clinical trials. Helen recently completed the first randomised controlled trial of the use of the Ketogenic Diet in childhood epilepsy. The Ketogenic diet is a high-fat, low carbohydrate diet that has been used to treat children since the 1920s. In 2008 Helen and her team published the findings of the first large trial showing that children between 2 and 16 saw an improvement in their seizures where anti-epileptic drugs had not worked. Although the diet had been used for over 100 years Helen and her team were the first to produce the evidence that the diet worked.

This research is now being developed further. After follow up it has been shown that there is both an immediate and sustained effect and that this it is usually maintained after the children come off the diet. A study is underway to determine whether the ketogenic diet leads to changes in tissue and improves outcome following surgery. Further, now working with Simon Heales at ICH the team are trying to understand the active ingredients within the diet. Deconic acid, a medium chain fatty acid that is a component of the diet, has been shown to have a marked antiepileptic effect in vitro, and has also been shown to increase the activity of mitochondria.

A trial of deconic acid is now planned, in collaboration with Vitaflo, a nutritional product company, to see if deconic acid alone can help control seizures. There is now a real chance of a targeted approach to treating epilepsy.

<u>Publications:</u>

JH The ketogenic diet in the treatment of epilepsy in children: a randomised, controlled trial
Neal EG, Chaffe HM, Edwards N, Lawson M, Schwartz R, Fitzsimmons G, Whitney A, Cross (NCT00564915). Lancet Neurology 2008;7:500-506

SJRThe ketogenic diet component decanoic acid increases mitochondrial citrate synthase and complex I activity in neuronal cells
Hughes SD, Kanabus M, Anderson G, Hargreaves IP, Rutherford T, O' Donnell M, Cross JH, Rahman S, Eaton S and Heales J Neurochem 2014 129:426-33

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 18th January 2016	
Equality & Diversity Annual Report **Submitted by:** Juliette Greenwood, Chief Nurse and Ali Mohammed, Director of HR & OD	**Paper No: Attachment T**
Aims / summary To provide Trust Board with assurance that the Trust is meeting its statutory obligations under the Equality Act 2010. To inform the Board about the new equality objectives.	
Action required from the meeting To note the content of the report.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Meeting statutory duty to report publically on this activity. Work promotes fairness and equity in service delivery and employment.	
Financial implications None.	
Who needs to be told about any decision? N/A	
Who is responsible for implementing the proposals / project and anticipated timescales? Family and Staff Equality and Diversity Groups.	
Who is accountable for the implementation of the proposal / project? Chief Nurse (families and patients) and Director of HR & OD (staff).	

Equality and Diversity Annual Report 2015/16

Introduction

The Equality Act came into force on 1st October 2010, simplifying existing equalities law into one single source of Statute. In addition to the Act, the statutory Equality Duty came into force in April 2011 which is applicable to all public sector bodies. As a Trust we must demonstrate that we comply with the Equality Act and are meeting the Equality Duty through the work we do, the involvement we have of the Trust Board in this work and through publishing a range of equalities data on an annual basis.

To comply with the first specific duty of the Act, the Trust is legally required to annually publish equality data relating to both service users and staff. A copy of the latest edition of this report is available on the GOSH website at **www.gosh.nhs.uk/about-us/equality-and-diversity/**. The 2016 report will be available at this location from the end of January. The second part of the specific duty requires the Trust to prepare and publish specific and measurable equality objectives, setting out how progress towards these objectives should be measured. To develop relevant equality objectives involving key stakeholders, the Family Equality and Diversity (FED) and Staff Equality and Diversity (SED) groups have utilised the NHS Equality Delivery System 2 (EDS2) to grade the Trust against several equality related outcomes. This involved extensive consultation of key stakeholder groups.

This paper sets out the six objectives, outlines how they were identified and how they will be monitored. The appendix covers how we assessed our organisation against the four goals and 18 outcomes of the Equality Delivery System (EDS). In addition other on-going activities are identified which will be carried out during the coming three - four year period.

Equality objectives for period 2016 to 2020/21

Six objectives have been identified; three relating to patients and families and three relating to staff. In selecting objectives, consideration has been given to objectives which will foster the aims of the general Equality Duty concerning issues which affect people with protected characteristics and which will have the most impact on the disadvantages they face.

As well as the objectives outlined below and required by law, other work will be on-going throughout the year to progress specific equality issues:

- **SED** will continue to support the work of the GROW network which aims to develop Black and Minority Ethnic staff, be involved in the Project Search Initiative which provides work experience to young adults who have learning disabilities and explore cultural competence training for managers.
- **FED** will continue to review the outcomes of last year's focus groups to ensure that any shortcomings are improved, such as weekend cleaning of toilets and reviewing availability of multisensory equipment for children and young people. Additional areas for improvement will be identified through the Friends and Family Test, which will also contain demographic data in the coming year.

Objective 1: Achieve Accessible Information Standard within timescale

The Accessible Information Standard (SCCI1605) 'directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to the disability, impairment or sensory loss'. By July 2016, the Trust will have 'core' information titles available in alternative formats suitable for people with visual and/or hearing impairment, such as British Sign Language. We will also have investigated methods of 'flagging' children, young people and families with visual and/or hearing impairment.

Measurement: Availability and 'hit rate' of information titles in alternative formats

Baseline measure: Currently, we have no BSL signed videos online. Children and young people with visual and/or hearing impairment can be tracked on PiMS but there is currently no facility to flag their parents' needs.

Target: Ten core information titles have been identified with help from the Patient and Family Engagement and Experience Committee. In addition, suitable video podcasts have been identified for production of BSL signed versions with video transcripts. By July 2016, these titles will be available in alternative formats.

Background: This objective is a requirement for all health and social care organisations. GOSH currently provides a wide range of information about medical conditions, procedures, treatments and medicines, but currently this is only translated into alternative formats on a basis of clinical demand and funded by individual departments. A bid to GOSH Children's Charity has been submitted to fund this work.

Objective 2: Publicise support for families including support organisations

This objective was identified as the most popular during our engagement with children, young people and families to identify key areas of equality and diversity work. There are a wide range of support mechanisms for families both within and outside GOSH but these are not always promoted as well as they could be.

Measurement: Number of hits for support services webpages at http://www.gosh.nhs.uk/parents-and-visitors/clinical-support-services

Baseline measure: 210 hits during December 2015

Target: To increase traffic to this set of pages

Background: Families of children and young people with rare medical conditions such as seen at GOSH often have feelings of isolation, compounded by the lack of knowledge of the condition in the community. While many excellent support organisations exist, families may not always be aware of their existence so we should be promoting them in the course of our clinical contact.

Objective 3: Support on-going work to improve transition to adult services

This objective was also popular during our engagement – transition to adult services has been a priority for GOSH. This work needs to continue, with a focus on the needs of children and young people with additional needs.

Measurement: Documented evidence of transition planning.

Baseline measure: In the most recent clinical audit of transition held in April 2015, 64 per cent of notes reviewed contained evidence of transition planning.

Target: Increase the proportion of young people having planned transition to adult services.

Background: Transition to adult services from GOSH can often be a complicated matter – children and young people may have been attending GOSH from early childhood so preparing to move on to an adult-focused service can be difficult. The Clinical Nurse Specialist (CNS) for Adolescent Health has developed a transition pathway to enable all children and young people are prepared for transition but use of this needs to be promoted further so everyone can benefit. There are also plans to develop a 'life skills' training for all over 12 year olds, regardless of whether they will transition or be discharged from GOSH.

Objective 4: Increase the overall visibility of the Trust Board and Senior Leaders

In 2016 - 2017 we aim to increase the overall visibility of the Trust Board and Senior Leaders in order to enhance their communication with staff. In 2018 - 2019 we aim to provide opportunities for Trust Board Members and Senior Leaders to clearly demonstrate their commitment towards Equality and Diversity.

Measurement: Staff reporting good communication between senior management and staff – as measured annually by the National NHS Staff Survey and at the end of year four via the EDS 2 scoring system. Other measures such as attendance at events, number of executive walkarounds / ward and area visits (per month, quarter and year), visits to dedicated intranet page will also be developed.

Baseline measure: Staff Survey 2014: GOSH score = 29%. Average score for acute specialist trust: 37%.

Target: By end of 2017, GOSH will score in the region of 33%; by the end of 2019, GOSH's score will mirror the average score of acute specialist trusts; improvements in the EDS 2 score will also be achieved.

Background: This outcome was chosen to form an equality objective as the EDS2 consultation showed that this scored the highest of all outcomes in the underdeveloped grade, albeit whilst still receiving an overall grade of 'developed'. Comments received suggested that respondents did not question Senior Leaders' commitment to equality and diversity issues, rather that this was not very visible to them. Overall the National Staff Survey shows that GOSH respondents do not rate communication from senior leaders as highly as at comparable trusts. Through this objective various approaches will be considered and will be phased over the life of the objective. These will include:

- Strategies to increase the visibility of leadership and enhancement of their communication with staff.
- Development of Trust Board and Senior Leaders around equality issues (using patient stories to highlight issues, consideration of unconscious bias training etc.).
- Trial of reverse mentoring with a member of the Trust Board and a BME member of staff.
- Engaging Senior Leaders with celebrations and events throughout the year to further improve visibility.

Objective 5: To develop the understanding of managers and employees in recognising and managing Harassment and Bullying in the workplace, with the longer term intention of a reduction in the instances of bullying and harassment concerns being raised by staff.

We will take a phased approach to this issue.

In 2016 - 2017 we aim to develop the understanding of managers in what constitutes harassment and bullying, recognising when it is occurring and how to manage concerns raised by employees. This will be linked to the protected characteristics whilst recognising that this behaviour may also be aimed at those not covered by the Equality Act 2010.

We also aim to develop the understanding of employees in defining what are harassment and bullying behaviours and how they make take action should they believe this behaviour is being aimed at them or their colleagues. In conjunction with this we will create a route map for employees to raise Harassment and Bullying concerns.

The first phase of this work will be to develop an integrated training plan which draws on training delivered by the Trust's Employee Relations team, by Care First, the Trust's counselling and support service, and other services, including Conflict Resolution training. This phase will be completed by the end of Quarter 2 16/17.

Roll out of the training, using a targeted approach for those areas that are the highest priority based on existing data, will take place over the remainder of 2016/17-2017/18.

A review will be undertaken at the end of the second year to assess the impact the training has had; and to identify any additional steps to reach the 2019 target.

Measurement:

- Measurement of the number of managers who have undertaken the Harassment and Bullying training as well as the difficult conversation training
- Measurement of the number of employees who have undertaken training in Harassment and Bullying training
- Levels of reported harassment and bullying via the staff survey will have reduced by 5% by 2019

Target: To reduce the number of employees reporting experiencing harassment, bullying or abuse from staff as reported in the staff survey**.**

Background: This outcome was chosen to form an equality objective because survey results and voting showed that it was one of the categories to score highest in the underdeveloped grade. The staff survey results for 2014 showed an increase in the number of staff experiencing harassment, bullying or abuse from staff in the last 12 months.
In 2016 - 2017 we aim to develop the understanding of managers in what constitutes harassment and bullying, recognising when it is occurring and how to manage employees who raise concerns. This will be linked to the protected characteristics whilst recognising that this behaviour may also be aimed at those not covered by the Equality Act 2010.

In 2018 - 2019 we aim to develop the understanding of employees in defining harassment and bullying behaviour and how they make take action should they believe this behaviour is being aimed at them or their colleagues.

Objective 6: To improve the representation of BME staff in senior posts.

Whilst data shows that the Trust has a good representation of band 2-4 shortlisted applicants from BME groups being appointed, data shows that shortlisted applicants from BME groups are less likely to be appointed to senior posts i.e. Band 7-9 jobs at GOSH than people from white groups.

	Shortlisted applicants 2015 band 2-4 roles	Appointed 2015 band 2-4 roles	Shortlisted applicants 2015 band 5-6 roles	Appointed 2015 band 5-6 roles	Shortlisted applicants 2015 senior posts (band 7-9) roles	Appointed 2015 senior posts (band 7-9) roles
BME	1,375 (54.7%)	100 (35.5%)	591 (38%)	49 (21%)	236 (35.5%)	17 (17%)
White	1,141 (45.3%)	182 (64.5%)	975 (62%)	185 (79%)	430 (64.5%)	83 (83%)
Total	2,516	282	1,566	234	666	100

To improve representation of BME staff in senior posts we will:

- Train the recruitment teams (medical, non-medical and bank teams) to deliver 'Understanding Unconscious Bias' training sessions to managers recruiting into senior posts. In 2017 we aim to include 'Understanding Unconscious Bias' in the current recruitment and selection training course which is targeted at new recruiters. In 2018 - 2019 we aim to roll out 'Understanding Unconscious Bias' to all managers involved in the recruitment and selection process.
- In 2016 we will implement an interview assessment form that is transparent, including a scoring methodology which is reflective of the trusts values. By the end of 2017 - 2018 we aim to roll out the assessment form to all managers involved in the recruitment and selection process.

Measurement/Target: By the end of 2019 the proportion of BME senior staff appointed will be more reflective of the number of BME staff shortlisted.

Other work to meet the General Duty

Family Equality and Diversity (FED) Group

As well as the objectives outlined above, we will continue to work on our previous objectives to improve recording of demographic data as we still have some way to go to hit our target. We will be reviewing our progress on this objective to date and seeking advice from experts outside the Trust to develop a new approach to recording demographic data. In addition, we will continue to improve the proportion of families who report that GOSH understands their additional needs and meet these, although it is not clear how we can continue to measure progress due to a change in annual surveying of children, young people and families.

FED will also continue to review the outcomes of last year's focus groups to ensure that any shortcomings are improved, such as weekend cleaning of toilets and reviewing availability of multisensory equipment for children and young people.

Staff Equality and Diversity (SED) Group

As well as the objectives outlined above and required by law, other work has been on-going throughout the year to progress specific equality issues:

- The Workplace Race Equality Scheme (WRES) was completed and published as required under statute.
- SED and senior members of the HR and OD teams continue to support the work of the GROW network. The Network aims to enhance interpersonal skills, provide networking opportunities and accredited learning and development to enhance knowledge, skills and career progression of BME staff.
- The previous equality objective of parity between the personal development rates of white and BME staff was achieved.
- The previous equality objective around testing applicants within the selection process was not achieved, in that it did not translate into parity between the rates of white and BME staff appointed. Objective 6 has been developed to ensure further work in this area.
- Many key HR policies have been simplified and are supported by easy to follow flow charts, ensuring their accessibility for all staff.
- The Trust launched and is now working on embedding its new set of Organisational values – Always Welcoming, Helpful, Expert, One Team. These provide an excellent opportunity to embed behaviours which are congruent with the equalities agenda.

Future Actions

Objectives 1, 2 & 3 will be formally monitored by FED and objectives 4, 5 & 6 by SED. Progress against each objective will be reviewed by the appropriate group every year. Progress against all objectives will be formally reported to Trust Board annually.

Action required

Trust Board are asked to note the contents of this report.

Equality Delivery System for the NHS

EDS2 Summary Report

Implementation of the Equality Delivery System – EDS2 is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS2 in accordance with the '9 Steps for EDS2 Implementation' as outlined in the 2013 EDS2 guidance document. The document can be found at: **http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf**

This *EDS2 Summary Report* is designed to give an overview of the organisation's most recent EDS2 implementation. It is recommended that once completed, this Summary Report is published on the organisation's website.

NHS organisation name:

Great Ormond Street Hospital

Organisation's Board lead for EDS2:

Ali Mohammed, Director of HR and OD / Juliette Greenwood, Chief Nurse

Organisation's EDS2 lead (name/email):

Sue Lyon/Beki Moult

Level of stakeholder involvement in EDS2 grading and subsequent actions:

Electronic survey to Foundation Trust Membership
Three-day event held in Hospital Restaurant
Electronic survey to all hospital staff
Workshop with hospital staff and other stakeholders including Trade Unions and representatives from NHS Employers.

Results of surveys and gradings discussed at Family Equality and Diversity Group and Staff Equality and Diversity Group to reach consensus regarding grading. Equality objectives discussed and agreed at these groups.

Organisation's Equality Objectives (including duration period):

Family Equality and Diversity Group
- Achieve Accessible Information Standard
- Improve publicity about support for children, young people and families
- Support ongoing work to improve transition to adult services

Previous equality objectives will also continue to be progressed and reported.
Staff Equality and Diversity Group
- Enhance general visibility of senior leaders and provide opportunities for them to visibly demonstrate their commitment to equality and diversity

Headline good practice examples of EDS2 outcomes (for patients/community/workforce):

A previous Equality Objective for staff was around improving Personal Development Review rates between white and BME (Black and Minority Ethnic) staff. This objective has been achieved and rates are broadly equivalent across both groups.

Publication Gateway Reference Number: 03247

Date of EDS2 grading November 2015 **Date of next EDS2 grading** Select month Select Year

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes	1.1	**Services are commissioned, procured, designed and delivered to meet the health needs of local communities** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation Evidence drawn upon for rating: Note: As a specialist tertiary and quaternary service, GOSH does not have a 'local' population, instead treating children and young people from UK and abroad. Equality analyses carried out for developing new services and improvements to existing.	☐
	1.2	**Individual people's health needs are assessed and met in appropriate and effective ways** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation Evidence drawn upon for rating: Standardised documentation is used to ensure holistic assessment of children and young people carried out at various points during their time at GOSH. Families are also asked to complete Family Form 2 to guide us about any additional needs their child might have so that we can make reasonable adjustments to meet those needs. Internal referrals to other specialties within GOSH are made where needed, including to clinical support services such as	☐
	1.3	**Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation Evidence drawn upon for rating: At GOSH, 'transition' is usually understood to cover the process of moving from children's health services to adult services. Our adolescent nurse specialist, in conjunction with other specialists, has developed a transition pathway document that includes guidance for preparing for this move. A recent audit showed that, of the 10 specialties examined, 64 per cent of patients audited had evidence of discussions about transition. Focus for coming years is	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes, continued	1.4	**When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation Evidence drawn upon for rating: In our latest survey of inpatients, our children and young people gave a score of 9.4 out of 10 for 'feeling safe' and their parents 9.3 out of 10. For the past three years, the average number of serious patient safety incidents has remained steady at two per month. There have also been a number of quality improvement projects in recent years aiming to reduce the risk of harm occurring.	☐
	1.5	**Screening, vaccination and other health promotion services reach and benefit all local communities** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation Evidence drawn upon for rating: Note: As a specialist tertiary and quaternary service, GOSH does not have a 'local' population, instead treating children and young people from UK and abroad. We routinely monitor the vaccination status of our patients and make arrangements to 'catch up' on missed vaccinations where necessary. In addition to routine vaccinations, additional	☐
Improved patient access and experience	2.1	**People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation Evidence drawn upon for rating: The last in depth study carried out at GOSH found there were no statistically significant inequalities in referral acceptance. All our clinical areas are accessible to wheelchair users and hearing induction loops are available in all reception areas and outpatient clinic rooms. Interpreters – both BSL and non-English – can be booked on request.	☐

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Improved patient access and experience	2.2	**People are informed and supported to be as involved as they wish to be in decisions about their care** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation Evidence drawn upon for rating: In our latest survey of patients and their families, respondents gave GOSH a score of 8.5 out of 10 regarding their level of involvement in decision making. In the latest telephone survey, 91 per cent of respondents said that we were good at involving them in decisions. All our health information gives opportunities for further information and support where they exist.	☐
	2.3	**People report positive experiences of the NHS** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation Evidence drawn upon for rating: In our latest survey, children and young people gave us a score of 8.5 out of 10 for a good experience, compared with 8.7 for parents. However, 95 per cent of respondents to our latest telephone survey were satisfied with their experience. In the last four months, between 97 and 99 per cent of respondents to the Friends and Family Test were likely to recommend our hospital.	☐
	2.4	**People's complaints about services are handled respectfully and efficiently** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership ☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex ☐ Sexual orientation Evidence drawn upon for rating: Over three-quarters of complaints responses are sent out on time. In our latest telephone survey, 75 per cent respondents felt they could complain and their complaint would be taken seriously. However, males were slightly less likely to complain than females (73 per cent to 77 per cent).	☐

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.1	**Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** **Grade:** Undeveloped; Developing; Achieving; Excelling **Which protected characteristics fare well:** ☐ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Questions were asked for all protected characteristics. Evidence drawn from Staff survey, GOSH equality data, staff voting events events and bespoke survey to staff. This outcome was chosen to form an equality objective because survey results and voting showed that it was one of the categories	☑
	3.2	**The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations** **Grade:** Undeveloped; Developing; Achieving; Excelling **Which protected characteristics fare well:** ☐ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Evidence from GOSH equality data which looks at pay gap for gender and race. Nationally set terms and conditions are prevalent within the Trust	☐
	3.3	**Training and development opportunities are taken up and positively evaluated by all staff** **Grade:** Undeveloped; Developing; Achieving; Excelling **Which protected characteristics fare well:** ☐ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Questions were asked for all protected characteristics. Evidence drawn from Staff survey, GOSH equality data, staff voting events events and bespoke survey to staff.	☐

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.4	**When at work, staff are free from abuse, harassment, bullying and violence from any source** **Grade:** Undeveloped; Developing; Achieving; Excelling **Which protected characteristics fare well:** Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation **Evidence drawn upon for rating:** Evidence drawn from Staff survey, GOSH equality data, staff voting events events and bespoke survey to staff. This outcome was chosen to form an equality objective because survey results and voting showed that it was one of the categories to score highest in the underdeveloped grade.	✓
	3.5	**Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives** **Grade:** Undeveloped; Developing; Achieving; Excelling **Which protected characteristics fare well:** Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation **Evidence drawn upon for rating:** Questions were asked for all protected characteristics. Evidence drawn from staff voting events events and bespoke survey to staff. Flexible working policy is open to all staff regardless of protected grounds or caring responsibilities.	
	3.6	**Staff report positive experiences of their membership of the workforce** **Grade:** Undeveloped; Developing; Achieving; Excelling **Which protected characteristics fare well:** Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation **Evidence drawn upon for rating:** Questions were asked for all protected charachteristics. Evidence drawn from Staff survey, GOSH equality data, staff voting events events and bespoke survey to staff	

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Inclusive leadership	4.1	**Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation Evidence drawn upon for rating: Questions were asked for all protected characteristics. Evidence drawn from Staff survey, GOSH equality data, staff voting events events and bespoke survey to staff. This outcome was chosen to form an equality objective because survey results and voting showed that it was one of the categories	✓
	4.2	**Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation Evidence drawn upon for rating: All policies have an equality assessment which is audited on an annual basis and results fed back to the policy approval group. All changes which go through our managing change policy have an equality assessment which is shared with our Staff Partnership Forum.	
	4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation Evidence drawn upon for rating: Questions were asked for all protected characteristics. Evidence drawn from Staff survey, GOSH equality data, staff voting events events and bespoke survey to staff	

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **27th January 2016**	
Quality and Safety **Submitted by: Vin Diwakar, Medical Director**	**Paper No: Attachment U**
Aims / summary The quality and patient safety report is in evolution as it is being redeveloped This month we present the current format as well as an early version of the new method of reporting that is being developed. There is no change in performance other than normal variation in all the measures over the past month.	
Action required from the meeting To note the current status and to comment on the proposed format as shown.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Each of the measures reflects one of the QI standards	
Financial implications N/A	
Who needs to be told about any decision? For information; QI team to be provided feedback	
Who is responsible for implementing the proposals / project and anticipated timescales? Relevant clinical teams	
Who is accountable for the implementation of the proposal / project? Medical Director	

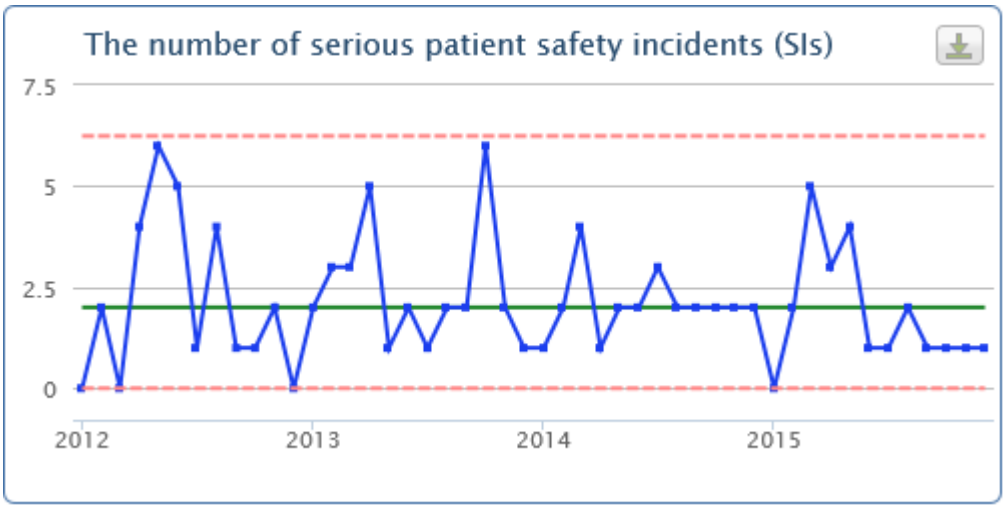
Attachment U

Quality and Safety Report for Trust Board
January 2016

Key for Control Charts

Blue line	-	The data itself
Solid green	-	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.
Dotted red	-	Upper control limits and lower control limits L). 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

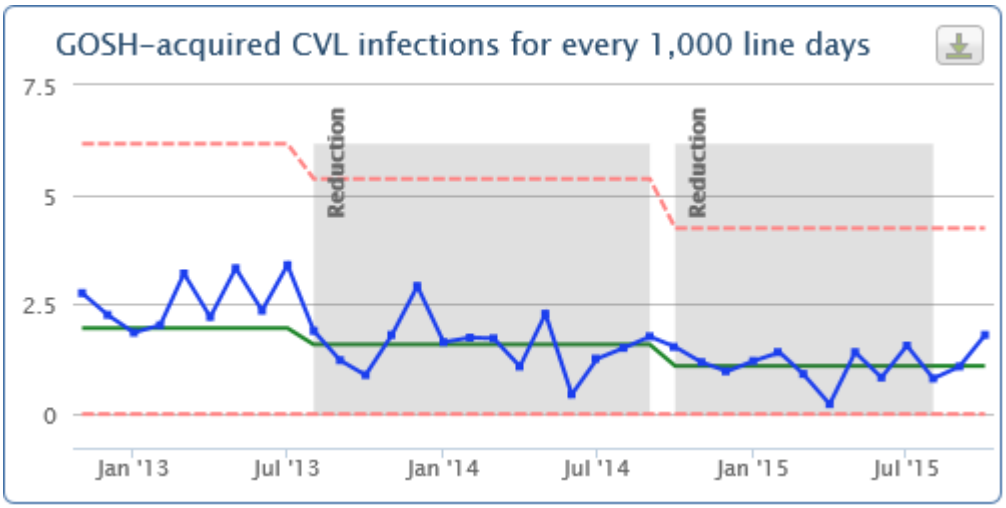


Trend: Performance is unchanged with all data points inside of the control limits. There has been no statistical change in the number of SIs – we are still running at 2 per month.

Comment: Serious incidents are a barometer of how the organisation is performing as well as an opportunity for the organisation to learn. On average we have a serious incident every 15 days. The aim should be to increase the number of days between a serious incident. The process of investigation and learning also will require some attention. The Safety team is exploring ways to improve processes so that learning can occur. The monthly Safety meeting assess the learning from each incident.

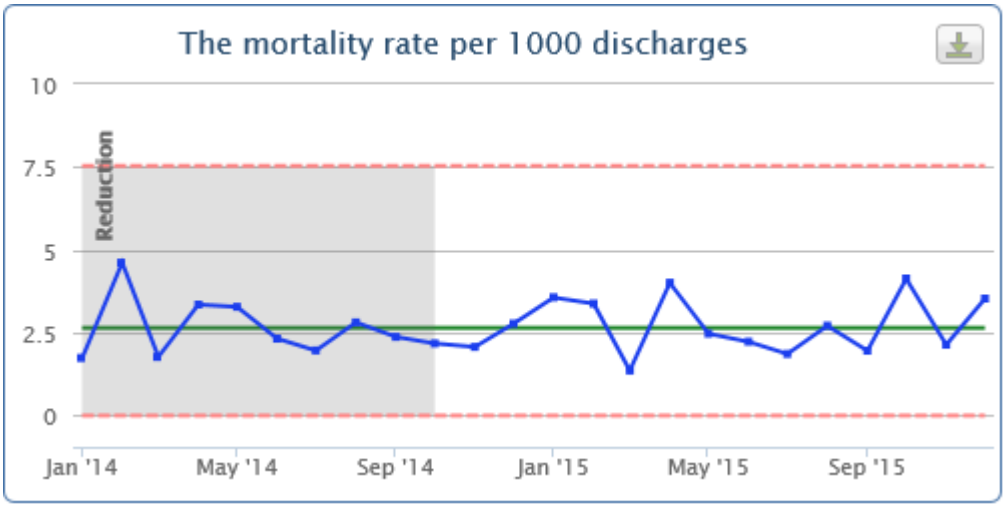
Attachment U

Standard 3: CVL Infections

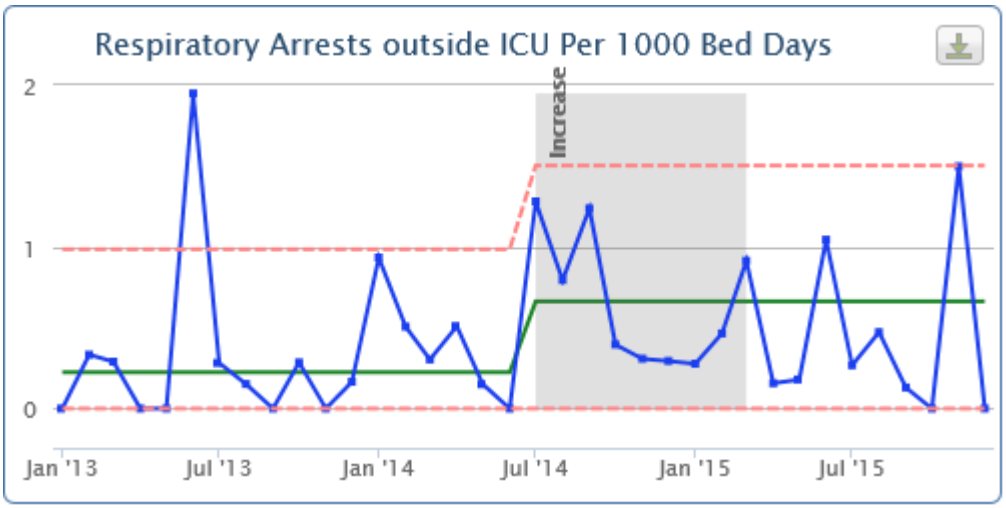


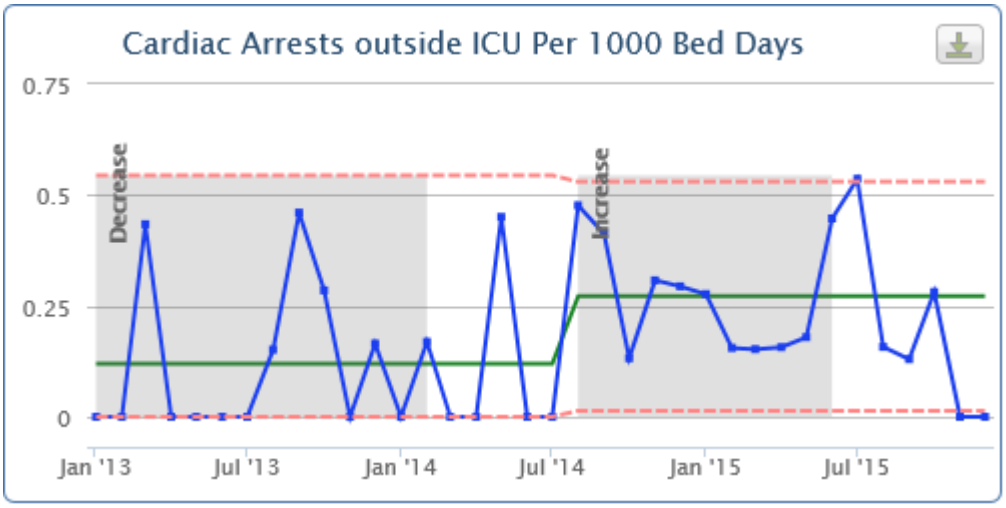
Aim:	To make statistically significant reductions in the rate of CVL infections.
Trend:	There has been a reduction in the CVL infection rate which was seen to have started in October 2014 and has subsequently been sustained.
What's going well:	The rate remains low at 1.0/1000 line days in September was observed. Rates of line infection within surgery are reducing. CVL infections are a proxy for how the organisation addresses hospital acquired infections. GOSH (B) continues to be a leader in the field in the UK. For detail go to http://www.mistuk.org/

Standard 6: Mortality and Deterioration



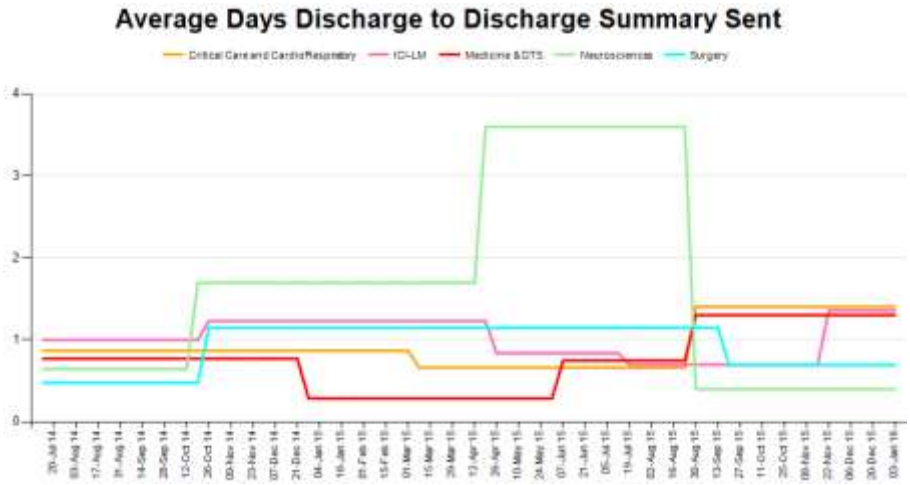
Attachment U





Aim:	To make reductions in the mortality rate To decrease the number of potentially avoidable cardiac and respiratory arrests
Trend:	The current rate is 2.5 deaths per 1000 discharges with no change. This is to be expected with the current case mix. Cardiac arrests – zero in November and December (both special causes) Respiratory arrests – November and December both special causes (on the upper and lower control limits) ie wide variation
What's going well:	We study every death via the mortality review to see if there are specific causes. Unexpected deaths are reviewed. We study every deterioration and arrest within 24 hours. We plan to look at potentially avoidable deterioration in greater detail as defined in the report on deterioration.
What's not going well:	Mortality has been constant and we do not anticipate a change; however we study each death to ensure that there is no missed opportunity for improvement.
What action is being taken:	The integrated programme of ePSAG, Safety Huddles and handover aims to decrease the number of potentially avoidable cardiac and respiratory arrests.

Standard 7: Discharge Summaries



Aim:	To make statistically significant reductions in the time taken to complete a discharge summary.
Trends:	There have been recent changes in the time from discharge to sending the summary for: • ICI-LM up from 0.7 to 1.4 days • Surgery down from 1.1 to 0.7 days
Interpretation	This is a process that will require frontline ownership in order to be sustainable. The data shows that there are some problems sustaining improvements after the project has ended, though there may be the December effect. Clinical teams will be requested to ensure that the improvements made are maintained. ICI-LM chose to delay in order that consultants could check that the junior doctor summaries were accurate and complete.

Attachment U

Matrix of Measures (MoM) Update

The proposal to the QI Committee and the Trust Board was to develop a Trust-wide reporting system to enable reporting from 'ward to board'.

The proposal seeks to provide answers to questions that the Board asks of the Trust.

The Matrix will consist of measures displayed using Statistical Process Control charts.

The rationale is that the Board would be able to assess the trends in performance with the aim of continual improvement over time. The selected vectors would provide the Board with the assurance that the Trust is meeting its strategic aims with regard to patient experience, safety, flow etc. through the system.

The plan

The plan is to work with safety and flow data – we have many measures that we can use already.

Using these measures we can test the functionality and design of the Matrix.

Once we are happy with the Matrix design we can work through the measures. This will entail working with teams that the QI team has not previously worked with e.g. Finance, Research, workforce etc. In these cases, in addition to defining what to measure we will also need to determine where the data is held and how to automate its storage in the data warehouse.

The Matrix so far

The draft Matrix of Measures is here: http://qst:100/spcworks/dashboard/mom#dashboardID=-151&p1=%

The Matrix can be run for the whole Trust, by division or ward.

Underneath each chart is a link 'More' which will take the user to a dashboard displaying multiple measures e.g. the link under the PATIENT SAFETY measure takes the user to a patient safety dashboard. The measures on that dashboard attempt to fit in with the 'framework for safety measurement and monitoring' from the Health Foundation. This is adapted for flow, patient experience etc.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27th January 2016

Performance Targets & Indicators **Submitted by:** Dena Marshall, Interim-Chief Operating Officer	**Paper No: Attachment V**

Aims / summary

Hospital Acquired Infections

In December 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 2 in 15/16

These cases were not attributed to lapses of care outlined in the assessment criteria from Monitor and agreed with NHS England.

No cases of MRSA were recorded in December. All episodes of positive blood cultures are reported to the DH via the HCAI submission site as bacteraemias and each case is discussed in detail with NHS England. There has been one case of MRSA reported in the year to date, attributed to an International Private Patient.

Two cases of E. Coli were reported in December following 48 hours of admission, taking the year to date total onset in Hospital to 9 cases in 15/16. One case of MSSA were reported in December following 48 hours of admission, taking the year to date total onset in Hospital to 6 cases in 15/16.

Activity & Patient Access

Following an increase in November across all activity types: spells, outpatients and ITU bed days, December has seen a downturn in volume. Consequently the year to date position remains in line with last month: spells remain fractionally below target, as do outpatients, whilst ITU bed days are above target.

December saw an increase of theatre sessions being unused, however over this period lists were being reviewed as a consequence of the time of year. Theatre bookings and sessional usage now forms a regular part of the weekly access meetings across the Trust looking at waiting lists and support services.

RTT and access is being reported to the Board separately.

Cancer standards are now broken into the 3 relevant reporting categories and the monthly year to date position are reflected in the report. The reported position in November (the most recent finalised position in line with national reporting) against the decision to treat to subsequent treatment (surgery), is due to a single patient breach.

Patient / Referrer Experience

Number of complaints in period

The Trust received 9 formal complaints in December 2015. There was one complaint graded as red (in line with the Trusts complaints policy). Communication was a key theme featuring in complaints, with some complaints featuring concerns about staff attitude to patients and their 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. Friends & Family Test As at December the FFT percentage of patients who would recommend the Trust is at 98.5% (very much in line with previous months). The level of respondents' remains low (21%). As reported previously, this is now due to the inclusion of Day Case areas (which previously had not been) and a refinement to the content of data being used to report this indicator
Action required from the meeting Trust Board to note performance for the period.
Contribution to the delivery of NHS Foundation Trust strategies and plans To assist in monitoring performance across external and internal objectives.
Financial implications Failure to achieve contractual performance measures may result in financial penalties
Who needs to be told about any decision?
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.

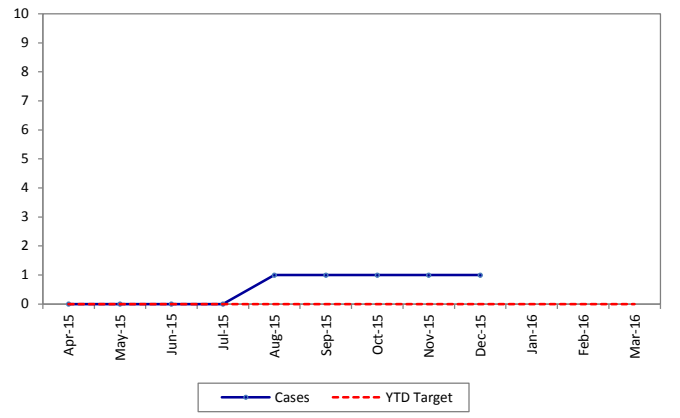
Targets & Indicators Report

	Indicator	Target	YTD Performance	Monthly Trend											
				Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Activity & Use of Resources	Number of patient spells	25,953	**25,898**	2,829	2,802	3,137	2,847	2,732	3,057	3,008	2,568	2,892	2,967	3,092	2,735
	Number of outpatient attendances	120,002	**112,854**	13,234	12,911	13,733	12,307	10,705	13,053	13,343	11,373	13,240	13,060	13,991	11,782
	DNA rate (new & f/up) (%)	<10	**8.2**	7.3	7.4	6.9	7.7	8.1	9.0	9.7	8.6	8.3	7.4	7.4	7.9
	Number of ITU bed days	8,098	**8,132**	840	774	856	710	1,221	935	933	959	875	844	882	773
	Number of unused theatre sessions	-	**169**	12	5	13	22	9	21	29	48	22	14	4	16*
	Average number of beds closed - Total Ward	-	**9.7**	14.1	10.5	13.7	20.2	13.5	15.5	11.1	5.5	4.0	5.1	4.6	8.2
	Average number of beds closed - Total ICU	-	**0.2**	0.0	0.5	0.4	0.4	0.1	0.2	0.2	0.0	0.2	0.2	0.0	0.2
Patient Access	Patient Refused Admissions - Trust Total Excluding PICU/NICU & CATS**	90	**107**	4	3	1	8	5	20	12	7	12	7	14	22
	PICU/NICU & CATS Refusals	<235	**184**	12	20	21	17	21	20	11	8	14	15	24	54
	Cancer - Decision To Treat to first treatment	96	**99.0**				100.0	92.3	100.0	100.0	100.0	100.0	100.0	100.0	
	Cancer - Decision To Treat to subsequent treatment - surgery	94	**95.3**				100.0	100.0	87.5	100.0	100.0	100.0	100.0	75.0	
	Cancer - Decision To Treat to subsequent treat - drugs	98	**100.0**				100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
Patient / Referrer Experience	Number of complaints	40	**113**	11	9	13	13	7	16	17	15	13	8	15	9
	Number of complaints - High Grade	4	**8**	1	1	3	2	0	0	4	1	0	0	0	1
	Friends & Family Test (% of those Likely & Extremely Likely to recommend)	>95	**98.3**	97.5	97.8	97.4	98.1	96.9	98.9	98.1	98.5	99.0	98.5	98.0	98.5
	Clinic Letter Turnaround, % letters on CDD - sent within 5 working days	50	**34.0**	31.6	34.9	37.8	36.0	30.0	36.7	33.1	33.4	33.0	34.5	34.8	
	Clinic Letter Turnaround, Average Days Letter Sent	-	**10.6**	12.1	11.2	10.0	11.0	10.9	10.6	10.5	11.3	10.7	10.3	9.9	
Work - force	Sickness Rate (%)	2.99	**2.6**	2.6	2.5	2.6	2.5	2.6	2.6	2.7	2.6	2.6	2.6	2.6	2.5
	Trust Turnover (%)	14.13	**18.6**	17.6	17.7	18.9	18.3	18.1	18.3	18.6	19.1	18.7	18.7	19.0	19.0

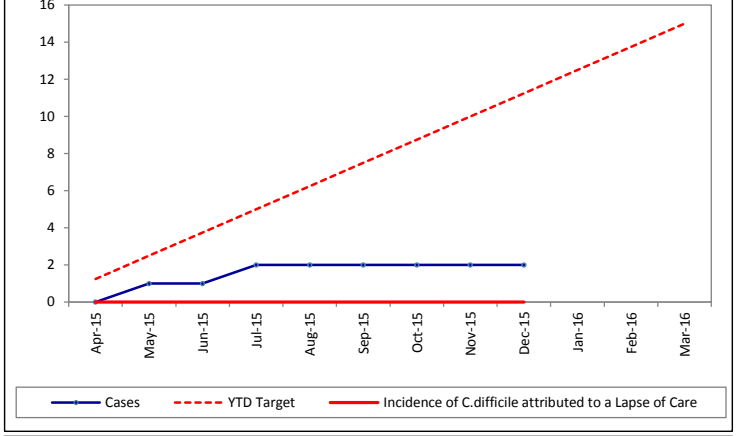
**Adjusted for Christmas Lists*

***Patient Refused Admissions - Trust Total Excluding PICU/NICU & CATS Figure is a live report and totals may be subject to change as Divisions upload data at different times*

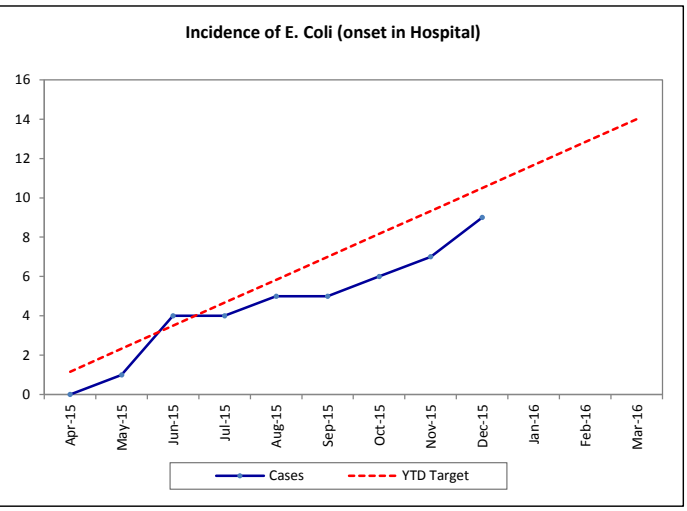
Health Care Associated Infection Indicators



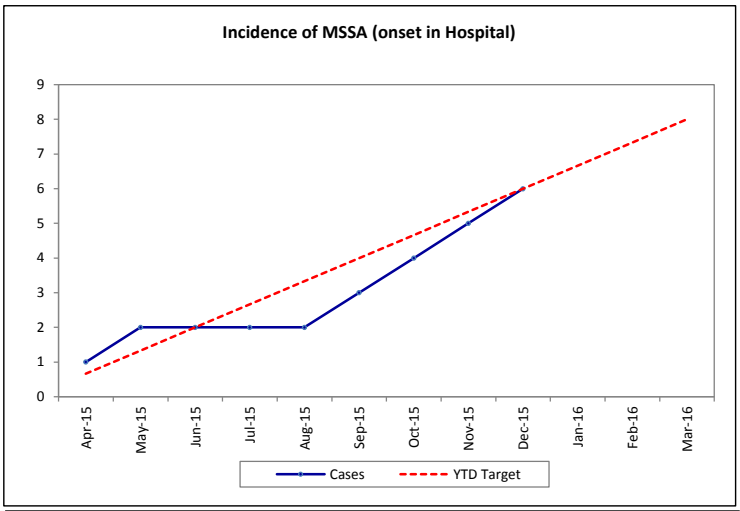
Description: MRSA bacteraemias
Target: Zero cases
Trend: 1 case reported to date
Comment: All episodes of positive blood cultures are reported to DH on HCAI site as bacteraemias



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 5
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 M5
Comment: Performance being monitored closely



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

Monitor Governance Risk Rating

Targets - weighted (national requirements)		Threshold	Score Weighting	Reporting Frequency	Score Weighting Q1				Score Weighting Q2				Score Weighting Q3**			
					M1	M2	M3	Q1	M4	M5	M6	Q2	M7	M8	M9	Q3
1	MRSA - meeting the MRSA objective *	0	1	Quarterly	0	0	0	0	0	1	0	-	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	0	0	0	-	0	0	0	0
3	All cancers: 31-day wait for second or subsequent treatment comprising either:	100%	1	Quarterly	0	0	0	0	0	0	0	-	0	0	0	0
	Surgery	94%			0	0	0	0	0	0	0	-	0	0	0	0
	Anti cancer drug treatments	98%			0	0	0	0	0	0	0	-	0	0	0	0
					0	0	0	0	0	0	0	-	0	0	0	0
4	Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96%	0.5	Quarterly	0	0	0	0	1	0	0	-	0	0	0	0
5	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	0.5	Annual	0	0	0	0	0	0	0	-	0	0	0	0
				Total	**0**	**0**	**0**	**0**	**1**	**1**	**-**	**-**	**0**	**0**	**0**	**0**
				Overall governance risk rating	**Green**	**Green**	**Green**		**Green**	**Green**	**Green**		**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

**Note that at the time of reporting the cancer standards performance is yet to be finalised

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **27th January 2016**	
Workforce Metrics & Exception Reporting – December 2015 **Submitted by:** Ali Mohammed, Director of HR & OD	**Paper No: Attachment W**
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	
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 – DECEMBER 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;

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

Contractual staff in post GOSH decreased its contractual FTE (full-time equivalent) figure by 22 in December to 3741. The decrease reflects the continuing focus on workforce control.

Sickness absence has decreased slightly to 2.5% and remains significantly below the London average figure of 2.8%. Short-term sickness (STS) (episodes of sickness up to 4-weeks) has decreased slightly across the Trust to 1.3% (down from 1.4% - following implementation of new sickness policy and management tools for supporting the Trust manage absence effectively) whilst long-term sickness has remained at 1.2%.

Turnover is reported as voluntary turnover in addition to the standard total turnover. Voluntary turnover currently stands at 16.5% (unchanged in comparison to November); this reported value excludes non-voluntary forms of leavers (e.g. dismissals, TUPE, fixed-term and redundancies). Total (voluntary and non-voluntary) has increased – currently at 19% in December (+0.3% from November). The (unadjusted) London benchmark figure is 15.1% (which includes voluntary and non-voluntary leavers). An additional report has now been included to demonstrate monthly (12 months) variance in monthly turnover; this report (split by division) is to provide trend history over a 12-month period including direction of travel.

The reported **unfilled vacancy rate** has increased to 5.5% in December.

Agency usage for 2015/16 (year to date) stands at 2.61% of total paybill; this has now exceeded the 2014/15 (at 2.5%) outturn and is expected to further increase. The significant increase to agency spend (as percentage of paybill) is largely driven by the investment of validators to support the RTT project works and also a number of senior interims in the organisation. Clinical & Medical operations retains the highest

spend on agency staff at 22.9% of total paybill (rising). Slight increases to Finance & ICT agency spend (+0.7%) whilst decreases to International (-0.4%) and Estates & Facilities (-1%).

PDR completion rates The Trust overall appraisal rate stands at 68% - a decrease of over 18% since April. This has been calculated using the new PDR framework calculation (linking increments to performance outcomes). Currently only one directorate is meeting the target of 95%, Human Resources & Organisational Development. The PDR rate increased to its highest rate in April 2015 (at 84%) based on the revised calculation linking increments to performance. The managers' window (band 7 staff and above) was open for PDR between April to June 2015, low completion of managers' PDRs has contributed to the significant decrease in PDRs in August, this has not reversed in the months following the close of the window. Feedback from managers indicates time lag between the PDR meeting taking place and completing/submitting the paperwork; based on this feedback, learning and development have introduced a summary sheet to capture PDR outcome scores and information to facilitate more efficient reporting.

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.

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

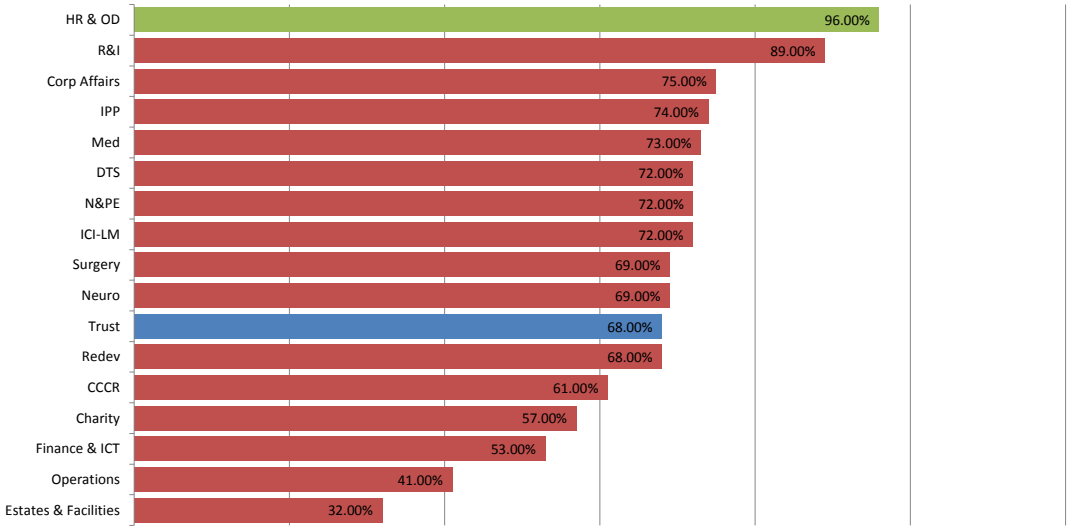
Division	**Contractual Staff in Post (FTE)**	**Voluntary Turnover Rate (%, FTE)** (voluntary leavers in 12-months in brackets, <14% green)	**Total Turnover Rate (%, FTE)** (number of leavers in 12-months in brackets, <18% green)	**Sickness Rate (%)** (0-3% green)	**PDR Completion (%)** (target 95%)	**Vacancy Rate (%, FTE)** (Unfilled vacancies, 0-10% green)	**Agency (as % of total paybill, £)** (Max 0.5% Corporate, 2% Clinical)
Critical Care & Cardio-Respiratory	727	15.7% (99.8)	17.4% (110.3)	2.3	61.0%	8.1%	1.4%
Diagnostic & Therapeutic Services	351	14.6% (52.4)	19.6% (70.4)	1.9	72.0%	10.0%	3.1%
Infection, Cancer & Immunity	673	16.9% (108.6)	18.1% (115.8)	2.6	72.0%	7.0%	0.7%
International	159	17.7% (27.2)	19.7% (30.1)	4.4	74.0%	14.0%	3.3%
Medicine	271	14.7% (34.1)	16.0% (37.1)	2.9	73.0%	4.7%	3.1%
Neurosciences	465	19.4% (85.5)	24.3% (106.6)	2.2	69.0%	2.0%	1.4%
Surgery	566	13.1% (63.9)	15.6% (76.4)	2.4	69.0%	4.7%	1.2%
Clinical & Medical Operations	59	23.2% (13.7)	26.6% (15.7)	1.1	41.0%	15.3%	22.9%
Corporate Affairs	9	11.7% (1.0)	11.7% (1.0)	0.2	75.0%	0.0%	0.0%
Estates & Facilities	105	6.8% (6.5)	12.0% (11.5)	3.6	32.0%	30.9%	7.6%
Finance & ICT	99	22.0% (21.4)	22.0% (21.4)	2.7	53.0%	0.0%	14.2%
Human Resources & OD	106	29.6% (30.2)	32.2% (32.8)	3.6	96.0%	4.9%	0.1%
Nursing & Patient Experience	41	16.4% (6.7)	16.4% (6.7)	1.3	72.0%	4.0%	0.0%
Redevelopment	23	9.2% (2.0)	10.2% (2.2)	2.4	68.0%	0.0%	0.0%
Research & Innovation	82	18.4% (14.0)	19.8% (15.0)	1.7	89.0%	0.6%	0.4%
Trust	3741	**16.5%► (569.6)**	**19.0%► (655.5)**	**2.5▼**	**68.0%▼**	**5.5%▲**	**2.6%▲**

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

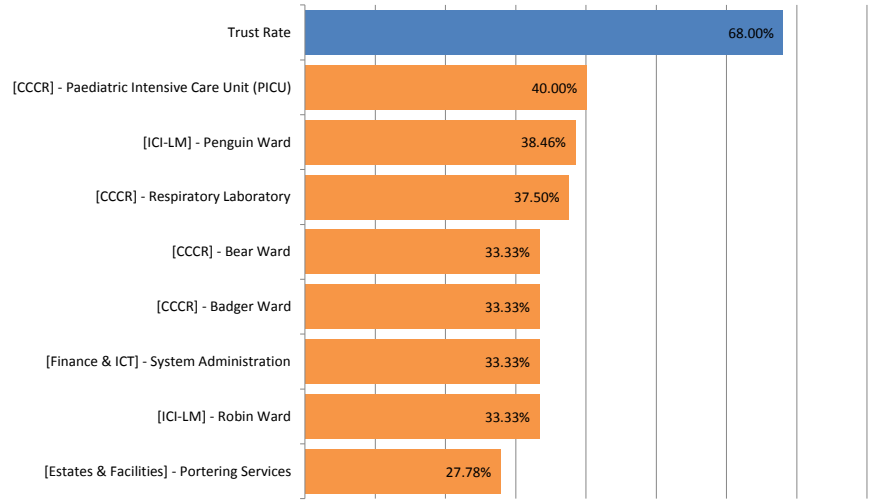
Division	Red Metrics / DoT	Metric	DoT	Actions & Comments
International	5 (previously 5)	Voluntary turnover worsened to 17.7%		Information from exit interview data to be utilised to address reasons for leaving in areas with highest turnover
		Sickness worsened to 4.4%		On-going focus on the management long-term sickness cases
		PDR rate unchanged at 74%		Staff without PDRs to be identified and contacted directly
		Agency usage improved to 3.3%		Agency usage continues to fall. Agency locum doctors' usage has now ceased.
		Vacancy rate improved to 14%		There has been increased recruitment in preparation for Hedgehog Ward opening in April.
Clinical & Medical Operations	4 (previously 4)	Voluntary turnover worsened to 23.2%		Feedback obtained from exit interviews will be reviewed to identify trends and appropriate actions
		PDR rate worsened to 41%		Contact to be made with line managers of staff without PDRs
		Vacancy rate improved to 15.3%		Vacancy rate has improved
		Agency rate worsened to 22.9%		The substantial increase in agency spend relates in the main to RTT (Data analysts in the Information team)
Estates & Facilities	4 (previously 4)	Sickness stands at 3.6%		Review of staff Bradford Scores implemented to target intermittent sickness
		PDR ratestands at 32%		Discussions to be held with Heads of Services to address barriers in completing PDRs.
		Vacancy rate stands at 30.9%		Support to be provided to help ensure vacancies are advertised as soon as possible.
		Agency usage stands at 7.6%		Agency spend has remained static over M5-M9. However current spend has reduced by c. 65% compared to M1-M4
DTS	3 (previously 4)	Voluntary turnover worsened to 14.6%		Further information to be obtained through exit interviews and questionnaires to address turnover
		PDR rate worsened to 72%		Staff without PDRs to be identified and contacted directly
		Agency usage worsened to 3.1%		The majority of DTS agency spend relates to Pharmacy. Pharmacy are currently employing 13 FTE agency workers (1 FTE funded by R&I)
Medicine	3 (previously 4)	Voluntary turnover improved to 14.7%		Turnover rate has reduced
		PDR rate worsened to 73%		Rate improved in October report - progress of completing PDRs to be reviewed
		Agency usage worsened to 3.1%		The majority of DTS agency spend relates to Pharmacy. Pharmacy are currently employing 13 FTE agency workers (1 FTE funded by R&I)
Finance & ICT	3 (previously 5)	Voluntary turnover improved to 22%		Turnover rate has reduced
		PDR rate unchanged at 53%		Contact to be made with line managers of staff without PDRs
		Agency usage worsened to 14.2%		The increase in agency usage relates to ICT projects (including EPR project spend)

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

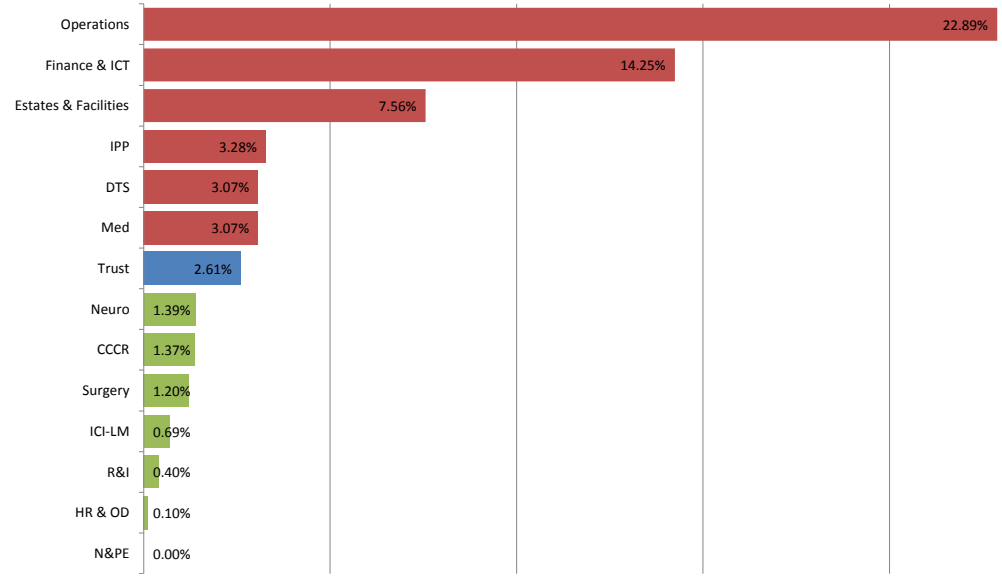
Divisional PDR (Target 95%)



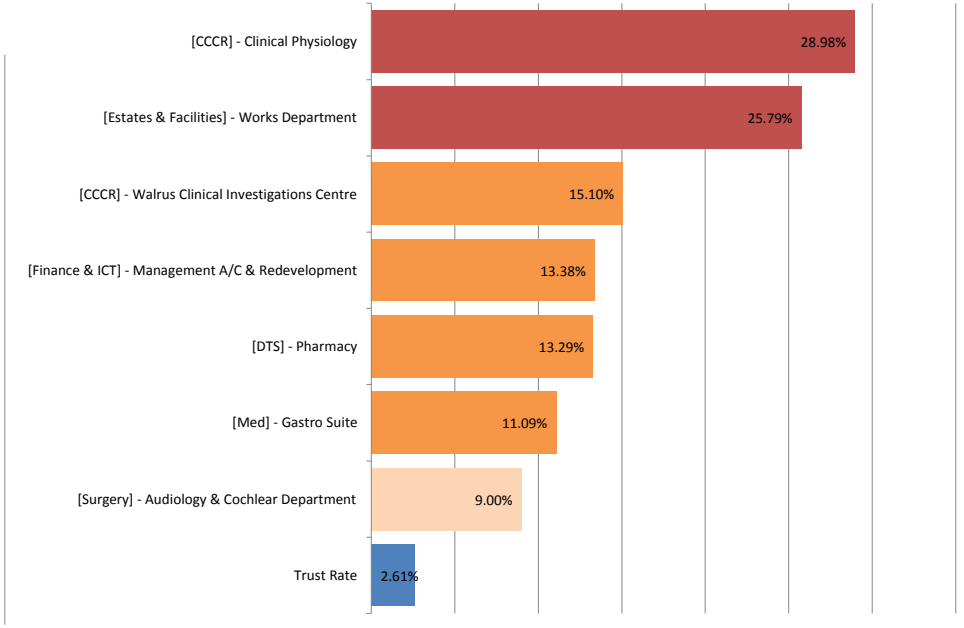
Exception Reporting PDR



Divisional Agency as % of paybill

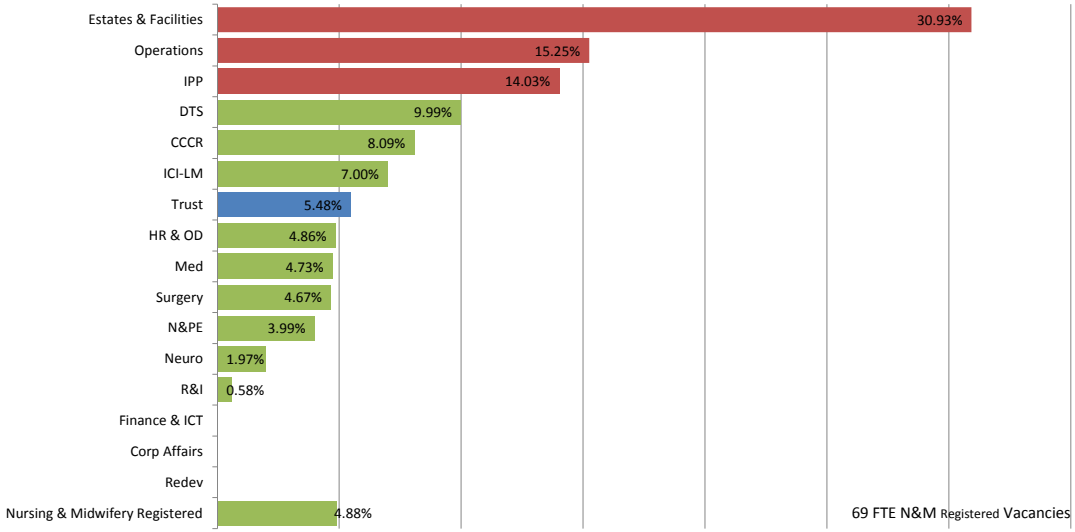


Exception Reporting Agency as % of Paybill



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

Divisional Vacancy Rate



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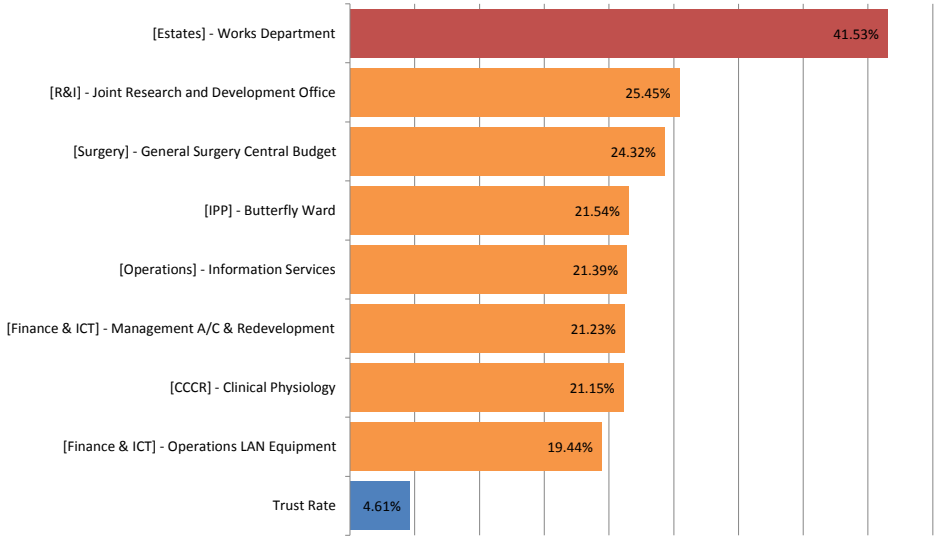
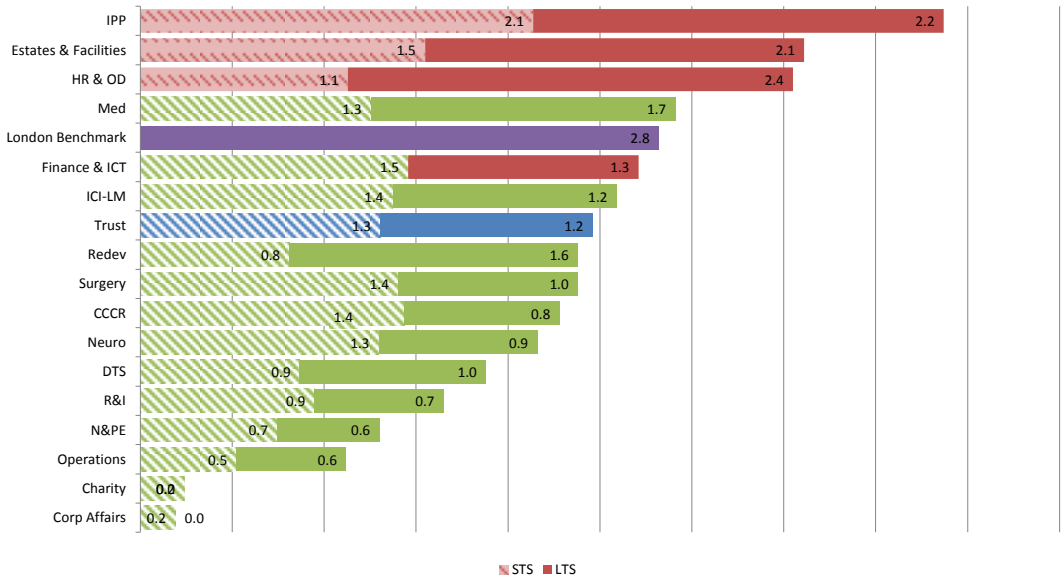
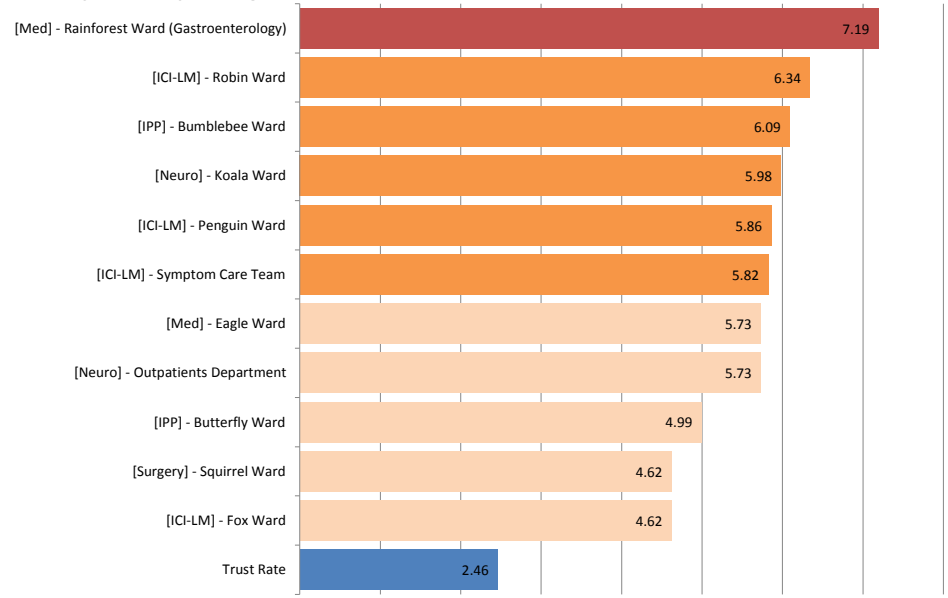


Divisional Sickness

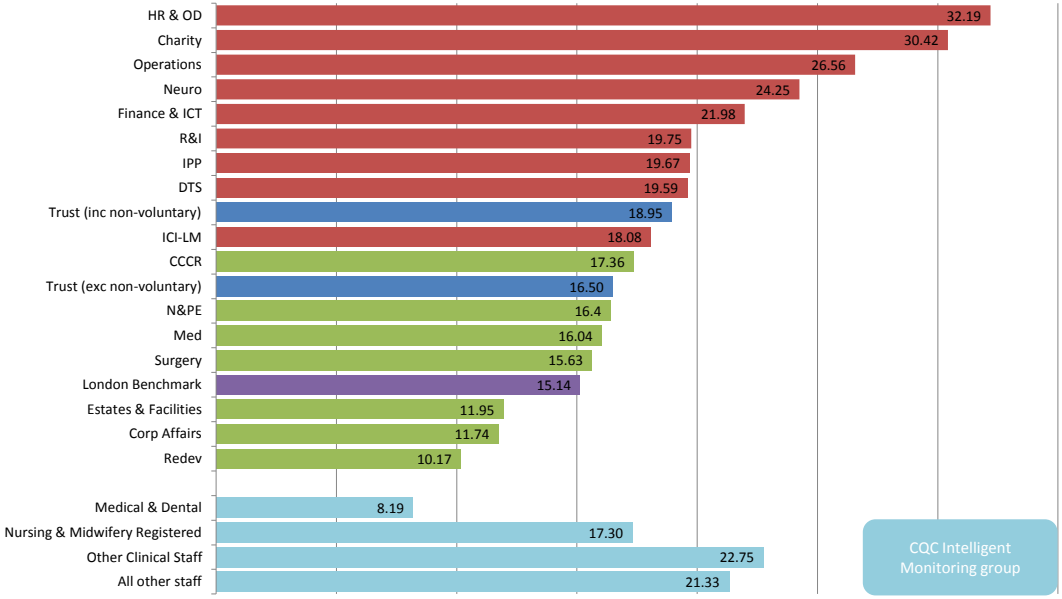


Exception Reporting Sickness

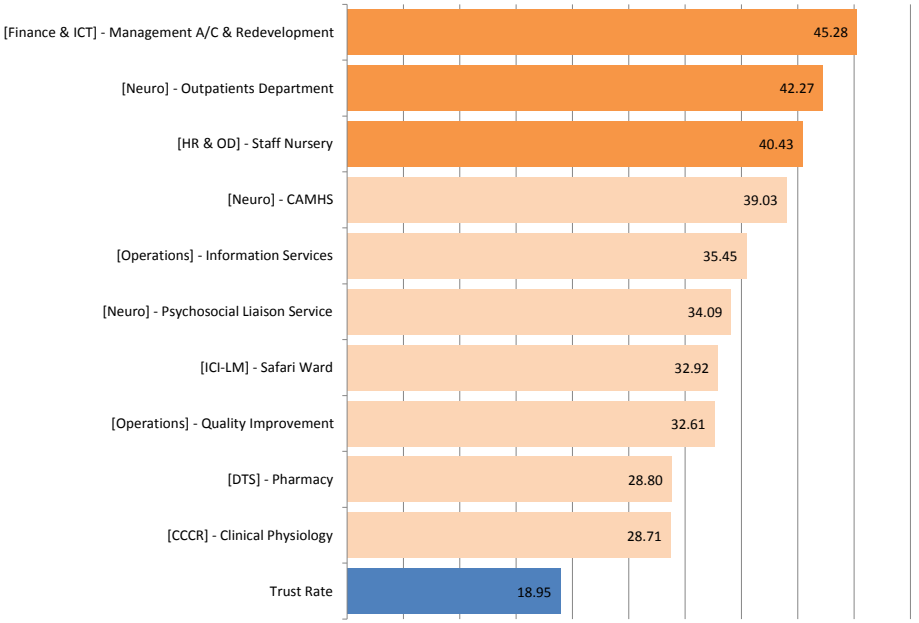


HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - DECEMBER 2015 REPORT

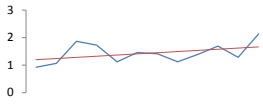
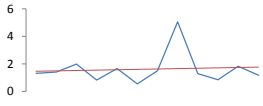
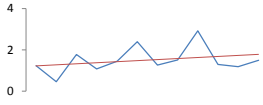
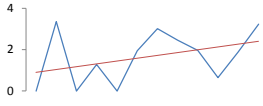
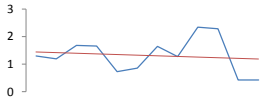
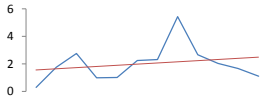
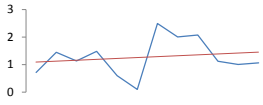
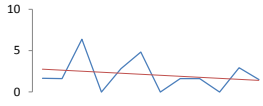
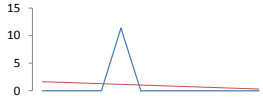
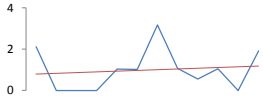
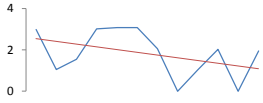
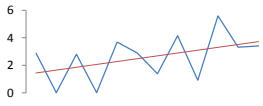
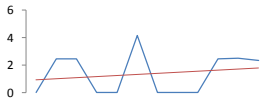
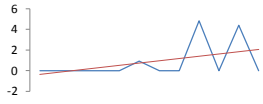
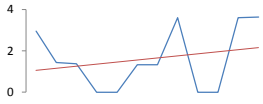
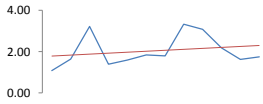
Divisional Turnover (Voluntary & Non-Voluntary)



Exception Reporting Turnover



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

Division	Total Turnover Rate (%, FTE) (number of leavers in 12-months in brackets, <18% green)	Total Turnover Rate (%, FTE) Monthly variation trend over 12 months
Critical Care & Cardio-Respiratory	17.4% (110.3)	
Diagnostic & Therapeutic Services	19.6% (70.4)	
Infection, Cancer & Immunity	18.1% (115.8)	
International	19.7% (30.1)	
Medicine	16.0% (37.1)	
Neurosciences	24.3% (106.6)	
Surgery	15.6% (76.4)	
Clinical & Medical Operations	26.6% (15.7)	
Corporate Affairs	11.7% (1.0)	
Estates & Facilities	12.0% (11.5)	
Finance & ICT	22.0% (21.4)	
Human Resources & OD	32.2% (32.8)	
Nursing & Patient Experience	16.4% (6.7)	
Redevelopment	10.2% (2.2)	
Research & Innovation	19.8% (15.0)	
Trust	**19.0%► (655.5)**	

The scale varies per division to enable a trend view for 12-month with sufficient detail (blue line). The red 'direction of travel' indicates the overall direction of travel across each of the 12-months. The 'total turnover rate' approximates to the total of each individual's months' turnover rate. There is a strong overall pattern for increased turnover in March and July across the organisation between years.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27th January 2016

Financial Performance 9 months to 31st December 2015 **Submitted by:** **Bill Boa, Interim Chief Financial Officer**	**Paper No: Attachment X**

Aims
To brief the Board on the financial performance for the 9 months to 31st December 2015

Summary

The attached report shows the financial performance for the month of December and first 9 months of the financial year.

The overall ***net operating deficit of £(3.3)m***, year to date, was ahead of plan by £5.0m for the following key reasons:

- An adverse variance on NHS and other Clinical Revenue which is largely caused by lower elective and outpatient activity.
- The adverse variance on pass through income is offset by a matching reduction in costs
- Private patient income is £5.8m above plan.
- Total employee expenses is £1.9 million above plan due to agency costs for data validation work in the Trust and higher than planned locum costs for Junior Doctors to cover rotas where training posts have recently been lost
- Non pay excluding pass through is £5.0m below plan due to the pass through costs noted above, the lower elective activity levels noted above and non-recurrent savings by Divisions.

Cash levels were above plan due to the delay in Trust funded capital expenditure and the benefit of the positive EBITDA variance.

Non NHS debt has continued to rise sharply, partly a result of the higher levels of activity. This is principally due to higher levels of debts from long standing customers which are not being cleared. Two significant payments have been received in the first two weeks of January 2016.

Capital expenditure is below plan due to timing delays in both the redevelopment projects and IT projects.

Forecast outturn is expected to be a deficit of £11.2 million as per the Trust plan for 2015/16.

Monitor Financial Risk rating remains at 4 and is forecast to be 4 by the end of the year

Action required from the meeting
To note the report

Contribution to the delivery of NHS Foundation Trust strategies and plans –
Delivering to the financial plan is critical

Attachment X

Financial implications As above
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 CFO

Great Ormond Street Hospital for Children NHS FT - Summary Financial Performance Report. 9 Months to 31 December 2015

~ The Trust is reporting a deficit of £3.3m -excluding capital donations - for the first nine months of 2015/16 , which is £5.0m favourable against the year to date plan. This is an improvement of £0.3m over the month eight YTD position.

~ EBITDA is £14.7m year to date, and is £0.4m in month nine. Year to date EBITDA is £4.5m better than plan and this represents 5% of income. In month EBITDA is £0.3m better than plan.

* NHS income (excluding pass through) is below plan by £1.1m, which is due to the net effect of underperformance in surgery offset by income from the prior years contract settlement and improved tariffs.
* Private patient income is £5.8m above plan to date and in Month 9 overperformed its plan by £1.7m.
* Pay is now £1.9m worse than plan, £0.8m of which was the in month variance.
* Non pay excluding pass through is £3.2m below plan. This is due to lower NHS activity, there are underspends in a number of areas.

~ Cash is ahead of plan due to the under spend on Trust funded capital, and the positive EBITDA variance

~ P&E is forecasting to deliver £8-9m by the year end once the value of schemes are adjusted for risk and delays in scheme delivery. Non-recurrent underspend are expected to provide some mitigation for the PE performance.

~ International debtor levels are higher than planned due to the higher level of activity and delays in payment. Meetings are taking place with all major debtors.

Statement of Financial Position	31 March 2015 Actual £m	31 Dec 2015 Planned £m	31 Dec 2015 Actual £m
Non-Current Assets	372.9	401.7	386.7
Current Assets (exc Cash)	56.3	62.0	56.9
Cash & Cash Equivalents	58.9	53.3	69.3
Current Liabilities	(47.9)	(58.4)	(57.0)
Non-Current Liabilities	(6.7)	(6.3)	(6.4)
Total Assets Employed	**433.5**	**452.3**	**449.5**

Capital Expenditure	Annual Plan £m	31 Dec 2015 Planned £m	31 Dec 2015 Actual £m
Redevelopment - Donated	37.6	23.5	16.2
Medical Equipment - Donated	2.9	2.1	1.8
Estates - Donated	0.0	0.0	0.0
ICT - Donated	2.0	1.5	0.0
Total Donated	42.5	27.1	18.0
Redevelop& equip - Trust Funded	9.9	8.5	5.7
Estates & Facilities - Trust Funded	4.9	3.3	0.8
ICT - Trust Funded	5.0	4.5	2.7
Total Trust Funded	19.8	16.3	9.2
Total Expenditure	**62.3**	**43.4**	**27.2**

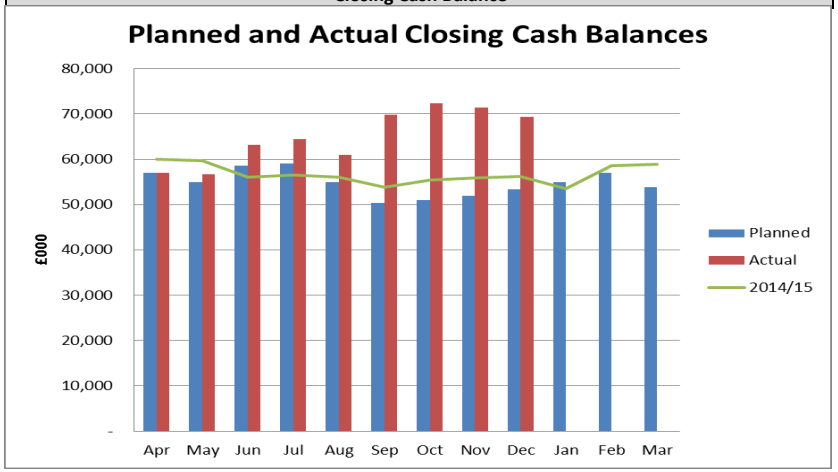
I&E	Current Month Budget (£m)	Current Month Actual (£m)	Current Month Variance (£m)	Current Year Year to Date Budget (£m)	Current Year Year to Date Actual (£m)	Current Year Year to Date Variance (£m)	YTD Prior Year Year to Date Actual 2014/15 (£m)	YTD Prior Year Year to Date Variance CY vs PY (£m)	RAG Rating Current Year Variance
NHS & Other Clinical Revenue	19.6	18.7	(0.9)	183.7	182.6	(1.1)	183.8	(1.3)	R
Pass Through	4.8	4.7	(0.1)	42.6	40.7	(1.8)	36.6	4.1	
Private Patient Revenue	3.2	4.9	1.7	31.6	37.4	5.8	32.5	4.9	G
Non-Clinical Revenue	3.8	3.2	(0.6)	32.7	31.3	(1.4)	35.6	(4.2)	R
Total Operating Revenue	**31.4**	**31.5**	**0.2**	**290.6**	**292.0**	**1.4**	**288.5**	**3.5**	
Permanent Staff	(17.7)	(16.5)	1.2	(159.6)	(147.6)	12.0	(144.3)	(3.3)	
Agency Staff	(0.0)	(0.9)	(0.9)	(0.2)	(4.3)	(4.1)	(4.2)	(0.0)	
Bank Staff	(0.2)	(1.3)	(1.1)	(1.4)	(11.2)	(9.9)	(11.0)	(0.2)	
Total Employee Expenses	**(17.9)**	**(18.7)**	**(0.8)**	**(161.2)**	**(163.1)**	**(1.9)**	**(159.5)**	**(3.6)**	R
Drugs and Blood	(0.9)	(1.0)	(0.0)	(8.5)	(7.9)	0.6	(8.7)	0.8	G
Other Clinical Supplies	(3.2)	(3.1)	0.1	(28.7)	(28.2)	0.5	(28.0)	(0.2)	G
Other Expenses	(4.4)	(3.7)	0.6	(39.4)	(37.4)	2.0	(36.1)	(1.2)	G
Pass Through	(4.8)	(4.7)	0.1	(42.6)	(40.7)	1.8	(36.6)	(4.1)	
Total Non-Pay Expenses	**(13.3)**	**(12.4)**	**0.9**	**(119.2)**	**(114.2)**	**5.0**	**(109.5)**	**(4.7)**	
EBITDA (exc Capital Donations)	**0.2**	**0.4**	**0.3**	**10.1**	**14.7**	**4.5**	**19.5**	**(4.8)**	G
Depreciation, Interest and PDC	(2.1)	(2.1)	0.0	(18.4)	(18.0)	0.4	(18.5)	0.6	
Net (Deficit)/Surplus (exc Cap. Don. & Ir	(2.0)	(1.7)	0.3	(8.3)	(3.3)	5.0	0.9	(4.3)	G
EBITDA %	**0.5%**	**1.4%**		**3.5%**	**5.0%**				
Estimated impairments									
Capital Donations	4.3	1.5	(2.8)	27.1	18.3	(8.8)			

	31-Mar-15	30-Nov-15	31-Dec-15	RAG
NHS Debtor Days (YTD)	25.53	6.71	4.50	G
IPP Debtor Days	130.73	172.32	191.40	R
IPP Overdue Debt (£m)	6.36	11.05	12.30	R
Creditor Days	33.00	30.77	38.20	A
BPPC - Non-NHS (YTD) (number)	88.3%	85.2%	85.3%	A
BPPC - Non-NHS (YTD) (£)	91.8%	87.8%	88.1%	A

Key Performance Indicators

KPI	Annual Plan	Q3 Plan	YTD Actual	Forecast	Rating
Liquidity	4	4	4	4	G
Capital Service Coverage	3	3	4	4	G
I&E Margin	4	4	4	4	G
Variance in I&E Margin as % of income	4	4	2	4	R
Overall	4	4	4	4	G

Closing Cash Balance



Attachment Y

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27 January 2016

Quarter 3 Monitor Return (3 months to 31 December 2015) **Submitted by:** Bill Boa, Interim CFO	**Paper No: Attachment Y**

Aims / summary
This paper summarises the Trust's 2015/16 Quarter 3 (Q3) Return to Monitor, the independent regulator of NHS Foundation Trusts.

Key points:

Finance

- The financial information included in the Monitor template for Q3 is entirely consistent with the Month 9 Board report.
- The Trust's capital programme continues to be monitored and is currently being reforecast on the basis of updated information.
- The Trust is forecasting a financial sustainability risk rating of at least 3 for the next 12 months.

Governance

- The Trust reported no cases of C.Difficile in Quarter 3, therefore the year to date total of assigned cases in patients aged two and over, tested on third day or later, remains at 2 cases. Of these 2 cases, neither has been attributed to a lapse of care outlined in the assessment criteria from Monitor and agreed with NHS England.
- There were no cases of MRSA reported in Quarter 3. With a year to date position of 1 case.
- The Trust is not able to confirm that it is compliant with the maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate and is not reporting against this target. The Trust is undertaking work to validate the position and ensure robust future reporting but believes that it will be unable to report against this target until 1 October 2016.
- The Trust cannot assure itself that it is reporting 62 day waits for cancer from urgent referral because of issues with referral information received by the Trust. The Trust is assured that patients are appropriately treated and is working with referrers to ensure that reporting is reliable and provides assurance. In addition, the Trust is implementing a robust internal reporting system related to all relevant cancer waits
- Cancer access standards (of these relevant to GOSH) at the time of reporting the final December position is not yet finalised (this is in line with the national reporting timetable). However due to one patient breach in November, it is likely that the quarter's performance against the decision to treat to subsequent treatment (surgery) is likely to be missed, with the other 2 indicators achieved.

Other

- [There are no other matters arising in the quarter requiring an exception report to Monitor.] ***Statement To be confirmed at Board meeting***

Action required from the meeting
The Board is asked to approve the Quarter 3 'In-Year Governance Statement' prior to submission to Monitor.

Attachment Y

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

Attachment Y

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

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (see notes below)	**Board Response**
For finance, that: The board anticipates that the trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months.	CONFIRMED
The Board anticipates that the trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return.	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.	NOT CONFIRMED
Otherwise: The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework, Table 3) 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.	ZERO

Signed on behalf of the board of directors

Signature		Signature	
Name		Name	
Capacity		Capacity	
Date		Date	

The board is unable to make one of more of the confirmations in the section above on this page and accordingly responds:

We have reported to Monitor our decision to suspend RTT reporting and related diagnostic reporting for a defined period. Monitor is party to regular Tripartite meetings with NHSE, our lead commissioner, where we are sharing and monitoring our plan to remedy the data issues in order to resume reporting and address any patients with long waits.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27th January 2016

Patient Experience Report **Submitted by:** Juliette Greenwood Chief Nurse	**Paper No: Attachment 9**

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:

- Quarter 3 Friends and Family test results
- Pals Quarter 3 Report
- Compliments
- Other patient and family engagement and experience activities.

Friends & Family Test (FFT)

The Inpatient FFT response rate has been between 18 – 21% ending the year at 19%. This is below the Trust target of 60% due to the issues previously reported around the inclusion of day case discharge data. The Information Services team have made the required updates to the reporting script and we are now very confident that the denominator is derived from all eligible inpatient and day case patients.

The overall percentage of inpatients 'likely to recommend' for Quarter 3 2015/16 has been 98% consistently throughout the quarter which is 3% above the Trust target of 95%.

The outpatient percentage 'likely to recommend' has remained consistently above the Trust target of 98.4% in October and 97.9% in November and 98.5% in December 2015.

Pals Quarter 2 Report

- A total of 403 pals cases were made this quarter.
- 4.1% increase in Pals contact compared to Q2 and a 3.07% increase compared to Q3 in 2014/2015.
- 11 cases were escalated to complaints- decrease from 18 in Q 2, and an increase from 8 in Q 3 of 2014/2015.
- 11 compliments were made regarding GOSH services
- 17 posts were made on NHS choices, Facebook and twitter

Compliments

In August 2015 a new initiative was launched by the Patient Experience Team to collect compliments received to ensure staff and the Trust focuses on positive feedback received as well as areas that are identified of concern or for improvement. In addition to the positive feedback and compliments received within the Friends and Family Test and Pals the team received the following numbers of compliments across a range of areas:-

• 5 compliments received in November • 21 compliments received in December
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

Attachment 9

Great Ormond Street Hospital for Children NHS Foundation Trust

Patient Experience Report January 2016

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:

- Quarter 3 Friends and Family Test (FFT) headline results
- Pals Quarter 3 Report
- Compliments
- Other patient and family engagement and experience activities.

1. Quarter 3 Friends and Family Test (FFT) summary

1.1 Inpatient and Day case FFT summaries

The Information Services team have made the required updates to the reporting script and we are now very confident that the denominator is derived from all eligible inpatient and day case patients. Day case areas are now incorporated within our inpatient data and NHS England and the Data Observatory have confirmed that they are happy with the changes. Although this has resulted in a significant drop in our overall response rate percentage, we believe that it provides complete transparency on the calculation of our response rates.

The response rate for inpatient and day case areas is as follows for Quarter 3 2015/16 is as follows:-

	October 2015	November 2015	December 2015
Number of patients eligible for FFT	3268	3125	2845
% Response rate	18%	21%	19%

The overall percentage of inpatients 'likely to recommend' for Quarter 3 2015/16 is as follows:-

October 2015		November 2015		December 2015	
No. of returns	% to recommend.	No. of returns	% to recommend	No. of returns	% to recommend
591	98.4%	655	97.9%	528	98.5%

All inpatient, day case and diagnostic areas within GOSH have initiated FFT. There are additional FFT stations within the Lagoon and the Patient Hotel. The Patient Transport team will launch FFT once the electronic FFT database has been completed as required by NHS England. Since FFT commenced at GOSH in April 2014 the number of responses has reached over 16,100.

We recognise that our response rate is significantly below the current trust target of 60%. Organisational pressures such as RTT have impacted and diverted resources within all divisions. There has been significant work already carried out in the areas with low response rates and we are looking to expand our pool of survey volunteers to support this further. It is important to note that the inclusion of day cases has increased the number of patients eligible for FFT significantly. The denominator increased from 1264 to 2697 when day cases were added in September 2015, (113% increase).

The outpatient percentage 'likely to recommend' has remained consistently above the Trust target of 98.4% in October and 97.9% in November and 98.5% in December 2015.

1.2 Outpatient FFT summary

Current response rates for outpatients have decreased in December which is unsurprising due to the reduction in clinics over the Christmas period.

The Outpatient percentage to recommend was very low within Radiology; this related to feedback from patients (aged 9) seen in December which is being followed up by the team in radiology.

	October 2015		November 2015		December 2015	
	No. of returns	% to recommend	No. of returns	% to recommend	No. of returns	% to recommend
Audiology	1	100%	15	100%	5	100%
CAHMS/ PANDA	25	100%	31	97%	19	89%
Cheetah	31	94%	76	99%	27	96%
Dental	78	96%	24	100%	36	100%
Haemophilia Centre	11	100%	17	100%	3	100%
Manta Ray	4	100%	9	78%	2	100%
Radiology	3	100%	14	93%	8	38%
Renal Outpatients	11	100%	1	100%	0	-
Rhino	21	100%	35	100%	4	0%
RLHIM Level 1	71	92%	16	100%	13	85%
RLHIM Level 2	219	98%	244	98%	290	99%
RLHIM Level 4	81	99%	61	100%	17	94%
Safari Outpatients	4	75%	24	100%	3	100%
Walrus	6	100%	20	97%	6	83%
Magpie	12	100%	10	90%	0	-
Lagoon	0	0	2	100%	1	100%
Patient Hotel	0	0	2	50%	0	-

*Lung function will officially commence FFT in January 2016.

The Outpatient Percentage to recommend has also remained consistently above the Trust target of 95% achieving 97% in October, 98% in November and 96% in December 2015.

1.3 Analysis of narrative comments and actions being taken in response to FFT feedback across the Trust

Analysis of the narrative comments continues to show that the positive comments are predominately related to staff behaviours and direct care. While areas highlighted for improvement related to access, admission, discharge and transfer arrangements and the environment and infrastructure. Over the last quarter we have seen an increase in negative comments in relation to:-

- Poor cleanliness within parent accommodation.
- Poor availability of kitchen equipment within the patient hotel.
- The comfort of waiting areas within day case medical and surgical ward.
- Requests for fasting and non-fasting patients to have separate waiting areas.
- Waiting times within outpatients and the lack of communication about the potential delay.
- Waiting time for prescriptions.
- Food quality, food variety and time food is served.
- The noise on wards throughout the night.

All negative comments were appropriately escalated to the relevant managers. Areas related to parent accommodation and facilities overnight are being addressed through the CQC Inpatient Survey Action Plan. Issues related to waiting times and communication in outpatients are being addressed through the outpatient improvement project, whilst waiting times for prescriptions in pharmacy is also being addressed by the Quality Improvement and pharmacy teams. Work in relation to the improvement of food and meal services is on-going with progress reported in the last Trust Board report.

2.0 Pals Quarter 3 Report (The full PALS reported is included at Appendix 1)

- A total of 403 pals cases were made this quarter.
- There was a 4.1% increase in Pals contact compared to Q2 and a 3.07% increase compared to Q3 in 2014/2015.
- 11 cases were escalated to complaints a decrease from 18 in Q 2, and an increase from 8 in Q 3 of 2014/2015.
- 11 compliments were made regarding GOSH services
- 17 posts were made on NHS choices, Facebook and twitter

2.1 Follow up of key themes from quarter 2

Compared to Q2 15/16, Q3 15-16 has seen a decrease in the Pals cases around communication and letters in outpatients (reduced from 57 in Q2 to 40 in Q£); an increase in admissions cancelled (increased from 26 in Q2 to 33 in Q3) and an increase in the outpatient appointments cancelled (increased from 26 in Q2 to 34 in Q3). All of these issues continue to be addressed by the Outpatient Improvement Projects and the Trusts work to address our RTT issues.

With regard to transport there has been a decrease in the number of Pals cases from Q2 which demonstrates that the interventions that have been put in place are starting to make a difference, but the numbers remain the same at Q3 14/15.

The full Pals report is included in appendix 1.

3.0 Compliments

In August 2015 a new initiative was launched by the Patient Experience Team to collect compliments received to ensure staff and the Trust focuses on positive feedback received as well as areas that are identified of concern or for improvement. In addition to the positive feedback and compliments received within the Friends and Family Test and Pals the team received the following numbers of compliments across a range of areas:-

- 5 compliments received in November
- 21 compliments received in December

Examples of compliments received include:-

'First time to the hospital, staff and volunteers were very helpful. Took us all the way to the restaurant instead of just pointing. Very clean, very impressed so far with the friendly and efficient services. Fantastic!'

'I enjoy the food as it is always very tasty with a variety to choose and comes in a big portion. Also everyone seems friendly and helpful'

4.0 Other Patient Engagement and experience activity

4.1 CQC Children's Inpatient Survey Action Plan

An action plan has been developed and approved by the Patient and Family Engagement and Experience Committee (PFEEC). A separate report summarising the actions being taken and the progress against them has been submitted as a separate report.

4.2 Embedding Our Always Values with patients and families

As part of improving our families experiences the Patient Experience Team are part of the Always Values Operational Delivery Group who are looking at ways to raise awareness of and embed the Values into the Trust, not just for the staff but also for patients and families. The Patient Experience Team will be looking to build on the patient journey mapping work which has already taken place by the Quality Improvement Team in the Outpatients Department. Each stage will be looked at through the lens of the Always values and assessed to see whether we are fulfilling our aims. In addition we will be undertaking a tonal audit of some of our letters and family information to see how these can better reflect Our Always Values.

The Patient Engagement and Experience Officer will be working with the Assistant Director of Organisational Development, Infection Prevention and Control Team and Creative Agency to find a fun and interactive way to help children and young people reward staff when they display the Always values.

The Communications Team are creating a plan to spread awareness of ways to show a GOSH welcome such as smiling, saying # Hello my name is, offering to help people/say what we are doing and asking someone what their name is. Once this plan is signed off by the Executive team the Patient Experience Team will support and help run activities to support the communications campaign.

4.3. Patient Bedside Entertainment System

A task group has been set up to investigate the future of the Patient Bedside Entertainment System. The group are investigating how adequate parents and patients feel our current system is, looking at what we could add or improve. A facilities manager will be attending the Young People's Forum on the 31st of January to begin discussions with young people. The Patient Engagement and Experience Officer has researched the websites of 18 other children's hospitals across the UK and the world to establish what other providers offer to patients. As the information on the websites is limited, we will be emailing all hospitals outside the UK and submitting Freedom of Information Requests for fuller details of how many channels they offer, whether they have phones, what their internet access is; we will then be able to carry out a full comparison of our systems.

4.4 Patient Bedside Information Folders

The Trust currently provides a vast amount of patient information via our website and leaflets in departments or via correspondence. In order to make this information more easily accessible, in December 2013, we piloted a large folder with key leaflets and information sheets about a range of

topics from an introduction to the ward to breastfeeding on Koala, Eagle and Bear. A few other wards have also implemented these subsequently.

We would now like to expand these folders onto every ward and create a young people friendly version at the back for teenagers. To make sure we have all the information that parents and staff feel is essential, the Patient Engagement and Experience Officer and Patient Experience Team Administrator have begun initial conversations with staff, patients and our parent representatives. We have also researched six other hospitals that offer this resource and compiled a template of what we could add to our own folders.

The folder is now being amended to reflect these changes. Staff will be consulted again. Once the folder is in a form that staff are happy with, we will set up a focus group or arrange a survey so we can gather feedback from families.

4.5 Patient Stories

In order to widen the use of Patient Stories across the Trust, we will be aiming to collect more experiences. We have created two leaflets, one for young people and one for parents, which can be given out by any member of staff from play specialists to the Chaplaincy team. Once approved by the Trust's Information Manager the leaflets will be printed and distributed to key teams and departments such as the Patient Advice and Liaison Service. The Patient Experience Team will also begin ward walkabout to speak to staff and parents to ascertain whether anyone would like to share their accounts. In time we will also recruit Patient Story Volunteers whose responsibility will be to find people who have had good and bad experiences and want to share these with staff. The Patient Involvement, Engagement and Experience Officer has also begun investigating how best to record and share stories.

4.6 Young People's Forum (YPF) Update.

During the YPF's November meeting, members met the Chief Executive of the Hospital, Dr Peter Steer and were able to find out about him professionally and personally. Questions ranged from what does a Chief Executive do? To what are your hopes for future improvements? The YPF also used the opportunity to ask the Chief Executive directly about future projects such as visiting wards to offer staff a teenager's view of what was good and what could be improved.

The group also met with Ruth Nightingale, Joint Lead for Patient and Public Involvement and Engagement in Research, to discuss the development of a GOSH tissue bank for research. Elisabeth Crowe, the Electronic Patient Record Programme Director, also visited the group to ask the young people what they would like from an Electronic Patient Record System, e.g. what functions and portals.

As it was the last meeting before Christmas the group decided to create a Christmas card which would be given to all teenagers on the wards to wish them a happy Christmas and to invite them to join the YPF. The group also wrote messages on stockings for the Charity's Christmas Stocking Appeal. As the teenagers were given a Christmas message from the Young People's Forum we created a Christmas tray liner for younger children to wish them a Happy Christmas from all the staff at GOSH, and provided them with a few festive games.

Due to the success of the YPF at GOSH, NHS England have asked GOSH to host an event on the 5th of March where healthcare providers and Clinical Commissioning Groups will be shown best practice examples of how to set up and run a youth forum. A working group of Patient Experience Leads across the country has been established to plan this event.

Attachment 9

Appendix 1 Pals Q3 Report.

Great Ormond Street Hospital for Children NHS Foundation Trust

Pals (Patient Advice and Liaison Service) Q3 Report October-December 2015

Key Themes

- A total of 403 pals cases were made this quarter.
- 4.1% increase in Pals contact compared to Q2 and a 3.07% increase compared to Q3 in 2014/2015.
- 11 cases were escalated to complaints- decrease from 18 in Q 2, and an increase from 8 in Q 3 of 2014/2015.
- 11 compliments were made regarding GOSH services
- 17 posts were made on NHS choices, Facebook and twitter

	Total	Escalated	Compliments
Q3 15/16	403	11	11
Q2 15/16	387	18	6
Q3 14/15	391	8	14

Cases	**Q3 15/16**	**Q2 15/16**	**Q3 14/15**
Information	**562**	**499**	**610**
Promptly resolved	**326**	**285**	**305**
Complex	**55**	**78**	**64**
Escalated	**11**	**18**	**8**

Update and key issues from Q2

Admission/Discharge

	14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2	15/16 Q3
Communication/Letters	34	24	31	26	34
Cancellations	16	11	21	26	33

Outpatients

	14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2	15/16 Q3
Communication/letters	57	60	70	57	40
Cancellation	18	28	21	20	30

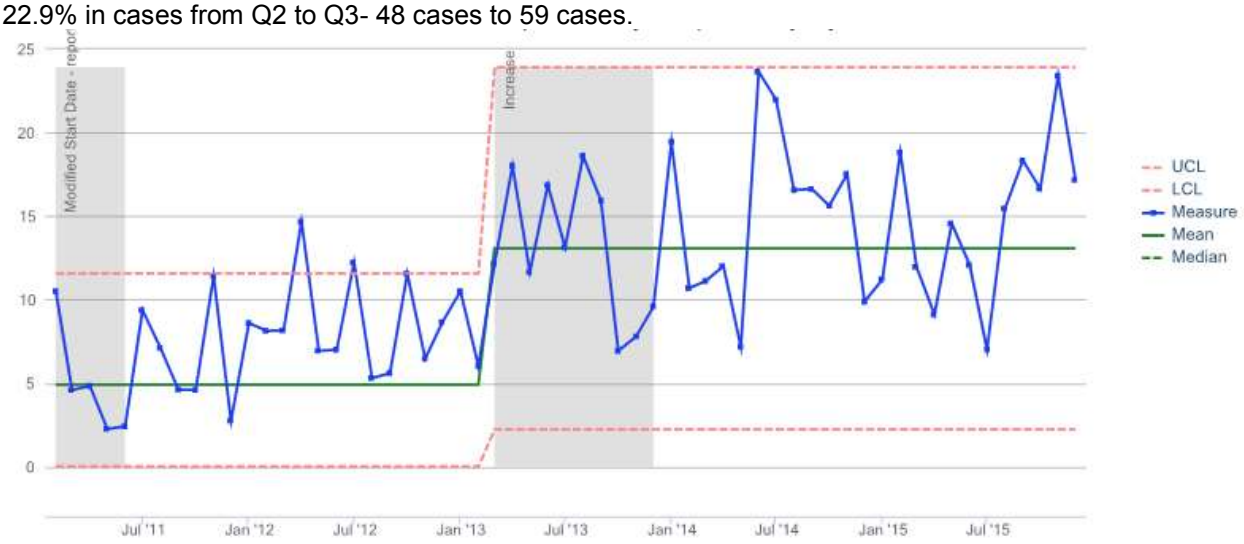
Compared to Q2 15/16, Q3 15-16 has seen a decrease in the Pals cases around communication and letters in outpatients; an increase in admissions cancelled and an increase in the outpatient appointments cancelled.

With regard to transport there has been a decrease in the number of pals cases from Q2 but the numbers remain the same at Q3 14/15.

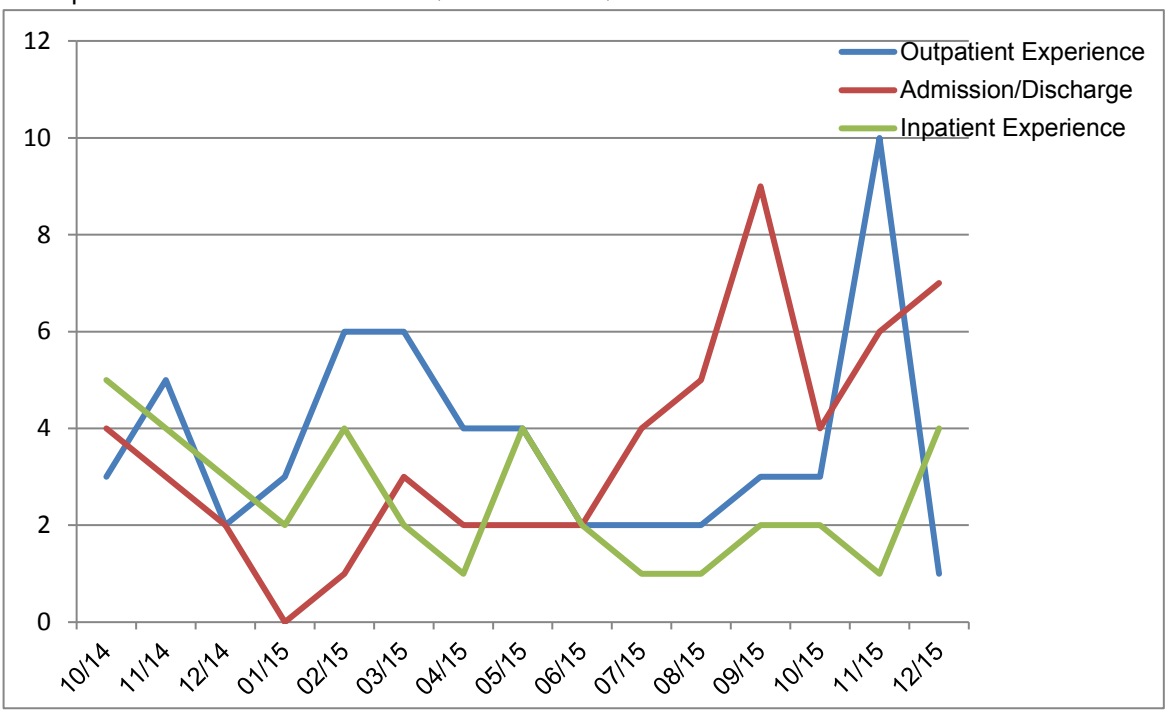
CCCR

The main activity in Pals is seen under the specialities of Cardiology (40.7%) Cardiac surgery (25.4%) Respiratory (15.3%). Pals cases in Q 3 15/16 have increased compared to the number of pals cases in Q3 14/15. Increase of 22.9% in cases from Q2 to Q3- 48 cases to 59 cases.

Attachment 9



Top 3 reasons for Pals referrals Q3 14/15 and Q3 15/16



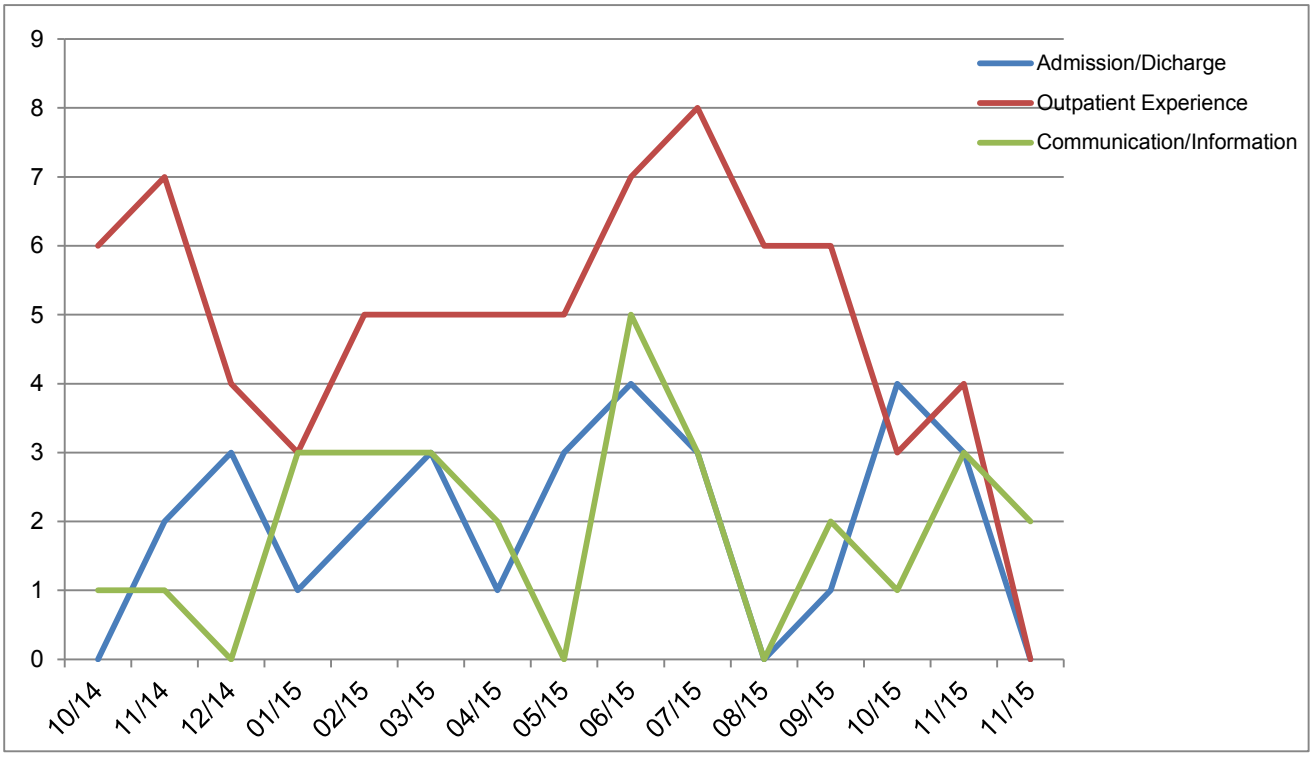
When comparing Q3 to Q2: Increase in the cases relating to **Outpatient Experience** (Communication / letters; Care advice and Cancellations) and **Inpatient Experience** (Care advice, Communication and letters and Environment and cleanliness); Decrease in cases due to **Admission/Discharge** (Cancellation, communication and letters and accommodation). **Promptly resolved cases**: Outpatient experiences (28.6%) Admission/discharge (28.6%) and Inpatient experience (11.9%) **Complex cases**: Admission/Discharge (33.3%) Clinical care (14.3%) other remaining issues: bereavement, communication, discharge, referrals, outpatient experiences-(8 each).

Case study: Patient C has been a cardiology patient at Great Ormond Street from 2013 (since she was a week old). Mother contacted Pals this quarter as she did not understand the contents of her recent clinic letter following her outpatient appointment and required clarification on the contents. The Pals team referred the Mothers queries to the cardiology secretary. Mother received a call from her consultant on the same day and her queries were addressed.

ICI-LM

The main activity in Pals is seen under the specialities **Rheumatology (43.8%) Oncology (12.5%) Immunology (9.4%) and Clinical Genetics (9.4%).** There has been a 31.9%decrease in cases between Q2 and Q3 47 cases to 32 cases

Top 3 reasons for referrals to Pals between Q3 14/15 and Q3 15/16

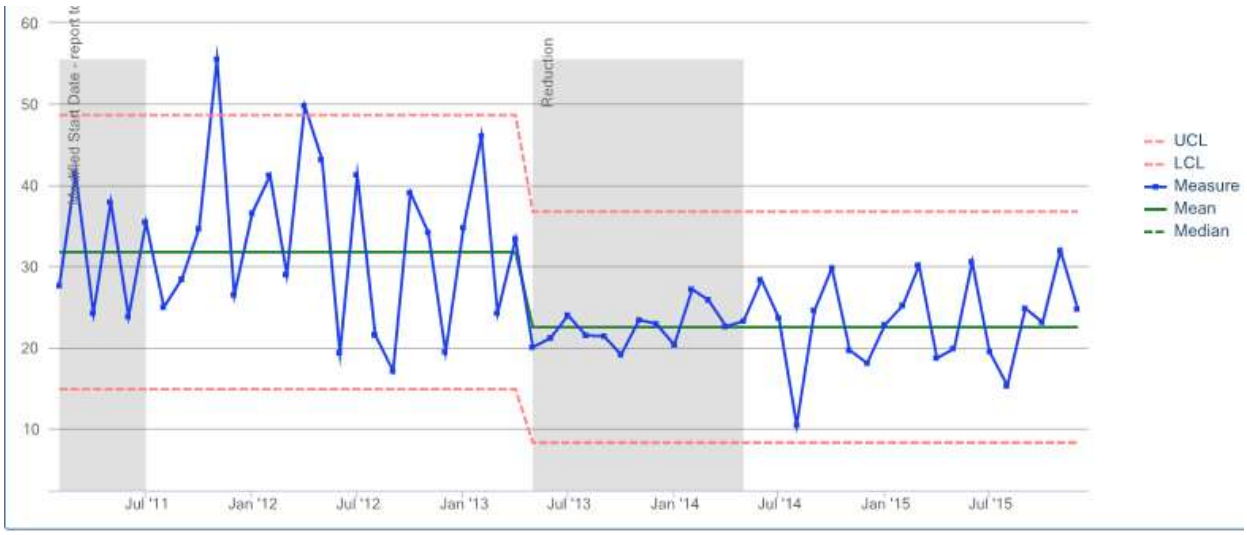


From the above graphs when comparing Q3 14/15 to the present Q3 15/16 there has been a decrease in cases due to **Outpatient Experiences** (communication and letters, care advice and cancellations). This is also true when comparing Q2 15/16 to the current Q3. However, there has been an increase in cases referred due to **Admission/Discharge** (Communication and letters; waiting times; accommodation) and **Communication / Information** (Lack of communication between parents, lack of information and lack of communication between staff). **Promptly resolved** cases the main themes were: Admission /discharge (25.9%) Outpatient experience (18.5%) Communication / Information (14.8%) Inpatient experience (14.8%) **Complex cases**: Outpatient experience (50%) and Communication / Information (50%)

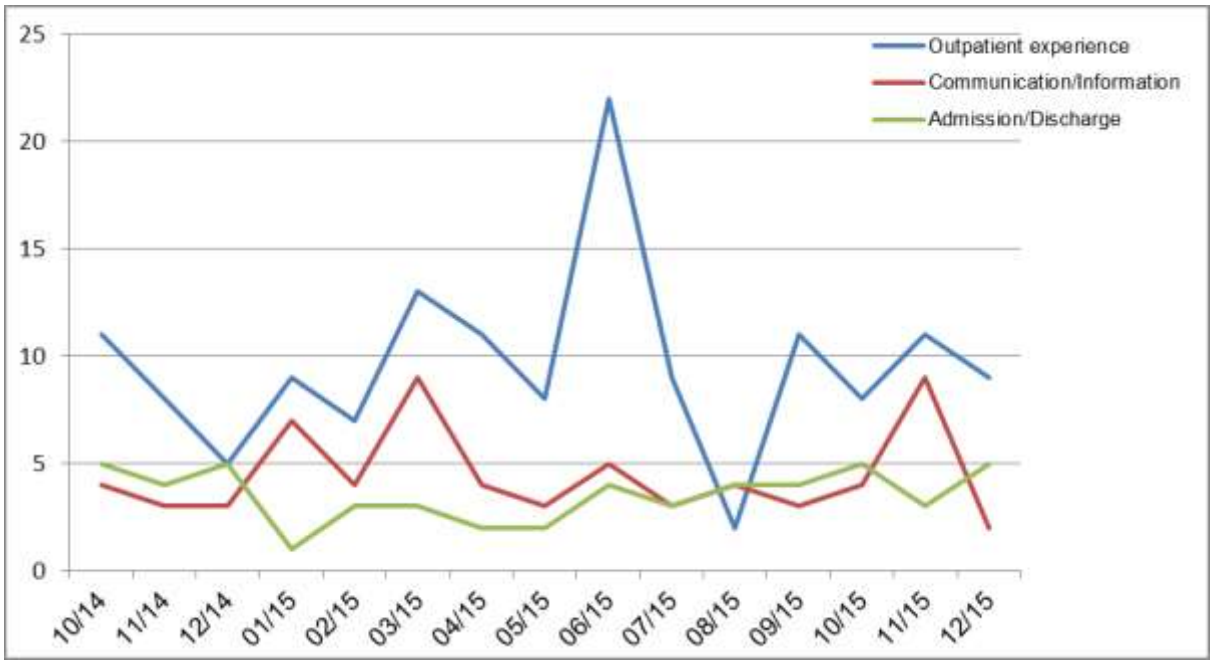
Case study: Patient R has been a patient at Great Ormond Street for 18 months and is 9 years old. She was being admitted for intensive physiotherapy for two weeks. Her mother contacted Pals in Q3 as she is a single parent and required support with managing the admission and caring for her two other children. The concerns were presented to the physiotherapy team, who discussed the situation during a MDT and were able to support the family with additional care for one extra sibling during the 1st week admission with a plan to review the case during that week.

MDTS

The main activity in Pals is seen under the specialities **Gastroenterology (59.8) Endocrine (13%) Social Work (6.5%).** There has been a 24.3% increase in cases from Q2 to Q3 (74 to 92).



Top 3 reasons for referrals to Pals between Q3 14/15 and Q3 15/16

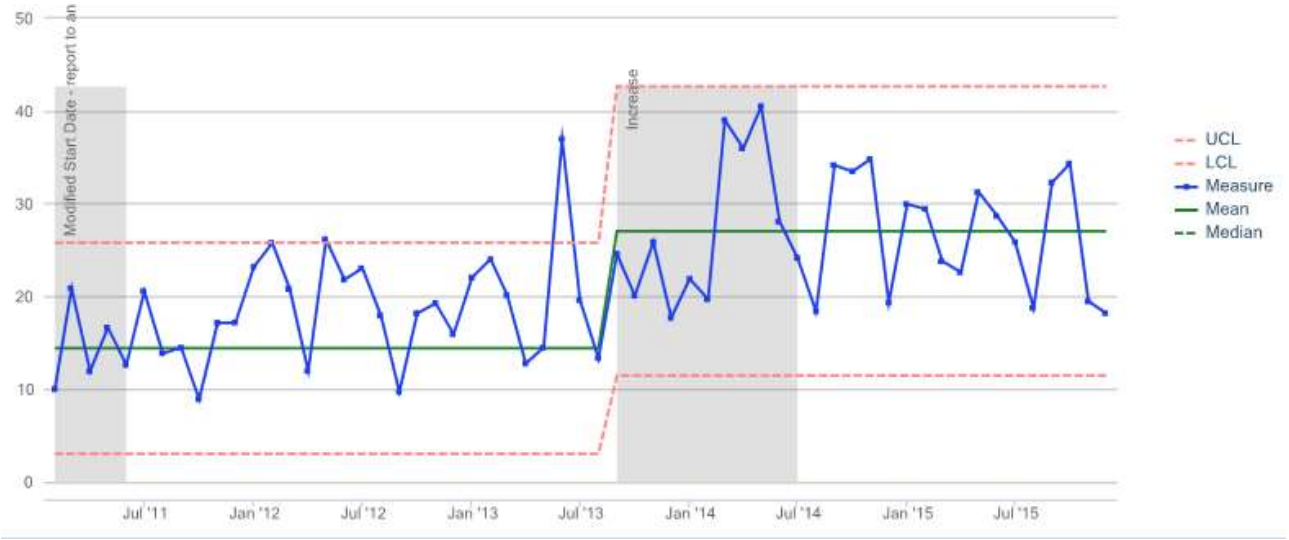


When comparing Q3 15/16 to Q3 14/15 what is noticeable is **Admission/Discharge (**Communication/letters Cancellation Care advice) and **Communication Information** (Lack of communication with parents/patients; Incorrect information; Lack of information to parents)has increased and **Outpatient Experience (**Communication/letters; Care advice; Cancellations) has slightly decreased**.** When comparing **Q2 15/16 to Q3 15/16** there is an increase overall in each of the top three reasons for coming to pals. **Promptly resolved** cases Outpatient experience (33.8%) Communication and Information (15.6%) Admission discharge (14.3%). **Complex case** themes are: Communication and information (33.3%) Admission /Discharge (22.2%) Outpatient experience (22.2%)

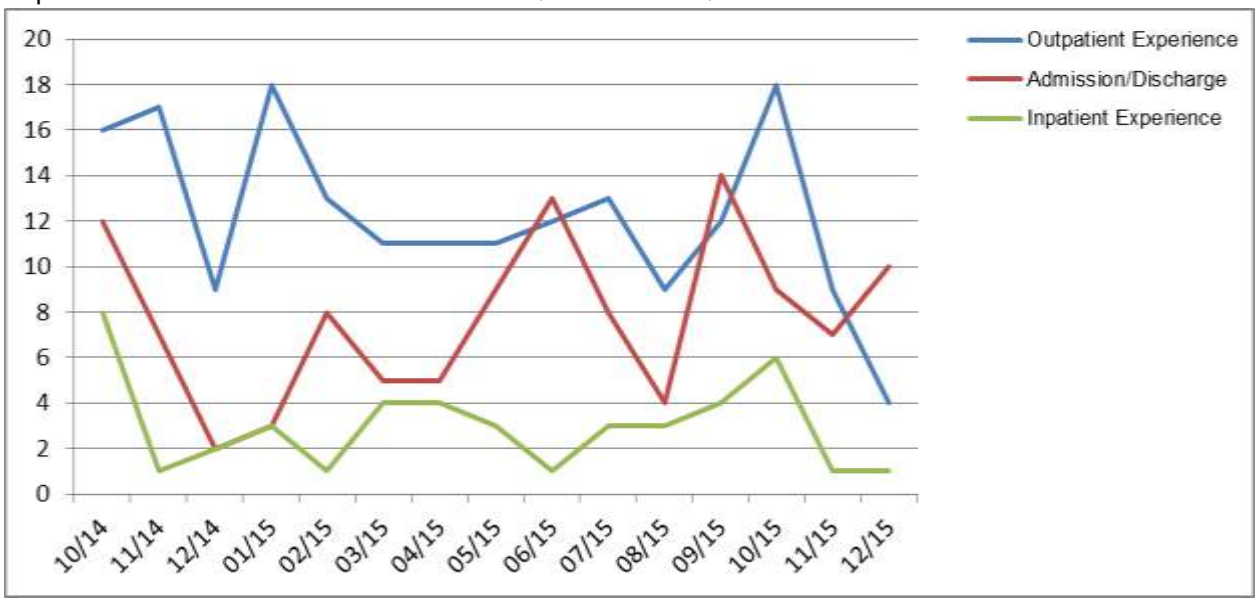
Case study; Patient G is 17 years old and has been a patient at Great Ormond Street for 8 years and is under gastroenterology for at least 5 years. Mother contacted Pals as she needed to reschedule an outpatient appointment due to conflicts with exams and other siblings appointments, and she needed an admission date. Pals liaised with the service manager who assisted in arranging a new outpatient appointment date and admission date that was convenient for the family's needs.

SURGERY

The main activity in Pals is seen under the specialities **General surgery (21.5%), Orthopaedics / Spinal surgery (18.3%) Urology (16.1%).** There has been a 6.1% decrease in cases between Q2 to Q3 (99 versus 93).



Top 3 reasons for referrals to Pals between Q3 14/15 and Q3 15/16



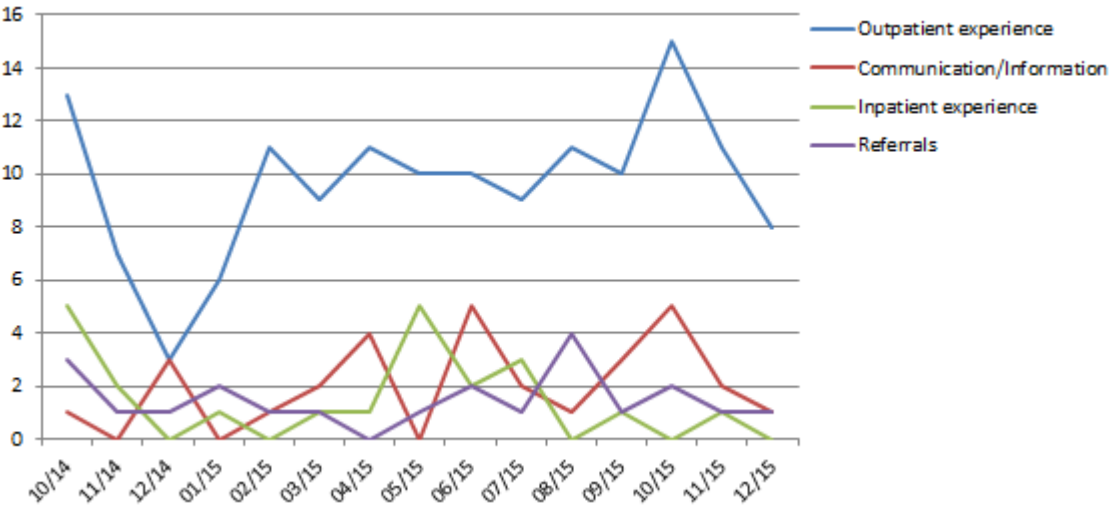
Between Q3 14/15 and Q3 15/16 there has been a reduction in the referrals to pals for Outpatient Experiences (Communication/letters; Cancellations; Care advice) and **Inpatient Experiences** (Care advice Communication/letters and Environment/cleanliness), this trend is also noted between Q2 15/16 and Q3 15/16 whilst **Admissions/Discharge** (Communication/letters, Cancellation and Accommodation) have increased. Between Q2 15/16 and Q3 15/16 this has remained steady. **Promptly resolved** cases, majority of the surgery Pals cases involved Outpatient experiences (34.2%) Admission /Discharge (30.2%) Inpatient experience (10.1%)
Complex cases it Outpatient experience (26.7%) Admission/Discharge (20%) Communication/Information (13.3%) Referrals (13.3%)

Case study: Patient S is a 4 ½ year old boy, who has been a patient at Great Ormond Street since 2012 under multi-disciplinary care. During Q3 his parent contacted Pals as they were awaiting transfer from another hospital and were encountering delays. Pals contacted the multidisciplinary team, who worked together and liaised with the admitting hospital to arrange a swift transfer. The patient was brought in and had the relevant procedures carried out.

NEUROSCIENCES

The main activity in Pals IS seen by specialities **Neurology (24.4%) Ophthalmology (17.1%) Outpatients (11%).** There was a 1.23% increase in cases between Q2 and Q3 from 81 to 82.

Top 3 reasons for referrals to Pals Q3 14/15 to Q3 15/16*



*Outpatient appointments were also one of the joint top 3 reasons for referrals to Pals in the Neurosciences directorate

Between Q3 14/15 and Q3 15/16 there has been an increase in the referrals to pals for Outpatient Experiences (Communication/letters; Cancellations; Care advice) and **Communication /Information** (Lack of communication with parents/patients, Lack of information to parents, Lack of communication between staff/teams) and **Admission/Discharge** (Cancellation, Care advice and Communication/letters)and a decrease in cases about **Inpatient Experiences** (Care advice, Communication/letters, Accommodation) and **Referrals** (Advice NHS, Communication/letters). This trend is also noted between Q2 15/16 and Q3 15/16. **Promptly resolved cases**: Outpatient experience (46.7%) Communication and information (7.7%) Medical records (7.7%). **Complex cases**: Communication/Information (25%) Outpatient experience 25%) Admission discharge (16.7%)

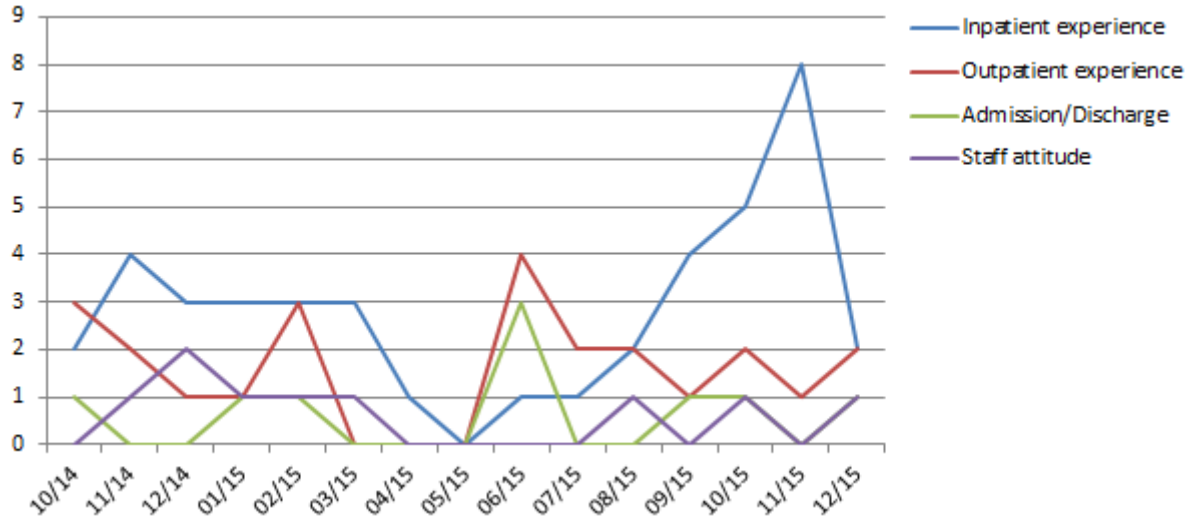
Case study: Patient N is a 12 year old boy who has been a patient at Great Ormond Street for 8 months under the Epilepsy team. Parents contacted Pals during Q3 as they had several concerns regarding shared care and patients feelings about their illness. This developed during the case to include emergency care plans and investigations being booked in. Pals relayed concerns to team, and the CNS, admin team and consultant in charge fed back information to ensure local services and family were are of a plan, and any necessary tests were arranged.

ESTATES AND FACILITATES

The main activity in Pals is seen under the areas of **Accommodation and patient transport (40%) Catering (24%) and Works (12%).** There was a 47.1% increase in cases between Q2 and Q3 –17 to 25

Attachment 9

Top 3 reasons for referral to Pals between Q3 14/15 to Q3 15/16



Comparing Q3 15/16 to Q3 14/15: A decrease in referrals due **Staff Attitude** (rudeness and uninterested) and **Admission and Discharge** (accommodation and transport); Increase in referrals for **Inpatient experiences** (accommodation, catering and environment/cleanliness) **and Outpatient experiences** (Accommodation, care advice and communication/letters) **. Q2 15/16 and Q3 15/16** - increase in cases for **Facilities, Inpatient experiences, outpatient experiences and Staff attitudes and Admission discharge. Promptly resolved themes were**: Inpatient experiences (60%) Outpatient experiences (20%) Admission/Discharge (8%)

Case study: Patient F is a long term inpatient whose family contacted Pals for a specialist diet. Pals liaised with the catering team, who sent a chef to discuss the diet with the patient and their family and subsequent meals were provided to the patients' satisfaction.

Our Always Values

As part of the implementation of 'Our Always Values' Pals now log each subject raised within referrals against one of the Trust's Values. One aim of this is to provide meaningful data about how the Trust is performing in relation to 'Our Always Values' and to help identify more specific issues in relation to the communication issues that arise. This data is provided in the table below.

	Numbers	Percentage
Helpful - Reliable	111	27.50%
Helpful - Helps others	50	12.40%
Expert - Professional	43	10.70%
One Team - Communication	40	9.90%
Helpful - Understanding	35	8.70%
Expert - Improving	23	5.70%
Helpful - Patient	23	5.70%
Welcoming - Reduce waiting	20	5.00%
One Team - Open	17	4.20%
Expert - Safe	15	3.70%
One Team - Listening	7	1.70%
Expert - Excellence	6	1.50%
Welcoming - Friendly	6	1.50%
One Team - Involve	4	1.00%
Welcoming - Respect	3	0.70%

27.5% of Pals cases during Q3 were regarding helpful and reliable. Outpatient experience accounted for 39.6% of the "Helpful reliable" cases and some examples of these included transport issues with not knowing if transport would arrive to take patients to clinic, communication- changes to plans made in appointments, accommodation arrangements for outpatient appointments and cancellation of appointments.

Same sex accommodation

There are no cases

Social media

Overall during Q3 17 queries/contacts were made via social media. They were pan Trust regarding multiple specialities, with no specific associations noted between medium used and contact received.

Cases formally escalated

11 cases were escalated in Q3 and they are managed and reported by the complaints Q3 report

Compliments

11 compliments were received. They were across the directorates and related to topics including positive feedback about treatment a long time ago, good experiences during admission and outpatients, positive experience with support from admin staff.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board Summary Report of CQC Inpatient Survey 2014 Action Plan

1 Introduction

The Trust received the results of the Care Quality Commission (CQC) 2014 inpatient survey in summer 2015. GOSH rated 'green' (amongst the best hospitals) on 4 scores and did not receive any scores in the red (amongst the worst performing hospitals); there were 4 questions which we were from 0.2 and 0.4 of being categorised as red. The table below details these questions:-

Respondents	Question	Score
Parents and carers of 0-7 year olds	Did the hospital change your child's admission date at all?	8.5 / 10 (0.25 away from red)
Children & young people 8-15 year olds	Did you like the hospital food?	5.4 / 10 (0.2 away from red)
All parents of 0-15 year olds	Did the members of staff caring for your child work well together?	8.5 / 10 (0.4 away from red)
Children & young people 8-15 year olds	If you had any worries, did someone at the hospital talk with you about them?	7.3 / 10 (0.3 away from red)
All parents of 0-15 year olds	They were given written information about the child's condition or treatment to take home	7.3 / 10 (0.5 away from red)
All parents of 0-15 year olds	The facilities for staying overnight for parents and carers were good	7.5/10 (1.2 away from red)

An action plan to address the areas of concern has been developed and has been ratified by the patient and family Engagement Committee in November 2015. This report summarises the actions being taken and the progress made since that time. Progress on these actions is detailed in section 2. A summary of actions being taken are listed below:-

We will:-

- Publicise and share the results of the survey
- Secure funding for, and purchase , a real time patient experience software system
- Improve patient access to appointments, diagnostic tests and treatment
- Improve Children and Young People's experiences of hospital food.
- Improve the way our staff work together
- Improve communication with Children and Young People
- Improve families experiences of facilities for staying over night
- Improve our families experiences of our discharge processes

2. Progress against actions

2.1 Sharing results and developing a real time patient experience system

The Trust has circulated the findings of the survey results across different levels of staff from Divisional Managers to placing the information in the staff internal newsletter Roundabout. As the results were a year old by the time they were received there is a real need for the Trust to have access to more up to date patient feedback information as we may be addressing issues that are no longer problematic. The Patient Feedback Project Manager has therefore submitted a business case to GOSHCC for funding of such a system and a detailed specification and tender documents are being developed in order for procurement to start in April 2016 in the event that funding is approved.

2.2 Patient access to appointments, diagnostic tests and treatment

The Trust is undertaking a significant amount of work on improving access to appointments, diagnostic tests and treatment in response to the concerns raised about Referral to Treatment Times (RTT). This work is reported through the Access Improvement Board to the board and is not repeated here.

2.3 Children and young people's experiences of hospital food

The Catering Team have developed and implemented a new one week menu which will be changed four times a year, rather than the annual three week rotating menu. This change allows patients to be offered more seasonal fruit and vegetables.

A new training video and e-learning course has been created for the teaching of the protected mealtime scheme which is being launched on the wards in February 2016. . The course covers nutritional care and management, how the ward meal service operates, and information on food preparation and safety. This is now being rolled out to food serving nursing staff and Health Care Assistants. This work aims to be complete at the end of March 2016.

2.4 Improving the way staff work together

GOSH has developed and launched 'Our Always values' and are now working to embed these into our culture. The Trust has facilitated workshops for our top leaders and managers staff to help them role model the values and embed them with their staff. Not all leaders have been captured so further training sessions are planned, along with new communications and the development of a video to be used on induction. The Operational Delivery Group for the values are currently working on a longer term communications plan to include quarterly campaigns on each value and the behaviours within them.

In May 2015 the Trust introduced Schwartz rounds for all staff to encourage staff to share how the impact of their work makes them feel to develop a greater culture of compassion for each other and working together as one team. The sessions have been very popular with staff and will continue throughout 2016.

There are increasing numbers of wards using safety huddles across the hospital to improve communication and situational awareness. In addition the Quality Improvement Team have been implementing Situation Awareness for Everyone (S.A.F.E) huddles on 5 wards to develop a Gold standard for huddles which can be rolled out across the Trust. These huddles ensure there is an exchange of information between clinical and non-clinical professionals involved in a patient's care. The Quality Improvement Team is looking to continue this roll out in 2016.

The Trust has also developed Electronic Patient Status at a Glance Boards currently used on about a third of wards. These information boards ensure that all members of a multi-disciplinary team are aware of activities and dates on the patient pathway and key items of information about patients which are regularly required to be communicated, they also help to facilitate the S.A.F.E huddles. The Trust are consulting parents and patients on what they would like to see on these boards before continuing to expand the programme. The Quality Improvement Team will be rolling these across the Trust over 2016 to all wards.

2.5 Improve our communication with children and young people

The Trust is currently developing an action plan to implement the 'Me First 'programme and training that aims to improve communication between healthcare professionals and children and young people. This will include awareness raising of the toolkit and resources available and development of a training programme. The Trust is exploring how to enable our Patient Advice and Liaison Service (PALS) and Complaints Team to be accessible to young people by September 2016.

2.6 Improve families' experience of facilities for staying overnight

The Trust has acted on information which had previously suggested that the parent chair beds in the Morgan Stanley Clinical Building were uncomfortable. Forty eight chair beds have now been replaced on Bear, Eagle, Flamingo and Koala wards.

The Trust has also reviewed a year's worth of comments regarding parent accommodation from the Patient Advice and Liaison Service, Complaints and the Friends and Family Test. From this information a specific accommodation survey has been created which will be distributed during January 2016. The aim of this survey is to find out in more detailed what the Trust needs to do to improve the systems and processes, and facilities for families staying overnight and to develop an action plan to respond to these issues.

2.7 Families' experiences of our discharge processes

Several divisions have improvement plans in relation to discharge and access improvement linked to the Access Improvement Programme. A further action plan is being developed to address compliance with discharge processes at ward level to ensure that families receive all relevant information prior to their discharge and are confident about who they can contact if they experience any problems once they are at home.

3 Conclusion

The Trust has begun to complete actions stipulated in GOSH's CQC response plan. There will be regular updates to the Patient and Family Engagement and Experience Committee on the progress of these projects and summaries in the patient experience report to the Board.

Caroline Joyce

Assistant Chief Nurse Quality and Patient Experience

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27th January 2016

CQC Inpatient Survey 2014 Action Plan report **Submitted by:** Juliette Greenwood, Chief Nurse	**Paper No: Attachment 3**

Aims / summary

The Trust received the results of the Care Quality Commission (CQC) 2014 inpatient survey in summer 2015. GOSH rated 'green' (amongst the best hospitals) on 4 scores and did not receive any scores in the red (amongst the worst performing hospitals); there were 4 questions which we were from 0.2 and 0.4 of being categorised as red. The table below details these questions:-

- Did the hospital change your child's admission date at all?
- Did you like the hospital food?
- Did the members of staff caring for your child work well together?
- If you had any worries, did someone at the hospital talk with you about them?
- They were given written information about the child's condition or treatment to take home
- The facilities for staying overnight for parents and carers were good

An action plan to address the areas of concern has been developed and has been ratified by the Patient and Family Engagement Committee in November 2015. This report summarises the actions being taken and the progress made since that time.

Action required from the meeting
Trust board to note the actions that are being taken to address the areas for improvement and the progress being made against these actions.

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

Trust Board
27th January 2016

Safe Nurse Staffing Report for November 2015 and December 2015 **Submitted by: Juliette Greenwood Chief Nurse**	**Paper No: Attachment 4**

Aims / summary

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

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

November 2015

1. Introduction

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

1.2 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'.

1.3 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.

2. GOSH Ward Nurse Staffing Information for Trust Board

2.1 Safe Staffing

2.1.1 The UNIFY Fill Rate Indicator for November is attached as Appendix 1. The spreadsheet 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, and extra staff booked to cope with changes in patient dependency and acuity from the Nurse Bank. Supernumerary shifts are excluded. In order to meet the fluctuations in acuity and dependency the number may exceed or be below 100%.
- 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.

2.1.2 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 November is:

RN Day	RN Night	HCA Day	HCA Night	Total Fill Rate
103%	91%	90%	70%	95%

ICI – No unsafe shifts reported in November Fox and Robin Ward had one bed closed on each ward for November. To meet patient/staffing requirements HCAs were moved from night shifts to day shifts hence some low percentages on nights on all wards. Elsewhere in the division there were varying levels of dependency between days and nights requiring staff to be moved between shifts and Wards across the Division to maintain safe staffing levels.
Surgery No unsafe shifts reported in November Sky Ward increased HCA hours on days due to patient acuity, HCAs were moved from day shifts to nights shifts on Peter Pan and Squirrel to meet patient dependency.
CCCR – No unsafe shifts reported in November Badger Ward reported a shift of particular concern where short notice sickness led to the ward being short staffed but not unsafe. Vacant HCA posts contributed to low fill rates on Badger, PICU and NICU. The Lead Nurse on Flamingo Ward reported 3 shifts where staffing was an issue and a case was cancelled. There are a total of 23 vacancies at Band 5 and 6. A number of new starters and HCAs have been appointed however concerns have been raised by the ward regarding the level of supervision required by new starters to the area.
MDTS - No unsafe shifts reported in November Eagle Ward report increased levels of Haemodialysis treatments requiring increased registered nurses on day shifts. To meet increasing pressure on beds across the Trust, Kingfisher Ward has experienced increased activity and overnight stays requiring extra staff. In an attempt to increase haemodialysis staff the Bank rates have been increased. Rainforest Endocrine/Metabolic have HCA vacancies. Extra Registered Nurse hours were employed to compensate for deficit in HCA hours.
Neurosciences - No unsafe shifts reported in November Koala Ward - more HCA hours during day shifts due staff working as Patient Pathway Coordinators.
IPP - No unsafe shifts reported in November Butterfly and Bumblebee both reported HCA's rostered to provide maximum support during the busier day periods due to theatre cases etc. Night registered nurse numbers were deliberately lowered on Butterfly ward due to changes in activity and acuity of patients. Staff were flexed across the division to ensure patient safety.

2.1.3 The Clinical Site Practitioners (CSPs) report that no wards were declared unsafe during November, however there were 4 shifts in total where CSPs moved staff between wards for part or a whole shift to maintain safe care.

3.0 General Staffing Information

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

3.0.2 There has been sustained effort over recent months to reduce the number of beds closed due to nurse staffing issues. 9 out of 23 inpatient wards closed beds at various points during November. An average of 4.5 beds were closed each day. Reasons cited for closures were; staff moved from Eagle Ward to Dialysis Service. Robin and Fox wards closed a bed each due to short term vacancies and skill mix.

3.0.3 For the inpatient wards, registered and non-registered vacancies for total 79 Whole Time Equivalents (WTE) a slight increase from 77 in October. This breaks down to 45 (45 in

October) registered nurse (RN) vacancies (5% of RN total). HCA vacancies number 34 (21% of HCA total) similar to the October position. Temporary nurses, mainly from GOSH Nurse Bank, employed on wards totalled 99 WTE, the November position was therefore 19 WTE posts above establishment (38 in October). This is not unusual for this time period, as we have many new starters who are going through orientation, induction and a period of supernumerary practice, during this period Bank staff provide the backup cover. There are 40 RNs and 8 HCAs in the recruitment pipeline undergoing pre-employment checks.

3.1 Vacancies and Recruitment

3.1.1 There remains 33 HCA vacancies, an extra round of recruitment commenced in December, the Trust is finding it difficult to recruit and train HCAs in sufficient numbers to keep pace with turnover. In addition IPP have recruited 5 HCAs for their new ward opening in April 2016.

3.1.2 In addition to the 40 nurses in the recruitment pipeline an additional 6 nurses have been recruited from Cork.

3.1.3 6 Adult Nurses will commence on the new Adult RN Programme with secondment to LSBU following clinical experience to the Child Branch programme.

3.1.4 An additional Newly Registered Rotation Programme is planned for March 2016, 12 posts have been ring fenced for this programme.

3.1.5 GOSH hosted a Recruitment Fair on 13th November 120 visitors attended. The next Newly Registered Nurses assessment centre is planned for December.

3.1.6 The new IPP Ward (Hedgehog) has started recruitment with a planned opening date of April 2016. An open day for staff was held on 18th November.

4. Key Challenges

- Recruitment and retention of HCAs.
- Recruitment of Band 6 Nurses.
- Retention of Band 5 and 6 Nurses.
- Recruit staff to meet plans for growth.

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 November 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	4	
E Coli Bacteraemia	2	
D & V and other outbreaks	0	
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 a comprehensive chlorine clean.

5.4 **Pressure ulcers**

	Number	**Ward**
Grade 3	1	Identified on admission to Flamingo Ward. Referred back to referring hospital for investigation.
Grade 2	6	3 on Squirrel ward, I Bumblebee, 1 PICU, 1 NICU.

5.4.1 We treat all pressure ulcers as avoidable at present. The Grade 3 incident was escalated for investigation. Two of the three ulcers reported on Squirrel ward relate to the same patient. A root cause analysis is underway to prevent this from reoccurring within a specific cohort of urology patients.

5.4.2 The Tissue Viability Nurse and Practice Educator have assessed the numbers of incidents related to devices and are developing guidance for staff on prevention e.g. for patients with tracheostomies or on non-invasive ventilation. Further work will commence with anaesthetists and nursing staff to reduce endotracheal pressure ulcers.

5.5 **Deteriorating patient**

5.5.1 For the month of November, 20 emergency calls were received, there were no cardiac arrests. There were 10 respiratory arrests, 5 relate to the same patient on Badger ward. There were 4 unplanned admissions to PICU – 1 Badger ward, 1 Rainforest Endocrine/Metabolic, 1 Koala and 1 from Bumblebee.

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

There were 5 incidents in total reported by staff through Datix regarding staffing levels, these all relate to Flamingo Ward. Three of these reports related to situations where either staff sickness or sudden deterioration of patients affected safe staffing levels, and the appropriate ratios of 1:1 nursing or 2:1 nursing for high dependency patients could not be maintained. 2 incidents related to patients with known grade 2 pressure ulcers who could not be turned 2 hourly in line with the Glamorgan Pressure Ulcer management guidance. In each instance the ward was made safe by obtaining staff from other ITU's or the Clinical Site Practitioners, or expediting the discharge of another patient from the ITU.

5.7 **Pals concerns raised by families regarding nurse staffing - 2**

Flamingo Ward – parent reported there were insufficient nurses to help her feed her child. The second related to a childs admission being cancelled on Rainforest due to lack of beds.

5.8 **Complaints received regarding nurse safe staffing - 0**

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

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

- Overall response rate for November was 21% (October 17%). The overall target is 40% response rate increasing to 60% at the end of Quarter 4 2015/16.
- The overall percentage to recommend score is 98%.
- For October families that were extremely likely to recommend GOSH to their friends and family equalled 573 (87%), and 68 (10%) likely to recommend, compared with 460 (90%) and 44 (9%) in October.
- Many comments were received regarding the friendliness of staff, confidence in care received and overall quality of care.
- Several comments received regarding waiting for medications and treatment and mis-communication.

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 November, 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. Whilst recruitment of staff is a high priority there will be a shift in focus on improving retention rates of nurses, work is underway to plan our strategy.

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.

7.4 The on-going challenges in retaining and recruiting nurses.

Attachment 4
Appendix 1: UNIFY Safe Staffing Submission – November 2015

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

Great Ormond Street Hospital For Children NHS Foundation Trust

ber_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)

http://www.gosh.nhs.uk/about-us/our-corporate-information/publications-and-reports/safe-nurse-staffing-report/

Comments

Hospital Site Details		Only complete sites your organisation is accountable for	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	Ward 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		2392	1995.5	356	356.5	2139	1926	356	239.7	83.4%	100.1%	90.0%	67.3%
RP401	Great Ormond Street Hospital Central London Site - R	Bear Ward	170 - CARDIOTHORACIC SURGERY	321 - PAEDIATRIC CARDIOLOGY	2852	3076.05	609	732	2852	2704	356	381.4	107.9%	120.2%	94.8%	107.1%
RP401	Great Ormond Street Hospital Central London Site - R	Flamingo Ward	192 - CRITICAL CARE MEDICINE		6951	6748.17	352	318	6541	6306.3	193	151.9	97.1%	90.3%	96.4%	78.7%
RP401	Great Ormond Street Hospital Central London Site - R	Miffy Ward (TCU)	340 - RESPIRATORY MEDICINE		713	732.8	1069	924.5	713	606.6	713	634.5	102.8%	86.5%	85.1%	89.0%
RP401	Great Ormond Street Hospital Central London Site - R	Neonatal Intensive Care Unit	192 - CRITICAL CARE MEDICINE		3208	3571.48	356	0	3208	2810.2	0	0	111.3%	0.0%	87.6%	-
RP401	Great Ormond Street Hospital Central London Site - R	Paediatric Intensive Care Unit	192 - CRITICAL CARE MEDICINE		6060	7077.22	356	263.8	6060	5482.26	356	108	116.8%	74.1%	90.5%	30.3%
RP401	Great Ormond Street Hospital Central London Site - R	Elephant Ward	370 - MEDICAL ONCOLOGY	823 - HAEMATOLOGY	1679	1956.52	356	419.7	1426	1311.4	356	292.3	116.5%	117.9%	92.0%	82.1%
RP401	Great Ormond Street Hospital Central London Site - R	Fox Ward	303 - CLINICAL HAEMATOLOGY	313 - CLINICAL IMMUNOLOGY and ALLERGY	2090	2034.05	348	230	1933	1467.8	348	216	97.3%	66.1%	75.9%	62.1%
RP401	Great Ormond Street Hospital Central London Site - R	Giraffe Ward	313 - CLINICAL IMMUNOLOGY and ALLERGY	350 - INFECTIOUS DISEASES	1066	1253.5	355	184	1066	876.2	355	118.8	117.6%	51.8%	82.2%	33.5%
RP401	Great Ormond Street Hospital Central London Site - R	Lion Ward	370 - MEDICAL ONCOLOGY	303 - CLINICAL HAEMATOLOGY	1675	1631.55	355	286.05	1423	1134.4	355	244.6	97.4%	80.6%	79.7%	68.9%
RP401	Great Ormond Street Hospital Central London Site - R	Penguin Ward	330 - DERMATOLOGY	410 - RHEUMATOLOGY	948	1244.28	350	593.8	700	637.6	350	54.7	131.3%	169.7%	91.1%	15.6%
RP401	Great Ormond Street Hospital Central London Site - R	Robin Ward	350 - INFECTIOUS DISEASES	313 - CLINICAL IMMUNOLOGY and ALLERGY	1993	1645	349	310.5	1746	1295.4	349	274.9	82.5%	89.0%	74.2%	78.8%
RP401	Great Ormond Street Hospital Central London Site - R	Bumblebee Ward	171 - PAEDIATRIC SURGERY	420 - PAEDIATRICS	2433	2300.17	347	644	2085	2015.88	695	621.2	94.5%	185.6%	96.7%	89.4%
RP401	Great Ormond Street Hospital Central London Site - R	Butterfly Ward	370 - MEDICAL ONCOLOGY	420 - PAEDIATRICS	2852	2311.3	356	621	2139	1255.3	356	327.5	81.0%	174.4%	58.7%	92.0%
RP401	Great Ormond Street Hospital Central London Site - R	Eagle Ward	361 - NEPHROLOGY		2136	3181.7	665	854	1331	1413.8	332	210.1	149.0%	128.4%	106.2%	63.3%
RP401	Great Ormond Street Hospital Central London Site - R	Kingfisher Ward	420 - PAEDIATRICS		1776	1750.35	914	587.5	312	492.3	0	10.8	98.6%	64.3%	157.8%	-
RP401	Great Ormond Street Hospital Central London Site - R	Rainforest Ward (Gastro)	301 - GASTROENTEROLOGY		966	1076.25	713	299	713	752.9	713	287.1	111.4%	41.9%	105.6%	40.3%
RP401	Great Ormond Street Hospital Central London Site - R	Rainforest Ward (Endo/Met)	302 - ENDOCRINOLOGY		1069	1154.55	713	253	1069	919.7	356	231	108.0%	35.5%	86.0%	64.9%
RP401	Great Ormond Street Hospital Central London Site - R	Mildred Creak	711- CHILD and ADOLESCENT PSYCHIATRY		1116	1081.85	612	544.8	507	401	454	413.2	96.9%	89.0%	79.1%	91.0%
RP401	Great Ormond Street Hospital Central London Site - R	Koala Ward	150 - NEUROSURGERY	421 - PAEDIATRIC NEUROLOGY	3135	3061.2	332	538	3028	2785.6	332	75.6	97.6%	162.0%	92.0%	22.8%
RP401	Great Ormond Street Hospital Central London Site - R	Peter Pan Ward	120 - ENT	160 - PLASTIC SURGERY	1575	1471.2	609	356.5	1460	1367.1	0	34.5	93.4%	58.5%	93.6%	-
RP401	Great Ormond Street Hospital Central London Site - R	Sky Ward	110 - TRAUMA & ORTHOPAEDICS	171 - PAEDIATRIC SURGERY	1886	1836.7	660	862	1833	1643.95	0	0	97.4%	130.6%	89.7%	-
RP401	Great Ormond Street Hospital Central London Site - R	Squirrel Ward	171 - PAEDIATRIC SURGERY	101 - UROLOGY	2954	3111.91	701	591	2649	2444.5	0	223.7	105.3%	84.3%	92.3%	-

Attachment 4
Appendix 2: Overview of Ward Nurse Staffing – November 2105

			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 Estabslishment	Total Vacancies	Bank Used	Net Vacant	Registered Starters	Non-registered Starters	Number of unsafe shifts	Average Bed Closures
CCCR	Badger	15	39.5	40.9	-1.4	7.5	5.2	2.3	47.0	0.9	3.9	-3.0	0.0	0	0	0.0
	Bear	22	47.7	46.2	1.5	9.0	9.4	-0.4	56.7	1.1	5.5	-4.4	6.0	0	0	0.1
	Flamingo	17	121.0	96.3	24.7	10.8	4.0	6.8	131.8	31.5	21.4	10.1	5.0	1	0	0.0
	Miffy (TCU)	5	14.1	13.4	0.7	7.8	6.5	1.3	21.9	2.0	5.4	-3.4	0.0	1	0	0.0
	NICU	8	51.5	46.6	4.9	5.2	0.0	5.2	56.7	10.1	11.3	-1.2	6.0	0	0	0.0
	PICU	13	83.0	107.8	-24.8	8.9	3.0	5.9	91.9	-18.9	6.8	-25.7	3.0	0	0	0.0
ICI-LM	Elephant	13	25.0	22.7	2.3	5.0	4.1	0.9	30.0	3.2	2.2	1.0	4.0	0	0	0.0
	Fox	10	31.0	28.1	2.9	5.0	4.9	0.1	36.0	3.0	1.8	1.2	0.0	0	0	0.8
	Giraffe	7	19.0	18.8	0.2	3.1	3.0	0.1	22.1	0.3	0.3	0.0	1.0	0	0	0.0
	Lion	11	22.0	21.9	0.1	4.0	3.0	1.0	26.0	1.1	3.1	-2.0	1.0	0	0	0.0
	Penguin	9	15.5	15.8	-0.3	5.8	5.6	0.2	21.3	-0.1	1.5	-1.6	0.0	0	0	0.0
	Robin	10	27.2	24.7	2.5	4.5	4.6	-0.1	31.7	2.4	4.5	-2.1	0.0	0	0	0.8
IPP	Bumblebee	21	38.3	33.8	4.5	9.7	9.0	0.7	48.0	5.2	8.7	-3.5	2.0	2	0	0.5
	Butterfly	18	37.2	31.4	5.8	10.5	8.9	1.6	47.7	7.4	2.8	4.6	1.0	1	0	0.1
MDTS	Eagle	21	39.5	33.0	6.5	10.5	10.0	0.5	50.0	7.0	3.4	3.6	4.0	0	0	1.3
	Kingfisher	16	17.1	15.2	1.9	6.2	5.8	0.4	23.3	2.3	1.7	0.6	0.0	0	0	0.0
	Rainforest Gastro	8	17.0	14.9	2.1	4.0	3.5	0.5	21.0	2.6	1.6	1.0	2.0	1	0	0.0
	Rainforest Endo/Met	8	15.6	15.6	0.0	5.2	3.5	1.7	20.8	1.7	1.6	0.1	2.0	1	0	0.4
Neuro-sciences	Mildred Creak	10	11.8	11.2	0.6	7.8	6.6	1.2	19.6	1.8	0.5	1.3	0.0	0	0	0.0
	Koala	24	48.2	43.4	4.8	7.8	5.0	2.8	56.0	7.6	1.8	5.8	0.0	0	0	0.1
Surgery	Peter Pan	16	24.5	24.6	-0.1	5.0	5.0	0.0	29.5	-0.1	0.9	-1.0	1.0	0	0	0.0
	Sky	18	31.0	25.6	5.4	5.2	5.0	0.2	36.2	5.6	3.7	1.9	1.0	0	0	0.4
	Squirrel	22	43.6	42.6	1.0	7.0	6.0	1.0	50.6	2.0	4.9	-2.9	1.0	0.6	0	0.0
	TRUST TOTAL:	**322**	**820.3**	**774.5**	**45.8**	**155.5**	**121.6**	**33.9**	**975.8**	**79.7**	**99.3**	**-19.6**	**40.0**	**7.6**	**0.0**	**4.5**

Great Ormond Street Hospital for Children NHS Foundation Trust

GOSH NURSE SAFE STAFFING REPORT

December 2015

1. Introduction

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

1.2 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'.

1.3 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.

2. GOSH Ward Nurse Staffing Information for Trust Board

2.1 Safe Staffing

2.1.1 The UNIFY Fill Rate Indicator for December is attached as Appendix 1. The spreadsheet 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, and extra staff booked to cope with changes in patient dependency and acuity from the Nurse Bank. Supernumerary shifts are excluded. In order to meet the fluctuations in acuity and dependency the number may exceed or be below 100%.
- 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.

2.1.2 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 December is:

RN Day	RN Night	HCA Day	HCA Night	Total Fill Rate
102%	91%	90%	70%	95%

ICI – No unsafe shifts reported in December Fox and Robin Ward had one bed closed on each ward for December. To meet patient/staffing requirements HCAs shifts were changed from the plan hence the variable fill rates across the division. Staffing was reduced depending on the divisional requirements over the Christmas break, several patients were on home leave. Penguin had an increase in day activity due to RTT work hence the increase in HCAs. There were a number of short notice sickness episodes on Robin affecting actual staffing numbers.
Surgery No unsafe shifts reported in December Beds and staffing were adjusted from plan hence the lower fill rates. Several HCAs were moved from days to nights which this template does not recognise, however these hours are included in the overall Trust fill rate.
CCCR – No unsafe shifts reported in December Bear has been open to 24 beds 2 above plan hence extra staff required. Miffy ward - some HCA shifts filled with registered staff. Flamingo has recruited HCAs who are not yet rostered, NICU and PICU have HCA vacancies.
MDTS - No unsafe shifts reported in December Eagle Ward report increased levels of Haemodialysis treatments requiring increased registered nurses on day shifts. Kingfisher Ward, Rainforest Gastro and Endo/Met had planned seasonal closures. 4 HCA vacancies have now been filled, therefore the fill rate is expected to improve. Extra Registered Nurse hours were employed to compensate for deficit in HCA hours.
Neurosciences - No unsafe shifts reported in December Koala Ward - more HCA hours during day shifts due staff working as Patient Pathway Coordinators. MCU had a particularly demanding time,
IPP - No unsafe shifts reported in December Bumblebee utilising HCAs to care for infants with absent parents during day shifts and moving staff across shifts to facilitate this. Butterfly Ward had a number of beds blocked for ICU repatriation and throughout December times of reduced activity. Night registered nurse numbers were deliberately lowered on Butterfly ward due to changes in activity and acuity of patients. Staff were flexed across the division to ensure patient safety.

2.1.3 The Clinical Site Practitioners (CSPs) report that no wards were declared unsafe during December, however there were 4 shifts in total where CSPs moved staff between wards for part or a whole shift to maintain safe care.

3.0 General Staffing Information

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

3.0.2 There has been sustained effort over recent months to reduce the number of beds closed due to nurse staffing issues. 10 out of 23 inpatient wards closed beds at various points during December. An average of 8.6 beds were closed each day. This includes seasonal closures of some wards/beds for Christmas and New Year. Eagle continued to close 2 ward beds on a number of occasions to staff the dialysis service. For most of December Robin and Fox wards also closed a bed each due to short term vacancies and skill mix.

3.0.3 For the inpatient wards at January 1st registered and non-registered vacancies total 90 Whole Time Equivalents (WTE) an increase from 79 in November. This breaks down to 61

(45 in November) registered nurse (RN) vacancies (7% of RN total). HCA vacancies number 29 (18% of HCA total) 5 less than reported in November. Temporary nurses, mainly from GOSH Nurse Bank, employed on wards totalled 81 WTE, the December position was therefore 10 WTE posts above establishment (38 in October and 19 in November). This is due to staff coming out of supernumerary status. There are 47 RNs and 11 HCAs in the recruitment pipeline undergoing pre-employment checks.

3.1 Vacancies and Recruitment

3.1.1 There remains 29 HCA vacancies, an extra round of recruitment commenced in December, the Trust is finding it difficult to recruit and train HCAs in sufficient numbers to keep pace with turnover. In addition IPP have recruited 5 HCAs for their new ward opening later in 2016.

3.1.2 In total 26 Newly Registered Nurses were recruited from the December Assessment Centre, this is in addition to the 18 recruited from the Republic of Ireland. An additional advert was placed in late December for Newly Registered Nurses with 13 applicants shortlisted, these candidates will go through an assessment centre on January 25th.

3.1.3 An additional Newly Registered Rotation Programme is planned for March 2016, 12 posts have been ring fenced for this programme.

3.1.4 Three agencies are working on our behalf to source overseas nurses. The process of registration with the NMC is costly for applicants and the level of assessment for language skills will change in January 2016 making the appointment of overseas staff more difficult. Agencies advise the use of 'benefits packages' to encourage nurses to relocate. This will be further discussed in line with the 2016 recruitment plan.

3.1.5 57% (35) of RN vacancies in December are at band 6.

4. Key Challenges

- Recruitment and retention of HCAs.
- Recruitment of Band 6 Nurses.
- Retention of Band 5 and 6 Nurses.
- Recruit staff to meet plans for growth.

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 December 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	2	
E Coli Bacteraemia	3	
D & V and other outbreaks	1	Norovirus on 1 ward - beds not closed.
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 a comprehensive chlorine clean.

5.4 **Pressure ulcers**

	Number	**Ward**
Grade 3	0	
Grade 2	7	2 on Squirrel Ward,3 PICU, 1 Koala Ward and 1 Flamingo Ward

5.4.1 We treat all pressure ulcers as avoidable at present. The 3 Pressure ulcers noted on Squirrel and Koala related to the use of anti-embolism stockings. An awareness campaign has reminded staff of the correct measuring and fitting of the stockings and the importance of good skin care.

5.4.2 3 of the remaining reports relate to the use of Non Invasive ventilation equipment. The Tissue Viability Nurse and Practice Educator are developing guidance for staff on prevention e.g. for patients with tracheostomies or on non-invasive ventilation. Further work will commence in January with anaesthetists and nursing staff.

5.5 **Deteriorating patient**

5.5.1 For the month of December, 7 emergency calls were received, there were no cardiac or respiratory arrests. Good practice in early recognition and detection of deteriorating patients has been noted. There were 12 unplanned admissions to PICU, these are patients whose condition was showing signs of deterioration and therefore were admitted semi electively to ICU for ongoing assessment and management.

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

There were 2 incidents in total reported by staff through Datix regarding staffing levels, both on Penguin Ward. On each occasion the nurses noted insufficient staff to manage the patient cohort. On investigation a gap in the knowledge of staff was apparent, this has now been rectified and staff are aware of the correct escalation procedure.

5.7 **Pals concerns raised by families regarding nurse staffing - 2**

Badger Ward – admission cancelled twice due to lack of beds, admission date agreed and patient admitted on the 23rd December. The second incident related to Walrus where a patient was cancelled due to lack of beds and staff.

5.8 **Complaints received regarding nurse safe staffing - 0**

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

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

- Overall response rate for December reduced to 18.5% (November 21%). The overall target is 40% response rate increasing to 60% at the end of Quarter 4 2015/16.
- The overall percentage to recommend remains at 98%.
- Families that were extremely likely to recommend GOSH to their friends and family totalled 90% (475) and 8% (45) responded as likely to recommend compared with 87.5% (573) and 10.4% (68) in November 2015.
- Many comments were received regarding the friendliness of staff, confidence in care received, overall quality of care and cleanliness.
- One family were unhappy with the level of care their child received when a blocked catheter required urgent attention.

6.0 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 December, 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. Whilst recruitment of staff is a high priority there will be a shift in focus on improving retention rates of nurses, work is underway to plan our strategy.

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.

7.4 The on-going challenges in retaining and recruiting nurses.

Attachment 4
Appendix 1: UNIFY Safe Staffing Submission – December 2015

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

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

Period: December_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		2403	2288.5	356	344	2139	2138.1	356	274.2	95.2%	96.6%	100.0%	77.0%
		RP401	Great Ormond Street Hospital Central London Site - R	Bear Ward	170 - CARDIOTHORACIC SURGERY	321 - PAEDIATRIC CARDIOLOGY	2852	3349.5	621	768	2852	3006.3	356	486	117.4%	123.7%	105.4%	136.5%
		RP401	Great Ormond Street Hospital Central London Site - R	Flamingo Ward	192 - CRITICAL CARE MEDICINE		7038	6618.97	356	310.5	6635	5990.45	218	109.85	94.0%	87.2%	90.3%	50.4%
		RP401	Great Ormond Street Hospital Central London Site - R	Miffy Ward (TCU)	340 - RESPIRATORY MEDICINE		713	827.4	1069	756	713	698.2	713	447.35	116.0%	70.7%	97.9%	62.7%
		RP401	Great Ormond Street Hospital Central London Site - R	Neonatal Intensive Care Unit	192 - CRITICAL CARE MEDICINE		3122	3329.8	346	138	3122	2865.5	0	32.4	106.7%	39.9%	91.8%	-
		RP401	Great Ormond Street Hospital Central London Site - R	Paediatric Intensive Care Unit	192 - CRITICAL CARE MEDICINE		6060	6806.6	356	276	6060	5827.9	356	129.6	112.3%	77.5%	96.2%	36.4%
		RP401	Great Ormond Street Hospital Central London Site - R	Elephant Ward	370 - MEDICAL ONCOLOGY	823 - HAEMATOLOGY	1690	1659.66	356	385.2	1426	1287	356	305.2	98.2%	108.2%	90.3%	85.7%
		RP401	Great Ormond Street Hospital Central London Site - R	Fox Ward	303 - CLINICAL HAEMATOLOGY	313 - CLINICAL IMMUNOLOGY and ALLERGY	1930	2042.05	321	171.1	1805	1604.7	321	239	105.8%	53.3%	88.9%	74.5%
		RP401	Great Ormond Street Hospital Central London Site - R	Giraffe Ward	313 - CLINICAL IMMUNOLOGY and ALLERGY	350 - INFECTIOUS DISEASES	1069	1387.3	356	218.5	1069	977.6	356	185.7	129.8%	61.4%	91.4%	52.2%
		RP401	Great Ormond Street Hospital Central London Site - R	Lion Ward	370 - MEDICAL ONCOLOGY	303 - CLINICAL HAEMATOLOGY	1690	1683.75	356	345	1426	1184.9	356	231.7	99.6%	96.9%	83.1%	65.1%
		RP401	Great Ormond Street Hospital Central London Site - R	Penguin Ward	330 - DERMATOLOGY	410 - RHEUMATOLOGY	959	1090.35	349	634.64	699	671.65	349	56.1	113.7%	181.8%	96.1%	16.1%
		RP401	Great Ormond Street Hospital Central London Site - R	Robin Ward	350 - INFECTIOUS DISEASES	313 - CLINICAL IMMUNOLOGY and ALLERGY	1871	1834.8	325	276	1629	1296.4	325	373.5	98.1%	84.9%	79.6%	114.9%
		RP401	Great Ormond Street Hospital Central London Site - R	Bumblebee Ward	171 - PAEDIATRIC SURGERY	420 - PAEDIATRICS	2495	2410.75	356	552	2139	2123.35	713	600.35	96.6%	155.1%	99.3%	84.2%
		RP401	Great Ormond Street Hospital Central London Site - R	Butterfly Ward	370 - MEDICAL ONCOLOGY	420 - PAEDIATRICS	2848	2231.5	356	854.5	2136	1236.5	356	326.8	78.4%	240.0%	57.9%	91.8%
		RP401	Great Ormond Street Hospital Central London Site - R	Eagle Ward	361 - NEPHROLOGY		2134	3404	658	981	1316	1468.85	329	220.2	159.5%	149.1%	111.6%	66.9%
		RP401	Great Ormond Street Hospital Central London Site - R	Kingfisher Ward	420 - PAEDIATRICS		1817	1442	931	484	349	485.17	0	0	79.4%	52.0%	139.0%	-
		RP401	Great Ormond Street Hospital Central London Site - R	Rainforest Ward (Gastro)	301 - GASTROENTEROLOGY		954	1110.7	696	218.5	696	793.3	696	174.9	116.4%	31.4%	114.0%	25.1%
		RP401	Great Ormond Street Hospital Central London Site - R	Rainforest Ward (Endo/Met)	302 - ENDOCRINOLOGY		1069	1153.35	713	287.5	1069	812.1	356	262.7	107.9%	40.3%	76.0%	73.8%
		RP401	Great Ormond Street Hospital Central London Site - R	Mildred Creak	711- CHILD and ADOLESCENT PSYCHIATRY		1126	1137.7	632	597.7	511	618.1	465	425.7	101.0%	94.6%	121.0%	91.5%
		RP401	Great Ormond Street Hospital Central London Site - R	Koala Ward	150 - NEUROSURGERY	421 - PAEDIATRIC NEUROLOGY	3246	3095.15	342	452.5	3158	2710.5	342	87.1	95.4%	132.3%	85.8%	25.5%
		RP401	Great Ormond Street Hospital Central London Site - R	Peter Pan Ward	120 - ENT	160 - PLASTIC SURGERY	1255	1012	487	230	1183	821.6	0	66.9	80.6%	47.2%	69.5%	-
		RP401	Great Ormond Street Hospital Central London Site - R	Sky Ward	110 - TRAUMA & ORTHOPAEDICS	171 - PAEDIATRIC SURGERY	2036	1725.75	709	751.17	1990	1520.1	0	11.5	84.8%	105.9%	76.4%	-
		RP401	Great Ormond Street Hospital Central London Site - R	Squirrel Ward	171 - PAEDIATRIC SURGERY	101 - UROLOGY	2952	2843.13	696	540.75	2649	2318.2	0	64.8	96.3%	77.7%	87.5%	-

Attachment 4
Appendix 2: Overview of Ward Nurse Staffing – December 2015

Division	Ward	Established Bed Numbers	Registered Nursing staff			Non Registered			Total Establishment	Total Vacancies	Bank Used	Net Vacant	Recruitment Pipeline		Number of unsafe shifts	Average Bed Closures
			Proposed Funded Establishment	Staff in Post	Vacancies	Proposed Funded establishment	Staff in Post	Vacancies					Registered Starters	Non-registered Starters		
CCCR	Badger	15	39.5	39.7	-0.2	7.5	5.0	2.5	47.0	2.3	3.9	-1.6	1.0	0	0	0.0
	Bear	22	47.7	49.8	-2.1	9.0	9.4	-0.4	56.7	-2.5	2.8	-5.3	7.0	0	0	0.0
	Flamingo	17	121.0	100.0	21.0	10.8	5.0	5.8	131.8	26.8	15.1	11.7	5.0	1	0	0.0
	Miffy (TCU)	5	14.1	12.7	1.4	7.8	5.5	2.3	21.9	3.7	3.3	0.4	0.0	2	0	0.0
	NICU	8	51.5	44.1	7.4	5.2	2.0	3.2	56.7	10.6	8.5	2.1	4.0	0	0	0.2
	PICU	13	83.1	89.0	-5.9	8.9	3.0	5.9	92.0	0.0	8.5	-8.5	7.0	0	0	0.0
ICI-LM	Elephant	13	25.0	24.6	0.4	5.0	4.1	0.9	30.0	1.3	2.3	-1.0	3.0		0	0.0
	Fox	10	31.0	28.2	2.8	5.0	4.0	1.0	36.0	3.8	1.3	2.5	0.0	0	0	1.0
	Giraffe	7	19.0	18.8	0.2	3.1	3.0	0.1	22.1	0.3	1.1	-0.8	1.0	0	0	0.0
	Lion	11	22.0	23.8	-1.8	4.0	3.0	1.0	26.0	-0.8	2.2	-3.0	0.0	0	0	0.0
	Penguin	9	15.5	15.8	-0.3	5.8	5.8	0.0	21.3	-0.3	1.7	-2.0	1.0	0	0	0.2
	Robin	10	27.2	23.7	3.5	4.5	5.1	-0.6	31.7	2.9	2.6	0.3	0.0	0	0	0.9
IPP	Bumblebee	21	38.3	33.8	4.5	9.7	9.0	0.7	48.0	5.2	7.5	-2.3	2.0	1	0	0.0
	Butterfly	18	37.2	31.4	5.8	10.5	8.9	1.6	47.7	7.4	2.8	4.7	1.0	2	0	0.0
MDTS	Eagle	21	39.5	33.6	5.9	10.5	11.0	-0.5	50.0	5.4	1.9	3.5	1.0	3	0	1.1
	Kingfisher	16	17.1	14.2	2.9	6.2	5.8	0.4	23.3	3.3	1.4	1.9	0.0	0	0	0.0
	Rainforest Gastro	8	17.0	16.9	0.1	4.0	3.5	0.5	21.0	0.6	0.9	-0.3	0.0	1	0	0.2
	Rainforest Endo/Met	8	15.6	14.6	1.0	5.2	3.5	1.7	20.8	2.7	1.4	1.3	2.0	1	0	0.0
Neuro-sciences	Mildred Creak	10	11.8	9.5	2.3	7.8	7.3	0.5	19.6	2.8	3.0	-0.2	0.0	0	0	0.0
	Koala	24	48.2	43.4	4.8	7.8	5.0	2.8	56.0	7.6	1.9	5.7	3.0		0	1.0
Surgery	Peter Pan	16	24.5	21.9	2.6	5.0	6.0	-1.0	29.5	1.6	1.0	0.7	3.0	0	0	3.4
	Sky	18	31.0	25.2	5.8	5.2	5.0	0.2	36.2	6.0	2.6	3.4	3.0	0	0	0.1
	Squirrel	22	43.6	44.7	-1.1	7.0	6.0	1.0	50.6	-0.1	2.9	-3.0	3.0	0	0	0.5
	TRUST TOTAL:	**322**	**820.4**	**759.4**	**61.0**	**155.5**	**125.9**	**29.6**	**975.9**	**90.6**	**80.6**	**10.1**	**47.0**	**11.0**	**0.0**	**8.6**

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 27th January 2016	
Redevelopment Progress Report **Submitted by: Matthew Tulley, Development Director**	**Paper No: Attachment 5**
Aims / summary Provides an update on progress of the redevelopment programme and major projects.	
Action required from the meeting The Board is asked to note progress and the current position.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Provide services in appropriate environment. Enhance the patient experience. Increase capacity. Meet sustainability obligations.	
Financial implications None	
Who needs to be told about any decision? N/A	
Who is responsible for implementing the proposals / project and anticipated timescales? Development Director	
Who is accountable for the implementation of the proposal / project? CEO	

Great Ormond Street Hospital for Children NHS Foundation Trust

Great Ormond Street Hospital Redevelopment Programme

Trust Board – 27th January 2016

1.0 Executive Summary

1.1 Works on the Premier Inn Clinical Building, second part of the Mittal Children's Medical Centre (Phase 2B), progress well. The building is now watertight and the risk of impacting on clinical operations has reduced but continues to be monitored closely. The project is approximately six weeks behind programme but this position is stable and on balance is likely to improve.

1.2 The Zayed Centre for Research (ZCR) (Phase 3) was officially named at an event in September 2015 following the completion of the funding agreement. The detailed design has been completed. In December 2015 negotiations with the then preferred contractor were terminated. We are in discussions with several potential main contractors for the construction stage and will go back to tender in March. Meanwhile, negotiations to undertake the basement construction (the next phase of works) with an alternative contractor are advanced. If concluded swiftly this will enable the project to proceed broadly to programme.

1.3 Following the approval of the revised GOSH masterplan work has focused on producing the strategic outline case (SOC) for the Phase 4 investment. This will be presented at the February strategy day.

1.4 Projects continue to be delivered within the existing estate outside of the main redevelopment work. The Theatre 10 upgrade was completed in November 2015. The first phase of the Southwood expansion project was completed in January, with the relocation of Puffin Ward to the Variety Club Building.

1.5 Following several years of updating the GOSH Sustainability Development Management Plan the hospital is undertaking a full review of our strategy and approach to this important issue. Stakeholder engagement is currently in progress. The revised SDMP will be presented to the board for discussion and approval later this year.

2.0 Premier Inn Clinical Building (PICB)

2.1 The PICB project is making good progress. As has been previously described the logistical challenge of this complex job is great and the risk of impacting GOSH clinical operations has always been significant. To date this element of the project has been managed well with very close engagement with key clinical teams, specifically the imaging team located on Level 1 of Cardiac Wing (CW). The project has reached the milestone where the new building is now watertight. This means that, although not eliminated, the risk of impacting on services has been reduced. Works do continue above L1 CW and the same level of management rigour will continue to be applied to ensure services are not affected by the project.

2.2 The programme is six weeks behind the contract programme. This time was lost during the early ground works. The project at one point was nine weeks behind programme so time has been gained and project delivery is stable. There are further opportunities to gain time and it is likely that the final outcome will show an improvement on the current position. The project is within budget.

2.3 The operational commissioning group that will lead the move into the PICB has been established and is meeting regularly. This is chaired by a Divisional Director and Head of Nursing to ensure there is proper clinically led engagement in the planning and delivery of the commissioning activities.

3.0 Zayed Centre for Research into Rare Disease in Children

3.1 The centre was officially named at an event held at Coram's Fields in September 2015. This followed the signing of the donation agreement confirming the gift from Her Highness Sheikha Fatima bint Mubarak, the wife of the late Sheikh Zayed bin Sultan Al Nahyan.

3.2 Design development is largely complete. Stage F design was completed in September 2015 but subsequent work has identified opportunities to refine and optimise the design from the construction and cost perspectives. The design team are incorporating these changes into the design. The design of the GMP laboratory is behind the rest of the building. An independent review in summer 2015 identified several potential concerns (and opportunities) related to MHRA accreditation of this facility. A revised design has been worked up, which has been reviewed by the MHRA and is now considered to be robust and will achieve the required regulatory approval.

3.3 The demolition of the existing building at 20 Guilford Street, to basement level, was completed to programme in December 2015.

3.4 The procurement of the main contractor was due to be completed by the end of 2015. However, although negotiations were useful and productive it became clear in October and November 2015 that it was not going to be possible to reach agreement on some key issues. It was therefore agreed to end discussions and that GOSHCC would seek a new main contractor to undertake the works. A programme is in place for the revised procurement and discussions are underway with a number of potential contractors. This is a significant change to the procurement plan and it creates some risk. However, the decision was taken after substantial consideration of all factors and is considered overall to be in the best interests of the ZCR.

3.5 The next stage of works can be delivered as a standalone contract in parallel with the selection of the main contractor. The project is very close to agreeing a contract for these works which will enable progress to be made in year and the overall project timetable to largely be maintained.

4.0 GOSH Masterplan 2015

4.1 Following the approval of the GOSH Masterplan 2015 as the preferred strategic approach to future redevelopment at GOSH there has been on-going work to develop the Phase 4 investment case. This will be presented in the form of a Strategic Outline Case (SOC) the first stage in the business case process. The SOC is being finalised and the intent is to present this for discussion at the February strategy day.

5.0 Projects

5.1 Outside of the main redevelopment works there are a number of projects delivered by the major projects team to support our clinical services and key strategic priorities. In October 2015 the upgrade of Theatre 10 to our first inter-operative theatre was completed. The first patient was treated in early November 2015. The work to provide additional capacity in Southwood to support our International Private Patient work continues. The first stage of this work was completed in January with the transfer of the same day admissions unit from Southwood to the Variety Club Building.

6.0 Queen's Square Neurosciences Project

6.1 University College London continues to lead on this project. The project has gained some momentum with the recent announcement of investment to create a Dementia Research Institute. GOSH continues to take part in discussions and the Trust Board will be kept informed of progress.

7.0 Sustainability Development Plan

7.1 Ensuring that GOSH delivers services in a manner that is consistent with our environmental and sustainability commitments has been an agreed objective and priority for some time. GOSH was an early adopter of developing and following a Sustainability Development Management Plan (SDMP) and supporting the establishment of the NHS Sustainability Development Unit (SDU). However, the SDMP is somewhat dated and it is appropriate to have a thorough review of our approach to sustainability and delivering our statutory and non-statutory requirements.

7.2 We have appointed an organisation called Carbon Credentials to support us in the development of our new SDMP. Stakeholder engagement commenced late last year and continues with a number of workshops in January. A draft plan will be developed during February for consultation and subsequent approval.

7.3 Our energy performance continues to improve. GOSH is on target to deliver an 8% reduction in energy use compared to 2014/15 with an associated financial saving of circa £180,000. The continued improvement is reflected in the annual Display Energy Certificate where we have improved to "E" for the first time from "G" in 2009 and "F" in 2012.

Matthew Tulley
Director of Redevelopment
18th January 2016

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
27th January 2016

Responsible Officer Appointment **Submitted by:** Vinod Diwakar, Medical Director	**Paper No: Attachment 7**

Aims / summary

The Medical Profession (Responsible Officer) Regulations came into force on 1 January 2011. They were amended on 1 April 2013. The regulations require all designated bodies to nominate or appoint a responsible officer (RO).

Duty to nominate or appoint responsible officers

(1) Subject to the following provisions of this regulation, every designated body must nominate or appoint a responsible officer.

(2) The Board must nominate or appoint a sufficient number of responsible officers.

(3) When a responsible officer nominated or appointed in accordance with paragraph (1) or (2) ceases to hold that position, subject to paragraph (4), the designated body must nominate or appoint a replacement as soon as reasonably practicable.

(4) When a responsible officer nominated or appointed in accordance with paragraph (2) ceases to hold that position, the Board is not required to nominate or appoint a replacement if, in its opinion, there remains a sufficient number of responsible officers appointed or nominated under that paragraph.

The responsible officer will be answerable to the GMC and his or her nominating or appointing organisation for ensuring that there are appropriate systems and processes in place for collecting and holding information that informs the evaluation of fitness to practise. This will include ensuring there are robust systems of appraisal in place to support doctors in improving their practice. Where conduct or performance is falling below the usual high standards that doctors are expected to work to, it is important to identify them early and take the appropriate action to avoid potential harm to patients and to support doctors to get back on track. It is the responsibility of the organisation to ensure that these systems are properly resourced, reviewed and maintained.

The role of the responsible officer will primarily be to ensure that systems within his/her organisation support doctors in delivering quality care that is constantly improving. Where a doctor falls below the standards set, the responsible officer will need to ensure that appropriate action is taken to bring the doctor back on track while ensuring the safety of patients.

Action required from the meeting
The Board is asked to **ratify** the appointment of Dr Vinod Diwakar, Medical Director as Responsible Officer from 11th January 2016.

Contribution to the delivery of NHS Foundation Trust strategies and plans
High quality appraisal processes are key to the continuation of GOSH as a world class children's hospital.

Financial implications
Who needs to be told about any decision? All GOSH employed Doctors
Who is responsible for implementing the proposals / project and anticipated timescales? Chief Executive
Who is accountable for the implementation of the proposal / project? Chief Executive

ATTACHMENT 6

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council update

A Members' Council meeting was held on Wednesday, 30th September 2015

The Council noted that the Trust was managing an emerging risk around the 18 week referral to treatment (RTT) metric. An external investigation was taking place to review the quality of the Trust's data and RTT and related diagnostic reporting had been paused for a defined period. It was confirmed that any cases where patients were found to have waited longer than the national standard were being addressed urgently. Work was underway to map the use of RTT data throughout the Trust to ensure it was not being relied upon elsewhere in the organisation and fortnightly tripartite meetings were taking place with NHS England and Monitor to track progress.

Councillors asked for assurance that International and Private Patient (IPP) services were not adversely affecting NHS patients. The Chief Executive agreed with the importance of the issue and said that if additional capacity was required in response to the RTT issue, then the level of IPP activity may need to be reviewed. It was noted that recent capacity issues in cardiac and ICU meant that the impact of IPP work had recently been reviewed but no adverse effects had been found.

Councillors expressed some concern about the change in process for Executive Safety Walkrounds which had made it more difficult for Councillors to take part. Walkround updates would be provided by exception through the Clinical Governance Committee update to the Council.

A presentation was given on the results of the first national CQC inpatient survey results, the action plan for which would be monitored through the Patient and Family Experience and Engagement Committee. It was noted that none of the specialist children's hospitals had appeared in the top five performing Trusts and contact would be made with other Trusts who had performed better. The top performing Trusts were generally very different types of Trust to GOSH.

The Council received a presentation about research performance at GOSH based on Thompson Reuters' bibliometric analysis of research papers - an objective way to benchmark academic output internationally. He said that GOSH/ICH publication citation impact had increased significantly between 2008-12 and 2010-14, with the partnership becoming the leading organisation.

An update was provided on the Members' Council subgroup on the International Private Patient Strategy. The group had discussed the Trust's wish to minimise dependency on the Middle Eastern market for education and training consultancy in order to spread risk. It was agreed that it was important to encourage GOSH Consultants who did private work at other hospitals to bring this work to GOSH but it was noted that that this would require a guarantee that the space and capacity was available so that patients could be seen quickly.

The Council considered and approved the Membership and Engagement Strategy.

The Council discussed and approved the process for the appointment of a Non-Executive Director to the GOSH Board.

It was reported that there had been an increase in central venous line (CVL) infections. Each case had been reviewed and no common themes had been found however training on the associated care bundle had been re-established and the Trust was auditing compliance with this. An increase was also noted in the number of arrests outside ICU. In a number of cases the early warning score for arresting patients had been normal so it would be important to review the validity of the type of early warning system used at GOSH.

The Council noted a fall in compliance with the cancer waiting time as a result of one patient whose treatment was rescheduled following the breakdown of a scanner. The case was being reviewed to look at lessons learnt.

It was reported that the process for closing beds had been tightened and all closures now required the approval of the Interim Chief Operating Officer. Where requests were made to close beds it was often due to nursing staff numbers however work was on-going to recruit and retain nurses.

The Chief Finance Officer reported that the Trust's deficit was currently better than plan as a result of non- recurring income and cash levels were good due to delayed capital payment. The Trust had experienced a significant increase in drugs costs which was not matched by the increase in patient activity due to a small number of patients who required extremely expensive drugs. An increase of a few of these patients would disproportionately increase the Trust's drugs costs.

The Council discussed the technical issues which had led to attendees on the telephone being disconnected from the meeting for a time. It was agreed that work would take place prior to the next meeting to look at ways to minimise this risk.

It was agreed that the Director of HR and OD would consider the way in which an Always Values update would be given at the Council meeting in future.

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council update

A Members' Council meeting was held on Wednesday, 25th November 2015

The Members' Council discussed the causes of cancelled admissions and surgery and noted the number of complaints in this area. It was reported that there was currently significant pressure on bed capacity, however following work to look at surgical cancellations it had been shown that one reason for cancellation was patient illness. Further work was required to ensure that pre-operative assessment is working as optimally as possible. Opportunities were being created by the current access improvement project to ensure that all parts of patient flow were as efficient as possible.

Discussion took place about the increase in the number of patient arrests which was small in terms of absolute numbers however all cases had been reviewed and learning gathered. It was reported that 75% of arrests did not trigger the Trust's early warning system and it was important to ensure that system being used was appropriate.

Concern was expressed around the change to the Friends and Family Test (FFT) completion rate which had previously been incorrectly calculated. It was reported that rather than being symptomatic of a wider date issues, the error was an isolated incident resulting from the Trust taking too long to change processes following a change in the way the FFT response rate should be calculated.

In response to Councillor queries it was confirmed that agency spend had increased as a result of the additional staff required to support the access improvement project.

The Council emphasised the importance of ensuring that the focus remained on the impact on GOSH patients as a result of the Trust's current data issues and of ensuring that patients were treated on the basis of need rather than waiting time.

The Council received a presentation on the Evening Standard and Independent Christmas appeal which involved a large number of articles in newspapers along with coverage on one television channel.

Discussion took place about the important issue of cyber security and the Council noted that this matter was also due to be discussed at the January 2016 Audit Committee meeting.

The Council received an update from the Clinical Governance Committee including an update on the Gastroenterology review. It was noted that the play service had been discussed and the Members' Council highlighted the importance of the service and the continued emphasis on play even at times of capacity constraints.

The Committee discussed the Trust's high cost base compared with other NHS organisations and noted that it was driven by being in central London and a high drugs bill in association with GOSH's unique case mix.

It was reported that both the Young People's Forum and the Food Group had been looking at meal times on wards and ensuring they were appropriate, particularly for older patients.

It was noted that as in previous years, the Council would be involved in selecting an indicator to be reviewed by the auditors as part of the Quality Report although this would be done by email as Monitor guidance had not yet been issued.

The Council discussed the issue of telephone calls made to teams being unanswered, which had been highlighted by the PALS report, and potentially outsourcing phone lines. Significant investment had been made in outpatients however there was a clear need to balance clinical and administration staff.

The reappointment of Professor Rosalind Smyth as the UCL representative on the GOSH Board was approved.

The Council approved the appraisal process for the Chairman and Non-Executive Directors subject to an amendment to include mention of the Members' Council under 'team working'.