Great Ormond Street Hospital for Children NHS Foundation Trust

# Meeting of the Trust Board
# Friday 1st April 2016

Dear Members

There will be a public meeting of the Trust Board on Friday 1st April 2016 at 12:45pm in the **Levinsky Room,** Institute of Child Health, 30, Guildford Street, WC1N 1EH.

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

## AGENDA

| | Agenda Item<br>STANDARD ITEMS | Presented by | Author | Attachment |
|---|---|---|---|---|
| 1. | **Apologies for absence** | Chairman | | |
| **Declarations of Interest**<br>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 27th January 2016** | Chairman | **Decision** | **J** |
| 3. | **Matters Arising/ Action Checklist** | Chairman | **Discussion** | **K** |
| 4. | **Chief Executive Report** | Chief Executive | **Information** | **Verbal** |
| | **STRATEGIC ISSUES** | | | |
| 5. | **Annual Plan 2016/17** | Interim Chief Finance Officer | **Decision** | **M** |
| 6. | **Update on access improvement programme** | Deputy Chief Executive | **Information** | **N** |
| | **PERFORMANCE** | | | |
| 7. | **Quality and Safety Report** | Chief Nurse | **Discussion** | **O** |
| 8. | **Targets and Activity Report** | Deputy Chief Executive | **Discussion** | **2** |
| 9. | **Workforce Summary Report** | Director of HR and OD | **Discussion** | **P** |
| 10. | **Finance Summary Report** | Interim Chief Finance Officer | **Discussion** | **Q** |
| 11. | **Infection Control Report** | Director of Infection Prevention and Control | **Discussion** | **R** |
| 12. | **Safe Nurse Staffing Report**<br>• **January 2016**<br>• **February 2016** | Chief Nurse | **Discussion** | **S** |
| 13. | **2015 Annual Staff Survey Results** | Director of HR and OD | **Information** | **T** |

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| **14.** | **Risk Management Strategy** | Company Secretary | **Decision** | **U** |
| | **GOVERNANCE** | | | |
| **15.** | **Register of Interests**<br><br>**And**<br><br>**Register of Gifts and Hospitality** | Company Secretary | **Information** | **V**<br><br><br><br>**W** |
| **16.** | **Members' Council Update – January 2016** | Company Secretary | **Information** | **X** |
| **17.** | **Update from the Audit Committee in January 2016** | Chair of the Audit Committee | **Discussion** | **Y** |
| **18.** | **Update from the Clinical Governance Committee in February 2016** | Chair of the Clinical Governance Committee | **Discussion** | **Z** |
| **19.** | **Update from the Finance & Investment Committee**<br>• **January 2016**<br>• **February 2016**<br>• **March 2016 (verbal)** | Chair of the Finance and Investment Committee | **Discussion** | **1** |
| **20.** | **Any Other Business**<br>(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**<br>The next Trust Board meeting will be held on Friday 20th May 2016 in the Charles West Room, Great Ormond Street, London, WC1N 3JH. | | | |

ATTACHMENT J

Great Ormond Street Hospital for Children NHS Foundation Trust

**DRAFT Minutes of the meeting of Trust Board on 27th January 2016**

**Present**

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| 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 |
| Mr Bill Boa | Interim Chief Finance Officer |

**In attendance**

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| Mrs Claire Newton | Interim Director of Strategy and Planning |
| Mr Matthew Tulley | Director of Redevelopment |
| Ms Cymbeline Moore* | Director of Communications |
| Professor David Goldblatt | Director of Research and Innovation |
| Ms Emma Pendleton | Deputy Director of Research and Innovation |
| Professor Maria Bitner | Professor of Clinical and Molecular Genetics |
| Mr Peter Hyland | Interim Director of Planning and Information |
| Dr Anna Ferrant | Company Secretary |
| Ms Victoria Goddard | Trust Board Administrator (minutes) |

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

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| **201** | **Apologies for absence** |
| 201.1 | Apologies for absence were received from Mr Robert Burns, Director of Planning and Information. |
| **202** | **Declarations of Interest** |
| 202.1 | No declarations of interest were received. |
| 203 | **Minutes of previous meeting** |
| 203.1 | The minutes of the meeting held on 25th November 2016 were **approved**. |
| **204** | **Matters Arising/ Action Checklist** |
| 204.1 | The actions taken were noted. |
| **205** | **Chief Executive Report** |
| 205.1 | Dr Peter Steer, Chief Executive gave an update on the following matters: |

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| | • The Executive Team restructure was almost complete and Mr Bill Boa had been welcomed to the role of Interim Chief Finance Officer. Mrs Claire Newton had taken on the role of Interim Director of Strategy and Planning.<br>• Mr Robert Burns, Director of Planning and Information had sadly taken up retirement due to ill health. The Board wished him well and thanked Mr Ali Mohammed, Director of HR and OD and Mr James Devine, Deputy Director of HR and OD for their work to support Mr Burns.<br>• Ms Rachel Williams, Chief Operating Officer had tendered her resignation and would be taking up a new role as Chief Operating Officer at Kingston Hospitals NHS Foundation Trust.<br>• Ms Loretta Seamer has been appointed as Chief Finance Officer and would be taking up the post on 1st April 2016.<br>• Excellent media attention had been paid to the 100,000 genomes project and GOSH was continue to work well in partnership with other organisations and to lead in appropriate areas.<br>• Good work had taken place during the Junior Doctor strike in order to ensure that patients were safe.<br>• An index case of measles had been reported and ward and infection control staff had worked together well to investigate it and manage it.<br>• A visit to GOSH had taken place by the Chancellor of the Exchequer, the Secretary of State for Health, the Mayor of London and the Chief Executive of NHS England to announce a new £800 million boost to biomedical research through the National Institute for Health Research (NIHR)<br>• RTT continued to be a pressing issue for the Trust and a further update was being provided later on the agenda |
| **206** | **Annual planning process** |
| 206.1 | Mrs Claire Newton, Interim Director of Strategy and Planning said that a draft annual plan must be submitted by 8th February 2016. She added that the template was very prescriptive and had been structured for a typical acute Trust so GOSH would be introducing some bespoke items. |
| 206.2 | It was confirmed that the Finance and Investment Committee would hold an extraordinary meeting by telephone to discuss the draft plan prior to submission. |
| **207** | **Update on access improvement work** |
| 207.1 | Ms Dena Marshall, Interim Chief Operating Officer said that good progress was being made in a number of areas and lots of work had taken place to cleanse data. Ms Marshall said that an accurate Patient Tracking List (PTL) was in place and validation of open pathways had begun. |
| 207.2 | It was reported that the longest waiting patients would be treated by the end of February 2016 with the exception of specialties where there was a capacity shortfall that had been agreed with commissioners. |
| 207.3 | Four of five divisions were now tracking patients to 18 weeks and plans to ensure all relevant staff had been trained in RTT by 1st April was in place. |
| 207.4 | Ms Marshall said that despite the fact that the highest risk patients' pathways were being validated no concerns around quality and safety had been found. |

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| 207.5 | <u>Demand and Capacity</u> |
| 207.6 | Mr Peter Hyland, Interim Director of Planning and Information gave a presentation on the demand and capacity models that had been mapped across most divisions to support mapping patient pathways. He said that this work would show the sustainable capacity surplus or deficit in each area and the waiting list backlog by each defined pathway. |
| 207.7 | Mr Hyland said that the Surgery Division was currently the most challenging position and MRI had always been challenging however as the third scanner was now operational, capacity was balanced. Areas without a sustainable solution had been escalated to commissioners and Mr Hyland said that there were some specialist areas with significant capacity gaps based on demand. |
| 207.8 | Mr Hyland said that demand and capacity models would be triangulated with bed capacity and would be used to develop recovery plans for capacity constraints. |
| 207.9 | The Board discussed progress that was being made towards 7 day working. Dr Vinod Diwakar, Medical Director said that the Trust was required to offer 7 day emergency services which it did, however it had been found that elective work over seven days would be very expensive and may not provide sufficient benefits to the Trust. He said that it would be important to reconsider this in light of current capacity constraints. Dr Diwakar said that three-session days had also been considered and emphasised that working efficiently would be equally as important. |
| 207.10 | Ms Marshall said that considerable work would be required to join this work to the findings of the Productivity and Efficiency review to develop an operating strategy. |
| 208 | **CQC Inspection Report** |
| 208.1 | Dr Anna Ferrant, Company Secretary said that GOSH had been inspected in April 2015 and inspectors had subsequently returned for an unannounced inspection. The report had been published on 8th January 2016 and the Trust had received a rating of 'good' which was very positive. Dr Ferrant said that many of the findings in the report were exemplary particularly around openness, compassion and partnership working. Of eight services which had been inspected, two had received an 'outstanding' rating. |
| 208.2 | Dr Ferrant said that surgery and outpatients had received a rating of 'requires improvement' primarily as a result of the Trust's RTT issues, however Dr Ferrant emphasised the excellent work which was also taking place in those areas. |
| 208.3 | Nine formal recommendations had been made, three of which were around access improvement for which significant work was already underway. |
| 208.4 | The Board emphasised the importance of conveying thanks to those staff who had been engaged in the process. Mr Ali Mohammed, Director of HR and OD said that this had been raised at all open staff meetings and team briefs since the publication of the report. |
| 208.5 | Ms Yvonne Brown, Non-Executive Director noted that mandatory training completion rates had not been as good as anticipated. She asked for a steer on the work being undertaken to improve this. |
| 208.6 | Mr Mohammed said that this was being taken seriously and the team would be |

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| | exploring the types of training that was currently being offered and its relevance to job roles. |
| 209 | **Research and Innovation Update** |
| 209.1 | Professor David Goldblatt, Director of Research and Innovation said that the Biomedical Research Centre (BRC) BRC Competition (2017-2022) invitation to submit a pre-qualifying questionnaire (PQQ) had been announced at GOSH in December during a visit by Sir Simon Stevens, the Chancellor of the Exchequer and the Mayor of London. Professor Goldblatt said that NIHR GOSH BRC received the eighth largest allocation of funding but were ranked substantially higher than eight in a large number of research outcome measures. |
| 209.2 | Professor Bitner, Professor of Clinical and Molecular Genetics said that GOSH was continuing to work on the 100,000 genomes project and was contributing the largest number of patients to the project. She said that GOSH was the leader of the North Thames Genomic Centre. |
| 209.3 | Ms Mary MacLeod, Non-Executive Director asked for a steer on the drivers to developing generic consent. |
| 209.4 | Professor Goldblatt said that there needed to be a clear trail of consent to use residual material for example blood after tests had been completed. He said it was important to be able to trace consent to the sample and the laboratory must be clear that consent for a particular sample had been given. |
| 209.5 | Dr Vinod Diwakar, Medical Director emphasised the importance of the work and its potential benefit to patients. He said it was a vital part of GOSH's strategic planning. |
| 209.6 | The Board congratulated the team involved in the 100,000 genome project for their outstanding work. |
| 210 | **Equality and Diversity Annual Report 2015** |
| 210.1 | Ms Juliette Greenwood, Chief Nurse said that six objectives had been proposed: three that would benefit patients and families and three to benefit staff. She said that objective three was around transition and would feed into the CQC action plan. Ms Greenwood said that the Trust would be publishing equality information on the website from the end of January 2016. |
| 210.2 | Mr Ali Mohammed, Director of HR and OD said that delivery of objective 5 around bullying and harassment, and objective 6 on the representation of BME staff in senior posts was challenging and the Trust was aiming to put in place practical steps which would have a positive impact. |
| 210.3 | The Board welcomed the thorough work. |
| 211 | **Summary of performance for the period:** |
| 211.1 | <u>Quality and Safety</u> |
| 211.2 | Dr Vinod Diwakar, Medical Director said that there had been an increase in respiratory arrests earlier in the year due to a combination of the time of year and |

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| | the patients who had been admitted, who tended to have breathing problems. He said that the increase had highlighted the need to improve protocols for managing these patients and the Resuscitation Committee was working on this. |
| 211.3 | Dr Diwakar said that progress continued to be made with the discharge summary completion rate however performance remained variable. He added that the quality of summaries was being reviewed in one division. |
| 211.4 | Targets and Indicators |
| 211.5 | Ms Dena Marshall, Interim Chief Operating Officer noted the increase in hospital acquired infections and said that a root cause analysis was conducted by the infection prevention and control team for each case. |
| 211.6 | It was reported that there had been a downturn in activity in December due to the number of public holidays in the period. Ms Marshall confirmed that, following a Board request, she had reviewed all planned activity throughout the Christmas period to ensure that the best and most efficient use was being made of capacity. |
| 211.7 | A deterioration was noted in the cancer 'decision to treat to subsequent treatment' metric which had been reduced as a result of a breach of patient whose family had made the decision to postpone treatment until after their child's birthday. |
| 211.8 | Mr David Lomas, Non-Executive Director queried the time scale for the improvement of clinic letter turnaround times. |
| 211.9 | **Action:** Dr Diwakar said that this was being reviewed in detail with divisions on a monthly basis. Discussion had taken place about whether a 5 day target was appropriate and consideration had been given to changing the target to 7 days which would allow for tests results to be added and multidisciplinary team meetings to discuss letters if necessary. It was emphasised that if the target was renegotiated with commissioners it was vital that the Trust worked hard to achieve the revised target. It was agreed that further discussion would take place on this subject. |
| 211.10 | Baroness Blackstone said that the Trust's staff turnover rate continued to be RAG rated red and queried whether the target was achievable. |
| 211.11 | Mr Ali Mohammed, Director of HR and OD said that the Trust monitored two metrics which were at 14% and 18%. The difference between these two numbers was turnover of staff on fixed term contracts. Mr Mohammed said the he believed 18% to be a more achievable target. He said that unusually, there was no relationship between sickness, turnover and agency usage and the Board noted the very low level of staff sickness. |
| 211.12 | Dr Peter Steer, Chief Executive emphasised the inefficiency and expense of maintaining a high level of turnover and said that given this cost, it was important to revisit the drivers to ensure nothing had been overlooked. |
| 211.13 | **Action:** Baroness Blackstone, Chairman said that a lot of work had been done around nurse turnover and retention and acknowledged that they were a key part of the hospital's staff but suggested that it was important to also have visibility of other staffing groups. It was agreed that a more in depth analysis of staff turnover would be presented at the next meeting. |
| 211.14 | Workforce |

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| 211.15 | Mr Mohammed said that PDR rates continued to decline across the Trust and discussion would take place on this issue at the Senior Team Meeting later in the week. |
| 211.16 | Mr Charles Tilley, Non-Executive Director emphasised the importance of appraisals and PDRs and said it was important to understand what was driving the low completion rate. |
| 211.17 | Ms Yvonne Brown, Non-Executive Director raised the issue of nursing revalidation and the requirement to complete appraisals and mandatory training. Ms Juliette Greenwood, Chief Nurse said that nurse revalidation would begin in April and would drive nursing appraisals. |
| 211.18 | **Action:** It was agreed that this would be discussed at a future meeting with a view to ensuring PDR completion rates had improved. |
| 211.19 | <u>Finance</u> |
| 211.20 | Mr Bill Boa, Interim Chief Finance Officer said that the Finance and Investment Committee had scrutinised the detail of the proposed financial plan. He said that the Trust was on plan to deliver the projected outturn of £11.2million deficit. |
| 211.21 | Mr Charles Tilley, Non-Executive Director said that creditor days had received media attention recently and asked for assurance that the Trust was not at risk of breaching any relevant regulations. |
| 211.22 | **Action:** It was agreed that Mr Boa would look into this further and provide an update at the next meeting. |
| 212 | **Monitor Self Certification Q3 2015/16** |
| 212.1 | Mr Bill Boa, Interim Chief Finance Officer said that the Trust was not able to confirm compliance with RTT targets and was not reporting against the target. He said that due to issues with referral information received by the Trust, GOSH could also not confirm the achievement of 62 day cancer waits. It was likely that cancer access standards, although not yet finalised, would be achieved against two of three indicators due to a breach of one patient for the 'decision to treat to subsequent treatment' (surgery) indicator due to a family's choice to delay treatment. |
| 212.2 | The Board **approved** the quarter three in year governance statement prior to submission to Monitor. |
| 213 | **Patient Experience Report** |
| 213.1 | Ms Juliette Greenwood, Chief Nurse reported that the Friends and Family Test data had been corrected and the team was now confident of the response rates although they were lower than previously thought. Feedback had shown that 98% of patients and families would recommend the Trust and all narrative comments were escalated to relevant managers. Ms Greenwood said that the aim was to provide collated feedback to the Patient and Family Engagement and Experience Committee (PFEEC). |
| 213.2 | **Action:** Mr David Lomas, Non-Executive Director noted that one of the themes of |

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| | complaints was around appointment cancellations and it was agreed that consideration would be given to having a visible metric for the number of cancelled appointments. |
| 213.4 | **Action:** The Board discussed the low percentage of responses received from the Friends and Family Test and noted that it was approximately 16,100 responses. It was reported that each patient visit was counted as being eligible to complete the survey and Ms Greenwood said that this was being discussed with other organisations as this skewed the percentage of responses provided. It was agreed that further discussion would take place outside the meeting about writing to NHS England. |
| 214 | **CQC Inpatient Survey Results** |
| 214.1 | Ms Greenwood said that the results of the survey had been provided in Summer 2015 and an action plan had been developed against the recommendations identified which would be monitored by the PFEEC. |
| 215 | **Safe Nurse Staffing** |
| 215.1 | Ms Greenwood said that a review was taking place of the guidance that brought in the safe nurse staffing report and this would impact the responsibilities of the Board. Ms Greenwood told the Board that a NICE requirement was to design work around safe nurse staffing and new workstreams had been implemented around safe and sustainable nursing guidance. |
| 215.2 | <u>November 2015</u> |
| 215.3 | Ms Greenwood said that there had been improved fill rates for both days and nights of 95% and no unsafe shifts had been reported. Bed closures had been maintained at a lower level and a number of new starters had been recruited; there were currently 79 vacant posts. |
| 215.4 | Ms Greenwood said that Flamingo Ward was experiencing a high level of pressure and acuity and a number of datix reports had shown the pressure that staff were experiencing. |
| 215.5 | <u>December 2015</u> |
| 215.6 | No unsafe shifts had been reported and fill rates remained high at 102%. 47 nurses had been recruited and had start dates. |
| 215.7 | Ms Mary MacLeod, Non-Executive expressed some disappointment that there had been grade 3 pressure ulcers however Ms Greenwood confirmed that there had been no hospital acquired grade 3 pressure ulcers in a number of months. |
| 216 | **Redevelopment Update** |
| 216.1 | Mr Matthew Tulley, Director of Development said that it had not been possible to agree a contractor for the Centre for Research into Rare Disease in Children (CRRDC) by the end of 2015. He said that the team which had been considered had changed and there were concerns around design and costs. Mr Tulley said that the Trust was in advanced discussions with a contractor to undertake the first part of the work and it was anticipated that the contract would be agreed in the coming |

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| | weeks. |
| 216.2 | Mr Tulley said that the Premier Inn Clinical Building had previously been 9 – 10 weeks behind plan and was now 5 – 6 week behind. He said that an agreement had been reached to enable changes to be made to level 2 of the building and to allow some outstanding time requested by Skanska. This had extended the project by 6 weeks and completion was now due in April 2017 with patients moving into the building in the summer of 2017. |
| 216.3 | **Action:** It was agreed that the Masterplan would be discussed at the February Strategy Day. |
| 217 | **Responsible Officer** |
| 217.1 | Dr Vinod Diwakar, Medical Director said that he had taken on the role of Responsible Officer following the stepping down of Dr Catherine Cale as Associate Medical Director. Dr Diwakar said that an appraisal lead would be appointed as a Deputy Medical Director and it was possible that as that role matured, there would the option to separate the role of the responsible officer from the Medical Director post. |
| 217.2 | The Board **ratified** the appointment of Dr Diwakar as responsible officer. |
| 218 | **Members' Council Update** |
| 218.1 | Dr Anna Ferrant, Company Secretary presented the updates which were noted. |
| 219 | **Update from the Audit Committee in January 2016** |
| 219.1 | Mr Charles Tilley, Chair of the Audit Committee confirmed that the report would also be covered in detail during the Members' Council meeting later in the day. He drew attention to the Data Quality Review which was being undertaken by KPMG and an extraordinary meeting of the Audit Committee was taking place in February to review the final report. |
| 219.2 | The Committee had particularly looked at an electrical failure which had taken place in the Trust and was being investigated as a serious incident. |
| 220 | **Update from the Finance & Investment Committee in January 2016** |
| 220.1 | Mr David Lomas, Chair of the Finance and Investment Committee said that the meeting had considered the projected outturn for 2015/16 and had agreed that it should be on plan. The Committee had looked at the forecast for 2016/17 and discussed whether this fitted the Trust's desired trajectory towards breakeven. It was confirmed that further teleconference meeting would take place prior to the submission deadline for the draft annual plan. |
| 221 | **Any other business** |
| 221.1 | Ms Mary MacLeod, Non-Executive Director asked for an update on recent IT outages and the potential impact on clinical care and the Trust's ability to treat patients in a timely fashion. |
| 221.2 | Ms Dena Marshall, Interim Chief Operating Officer said that one of the Trust's |

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| | systems Carevue had gone down overnight and the IT team had been deployed during the night and had brought in the provider who had been working throughout the weekend and the week so far. |
| 221.3 | Ms Marshall said that contingencies were in place but it had not been anticipated that papers systems would be required for much longer. |
| 221.4 | Dr Peter Steer, Chief Executive emphasised that patients were safe but said that the current paper based system was inefficient. He said it was important to involve the provider at the earliest opportunity to ensure issues were fixed as soon as possible. |

ATTACHMENT K

Attachment K

**TRUST BOARD – PUBLIC ACTION CHECKLIST**
**March 2016**

| Paragraph Number | Date of Meeting | Issue | Assigned To | Required By | Action Taken |
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| 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 | Agreed at February Board Strategy Day |
| 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 | This will now be monitored via the Clinical Governance Committee |
| 211.9 | 27/01/16 | Discussion had taken place about whether a 5 day target was appropriate for clinic letter turnaround and consideration had been given to changing the target to 7 days which would allow for tests results to be added and multidisciplinary team meetings to discuss letters if necessary. It was emphasised that if the target was renegotiated with commissioners it was vital that the Trust worked hard to achieve the revised target. It was agreed that further discussion would take place on this subject. | VD/ DM | March 2016 | Actioned and included in the targets and activity report |
| 211.13 | 27/01/16 | It was agreed that a more in depth analysis of staff turnover would be presented at the next meeting. | AM | March 2016 | On agenda- included with workforce report |

Attachment K

| Paragraph Number | Date of Meeting | Issue | Assigned To | Required By | Action Taken |
|---|---|---|---|---|---|
| 211.18 | 27/01/16 | It was agreed that PDR completion rates would be discussed at a future meeting with a view to ensuring they had improved. | AM | May 2016 | Not yet due |
| 211.22 | 27/01/16 | It was agreed that Mr Boa would look into creditor days further to ensure the Trust was not at risk of breaching legislation and provide an update at the next meeting | BB | March 2016 | Mr Boa provided an update to the Audit Committee Chairman, Charles Tilley between meetings |
| 213.2 | 27/01/16 | It was agreed that consideration would be given to having a visible metric for the number of cancelled appointments. | DM | March 2016 | Work is on-going to review the integrated performance report for the Board and this metric will be considered as part of this review. . In the short term it is being explored what appropriate metric can be included for the new financial year. An update will be provided in May 2016 |
| 213.4 | 27/01/16 | It was agreed that further discussion would take place outside the meeting about writing to NHS England about a patient being eligible at each visit to complete the Friends and Family Test. | JG | May 2016 | Not yet due |
| 216.3 | 27/01/16 | It was agreed that the Masterplan would be discussed at the February Strategy Day. | MT | February 2016 | Actioned at the February Strategy Day on 24th February |

Attachment M

Great Ormond Street Hospital for Children NHS Foundation Trust

| Trust Board<br>1st April 2016 | |
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| **Annual Plan 2016/17 – Public Version**<br><br>**Submitted by:** Claire Newton, Interim Director of Strategy and Planning | **Paper No: Attachment M** |
| **Aims / summary**<br>To present the Annual Plan narrative submission.<br><br>NHS Improvement will publish this document on their website. The content must be consistent with the detailed plan to be submitted to NHSI but we are allowed to exclude commercially sensitive information.<br><br>This separate document should be written for a wide audience. As a result the document is shorter than the detailed version (8 pages rather than 15) but includes additional contextual information about the hospital. | |
| **Action required from the meeting**<br>Approve the public version of the GOSH Operating Plan for 2016/17 | |
| **Contribution to the delivery of NHS Foundation Trust strategies and plans**<br>A core part of the annual planning process set by NHS Improvement | |
| **Financial implications**<br>These are discussed within the paper | |
| **Who needs to be told about any decision?**<br>NHS Improvement | |
| **Who is responsible for implementing the proposals / project and anticipated timescales?**<br>Interim Director of Strategy & Planning | |
| **Who is accountable for the implementation of the proposal / project?**<br>The Chief Executive Officer | |

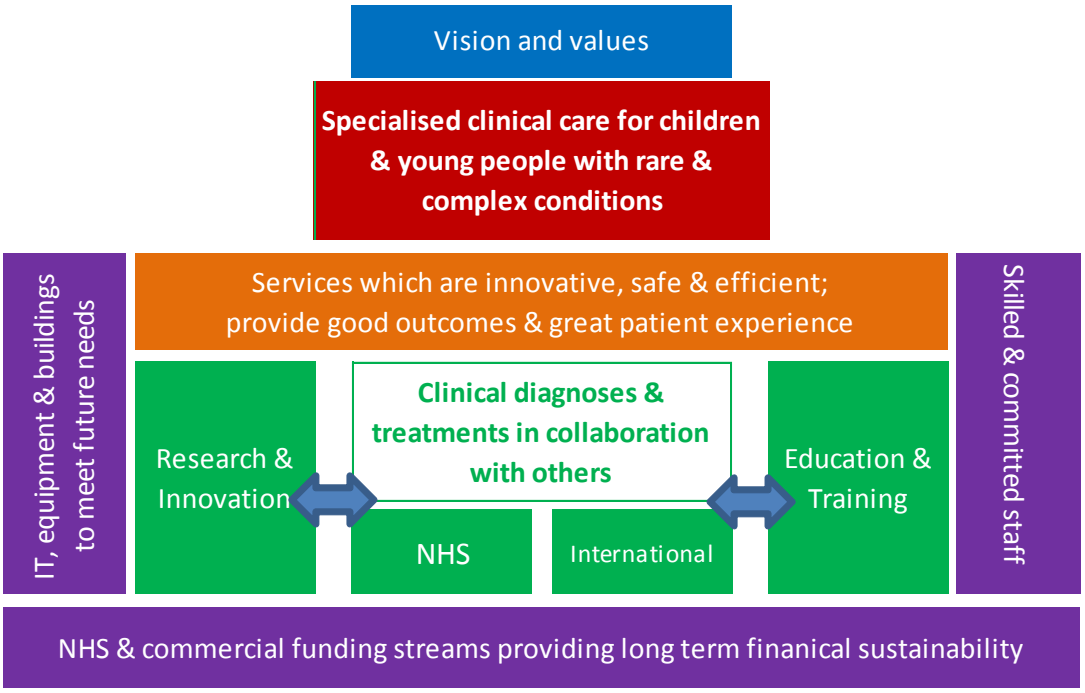
Attachment M

# Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH)
# DRAFT PUBLIC Annual Operational Plan 2016/17

## 1 Introduction

Our vision is to be the leading children's hospital in the world. This will only be possible with the continuing commitment of our highly skilled and knowledgeable staff and the close working relationships with our partners: the UCL Institute of Child Health and the GOSH Children's Charity.

We are a hospital which specialises in caring for children and young people with complex and rare illnesses or disabilities. We do not have an A&E Department, and we accept mainly specialist referrals of patients from other hospitals and community services. The following diagram shows our key activities; how these activities combine to deliver our vision; and how they are supported by the key enabling resources of staff, funding, information technology and physical assets.




The key outcomes we aim to deliver are as follows:

- World class ***clinical outcomes*** for patients in all our specialised services
- High levels of ***patient satisfaction*** with our services
- Use of our ***research*** to develop new and innovative specialist treatments for children with complex or rare diseases
- A wide-ranging education programme of ***specialist paediatric training***
- ***Financially sustainable*** activities
- A hospital for the NHS to be proud of.

# 2 Planning for our services in 2016/17

## 2.1 Our forecasts of patient activity in 2016/17

During 2015/16 GOSH has been working closely with its commissioner, NHS England Specialised Commissioning ("NHSE SC"), and Monitor to address the challenges and requirements to delivering waiting list targets. The complex nature of the services delivered at GOSH and the on-going actions and plans addressing the Trust's legacy data issues mean that this is an iterative process. The funding challenges for specialised services are a major risk for the Trust due to the fact that 90% of the Trust's activity is specialist which means that these challenges are more concentrated in GOSH.

In setting the patient activity plan for 2016/17, GOSH has started with its expected activity in 2015/16 and added known demographic and service changes and short term increases in activity to reduce long waiting lists. The Trust has recently developed a Demand and Capacity tool, which shows both capacity, expected demand and the capacity required to reduce waiting lists and ensure no subsequent build-up of long waiting patients.

A number of capacity constraints have already been identified. In collaboration with NHSE SC a selection of services have either been paused, referral criteria reviewed, or activity transferred, where possible, to alternate providers. In some cases there are capacity constraints nationally as GOSH is very often the provider of last resort in a number of areas.

The Trust intends to return to reporting against waiting list targets mid 2016/17. In the meantime resolving the process and data issues and reducing long waiters is one of the highest operational priorities in 2016/17.

## 2.2 Longer term activity planning

The Trust is working with NHSE SC on a strategic programme which will influence activity growth in some major priority areas for NHSE in future years. These include; congenital cardiac surgery, the London paediatric cancer review, paediatric critical care and further development of tertiary neurological services and Tier 4 inpatient CAMHS. The Trust is waiting for NHSE SC to issue policy documents in all of these areas and is also waiting for NHSE SC to issue the invitation to tender to provide genetic laboratory services.

## 2.3 Physical capacity changes

A new 10 bed inpatient ward is due to be opened in mid 2016/17 providing some relief to the current pressures on our beds. In addition further bed spaces will be created in existing ward areas.

Work continues on the Trust's major redevelopment programme with two construction projects progressing in 2016/17 for opening in 2018 and 2019 respectively. These are the new Inpatient wing, the Premier Inn Clinical Building, and an outpatient facility in the Zayed Centre for Research into Rare Diseases. In addition the Trust is commencing preparation of an outline business case for the next phase of the site redevelopment which would start in 2019 for completion in 2022.

## 2.4 RightCare

We are not actively involved in any RightCare programme as there are no tertiary paediatric initiatives, however we support the objectives of this programme.

# 3 Approach to quality planning

## *3.1* Our quality approach

Our quality approach addresses NHSI's "well-led" guidance in the following ways:

- The Trust has a clearly defined governance structure.
- The Board prioritises quality and safety through recurring agenda items addressing, safety indicators, patient complaints, incidents and safe nurse staffing.
- Each division has a risk action group attended by key managers and staff at all levels with clear action plans and follow up. Relevant clinical staff engage through the Patient, Safety and Outcomes; the Quality Improvement; and Patient, Family Experience and Engagement Committees chaired by the executive leads.
- The Trust is committed to learning from incidents which is achieved through regular Trust-wide communications and protected to share learning from other divisions.
- We seek to cultivate a spirit of openness between staff and between staff and patients and their families.
- Staff are motivated and encouraged to continually improve the quality of care we deliver through innovation and new ideas.

In addition our strategy includes the following quality related objectives:

- Our patients will receive timely access to services and the highest quality care, experience and health outcomes (No Waste, No Waits, Zero Harm).
- Our staff will have the skills required of them to continually improve and transform the organisation and support other providers in caring for children with complex conditions.
- We will measure our progress against UK and international comparators.

National and local commissioning priorities and other quality and safety indicators are reviewed at regular Clinical Quarterly Review Group meetings (CQRG) with commissioners.

## *3.2* Our three quality priorities for 2016/17

### *3.2.1 Addressing recommendations included in the CQC (and other external) reports*

In 2015 the CQC conducted a comprehensive inspection of the Trust and rated it as 'Good' overall, with 'Outstanding' ratings awarded for both the Effectiveness and Caring lines of enquiry. However, the report identified a number of actions to improve the quality of care as well as some opportunities for improvements. There are a number of activities that will continue into 2016/17 which include:

- work to ensure our systems operate effectively to enable us to assess, monitor and mitigate risks, particularly in relation to the management and recording of patient waiting lists.
- ensure observational WHO (World Health Organisation) checklist audits are completed for all operations.
- improve Trust-wide compliance against mandatory training targets.
- develop a dedicated advocacy service for patients within the Child and Adolescent Mental Health Service (CAMHS).

Some of the opportunities for improvement identified by the CQC that will be implemented in 2016/17 include:

- a comprehensive review of the gastroenterology service with a view to improve the responsiveness and quality of care provided.

- continuing the work to assess the current efficiency of operating theatres, with a view to create additional capacity to treat more patients.
- a number of records management improvement initiatives including the improving the timely availability of clinic notes and management of loose filing.

### *3.2.2 Introducing real time patient experience reporting*

The Trust is refreshing its strategy for engaging with patients, carers and other stakeholders and a key priority for 2016/17 is the introduction of a real time system for collecting patient and carer feedback.

### *3.2.3 Extending collection of clinical outcomes and safety measures and ensuring they are appropriately benchmarked*

In the past, our approach has been to define some clinical outcome measures for each specialty and publish them on our website. In order to ensure continuing improvement with outcome measurement and reporting we will:

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

In addition to the above three priorities, the Trust will be procuring and starting to implement an Electronic Patient Record System (EPR) for completion in 2018. There will be significant qualitative benefits of such a system both through the use of integrated technology, improved access to patient information, and also through the adoption of more standardised processes.

## 3.3 Top three risks to quality, together with the plans for mitigation

The three risks which may adversely affect our quality related objectives for which we have detailed action plans are:

- Difficulties in ensuring Timely access to services and meeting waiting list targets due to shortages of staff or beds in certain specialties.
- Ensuring our clinical cover out of hours cover appropriately addresses the complex case mix of our patients
- Recognition of the deteriorating child

## *3.4* Quality Improvement initiatives

The priorities of our Quality Improvement Programme are as follows:

- ***Enable delivery of our strategic objectives***
  - Enable change that will help us to achieve our strategic aims whilst also supporting innovation and creative ideas from the front line.
  - Align with other enablers of transformational change such as our redevelopment programme, electronic patient records and research and innovation.
- ***Facilitate continuous improvement in clinical outcomes and the experience of our children, young people and families***
  - Have a direct impact on outcomes, safety and the experience of patients and staff
  - Strengthen partnerships through co-leadership with patients and families
  - Transform operational management and business intelligence through the use of data

- ***Transform the culture of Great Ormond Street Hospital so that everyone is looking for ways to improve patient care every day***

### 3.5 Assurance that the Association of Medical Royal Colleges' guidance on the responsible consultant is being followed

In September 2015 a survey showed that over 95% of GOSH inpatients know the name of their lead consultant, their lead nurse, and that this information is visible and documented in the care plan. We plan to repeat this work as part of our 2016/7 audit plan.

### 3.6 Annual publication of avoidable deaths

In the future the Trust will publish avoidable deaths. All deceased patients are discussed at a Local Case Review Meeting, with an outcomes form completed and shared with the Trust-wide Mortality Review Group (MRG) which reviews all deaths in the hospital. Every case is then independently reviewed by the MRG within 8 weeks of the child's death. This provides a Trust-level overview of themes/risks which would be used to identify improvement actions where relevant.

### 3.7 Seven day services

GOSH does not have an A&E department and the majority of its Inpatient admissions are on an elective basis. Certain services such as paediatric critical care, Acute Transport and Non-elective surgery are staffed by consultants all days of the week; a Daycase Ward operates on a Saturday and some outpatient clinics are held on Saturdays. We have comprehensive on call arrangements, in some cases shared with other Trusts in order to ensure the Trust can access specialised skills at all times.

### 3.8 Triangulation of Indicators

Performance indicators and other qualitative and risk information are reported at Divisional Performance reviews and, for the Trust as a whole, at Board Assurance Committees and the Trust Board. Through this process, there is the opportunity to consider information coming from different sources ie internal reporting and external stakeholders (eg PALs, complaints, safety indicators, activity delivery and financial information) and identify potential linkages.
The Board has historically triangulated sources of quality performance data through the reports on incidents, complaints, claims, risks and productivity metrics.

## 4 Approach to Workforce Planning

### 4.1 Overview of the workforce planning process

The Trust undertakes workforce planning throughout the organisation as part of its business planning and operational activities. Based on the six step methodology, the plan is based upon the activity and finance planning cycle to establish demand requirements for the forthcoming years.
A gap analysis, in conjunction with a risk analysis, is carried out to support the Trust's business plans to meet the level of anticipated demand. New positions and business developments identified through this process are aligned with our operational plans and linked to the annual local education and training board (LETB) submissions. As the Trust is a major employer of specialist paediatric staff, we actively participate in the modelling of paediatric staff requirements for educational commissioning with the LETB.


## 4.2 Monitoring of workforce information

The Board regularly reviews HR/Workforce key performance indicators: benchmarkable metrics including staffing profile, voluntary and non-voluntary turnover, sickness, agency usage (as a percentage of paybill), vacancies and the number of up-to-date personal development reviews – by division. Where available, benchmark data is used to compare the Trust to other London Trusts to scan for local trends and deep-dive further.

This information is also reviewed at divisional level at the relevant performance meetings.

## 4.3 Organisational change; service developments and workforce productivity

The Trust is planning to introduce a new organisational management structure in 2016/17 with fewer clinical divisions and more integrated corporate support functions. This will result in more standardised support processes and resource levels. Service developments, either within the activity planning cycle, or outside are subject to scrutiny to ensure that the business cases are fit for purpose, have considered risk and mitigations, and retain or improve quality and outcomes. Organisational changes across the organisation are subject to similar considerations, prior and during consultations.

## 4.4 Staffing optimisation, Safe staffing and Use of temporary staff

The Trust utilises e-rostering for both its medical and nursing workforce (and some non-clinical areas) to plan and communicate rosters in advance. Nurse rosters are based upon agreed establishments with the Assistant Chief Nurse (Workforce) and finance representatives and reviewed on a regular six-month basis.

The Trust also complies with the publication of the safe staffing monthly report which includes:

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

In relation to temporary staffing, the Trust has undergone a dramatic profile change over the previous five years. The Trust currently has relatively low agency spend on doctors; and agency nursing usage has decreased year-on-year and complies with the November agency price cap.

The Trust currently has a number of senior interims with immediate plans to move over to bank arrangements due to the agency cap rules.

### *4.5* Management of workforce risks

The Trust recognises the need to prioritise the development of a wide-ranging recruitment and retention strategy for key clinical posts, particularly paediatric nurses.

Trust-wide strategies to mitigate workforce risks are formulated which include nurse recruitment strategies, nurse retention committees, overseas fellowship programme (for medical staff) and other actions all form part of the Trust's developing workforce plans.

## 5 Approach to financial planning

### 5.1 Overview of the financial planning process

The Trust's draft financial plan for 2016/17 has been derived from a projection of the forecast out-turn for 2015/16 with appropriate adjustments for non-recurring income and expenditure, changes in tariff, the reinstatement of CQUIN funding, expected activity changes (see Section 1), cost inflation and cost pressures.

There are a number of strategic developments outlined in the NHSE SC plans in relation to 2016/17 but none as yet have been approved or have detailed impact assessments, or implementation plans. As a result, the Trust has not made any material changes to its activity projections for these plans.

### 5.2 Financial risks

The significant funding constraints for specialised services is a major concern for the Trust and threatens effective planning of new services and delivery structures in collaboration with other providers of care to our patients.

### 5.3 Efficiency Savings for 2016/17

The Trust has engaged consultants to work in collaboration with the Trust on the development of a three year productivity and efficiency programme. The aim is to develop a small number of major trust wide schemes, focussing on clinical productivity, procurement processes and corporate costs. The scope of these workstreams address all areas of the Carter Review although his recent work to identify targets for acute hospitals did not include Specialist hospitals.

During 2015/16 the Trust increased its rigour in regard to the review and assessment of Cost Improvement Programme schemes within the organisation, in order to ensure there is no adverse impact on quality.

### 5.4 Capital plan

The capital plan has been built up from the following components:

- the Trust's major site redevelopment programme,
- the planned investment in an Electronic Patient Record system to be operational in 2018,
- an assessment of the expenditure required for major maintenance of the estate,
- a specific project to increase inpatient capacity in 2016/17 pending further capacity coming on line within the redevelopment programme in 2017 and 2022; and
- detailed investment and replacement programmes for IT and medical equipment.

Estate maintenance and equipment replacement is part of a longer term risk assessed replacement programme which is currently being updated.

## 6 Link to the emerging 'Sustainability and Transformation Plans' (STP)

The NHS Planning Guidance sets out a process by which long term plans will be produced in conjunction with other providers in a region. The Trust's local commissioning partner is NE Central London commissioning cluster, led by Camden CCG. This planning model is not meaningful for the Trust's tertiary services which extend both across London but also throughout England. We are currently in discussions with NHSE SC as to how we can influence the STPs to proactively address improvement of children's services from home to hospital and back.

The Trust believes that over the next five years, further collaborative service models should be developed to include tertiary paediatric services and that GOSH has a pivotal role to play in developing and in many cases leading such networks. In a number of services there are already informal shared care and network arrangements being developed.

## 7 Membership and elections

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

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

| *Patient and Carer* | **Numbers** | *Public* | **Numbers** |
|---|---|---|---|
| Patients from London | 2 | North London & surrounding areas | 4 |
| Patients from outside London | 2 | South London & surrounding areas | 1 |
| Parents and Carers:<br>• from London | 3 | Rest of England and Wales | 2 |
| • from outside London | 3 | | |
| *Appointed* | 5 | *Staff* | 5 |

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

- Councillor Recruitment: Pre election information sessions are held for councillor recruitment alongside a dedicated page on the Trust website, including podcasts etc
- Training and development: On appointment, councillors receive mandatory Trust training and continued development by attending tailored information sessions delivered by key Trust staff. Councillors are also encouraged to attend Foundation Trust Network events and Deloitte Governor Lunches.
- Membership and public engagement: The monthly Members' Council eBulletin offers a variety of opportunities for councillors to engage with their members including:

  - regular "meet your councillor" engagement sessions in the hospital
  - visits to schools including the Hospital School and Activity Centre
  - holding membership stalls at community events and GOSH Children's charity events
  - attending Trust committees and Patient forums
  - writing personalised letters and articles in Member Matters Newsletter, Staff Newsletter and Welcome Pack for new members
  - online link to contact a councillor is included in all Annual Plan surveys to membership

Attachment N

Great Ormond Street Hospital for Children NHS Foundation Trust

| Trust Board<br>1st April 2016 | |
|---|---|
| **Update on access improvement programme**<br><br>**Submitted by:**<br>Nicola Grinstead, Chief Operating Officer | **Paper No: Attachment N** |
| **Aims / summary**<br><br>This report is to provide an update to the Board in regard to the Access Improvement Programme for Referral to Treatment (RTT) and Cancer. | |
| **Action required from the meeting**<br>Trust Board to note progress and the issues flagged within the report. | |
| **Contribution to the delivery of NHS Foundation Trust strategies and plans**<br>Delivery of the national access standards is a NHS and Foundation Trust requirement | |
| **Financial implications** | |
| **Who needs to be told about any decision?**<br>Monitor and Commissioners | |
| **Who is responsible for implementing the proposals / project and anticipated timescales?**<br>Executive Directors. | |
| **Who is accountable for the implementation of the proposal / project?**<br>Executive Directors. | |

Attachment N

# REFERRAL TO TREATMENT (RTT) & CANCER ACCESS UPDATE

## PUBLIC TRUST BOARD

## MARCH 2016

**Overview**
Work continues across the Trust in rectifying the RTT and Cancer data quality issues, improving operational systems and processes and ensuring that those patients waiting the longest are being treated. This report builds on the one provided in January to the Trust Board, with updates on the main programme deliverables and performance key milestones.

**Patient Tracking Lists (PTL)**
As reported in January, the Trust now has a robust PTL, a planned PTL, a radiology PTL and a non-radiology diagnostic PTL. The main RTT PTL now has approximately 10,000 pathways (from 9,000 in January). This number will continue to fluctuate slightly as validation of the open pathways continues.

The Trust has seen reductions in the numbers of its longest waiting patients during this period. Some areas have found this challenging as a consequence of capacity constraints and this is being reviewed jointly by the Trust and its main commissioner. Additionally patient choice, as well as complex pathways also have an impact.

As reported last time, the Planned PTL is being well managed with minimal numbers of patients going beyond their "admit by date", and where these are doing so, if not seen by the end of the respective month are being transferred onto the main RTT PTL (in line with national guidance).

The receipt of accurate and timely data from those patients who are referred into the Trust from secondary care remains a significant challenge and this is impacting the Trust's ability to accurately manage patients waiting times.

**Diagnostics**
The Trust has previously committed to commencing reporting against this standard from April 2016 (i.e. will report April's delivery in May 2016) via the national DM01 return. This will be focused on both the active diagnostic and planned diagnostic waiting lists.

**Clinical Review Group**
The governance process for the Clinical Review Group (CRG) is now managed by the Clinical Governance and Safety team under the Medical Director. The Clinical Review Group meets on a weekly basis, to review patients who have waited over a defined period of time.

**RTT Improvement trajectories**
As part of the annual planning round this year, the Trust is required to submit RTT improvement trajectories for each speciality to Monitor and NHS England. These trajectories will demonstrate how much activity the Trust needs to undertake to clear any backlogs (i.e. patients currently waiting over 18 weeks), and also to sustain delivery of the 18 week standard.

A recent demand and capacity exercise has highlighted that in certain specialities the Trust does not currently have capacity to meet the demand for the service. The Trust is reviewing the options in regard to bed capacity and staffing to deliver this. A number of sub speciality areas have been

highlighted where the Trust will continue to struggle to achieve the wait time standards. As referenced previously, on-going discussions continue with commissioners on how this is resolved.

**Cancer Access**
The Trust has successfully completed all necessary actions to assure itself and external stakeholders in regard to its management of cancer pathways and their reporting. Following the imminent implementation of an automated PTL system for cancer pathways, a recommendation will be made to the Board (along with commissioners and Monitor) to move cancer waiting times management, back to "business as usual", and stand down the recovery programme.

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**Other update areas**

**Validation**
The Trust has made good progress in validating its PTL and associated pathways / referrals. A central team is now fully established to co-ordinate this and work with the operational divisions.

**Access Policies**
The Trust access policies for RTT and cancer have now been finalised and circulated internally and with key stakeholders for final sign off. These will be implemented by the Trust from 1st April 2016.

**Training**
The Trust has now completed a significant volume of training for those staff (clinical and non-clinical) in the management of patients on RTT pathways. This is being kept under close review and monitored fortnightly.

**Standard Operating Procedures**
A review of all processes is being undertaken and Standard Operating Procedures are being refreshed or redrafted where necessary.

**Unknown clock starts**
Regarding retrieval of the Minimum Data Set (MDS) from other providers, the Trust is implementing practices to work more closely with its main referring hospitals to try and ensure all the necessary referral information is provided, inclusive of the clock start date of those referrals. The Board will be updated on progress.

**National Intensive Support Team (NIST)**
The Trust is having a stocktake visit on 24th March to assess progress against the original IST report and visits.

---

**Summary**
Good progress continues in terms of training staff, validation, developing standard operating procedures and treating the longest waiting patients.

Looking forward the key challenges are:

1) having sufficient, staffed, capacity (beds and outpatient slots) to deal with the back log and to sustain performance against the RTT, diagnostics and cancer standards

2) reviewing those sub speciality areas where compliance against the standards is going to be most challenging over the course of the next 12 months.

**Dena Marshall**
**Interim Chief Operating Officer**
**March 2016**

Attachment O

Great Ormond Street Hospital for Children NHS Foundation Trust

| Trust Board<br>1st April 2016 | |
|---|---|
| **Quality and Safety Summary Report**<br><br>**Submitted by:** Dr Vin Diwakar, Medical Director | **Paper No: Attachment O** |
| **Aims / summary**<br><br>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**<br>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**<br>Each of the measures reflects one of the QI standards | |
| **Financial implications**<br>N/A | |
| **Who needs to be told about any decision?**<br>For information; QI team to be provided feedback | |
| **Who is responsible for implementing the proposals / project and anticipated timescales?**<br>Relevant clinical teams | |
| **Who is accountable for the implementation of the proposal / project?**<br>Medical Director | |

Attachment O

**Quality and Safety Report for Trust Board**
**March 2016**

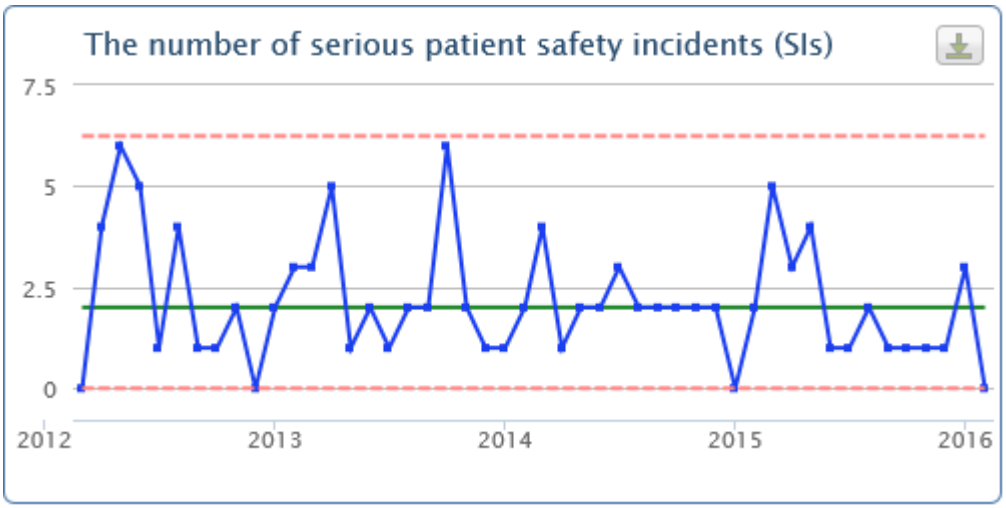
Key for Control Charts

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

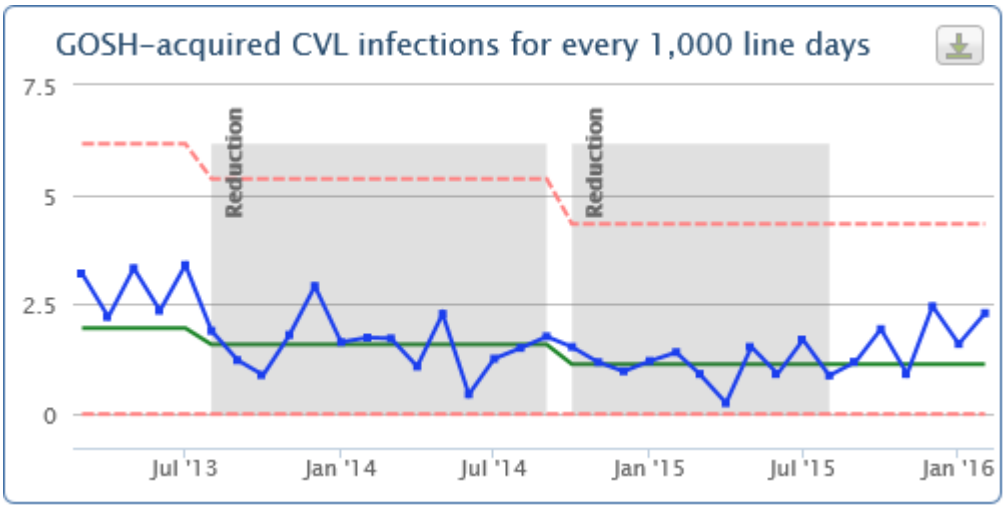



Trend: Performance is unchanged with all data points inside of the control limits. There has been no statistical change in the number of SIs – we are still running at 2 per month.

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 assesses the learning from each incident. A focus is to review the process so that it is timelier.

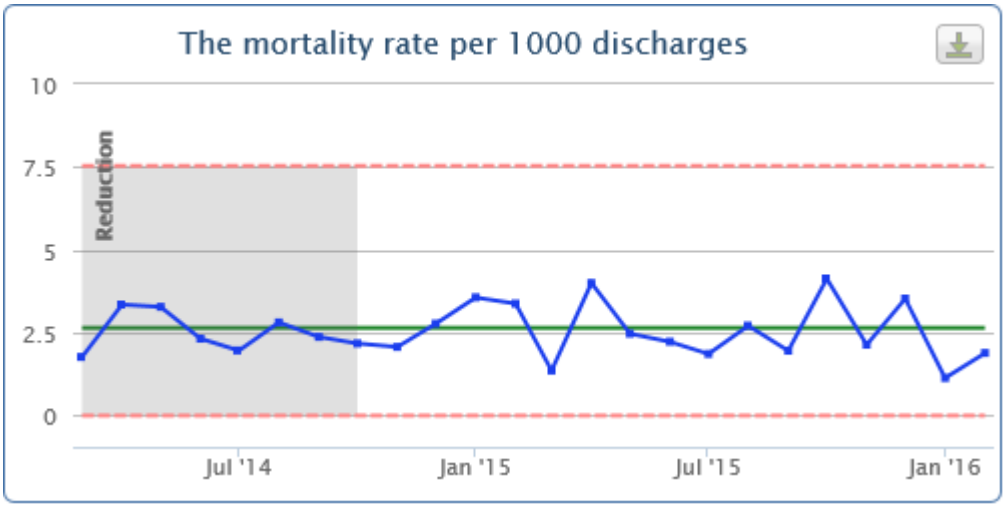
Attachment O

## Standard 3: CVL Infections

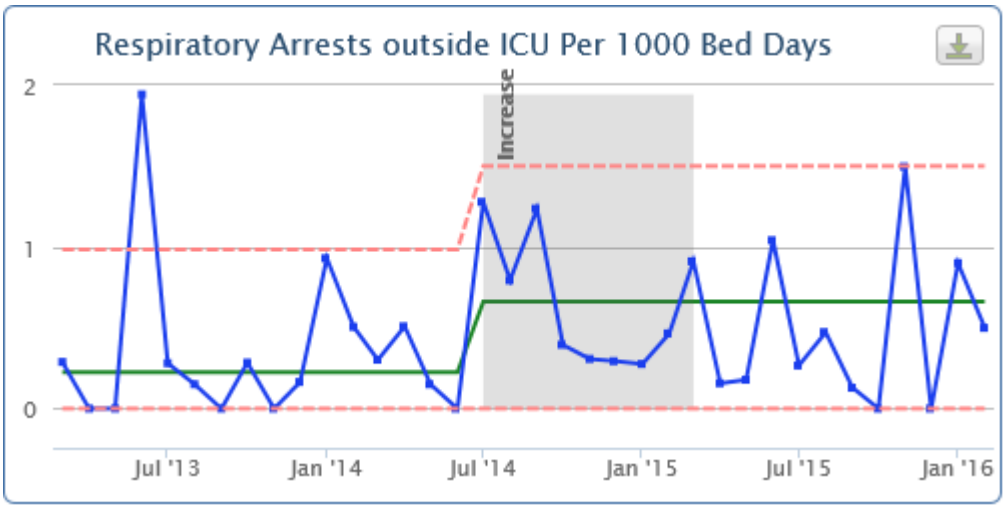


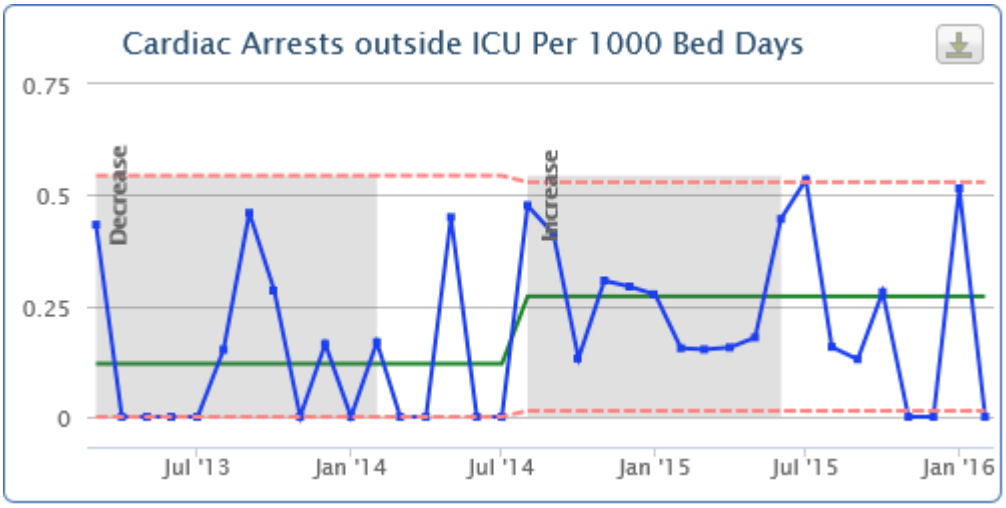

| | |
|---|---|
| Aim: | To make statistically significant reductions in the rate of CVL infections. |
| Trend: | There was a reduction in the CVL infection rate which started in October 2014 and was subsequently been sustained. Subsequent data is within normal variation. |
| What's going well: | No narrative available |

## Standard 6: Mortality and Deterioration



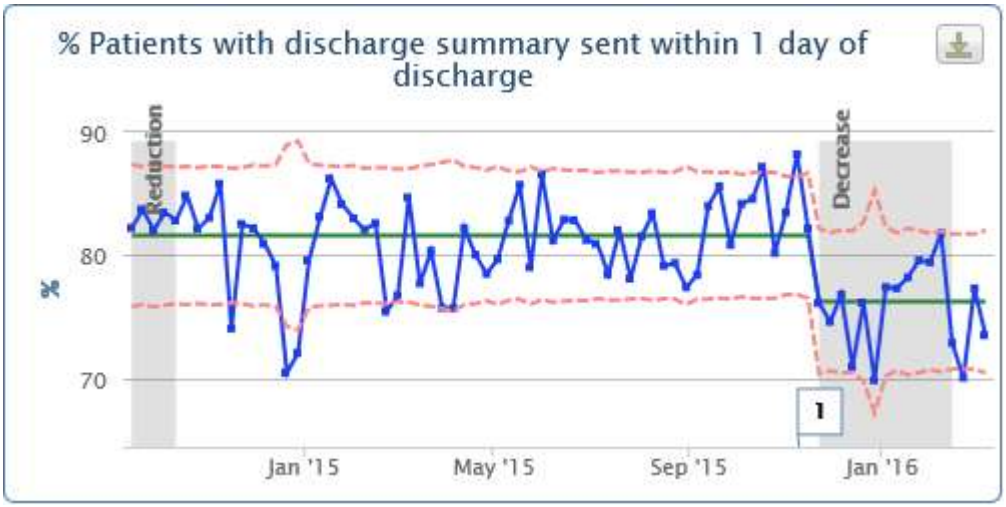
Attachment O




| | |
|---|---|
| Aim: | To make reductions in the mortality rate<br><br>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.<br>Cardiac arrests – zero in November, December and March (special causes)<br>Respiratory arrests – October, November and December were 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. The programmes are being integrated so that the impact will be more readily achieved. |

## Standard 7: Discharge Summaries




| | |
|---|---|
| Aim: | To make statistically significant reductions in the time taken to complete a discharge summary. |
| Trends: | There has been a reduction in the percentage of patients with a discharge summary sent within 1 day of discharge from 81% to 76% |
| 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.<br><br>ICI-LM chose to delay in order that consultants could check that the junior doctor summaries were accurate and complete. |

Attachment O

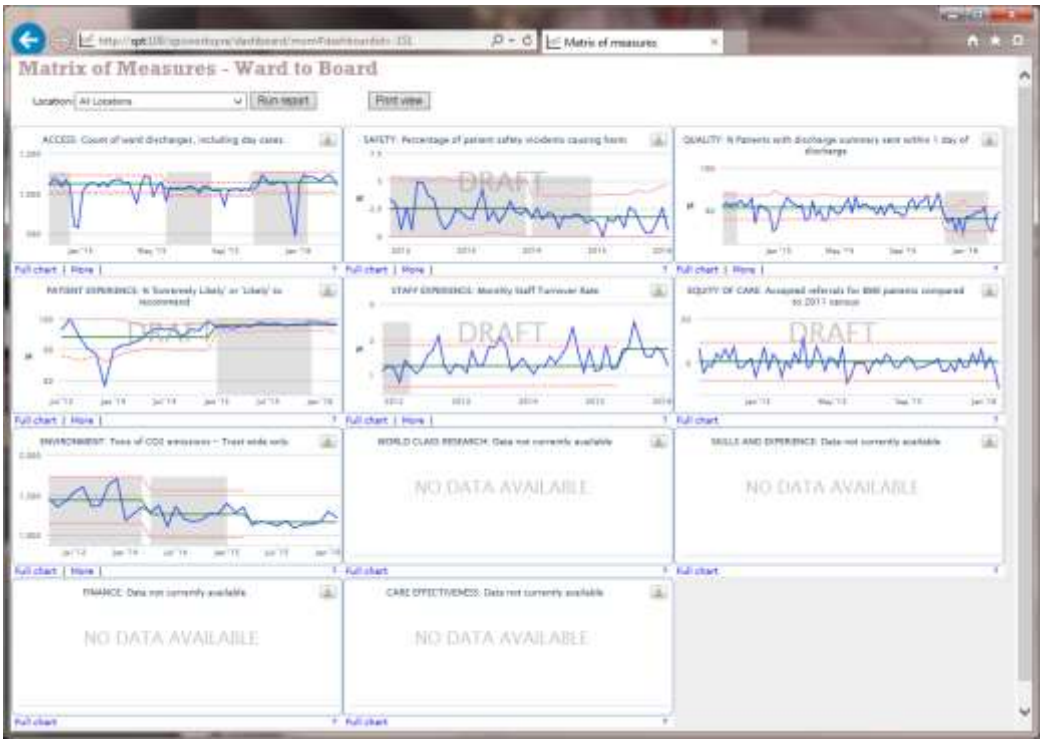
## Matrix of Measures (MoM) Update

### The plan

The plan is to populate the Matrix with a chart which will help to answer each question. The Matrix can be run at Ward level, aggregated to Division and then to Board.

Once this milestone is complete, work will focus on dashboards behind each of these measures, linked to from the Matrix itself. Finally there will be a process of measure and data validation to ensure assurance of good data quality.

### The Matrix so far




Progress update:

1. It was decided that all these measures are potentially of interest to referrers and commissioners and therefore the discharge summaries measure was moved into the patient safety dashboard
2. The environmental measure of total tons of CO2 emissions has been added. Behind this is a new dashboard containing this and also separate charts for CO2 from electricity and from gas. These will be followed with more energy management data when available
3. The Research division have provided some initial data which is currently being uploaded
4. Discussions have been had with the Workforce team regarding data pertaining to staff skills and experience. Work has started on migrating data from the Workforce system into the data warehouse from where it can be reported onto the MoM
5. Attended the Families Equality and Diversity group to discuss potential measures and data
6. Awaiting data from the Finance department
7. Work has started on functionality to add narrative to these measures for reporting purposes

Great Ormond Street Hospital for Children NHS Foundation Trust

**Trust Board**
**1st April 2016**

| **Performance Targets & Indicators: February 2016**<br><br>**Submitted by:**<br>Nicola Grinstead, Chief Operating Officer | **Paper No: Attachment 2** |
|---|---|

**Aims / summary**

This report provides an overview of February 2016's reported position across a number of key indicators

**Hospital Acquired Infections**

In February the Trust reported 3 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 7 in 2015/16. 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 February. 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.

1 new case of E. Coli and 1 new case of MSSA were reported in February following 48 hours of admission. Therefore, the year to date total onset in hospital remained at 10 cases of E. Coli and 8 cases of MSSA respectively in 15/16.

**Activity & Patient Access**

Following a decrease in activity levels in December, February continued to see an increase across NHS activity. Consequently the year to date position for spells has improved reaching above the year to date target; outpatient activity remains below target, whilst ITU bed day activity levels are maintained above target.

The average number of bed closures in February compared to all months year to date was at one of the lowest levels.

February saw an increase in theatre sessions being unused compared to the previous month, due in part to industrial action. 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 relevant reporting categories and the monthly year to date positions is reflected in the report. All 3 standards were achieved in January.

Great Ormond Street Hospital for Children NHS Foundation Trust

**Patient / Referrer Experience**

Number of complaints in period
The Trust received 16 formal complaints in February 2015. There was one complaint graded as red (in line with the Trusts complaints policy). Themes reported by families within their complaints include poor communication within teams, delays in care and treatment due to cancelled admissions, surgery and outpatient appointments.

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 February the FFT percentage of patients who would recommend the Trust is at 98.35% (very much in line with previous months). The level of respondents' remains low (23.7%). 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.

Clinic Letter Turnaround
This measure is now being reported as the percentage of letters CDD sent within seven working days (as agreed by the Board, with it previously having been five working days). The position for February is that over 55% of letters are being sent within this timeframe. The average time for clinic letter turnaround in February was 7.7 days.

Note:
Further refinement and review of this report is being undertaken at this time

**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?**

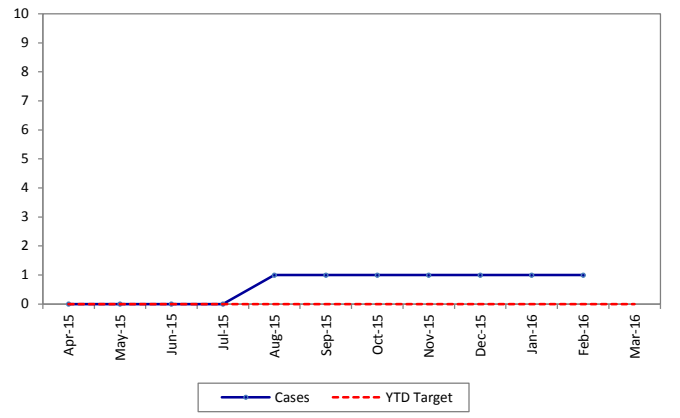
**Who is responsible for implementing the proposals / project and anticipated timescales?**
Executive Directors.

**Who is accountable for the implementation of the proposal / project?**
Executive Directors.

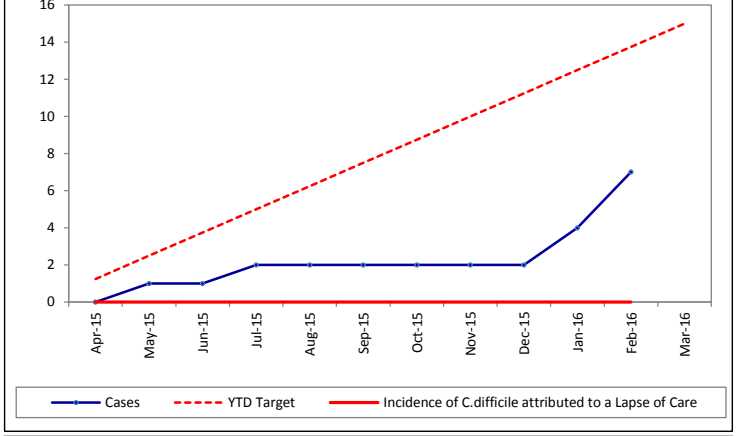
## Targets & Indicators Report

| | | Target | YTD Performance | Monthly Trend | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Mar-15 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 |
| Activity & Use of Resources | Number of patient spells | 31,583 | **31,811** | 3,137 | 2,847 | 2,732 | 3,057 | 3,008 | 2,568 | 2,892 | 2,967 | 3,092 | 2,735 | 2,873 | 3,040 |
| | Number of outpatient attendances | 146,034 | **137,671** | 13,733 | 12,307 | 10,705 | 13,053 | 13,343 | 11,373 | 13,240 | 13,060 | 13,991 | 11,782 | 12,110 | 12,708 |
| | DNA rate (new & f/up) (%) | <10 | **8.0** | 6.9 | 7.7 | 8.1 | 9.0 | 9.7 | 8.6 | 8.3 | 7.4 | 7.4 | 7.9 | 7.0 | 6.7 |
| | Number of ITU bed days | 9,865 | **10,047** | 856 | 710 | 1,221 | 935 | 933 | 959 | 875 | 844 | 882 | 773 | 1,005 | 910 |
| | Number of unused theatre sessions | - | **205** | 13 | 22 | 9 | 21 | 29 | 48 | 22 | 14 | 4 | 16* | 9 | 27 |
| | Average number of beds closed - Total Ward | - | **8.3** | 13.7 | 20.2 | 13.5 | 15.5 | 11.1 | 5.5 | 4.0 | 5.1 | 4.6 | 8.2 | 2.1 | 1.9 |
| | Average number of beds closed - Total ICU | - | **0.1** | 0.4 | 0.4 | 0.1 | 0.2 | 0.2 | 0.0 | 0.2 | 0.2 | 0.0 | 0.2 | 0.1 | 0.05 |
| Patient Access | Patient Refused Admissions - Trust Total Excluding PICU/NICU & CATS** | 90 | **138** | 1 | 8 | 5 | 20 | 12 | 7 | 12 | 7 | 14 | 22 | 15 | 16 |
| | PICU/NICU & CATS Refusals | <235 | **253** | 21 | 17 | 21 | 20 | 11 | 8 | 14 | 15 | 24 | 54 | 26 | 43 |
| | Cancer - Decision To Treat to first treatment | 96 | | | 100.0 | 92.3 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 94.4 | 100.0 | 100.0 | |
| | Cancer - Decision To Treat to subsequent treatment - surgery | 94 | | | 100.0 | 100.0 | 87.5 | 100.0 | 100.0 | 100.0 | 100.0 | 75.0 | 100.0 | 100.0 | |
| | 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 | 100.0 | 100.0 | |
| Patient / Referrer Experience | Number of complaints | 40 | **143** | 13 | 13 | 7 | 16 | 17 | 15 | 13 | 8 | 15 | 9 | 14 | 16 |
| | Number of complaints - High Grade | 4 | **10** | 3 | 2 | 0 | 0 | 4 | 1 | 0 | 0 | 0 | 1 | 1 | 1 |
| | Friends & Family Test (% of those Likely & Extremely Likely to recommend) | >95 | **98.4** | 97.4 | 98.1 | 96.9 | 98.9 | 98.1 | 98.5 | 99.0 | 98.5 | 98.0 | 98.5 | 99.5 | 98.3 |
| | Friends & Family Test (% Response Rate) | - | **22.5** | 35.0 | 27.8 | 28.3 | 28.1 | 29.7 | 16.6 | 13.3 | 18.1 | 21.0 | 18.6 | 22.8 | 23.7 |
| | Clinic Letter Turnaround, % letters on CDD - sent within 7 working days | - | **46.1** | 47.7 | 43.5 | 40.7 | 49.3 | 43.6 | 47.2 | 45.0 | 48.0 | 45.4 | 38.4 | 50.8 | 55.3 |
| | Clinic Letter Turnaround, Average Days Letter Sent | - | **10.3** | 10.0 | 11.0 | 10.9 | 10.6 | 10.5 | 11.3 | 10.7 | 10.3 | 9.9 | 11.7 | 8.6 | 7.7 |
| Work -force | Sickness Rate (%) | 3 | **2.6** | 2.6 | 2.5 | 2.6 | 2.6 | 2.7 | 2.6 | 2.6 | 2.6 | 2.6 | 2.5 | 2.5 | 2.5 |
| | Voluntary Turnover Rate (%) | 14 | **16.4** | 15.7 | 16.4 | 16.1 | 15.8 | 15.9 | 15.9 | 16.1 | 16.3 | 16.4 | 16.5 | 17.4 | 17.2 |
| | Trust Turnover (%) | 18 | **18.8** | 18.9 | 18.3 | 18.1 | 18.3 | 18.6 | 19.1 | 18.7 | 18.7 | 19.0 | 19.0 | 19.4 | 19.6 |

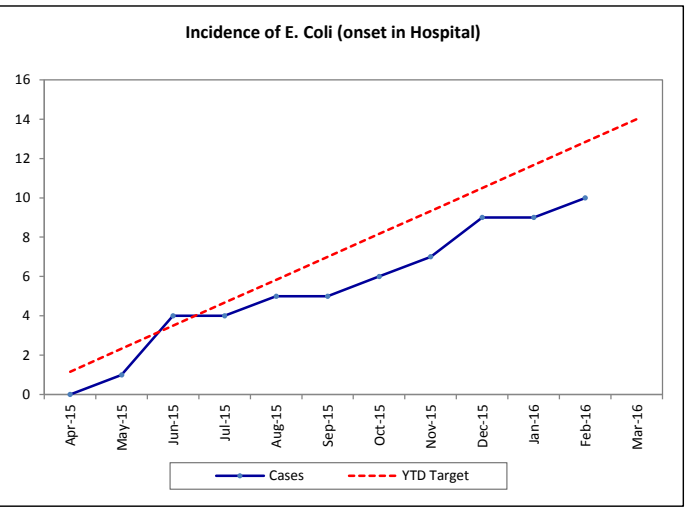
## Health Care Associated Infection Indicators



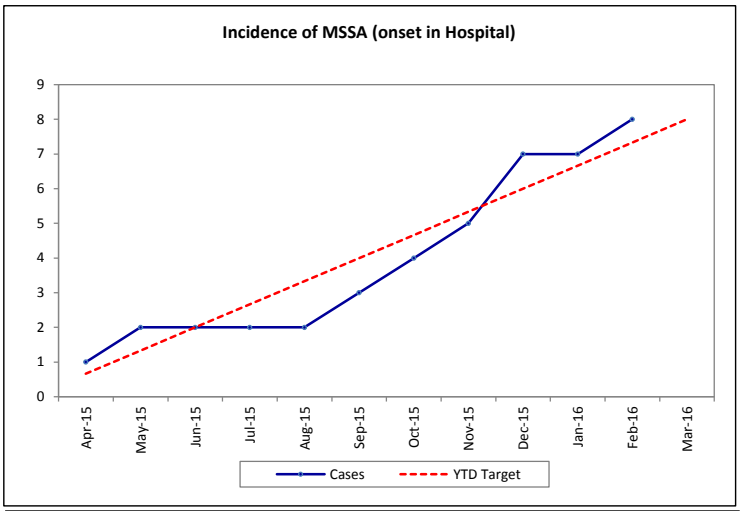

**Description: MRSA bacteraemias**
**Target:** Zero cases
**Trend:** 1 case reported to date
**Comment:** All episodes of positive blood cultures are reported to DH on HCAI site as bacteraemias




**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 remains below trajectory
**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 below trajectory
**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 n't yet 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**<br>**1st April 2016** | |
| **Workforce Metrics & Exception Reporting – February 2016**<br><br>**Submitted by:**<br>Ali Mohammed, Director of HR & OD | **Paper No: Attachment P** |
| **Aims / summary**<br>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**<br>To note the content of the report. | |
| **Contribution to the delivery of NHS Foundation Trust strategies and plans** | |
| **Financial implications**<br>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?**<br>Not applicable. | |
| **Who is responsible for implementing the proposals / project and anticipated timescales?**<br>Divisional management teams; supported by members of the HR & OD team. | |
| **Who is accountable for the implementation of the proposal / project?**<br>Divisional management teams. | |

Great Ormond Street Hospital for Children NHS Foundation Trust

HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT

# TRUST BOARD WORKFORCE METRICS & EXCEPTION REPORTING – FEBRUARY 2016

## 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 18 in February to 3745. The decrease reflects the continuing focus on workforce control.

**Sickness absence** has decreased slightly to 2.5% (from 2.6%) and remains below the London average figure of 2.8%. Short-term sickness (STS) (episodes of sickness up to 4-weeks) has remained static across the Trust at 1.3% and long-term sickness has remained at 1.2%. An additional report has now been included to demonstrate monthly (12 months) variance in monthly sickness rate; this report (split by division) is to provide trend history over a 12-month period including direction of travel.

**Turnover** is reported as voluntary turnover in addition to the standard total turnover. Voluntary turnover currently stands at 16.5% (**unchanged throughout November 15 to February 2016**); this reported value excludes non-voluntary forms of leavers (e.g. dismissals, TUPE, fixed-term and redundancies). Total (voluntary and non-voluntary) turnover continues to increase – currently at 19.6% in February (+0.07% from January). 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 4% in February.

**Agency usage** for 2015/16 (year to date) stands at 3.08% of total paybill (+0.32% from January); 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

(Medical Director's Directorate & Operations Directorate) retains the highest spend on agency staff at 29.7% (up from 22.9% in December) of total paybill (rising). Increases to Finance & ICT agency spend (+1.5%) whilst significant and continued decreases to International (-0.44%, no longer exceeding target) and Estates & Facilities (-0.3%).

**PDR completion rates** The Trust overall appraisal rate stands at 70% - a 2% increase since December. Currently only one directorate is meeting the target of 95%, Human Resources & Organisational Development. HR & OD are currently revisiting the PDR mechanism and will remove the PDR window and provide a simplified route of compliance to address the Trust's position of low completion across the organisation

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 - FEBRUARY 2016 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 | 732 | 16.9% (108.1) | 18.7% (119.3) | 2.4 | 64.0% | 5.4% | 1.4% |
| Diagnostic & Therapeutic Services | 347 | 15.1% (53.5) | 20.7% (73.5) | 1.9 | 70.0% | 9.4% | 3.1% |
| Infection, Cancer & Immunity | 662 | 18.5% (118.5) | 20.2% (129.2) | 2.6 | 74.0% | 7.7% | 0.8% |
| International | 169 | 16.7% (26.0) | 19.3% (30.0) | 4.5 | 82.0% | 8.5% | 2.8% |
| Medicine | 264 | 14.8% (34.3) | 16.5% (38.2) | 3.0 | 75.0% | 5.4% | 3.1% |
| Neurosciences | 467 | 19.9% (87.3) | 24.5% (107.4) | 2.1 | 73.0% | 0.0% | 1.8% |
| Surgery | 568 | 12.8% (63.1) | 15.4% (75.6) | 2.4 | 65.0% | 1.7% | 1.3% |
| Clinical & Medical Operations | 57 | 15.5% (15.5) | 15.5% (15.5) | 1.7 | 47.0% | 14.0% | 29.7% |
| Corporate Affairs | 10 | 11.6% (1.0) | 11.6% (1.0) | 1.8 | 89.0% | 0.0% | 0.0% |
| Estates & Facilities | 107 | 4.6% (4.5) | 9.7% (9.5) | 3.6 | 55.0% | 30.0% | 7.2% |
| Finance & ICT | 100 | 21.8% (21.6) | 21.8% (21.6) | 3.0 | 48.0% | 3.1% | 15.7% |
| Human Resources & OD | 110 | 27.5% (28.2) | 30.1% (30.8) | 3.3 | 95.0% | 3.1% | 0.2% |
| Nursing & Patient Experience | 45 | 17.2% (7.2) | 17.2% (7.2) | 1.8 | 72.0% | 0.0% | 0.1% |
| Redevelopment | 22 | 13.8% (3.0) | 14.8% (3.2) | 2.8 | 78.0% | 0.0% | 4.0% |
| Research & Innovation | 85 | 15.1% (12.0) | 16.4% (13.0) | 1.8 | 84.0% | 0.0% | 0.3% |
| **Trust** | 3745 | **17.2%▲ (586.5)** | **19.6%▲ (667.4)** | **2.5%►** | **70.0%▲** | **4.0%▼** | **3.1%▲** |

**HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT**
**WORKFORCE METRICS EXCEPTION REPORTING - FEBRUARY 2016 REPORT**

## Highlights & Actions

| Vacancy Rate | |
|---|---|
| Comments | Actions |
| • The vacancy rate is above the 10% threshold in two divisions, **Clinical & Medical Operations** and **Estates & Facilities** which has a vacancy rate of 30% | • Vacant posts within **Clinical & Medical Operations** are being reviewed to ensure they fit with the new divisional structure and meet the on-going requirements of the service with a view to recruit in the coming months.<br>• The Senior HR Manager will work with the recruitment team to identify the vacancies and support the recruitment in to posts with the Head of Estates and Head of Facilities. |

| Sickness Rate | |
|---|---|
| Comments | Actions |
| • **IPP** continue to have the highest sickness percentage in the Trust at 4.5%<br>• Three other divisions have sickness percentages over the threshold – **Medicine**, **Estates & Facilities** and **HR&OD**<br>• **HR&OD** has a high percentage due to a high level of long term sickness over the last twelve months, the majority of which have returned to work | • **IPP** - A Senior HR Manager runs a weekly drop in session for managers to discuss their sickness cases. This is predominantly made up of short term sickness as they have a very low long sickness rate.<br>• **Estates & Facilities** – a dedicated HR lead is working with the estates and facilities team to support their intermittent cases which is predominantly what drives the higher percentage.<br>• **Medicine** – A Senior HR is introducing weekly drop in sessions for managers within Medicine starting from week commencing 21st March.<br>• **HR&OD** – OH advice is being provided to the manager of the remaining long term sickness case to support the employees return to work. |

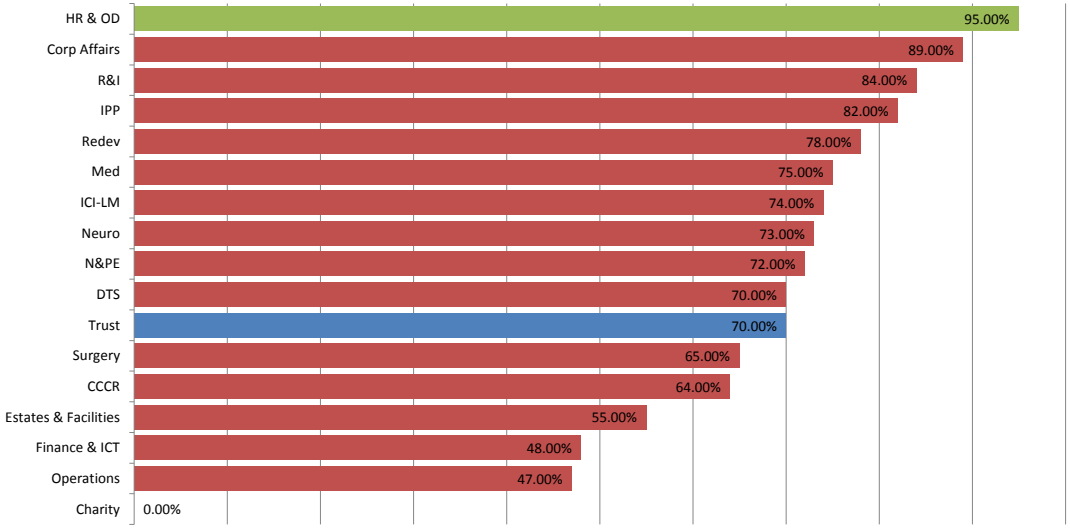
| Agency Spend | |
|---|---|
| Comments | Actions |
| • **Finance & ICT** have high agency spend at 15.7% due to senior interims covering posts.<br>• **Clinical & Medical Operations** has continued high agency spend largely due to RTT Project resourcing.<br>• There are also higher agency spend in the following divisions – **Diagnostic & Therapeutic Services**, **International**, **Medicine**, **Estates & Facilities**, **Redevelopment** | • On-going recruitment in to the senior posts within **Finance & ICT** with applicants due to start in post imminently.<br>• Continued compliance with the Monitor Agency Spend Cap in all professions<br>• Working with agencies and providers to achieve the April Monitor Agency Spend Cap,<br>• Continued work to convert agency staffing to bank staffing across all areas |

| Voluntary Turnover Rate | |
|---|---|
| Comments | Actions |
| • Across the Trust there is high turnover with **Finance & ICT** and **HR&OD** over 20% | • From April all leavers will be offered a face to face exit interview with a member of the ER team, with personal emails sent to leavers from the team to those within **Finance & ICT** and **HR&OD**.<br>• A new exit survey will be launched from the start of May utilising survey monkey and monthly/quarterly (dependent on the number of responses) reports will be produced for the divisions on the information collated<br>• From the start of June a retention survey will be launched on survey monkey to collate information from new starters on their experience of on-boarding in to the Trust.<br>• The Nursing Workforce retention group is taking specific actions to reduce turnover in nursing including a career pathway and a career advice intranet page. |

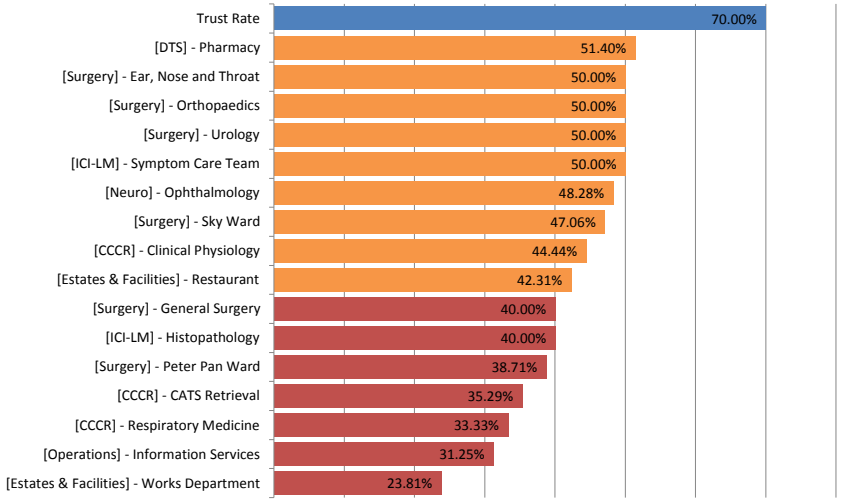
| PDR Completion | |
|---|---|
| Comments | Actions |
| • Completion rates range from 47% to 95%. Only one division is compliant with the rest of the Trust below 90%. | • Amendment of the policy to temporarily withdraw the defined PDR window for Band 7 and above from April to June<br>• Monthly PDR emails to non-compliant employees<br>• Monthly reports to managers on outstanding PDRs<br>• ER team to discuss PDR compliance when meeting managers, including their non-compliant report |

**HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT**
**WORKFORCE METRICS EXCEPTION REPORTING - FEBRUARY 2016 REPORT**

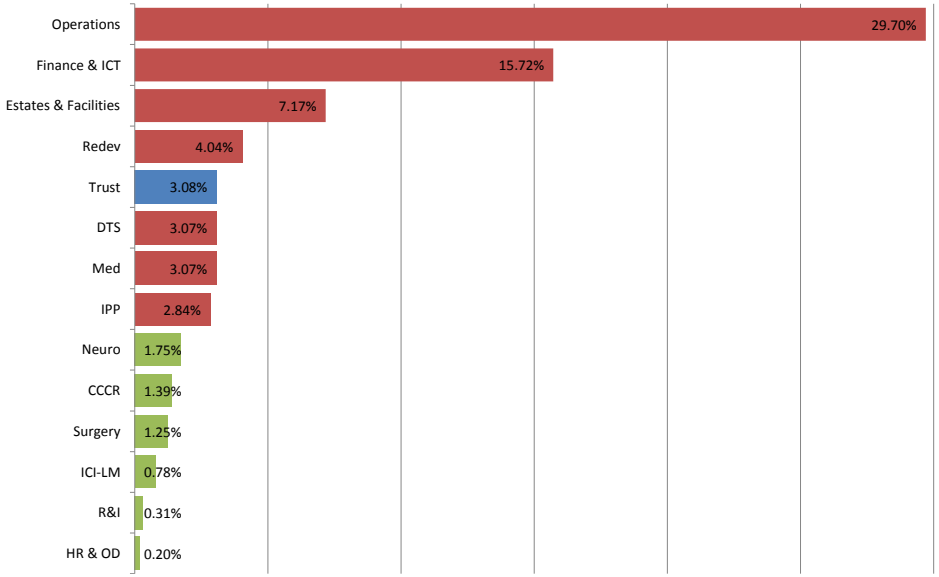
## Divisional PDR (Target 95%)



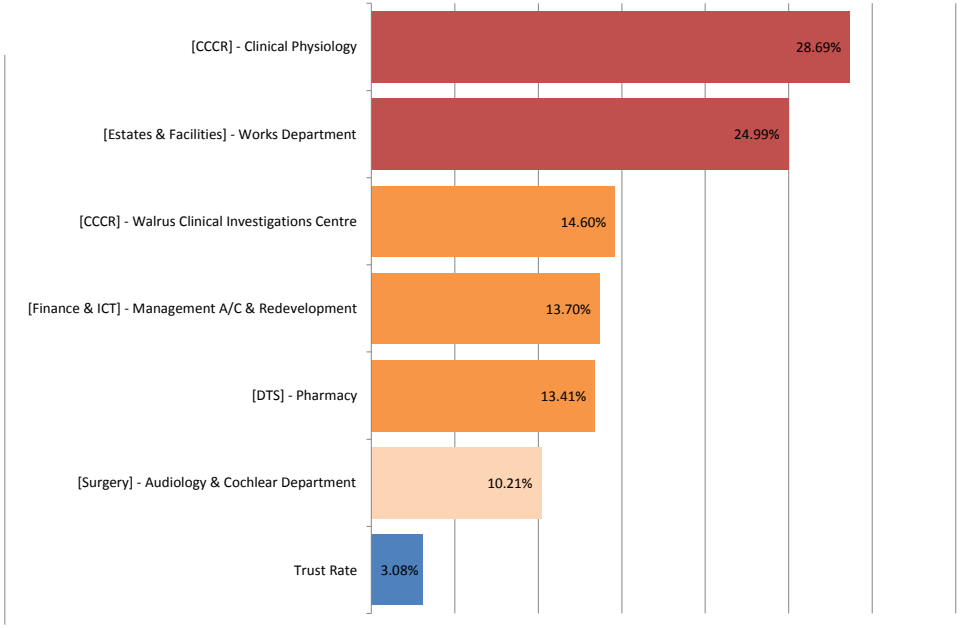

## Exception Reporting PDR




## Divisional Agency as % of paybill

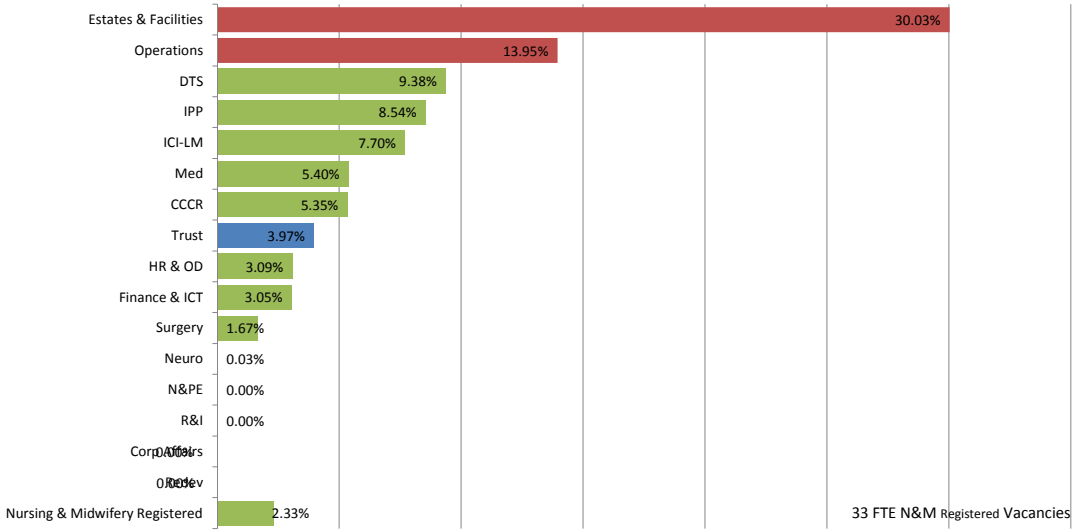



## Exception Reporting Agency as % of Paybill

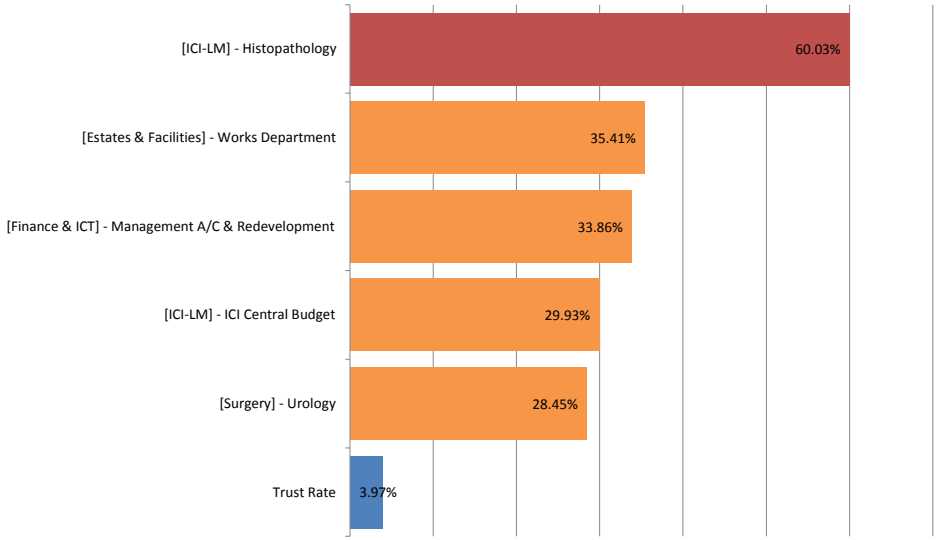


**HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT**
**WORKFORCE METRICS EXCEPTION REPORTING - FEBRUARY 2016 REPORT**

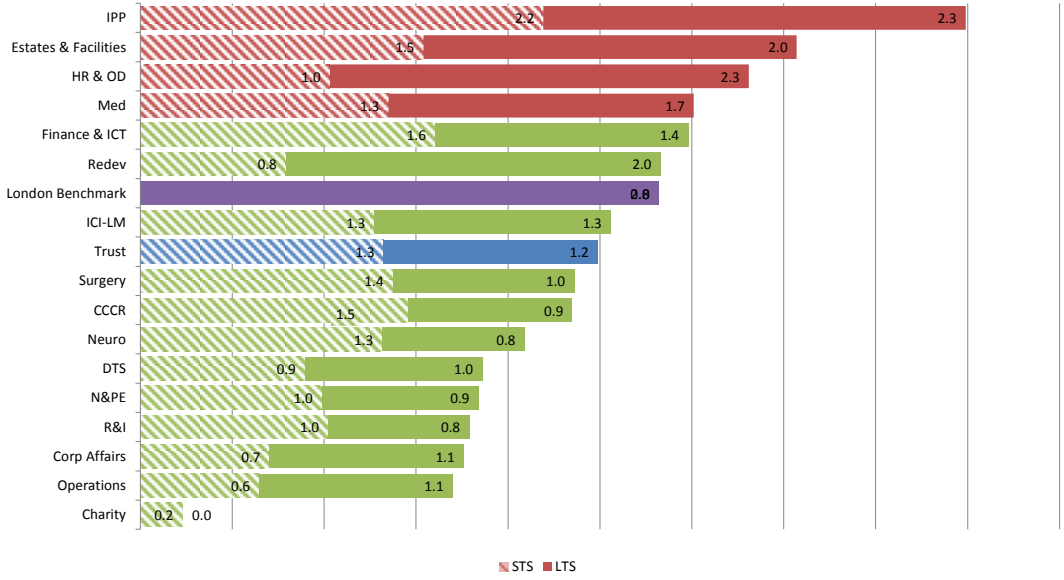
## Divisional Vacancy Rate



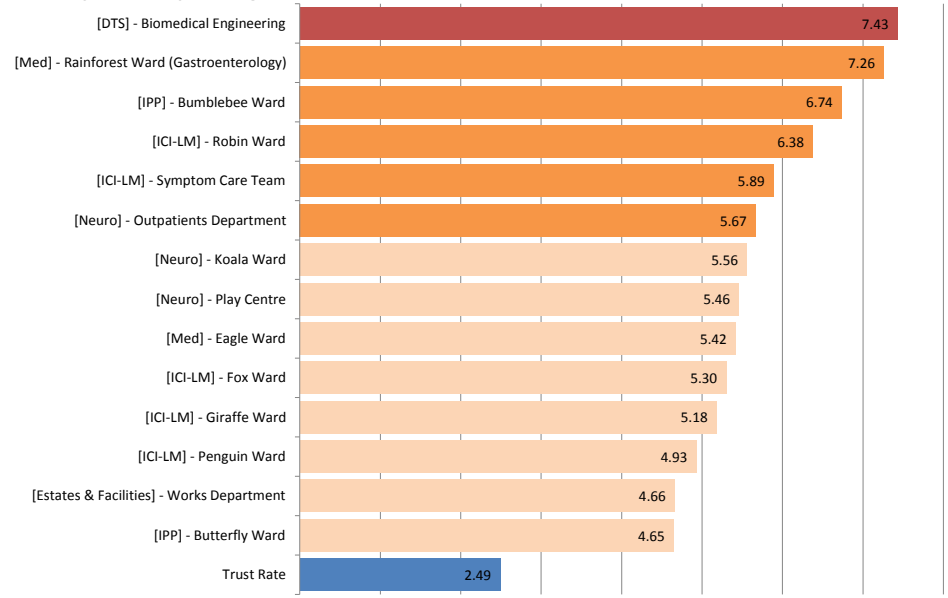

## Exception Reporting Vacancy Rate




## Divisional Sickness

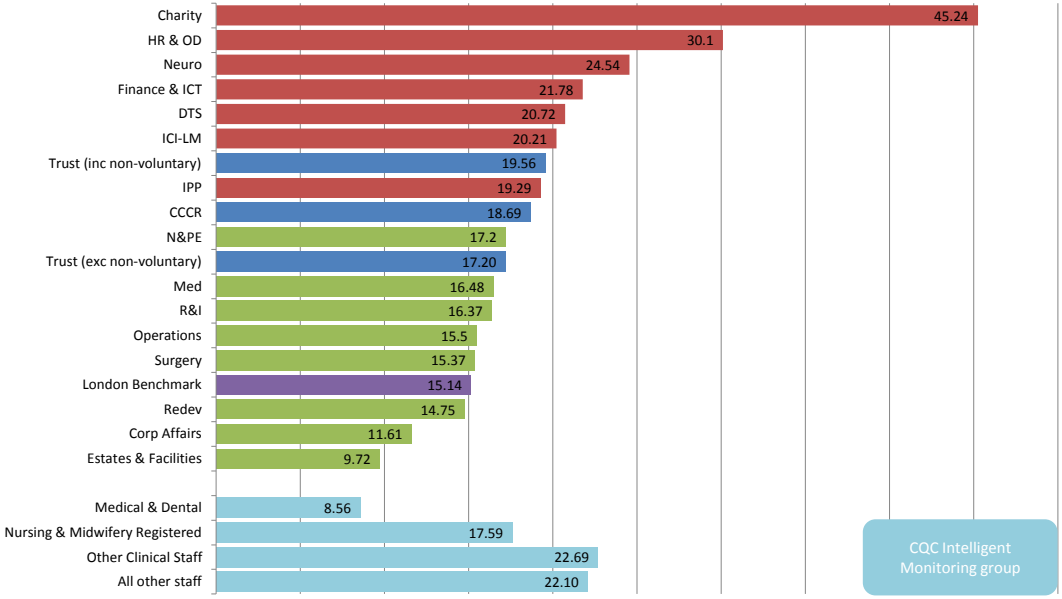



## Exception Reporting Sickness

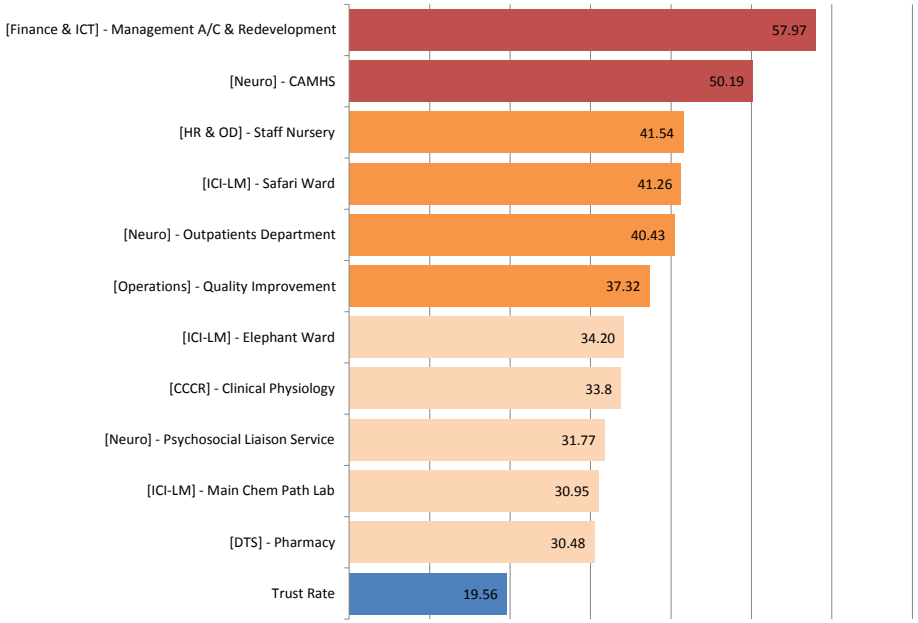


**HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT**
**WORKFORCE METRICS EXCEPTION REPORTING - FEBRUARY 2016 REPORT**

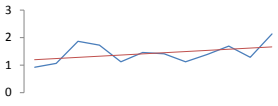
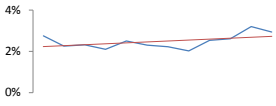
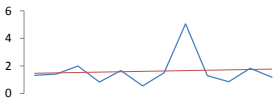
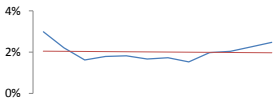
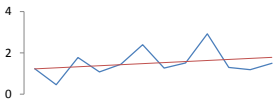
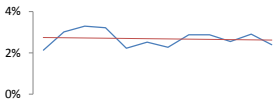
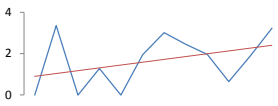
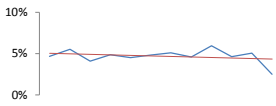
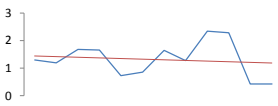
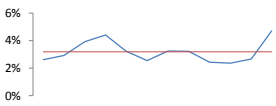
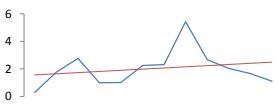
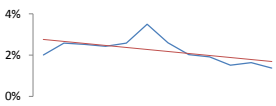
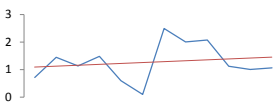
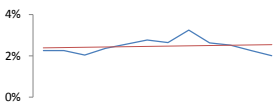
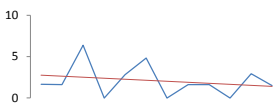
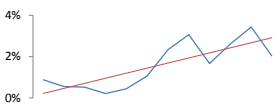
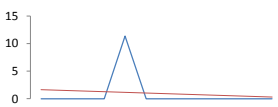
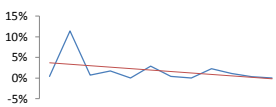
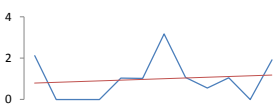
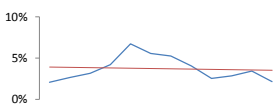
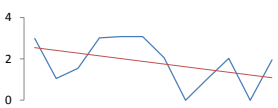
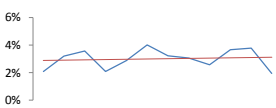
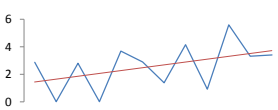
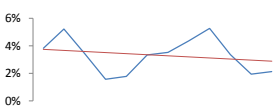
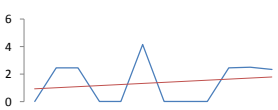
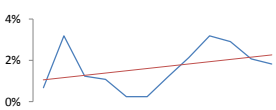
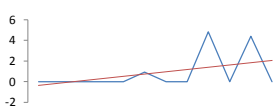
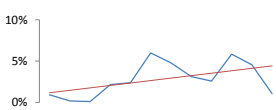
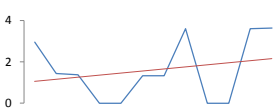
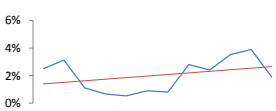
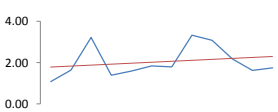
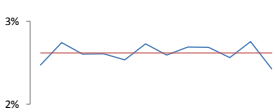
## Divisional Turnover (Voluntary & Non-Voluntary)




## Exception Reporting Turnover



**HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT**
**WORKFORCE METRICS EXCEPTION REPORTING - FEBRUARY 2016 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 | Sickness Rate (%) (0-3% green) | Sickness Rate (%, FTE) Monthly variation trend over 12 months |
|---|---|---|---|---|
| Critical Care & Cardio-Respiratory | 18.7% (119.3) |  | 2.4 |  |
| Diagnostic & Therapeutic Services | 20.7% (73.5) |  | 1.9 |  |
| Infection, Cancer & Immunity | 20.2% (129.2) |  | 2.6 |  |
| International | 19.3% (30.0) |  | 4.5 |  |
| Medicine | 16.5% (38.2) |  | 3.0 |  |
| Neurosciences | 24.5% (107.4) |  | 2.1 |  |
| Surgery | 15.4% (75.6) |  | 2.4 |  |
| Clinical & Medical Operations | 15.5% (15.5) |  | 1.7 |  |
| Corporate Affairs | 11.6% (1.0) |  | 1.8 |  |
| Estates & Facilities | 9.7% (9.5) |  | 3.6 |  |
| Finance & ICT | 21.8% (21.6) |  | 3.0 |  |
| Human Resources & OD | 30.1% (30.8) |  | 3.3 |  |
| Nursing & Patient Experience | 17.2% (7.2) |  | 1.8 |  |
| Redevelopment | 14.8% (3.2) |  | 2.8 |  |
| Research & Innovation | 16.4% (13.0) |  | 1.8 |  |
| **Trust** | **19.6%▲ (667.4)** |  | **2.5%►** |  |

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.

Attachment Q

Great Ormond Street Hospital for Children NHS Foundation Trust

**Trust Board**
**1st April 2016**

| **Financial Activity Board Report to 29 February 2016**<br><br>**Submitted by:**<br>Bill Boa, Interim Chief Financial Officer | **Paper No: Attachment Q** |
|---|---|

**Aims / summary**
To present the Trust's financial performance for the **11 month period to 29 February 2016.**

The Trust has received a letter dated 10 March 2016 from NHS England Specialist Commissioning confirming their intention to fine the Trust £1,296,494.28 for an information breach (non-reporting). Following ongoing discussions the Commissioner has agreed to reinvest 50% of this sum and discussions continue regarding the balance.

The Trust is therefore reporting **a deficit of £8.9 million** for the eleven month period ending 29 February 2016. This position is £2.1 million better than planned.

The Trust reported an in month deficit of £3.9 million which was £2.9 million worse than planned.

The Trust continues to **forecast a deficit of £11.1 million**. The Trust will mitigate the 50% fine not reinvested while continuing to work towards full reinvestment by the Commissioner.

The Finance and Investment Committee will consider the position at its meeting of 24 March 2016. The reflections of the Committee are not incorporated into this paper but will be reported to the Board verbally.

**Income**
NHS and clinical income is £1.3 million behind plan and £1.9 million lower than last year. NHS and clinical income was £0.7 million worse than planned in month. The main drivers of the run rate continue to be lower elective inpatient care income and lower outpatients income. January saw some recovery in elective income and a material increase in day case activity and some abatement in the rate of underperformance in outpatient income. February, however, saw this position fall back for Elective inpatient care income.

Elective Inpatient activity is 0.7% higher than last year but income is 2.3% lower.

Day case is performing above plan and this is largely driven by activity increases. Elective income is lower than plan in terms of volumes and price. Outpatient income is showing material variation in volume and the price variations noted in earlier months have been partly corrected. Overall activity is lower than planned but price is higher which suggests increasing acuity.

Pass through income is down by £1.7 million against plan but this is an "at cost" supply of drugs, bloods and devices and is matched by an equal reduction in costs. Pass through income is £3.8 million higher than 2014/15. Pass through income accounts for £50.1 million for the 11 months to 29 February 2016.

Private Patient Income is £6 million ahead of plan and £6.5 million ahead of the previous year. This increase is largely driven by Cardio Respiratory services. Private

Patient income is £0.2 million below plan in month and this may indicate the start of the anticipated impact of additional NHS activity in the latter months of the year. The Trust planned to grow private patient income and is being very successful in this area with £45 million of income coming from this source in these 11 months. The anticipated reduction in private patient income has not been as material as forecast with December and January operating ahead of plan and February marginally below plan. The reduction was anticipated in the light of bed pressures and work to remedy the Referral to treatment (RTT) backlog activity.

NHS activity has previously been undertaken in underutilised private patient beds in many services and the performance of private patient income marks a movement to the levels of activity anticipated in the original Business cases of services.

Non Clinical Revenue is on plan and £1.8 million less than last year. This is an improvement in month of £1 million. This is heavily impacted by Charitable donations, however, if the impact of charitable donation variation between years is excluded the most significant issue here is the non-delivery of income from a planned Education contract to the Middle East. This contract was substantial and the adverse variance to month 10 is £1.6 million. This contract will not deliver this year. This has been offset by a significant improvement in Research and Development income this year with a late allocation of funding and recent work to cleanse our Research databases. We have also reviewed the ledger position for any revenue items that have been included in capital. We have moved £1 million of expenditure to revenue codes but £0.7 million of this is charitable donation funded. This net impact of £0.3 million appears as a Gross expenditure impact and Gross income impact.

The Trust has received a letter dated 10 March 2016 from NHS England Specialist Commissioning confirming their intention to fine the Trust £1,296,494.28 for an information breach (non-reporting). The Commissioners have removed £1,080,411.92 from the Trust monthly contract payment in February and have signalled their intention to remove £216,082.36 in March. Recent discussions have seen the Commissioner offer 50% reinvestment to contribute to costs of mitigation incurred by the Trust. This represents £540,205.96 for the first ten months of the year which the Trust has recognised in the position reported here. The Trust has incurred expenditure in excess of £2.3 million to remedy the non-reporting of activity this year. The Trust requested support for these validation costs but was rejected. The Trust has proposed a further reinvestment based upon forecast outturn against the is contract and this is still subject to negotiation.

**Forecast**

The Trust is forecasting a deficit of £11.1 million. The Trust will seek to mitigate the fine not reinvested. The significant items affecting spend in the last month of the year include:

- The balance of the March fine assuming 50% reinvestment
- Depreciation charges for assets under construction coming into use and the late profiled spend of the Capital programme
- Gastro income reduction and review costs - £0.4 million.
- Costs of validation - £0.4 million. These costs were anticipated to be £300,000 per month in Month 9 but have increased to £400,000-500,000 in the final two months
- Debt provision - £0.9 million. This has increased in light of the continuing growth in IPP trading and following a detailed review in Month 11.
- The adjustment to straight line extrapolation recognises that a number of one off adjustments have been made in month including the Capital to Revenue adjustment.

Attachment Q

| | M11 Actual | M10 Actual £m's | M09 Actual £m's |
|---|---|---|---|
| | | | |
| **M10 Position** | **(8.9)** | **(5.0)** | **(3.3)** |
| Extrapolation M11-12 | (0.5) | (1.0) | (1.1) |
| **Forecast Straight-line Extrapolation** | **(9.4)** | **(6.0)** | **(4.4)** |
| Adjustments to the straightline extrapolation | 0.8 | (0.5) | (2.1) |
| **Adjusted Extrapolation** | **(8.6)** | **(6.5)** | **(6.5)** |
| Depreciation | (0.6) | (0.8) | (0.9) |
| RTT Validators | (0.4) | (0.5) | (0.6) |
| RTT Fine | (0.2) | - | (1.5) |
| IPP Income provision | - | (0.3) | - |
| IPP Debt Provision | (0.9) | (1.2) | - |
| Gastro service reduction & review | (0.4) | (0.7) | (1.1) |
| P&E consultancy | - | (0.3) | (0.4) |
| Additional temporary staffing and consumables | - | (0.5) | (0.5) |
| IPP adjustments including spinal reduction | - | (0.3) | (0.7) |
| Other | - | - | 1.1 |
| **Total Adjustments** | **(2.5)** | **(4.6)** | **(4.6)** |
| | | | |
| **Forecast** | **(11.1)** | **(11.1)** | **(11.1)** |

**Pay**

Pay is £4.1 million overspent against plan and £6.5 million higher than the previous year (3.3%). We have increased spend on our permanent workforce by £5.1 million since last year but remain £13.8 million underspent against budget (7.1%). We are filling these vacant posts and meeting other operational pressures with £13.7 million of Bank expenditure and £6.2 million of Agency expenditure. The Trust has seen agency spending rise from 2.8% of permanent and bank pay in January to 3.2% in February, which is partly due to a transfer of costs from consultancy to agency (£0.2 million) and is also being impacted by the monthly spend on validation of £0.4 million. The Trust has been issued with an agency cap target for 2016/17. There is some risk that this cap will impair the ability of the Trust to continue validation of RTT records and this will be raised with the Regulator.

Bank and Agency spending appears stable between this year and last with the exception of validator costs in Administrative functions but analysis of the make-up of the spend shows that there is some shift in where expenditure is being incurred. There is a discernible shift from Agency to Bank in the Healthcare Support worker group but this is counteracted in the Administration roles. The driver for this pattern is the remedial action for Referral to Treatment (RTT) times. There is an additional pay pressure within the Junior Doctor pay group. At the start of the year the Trust had Junior Doctor training posts withdrawn. The removal of these posts by Health Education North, Central and East London Deanery created sustainability issues with night time cover. This was initially covered by Consultant cover. Locum Junior Doctors and other permanent posts have now been recruited to cover this pressure. This is, however, an unplanned pressure this year. The Trust has been informed that a number of these training posts will be reinstated in 2016/17.

**Non Pay**
Non Pay is below plan by £2.2 million; however, this is £7.9 million higher than last year. The change from last year is largely attributable to the £3.8 million reduction in pass through payments, the fine and the £1 million capital to Revenue gross impact noted above. The favourable variance against plan is, however, driven by multiple factors including lower activity and thus lower activity related costs but also a significant proportion is managed underspends in central and Divisional budgets.

**Conclusion**
The deterioration in month is therefore largely attributable to an underlying fall in income (£1 million) including a reduction in IPP private patient income (£0.2 million), Fines (£0.5 million), increasing staff costs (£0.9 million) including continuing RTT validation agency costs (£0.5 million), a Capital to Revenue transfer in month (£0.3 million), and increased non pay costs for clinical supplies (£0.2 million).

**Monitor Financial Sustainability rating**
The key performance indicator for variance in Income & Expenditure Margin as a percentage of income has scored as 2. This target measures accuracy of planning and because we are over 1% away from plan our score has dropped. The score does not consolidate into the overall Monitor risk rating. The impact of the fine is to reduce the overall metric from a planned 4 to 3 in our forecast and current position.

**Balance Sheet**
The Trust continues to enjoy a strong Balance Sheet. There are total Gross Debtors of £32.6 million of which Private Patients account for £20.9 million. We have provisions of £6.6 million against these debts and £1.6 million is debt with the Charity. Private Patient debt is climbing in March and action is planned to address this in the next few days.

**Cash**
Cash balances are higher than plan due to the better than planned EBITDA position and underspend on the Capital programme. We currently have £72.4 million of cash on deposit or in hand. The cash deposits are monitored daily and generally placed on 7 day deposit. We are currently paying 87% of the value of creditors within the better payment practice code target. The Trust is seeking to improve this.

**Action required from the meeting**
The Committee is asked to note the financial position for the eleven month period to 29 February 2016.

**Contribution to the delivery of NHS / Trust strategies and plans**
The delivery of the financial outturn and financial plan for 2015/16

**Financial implications**
As noted within the report

**Who needs to be told about any decision?**
None Noted

**Legal issues**
None

**Who is responsible for implementing the proposals / project and anticipated timescales**
None noted

**Who is accountable for the implementation of the proposal / project**
Executive Directors

# Great Ormond Street Hospital for Children NHS FT - Summary Financial Performance Report. 11 Months to 29 February 2016

~ The Trust is reporting a deficit of £9.0m, excluding capital donations, for the first eleven months of 2015/16, which is £2.0m favourable to the year to date plan.
~ The Trust has been fined £0.5 million and is forecasting a year end fine of £0.6 million and is forecasting a deficit for the year of £11.1 million.

~ EBITDA is £13.5m year to date, a deficit of £1.7m in Month 11. The year to date EBITDA is £1.5m better than plan and represents 3.8% of income. EBITDA in Month 11 is £2.9m adverse against the plan.
* NHS income (excluding pass through) is below plan by £1.7m, which is due to the net effect of underperformance in surgery offset by income from the prior years contract settlement and improved tariffs. In month NHS income is £0.7m adverse to plan.
* Private patient income is £6.0m above plan to date, but in Month 11 underperformed by £0.2m.
* Pay is £4.1 worse than plan, £1.4m of which was the in month variance, and £6m of which is year to date agency spend.
* Non pay excluding pass through is £1m less than 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.*

| I&E | Current Month | | | Current Year Year to Date | | | YTD Prior Year Year to Date | | RAG Rating |
|---|---|---|---|---|---|---|---|---|---|
| | Budget | Actual | Variance | Budget | Actual | Variance | Actual 2014/15 | Variance CY vs PY | Current Year Variance |
| | (£m) | (£m) | (£m) | (£m) | (£m) | (£m) | (£m) | (£m) | |
| NHS & Other Clinical Revenue | 20.3 | 19.6 | (0.7) | 223.5 | 222.3 | (1.3) | 224.1 | (1.9) | R |
| Pass Through | 4.5 | 4.9 | 0.4 | 51.9 | 50.1 | (1.7) | 46.3 | 3.8 | |
| Private Patient Revenue | 3.7 | 3.5 | (0.2) | 38.9 | 45.0 | 6.0 | 38.5 | 6.5 | G |
| Non-Clinical Revenue | 3.8 | 4.7 | 1.0 | 40.3 | 40.3 | (0.0) | 42.1 | (1.8) | G |
| **Total Operating Revenue** | **32.3** | **32.7** | **0.5** | **354.6** | **357.6** | **3.0** | **351.0** | **6.6** | |
| Permanent Staff | (17.7) | (16.8) | 0.9 | (195.1) | (181.3) | 13.8 | (176.2) | (5.1) | |
| Agency Staff | (0.0) | (1.2) | (1.2) | (0.2) | (6.2) | (6.0) | (5.1) | (1.1) | |
| Bank Staff | (0.2) | (1.3) | (1.1) | (1.7) | (13.7) | (12.0) | (13.3) | (0.4) | |
| **Total Employee Expenses** | **(17.9)** | **(19.3)** | **(1.4)** | **(197.0)** | **(201.2)** | **(4.1)** | **(194.6)** | **(6.5)** | R |
| Drugs and Blood | (1.0) | (1.0) | 0.0 | (10.5) | (9.8) | 0.6 | (9.7) | (0.1) | G |
| Other Clinical Supplies | (3.2) | (4.3) | (1.1) | (35.1) | (36.3) | (1.1) | (34.1) | (2.1) | R |
| Other Expenses | (4.4) | (4.9) | (0.5) | (48.1) | (46.7) | 1.4 | (45.3) | (1.4) | G |
| Pass Through | (4.5) | (4.9) | (0.4) | (51.9) | (50.1) | 1.7 | (46.3) | (3.8) | |
| **Total Non-Pay Expenses** | **(13.1)** | **(15.2)** | **(2.1)** | **(145.6)** | **(142.9)** | **2.7** | **(135.5)** | **(7.4)** | |
| **EBITDA (exc Capital Donations)** | **1.2** | **(1.7)** | **(2.9)** | **12.0** | **13.5** | **1.5** | **20.9** | **(7.4)** | G |
| Depreciation, Interest and PDC | (2.3) | (2.2) | 0.0 | (23.0) | (22.5) | 0.5 | (22.1) | (0.4) | |
| Net (Deficit)/Surplus (exc Cap. Don. & Im | (1.0) | (4.0) | (2.9) | (11.0) | (8.9) | 2.1 | (1.2) | (7.8) | G |
| **EBITDA %** | **3.8%** | **-5.2%** | | **3.4%** | **3.8%** | | | | |
| Estimated impairments | | | | | | | | | |
| Capital Donations | 5.1 | 6.0 | 0.9 | 37.4 | 26.8 | (10.6) | | | |

## Key Performance Indicators

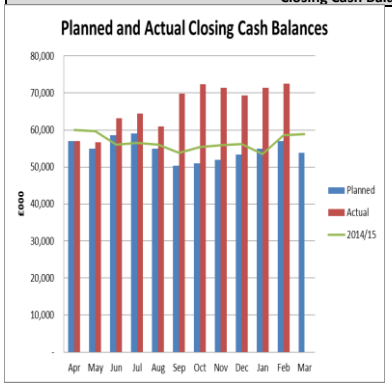
| KPI | Annual Plan | Q4 Plan | YTD Actual | Forecast | Rating |
|---|---|---|---|---|---|
| Liquidity | 4 | 4 | 4 | 4 | G |
| Capital Service Coverage | 3 | 3 | 3 | 4 | G |
| I&E Margin | 4 | 4 | 4 | 4 | G |
| Variance in I&E Margin as % of income | 4 | 4 | 1 | 3 | R |
| Overall | 4 | 4 | 4 | 4 | G |

| Statement of Financial Position | 31 March 2015 Actual | 29 Feb 2016 Planned | 29 Feb 2016 Actual |
|---|---|---|---|
| | £m | £m | £m |
| Non-Current Assets | 372.9 | 411.4 | 393.7 |
| Current Assets (exc Cash) | 56.3 | 59.1 | 62.2 |
| Cash & Cash Equivalents | 58.9 | 57.0 | 72.4 |
| Current Liabilities | (47.9) | (61.5) | (70.2) |
| Non-Current Liabilities | (6.7) | (6.2) | (6.3) |
| **Total Assets Employed** | **433.5** | **459.8** | **451.8** |

| Capital Expenditure | Annual Plan | 29 Feb 2016 Planned | 29 Feb 2016 Actual |
|---|---|---|---|
| | £m | £m | £m |
| Redevelopment - Donated | 37.6 | 32.9 | 25.2 |
| Medical Equipment - Donated | 2.9 | 2.7 | 1.6 |
| Estates - Donated | 0.0 | 0.0 | 0.0 |
| ICT - Donated | 2.0 | 1.8 | 0.0 |
| Total Donated | 42.5 | 37.4 | 26.8 |
| Redevelop& equip - Trust Funded | 9.9 | 9.4 | 7.3 |
| Estates & Facilities - Trust Funded | 4.9 | 4.4 | 0.9 |
| ICT - Trust Funded | 5.0 | 4.8 | 2.7 |
| Total Trust Funded | 19.8 | 18.6 | 10.9 |
| **Total Expenditure** | **62.3** | **56.0** | **37.7** |

| | 31-Mar-15 | 31-Jan-16 | 29-Feb-16 | RAG Rating |
|---|---|---|---|---|
| NHS Debtor Days (YTD) | 25.53 | 4.65 | 6.85 | G |
| IPP Debtor Days | 130.73 | 181.90 | 182.25 | R |
| IPP Overdue Debt (£m) | 6.36 | 11.08 | 11.37 | R |
| Creditor Days | 33.00 | 30.90 | 36.20 | A |
| BPPC - Non-NHS (YTD) (number) | 88.3% | 85.0% | 85.4% | A |
| BPPC - Non-NHS (YTD) (£) | 91.8% | 87.7% | 87.2% | A |

**Closing Cash Balance**



Attachment R

Great Ormond Street Hospital for Children NHS Foundation Trust

| | |
|---|---|
| **Trust Board**<br>**1st April 2016** | |
| **Regular report on Infection Prevention and Control**<br><br>**Submitted by: Dr John Hartley, DIPC** | **Paper No: Attachment R** |
| **Aims / summary**<br>To update the Board on Infection Prevention and Control issues since the last report and current plans | |
| **Action required from the meeting**<br>Board support for actions and feedback. | |
| **Contribution to the delivery of NHS Foundation Trust strategies and plans**<br>Essential to achieve zero harm; minimising risk of infection is a central Trust goal | |
| **Financial implications**<br>Failure to prevent or control infections leads to harm and cost.<br>Individual penalties may follow specific HCAIs in future. | |
| **Who needs to be told about any decision?**<br>Infection prevention and control is responsibility of all staff. | |
| **Who is responsible for implementing the proposals / project and anticipated timescales?**<br>Divisional and Corporate Units and all staff<br>Infection Prevention and Control Team. | |
| **Who is accountable for the implementation of the proposal / project?**<br>Director of Infection Prevention and Control | |

Great Ormond Street Hospital for Children NHS Foundation Trust

**Regular DIPC Infection Prevention & Control Report to Trust Board**
**29/3/2016**

1. **Infection Prevention and Control (IPC) management arrangements - Administration, data and electronic infection prevention management system**

Issue: administration/data management post vacant; electronic management system outdated.
Risk: data not provided; surveillance and control systems not optimal; staff withdrawn from clinical work as they struggle with data management and preparation.
Solution: Obtain support from Division and use short term staff appointments
**Action required** – bid for new system or inclusion in EPR brief.

2. **Antibiotic stewardship** –

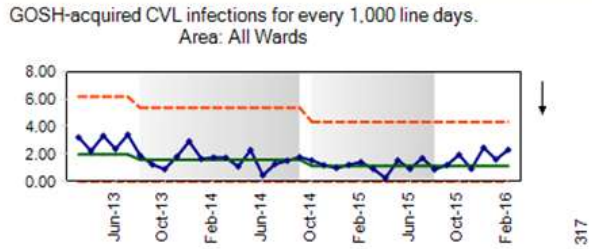
Requirement – to develop programme in line with National guidance.
Progress: meeting of Microbiology/Infection Control/Infectious diseases with Deputy medical director assigned work into three broad streams: antimicrobial policy, audit of compliance, and communication/education/engagement with assigned responsibility.
**Action Required**: Develop plan for 2016/17

3. **Health care associated infection (HCAI) statistics**

| | **Last three months Dec 15 – Feb 16** | | **Previous 3 months Sept 15 – Nov 15** | |
|---|---|---|---|---|
| | **Developed in hospital** | **Admitted with** | **Developed in hospital** | **Admitted with** |
| **HCAI Mandatory national reporting** | | | | |
| MRSA bacteraemia | **0** | **0** | **0** | **0** |
| MSSA bacteraemia | **3** | **1** | **3** | **8** |
| E. coli bacteraemia | **3** | **2** | **2** | **2** |
| C. difficile infection | **5** | **3** | **0** | **1** |
| | | | | |
| **HCAI non-mandatory internal reporting** | | | | |
| Infection: | | | | |
| GOS acquired CVC related bacteraemia | **28 (2.1/1000 day) See graphs below** | | **18 (1.4/1000 day)** | |
| Respiratory viral infection | **63 acquired** | **137** | **36** | **64** |
| Enteric viral infection | **45 acquired** | **49** | **29 acquired** | **44** |
| | | | | |
| Colonisation: | | | | |
| MRSA colonisation | **2 acquired** | **35** | **3 acquired** | **48** |
| | | | | |
| MDR GN (non CPO) colonisation | **8** | **31** | **14** | **42** |
| Carbapenemase producing (CPO) GN | **1 (possible)** | **5** | **0** | **2** |
| | | | | |
| MDR GN = Multi antibiotic resistant gram negative 'alert' organism ; CPO = carbapenemase producing organism | | | | |

Attachment R

. (Central Venous Lines)

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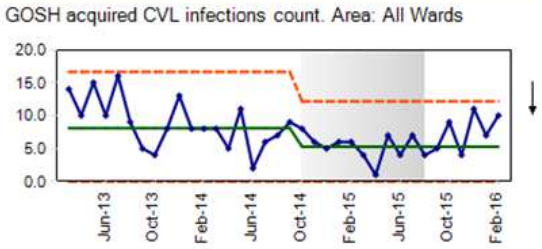



| **Surgical site infection** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Procedure** | **Lost to follow up** | **Parent reported** | **Superficial incisional** | **Deep incisional** | **Organ space** | **Annual total** | **% infection** |
| **All spines 2015** | **6** | **7** | **6** | **0** | **0** | **188** | **6.9** |

Other Surgical specialty surveillance – routine surveillance is undertaken in cardiothoracic, other surgical specialties and neurosurgery through divisional specific groups.
**Action**: Develop data such that it can be presented quarterly to Board.
Focus on standardisation and compliance with all elements of care bundle across patient pathways, aligning with the 'One Theatre' project already initiated.

### 4. Outbreaks or preventable high risk exposure events. Dec 15 – Feb 16

| **Date** | **Organism and issue** | **Ward** | **Outcome** |
|---|---|---|---|
| Dec 2016 | Norovirus cross infection | Elephant, level 6 | Restricted entry |
| Dec 2016 | Pertussis – patients exposure | Staff member | Prophylaxis given to children |
| Dec 2016 | Cluster of wound | Cardiothoracic | Investigation undertaken |
| Jan 2016 | Measles – staff and patient exposure. | PICU and Rainforest | Staff exclusions and adverse impact on admissions.<br>Unverified ventilation exposed further impacting on service. |
| Jan 2016 | Measles | Lion | 'Near miss' measles exposure |
| Jan 2016 | Influenza A cross infection | Rainforest | Ward closed 4 days; additional cleaning, prophylaxis given |
| Feb 2016 | Diarrhoea and vomiting | Peter Pan | Beds temporarily closed to enable cleaning; entry restrictions 2 weeks |
| Feb 2016 | RSV B (respiratory) | Bumblebee | Ward closed to admissions 9 days |

### 5. Infection prevention and control regular audits and data display

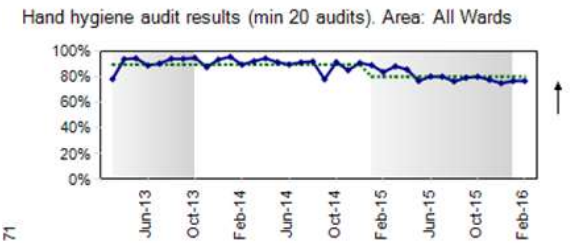
Audits undertaken by link staff, according to a monthly schedule.

Data:

| Hand hygiene compliance: | **Jan 2016** | **Feb 2016** |
|---|---|---|
| All trust – based on all returns | 96% | 94% |
| All trust (scored non-compliant if minimum audits not done) | 76% | 76% |
| CVC insertion – all returns | 100% | 100% |
| CVC ongoing care bundles: | | |
| All trust – based on returns | 91% | 91% |
| All trust (scored non-compliant if minimum audits not done) | 76% | 79% |
| PIVC insertion – all returns | 89% | 93% |

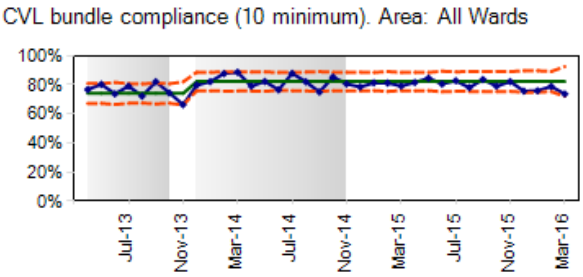
| | | |
|---|---|---|
| PIVC ongoing care – all returns | 92% | 91% |

Dash board display of continuous data:




Wards that have not completed at least 20 returns in February

Cardiac Catheter Lab, Giraffe, Haemophilia Centre, Koala, Lion, Miffy, Neonatal Intensive Care Unit, Ophthalmology Outpatients, Paediatric Intensive Care Unit, Radiology, RANU, Renal Support Unit, Respiratory Sleep Unit, Safari, Theatres, Woodpecker

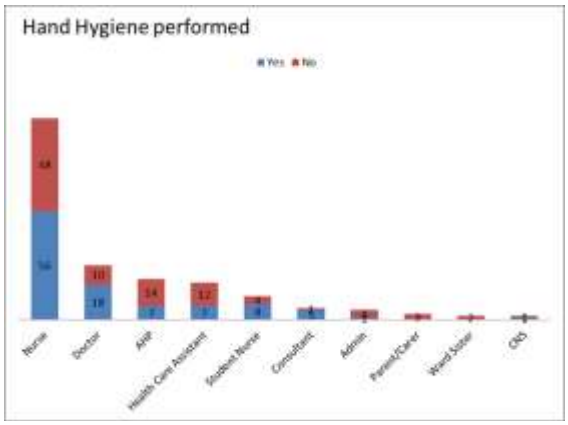


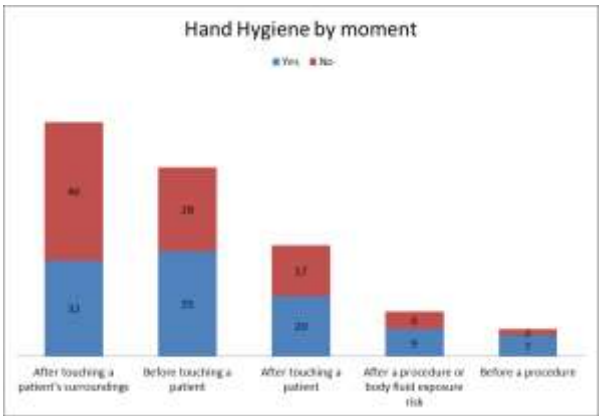

Wards that have not completed at least 10 returns in February

Lion, Neonatal Intensive Care Unit, Paediatric Intensive Care Unit

## 6. Hand hygiene audit undertaken by IPC team

202 observations undertaken of 21 wards by IPC team, against the '5 moments'




| Staff Group | Observations | % undertaking hand hygiene |
|---|---|---|
| Admin | 5 | 20% |
| AHP | 21 | 33% |
| CNS | 2 | 50% |
| Consultant | 6 | 83% |
| Doctor | 28 | 64% |
| Health Care Assistant | 19 | 37% |
| Nurse | 104 | 54% |
| Parent/Carer | 3 | 0% |
| Student Nurse | 12 | 67% |
| Ward Sister | 2 | 0% |

**Actions;** See IPC committee report comments

**7. Estates and facilities – issues since last report:**
a. Legionella control in tap water –. The Frontage Building continues to have failures and additional work is underway. Clinical risk is not high and the building is in use.

c. Critical ventilation systems – verification schedule was not completed. Clinical areas and estates are working to implement this.

e. Heater cooler units for cardiac bypass- mycobacterium infection risk remains but is low.

**8. IPC Training - At March 11th 2016**

Trust compliance with level 1 training – 86%
Trust compliance with level 2 training – 58%
(Data may not be accurate)
Actions:

1. To improve data IPC will be part of the new learning information management trial
2. Divisions need to monitor and enable compliance.

**9. Infection Prevention and Control Committee – Main areas of discussion in meetings since last report**

1. Issue: Staff may not be immune, or not know their immunity, to measles, chicken pox (and whooping cough). a. New starters do not always complete appropriate screening before starting and b. no access to records of immunity out of hours c. Immunisation not mandatory, and does not offer long term protection for whooping cough.
   Outcome: For measles and chickenpox it was agreed OH clearance is mandatory and agreement has now been reached between OH and HR for a process. OH will verify current staff. An out of hours method will be created to permit review of immunity.
2. Issue: Staff are unable to implement isolation precautions for MRSA and MDR-GN colonised children in outpatient areas because number of children currently exceeds cubicles available.
   Outcome: Proposal was made to reduce some patient specific standards while focussing on general standards with cleaning and specific highly resistant children but the committee requested re-review of resource use to see if this could be avoided. Under review.
3. Issue: Staff do not always use personal respiratory protective equipment when advised.
   Outcome: Proposed modification of mask type for use in isolation precautions to increase staff compliance while maintaining adequacy. Working group to implement.
4. Issue: Estates are unable to implementing annual specialist ventilation schedule.
   Outcome: Escalation to executive level.
5. Issue: Parents are not informed of screening results, especially multidrug resistant gram negative organisms.
   Outcome: Committee approved information letter to be sent to parents of outpatients by IPC.
6. Issue: Increase in HCAI observed in trust - line infections, viral infections and cross infection
   Discussed under a number of headings:
7. Issue: Transmission based IPC precautions are often not implemented on recognition of symptoms.
   Outcome: Need to increase education and compliance with training.
8. Issue: Lower hand hygiene compliance detected in IPC audit
   Outcome: Discussed through heads of nursing. To move towards local audit based on the '5 moments'. To run an event on World Hand Hygiene day. **
9. Increase in GOS acquired CVC infections
   Discussion: CATCH trial data on blood stream infection presented.

   ** Since the last IPC meeting a Hand Hygiene CQUIN has been proposed that Trusts incorporate electronic monitoring into compliance. We will be seeking support for this, which will have a £2000 per bed start-up cost.

Attachment R

J C Hartley Consultant Microbiologist and DIPC
H Dunn Lead Nurse in Infection Prevention and Control 29/3/2016

Great Ormond Street Hospital for Children NHS Foundation Trust

**Trust Board**
1st April 2016

| **Safe Nurse Staffing Report for January 2016 and February 2016**<br><br>**Submitted by: Juliette Greenwood, Chief Nurse** | **Paper No: Attachment S** |
|---|---|

**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

## January 2016

## 1. Introduction

1.1 This report on GOSH Safe Nurse Staffing contains information from the month of January 2016. 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 January 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 January is:

| RN Day | RN Night | HCA Day | HCA Night | Total Fill Rate |
|---|---|---|---|---|
| 103% | 90% | 97% | 71% | 91% |

**ICI – No unsafe shifts reported in January**

- Fox and Robin had less dependent patients due to an increase inhaematology activity.
- Penguin and Giraffe had a rise in HCA requirement, due to an increase in day case activity (RTT) and a decrease in patient dependency at night.
- Elephant had an upturn bank usage due to the requirement to supervise of new starters.

**Surgery No unsafe shifts reported in January**

- The variance is due to vacancies and long term sickness
- Occasional bed closure on Sky due to nurse vacancies, some night shifts were back filled with HCA staff.

**CCCR – No unsafe shifts reported in January**

- Miffy ward - HCA shifts filled with registered staff as a result of the HCA vacancies and availability of trachy vent competent HCA's.
- Badger variation is due to sickness and maternity leave and fewer registered nurses required at night, the nurse in charge was able to take patients.
- Bear has had an increase in patient dependency which required both additional HCA and registered nurses.
- PICU at full capacity, increasing to 15 beds, 2 above plan on occasions, increased staffing numbers reflect this. Flamingo has recruited HCAs who are not yet rostered and both NICU and PICU have HCA vacancies.

**MDTS - No unsafe shifts reported in January**

- Eagle ward reports a slight increase registered staff due to newly recruited Band 5 requiring supervision and support.
- Kingfisher Ward has lower numbers, as it had planned seasonal closures at the beginning of the month.
- Rainforest Endo has required an increased need for registered staff due to high patient acuity.
- The HCA's variance is due to sickness and vacancies, the fill rate expected to improve when newly recruited staff start.

**Neurosciences - No unsafe shifts reported in January**

- Koala's variance is due to sickness or vacancies and this was covered with either bank staff, moving staff around or a ward sister/CNS working clinically. Koala more non registered staff working days which includes staff working as Patient Pathway Coordinators.
- MCU had a reduction in planned staffing, as patients were on home leave at the beginning of the month.

**IPP - No unsafe shifts reported in January**

- Bumblebee continues to utilise HCAs to care for infants without resident parents and tracheostomy patients. High acuity of patients requiring 1:1 nursing, registered nurses used when HCA's requests were unfilled.
- Butterfly Ward staffing at night reflects the patient cohort which was predominately Day Case Surgery activity. Ward Sister worked clinically to manage workload to ensure patient safety.
- Increase in HCAs, now fully established, however new starters are currently working in a supernumerary capacity whilst on induction.

2.1.3 The Clinical Site Practitioners (CSPs) report that no wards were declared unsafe during January, however there were 7 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 January. The table provides information on staff in post, vacancies and staff in the recruitment pipeline and includes bed closure information.

3.0.2 There continues to be a sustained effort over recent months to reduce the number of beds closed due to nurse staffing issues.12 out of 23 inpatient wards closed beds at various points during January. An average of 2.2 beds, were closed each day.

3.0.3 For the inpatient wards at February 1st registered and non-registered vacancies total 91 Whole Time Equivalents (WTE) a slight increase from 90 in December. This breaks down to 61 (61 in December) registered nurse (RN) vacancies (7.9% of RN total). HCA vacancies number 29 (18% of HCA total). Temporary nurses, mainly from GOSH Nurse Bank, employed on wards totalled 90 WTE, the January position was therefore the net vacancy rate was 1 WTE (19 in November and in December 10). This is due to staff coming out of supernumerary status. There are 52 RNs and 13 HCAs in the recruitment pipeline undergoing pre-employment checks.

### 3.1 Vacancies and Recruitment

3.1.1 There remains 29 HCA vacancies, this month's figures include Miffy ward's increase in establishment (3 posts). The challenge remains in recruiting and training HCAs in sufficient numbers to keep pace with turnover and high numbers failing to attend the assessment centre or are unsuccessful due to not demonstrating basic numeracy and literacy skills. There continues to be 17 unregistered (HCA) vacancies across the ICU areas (14) and Neurosciences (3), recruitment has remained on hold pending further work on the education pathway and local recruitment plans.

3.1.2 In total 52 Newly Registered Nurses were recruited from the December and January Assessment Centres, this includes 18 recruited from the Republic of Ireland, all are progressing through pre-employment checks and will commence employment at the end of March 2016. A further advert for Newly Registered Nurses was placed in early February and 13 were shortlisted for an assessment centre on the February 19th.

3.1.3 12 nurses are due to start the Newly Registered Rotation Programme planned for March 2016.

3.1.4 Over February and March the Trust will be represented at the Anglia Ruskin, Suffolk and Kingston Universities and Birmingham RCN jobs Fair.

3.1.5 We are again planning recruitment activity for the forthcoming year which includes attending a number of job fairs. These comprise of universities career fairs where we have successfully recruited from previously, as well as approaching new universities where child branch programmes are run, the national fairs and the fairs hosted at GOSH. Also additional HCA Assessment centres and Care Certificates are planned for 2016.

3.1.6 International recruitment (overseas nurses) continues and currently includes Ireland, the Netherlands, Italy, Australia and New Zealand. The process of registration with the NMC is costly for applicants and the level of assessment for language skills is planned to change this month, making the appointment of overseas staff more difficult. Agencies advise the use of 'benefits packages' to encourage nurses to relocate and a paper around these issues and costing is due to be discussed will be going to Nursing Workforce Programme Board for discussion.

3.1.7 An Adult Band 5 conversion programme is in the recruitment pipeline for this year and there are potentially 19 applicants interested from across the Trust, however there may be an issue with the amount of Salary Support funding following the national changes to Nurse Education.

3.1.8 51% (31) of RN vacancies in January are at band 6.

## 4. Key Challenges

- Recruitment and retention of HCAs.
- Recruitment of Band 6 Nurses.
- Retention of Band 5 and 6 Nurses.
- Recruitment of 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 January 2016.

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

| | |
|---|---|
| Numbers of C diff's | 3 |
| Number of MRSA bacteraemias | 0 |
| Number of MSSA bacteraemias | 0 |
| Number of E.coli bacteraemias | 1 |
| Number of outbreaks and whether any beds closed | 1 – Norovirus outbreak on level 6 VCB; no bed closures<br>1 – Measles exposure resulting in a number of staff having to be excluded from work during the incubation period; no beds closed<br>1 – Swine flu outbreak on Rainforest E/M; 1 bed space in the bay was closed for 4 days due to lack of single rooms |
| Carbapenemase-producing Enterobacteri-aceae | 4 possible CPEs awaiting confirmation from reference lab |

### 5.4 Pressure ulcers

| | | |
|---|---|---|
| **Grade 3** | **0** | |
| **Grade 2** | **7** | 2 Bumblebee, 1 Bear, 1 Eagle , 1 PICU, 1 NICU, 1 CICU, |

5.4.1 Positively - the Trust has not had a grade 3 pressure ulcer for 21 months. However, the Trust continues to report higher levels of grade 2 pressure ulcers than previously linked to medical devices such as non-invasive ventilation, endotracheal tubes and more recently thrombo-embolitic stockings.

All of these pressure ulcers are currently seen as avoidable as the Trust continues to seek prevention of such ulcers. Interventions have been put in place and raising awareness continues as previously reported.

5.5 **Deteriorating patient**

There were 16 2222 calls made in January 2016. There were 4 cardiac arrests, 2 of which may have been preventable and 6 respiratory arrests 2 of which may have been preventable. There were also 8 unplanned admissions to Paediatric intensive care. Reviews showed that these situations were well managed and there were many examples of good practice. In 5 cases it was identified that frequency of observations and escalation of the patient's condition in line with the policy could have been better.

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

There were 2 incidents reported by Staff on Miffy ward related to unsafe staffing. On both occasions a patient deteriorated and support was needed from the clinical emergency team in the hospital. The incidents were well managed and a review of the patient's deterioration did not find any gaps in the patients care prior to the deterioration and the deterioration was well managed. The ward sister reflected that staffing levels were safe and there was an appropriate level of care for the patients, a clear escalation plan for staff is in place.

5.7 **Pals concerns raised by families regarding nurse staffing - 1**

1 family raised concerns to Pals in January due to their admission being cancelled on the day due to lack of beds.

5.8 **Complaints received regarding nurse safe staffing – 1**

The Trust received 1 formal complaint in January 2016 where a private patient's mother raised several concerns one of which related to being sent to a closed ward in the Southward building which did not have nursing cover. The subsequent investigation has concluded that this was not the case.

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 January 2016 has increased to 22% (December 19%). The target response rate has increased to 60%.
- The overall percentage to recommend score is 99%.
- Families that were extremely likely to recommend GOSH to their friends and family equalled 88% (555) and 11% responded as likely to recommend compared with 90% (475) and 8% (45) in December 2015.
- The following very positive comments were received regarding the kindness, caring, knowledgeable, professionalism and friendliness of staff.

- Four families (Fox, Kingfisher, Squirrel & Koala) commented on concerns about plans of care, being kept informed and unhappy with the level of care their child received.

## 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 January, 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 and HCA's.

# GOSH NURSE SAFE STAFFING REPORT

## February 2016

## 1. Introduction

1.1 This report on GOSH Safe Nurse Staffing contains information from the month of Februaryuary 2016. 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 February 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 February is:

| RN Day | RN Night | HCA Day | HCA Night | Total Fill Rate |
|---|---|---|---|---|
| 105.9% | 91.1% | 95.3% | 63.3% | 91.7% |

**ICI – No unsafe shifts reported in February**

- HCA' s have been move within the division due to an increase in sickness across Fox, Giraffe, Lion, Robin and Penguin and vacancies on Fox and Robin.
- Elephant and Penguin have had a rise in the dependency of patients.

**Surgery - No unsafe shifts reported in February**

- The variance in HCA's is due to staff being moved from days to nights which is not currently part of planned staff hours and one member staff reducing their hours recently on Peter Pan.
- Beds closed on Sky ward due to nurse vacancies.

**CCCR – No unsafe shifts reported in February**

- The variance across all intensive care areas in care staff (CICU, PICU & NICU) is due to HCA's vacancies. NICU opened 2 additional beds to support an increase in patient activity, registered staff numbers reflect this.
- Miffy - More qualified nurses used due to lack of availability trachy vent competent HCA staff and HCA vacancies
- Bear – Additional staff required due to patient dependency and acuity – 10 high dependency patients plus a child requiring 1:1 nursing in a cubicle.
- Badger continues to have 2 x HCA's on maternity and one on long term sick and discrepancy in registered staffing is as a result of sickness, 1 x on secondment and another on a career break.

**MDTS - No unsafe shifts reported in February**

- Eagle's variance is due to high patient acuity and dependency which includes an unplanned Transplant and 2 x patients on an end of life pathway
- Kingfisher, Rainforest Gastro and Endo/Met is due to HCA vacancies and nurse vacancy on Rainforest Endo/Met, this will improve in March when newly recruited Nurse and HCA's commence.

**Neurosciences - No unsafe shifts reported in February**

- The difference is due to short notice sickness or vacancies which were covered by either swapped shifts, ward sister/CNS working clinically or bank staff and 2 non-registered staff working days as a HCA & a Patient Pathway co-ordinator.

**IPP - No unsafe shifts reported in February**

- Bumblebee continues to utilise HCAs to care for infants without resident parents and tracheostomy patients requiring 1:1 care.
- Butterfly Ward registered staffing at night reflects the patient cohort which was predominately Day Case Surgery and the moving of nursing staff to support patient dependency on Bumblebee. The increase in HCA's number is due the provision of additional support to long term patients and newly appointed staff working in a supernumerary capacity.

2.1.3 The Clinical Site Practitioners (CSPs) report that no wards were declared unsafe during February, however 2 shifts are noted where wards reported being short of staff but safety was not compromised.

## 3.0 General Staffing Information

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

3.0.2 9 (12 in January) out of 23 inpatient wards closed beds at various points during February. An average of 2.2 beds, were closed each day which is a significant improvement from February 2015 which had an average of 11.3 beds closed each day.

3.0.3 For the inpatient wards at March 1st registered and non-registered vacancies total 116 Whole Time Equivalents (WTE) increase from 91 in January. This breaks down to 88 (61 in January) registered nurse (RN) vacancies (10.6% of RN total) and HCA vacancies number 28 (29 in January), (18% of HCA total). Temporary nurses, mainly from GOSH Nurse Bank, employed on wards totalled 113 WTE, the February position was therefore a 3 net vacancy rate (10 in December and 1 in January). The slight increase in registered nurses vacancies is in keeping with seasonal trends however in comparison to February 2015 there has been a small decrease in overall vacancies despite the recent increase in establishments for CCCR.

## 3.1 Vacancies and Recruitment

3.1.1 There continues to be 28 HCA vacancies and there remain a significant number of unregistered (HCA) vacancies (15) across the ICU areas (12) and Neurosciences (3) where recruitment is still on hold pending local work on the education pathway and recruitment plans.

3.1.2 Of 52 Newly Registered Nurses who were recruited from the December and February Assessment Centres, 45 are to commence employment at the end of March with a further 7 with a delayed start date, due to pre-employments checks and on their successful completion of their nurse training. There are also 7 newly appointed HCA's due to start on inpatients ward across the Trust at the beginning on the 8th March 2016.

3.1.3 10 nurses will start the Newly Registered Rotation Programme planned for March 2016.

3.1.4 At the end of February, a meeting was held with purpose of gathering and sharing of ideas for developing a 5 year nurse recruitment and retention strategy which will include current recruitment & retention activity; Newly Qualified & experienced nurses' recruitment; trust, local, national & overseas/international recruitment; centralised & standardised recruitment; welcome, recruitment & retention packages; career pathways; service growth/expansion plans. This will interlinked with other work streams in the Trust and will be part of a wider programme.

3.1.5 42% (37) of RN vacancies in February are at band 6.

## 4. Key Challenges

- Recruitment and retention of HCAs.
- Recruitment of Band 6 Nurses.
- Retention of Band 5 and 6 Nurses.
- Recruitment of 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 February 2016.

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

| | |
|---|---|
| Numbers of C diff's | 5 (3 HAI, 2 CAI) |
| Number of MRSA bacteraemias | 0 |
| Number of MSSA bacteraemias | 2 (1 HAI, 1 CAI) |
| Number of E.coli bacteraemias | 1 |
| Number of outbreaks and whether any beds closed | 2 outbreaks, I vomiting on Peter Pan- control measures in place, 1 RSV B outbreak on Bumble-bee- ward closed (03/03/2016) |
| Carbapenemase-producing Entero-bacteriaceae | ?1 ( sent to reference lab for further testing) |
| Hospital acquired enteric virus infec-tions | 7 |
| Hospital acquired viral respiratory in-fections | 15 |

### 5.4 Pressure ulcers

| | | |
|---|---|---|
| **Grade 3** | **0** | |
| **Grade 2** | **7** | CICU x 5 (4 x ETT-avoidable, 1 x occipital –avoidable)<br><br>Squirrel x 2 (heel, back – avoidable) |

The number of pressure ulcers remains in line with previous months but higher than had been achieved in recent years. 4 of the pressure ulcers above refer to injuries from nasal

endotracheal tubes (NEET). A multidisciplinary working group is meeting to establish new working practice to reduce these incidences and increase educational awareness through the development of new prevention guidance. The new root cause analysis process is being used at present to investigate and implement action plans for all the above pressure ulcers. A trial of preventative dressings under NEET is also in progress.

5.5 **Deteriorating patient**

There were 7 x 2222 calls in February 2016, a reduction from the 16 in January. There was 1 cardiac arrest (considered not preventable) on Flamingo ward where sadly the child passed away. There were 3 respiratory arrests one of which may have been preventable. In addition there were 8 unplanned admissions to the Intensive care units. Reviews demonstrated that the majority of these cases were well managed with good observations and escalation of concerns about the patient's conditions.

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

There were 3 incidents reported by nursing staff regarding shortages of nurses or inadequate skill mix on shifts that resulted in delays in patient care such as administration of medications, placement of urinary catheters, turning of patients for pressure area care. These incidents occurred on Flamingo, Fox and Squirrel wards. The staffing was not felt to be unsafe but there was an adverse impact on patient care and experience.

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

There were 7 referrals to Pals relating to 5 operations/procedures that were cancelled on the day, 1 cancelled admission and 1 concern from a parent that their child was deteriorating in the 10 weeks they had waited for admission. The Trust has been operating at maximum capacity with increased pressures from RTT and it is unclear from these referrals whether nursing staff numbers contributed to the concerns reported

5.8 **Complaints received regarding nurse safe staffing – 1**

The Trust received 1 formal complaint in February 2016 in relation to 'substandard' nursing care on Fox ward where the mother cited long delays in nursing staff responding to problems with their child's intravenous infusions and how these problems were resolved.

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

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

Overall response rate for February 2016 has increased to 23.6% (data extracted 9/3/2016) compared to 22% in January 2015. The target response rate has increased to 60%.

- The overall percentage to recommend score is 98% (data extracted 9/3/2016).
- Families that were extremely likely to recommend GOSH to their friends and family equalled 87% (624) and 11% responded as likely to recommend compared with 88% (555) and 11% (69) in January 2016.

**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 February, 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. Work is currently underway on a 5 year Recruitment and Retention 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 and HCA's.

Attachment S

| Only complete sites your organisation is accountable for | | | Day | | | | Night | | | | Day | | Night | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward name | Main 2 Specialties on each ward | | Registered midwives/nurses | | Care Staff | | Registered midwives/nurses | | Care Staff | | Average fill rate - registered nurses/midwives (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses/midwives (%) | Average fill rate - care staff (%) |
| | 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 | | | | |
| Badger Ward | 340 - RESPIRATORY MEDICINE | | 2235 | 2306.25 | 332 | 296.69 | 1994 | 2069 | 332 | 208 | 103.2% | 89.4% | 103.8% | 62.7% |
| Bear Ward | 170 - CARDIOTHORACIC SURGERY | 321 - PAEDIATRIC CARDIOLOGY | 2644 | 3274.2 | 570 | 700.5 | 2644 | 2939.5 | 330 | 291.6 | 123.8% | 122.9% | 111.2% | 88.4% |
| Flamingo Ward | 192 - CRITICAL CARE MEDICINE | | 6578 | 7106.55 | 333 | 342.95 | 6198 | 6327.1 | 195 | 87.1 | 108.0% | 103.0% | 102.1% | 44.7% |
| Miffy Ward (TCU) | 340 - RESPIRATORY MEDICINE | | 663 | 763.25 | 995 | 614 | 663 | 600.3 | 663 | 481.2 | 115.1% | 61.7% | 90.5% | 72.6% |
| Neonatal Intensive Care Unit | 192 - CRITICAL CARE MEDICINE | | 2983 | 3515 | 331 | 103.5 | 2983 | 2718.38 | 0 | 32.4 | 117.8% | 31.3% | 91.1% | - |
| Paediatric Intensive Care Unit | 192 - CRITICAL CARE MEDICINE | | 5669 | 7021.9 | 333 | 230 | 5669 | 5633.15 | 333 | 151.2 | 123.9% | 69.1% | 99.4% | 45.4% |
| Elephant Ward | 370 - MEDICAL ONCOLOGY | 823 - HAEMATOLOGY | 1572 | 1578.82 | 332 | 414 | 1331 | 1147.3 | 332 | 340.4 | 100.4% | 124.7% | 86.2% | 102.5% |
| Fox Ward | 303 - CLINICAL HAEMATOLOGY | 313 - CLINICAL IMMUNOLOGY and ALLERGY | 1981 | 1732 | 330 | 181.9 | 1845 | 1467.5 | 330 | 174.2 | 87.4% | 55.1% | 79.5% | 52.8% |
| Giraffe Ward | 313 - CLINICAL IMMUNOLOGY and ALLERGY | 350 - INFECTIOUS DISEASES | 1000 | 1127 | 333 | 155.75 | 1000 | 772.4 | 333 | 164.8 | 112.7% | 46.8% | 77.2% | 49.5% |
| Lion Ward | 370 - MEDICAL ONCOLOGY | 303 - CLINICAL HAEMATOLOGY | 1575 | 1405.95 | 333 | 322 | 1334 | 1006.9 | 333 | 278.4 | 89.3% | 96.7% | 75.5% | 83.6% |
| Penguin Ward | 330 - DERMATOLOGY | 410 - RHEUMATOLOGY | 908 | 1104 | 333 | 584.35 | 667 | 616.7 | 333 | 64.85 | 121.6% | 175.5% | 92.5% | 19.5% |
| Robin Ward | 350 - INFECTIOUS DISEASES | 313 - CLINICAL IMMUNOLOGY and ALLERGY | 1831 | 1568.05 | 320 | 253 | 1600 | 1242.7 | 320 | 314.3 | 85.6% | 79.1% | 77.7% | 98.2% |
| Bumblebee Ward | 171 - PAEDIATRIC SURGERY | 420 - PAEDIATRICS | 2308 | 2507 | 329 | 540.5 | 1978 | 2232.4 | 659 | 530.35 | 108.6% | 164.3% | 112.9% | 80.5% |
| Butterfly Ward | 370 - MEDICAL ONCOLOGY | 420 - PAEDIATRICS | 2668 | 1919.5 | 333 | 724.55 | 2001 | 1135.45 | 333 | 282.2 | 71.9% | 217.6% | 56.7% | 84.7% |
| Eagle Ward | 361 - NEPHROLOGY | | 2095 | 2923.9 | 649 | 779.95 | 1299 | 1300.5 | 324 | 167.6 | 139.6% | 120.2% | 100.1% | 51.7% |
| Kingfisher Ward | 420 - PAEDIATRICS | | 1679 | 1772.95 | 862 | 526 | 312 | 379.4 | 0 | 66.9 | 105.6% | 61.0% | 121.6% | - |
| Rainforest Ward (Gastro) | 301 - GASTROENTEROLOGY | | 908 | 1170.8 | 667 | 318 | 667 | 731.3 | 667 | 206.6 | 128.9% | 47.7% | 109.6% | 31.0% |
| Rainforest Ward (Endo/Met) | 302 - ENDOCRINOLOGY | | 994 | 1029.15 | 663 | 253 | 994 | 673.8 | 331 | 262.7 | 103.5% | 38.2% | 67.8% | 79.4% |
| Mildred Creak | 711- CHILD and ADOLESCENT PSYCHIATRY | | 1048 | 923.1 | 581 | 570.35 | 476 | 369.2 | 431 | 303.1 | 88.1% | 98.2% | 77.6% | 70.3% |
| Koala Ward | 150 - NEUROSURGERY | 421 - PAEDIATRIC NEUROLOGY | 3147 | 3054.15 | 333 | 434.5 | 3055 | 2783.5 | 333 | 75.6 | 97.0% | 130.5% | 91.1% | 22.7% |
| Peter Pan Ward | 120 - ENT | 160 - PLASTIC SURGERY | 1483 | 1449 | 575 | 379.5 | 1391 | 1229.5 | 0 | 78.4 | 97.7% | 66.0% | 88.4% | - |
| Sky Ward | 110 - TRAUMA & ORTHOPAEDICS | 171 - PAEDIATRIC SURGERY | 1863 | 1867.9 | 651 | 694.5 | 1818 | 1594 | 0 | 57.5 | 100.3% | 106.7% | 87.7% | - |
| Squirrel Ward | 171 - PAEDIATRIC SURGERY | 101 - UROLOGY | 2811 | 2933.01 | 665 | 576 | 2524 | 2402.42 | 0 | 197.6 | 104.3% | 86.6% | 95.2% | - |

Attachment S

Appendix 2: Overview of Ward Nurse Staffing – February 2016

| 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 | 37.0 | 2.5 | 7.5 | 7.0 | 0.5 | 47.0 | 3.0 | 2.2 | 0.8 | 3.0 | | 0 | 0.1 |
| | Bear | 24 | 53.5 | 47.2 | 6.3 | 9.0 | 11.4 | -2.4 | 62.5 | 3.9 | 8.5 | -4.6 | 6.0 | 0 | 0 | 0.2 |
| | Flamingo | 17 | 121.0 | 101.8 | 19.2 | 10.8 | 4.0 | 6.8 | 131.8 | 26.0 | 21.8 | 4.3 | 8.0 | 1 | 0 | 0.0 |
| | Miffy (TCU) | 5 | 14.1 | 11.4 | 2.7 | 10.4 | 8.0 | 2.4 | 24.5 | 5.1 | 4.5 | 0.6 | 1.0 | | 0 | 0.0 |
| | NICU | 8 | 51.5 | 45.1 | 6.4 | 5.2 | 2.0 | 3.2 | 56.7 | 9.6 | 11.4 | -1.8 | | | 0 | 0.1 |
| | PICU | 13 | 83.1 | 96.3 | -13.2 | 8.9 | 3.0 | 5.9 | 92.0 | -7.3 | 9.3 | -16.6 | | | 0 | 0.0 |
| ICI-LM | Elephant | 13 | 25.0 | 19.0 | 6.0 | 5.0 | 3.9 | 1.1 | 30.0 | 7.1 | 4.1 | 3.0 | | | 0 | 0.0 |
| | Fox | 10 | 31.0 | 26.1 | 4.9 | 5.0 | 3.9 | 1.1 | 36.0 | 6.0 | 3.3 | 2.7 | | | 0 | 0.1 |
| | Giraffe | 7 | 19.0 | 17.0 | 2.0 | 3.1 | 3.1 | 0.0 | 22.1 | 2.0 | 1.0 | 1.0 | | | 0 | 0.0 |
| | Lion | 11 | 22.0 | 22.0 | 0.0 | 4.0 | 3.0 | 1.0 | 26.0 | 1.0 | 3.1 | -2.1 | | | 0 | 0.0 |
| | Penguin | 9 | 15.5 | 13.5 | 2.0 | 5.8 | 5.8 | 0.0 | 21.3 | 2.0 | 1.6 | 0.5 | | | 0 | 0.0 |
| | Robin | 10 | 27.2 | 22.7 | 4.5 | 4.5 | 2.2 | 2.3 | 31.7 | 6.8 | 3.9 | 2.9 | | | 0 | 0.4 |
| IPP | Bumblebee | 21 | 38.3 | 33.2 | 5.1 | 9.7 | 9.0 | 0.7 | 48.0 | 5.8 | 9.7 | -3.9 | 1.0 | 1 | 0 | 0.3 |
| | Butterfly | 18 | 37.2 | 27.4 | 9.8 | 10.5 | 9.9 | 0.6 | 47.7 | 10.4 | 4.1 | 6.3 | 0.0 | 0 | 0 | 0.0 |
| MDTS | Eagle | 21 | 39.5 | 33.5 | 6.0 | 10.5 | 11.0 | -0.5 | 50.0 | 5.5 | 3.1 | 2.4 | 0.0 | 3 | 0 | 0.4 |
| | Kingfisher | 16 | 17.1 | 14.2 | 2.9 | 6.2 | 4.9 | 1.3 | 23.3 | 4.2 | 1.1 | 3.2 | | | 0 | 0.0 |
| | Rainforest Gastro | 8 | 17.0 | 14.9 | 2.1 | 4.0 | 4.5 | -0.5 | 21.0 | 1.6 | 1.1 | 0.5 | | | 0 | 0.0 |
| | Rainforest Endo/Met | 8 | 15.6 | 12.6 | 3.0 | 5.2 | 3.5 | 1.7 | 20.8 | 4.7 | 1.8 | 2.9 | 3.0 | | 0 | 0.0 |
| Neuro-sciences | Mildred Creak | 10 | 11.8 | 11.2 | 0.6 | 7.8 | 6.4 | 1.4 | 19.6 | 2.0 | 0.5 | 1.5 | | | 0 | 0.0 |
| | Koala | 24 | 48.2 | 40.6 | 7.6 | 7.8 | 6.0 | 1.8 | 56.0 | 9.4 | 7.7 | 1.7 | | | 0 | 0.0 |
| Surgery | Peter Pan | 16 | 24.5 | 21.3 | 3.2 | 5.0 | 5.0 | 0.0 | 29.5 | 3.2 | 1.3 | 1.9 | 3.0 | | 0 | 0.0 |
| | Sky | 18 | 31.0 | 25.2 | 5.8 | 5.2 | 5.0 | 0.2 | 36.2 | 6.0 | 4.2 | 1.8 | 3.0 | | 0 | 0.5 |
| | Squirrel | 22 | 43.6 | 44.7 | -1.1 | 7.0 | 7.0 | 0.0 | 50.6 | -1.1 | 4.7 | -5.8 | 3.0 | | 0 | 0.1 |
| | **TRUST TOTAL:** | **324** | **826.2** | **737.9** | **88.3** | **158.1** | **129.5** | **28.6** | **984.3** | **116.9** | **113.7** | **3.2** | **31.0** | **5.0** | **0.0** | **2.2** |

Attachment S
Appendix 1: UNIFY Safe Staffing Submission – January 2016

| Only complete sites your organisation is accountable for | | | | | Day | | | | Night | | | | Day | | Night | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hospital Site Details | | Ward name | Main 2 Specialties on each ward | | Registered midwives/nurses | | Care Staff | | Registered midwives/nurses | | Care Staff | | Average fill rate - registered nurses/midwives (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses/midwives (%) | Average fill rate - care staff (%) |
| Site code *The Site code is automatically populated when a Site name is selected | Hospital Site name | | Specialty 1 | Specialty 2 | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | | | | |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Badger Ward | 340 - RESPIRATORY MEDICINE | | 2391 | 2277 | 354 | 299 | 2128 | 1891.1 | 354 | 216.7 | 95.2% | 84.5% | 88.9% | 61.2% |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Bear Ward | 170 - CARDIOTHORACIC SURGERY | 321 - PAEDIATRIC CARDIOLOGY | 2839 | 3349.5 | 618 | 687.5 | 2839 | 3158.6 | 354 | 497.5 | 118.0% | 111.2% | 111.3% | 140.5% |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Flamingo Ward | 192 - CRITICAL CARE MEDICINE | | 7038 | 6939.38 | 356 | 310.5 | 6635 | 6544.15 | 218 | 109.85 | 98.6% | 87.2% | 98.6% | 50.4% |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Miffy Ward (TCU) | 340 - RESPIRATORY MEDICINE | | 713 | 877.15 | 1069 | 848 | 713 | 698.2 | 713 | 548.1 | 123.0% | 79.3% | 97.9% | 76.9% |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Neonatal Intensive Care Unit | 192 - CRITICAL CARE MEDICINE | | 3188 | 3419.39 | 354 | 138 | 3188 | 2737.85 | 0 | 32.4 | 107.3% | 39.0% | 85.9% | - |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Paediatric Intensive Care Unit | 192 - CRITICAL CARE MEDICINE | | 6060 | 6593.85 | 356 | 264.5 | 6060 | 5705.98 | 356 | 129.6 | 108.8% | 74.3% | 94.2% | 36.4% |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Elephant Ward | 370 - MEDICAL ONCOLOGY | 823 - HAEMATOLOGY | 1690 | 1716.11 | 356 | 431.2 | 1426 | 1388.85 | 356 | 362.7 | 101.5% | 121.1% | 97.4% | 101.9% |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Fox Ward | 303 - CLINICAL HAEMATOLOGY | 313 - CLINICAL IMMUNOLOGY and ALLERGY | 2096 | 2030.55 | 349 | 148.1 | 1960 | 1667.8 | 349 | 250.5 | 96.9% | 42.4% | 85.1% | 71.8% |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Giraffe Ward | 313 - CLINICAL IMMUNOLOGY and ALLERGY | 350 - INFECTIOUS DISEASES | 1069 | 1352.8 | 356 | 195.5 | 1069 | 931.6 | 356 | 174.2 | 126.5% | 54.9% | 87.1% | 48.9% |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Lion Ward | 370 - MEDICAL ONCOLOGY | 303 - CLINICAL HAEMATOLOGY | 1690 | 1781.75 | 356 | 333.5 | 1426 | 1265.4 | 356 | 277.7 | 105.4% | 93.7% | 88.7% | 78.0% |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Penguin Ward | 330 - DERMATOLOGY | 410 - RHEUMATOLOGY | 977 | 1090.35 | 356 | 623.14 | 713 | 590.9 | 356 | 56.1 | 111.6% | 175.0% | 82.9% | 15.8% |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Robin Ward | 350 - INFECTIOUS DISEASES | 313 - CLINICAL IMMUNOLOGY and ALLERGY | 1990 | 1941.3 | 346 | 195.5 | 1733 | 1192.9 | 346 | 409.4 | 97.6% | 56.5% | 68.8% | 118.3% |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Bumblebee Ward | 171 - PAEDIATRIC SURGERY | 420 - PAEDIATRICS | 2465 | 2541.75 | 352 | 622.25 | 2113 | 2446.15 | 704 | 690.85 | 103.1% | 176.8% | 115.8% | 98.1% |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Butterfly Ward | 370 - MEDICAL ONCOLOGY | 420 - PAEDIATRICS | 2852 | 2309.5 | 356 | 979.5 | 2139 | 1254.92 | 356 | 303.8 | 81.0% | 275.1% | 58.7% | 85.3% |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Eagle Ward | 361 - NEPHROLOGY | | 2228 | 3485 | 687 | 1004 | 1375 | 1652.85 | 343 | 220.53 | 156.4% | 146.1% | 120.2% | 64.3% |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Kingfisher Ward | 420 - PAEDIATRICS | | 1817 | 1380.75 | 931 | 599 | 349 | 347 | 0 | 0 | 76.0% | 64.3% | 99.4% | - |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Rainforest Ward (Gastro) | 301 - GASTROENTEROLOGY | | 977 | 1115.95 | 713 | 253 | 713 | 758.8 | 713 | 301.65 | 114.2% | 35.5% | 106.4% | 42.3% |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Rainforest Ward (Endo/Met) | 302 - ENDOCRINOLOGY | | 1046 | 1093.77 | 697 | 264.5 | 1046 | 810.35 | 348 | 262.7 | 104.6% | 37.9% | 77.5% | 75.5% |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Mildred Creak | 711- CHILD and ADOLESCENT PSYCHIATRY | | 1126 | 930.03 | 632 | 586.2 | 511 | 427.1 | 465 | 391.2 | 82.6% | 92.8% | 83.6% | 84.1% |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Koala Ward | 150 - NEUROSURGERY | 421 - PAEDIATRIC NEUROLOGY | 3373 | 3302.65 | 355 | 452.5 | 3282 | 3078.5 | 355 | 121.6 | 97.9% | 127.5% | 93.8% | 34.3% |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Peter Pan Ward | 120 - ENT | 160 - PLASTIC SURGERY | 1588 | 1380 | 617 | 425.5 | 1497 | 1157 | 0 | 21.6 | 86.9% | 69.0% | 77.3% | - |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Sky Ward | 110 - TRAUMA & ORTHOPAEDICS | 171 - PAEDIATRIC SURGERY | 2035 | 1812.25 | 709 | 745 | 1989 | 1362.6 | 0 | 0 | 89.1% | 105.1% | 68.5% | - |
| RP401 | Great Ormond Street Hospital Central London Site - Rt | Squirrel Ward | 171 - PAEDIATRIC SURGERY | 101 - UROLOGY | 3017 | 2759.13 | 711 | 522 | 2707 | 2216.7 | 0 | 76.3 | 91.5% | 73.4% | 81.9% | - |

Attachment S

Appendix 2: Overview of Ward Nurse Staffing – January 2016

| | | | 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 | 36.0 | 3.5 | 7.5 | 5.0 | 2.5 | 47.0 | 6.0 | 2.4 | 3.6 | 2.0 | | 0 | 0.1 |
| | Bear | 24 | 53.5 | 55.0 | -1.5 | 9.0 | 9.0 | 0.0 | 62.5 | -1.5 | 3.7 | -5.2 | | | 0 | 0.1 |
| | Flamingo | 17 | 121.0 | 102.9 | 18.1 | 10.8 | 5.0 | 5.8 | 131.8 | 23.9 | 20.7 | 3.2 | 1.0 | 1 | 0 | 0.0 |
| | Miffy (TCU) | 5 | 14.1 | 12.4 | 1.7 | 10.4 | 6.5 | 3.9 | 24.5 | 5.6 | 4.8 | 0.8 | 1.0 | 3 | 0 | 0.0 |
| | NICU | 8 | 51.5 | 44.7 | 6.8 | 5.2 | 2.0 | 3.2 | 56.7 | 10.0 | 8.1 | 1.9 | | | 0 | 0.1 |
| | PICU | 13 | 83.1 | 97.2 | -14.1 | 8.9 | 3.0 | 5.9 | 92.0 | -8.2 | 7.6 | -15.8 | | | 0 | 0.0 |
| ICI-LM | Elephant | 13 | 25.0 | 23.8 | 1.2 | 5.0 | 4.2 | 0.8 | 30.0 | 2.0 | 0.1 | 1.9 | | | 0 | 0.0 |
| | Fox | 10 | 31.0 | 28.3 | 2.7 | 5.0 | 5.0 | 0.0 | 36.0 | 2.7 | 2.2 | 0.5 | | | 0 | 0.2 |
| | Giraffe | 7 | 19.0 | 18.8 | 0.2 | 3.1 | 3.0 | 0.1 | 22.1 | 0.3 | 0.4 | -0.1 | | | 0 | 0.0 |
| | Lion | 11 | 22.0 | 22.1 | -0.1 | 4.0 | 3.0 | 1.0 | 26.0 | 0.9 | 3.5 | -2.6 | | 1 | 0 | 0.0 |
| | Penguin | 9 | 15.5 | 15.0 | 0.5 | 5.8 | 5.6 | 0.2 | 21.3 | 0.7 | 1.1 | -0.4 | | 1 | 0 | 0.0 |
| | Robin | 10 | 27.2 | 24.8 | 2.4 | 4.5 | 4.7 | -0.2 | 31.7 | 2.2 | 3.1 | -0.9 | | 2 | 0 | 0.3 |
| IPP | Bumblebee | 21 | 38.3 | 33.2 | 5.1 | 9.7 | 9.0 | 0.7 | 48.0 | 5.8 | 11.7 | -5.9 | 1.0 | 1 | 0 | 0.3 |
| | Butterfly | 18 | 37.2 | 27.4 | 9.8 | 10.5 | 9.9 | 0.6 | 47.7 | 10.4 | 3.2 | 7.2 | | | 0 | 0.0 |
| MDTS | Eagle | 21 | 39.5 | 34.6 | 4.9 | 10.5 | 11.0 | -0.5 | 50.0 | 4.4 | 3.7 | 0.7 | | 3 | 0 | 0.5 |
| | Kingfisher | 16 | 17.1 | 14.2 | 2.9 | 6.2 | 4.8 | 1.4 | 23.3 | 4.3 | 0.8 | 3.5 | | 1 | 0 | 0.0 |
| | Rainforest Gastro | 8 | 17.0 | 15.9 | 1.1 | 4.0 | 4.5 | -0.5 | 21.0 | 0.6 | 1.7 | -1.1 | | | 0 | 0.0 |
| | Rainforest Endo/Met | 8 | 15.6 | 12.6 | 3.0 | 5.2 | 3.5 | 1.7 | 20.8 | 4.7 | 0.9 | 3.8 | | | 0 | 0.2 |
| Neuro-sciences | Mildred Creak | 10 | 11.8 | 10.0 | 1.8 | 7.8 | 7.6 | 0.2 | 19.6 | 2.0 | 0.2 | 1.8 | | | 0 | 0.0 |
| | Koala | 24 | 48.2 | 43.4 | 4.8 | 7.8 | 5.0 | 2.8 | 56.0 | 7.6 | 5.6 | 2.0 | | | 0 | 0.1 |
| Surgery | Peter Pan | 16 | 24.5 | 23.6 | 0.9 | 5.0 | 5.0 | 0.0 | 29.5 | 0.9 | 0.1 | 0.8 | 2.0 | | 0 | 0.1 |
| | Sky | 18 | 31.0 | 24.2 | 6.8 | 5.2 | 5.0 | 0.2 | 36.2 | 7.0 | 2.7 | 4.3 | 4.0 | | 0 | 0.1 |
| | Squirrel | 22 | 43.6 | 44.8 | -1.2 | 7.0 | 7.0 | 0.0 | 50.6 | -1.2 | 1.7 | -2.9 | 2.0 | | 0 | 0.1 |
| | **TRUST TOTAL:** | **324** | **826.2** | **764.9** | **61.3** | **158.1** | **128.3** | **29.8** | **984.3** | **91.1** | **90.0** | **1.1** | **13.0** | **13.0** | **0.0** | **2.2** |

Attachment S

| Only complete sites your organisation is accountable for | | | Day | | | | Night | | | | Day | | Night | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward name | Main 2 Specialties on each ward | | Registered midwives/nurses | | Care Staff | | Registered midwives/nurses | | Care Staff | | Average fill rate - registered nurses/midwives (%) | Average fill rate - care staff (%) | Average fill rate - registered nurses/midwives (%) | Average fill rate - care staff (%) |
| | 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 | | | | |
| Badger Ward | 340 - RESPIRATORY MEDICINE | | 2235 | 2306.25 | 332 | 296.69 | 1994 | 2069 | 332 | 208 | 103.2% | 89.4% | 103.8% | 62.7% |
| Bear Ward | 170 - CARDIOTHORACIC SURGERY | 321 - PAEDIATRIC CARDIOLOGY | 2644 | 3274.2 | 570 | 700.5 | 2644 | 2939.5 | 330 | 291.6 | 123.8% | 122.9% | 111.2% | 88.4% |
| Flamingo Ward | 192 - CRITICAL CARE MEDICINE | | 6578 | 7106.55 | 333 | 342.95 | 6198 | 6327.1 | 195 | 87.1 | 108.0% | 103.0% | 102.1% | 44.7% |
| Miffy Ward (TCU) | 340 - RESPIRATORY MEDICINE | | 663 | 763.25 | 995 | 614 | 663 | 600.3 | 663 | 481.2 | 115.1% | 61.7% | 90.5% | 72.6% |
| Neonatal Intensive Care Unit | 192 - CRITICAL CARE MEDICINE | | 2983 | 3515 | 331 | 103.5 | 2983 | 2718.38 | 0 | 32.4 | 117.8% | 31.3% | 91.1% | - |
| Paediatric Intensive Care Unit | 192 - CRITICAL CARE MEDICINE | | 5669 | 7021.9 | 333 | 230 | 5669 | 5633.15 | 333 | 151.2 | 123.9% | 69.1% | 99.4% | 45.4% |
| Elephant Ward | 370 - MEDICAL ONCOLOGY | 823 - HAEMATOLOGY | 1572 | 1578.82 | 332 | 414 | 1331 | 1147.3 | 332 | 340.4 | 100.4% | 124.7% | 86.2% | 102.5% |
| Fox Ward | 303 - CLINICAL HAEMATOLOGY | 313 - CLINICAL IMMUNOLOGY and ALLERGY | 1981 | 1732 | 330 | 181.9 | 1845 | 1467.5 | 330 | 174.2 | 87.4% | 55.1% | 79.5% | 52.8% |
| Giraffe Ward | 313 - CLINICAL IMMUNOLOGY and ALLERGY | 350 - INFECTIOUS DISEASES | 1000 | 1127 | 333 | 155.75 | 1000 | 772.4 | 333 | 164.8 | 112.7% | 46.8% | 77.2% | 49.5% |
| Lion Ward | 370 - MEDICAL ONCOLOGY | 303 - CLINICAL HAEMATOLOGY | 1575 | 1405.95 | 333 | 322 | 1334 | 1006.9 | 333 | 278.4 | 89.3% | 96.7% | 75.5% | 83.6% |
| Penguin Ward | 330 - DERMATOLOGY | 410 - RHEUMATOLOGY | 908 | 1104 | 333 | 584.35 | 667 | 616.7 | 333 | 64.85 | 121.6% | 175.5% | 92.5% | 19.5% |
| Robin Ward | 350 - INFECTIOUS DISEASES | 313 - CLINICAL IMMUNOLOGY and ALLERGY | 1831 | 1568.05 | 320 | 253 | 1600 | 1242.7 | 320 | 314.3 | 85.6% | 79.1% | 77.7% | 98.2% |
| Bumblebee Ward | 171 - PAEDIATRIC SURGERY | 420 - PAEDIATRICS | 2308 | 2507 | 329 | 540.5 | 1978 | 2232.4 | 659 | 530.35 | 108.6% | 164.3% | 112.9% | 80.5% |
| Butterfly Ward | 370 - MEDICAL ONCOLOGY | 420 - PAEDIATRICS | 2668 | 1919.5 | 333 | 724.55 | 2001 | 1135.45 | 333 | 282.2 | 71.9% | 217.6% | 56.7% | 84.7% |
| Eagle Ward | 361 - NEPHROLOGY | | 2095 | 2923.9 | 649 | 779.95 | 1299 | 1300.5 | 324 | 167.6 | 139.6% | 120.2% | 100.1% | 51.7% |
| Kingfisher Ward | 420 - PAEDIATRICS | | 1679 | 1772.95 | 862 | 526 | 312 | 379.4 | 0 | 66.9 | 105.6% | 61.0% | 121.6% | - |
| Rainforest Ward (Gastro) | 301 - GASTROENTEROLOGY | | 908 | 1170.8 | 667 | 318 | 667 | 731.3 | 667 | 206.6 | 128.9% | 47.7% | 109.6% | 31.0% |
| Rainforest Ward (Endo/Met) | 302 - ENDOCRINOLOGY | | 994 | 1029.15 | 663 | 253 | 994 | 673.8 | 331 | 262.7 | 103.5% | 38.2% | 67.8% | 79.4% |
| Mildred Creak | 711- CHILD and ADOLESCENT PSYCHIATRY | | 1048 | 923.1 | 581 | 570.35 | 476 | 369.2 | 431 | 303.1 | 88.1% | 98.2% | 77.6% | 70.3% |
| Koala Ward | 150 - NEUROSURGERY | 421 - PAEDIATRIC NEUROLOGY | 3147 | 3054.15 | 333 | 434.5 | 3055 | 2783.5 | 333 | 75.6 | 97.0% | 130.5% | 91.1% | 22.7% |
| Peter Pan Ward | 120 - ENT | 160 - PLASTIC SURGERY | 1483 | 1449 | 575 | 379.5 | 1391 | 1229.5 | 0 | 78.4 | 97.7% | 66.0% | 88.4% | - |
| Sky Ward | 110 - TRAUMA & ORTHOPAEDICS | 171 - PAEDIATRIC SURGERY | 1863 | 1867.9 | 651 | 694.5 | 1818 | 1594 | 0 | 57.5 | 100.3% | 106.7% | 87.7% | - |
| Squirrel Ward | 171 - PAEDIATRIC SURGERY | 101 - UROLOGY | 2811 | 2933.01 | 665 | 576 | 2524 | 2402.42 | 0 | 197.6 | 104.3% | 86.6% | 95.2% | - |

Attachment S

Appendix 2: Overview of Ward Nurse Staffing – February 2016

| 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 | 37.0 | 2.5 | 7.5 | 7.0 | 0.5 | 47.0 | 3.0 | 2.2 | 0.8 | 3.0 | | 0 | 0.1 |
| | Bear | 24 | 53.5 | 47.2 | 6.3 | 9.0 | 11.4 | -2.4 | 62.5 | 3.9 | 8.5 | -4.6 | 6.0 | 0 | 0 | 0.2 |
| | Flamingo | 17 | 121.0 | 101.8 | 19.2 | 10.8 | 4.0 | 6.8 | 131.8 | 26.0 | 21.8 | 4.3 | 8.0 | 1 | 0 | 0.0 |
| | Miffy (TCU) | 5 | 14.1 | 11.4 | 2.7 | 10.4 | 8.0 | 2.4 | 24.5 | 5.1 | 4.5 | 0.6 | 1.0 | | 0 | 0.0 |
| | NICU | 8 | 51.5 | 45.1 | 6.4 | 5.2 | 2.0 | 3.2 | 56.7 | 9.6 | 11.4 | -1.8 | | | 0 | 0.1 |
| | PICU | 13 | 83.1 | 96.3 | -13.2 | 8.9 | 3.0 | 5.9 | 92.0 | -7.3 | 9.3 | -16.6 | | | 0 | 0.0 |
| ICI-LM | Elephant | 13 | 25.0 | 19.0 | 6.0 | 5.0 | 3.9 | 1.1 | 30.0 | 7.1 | 4.1 | 3.0 | | | 0 | 0.0 |
| | Fox | 10 | 31.0 | 26.1 | 4.9 | 5.0 | 3.9 | 1.1 | 36.0 | 6.0 | 3.3 | 2.7 | | | 0 | 0.1 |
| | Giraffe | 7 | 19.0 | 17.0 | 2.0 | 3.1 | 3.1 | 0.0 | 22.1 | 2.0 | 1.0 | 1.0 | | | 0 | 0.0 |
| | Lion | 11 | 22.0 | 22.0 | 0.0 | 4.0 | 3.0 | 1.0 | 26.0 | 1.0 | 3.1 | -2.1 | | | 0 | 0.0 |
| | Penguin | 9 | 15.5 | 13.5 | 2.0 | 5.8 | 5.8 | 0.0 | 21.3 | 2.0 | 1.6 | 0.5 | | | 0 | 0.0 |
| | Robin | 10 | 27.2 | 22.7 | 4.5 | 4.5 | 2.2 | 2.3 | 31.7 | 6.8 | 3.9 | 2.9 | | | 0 | 0.4 |
| IPP | Bumblebee | 21 | 38.3 | 33.2 | 5.1 | 9.7 | 9.0 | 0.7 | 48.0 | 5.8 | 9.7 | -3.9 | 1.0 | 1 | 0 | 0.3 |
| | Butterfly | 18 | 37.2 | 27.4 | 9.8 | 10.5 | 9.9 | 0.6 | 47.7 | 10.4 | 4.1 | 6.3 | 0.0 | 0 | 0 | 0.0 |
| MDTS | Eagle | 21 | 39.5 | 33.5 | 6.0 | 10.5 | 11.0 | -0.5 | 50.0 | 5.5 | 3.1 | 2.4 | 0.0 | 3 | 0 | 0.4 |
| | Kingfisher | 16 | 17.1 | 14.2 | 2.9 | 6.2 | 4.9 | 1.3 | 23.3 | 4.2 | 1.1 | 3.2 | | | 0 | 0.0 |
| | Rainforest Gastro | 8 | 17.0 | 14.9 | 2.1 | 4.0 | 4.5 | -0.5 | 21.0 | 1.6 | 1.1 | 0.5 | | | 0 | 0.0 |
| | Rainforest Endo/Met | 8 | 15.6 | 12.6 | 3.0 | 5.2 | 3.5 | 1.7 | 20.8 | 4.7 | 1.8 | 2.9 | 3.0 | | 0 | 0.0 |
| Neuro-sciences | Mildred Creak | 10 | 11.8 | 11.2 | 0.6 | 7.8 | 6.4 | 1.4 | 19.6 | 2.0 | 0.5 | 1.5 | | | 0 | 0.0 |
| | Koala | 24 | 48.2 | 40.6 | 7.6 | 7.8 | 6.0 | 1.8 | 56.0 | 9.4 | 7.7 | 1.7 | | | 0 | 0.0 |
| Surgery | Peter Pan | 16 | 24.5 | 21.3 | 3.2 | 5.0 | 5.0 | 0.0 | 29.5 | 3.2 | 1.3 | 1.9 | 3.0 | | 0 | 0.0 |
| | Sky | 18 | 31.0 | 25.2 | 5.8 | 5.2 | 5.0 | 0.2 | 36.2 | 6.0 | 4.2 | 1.8 | 3.0 | | 0 | 0.5 |
| | Squirrel | 22 | 43.6 | 44.7 | -1.1 | 7.0 | 7.0 | 0.0 | 50.6 | -1.1 | 4.7 | -5.8 | 3.0 | | 0 | 0.1 |
| | **TRUST TOTAL:** | **324** | **826.2** | **737.9** | **88.3** | **158.1** | **129.5** | **28.6** | **984.3** | **116.9** | **113.7** | **3.2** | **31.0** | **5.0** | **0.0** | **2.2** |

Great Ormond Street Hospital for Children NHS Foundation Trust

| | |
|---|---|
| **Trust Board**<br>**1st April 2016** | |
| **2015 Annual Staff Survey Results**<br><br>**Submitted by:**<br>Ali Mohammed, Director of HR&OD | **Paper No: Attachment T** |
| **Aims / summary**<br>To provide the Trust Board with a high level summary of results and key areas of action. | |
| **Action required from the meeting**<br>To note the results and proposed actions | |
| **Contribution to the delivery of NHS Foundation Trust strategies and plans**<br>The results provide evidence of areas of strength and for development in staff experience, allowing improvement plans to be developed in a range of areas. CQC and commissioners review our results and action plans. | |
| **Financial implications**<br>No direct financial implications | |
| **Who needs to be told about any decision?**<br>The results and actions are being communicated to staff. | |
| **Who is responsible for implementing the proposals / project and anticipated timescales?**<br>Helen Cooke, Assistant Director of OD | |
| **Who is accountable for the implementation of the proposal / project?**<br><br>Ali Mohammed, Director of HR&OD | |

Great Ormond Street Hospital for Children NHS Foundation Trust

**Trust Board**

1st April 2016

Paper from the Director of HR&OD

**Summary of the 2016 Staff Survey Results**

**Background**

NHS England have now published the results of the 2015 Annual Staff Survey. A full copy of the report is available here **http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2015_RP4_full.pdf**

Our response rate was 53% - a reduction from last year but still higher than average for our comparator group of 16 other acute specialist trusts.

**Headline issues**

Last year's key concerns for GOSH were:-

a. Team working - we remain worse than average. However, the wording of the questions has changed so a direct comparison to last year's scores is problematic) and;

b. Communications between senior managers and staff were below average last year and have now improved to average.

**Key positive areas**

Some positive indicators in our top scores:

- Staff feeling that their role makes a difference to patients – 93%
- Staff being appraised in last 12 months – 89%
- Staff feeling able to contribute to improvements at work – 78%

**A major new theme has emerged about health and wellbeing:**

- Staff feeling pressure to attend work when unwell – 65% (average is 59%) - of these, 18% of GOSH staff reported pressure from their manager, compared to 27% nationally. 93% said pressure came from themselves – in particular nurses and admin staff.
- Staff working extra hours – 80% (average is 75%) of which 73% reported these were unpaid (average is 62%)
- Staff feeling they are suffering work-related stress – 37% (average is 34%). Highest amongst scientific and technical and medical staff.
- % of staff experiencing physical violence from patients, relatives or public – 10% (up from 6% in 2014, average is 6%)
- % of staff reporting most recent experience of harassment, bullying or abuse from patients/staff at work – 40% (down from 48% in 2014, average is 42%)

But staff recognise that as a hospital we are more concerned about their health and well-being.

- Organisation and management interest in and action on health and wellbeing – 3.79 (average is 3.72)

**WHAT NEXT**

- Communications plan to the Trust in conjunction with internal communications and divisional/corporate leaders, including a focus on the results in an Executive open briefing session.
- HR leads will work with divisional and directorate teams on analysing their local results and developing action plans, recognising the direct connection between areas of feedback (for example on teamworking) and developing Our Always Values.
- Incorporating staff survey feedback within new performance dashboards
- Chief Nurse has developed a proposal for conflict-resolution training. This now needs to be actioned given the worsening perception of their experience by staff in this area.
- Propose to develop a more integrated campaign on health and wellbeing. In particular, reviewing how we promote the existing routes for dealing with stress and further areas for action.
- We will review detailed results from AUKUH hospitals (due mid-March) and identify further areas for attention.

Great Ormond Street Hospital for Children NHS Foundation Trust

| Trust Board<br>Friday 1st April 2016 | |
|---|---|
| **Risk Management Strategy**<br><br>**Submitted by:**<br>Anna Ferrant, Company Secretary | **Paper No: Attachment U** |
| **Aims / summary**<br>To seek the Trust Board's approval of the revised Risk Management Strategy.<br><br>This revision of the Risk Management Strategy has been widely consulted on and revised. The main changes are:<br>- Updated definitions and responsibilities for key individuals and committees, to reflect staff and organisational changes; and<br>- Inclusion of the Board approved risk appetite statement. | |
| **Action required from the meeting**<br>To approve the revised Risk Management Strategy. | |
| **Contribution to the delivery of NHS Foundation Trust strategies and plans**<br>Effective management of risk is a primary role of the Board and it is critical to the achievement of the Trust's Strategic Plan. | |
| **Financial implications**<br>Not applicable. | |
| **Who needs to be told about any decision?**<br>All staff will be advised of the approval of the revised Risk Management Strategy. | |
| **Who is responsible for implementing the proposals / project and anticipated timescales?**<br>The Head of Clinical Governance and Safety is the document lead for this Strategy; however, the detailed duties and responsibilities for risk management are outlined in the Strategy. | |
| **Who is accountable for the implementation of the proposal / project?**<br>Medical Director. | |

Great Ormond Street Hospital for Children NHS Foundation Trust

# Risk Management Strategy

[NHSLA Standards 1.1, 1.3, 1.4 and 1.5]

**LEAD EXECUTIVE DIRECTOR:** **Medical Director**

**APPROVED BY:** **Risk, Assurance and Compliance Group (to be considered by Trust Board 01/04/2016)**

**DATE OF APPROVAL:**

**IMPLEMENTATION DATE:**

**REVIEW DATE:**

| | **Document Control Sheet** |
|---|---|
| **Policy/Strategy Title** | Risk Management Strategy |
| **Purpose of Policy/Strategy/ Assurance Statement** | This strategy sets out the strategic direction for Great Ormond Street Hospital to systematically manage its risks and underpins the commitment by the Trust Board to ensuring a robust risk management system is in place. This extends across the organisation from the front-line service through to the Board to promote the reduction of clinical and non-clinical risks associated with healthcare and research and to ensure the business continuity of the Trust. |
| **Target Audience (relevant to)** | All Great Ormond Street Hospital staff regardless of location. This includes Partnership and satellite sites where appropriate. |
| **Lead Executive Director** | |
| **Name of Originator/ author and job title** | Salina Parkyn – Head of Clinical Governance and Safety |
| **Version (state if final or draft)** | Final (March 2016) |
| **Date reviewed** | July 2012, September 2014, November 2015 |
| **(Previous review dates)** | March 2011 |
| **Circulated for Consultation to (*Please list Committee/Group Names*):** | Trust Board<br>Risk, Assurance and Compliance Group<br>Executive Management Team |
| **Amendments:** | Updated to include the approved risk appetite statement and to reflect staff and organisational structure changes. |
| **Links to other policies or relevant documentation** | • Health and Safety Policy<br>• Child Protection Policy<br>• Incident Reporting and Management Policy<br>• Complaints Policy<br>• Management of NICE Guidance Policy<br>• Medications Administration Policy<br>• Storage of Medicines Policy Infection Control Assurance Framework and Operational Policy<br>• Being Open Policy<br><br>This list is not exhaustive |

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## 1. Assurance Statement/Scope

This strategy sets out the strategic direction for Great Ormond Street Hospital to systematically manage its risks and underpins the commitment by the Trust Board to ensuring a robust risk management system is in place. This extends across the organisation from the front-line service through to the Board to promote the reduction of clinical and non-clinical risks associated with healthcare and research and to ensure the business continuity of the Trust.

It identifies the organisational risk management structure, the roles and responsibilities of committees and groups that have some responsibility for risk and the duties and authority of key individuals and managers with regard to risk management activities. It describes the process to provide assurance for the Trust Board review of the strategic organisational risks and the local structures to manage risk in support of this policy.

The Risk Strategy is integrated into the management, performance monitoring and assurance systems of the Trust to ensure that safety and improvement is embedded in all elements of the Trusts work, partnerships and collaborations and existing service developments. This enables early identification of factors whether internally or externally driven, which may prevent the Trust from achieving its strategic objectives of ensuring care is provided in a cost effective way without compromising safety. It provides the framework in which risk can be managed, reduced and monitored regardless of source and the process to be followed where gaps in risk management processes are identified. It assists the Trust Board to identify the scope of the Trust risk appetite.

The Trust is committed to this positive approach to the consistent management of risk, where managing for safety, in a culture that is open and fair, supports learning, innovation and good practice for the benefit of the child.

This strategy is based on the requirements of the Department of Health (2006) Integrated Governance Handbook, guidance issued by the National Health Service Litigation Authority (NHSLA), National Patient Safety Agency (NPSA), Medicines and Healthcare Products Regulatory Agency (MHRA) among others, and identifies the consistent approach to be taken to all hazards and risks however caused, across the organisation at strategic and operational level.

## 2. Introduction

Great Ormond Street Hospital for Children NHS Foundation Trust is committed to providing high quality patient services in an environment where patient safety is paramount. The Risk Management Strategy identifies how the principal risks and hazards which may prevent this occurring are assessed, prioritised, and controlled, supporting the safe development of clinical care and maintaining continuity of service delivery.

## 3. Aims and objectives

3.1. The Risk strategy identifies:

- the organisational structure and reporting systems for the management of risk
- the duties, scope, responsibility, accountability and authority of individuals, teams, departments, committees and subgroups
- requirements for local management of risk to reflect this policy and the link into existing committee structures, performance monitoring and assurance processes
- the management tools which enable the Trust to assess its risks systematically at strategic and operational levels, document the outcome of risk assessment and improve transparency of decision making
- the process to ensure consideration of risks and options of managing them is integrated into the wider management and operational processes of the Trust
- the process to ensure regular review, monitoring of required actions to mitigate risks and obtaining assurance on mitigation
- the process for monitoring compliance with this policy at strategic and local level and to remedy any deficiencies identified

- the process to disseminate the policy and share lessons learned

This strategy does not consider the detailed management of financial risk as this is subject to statutory control systems documented elsewhere[1], but does recognise that poor management of risk whether clinical, non-clinical or financial can have an impact on the Trust's ability to meet its strategic and financial objectives.

The Risk Strategy drives the risk management process but this is underpinned by other operational policies and procedures.

## 4. Definitions

### 4.1. Glossary of Terms

- **Risk management**

Risk Management is the process to identify, assess and prioritise the Trusts exposure to risk whether clinical or non-clinical, which may affect its ability to meet its objectives. This may be as a result of loss or damage however caused, to patients, staff, visitors, contractors, finances, business continuity or the reputation of the Trust. Consideration of all service provision from a risk perspective and the factors which affect this, whether financial, environmental or staff related, assists the process to identify risks and mitigate their effect. It informs the decision as to whether a risk can be accepted, delegated, transferred or eliminated[2].

- **Clinical risk**

An adverse patient safety incident has been defined by the National Patient Safety Agency as 'any event or circumstance arising during NHS care that could have or did lead to unintended or unexpected harm, loss or damage'. Harm is defined as 'injury (physical or psychological), disease, suffering, disability, or death'. In most instances, harm can be considered to be unexpected if it is not related to the natural cause of the patient's illness or underlying condition. Those incidents that did not lead to harm, but could have, are referred to as prevented incidents. Loss or damage occurring within the context of clinical risk to the patient, can equally apply to their family, staff or the organisation and may be both financial and/or to reputation. Clinical risk can also occur due to latent decisions e.g. change to service delivery which create different risks not just an adverse event but which may not be apparent at the time the change is made

- **Non-clinical risk**

Non Clinical risks are any event or circumstance arising during NHS care that could have or did lead to impairment of the Trust's ability to deliver its objectives, whether intended or unexpected. These risks are the outcome of hazards that have the potential to cause, or actually cause, harm by affecting the organisations ability to deliver high quality services. They may relate to a number of the Trusts support mechanisms including health and safety, estates and facilities, technical, information technology, personnel, training or financial aspects of the Trusts business. They may have a direct or indirect effect on patient care, member of staff, visitor, contractor or other stakeholder and result in loss or damage. This loss may be both financial and/or to reputation.

- **Principal risks (Board Assurance Framework (BAF) risks)**

Principal risks are those that have significant potential to impair or affect the operational or financial ability of the organisation to deliver on-going services. These can be strategic or operational and may relate to a change or development in an existing service, or in response to an internal or external driver. As such, they require a system of regular review, as their priority for the Trust in relation to meeting its objectives may change over time.

The Assurance Framework is the means by which the principal risks to the Trust are identified and control and assurance gaps reported. It is the tool by which the Trust Board is able to take a view as

[1] Standing Financial Instructions and Scheme of Delegation
[2] See appendix 3

to whether a specific risk has been reduced to an appropriate level and whether any residual risk in that instance will be accepted.

- **Significant risk**

A significant risk is defined as any risk identified as having a medium or high risk consequence and which requires an achievable action plan[3] to identify the controls to be put in place and monitored for effectiveness at reducing the risk. Hazards are assessed using a matrix to identify the likelihood of harm occurring and the impact of the risk. Risks are prioritised using a common format and system across the Trust (See Appendix 3).

- **Acceptable risk**

The Trust makes every effort to ensure that all risks are as low as reasonably achievable. It is not possible to reduce all risks to zero, as there is no such thing as clinically neutral care and decisions must be made as to whether the benefits and best use of resources outweigh the risks. The risk assessment tool enables the Trust to assess the impact and likelihood of a risk occurring and is an aid to decision making to identify what it is reasonable to accept.
Acceptable risk is defined using the following principles:

- If following the rigorous approach to risk assessment, it is decided on balance to accept a risk, those accepted risks should still be controlled. To tolerate risk and/or accept a risk does not mean to disregard it. Any accepted risk must be reviewed on an annual basis and all options reviewed with an aim to reduce risks further. Patients, staff, visitors, contractors must be made aware of the risks they are being exposed to. No person should be exposed to serious risk unless they agree to accept the risk. In order to be fully informed of the risk, this must be done in a way they can understand.
- It is reasonable to accept a risk that under normal circumstances would be unacceptable if the risk of all the other alternatives, including doing nothing, is even greater.
- Risks with a score of 20 cannot be accepted, due to the fact that the likelihood score is greater than 3 ('possible').

The Risk, Assurance and Compliance Group (RACG) is responsible for agreeing when a high level risk, trust wide risk or BAF risk can be accepted, using the risk appetite statement and risk acceptance framework as a guide.

Division and Corporate Risk Action Groups may apply the risk acceptance process for risks on local risk registers, following the escalation process for approval as outlined in the Risk Management Strategy.

- **Open and fair culture**

The Trust continues to develop a culture that is open and fair where patients and their families know they can approach staff about problems without their treatment being affected; and staff feel able to report hazards, risks and mistakes without fear. Prejudging events by adopting a punitive approach to staff stops information giving, learning and improvement and the risk to patients is increased.

The Trust has a Being Open and the Duty of Candour policy which lays out the Trusts processes for ensuring compliance.

The Trust Whistle Blowing policy ("Raising Concerns in the Workplace") provides the framework by which members of staff can raise concerns about risks, safety and quality.

A fair culture recognises that events rarely occur as a result of a single, negligent, deliberate or reckless action, but as part of a sequence of human error, systems failures and contributory factors. Each of these factors is considered in any investigation which is undertaken.

[3] An action plan may be in the form of a business case, written report, included on the risk register or be presented in any applicable format. It should contain what action is required, who is responsible for taking the action, when it will be completed and where it will be reported to.

- **Risk appetite**

The Trust defines its risk appetite as the amount of risk it is prepared to accept, tolerate, or be exposed to at any particular time. The level of risk deemed acceptable (affected by both internal and external drivers) is kept under review by the Trust Board.

The Board recognises that the Trust's clinical services and research activity are delivered within a high risk environment. The delivery of GOSH's strategic objectives and its relationships with its patients, the public, its funders and other strategic partners determines the Trust's long term sustainability. As such, the Board has agreed that the Trust has an overall low appetite for risks relating to its clinical service and research delivery. The lowest risk appetite applies to all safety and compliance objectives, including preventable patient harm, public and employee health and safety. The Trust has a marginally higher risk appetite for the pursuit of innovation and its strategic and operations objectives. This means that the risks originating from clinical and research processes as well as meeting legal and other regulatory obligations will take priority over other business objectives.

More detailed information of the Trust's risk appetite by business mode segment is provided in Appendix 7.

4.2. **Abbreviations**

- **NHSLA-** National Health Service Litigation Authority
- **NPSA-** National Patient Safety Agency
- **MHRA-** Medicines and Healthcare Products Regulatory Agency
- **NHS-** National Health Service
- **GOSH**- Great Ormond Street Hospital
- **SIRO-** Senior Information Risk Officer
- **RAG**- Risk Action Group
- **CGC-** Clinical Governance Committee

## 5. Duties and responsibilities

5.1. The following gives the duties, roles and responsibilities for risk management activity in the Trust at individual, department and team level. Due to the variable nature of risk, this is not exhaustive and may change depending on the type of risk identified and the action required to mitigate it. Where authority is devolved, the extent of this authority is identified with the member of staff or in the relevant job description. Assessment of risks (Appendices 6 & 7) assists in identifying how a risk will be managed and the level of management responsibility required.

All members of staff are responsible for their own safety and for ensuring risks to the organisation, colleagues, patients and visitors are minimised. All managers have authority to reduce risk within their areas of responsibility whether clinical, non-clinical or financial and are responsible for ensuring safe systems are in place. Staff are required to report incidents when they occur, mitigate their effect, lead on investigating the causes and escalate to their unit chair, general manager or relevant director as appropriate. If in doubt, advice can be sought from the Risk Management team.

5.2. **Chief Executive Officer**

The Chief Executive is accountable to the Board for ensuring that it receives the appropriate level of information to enable it to be assured that systems of internal control to manage risks, regardless of source, are in place.

The overall and final responsibility for all risk and quality management rests with the Chief Executive, who is accountable for providing the Trust with the necessary organisational structure and resources to implement policy and manage risks effectively. In line with the general philosophy of the Trust, delegation of responsibility occurs. Individuals are encouraged to assume responsibility for their own actions.

The Chief Executive or their Deputy is actively involved in the work of the sub committees with responsibility for managing risk, ensuring that there is a system to assess and review the effectiveness of the controls put in place to mitigate those risks. As the Chair of Executive Management Team and Senior Management Team, they are aware of all key decisions made within the Trust and ensure actions to reduce risk are considered when strategic, operational or financial decisions are made, and the means by which effectiveness of action to reduce risk is monitored.

### 5.3. **Non-Executive Directors**

Assurance sub committees of the Trust Board are chaired by a Non-Executive Director. They are responsible for ensuring that they are provided with the appropriate information to enable them to make a reasoned judgement as to whether the elements of risk for which they assure the Board, are being managed with proper controls in place. They have a duty and the authority to raise with the Trust Board any risk issue they believe is not being managed appropriately, that may be a threat or opportunity to the Trust or which has caused them concern. They have a duty and authority to request additional information from any source to enable them to fulfil this function to ensure provision of safe, high quality services.

### 5.4. **Executive Directors**

The Trust Board has designated accountability for risk management and quality service provision to nominated executive directors and as such this is identified within their job descriptions. They meet regularly with the Chief Executive to ensure all aspects of risk are managed appropriately within their areas of responsibility and enable early identification of an actual or potential problem.

All Executive Directors remain accountable for reducing risk within their areas of responsibility by best practicable means and ensuring the impact of decisions taken and effect on the viability and reputation of the Trust is assessed as part of this decision making process. They delegate authority to nominated managers as appropriate to manage local risks and to specific committees or project groups to manage corporate risks[4]. They ensure a feedback mechanism is in place to monitor actions taken and compliance with internal and external regulatory or statutory compliance.

The Executive Directors are part of the Trust management structure and represent their specific areas of risk management responsibilities at Trust Board, Sub Committees and Senior Management Team levels. They may also chair or be members of specific groups or committees to consider areas within their expertise which may be time limited or to oversee specific tasks. As part of their risk management role, they will delegate areas of accountability to nominated individuals as appropriate.

The Executive Directors with delegated responsibility for risk management are:

### 5.5. **Deputy Chief Executive Officer:**

Responsibility for ensuring that clinical and non-clinical risk management is embedded at Divisions and departmental level to ensure compliance at local level with strategic objectives. They are accountable for ensuring effective management and mitigation of risk as part of the day to day and operational practice of the Trust. This includes but is not limited to objective setting, business planning, service development and performance management of risk. Executive responsibility for Major Incident Planning and implementation and overseeing the operational review process. Executive management of facilities to reduce risk in the delivery of support services to patients, families and staff and the effective management of the human resource functions within their remit.

### 5.6. **Chief Finance Officer:**

Executive responsibility and accountability for all aspects of financial risk and compliance with statutory financial requirements. This includes but is not limited to financial planning, objective setting and fraud, information governance and information risk. Acts as the Senior Information Risk Officer

[4] Corporate risks – these are risks which need either a Trust wide approach or which may arise as a result of external factors over which the Trust may have limited control. They are owned by the executive team who delegate their management to either a nominated individual, designated committee or designated, time limited project group. If a risk is accepted, i.e. no appropriate action to mitigate it identified, this must be agreed with by the Chief Executive or the Deputy Chief Executive and identified to Trust Board.

(SIRO) for the Trust.

5.7. **Medical Director:**
This role provides but is not limited to executive responsibility and accountability for clinical and non-clinical risk management. Executive responsibility for the implementation of risk management to mitigate the risks regarding clinical incidents, complaints, clinical negligence, clinical audit and effectiveness, litigation issues such as consent, confidentiality, data protection, infection control, radiation protection and health and safety. Executive responsibility for medical postgraduate training and managing associated risks as a result of changes to medical workforce, whether internally or externally driven.

5.8. **Chief Nurse:**
Executive responsibility and accountability for Child Protection, safeguarding, infection prevention and control and the implementation of risk management systems with regard to nurse staffing, staff management, education and workforce issues within their remit.

**5.9 Director of HR and OD**
Executive responsibility for delivery of the Trust's human resources and organisational development policy, strategy and improvement programmes. Also responsible for Health and Safety.

5.9. **Director of Development**
Executive responsibility for ensuring all risks related to the Trust estate and redevelopment of the hospital are mitigated and managed. This includes the management of contractors, safe operating procedures and safe systems of work as well as financial and service continuity risks associated with redevelopment programmes.

5.10. **Director of Research and Development**
Executive responsibility for ensuring that all risks related to research are mitigated and managed and that the research governance framework requirements are implemented.

5.11. **Company Secretary**
The Company Secretary is responsible for ensuring that the Risk Management Strategy meets the requirements for and links into, the systems for Corporate and Integrated Governance. They coordinate the main high level sub committees and the Trust Board and ensure relevant papers are provided in line with the agreed reporting schedule. They ensure appropriate reporting occurs from the operational committees to support the governance framework. They oversee the management of the Document library and the administration of the Assurance Framework and monitor compliance with the Data Protection Act in their role as Data Protection Officer. They manage any additional risk and compliance function, such as registration and requirements of external agencies, as delegated by the Chief Executive to ensure compliance with internal, external and statutory requirements.

5.12. **Senior Managers**
Senior Managers are required to manage risks within their own areas of responsibility and to implement the requirements of this Risk Management Strategy. They ensure appropriate and effective risk management processes are in place to reduce risks within the work environment, implement and comply with corporate, financial, departmental and unit policies and guidelines. They ensure internal and external compliance with any regulations relevant to their own areas of work and seek advice from appropriate advisors where necessary eg. Health & Safety, Occupational Health, Infection Control, Security, Estates, Facilities, Clinical Governance & Safety, Human Resources, Finance etc. This is to ensure the reputation and continuity of services are developed and maintained. They are accountable for identifying deficits in compliance within their department or unit, however caused, and agreeing an action plan to remedy any such deficiency with their line manager and relevant Executive Director.

5.13. **Divisional Directors & General Managers**
The Divisional Directors and General Managers are responsible for implementing and overseeing corporate and division policies, guidelines and procedures within their specific clinical areas in accordance with this Risk Management Strategy and ensuring the internal structure within the unit is

in place to do so. The Divisional Directors may delegate authority for these roles to specific competent named individuals within their unit or specialty teams who report back to the Division Chair through the existing internal structures or division board as appropriate. They ensure the Divisional board review of risk management issues, whether clinical, non-clinical or financial and that these are included where appropriate on the local risk register and discussed as part of the unit board rolling agenda. They will ensure a governance framework is in place within their units which enables information to be shared with their teams, deficits identified and actions monitored and reported back into the wider governance structure of the Trust through the Senior Management Team.

5.14. **Corporate and Clinical teams**

Corporate and clinical teams manage risk related to their operational areas of responsibility on a daily basis. They have a duty to ensure that any factors which may create additional risk or affect the ability to manage or control risk relevant to their area of work or service risks are highlighted to the relevant senior manager or division director.

Each corporate department must ensure compliance with its policies and procedures by a process of regular review. Staff must be informed of these policies and procedures by means of an induction process that is documented. Each head of department is responsible for ensuring that the current versions of any policy or pan Trust operational document is available on the Document Library website. The process to ensure policies are current and to alert teams when policies are due for renewal is managed by the Company Secretary.

5.15. **Clinical Governance and Safety team**

The Clinical Governance and Safety team reports to the Medical Director. It consists of the Risk Management team responsible for the management of clinical incident reporting, root cause analysis, aggregated analysis of reported incidents and investigations. The Complaints team responsible for the management and investigation of complaints. The Clinical Audit team responsible for the management of the clinical audit process across the Trust. The Clinical Governance and Safety team will provide information to all levels of the Trust, the Divisional boards and RAG groups to support effective local implementation of this risk strategy on a monthly basis or as required by the division chair and general manager. It maintains the Trust wide risk register and incorporates information from this into the assurance framework.

5.16. **Trust Solicitor**

Responsible for the effective functioning of the Legal team in early identification of potential risk and on-going management of claims or legal action. They are responsible for sharing learning to reduce risk across the Trust. They report to the Medical Director and provide legal advice to support decision making by the Executive team wherever necessary.

5.17. **Planning, Performance Management and Information Services**

The Planning and Performance Management and Information services teams liaise with divisions and corporate departments to ensure access to appropriate and timely information on service provision and the key performance indicators to support the management and monitoring of risks (See Performance Strategy). They support management of the Assurance Framework to ensure that the Trust objectives are linked to internal and external monitoring of high level performance indicators.

5.18. **All employees and visitors**

Employees, whether part of clinical or non-clinical teams, are made aware of the risks within their work environment, their personal responsibilities for reporting risks and minimising risk to themselves and others. They are given the necessary information and training to enable them to work safely. All clinical and non-clinical staff are expected to report incidents when they occur and be involved where appropriate in any investigation to identify the cause of specific risks or as the result of an adverse event (See Incident Reporting & Management Policy, Health & Safety Policy, Induction Policy). While visitors have a responsibility for maintaining their own health and safety while on site, employees have a responsibility to ensure that visitors are not exposed unnecessarily to risks, to report and take action to minimise any such exposure.

### 5.19. Contractors

Contractors carrying out work on the Trust's property are expected to comply with statute. It is the responsibility of the Executive Director contracting with them on behalf of the Trust to ensure that contractors comply with the relevant safety procedures and, where appropriate, specify detailed health and safety and performance management requirements in any written terms of agreement before work commences.

### 5.20. Partnership working with other organisations

Where the Trust links in with other health care providers to deliver a specific clinical service a risk assessment is undertaken as part of the planning process and used to inform any Service Level agreement. This identifies potential risks to the individual parties, service users, the public, patients and other stakeholders and ways to reduce these. It is the responsibility of the project manager, under the guidance of the relevant Executive Director, to ensure this occurs. Wherever possible, systems to monitor and reassess risk are included as part of the business plan and incorporated into the regular performance monitoring process of the Trust.

### 5.21. Trust Board

The Trust Board is responsible for the effective functioning of the Trust, the provision of managerial leadership and accountability. Its purpose is to ensure that the Trusts systems and working practices support good corporate governance, financial probity and the management of risk to underpin safe high quality service delivery. To do this Trust Board:

- Establishes the strategic objectives for the Trust
- Ensures these support delivery of the Quality Strategy
- Sets out the arrangements for obtaining assurance on the effectiveness of key controls across areas of principal risk, which may threaten achievement of those objectives
- Establishes a reporting system to receive relevant documents in an appropriate timeframe to enable the Board to ensure that its members are properly informed of the totality of their risks, not just financial, and to be assured that the systems to manage the principal risks are in place
- Reviews the strategic risks as part of the Assurance Framework, at least once a year as per the schedule of reporting.
- Evaluates the key controls to manage the principal risks, using external and internal assessment and assurance processes.
- Receives summary reports on progress against compliance with specific aspects of identified risks that may occur. Frequency of these reports is agreed with the Company Secretary if they are not part of the routine reporting schedule.
- Receives performance management reports identifying key indicators monthly.
- Delegates the daily strategic management of risk to the Chief Executive who is accountable for delivery of this strategy.
- Approves the Risk Management Strategy and reviews it annually or more frequently in the event of significant changes whether internally or externally driven.
- Demonstrates that it takes reasonable action to assure itself that the Trusts business is managed efficiently through the implementation of internal controls to manage risk and a self- assessment process annually.

### 5.22. Sub-committees of the Trust Board

Any high level sub-committee where the responsibility for overseeing the different elements of risk management has been delegated by Trust Board, clearly indicates by its terms of reference which aspects of risk management it is responsible for, and whether its role is one of assuring or being assured. It also identifies the extent of its delegated authority.

Each delegated sub-committee receives regular reports as part of its schedule of reporting to enable it to take a view as to whether it can assure the Board that the controls to manage specific aspects of risk which fall within its remit are in place and working.

It is the responsibility of the Chair of the delegated sub-committee to alert the Trust Board to any

concerns regarding the management of risk it oversees and to request additional information as necessary. To assist this process, sub committees have cross membership and appropriate representation from the executive team, senior managers and clinical teams. Minutes or summary action points from the high level assurance sub-committees are received by Trust Board at the next available meeting.

The main high level sub committees are:

### 5.23. Clinical Governance Committee

The Clinical Governance Committee (CGC) meets quarterly and reports to the Trust Board. It has delegated authority to assure the Trust Board and to be assured that appropriate action is taken to minimise and control aspects of clinical risk, clinical governance and improvement work across the Trust. This includes but is not exclusive to risks from clinical incidents, complaints, claims, litigation, health and safety, and clinical audit as identified within its terms of reference. It receives relevant reports and updates on actions taken to comply with specific external assessments to fulfil this remit and within an appropriate timescale. On agreement with the Committee Chair, it also receives additional items on any other activity which creates a potential or actual risk to good clinical governance. It reviews the trust wide risk register and specific objectives from the assurance framework which fall within its remit at least once a year as per its reporting schedule.

The Chair is a Non-Executive Director and cross membership of this committee assists in ensuring an integrated approach to manage clinical, non-clinical and any financial risk which may affect the clinical service delivery and the Trust's ability to meet its strategic objectives. Its minutes are shared with the Audit Committee and received by Trust Board for information at the next available meeting. Additional members may be required to attend when necessary to inform the committee on any specific aspects of risk identified.

### 5.24. The Audit Committee

The Audit Committee reports to the Trust Board. The committee has the responsibility to assure the Trust Board and to be assured, that appropriate action is taken to minimise and control all aspects of non-clinical risk including financial within its remit. It receives relevant reports to enable it to do this and in an appropriate time scale. This includes reports from internal and external auditors in respect of the Trusts effectiveness at mitigating specific risks. As such it has delegated authority from the Board as identified in its terms of reference. It monitors the actions taken and progress against all financial requirements, certain external assessments and reviews the effectiveness of specific objectives from the assurance framework and trust risk register to identify and control risks as per the reporting schedule.

As the assurance agenda crosses clinical and non-clinical boundaries, the minutes are shared between this committee and the Clinical Governance Committee and received by Trust Board for information. The Chair is a Non-Executive Director and the Chair of the CGC is a member of the Audit Committee - cross membership of this committee assists in ensuring an integrated approach to managing all risk financial, non-clinical and clinical risk. The Audit Committee meets quarterly.

Additional members may be required to attend when necessary to inform the committee on any specific aspects of risk identified.

### 5.25. Finance and Investment Committee

The Finance and Investment Committee (F&IC) is a sub-committee of the Trust Board with the aim of assisting the Board in overseeing financial strategy and planning, financial policy, investment and treasury matters and reviewing and recommending for approval major financial transactions. The F&IC maintains oversight of the Trust's financial position and relevant activity data and productivity metrics.

The Chair of the committee is a Non-Executive Director (NED) with the membership comprising of the Chief Executive Officer, The Deputy Chief Executive, the Chief Finance Officer and the Interim Director of Strategy and Planning.

5.26. **Executive Management Team (EMT)**

The Executive Management Team has delegated authority for the operational and performance management of the clinical services, research and development, education and training of the Trust. It is responsible for co-ordinating and prioritising all aspects of risk management issues which may affect the delivery of the clinical service as stated in its terms of reference. It is the main operational decision making committee of the Trust. It is responsible for co-coordinating and prioritising all aspects of risk that have the potential to prevent the Trust meeting its strategic objectives:

- It ensures that all aspects of Trust activity are considered and risk assessed when decisions are made, to minimise organisational risks whether clinical, non-clinical or financial.
- Delegates authority to the divisions/departments to manage risk to local service provision as appropriate.
- Monitors performance against the Trust objectives, identifying variance, assessing risk management priorities and co-ordinating the Trust response.
- Supports division and departmental activities to ensure appropriate use and allocation of resources to support and maintain service delivery and to minimise and control risks.
- Receives updates on work and measures undertaken to mitigate risks by specific subgroups, operational committees and any other time limited group which it has established or delegated authority to, to take forward specific work.

EMT is made up of the Executive team,. Its membership reflects its role to ensure appropriate consideration and endorsement of decision-making on specific areas of risk. This includes: service delivery, staffing and staff management, audit, clinical and nonclinical risk, estates and facilities, human resources, finance, information services, technology, improvement and organisational development work, including partnership or joint working activity.

Where high risks are identified which require a Trust wide approach and further action, they are discussed and reviewed by the Senior Management Team. The Chief Executive is the Chairman of the EMT and meetings are held weekly.

5.27. **Senior Management Team**

The Senior Management Team (SMT) provides a regular meeting where relevant issues and risks relating to the day to day operational management of the Trust are discussed and decisions taken to ensure the Trust operates as efficiently and effectively as possible, maintaining quality standards. The SMT are also responsible for maintaining the Trust wide risk register.

The Chief Executive is the Chairman of the SMT and meetings are held fortnightly.

5.28. **Standing Committees**

A standing committee is a committee with delegated authority from EMT (Appendix 2). Each standing committee is responsible for managing the cross Trust issues relevant to their area of expertise and as such has delegated authority within its terms of reference for a specific remit. This includes assessing the effectiveness of the control systems in place to reduce the risks relevant to their areas of expertise. A standing committee may be established either because it is required by statute or because it covers a key management function for the Trust to meet its objectives of efficient, effective and safe care. The clinical standing committees will provide a summary of their work as part of the schedule of reporting to the Patient Safety and Outcomes Committee at least once a year.

The Patient Safety and Outcomes Committee and Patient, Family Experience and Engagement Committee reports into the Executive Management Team and the Board assurance committees which subsequently report in to Trust Board.

5.29. **Operational, time limited or task specific groups**

In addition to clinical and operational standing committees, other groups may be established to cover work which may be strategic, time limited, task driven or have a combined operational role. These may be required to oversee large projects or to co-ordinate delivery of a specific objective. These groups or committees are chaired by a senior manager or executive director and the remit of the group, scope of authority, any time limits and reporting lines are included in the terms of reference.

Reporting lines wherever possible link back into management board or an identified committee. This is to ensure that all work undertaken on behalf of the Trust can link into the existing reporting, monitoring and assurance systems in place.

## 6. Organisational Structure for Risk Management[5]

6.1. The organisational structure for risk management provides an integrated framework for decision making, escalation and provision of assurance. It ensures the operational framework required to deliver the trust objectives links into the wider assurance and corporate governance processes, and that all reasonable action is taken to identify, assess and manage risks to the Trust and its stakeholders in a consistent and transparent way.

To manage risk effectively, the Trust must be aware of its risk profile across the entire range of its activities whether, clinical, non-clinical or financial. These may be strategic or operational and may relate to a change or development in an existing service, or in response to an internal or external driver. As such, they require regular review and a consistent approach to assessment as their priority may change over time. The Trust committee structure, which links into this process, can be found in Appendix 1.

## 7. Process for managing risk locally in support of this strategy

### 7.1. Divisional and Department Structures

The management of risk locally will reflect this organisational risk management strategy. Divisions and departments will have in place:

- Internal meeting structures
- Authority within staff roles and responsibilities to manage risk at local level including financial and service risks
- Comply with the requirements of the Incident Reporting & Management Policy for reporting incidents, assessing the impact and likelihood of identified risks, scoring and grading them
- Comply with the Complaints Policy to ensure these are managed appropriately at local level and the learning used to enhance patient experience
- Ensure that clinical, financial, service risks and complaints are used as an indicator of quality and as part of the process to identify safety indicators and required actions
- Comply with Trust policies in respect of workforce management
- A risk register
- A risk action group
- Process to monitor required actions
- Process to share information and learning
- Process to escalate unresolved risks

These processes will be managed by the division board or equivalent. The internal structures will meet the need of the division or department to deliver excellent clinical care and to identify, assess and control risk, with delegated authority to staff as appropriate. Each division and department will have a designated Risk Lead from within the Clinical Governance and Safety team, or the Health and Safety team were appropriate, who acts as a risk link for their areas.

### 7.2. Incident reporting

Divisions and departments will have a process to review their reported incidents and levels of

[5] The two assurance committees (the Audit Committee and Clinical Governance Committee) receive reports as outlined in their terms of reference. This may be from a variety of sources where assurance on any aspect of the Trust business within their remit is required or delegated from Trust Board. This may be from stand-alone reports, specific committees and/or individual teams or departments.

reporting monthly. The Incident Reporting & Management Policy describes the process to report, record and investigate individual incidents in detail. Levels of reporting and aggregated analysis will be monitored by the Risk Management team and reported through to the Patient Safety and Outcomes Committee with feedback to the local teams.

### 7.3. **Risk assessment**

Each division or department will undertake risk assessments where appropriate. They will score, grade and prioritise the risks using a common approach (Appendix 3). A risk assessment will be undertaken prior to planned service changes or changes to service delivery to identify any additional risks that may be caused. They may be used to demonstrate consideration of risks as part of the business planning process, as part of a departmental review of compliance with statute; e.g. a Health Technical Memorandum related to specific aspects of corporate risk such as Fire, or following an actual event.

### 7.4. **Local risk registers**

The division board or equivalent, or departmental meeting will have a process in place to keep their risk register updated. They will update the content of their risk register monthly on the Datix system which in turn will be included on the Trust wide risk register. Risks will be reviewed within a stated time frame by the local team to ensure that controls in place are working, and assess whether the risk changes over time (Appendix 4). Risks may be identified through internal processes e.g. complaints, incidents, claims, service delivery changes, risk assessments or financial interests. They may be identified by external factors e.g. national reports and recommendations. Reports are run monthly for the clinical / department teams on reported incidents for consideration by the RAG groups and division boards or senior meetings. This information is used to inform the decision as to whether risks need to be added to the risk register, re-graded or removed. Changes to the risk registers are monitored centrally by the Risk Management team.

### 7.5. **Risk Action Groups (RAG)**

Local Risk Action groups or an equivalent meeting will be established at which the principal risks to patient safety and service delivery will be discussed. Their role, remit and areas of delegated authority will be identified by the Division Board or equivalent and reflected in their terms of reference (Appendix 5). Risk Action Groups will be multidisciplinary and may consist of a core group with additional expertise brought in pertinent to the level or type of risk identified. Each specialty is responsible for identifying its specific hazards and risks relevant to its own area of clinical expertise and practice and ensuring these are included on the risk register where appropriate and that regular review of the risk register takes place. RAG's receive information monthly on their clinical and non-clinical incidents reported through the central reporting system to identify key themes and where actions to control risks are required. Corporate departments establish similar systems either through a dedicated Risk Action Group or an equivalent meeting. The Senior Management Team must establish similar processes for the management of the Trust Wide Risk Register (see section 7.7 below). The RAG will review reported incidents and complaints and identify to the division board or departmental meeting, issues they think should be added to the risk register, re-graded or removed.

### 7.6. **Trust Wide Risk Register**

The Trust Wide Risk Register contains all risks that have been identified as affecting more than one division or is unable to be mitigated by the individual division. Each risk on the Trust Wide Risk Register is assigned to an Executive Lead who is accountable the management of the Trust Wide risk. The Trust wide Risk Register is managed by the Senior Management Team, which fulfils the same obligations as Risk Action Groups as outlined in section 7.5 above. The RACG reviews the Trust Wide Risk Register on a quarterly basis.

### 7.7. **Assurance Framework**

The Assurance Framework provides a record of the principal strategic risks to the Trust achieving its objectives. It identifies the controls in place, the methods of assurance and the control and assurance gaps. It is informed by the risks graded 12 or above on the Trust risk register as well as internal, external and strategic risks which may affect the Trusts business. It includes those identified by the

Executive Team or any additional source where local controls are not sufficient to manage the risk e.g. infection control, finance or information risk. It includes key risks identified through aggregated analysis of incidents, complaints and claims which may not already appear on the Trust risk register. These are added to the Assurance Framework for executive review. It provides a vehicle for the Trust Board to be assured that the systems, polices and people in place are operating in a way that is effective and focussed on the key risks which might prevent the Trust objectives being achieved. Each risk is linked to a Trust objective and has an Executive lead, responsible for updating the controls and ensuring the actions required to mitigate the risk are completed at either local, operational or strategic level.

7.8. **The Risk, Assurance and Compliance Group**

The Risk, Assurance and Compliance Group meets every 6 weeks and reports to the Audit Committee and Clinical Governance Committee. The purpose of the Group is to:

- monitor the effectiveness of risk management systems and the control and assurance process;
- advise the assurance committees on the co-ordination and prioritisation of risk management issues throughout the Trust;
- ensure the Trust maintains and overview with all requirements of the Assurance Framework;
- ensure the Trust complies with all requirements of the Health and Social Care Act 2008 (Registration Requirements) and other legislative, regulatory and external authority requirements;
- monitor the implementation of this strategy
- monitor integration of the governance framework.

The Group is chaired by the Chief Executive Officer and has representation from executive directors and senior managers.

## 8. Dissemination of this Strategy

The Trust Board recognises that good channels of communication are vital to the achievement of the aims of the Risk Management Strategy. An open and fair culture which welcomes direct interaction between managers and staff at all levels assists in ensuring the aims of this strategy are achieved.

All staff are informed of this strategy and linked policies on induction and during mandatory update training sessions.

The strategy is available on the Document Library, with links from the Clinical Governance and Safety web pages.

Local Risk registers, performance reports and the outcome of any external assessments regarding the Trust's ability to manage risks are made available to staff via the internal communication systems.

The Terms of Reference, schedules of meetings, minutes and papers of the key committees with delegated responsibility for the management of risk are available and accessible to staff on the Corporate Meeting Papers website, accessible from the GOSH web pages.

## 9. Specialist advice

9.1. Further advice on any aspect of risk management, reporting, assessing, monitoring, compilation of risk registers etc. or to identify where additional information is available can be obtained from the Risk Management team.

Additional staff available to give specialist advice on aspects of managing risk are:

9.2. **Deputy Chief Executive Officer**

Advice on all aspects of the Trusts business, including where risks may need to be accepted, the operational management and facilities of the Trust

9.3. **Chief Finance Officer**

Advice financial risk including fraud/ the Bribery Act, information governance and information risk and

non-clinical audit

9.4. **Medical Director**
Advice on medical staffing, clinical issues, clinical scientists, partnership working and patient safety

9.5. **Chief Nurse**
Advice on nursing, clinical care, allied health professionals, child protection and safeguarding issues

9.6. **Director of Development**
Advice on risks related to construction and redevelopment work and all aspects of estates management

9.7. **Director of ICT**
Information risk and data security and business continuity lead.

9.8. **Head of Clinical Governance and Safety**
Advice and guidance on aspects of clinical and non-clinical risk management, complaints, analysis, effectiveness and audit

9.9. **Head of Planning & Performance Management**
Aspects of performance management, indicators and reporting processes

9.10. **Risk Managers**
Advice training and guidance on aspects of clinical risk management, risk assessments, risk registers and root cause analysis

9.11. **Complaints Manager**
Advice training and guidance on aspects of risk management, complaints and root cause analysis

9.12. **Trust Solicitor**
Advice training and guidance on aspects of litigation, consent, confidentiality

9.13. **Health and Safety Advisor**
Advice training and guidance on aspects of non-clinical risks, health and safety litigation and risk assessments

9.14. **Radiation Protection Advisor**
Advice training and guidance on aspects of radiation safety

9.15. **Counter Fraud Adviser**
Aspects of fraud or potential fraud or financial loss to the Trust

9.16. **Company Secretary**
Care Quality Commission registration, aspects of the Trust constitution and data protection

9.17. **Head of Information Governance**
Advice on information governance requirements

This list is not exhaustive but any of the above are able to give advice on additional sources of information whether internal or external to the Trust.

## 10. Process for implementation

The Risk Management Strategy will be promoted across the Trust in a number of ways including:

- Publishing on GOSHWeb under the Document Library and the Clinical Governance and Safety Team intranet page
- Inclusion in the Trust's Newsletter publication
- Senior Management Team will be briefed and asked to disseminate information to staff as required

In addition, Risk Managers will work with Risk Action Groups and key staff involved in Divisions and Departments risk processes to ensure they understand what is required under the Strategy.

The RACG is responsible for overseeing the implementation of the Risk Management Strategy.

## 11. Summary of Monitoring Table:

A report will be received by the relevant committee which will include as a minimum:

- Rationale for the audit or review
- What is being measured eg attendance, receipt of minutes, completeness of minutes, and compliance with any reporting schedule or applicable measure identified to demonstrate compliance.
- Results of the audit or review and whether compliance was demonstrated.

### 11.1. Compliance Scores

| Score for compliance | Grade | Action required |
|---|---|---|
| 90-100% | | Report to named committee as per reporting schedule |
| 76-89% | | Report to named committee with action identified to improve compliance and time scales. Monitoring to be incorporated into the named committee meeting schedule once agreed. |
| <75% | | As above. Discuss with responsible person depending on deficit identified eg relevant committee chair, General Manager, Divisional Director, Director, to identify deficit and means to rectify. |

### 11.2. Strategic Performance Reviews

These meetings are held quarterly and include review of the unit or department risk register as well as operational key performance indicators, financial status and business development. They are chaired by the Deputy Chief Executive or another Executive Director and are carried out with all the units.

### 11.3. Management of non-compliance

Aspects of this policy are audited annually prior to updating and reviewed to assess the effectiveness of the processes and tools identified within it and compliance with the stated requirements. Where deficiencies are identified, discussion with the relevant manager, executive director or at a relevant committee occurs to assess whether remedial action is required. Progress against internal and external audit recommendations is reported back through the Audit Committee.

## 12. Equality impact statement

This policy has been assessed for its impact on equality and will have a low level of impact on the protected groups identified in the assessment from the groups listed below (see appendix 6):

- Age
- Disability (including learning disability)
- Gender reassignment
- Marriage or Civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

## 13. Training

13.1. The following table summarises the requirement for training for all staff in respect of clinical and non-clinical risk management.

| Staff Member | How | Delivered by | Assurance |
|---|---|---|---|
| Executive Directors | Induction & Updates | CGST | Attendance monitoring and Board self assessment |
| Senior Managers | Induction & Updates | CGST | Attendance monitoring |
| Clinical Staff | Induction & Updates | CGST | Attendance monitoring |
| Non Clinical Staff | Induction & Updates | CGST | Attendance monitoring |
| Non-Executive Directors | Induction & Updates | CGST | Attendance monitoring and Board self-assessment |
| Staff with responsibility for investigating | Bespoke training &/or Risk Management Training | CGST | Attendance monitoring |
| Staff with responsibility for undertaking Root | Bespoke training and /or Risk Management Training | CGST | Attendance monitoring |
| New Managers | Bespoke Training | CGST | Attendance monitoring |

Additional specific financial, business continuity, major incident and information governance training is identified for staff relevant to their roles and delivered and monitored through the Education & Training team.

## 14. Other policies of relevance

14.1. Further detail on the management of specific types of risk e.g. Clinical, Human Resources, Health & Safety, Information Governance can be found within the policies relevant to those areas, some of which are given below[6]:

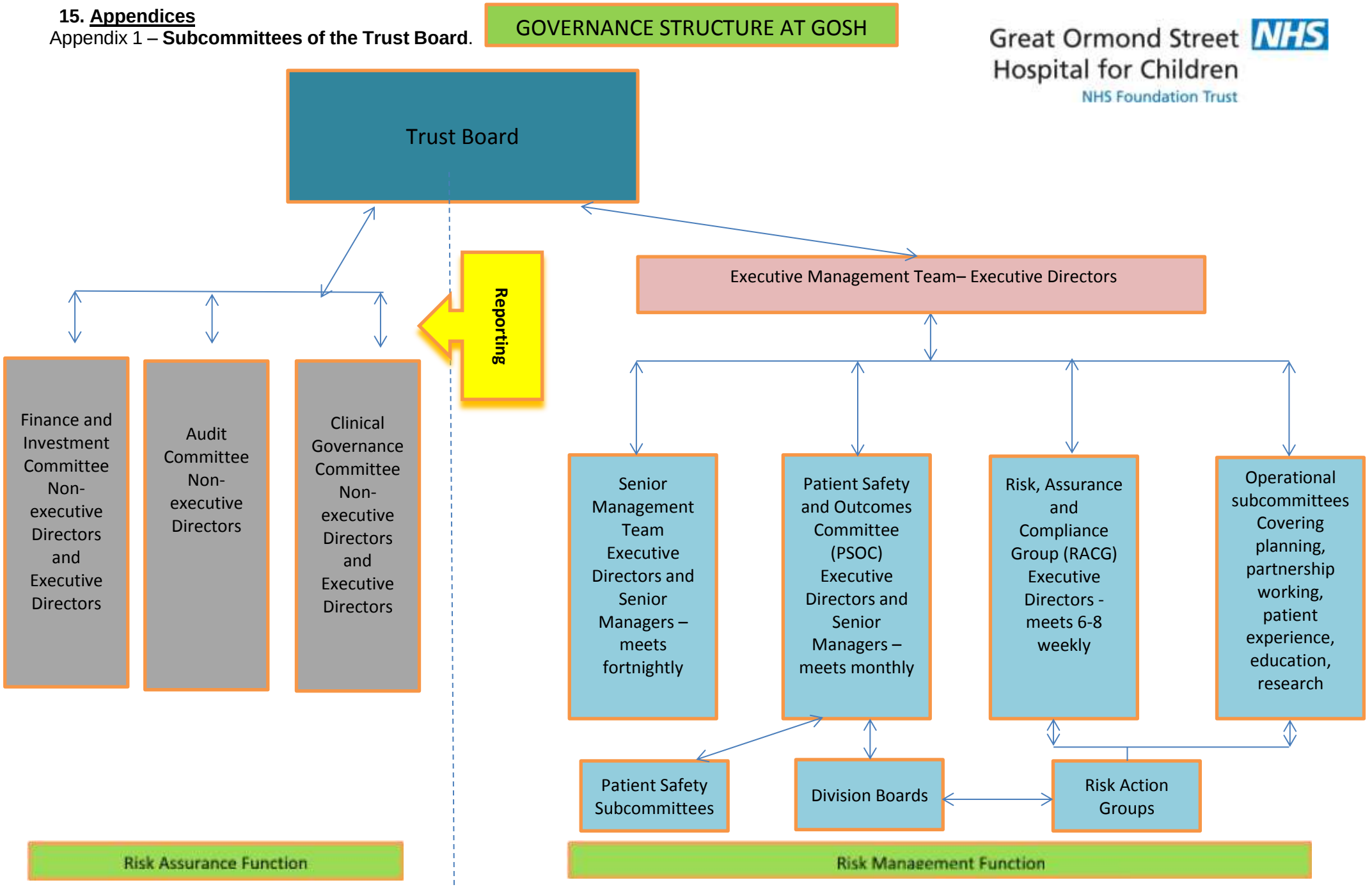
All IT policies
All Personnel policies
Assurance Framework
Building and site development strategies
Complaints Policy
Continuity and Business planning procedures
Framework Fraud and Corruption Policy
Health & Safety Policy
Standing Financial Instructions and policies
Information Risk and Governance Policies
Legal Policy
Major Incident Policy
Management of external visits and inspections
Performance Strategy
Personal Responsibility
Quality Strategy
Incident Reporting & Management Policy
Trust Vision & Objectives

Safeguarding Children and Young People Policy

[6] This list is not exhaustive and is updated as policies are reviewed

**15. Appendices**

Appendix 1 – **Subcommittees of the Trust Board**.



Appendix 2- **Standing Committees**

The purpose of a Standing Committee is to review specific aspects of work which falls within its area of expertise and which usually has a Trust wide remit. As such these committees are key parts of the structure to manage risk from clinical and non-clinical sources and may be operational or clinical in focus. The main standing committees[7] with a remit for clinical risk are given in Appendix 1.

This role of a clinical standing committee is delegated by Senior Management Team and is an important part of managing risk in areas known to involve high risk to patients.

The Senior Management Team establishes other operational committees or time limited working groups to manage specific areas of risk as necessary.

The following outlines the basic requirements expected by Trust Board and with which Standing Committees are required to comply.

**Guideline on the drafting of Terms of Reference**

This section provides guidance on the drafting of committee/ board terms of reference. It has been produced in order to ensure consistency of approach by all committees/ boards at Great Ormond Street Hospital NHS Foundation Trust.

**What is the purpose of a committee/ board's 'terms of reference'?**

The terms of reference outlines the role and function of a committee/ board. The document provides a summary of the role and purpose of the meeting, who should attend the meeting, and where the findings of the meeting should be reported.

**Who is responsible for monitoring implementation of the terms of reference?**

The Chair of the committee/ board is responsible for ensuring that the terms of reference are followed, supported by the secretary to the committee. This will be achieved by drafting the agenda in light of the purpose of the committee/ board, ensuring that the meeting is quorate and ensuring that reports are made to the relevant committees.

**What areas should they cover?**

The terms of reference for any committee or board at GOS should cover the following areas:

a. **Duties** – this first section should detail the role of the committee/ board and its authority. This can include responsibilities for approving or monitoring strategies and the implementation of policies; agreeing resources; recommending actions etc. The committee/ board may choose to agree an annual workplan.

b. **Reporting arrangements to the board/ high level committee** – the document should state where the committee/ board sits in the organisational structure (i.e. the committee is a subgroup of the Senior Management Team). It should also record where the committee/ board is expected to report to and the frequency of these reports.

c. **Membership, including nominated deputy where appropriate** – The terms of reference should detail the job title of each member. Names of members should not be included. It should be clear who the Chair of the committee/ board is. Scope may be given to invite additional members on to the committee/ board for specific items of business. Each member of the Board should have a nominated deputy who will be entitled to attend and 'vote' on the committee/ board.

d. **Required frequency of attendance by members** – It is important that members are clear about the number of meetings they are expected to attend in a year. For example, for a committee/ board that meets monthly, it would be prudent to expect attendance at a minimum of 10 meetings within a 12 month period.

[7] This list is not exhaustive and is reviewed annually as a minimum.

e. **Reporting arrangements into the committee** – The terms of reference should record those reports it expects to receive from teams or other committees and the frequency with which these should be made.

f. **Requirements for a quorum –** a quorum details the minimum number of officers and members of a committee, usually a majority, who must be present for the valid transaction of business. It should state the number of nominated deputies who may be included in the quorum to enable the committee to function (it would be expected that for a quorum of 4, a maximum of one member of the quorum would be allowed to be a deputy).

g. **Frequency of meetings** – The terms of reference should identify how often the committee / board shall meet and when papers will be expected to be received by members (usually 5 working days before the meeting).

h. **Monitoring compliance with the terms of reference** - The committee/ board will need to record in the document how it intends to monitor compliance with the terms of reference. Examples include reviewing:

- the frequency of meetings
- the attendance at meetings
- compliance with the duties of the committee/ board detailed in the terms of reference.
- Evidence based outcomes resulting from decisions taken at the committee/ Board

**How often should the terms of reference be reviewed?**
The committee/ board should review its terms of reference annually to ensure that its purpose and duties align with the governance arrangements in the organisation and any relevant legislation (where applicable).

All terms of reference must be uploaded to the Meeting Papers' Library.

Minutes from standing committees and meetings are made available to staff on the Meeting Papers section of the corporate website. Advice can be sought on how to action this from the Company Secretary ext 8230.

On occasion, standing committees will be required to present examples of actions taken on key areas within their remit to the Clinical Governance Committee.

The above format is recommended as good practice for any time limited or group set to complete specific tasks including reporting lines. This is to ensure decisions taken are recorded and work monitored appropriately.

The clinical standing committees will report to the Patient Safety and Outcomes Committee (PSOC) committee at least twice each year to provide a summary of the work undertaken. The PSOC will provide a report twice a year to Senior Management Team. This process forms part of the system to monitor the effectiveness of the committee structure.

## Appendix 3- Risk assessment

### Assessment tools

Minimising risk requires the hazard to be identified, the risk assessed and a decision to be taken as to what control is required to mitigate that risk. The purpose of the grading assessment tool is to provide a consistent means for clinical and corporate staff to identify the key areas of risk which need to be incorporated into their risk registers, financial plans or into their business planning cycle. It assists in identifying the management responsibility and where this sits.

Risk assessments may be carried out to identify the significant risks arising out of planned changes to any of the following: Trust procedures, environmental, financial, health and safety or clinical services. They may be required following a specific event to assess the degree of risk posed to the Trust and may be internally or externally driven. They should be documented to assist in assessing the action required. This may be by using a designated risk assessment form (see examples in the Incident Reporting &Management Policy and Health & Safety policy), or a report format if this is more appropriate to the forum in which the assessment is to be considered. As a minimum, the risk assessment must include a description of the risk, the source of the risk, the likelihood of the risk occurring and the impact if it did. It should also include any current controls in place or additional controls that may be required. Where appropriate, consideration of resource and reputational risk should be included.

| **SEVERITY** | **LIKELIHOOD** | | | | |
|---|---|---|---|---|---|
| | **1 Very Unlikely** ***(Freak event – no known history- 1 in 100,000 or less)*** | **2 Unlikely*****(Unlikely sequence of events1 in 100,000 to 1 in 10,000)*** | **3 Possible** ***(Foreseeable under unusual circumstances 1 in 10,000 to 1 in 1000)*** | **4 Likely*****(Easily foreseeable – 1 in 100 - 1000)*** | **5 Very Likely*****(Common occurrence – 1 in 100 chance in any one year)*** |
| **1 No harm** ***(No injury, no treatment required, no financial loss.)*** | Low | Low | Low | Low | Low |
| **2 Minor** ***(Short term injury, first aid treatment required, minor financial loss)*** | Low | Low | Low | Medium | Medium |
| **3 Moderate** ***(Semi permanent injury, possible litigation, medical treatment required, moderate financial loss)*** | Low | Low | Medium | High | High |
| **4 Major*****(Permanent injury, long term harm or sickness, potential litigation, fire, major financial loss)*** | Low | Medium | High | High | High |
| **5 Catastrophic** ***(Unexpected death, potential litigation, catastrophic financial loss)*** | Low | Medium | High | High | High |

### Risk scoring

Using the 5x5 matrix the likelihood of the risk occurring is multiplied by its impact to produce a risk score and grading. For a potential risk or hazard or one that nearly happened, the risk is scored for its potential impact and likelihood of occurring again.

The grading provides guidance on the action required and can be **High, Medium or Low.**

The purpose of grading is to establish a baseline level of risk from the identified hazard. This enables

regrading to occur where appropriate, based on review of the effectiveness of the control identified to mitigate and manage the risk. Grading of risks is most effective when undertaken using a multidisciplinary approach wherever possible or as part of the Risk Action Group. This ensures the risk can be considered for its broadest effect on the service and referred if necessary to the division board for addition to the local risk register. The scoring assists in the prioritisation of risks of the same grade. For addition of risks to the risk registers see Appendix 4.

**Management responsibility and review of risks**

The following identifies the expected review schedule of risks included on the risk register for division boards and corporate departments based on the scores and grading.

| Grade | Score on Risk Matrix | Frequency | By |
|---|---|---|---|
| High Risks | Score of 12 or above | Monthly review | Divisional Board Executive team Assurance Framework Group |
| Medium | Score of 8 to 10 | Two monthly review | Divisional RAG |
| Low | Score of 1-6 | Quarterly review | Divisional RAG |

**Low risks** - included in risk register where appropriate for quarterly review by division board or Risk Action Group

**High and medium risks** - require actions and controls to be identified by the division board or equivalent. High and Medium risks are reviewed by the unit board to ensure the grading and actions to be taken are appropriate to minimise the identified risks prior to inclusion on the Risk Register. The aim is to reduce, transfer or eliminate the risk wherever possible. This includes a date for further review by the unit team and a check on the grading, facilitated by the Patient & Staff Safety Link where necessary.

**Corporate risks** – or those requiring a Trust wide approach are managed by agreement with the relevant Executive Director and may be overseen by a nominated individual, time limited project group or Trust committee.

**Local risks** –are managed by the clinical team, unit board or department and escalated through their existing reporting line and meeting structure to the relevant executive Director

**High risk monitoring**

Progress against High risks is monitored initially by the division boards monthly and included as part of the key performance indicator reports.

All high risks of 12 and above are included in the Assurance Framework and reviewed by the Executive Team to support early identification of trends or where additional action needs to be taken.

Quarterly reports go to the Audit Committee as part of the Assurance Framework on the progress to manage assurance or control gaps for high risks.

The above is only a guide and high risks can be escalated for consideration by the assurance framework group in discussion with the relevant executive director. The Executive Group will also discuss specific high risk issues to ensure rapid action is taken where necessary and prevent delays in mitigating such risks.

## Appendix 4- Risk registers

**Purpose of risk registers**
The Risk Register provides a means to identify and prioritise the principal risks that may affect either service delivery or the environment in which services are delivered. In this way they are applicable to every clinical and non-clinical division or department within the Trust and every layer of management within the organisation.

**Management of risk registers**
**Local Risk Registers** are made up of the key reported events for each unit or department and any specific issues of concern affecting local service delivery or business continuity. They are maintained and updated by the division or local department by using the on line risk management database (Datix).

**Adding risks to the Risk Register**
A risk identified for inclusion in the register may be from any source eg internal or external factors, adverse events, complaints, claims, PALS, audits, resource issues both staffing and/or financial or by potential changes to other services within the organisation. It could be as a result of a trend following analysis of reported incidents, or something which may affect service delivery or the ability of the unit or department to meet the Trust objectives. The Risk Action groups reviewing and discuss risks to be added to the risk register, this is to ensure that robust assessment of impact and likelihood, controls, mitigations and escalation are considered and clearly documented on Datix. The risk registers are then reviewed at the Divisional Boards for further support and advice.

**A Trust Wide Risk** is a risk that has been identified as affecting more than one division or is unable to be mitigated by the individual division.

A member of the team will present the suggest trust wide risk to the Risk Assurance and Compliance group where an appropriate trust wide lead and executive lead will be allocated. The Trust wide risk register is reviewed and updated at the Senior Management Team Meeting (SMT) whilst the RACG monitor the compliance with this strategy.

**Risk Action Groups and risk registers**
The purpose of the Risk Action Group is to systematically review risks on the unit risk registers within the time scales identified in the Risk Assessment tool (Appendix 3). They also review the incidents that have been reported by the unit. Due to the specialty mix, it may be appropriate for a division to have more than one Risk Action Group or one larger group with cross specialty representation. Corporate areas may combine this function within an existing meeting schedule.

Information to inform this process for clinical, non-clinical risk, complaints, and audit can be obtained from the Datix Risk Management System. Information specific to other risk such as Finance, Personnel, and Information Services is supplied by the relevant link from each of these areas on request. RAGs are facilitated by the Risk Links. Compliance with the required frequency of high risk review is a performance indicator and is monitored by the Risk Management team.

## Appendix 5 - Risk Action Group Terms of Reference Template

### Introduction

The Risk Action Group is a delegated sub-group of the Division Board with overarching responsibility for the system of patient safety and risk management in accordance with the reporting requirements of NHS London, National Patient Safety Agency and the Care Quality Commission.

### Purpose

The Group will:

- Ensure a systematic and multi-disciplinary approach is applied to the identification, recording, management and monitoring of patient safety issues and operational risk;
- Provide assurance to the Division Board on patient safety and risk management, and where necessary escalate matters of concern to the Division Board;

### Functions

The Group will:

- Review incidents, serious incidents, complaints, PALS enquiries and CAS Alerts reported, and where appropriate- initiate follow up or investigation;
- Obtain assurance that remedial action has been taken with regards to incidents, serious incidents, complaints, PALS enquiries and CAS Alerts;
- Identify opportunities and approaches for sharing lessons learned from incidents, serious incidents, complaints, PALS enquiries and CAS Alerts;
- Provide scrutiny and challenge in relation to investigations;
- Receive and review completed reports related to incidents, serious incidents, and complaints;
- Endorse or otherwise, report recommendations and ensure that appropriate action plans are implemented and monitored;
- Identify trends and associated risks from incidents, serious incidents, complaints, PALS enquiries and CAS Alerts and ensure that these are being addressed;
- Identify issues that need to be addressed through either clinical audit; service improvement quality initiatives; or risk management;
- Ensure consistency of approach in the methodology used to assess and score incidents and risks;
- Ensure risk register action plans, controls and risk assessments are up to date and reflected accurately on Datix during or following each RAG meeting;
- Promote a positive culture of patient safety and risk management by ensuring that effective communication is maintained by cascading information across the clinical specialty;
- Escalate matters of concern to the Division Board using the Escalation Report Template;
- Monitor compliance with the Trust Risk Management Strategy.

**Membership**

| MEMBERSHIP | |
|---|---|
| **LISTED MEMBER** | **AGREED DEPUTY** |
| Chair [Senior Clinician] | Deputy Chair [Senior Clinician] |
| Service Improvement Manager | Na |
| Member 1 | Deputy 1 |
| Member 2 | Deputy 2 |
| Member 3 | Deputy 3 |
| **IN ATTENDANCE** | |
| Risk Manager | |
| Note Taker | |

**Accountability**

The Risk Action Group is accountable to the Division Board.

**Quorum**

Needs to be agreed at the RAG

**Appendix 6- Equality Analysis Form**

**TITLE OF DOCUMENT**
Risk Management Strategy

**COMPLETED BY** **DATE COMPLETED**

**SUMMARY OF STAKEHOLDER FEEDBACK**
None required

**POTENTIAL EQUALITY IMPACTS AND ISSUES IDENTIFIED**

| Protected group | Potential issues identified | Actions to mitigate/Opportunities to promote |
|---|---|---|
| Age | None | |
| Disability (including learning disability) | 1 Colour blindness - Due to use of colour coded risk matrix<br><br>2. Completion of risk assessments<br><br>3. Communication of outcomes from risk reports/risk assessments | 1.A colour coded grid is used with the narrative of the colour in addition to the actual block colour<br><br>2.Staff are provided with training on the completion of risk assessments and risk management and this is provided in a suitable format and at a suitably accessible location<br><br>3.Reasonable adjustments will be made as appropriate for staff requiring support with any area of communication |
| Gender re-assignment | None | |
| Marriage or civil partnership | None | |
| Pregnancy and maternity | None | Arrangements relating to this area will be accounted for as per the Trust health and safety policy |
| Race | Translation of risk assessment forms and documentation | Translation services can be arranged as required |
| Religion or belief | None | Taken in to account as appropriate |
| Sex | None | Arrangements relating to this area will be accounted for as per the Trust health and safety and lone worker policies |
| Sexual orientation | None | |

**ASSESSMENT OF EQUALITY IMPACT**
Reasonable adjustments will be made in certain circumstances to account for individual requirement.

## APPENDIX 7 – GOSH risk appetite

### Overview

The Trust defines its risk appetite as the amount of risk it is prepared to accept, tolerate, or be exposed to at any particular time, in the context of highly specialised services the Trust offers. The Board is committed to doing everything possible to reduce risk for children and to deliver high quality, efficient and effective care.

The Board recognises that the Trust's clinical services and research activity are delivered within a high risk environment. The delivery of GOSH's strategic objectives and its relationships with its patients, the public, its funders and other strategic partners determines the Trust's long term sustainability. As such, the Board has agreed that the Trust has an overall low appetite for risks relating to its clinical service and research delivery. The lowest risk appetite applies to all safety and compliance objectives, including preventable patient harm, public and employee health and safety. The Trust has a marginally higher risk appetite for the pursuit of innovation and its strategic and operations objectives. This means that the risks originating from clinical and research processes as well as meeting legal and other regulatory obligations will take priority over other business objectives.

### Risk appetite by GOSH business mode segment

Quality

The Board has low risk appetite for preventable patient harm and patient experience. Clinicians manage risk in line with national clinical and research guidelines (where available) and evidence based practice and all staff are committed to delivering a service consistent with the 'always values' and the highest possible standards of care, compassion, safety and quality. The lowest risk appetite applies to all safety and compliance objectives, including preventable patient harm and safety. While the Trust is committed to pursuing innovation this cannot result in increased risk of patient harm or experience and/or compromised compliance with statutory, regulatory or best practice safety and quality standards. (LOW RISK APPETITE).

Financial

The Board has a low appetite for financial risk in respect of delivering its financial plan . In the current NHS economic environment, particularly that affecting Trusts with specialist services the Board is prepared to accept some financial risk created by external tariff and commissioning changes but not to the extent that the organisation cannot continue to be financially sustainable within the current and following financial period. Value for money, within the context of safe clinical service delivery, is still a primary concern, but the Board will consider other benefits or constraints consistent with its overall strategy. The Board recognises that at times we need to invest to achieve future financial and non-financial benefits and that we may need to support investments for longer term return while minimising the possibility of financial loss by managing associated risks to a tolerable level. The potential for increasing operational and financial value will be considered and resources allocated in order to capitalise on opportunities. (LOW RISK APPETITE)

Research and Innovation

Research is a key component of our strategy and our activity, and is, by definition, innovative. Innovation will be pursued with a desire to 'break the mould' and challenge all current clinical work practices. Whilst authority for seeking innovative practice is devolved to clinician and team levels, governance structures are in place to ensure that a detailed risk assessment (clinical, ethical, financial and multi-disciplinary) of all clinical programmes and projects is performed. (MODERATE RISK APPETITE)

Commercial

In light of the specialist nature of the work undertaken at GOSH and the demand for some of its services world-wide, the Trust's business development strategy will consider potential international markets where children could benefit from the care available and demand is high. In the main, this will be within well-established business areas and markets on a controlled basis, where the delivery options available do

not compromise delivery of NHS services. (MODERATE RISK APPETITE)

Regulation and Compliance
The Board acknowledges that healthcare and the NHS operates within a highly regulated environment, and that, as a Foundation Trust, the Trust has to meet high levels of compliance expectations from an overwhelming number of regulatory sources. It will endeavour to meet those expectations within a framework of prudent controls, balancing the prospect of risk elimination against cost and pragmatic operational imperatives. The general approach would be one of ensuring a low degree of inherent risk. (LOW RISK APPETITE)

Leadership
Organisational development is required to ensure that the organisation is well positioned for the future by creating an environment that allows employees to understand and deliver the organisation's objectives. The Board has a low appetite for having other than appropriately qualified and competent staff. Clear policies and procedures are key to ensuring staff understand the parameters within which they operate, whilst at the same time, promoting a culture of innovation which will involve risk (without compromising patient safety or statutory compliance). (LOW RISK APPETITE)

Performance
The Trust is committed to meeting standards on high quality patient care, national standards or those that may result in financial consequences. The Trust will look at innovative ways to meet these standards. The Trust has a low risk appetite for breaching those standards which are directly linked to patient care. (LOW – MODERATE RISK APPETITE)

Reputation and partnership working
The Board is prepared to take decisions consistent with the vision and values that have the potential to bring scrutiny of the organisation. Prospective management of the Trust's reputation is key with continual horizon scanning conducted by the Trust's Communication Team.

The Trust recognises the importance and potential advantages for our patients and the wider community of developing closer relationships with our partners to develop integrated care pathways and reap improvements in quality, efficiency and patient experience. Working collaboratively requires some moderate risk to be accepted as we develop joint strategic plans to deliver a stronger and more resilient service. All actions taken will be subject to the highest standards of accountability and transparency. (MODERATE RISK APPETITE).

Great Ormond Street Hospital for Children NHS Foundation Trust

| Trust Board<br>1st April 2016 | |
|---|---|
| **Register of Interests (Directors and Staff)**<br><br>**Submitted by:** Anna Ferrant, Company Secretary | **Attachment: Attachment V** |

**Aims / summary**

Great Ormond Street Hospital's Declaration of Interest Policy requires that all members of staff (including temporary and agency staff) and directors of the Board declare any potential or actual conflict on joining the organisation or when the potential for conflict arises.

Paragraph 31 of the Board of Director's Standing Orders outlines the requirements for directors to disclose any pecuniary, personal or family interest, whether that interest is direct or indirect, in any proposed contract or other matter that is under consideration or is to be considered by the Board

A conflict of interest occurs when the private or personal interests of a member of staff/ member of the Board could affect their role at the Trust in terms of bringing some possible advantage to them or close relatives.

Any declared interests are reconfirmed annually until such time as either the member of staff/ member of the Board leaves GOSH or the potential for a conflict of interest no longer exists.

Details and examples of potential conflicts of interests are set out in the Declaration of Interest Policy.

The Company Secretary is required to draw up a register of interests declared by members of staff and members of the Board and to report on this annually in the public part of a Trust Board meeting. The returns are maintained in a register which is open for inspection. The registers for Trust Board members and staff are attached with this report.

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|---|
| **Action required from the meeting**<br>To note the content of the report. |
| **Contribution to the delivery of NHS / Trust strategies and plans**<br>Transparency |
| **Financial implications**<br>None |
| **Who needs to be told about any decisions**<br>N/A |
| **Who is responsible for implementing the proposals / project and anticipated timescales**<br>The Company Secretary |
| **Who is accountable for the implementation of the proposal / project**<br>The Company Secretary |

| Name | Role | Declaration | Declared/Renewed |
|---|---|---|---|
| ASHWORTH, Michael | Consultant, Histopathology | I pay my private earnings into a private company known as 'Repath' of which I am a director. The income is derived entirely from the International Private Patients Wing, which is managed by the NHS. The fees are for expert opinion. The Company is essentially a handling mechanism for the consultants' private fees. The accounts are audited and subjected to company tax. The fees are used to pay for expenses in the Histopathology Department, e.g. training fees for non-medical staff. The remainder is paid to the consultants as annual dividends. I declare these earnings in my own income tax return. This is a longstanding arrangement of which managers are aware, and it has been suggested as a model for others. However, it has come to my attention that a formal declaration should be made to the Trust, and this I now do. | Feb-16 |
| BARNACLE, Alex | Consultant Paediatric Radiologist | I have practising privileges at the Portland Hospital for Women and Children. I undertake diagnostic imaging sessions at the Portland Hospital averaging 3 hours per fortnight, which is done in my own time. I now also run a regular interventional radiology (IR) operating list in my own time at the Portland Hospital, which takes place approximately once per month and is almost exclusively for the treatment of vascular malformations. I do occasional ad hoc IR procedures for other clinical teams at the Portland Hospital when referred specific patients.<br><br>I am currently the lead clinician for the Radiology department at the Portland Hospital and represent the department on the Portland Hospital Medical Advisory Committee.<br><br>I have no involvement in any financial institutions that would cause a conflict of interest. | Feb-16 |
| BEATTIE, Mark | Consultant Paediatric Gastroenterologist, University Hospital Southampton NHS Foundation Trust | Past President of BSPGHAN<br>Past Convenor BSPGHAN<br>Editor in Chief Archives of Disease in Childhood | Nov-15 |
| BERLIN, Cheryl | Genetic Counsellor | I undertake private work as a genetic counsellor. I work at private patient unit of the Royal Free Hospital. In addition I work at a genetic counselling company - GeneHealth UK | Mar-16 |
| BLADEN, Melanie | Clinical Specialist Physiotherapist | I have received £600 for organising and presenting on the National Haemophilia Physiotherapy conference that is sponsored by Bayer February 2015 and February 2016 (annual leave taken).<br><br>I have also received research funds from Pfizer totally £35,000 to date - processed through R&D | Mar-16 |
| BRIERLEY, Joe | Consultant Paediatric Intensivist | I undertake private practice at the Portland Hospital PICU. This is undertaken outside my GOSH hours and I do not personally perceive a conflict as I also undertake private practice | Feb-16 |
| BROWN, Caroline | Childcare Services Manager | I have recently set up a limited company providing HR management and leadership training. I am a Director in this company. | Dec-15 |

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|---|---|---|---|
| CALDER, Alistair Duncan | Consultant Paediatric Radiologist | Undertakes sessions at the Portland Hospital in paediatric Radiology, averaging 3 sessions per month. These do not occur during scheduled NHS sessions, are included in my job plan and do not otherwise conflict with work at GOSH. | Feb-16 |
| CALE, Catherine | Consultant Immunologist | My husband is a corporate accounts manager for Thermo Fisher Scientific who supply GOSH with laboratory equipment and consumables. | Feb-16 |
| CHAUDHRI, Waseema | PALS Officer | I am typing Prof Milla's medico-legal reports. The claimants are not Great Ormond Street patients. I do not receive any payment for this work.<br>Only for Prof Milla<br>Assist when Prof has too many cases needing to be finished at the same time. | Feb-16 |
| CHUGH, Deepti | Highly specialist physiotherapist (NDS&SDR service) | I provide domiciliary physiotherapy services (2-3 hours/wk). This work is conducted outside of the NHS contracted hours. | Feb-16 |
| CLOUTMAN-GREEN, Elaine | Clinical Scientist, Infection Control | That I am working with Auspherix Ltd in a consultancy capacity in relation to infection control and clinical microbiology | Jul-15 |
| CROFT, Nick | Consultant Paediatric Gastroenterologist. Barts Health | President Elect BSPGHAN<br>Past Convenor BSPGHAN | Nov-15 |
| CURRAN, Steven | Head of Facilities | I am Leader of the London Borough of Hounslow | Mar-16 |
| DUNAWAY, David | Consultant Plastic Surgeon, Craniofacial Department | I am a Trustee of Facing Africa (a charity providing care to children in Africa).<br>I am a Director and 25% shareholder of 152 Harley Street Ltd (A registered day hospital providing consulting facilities, radiology and local anaesthetic and sedation operating facilities and also registered for paediatric care).<br>I am a Director and 50% shareholder of the London Craniofacial Unit Ltd (a company co-ordinating local, private and overseas craniofacial care). | Feb-16 |
| Dunn, Helen | Lead Nurse for Infection Control | I will be undertaking ad hoc consultancy work for Infection Prevention Solutions for approx 20 hours a month. It will not be carried out in GOSH time. This does not represent a conflict of interest | Nov-15 |
| EASTWOOD, Deborah | Consultant, Orthopaedics | 1. Occasional private practice (approx. 3 cases per year) at the Royal National Orthopaedic Hospital<br>2. Participation in a symposium on Morquio's Disease (discussing orthopaedic issues) at the Japanese Orthopaedic Association meeting Dec 2015 sponsored by Biomarin. (non recurring)<br>3. Trustee of Humanitas charity ongoing | Feb-16 |

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| EASTY, Marina | Consultant Paediatric Radiologist | Takes sessions at the Portland Hospital, performing ultrasound scans, screening, general reporting and MRI. Also GOSH in-house private patient work, as requested by the referring clinicians. There is no conflict of interest because the work is done out of NHS time. | Feb-16 |
| FANE, Andrew | Lay Chair for Advisory Appointments Committee | I hereby declare that with effect from Thursday, 10 July 2014 my wife became President of Royal College of Surgeons of England.<br><br>I will make this declaration briefly at the outset of all future AACs making a surgical appointment. | Feb-16 |
| GASPAR, Bobby | Honorary Consultant in Paediatric Immunology | I have equity in a newly formed company called Orchard Therapuetics. I also receive a consultancy from the company. | Mar-16 |
| GOLDMAN, Allan | Divisional Director Critical Care | I run a ventilator course once a year for 2 days. I get paid for this and take both days as annual leave.<br><br>I did a Grand Round in Washington DC Children's Hospital in September 2015. An honorarium was received and I therefore took annual leave that day | Mar-16 |
| HARTLEY, Benjamin | ENT Consultant | I do private practice at the Portland Hospital | Feb-16 |
| HEALES, Simon | Head of Clinical Services for Laboratory Medicine | I have received honoraria and consultancy fees from the following commercial organisations: Shire, Genzyme, Vitaflow | Mar-16 |
| HEUSCHKEL, Robert | Consultant Paediatric Gastroenterologist. Addenbrookes Hospital | Divisional Director Women and Children's services<br>Previously worked at Royal Free Hospital | Nov-15 |
| HILL, Robert | Consultant Orthopaedics Surgeon | I am a part time NHS consultant and have a paid role as Medical Director for the Portland HCA Hospital. I have not been involved in any financial negotiations in relation to NHS work taking place within the HCA hospitals and my position at the Portland is not dependent on turnover or financial targets. | Mar-16 |
| HILL, Susan | Consultant, Gastroenterology | 2015-16 I am acting in a consultant capacity to Abbott Nutrition which includes sponsoring travel conferences and presenting on their behalf | Mar-16 |
| HINDMARSH, Peter | Professor of Paediatric Endocrinology | I receive payment as member of Medtronic Diabetes Medical Advisory Board of £600 per annum | May-15 |
| HIORNS, Melanie | Consultant Radiologist, Radiology | I do some radiology scanning/reporting sessions at the Portland Hospital | Feb-16 |
| HUDSON, Lee | Consultant General Paediatrician | I work occasionally on an ad hoc basis in a private capacity, outside of my contracted NHS hours, for Ellern Mede Eating Disorder Unit as a paediatric consultant. I also work privately in GOSH IPP Outpatients outside of NHS contracted hours | Feb-16 |
| JACKSON, Elizabeth | Consultant Anaesthetist/Divisional Director, Surgery | I have practicing privileges and undertake private anaesthetic practice at HCA hospitals in London within the times stated in my job plan. | Feb-16 |

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| JACQUES, Thomas | Honorary Consultant in Paediatric Neuropathology | I am an executive editor at the journal, Neuropathology and Applied Neurobiology. This is a medical and scientific journal and is the journal of the British Neuropathological Society. I am paid a fee for each manuscript I handle at the journal and have the potential to access travels funds from the journal.<br><br>I derive some income from royalties from authoring medical books or chapters thereof.<br><br>I pay my private earnings into a private company known as 'Repath Ltd' of which all the consultant histopathologists, including myself are directors and shareholders. I am the Company Secretary. The Company is a mechanism for handling the consultants' private fees.<br><br>I undertake reports for HM courts as an expert witness. The fees for this work is paid to Neuropath Ltd for which I am also a director and shareholder. My wife is also a shareholder and director at Neuropath Ltd.<br><br>I am the chair of the Clinical Practices Committee of the British Neuropathological Society. This is the committee of my professional society responsible for leading on clinical matters. There is no remuneration for this work.<br><br>I am the chief investigator and chair of the scientific committee of the Children's Cancer Leukaemia Group (CCLG) national tissue bank. There is no remuneration for this work.<br><br>I am an elected committee member and trustee of the Pathological Society of Great Britain and Ireland. There is no remuneration for this work. | Mar-16 |
| KHAIR, Kate | Consultant Nurse, Haemophilia | I am a Trustee of two charities: Haemnet and The Haemophilia Society. Haemnet is funded to do research work from GOS Heamophilia Research funds. I do not gain financially from being a Trustee of these charities. | Feb-16 |
| LEECH, Susan | Consultant Paediatric Allergist, King's College Hospital - undertaking work for GOSH | Past Chair Paediatric Allergy Group BSACI | Nov-15 |
| LISTER, Paula | Consultant Paediatric Intensivist | I have begun private practice at the Portland Hospital PICU. The work will be entered on my new Job Plan. This work is conducted outside of the time I am contracted to Great Ormond Street Foundation Trust. It does not conflict with my NHS work and is not detrimental to it. | Feb-16 |
| LYON, Susan | Organisational Development Manager | I am a Director in a registered company providing HR, management and leadership training | Dec-15 |
| MCHUGH, Kieran | Consultant Paediatric Radiologist | Occasionally reports MRIs, x-rays and ultrasounds at the Portland Hospital. | Feb-16 |
| MELLERIO, Jemima | Constultant Dermatologist | I undertake private dermatology clinics at The London Skin and Hair Clinic, 19 Cavendish Square, London. I have a limited company Mellerio Dermatology Ltd | Feb-16 |

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| MORRIS, Samantha | Endocrine Nurse Specialist | Novo Nordisk have paid for me to attend the Novo Nordisk Endocrine Nurse Workshop on 21st April 2016. This includes train fares and hotel accommodation. | Mar-16 |
| MUNTONI, Francesco | Professor/Honorary Consultant Paediatric Neurology | Since the end of 2014 I have provided ad-hoc consultations for the following companies:<br>PTC Therapeutics<br>Roche<br>Servier<br>Summit<br><br>I have provided lectures at the following industry sponsored symposia in the course of international meetings:<br>Biogen Sarepta Symposium (European Paediatric Neurology Society, 2015)<br><br>I have served (and continue to serve) in the following Scientific Advisory Boards;<br>Scientific Foundation Telethon (Muscular Dystrophy Research Charity, Italy)<br>Myotubular Trust UK (Scientific Foundation, I chair the SAB)<br>Pfizer Rare Disease SAB (two meetings in 2015, one in 2016)<br><br>I am involved in the current clinical trials, for which GOSH and UCL receive funds:<br>Biomarin<br>Summit<br>British Heart Foundation<br>MRC<br>Wellcome Trust<br>Association Franciase Myopathyes<br>NIH<br>Muscular Dystrophy UK<br>ISIS<br>Roche<br>European Commission (in collaboration with Sarepta)<br>PTC Therapeutics | Feb-16 |
| MUSHTAQ, Imran | Consultant Urologist | I participate in private practice both within this Trust and outside | Dec-14 |
| OLSEN, Oystein | Consultant, Radiology | I have admission rights at The Portland Hospital for Women and Children where, along with colleagues in Radiology I provide an average of 3 hours per fortnight of paediatric plain film reporting, ultrasound, fluoroscopy and MRI reports. I have acted as a consultant for Bayer-Schering Healthcare and Guerbut Laboratories. This does not conflict on either a financial or a time basis with any of my work at GOSH. I therefore have no conflict of interest. | Feb-16 |

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| ONG, Juling | Locum Craniofacial Plastic Surgeon | That I hold an honorary consultant appointment at the Chelsea & Westminster Hospital and that from time to time will be required to provide clinical sevices are required. These will only be provided in the time outside of my clinical commitment at Great Ormond Street Hospital. Remuneration will be on an ad hoc basis.<br><br>That I will be seeing private patients on occasion outside Great Ormond Street Hospital. These clinical commitments will only be provided in the time outside of my commitment at Great Ormond Street. Remuneration will be on a private patient basis. | Mar-16 |
| OWENS, Catherine | Consultant Radiologist | Employed at the Portland Hospital where, along with her colleagues in Radiology, she provides an average of 3 hours per fortnight of paediatric plain film reporting, ultrasound and fluoroscopy, and occasional MRI/CT reports. Not perceived as a conflict to GOSH Practice as declared in job plan | Feb-16 |
| PETERS, Mark | Senior Lecturer in Paediatric and Neonatal ICU | I provide occasional medical expert witness reports for a variety of legal cases including medical negligence cases within my expertise. I have provided professional and expert reports to the family, criminal and appeal courts in response to both prosecution and defence instructions predominantly in cases of suspected inflicted head injury. I now undertake private practice as a Paediatric Intensivist at the Portland Hospital as one of a team of 8. This work is conducted entirely outside of my contracted time to ICH/Great Ormond Street and does not conflict with my University/NHS work and is not detrimental to it. | Feb-16 |
| PETROS, Andy | Consultant PICU | I undertake private practice intensive care and anaesthesia at the Portland Hospital and private anaesthesia at the Harley Street Clinic. This work forms part of my new job Plan and I do not believe there to be any conflict of interests in these roles.<br><br>I am very careful to be as open and transparent as possible in separating out my various activities to avoid any conflict of interests. This work is conducted outside of the time I am contracted to Great Ormond Street Foundation Trust. It does not conflict with my NHS work and is not detrimental to it. | Feb-16 |
| PROTHEROE, Sue | Consultant Paediatric Gastroenterologist. Birmingham Children's Hospital NHS Foundation Trust | Past Convenor of BSPGHAN<br>CSAC Chair Paediatric Gastroenterology<br>Quality advisor to GOSH invited review of Gastroenterology by RCPCH 2015 | Nov-15 |
| RAGLAN, Ewa | Consultant Audiovestibula Physician | I have private practice, I consult my patients at GOSH, London Hearing and Balance Centre, Parkside Hospitals and St Anthony's Hospital | Feb-16 |
| RAMNARAYAN, Padmanabhan | Consultant, CATS | I act as a part-time Medical Advisor for Isabel Healthcare Ltd, a diagnostic software system I have begun private practice at the Portland Hospital PICU. This will be entered on my Zircadian Job Plan. This work is conducted outside of the time I am contracted to Great Ormond Street Foundation Trust. It does not conflict with my NHS work and is not detrimental to it. | Feb-16 |

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| SAMUELS, Martin | Locum Consultant in Respiratory Paediactrics, Paediatric Respiratory Medicine | I am a Trustee for the charity Advanced Life Support Group, based in Manchester. This organisation provides hospital and community trusts around the UK with educational courses for staff. I receive no financial remuneration from the charity.<br>I am medical advisor to two other UK charities: Breathe On (a charity for children receiving long term ventilation) and the UK CCHS Family Support Network. I do not receive any financial remuneration from these organisations.<br>I have no other declarations of interest. | Feb-16 |
| SEBIRE, Neil | Consultant, Histopathology | I pay my private earnings into a private company known as 'Repath' of which all the consultant histopathologists, including myself are directors and shareholders. The Company is essentially a mechanism for handling the consultants' private fees, which are requests for opinions regarding reporting of specimens. The income is primarily derived from the International Private Patients Wing of GOSH, which is managed by the NHS. I also perform occasional reporting work to cover for colleagues in other centres who may be off-work, for which I also get paid on a case by case basis. The accounts are audited and subjected to company tax. The fees are used to pay for expenses in the Histopathology Department, such as training fees for non-medical staff. The remainder of the income is paid to the consultants as annual dividends. I declare these earnings in my own income tax return. This is a longstanding arrangement of which managers are aware, and it has been suggested as a model for others. However, it has come to my attention that a formal declaration should be made to the Trust, and this I now do. | Feb-16 |
| SHAH, Neil | Consultant Paediatric Gastroenterologist | Consultancy work Mead Johnson<br>Unrestricted Grant for lecture from Nestle and Nutricia | Mar-16 |
| SHARMA, Sanjiv | Consultant Paediatric Intensivist | I continue to do private work at the Portland Hospital PICU and this has been recorded on my job plan. The work continues to be done outside of the time I am contracted to Great Ormond Street Hospital NHS Foundation Trust. It does not conflict with my NHS work and is not detrimental to it. | Feb-15 |
| SIRIMANNA, Tony | Consultant Audiological Physician | That I have private practice privileges at The Portland Hospital, 234 Great Portland Street, London where I hold a clinic on a few Monday mornings. I do not do any NHS clinics there. This is in my free time outside my 10PA contract.<br>Similarly I see private patients at GOSH but this again is outside the NHS time.<br>I do not think there is anything that I do will have any conflict with my NHS work | Feb-16 |
| SKELLETT, Sophie | Consultant Paediatric Intensivist | I have begun private practice at the Portland Hospital PICU. The work has been entered on my new Job Plan. This work is conducted outside of the time I am contracted to Great Ormond Street Foundation Trust. It does not conflict with my NHS work and is not detrimental to it. | Mar-14 |
| SMITH, Gillian | Consultant Plastic Surgeon | I have taken up a part-time substantive post in Chelsea and Westminster starting on 28th September 2015 in Plastic Surgery with an interest in Adult and Paediatric Hand surgery. Two thirds of the work there is in adult practice. | Dec-15 |
| THOMAS, Mark | Consultant Anaesthetist | That I undertake occasional private practice cases within my clinical scope of expertise in private hospitals (The Cromwell and The Portland). This is always done in non-clinical time and does not interfere with my GOSH NHS work. | Feb-16 |

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| VAN'T HOFF, William | Consultant Paediatric Nephrologist and Head of Clinical Research Facility | I have entered into a consultancy agreement, contracted by Dr Vanshree Patel, R&D Office, to contribute to the Scientific Advisory Board (SAB) for Ultragenyx, related to the development of a new treatment for X linked rickets, and am leading contracted clinical research in the Trust with that drug. I receive no personal reward for the SAB, having asked for any funding through the agreement to be passed to R&I for support for research in the Trust (agreed through Emma Pendleton, Deputy Head of R&I). My role in the trial is fully costed and contracted through the Trust. I have received hospitality (flights, hotel accommodation) to attend 2 meetings (one day Dublin September 2014, two days Salzburg summer 2015) on this new trial drug development.<br><br>I am undertaking contracted (through standard Trust processes) commercial research with other innovative drugs in renal disease:<br>Raptor: a trial of a new delayed release drug ProCysbi, in cystinosis<br>AINylam: forthcoming trial in new therapy for hyperoxaluria<br>Participating as co-investigator in trials on hyponatraemia (Otsuka), immunosuppression for renal transplant (Astellas).<br><br>I have not received any hospitality from these companies, though there is a forthcoming investigators meeting for Raptor trial in Paris April 2016 (trial +/- 1 hotel night. | Mar-16 |
| WATERS, Jonathan | Consultant Clinical Scientist/Head of Service (Cytogenics) | At the invitation of Dr Sandra Edwards, Head of Laboratory, Cytogentics Laboratory, Norfolk and Norwich Hospital I act as a Consultant to the Cytogenics laboratory on an occasional basis.<br><br>This involves advising of the content of complex reports and e-authorisation (electronic authorisation) of reports viewed by secure means (via NHS.net) as requested by the Head of Service in her absence. There is no managerial involvement or responsibility.<br><br>I am confident that providing this service does not constitute a conflict of interest for the Trust. | Mar-16 |
| WELLESEY, Hugo | Consultant Anaesthetist | I undertake some private practice on an ad hoc basis at The Portland Hospital in my spare time | Feb-16 |
| WILLIAMS, Emma | Genetic Counsellor | I undertake private work as a genetic counsellor. I work through a company providing genetic counselling services called Genehealth UK | Mar-16 |
| WILLISS, Janet | Deputy Chief Nurse | Fitness to practice panelist with the NMC to finish 30/04/2016 | Mar-16 |
| WYATT, Michelle | Consultant ENT Surgeon | I hereby declare that I undertake private practice at the Portland Hospital, London W1W 5QT | Feb-16 |

**Register of Interests: Great Ormond Street Hospital for Children NHS Foundation Trust**

**Directors 2015-16**

**Non – Executive Directors**

| Name | Declared Interests |
|---|---|
| Baroness Tessa Blackstone | Member, House of Lords<br>Chair, British Library Board<br>Director of UCL Partners<br>Chair Orbit Group<br>Co-Chair of the Franco-British Council |
| Ms Yvonne Brown (until 29th February 2016) | None |
| Mr David Lomas | None |
| Mrs Mary MacLeod OBE | Deputy Chair, Cafcass (Child and Family Court Advisory and support service)<br>Chair of Ethics Committee, Internet Watch Foundation<br>Non-Executive Director Video Standards Council<br>Trustee Columba 1400 |
| Mr Akhter Mateen | NED – Super-Max Offshore Holdings<br>Director – Bristish Pakistan Foundation<br>NED – CAB International |
| Professor Rosalind Smyth CBE | Director, UCL Institute of Child Health (ICH)<br><br>As Director of ICH, I have overall responsibility for all research funding applications and awards to staff in ICH.<br><br>Honorary Consultant, Great Ormond Street Hospital for Children NHS FT<br><br>Board Director, Public Library of Science<br><br>Honorary Professor, University of Liverpool |
| Mr Charles Tilley OBE | Chief Executive, Chartered Institute of Management Accountants<br>Director (Corporate representative) CIMA China Ltd<br>Director (Corporate representative) CIMA Enterprises Limited (CEL)<br>Board member of the Association of International Certified Professional Accountants<br>Member of the International Integrated Reporting Council (IIRC)<br>Chairman of the Professional Accountants in Business Committee (PAIBC)<br>Member of the Advisory Council of HRH The Prince of Wales' Accounting for Sustainability Project (A4S)<br><br>Also corporate representative of the following:<br>• Corporate society of financial management ltd<br>• Institute of cost and works accountants ltd<br>• Global professional accountants in business ltd<br>• Professional accountants in business ltd<br>• Management accountants in business ltd<br>• Global management accountants in business ltd |

## Register of Interests: Great Ormond Street Hospital for Children NHS Foundation Trust

### Directors 2015-16

| Name | Declared Interests |
|---|---|
| Professor Stephen Smith (from 1st March 2016) | Stephensmith Limited |

### Executive Directors

| Name | Declared Interests |
|---|---|
| Dr Catherine Cale (until 1st June 2015) | None<br><br>[Husband is a corporate account manager for Thermo Fisher Scientific who supply GOSH with laboratory equipment and consumables.] |
| Mr Ali Mohammed | None |
| Mrs Juliette Greenwood (from 1st April 2015) | None |
| Dr Vinod Diwakar (from 1st June 2015) | I am on the Medical Advistory Committee of the Noonan Syndrome Society. |
| Mrs Claire Newton | None<br><br>[Nephew works for the Trust in an administration role. Niece worked for the Trust for a very short period on the staff bank in an administration role.] |
| Mr Bill Boa (from 7th December 2015) | Director and shareholder of BOA & Associates Consultancy Ltd<br>Director of Arts and Health South West, a charity incorporated under the Companies Act. |
| Dr Peter Steer | Committee member – Research Advisory Committee Children's Health Queensland Foundation Brisbane Australia. |
| Ms Rachel Williams (until 31st March 2016, maternity leave from May 2015) | None |
| Mrs Dena Marshall (May 2015 until 31st March 2016) | Director, Tintermed Limited<br><br>[Husband is a Director of PHPC Limited] |
| Mrs Loretta Seamer (from 1st April 2016) | None |
| Mr Robert Burns (until 31st March 2016) | Full member of the Chartered Institute of Public Finance and Accountancy.<br><br>[Wife is a:<br>Partner at Stokewood & Old Anchor GO Surgeries, Hampshire<br>Partner in Mid Hampshire Healthcare Ltd, Hampshire |

## Register of Interests: Great Ormond Street Hospital for Children NHS Foundation Trust

### Directors 2015-16

| Name | Declared Interests |
|---|---|
| | GPwSI in Dermatology for Hampshire Hospitals NHS Foundation Trust<br>Member of the Winchester & Rural Locality Group for West Hampshire Clinical Commissioning Group<br>Member of the Royal College of General Practitioners<br>Member of the British Medical Association<br>Member of the Primary Care Dermatology Society] |
| Mr Trevor Clarke | None |
| Professor David Goldblatt | Department of Health JCVI subcommittees: meningococcal and pneumococcal.<br><br>UCL-ICH laboratory performs contract research with GSK, Merck, Sanofi.<br><br>Occasional expert member of panels for WHO, GSK, Sanofi, Merck and Imbio. |
| Mr Matthew Tulley | None |
| Ms Cymbeline Moore | None |
| Mr Michael Bone (until December 2015) | Managing Director A&M Informatics Limited<br><br>[Wife is Company Secretary A&M Informatics Limited and Senior Finance Manager, Pioneer Care Partnership.] |

Great Ormond Street Hospital for Children NHS Foundation Trust

| Trust Board<br>1st April 2016 | |
|---|---|
| **Register of Gifts and Hospitality**<br><br>**Submitted by:**<br>Anna Ferrant, Company Secretary | **Paper no: Attachment W** |

**Aims / summary**

The Trust is directly responsible for ensuring that staff and board members are impartial and honest in the conduct of their official business, and that they do not abuse their official positions for personal gain or to the benefit of their family and friends.

The Trust complies with the requirement in the Constitution that board members and members of staff are required to declare hospitality and sponsorship offered by and accepted from contractors, suppliers and others.

The Company Secretary holds and maintains the Trust's 'Register of Gifts and Hospitality'. All staff should complete the "Gifts, Hospitality and Sponsorship Form" if they accept or refuse any gifts, inducement or hospitality.

The Register of Gifts and Hospitality for 2015/16 is attached to this report.

**Action required from the meeting**

The Board is asked to note the entries in the Register.

**Contribution to the delivery of NHS / Trust strategies and plans**

Transparency where gifts/ hospitality are offered

**Financial implications**

None

**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 implementation of the proposal / project**

N/A

**Great Ormond Street Hospital for Children NHS Foundation Trust**

**Register of Gifts and Hospitality 2015-16**

| *Name of recipient* | *Name of Authoriser* | *Host* | *Event (for sponsorship/ hospitality)* | *Accepted/declined* | *Date* |
|---|---|---|---|---|---|
| Allaway, Rachel | Jilly Hale | Medstrom Healthcare | EWMA (European Wound Management Association) Conference, London 2015 | Accepted | Apr-15 |
| Barrie, Alpha-Umaru | Kate Khair | Bayer | I received an honorarium from Bayer for giving a talk at the Paediatric Haemophilia Senior Nurses' meeting on 8th October 2015 in Birmingham. I was on annual leave. | Accepted | Mar-16 |
| Bone, Michael | Claire Newton | Allscripts | Meeting over dinner with Allscripts senior team to discuss business relating to A&M Informatics Limited planning to commence in 2016.<br>Michael Bone is a Director of A&M Informatics Limited and the discussions did not include any material conversation regarding GOSH or any business relating to the GOSH EPR procurement. | Accepted | Aug-15 |
| Clarke, Simon | Steve Curran | Food Standards Agency - Tracey Smith | As thanks for supporting site visit from Harvard University Delegates. Gift of: 1 bottle red Bordeaux wine, value £15; 1 leather wallet, value £25 | Accepted | Jan-16 |
| Clarke, Simon | Steve Curran | In house manager | Invited to attend as a guest of IHM the Cost Sector Awards dinner and hotel, value £365+VAT | Declined | Jan-16 |
| Cochrane, Lynne | Kuan Ooi | Dr Maria de Como, Ramon Y Cajal hospital, Madrid | Pharmaceutical information sharing workshop. Flight to Madrid funded by Bayer - Bayer had no input into the content of the meeting | Accepted | Mar-15 |
| Devine, James | Ali Mohammed | DAC Beachcroft Employment Law Firm | Healthcare People Management Association (HPMA) Annual Awards complimentary place Value c. £100. | Accepted | Jun-15 |
| Gilmour, Kimberley | Catherine Cale | FOCUS association for clinical biochemistry and laboratory medicine | Travel (£44) and accommodation (£105) as speaker at FOCUS national meeting, Cardiff 2015. | Accepted | Jun-15 |

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|---|---|---|---|---|---|
| Gilmour, Kimberley | Catherine Cale | Jeffry Model Foundation, Octo Pharma | Jeffry Model Central & Eastern European meeting (flights and accommodation to Zagreb, Croatia approximately £200) | Accepted | Apr-15 |
| Goddard, Victoria | Anna Ferrant | GOSH | 1x ticket for Billy Elliott the Musical. This ticket was one of a number offered to all staff on the GOSH intranet message board. | Accepted | Nov-15 |
| Goddard, Victoria | Anna Ferrant | ISCA Software | Christmas tree ornament - glass, bell shaped. Gift sent to me - I take no part in the procurement of electronic Board paper technology | Accepted | Dec-15 |
| Heales, Simon | Allan Goldman | Shire, Genzyme, Vitaflow | I receive honoraria and consultancy fees from these commercial organisations | Accepted | Mar-16 |
| Holubinka, Mike | Clare Simcock | Bayer Plc | Inaugural meeting of the Radimetrics user group European Congress of Radiology Vienna. Travel, ECR registration and accommodation | Accepted | Mar-16 |
| Jackson, Elizabeth | Catherine Cale | Parent | One bottle red wine (Marks and Spencer), approximately £25. | Accepted | May-15 |
| Khair, Kate | Janet Williss | Baxalta<br>Novo Nordisk<br>Octapharma<br>Pfizer<br>Sobi | I have received speaker/consultancy fees and or research funding from these companies | Accepted | Mar-16 |
| Khan, Tehmoor | Anna Ferrant | GOSH | 1x ticket for Billy Elliott the Musical. This ticket was advertised on GOSHweb for all GOSH staff | Accepted | Nov-15 |
| Male, Alison | Jane Hurst | Novartis | TSC dats 2014 Dublin, Ireland. International interdisciplinary meeting on care for patients with Tuberous Sclerosis | Accepted | 12-13/09/2014 |

| | | | | | |
|---|---|---|---|---|---|
| Mathius, Mary | Ri Liestner | Bayer<br>Bayer<br><br>Novonordisk<br>CSL Behring<br><br>Bayer<br><br>Bayer | Expert clotters educational meeting, Birmingham<br>Fee for lecture at Physiotherapy Meeting, Birmingham<br>Fee for lecture: Haemostasis Academy<br>Travel and accommodation expenses to ISTH Meeting in Toronto<br>Fee for lecture on Neonatal Haemostasis: Junior Clotters meeting<br>Travel and accommodation expeses to EAHAD meeting in Malmo | Accepted<br>Accepted<br><br>Accepted<br>Accepted<br><br>Accepted<br><br>Accepted | January 2015<br>February 2015<br><br>March 2015<br>June 2015<br><br>December 2015<br>February 2016 |
| Mohammed, Ali | Peter Steer | DAC Beachcroft Employment Law Firm | Healthcare People Management Association (HPMA) Annual Awards complimentary place Value c. £100. | Accepted | May-15 |
| Mohammed, Ali | Peter Steer | Healthcare People Management Association and DAC Beachcroft | Development event with HR Directors over evening dinner | Accepted | Mar-16 |
| Newton, Claire | Peter Steer | GS1 | Working dinner (x2) in my capacity as a member of the GS1 Advisory Board (healthcare) | Accepted | 25/02/2015<br>24/06/2015 |
| Plumbly, Patricia | D. Walshie | Becton Dickinson | Flow cytometry course | Accepted | |
| Rees, Clare | Pippa Last | Patient's Family | Gift of Calvin Klein leather handbag and wallet from patient's family. Approximate value £50 - £75 | Accepted | Feb-16 |
| Rees, Lesley | Melanie Hirons | Alexion | I received a travel grant from Alexion to attend the annual European society of pediatric nephrology academic meeting in September 2015 in Brussels. | Accepted | Sep-15 |
| Rockenbach, Chris on behalf of GOSH | Trevor Clarke | President of Malta | Silver coloured small plate from the President of Malta | Accepted | Nov-15 |

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|---|---|---|---|---|---|
| Rockenbach, Chris on behalf of GOSH | Trevor Clarke | Relatives of the late Octav and Camelia Botnar | Decorated ostrich egg | Accepted | Oct-15 |
| Sharp, James | Pippa Last | Cochlear Implant Manufacturer | I have been invited to present on a training course by a cochlear implant manufacturer in Singapore and Sydney. They have offered to cover all expenses associated with this. | Accepted | Aug-15 |
| Shaw, Vanessa | Anna Jebb | SMA Nestle Nutrition | European Society for Paediatric Gastroenterology, Hepatology and Nutrition. Approximately £1300 | Accepted | Apr-15 |
| Skeath, Rachel | Vanessa Shaw | Vitaflo | Payment of travel expenses, accommodation and registration for attendance at SSIEM annual symposium | Accepted | Sep-15 |
| Steer, Peter | Tessa Blackstone | Warner Brothers | 4x tickets for 'Pan' film premiere | Accepted | 20th November 2015 |
| Steer, Peter | Tessa Blackstone | Hospital Sant Joan de Due (Barcelona) - visit to GOSH | 3x scarves and 4x ties | Accepted | Oct-15 |
| Van Rijswijk, Elsje | Nick Goulden | Jazz Pharmaceuticals | SIOP 2015 conference | Accepted | 8/10/15 - 11/10/15 |
| Williamson, Stephanie | Matthew Tulley | Drager | VisMed 2015 - a roundtable for visionary medical workplaces: Luebeck, Germany<br><br>I have been invited to attend as a guest of Drager because of my role on the Board of Architects for Health. It includes flights, meals and accommodation in return for participating in round table discusions on The Healing Environment. | Accepted | 18th-20th May 2015 |
| Williamson, Stephanie | Matthew Tulley | Troup Bywaters & Anders | Guest at the Building Better Healthcare Awards 2015 - lunch reception | Accepted | Nov-15 |

ATTACHMENT X

Great Ormond Street Hospital for Children NHS Foundation Trust

**Members' Council update**

A Members' Council meeting was held on Wednesday, 27th January 2016

The Council discussed the Evening Standard/Independent Appeal and noted that the £3million fundraising target had been reached and the news would be released on 29th January.

It was noted that GOSH's monitor rating currently remained at the highest possible rating of 4 due to capital donations and that GOSH was undertaking business planning to ensure that a rating of 3 would be the minimum rating achieved in 2016/17 as was Monitor's expectations of all Trusts. It was reported that the risk facing GOSH was around specialist tariff top ups which had not yet been agreed however historically GOSH had done well in engaging with tariff discussions.

The Council expressed some concern about the format and quality of text message reminders for outpatient appointments. It was agreed that feedback would be taken forward outside the meeting and noted that the Outpatients Improvement Project was looking at a number of issues including work to join up central booking with ICT and switchboard.

It was noted that the discharge summary completion rate was improving overall and discussion had taken place at Trust Board about clinic letter turnaround times, the target for which was set at 5 days. The Board had discussed whether 7 or 8 days would be more clinically appropriate and further work would take place on this.

It was reported that GOSH had received a rating of 'good' in the CQC inspection which had taken place in April 2015. Nine recommendations had been made, three of which were around RTT and therefore already had extensive action plans in place. Two services had been rated as 'requires improvement': outpatients and surgery for which RTT had been a key driver behind this rating. The Council welcomed the report and in particular the 'outstanding' ratings for end of life care and medicine. The Council noted the work that would be taking place around transition.

Updates were received from the Audit Committee and the Finance and Investment Committee. The Members' Council discussed the extremely complex nature of the RTT metric and that GOSH was part of a complex system and a number of elements were outside the Trust's control. It was agreed, however, that it was important to look at the reporting mechanisms to the Board to highlight potential areas for additional scrutiny.

The Council unanimously approved the reappointments of Baroness Blackstone, Chairman and Ms Mary MacLeod, Non-Executive Director and approved the outcome of the appraisals of the Chairman and Non-Executive Directors. The Council also approved the appointment of Professor Stephen Smith as a Non-Executive Director on the GOSH Board.

The Council received a presentation on the annual operational plan being developed for 2016/17 and reported that the Membership and Engagement Committee were developing an annual plan survey to receive feedback from the public. The Council supported the proposed priorities.

Councillors reported that they had taken part in a ‘Medicine for Members’ event at St. George’s Medical School and had spoken to medical students and recruited members and attended a Governor Event Run by Deloitte.

ATTACHMENT Y

Great Ormond Street Hospital for Children NHS Foundation Trust

**Update from the Audit Committee meeting held on 18th January 2016**

**Board Assurance Framework**

The Committee discussed the meeting which had taken place to review the management of the BAF. It had been agreed that the revised BAF would be in a simplified format to enable more in depth discussions into the risks themselves rather than definitions.

The revised Trust risk appetite was considered and comments made. It was agreed that the statement would be considered by the Trust Board at the meeting in February 2016.

**Risk 6: Operational Capacity**

It was reported that a divisional re-organisation would be taking place and the Committee discussed the risks of a few people being responsible for a large number of key pieces of work. It was noted that the divisional reorganisation offered the opportunity to consolidate operational management and develop and operational substructure.

**Analysis of Top 3 Risks**

The Committee noted the responses to the top 3 risks survey and agreed that as risks were updated it would be important to bear in mind how risks had been articulated by respondents. The important issue of cyber security was discussed and it was agreed that it was important to understand the steer from the wider NHS when developing a strategy.

**Update on data quality review**

The review which was being undertaken by KPMG was not yet complete and the full report would be presented at an extraordinary meeting of the Audit Committee on 23rd February.

**RTT Update**

The Committee noted that good progress was being made on RTT in all areas with a robust patient tracking list now in place to track all patients and 4 out of 5 divisions managing patient pathways down to 18 weeks.

It was reported that commissioners were able to fine the Trust 1% of the contract value prorated and there was also the longer term risk of funding being based on meeting access targets.

**Electrical Infrastructure Failure - Serious Incident**

It was reported that the Serious Incident investigation was on-going but it was thought that the failure of the mains electrical supply in three GOSH buildings was caused by debris in the electrical switchboard panel which could only be found by removing a wall. It was confirmed that remaining panels had been accessed and no debris found. The final report would be provided at the next meeting.

**Review of the Trust's insurance arrangements**

The Committee received an update on the Trust's current insurance arrangements and noted that the Trust did not currently take out Trust wide insurance cover against terrorism or cyber attacks due to the difficulty in agreeing a policy which would cover the various scenarios in which a claim would be made.

**Information Governance and Cyber Security risk assessment**

The Committee approved the Trust's Information Governance Toolkit and agreed that it would be reconsidered later in 2016 following the review by KPMG.

It was agreed that the newly appointed IT Director would give a presentation on cyber security at the next meeting.

**Care Quality Commission Report Update**

The CQC inspection report had been published on 8th January and an action plan was being developed for the nine key recommendations made and other issues with had been raised in the report. It was requested that the actions around estates issues were confirmed as completed with the actions when appropriate.

**External Audit Sector Update**

The National Audit Office had released their guidance upon which Deloitte would base their Value for Money statement which was more detailed than in previous years and could result in additional testing being undertaken and the risk of an 'except for' opinion.

It was confirmed that in terms of a reference cost audit undertaken by Monitor, GOSH's result would be published in their annual report. She said that it was vital to ensure that the Trust's work in this area was in good order and added that a new reference cost system was being introduced along with an experienced new member of staff.

**Internal Audit Progress Report (November 2015 – January 2016) and Technical Update**

It was agreed that the review of governance within divisions would be removed from the calendar of work due to the upcoming divisional reorganisation. The Committee discussed the Productivity and Efficiency internal audit report and noted that it had been difficult for KPMG to review the calculations used to derive the value of schemes and in many cases it had not been possible to confirm the way a scheme values had been calculated.

The number of amber red reports issued in 2015/16 was noted and the committee queried the likely impact on the Head of Internal Audit Opinion. Mr Thomas said that he did not currently foresee any issues due to the ratings of various key audits.

**Planning for 2015/16 year-end including review of Accounting Policies**

It was reported that the Annual Reporting Manual had been issued and there were no significant changes affecting the Trust and its policies.

**Raising Concerns in the Workplace Update**

It was noted that no new concerns had been raised and GOSH's policy was being peer reviewed by another Trust.

**Losses and ex-gratia payments**

The Committee noted the losses around blood and drugs and it was agreed that this would be followed up to look at usual levels of wastage and to identify learning to mitigate the risk of further wastage at this level.

ATTACHMENT Z

Great Ormond Street Hospital for Children NHS Foundation Trust

**Update from the Clinical Governance Committee meeting held on 3rd February 2016**

Mortality Review Update

The Committee received a presentation on the mortality review process that was being undertaken to provide assurance that patients who had died at the Trust had been managed appropriately. It was reported that it was difficult, using the current GOSH IT system, to gain an overview of a patient who had died. It was suggested that a standardised form should be developed to be completed by the lead consultant to get a sense of the chronology and the thinking process prior to a patient's death. The Committee agreed that it was important for the EPR programme to consider the work of the mortality review group in its development and ensure that information from different systems could be seamlessly accessed.

Update on quality and safety impact of Productivity & Efficiency (P&E) programme

Two P&E schemes were reviewed and it was noted that neither had resulted in any adverse quality and safety impact. The Committee received an update on the work that had been taking place with PwC to develop a three year P&E plan to begin on 1st April 2016. It was reported that in future there would a reduced number of high value schemes, all of which would have a robust Quality Impact Assessment. It was noted that this process was currently difficult to follow due to the large number of schemes operating.

Validation of referrals in haematology and oncology

The Committee welcomed the significant assurance provided by the work which was taking place to validate referrals in Haematology and Oncology. It was reported that work was continuing to ensure that minimum data sets were received from referring hospitals and those outstanding had now been escalated to commissioners.

Work of the clinical review group

It was reported that work had been done to implement a robust clinic outcome form and clinic cash-up process and in the coming weeks these paper based systems would become electronic. The Medical Director confirmed that he was satisfied that the correct process was in place going forward.

Risk 7: Recruitment and retention of sufficient highly skilled staff with specific experience

It was noted that a Nursing Workforce Recruitment Board had been established and would be working on current recruitment issues and forward planning. In depth exit surveys had been offered to all nursing staff leaving the Trust and key causes had been management relationships, flexible working and cost of living. It was agreed that the results of the exit surveys would be discussed at the next meeting.

Head of Nursing Report

The Committee noted that only 60% of staff was up to date with their level 2 infection prevention and control training and asked for an update showing improvement at the next meeting.

A report was requested on babies being treated in IPP who were not being visited by parents for long periods to ensure that the Trust had clarified the legal position and was operating within the relevant regulations.

Top Three Risks Analysis

The Committee noted that risks had been raised around medical care of the surgical patient and it was agreed that a report would be discussed at the next meeting.

Trust Workforce Metrics & Exception Report

It was agreed that as staff turnover levels had been high for a long time a deep dive would take place into the assumed drivers for this to ensure that assumptions were correct.

Intellectual (Learning) Disability Annual Report

The Committee received the report and welcomed the good work that was taking place around the Trust.

Quarterly Safeguarding Report (October 2015 – January 2016)

It was agreed that a report being produced to look at the capacity of the safeguarding team along with the effectiveness of training and the working relationship with the social work team would be shared with either the committee or Trust Board.

Internal Audit Progress Report (October 2015- January 2016)

The Committee noted that significant assurance had been provided for the risk management internal audit report which had focused on reviewing risks particularly at divisional level and the link between risk management and the Board Assurance Framework.

Clinical Audit update October 2015 – January 2016

The committee welcomed the work that had shown that learning points from a Serious Incident in 2015 had been well embedded.

Matters to be raised at Trust Board

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

- Clinical Audit
- Top 3 Risks
- Mortality review

ATTACHMENT 1

Attachment 1

Great Ormond Street Hospital for Children NHS Foundation Trust

**Update from the Finance and Investment Committee meeting held on 25th January 2016**

**Q3 results including Forecast for the year to Mar 2016**
The Committee discussed the Trust's financial performance for Q3 as well as the forecast for the year to March 2016.

The Q3 results excluded a fine in relation to RTT and the forecast outturn included additional pay costs in relation to RTT and increased locum costs (as funding for junior doctors posts have been reduced by Health Education North, Central and East London Deanery (HENCEL)).

**2016/17 Draft Annual Plan**
The 2016/17 Draft Annual Plan was reviewed and it was agreed that a special meeting of the Committee would take place before submission of the Annual Plan to Monitor.

The Committee requested a routine post implementation review of approved Business cases in order to monitor and assess delivery against the Annual Plan.

**Productivity and Efficiency**
The committee was advised that PwC has been engaged to assist in the identification of P&E schemes and it was agreed that P& E reporting will be reviewed once PwC has submitted their finalised report. The review will consider best practice in relation to productivity reporting as per Monitor and TDA guidance.

**Financial Sustainability risks**
The Committee discussed the risks around the Trust's Financial Sustainability and its ability to reach an Income and Expenditure breakeven position.

**Development and Estates**
The Business Case for Phase 4 remains work in progress as the financing of the building has not been finalised.

**Trust Brand**
The Committee discussed the need for the Trust to have the right to terminate agreements for misuse of the Trust brand and requested sight of the final agreement after obtaining legal advice.

Attachment 1i

Great Ormond Street Hospital for Children NHS Foundation Trust

**Update from the Finance and Investment Committee meeting held on 5th February 2016**

**2016/17 Draft Annual Plan**

Further to the meeting on 25th January the Committee discussed the contents of the Draft Annual Plan for 2016/17.

The areas considered were as follows:

1. Internal CIP target £12m with assumed delivery of £10m and £2m provision for attrition/costs of delivery
2. PwC Productivity and Efficiency report
3. Revenue contingency
4. The impact on CICU, IPP, EPR and the capital programme for the year
5. The Trust's ability to reach an Income and Expenditure breakeven position

The Committee approved the submission of the draft plan to Monitor.