Great Ormond Street Hospital for Children NHS Foundation Trust

Meeting of the Trust Board
20th July 2016

Dear Members

There will be a6 public meeting of the Trust Board on Wednesday 20th July 2016 at 1:00pm in the **Charles West Room**, Great Ormond Street, London, WC1N 3JH.

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

AGENDA

	Agenda Item **STANDARD ITEMS**	Presented by	Author
1.	**Apologies for absence**	Chairman	**Verbal**
Declarations of Interest All members are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.			
2.	**Minutes of Meeting held on 20th May 2016**	Chairman	**A**
3.	**Matters Arising/ Action Checklist**	Chairman	**B**
4.	**Chief Executive Report**	Chief Executive	**Verbal**
	STRATEGIC ISSUES		
5.	**Board Assurance Framework** **Update from Risk management Meeting on 20th July 2016**	Company Secretary Mr Charles Tilley. NED	**C** **Verbal**
6.	**Access Improvement Programme Update**	Deputy Chief Executive	**D**
7.	**North Central London Sustainability and Transformation Plan**	Chief Executive/ Interim Director of Strategy and Planning	**1**
	PERFORMANCE		
8.	**Quality and Safety Update – June 2016**	Medical Director	**E**
9.	**Integrated Performance Report: May / June 2016**	Deputy Chief Executive	**F**
10.	**Workforce Metrics & Exception Reporting – June 2016**	Director of Human Resources &OD	**G**
11.	**Finance Update - June 2016**	Chief Finance Officer	**H**
12	**Research and Innovation Update – July 2016**	Deputy Director of Research and Innovation	**I**

13.	**Education Annual Report 2015/16**	Chief Nurse/ Medical Director/ Director of HR & OD	**J**
	ASSURANCE		
14.	**Safe Nurse Staffing Report – May and June 2016**	Chief Nurse	**K**
15.	**Annual Reports**		
	• **Infection Prevention and Control Report – Executive Summary 2015/16**	Director of Infection, Prevention and Control	**L**
	• **Health and Safety Annual Report 2015/16**	Director of HR and OD	**M**
	• **Clinical Audit Annual Report 2015/16**	Medical Director	**N**
	GOVERNANCE		
16.	**Quarter 1 Monitor Return (3 months to 30 June 2016)**	Chief Finance Officer	**O**
17.	**Revised Board of Directors' Terms of Reference**	Company Secretary	**P**
	REPORTS FROM COMMITTEES		
18.	**Audit Committee update – May 2016 meeting**	Chair of the Audit Committee	**Q**
19.	**Clinical Governance Committee update – July 2016 meeting**	Chair of the Clinical Governance Committee	**Verbal**
20.	**Finance and Investment Committee Update – May and June 2016**	Chair of the Finance and Investment Committee	**R**
21.	**Members' Council Update –June 2016**	Chairman of the Members' Council	**S**

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

Next meeting
The next Trust Board meeting will be held on Wednesday 28th September 2016 in the Charles West Room, Great Ormond Street, London, WC1N 3JH.

ATTACHMENT A

Attachment A

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT Minutes of the meeting of Trust Board on 20th May 2016

Present

Baroness Tessa Blackstone	Chairman
Dr Peter Steer	Chief Executive
Mr Akhter Mateen	Non-Executive Director
Mr David Lomas	Non-Executive Director
Professor Stephen Smith	Non-Executive Director
Professor Rosalind Smyth	Non-Executive Director
Mr Charles Tilley	Non-Executive Director
Ms Nicola Grinstead	Deputy Chief Executive
Dr Vinod Diwakar	Medical Director
Mr Ali Mohammed	Director of Human Resources and OD
Ms Juliette Greenwood	Chief Nurse
Ms Loretta Seamer	Chief Finance Officer

In attendance

Mrs Claire Newton	Interim Director of Strategy and Planning
Mr Matthew Tulley	Director of Redevelopment
Ms Cymbeline Moore	Director of Communications
Dr Anna Ferrant	Company Secretary
Ms Victoria Goddard	Trust Board Administrator (minutes)
Mr Matthew Norris	Members' Council (observer)
1 member of the public	

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

23	**Apologies for absence**
23.1	Apologies for absence were received from Ms Mary MacLeod, Non-Executive Director.
24	**Declarations of Interest**
24.1	No declarations of interest were received.
25	**Minutes of Meeting held on 1st April 2016**
25.1	The Board **approved** the minutes.
26	**Matters Arising/ Action Checklist**
26.1	The actions taken were **noted**.
27	**Chief Executive Report**
27.1	Dr Peter Steer, Chief Executive gave an update on the following matters: • A successful visit to Abu Dhabi took place in mid-May to continue to build relationships following the £60million donation to the Zayed Centre for

	Research in Rare Disease in Children • Hand hygiene audit: The Board expressed disappointment with results reported at the last Trust Board however following discussion with the Director for Infection Prevention and Control, Dr Steer confirmed he was assured that a lot of work was taking place to highlight available training and ensure that audits taking place were of high quality. Dr Steer added that research suggested that once a level of hand hygiene was in place, there was no evidence to suggest that increasing compliance reduced infection rates. • Executive Breakfast sessions had started as part of the work to improve communications throughout GOSH. • International Nurses' Day had taken place which was a successful day • A telephone call had taken place between GOSH inpatients and Major Tim Peake from the International Space Station • Positive engagement had taken place with the GOSH Children's Charity around the RBC Race for the Kids.
28	**GOSH Foundation Trust annual financial accounts and annual report 2015/16, Quality Report 2015/16 and Audit Committee Annual Report 2015/16**
28.1	Mr Charles Tilley, Chair of the Audit Committee said that the Committee meeting earlier in the day had spent considerable time receiving and reviewing the annual accounts, annual report, annual governance statement and letter of representation. He confirmed that the committee had recommended the documents to the Board for approval.
28.2	Mr Tilley said that it had been confirmed that it was appropriate to sign the accounts on a going concern basis. There had been a significant increase in IPP debt which would be monitored and increased provisioning had been agreed at the April meeting. There had been an increase in the value of GOSH's buildings which Deloitte confirmed was within reasonable limits.
28.3	It was confirmed that the Annual Report had been subject to considerable review with the emphasis being to ensure that RTT was being addressed appropriately.
28.4	Mr Tilley said that the Head of Internal Audit Opinion had provided significant assurance with minor areas for improvement.
28.5	The Board **approved** the following documents: • Annual Report • Annual Accounts • Annual Governance Statement • Letter of Representation • Quality Report • Audit Committee Annual Report
29	**Overview of performance against strategic objectives 2015/16**
29.1	Mrs Claire Newton, Interim Director of Strategy and Planning presented the paper which summarised the key external metrics that could be benchmarked against other Trusts. She confirmed that the GOSH performed well in key metrics such as financial performance against plan and CQC report results.

30	**Update on access improvement programme**
30.1	Ms Nicola Grinstead, Deputy Chief Executive said that the Trust had committed to validating patient pathways for data accuracy purposes and reviewing patients who had waited over 30 weeks through a clinical review group led by the Medical Director. It was confirmed that work remained on target to be completed by the end of August and no patients had been identified who had suffered harm as a result of a long wait.
30.2	Ms Grinstead said that it had been agreed with commissioners that GOSH would begin reporting on diagnostics in 2016/17 and this was being done, however as discussed with commissioners, the Trust did not anticipate meeting the diagnostic standard until September 2016. RTT data was also on target to be reported from September.
31	**Quality and Safety Report**
31.1	Dr Vinod Diwakar, Medical Director presented the newly formatted report and highlighted the following three areas: • Cardiac and respiratory arrests had increased. Dr Diwakar said that this had been reviewed at by the Resuscitation Committee and was primarily due to the patient profile in the Trust. • The early warning score which was being used to detect deterioration in patients was not as sensitive as others and an objective for 2017 would be to move to a new system. • Extravasation – Dr Diwakar reported that work would take place in this area to monitor compliance with the policy and consider how data should be collected. • Discharge summaries – An improvement programme had been in place however the compliance had decreased following completion of the programme. Dr Diwakar said that a comprehensive plan was in place and results were being performance managed through 'business as usual'.
32	**Performance Targets & Indicators: April 2016**
32.1	Ms Nicola Grinstead, Deputy Chief Executive presented the report and said that the format would be amended for future reports. She said additional information would be captured to inform different indicators to ensure that cause and effect was being captured throughout the organisation.
33	**Workforce Update**
33.1	Mr Ali Mohammed, Director of HR and OD said that GOSH continued to have very low sickness levels however he noted that the staff survey reported that staff put pressure on themselves to come to work when unwell. Mr Mohammed said that work would take place to look at this.
33.2	It was confirmed that the new Learning Management System was now live and positive feedback had been received.
33.3	**Action:** It was agreed that future reports would include the number of WTEs by staff group and the trend over time.

33.4	PDR Appraisal Rate Update
33.5	Mr Mohammed said that although the PDR process was straight forward, feedback had been that the guidance was complex and work would take place to update the guidance. Mr Mohammed said that an electronic reminder system would be put in place and recommendations would be taken to the Executive Management Team meeting around the consequences of failing to complete PDRs.
33.6	Professor Rosalind Smyth, Non-Executive Director emphasised that appraisals were very valuable developmentally and it was important that they were completed without becoming a 'tick box exercise'.
34	**Finance Update**
34.1	Month 12 – March 2016
34.2	Ms Loretta Seamer, Chief Finance Officer said that the Trust had met its planned year end outturn of £11.1million with the key variance being capital donations being £3million less than plan due to six weeks' slippage in timescales. Ms Seamer said that this variance triggered a rating of 2 in the NHS Improvement Governance Rating. It was reported that NHS Improvement were recommending a 2* rating noting the drivers.
34.3	Month 1 – April 2016
34.4	Ms Seamer said that there had been an in month deficit was £0.8million against a plan of £1.2million due to the over performance in IPP however NHS activity had been below plan. It was confirmed that the Trust's contract with NHS England for 2016/17 had been signed subject to a side letter and it had been agreed at the Finance and Investment Committee that a two year trend analysis would be undertaken on income, costs and staffing.
35	**PALS Annual Report 2015/16**
35.1	Ms Juliette Greenwood, Chief Nurse presented the report and said that the themes of PALS contacts were primarily outpatient experience, discharge and communication.
35.2	Mr David Lomas, Non-Executive Director expressed some concern at the number of cancellations where patients had not been notified in advance. Ms Nicola Grinstead, Deputy Chief Executive said that it was clear that MRIs and surgery appointments were being cancelled on the day which was having a significant impact on patient experience and resources. She said that the key reason for these cancellations was bed availability so work was being done to look at pooling beds in the most efficient way.
36	**Friends & Family Test Q4 2015/16 Report - experience of children, young people and their families at GOSH**
36.1	Ms Greenwood told the Board that there had been an improved quarter 4 response rate however it continued to be below the Trust's target of 60%. She confirmed that GOSH was consistently above the 95% target for respondents being likely to recommend the Trust for both inpatients and outpatients.

36.2	**Action:** Dr Peter Steer, Chief Executive said that it was important to ensure that a mechanism was in place to capture patients coming to GOSH for the first time. The Board asked that this issue was addressed by the next report.
37	**Staff Friends and Family Test results – Quarter 4 2015/16**
37.1	Mr Ali Mohammed, Director of HR and OD presented the report and said that feedback on results had been provided at the all staff Executive forums.
38	**Annual Complaints Report 2015-16**
38.1 38.2	Ms Juliette Greenwood, Chief Nurse said that there had been a 5% increase in the number of complaints, however there had been a decrease in the number of red complaints; themes mirrored those of the PALS contacts. The Board noted the challenges around the timeliness of responses and Ms Greenwood said that it was likely that the new divisional structure would support work to improve this.
39	**Annual Safeguarding report 2015/16**
39.1 39.2	It was reported that there had been an increase in safeguarding supervision and input from GOSH staff to safeguarding conferences. An internal review of the safeguarding team in line with recommendations made in the Lampard report had taken place and the report was currently going through factual accuracy. **Action:** It was agreed that the report on the internal safeguarding review would be discussed at Board once complete.
40	**Safe Nurse Staffing Report (March and April 2016)**
40.1	Mr Juliette Greenwood, Chief Nurse said that work around recruitment continued with a significant number of staff having been recruited in March and April. An open day held in April led to 185 applications for posts and it was anticipated that successful applicants would begin in post in October 2016.
41	**Annual Risk Report 2015-16**
41.1	The Board noted the report.
42	**Audit Committee update – April 2016 meeting and revised Audit Committee Terms of Reference and workplan**
42.1 42.2	Mr Charles Tilley, Chair of the Audit Committee gave an update on the May meeting. The Board **ratified** the Committee's updated Terms of Reference.
43	**Finance and Investment Committee Update – May 2016**
43.1	Mr David Lomas, Chair of the Finance and Investment Committee said that the May meeting had discussed the financial results for 2015/16, considered the IMRI business case, phase 4 strategic outline case and looked at service line reporting.

44	**Clinical Governance Committee update – May 2016 meeting including revised terms of reference**
44.1 44.2	Dr Anna Ferrant, Company Secretary said that the committee had approved revised Terms of Reference to broaden the scope of work. This included a name change to the Quality and Safety Assurance Committee (QSAC). The Board **ratified** the updated terms of reference.
45	**Members' Council Update – April 2016**
45.1	Baroness Blackstone, Chairman said that a Non-Executive Director post to replace Mr Charles Tilley, who was due to step down in July 2016, was being advertised. Interviews would take place with three members of the Members' Council Nominations and Remuneration Committee on 8th June 2016.

ATTACHMENT B

Attachment B

TRUST BOARD – PUBLIC ACTION CHECKLIST
July 2016

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
258.1	01/04/16	The Board discussed the number of staff who declared interests and gifts and agreed that it was unlikely that all relevant interests and gifts were being declared. It was agreed that work would take place to look at making declarations of interest and receipt of hospitality part of the appraisal process.	AF&AM	October 2016	Not yet due
261.1	01/04/16	Ms Mary MacLeod, Chair of the Clinical Governance Committee said that the Committee had received a presentation from the mortality review group. She suggested that this presentation should be given at the Members' Council.	AF/ Deirdre Leyden	June 2016	To be presented at the September Members' Council meeting
33.3	20/05/16	It was agreed that future workforce reports would include the number of WTEs by staff group and the trend over time.	AM	July 2016	On agenda
36.2	20/05/16	Dr Peter Steer, Chief Executive said that it was important to ensure that a mechanism was in place to capture FFT responses from patients coming to GOSH for the first time. The Board asked that this issue was addressed by the next report.	JG	September 2016	Not yet due
39.2	20/05/16	It was agreed that the report on the internal safeguarding review would be discussed at Board once complete.	JG	September 2016	Not yet due

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
20 July 2016

Board Assurance Framework Update **Submitted by:** Dr Anna Ferrant, Company Secretary	**Paper No: Attachment C**

Aims / summary

The last update on the Board Assurance Framework (BAF) was provided at the May 2016 meeting, where the 2016/17 BAF risks were presented and approved.

Appendix 1 presents a summary of the BAF risks and movement in risk scores since the last update. All BAF risks were reviewed in June by risk owners as well as the Risk, Assurance and Compliance Group (RACG) and minor updates have been made where relevant. The RACG asked that:

- The risk definition and scoring for risk 12: Electronic Patient Record (EPR) is to be reconsidered to reflect that the project is still in its early stages– these updates will be made following the July EPR Board meetings.
- The risk statements and breadth of assurances and controls for other risks, in particular 3: Productivity and Efficiency; 6. Operational Performance; and 9. Unreliable data be reviewed and clarified – this is to be actioned.

At the annual risk management meeting, held on 20 July, members will review the Trust business model to validate existing risks and identify and assess new risks facing the organisation as well as consider the balance of clinical and non-clinical risks on the BAF. Mr Charles Tilley, Audit Committee Chair and Chair of the annual risk meeting will provide a verbal update on the annual risk meeting at the Trust Board meeting.

A full copy of the revised risk following the annual risk management meeting will be presented at the September 2016 Board.

Action required from the meeting
To note the update provided.

Contribution to the delivery of NHS Foundation Trust strategies and plans
Effective management of risk is a primary role of the Trust Board and it is critical to the achievement of the Trust's Strategic Plan.

Financial implications
Not applicable.

Who needs to be told about any decision?
Not applicable.

Who is responsible for implementing the proposals / project and anticipated timescales?
The risk owners are identified alongside each BAF risk.

Who is accountable for the implementation of the proposal / project?
The Executive Leads identified alongside each BAF risk.

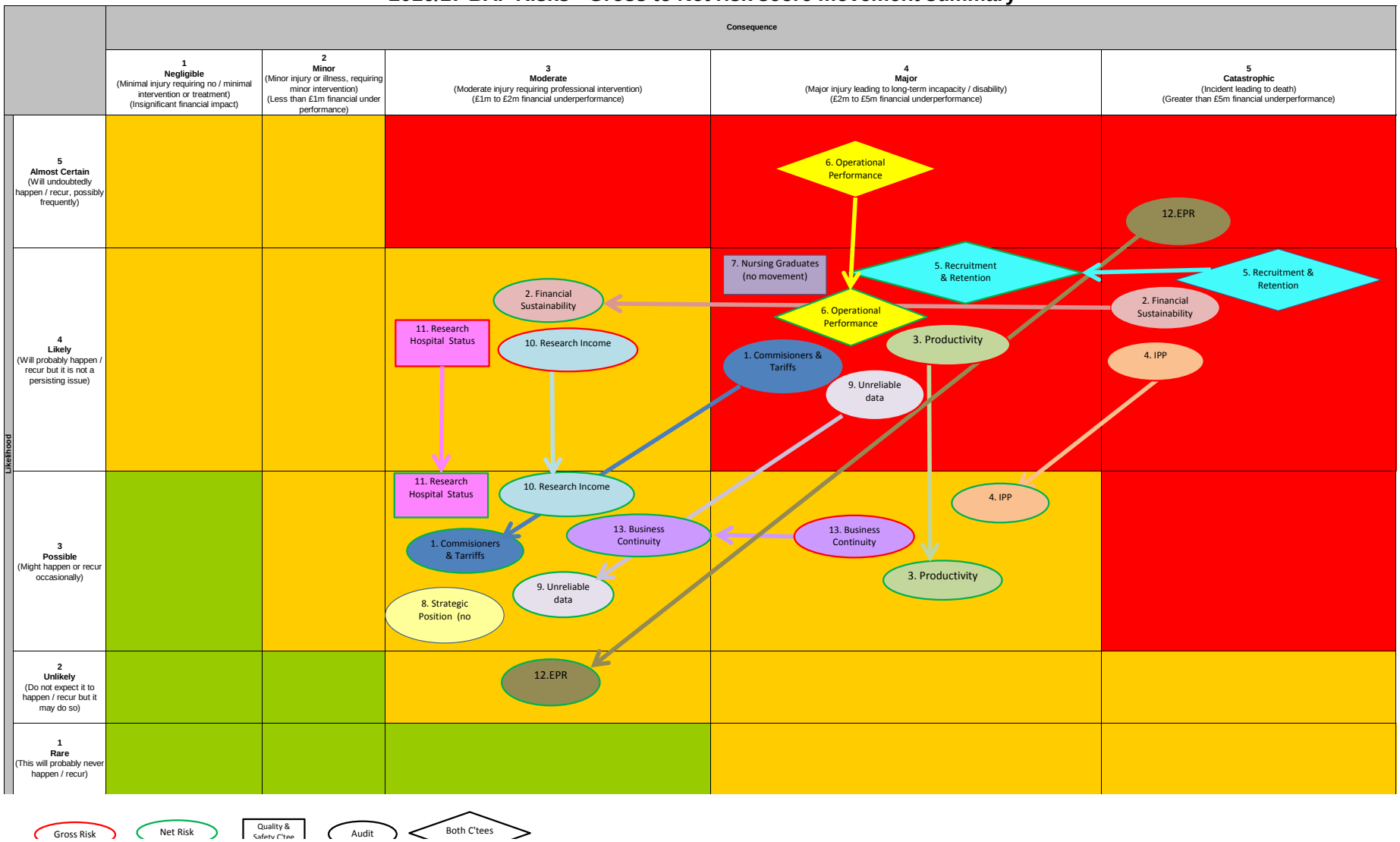
Board Assurance Framework Summary (as at 6 July 2016)

Great Ormond Street Hospital for Children NHS Foundation Trust

No.	Short Title	Risk type and description		Gross Risk Score					Net Risk Score					Director Lead	Reviewed By	Last Updated by Risk Owner	Assurance Committee	Last Reviewed by Assurance Committee
				L	x	C	=	T	L	x	C	=	T					
1	1. NHS Funding – Commissioners and Tariffs	Strategic & Operational	The risk of deterioration in the Trust's financial position as a result of: o the significant reductions in tariff; o challenges in completing contracts with NHS Commissioners for 2016/17 o Commissioner actions eg fines o Additional costs incurred in addressing the remedial action plan	4	x	4	=	16	3	x	3	=	9	Chief Finance Officer	Loretta Seamer, Chief Finance Officer	28/06/2016	Audit Committee	May-16
2	Financial Sustainability	Strategic & Operational	The risk that the organisation will not continue to be able to maintain a financially sustainable position.	4	x	5	=	20	4	x	3	=	12	Chief Finance Officer	Loretta Seamer, Chief Finance Officer	28/06/2016	Audit Committee	May-16
3	Productivity	Operational	The risk that the organisation will not deliver productivity and efficiency targets	4	x	4	=	16	3	x	4	=	12	Deputy Chief Executive Officer	Jon Schick, Project Management Office	28/06/2016	Audit Committee	May-16
4	IPP Contribution	Operational & Strategic	The risk that the organisation will not deliver IPP contribution targets	4	x	5	=	20	3	x	4	=	12	Deputy Chief Executive Officer	Trevor Clark, Director of IPP	28/06/2016	Audit Committee	May-16
5	5. Recruitment and Retention	Operational	The trust is unable to demonstrate compliance with the 2016/17 regulatory framework	4	x	5	=	20	4	x	4	=	16	Director, Human Resources/ Chief Nurse	James Devine, Deputy Director of HR and OD/ Juliette Greenwood, Chief Nurse	28/06/2016	Audit Committee/ Quality & Safety Assurance Committee	Jul-16
6	Operational Performance	Operational	Provide sufficient capacity to meet current demands and have adequate plans in place to develop and flex capacity to meet future demands.	5	x	4	=	20	4	x	4	=	16	Deputy Chief Executive Officer	Graham Terry, Head of Planning & Performance	28/06/2016	Audit Committee/ Quality & Safety Assurance Committee	Jul-16
7	Nursing Graduates	Strategic & Operational	The risk that due to external factors, there will be insufficient nursing graduates available to work at GOSH	4	x	4	=	16	4	x	4	=	16	Chief Nurse	Juliette Greenwood, Chief Nurse	28/06/2016	Quality & Safety Assurance Committee	Jul-16
8	GOSH Strategic Position	Strategic	Lack of priority given to specialist paediatrics in the NHS wide strategies leading to lack of progress in developing appropriate system wide services and support for GOSH's role	3	x	3	=	9	3	x	3	=	9	Deputy Chief Executive Officer	Nicola Grinstead, Deputy Chief Executive Officer	28/06/2016	Audit Committee	May-16
9	Unreliable Data	Operational	Failure to manage data recording and data management processes in a way which supports timely, relevant, accurate, consistent and appropriate reporting, billing and decision making across all segments of the Trust.	4	x	4	=	16	3	x	3	=	9	Deputy Chief Executive Officer	Nicola Grinstead, Deputy Chief Executive Officer	28/06/2016	Audit Committee	May-16
10	Research Income	Strategic	The Trust may not be able to provide the required level of research infrastructure or leverage additional research income if core research funding streams are reduced	4	x	3	=	12	3	x	3	=	9	Director, Research & Innovation	Emma Pendleton, Deputy Director, Research & Innovation	28/06/2016	Audit Committee	May-16
11	Research Hospital Status	Strategic	The Trust may not deliver its full Research Hospital vision if key research alliances are not fostered	4	x	3	=	12	3	x	3	=	9	Director, Research & Innovation	Emma Pendleton, Deputy Director, Research & Innovation	28/06/2016	Quality & Safety Assurance Committee	Jul-16
12	Electronic Patient Records	Operational	The trust may not deliver the Electronic Patient Record programme on time or at cost	5	x	5	=	25	2	x	3	=	6	Medical Director	Elizabeth Crowe, ICT Transformation Director	28/06/2016	Audit Committee	May-16
13	Business Continuity	Operational	The trust is unable to deliver normal services and critical functions during periods of significant disruption.	3	x	4	=	12	3	x	3	=	9	Deputy Chief Executive Officer	Noel James, Emergency Planning Officer	28/06/2016	Audit Committee	May-16

Great Ormond Street Hospital for Children NHS Foundation Trust

2016/17 BAF Risks - Gross to Net risk score movement summary



Attachment D

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **20th July 2016**	
Access Improvement Update **Submitted by:** Nicola Grinstead, Deputy Chief Executive	**Paper No: Attachment D**
Aims / summary This paper provides an update to the Trust Board on the Access Improvement Programme	
Action required from the meeting Board members to note	
Contribution to the delivery of NHS Foundation Trust strategies and plans The delivery of improved patient access is key	
Financial implications There are contractual implications associated with non-reporting	
Who needs to be told about any decision? Where appropriate and applicable: Internal stakeholders, NHS Improvement and NHS England Special Services Commissioners	
Who is responsible for implementing the proposals / project and anticipated timescales? Leads for the various aspects of the Programme	
Who is accountable for the implementation of the proposal / project? Deputy Chief Executive	

Attachment D

Great Ormond Street Hospital for Children NHS Foundation Trust

ACCESS IMPROVEMENT PROGRAMME:
UPDATE - JULY 2016

Summary
As reported previously to the Board, overall good progress is being made with the programme. The governance supporting this process is: an internal Access Improvement Board (supported by a number of sub-groups focused on key actions / themes); Fortnightly Tripartite meetings with NHS Improvement, NHS England and the CQC and the Commissioner's Clinical Quality Review Group.

Additionally to this the Trust has access to on-site support one day a week (minimum) from the National Elective Intensive Support Team, from NHS Improvement.

Below provides an overview by theme of the current position and progress which is aligned to the recovery action plan between the Trust and NHS England.

Training & Standard Operating Procedures
Having successfully implemented Phase 1 Training, phases 2 and 3 are now being finalised and rolled out – which will involve the implementation of the circa 50 developed SOPs across the Trust. Work has already been underway in a number of areas (as has been necessitated by need) and this is now the formal role out process.

This is to be underpinned by an on-going training programme for RTT across the Trust

Operational Delivery & Waiting List Management
The new Trust Access Policy has been signed off, implemented and rolled out across the Trust. With the Trust weekly local and Trust wide waiting list (PTL) review meetings, this also ensures there is adherence to the policy. An enabler to this has been the successful implementation of a new Electronic Clinical Outcome Form (E-CoF) with clinicians and is in use across the Trust with good success.

There remains on-going work with Commissioners to ensure that the demand into services within the Trust is deliverable within the existing capacity.

Validation
Excellent progress continues to be made in conjunction with the above work-stream. As reported previously, no clinical harm has been evidenced as a consequence of this exercise. The Trust is now in discussion with Commissioners in regard to the next stages.

Return to Reporting
NHS London and NHS Improvement have released guidance to Trusts how are currently not reporting RTT on what assurances need to be provided in readiness to return. Positively all these requirements are in line with the action plan and improvement programme. The Trust is working with NHS England and NHS Improvement with the aim of starting to re-report towards the end of the year

Nicola Grinstead
Deputy Chief Executive Officer

July 2016

Attachment 1

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board Meeting
20th July 2016

North East & Central London (NECL) Sustainability & Transformation Plan (STP) **Submitted by:** Claire Newton, Interim Director of Strategy and Planning	**Paper No: Attachment 1** **Attached Summary**

Aims
To brief the Trust Board on the current status of the NHS's Sustainability & Transformation Plan submissions and the impact for GOSH.

Summary:

The original STP structure set up by NHS England envisaged that all NHS and Local Authority organisations would fit within regional structures and that the provision of health and social care could be redesigned and made more efficient through integration at regional level.

In common with other wholly specialist trusts GOSH did not naturally fit within the local regional STP, North East and Central London (NECL), and was therefore excluded from their submission but we choose to send a representative to their programme Board to ensure engagement where appropriate.

NHSE has recently launched a framework for a specialised services STP and our CEO is currently participating in the development of this structure and will update the Board on progress so far through the CEO report.

The NECL STP have requested that Boards of all organisations in their region are updated on the progress on the STP submission at the July Board meeting. The attached presentation is being shared with all such organisations.

Although GOSH is not included in the STP, it is important to be aware of the key priorities in the region as they will indirectly impact GOSH. Key items to be noted from the presentation are as follows:

- The priorities are currently improving primary care and emergency care – which in turn will ease pressures on acute beds
- The public health indicators for children in the region are poor and there are high rates of mental illness in children (as well as adults)
- IT needs to be improved to support integrated care
- Systems for caring for individuals with long term conditions need to be improved through integrated care
- The changes will require new governance and commissioning structures to enable integration
- The initial submission was made at the end of June but further refinement and development of a more comprehensive plan will take until January 2017. This is likely to address specialised services in the region in more detail than has been done so far.

Action required
To note the information provided

Contribution to the delivery of NHS Foundation Trust strategies and plans
The update reflects the external strategy of the NHS

Financial implications – There is no impact on GOSH currently of these plans but over the long term, there are significant financial pressures on all NHS and Local Authority organisations involved in delivering care including GOSH.

Who needs to be told about any decision?
The NECL STP programme board asked all Trusts in their region to be updated on the

current status of their submission
Who is responsible for implementing the proposals / project and anticipated timescales? The NECL STP does not currently involve the Trust. However the CEO is meeting with other CEOs of specialist Trusts in London to agree a plan for a specialised services STP.
Who is accountable for the implementation of the proposal / project? CEO

North Central London
Sustainability and
Transformation Plan

North Central London
Sustainability and Transformation plan

Summary of progress to date
June 2016

NHS England
Barnet Clinical Commissioning Group
Camden Clinical Commissioning Group
Enfield Clinical Commissioning Group
Haringey Clinical Commissioning Group
Islington Clinical Commissioning Group

Barnet
Camden
Enfield Council
Haringey
Islington

Barnet, Enfield and Haringey Mental Health NHS Trust
A University Teaching Trust
Camden and Islington NHS Foundation Trust
Central London Community Healthcare NHS Trust
Your healthcare closer to home
Central and North West London NHS Foundation Trust
Moorfields Eye Hospital NHS Foundation Trust
North Middlesex University Hospital NHS Trust
Royal Free London NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
Whittington Health NHS

Content

North Central London Sustainability and Transformation Plan

1 The background of Sustainability and Transformation Plans

North Central London Sustainability and Transformation Plan

1. The NHS Five Year Forward View team set out a challenging vision for the NHS. Its aim is to bring local health and care partners together to set out clear plans to pursue the Forward View's **'triple aim'** to improve:

- the health and wellbeing of the population
- the quality of care that is provided
- NHS finance and efficiency of services

The NHS England 2016/17 **planning guidance** outlines a new approach to help ensure that health and care service are planned by **place** rather than around individual organisations.

There are 44 **Sustainability and Transformation Plans (STPs)** being developed in local geographical areas or **'footprints'** across the country that are being submitted to NHS England for approval. North Central London (NCL) is one of the five London footprints.

3. The most **compelling and credible** STPs will secure **funding from April 2017 onwards**. NHS England will consider:
   - the **quality of plans**, particularly the **scale of ambition** and **track record of progress already made**. The best plans will have a **clear and powerful vision**. They will create **coherence across different elements**, for example a prevention plan; self-care and patient empowerment; workforce; digital; new care models; and finance. They will systematically **borrow good practice from other geographies**, and adopt **national frameworks**;
   - the **reach and quality of the local process**, including community, voluntary sector and local authority engagement;
   - the **strength and unity of local system leadership and partnerships**, with **clear governance structures** to deliver them; and
   - how **confident are NHS England that a clear sequence of implementation actions will follow as intended**, through defined governance and demonstrable capabilities.

1 North Central London has a complex health and social care landscape

North Central London Sustainability and Transformation Plan

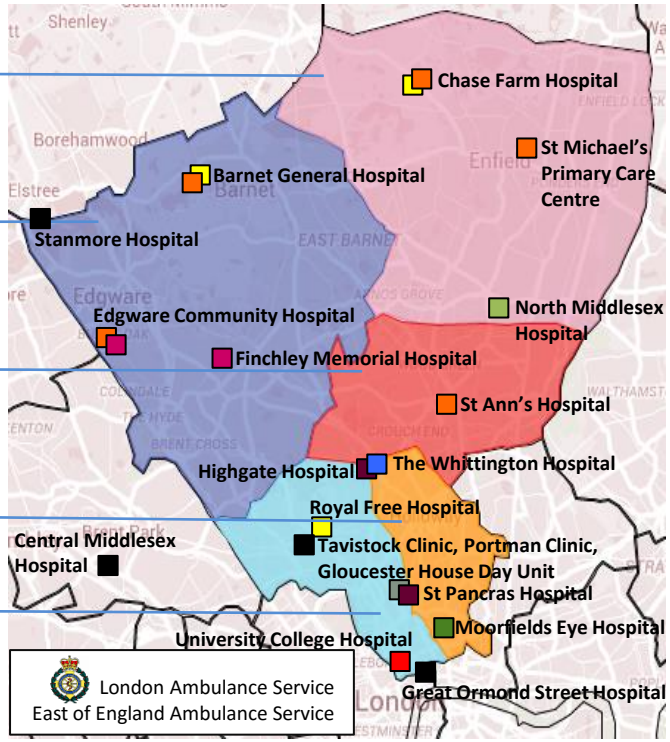
Enfield CCG / Enfield Council
~320k GP registered pop, ~324k resident pop
48 GP practices
CCG Allocation: £362m (-£14.9m 15/16 OT)
LA ASC, CSC, PH spend: £184m

Barnet CCG / Barnet Council
~396k GP registered pop, ~375k resident pop
62 GP practices
CCG Allocation: £444m (£2.0m 15/16 OT)
LA ASC, CSC, PH spend: £158m

Haringey CCG / Haringey Council
~296k GP registered pop, , ~267k resident pop
45 GP practices
CCG Allocation: £341m (-£2.8m 15/16 OT)
LA ASC, CSC, PH spend: £163m

Islington CCG / Islington Council
~233k GP registered pop, , ~221k resident pop
34 GP practices
CCG Allocation: £339m (£2.7m 15/16 OT)
LA ASC, CSC, PH spend: £138m

Camden CCG / Camden Council
~260k GP registered pop, , ~235k resident pop
35 GP practices
CCG Allocation: £372m (£7.2m 15/16 OT)
LA ASC, CSC, PH spend: £191m



Vanguards in scope
- Royal Free multi-provider hospital model
- Accountable clinical network for cancer (UCLH)

NCL CCGs activity stats

A&E	522,838
Elective	134,513
Non-elective	163,487
Critical Care	25,718
Maternity	45,528
Outpatients	1,803,202

Total GP registered population 1.5m

Our population
- Our population is **diverse and growing**.
- Like many areas in London, we experience **significant churn** in terms of people using our health and care services as people come in and out of the city.
- There is a **wide spread of deprivation** across NCL – we have a younger, more deprived population in the east and south and an older, more affluent population in the west and north.
- There are high numbers of households in **temporary accommodation** across the patch and around a quarter of the population in NCL **do not have English as their main language**.
- Lots of people come to settle in NCL from abroad. The largest **migrant communities** arriving during 2014/15 settling in Barnet, Enfield and Haringey were from Romania, Bulgaria and Poland. In Camden and Islington in 2014/15 the largest migrant communities were from Italy, France and Spain.

Total health spend £2.5b

Total care spend c.£0.8b

NHS England
- Primary care spend ~£180m
- Spec. comm. spend ~£730m

15/16 OT		
£185m	-£12.4m	BEH Mental Health NHS Trust (main sites, incl Enfield community)
£136m	£0.7m	Camden and Islington NHS FT (and main sites)
£249m	-£8.3m	North Middlesex University Hospital NHS Trust
£951m	-£51m	The Royal Free London NHS FT
£940m	-£31m	University College London Hospitals NHS FT
£293m	-£14.8m	Whittington Health NHS Trust (incl Islington and Haringey Community)
£202m	£2m	Moorfields Eye Hospital NHS FT
N/A – not in scope for NCL STP finance base case		Central and North West London NHS FT (Camden Community)
		Central London Community Healthcare NHS Trust (Barnet Community)

The specialist providers are out of scope: GOSH and RNOH
Tavistock and Portman NHS FT is out of scope financially but within scope for mental health

Note: all OT figures are normalised positions

1 We have agreed a number of objectives for the NCL STP

North Central London Sustainability and Transformation Plan

Goals

The **goals** of our STP are:

- To improve the quality of care, wellbeing and outcomes for the NCL population
- To deliver a sustainable, transformed local health and care services
- To support a move towards place-based commissioning
- To gain access to a share of the national transformation funding which will ensure our hospitals get back to being viable, to support delivery of the Five Year Forward View, and to enable new investment in critical priorities

Outputs

The STP needs to deliver several **key outputs:**

- A compelling clinical case for change that provides the foundation for the programme and is embedded across the work, and supports the identification of priorities to be addressed through the STP
- A single version of the truth financial 'do nothing' base case with quantified opportunity impacts based on the priorities identified
- A robust and credible plan for implementation and delivery over five years
- A governance framework that supports partnership working across the STP and collective decision making
- The resource in place to deliver transformation at scale and pace in the key areas identified

Process

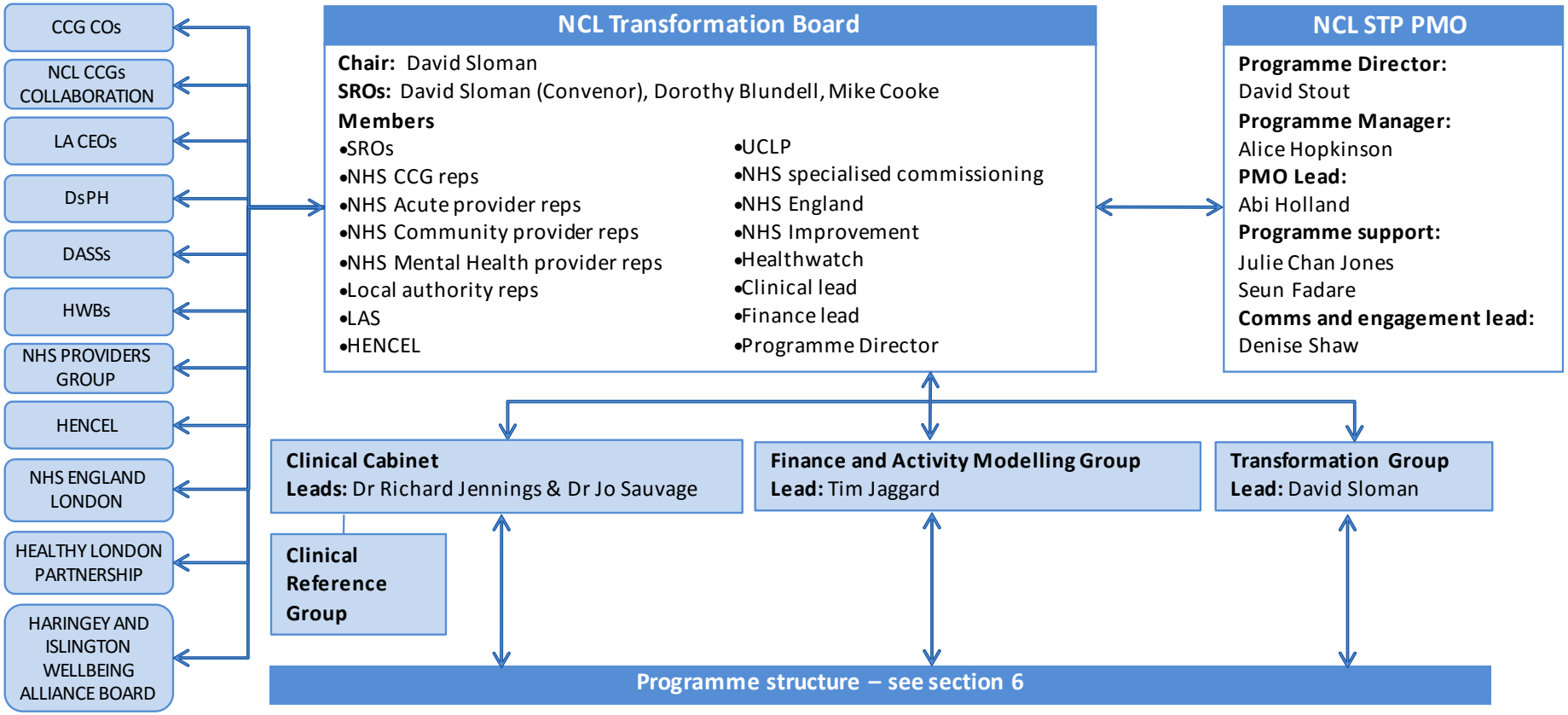
The **process** to developing our STP needs to:

- Be collaborative, and owned by all programme partners in NCL
- Be structured and rigorous
- Move at pace, ensuring quick wins are implemented and transformation is prioritised
- Involve all areas of CCG, local authority and NHS England commissioned activity, including specialised services, primary care and reflecting local HWB strategies

2 We have developed a robust governance structure that enables collaborative input and steer from across the STP partners

North Central London Sustainability and Transformation Plan

The NCL STP **Transformation Board** meets monthly to oversee the development of the programme and includes representation from all programme partners. It has no formal decision making authority, but members are committed to steering decisions through their constituent boards and governing bodies. There are three subgroups supporting the Transformation Board. The **Clinical Cabinet** provides clinical and professional steer and input with CCG Chair, Medical Director, nursing, public health and adult social services and children's services membership. The **Finance and Activity Modelling Group** is attended by Finance Directors from all partner organisations. The **Transformation Group** is a smaller steering group made up of a cross section of representatives from organisations and roles specifically facilitating discussion on programme direction for presentation at the Transformation Board. Every workstream has a senior level named SRO to steer the work and ensure system leadership filters down across the programme. The **Clinical Reference Group** will be mobilised over the summer of 2016 and will provide a forum for input, review and co-design with a broader pool of clinicians and practitioners.



* Programme Governance Structure to be reviewed as programme moves into implementation

3 Case for Change

North Central London Sustainability and Transformation Plan

Clinical cabinet	• The NCL STP Clinical Cabinet is responsible for the Case for Change. Their role is to is lead the further development of STP work • The Clinical Cabinet will sign off the Case for Change with ultimate responsibility falling to the NCL STP clinical lead
Development and engagement process to date	• The Clinical Cabinet has met five times, since its inception, to develop a robust and accurate Case for Change for North Central London's health and social care • On 13 June, the Clinical Cabinet agreed the draft Case for Change, pending some outstanding issues; this was then endorsed by the Transformation Board on 22 June • Draft Case for Change was part of the submission sent to NHS England on 30 June; their feedback is expected in July • From now until the end of September, the Clinical Cabinet will move the Case for Change from draft to a comprehensive, final document which will be published in late Summer.

Initial messages from the Case for Change	• Some high level messages from analysis relating to our population's health and wellbeing are:
	  • People are living longer but in poor health
	  • Our different ethnic groups have different health needs
	  • There is widespread deprivation and health inequalities
	  • High levels of homelessness and households in temporary housing
	  • Lifestyle choices put people at risk of poor health and early death
	  • There are poor indicators of health for children
	  • High rates of mental illness among both adults and children
	• When analysing our care and quality metrics, we identify the following:
	  • There is not enough focus on prevention across the whole NCL system
	  • Disease could be detected and managed much earlier
	  • There are challenges in provision of primary care
	  • There is a lack of integrated care and support for those with a LTC
	  • Many people are in hospital beds who could be cared for at home
	  • There are differences in the way planned care is delivered
	  • There are challenges in mental health provision and in the provision of cancer care
	  • Some buildings are not fit for purpose
	  • Information technology needs to better support integrated care.
	• Initial financial analysis show we face a significant financial challenge. If we continue on our current spending path, the deficit will rise substantially over the next five years

4 In response to the case for change, we have collectively developed an overarching vision for NCL which will be delivered through the STP

North Central London Sustainability and Transformation Plan

Our vision is for North Central London to be a place with the best possible health and wellbeing, where no-one gets left behind. It will be supported by a world class, integrated health and social care system designed around our residents.

This means we will:

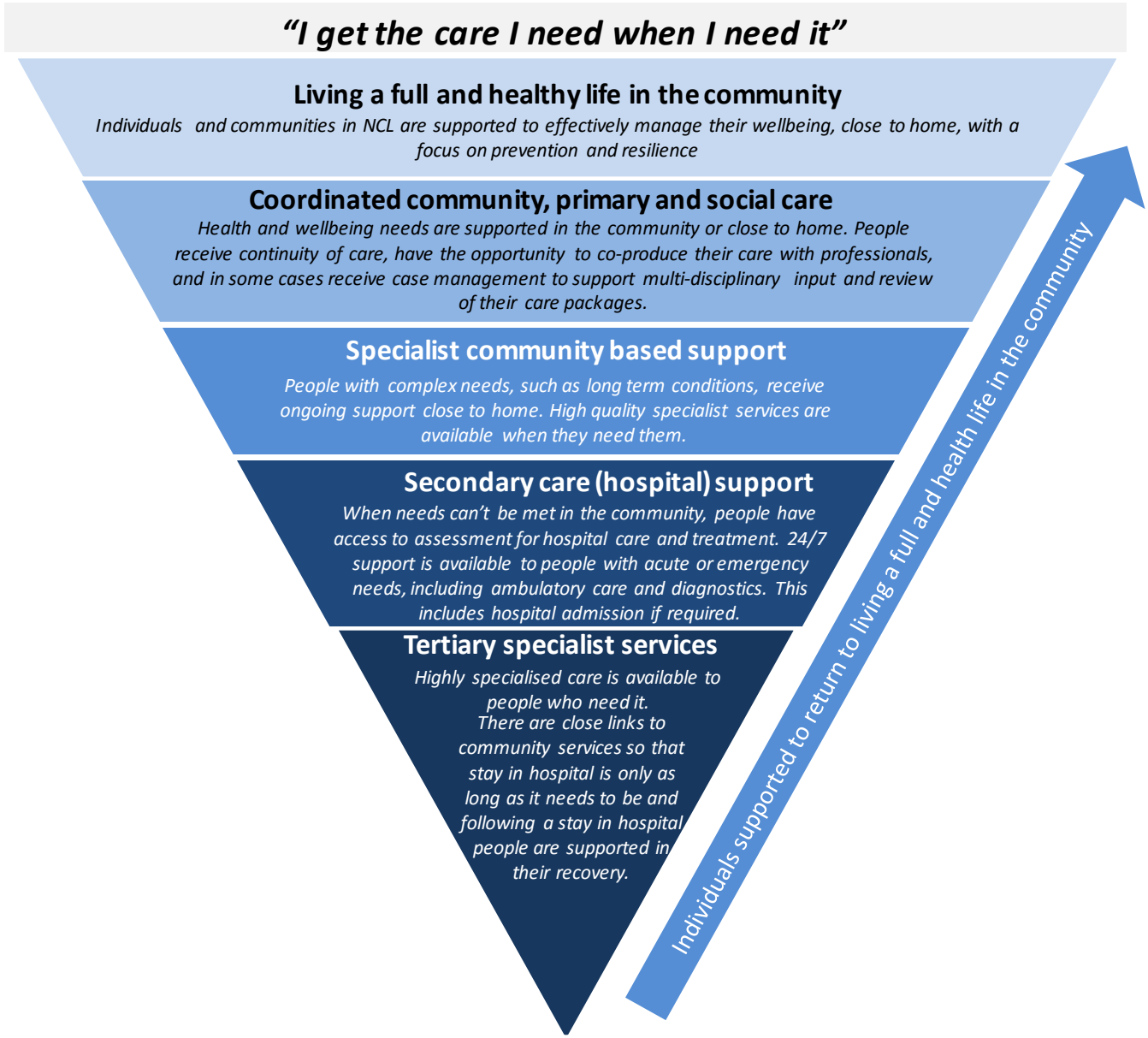
- help people who are well, to stay healthy
- work with people to make healthier choices
- use all our combined influence and powers to prevent poor health and wellbeing
- help people to live as independently as possible in resilient communities
- deliver better health and social care outcomes, maximising the effectiveness of the health and social care system
- improve people's experiences of health and social care, ensuring it is delivered close to home wherever possible
- reduce the costs of the health and social care system, eliminating waste and duplication so that it is affordable for the years to come
- at the same time we will ensure services remain safe and of good quality
- enable North Londoners to do more to look after themselves
- have a strong digital focus, maximising the benefits of digital health developments.

Our core principles are:

- residents and patients will be at the heart of what we do and how we transform NCL. They will participate in the design of the future arrangements.
- we will work together across organisational boundaries and take a whole system view
- we will be radical in our approach and not be constrained by the current system
- we will harness the world class assets available to us across the North Central London communities and organisations
- we will be guided by the expertise of clinicians and front line staff who are close to residents and patients
- we will build on the good practice that already exists in North Central London and work to implement it at scale, where appropriate
- we will respect the fact that the five boroughs in NCL have many similarities, there are significant differences which will require different responses in different localities.

4 The vision will be delivered through a consistent model of care

North Central London Sustainability and Transformation Plan



5 We are in the process of designing a cohesive programme that is large scale and transformational in order to meet the challenge

North Central London Sustainability and Transformation Plan

	A Health and wellbeing	B Care and quality	C Productivity	D Enablers
High level impact	• Improves population health outcomes • Reduces demand	• Increases independence and improves quality • Reduces length of stay	• Reduces non value-adding cost	• Facilitates the delivery of key workstreams
Initiatives	1. Population health including prevention *(David Stout, STP PD)* 2. Primary care transformation *(Alison Blair, ICCG CO)* 3. Mental health *(Paul Jenkins, TPFT CEO)*	4. Urgent and emergency care *(Alison Blair, ICCG CO)* 5. Optimising the elective pathway *(Richard Jennings, Whittington MD)* 6. Consolidation of specialties *(Richard Jennings, Whittington MD)*	7. Organisational-level productivity including: a) Commissioner b) Provider *(FDs)* 8. System productivity including: a) Consolidation of corporate services b) Reducing transactional costs and costs of duplicate interventions *(Tim Jaggard, UCLH FD)*	9. Health and care workforce *(Maria Kane, BEHMHT CE)* 10. Health and care estates *(Cathy Gritzner, BCCG CO and Dawn Wakeling, Barnet Council DASS)* 11. Digital / information *(Neil Griffiths, UCLH DCEO)* 12. New care models & new delivery models *(David Stout, STP PD)* 13. Commissioning models *(Dorothy Blundell, CCCG CO)*

6 What we aim to achieve from each of our workstreams

North Central London Sustainability and Transformation Plan

A Health and wellbeing	Population health	Focus on preventative care to achieve better health and care at a lower, cost, with a reduction in health inequalities
	Primary care transformation	Reduce demand by upgrading out of hospital care and support, for individuals with different types of needs
	Mental health	Joining up of mental and physical health, analysis of social determinants and supporting population to live well
B Care and quality	Urgent and emergency care	Improve care through integrated approach across health and social care
	Optimising the elective pathway	Understand the variation in delivery between acute providers to improve patient safety, quality and outcomes
	Consolidation of specialities	Identifying clinical areas which might benefit form consolidation
C Productivity	Organisational-level productivity	Efficiencies gained through better alignment of health and care services
	System productivity	Improved delivery opportunities in areas such as: workforce management, pharmacy, medical, surgical and food procurement and distribution, pooled digital information and corporate functions
D Enablers	Health and care workforce	Develop new workforce model, focused on prevention and self-care, including review of existing roles and requirements
	Health and care estates	Management of One Public Estate to maximize the asset and improve facilities for delivering care
	Digital/ information	Develop the digital vision: inc. digitally activated population, enhanced care delivery models, integrated digital record access and management
	New care models & new delivery models	Work with Kings Fund to develop our delivery model for population health for NCL
	Commissioning models	Develop strong commissioning through partnership working to develop whole population models of care, improve patients outcomes and financial and quality gaps

7 Current position

North Central London Sustainability and Transformation Plan

Establishing effective partnership working

- NCL-wide collaborative working is a relatively new endeavour and we continue to **build relationships** across the programme partners to ensure that health and care commissioners and providers are aligned in our ambition to transform care
- We have established a governance framework that supports **effective partnership working** and will provide the **foundation** for the planning and implementation of our strategic programme going forward
- The SROs are working to bring CCGs, providers and local authorities together across the 5 boroughs together **recognising the history and context** that underlies working together in a new way

Understanding the size of the challenge

- We have undertaken **analysis to identify the gaps** in health and wellbeing, and care and quality in NCL in order to prioritise the areas we need to address
- Our draft Case for Change provides a narrative in support of **working in a new way** and provides the platform for **strategic change** through identifying key areas of focus
- Finance directors from all organisations have been working to identify the **projected NCL health and care position** in 20/21 should we do nothing

Delivering impact in year one

- There is already **work in train** that will ensure delivery of impact before next April, in particular, CCG plans to build capacity and capability in primary care and deliver on the 17 specifications in the **London Strategic Commissioning Framework** (SCF).
- However, **further work** must be done to broaden our **out of hospital strategy** and address issues with regard to the short-term sustainability and viability of general practice
- The **implementation of our Local Digital Roadmap** will support the delivery of the mental health, primary care and estates work, and our two Vanguards are continuing to progress with their plans.

8 We will ensure all our stakeholders and wider programme partners are appropriately involved in the development of the programme

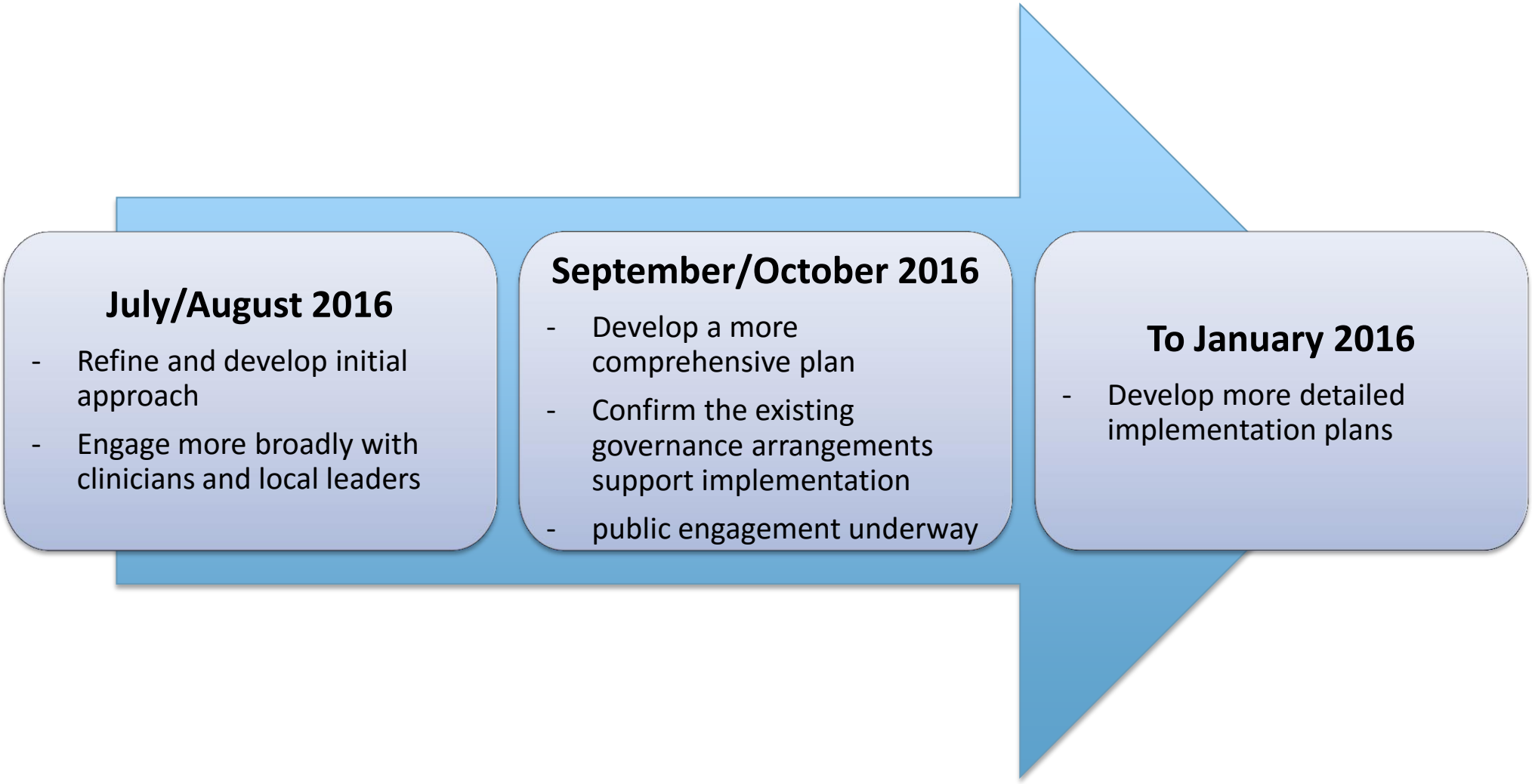
North Central London Sustainability and Transformation Plan

Engagement to date	Communications & engagement objectives	Delivering the objectives

Workstreams have been engaging with relevant stakeholders to develop their plans.
• The general practice transformation workstream has worked collaboratively with the London CCGs (and local groups of GPs) to develop pan-London five year plan
• Mental health workstream was initiated at stakeholder workshop in January 2016 and a further workshop in May. Further service user and carer engagement is done via programme updates and specification for a citizens panel is being developed
• Significant engagement was undertaken through reprocurement of 111 process in urgent and emergency care workstream
• The estates workstream has been developed through a working group, with representatives from all organisations in scope including Moorfields, the Office of the London CCGs, Community Health Partnerships, Healthy Urban Development Unit (HUDU) and GLA
• NCL Digital Roadmap Group meets to define, shape and contribute to the interoperability programme with representation from all key organisations
• Early engagement with Health & Wellbeing Boards and the Joint Overview & Scrutiny Committee
	• To support the engagement and involvement of STP partners across all organisations at all levels
	• To ensure a strong degree of organisational consensus on the STP content and on the approach to further developing the strategic plan and implementation approach, in particular political involvement and support
	• To support and co-ordinate STP partners in engaging with their stakeholders to raise awareness and understanding of:
	  • the challenges and opportunities for health and care in NCL
	  • how the STP – specifically the emerging priorities and initiatives - seeks to address the challenges and opportunities so that we can develop the best possible health and care offer for our population
	  • what the NCL strategic plan will mean in practice and how they can influence its further development and implementation
	• To encourage and gather feedback from stakeholders – NHS, local government, local and national politicians, patients and the wider community – that can:
	  • influence our emerging plans and next steps
	  • help build support for the STP approach
	• To ensure equalities duties are fulfilled, including undertaking equalities impact assessments
		• Forward planning underway to join up all partners and stakeholders in NCL footprint
		• Dedicated communications lead now in place to undertake this
		• Stakeholder mapping underway for external and internal bodies through integrated work approaches with CCG communications and engagement leads to include partners such as local authorities, NHS providers, GP practices and others to be determined
		• In addition to partners and stakeholders already consulted, we will identify opportunities for more STP partners clinicians/staff to have input into specific work streams asap, particularly local political engagement which will be key for community leadership of change
		• Plan to engage more formally with boards and partners after the July conversations
		• Effective communications channels will be established for all stakeholders and partners for transparent contributions to ongoing plans and discussions, including staff, clinicians, patients, politicians etc.
		• A core narrative is being created to cover our health and care challenges and opportunities, STP purpose, development, goals, strategic approach and priorities – in person-centred, accessible language
		• Review requirements for consultation before March 2017

9 Next steps for development of the STP

North Central London Sustainability and Transformation Plan



Attachment E

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board July 2016	
Quality and Safety Report **Submitted by:** Dr Vinod Diwakar, Medical Director	**Paper No: Attachment E**
Aims / summary This is a combined Quality and Safety report focused around the GOSH Quality Framework. The report combines keys measures of interest with learning from complaints, SIs and patient experience. The aim of the report is to provide assurance on work undertaken in line with the GOSH Quality Framework.	
Action required from the meeting To note the report and the work that has been undertaken within the Trust regarding Quality and Safety.	
Contribution to the delivery of NHS / Trust strategies and plans	
Financial implications n/a	
Legal issues n/a	
Who is responsible for implementing the proposals / project and anticipated timescales Salina Parkyn, Head of Clinical Governance and Safety and Interim Head of Quality Improvement	
Who is accountable for the implementation of the proposal / project Dr Vinod Diwakar, Medical Director	

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

Quality & Safety Report

Dr Vin Diwakar, Medical Director
Juliette Greenwood, Chief Nurse

July 2016

GOSH Quality Framework

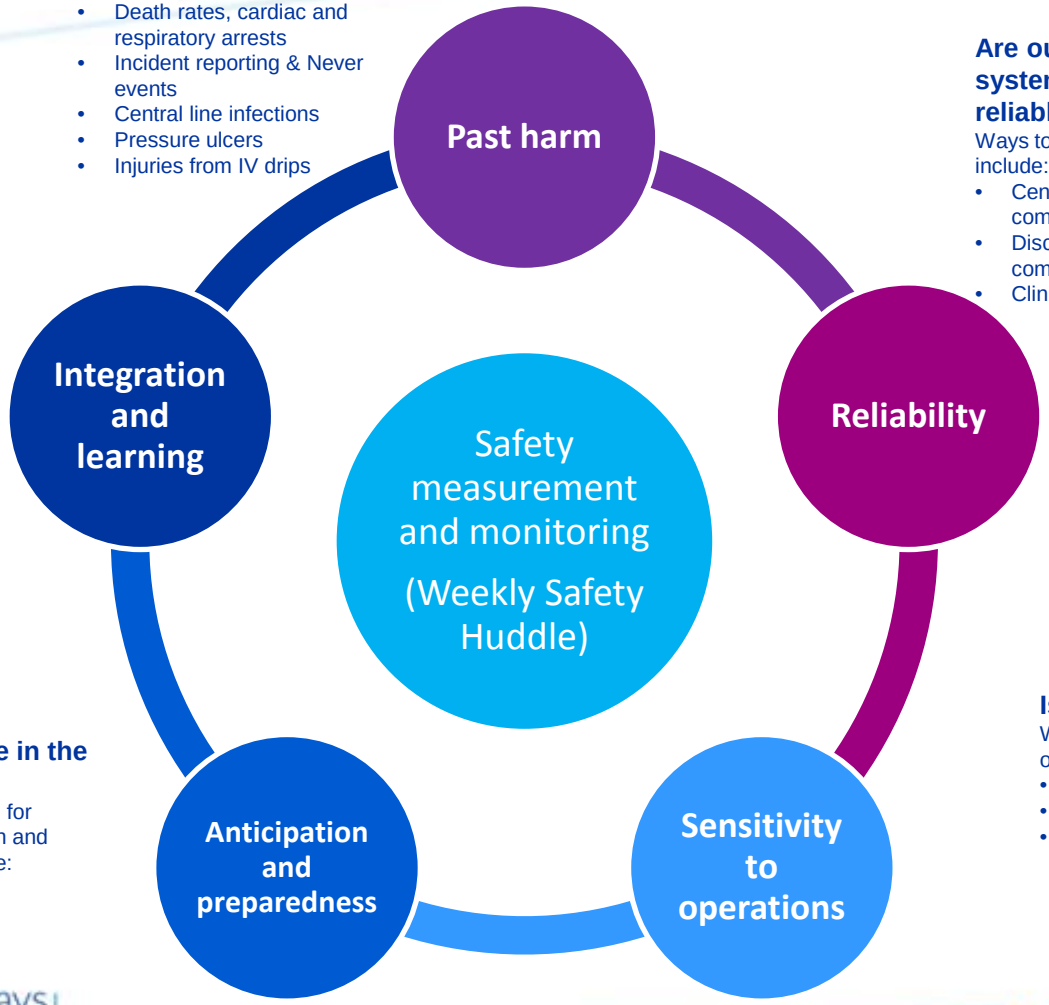
Source: Vincent C, Burnett S, Carthey J.
The measurement and monitoring of safety. The Health Foundation, 2013

Great Ormond Street Hospital for Children NHS Foundation Trust

Has patient care been safe in the past?
Ways to monitor harm:
- Death rates, cardiac and respiratory arrests
- Incident reporting & Never events
- Central line infections
- Pressure ulcers
- Injuries from IV drips

Are our clinical systems and processes reliable?
Ways to monitor reliability include:
- Central line bundle compliance
- Discharge summary completion
- Clinical audit

Are we responding and improving?
Sources of information to learn from include:
- Learning from SIs and complaints
- Audit to check that learning is embedded



Will care be safe in the future?
Possible approaches for achieving anticipation and preparedness include:
- risk registers

Is care good today?
Ways to monitor sensitivity to operations include:
- quality walk-rounds
- patient feedback
- Complaints and PALS

The child first and always

Welcoming Helpful Expert One Team

Has patient care been safe in the past?

Measures where we have no concerns

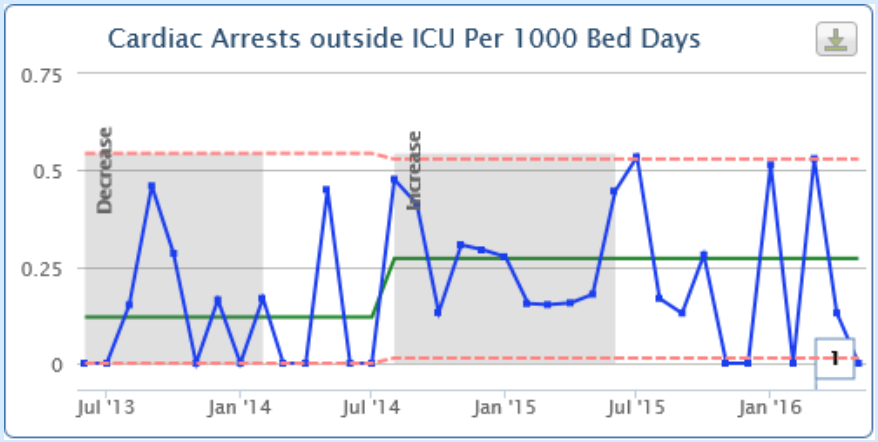
Great Ormond Street Hospital for Children NHS Foundation Trust

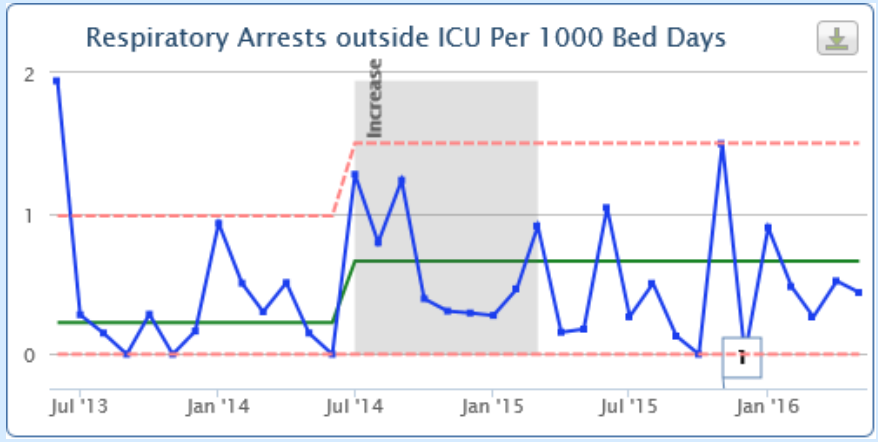
Measure	Comment
Patient safety incidents causing harm	No worrying trends this month
Medication Incidents reported via Datix causing harm	No worrying trends this month
Never Events	430 days since last Never Event reported to NHS England (as of 30.06.2016)
Hospital acquired pressure ulcers reported (grades 2+) per 1000 bed days	No worrying trends this month
Non-2222 patients transferred to ICU by CSPs	No worrying trends this month
Serious Patient Safety Incidents	No worrying trends this month
GOSH acquired CVL infections	The CVL line infections data tells us that a number of line infections still occur each month therefore we have not yet reached our aim of zero. The rate remains steady with an average of 1.14/1000 line days.
Mortality	No worrying trends this month

Has patient care been safe in the past?

Important measures of interest

Great Ormond Street Hospital for Children NHS Foundation Trust





Cardiac and Respiratory Arrests

Do you have concerns about safety in this area?	No

What the data tells us:

We had no cardiac arrests in May

We had 3 respiratory arrests. 2 calls were from the same patient on Miffy ; one due to his new tracheostomy tube which was difficult to re-insert and the second of unknown cause. He recovered quickly form both events and remained on the ward.

The other respiratory arrest was on Bear. The child had been discharged from CICU 4 hours previously and required re-intubation

Actions to improve:

We are focusing on

•1 respiratory arrest was due to a lack of knowledge on the new tracheostomy tube. Training has been put in place for ward staff.

• We have seen an increase of unplanned ICU admissions from Bear ward. No clear themes are apparent except for work load and complexity of patients conditions. We have also highlighted that CICU transfers from Bear do not always involve the CSP's and so these numbers are not included in our monthly measures. We will start to measure these transfers and RECALL them as we do for PICU

Has patient care been safe in the past?

Great Ormond Street Hospital for Children NHS Foundation Trust

Serious Incidents and Never Events Opened in Q1 (01.04.2016-30.06.2016)

No of new SIs declared in quarter 1:	**3**	No of new Never Events declared in quarter 1:	**0**
No of closed SIs/ Never Events in the quarter 1:	**4**	No of de-escalated SIs/Never Events in quarter 1:	**1**

Learning from closed SIs in Q1:

Ref:	Summary:	Learning/Recommendations:
SI 2016/ 2368	**Failure to diagnose a genetic predisposition to bowel cancer:**	Staff must not rely on communications from other colleagues, departments, or organisations to remind them to carry out a task; they must have robust reminder systems in place for anything which might be forgotten.
SI 2015/ 37127	**Major power failure resulting in activation of major incident protocol:**	It is essential to have a clear robust communication plan that involves all stakeholders that could be affected (particularly clinical services) by the works carried out, this will ensure senior managers authorised and approved the work that is to be carried out.
SI 2015/ 15280	**Additional procedure (emergency):** patient underwent a cardiac catheter procedure to stent their pulmonary artery. The incorrect stent was used for the procedure (covered not bare) resulting in no blood flow to the lungs; the patient required an additional emergency procedure to rectify this.	The team brief should incorporate a routine check of the size and availability of the stent required for the procedure. Cases known to be potentially complex should be identified at the joint cardiac/cardiology meeting and discussion of number of operators required to undertake the procedure. The risk benefits of proceeding in the event there is one operator should be considered.
SI 2015/ 38180	**Inappropriate attempt to section a patient:**	All staff are reminded that the Trust has a zero tolerance policy of violence against staff. It is important to continue to benchmark the inpatient ward against other similar units across the country to ensure that we are offering the same standards of care. This should be undertaken in addition to monitoring by external agencies including the Quality Network for Inpatient CAMHS (QNIC)

Has patient care been safe in the past?

Great Ormond Street Hospital for Children NHS Foundation Trust

Red Complaints in Q1 (01.04.2016-30.06.2016)

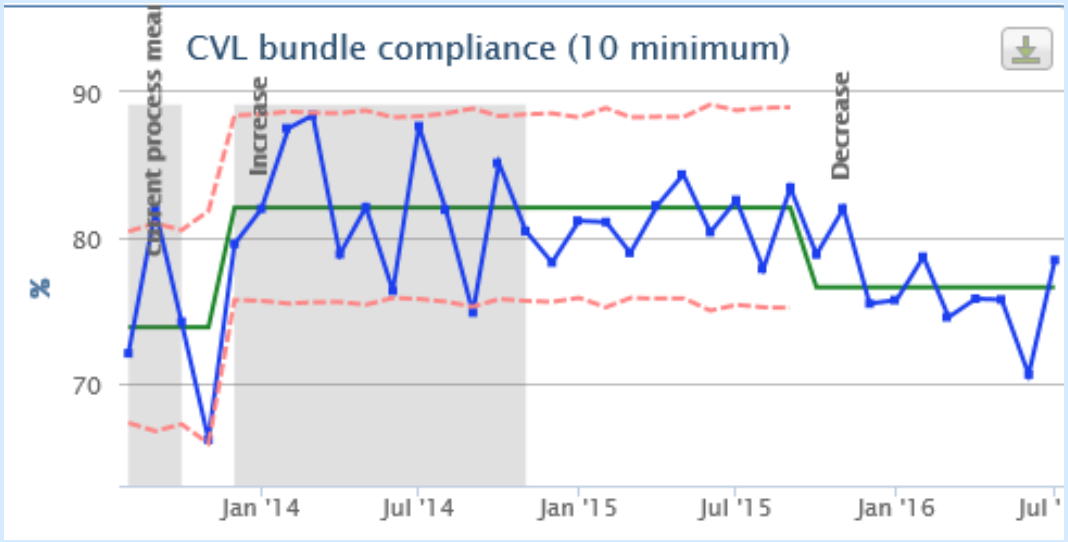
No of new red complaints declared in quarter 1:	**0**	No of re-opened red complaints in quarter 1:	**0**
No of closed red complaints in the quarter 1:	**2**		

Learning from closed complaints in Q1:

Ref:	Summary of complaint:	Learning/Recommendations:
15/141	Concerns were raised regarding the patient's experience and aspects of the care prior to their death.	The importance of robust processes around ensuring telephone calls, messages and e-mails are checked and responded to in a timely manner has been clearly reiterated to all administration staff. Practice is being monitored to ensure that the expected standards are met. The administrative process now has more robust checking mechanisms to prevent any further incidents of this nature occurring. The administrative staff will validate address and copy lists when they finalise letters and will undertake a final check of whether there are any concerns to be aware of, including whether a patient has died, immediately before posting letters.
15/143	Management and processing of genetic samples. *Please note that due to the risk of identification of the family involved further details are not contained in this report*	The department has made significant improvements since 2012, and has progressed to a more stringent quality accreditation, achieved through the application of more thorough operating procedures, including the quality of record keeping. The process of assessing the quality of the department is through external assessment over a number of days by the United Kingdom Accreditation Service, against an international standard. The standard operating procedure for storing and tracking samples (SSOP 10.05) is considerably more detailed now. In particular, it is much clearer both as to how records pertaining to samples should be made and where the record should be made. As part of the Histopathology laboratory's Quality Management System, there is a training record for all staff who need to use this standard operating procedure, and the staff member's competency to use the procedure is documented and assured. In order to make sure that this procedure is effective, the Pathology Lead Quality and Risk Manager will conduct an audit of the records generated by the Histopathology Department.

Are our clinical systems and processes reliable? Central line bundle compliance

Great Ormond Street Hospital for Children NHS Foundation Trust



CVL bundle compliance

Do you have concerns about quality in this area?	**Maybe**

Commentary:

We have detected a fall in compliance (a run of 8 points below the mean)

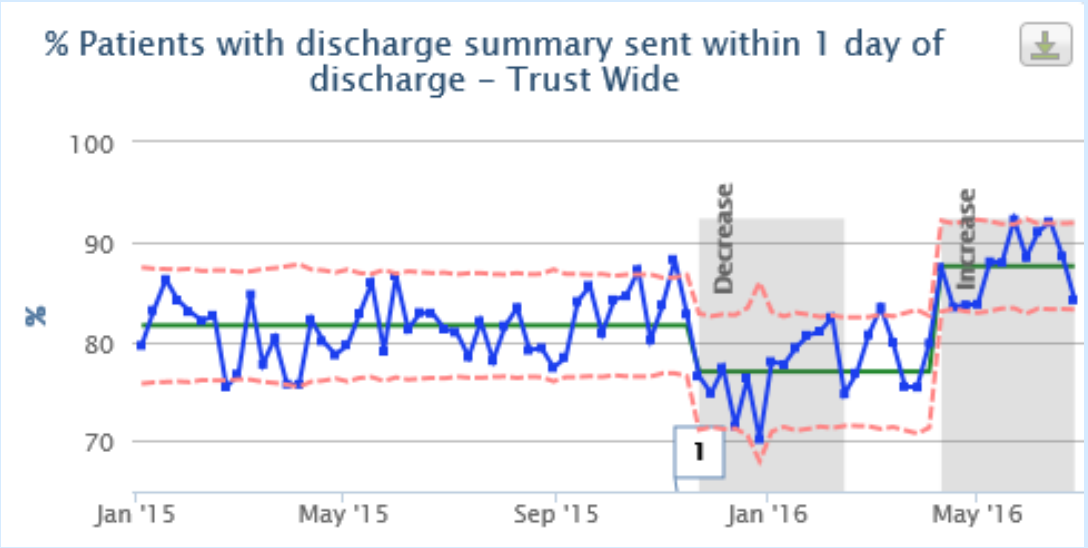
The compliance shown in the chart includes the wards that have not completed their audits; which lowers the %compliance. When these are excluded, compliance on wards who complete the audit is above 90%. The new Divisional structures will ensure there is an assurance process for monitoring that audits are complete.

CVL bundle compliance is discussed at every Divisional Infection Control meeting and at the Trust Infection Control meeting in order to remind staff to complete the data. Work is also underway to review the dashboards to ensure that the information is easy to locate and update.

Note that the data collected so far for June (incomplete as we're only part way through the month) indicates this may not be sustained although we saw the same last month and as data came in it was clear that it was also below the previous process mean.

Are our clinical systems and processes reliable? Discharge summary completion

Great Ormond Street Hospital for Children NHS Foundation Trust



Discharge Summaries

Do you have concerns about quality in this area?	**No concerns at this time**

Commentary:

The month of May 16 saw a significant improvement in performance overall with an increase of 6% more discharge letters being sent within 24hrs from the previous month. Recent data points are within the control limits indicating that performance has been sustained.

It is acknowledged that continued support is required at an operation level to increase awareness and improvement in performance. This is being undertaken via weekly reports and where applicable investigation into poor or deteriorating performance to understand challenges.
Discharge Summary Performance is included at specialty level within the new Divisional Performance Reports to be discussed at both Service Specialty and Divisional Performance Management Meetings. Action plans will be drawn up for failing areas, this work is to commence during June 16.
Work has been requested to include IPP patients to ensure full coverage of activity.

Clinical teams are being sent reminder emails 24 hours following the patients discharge if no letter has been produced. With escalation to Division Directors after 48 hours.

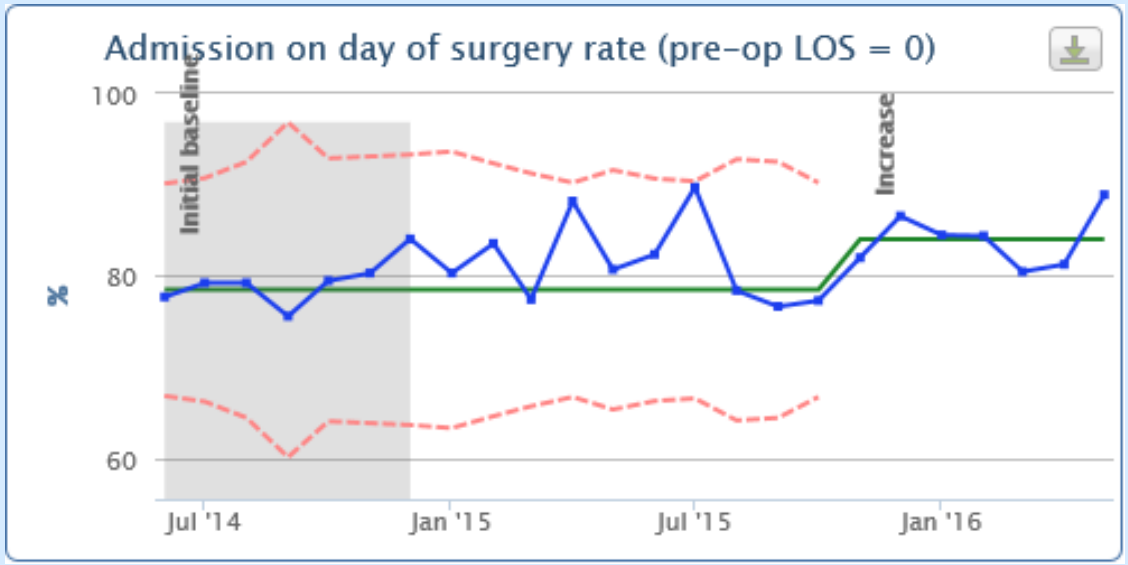
Are our clinical systems and processes reliable? Measures where we have no concerns

Great Ormond Street Hospital for Children NHS Foundation Trust

Measure	Comment
Pressure ulcer risk assessments	No special cause variation detected this month. The current process mean remains at 94%
Extravasation referrals to Plastics	No special cause variation detected this month. The current process mean is 12 per month

Are our clinical systems and processes reliable? Admission on the day of surgery

Great Ormond Street Hospital for Children NHS Foundation Trust



Admission of the day of surgery

Do you have concerns about quality in this area?	**No**

Commentary:

The IPP division has achieved an increase in 'Admission on the day of surgery'. The reasons are multifactorial and include :

1. Improved preadmission and treatment planning so that zero days, i.e. days when nothing happens e.g. waiting for treatment /scans etc. is significantly reduced
2. Better attention to discharge planning, although on-going work continues, which impacts bed capacity i.e.
   - Every patient has an EDD which is regularly reviewed and updated
   - TTO's/supplies/parental training procured in advance
3. Improved team working/communication which oils processes/encourages joined up working and improved efficiencies. This has been achieved through successful implementation of daily bed meeting/huddle at 9am, regular preadmission meetings the frequency has been recently reviewed and increased and the TOR updated and changes implemented, the Thursday afternoon MDT bed capacity meeting.
4. Additional weekend theatre lists/capacity as well as dedicated lists on a fortnightly basis (weeks 1,3 and 5) for Urology (which commenced on 30 July 2015) has maximised theatre capacity.

Are we delivering high quality care today? Measures where we have no concerns

Great Ormond Street Hospital for Children NHS Foundation Trust

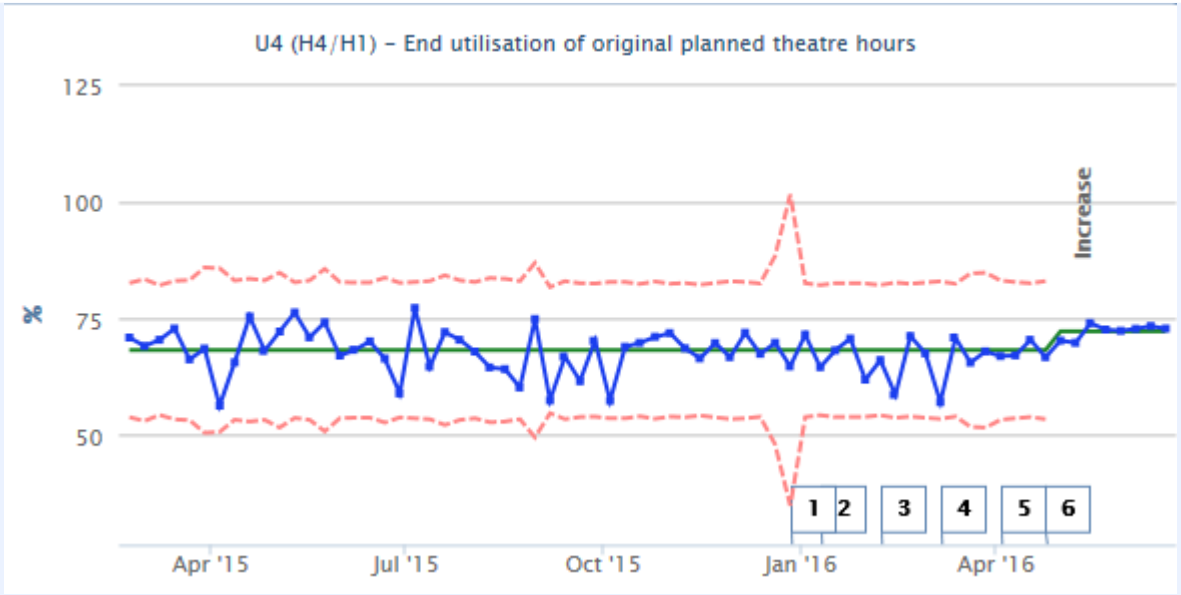
Measure	Comment
Delayed discharges	No change this month – the process mean remains at nearly 10 patients per month being delayed
All complaints	The process mean remains at about 11 complaints per month
Red complaints	The process mean remains at about 1 red complaint per month
Amber complaints	The process mean remains at about 2 complaints per month
Yellow complaints	The process mean remains at about 7 complaints per month
PALS contacts per 1000 adjusted patient days	No change – this is a very stable process at 18 contacts per 100 adjusted patient days
Friends and Families test – extremely likely/likely to recommend	The process mean remains at about 98% - but looks as though it is increasing. We'll know next month.
Friends and Families test – extremely unlikely/unlikely to recommend	The process mean remains at about 1%

Are we responding and improving?

(as of 05.07.2016)

Great Ormond Street Hospital for Children NHS Foundation Trust

Quality Improvement Measure of the Month- End utilisation of original planned theatre hours



Recent and on-going work conducted as part of the Elective Pathway Programme has seen an increase in mean **theatre utilisation for the old surgery division**, from a mean level of 68% to a new mean of **72%.**

Well done and a big thank you to the clinical, management and administrative staff whose hard work and dedication to patient care has made this happen.

This increase in utilisation should mean that we are able to treat more patients and therefore keep patient waiting times to a minimum.

Are we responding and improving?

Learning from Friends and Family Test

Great Ormond Street Hospital for Children NHS Foundation Trust

May Inpatients Results:
Overall FFT Response Rate = 27.52%
Overall Percentage to Recommend = 98.3%

May Outpatients Results:

Overall Percentage to Recommend = 96.2%

In May, the top positive themes are Staff Behaviour, Care and Welcoming. The bottom 3 are Environment/Infrastructure, Admission/Discharge, Catering and Staff Behaviours. Included here are example comments from May's FFT.

"At this difficult time we couldn't fault our experience here! staff were so lovely and helpful happy to help with whatever and at any time. (patient name) was truly in the best hands and care."

"I would recommend this ward highly because everyone is so friendly, kind and caring it makes you feel very comfortable."

"Firstly, I hope I never have to recommend a ward to anyone but all the staff have been excellent. Our daughter has been well cared for and we were kept well informed at all times. We are very grateful to all the staff for everything they have done."

"(Staff name) the hearing lady was amazing & so patient with (patient name). (names of 2 staff) are welcoming as usual & (staff name) - what can I say "an amazing team!" Hopefully (staff name) will go far."

"Came for assessment and service was amazing, so professional, caring, efficient, informative and skilled to unpick a very complex child. Certainly recommend care to others - hopefully they'll be lucky enough to get here as it can be hard to get referrals. Fantastic service, we are very grateful.

"I was dealt with in a polite, patient and courteous manner. I had information given to me in a clear way and all my questions were answered. My concerns were listened to, acknowledged and addressed appropriately. Thank you."

"No proper shower facilities for patients/parents. One bath for whole ward which was out of use. No safe storage of patients own medications! "

"The only issue is that on every occasion we have been on this ward we end up spending a long period of time before receiving care/treatment"

"Some of the food wasn't very nice."

"Poor attitude from some nursing staff - arrogant and unapproachable."

"Slow service. Staff chatting between themselves while I was being served. I felt like I was interrupting them. Numbers were not changed in waiting area even when there was no-one in the reimbursement team."

"Everyone always helpful when having to find anything out, but only when we asked! We visit every 4 weeks and constantly find that we have to wait for over an hour to be seen. Plus when have a procedure the delays are even long with no explanation coming from staff."

"Had to wait for a long time on uncomfortable chairs before my appt. Nearly an hour wait + I had to travel to get here."

Attachment F

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 20 July 2016	
Integrated Performance Report: May / June 2016 **Submitted by:** Nicola Grinstead, Deputy Chief Executive	**Paper No: Attachment F**
Aims / summary The new revised Trust Integrated Performance Report (IPR) is designed to focus on the key areas/ domains in like with the CQC, in order to be assured that our services are delivering to the level our patients and families, Trust Board and our commissioners and regulators expect. The indicators included are those that have been recommended by the Trust Board, Clinical Divisions and other relevant parties. It is expected that these will evolve and iterate overtime. The report for the Trust Board this month includes data up until the end of May 2016 for the most part. The date for the Board this month falls too early for the papers to have included updates for indicators and measures for June, as per national submission deadlines. Where possible verbal updates at the Board will be provide as more finalised updates are known. The narrative provides provide more detail / analysis from the IPR of those indicators not meeting the required standards or where they warrant further mention.	
Action required from the meeting Board members to note and agree on actions where necessary	
Contribution to the delivery of NHS Foundation Trust strategies and plans All the indicators within the IPR contribute to the delivery of either regulatory or commissioner requirements, and as such are aligned to the objectives and strategy of the Trust	
Financial implications For indicators that have a contractual consequence there could be financial implications for under-delivery	
Who needs to be told about any decision? Where appropriate and applicable: Internal stakeholders, NHS Improvement and NHS England Special Services Commissioners	
Who is responsible for implementing the proposals / project and anticipated timescales? Each Domain / Section has a nominated Executive Lead	
Who is accountable for the implementation of the proposal / project? As above	

Great Ormond Street Hospital for Children NHS Foundation Trust

July 2016 – Trust Board - Public: Integrated Performance Report Narrative

The new revised Trust Integrated Performance Report (IPR) is designed to focus on the key areas/ domains below, in order to be assured that our services are delivering to the level our patients & families, Trust Board and our commissioners & regulators expect.

The domains are consistent with the Care Quality Commission and cover:

- Caring
- Safe
- Responsive
- Well-led
- Effective

The IPR additional includes further indicators and metrics with regard to Our Money (Finance) and Productivity. These indicators are those that have been recommended by the Trust Board, Clinical Divisions and other relevant parties. It is expected that these will evolve and iterate overtime.

Summary

The report for the Trust Board this month includes data up until the end of May 2016. The date for the Board this month falls too early for the papers to have included updates for indicators and measures for June, as per national submission deadlines. Where possible verbal updates at the Board will be provide as more finalised updates are known.

Headlines for those areas which are achievements, concerns and key lines of enquiry for the reporting period are highlighted on the IPR. The key lines of enquiry section will develop month on month and will be driven to some extent by the monthly Trust Divisional Performance Meetings.

The following sections of the report provide more detail / analysis from the IPR of those indicators not meeting the required standards or where they warrant further mention.

Caring

Indications support the Trust as being caring and providing a good level of care to our patients. However there are areas for focus and improvement for forth coming months – these are highlighted below by exception:

Friends and Family Test (FFT) – see Dashboard for the current position	
Definition:	A feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming NHS services and supporting patient choice
What:	Whilst the % of response that are positive remains high (above the national 95% standard) for inpatients, the Trust must improve upon its current response rate (averaging around 26-27% - which is however in line with national response rates of other Trusts)

Why / How:	The current response rate is hampered to some extent for inpatients by the frequent attendance nature of a number of our patients and families for whom repeatedly responding to this survey is challenging. The patient experience team continue to assess how best this can be resolved. Work continues with our ward staff to ensure all efforts are made to improve engagement and uptake of the overall rate

Complaints	
Definition:	This indicator provides the total number of formal complaints received by the Trust during the reporting period
What:	In May the Trust saw an increase in the number of complaints, from the previous 2 months, taking the YTD to 18
Why / How:	The number of complaints should not necessarily be viewed as a negative, as it is imperative we are able to empower our patients and families to raise issues with their experiences at the Trust. The key dynamic and one which will be built into the future reporting is the timeliness of response and the Trust acting on themes that emerge. The Quality and Safety reports will address this in more detail This IPR will track progress and the actions being undertaken from the learning in order to see improvements in the relevant parts of the Trust

Safe

There are no particular concerns under the safe domain this month. C Difficile is within the agreed volume of reportable cases year to date. Up to May 2016, the Trust has not reported a Never Events. With regard to Serious Incidents, 2 have been reported up until May 2016 and are being investigated in line with the Trust's policy.

In future iterations of the IPR it will complement the Quality and Safety report, showing time lapses between Serious Incidents raised and closed, and the duration between the last reported Never Event.

CV Line infection rates per 1000 have seen a decrease in May from the previous month.

Responsive

Whilst the Trust remains off line with regard to reporting on Referral to Treatment Times (RTT), it remains on course with the agreed Access Improvement Programme, and submitted recovery trajectory.

Diagnostic: Patients waiting	
Definition:	The percentage of patients waiting greater than 6 Weeks for a Diagnostic Test at the given month end census date based on the Nationally defined basket of 15 ket diagnostic tests / procedures The national standard is 1% can be waiting > 6 weeks
What:	For May the reported position was 10.97% against the 1% standard. Whilst this is not a

	good position for the Trust to be reporting, this is in line with (and in fact a little ahead) of the submitted recovery the Trust had to make for this standard. The recovery trajectory has the Trust delivering the standard from end of September into October.
Why / How:	Operational teams have recovery plans for each of the modalities to ensure that the trajectory is attained each month. With the standard only having a 1% tolerance, and with some of the capacity limitations within the Trust in some areas, there is limited flexibility within the recovery plans. These are reviewed operationally on a frequent on-going basis.

Cancer – 31 Day: Decision to Treat to Subsequent Treatment - Surgery	
Definition:	The percentage of patients receiving subsequent treatment of surgery for new cases of primary or recurrent cancer within 31 Days The national standard is 94% of patients must be treated within 31 days on a subsequent surgical pathway. The Trust is performance managed on a quarterly basis, and at this time the June position has yet to be confirmed and submitted.
What:	For May 2016 the reported position is 90%, as a consequence of one breach. This reflects the fragility of this standard, as one pathway can result in not achieving the standard for the month.
Why / How:	The breach was as a result of a number of complications along the pathway which are being picked up operational to reduce them reoccurring in the future.

Well-led

At a headline level under Well-led the Trust is showing very positive areas of performance for which these should be noted (and are visible on the IPR with by their green trend arrows). There are though areas by exception which do require comment (as below).

Turnover (Total & Voluntary)	
Definition / What:	Turnover is reported as voluntary turnover in addition to the standard total turnover. Voluntary turnover at May is at 17.5% (a 0.3% increase from April 2016); this reported value excludes non-voluntary forms of leavers (e.g. dismissals, TUPE, fixed-term and redundancies). Total (voluntary and non-voluntary) turnover has increased marginally from April to 19.8% (by 0.1%) Both of which exceed the Trust plan / target
Why / How:	Across the Trust there is high turnover with many corporate areas over 20% Trust wide retention surveys are being devised to identify areas for improvement

	All leavers are 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 corporate areas A new exit survey has been launched utilising survey monkey and monthly/quarterly (dependent on the number of responses) reports will be produced for the divisions on the information collated.

Mandatory Training	
Definition / What:	At an aggregate level for all statutory and mandatory training in May the Trust was at 83.6% against a plan of 95%
Why / How:	Compliance rates range from 74% to 95%. Organisationally there is only one department / division achieving the Trust's plan of 95% (HR & OD). Actions being undertaken to address this include: increased visibility through Learning Management System (LMS), Learning and Development & ER team will work with managers to identify those who are non-compliant and further developments to LMS to support employees ensure compliance

Agency Spend	
Definition / What:	As at May 2016, this stood at 3.7% of total paybill. NHS Improvement have set an agency spend ceiling for all Trusts (3% for GOSH).
Why / How:	The significant spend on agency staff (as percentage of paybill) is largely driven by the investment of validators to support the Access Improvement work and also a number of senior interims in the organisation. Trust spend on business as usual (BAU) agency staff is significantly below the ceiling.

Effective

Predicated on the top level indicators associated with the Trust demonstrating it is an effective organisations, at present the evidence and performance would suggest there remains room for improvement.

Discharge Summaries	
Definition:	This measures compliance with the requirement to issue a Discharge Summary within 24 hours following discharge to the Service User's GP and/or Referrer and to any third party provider
What:	The Trust is seeing a significant improvement in this area, with the most recent month at 88.37%
Why / How:	This is being achieved with focused resource in this area, to ensure consistent systems, processes and checks are happening in all areas (using a combination of enhanced reporting, escalation to clinical leads etc). Areas where this remains an issue will be picked up via the Divisional Performance Reviews and specific action plans with deliverables required.

Clinic Letter Turnaround	
Definition:	The % of clinic letters that are sent within 7 days of the Outpatient Clinic The contractual requirement for 2016/17 is 14 days turnaround, however the guidance is clear this will be significantly reduced from 17/18. This is also potentially the content of a CQUIN
What:	The Trust is currently reporting 40.49% of clinic letters being completed with 7 days of the clinic appointment. This is broadly in line with the last 3 months, with the % fluctuating slightly month on month.
Why / How:	This area is one that is being looked into across the Trust, with specific areas and / or actions being put in to improve this position. For future month reporting the analysis will show against 14 days and then 7 - 10 day turnaround (whichever is in line with the finalised CQUIN).

Our Money

This section of the IPR includes an up to date position inclusive of June 2016 (M3). In line with the figures presented, the Trust deficit is £1.0m lower than planned for this reporting period. This is a a result of a combination of factors including:

- Clinical Income (exc International Private Patients) is £0.3m better that planned after adjusting for £1m reduction in income relating to 2015/16 outturn
- International Private Patients income is £2.0m higher than planned
- Staff costs are in line with budget at the end of month 3.

Areas of concern at this point include the Trust include:

- Non pay costs being are higher than planned on Blood and Drugs and other clincial supplies which is being driven by higher than planned clincial activity (£0.4m)
- Current delivery of recurrent P&E savings is lower than planned year to date (£1m)
- IPP Debtor days have increased in June due to the increased activity through International Private Patients.

Actions being taken to address these concerns are:

- IPP have drafted a revised debtors escalation policy for approval which identifies potential triggers for bad debt review
- The PMO and Finance teams are currently working with all clinical and non-clinical divisions / departments to monitor progress against current P&E savings schemes and to support the identification and implementation of additional schemes required to close the current gap in savings.

Productivity

This section is under development and will be iterative over the course of the next couple of months.

Trust Board Dashboard - May 2016

Great Ormond Street Hospital for Children NHS Foundation Trust

Caring

	Mar	Apr	May	Trend	Plan	NHS Standard
Access to Healthcare for people with Learning Disability					-	-
% Positive Response Friends & Family Test: Inpatients	99.73%	97.15%	98.32%	↑		>95%
Response Rate Friends & Family Test: Inpatients	26.40%	33.35%	32.36%	↓	40%	
% Positive Response Friends & Family Test: Outpatients	98.27%	95.50%	96.20%	↑		>95%
Number of Complaints	8	4	14	↑		
Number of Complaints -Red Grade	0	0	0	→		
Mental Health Identifiers: Data Completeness	98.4%	98.5%	98.2%	↓		97%

Safe

	Mar	Apr	May	Trend	Plan	NHS Standard
Serious Patient Safety Incidents	0	1	1	→		
Never Events	0	0	0	→		0
Incidents of C. Difficile	0	1	0	↓		1
C.Difficile due to Lapses of Care	0	0	0	→		1
Incidents of MRSA	0	0	0	→		0
CV Line Infection Rate (per 1,000 line days)	1.31	2.47	1.13	↓		

Responsive

	Mar	Apr	May	Trend	Plan	NHS Standard
Diagnostics: Patients Waiting >6 Weeks		19.22%	10.97%	↓		1%
Cancer 31 Day: Decision to Treat to First Treatment	100%	100%	100%	→		96%
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Surgery	100%	100%	90%	↓		94%
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Drugs	100%	100%	100%	→		98%
Last Minute Non-Clinical Hospital Cancelled Operations		Quarterly report				
Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard		Quarterly report				

People, Management & Culture: Well-Led

		March	April	May	Trend	Plan	NHS Standard
Sickness Rate		2.64%	2.57%	2.41%	↓	3%	
Turnover	Total	19.7%	19.7%	19.8%	↑	18%	
	Voluntary	17.3%	17.2%	17.5%	↑	14%	
Appraisal Rate		71%	73%	73%	→	95%	
Mandatory Training			79.3%	83.6%	↑	95%	
% Staff Recommending the Trust as a Place to Work: Friends & Family Test		74%				61%	
Vacancy Rate		4%		8%	↑	10%	
Bank Spend			7.1%	5.7%	↓		
Agency Spend		3.4%	2.9%	3.7%	↑	2%	

Effective

	March	April	May	Trend	Plan	NHS Standard
Discharge Summary Turnaround within 24hrs	80.31%	82.08%	88.32%	↑		100%
Clinic Letter Turnaround within 7 Working Days	40.05%	41.92%	40.49%	↓		
Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)	7.19%	7.62%	7.76%	↑	8.36%	

Productivity

	March	April	May	Trend	Plan	NHS Standard
Theatre Utilisation (NHS UO4)	62.0%	64.1%	67.6%	↑		
Clinic Utilisation						
Bed Occupancy						
Hospital Cancelled Appointments						
Activity v Outturn						

Our Money

	April	May	June	Trend	YTD Target	Variance
Net Surplus/(Deficit) v Plan	(0.8)	(0.4)	(0.6)	↓	(2.8)	1.0
Forecast Outturn v Plan	(9.5)	(6.3)	(6.3)	→	(6.3)	0.0
P&E Delivery	0.3	0.3	0.3	→	1.9	(1.0)
Pay Worked WTE Variance to Plan	43.0	(18.0)	24.0	↑	0.0	24.0
Debtor Days (IPP)	203.1	186.5	191.7	↓	120.0	(71.7)
Quick Ratio (Liquidity)	1.85	1.86	1.80	↓	1.50	0.30
NHS KPI Metrics	2.0	2.0	4.0	↑	3.0	1.0

Areas of Concern

FFT Response Rate
Increase in Complaints
Access Standards
Turnover Rate
Mandatory Training
Agency Spend
P&E Recurrent Delivery
IPP Debt

Achievements

On going progress with regard to the Access Improvement Programme (training, SOPs, Validation, recovery trajectories)
Trust deficit is £1m lower than planned for the reporting period
Trust remains within expected level for HCAIs
Significant improvement in Discharge Summaries sent within 24hrs
Trust sickness rate below planned levels
Improvements seen in Mandatory Training performance

Key Lines of Enquiry

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **20th July 2016**	
Workforce Metrics & Exception Reporting – June 2016 **Submitted by:** Ali Mohammed, Director of HR & OD	**Paper No: Attachment G**
Aims / summary This report provides an updated position of a number of workforce metrics, together with a summary of interventions for those areas of concern.	
Action required from the meeting To note the content of the report.	
Contribution to the delivery of NHS Foundation Trust strategies and plans	
Financial implications The report details metrics on a number of areas which have a direct and indirect financial implication; these include absence (sickness) and the percentage of the total paybill spent on agency usage; the report shows that both of these areas have reduced from the previous month.	
Who needs to be told about any decision? Not applicable.	
Who is responsible for implementing the proposals / project and anticipated timescales? Divisional management teams; supported by members of the HR & OD team.	
Who is accountable for the implementation of the proposal / project? Divisional management teams.	

Great Ormond Street Hospital for Children NHS Foundation Trust

HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT

TRUST BOARD WORKFORCE METRICS & EXCEPTION REPORTING – JUNE 2016

Introduction

This suite of workforce reports includes:

- Voluntary turnover and total turnover;
- Sickness absence;
- Vacancy rates;
- PDR appraisal rates;
- Statutory & Mandatory training compliance;
- 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 increased its contractual FTE (full-time equivalent) figure by 11 in June to 3896 compared to May 2016.

Sickness absence has decreased slightly to 2.34% (from 2.46%) and remains below the London average figure of 2.8%. Short-term sickness (STS) (episodes of sickness up to 4-weeks) has not changed across the Trust at 1.26% whilst long-term sickness has remained at 1.08%.

Turnover is reported as voluntary turnover in addition to the standard total turnover. Voluntary turnover currently stands at 17.0% (a 0.5% decrease from May 2016); this reported value excludes non-voluntary forms of leavers (e.g. dismissals, TUPE, fixed-term and redundancies). Total (voluntary and non-voluntary) turnover has decreased to 19.3% in June (-0.5% from May). The (unadjusted) London benchmark figure is 15.1% (which includes voluntary and non-voluntary leavers).

Unfilled vacancy rate: The Trust's unfilled vacancy rate stands at 5.6% (decrease of 2.4% compared to May).

Agency usage for 2016/17 (year to date) stands at 3.7% of total paybill. The significant spend on agency staff (as percentage of paybill) is largely driven by the investment of validators to support the RTT improvement work and also a number of senior interims in the organisation. NHS Improvement have set an agency spend ceiling for all Trusts (3% for GOSH, £6.525 million). The Trust is currently exceeding the agency ceiling for June due to RTT and the gastro review; however, Trust spend on business as usual (BAU) agency staff is significantly below the ceiling. The Trust also reports on the number of breaches

against the agency rules (spend cap by shift and/or framework compliance and direct engagements); in June, 88 shifts (down from 152 shifts in May) breached the agency cap. New charts have been included to monitor both the agency spend ceiling and shift breaches per month. Clinical Operations (including ICT) retains the highest spend on agency staff at 68% of total paybill (RTT and senior interims). Finance currently spends 27.5% of paybill on agency staff.

Agency Measure	Spend YtD (June 2016)	Shifts breaching agency cap
RTT agency staff	*£873k*	*0*
Gastro review agency staff	*£163k*	*8*
Business as usual agency staff	*£1,126k*	*80*
Total agency staff	*£2,163k*	88
Agency ceiling	*£1,631k*	

PDR completion rates The Trust overall appraisal rate stands at 73% - unchanged since May. Currently two areas are meeting the target of 95%, Human Resources & Organisational Development (at 95%) and International (at 96%).

Statutory & Mandatory training compliance: In June the compliance across the Trust increased by 1%. Currently three directorates/divisions are meeting the 90% compliance requirement, Human Resource & Organisational Development, Research & Innovation and International. The 90% target is to reflect the ongoing organisational changes and the current challenges with a target of 95% for 2017/18.

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 - JUNE 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%)	**Statutory & Mandatory Training Compliance (%)** (target 90%)	**Vacancy Rate (%, FTE)** (Unfilled vacancies, 0-10% green)	**Agency (as % of total paybill, £)** (Max 0.5% Corporate, 2% Clinical)
West Division	1581	17.2% (245.3)	19.4% (275.8)	2.3	70.0%	81.0%	4.6%	1.4%
Barrie Division	1600	16.3% (225.7)	19.0% (264.0)	2.1	74.0%	81.0%	4.2%	1.3%
International Division	171	19.2% (30.3)	20.4% (32.3)	3.6	96.0%	90.0%	26.1%	0.0%
Corporate Affairs	9	11.5% (1.0)	11.5% (1.0)	1.6	88.0%	85.0%	0.0%	5.9%
Clinical Operations	83	6.6% (4.9)	6.6% (4.9)	3.3	42.0%	82.0%	10.0%	68.7%
Human Resources & OD	76	32.5% (25.6)	35.5% (28.0)	4.1	95.0%	95.0%	14.3%	1.5%
Nursing & Patient Experience	72	14.6% (9.3)	17.1% (10.9)	1.2	72.0%	85.0%	0.0%	0.0%
Medical Directorate	34	29.7% (10.9)	29.7% (10.9)	0.9	50.0%	83.0%	26.8%	0.0%
Finance	53	27.0% (14.0)	30.8% (16.0)	2.7	66.0%	89.0%	2.2%	27.5%
Development & Property Services	131	9.1% (11.2)	13.1% (16.2)	3.4	78.0%	74.0%	12.1%	9.7%
Research & Innovation	86	16.6% (14.0)	17.9% (15.0)	2.0	88.0%	90.0%	19.5%	0.0%
Trust	3896	**17.0%▼ (594.2)**	**19.3%▼ (676.0)**	**2.3%▼**	**73.0%►**	**84.0% ▲**	**5.6%▼**	**3.7%►**

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

Highlights & Actions

Vacancy Rate	
Comments	Actions
• High vacancy rate within Internation (26%) and Medical Directorate (26%)	• Recruitment Advisors will be attending regular meetings with Ward Sisters to identify vacancies, offering support on filling those vacancies • ER Team working with Barrie Division and Workforce Intelligence to identify vacancies to support with recruitment strategies.

Sickness Rate	
Comments	Actions
• Three other divisions have sickness percentages over the threshold – Clinical Operations, Development & Property Services and International • HR&OD has a high percentage due to a number of long term sickness over the last twelve months (5 cases), the majority of which have returned to work	• IPP - Drop in sessions ran for managers in IPP to discuss employees with sickness concerns. This is predominantly made up of short term sickness as they have a very low long sickness rate. • Development & Property Services – 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. • HR&OD – Long term sickness cases are driving high sickness rates, these are being managed in line with policy

Agency Spend	
Comments	Actions
• Finance high agency spend at 27% due to senior interims covering post/project. • Clinical Operations has continued high agency spend mainly due to RTT Project resourcing and the Gastro review (68% of paybill). .	• On-going recruitment to posts within finance

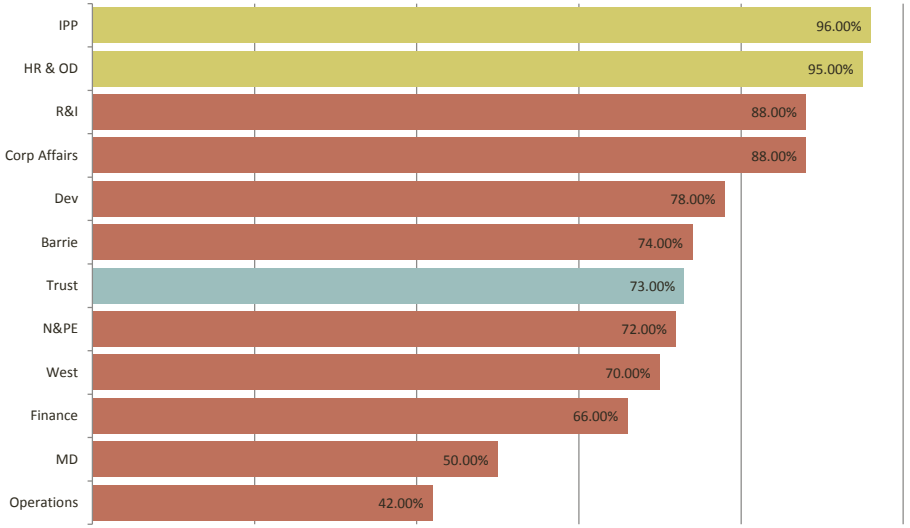
Voluntary Turnover Rate	
Comments	Actions
• Across the Trust there is high turnover with **many corporate areas** over 20%	• There has been a significant amount of work undertaken over the past few months to better understand the broader turnover position - with specific focus on areas of low stability and high turnover. Whilst this is work in progress, there have been developments in also understanding the reasons why people leave and where they go. In addition, the work around nurse recruitment and retention is now a focused project under the Nursing Workforce Board.

PDR Completion	
Comments	Actions
• Completion rates range from 42% to 96%. Two divisions are compliant (International & HR&OD) with the rest of the Trust below 90%.	• PDRs now to be managed through the LMS system which will give managers greater visibility of the outstanding appraisals due.

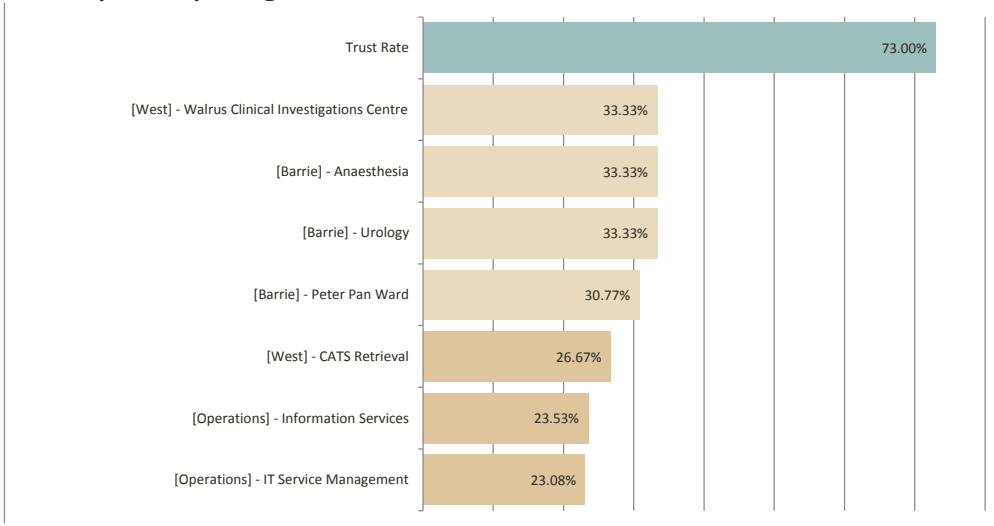
Statutory & Mandatory Training Compliance	
Comments	Actions
• Compliance rates range from 74% to 95%. Only one directorate is currently meeting target compliance HR&OD.	• More visibility through LMS • Learning and Development & ER team will work with managers to identify those who are non-compliant including further developments to the new LMS

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

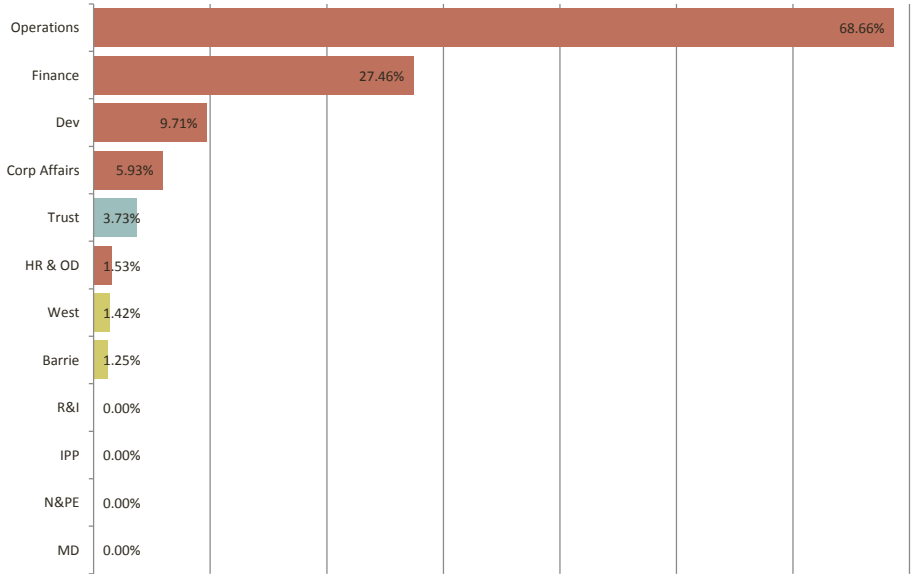
Divisional PDR (Target 95%)



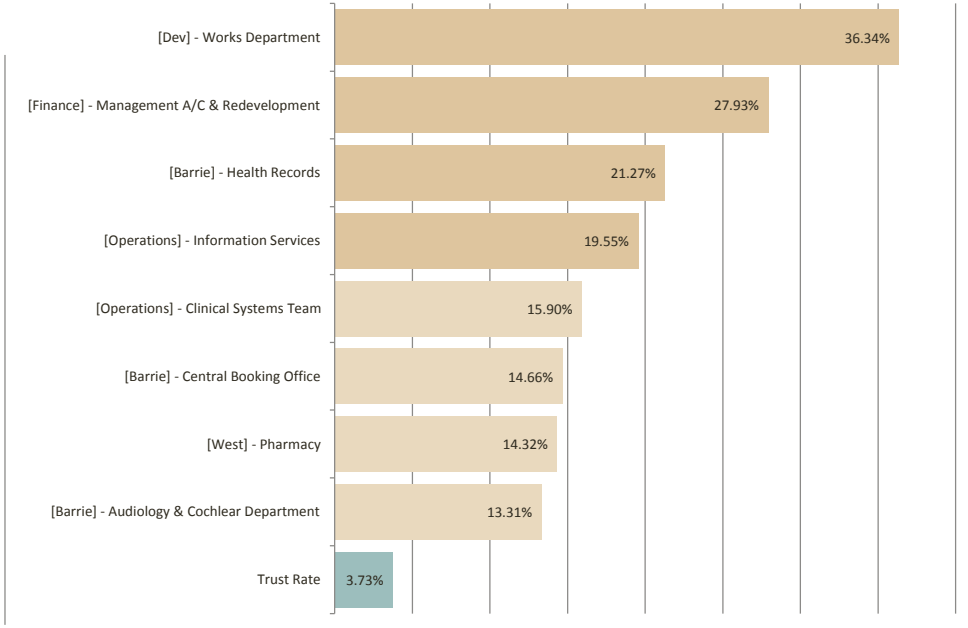
Exception Reporting PDR



Divisional Agency as % of paybill

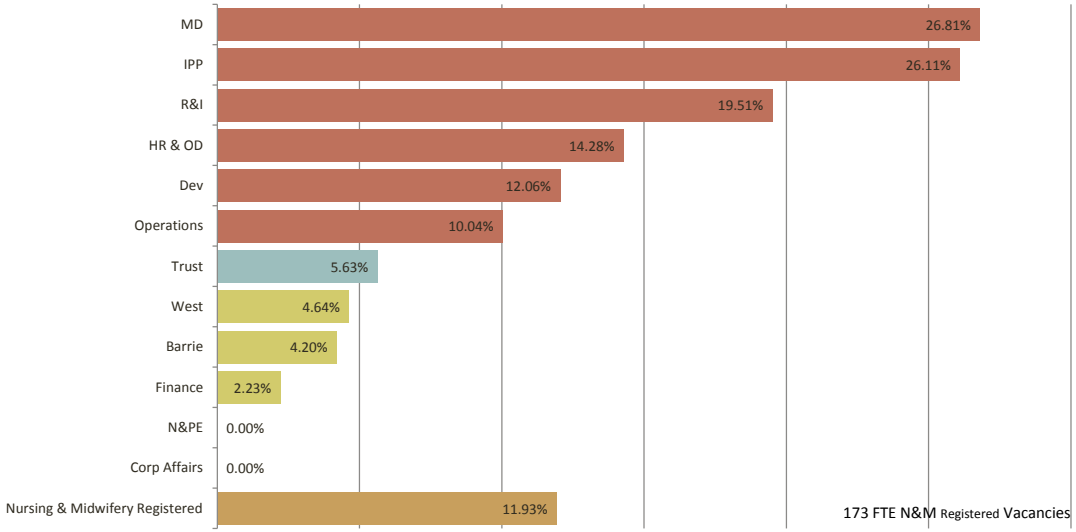


Exception Reporting Agency as % of Paybill

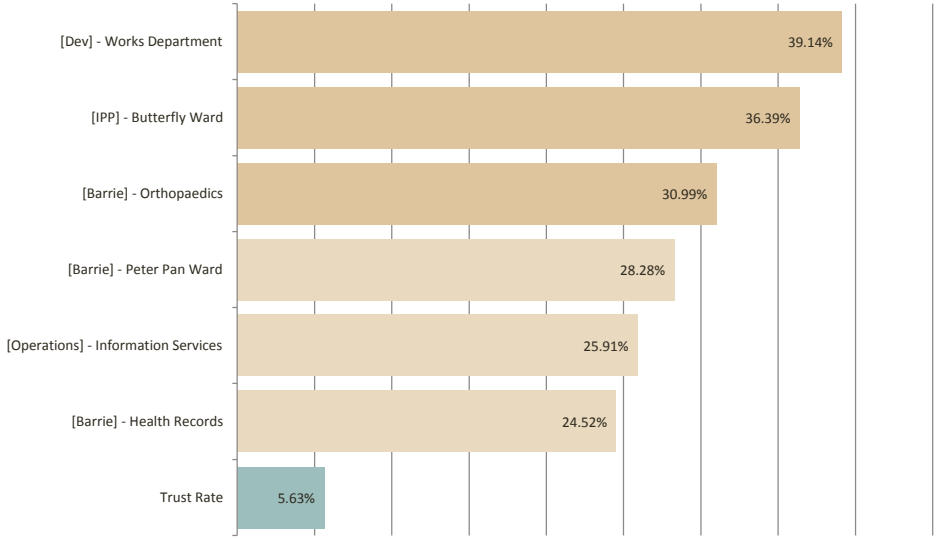


HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - JUNE 2016 REPORT

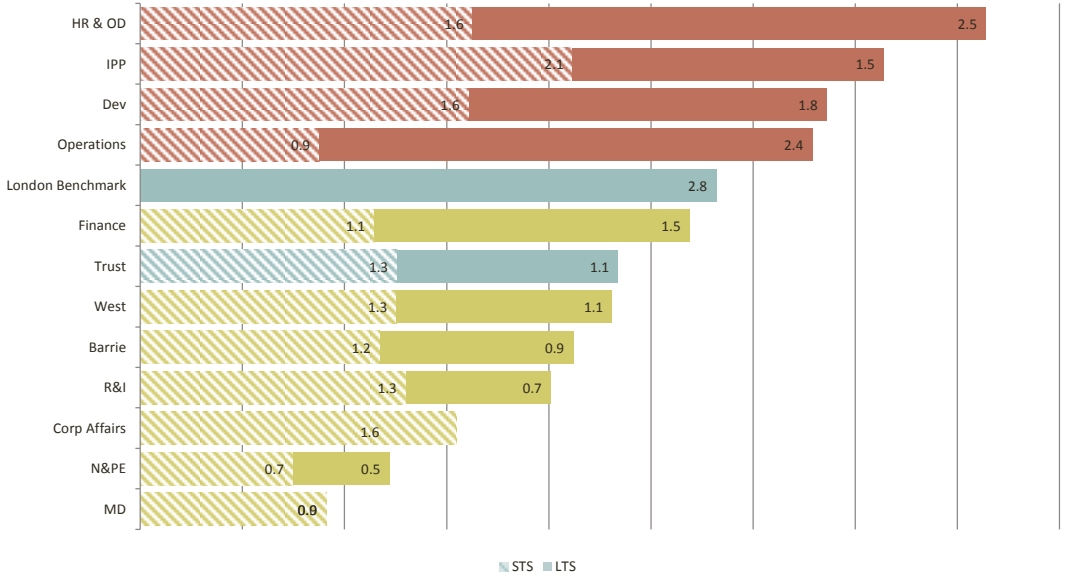
Divisional Vacancy Rate



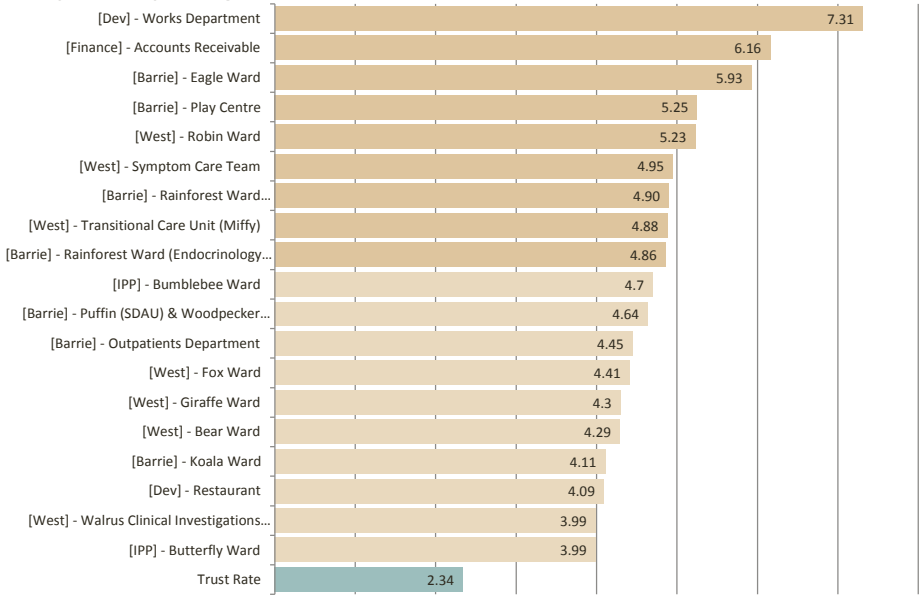
Exception Reporting Vacancy Rate



Divisional Sickness

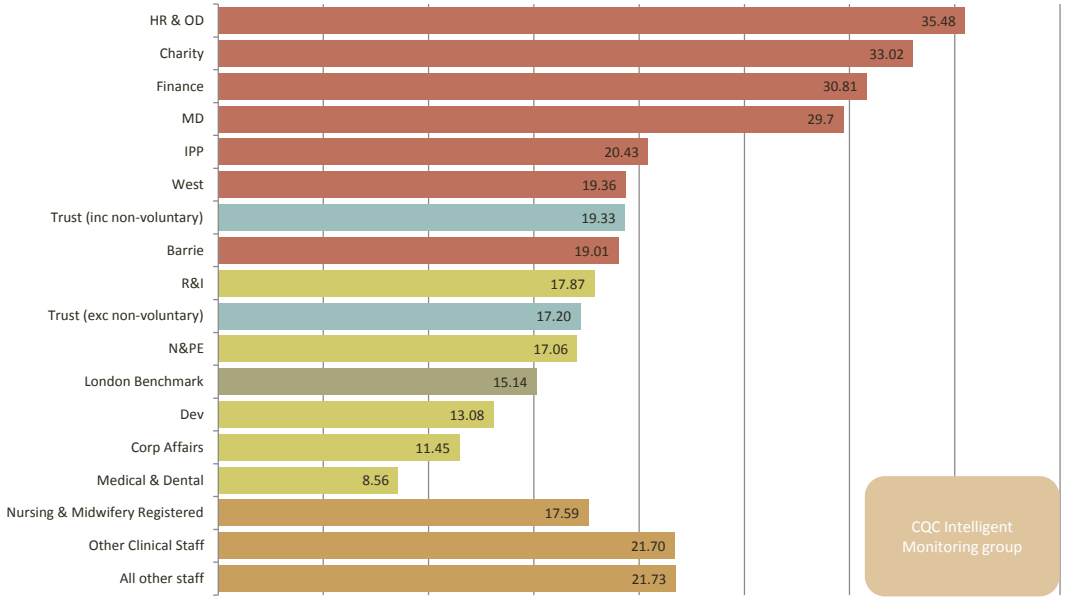


Exception Reporting Sickness

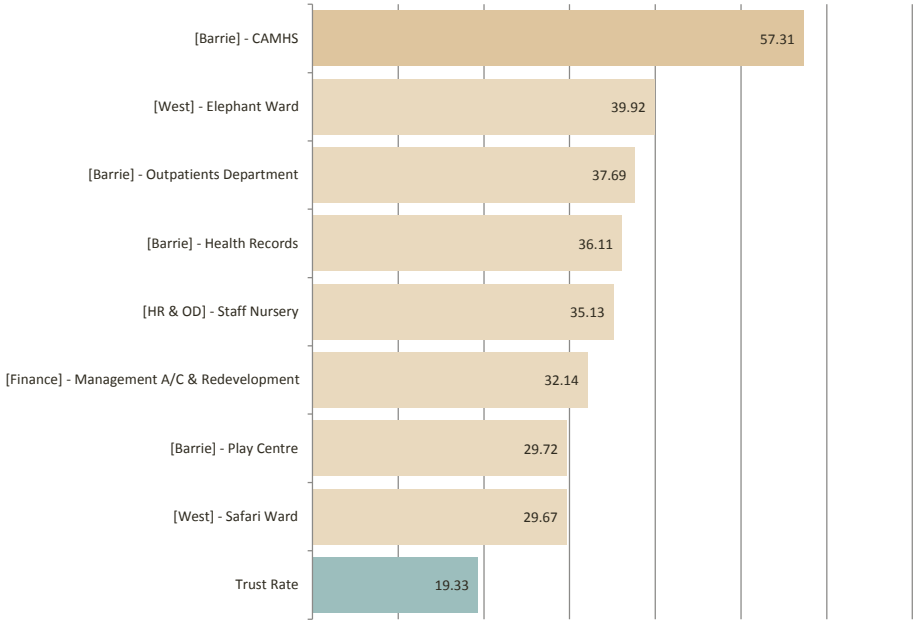


HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - JUNE 2016 REPORT

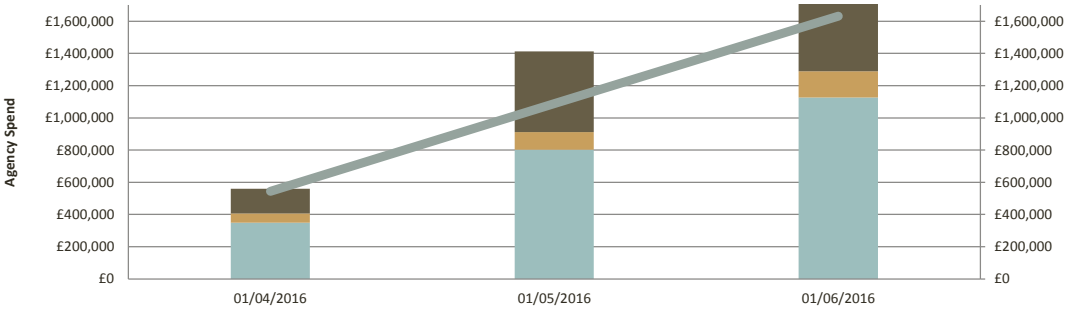
Divisional Turnover (Voluntary & Non-Voluntary)



Exception Reporting Turnover

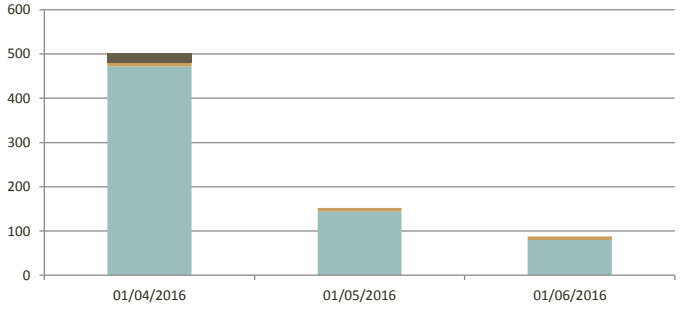


Agency Spend Ceiling (NHS Improvement Directive, Cumulative)



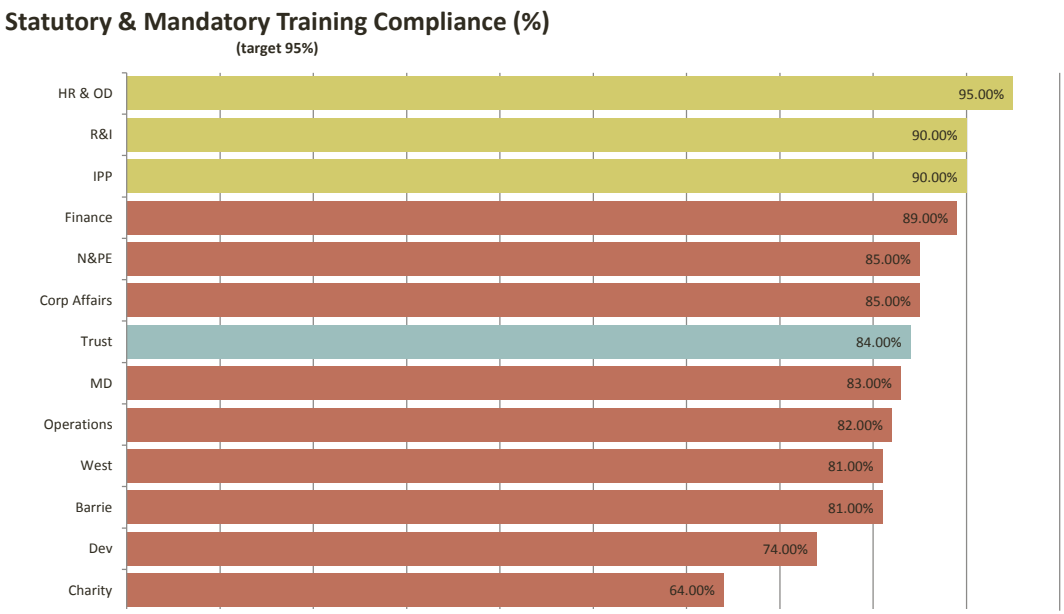
	30/04/2016	31/05/2016	30/06/2016
RTT	£153,012	£499,693	£873,238
Gastro Review	£57,040	£110,080	£163,120
Agency BAU	£349,203	£802,378	£1,126,514
Agency Ceiling	£543,750	£1,087,500	£1,631,250

NHS Improvement Agency Rule Breaches (shifts per month, target zero)

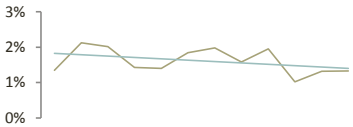
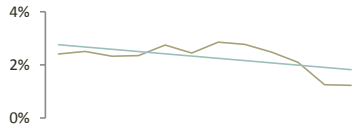
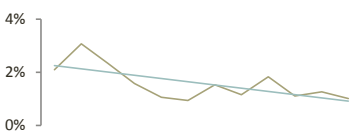
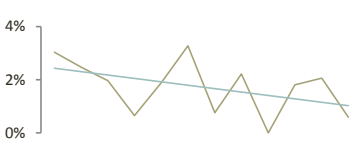
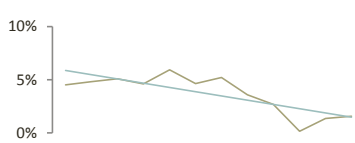
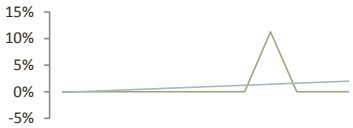
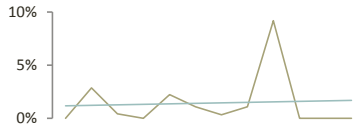
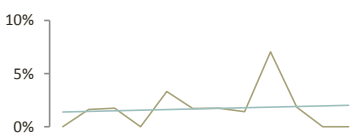
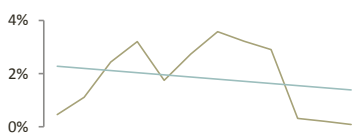
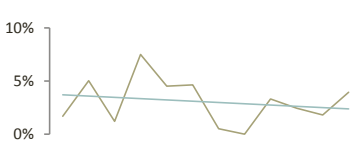
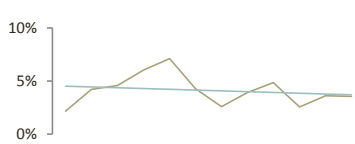
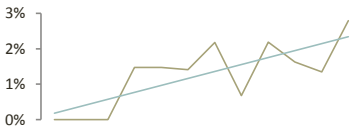
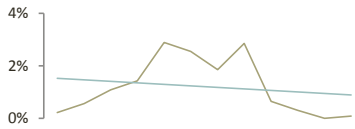
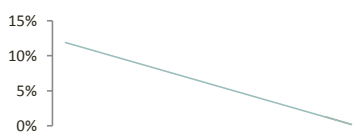
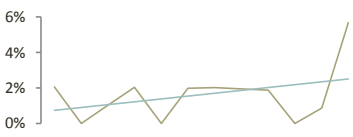
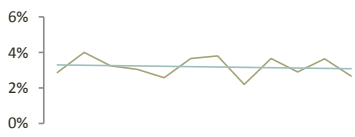
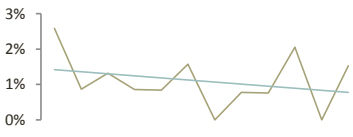
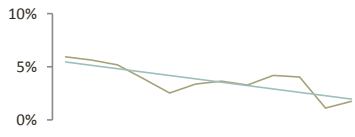
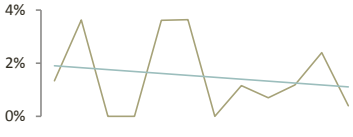
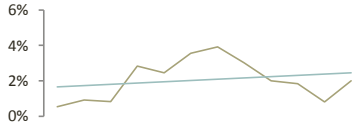
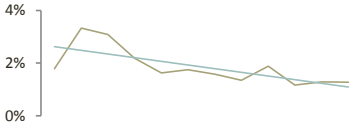
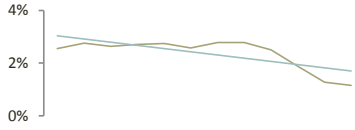


	30/04/2016	31/05/2016	30/06/2016
Shifts breached per month RTT	21	0	0
Shifts breached per month Gastro Review	9	8	8
Shifts breached per month BAU	472	144	80

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



HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - JUNE 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
West Division	19.4% (275.8)		2.3	
Barrie Division	19.0% (264.0)		2.1	
International Division	20.4% (32.3)		3.6	
Corporate Affairs	11.5% (1.0)		1.6	
Clinical Operations	6.6% (4.9)		3.3	
Human Resources & OD	35.5% (28.0)		4.1	
Nursing & Patient Experience	17.1% (10.9)		1.2	
Medical Directorate	29.7% (10.9)		0.9	
Finance	30.8% (16.0)		2.7	
Development & Property Services	13.1% (16.2)		3.4	
Research & Innovation	17.9% (15.0)		2.0	
Trust	**19.3% (676.0)**		**2.3**	

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.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 20 July 2016	
2016/17 Finance Report – Month 3 **Submitted by:** **Loretta Seamer, Chief Finance Officer**	**Paper No: Attachment H**

Purpose

The purpose of this paper is to update the Board on progress at month 3 against the Trust financial plan for 2016/17.

Update on Control Total 16/17

The initial Trust Financial Plan for 2016/17, agreed earlier in the year, established a forecast outturn deficit of £9.5m. In arriving at this deficit the Trust was unable to meet the requirements set by NHS Improvement to access the Sustainability and Transformation Fund (STF) of £2.4m, which would have required the Trust to meet an outturn control total of £4.8m deficit (excluding capital donations and impairments).

NHS Improvement issued a revised control total offer to all Trusts who had not accepted their original offer on 9 June 2016. The revised control total for GOSH was £6.3m deficit (excluding capital donations and impairments). Agreement to this allowed the Trust to access the £2.4m STF. The Trust therefore had to identify £0.8m of further savings. The bridge from the initial forecast is set out below:

	£'m
Initial Plan Deficit	**(9.5)**
Sustainability and Transformation Fund	2.4
Additional GOSH savings	0.8
Revised Control Total	**(6.3)**

The Trust agreed to the revised control total of £6.3m to enable access to the additional £2.4m funding available via the STF.

The financial plan for 2016/17 (attached) has therefore now been updated in month 3 for the revised control total with the £0.8m savings identified through reducing the level of investment required to deliver the P&E programme (£0.4m of the £2.0m included in the initial plan) and through an additional contribution from IPP (£0.4m) funded through over performance.

Financial Position – Quarter 1

The Trust is reporting a year to date deficit of £1.8m (excluding capital donations and impairments) for the three months ending 30 June 2016, £1.0 better than the plan deficit of £2.8m. The Trust is currently forecasting that it will achieve its control total deficit of £6.3m for 2016/17.

Income

At the end of month 3, year to date income is £2.8m higher than plan. International Private

Patients has exceeded plan income by £2.0m. NHS and other clinical income (excluding pass through) is £0.3m better than plan after adjusting for the £1.0m reduction in income relating to 2015/16 outturn.

The year to date income position also includes £0.6m representing the first quarter of the £2.4m Sustainability and Transformation Fund agreed with NHS Improvement and £0.7m for additional income expected in quarter 1 from the outcome of the local price review work recently undertaken by PwC on behalf of GOSH and NHS England. NHS Improvement released guidance on 7 July 2016 detailing the criteria that needs to be met to access the fund in each quarter of 2016/17.

Expenditure

Pay costs for the year to date are broadly on plan with a small overspend of £0.1m. The Trust is currently exceeding the agency cost ceiling set by NHS Improvement for the year to date due to the additional costs of RTT validation and the Gastroenterology review; however it is anticipated that the Trust will remain within the ceiling for the last two quarters of the financial year when the validation work is completed.

Trust non pay costs are higher than plan on Blood and Drugs and other Clinical Supplies (£0.4m), this is being driven by the higher than planned level of activity being undertaken by the Trust.

Current delivery of recurrent P&E savings are £1.0m lower than plan for the first three months of 2016/17. The PMO and Finance teams are currently working with all clinical and non-clinical divisions to monitor progress against current P&E savings schemes and to support the identification and implementation of additional schemes required to close the current gap in savings.

Risks

Delivery of the Financial Plan for 2016/17 remains dependent on delivery of a number of key assumptions/risks:

- Net £10m delivery of P&E savings (£11.6m savings offset by £1.6 for cost of delivery)
- Achievement of £4.7m CQUIN Income
- IPP Income £1.4m higher than plan
- Local price review increasing NHS Income by £3.0m higher than plan
- NHS activity and income remaining at or above contracted levels excluding commissioner QIPP assumptions.
- The impact of currency fluctuations post referendum not impacting significantly on the price of non-pay expenditure in the short to medium term.

Action required from the meeting

- To note the updated Financial Plan for 2016/17
- To note the year to date financial position as at 30 June 2016
- To note the risks to achievement of the 2016/17 forecast outturn.

Contribution to the delivery of NHS / Trust strategies and plans

This paper details the Trusts delivery against its agreed Financial Plan for 2016/17.

Financial implications

None

Legal issues None
Who is responsible for implementing the proposals / project and anticipated timescales Chief Finance Officer
Who is accountable for the implementation of the proposal / project Chief Finance Officer

Great Ormond Street Hospital for Children NHS Foundation Trust

Finance Report - Month 3

Contents

Great Ormond Street NHS Hospital for Children
NHS Foundation Trust

Trust Income and Expenditure Performance Summary for the 3 months ending 30 June 2016

2016/17 Annual Budget (£m)	Income & Expenditure	2016/17 Month 3 Budget (£m)	Month 3 Actual (£m)	Month 3 Variance (£m)	Month 3 Variance %	Year to Date Budget (£m)	Year to Date Actual (£m)	Year to Date Variance (£m)	Year to Date Variance %	RAG Rating Current Year Variance	Note	2015/16 YTD Actual (£m)	CY vs PY Variance (£m)
255.2	NHS & Other Clinical Revenue	22.2	22.5	0.3	1.1%	63.4	63.7	0.3	0.4%	G	1	59.1	4.6
57.3	Pass Through	4.7	5.4	0.7	15.5%	14.3	14.5	0.2	1.6%			12.3	2.1
54.1	Private Patient Revenue	4.3	4.6	0.3	7.6%	12.1	14.1	2.0	16.2%	G	2	10.7	3.4
43.3	Non-Clinical Revenue	3.7	3.9	0.2	4.6%	10.7	11.1	0.4	3.8%	G		10.2	0.9
410.0	**Total Operating Revenue**	**34.9**	**36.4**	**1.5**	**4.2%**	**100.5**	**103.3**	**2.8**	**2.8%**			**92.3**	**11.0**
(227.3)	Permanent Staff	(18.8)	(17.1)	1.7	8.8%	(56.5)	(51.8)	4.7	8.3%			(49.2)	(2.6)
(2.1)	Agency Staff^	(0.3)	(0.8)	(0.4)	-125.2%	(1.0)	(2.2)	(1.2)	-116.3%			(1.0)	(1.2)
(1.4)	Bank Staff^	(0.1)	(1.4)	(1.3)	-1108.2%	(0.3)	(4.0)	(3.6)	-1059.3%			(3.5)	(0.5)
(230.8)	**Total Employee Expenses**	**(19.3)**	**(19.3)**	**(0.0)**	**0.1%**	**(57.9)**	**(58.0)**	**(0.1)**	**-0.1%**	A	3	**(53.7)**	**(4.3)**
(12.3)	Drugs and Blood	(1.0)	(1.3)	(0.2)	-24.1%	(3.0)	(3.2)	(0.2)	-6.2%	R		(2.4)	(0.9)
(41.4)	Other Clinical Supplies	(3.5)	(3.9)	(0.4)	-12.4%	(10.3)	(10.5)	(0.2)	-1.6%	A		(9.3)	(1.2)
(48.5)	Other Expenses	(3.8)	(5.1)	(1.3)	-33.6%	(11.5)	(12.6)	(1.2)	-10.3%	R		(12.2)	(0.5)
(57.3)	Pass Through	(4.7)	(5.4)	(0.7)	-15.5%	(14.3)	(14.5)	(0.2)	-1.6%			(12.3)	(2.1)
(159.6)	**Total Non-Pay Expenses**	**(13.0)**	**(15.6)**	**(2.7)**	**-20.6%**	**(39.1)**	**(40.8)**	**(1.8)**	**-4.5%**	R	4	**(36.2)**	**(4.7)**
(390.4)	**Total Expenses**	**(32.2)**	**(34.9)**	**(2.7)**	**-8.4%**	**(97.0)**	**(98.8)**	**(1.8)**	**-1.9%**	A		**(89.9)**	**(8.9)**
19.6	**EBITDA (exc Capital Donations)**	**2.7**	**1.5**	**(1.2)**	**45.6%**	**3.5**	**4.5**	**1.0**	**28.8%**	G		**2.5**	**2.0**
(25.9)	Depreciation, Interest and PDC	(2.0)	(2.1)	(0.1)	5.9%	(6.3)	(6.3)	0.0	-0.1%			(6.0)	(0.3)
(6.3)	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**0.7**	**(0.6)**	**(1.3)**	**-191.4%**	**(2.8)**	**(1.8)**	**1.0**	**35.8%**	G		**(3.5)**	**1.7**
4.8%	**EBITDA %**	**7.7%**	**4.0%**			**3.5%**	**4.3%**					**2.7%**	
0.0	Impairments	0.0	0.0	0.0	0.0%	0.0	0.0	0.0	0.0%			0.0	0.0
35.2	Capital Donations^^^	(2.1)	3.3	5.4	258.2%	9.9	9.9	(0.0)	-0.2%			4.2	5.8
28.9	**Net Result**	**(1.4)**	**2.7**	**4.0**	**292.0%**	**7.1**	**8.1**	**1.0**	**14.0%**			**0.7**	**7.4**

Green = Favourable YTD Variance; Amber = Adverse YTD Variance Less than 5%; Red = Adverse YTD Variance greater than 5%

NHSI Key Performance Indicators

KPI	Annual Plan	M3 YTD Plan	M3 YTD Actual	Rating
Liquidity	4	4	4	G
Capital Service Coverage	3	2	3	G
I&E Margin	4	4	4	G
Variance in I&E Margin as % of income^^	2	2	4	G
Overall	3	3	4	G
Overall after Triggers	3	3	4	G

5

Notes:
^ The Trust has only set bank and agency budgets for planned short term additional resource requirements ie RTT and Gastro
^^ Plan for variance in I&E margin as % of income was set for 2016/17 based on 2015/16 outurn and cannot be revised
^^^ Budget profile revised in month 3 following review of forecast on capital donations

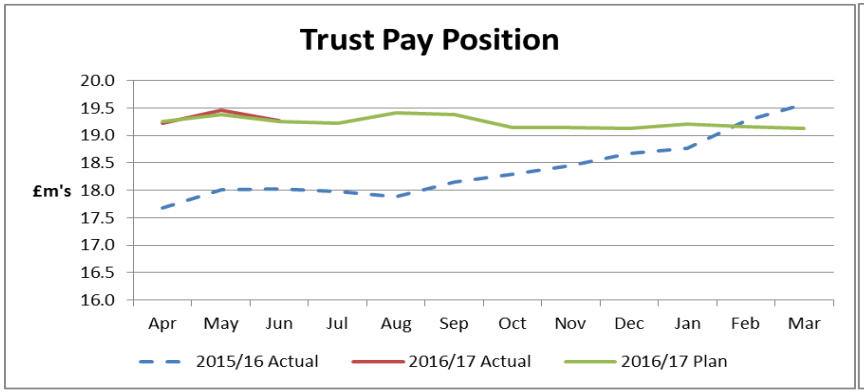
Summary:

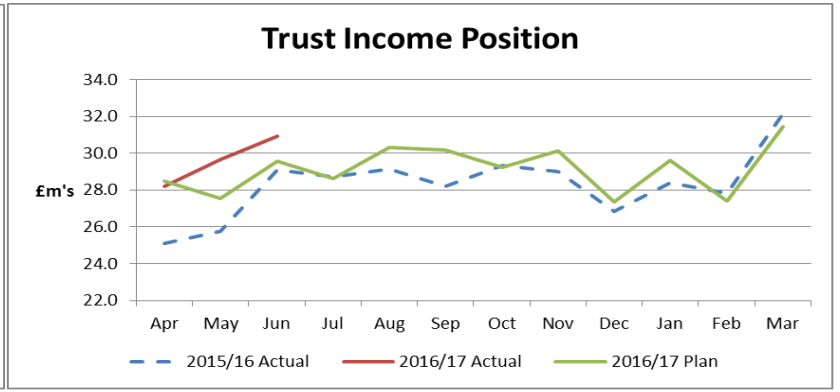
- For the year to the end of June the Trust is reporting a £1.8m deficit, excluding capital donations. This is £1m better than plan year to date.
- The position in month 3 was a £0.6m deficit, £1.3m worse than plan.
- The month 3 YTD EBITDA was a £4.5m surplus which is £1.0m favourable to plan and represents 4.5% of Income.

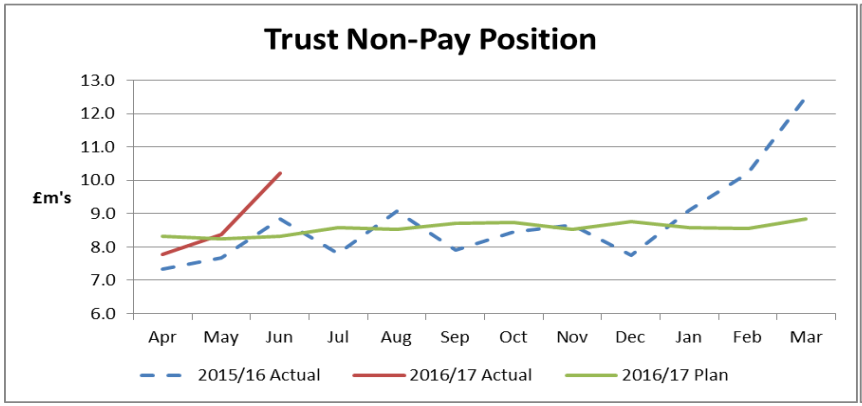
Notes:
1) NHS income (excluding pass through) YTD is above plan by £0.3m. The year to date plan includes £0.6m (1/4) of the agreed £2.4m Sustainabilty and Transformation funding £0.7m for the outcome of the local pricing review following the publication of the PwC report, accrued income has also been included for both these items in the year to date position. The YTD position also includes a £1.0m reduction in income for the movement in contract outturn between annual accounts production and final chargeable activity for last financial year.
2) Private patient income YTD is £2.0m above plan. This was delivered through increased activity and a high level of complex patients.
3) Pay is on-plan in month, with agency spend £0.4m above plan. The agency spend is higher than the prior year due to the continuing cost of RTT validation and the Gastro review.
4) Non pay excluding pass through YTD is £1.5m adverse to plan. This is due to increased bad debt provision (£0.6m) and lower than planned delivery against the P&E programme.
5) The overall weighted Monitor rating for M3 was a 4. This has changed from the 2 reported last month as a result of the revised budget profile in month 3 following review of forecast on capital donations

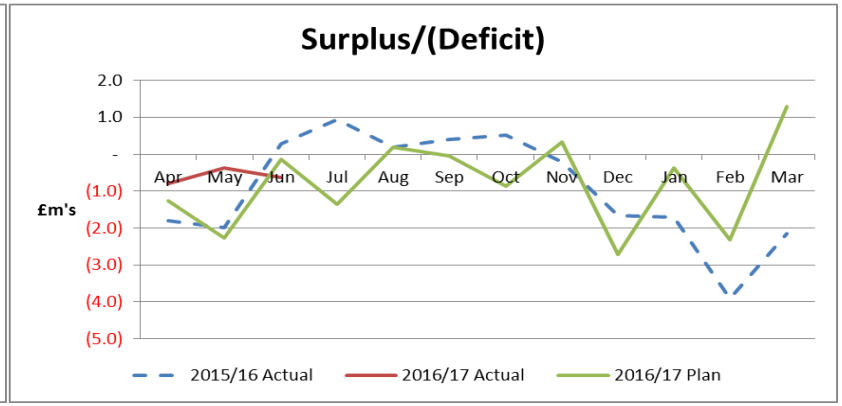
I&E Run Rate Summary for the 3 months ending 30 June 2016

Great Ormond Street Hospital for Children NHS Foundation Trust









Income

- Private patient income overperformed by £2.0m YTD at month 3 due to increased bed occupancy levels and an increase in the proportion of complex cases being seen.
- Other NHS income has overperformed by £0.3m after adjustment for the 2015/16 Income of £1.0m.

Pay

- The Trust's pay expenditure has risen every month since September 2015, due to staff working on RTT, until April 2016 when spend fell due to a reduction in ICT temporary staffing
- The Trust pay budget profile takes into account the planned reduction in RTT validation staff at month 6 offset by the planned opening of Hedgehog ward.

Non Pay

- The trusts non-pay expenditure has fallen from M12 2015/16 following one off expenditure in M12 relating to medical equipment purchased less than £5,000 (which was offset by charitable donations).
- Expenditure has increased in month 3 due to increased pass through drug and blood expenditure (offset by income), additional costs for work on the governance review and increased research costs (offset by income), including an increase in the cost of genomics (£0.2m). The spend has increased from 2015/16 in line with inflationary increases.

Surplus/Deficit

- The higher than planned income at month 3, is partly offset by higher than planned non pay costs resulting in an overall deficit which is lower than planned. The Trust is now focused on delivering its P&E savings to ensure costs are reduced whilst maintraining planned levels of activity and income.

Great Ormond Street Hospital for Children NHS Foundation Trust

Cash, Capital and Statement of Financial Performance Summary for the 3 months ending 30 June 2016

Cash
The closing cash balance was £62.3m, £3.5m higher than plan. This was due to higher than planned EBITDA (£1.0m), lower than planned trust funded capital expenditure (£0.5m) and the movement on working capital (£1.1m), net of lower than planned capital debtors (£0.9m),

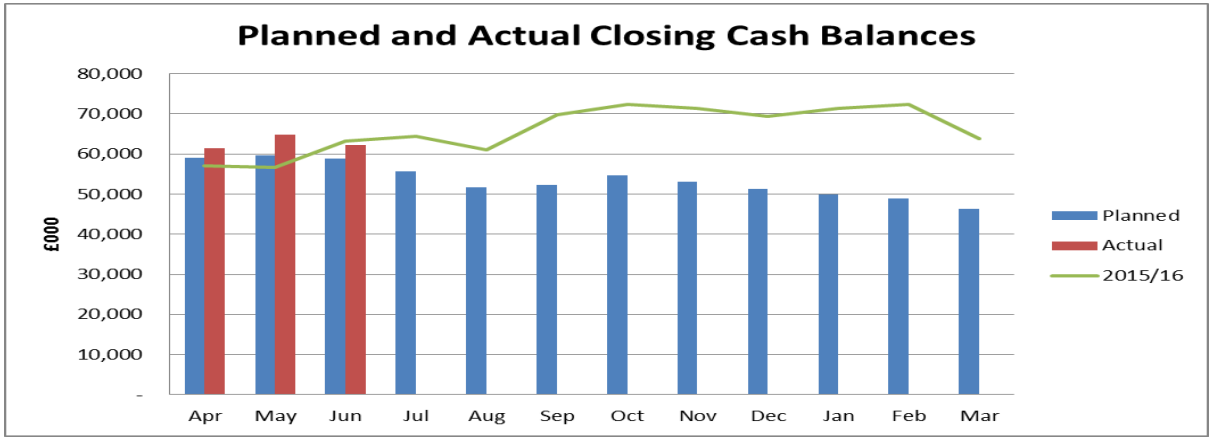
NHS Debtor Days
NHS debtor days increased in month as a result of lower receipts in relation to non-SLA related invoices in month.

IPP
IPP debtor days increased in month. Although receipts (net of deposits) in June were £0.1m higher than average for the last 12 months (£3.6m), a large part of the cash recovered settled newer, not yet due invoices. The provision for bad debt has been increased in month , however a review of all aged debts does not highlight any new risks with any existing debtors.

Creditor Days
Improvements in the Accounts payable process led to the payment of a large number and value of older, overdue invoices. Whilst this has resulted in a reduction in creditor days it has led to a worsening of BPPC.

Non-Current Assets
Non-current assets increased by £3.2m in month, the effect of capital expenditure of £4.7m less depreciation of £1.5m. The closing balance is £0.5m lower than plan largely as a result of the M3 YTD capital expenditure being less than plan by £0.5m.

Closing Cash Balance



Statement of Financial Position	31 Mar 2016 Actual £m	30 Jun 2016 Plan £m	30 Jun 2016 Actual £m
Non-Current Assets	440.8	449.8	449.3
Current Assets (exc Cash)	58.9	61.4	66.9
Cash & Cash Equivalents	63.7	58.8	62.3
Current Liabilities	(60.3)	(60.9)	(67.4)
Non-Current Liabilities	(6.3)	(6.1)	(6.2)
Total Assets Employed	**496.8**	**503.0**	**504.9**

Capital Expenditure	Annual Plan £m	30 June 2016 Plan £m	30 June 2016 Actual £m	YTD Variance £m
Redevelopment - Donated	32.3	9.9	9.5	0.4
Medical Equipment - Donated	2.9	0.0	0.4	(0.4)
Estates - Donated	0.0	0.0	0.0	0.0
ICT - Donated	0.0	0.0	0.0	0.0
Total Donated	**35.2**	**9.9**	**9.9**	**0.0**
Redevelop& equip - Trust Funded	9.0	2.4	2.1	0.3
Estates & Facilities - Trust Funded	2.4	0.1	0.2	(0.1)
ICT - Trust Funded	10.0	1.2	0.9	0.3
Contingency	3.0	0.0	0.0	0.0
Total Trust Funded	**24.4**	**3.7**	**3.2**	**0.5**
Total Expenditure	**59.6**	**13.6**	**13.1**	**0.5**

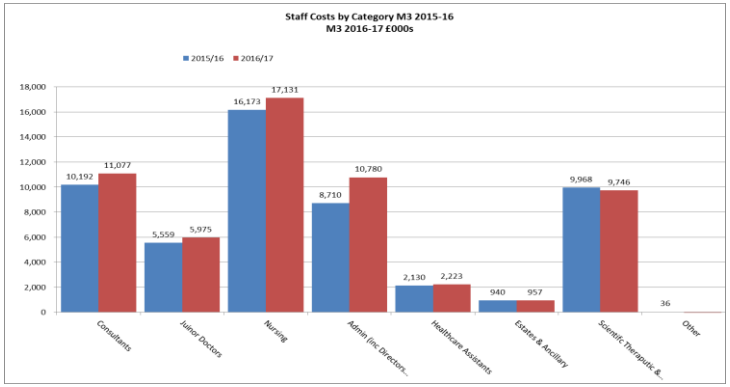
Working Capital	31-Mar-16	31-May-16	30-Jun-16	RAG
NHS Debtor Days (YTD)	11.8	7.4	10.2	G
IPP Debtor Days	197.1	186.5	191.7	R
IPP Overdue Debt (£m)	13.0	14.9	17.3	R
Creditor Days	35.0	36.6	31.6	A
BPPC - Non-NHS (YTD) (number)	85.2%	85.0%	80.9%	A
BPPC - Non-NHS (YTD) (£)	87.8%	84.7%	81.7%	A

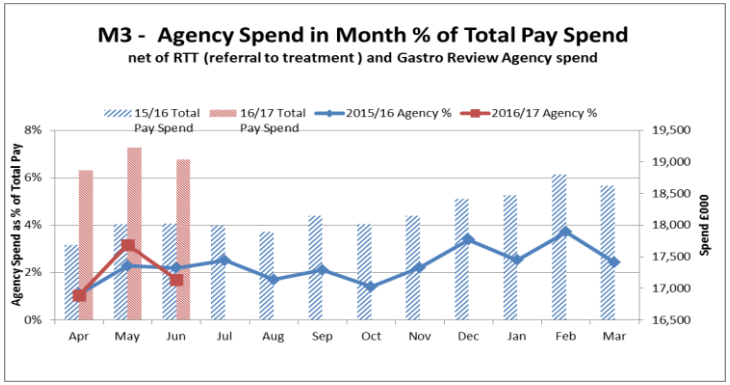
RAG Criteria:
NHS Debtor and Creditor Days: Green (under 30); Amber (30-40); Red (over 40)
BPPC Number and £: Green (over 90%); Amber (85-90%); Red (under 85%)
IPP debtor days: Green (under 120 days); Amber (120-150 days); Red (Over 150 days)

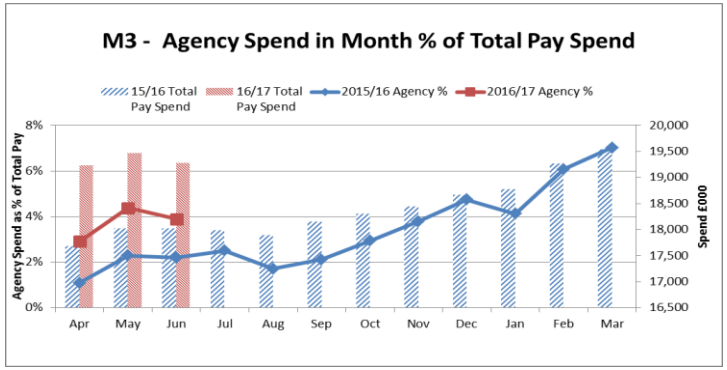
Workforce Summary

Great Ormond Street Hospital for Children NHS Foundation Trust

*WTE = **Worked WTE**, Worked hours of staff represented as WTE





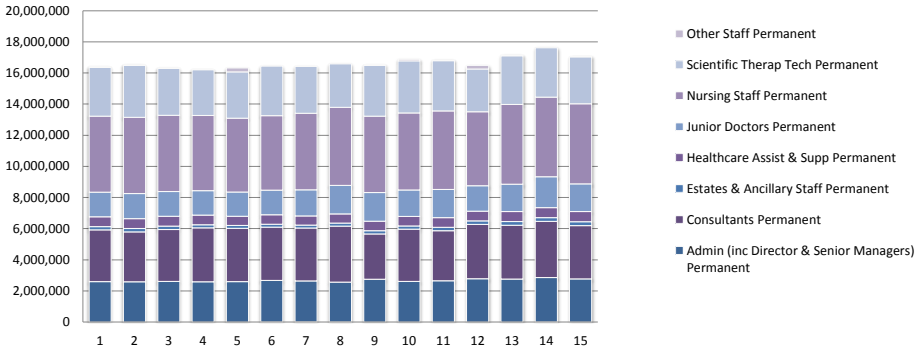


- The agency spend graphs show agency spend as a proportion of total pay spend,
  - Top Graph shows this gross of referral to treatment (RTT) and Gastro spend.
  - Bottom Graph shows this net of £1.0m RTT validation agency staff and Gastro review agency staff. Divisional RTT agency staff are still included
- Temporary staffing levels between M2 and M3 have remained consistent with a rise in bank staffing levels being offset by a reduction in agency staffing levels.
- As at month 3 there are over 100 agency staff still working on RTT.
- The percentage of agency spend against substantive staff has decreased in M3 due to a reduction in agency spend on Junior Doctors.
- The RTT agency staff are the main reason for the increase in pay costs throughout the last 6 months of 2015/16 and into 2016/17. They are the key reason behind the change in M1 pay spend between 2015/16 and 2016/17. M3 agency spend has fallen, as a percentage of total pay, below the 2015/16 levels, although this has been offfset by an increase in bank spend.
- A change in National Pay rules removing discounted employer National Insurance rates has increased the Monthly pay bill by £0.3m
- Other reasons for an increase in pay costs are associated with inflationary increase, pay increments and research costs (offset by income) partly offset through the introduction of NHS agency Caps.

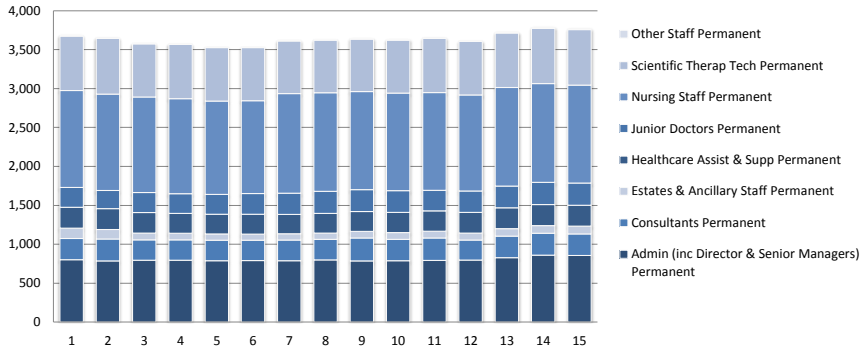
  The Trust is currently running above its NHSI notified cost ceiling for agency staff due to the continued cost of RTT validation and the Gastro review. RTT validation costs are expected to reduce significantly in September when the Trust should return to below its notified c eiling.

Great Ormond Street Hospital for Children NHS Foundation Trust

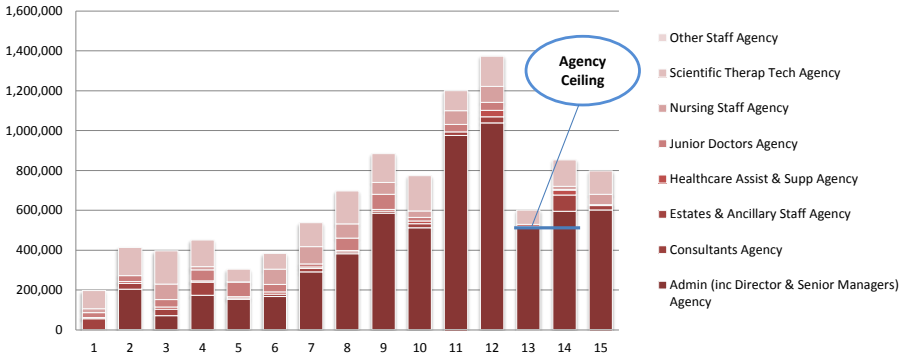
Substantive Staff Costs by staff grade over 15 months to June 2016



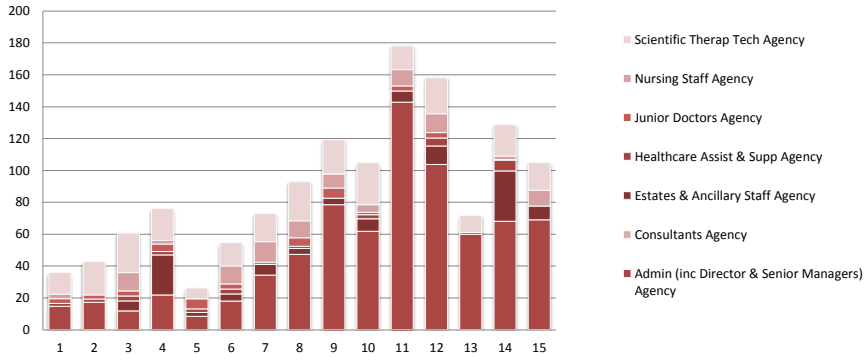
Substantive WTE by staff grade over 15 months to June 2016



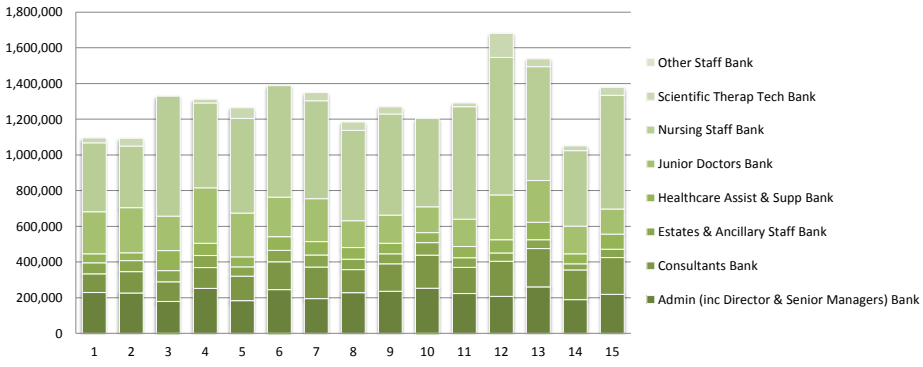
Agency Staff Costs by staff grade over 15 months to June 2016



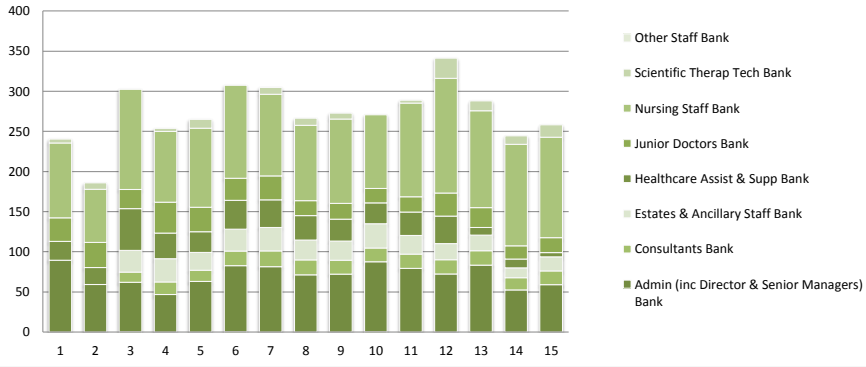
Agency WTE by staff grade over 15 months to June 2016



Bank Staff Costs by staff grade over 15 months to June 2016



Bank WTE by staff grade over 15 months to June 2016



NHS Clinical Activity & Income Summary for the 3 months ending 30 June 2016

Great Ormond Street Hospital for Children NHS Foundation Trust

	2016/17 YTD								2015/16 YTD					
	Income				Activity				Income			Activity		
	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan £'000	Actual £'000	Variance £'000	Variance %	Actual £'000	Variance 16/17 to 15/16 £'000	Variance 16/17 to 15/16 %	Actual £'000	Variance 16/17 to 15/16	Variance 16/17 to 15/16 %
Day case	**6,002**	**6,240**	**238**	**4.0%**	**4,403**	**5,298**	**895**	**20.3%**	**6,855**	**(615)**	**-9.0%**	**5,258**	**40**	**0.8%**
Elective	13,193	14,183	990	7.5%	3,049	3,306	257	8.4%	12,818	1,365	10.6%	2,959	347	11.7%
Elective Excess Bed days	748	737	(12)	-1.6%	1,376	1,444	68	5.0%	738	(1)	-0.2%	1,362	82	6.0%
Elective	**13,941**	**14,919**	**978**	**7.0%**					**13,556**	**1,363**	**10.1%**			
Non Elective	3,629	3,286	(343)	-9.5%	419	393	(26)	-6.1%	3,388	(103)	-3.0%	419	(26)	-6.2%
Non Elective Excess Bed Days	530	792	262	49.5%	886	1,567	681	76.9%	480	311	64.7%	877	690	78.7%
Non Elective	**4,158**	**4,077**	**(81)**	**-2.0%**					**3,869**	**208**	**5.4%**			
Outpatient	**9,268**	**9,362**	**94**	**1.0%**	**36,201**	**36,464**	**263**	**0.7%**	**9,149**	**213**	**2.3%**	**36,065**	**399**	**1.1%**
Undesignated HDU Bed days	1,280	1,147	(133)	-10.4%	1,247	1,099	(148)	-11.9%	1,280	(132)	-10.3%	1,265	(166)	-13.1%
Picu Consortium HDU	731	866	136	18.6%	652	897	245	37.6%	649	217	33.5%	651	246	37.8%
HDU Beddays	**2,011**	**2,014**	**3**	**0.1%**	**1,899**	**1,996**	**97**	**60.0%**	**1,929**	**85**	**4.4%**	**1,916**	**80**	**4.2%**
													0	
Picu Consortium ITU	6,685	6,598	(88)	-1.3%	2,895	2,704	(191)	-6.6%	6,774	(176)	-2.6%	2,866	(162)	-5.7%
PICU ITU Beddays	**6,685**	**6,598**	**(88)**	**-1.3%**	**2,895**	**2,704**	**(191)**	**-6.6%**	**6,706**	**(108)**	**-1.6%**	**2,866**	**(162)**	**-5.7%**
Ecmo Bedday	115	250	135	118.1%	21	46	25	117.5%	79	171	214.7%	15	31	206.7%
Psychological Medicine Bedday	286	262	(23)	-8.2%	719	650	(69)	-9.6%	306	(43)	-14.2%	772	(122)	-15.8%
Rheumatology Rehab Beddays	328	270	(58)	-17.7%	585	475	(110)	-18.9%	398	(129)	-32.3%	621	(146)	-23.5%
Transitional Care Beddays	594	752	157	26.5%	416	519	103	24.7%	615	137	22.3%	430	89	20.7%
Total Beddays	**1,323**	**1,534**	**211**	**16.0%**	**1,741**	**1,690**	**(51)**	**-2.9%**	**1,398**	**136**	**9.7%**	**1,838**	**(148)**	**-8.1%**
Packages Of Care Elective	**1,760**	**1,803**	**44**	**2.5%**					**1,677**	**127**	**7.6%**			
Highly Specialised Services (not above)	5,932	5,723	(209)	-3.5%					5,802	(79)	-1.4%			
Other Clinical	8,971	8,720	(251)	-2.8%					7,116	1,604	22.5%			
Adjustment for 2015/16 Outturn	0	(890)	(890)	-					0	(890)	-			
STF Funding	600	600	0	0.0%					0	600	-			
Pricing Adjustment	743	743	0	0.0%					0	743	-			
Non Nhs Clinical Income	2,027	2,238	211	10.4%					1,148	1,089	94.9%			
NHS and Other Clinical Income	**63,421**	**63,680**	**260**	**0.4%**					**59,205**	**4,476**	**7.6%**			
Pass Through	14,254	14,480	227	1.6%					12,341	2,139	17.3%			
Private Patient	12,118	14,079	1,961	16.2%					10,497	3,582	34.1%			
Total Clinical Income	**89,793**	**92,240**	**2,448**	**2.7%**					**82,043**	**10,197**	**12.4%**			
Non Clinical Income	**10,667**	**11,068**	**401**	**3.8%**					**10,206**	**862**	**8.4%**			
Total Income	**100,459**	**103,308**	**2,849**	**2.8%**					**92,249**	**11,059**	**12.0%**			

Elective/Non Elective
- Charles West Haematology/oncology Elective income is above plan by £0.5m
- JM Barrie Urology is £0.2m above plan following push to clear RTT backlog
- Neurosurgery non-elective income is £0.3m behind plan, deferring referrals from other trusts due lack of beds

Day case
- Rheumatology increase in infusion/injections following a change in clinical commissioning policies £0.2m

Other Clinical
- This includes income for CQUIN and the target for the local pricing review
- The £1m reduc tion in income for 2015/16 outturn is included within Other Clinical Income.

Outpatients
- Outpatient Income to the end of month 3 is £0.1m above plan, however in month 3 performance was £0.3m lower than plan
- New Ophthalmology consultant in March leading to increased activity and income.

Bed days
- Fluctuates due to a small number of atypical very sick patients staying beyond their trim points
- A drop in Medical Gastroenterology Elective Excess bed days is offset by an increase in the services Non-Elective Excess bed days. Clinical immunology Non-Elective excess bed days increased by £0.2m.
- Ecmo is a low volume service and very sensitive to small changes in unplanned activity

**Activity = Billable activity*

Attachment I

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 20th July 2016	
Research and Innovation Update **Submitted by:** Professor David Goldblatt, Director of Research and Innovation, Emma Pendleton Deputy Director of Research and Innovation	**Paper No: Attachment I**

Aims / summary
This report provides Trust Board with an oversight of research activity and performance at GOSH.

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

- The predicted increase in research income in 16/17, in particular an increase in commercial research income.
- The increase in NIHR Biomedical Research Centre funding in 16/17 is due to an agreed re-profile of funds across years.
- Performance in NIHR portfolio recruitment in 15/16: through close collaboration with the CRN, GOSH was the biggest single contributor to the children's theme delivering 2,144/21,923 (9.8%) recruits, and contributing over 1,600 recruits to other themes

Key activities in the last six months include a reapplication for NIHR Biomedical Research Centre funding and a separate application, for the first time, for standalone NIHR Clinical Research Facility funding. Outcome for both expected in September.

Contribution to the delivery of NHS Foundation Trust strategies and plans
Research is one of the Trust's strategic objectives: With partners maintain and develop our position as the UK's top children's research and innovation organisation.

Financial implications
Loss of research income is on the Trust's Risk Register, the Trust needs to ensure there is a strategy and systems in place to retain and increase research income.

Who needs to be told about any decision?
Professor David Goldblatt, Director of Research and Innovation

Who is responsible for implementing the proposals / project and anticipated timescales?
Emma Pendleton, Deputy Director of Research and Innovation

Who is accountable for the implementation of the proposal / project?
Professor David Goldblatt, Director of Research and Innovation

Great Ormond Street Hospital for Children NHS Foundation Trust

Research and Innovation July 2016

This report provides Trust Board with an oversight of research activity and performance at GOSH.

Research Inputs

1. Research Income: The table below provides details of Trust research income at month 12 for 15/16. Income as at month 2 for 16/17 is provided, with income at month 2 15/16 provided for direct comparison, along with forecast income for 16/17.

Table 1 Direct Funding to GOSH

Funding Type	Funding Source	Income as at Month 12 15-16 (£000)	Income as at Month 2 15-16 (£000)	Income as at Month 2 16-17 (£000)	Forecast 16-17 (£000)
A. Centre Grants and Infrastructure, Research Delivery Support					
Biomedical Research Centre	NIHR	7,262	1,210	1,382	8,292
Research Capability Funding	NIHR	1,908	311	311	1,867
Local Comprehensive Research Network	NIHR	2,332	304	348	2,042
B. Programme and Project Grants					
NIHR Programme, Project Grants	NIHR	854	0	268	1,871
Charity Research Project Grants	Variable*	1,449	176	282	1,280
European Union Research Project Grants	EU	118	26	118	735
Commercial Research Contracts	Variable	2,085	172	525	2,649
Other	Variable	1,080	259	114	1,288
Total income		**17,089**	**2,458**	**3,347**	**20,024**

*Charity funding is mostly GOSH Children's Charity

2. Directly funded research staff: As at month 2 16/17 there are 157 WTE staff directly funded through the research income sources detailed in Table 1 above.

Table 2: Directly funded research staff

The table below provides details of directly funded staff at month 2 for 16/17 with month 2 15/16 shown for comparison.

Staff Group	Month 12 15-16	Month 2 15-16	Month 2 16-17
Administration, Data Managers, Trial Coordinators	50	46	50
Consultants	15	5	14
Directors & Senior Managers	10	8	9
Junior Doctors	1	0	3
Nursing Staff	48	33	44
Nursing Staff Bank	3	1	0
Scientific, Therapeutic, Technical	33	52	36
TOTAL	**169**	**145**	**157**

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

Great Ormond Street Hospital for Children NHS Foundation Trust

Research outputs

1. **Research Projects:** The table below details the number of projects directly funded by the Programme and Project Grant income detailed above in Table 1B only. Activity is defined by spend on a grant account. Final year figures are provided for month 12 15/16 along with activity at month 2 for 16/17, with activity at month 2 15/16 provided for comparison.

Table 3: Directly funded research projects

Funding Stream (Direct Income to GOSH)	Number Active YTD M12 15-16	Number Active YTD M2 15-16	Number Active YTD M2 16-17
NIHR Programme and Project Grants	23	5	27
Charity Research Project Grants	18	51	21
European Union Research Project Grants	7	5	7
Commercial Research Contracts	137	75	82
Total	**185**	136	**137**

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

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

Table 4: Total number of research projects by Clinical Division

The table below details the number of research projects undertaken during 15/16, along with the activity to month 2 16/17, with month 2 15/16 for comparison. These totals include directly funded projects, indirectly funded and own account. Projects are considered active as soon as they receive R&D Approval, these totals include projects that are currently open to recruitment and also those that are in set-up or closed to recruitment but in follow-up.

Division	Total number of projects YTD M12 15/16	Total number of projects YTD M2 15/16	Total number of projects YTD M2 16/17	UKCRN Portfolio projects YTD M2 16/17
JM Barrie Portfolio A	144	117	114	40
JM Barrie Portfolio B	287	227	228	76
Charles West A	370	293	303	96
Charles West B	157	127	121	29
Other GOSH	154	131	105	9
Total	**1112**	**895**	**871**	**250**

Great Ormond Street Hospital for Children NHS Foundation Trust

2. Research recruitment

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

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

Table 5: Patient recruitment to UKCRN Portfolio studies

Division	Patient recruitment YTD M12 15/16	Patient recruitment YTD M2 15/16	Patient recruitment YTD M2 16/17
JM Barrie Portfolio A	683	118	75
JM Barrie Portfolio B	516	65	110
Charles West A	717	112	88
Charles West B	1174	227	109
Other GOSH	734	169	65
Total	**3824**	**691**	**447**

Last year, through close collaboration with the CRN, GOSH was the biggest single contributor to the children's theme delivering 2,144/21,923 (9.8%) recruits, and contributing more than 1,600 recruits to other themes.

3. NIHR performance metrics in initiating and delivering clinical research

All NHS organisations in receipt of NIHR funding are required to report performance against the following two metrics on a quarterly basis:

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

Table 6 Performance in initiation:

	Trials submitted	Adjusted total	Adj. trials meeting benchmark	% adj. total meeting benchmark	% all orgs' adj. total meeting benchmark	GOSH rank	Mean days
Q3 13/14	33	23	14	61%	52%	20 / 52	91 days
Q4 13/14	33	18	15	83%	57%	13 / 60	67 days
Q1 14/15	37	18	14	78%	65%	21 / 60	47 days
Q2 14/15	36	18	13	72%	66%	24 / 61	53 days
Q3 14/15	47	20	16	80%	80%	31 / 61	40 days
Q4 14/15	51	26	19	73%	72%	96 / 209	48 days
Q1 15/16	51	24	19	79%	75%	104 / 210	46 days
Q2 15/16	56	29	22	76%	78%	112 / 205	47 days
Q3 15/16	49	22	16	73%	81%	129 / 213	43 days
Q4 15/16	43	21	15	71%	81%	137 / 222	49 days

Table 7 Performance in delivery:

	Trials submitted	Closed trials	Closed trials meeting target	% closed trials meeting target	% all orgs' closed trials meeting target	GOSH rank
Q3 13/14	58	31	17	55%	43%	12 / 53
Q4 13/14	63	27	18	67%	46%	5 / 61
Q1 14/15	66	32	23	72%	47%	5 / 58
Q2 14/15	68	31	22	71%	47%	4 / 59
Q3 14/15	76	36	24	67%	51%	8 / 59
Q4 14/15	86	42	32	76%	53%	22 / 187
Q1 15/16	88	38	26	68%	50%	15 / 185
Q2 15/16	89	42	28	67%	52%	34 / 183
Q3 15/16	89	43	30	70%	53%	40 / 190 [estimated]
Q4 15/16	18 *	18 *	10 *	60%	53%	TBC

* Performance in delivery data is collected in a modified way starting with Q4 15/16.

Research Outcomes

4. Publications

Publication numbers for the last seven financial years are shown below. The numbers are updated quarterly by the R&I; latest data provided below is for 15/16.There can also be a lag in the indexing of publications, so we expect that our 15/16 total will only represent 90-95% of the final total. Only publications credited to GOSH and/or UCL Institute of Child Health are identified, and these can then be assigned to Clinical Divisions based on where the authors are employed. The numbers include all publication types (articles, reviews, proceedings papers, letters, editorials, book chapters etc.).

Table 8: Number of publications

	09/10	10/11	11/12	12/13	13/14	14/15	15/16
GOSH-only and GOSH/ICH	737	876	783	1016	1014	1327	1179
ICH-only	566	612	611	724	614	368	256
Total	**1303**	**1488**	**1394**	**1740**	**1628**	**1695**	**1435**

Table 8b: Number of publications by Clinical Division

Division	Publications YTD M12 15/16	Publications YTD M2 16/17
JM Barrie Portfolio A	227	52
JM Barrie Portfolio B	371	62
Charles West Portfolio A	400	66
Charles West Portfolio B	195	36
Other GOSH	147	32
Total	**1179**	**216**

"Other GOSH" papers tend to be written by authors who have given their address as GOSH but we cannot identify their Division (often honorary staff).

Great Ormond Street Hospital for Children NHS Foundation Trust

Case Study 1: Professor Lyn Chitty

Lyn Chitty is Professor of Genetics and Fetal Medicine; NIHR Senior Investigator; Clinical Director of North Thames Clinical Research Network and North Thames Genomic Medicine Centre. Professor Chitty completed her PhD at King's College Hospital, she received a Medical Research Council research training fellowship and trained jointly in genetics (at GOSH) and fetal medicine (at King's) before taking up an appointment at GOSH, the ICH and UCLH. Professor Chitty is the only consultant in genetics and fetal medicine in the UK. Professor Chitty's research aims to make prenatal testing for genetic conditions safer for parents who are expecting a baby and has transformed the prenatal diagnosis pathway.

Professor Chitty has published over 200 papers and since 2011 has attracted grant income of £12.5M including NIHR, Wellcome Trust, EU Horizon 2020 and GOSH CC funding. Her most recent research award explores informed choice for genome sequencing, linked closely with the 100,000 genomes programme.

Accurately diagnosing genetic conditions in unborn children requires a sample of the developing baby's DNA for analysis. Until recently, the only way of getting access to the genetic material from an unborn child was to take a small sample from the amniotic fluid or from the placenta. Both procedures carry a very slight risk of miscarriage, between 0.5-1%, enough to dissuade some parents from taking a test. Professor Chitty's research is helping make the choice an easier one for parents. It is now known that it is possible to detect fragments of the baby's DNA circulating in the mother's blood, therefore rather than using an invasive test a small sample of the mother's blood can be taken and DNA extracted to analyse the genetic material to look for any potential problems. This research is truly transformational; making prenatal diagnosis of genetic conditions safer by reducing the need for invasive tests and making it more accessible for parents. The tests that have been developing fall into two separate groups. The first can help diagnose children with genetic diseases caused by faults in individual genes, conditions like cystic fibrosis, Apert's syndrome (a genetic disorder that affects the formation of the head and other parts of the body) and achondroplasia (a form of dwarfism). Until recently, GOSH hosted the only accredited public service laboratory in the country offering non-invasive diagnosis for these single-gene disorders. We receive referrals from across the world, and >30% of all our molecular prenatal diagnosis is via NIPD. The second group of tests help screen pregnancies for conditions like Down's syndrome. Research has shown that this is a highly accurate test, but, unlike the tests developed for single gene disorders, a positive test result needs to be confirmed by analysing cells from the amniotic fluid or placenta. However, because the new test is very accurate and safe, parents have been very keen to take it with more cases of Down's syndrome picked up before birth. Currently, this test is only available privately; however Professor Chitty's research has shown that this could work in the NHS. Data has been presented to the UK National Screening Committee who are now consulting on implementing this into the NHS. Prof Chitty's work is an exemplar of translational research, taking work from the bench to clinical practice, working with laboratory and social scientists, and then commissioners of health to deliver to significant and patient focussed improvements in care.

<u>Publications:</u>

Hill M, Twiss P, Verhoef T, Drury S, McKay F, Mason S, Jenkins L, Morris S, Chitty LS: Non-invasive prenatal diagnosis for cystic fibrosis: detection of paternal mutations, exploration of patient preferences and cost analysis. Prenat Diagn 2015;35:950-8.

Lyn S Chitty, David Wright, Melissa Hill, Talitha I Verhoef, Rebecca Daley, Celine Lewis, Sarah Mason, Fiona McKay, Lucy Jenkins, Abigail Howarth, Louise Cameron, Alec McEwan, Jane Fisher, Mark Kroese, Stephen Morris: Uptake, outcomes, and costs of implementing non-invasive prenatal testing for Down's syndrome into NHS maternity care: prospective cohort study in eight diverse maternity units. BMJ 2016;354:i3426

Great Ormond Street Hospital for Children NHS Foundation Trust

Case Study 2: Dr Kate Brown

Dr Kate Brown is a Consultant Intensivist and Research and Outcomes Lead for the Cardiac Intensive Care Unit. Dr Brown completed her medical degree at Cambridge University, and then trained in paediatrics in London. From there she worked at Massachusetts General Hospital and the Children's Hospital of Philadelphia to train in intensive care for children before coming back to the UK and GOSH. Dr Brown completed an MSc in public health and shortly after started applying for grants.

Dr Brown's first grant was received from NIHR to enable the team at GOSH and colleagues from the Clinical Operational Research Unit at UCL to develop and test a risk adjustment model for paediatric cardiac surgery, which is now used across the UK. This formed the basis for Dr Brown's MD degree for which she was awarded the Ralph Noble prize from Cambridge University. Dr Brown went on to receive further grants including an award from GOSH Children's Charity to analyse national audit data of outcomes for children after heart surgery, and two further NIHR grants both from the Health Services and Delivery Research Programme that she has led.

The aim of GOSH CC funded project was to explore whether it is feasible to analyse the longer-term survival rates of children that have undergone heart surgery based on the condition that they were born with. Within the scope of this research, a study was published showing that practice has evolved and improved, and with this, the mortality rate for children within 30 days of an operation across the UK fell by about half over a ten-year period. This means there are more children living with the after-effects of these very complex operations and as a specialist centre we have a responsibility to think about what happens when they go home.

Dr Brown's NIHR funded Infant Heart Study aimed to explore risk factors for poor outcomes after hospital discharge for infants undergoing heart surgery, to understand how the health system works for them after discharge and to propose interventions to improve outcomes. Results indicate the need for improved discharge planning and communication between professionals in specialist hospital, local hospital and community settings that care for infants discharged after heart surgery; for infants identified as being at high risk to be discharged from the specialist hospital to their local hospital before going home; for a home-monitoring programme for infants at high risk; for clear guidance to families and health professionals about spotting early warning signs in a baby who has had heart surgery; for standardised training and information for families prior to discharge; and for the opportunity for families to seek peer support from other families through charity-based groups or social media.

The NIHR funded paediatric cardiac surgery morbidity study, led by Dr Brown and Professor Tsang aims to measure the incidence and impact of events that may be linked to heart surgery over a 6-month period. As part of this project the team are currently testing a screening tool called the Brief Developmental Assessment (BDA) in a large group of children who have heart disease. The BDA is designed for use in the NHS as a screening tool for nurses and doctors to pick up those children that might need extra help, whether that might be speech and language therapy, help with school work or physiotherapy, so that they can be referred for assessment. If young people can be identified that need extra attention as early as possible while they're growing up, the hope is that it will help more children grow up to lead fuller lives.

<u>Publications:</u>

Infant deaths in the UK community following successful cardiac surgery: building the evidence base for optimal surveillance, a mixed-methods study. Brown KL, Wray J, Knowles RL, Crowe S, Tregay J, Ridout D, Barron DJ, Cunningham D, Parslow R, Franklin R, Barnes N, Hull S, Bull C. Southampton (UK): NIHR Journals Library; 2016 May

Trends in 30-day mortality rate and case mix for paediatric cardiac surgery in the UK between 2000 and 2010. Brown KL, Crowe S, Franklin R, McLean A, Cunningham D, Barron D, Tsang V, Pagel C, Utley M.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **20th July 2016**	
Education Annual Report 2015/16 **Submitted by:** Ali Mohammed, Director of HR&OD Dr Vinod Diwakar, Medical Director Juliette Greenwood, Chief Nurse	**Paper No: Attachment J**
Aims / summary To provide a summary update on key elements of education, learning and development activity that have taken place in 2015/16..	
Action required from the meeting To note the report	
Contribution to the delivery of NHS Foundation Trust strategies and plans Demonstrates development towards the Trust's strategic objective to be a great place to work and learn	
Financial implications None within the paper	
Who needs to be told about any decision? No decision required	
Who is responsible for implementing the proposals / project and anticipated timescales? No proposals within the paper	
Who is accountable for the implementation of the proposal / project? No proposals within the paper	

Great Ormond Street Hospital for Children NHS Foundation Trust

Education Report 2016

Executive summary

This paper provides a summary of education activity over the period April 2015 to March 2016. Education at GOSH is delivered by three teams. Accountability for education delivery changed over this period. Instead of the Director of HR&OD managing all three functional teams, they now report as follows:

- **Postgraduate medical education design – Medical Director**
- **Nursing and non-medical education – Chief Nurse**
- **Learning and development – Director of HR&OD**

All three teams have seen significant changes in leadership and staffing and this has been managed in order that education activity has been maintained and there has been no impact on service delivery. Two themes for each of the teams in the last year have been in ensuring that core functions are maintained and strengthened; and starting to build improved governance arrangements. This includes the creation of the new Executive-led Education and Workforce Development Board, to provide oversight of all education activity.

Funding for clinical education at GOSH comes predominantly from Health Education North Central and East London and is based on the types and numbers of clinical staff and students based at GOSH.

Postgraduate medical education

During 2015/16, 27 of the 47 recommendations made by HENCEL have been satisfactorily addressed, and recent feedback from regional Heads of Specialty schools confirms satisfaction with progress towards meeting the remaining recommendations. Confirmation has been received from HENCEL that Higher Specialty Trainees will return to Haematology/Oncology from September 2016, a further endorsement of the improvement in quality of PGME at GOSH.

The accreditation rate for education supervisors has continued to increase, and at the end of 2015/16 stands at 97%.

The PGME Design Team has continued to design, run and commission a range of courses for doctors in training and consultant staff, 600 places taken on centrally-run (as opposed to specialty-based) courses, with high satisfaction levels. This training includes clinical skills for doctors in training as well as communication and leadership development.

Grand rounds, which are lectures and case studies given by internal and external clinical experts, were reintroduced in 2015 with high levels of interest. These promote shared learning across specialties.

Communication about medical education continues via the PGME website and newsletter but with the addition of the PGME app which allows users to see training activities, and their own teaching and speciality training events on mobile devices.

Nursing and non-medical education

GOSH continues to provide placements to up to 400 student nurses each year, the highest in the region. There is a significant education infrastructure at GOSH in order to support these students, and the increased levels of feedback in 2015/16 indicate a positive student experience. Attrition is comparable with other organisations.

Significant resource is also invested in ensuring student nurses move safely into practice following completion of their studies, and this has been tailored to suit the specific needs of newly qualified nurses at GOSH. Once again, this is positively evaluated and is a critical factor in ensuring the recruitment and retention of newly qualified nurses.

The focus on continuing professional development for nurses has continued. 470 places were commissioned by GOSH on post-registration specialist nursing courses, in addition to supporting staff on a variety of Masters programmes. This opportunity for continuing education is essential in ensuring staff are able to progress to more senior roles within specialties and is linked directly to our ability to attract and retain staff.

In response to the Francis Report and Cavendish Review the Government mandated an education and development programme for all Healthcare Assistants (HCAs) entering employment – the Care Certificate. GOSH developed a bespoke programme which was launched in April 2015. 90 HCAs have completed the course – 79% of eligible HCAs. Ensuring access for the remaining HCA workforce will be a priority in 2016/17.

Two Education Working Groups have been established to ensure the education needs of healthcare scientists and AHPs are appropriately understood and met.

In 2014/15, GOSH was commissioned by HENCEL to design a programme – Me First - for use across the region to improve communication between clinical and non-clinical staff with children and young

people. In 2015/16 the second phase of the project was completed and 264 delegates across NCEL have been trained. The programme has won and been shortlisted for a number of external awards.

In terms of funding, there has been a 30% reduction in workforce development monies from HENCEL. Further reductions are anticipated, which would potentially have a significant impact on staffing within the team (which is mainly funded by HENCEL income and supports student nurses) as well as the ability to commission courses for professional education. Nb. this funding reduction has not affected medical education.

Learning and Development

Over 60,000 centrally-managed face-to-face or e-learning sessions were taken up in 2015/16, with new courses being launched for both clinical and non-clinical staff in response to identified training needs.

Preparation for the launch of the new GOLD Learning Management System (LMS) was a significant feature of work in 2016/17. Launch was delayed as a result of serious technical shortfalls but following the allocation of additional resources from the supplier launch was planned for May 2016. This platform is essential to the effective management of training in the future, including recording, reporting and management of mandatory training and appraisals, and the ability to introduce more efficient working practices in the L&D team.

An action plan for mandatory training compliance was agreed, which addresses barriers to compliance as well as utilising the new GOLD LMS and the revised performance management process. A similar approach will be taken for appraisal rates.

A Head of Leadership role was created, and engagement with Trust leaders in the Executive and divisional teams took place to draw up a comprehensive programme of leadership development. This will be targeted at senior leaders and those in mission critical roles and will include practical knowledge, for example on financial and business management, as well as skills relating to the leadership of people.

This leadership plan includes the new Heads of Clinical Service. 27 Heads of Clinical Service were appointed into these new roles, in a process which included the creation of individual feedback and development plans. Each HOCS was partnered with a mentor from Morgan Stanley, with positive feedback being received.

Following the launch of Our Always Values in March 2015 over 220 Trust leaders, including Executive Directors, took part in development sessions on how to role model the values. The values were also embedded in our appraisals process.

GOSH had 46 staff in apprenticeships in 2015/16, and was the only trust in the HENCEL region to exceed its apprenticeship target. Preparation for the introduction of the Apprenticeship Levy, due to be introduced in April 2017, will take place during the course of 2015/16.

A rapid programme of RTT training was created and rolled out January-April 2016, ensuring that the Trust met the target agreed with the Tripartite group.

Future priorities

Future priorities for all three teams are focused on ensuring a strong infrastructure for education that meets regulatory requirements; embedding governance arrangements (including in response to the Education and Strategy Governance Audit that reported in February 2016); developing a training needs analysis that ensures education at GOSH is demonstrably linked to the organisation's needs; and continuing to develop innovative education that supports recruitment, retention, and the Trust's vision to be the world's leading children's hospital.

Introduction

The format reflects the structure of education provision in the hospital, which is delivered as follows:

- **Postgraduate medical education**: professional clinical education to all consultants, junior doctors (those in training and non-training posts); external commissioning.
- **Nursing and non-medical education**: professional clinical education to all registered and non-registered nursing roles, allied health professionals, healthcare scientists and pharmacists; external commissioning.
- **Learning and development**: training and development (including oversight of mandatory training and appraisals) for all staff; training for non-clinical skills and knowledge including leadership, team working, basic skills (numeracy, literacy); e-learning development.

Structure of education delivery

In 2015/16, with the appointment of a new Chief Nurse and Medical Director and the departure of the two assistant directors with responsibility for all the Trust's education, the decision was taken to re-align the education portfolios.

Previously, all three strands of education reported into the Director of HR&OD (with dotted line links to the Chief Nurse and Medical Director). The following changes were made during 2015/16:

- The **PGME Design Team** reports (via the Director of Medical Education) to the Medical Director. (PGME Services, which provides transactional and employment services for junior doctors and consultants, continues to report to the Director of HR&OD)
- **Nursing and non-medical education** reports (via the Associate Director of Education) to the Chief Nurse.
- **Learning and Development** reports (via the Assistant Director of Organisation Development) to the Director of HR&OD.

This structure ensures clear professional lines of accountability, but to ensure consistency and governance around all aspects of education an Education and Workforce Development Board was established. The membership of this group includes the three directors as well as representation from the divisional management teams. At the end of 2015/16, draft terms of reference for the board were in development, including reporting structures.

The Board will, on behalf of the Executive, ensure the design and delivery of high quality education and training that meets the Trust's strategic and operational objectives; ensure congruence of the various streams of educational activity; review education contracts and activity; review value-for-money of educational activity.

Education and Strategy Governance audit

An audit of education in the Trust was carried out in autumn 2015, with the final report and management actions being signed off at the Trust's Audit Committee in February 2016. The audit

noted achievements but made a number of recommendations around governance (including setting up processes to deliver training needs analysis; ensuring regular feedback from junior doctors in training; and establishment of an education board which has specific responsibility for overseeing education performance). These recommendations were welcomed by the Trust, which had already identified these shortfalls and was using the change in structures and staffing to implement change.

An action plan to address the recommendations was agreed, including the establishment of the Education and Workforce Development Board. This Board will monitor the delivery of this plan, which has deliverables in 2016/17.

1 Postgraduate Medical Education

Introduction

Postgraduate Medical Education (PGME) has had some terrific successes through a difficult year. The main challenges have been to ensure continuing development and promotion of available courses, resourcing capacity of the department and the broader financial constraints within the NHS for training. The *At the Coalface Trainee Report* (2014) and the *Quality Inspection Report: Conversations of Concern* (2015) both stated the need for junior doctors to be offered the appropriate training and support, particularly specialty training and the need to raise awareness of training available. *The Five Year Forward View* (2015), anticipating the financial pressure on the NHS as a whole, and the impact on availability of training GOSH is able to offer across the Trust, has been a key driver in the re-structure and development of the PGME Design Team.

Throughout 2015-16, PGME departmental staffing levels were low, impacting on the further development of initiatives planned from 2014-15. However, established courses, programmes and events have been delivered and have been met with excellent feedback and a high level of attendance. The promotion of training and education has continued through the PGME App, Newsletter, dedicated website and group emails. On the back of these successes, a crucial objective for the coming year will be to develop a channel integration plan ensuring that all courses are marketed with more precision to appropriate audiences.

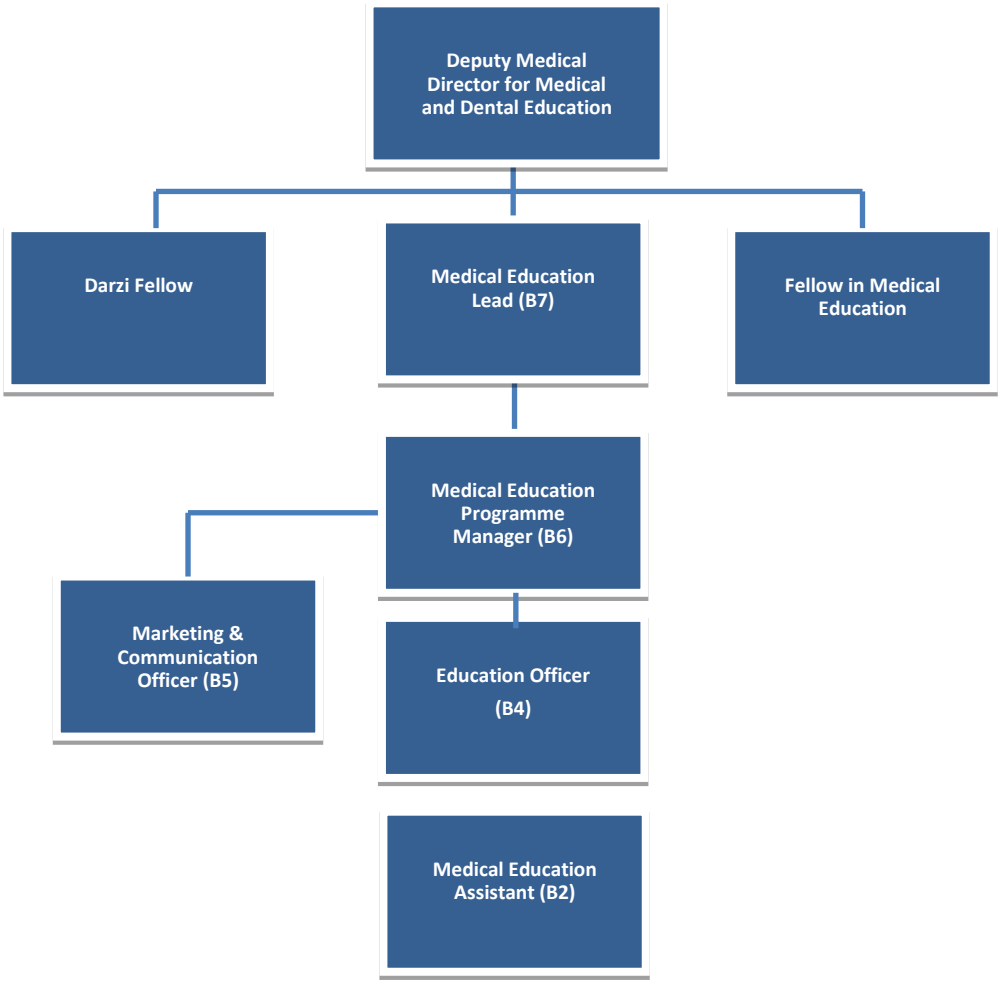
Moving forward with a new team structure and staff, the PGME Design Team is in good shape to develop further relevant, core clinical and leadership training to meet the needs of all learners. The focus for the coming year is to develop robust analysis tools and a quality assurance and improvement framework that will meet and maintain GMC standards and the goal of education at GOSH 'to be an excellent place to work and learn'. Furthermore, devolved budget planning with rigorous monitoring of income and expenditure will drive our ability to deliver an efficient service creating cost savings contributing to the department's financial stability.

PGME develops and supports the delivery of education and training for doctors throughout the Trust. The content of the prospectus is designed to put patient safety and quality of care at the heart of learning. PGME provides a culture that is supportive of learners so they are able to reflect and demonstrate what is expected in good medical and working practice, and promotes the principles and values of good leadership. The prospectus has been developed to:

- *Fulfil the Trust's role as an employer and education provider*
- *Support the Trust's mission as a world leader in paediatrics and child health*
- *Meet the Trust's mandatory requirements*
- *Build a financially sustainable education function which identifies and acts upon commercial opportunities*

PGME Design Team

The PGME Design Team has recently transitioned to the Medical Directorate. There are a number of current vacancies within the team, currently covered by interim staff. It is expected that these vacancies will be filled by September 2016. The Divisional Restructure Consultation together with a training needs analysis and the current vacancies within PGME have given opportunity to develop a multi-professional team, aligned to meet the targets and goals of the Education Strategy. The Director of Medical Education together with the Medical Education Lead will focus on developing new innovative and dynamic education programmes that meet the needs and legislative requirements of postgraduate medical education. Appointing an Education Communications and Marketing Officer will develop and raise the profile of GOSH PGME, ensuring as large an audience as possible are aware of the department's remit and availability of relevant training. Developing robust process systems for quality and detailed financial oversight will also be priorities undertaken in the next year.



Quality Assurance

The PGME Team embraced the challenges identified by the 2014 'At the Coalface' trainee report and the 2015 HENCEL Quality inspection recommendations.

During 2015/16 PGME has continued to develop and improve the quality and accessibility of its programmes and courses whilst supporting specialty College Tutors and Unit Training Directors to deliver improvements to satisfy HENCEL recommendations. During 2015/16, 27 of the 47 recommendations made by HENCEL have been satisfactorily addressed, and recent feedback from regional Heads of Specialty schools confirms satisfaction with progress towards meeting the remaining recommendations. Confirmation has been received from HENCEL that Higher Specialty Trainees will return to Haematology/Oncology from September 2016, a further endorsement of the improvement in quality of PGME at GOSH.

PGME continues to support the accreditation of educational supervisors through the regular provision of Educational Supervision training courses and one-to-one support for portfolio completion. The accreditation rate for 2015-16 was 97%.

The PGME ethos is to set out to exceed the requirements as set out in the General Medical Council's (GMC) Quality Improvement Framework. These requirements will form the foundations of the development of a PGME Governance Framework, at the heart of which will be quality assurance and improvement

Education Activity

Courses

Approximately 600 places were taken on centrally run courses in 2015-16. Future development towards quality assurance and improvement will enable PGME to accurately complete data analysis to give a detailed overview of how training programmes impact throughout the Trust. This data will give detail on quality of teaching, ensure that content and delivery is fit for purpose, uptake and spread across divisions and specialties.

Title	Synopsis
Educational Supervision	Guides the learner to identify the importance of the education interview and discusses how to construct and run a useful education interview. Helps the learner to set valuable educational objectives with considered feedback, develop listening skills and identify trainees with problems. The course has been run six times in 2051/16 and well attended.
MRPCH Exam	A structured teaching programme for the clinical MRCPCH examination and covers all clinical exam stations including; history taking, communication, development and physical examination. Sessions involve bedside teaching and small group work delivering OSCE-style teaching relevant to the examination. During 2015-16, 55 bedside training episodes occurred. Our hope is to open up

	these opportunities to our North London partner training organisations.
SHO Teaching Programme	This programme covers specialties and topics that align with the RCPCH curriculum and is based on the structure of the RSM paediatric teaching days. The programme focuses on the learning needs of level 1 trainees but is open to all junior doctors. Recently this has been opened up to the London School of Paediatrics. The attendance rate is high with the split across specialties being fairly even.
Grand Rounds	Reintroduced to GOSH in 2015. Lectures and case studies given by internal and external medics, to an expanding audience including medical and non-medical staff. Attendance and interest has been high with approximately 50 people attending each session. Some examples of topics are: All in your head? Perplexing cases of underweight children The Waiting Game: Bridging children to heart transplantation The Scourge of Button Batteries Learning from Excellence
Inter-Professional Education Network	A set of seminars and workshops designed to draw on the expertise of educators across the Trust and share good practice. Within a dynamic and progressive learning environment, IPEN offers an opportunity to learn from and with colleagues from all professional groups who share an enthusiasm for education, integrating best practice with practical application to high quality education and training.
Clinical Leadership in Action	Aimed at senior medical trainees and nursing staff to help them prepare for transition to a consultant/senior role. Includes a simulated scenario based around a patient complaint. Across 3 days, participants work in small groups to prepare a presentation to a simulated hospital board. The feedback from attendance has been excellent and delegates have been fully engaged and enjoyed the course.
Improving communication skills	A one day multi-disciplinary course designed on focusing and improving communication skills. Participants take away 'lifelong learning skills' to assist in personal development.

Additional Commissioning of Teaching

The PGME Design team has continued to provide administrative support for the successful delivery of a number of training programmes available to all staff across the Trust, commissioned from external providers. There is good attendance at these courses and the satisfaction rate is an excellent 97% with staff agreeing that the courses are relevant and well facilitated.

Title	Synopsis
Coaching & Mentoring	Embedding a coaching and mentoring culture has benefits including; improved trainee satisfaction, higher morale reduced absence, improved retention of doctors and improved leadership. There has been good interest and attendance from Consultants and Junior Doctors enabling a mixed level, shared learning experience.
Train the trainer	A comprehensive one day course focused on the knowledge and skills required to

	be a confident facilitator of learning. The theory and practice of teaching as a process of facilitating learning is integrated into activities with practical application.
Power, Politics and Persuasion	A course focused on the local health economy which explores the relationships and tensions between NHS organisations and discusses some of the current challenges facing health professional today, including the White Paper, reconfiguration, practice based commissioning, public health, patient safety and media interest.

Improvement and Development

PGME App (hosted by Guidebook)

The PGME App was launched in July 2015 and is accessible across all Trust and personal devices. The App is designed to allow users to connect with the latest training activities and functionality includes personalisation, enabling individuals to keep track of their own personal teaching, access to reading materials and review PGME, paediatric and speciality training events. To April 2016 PGME has tracked 125 downloads with an increase in this rate predicted for 2016-17 with further promotion.

PGME Website

The PGME website continues to be a reliable and user friendly resource. The PGME Design team will review content in 2016-17 to ensure the information given is accurate and up-to-date and look at ways to develop the website further.

PGME Newsletter

The PGME newsletter continues to be a success and now reaches its target audience through a distribution list that includes Consultants, Junior Doctors, Nursing and Non-Medical Education leads (e.g. Heads of Nursing, Practice Educators) and is accessible via the intranet to all staff at GOSH. The Newsletter is a valuable source of information about upcoming courses and positive feedback continues to be received.

Financial Overview

PGME's main source of income continues to be from HENCEL through the Learning and Development (LDA) agreement. There are two main financial streams: Clinical Placement Fees and salary support for Postgraduate Medical Education, and SIFT (Service Increment for Teaching) for undergraduate medical student placements. GOSH receives funding to support the infrastructure required to deliver PGME activity and resources and to support the ICH Library Service.

PGME HR services administers the level of study leave funding accessed and uses the infrastructure funding to support the development and delivery of innovative learning

programmes. Over the 2015/16 financial year there was notable salary underspend against plan. In the coming financial year, it is expected that this will revert to our expected budget plan as vacant and new posts become filled allowing the Trust meet the needs and requirements of postgraduate medical education and to look to develop and enhance our teaching programmes. During 2016/17 emphasis will be placed on expanding the number undergraduate medical student placements within GOSH, to establish further income streams for medical education.

The Future

The main focus for the PGME Design team in 2016-17 will be to build a solid foundations and a stable platform from which to develop PGME to meet our obligations as an education provider, demonstrate success through metrics and data analysis, understand and ensure our financial health and develop new income streams, and maintain and develop external partnerships. GOSH is committed to ensuring that learning at work for students and staff reflects the Trust's values and objectives and support delivery of the highest standard of care for children, young people and families.

The key priorities for the upcoming year will be to:

- Recruit the expertise to administer, design and deliver education encompassing a business intelligence function that supports quality monitoring, governance and commercial activity.
- Develop educational leadership roles throughout the hospital and a robust educational structure through to departmental levels
- Undertake a comprehensive review of core and specialty medical training to meet the training needs for the curricula and ensure training is targeted at the appropriate level
- Develop a governance structure for education that demonstrates engagement across the organisation and an effective process for ensuring education is linked to the Trust's workforce development plans; local faculty group establishment is a core part of this
- Review income streams and understand the potential for growth and generation of income
- Review and report on expected requirements for space to meet current and future demands for education and training activity
- Development of a portfolio of level specific training opportunities for talent management and leadership development throughout the post graduate medical workforce

2 Nursing and Non-medical Education

Introduction

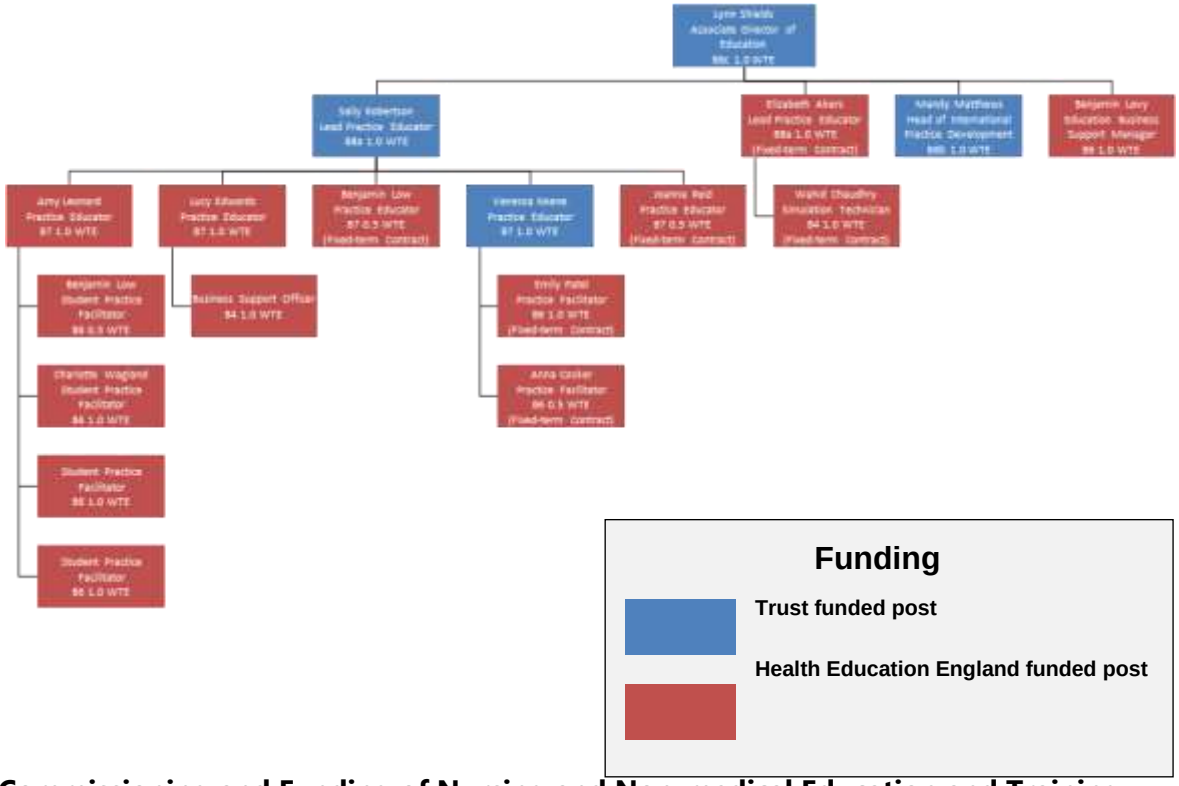
The Nursing and Non-medical Education Team (NNMET) lead on the scoping, commissioning, and provision of all nursing and non-medical education. They ensure that the trust meets its responsibilities in relation to pre-registration nurse education / under graduate non-medical education, education of the non-registered workforce, and the on-going professional development of other non-medical clinical staff in response to national and local regulatory frameworks.

2015/16 saw the external promotion of the then Assistant Director, Clinical and Professional Education and following consideration between the Chief Nurse, Medical Director, and Director of HR and OD, the accountability for work-streams under report here were moved to the Chief Nurse (with effect from 01.04.2016). The new post holder of Associate Director of Education started in post 04.04.2016.

The Associate Director of Education together with the Education Business Support Manager and Lead Practice Educator for NNMET provide leadership and direction in the development of an innovative, robust, financially viable education strategy that is responsive to the needs of the Trust.

The financial resources that underpin the GOSH Trust education work are aligned with income from HEE NCL with only limited (4) posts being GOSH funded. Following national budget allocation changes to HEE, it is expected that this will be passed through to NHS providers such as GOSH from 2016/17.

Nursing and Non-medical Team – Current Structure



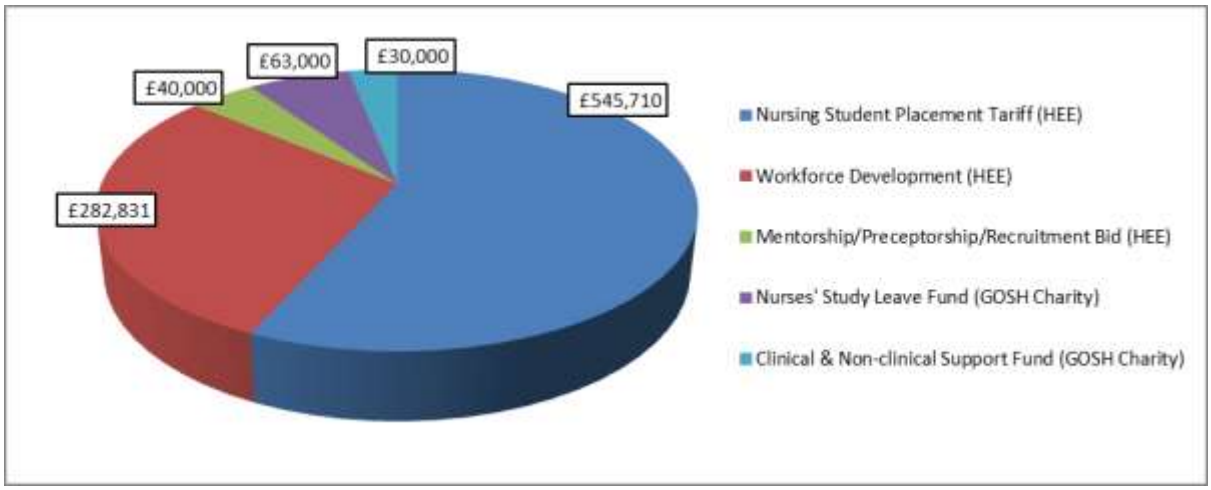
Commissioning and Funding of Nursing and Non-medical Education and Training

Education Funding for 2015-16: The nursing and non-medical education delivery within GOSH is solely reliant on the external HEE (Health Education England) funding and charity income. The total income is £961,541 with £868,541 from HEE NCL and £93,000 from the GOSH Charity. Of this funding, that which is available for workforce development thus equates to £115.55 per eligible non-medical staff.

The Learning and Development Agreement (LDA) between the Trust and HEE NCL (Health Education North Central London) sets out the Trust's responsibilities in relation to funding streams for Non-medical Education and Training (NMET), and workforce development funding for Bands 1-9. T545he LDA requires compliance with performance and quality monitoring procedures as determined by HEE NCL / HEE. The Trust is required to account to HEE NCL for spend against each funding stream, and the Trust is expected to show progress against national and Local Education Training Board (LETB) priorities as well as Trust priorities. Funding is released on a quarterly basis, dependant on HEE NCL workforce Education Plan quarterly review and submission

The Trust is fortunate to receive some financial support for educational activity from the GOSH Charity for Nurses, Allied Health Professionals (AHPs), Healthcare Scientists (HCS), and non-clinical staff.

Funding overview



Pre-Registration Nursing

GOSH hosts between 300 and 400 pre-registration nursing students per year, totalling approximately 4-5,000 placement weeks. In a response to placement capacity GOSH actively sought to reduce the first year student numbers until the revised undergraduate course plan is released. This is a temporary measure until the new course plan is implemented in September 2016. Students are supported in practice by designated mentors based in the clinical area and the Practice Educator and Student Practice Facilitators (SPFs) from the NNMET. In 2015/2016, GOSH commissioned 115 places on mentoring courses for registered nurses to ensure the Trust is able to continue to deliver a high quality placement learning environment and meet the NMC requirements for support of students.

Student nurses continue to evaluate their placement experience at GOSH positively. Students provide feedback via formal evaluations initiated by the university, by informal feedback at student forum to NNMET staff, and via an online questionnaire administered by NNMET. As a direct result of the SPF student forums in raising the awareness of its importance, compliance rate has increased from 20% to 70% in 2015/16.

Student attrition at GOSH is comparable to that at other Trusts where LSBU students are placed. GOSH has by the far the largest cohorts of nursing students within our region. The predominant reasons for attrition across all cohorts and Trusts are academic failure and personal reasons.

The Nursing and Midwifery Council (NMC) requires that all mentors of nursing students must produce, at a formal review held every three years, evidence that they have mentored at least two students within the previous three years, completed an annual mentorship update, and had the opportunity to consider, in a group setting, the validity and reliability of judgements made when assessing practice in challenging circumstances. The Trust has continued to build on its initial success of the new pro forma launched last year and compliance rate is now 91% (target 90%). Compliance with mentorship update and triennial review is reported to the Nursing Education Working Group.

The Trust continues to support adult nurses working at GOSH to undertake a shortened children's nursing programme in order to register as a children's nurse. This is a vital avenue for adult qualified nurses to access a career in children's nursing. Four nurses completed the programme this year, and another four are currently in training. The Trust has secured salary support for ten nurses to undertake the programme in September 2016. The Trust commissioned four salary-supported places for support staff to enter an undergraduate professional training programme. These staff are now in their first year of training, two as a children's nurse and two as an Operating Department Practitioner. Salary support has been secured for a further two places on each programme in 2017.

Education Activity

Preceptorship for newly registered nurses (NRNs)

The Preceptorship Programme is designed to support NRNs through the transition phase from pre-registered to newly registered nurse. The programme provides a structure through which to implement more effective monitoring of NRNs and to enable early intervention where staff need additional support.

Within preceptorship is the mandatory Professional Development Programme composed of four study days during the first six months of employment. The programme has been designed and adapted to suit the evaluation and needs of the NRNs and allows for adaptation of content for future intakes. The NNMET facilitated the programme for three cohorts of a total of 177 NRNs from April 2015-16. Evaluation from the NRNs is positive, and they particularly highlighted the value of time spent with their immediate peers to learn, reflect, and seek support.

The Preceptorship Programme also includes support from an identified Preceptor, bespoke orientation/induction, monitoring of competencies, the Clinical Skills Toolkit, and a variety of study days held centrally and locally.

With increased intake of NRNs, the NNMET anticipates accommodating 150 NRNs alone in September 2016.

Rotation Programme for newly registered nurses

Currently there are 60 NRNs within the Trust enrolled onto the Rotation Programme, completing eight-month placements in three different areas across the Trust. In addition to the support provided in their local areas, they are also provided with dedicated support from the Practice Educator for Newly Registered Nurses, which includes bespoke training and additional study days.

Evaluation from the rotation nurses is positive, and there is 97% retention of the workforce who completes the programme. Building on the success and the resultant retention of rotational staff, all elements of the Rotation Programme will now be incorporated into the Preceptorship Programme for all NRNs across the trust.

Nursing CPPD

The education team worked with internal stakeholders to ensure all available educational funding streams were used to best advantage. Heads of Nursing, Lead Nurses, and Practice Educators determined the key principles by which divisions were asked to commission post-registration nursing courses. This ensures that training requests are closely aligned to clinical and service priorities. Priority is given to education programmes which are deemed 'clinically essential', i.e. considered as providing the essential knowledge and skills to care for children and young people in the speciality/clinical area, e.g. PICU course, cancer course, etc.

Every year the initial 'bids' made by divisions for CPPD modules exceed funds available and have to be adjusted according to the budget available using the principles outlined above. The identified demand for 'clinically essential' modules accounted for approximately 50% of the indirect CPPD budget provided by HEE NCL. Despite the funding limitations, GOSH commissioned 470 places on post-registration specialist nursing courses, in addition to supporting staff on a variety of Masters programmes.

Between September 2015 and July 2016 (2015/16 academic year), students have undertaken 478 nursing modules at LSBU. We are currently working in partnership with LSBU in regards to the revalidation of their CPD curriculum and module provision ensuring it is fit for purpose for our staffs educational requirements and Trust service delivery needs.

Talent for Care

In response to both the Francis Report and Cavendish Review, in October 2014, the Government announced that the Care Certificate would be introduced. This is a mandatory programme required for all Healthcare Assistants (HCAs) upon entering employment in order to ensure that staff have the knowledge and skills in order to provide quality, effective, and safe care. All trusts were then mandated by HEE to ensure full implementation of the Care Certificate by April 2015.

The HEE standards were mapped against GOSH's current induction and e-learning for HCAs. Using findings from both these processes, a bespoke taught programme was designed to deliver educational outcomes not covered via induction / e-learning. An assessor's guide was developed to show how the competencies relate to children and young people using exemplars to demonstrate how each competency can be achieved in practice. Competency Assessment Documents to ensure programme completion were designed and are reviewed regularly by the NNMET.

The first cohort of the Care Certificate ran in April 2015 with a further six cohorts during 2015-16. In total 90 HCAs have completed the course, and all but six passed, of which all were either performance managed and resigned or left the trust for other reasons. The course is well evaluated with positive feedback from the candidates and clinical areas.

Our locally designed University Certificate of Competence, a Level 3 qualification for HCAs, continues to run and evaluate positively. NNMET facilitated 32 study days for 62 candidates, 9 of which were externals, from April 2015-16. Ensuring access for the Trust's current HCA workforce to the Care Certificate remains a challenge with 79% of eligible HCAs having completed the course. This has been discussed in detail at the Nurse Practice Educators Group, the Nursing Education Working Group, the Clinical Bands 2-4 Working Group, and identified as a priority in the coming year by both the NNMET and Trust Workforce Planning team.

AHPs, Pharmacy, and Healthcare Scientists

We continue to provide equity in access to education funding for staff from the allied health professions, pharmacy, healthcare science and non-clinical staff with Medical and Nursing staff. Individuals have been supported in continuing professional activity that includes:

- Post-graduate education for dieticians, physiotherapists, radiologists and pharmacists
- Postgraduate certificate in clinical pharmacy practice, dissertation to complete an MSc in Diagnostic Imaging, Master's degrees in physiotherapy and paediatric dietetics
- Clinically focused conferences for speech and language therapists, including CLEFT patient pathways
- Family Therapy and Systemic Practice Course: affiliated with Association of Family Therapy the fund supported the development for an accredited bespoke course in paediatric family therapy supporting the Child and Adolescent Mental Health Team strategic vision

The education team have been enabled to support the newly developed Healthcare Scientists Education Working Group with further networking events bringing scientists together to consider their education needs, share, and identify areas of good practice and co-ordinate educational activity across healthcare science. Healthcare Scientists are an under-represented group yet provide a significant amount of training for doctors and scientists in training. This group now leads the Pan London Scientific Activity in supporting elective placements for school leavers opening career opportunities in different NHS environments.

The NNMET have been working with Allied Health Professionals (AHPs) to establish an education working group for AHPs. This was initiated with a networking event to bring together department leads to consider their education needs, share, and identify areas of good practice and consider how to co-ordinate education activity across the Trust.

In 2015/16 discussions were held regarding the appointment of a Lead Healthcare Scientist and Lead Allied Health Professional for the Trust. The NNMET supports this recommendation, as it would in part assist better education delivery to these groups of staff. These discussions are still on-going.

Clinical Simulation Centre

The Clinical Simulation Centre is open to all professional staff groups; whilst simulation is most commonly accessed by medicine and nursing, work is underway to develop a multi-professional programme better reflecting patient pathways. The ability to innovate and respond to new technologies sets simulation apart in terms of safety; it is anticipated that the use of simulation to 'test' new technologies and approaches will continue to grow.

The nursing and non-medical education delivery of simulation within GOSH is solely reliant on the external HEE NCL funding and non-recurrent charity income.

International Education

While awaiting confirmation on the Kuwait contract confirmation we are continuing to review and validate both graduate and postgraduate courses for the commercial and international market. Discussions re confirmation of contract with Kuwait representatives have been on-going for two years.

'Me first' Children and Young People Communication Project

The 'Me first' communication project was commissioned by HEE NCL in 2014/15 after a need was identified across the region for the education of both clinical and non-clinical staff in communication with children and young people. The NNMET was requested and funded by HEE NCL to design a programme with feedback from external stakeholders, communication specialists, NHS staff, and children and young people.

In 2015/16, Phase 2 of the programme was completed. The project has now delivered 16 one-day inter-professional face-to-face training sessions across the North Central London region, with 264 delegates trained. Participants were representative of a number of professions across nursing, medicine, healthcare science, allied health, psychology, social work and play. The bespoke in-house training days have been very successful in working with specific teams to transform their workforce and embed changes to their practice. The training continues to be evaluated very highly.

In addition to positive feedback, the project has won a number of awards, including the Patient Experience Network 'Personalisation of Care Award' and overall winner of all categories, an HEE NCL Quality Award 'Highly Commended for Patient and Carer Centred Education', and have been shortlisted for the 'Team of the Year Award' by the Nursing Times.

Quality Assurance

Nursing placement learning is audited according to Nursing Midwifery Council requirements. The Trust is required to audit all ward areas that offer student places every two years. In practice, 50% of such areas are audited each academic year.

The Nursing Education Working Group (NEWG), which includes a student representative, receives reports on student nurse evaluations and compliance with mentorship update and triennial review in line with NMC guidance. These evaluations are distributed to local Ward Managers, Practice Educators, and Practice Facilitators in order to review feedback and implement changes to benefit the local student placement experience.

The Trust is required to submit a workforce development plan to the HEE NCL, detailing intended spend in regard to workforce development funding prior to ensure funding approval in Q2.

Risks

Following the Government's Comprehensive Spending Review the current NHS plan to remove the undergraduate bursary for health care training will increase the financial burden to the student and subsequently threaten to reduce the supply of future nurses and AHPs. This is at a time when our patient complexity and demand is increasing.

There has been an expected 30% reduction in Workforce Development Funding from HEE in 2016/17 with uncertainty as to what funding might be available in 2017/18. If there is a repeat reduction of 30% funding, we will be unable to meet staff team costs or support professional education within the Trust.

The Future

The main focus for the Nursing and Non-medical education Team in 2016-17 will be to build on our success and to become the education provider of choice for both the undergraduate and postgraduate workforce.

The key priorities for the upcoming year will be to:

- Develop and implement the Education and Training Trust strategy
- Undertake a comprehensive training needs analysis of the workforce to ensure we meet the educational needs of our staff and clinical areas
- Develop a governance structure for education that demonstrates engagement across the organisation and an effective process for ensuring education is linked to the Trust's workforce development plans
- Taking forward recommendations arising from the Shape of Caring Report 'Raising the Bar'

3 Learning and Development

Introduction

There has been a three-part emphasis for Learning and Development in 2015/16:

- Reviewing, developing and delivering the underpinning elements for learning (this includes mandatory training; appraisals; learning technology)
- Developing leadership
- Responding to operational needs and building capability

Reviewing, developing and delivering the underpinning elements for learning

Learning technology

Although the Trust has a successful e-learning platform, GOLD, and produces significant amounts of e-learning courses, all training records have been managed via a database. This was not fit for purpose, and in particular did not provide easily accessible or reliable reporting on staff compliance with mandatory training or appraisals. This has made performance managing these issues challenging.

A learning management system was procured in 2014, and during 2015/16 extensive work took place on developing the system to meet the Trust's specifications. Significant challenges were encountered, resulting in the go live date of November 2015 being missed. Following a change in project management from the supplier and the re-allocation of project support from ICT, the system was launched in May 2016. No significant technical issues were encountered and the system has been widely welcomed as simple to use and delivering considerable benefits.

The LMS will provide a significant resource in managing mandatory training compliance and streamlining processes as it allows staff to self-book onto training rather than the line manager needing to perform this function. It also provides a portal for external bookings onto training, including making electronic payments, which will allow GOSH to increasingly develop its profile (and commercial opportunities) as a provider of education nationally and internationally.

Statutory and mandatory training

The CQC inspection in March 2015 highlighted the Trust's failure to meet its own target of 95% in mandatory training across a range of departments and subjects.

Compliance rates for GOSH employees in mandatory topics at the end of 2015/16 was as follows:

Equality Diversity and Human Rights	87%
Fire Safety	81%
Health Safety and Welfare	86%
Infection Prevention and Control Level 1	86%
Infection Prevention and Control Level 2	58%
Information Governance	81%

Moving & Handling Level 1	59%
Moving & Handling Level 2	72%
Resuscitation Level 1	61%
Resuscitation Level 2	62%
Resuscitation Level 3	71%
Safeguarding Adults Level 1	85%
Safeguarding Children Level 1	85%
Safeguarding Children Level 2	71%
Safeguarding Children Level 3	87%

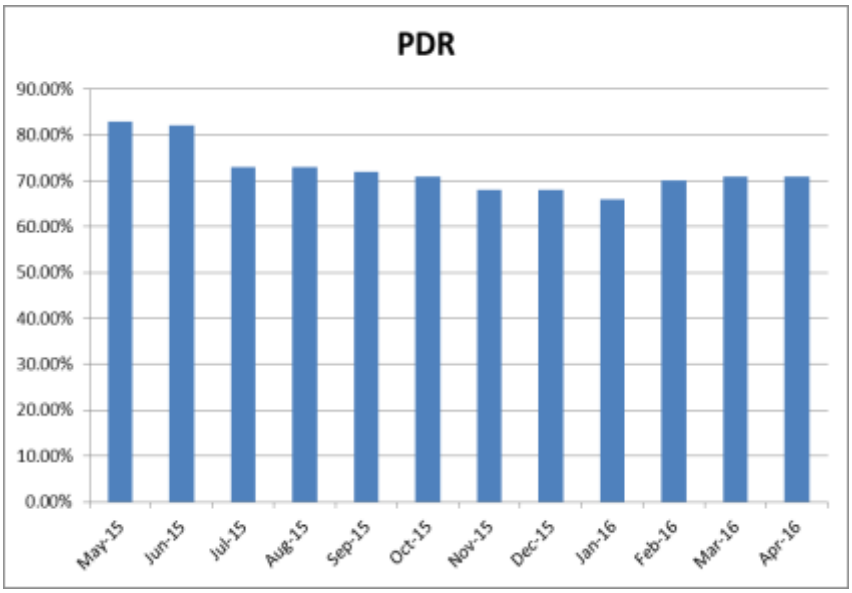
There are likely to be a range of factors involved in this shortfall, including a view amongst staff often see mandatory training as a bureaucratic exercise which does not add value; some training not being sufficiently relevant to GOSH specialties/of good enough quality; and the difficulty in accessing accurate information on mandatory training compliance for individuals and managers.
In response to the CQC report, and in light of the issues above, the Trust agreed an action plan which included:

- Establishment of a multi-disciplinary group to review the content, quality and frequency of mandatory training
- Launch the LMS, which will provide a dashboard for each member of staff, listing their mandatory training requirements and completion status; automated email reminders to staff and managers when training is due, and overdue; manager dashboard for managers so they can view compliance of individuals at-a-glance
- Introduce a robust performance management process

At the end of 2015/16, the actions of this plan were being delivered to time. It will continue to be closely managed during 2016/17, with mandatory training data being reported regularly as part of the Trust's performance management process.

PDR Appraisals

PDR appraisal rates dropped in 2015/16 following an initial improvement after the introduction of the updated PDR Appraisal policy in April 2015.



Compliance has started to improve again towards the end of the financial year, and PDR appraisal notifications and recording on GOLD LMS will be implemented in July 2016. This will further support staff to always have a current PDR appraisal as they and their managers will be able to see when the appraisal is due and receive reminders.

In addition, simplification of the process and bite sized training sessions will be put in place to remove perceived barriers to appraisals; and performance management, in line with that for mandatory training, will be introduced.

Developing leadership

Following a realignment of resources, a new post of Head of Leadership was established and recruited to. This was in recognition of the considerable internal leadership agenda, which included the the development of the new Head of Clinical Service roles; organisational redesign; and a largely new executive team. It was also intended to support the development of leaders who will be able to meet the operational and strategic challenges faced by the Trust, for example managing waiting times and the need for increased capacity. Finally, it recognises the external focus on leadership from Lord Rose's *Better leadership for tomorrow: NHS leadership review* (July 2015) and Lord Carter's review into *Operational productivity and performonace in English NHS acute hosptials* (February 2016).

During spring 2016, the Head of Leadership engaged with clinical and non-clinical leaders across the organisaiton, including in OD workshops that supported and informed the divisional restructure. The intelligence gained through this process will be used to develop a plan for targeted leadership development programmes for:

- Executive team
- Heads of Clinical Service
- Divisional leadership teams

Input will still be provided to support the development of other staff, in particular those in nursing and other clinical leadership roles, but the approach marks a shift in thinking for GOSH, away from offering leadership programmes to staff who applied for them, to focusing resources on staff in key leadership roles in the first instance.

The HR&OD team also launched a series of leadership masterclasses, with expert speakers talking on a range of topics including high-impact presentations, emotional intelligence in leadership, and courageous conversations. These were all extremely well attended, particularly by medical leaders.

Heads of Clinical Service

The new role of Head of Clinical Service was developed at the end of 2014 as part of the first phase of the Trust redesign. The role created a consistent clinical leadership role at specialty level, with some specialties where there were synergies being brought together under a single Head of Clinical Service. During the remainder of 2014/15 and 2015/16, 27 Heads of Clinical Service were appointed. The selection process did not only involve a panel interview but also had one or more elements of an assessment centre which provided the panel with a rounded assessment of the candidates' leadership capabilities, and gave all candidates a personalised overview of their strengths and areas for development. This approach recognised that many of the appointed Heads of Clinical Service had not held formal leadership roles in the past, and had not had received formal leadership training. The plans therfore provided a starting point for individual development.

In addition, each HOCS was partnered with a mentor from Morgan Stanley. Overwhelmingly, this was felt to be a very positive experience bringing HOCS what they described as a rare opportunity for personal reflection; challenge from outside the NHS of "how we do things round here"; and advice on practical issues.

Values-based leadership

The Trust's Our Always Values were launched formally by the Chief Executive in March 2015. As part of the roll out plan, between January and May, leadership sessions were attended by over 220 key clinical and non-clinical leaders, including all Executive Directors. These sessions provided a clear explanation of how living Our Always Values will result in improved patient outcomes. They also gave leaders tools to promote positive behaviours and reflect back to colleagues the impact of behaviours that do not demonstrate our values.

In addition, we have fully incorporated our values into our annual staff appraisals, so that staff must demonstrate that they consistently live our values in order to achieve an overall excellent ranking.

Developing leaders whose values are aligned with those of the Trust and who act as role models will be an inherent part of our leadership development programmes.

Responding to operational needs and building sustainability

All three of the education teams delivered very high levels of learning activity over 2015/16. The take up of formal face-to-face training and e-learning (that is, training that is reported centrally) was as follows:

Face to face	29,002
E-learning	31,563
TOTAL	60,565

Booking onto face-to-face courses and confirming attendance with participants is currently a manual process which involves considerable input from administrative staff in the L&D and other education teams. The new Learning Management System allows self-booking, which will allow administrative staff to focus on more value-added activities.

These figures include the large number of staff attending corporate induction on a monthly basis – approximately 100 – as well as large cohorts of newly qualified nurses and junior doctors on rotation. In 2016/17 the Trust will develop its ability to recognise learning from previous organisations which means that staff do not have to complete all parts of face-to-face or e-learning again during GOSH induction.

Apprenticeships

Apprenticeships are increasingly providing a route for us to bring new staff into the organisation with a programme of learning that allows them to develop whilst working. In addition, we are able to offer existing staff vocational training that increases their skill and knowledge.

The Trust has seen a significant increase in apprentice numbers. In 2012, the first year GOSH ran apprenticeships, 14 staff were in these roles; in 2015/16, 46 staff started an apprenticeship. In 2016/17, the planned number is 65.
Of the 46 staff in apprenticeships in 2015/16, 11 were employed as apprentices and 35 existing staff were on apprenticeship programmes. Apprentices were employed in roles including ward clerks, medical records, HR admin, trainee chefs, pharmacy stores and management accounts. In 2016/17 there are plans to develop apprenticeships for electrical and plumbing roles, and a combined apprenticeship between the Staff Nursery and the Play Department, providing increased sustainability for both these departments.

GOSH was the only trust in the HENCEL region to exceed its apprenticeship starts target in 2015/16.

The apprenticeship levy will come into effect in April 2017 at a rate of 0.5 per cent of an employer's wage bill, and will be paid through Pay As You Earn (PAYE). The monies will be placed into a fund which employers may only use to purchase apprenticeship development. Throughout 2016/17 the Trust will be actively seeking to develop its apprenticeship capacity to mitigate the potential losses incurred under the levy. These include working with others to look at innovative models for apprenticeships including becoming a provider and developing higher level apprenticeships at graduate level and above.

Equipping line managers with basic skills

Historically, the Trust has run classroom-based courses for line managers in a range of HR skills such as recruitment, managing performance and managing appraisals. Increasingly, it is clear that whilst the requirement for these skills still exists there is limited capacity for line managers to take time away from the workplace. The HR&OD team therefore started to develop "bitesize learning sessions" which provide practical advice and on management issues in an interactive short format.

Referral to Treatment training

In support of the work to manage waiting times, the Trust rapidly developed and launched bespoke e-learning to improve the knowledge about 18 week and cancer pathways of approximately 1400 targeted clinical and non-clinical staff in the hospital. A challenging trajectory for all these staff to be trained by mid April 2016 was agreed with the Tripartite group and achieved. Further mandatory training on how to apply 18 week and cancer pathway rules across specific clinical and non-clinical roles will be developed and rolled out in the first half of 2016/17.

Maintaining and enhancing education activity

During 2015/16 new face-to-face courses were introduced, including Prevent Level 3 and the NHS Finance Operating Game which improves financial management skills for non-finance staff.
7 e-learning courses, the majority of which related to patient care, were built and launched.
4 further e-learning courses were updated.

Quality Assurance

Feedback is requested for all taught courses, including induction, and for e-learning. Changes are made on the basis of feedback received (for example, a new Safeguarding e-learning package will be introduced in 2015/16). As part of the TNA process recommended by the education audit, a more robust and regular process to ensure that training is of consistently high quality and meets individual and service and strategic needs will be developed in 2015/16. This is already underway with the systematic review of all mandatory training.

Priorities for 2015/16

The priorities for the next 12 months will continue along the same themes:

Reviewing, developing and delivering the underpinning elements for learning. This will include:

- Further develop the capabilities within the Learning Management System to include appraisals, accessibility to staff prior to commencement, and the ability to support commercial learning opportunities
- Complete work on mandatory training and appraisals compliance so that the Trust meets and sustains its targets

Developing leadership

- Deliver the first phase of the leadership plans for the Executive team, new divisional teams and Heads of Clinical Service

Responding to operational needs and building capability

- Redesign the structure of Learning and Development so that it delivery high quality core functions but also meets the changing needs of the hospital particularly around organisation development such as teamworking and leadership.

- Develop the methodology and undertake a training needs analysis so that training that meets organisational need is delivered

Conclusion

This has been a period of considerable change across all of the Trust's education functions. Each has gone through a process of building on existing strengths and developing new thinking at the same time as continuing to deliver education, training and development to the Trust. This process of transformation will continue over the coming 12 months partly in response to the challenges that are anticipated in particular in nursing and non-medical clinical education, but also in order to progress the vision of education at GOSH being world class.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
20th July 2016

Safe Nurse Staffing Report for May 2016 and June 2016 **Submitted by: Juliette Greenwood, Chief Nurse**	**Paper No: Attachment K**

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 16/17 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 Nurses, Head of Nursing

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

GOSH NURSE SAFE STAFFING REPORT

May 2016

1. Introduction

1.1 This report on GOSH Safe Nurse Staffing contains information from the month of May 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 May is attached as Appendix 1. The spread sheet contains:

- Total monthly planned staff hours; the Divisional Assistant Chief Nurses and Head 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:

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

RN Day	RN Night	HCA Day	HCA Night	Total Fill Rate
102.2% (106%)	91.0 (99%)	95.7% (107%)	86.0% (74%)	96.3% (95%)

Barrie – (MDTS/Neuro/Surgery) - No unsafe shifts reported in May

- Eagle – Acuity of complex transplant patients accounts for an increase above 10% tolerance for qualified staff. HCA below 10% tolerance due to long term sickness and a HCA on phased return from sickness.
- Kingfisher – Qualified nurses below 10% tolerance due to vacancies. 2WTE HCAs are on maternity leave. 1 vacancy now filled but is supernumerary whilst undertaking the care certificate course.
- Rainforest Gastro –HCAs below 10% tolerance due to one member of staff undertaking the Care Certificate course and one on unpaid leave.
- Rainforest Endo/Met – Qualified nurses below 10% due to sickness and staff vacancies, these posts have now been filled but the staff cannot do nights straight away as they are still required to complete their medication competency training. 1 HCA vacancy now filled but the member of staff is undertaking the care certificate course.
- 2 beds continue to be closed on Sky due to registered staff vacancies (see Appendix 2) and an increase in patient acuity.
- Staff were moved across the Division to maintain safe staffing levels and to maximise activity.

IPP – No unsafe shifts reported in May

- Bumblebee and Butterfly - continue to utilise HCAs to care for infants without resident parents and tracheostomy patients requiring 1:1 care. The variance with registered staff and bank staff is in a response to patient dependency.
- The increase in HCAs numbers is due to the provision of additional support for long term patients and recruitment of staff in preparation for the opening of the new Hedgehog ward.
- Work is also underway with the Trust Bank to recruit bank staff to undertake lines of work to support the opening of Hedgehog in August

West – (CCCR/ICI) - No unsafe shifts reported in May

- Higher fill rates were due to an increase in dependency of patients and increased patient activity across the division
- Fox and Robin - Lower fill rates were due to the wards being moved, staff sickness and staff being moved across the division to support patient activity.
- Robin – one bed closed for planned maintenance work.

2.1.3 The Clinical Site Practitioners (CSPs) report that no wards were declared unsafe during May; however 17 compared to 12 shifts in April are noted where wards reported being short of staff but safety was not compromised.

2.1 General Staffing Information

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

2.2 8 out of 23 inpatient wards closed beds at various points during May compared to 9 in April. An average of 3.4 beds were closed each day, this is a decrease from 6.7 bed closures in April. The main reasons for bed closures were due to vacancies on Sky and planned maintenance work on Robin.

2.3 For the inpatient wards, at 1st May 2016, the registered and non-registered vacancies totalled 115.4 96 WTE, an increase from 96 in April. This breaks down to: 97.4 (11.8%) registered nurse vacancies (72 in April); 18 (11.4% of total HCAs) HCA vacancies (23 in March). Temporary nurses, mainly from GOSH Nurse Bank, deployed on the wards totalled 102.7 WTE, the May position was therefore 12.8WTE net vacancies (-3.2 WTE in April and -10 WTE in March).

3 Vacancies and Recruitment

3.3 Staff attended recruitment fairs in Bedfordshire and Napier University (Edinburgh) this month, both were reviewed well by those attending. As with all the current and planned nurse recruitment events, the candidate's expressions of interest will be followed up, tracked and analysed against job applications received and their successful appointment.

3.4 Following the recruitment fair held in April, 176 Newly Qualified Nurses (NQNs) have been shortlisted and invited to attend assessments centre days in June and July. A total of 185 applicants were received, the majority of the 9 not invited to the assessment days were from overseas and will be reviewed separately.

3.5 10 Band 3's, have been successfully recruited at April's Assessment centre and pending pre-employment checks are due to start in June 2016.

3.6 27 either newly registered or experienced nurses are in the pipeline to start between June and July.

3.7 The 6 monthly nurse establishment reviews are planned to commence July 2016.

3.8 51% (50WTE) of RN vacancies in May are at band 6, this is an increase of 9 vacancies over the last month. This increase in leavers is currently being investigated.

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 in particular the opening of Hedgehog ward planned for August 2016.

5. Key Quality and Safety Measures and Information

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

5.3 Infection control

Numbers of C diff's	0
Number of MRSA bacteraemias	0
Number of MSSA bacteraemias	4
Number of E.coli bacteraemias	3
Number of outbreaks and whether any beds closed	1(no beds closed)
Carbapenemase-producing Enterobacteriaceae	1(confirmed) 2 (possible)
Hospital acquired enteric virus infections	16
Hospital acquired viral respiratory infections	19

5.4 Pressure ulcers

Grade 3	**0**	
Grade 2	**5**	CICU x 3 (2 x ETT – avoidable, 1 x Occiput - avoidable) PICU x 1 (1 x Ear – avoidable) NICU x 1 (1 x ETT - avoidable)

The number of pressures sores occurring in May is the same as seen in April. The new root cause analysis process is being used at present to investigate and implement action plans for all the above pressure ulcers.

5.5 Deteriorating patient

There were 16 2222 calls in May 2016 (6 in April). There were 0 cardiac arrests. There were 3 respiratory arrests, 1 of which may have been preventable, following a difficult tracheostomy tube change, it is reported that this was a well-managed event .

In addition there were 10 unplanned admissions to the Intensive care units; 2 x Barrie Division (1 Sky & 1 Rainforest Endo/Met); 6 x West Division (4 Bear, 1 Fox & 1 Robin); 2 x IPP (1 Bumblebee & 1 Butterfly).

5.6 Numbers of safety incidents reported about inadequate nurse staffing levels

There was 1 incident reported by staff regarding shortages of nurses, this occurred on a day shift on Flamingo ward (CICU). It had been agreed that two PICU nurses could be relocate to CICU for the night shift to cover short staffing, this agreement was later cancelled as PICU activity had increased. CICU had already agreed to go ahead with a transplant based on having the additional

nurses; however the transplant case was cancelled due to the donor organ not being viable. The nurses were sent back to PICU.

5.7 Pals concerns raised by families regarding nurse staffing – 1

There was 1 referral to Pals where an operation was cancelled due to lack of post-op bed availability. The Trust continues to operate at maximum capacity with increased pressures from RTT. It is unclear from the referral whether nursing staff numbers contributed to the concerns reported or if there was no bed capacity.

5.8 Complaints received regarding nurse safe staffing – 0

The Trust did not receive any complaints in regards to nurse safe staffing during May 2016.

5.9 Friends and family test (FFT) data

Overall response rate for May 2016 has increased to 27.52% (data extracted 07/06/2016) compared to 23.58% in April 2016. The target response rate has increased to 60%.

- The overall percentage to recommend score is 98.3% (data extracted 07/06/2016).
- Families that were extremely likely to recommend GOSH to their friends and family equalled 89.6% (740) and 8.7% (72) responded as likely to recommend compared with 89% (628) and 9.6% (68) in April 2016.
- For information, the following negative comments or suggestions regarding staffing issues/staff behaviour have been received for the following wards.

Response	Ward/Area	Comment related to response
Extremely Unlikely	Rainforest Gastro	While in isolation all nurses put aprons on and gloves on before entering the room. Not one doctor or consultant did, one did after being told by a nurse. My child has a bug that would easily be passed to others. There is a sign on the door and he also has a MDRO Alert! on notes.

- The following positive comments regarding outstanding performance regarding staff behaviour have been received for the following wards:

Response	Ward/Area	Comment related to response
Extremely Likely	Koala	The nurses on Koala work extremely hard and are always willing to offer up their time to discuss any issues we have. Their expertise and care is second to none- they are invaluable. I want to add also a thank you to (staff name) who works extremely hard. She has taken time out to come and discuss (patient name) care with me when I was unsure of his ICP results. We were very grateful. (name and contact number of parents provided)
Extremely Likely	Respiratory Sleep Unit	Here with my 5yr old daughter, staff were just amazing, we were beautifully looked after by (names of 3 staff) and Dr (name of Dr). My daughter was reassured and treated beautifully. Day staff (I didn't catch names) were so kind and helpful, the service was amazing, thank you!
Extremely Likely	Squirrel	From the very moment we arrived by ambulance (from another hospital in Oxfordshire) we received the most outstanding care. I had been told that my daughter required emergency major surgery and that her condition was very serious. However thanks to the decisive actions of (name of staff), her team and the ENT team, my daughter avoided surgery and is now well enough to go home. I cannot thank GOSH enough for what they have done. It is a very special place staffed by ex-

		ceptional people.
Extremely Likely	Sky	Everything went exceptionally smoothly from arrival to discharge. All staff, polite, efficient and courteous and made my daughter feel at ease. When staff said they would return, they did and we were never kept waiting. Last admission here was 3 years ago and if anything service has improved. Very happy.

6. Conclusion

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

Appendix 1: UNIFY Safe Staffing Submission – May 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 CEN	Badger Ward	340 - RESPIRATORY MEDICINE		2331	2625.85	347	287.5	2084	2053.6	347	226.8	112.6%	82.9%	98.5%	65.4%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Bear Ward	170 - CARDIOTHORACIC SURGERY	321 - PAEDIATRIC CARDIOLOGY	2768	3218.3	591	414	2768	3010.3	346	314.6	116.3%	70.1%	108.8%	90.9%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Flamingo Ward	192 - CRITICAL CARE MEDICINE		7026	7927.75	356	184	6624	6953.3	207	118.8	112.8%	51.7%	105.0%	57.4%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Miffy Ward (TCU)	340 - RESPIRATORY MEDICINE		713	786.25	1069	871.5	713	572.8	713	680.8	110.3%	81.5%	80.3%	95.5%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Neonatal Intensive Care Unit	192 - CRITICAL CARE MEDICINE		3208	3364.9	356	0	3208	3017.55	0	0	104.9%	0.0%	94.1%	-
RP401	GREAT ORMOND STREET HOSPITAL CEN	Paediatric Intensive Care Unit	192 - CRITICAL CARE MEDICINE		6060	6456.72	356	207	6060	5353.9	356	183.6	106.5%	58.1%	88.3%	51.6%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Elephant Ward	370 - MEDICAL ONCOLOGY	823 - HAEMATOLOGY	1679	1734	356	350	1426	1341.7	356	303.1	103.3%	98.3%	94.1%	85.1%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Fox Ward	303 - CLINICAL HAEMATOLOGY	313 - CLINICAL IMMUNOLOGY and ALLERGY	2123	1801.5	353	230.5	1975	1555.6	353	240.47	84.9%	65.3%	78.8%	68.1%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Giraffe Ward	313 - CLINICAL IMMUNOLOGY and ALLERGY	350 - INFECTIOUS DISEASES	1069	1354.7	356	218.5	1069	873.1	356	164.8	126.7%	61.4%	81.7%	46.3%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Lion Ward	370 - MEDICAL ONCOLOGY	303 - CLINICAL HAEMATOLOGY	1679	1621.45	356	379.5	1426	1069.6	356	393.4	96.6%	106.6%	75.0%	110.5%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Penguin Ward	330 - DERMATOLOGY	410 - RHEUMATOLOGY	966	1187.78	356	642.18	713	646.15	356	207.3	123.0%	180.4%	90.6%	58.2%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Robin Ward	350 - INFECTIOUS DISEASES	313 - CLINICAL IMMUNOLOGY and ALLERGY	2035	1503.8	356	563.5	1782	1115.9	356	577.7	73.9%	158.3%	62.6%	162.3%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Bumblebee Ward	171 - PAEDIATRIC SURGERY	420 - PAEDIATRICS	2427	2460.1	346	954.5	2080	2241.35	693	875.3	101.4%	275.9%	107.8%	126.3%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Butterfly Ward	370 - MEDICAL ONCOLOGY	420 - PAEDIATRICS	2848	2323.25	356	1070.5	2136	1658.2	356	472.8	81.6%	300.7%	77.6%	132.8%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Eagle Ward	361 - NEPHROLOGY		2288	2837.32	713	725.5	1426	1270.6	356	277.7	124.0%	101.8%	89.1%	78.0%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Kingfisher Ward	420 - PAEDIATRICS		1776	1479.64	914	484.05	331	348.4	0	66.2	83.3%	53.0%	105.3%	-
RP401	GREAT ORMOND STREET HOSPITAL CEN	Rainforest Ward (Gastro)	301 - GASTROENTEROLOGY		943	1100.1	696	333.5	696	725	696	222.3	116.7%	47.9%	104.2%	31.9%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Rainforest Ward (Endo/Met)	302 - ENDOCRINOLOGY		1069	1088.5	713	253	1069	877.3	356	274.2	101.8%	35.5%	82.1%	77.0%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Mildred Creak	711- CHILD and ADOLESCENT PSYCHIATRY		1116	1056.55	612	555.5	509	390.2	460	351.2	94.7%	90.8%	76.7%	76.3%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Koala Ward	150 - NEUROSURGERY	421 - PAEDIATRIC NEUROLOGY	3318	3192.32	352	598.5	3227	2630.6	352	205.9	96.2%	170.0%	81.5%	58.5%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Peter Pan Ward	120 - ENT	160 - PLASTIC SURGERY	1439	1211.25	556	460	1355	966.1	0	21.6	84.2%	82.7%	71.3%	-
RP401	GREAT ORMOND STREET HOSPITAL CEN	Sky Ward	110 - TRAUMA & ORTHOPAEDICS	171 - PAEDIATRIC SURGERY	1852	1721.8	648	824	1810	1547.3	0	11.5	93.0%	127.2%	85.5%	-
RP401	GREAT ORMOND STREET HOSPITAL CEN	Squirrel Ward	171 - PAEDIATRIC SURGERY	101 - UROLOGY	2796	2860.97	664	667	2518	2553.85	0	152.6	102.3%	100.5%	101.4%	-

Attachment K
Appendix 2: Overview of Ward Nurse Staffing – May 2016

Speciality	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		
CardioRespiratory	Badger	15	39.5	38.0	1.5	7.5	8.0	-0.5	47.0	1.0	1.8	-0.8	2.0	1	0	0.0
	Bear	24	53.5	51.4	2.1	9.0	8.4	0.6	62.5	2.7	5.5	-2.8	4.0	0	0	0.0
	Miffy (TCU)	5	14.1	10.5	3.6	10.4	9.5	0.9	24.5	4.5	6.6	-2.1	0.0	1	0	0.0
Critical Care	Flamingo	17	121.0	101.0	20.0	10.8	5.0	5.8	131.8	25.8	20.2	5.7	8.0	0	0	0.0
	NICU	8	51.5	45.0	6.5	5.2	2.0	3.2	56.7	9.7	7.6	2.1			0	0.0
	PICU	13	83.1	84.0	-0.9	8.9	3.0	5.9	92.0	5.0	5.6	-0.6			0	0.1
Haematology/Oncology/Dermatology/Rheumatology	Elephant	13	25.0	19.0	6.0	5.0	5.0	0.0	30.0	6.0	2.8	3.2			0	0.0
	Fox	10	31.0	25.8	5.2	5.0	4.0	1.0	36.0	6.2	2.9	3.3			0	0.0
	Giraffe	7	19.0	16.4	2.6	3.1	2.0	1.1	22.1	3.7	0.8	2.9	1.0	0	0	0.0
	Lion	11	22.0	18.8	3.2	4.0	4.0	0.0	26.0	3.2	4.1	-0.9	2.0	0	0	0.0
	Penguin	9	15.5	13.8	1.7	5.8	6.6	-0.8	21.3	0.9	0.5	0.4			0	0.0
	Robin	10	27.2	21.7	5.5	4.5	4.4	0.1	31.7	5.6	4.2	1.4			0	0.7
IPP	Bumblebee	21	38.3	26.1	12.2	9.7	12.0	-2.3	48.0	9.9	10.3	-0.4	1.0		0	0.0
	Butterfly	18	37.2	25.6	11.6	10.5	9.9	0.6	47.7	12.2	7.1	5.1	2.0		0	0.0
MDTS	Eagle	21	39.5	38.0	1.5	10.5	10.0	0.5	50.0	2.0	3.0	-1.0	1.0	0	0	0.1
	Kingfisher	16	17.1	13.2	3.9	6.2	3.9	2.3	23.3	6.2	1.7	4.5			0	0.0
	Rainforest Gastro	8	17.0	15.9	1.1	4.0	3.5	0.5	21.0	1.6	0.9	0.8			0	0.0
	Rainforest Endo/Met	8	15.6	10.8	4.8	5.2	5.5	-0.3	20.8	4.5	2.4	2.1	2.0	2	0	0.4
Neuro-sciences	Mildred Creak	10	11.8	16.2	-4.4	7.8	8.4	-0.6	19.6	-5.0	0.8	-5.8			0	0.0
	Koala	24	48.2	44.0	4.2	7.8	8.0	-0.2	56.0	4.0	5.0	-1.0			0	0.1
Surgery	Peter Pan	16	24.5	23.1	1.4	5.0	5.0	0.0	29.5	1.4	1.0	0.4	1.0		0	0.2
	Sky	18	31.0	25.0	6.0	5.2	5.0	0.2	36.2	6.2	4.1	2.1	4.0		0	1.9
	Squirrel	22	43.6	45.5	-1.9	7.0	7.0	0.0	50.6	-1.9	4.0	-5.9	2.0		0	0.1
	TRUST TOTAL:	**324**	**826.2**	**728.8**	**97.4**	**158.1**	**140.1**	**18.0**	**984.3**	**115.4**	**102.7**	**12.8**	**30.0**	**4.0**	**0.0**	**3.4**

Great Ormond Street Hospital for Children NHS Foundation Trust

GOSH NURSE SAFE STAFFING REPORT

June 2016

1. Introduction

1.1 This report on GOSH Safe Nurse Staffing contains information from the month of June 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 June is attached as Appendix 1. The spread sheet contains:

- Total monthly planned staff hours; the Divisional Assistant Chief Nurses and Head 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:

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

RN Day	RN Night	HCA Day	HCA Night	Total Fill Rate
101.4% (102.2%)	89.8% (91.0%)	97.6% (95.7%)	85.8% (86.0%)	95.5% (96.3%)

Barrie – (MDTS/Neuro/Surgery) - No unsafe shifts reported in June

- **Eagle:** Acuity of complex transplant patients accounts for an increase above 10% tolerance for qualified staff.
- **Kingfisher:** Qualified nurses above 10% tolerance at night due to PH study requiring 1:1 nursing.
- **Rainforest Gastro:** Qualified nurses above 10% tolerance due to specialised / observed patients. HCAs below 10% tolerance due to one member of staff on phased return from sick leave.
- **Rainforest Endo/Met:** HCA below 10% tolerance due to long-term sickness.
- **Peter Pan:** Below 10% tolerance due to mat-leave and vacancies. Fill-rate no impact on safe staffing, as no high dependency patients.
- **Sky:** Qualified nurse (night) above 10% tolerance due to two invasive procedures, and one requiring 1:1 nursing.

IPP – No unsafe shifts reported in June

- **Butterfly:** Qualified staffing deficit and associated risks were mitigated by additional bank HCAs and careful staff allocation. Reduced registered nursing staff at night and increased HCAs as dependency of patients was reduced at night (due to BMT patients requiring blood products and increased IVs during day) and due to numbers of day case surgical patients.
- **Bumblebee:** Qualified staffing deficit and associated risks were mitigated by additional bank HCAs and careful allocation. Additional HCAs with tracheotomy skills were also used to support/care for patients with tracheostomies in cubicles.

West – (CCCR/ICI) – 1 shift reported in June

- 1 confirmed unsafe shift on Elephant reported on 26th June, with a junior member of staff having to take charge. The appropriate escalation process was used though additional staff could not be found with the right experience. There was no adverse incident reported due to the lack of experienced nursing staff.
- Nursing staff moved to ensure the wards were safe as required.

2.1.3 The Clinical Site Practitioners (CSPs) confirm the report that Elephant was declared unsafe on 26th June 2016; a further 16 shifts were reported as being short of staff but safety was not compromised.

2.1 General Staffing Information

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

2.2 12 out of 23 inpatient wards closed beds at various points during June compared to 8 in May. An average of 6.7 beds were closed each day, this is an increase from 3.4 bed closures in May. The main reasons for bed closures were due to staffing/sickness on Eagle, Sky and Squirrel; planned maintenance work on Robin, Fox, and Bear; and flooding in Rainforest Endo/Met.

2.3 For the inpatient wards, at 1st June 2016, the registered and non-registered vacancies totalled 125.8 WTE, an increase from 115.4 in May. This breaks down to: 93.7 (11.3%) registered nurse vacancies (97.4 in May); 32.1 (20.3%) HCA vacancies (18 in May). Temporary nurses, mainly from GOSH Nurse Bank, deployed on the wards totalled 106.5 WTE, the May position was therefore 19.3 WTE net vacancies (-12.8WTE in May, 3.2 WTE in April and -10 WTE in March).

3 Vacancies and Recruitment

3.1 118 out of a total of 123 Newly Qualified Nurses have been recruited from the assessment centres held in June (3 withdrawals and 2 failures). Another 2 assessment centres are taking place in July with another 36 candidates attending.

3.2 An additional 20 NQNs are also in the pipeline following the January 2016 assessment centres who qualify this month.

3.3 11 Band 3's, have been successfully recruited from June's Assessment centre and pending pre-employment checks are due to start in September 2016.

3.4 There are currently 25 experienced nurses in the recruitment pipeline waiting to start in July and August.

3.5 The 6 monthly nurse establishment reviews are planned to commence July 2016.

4. Key Challenges

- There is a risk that the planned changes to the funding for undergraduate nurse training will impact adversely on the number of student nurses studying in London. From 1st August 2017 new nursing students will no longer receive the NHS bursary but will have access to the current student loan system requiring them to pay back a loan of circa £60K, for university fees and living expenses. There is a concern that this will put potential nursing students off studying in London, where the cost of living is already higher than the rest of the country. There is a concern that this will then impact on the recruitment of newly qualified nurses on the completion of their course.
- Recruitment of Band 6 Nurses.
- Retention of Band 5 and 6 Nurses.

5. Key Quality and Safety Measures and Information

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

5.3 Infection control

Infection	Number of incidents	Comment (optional)
C diff's	0	
MRSA bacteraemias	1	Data still awaiting final sign off
MSSA bacteraemias	2	
E.coli bacteraemias	2	
Outbreaks and whether any beds closed	2- no beds closed	Control measures put in place to control outbreak

Carbapenemase-producing Enterobacteriaceae	**2 confirmed on admission and 2 potential (awaiting results of ref lab)**	
Hospital acquired enteric virus infections	**10**	
Hospital acquired viral respiratory infections	**8**	

Narrative / comments:
Hospital acquired enteric and respiratory infections are decreasing over the summer months as it is expected.

5.4 Pressure ulcers

Grade	Ward / Area	Site	Avoidable?
2	**CICU**	Ear	**Avoidable**
2	**CICU**	Sacrum	**Unavoidable**
2	**PICU**	Ear	**Avoidable**
2	**CICU**	Axilla	**Avoidable**
2	**SKY**	Coccyx	**Avoidable**
2	**PICU**	Occiput	**Unavoidable**
2	**Sky**	Achilles	**Avoidable**

Narrative / comments:
The above figures represent 6 patients. A new pressure ulcer policy has been approved through the policy approval group with a new section on the investigation of pressure ulcers and Root Cause Analysis for Grade 2 pressure Ulcers. A new Tissue Viability Website has begun construction with information on grading pressure ulcers, pressure ulcer prevention strategies and how to access the team. A new band 7 Tissue Viability nurse started this month to support the Tissue Viability service delivery, teaching training and education.

5.5 Deteriorating patient

Event	Total Number	Number of Preventable
2222 calls	**13 (16 in April)**	**4**
Cardiac Arrests	**4**	**1**
Respiratory Arrests	**1**	**0**
Unplanned admissions to ITUs	**9**	**N/A**

Narrative / comments:
2 cardiac arrests in ward areas both graded as potentially preventable:

- 1 on Badger - no ECG leads available, additional ECG leads have been purchased.
- 1 on Koala – Patient transferred from PICU 12 hours prior to arrest without a clear management plan. This case is currently being investigated by the Risk and Resuscitation team as it is unclear if patient was on an End of Life plan. Meeting arranged on Tuesday 12th July 2016.

5.6 Numbers of safety incidents reported about inadequate nurse staffing levels

There were 4 Datix submitted by staff regarding shortages of nurse in June which have yet to be validated by the Divisional teams. No incident resulted in any harm to patients and in all cases the correct escalation pathway was followed.

5.7 Pals concerns raised by families regarding nurse staffing – 0

The Trust did not receive any PALs referrals in regards to nurse safe staffing for June 2016.

5.8 Complaints received regarding nurse safe staffing – 1

There was 1 complaint received. The family reported that the mother had to carry out all cares for her child with a tracheostomy as there were insufficient nurses on the ward (Peter Pan) though there was no datix submitted by the ward staff for this incident. This complaint is currently being investigated.

5.9 Friends and family test (FFT) data

- Overall response rate for June 2016 has decreased to 25.0% (data extracted 07/07/2016) compared to 27.52% in May 2016. The target response rate is currently 60%.
- The overall percentage to recommend score is 97.5% (data extracted 07/07/2016).
- Families that were extremely likely to recommend GOSH to their friends and family equalled 84.2% (678) and 13.3% (107) responded as likely to recommend compared with 89.6% (740) and 8.7% (72) in May 2016.

For information, the following negative comments or suggestions regarding staffing issues/staff behaviour have been received for the following wards:

Response	Ward/Area	Comment related to response
Extremely Likely	Sky	Good ward with good people but a little under resourced (people and stuff) (patient name)'s answer - Had to stay due to no physio and didn't get blue plaster!

The following positive comments regarding outstanding performance regarding staff behaviour have been received for the following wards:

Response	Ward/Area	Comment related to response
Extremely Likely	Eagle Acute	The team on Eagle ward have been absolutely fantastic, child centred, positive with very clear communication. We would like to make a special "thank you" message to (staff name), play specialist on eagle ward. Extremely positive outcomes with the 1:1 work she completed.
Extremely Likely	Elephant	Childrens FFT: good: what I really like about elephant ward is care and love and treatment that the nurses and doctors do for every patient in this ward.

		also thank you for all done for me and all the hard work you have done. bad: the only bad thing is food
Extremely Likely	Kingfisher	(staff name) has been caring for my son since his initial diagnosis in 2011 she has always been incredibly kind supportive and professional we are always pleased to see she is on duty when we are admitted. A true credit to her profession. Thank you (staff name) xx - (name and contact details of parents provided)
Extremely Likely	Koala	Level of care has been absolutely fantastic from the PICU unit + HDU on Koala ward. The physio, occupational therapist and nurses have been out-standing. (names of 3 staff) along with their colleagues (so many should be mentioned) helped bring our princess back to us and for that we are forever grateful.
Extremely Likely	Puffin	The way the children are approached by all the staff, the acknowledging of their experiences, their potential fear was excellent. All their needs are met in a caring way.
Extremely Likely	Respiratory Sleep Unit	Staff on the unit very lovely (Names of 2 staff), especially (staff) who was particularly polite & reassuring even thanking me for my small amount of help during our stay. Both staff knowledgeable and helpful plus very re-spectful during the night in disturbing myself and my daughter as minimally as possible during checks.

6. Conclusion

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

7.5 The impact of the reform to student nurse funding on nurse recruitment.

Attachment K
Appendix 1: UNIFY Safe Staffing Submission – June 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 CEN	Badger Ward	340 - RESPIRATORY MEDICINE		2308	2432.7	342	264.5	2057	2106.4	342	227.65	105.4%	77.3%	102.4%	66.6%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Bear Ward	170 - CARDIOTHORACIC SURGERY	321 - PAEDIATRIC CARDIOLOGY	2657	3318	575	552	2657	2773.3	332	367.9	124.9%	96.0%	104.4%	110.8%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Flamingo Ward	192 - CRITICAL CARE MEDICINE		6789	7331.68	344	310.5	6399	6622.45	206	86.4	108.0%	90.3%	103.5%	41.9%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Miffy Ward (TCU)	340 - RESPIRATORY MEDICINE		690	748.15	1035	960.25	690	623.3	690	587.8	108.4%	92.8%	90.3%	85.2%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Neonatal Intensive Care Unit	192 - CRITICAL CARE MEDICINE		3087	3291.34	343	23	3087	2895.6	0	32.4	106.6%	6.7%	93.8%	-
RP401	GREAT ORMOND STREET HOSPITAL CEN	Paediatric Intensive Care Unit	192 - CRITICAL CARE MEDICINE		5793	6402.8	340	92	5793	5148.8	340	129.6	110.5%	27.1%	88.9%	38.1%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Elephant Ward	370 - MEDICAL ONCOLOGY	823 - HAEMATOLOGY	1624	1692.67	343	494.5	1372	1208.3	343	381.5	104.2%	144.2%	88.1%	111.2%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Fox Ward	303 - CLINICAL HAEMATOLOGY	313 - CLINICAL IMMUNOLOGY and ALLERGY	2008	1590.35	334	296.9	1874	1485.6	334	163.7	79.2%	88.9%	79.3%	49.0%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Giraffe Ward	313 - CLINICAL IMMUNOLOGY and ALLERGY	350 - INFECTIOUS DISEASES	1035	1012	345	149.5	1035	707.6	345	194.8	97.8%	43.3%	68.4%	56.5%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Lion Ward	370 - MEDICAL ONCOLOGY	303 - CLINICAL HAEMATOLOGY	1629	1343.45	344	367.33	1377	801	344	390.7	82.5%	106.8%	58.2%	113.6%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Penguin Ward	330 - DERMATOLOGY	410 - RHEUMATOLOGY	943	1075.56	345	604.66	690	635.55	345	154	114.1%	175.3%	92.1%	44.6%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Robin Ward	350 - INFECTIOUS DISEASES	313 - CLINICAL IMMUNOLOGY and ALLERGY	1757	1450.85	306	402.5	1532	1053.9	306	509.4	82.6%	131.5%	68.8%	166.5%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Bumblebee Ward	171 - PAEDIATRIC SURGERY	420 - PAEDIATRICS	2415	2300	345	963	2070	2121.6	690	844.2	95.2%	279.1%	102.5%	122.3%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Butterfly Ward	370 - MEDICAL ONCOLOGY	420 - PAEDIATRICS	2760	2285	345	972	2070	1573.2	345	387.8	82.8%	281.7%	76.0%	112.4%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Eagle Ward	361 - NEPHROLOGY		2187	2790.8	676	833.2	1353	1332.3	338	254	127.6%	123.3%	98.5%	75.1%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Kingfisher Ward	420 - PAEDIATRICS		1748	1526.25	897	276	331	390.2	0	67.6	87.3%	30.8%	117.9%	-
RP401	GREAT ORMOND STREET HOSPITAL CEN	Rainforest Ward (Gastro)	301 - GASTROENTEROLOGY		943	1210.55	690	333.5	690	660.2	690	301.4	128.4%	48.3%	95.7%	43.7%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Rainforest Ward (Endo/Met)	302 - ENDOCRINOLOGY		990	1066.15	660	230	990	754.85	330	216.7	107.7%	34.8%	76.2%	65.7%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Mildred Creak	711- CHILD and ADOLESCENT PSYCHIATRY		1087	1103.5	606	549.6	494	378	448	336.2	101.5%	90.7%	76.5%	75.0%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Koala Ward	150 - NEUROSURGERY	421 - PAEDIATRIC NEUROLOGY	3247	2930.3	343	571.5	3155	2562.9	343	205.2	90.2%	166.6%	81.2%	59.8%
RP401	GREAT ORMOND STREET HOSPITAL CEN	Peter Pan Ward	120 - ENT	160 - PLASTIC SURGERY	1490	1181.5	578	425.5	1401	1142.45	0	44.6	79.3%	73.6%	81.5%	-
RP401	GREAT ORMOND STREET HOSPITAL CEN	Sky Ward	110 - TRAUMA & ORTHOPAEDICS	171 - PAEDIATRIC SURGERY	1733	1565	604	875.5	1692	1392.6	0	23	90.3%	145.0%	82.3%	-
RP401	GREAT ORMOND STREET HOSPITAL CEN	Squirrel Ward	171 - PAEDIATRIC SURGERY	101 - UROLOGY	2827	2832.29	667	587	2538	2329.1	0	197.2	100.2%	88.0%	91.8%	-

Attachment K

Appendix 2: Overview of Ward Nurse Staffing – June 2016

Speciality	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		
Cardiorespiratory	Badger	15	39.5	40.0	-0.5	7.5	7.0	0.5	47.0	0.0	2.1	-2.1	3.0		0	0.1
	Bear	24	53.5	49.7	3.8	9.0	8.4	0.6	62.5	4.4	5.0	-0.6	5.0	0.6	0	0.8
	Miffy (TCU)	5	14.1	10.3	3.8	10.4	8.5	1.9	24.5	5.7	5.0	0.7	1.0	1.0	0	0.0
Critical Care	Flamingo	17	121.0	109.0	12.0	10.8	3.0	7.8	131.8	19.8	20.8	-1.0	4.0		0	0.0
	NICU	8	51.5	46.0	5.5	5.2	1.0	4.2	56.7	9.7	8.7	1.0			0	0.0
	PICU	13	83.1	86.0	-2.9	8.9	3.0	5.9	92.0	3.0	8.0	-5.0			0	0.2
Haematology/Oncology/Dermatology/ Rheumatology	Elephant	13	25.0	18.5	6.5	5.0	5.0	0.0	30.0	6.5	4.1	2.4			1	0.1
	Fox	10	31.0	27.0	4.0	5.0	5.0	0.0	36.0	4.0	2.7	1.3			0	0.3
	Giraffe	7	19.0	16.7	2.3	3.1	2.0	1.1	22.1	3.4	2.2	1.2	2.0		0	0.0
	Lion	11	22.0	17.8	4.2	4.0	4.0	0.0	26.0	4.2	4.8	-0.6	1.0		0	0.0
	Penguin	9	15.5	14.8	0.7	5.8	5.8	0.0	21.3	0.7	1.5	-0.8			0	0.0
	Robin	10	27.2	21.7	5.5	4.5	4.4	0.1	31.7	5.6	3.0	2.6			0	1.1
IPP	Bumblebee	21	38.3	32.3	6.0	9.7	13.0	-3.3	48.0	2.7	9.4	-6.7	3.0		0	0.0
	Butterfly	18	37.2	23.7	13.5	10.5	9.9	0.6	47.7	14.1	7.2	6.9	3.0		0	0.0
MDTS	Eagle	21	39.5	38.0	1.5	10.5	10.0	0.5	50.0	2.0	3.7	-1.7			0	0.3
	Kingfisher	16	17.1	11.2	5.9	6.2	3.9	2.3	23.3	8.2	1.2	7.0			0	0.0
	Rainforest Gastro	8	17.0	15.9	1.1	4.0	3.0	1.0	21.0	2.1	1.3	0.8			0	0.0
	Rainforest Endo/Met	8	15.6	16.6	-1.0	5.2	4.0	1.2	20.8	0.2	1.6	-1.4			0	0.3
Neuro-sciences	Mildred Creak	10	11.8	12.5	-0.7	7.8	5.3	2.5	19.6	1.8	0.1	1.7			0	0.0
	Koala	24	48.2	37.7	10.5	7.8	6.0	1.8	56.0	12.3	4.8	7.5		1.0	0	0.1
Surgery	Peter Pan	16	24.5	22.3	2.2	5.0	3.8	1.2	29.5	3.4	1.3	2.1	1.0	2.0	0	0.5
	Sky	18	31.0	24.0	7.0	5.2	3.0	2.2	36.2	9.2	3.3	5.9	2.0		0	2.2
	Squirrel	22	43.6	40.8	2.8	7.0	7.0	0.0	50.6	2.8	4.7	-1.9		1.0	0	0.7
	TRUST TOTAL:	**324**	**826.2**	**732.5**	**93.7**	**158.1**	**126.0**	**32.1**	**984.3**	**125.8**	**106.5**	**19.3**	**25.0**	**5.6**	**1.0**	**6.7**

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **20th July 2016**	
Annual Report on Infection Prevention and Control 2015/16 **Submitted by:** Dr John Hartley, DIPC Helen Dunn, Lead Nurse IPC	**Paper No: Attachment L**
Aims / summary To present to the Board the progress and issues in Infection Prevention and Control in 2015/16	
Action required from the meeting Feedback from Board. Approval for display on public web site	
Contribution to the delivery of NHS Foundation Trust strategies and plans Essential to achieve zero harm; minimising risk of infection is a central Trust goal	
Financial implications Failure to prevent or control infections leads to harm and cost. Individual penalties may follow specific HCAIs in future.	
Who needs to be told about any decision? Infection prevention and control is responsibility of all staff.	
Who is responsible for implementing the proposals / project and anticipated timescales? Divisional and Corporate Units and all staff Infection Prevention and Control Team.	
Who is accountable for the implementation of the proposal / project? Director of Infection Prevention and Control	

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST
INFECTION PREVENTION AND CONTROL ANNUAL REPORT
April 2015 - March 2016

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

Part A Executive summary

1 Introduction

Great Ormond Street Hospital for Children NHS Trust recognises the obligation placed upon it by the Health Act 2006, (updated 2015) to comply with the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.
The Trust supports the principle that infections should be prevented wherever possible or, where this is not possible, minimised to an irreducible level and that effective systematic arrangements for the surveillance, prevention and control of infection are provided within the Trust. This is recognised as a key Trust strategy in the Quality Statement for 2015/16:

Standard 3 Decrease and eliminate hospital acquired infections

The aim of this programme is to focus on

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

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

A great effort is employed to reduce HCAI through adoption of standard and transmission based isolation precautions, through care bundles, environmental control, screening and audit but they still occur – there were 345 potential bacteraemias, with 75 acquired line infections, or 242 hospital onset respiratory and enteric virus infection - and some are preventable.

Health care associated infection is an ever present risk for patients and staff and requires constant application of best practice to reduce to a truly unavoidable minimum.

2) Description of infection control arrangements

Director of Infection Prevention and Control (DIPC) and Infection Control Doctor
- Dr John Hartley, Consultant Microbiologist
Executive lead for IPC -The Chief Nurse, Juliette Greenwood.
Lead Nurse for Infection Prevention and Control – 1 wte, Helen Dunn
Deputy Lead Nurse in IP&C 1 wte; IPC nurse 1 wte commenced June 2014; 0.4 wte Clinical Scientist in IP&C

Other consultant microbiologists – 3 PAs
IPC Administrative support and Data Management **–** 1 wte band 4; vacant
(The CNSs for Tuberculosis and ID lead on Tuberculosis related issues;
ID consultants contribute to the out of hours advice.)
Antibiotic pharmacist – 1 day of time, post within pharmacy
Quality Improvement team – dashboard development and display

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

Divisions had chosen to structure this in different ways with an active IPC Board now formed and meeting regularly for the Surgical, Cardiorespiratory, International and Private Patients, Infection Cancer and Immunity and Neurosciences divisions, and as part of the Quality and Risk group for MDTS.This will be reviewed in light of the Divisional restructuring in 26/17.

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

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

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

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

4 Budget allocation to IP&C activities

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

5 HCAI Statistics *2015/16*

5:1 **MRSA bacteraemia =** 2 (one was present before admission therefore not attributed to Trust, so it is and not on National data return; the one reported was a contaminant)
5:2 MSSA bacteraemia = 23 RCAs showed line infection is the most common cause.
5:3 E. coli bacteraemias = 17 episodes
5:4 ***Glycopeptide resistant enterococcal bacteraemia (GRE)*** *= 2*
5:5 Clostridium difficile **associated disease** = 7 reported; 2 judged as lapse in clinical care due to probable cross infection (against objective of less than 14).
5:7 GOS acquired Central Venous Catheter related bacteraemia = 1.4/1000 line days. Maintained last year's rate. Still 75 episodes. Effort is underway to reduce further.
5:8 Other bacteraemia episodes and antimicrobial resistance – 345 episodes (so potentially 280 non GOSACVCRB bacteraemias).

Review of the antibiotic resistance of the 20 coliforms in haematology/oncology /immunology/BMT children still shows a high level of resistance (although less than 14/15):

	Amikacin	Gentamicin	Ciproflox	Ceftaz	P/Taz	Carbaepnem
% resistant	0	10	30	20	15	5

5:10 Surgical Site Infection Surveillance

Surgical division –SSIS programme including at least one procedure from each specialty. Reports at Surgical IPC Board. Spinal surgery cluster investigated.
Critical care and cardiorespiratory – a continuous surveillance programme. Reports to the CCCR M&M and the SSIP group. 769 procedures. Deep and organ space SSI 0.4%
Neurosciences – continuous audit is performed for permanent shunt procedures, and displayed on the dashboard. 2015/16 - 6 infections from 165 procedures at a rate of 3.6

5:14 Viral infections detected while at hospital

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

Respiratory viral infections detected:			
	Total	Community onset	Hospital onset
Total in 2013/14	252	172	80
Total in 2014/15	399	302	97
Total in 2015/16	333	230	103
Enteric viral infections detected			
Total in 2013/14	360	229	131
Total in 2014/15	352	199	153
Total in 2015/16	351	212	139

Over all there has been little change in detection of viruses in children admitted to the trust. 5 wards were closed or on restricted admissions because of viral risk.

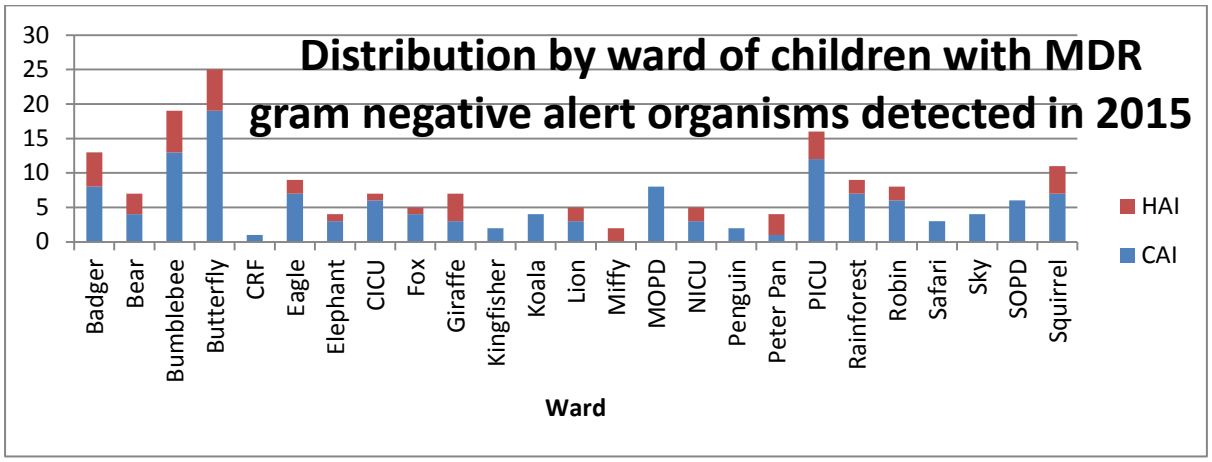
5:11 MRSA Admission Screening and rates
Nose and throat swab screening rate at 48 hours for inpatient admissions remaining in for > 48 hours, all patients. Target > 95%: 2015 screen compliance = 98%

MRSA cases of colonisation/carriage at GOSH
In 2015 there were 187 children with first detections, 19 probably or possibly acquired in the hospital. Each case is investigated. There was an outbreak on Bumblebee ward.

5:12 Multiple resistant 'gram negative' (MDRGN) organisms screening and rates
Faecal screening for inpatients remaining in for > 48 hours; target >75%: 2015 rate = 88%

MDR-GN carriage/colonisation - In 2015 testing revealed 186 first detections, 130 came in colonised, 50 were possible cross infection. These are found across the Trust.

Bar chart showing location of children colonised on admission or subsequently found to be colonised with multiple resistant gram negative bacteria by ward in 2015



A number of small clusters were detected.

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

No SIs.
Complaints with IPC component – 4 (3 re-communication, 1 staff re-screening)
Major outbreak episodes - MRSA; influenza A
Significant control events – Measles, Pertussis x 3, M. tuberculosis
SSI clusters – investigations undertaken in spinal surgery and Nuss bars.

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

The Trust clinical practice guidelines are available on the GOSH Web within the Infection Control link. Alcohol gel hand hygiene products are placed inside all ward areas to encourage staff, visitors and patients to decontaminate their hands within the clinical area. Regular hand hygiene audit is undertaken by ward staff showing good compliance (96%), although number of audits completed has fallen (19,258 audits compared to 23,568 last year)
However, IPC team audit (202 observations) demonstrated lower compliance (51%). A review and relaunch of hand hygiene is planned.
Compliance with the CVL ongoing care bundle is essential for the prevention of line infections. There has also been a decrease CVC bundle audit, with compliance steady at 88%. We would like this to be higher.

7) <u>Facilities</u>

Environment

Additional measures that were put in place in 2015 to validate the Domestic Services audit process has evidenced an improved standard in the quality of cleaning across the Trust. Weekly waste compliance audits are carried out by the Waste & Sustainability Manager. Key highlights include the roll-out of recycling in main non-clinical buildings, trial of food waste collections and a project group has been set up with Theatres to review the segregation of Theatres' waste.

Decontamination

The Sterile Services provision of service for GOSH remains of site at Guys and ST Thomas Hospitals NHS Foundation Trust (since September 2013). The quality of service delivered has been monitored as deemed acceptable by the Clinical staff at GOSH
GOSH have maintained accreditation status to BS ISO 13485:2003 for Endoscopy and Medical Equipment decontamination. Implementation of NICE IPG 196 for reduction of risk of transmission of Creutzfeldt-Jacob disease (CJD) vie interventional procedures is nearly complete.

8. Estates

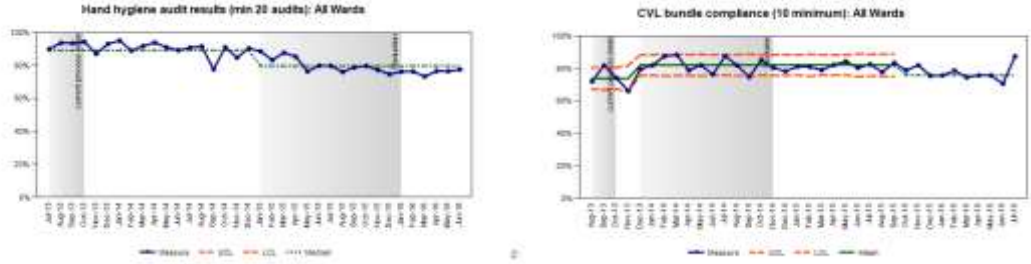
The extensive programme of verification of specialist ventilation was followed in theatres and most areas, but was not able to proceed to schedule in clinical ward areas. This has been prioritised in 2016/17 with ward closures underway to accommodate plan.
Water Safety Management Group continues to develop and manage risk associated with water. There is an expanded programme to control risk from *Pseudomonas aeruginosa*.
Risk from heater cooler units has been identified as low risk but on going pending manufacture of new equipment.

9 Trust wide audit

A Trust annual IPC audit programme is followed. Individual ward and 'All Trust' compliance is published monthly on the dashboards and reviewed by Divisional and Nursing boards.

Hand Hygiene and CVL care bundle compliance

Audit completion compliance rates have decreased in hand hygiene and CVL bundle compliance, when scoring negative for incompleted audits as shown in graphs below:



Absolute number hand hygiene audit compliance for ward based audit was 96% but IPC Team surveillance of hand hygiene showed 51% compliance.

9:5 Antibiotic prescribing and audit

The Drug and therapeutics Committee ruled that if amikacin is used in non-septic patients this should ideally only be following a negative screen for m.1555A>G (a mutation that predisposes patients to deafness following aminoglycoside use). This is a major change. As a result the antimicrobial policy group created a list of all GOSH prophylaxis policies that included amikacin and reviewed many of them during the financial year 2015-16. Other policies were reviewed as they became out of date.

Regular audit was undertaken for recording of indication for antibiotic prescription was with electronic prescribing on JAC. Satisfactory outcome > 90%.

10 Occupational Health

OH continues to provide 'new entrants' screening, "Exposure Prone Procedures" clearance, staff immunisation (including influenza, final uptake 48%, 8% up on last year)) and blood borne virus exposure follow up (88 events, compared to 74 in previous year).
In response to difficulty ensuring new started OH attendance and readily available knowledge of staff immunity status (especially to measles and chicken pox) a new procedure has been introduced, in conjunction with HR. Further work is required to ensure all information is collected, documented and available when needed for all staff. This is underway.

11 Targets and Outcomes	Target	Outcome
MRSA bacteraemia –	0	1
MRSA Screening for children admitted > 48 hours (total screens done = 23,274)	95%	98%
Faecal screens for children in > 48 hours	> 75%	88%
Clostridium difficile infection lapses in care	<14	2
Rate of GOS acquired line infection /1000 days	< 1.3	1.4
Root cause analysis for S. aureus bacteraemias	100%	100%
MRSA colonisation acquisition	0	19
Hand hygiene audits (total audits 19258)	95%	96%
(IPC team undertaken audit (n=202)		51%)
CVL care bundle audits (total audits 3405)	90%	88%
IPC level 1 induction	95%	88%
IPC level 2 update	95%	59%

12. Training activities

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

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

IPC training days: A popular training day programme continues.

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

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

Training and competency assessment for intravascular catheter insertion is provided locally and all divisions should be working towards a standard policy. This is not yet completed.

Attachment M

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board **20th July 2016**	
Health and Safety Annual Report 2015/16 **Submitted by on behalf of Ali Mohammed, Director of HR and OD**	**Paper No: Attachment M**
Aims / summary To inform the committee of the work being undertaken by the safety team and give assurance that the Trust is committed to maintaining safe systems of work and where any gaps in systems are found, remedial action is put in place to mitigate any risks.	
Action required from the meeting Disseminate learning, Promote safety culture.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Zero harm	
Financial implications If we fail to comply with health and safety legislation the Trust will be liable to prosecution and subsequent financial penalties.	
Who needs to be told about any decision? Trust employees/Union Representatives where necessary/H&S Team	
Who is responsible for implementing the proposals / project and anticipated timescales? Aidan Holmes	
Who is accountable for the implementation of the proposal / project? Aidan Holmes	

Health and Safety Annual Report 2015 – 16

1. Executive Summary

The purpose of this report is to provide information relating to health and safety within the Trust for the year 2015/16. It details recent advances, current activities and continuing plans to take forward and improve the management of health and safety in the Trust. It also contains incident trends analysis and performance.

2. Introduction

The Fire, Health and Safety Team at GOS is made up of three full time members who help the Trust in adhering to fire and health and safety legislation and facilitate the Trusts' undoubted commitment to controlling risks and precluding the chance of harm to patients, visitors and staff.

The team is responsible for:

a) Advising managers, safety representatives and staff on matters of health and safety at work;
b) Developing, implementing and maintaining an Occupational Safety Management System on behalf of the Trust (See objectives 2016/17);
c) Developing and implementing health and safety policies and procedures to improve the management of health and safety across the Trust (on-going);
d) Developing and delivering bespoke health and safety training courses as appropriate;
e) Providing information and corporate data analysis in respect of Trust-wide health and safety compliance.

The Trust has a systematic audit process in place with department types having bespoke audits for the particular work they undertake. Checklists are used in conjunction with the audits as a means of a reminder for staff to help them, and the Trust, meet its statutory targets and facilitate a process of continual improvement.

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

- An electronic audit toolkit which covers both health and safety and fire risk assessments has been devised and used to complete audits and assessments. Any remedial actions coming out of the audits are emailed to the relevant departments to remedy in a timely fashion and monitored by the Health and Safety and Fire Team. The Health and Safety Committee will receive reports on all aspects of fire and health and safety, including evidence of statutory and mandatory compliance, holding all parties to account and promoting continuous improvement (See Health and Safety Committee minutes).
- The team is now situated in 40 Bernard Street which allows closer working relationships with the Projects and Estates and Facilities Teams.
- Improved access to all health and safety risk assessments through the creation of local health and safety intranet sites with follow up nudge reminders for action plans/risk assessment reviews.
- Continued use of the Control of Substances Hazardous to Health toolkit and protocol to make the use of dangerous materials as safe as possible.
- The team aim to respond to all health and safety incidents within one working day of reporting.

- Generic assessments undertaken of all hazardous substances used in the Trust to facilitate local area bespoke assessments.
  Taking over the responsibilities for fire safety. Increasing statutory fire training compliance from 49% to over 82% and maintaining an upward trajectory (Figures supplied by Education and Training Department).Health and safety mandatory training rates in excess of 92% (Figures provided by Education and Training Department).

There have been no health and safety related improvement or prohibition notices issued by the two inspectorate bodies who visited the Trust: The Health and Safety Executive and the London Fire Brigade.

Staff in local areas are receiving bespoke training to meet their fire, health and safety needs and keep them abreast of any changes in fire, health and safety legislation. Training has been earmarked as an area for improvement following feedback from the staff survey. The team are working with the Education and Training Department to review all health and safety and fire training packages.

3. Incidents

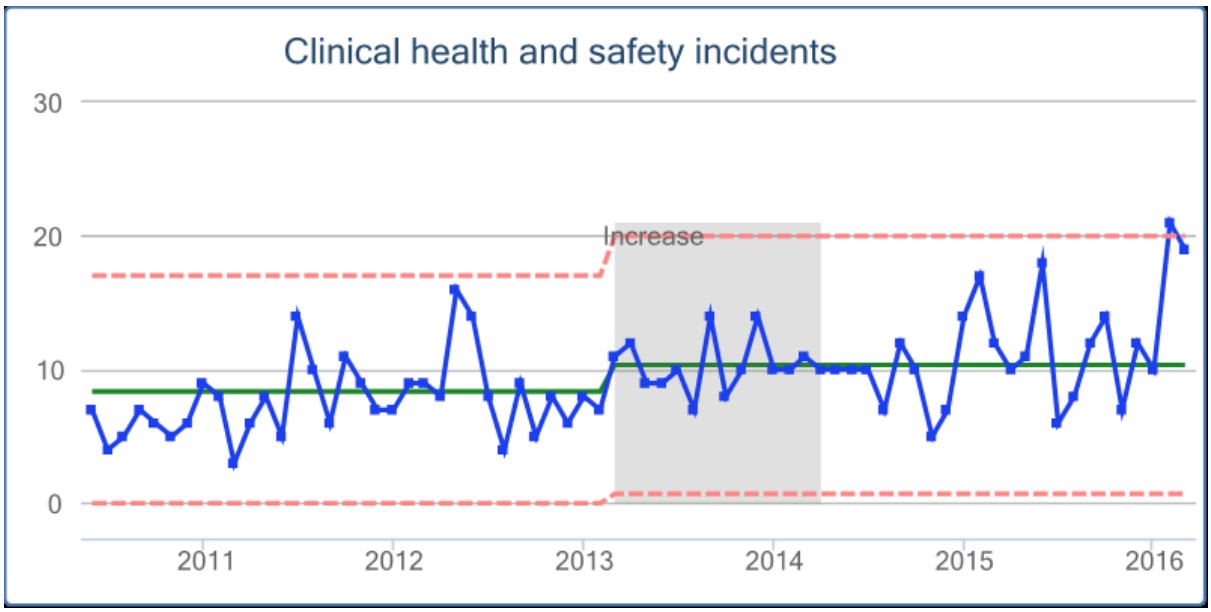
Number and severity of incidents reported (Pan Trust)

GOSH employees reported 760 (822 – last year) health and safety incidents in the year from April 2015. These included including 148 patient safety incidents.

During the period, there were:

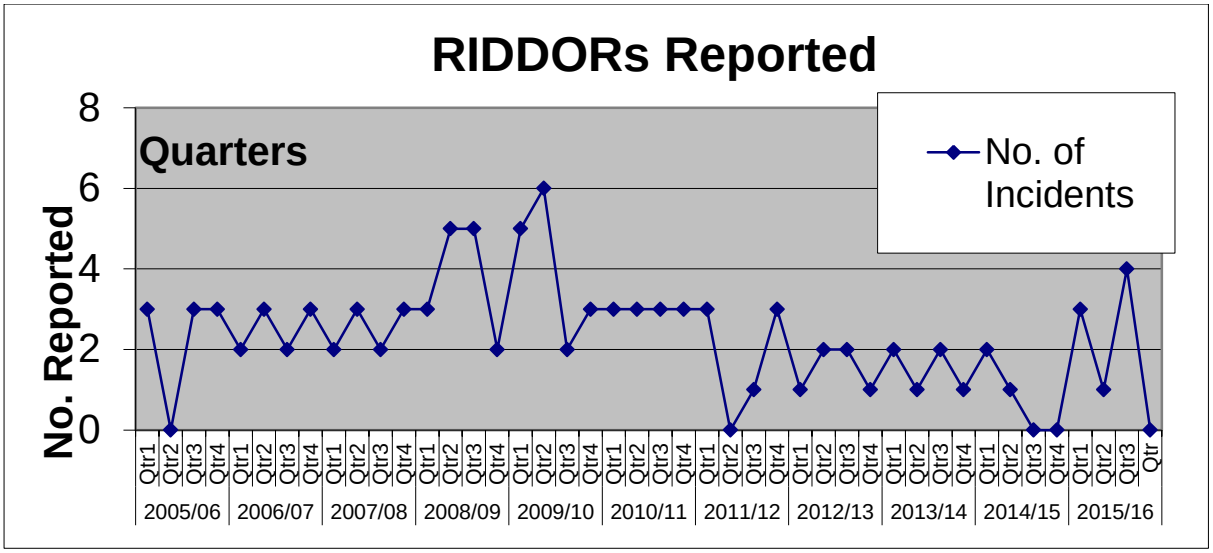
- 8 RIDDOR reportable incidents (0 reported as severe)
- There was one patient safety accident graded as severe (patient burnt by laser). The incident was reported as a health and safety incident but investigated by the Clinical Governance Team.
- 39 (27 last year) incidents reported as moderate severity.
- 387 incidents reported as low harm, and
- 335 incidents reported as no harm.

2015-16 was characterised by a drop in non-clinical incident reporting. Clinical health and safety incident numbers have risen slightly. The Trust's health and safety management arrangements continue to function effectively.



4. Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR)

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



Proportion of near misses reported:

The HSE state that if an organisational reporting profile does not comprise 70% near misses/no or low harm events, there is a need to raise awareness of the importance of reporting near misses; they are free safety lessons. As a percentage of all incidents GOS near misses comprised:

Severity	GOS Data as % (2015 -16) clinical	GOS Data as % (2015 -16) Non- clinical
Negligible	44.5% (65)	54.6% (335)
Minor	53.4% (78)	39.7% (242)
Moderate	1.4% (2)	5.7% (35)
Major	0.7% (1)	N/A%
Catastrophic	N/A (0)	N/A

5. Annual Work Plan

Below is a précis of the work being undertaken by the Fire/Health and Safety Team in the ensuing year. Please see the Trust Health and Safety Policy 2016.

An audit program is in place for clinical/non-clinical/Estates and Facilities and the laboratories. The audit tools primary function is to ensure statutory compliance, contribute to embedding risk management into the organisation's culture and provide assurance to GOS. The progression of GOS through the tool is logical and follows the development, implementation, monitoring and review of policies and procedures model.

Where deficiencies have been identified, action plans have been drawn up and changes made to reduce the risks. These action plans and subsequent changes are monitored by local Risk Action Groups (RAGS).

Safety checklists are used to support local managers in meeting their statutory responsibilities. The Health and Safety Team use them to ensure that patients and staff are in a safe environment and also as a reminder to senior staff of their duties under the Trust's Health and Safety Policies.

There are 4 separate audits undertaken:

- Estates and Facilities
- Clinical
- Non-clinical
- Laboratory

The safety team undertake the documentation audit and assist in all aspects of the audit tool to make the process easier and less burdensome to staff.

6. Objectives for 2016-2017

Framework 'Plan, Do, Check, Act'	Objective	RAG rating as of 01/04/2016	Person Responsible: date
1. Plan	**A. Policies** Review and revise the Trust's Health, Safety and Fire Policies to ensure they are up to date and aligned with current legislation, contact details and good practice. Encouraging and support consultation in policy development and continue with the implementation of approved Health and Safety Policies.	The Trust Health and Safety Policy was reviewed in April 2016	Health and Safety Manager July 2016
2. Do	Datix risk register up-to-date as per findings of the developed on-line tools	Risks updates on a monthly basis	Health and Safety Manager April 2017
	Complete fire risk assessments across the Trust	Fire risk assessments are in place across the Trust	Fire Officer April 2017
	Any actions are undertaken within the Estates response times.	Any emergency work is prioritised. Improvements can still be made on non-emergency tasks	Head of Estates April 2016
	Review the Trust wide risk assessment and audit process The HSE asked the Trust to review our processes	Review the Trust wide risk assessment and audit process	Pathology Lead Quality and Risk Manager CBL review July 2016
	Action the other findings of the HSE review	The Trust is still in the review period	Health and Safety Manager August 2016

	Weekly fire/health and safety walk around of the Trust to help risk mitigation and bolster the audit process (1 building per week)	Undertaken in conjunction with the Fire Officer	Health and Safety Manager April 2017
	Fire drills in all non-clinical areas as per fire safety work plan	Program in place	Health and Safety Manager April 2017
	Ensure timely communication of changes and promote health and safety	Communications will be improved by including Union representatives in the communication process	Health and Safety Manager April 2017
	Health and Safety/Fire sign off for all redevelopment projects	In situ	Health and Safety Manager April 2017
	Maintain full compliance with health and safety inspections	Currently achieved	Health and Safety Manager April 2017
	Continue to complete actions arising from health and safety inspections	Currently achieved	Health and Safety Manager April 2017
3. Check (Measuring performance /auditing)	**Passive:** Monitor accident and incident investigations and statistical analysis using Datix quarterly reports. Health and Safety Committee to address any outcomes of the monitoring of incidents	Incidents reviewed on a daily basis. Reports produced for the Health and Safety Committee and bespoke reports when requested	Health and Safety Manager April 2017
	Ensure correct RIDDOR reporting is provided to the HSE (over seven days reporting)	Currently achieved	Health and Safety Manager April 2017
	Ensure all non-clinical teams across the Trust have a maximum of two trained fire wardens or more as identified in the fire risk assessment	Achieved in June 2016	Health and Safety Manager July 2016
4. Act (Measuring performance /auditing)	**Active:** Ensure that evidence is available to meet health and safety legislation, best practise and outcome 10 of the CQC standards	Evidence documented appropriately	Health and Safety Manager April 2017

7. Sharps Safety

In the UK it was reported that percutaneous injuries accounted for 17% of accidents involving NHS staff and were the second most common cause of injury after moving and handling (18%)[1]. At GOSH there were 70 sharps injuries reported during the last financial year, which represented 9.43% of injuries to staff reported via Datix.

A safety drive will be undertaken in the ensuing year to reduce the number of sharps injuries by a minimum 10% by ensuring the EU 2013 sharps Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 are followed to the letter e.g. staff are made aware that using their existing choice of sharps is permitted as long as a suitable assessment has been undertaken.

8. Audit

An online survey will replace the audit tool for clinical and non-clinical audits during 2016/17 to ease the workload of the local staff, yet maintain safety standards.

9. Redevelopment Work

Continuation of the close relationships built with the Redevelopment department/Estates and Facilities/ICT as well as maintaining the monitoring of the considerable contractual work undertaken and its inherent hazards. All work is monitored via a twice weekly meeting held between all relevant parties. This has proven successful in mitigating risks to patients/visitors and staff.

10. Conclusion

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

The Trust has a multimillion pound building/redevelopment program underway which brings with it inherent problems especially when juxtaposed with the clinical environment. There are measures in place (audits of work undertaken/strict adherence to Trust site rules above and beyond legislative requirements etc.) which put additional controls on the construction work and ensures this work fits around the delivery of the clinical care rather than vice versa.

[1] Protecting healthcare workers from occupational exposure to blood borne pathogens: the role of Work Safe BC

Attachment N

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
20th July 2016

Clinical Audit Annual Report 2015/16 **Submitted by:** Dr Vin Diwakar, Medical Director. Andrew Pearson, Clinical Audit Manager. Nicole Douglas, Clinical Governance and Audit Assistant	**Paper No: Attachment N**

Aims / summary

The Clinical Audit department sits within the Clinical Governance and Safety Team (CGST) to ensure that there is an integrated clinical governance function, which includes a mechanism for evaluating and assessing the implementation and effectiveness of learning. The department has a central clinical audit plan where work is prioritised to support learning from serious incidents, risk, patient complaints, and to investigate areas for improvement.

This report provides some of the highlights of the Clinical Audit Work plan for 2015/16 as reported in the Trust Quality Report including:

- Learning from the priority Clinical Audit Plan
- Participation in local clinical audit
- Participation in National Clinical Audit

In addition this outlines the drivers for the Clinical Audit work plan for 2016/17

Included is an overview of management of NICE guidance issued in 2015/16

Action required from the meeting
To review the annual clinical audit report as requested by the Board

Contribution to the delivery of NHS Foundation Trust strategies and plans

Financial implications
N/A

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

Participation in national clinical audit

During 2015/16, 11 national clinical audits and clinical outcome review programmes covered the NHS services that GOSH provides. The Trust has participated in them all and data submissions are outlined below.

Name of audit/clinical outcome review programme	Cases submitted as a percentage of the number of registered cases required
Cardiac arrhythmia (National Institute for Cardiovascular Outcomes Research [NICOR])	154 / 154 (100%)
Congenital heart disease including paediatric cardiac surgery [NICOR]	1212 / 1212 (100%)
Diabetes (paediatric) (National Paediatric Diabetes Association)	25 / 25 (100%)
Maternal, Newborn and Infant Clinical Outcome Review Programme Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK [MBRRACE-UK])	13 / 15 (87%)
National Cardiac Arrest Audit (Intensive Care National Audit & Research Centre [ICNARC])	22 / 22 (100%)
National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	We have reviewed all cases provided by NCISH to assess whether clinical case note reviews are required. No cases met the inclusion criteria.
Inflammatory bowel disease (Royal College of Physicians)	112 / 146 (77%)
Paediatric Intensive Care Audit Network (PICANet)	1,847 / 1,847 (100%)
Pulmonary hypertension (Health and Social Care Information Centre)	343 / 343 (100%)
Renal replacement therapy (UK Renal Registry)	192 / 192 (100%)
UK Cystic Fibrosis Registry (Cystic Fibrosis Trust)	179 / 179 (100%)

What is clinical audit?

'A clinical audit is a quality improvement cycle that involves measurement of effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.'

Healthcare Quality Improvement Partnership (HQIP) Principles of Best Practice in Clinical Audit 2011

Learning from National Audit reports

The following National Audit reports relevant to GOSH practice were published during 2015/16:

- Congenital Heart Disease (CHD) Audit Annual Report 2011–2014
- Inflammatory Bowel Disease (IBD) Paediatric Report
- Maternal Newborn and Infant Clinical Outcome Review Programme – Perinatal Mortality Surveillance Report 2013 data
- National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH) Annual Report July 2015
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Just Say Sepsis Report
- Neonatal Intensive and Special Care (National Neonatal Audit Programme)
- Paediatric Intensive Care Audit Network Annual Report (PICANet)
- UK Cystic Fibrosis Registry Annual data report 2014

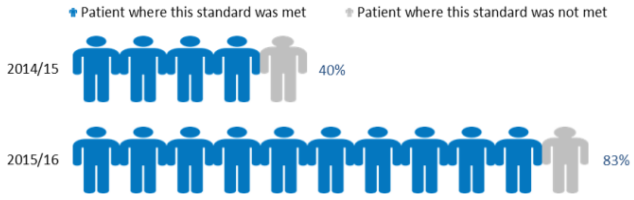
The reports have been reviewed by appropriate professionals within the organisation. Summaries of the learning from these audits and any actions required have been reported to the Patient Safety and Outcomes Committee (PSOC).

Key learning from priority clinical audit in 2015/16

The Clinical Audit team sits within the Clinical Governance and Safety department to ensure that there is integrated clinical governance. A central clinical audit plan is used to prioritise work to support learning from serious incidents, risk, patient complaints, and to investigate areas for improvement. A selection of key findings are listed below:

Learning disabilities

Audit has taken place to support the improvement work on awareness and management of patients with learning disabilities.



The audit shows progress with documenting and meeting reasonable adjustments of care for children and young people with learning disabilities.

Surgical site marking

This audit took place to determine if patients were being appropriately 'site marked' before arrival in the operating theatre. Site marking helps to minimise the risk of surgery taking place in the wrong part of the patient. Wrong site surgery is classified as an NHS Never Event, an error that should never happen. 119 out of 121 cases (98 per cent) reviewed had appropriate site marking arrangements.

98%

of cases reviewed had appropriate site marking arrangements in place

The audit shows we have a very high level of performance with safety precautions to prevent wrong site surgery. To help us get to 100 per cent, we are reviewing our guidance to make it even clearer.

Learning from incidents

Clinical Audit plays an important part in the effective implementation of recommendations from Serious Incidents (SIs). Some examples of work completed in 2015/16 are outlined below.

- An incident in January 2013 occurred when a patient's sutures were removed earlier than planned, which resulted in an additional general anaesthetic. The learning from the SI identified the need for clarity of post-operative instructions and communication at ward rounds. Completion of a re-audit this year showed that the recommended changes have been sustained.
- An SI occurred in May 2014 where a needle was retained in the patient. Audit showed that practice had changed in line with the recommendations of the investigation, but that further work is required to ensure that specific types of syringes are always used for closed cavity injections. As a result of this audit, a stock review of the specific syringes was undertaken and the location of the syringes was highlighted at relevant theatre handover. The audit results have been shared at a learning forum for all theatres staff, and changes made to the theatres care plan based around staff suggestions. This will be re-audited in 2016/17.
- In July 2014, an SI occurred where a child in a specialist chair slipped down and suffered positional asphyxiation. The findings of the audit this year showed good progress with the implementation of recommendations. As a result of the audit, staff have been offered additional training to ensure they are aware of the need for patients to be supervised in a specialist chair. We have also modified the instruction sheets that are kept at the patient's bedside when such chairs are used, to make the requirement for supervision clearer. This is currently being re-audited.

- Audit was prioritised to assess the Implementation of learning following the unexpected death of a child who had been admitted for the insertion of a gastrostomy. The audit found that the recommendations made in the SI were implemented and no further actions were required.

Audit of completed actions for patients reviewed at the Clinical Review Group (CRG)

The aim of this audit is to provide assurance as whether agreed actions for individual patients reviewed at CRG have taken place. 50 cases where there were actions between September 2015 and February 2016 were audited.

96%

of the agreed actions for patients reviewed at CRG have taken place

4%

of the agreed actions were not possible to be completed, due to the circumstances of the patient

0%

There were no cases where the actions agreed had not been completed where they were needed

This audit will be undertaken every quarter as a part of the Clinical Audit Plan for 2016/17.

Infection Prevention and Control (IPC) Hand Hygiene Audit

An annual audit took place to review whether IPC Hand Hygiene standards were being met. These are expert led quality audits and are in addition to key performance indicators that are routinely collected by wards.

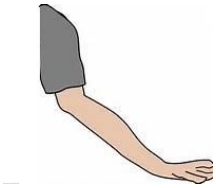
Hand Hygiene was performed for

51%*

of opportunities

88%

were bare below the elbows at the moment of observation



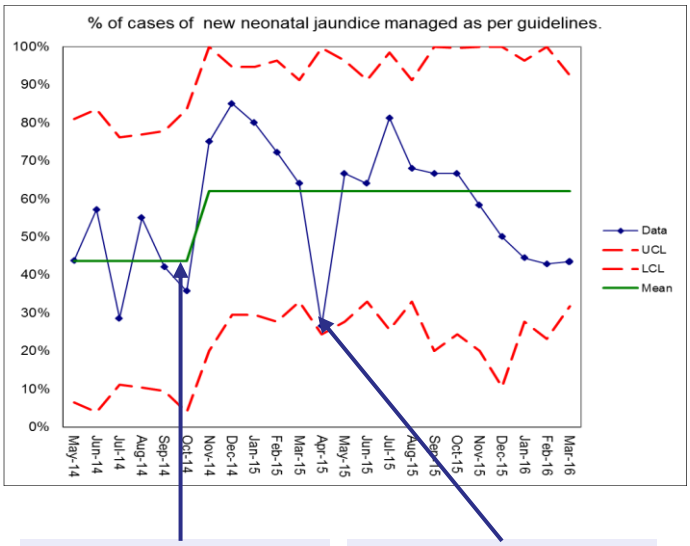
*The evidence base for similar independent observational audits typically finds a performance level of around 60%[1]

[1]Measuring Hand Hygiene Adherence, The Joint Commission, 2009

Divisional action plans were created by the Heads of Nursing in response to the audit. This audit will continue as a quarterly quality measure to stimulate improvement.

Neonatal Jaundice

This on-going audit aims establish how far the Trust is following best practice for identifying and managing neonatal jaundice and identify areas for improvement and potential solutions.



Statistically significant improvement following interventions

Outlier shows reliance on Neonatal Nurse Advisor to chase and guide practice (Neonatal Nurse Advisor not in the trust for two weeks here).

This issue has been identified as a Trust Wide High Risk.

Recommendations have now been made for a working group with executive sponsorship to improve performance.

In the short term, to support practice, a laminate is being trialled to on the front of their nursing case notes to sign post staff to existing supportive management resource and to clarify the essential neonatal care 'must dos'.

Audit in response to national and local safety alerts

National patient safety alert

We audit patient safety alerts issued by NHS England, to support their implementation. An NHS England patient safety alert was issued in February 2015 following an incident where an adult patient in a nursing home choked after accessing a tub of thickening powder. In response to the alert, we devised an action plan to minimise the risk to our patients with dysphagia, who have thickened feeds. Practices to minimise the risk of accidental ingestion were evident in all cases audited.

Developing an internal alert in response to a 'near miss' incident

An internal safety alert was generated as a result of learning from a 'near miss' due to a false blood glucose reading. This was prepared by the Clinical Governance and Safety Team in April 2015 in order to proactively minimise the risk of a further incident. Audit showed:

84%

of cases in May 2015 met the safety alert requirements

To improve, an action plan was implemented, followed by re-audit to assess the effectiveness of implementation of the requirements

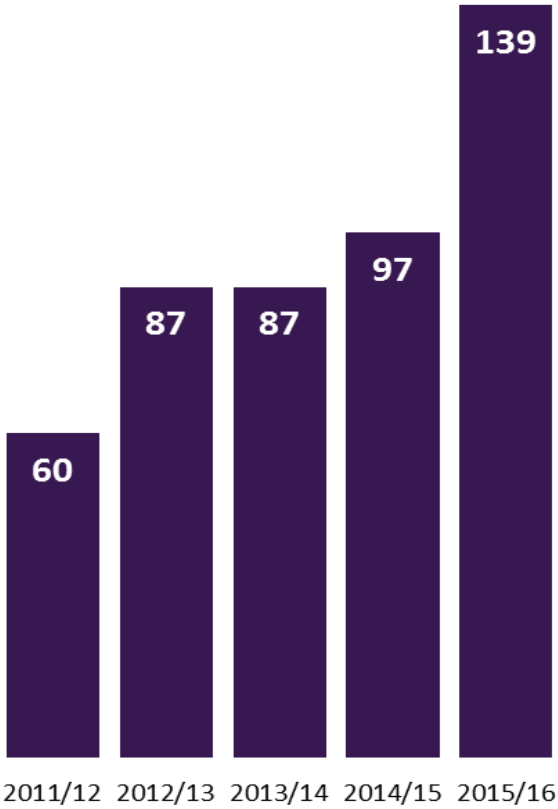
95%

of cases in August 2015 met the safety alert requirements

The safety alert and audit of blood glucose monitoring has improved the safety of our patients'
Clare Gilbert, Clinical Nurse Specialist, Hypoglycaemia

Local clinical audit

139 local clinical audits were completed during 2015/16., and the findings were shared. Our data shows we are improving our completion and sharing of local clinical audits over time.



To promote the sharing of information and learning, a summary of completed projects is published on the Trust's intranet and shared with the Patient Safety and Outcomes Committee.

The Clinical Audit team support staff with clinical audit so they can assess and improve the quality of their care. The audit team also recognises and promotes the Model For Improvement, which is taught by our Quality Improvement team and used in the Trust for improvement projects.

Excellent examples of local clinical audit 2015/16

Congenital hyperinsulinism feeding audit

The Endocrinology service has completed their audit to look at feeding difficulties in children admitted with congenital hyperinsulinism. Compared with the previous audit in 2012, there have been no delayed discharges as a result of feeding issues, and an improvement in patients being able to feed orally on discharge. Parental anxiety about their child's feeding was also shown to have reduced since 2012.

Learning from a complaint – Neurology team

Learning from a complaint in December 2015 highlighted the importance of rescue medication being written on a paper prescription for patients admitted for telemetry. An audit of the recommendations took place in February 2016, which showed that the recommendations have been met and are effective. This will be re-audited to ensure sustained change.

Visual Infusion Phlebitis (VIP) scores on Koala Ward

Injury from extravasation (the leakage of fluid from its intended vascular pathway) is a potential risk to any patient admitted to hospital. An audit was undertaken to review the number of staff recording VIP scores to prevent extravasation. The results showed that 66 per cent of patients had a VIP score documented appropriately. A different type of bandage is now being implemented to ensure all patients have a VIP score documented.

Holding bay trial – Ocean Theatres

Members of the Theatres Team used an audit to evaluate an intervention designed to reduce delayed start times for theatre lists in two operating theatres. A new sending system was implemented, initiated by the anaesthetist, which involves allocated recovery staff members collecting patients and 'holding' them in the Ocean recovery area until the lists are ready to start. A trial of the intervention showed a statistically significant reduction in mean delay time (from 26 to 11 minutes). The team now plan to roll out this intervention further in theatres.

Use of the fronto-facial protocol to reduce post-operative infections

The Craniofacial Team were able to show through audit that their protocol had reduced variations in treatment, which led to significantly reduced infection rates and improvement in quality of care.

The protocol was implemented in 2014 following four consecutive cases of mid-face infection. There have been no mid-face infections since the implementation of the protocol.

Clinical Audit Plan 2016/17

The Trust Clinical Audit Plan is a priority programme of work to review risk and whether lessons learned from incidents and complaints have been implemented.

Individual items will be identified and added to the plan throughout 2016/17 as follows:

Learning from complaints	Learning from serious incidents
Patient Safety Alerts	Key clinical policies
Mandatory National Audits	Support key risk issue and strategic priorities
NICE Guidance	Clinician led audit
Support for compliance register leads	Never events

Management of NICE guidance

Trusts have a requirement to ensure that relevant NICE guidance is assessed and acted on to ensure that evidence based practice is implemented.

The Clinical Audit team manages the process of ensuring that NICE guidance is reviewed by the appropriate teams and actions are put in place and monitored where necessary.

NICE guidance has been scored as low risk on our compliance register for the following reasons:

- A lot of guidance isn't directly relevant to paediatric specialist care (approximately 15% of guidance was relevant in 2015/16)
- We have been able to evidence that we implement relevant guidance to CQC, Monitor, and commissioners

'The trust had an effective process of monitoring the implementation of NICE guidance by regular review. We found that all of the guidelines had been reviewed in 2014'

CQC Report, January 2016

- We have a clear and well established process and policy for reviewing NICE guidance.
- Progress with NICE guidance is reported every quarter to the Patient Safety and Outcomes Committee (PSOC) and the Clinical Governance Committee (CGC)

NICE guidance released 1st March 2015 - 1st March 2016:

- 168 sets of guidance were issued.
- 26 sets of guidance were reviewed by a clinical lead/team as relevant to the Trust.

The following guidance is relevant and actions have been identified to support implementation:

- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes
- Challenging behaviour and learning disabilities (LD): prevention and interventions for people with LD whose behaviour challenges.
- Pressure ulcers
- Obesity: prevention and lifestyle weight management in children and young people
- Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use
- Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care
- Blood transfusion
- Intravenous fluid therapy in children and young people in hospital
- Domestic violence and abuse
- Transition from children's to adults' services for young people using health or social care services

Report designed and written by the Clinical Audit Team

Attachment O

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
20 July 2016

Quarter 1 NHS Improvement (formerly Monitor) Return (3 months to 30th June 2016) **Submitted by:** Loretta Seamer, Chief Finance Officer	**Paper No: Attachment O**

Aims / summary
This paper summarises the Trust's 2016/17 Quarter 1 (Q1) Return to NHS Improvement.

Key points:

Finance

- The financial information included in the Monitor template for Q1 is entirely consistent with the Month 3 Board report. The Trust is reporting a retained deficit of £1.8m after adjusting for capital donations (£9.9m).
- The Trust's capital expenditure for the quarter ended 31 July 2016 was £13.1m against planned expenditure of £13.6m.
- The Trust is forecasting to maintain a financial sustainability risk rating of at least 3 over the next 12 months.

Governance

- At the time of writing the Trust's known position is up to May 2016. The year to date position for the Trust is that there has been one case of C.Difficile assigned cases in patients aged two and over, tested on forth day or later (against full year target of < 15 cases), This case remains to be reviewed with NHS England with regard to whether it is attributed to a lapse of care outlined in the assessment criteria from Monitor and agreed with NHS England.
- There were no cases of MRSA reported up to and including Month 2.
- The Trust is not able to confirm that it is compliant with the maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate and is not reporting against this target. The Trust is undertaking work to validate the position and ensure robust future reporting but believes that it will be unable to report against this target until 1 October 2016. The Trust has submitted, as part of the SPF, a trajectory which shows that the Trust will not be delivering to the standards until October – December 2017.
- For Cancer access standards (of those relevant to GOSH) at the time of reporting the final quarterly position (i.e. June) is not yet finalised (this is in line with the national reporting timetable), therefore it is only possible to report up until May 2016.

  The Trust has one confirmed breach of the 31 Day "Decision to Treat to Subsequent Treatment – Surgery" standard for May 2016. Up until May there have been no other breaches of the relevant cancer 31 Day standards.

Other

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

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

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

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

Who needs to be told about any decision?
Monitor

Attachment O

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

Attachment O

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

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (see notes below)	**Board Response**
For finance, that: The board anticipates that the trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months.	CONFIRMED
The Board anticipates that the trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return.	CONFIRMED
For governance, that: The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.	NOT CONFIRMED
Otherwise: The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework, Table 3) which have not already been reported.	CONFIRMED
Consolidated subsidiaries: Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds.	ZERO

Signed on behalf of the board of directors

Signature		Signature	
Name		Name	
Capacity		Capacity	
Date		Date	

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

We have reported to Monitor our decision to suspend RTT reporting and related diagnostic reporting for a defined period. Monitor is party to regular Tripartite

meetings with NHSE, our lead commissioner, where we are sharing and monitoring our plan to remedy the data issues in order to resume reporting and address any patients with long waits.

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board 20th July 2016	
Revised Board of Directors' Terms of Reference **Submitted by:** Anna Ferrant, Company Secretary	**Paper no: Attachment P** For approval

Aims / summary

The Trust Board terms of reference have been reviewed and updated as follows:

Monitor's revised Code of Governance
In 2015, the terms of reference were reviewed and updated against Monitor's revised Code of Governance (July 2014).

The NHS Foundation Trust Code of Governance is based on the principles of the UK Corporate Governance Code issued in 2012. The Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The Board considers that from 1 April 2015 to 31 March 2016 it was compliant with the provisions of the NHS Foundation Trust Code of Governance. The Schedule of matters for the Board and the induction and development programme for directors is currently under review. These will be informed by completion of the review of the reporting frameworks of the committees and the results of the Well Led Framework assessment (see below).

Monitor's Well Led Framework (April 2015)
In 2015, the terms of reference were reviewed and updated against Monitor's Well Led Framework (April 2015).The framework has been developed to support NHS foundation trusts to gain assurance that they are well led and can continue to meet patients' needs and expectations in a sustainable manner under challenging circumstances.

An externally led assessment against the framework is currently underway and the findings from the assessment will be used to review the Board terms of reference and the workplan.

Revised terms of reference
The following revisions have been made to the Board's terms of reference:

- Removal of reference to the Chief Operating Officer and inclusion of the role of Deputy Chief Executive
- Removal of reference to the role of Director of Planning and Information
- Change from Director of Redevelopment to Director of Development

A revised version of the terms of reference is attached at appendix 1 and amendments are shown in highlighted text.

Board workplan

Work is underway to review and tighten reporting between committees and directly to the Board. This includes:

- A revised terms of reference and workplan for the Executive Management Team (EMT), with a clearer reporting framework between subcommittees and the EMT;
- A review of the effectiveness of the Patient Safety and Outcomes Committee and the Patient and Family Experience and Engagement Committee;
- A review of the role and work programme of the Senior Management Team.
- A review of the effectiveness and terms of reference and workplan of the Audit Committee and Finance and Investment Committee;
- The Clinical Governance Committee has been restructured and renamed the Quality and Safety Assurance Committee, with a role in not only seeking assurance that clinical governance systems and processes are in place, but that high quality, safe, patient centred care is provided
- With the introduction of the new Performance Management Framework, a review is underway of the information reported to the Board, EMT and divisions, with the development of a core scorecard template, supported by appropriate narrative explaining key variances, additional relevant content and recovery actions. The template is currently being consulted on with the Board and divisions.

In light of the above, the Board workplan is subject to a comprehensive review to ensure that:

- reporting frameworks are streamlined;
- assurance committees receive the appropriate level of information to discharge their duties and
- the Board is appropriately informed of the strategic risks facing the organisation and receives sufficient assurance information from the Board committees about the control of clinical and non-clinical risk.

An updated version of the Board workplan will be presented to the Board later in the year.

Action required from the meeting

To approve the amendments to the terms of reference and note that the revised Board Workplan will be presented at a meeting later in the year

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

Financial implications
No direct financial implications.

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

Who needs to be told about any decision
N/A

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

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

Great Ormond Street Hospital for Children NHS Foundation Trust

TRUST BOARD TERMS OF REFERENCE

The Trust has Standing Orders for the practice and procedures of the Trust Board (Annex 9 of the Constitution)[1]. For the avoidance of doubt, those Standing Orders take precedence over these Terms of Reference, which do not form part of the Trust's Constitution.

1. Constitution

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

2. Role

The role of the Great Ormond Street Hospital for Children NHS Foundation Trust Board is:

- To provide leadership in establishing and promoting the vision, values and standards of conduct and ethical behaviour for the Trust and its staff;
- To establish a clear strategic direction, by setting strategic objectives that are supported by quantifiable and measurable outcomes and performance indicators;
- To seek and receive assurance on the quality and sustainability of the Trust's services, promoting high standards of effectiveness, patient safety and patient experience;
- To be accountable for the Trust's performance, ensuring that the necessary financial and human resources are in place for the organisation to meet its objectives and deliver its business plans; and that systems are in place to minimise the risk of adverse performance; and, to take account of independent scrutiny of performance.
- To ensure the Trust develops and implements appropriate risk management strategies and policies to identify, monitor and address current and future risks on the quality and financial sustainability of services and comply with regulatory and statutory requirements.
- To ensure that strategic development proposals have been informed by open and accountable consultation and involvement processes with staff, patients and their representatives, councillors, members, the wider community and other key external stakeholders, as appropriate.

[1] The Trust Board is referred to as the Board of Directors in the Trust Constitution

- To exercise financial stewardship, ensuring that the Trust is operating effectively, efficiently and economically and with probity in the use of resources;

- To support continuous learning and improvement and ensure the development of extensive internal and external feedback systems.

- To encourage and promote openness, honesty and transparency in the Trust's relationships with, patients and their representatives, the public, staff, councillors, members and other stakeholders;

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

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

- Audit Committee
- ~~Clinical Governance Committee~~Quality and Safety Assurance Committee
- Finance and Investment Committee

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

3. Membership

The Board shall comprise 12 directors excluding the Chairman.

There shall be 6 non-executive directors. The Deputy Chairman may deputise for the Chairman. No other person will be authorised to deputise for a non-executive director.

There shall be 6 executive directors:

- the Chief Executive
- Deputy Chief Executive
- Chief Finance Officer
- ~~Chief Operating Officer~~
- Medical Director
- Chief Nurse
- Director of Human Resources and Organisational Development

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

The Board may approve deputies with formal acting up status or interim directors.

4. Attendance at meetings

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

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

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

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

- ~~Director of Planning and Information~~
- Director of Operational Performance
- Director of ~~Red~~Development
- Director of Research and Innovation
- Director of International Private Patients

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

These invited individuals do not hold a vote.

5. Quorum

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

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

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

6. Frequency of meetings

The Board shall normally hold 6 formal Board meetings a year

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

Executive directors and non-executive directors are expected to attend a minimum of 5 formal Board meetings per year.

7. Performance evaluation

The Board will undertake an evaluation of its own performance on an annual basis. Every third year evaluation of the Board will be led by an external facilitator.

Directors will be subject to individual performance evaluation on an annual basis:

- The Chief Executive will evaluate the performance of the executive directors;
- The Chairman will evaluate the performance of the non-executive directors and the chief executive;
- The Senior Independent director will evaluate the performance of the Chairman.

Committees of the Board will conduct an evaluation of their effectiveness on an annual basis.

Appropriate action will be taken where recommendations are highlighted.

8. Secretariat

The Company Secretary shall act as Secretary to the Board.

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

Signed minutes shall be maintained by the Secretariat.

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

9. Review of the terms of reference

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

July 2016

ATTACHMENT Q

Great Ormond Street Hospital for Children NHS Foundation Trust

Update from the Audit Committee meeting held on 20th May 2016

Internal Audit Progress Report

The Committee noted Education Strategy and Governance internal audit report which provided partial assurance with improvements required. It was reported that progress had already been made to review and improve the structure of education provision. Some concern was raised that the Trust had been criticised for operating in silos and having joint Executive accountability for education. The Chief Executive noted these concerns and agreed to take them forward.

Chief Financial Officer's review of the Annual Financial Accounts 2015/16, including the Going Concern assessment

It was reported that the key significant adjustment in the 2015/16 accounts was around the revaluation of the buildings. The Committee discussed this matter and agreed that the requirement to revalue the buildings annually and the implications of this would be discussed at the Finance and Investment Committee.

The committee discussed the GOSH Children's Charity contribution and agreed that it was important that there was clarity around what was recurring. The committee agreed that this was a medium term risk.

The Committee recommended the Annual Financial Accounts 2015/16 and Annual Report 2015/16, including the Annual Governance Statement to the Board for approval.

Internal Audit Annual Report 2015/16 including Head of Internal Audit Opinion 2015-16

The Committee received the final report and noted that a Head of Internal Audit Opinion of 'significant assurance with minor improvements required' had been provided.

Final Report on the financial statement audit for the 12 month period ended 31 March 2016

It was reported that an unmodified opinion would be issued by the external auditors on the financial statement with an 'except for' related to the work around RTT. An unmodified opinion would also be issued for the Quality Report.

Deloitte reported that IPP income had risen by 17% however debtors were 80% higher and agreed that the Trust's provisioning was adequate. It was confirmed that GOSH was not unusual in terms of its IPP debt position.

Quality Report 2015/16 and Final Report on the 2015/16 Quality Report Quality Assurance Review

The Committee recommended the Quality Report for Board approval.

It was noted that both mandatory indicators had been given clean opinions with minor issues that had not moved any data from non-breach to breach. It was reported that in line with previous years, elements of the review of discharge summaries had been red or amber rated as a result of insufficient evidence that previous recommendations had been implemented.

Audit Committee Annual Report to the Trust Board for the financial year 2015/16

The Committee recommended the report for Board approval.

Board Assurance Framework 2016/17 including update from RACG

The Committee discussed and approved the gross risk scores subject to one amendment and agreed that the next piece of work would be to challenge risk scores using performance indicators as supporting evidence.

Clinical Negligence Scheme for Trust's outstanding claims

It was noted that the Trust's clinical negligence liabilities as a result of claims against the Trust had increased significantly. A review of claims had shown that there were a number of high value claims that had not been investigated using a serious incident approach. It was confirmed that this was now being done and it was agreed that this would be discussed at the Quality and Safety Assurance Committee.

IT Programme Risk Update

The Committee agreed that it was important to have an IT strategy in place by the end of 2016 to avoid slippage in the EPR timescales.

Response to Reference Cost 2014-15 Audit Report by PWC

Following an audit by PwC, the Trust had been found non-compliant due to issues in Critical Care where costs had been understated. It was confirmed that the plan for 2015/16 addressed the findings and had been approved by KPMG.

ATTACHMENT R

Attachment R

Great Ormond Street Hospital for Children NHS Foundation Trust

Update from the Finance and Investment Committee meeting held on 16th May 2016

Finance & Activity Report – M12 Outturn

The Committee reviewed the 2015/16 financial outturn.

Contract Status Update
The Committee were given an update on the Trust's performance against 2015/16 contract performance. A brief was also given on the status of 2016/17 contract negotiations. Executive indicated the 2016/17 contract was signed on the 13th May 2016 subject to agreed final variations.

Operational Performance Update
The Committee were given a brief on the new Performance Management Framework principles that will be implemented for the new Divisional performance meetings.

Annual Effectiveness Review
The Committee noted the feedback from the survey and comments. There were no substantial changes to the TOR due to the feedback.

Committee Annual Workplan Update
The Committee agreed to have a greater focus on Service Line Reporting, Post Implementation Reviews of successful business cases and workforce planning.

Service Line Reporting Update
The Committee was given a brief on the implementation on the Trust's new service line reporting and patient-level costing tools. The non-executive directors questioned interfaces required with the new Electronic Patient Record system and discussed any impacts of the change to the new system in particular impacts of changes in methodology for the costing. It was acknowledged that this project will be important to improve analysis and reporting for services and patient costs.

Phase 4 – Strategic Outline Business Case
The Committee discussed the costs and financing methods of Phase 4 of the Trust's redevelopment programme. The non-executive directors expressed concern at potential financing costs and indicated a preference for a higher contribution from charity to minimise any borrowing requirements. The Committee approved £600k to fund the design stage on the understanding that no financing agreements would be entered into at this stage and the Outline Business Case would undertake the next stage of detailed planning to inform the development. The Committee also noted key risks for further review are the link to NHS activity plans, IPP activity and staff resourcing on the expansion of services.

Inter-Operative MRI (iMRI) Business Case
The Committee approved the proposal to undertake a feasibility study to identify the optimal solution for providing iMRI.

Annual Review of Treasury Management
The Committee approved the Treasury Management Policy.

Committee Terms of Reference
The Committee approved the terms of reference.

Attachment R

Great Ormond Street Hospital for Children NHS Foundation Trust

Update from the Finance and Investment Committee meeting held on 16th June 2016

Finance Report – M02

The Committee reviewed the month 2 financial position. There was discussion about the impact of PICB slippage on the Trusts' Financial Sustainability Risk Rating as well as the positive effect of higher than planned IPP income. The Committee also noted that NHS income had risen 9% on the previous period in the last financial year due to improvements in theatre utilisation and new outpatient attendances.

Procurement Productivity and Efficiency

The Committee discussed the update on Procurement P&E and Procurement developments. The non-executive directors questioned the level of 2015/16 savings delivered by Procurement compared to relevant Procurement costs. The non-executive directors also stressed the need for expertise in the contract negotiations for EPR.

Workforce Analysis

The Committee reviewed workforce trend analysis for the financial years 2013/14 to 2015/16. The non-executive directors commented that even allowing for RTT costs, administrative staff costs had increased significantly. It was agreed that the workforce analysis would be developed further and brought back to the next meeting for discussion.

ATTACHMENT S

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council update

A Members' Council meeting was held on Wednesday, 29th June 2016

The Council expressed some concern about the timeliness with which documents were being disseminated to the Council in particular the Deloitte report on the Quality Report and the confidential Trust Board agendas and minutes. It was noted that the Deloitte report had been shared with the Audit Committee at the May meeting and was presented to the Members' Council at its next meeting. It was agreed that confidential Trust Board agendas and minutes would be circulated to the council in the week beginning 11th July.

The Quality Report was noted and the Council expressed some concern that there remained outstanding external auditor recommendations from 2015/16 on Referral to Treatment targets (RTT) and discharge summaries. It was reported that GOSH was ahead of its trajectory for RTT which had been agreed by NHS England, NHS Improvement and CQC and work was continuing on discharge summaries which was a challenging issue. A presentation to the Councillors on discharge summaries showed that progress had been made across the Trust.

The Membership and Engagement Committee presented a patient story case study that had been collected whilst engaging with the hospital community. This highlighted the challenges caused to families by issues with communication.

Councillors asked about the increased number of contacts in PALS by Gastroenterology patients and carers and the Chief Executive reported that the Trust faced complex issues with the service and confirmed that significant work was underway. It was confirmed that the Quality and Safety Assurance Committee reviewed actions plans and received updates on the work programme at every meeting.

Discussion took place on benchmarking complaints and the Council noted that the Trust was focusing on improving responsiveness and there had been a reduction in the number of red complaints.

The Chief Executive provided an update on the following matters:

- Generous donation of the Chelsea garden to GOSH by Morgan Stanley.
- Excellent work from clinicians on RTT.
- Inpatient themes from Friends and Family Test: access, transfer and discharge.
- The Trust had begun the year well, but there were significant challenges ahead including the delivery of a £12million productivity and efficiency programme
- The result of the referendum on Britain leaving the EU – a significant proportion of GOSH staff are non-UK passport holders and it is vital to support staff at this uncertain time.

The Council received an update on the meetings of the Board subcommittees and highlighted the significant increase in IPP debt and debtor days. It was confirmed that this was an issue that Audit Committee was monitoring closely and that the vast majority of debt was with embassies where a debt had never been written off with the exception of a failed state.

It was noted that it would be Mr Charles Tilley, Non-Executive Director's last Members' Council meeting. The Council thanked Mr Tilley for his enormous contribution to GOSH. It was agreed that Ms Mary MacLeod would be appointed as Deputy Chairman from 1st September for 6 months, following Mr Tilley's departure.

The Council approved the appointment of Mr James Hatchley as a Non-Executive Director for three years until 31 August 2019.

The Council noted that GOSH was undertaking a Well Led Governance Review which was being led by Deloitte. Councillors' involvement in the process was outlined.