Great Ormond Street Hospital for Children NHS Foundation Trust

**GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST**
**MEETING OF THE COUNCIL OF GOVERNORS**
**Wednesday 17 July 2019**
**3:00pm – 5:30pm**
**Charles West Room, Paul O'Gorman Building**

| NO. | ITEM | ATTACHMENT | PRESENTER | TIME |
|---|---|---|---|---|
| 1. | **Welcome and introductions** | | Michael Rake, Chair | 3:00pm |
| 2. | **Apologies for absence** | | Michael Rake, Chair | |
| 3. | **Declarations of interest** | | Michael Rake, Chair | |
| 4. | **Minutes of the meeting held on 6 February 2019** | **A** | Michael Rake, Chair | |
| 5. | **Matters Arising and action log** | **B** | Anna Ferrant, Company Secretary | |
| | **STRATEGY, PERFORMANCE and ASSURANCE** | | | |
| 6. | **GOSH Children's Cancer Centre Update** | **C** | Matthew Shaw, Chief Executive/ Matthew Tulley, Director of Development | 3:10pm |
| 7. | **Update on implementation of EPIC Electronic Patient Record** | **D** | Richard Collins, Programme Director EPR/ Shankar Sridharan, Chief Clinical Information Officer | 3:30pm |
| 8. | **Chief Executive Report including:**<br>• **Integrated Quality and Performance Report May 2019**<br>• **Finance report (highlights)** | **E** | Matthew Shaw, Chief Executive/ Helen Jameson, Chief Finance Officer | 3.50pm |
| 9. | **Reports from Board Assurance Committees**<br>• **Quality, Safety and Experience Assurance Committee (July 2019)**<br>• **Finance and Investment Committee (March and June 2019)**<br>• **People and Education Assurance Committee** | **N and Verbal**<br>**F**<br>**M and verbal** | Amanda Ellingworth, Chair of the QSEAC<br>James Hatchley, Chair of the F&I Committee<br>Kathryn Ludlow, Chair of the People and Education Assurance Committee | 4:15pm |
| 10. | **Update from the Young People's Forum (YPF)** | **G** | Emma James, Patient Involvement and Experience /Chair of the YPF | 4:25pm |

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| 11 | **GOSH Quality Report** | **H** | Meredith Mora, Clinical Outcomes Development Lead | 4:30pm |
| 12. | **Findings and Recommendations for the 2018/19 NHS Quality Report External Assurance Review** | **I** | Craig Wisdom, Partner (Deloitte | 4:35pm |
| 13. | **Update from the Constitution Working Group**<br>• **Council of Governors' Effectiveness Review Survey** | **J** | Paul Balson, Deputy Company Secretary | 4:50pm |
| 14. | **CQC inspection update** | **Presentation** | Anna Ferrant, Company Secretary | 5:00pm |
| 15. | **Re-appointment of a Non-Executive Director on the GOSH Board** | **K** | Anna Ferrant, Company Secretary | 5:10pm |
| 16. | **Governance Update including:**<br>• **Review of Buddying Programme**<br>• **AGM planning**<br>• **Revised process for declaring interests** | **L** | Paul Balson, Deputy Company Secretary | 5:20pm |
| 17. | **Any Other Business** | **Verbal** | Chair | 5:30pm |

ATTACHMENT A

Great Ormond Street Hospital for Children NHS Foundation Trust

**DRAFT MINUTES OF THE COUNCIL OF GOVERNORS MEETING**
**17th April 2019**
**Charles West Boardroom**

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| Sir Michael Rake | Chair |
| Miss Faiza Yasin | Patient and Carer Governor: Patients outside London |
| Miss Zoe Bacon | Patient and Carer Governor: Patient from London |
| Miss Elena-May Reading | |
| Mrs Stephanie Nash | Patient and Carer Governor: Parents and Carers from London |
| Dr Emily Shaw | |
| Mrs Mariam Ali** | |
| Mrs Lisa Allera | Patient and Carer Governor: Parents and Carers from outside London |
| Dr Claire Cooper-Jones | |
| Mr Yu (Simon) Tan | Public Governor: North London and surrounding area |
| Miss Teskeen Gilani* ** | |
| Mr Colin Sincock | Public Governors: The rest of England and Wales |
| Ms Fran Stewart | |
| Dr Sarah Aylett | Staff Governor |
| Mr Nigel Mills | |
| Mr Paul Gough | |
| Miss Emma Beeden | Appointed Governor: Young People's Forum |
| Mr Josh Hardy | Appointed Governor: Young People's Forum |

**In attendance:**

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| Mr Akhter Mateen | Non-Executive Director |
| Lady Amanda Ellingworth** | Non-Executive Director |
| Mr Chris Kennedy | Non-Executive Director |
| Ms Kathryn Ludlow | Non-Executive Director |
| Mr Matthew Shaw | Chief Executive |
| Ms Helen Jameson | Chief Finance Officer |
| Dr Anna Ferrant | Company Secretary |
| Mr Paul Balson | Deputy Company Secretary |
| Ms Margaret Bugyei-Kyei | Newly appointed Staff Governor |
| Ms Victoria Goddard | Trust Board Administrator (minutes) |
| Mr Peter Hyland* | Director of Operational Performance and Information |
| Mr Jon Shick* | PMO Director |
| Mr James Scott* | Head of Strategy and Planning |

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

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| **1** | **Apologies for absence** |
| 1.1 | Apologies for absence were received from: Ms Alice Rath, Patient and Carer Governor; Mr Simon Hawtrey-Woore, Public Governor; Mr Theo Kayodi Osiyemi, Public Governor; Mr Julian Evans, Public Governor; Dr Quen Mok, Staff Governor; Cllr Lazzaro Pietragnoli, Appointed Governor; Professor Jugnoo Rahi, Appointed Governor. |
| **2** | **Declarations of Interest** |
| 2.1 | No declarations of interest were received. |
| **3** | **Minutes of the meeting held on 6 February 2019** |
| 3.1 | The Council of Governors **approved** the minutes of the previous meeting. |
| **4** | **Matters Arising and action log** |
| 4.1 | Action 49.12: Dr Anna Ferrant, Company Secretary reminded Governors of the importance of completing their statutory and mandatory training. |
| **5** | **Lead Governor and Deputy Lead Governor Appointment** |
| 5.1 | Sir Michael Rake, Chairman thanked Ms Mariam Ali outgoing Lead Governor for her work through the transitional period of a new Council of Governors becoming embedded in the Trust. |
| 5.2 | Dr Ferrant said that following a call for nominations by email to all elected Governors for both the role of Lead and Deputy Lead Governor, one nomination remained for each role: Dr Claire Cooper-Jones. Patient and Carer Governor for Lead Governor and Mr Paul Gough, Staff Governor. Nominees outlined to the Council their reasons for standing for the roles and the Council **approved** their appointments. |
| **6** | **Update from Council of Governors' Nominations and Remuneration Committee** |
| 6.1 | <u>Appraisal of two GOSH NEDs</u> |
| 6.2 | Dr Ferrant presented the outcome of the appraisals of Lady Amanda Ellingworth, Non-Executive Director and Mr Chris Kennedy, Non-Executive Director which had been recommended to the Council by the Council of Governors' Nominations and Remuneration Committee. The Council **approved** the outcome of the appraisals. |
| 6.3 | <u>Remuneration of NEDs</u> |
| 6.4 | In light of the current financial position of the Trust, the Chair and Non-Executive Directors had confirmed that they did not wish to receive a cost of living award in 2019/20. This had been recommended for approval by the Council of Governors Nominations and Remuneration and was **approved** by the Council. |

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| 6.5 | Revised terms of reference for Committee |
| 6.6 | Amendments had been made in relation to the process for queries around the Fit and Proper Person Test. The revised Terms of Reference were **approved** by the Council. |
| 6.7 | Nominations for members of the Committee |
| 6.8 | The Council **approved** the following Governors' seats on the Committee:<br>• Quen Mok, Staff Governor<br>• Colin Sincock, Public Governor<br>• Fran Stewart, Public Governor; and<br>• Lisa Allera, Patient and Carer Governor. |
| **7** | **Compliance with the NHS provider licence – self assessment** |
| 7.1 | Dr Anna Ferrant, Company Secretary presented the report and said that the provider licence was NHS Improvement's primary tool for regulating providers of NHS services setting out key conditions that providers must meeting. Foundation Trusts were required to annually declare compliance or otherwise with a small number of licence conditions and a requirement of the Health and Social Care Act. |
| 7.2 | There were four elements for self-assessment: ensuring that effective systems and processes were in place; availability of resources; arrangements in relation to the Code of Governance; and the Health and Social Care Act requirements around providing the necessary training to Governors. Dr Ferrant proposed that all areas were confirmed with the exception of Code of Governance arrangements which would be explained. |
| 7.3 | Discussion took place around the element which required confirmation of the availability of sufficient resources. Ms Fran Stewart said that funding had been discussed in the pre-meet with the Chair and queried how these challenges impacted the declaration. Mr Matthew Shaw, Chief Executive said that the tariff changes negatively impacted the Trust by approximately £10million and confirmed that whilst the Trust had discussed the matter with regulators and MPs extensively, GOSH had signed up to the control total. He added that if the Trust were not to confirm this element, it would be incongruous with signing up to the Control Total. Ms Stewart queried the Trust's ability to meet the control total given the current gap in the budget and Better Value schemes. She also queried the message sent to the wider system by agreeing the control total when the tariff was unsatisfactory. Sir Michael Rake, Chair said that whilst GOSH had agreed the control total and would be able to work towards it, it had been made clear by the Trust that there were issues within the system and that the tariff changes were unsustainable. He added that whilst it was reasonable to say that the Trust would reach the control total it would be kept closely under review. |
| 7.4 | **Action:** Mr Shaw said that the Trust had been very open about the tariff challenges and had met with key individuals at NHS England, London Region. The Children's Alliance had twice written to the leadership of NHS England to explain the challenges. Ms Helen Jameson, Chief Finance Officer said that all |

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| | Trusts in London were experiencing a similar issue and that this was compounded for GOSH due to its highly specialist nature. It was agreed that an update would be provided at the next meeting on the Trust's position both in financial terms and also in terms of lobbying on this matter. |
| 7.5 | Mr Akhter Mateen, Non-Executive Director and Chair of the Audit Committee highlighted that the statement was essentially a going concern statement and notwithstanding the Trust's ability to reach the control total, it would continue as a going concern and intended to sign the annual report and accounts on this basis. He added that the Trust's external auditors would provide assurance in this regard. |
| 7.6 | Dr Sarah Aylett, Staff Governor queried whether consideration had been given to lobbying in a more public arena as the Government had highlighted the substantial additional funding provided to the NHS. Mr Shaw said that the GOSH had joined the Federation of Specialist Hospitals which had a more developed lobbying function than the Children's Alliance and although changes were unlikely to be made in year, work would take place to ensure that the Trust was not disproportionately affected in the following years. Sir Michael said he felt that it could be beneficial for the discussion to become public in future however focus was currently being placed on negotiation. |
| 7.7 | **Action:** Dr Ferrant said that an independent evaluation of the Board would be undertaken by an external organisation in 2020 in light of the CQC inspection which was expected to take place in Autumn 2019. An evaluation of the Council of Governors was also required and a questionnaire would be developed with the Constitution Working Group. The results would be shared with the Council later in the year to ensure that learnings were incorporated into the work of the Council. |
| 7.8 | Dr Ferrant said that NHS Providers would be providing some training to the Council in July about the Governor role. |
| **8** | **Draft Council of Governors' section in GOSH Annual Report 2018/19** |
| 8.1 | **Action:** Mr Paul Balson, Deputy Company Secretary presented the Governors' annual report which was a required part of the Trust's annual report as a whole. He requested that any comments were forwarded to him outside the meeting. |
| **9** | **GOSH Strategy – Our vision and objectives for 2025** |
| 9.1 | Mr Matthew Shaw, Chief Executive said that over the next six months GOSH would be running a consultation for staff, patients, families and external partners to further develop the Trust's strategy 'Fulfilling Our Potential' focusing on what GOSH should seek to preserve and change. The development of the 'House' depiction of Fulfilling Our Potential was through the top 100 leaders and the additional work would be more inclusive with a large number of engagement events scheduled. |
| 9.2 | Dr Sarah Aylett, Staff Governor asked how the Trust would work with ICH and Mr Shaw said that there were existing links as a result of the research and education strategies. |

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| 9.3 | The Council suggested working with the Membership Engagement Recruitment and Representation Committee (MERRC) which had links with the membership. Ms Zoe Bacon, Chair of MERRC said that work was currently taking place around articulating the benefits of becoming a member and being involved with shaping the strategy was a key benefit. |
| 9.4 | Mr Colin Sincock, Public Governor asked whether there was a risk of GOSH merging or becoming subsumed into another Trust and Mr Shaw said that historically this had been a risk and that internationally there were fewer stand-alone children's hospitals. He said that although it was important for GOSH to be collaborative it was vital that the Trust remained independent. |
| 9.5 | Mr Josh Hardy, Appointed Governor asked how the views of people who had engaged in the consultation would be incorporated into the strategy and Mr Shaw said that views would be grouped into themes which would influence the strategy. He said that he anticipated that there would be key themes which would resonate with all stakeholders. Dr Claire Cooper-Jones, Patient and Carer Governor highlighted the importance of ensuring there was no bias in theming the feedback received from the consultation. Mr Chris Kennedy, Non-Executive Director said that it was vital to ensure that feedback was provided for everyone who had engaged in the consultation. |
| 9.6 | Mr Sincock asked for a steer on the long term plan for the NHS as a whole and whether this gave sufficient consideration to illness prevention. Mr Shaw said that the NHS Long Term Plan had been published in 2019 and it was likely that transition would change over time. It was often challenging for patients with complex conditions to transition to adult services and Mr Shaw said that rare and complex conditions were a key area where GOSH should consider the age of transition though he noted that a revised model would have implications for staff skills sets. Mr Shaw said that it was important for GOSH to be collaborative in the interests of paediatric health and added that the Trust hosted the North Thames Paediatric Network. He said that there was a substantial section in the long term plan on prevention. Ms Helen Jameson, Chief Finance Officer added that since Public Health England had become consolidated into NHS Improvement, this work would now be delivered through the long term plan. |
| 9.7 | Mr Nigel Mills, Staff Governor said that there would be substantial staffing implications around a change in transition and as there was not a standard NHS process it was important to collaborate with others and their expectations. |
| 9.8 | Dr Aylett highlighted that the Royal College of Paediatrics and Child Health (RCPCH) had published a report on the health of children in the UK and queried whether GOSH should consider closer working in this area. Mr Shaw agreed that working more closely with the College would be positive however a strategic decision was required about whether the Trust should become involved in more general paediatric health. |
| **10** | **Chief Executive Report** |
| 10.1 | <u>Electronic Patient Record (EPR)</u> |
| 10.2 | EPR was scheduled to go live on 19th April and the Trust was in a good position. As a result of the bank holiday weekend there would be far fewer in patients in |

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| | the Trust and therefore there would be a challenge on 23rd April once activity increased however overall activity had been reduced in light of the go live period for between two and six weeks depending on the area. Approximately 95% of staff had received training and the consensus from staff was that the Trust was ready for go live. An issue with the wireless internet service had been rectified however sufficient mitigations were in place that a recurrence of the issue would not impact go live. |
| 10.3 | Mr Akhter Mateen, Chair of the Audit Committee said that the Committee had been focusing on EPR for a number of meetings and were satisfied that the go/no go criteria would be met. Business continuity had been tested and the Committee was assured that patients would not be at risk if issues arose during or post go live. A NED walkround had also taken place to the on site EPR training facility. |
| 10.4 | Dr Aylett said that in her experience staff were positive about the transformation and despite the apprehension about go live itself were clear that substantial benefits for patients, families and staff would be realised as well as efficiency benefits. Mr Paul Gough, Staff Governor highlighted that a large number of EPR staff were experienced GOSH staff and knew the Trust well. He added that the clinical input had been significant and said that he also felt positive about the potential. |
| 10.5 | Ms Faiza Yasin, Patient and Carer Governor said that she was the patient representative for the EPR project and had been focusing on the patient portal which was very positive. She said that following go live staff would be touring the hospital encouraging families to sign up to the portal. Mr Shaw agreed that patient experience should be substantially improved by the introduction of EPR. |
| 10.6 | Mr Simcock asked for a steer on the legal implications in the event that there were issues with go live. Mr Shaw said that it was not anticipated that a legal issue would arise and Ms Kathryn Ludlow, Non-Executive Director agreed that, although in principle there could be legal implications, this would have a substantial impact on the Trust. |
| 10.7 | <u>Integrated Quality and Performance Report</u> |
| 10.8 | Mr Shaw said that the quality and performance reports had been integrated for the first time to allow better triangulation of information and a well led dashboard was also being presented for the first time. The 92% RTT target continued to be achieved however RTT compliance would reduce through go-live as a result of the reduced activity. It had been agreed that the Trust would work towards compliance by the end of 2019. Mr Shaw said that it was important to increase performance in some basic areas such as statutory and mandatory training and PDR completion. The Electronic Patient Record would support meeting some targets which had historically been challenging to meet such as discharge summary completion time. |
| 10.9 | Mr Paul Gough, Staff Governor noted the time taken to close incidents that had taken place in 2018-19 and said that although it was important to produce high quality reports it was also vital that they were closed in a timely fashion. Mr Shaw said that substantial work was taking place to reduce the backlog however this was not yet reduced to a satisfactory level. |

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| 10.10 | Sir Michael Rake, Chair said that the Non-Executive Director walkround had raised issues around insufficient utilisation during holiday periods and the need to be more efficient in terms of bed management. Mr Shaw said that the annual leave policy had been agreed by the consultant committee and local teams would now be responsible for agreeing the number of people who could be away from the Trust and ensure the service could still function. Mr Shaw agreed that patient flow could be improved and said that a large software company had approached the Trust to discuss partnering in this area. |
| 10.11 | Finance report February 2019 (highlights) |
| 10.12 | Ms Helen Jameson, Chief Finance Officer said that the Trust had submitted the draft year end results to NHS Improvement on 15th April 2019 which showed a position which was £116,000 surplus to Control Total. She said that this had been challenging to achieve and thanked the finance team for their work. |
| 10.13 | The external auditors would receive the full accounts on 24th April 2019 and business continuity had been tested to ensure that this would still be possible in the event of an issue post EPR go live. |
| 10.14 | The Council welcomed the result and congratulated the team. |
| **11** | **Update from the Young People's Forum (YPF)** |
| 11.1 | Ms Emma Beeden, Appointed Governor said that since the last Council of Governors' meeting three YPF meetings had been held. Mr Josh Hardy, Appointed Governor said that the group had discussed the clean air hospital framework and suggested that the Trust work with suppliers to work towards using more energy efficient means of delivery such as electric vehicles or less frequent deliveries. |
| 11.2 | Ms Beeden said that a careers fair had been held at the Trust which allowed companies to meet patients and become more aware that conditions were not limiting. This event led to one company hosting a workshop at their offices and others being inspired to do the same in future years. |
| 11.3 | The YPF had been invited to speak to apprentice Health Care Assistants (HCAs) about the experience of being a teenage patient and explored the rights and emotions of young people in hospital. Positive feedback was received from the HCAs involved. |
| 11.4 | The Council welcomed the excellent work that the YPF were leading and discussed the possibility of patients taking on work experience in the companies involved. Ms Zoe Bacon, Patient and Carer Governor suggested that the hospital school should partner with companies to develop a programme for young people who were writing CVs or personal statements. Ms Fran Stewart, Public Governor asked whether, given GOSH's links with UCL, work could take place to support UCAS statements and the requirements for young people thinking of applying to university. Mr Nigel Mills, Staff Governor said that the Association for Young People's Health was beginning to look at this and he was engaged with the project. |

| 12 | **Reports from Board Assurance Committees** |
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| 12.1 | Quality, Safety and Experience Assurance Committee (QSEAC) (April 2019) |
| 12.2 | Ms Kathryn Ludlow, Member of the QSEAC said that the committee was working to improve the information and presentation provided as part of the integrated quality and performance report which was an on-going process and good progress had been made. The Committee received a presentation on transition which highlighted that the process was primarily around supporting young people to transition to adulthood rather than solely adult services. A new People and Education Assurance Committee had been established which would be beneficial as it would allow substantially more focus on discussions around people and culture. |
| 12.3 | The committee reviewed the pharmacy risk and highlighted the issue with the number of pharmacists nationally. |
| 12.4 | Audit Committee (January 2019 and April 2019) |
| 12.5 | Mr Akhter Mateen, Chair of the Audit Committee said that focus had been placed on the risk around Electronic Patient Record implementation for a number of meetings and now that go-live was approaching the risk was changing. The committee had requested that the risk was redefined. The Committee reviewed the research income, business continuity and information governance risks. |
| 12.6 | The draft Head of Internal Audit Opinion had been issued and provided a rating of 'significant assurance with minor improvement potential' which was in line with the rating in 2017/18. Six outstanding recommendations were overdue which was a significant improvement however the internal auditors had reported that other Trusts had zero overdue actions. |
| 12.7 | Focus continued to be placed on IPP debtors which had increased substantially compared to the previous year. The external auditors reported that GOSH's provisioning policy was one of the most prudent of their Trusts and whilst some debt had been recovered, debtors had increased more quickly that the recovery. |
| 12.8 | The Committee continued to review wastage and was in the middle of the group when benchmarked with other Trusts. Reduction in this could support the achievement of a challenging Better Value target. |
| 12.9 | Mr Paul Gough, Staff Governor queried whether there had been a discussion about the wider IT risk during EPR go-live. He noted the importance of a robust IT infrastructure during this time. Mr Mateen said that work had taken place to make improvements as much as possible and although there had been an issue with the wifi service this was not as a result of pressure on the system. Ms Jameson said that GOSH commissioned another London Trust to undertake a peer review of the IT infrastructure which found that the Trust was in a good position. |
| 12.10 | Ms Fran Stewart, Public Governor asked for a steer on the potential impact of Brexit on pharmacy and whether stockpiling was taking place. She queried whether there was a trend in the number of procurement waivers. Ms Jameson |

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| | said that stock had totally approximately £9million in the annual accounts for 2017/18 and had risen to £10million in 2018/19. She said that stock in pharmacy had increased however this was due to a change in process rather than being Brexit related. A Brexit Steering Group had been established to consider these issues. |
| 12.11 | Ms Jameson said that waivers were often submitted when they were not required and added that as this was corrected there would be a reduction going forward. A spike in waivers in Q3 2018/19 was as a result of commissioning for the Zayed Centre for Research and the need to have the same equipment as was currently in place for gene therapy. |
| 12.12 | Mr Colin Sincock, Public Governor highlighted the discussion which had taken place at Audit Committee around two overdue actions from the internal audit on contract management which had been removed from the tracker prior to their implementation. Mr Mateen confirmed that this was a matter of governance and had been raised with the Executive Team and internal auditors during the meeting. The actions had been removed as it was assumed they had been implemented during the move to a new procurement partner. Mr Mateen said that he did not believe this change in outstanding recommendations changed the risk profile. Ms Jameson said that the actions were around the maintenance of a contracts database and whilst contracts had been recorded, this was not on a single database. Ms Jameson confirmed that she was satisfied that the Trust was managing contracts appropriately. |
| **13** | **Governance update** |
| 13.1 | Mr Paul Balson, Deputy Company Secretary said that the Trust had been unable to appoint to the Membership Relationship Manager role and would therefore be re-advertising the post later in the year. |
| 13.2 | The MERRC had piloted Regibox, software that would enable Governors to have a library of documents to refer to and this had now been rolled out to all Governors. |
| **14** | **Any Other Business** |
| 14.1 | Mrs Stephanie Nash, Patient and Carer Governor asked if the Council would have the chance to meet privately and Sir Michael said that whilst Governors were free to arrange this it was important to achieve a balance and respect Governors' time. |

ATTACHMENT B

Attachment B

## COUNCIL OF GOVERNORS ACTION CHECKLIST
## July 2019

**Checklist of outstanding actions from previous meetings**

| Paragraph Number | Date of Meeting | Issue | Assigned To | Required By | Action Taken |
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| 45.13 | 06/02/19 | It was agreed that a paper would be presented to the Council post EPR go live on the successes and learnings of the go live process. | **MS** | **July 2019** | On agenda |
| 49.12 | 06/02/19 | Mr Balson said that it was a key priority for Governors to complete their online statutory and mandatory training. He asked Governors to contact him if they needed access to their GOSH email or any other support. | **All Governors** | **April 2019** | Governors are asked as a priority to complete the mandatory training by **Friday 17 May 2019**.<br><br>TBC |
| 7.4 | 17/04/19 | Mr Shaw said that the Trust had been very open about the tariff challenges and had met with key individuals at NHS England, London Region. The Children's Alliance had twice written to the leadership of NHS England to explain the challenges. Ms Helen Jameson, Chief Finance Officer said that all Trusts in London were experiencing a similar issue and that this was compounded for GOSH due to its highly specialist nature. It was agreed that an update would be provided at the next meeting on the Trust's position both in financial terms and also in terms of lobbying on this matter. | **HJ/MS** | **July 2019** | On agenda |
| 7.7 | 17/04/19 | Dr Ferrant said that an independent evaluation of the Board would be undertaken by an external organisation in 2020 in light of the CQC inspection which would take place in Autumn 2019. An evaluation of the Council of Governors was also required and a questionnaire would be developed with the Constitution Working Group. The results | **PB** | **July 2019** | A copy of the draft survey is attached for review by the CoG. |

Attachment B

| Paragraph Number | Date of Meeting | Issue | Assigned To | Required By | Action Taken |
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| | | would be shared with the Council later in the year to ensure that learnings were incorporated into the work of the Council. | | | |
| 8.1 | 17/04/19 | Mr Paul Balson, Deputy Company Secretary presented the Governors' annual report which was a required part of the Trust's annual report as a whole. He requested that any comments were forwarded to him outside the meeting. | **All Governors** | **May 2019** | Annual report submitted to NHSI prior to deadline of 3 May 2019. Final version will be made available once presented before Parliament in July 2019. The External Auditor will attend the Council meeting in July to provide an overview of Deloitte's audit into the accounts and the Quality Report (on agenda) |

Attachment C

Great Ormond Street Hospital for Children NHS Foundation Trust

# Council of Governors

**17th July 2019**

## GOSH Children's Cancer Centre Update

**Summary & reason for item:**

The paper provides an update on the current status of the Children's Cancer Centre project. Due to revised funding parameters the project has been revised and reduced in scale whilst maintaining the essential service objectives and benefits. The Trust and Charity have agreed the parameters within which the project will proceed. The Outline Business Case is to be presented to the Trust Board in September and if approved design development of the CCC will re-commence.

**Governor action required:**

To note.

**Report prepared by:**
Matthew Tulley, Director Built Environment

**Item presented by:**
Mat Shaw, Chief Executive and Matthew Tulley, Director Built Environment

Attachment C

# Children's Cancer Centre

July 2019

**Update for the Council of Governors.**

**Summary:**

**The Council will be aware the Children's Cancer Centre project has been in development for a number of years. In December 2018 the Trust Board approved a scheme which would see the development of the whole of the Frontage and Paul O'Gorman sites along Great Ormond Street. However, shortly after this approval the changing NHS financial landscape made it apparent that the scheme could not be funded.**

**From February to May 2019 the Trust and Charity worked together to develop an alternative proposal that delivers similar benefits to the previously developed project but is Charity funded only. The development team has established we can deliver the essential elements of the Children's Cancer Centre within a smaller footprint on the Frontage Building site within the revised funding envelope.**

**In May a joint meeting of the Trust and Charity Boards agreed the principles of the development and agreed that the Business Case should continue to be developed. On the current timetable the Outline Business Case will be submitted to the Trust Board in September. If approved design development, with our design partners John Sisk & Son and BDP will re-commence in October.**

## 1. A Reminder of the Purpose of the Children's Cancer Centre

### a. Our Place in the World

GOSH is the world leading children's hospital for research into and treatment of complex and rare disease. It has a track record of research breakthroughs and innovation and childhood cancer is a rare disease.

Recent major developments have delivered the world class facilities required for neurosciences, cardiac and rare disease research. We now require similar facilities for children with cancer and the staff and researchers who look after them delivering:

- Scale to make untreatable cancer treatable
- Care for those surviving with complex needs

| Strategic Direction | Key Drivers for Change |
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| Masterplan 2015 | 1. Limitations of the existing estate |
| | 2. Increasing demand for clinical services |
| | 3. Need to improve clinical quality |
| | 4. Drive to implement principles of research hospital |

GOSH's overarching priorities for improving the quality of care delivered are:

- Safety - to reduce all avoidable harm to zero.
- Effectiveness: to consistently deliver clinical outcomes that places GOSH among the top five children's hospital in the world.
- Experience: to consistently deliver an excellent experience that exceeds patients', families' and referrers' expectations.

Phase 4 will incorporate the departments that form GOSH's cancer centre and a core aim is to provide a first class facility and outstanding environment for this patient population and their families. Cancer Services are one of GOSH's most significant clinical departments and GOSH is the largest children's cancer centre in the UK. As a regional, highly specialised, tertiary and quaternary referral centre, children and their families travel long distances for treatment and care at GOSH. GOSH is proud of the care that is provided to this patient population and the intention is to deliver facilities that will support clinicians in providing high quality, consistent care and a patient and family experience that is the best it can possibly be in what are extremely difficult and stressful circumstances.

GOSH, in common with other hospitals, with a long history of providing excellent healthcare on their original sites, iteratively seeks to repurpose available space on its constrained 'island' site to ensure it is fit for modern healthcare.

Over time expert understanding of the importance of the healthcare environment has evolved to a point where GOSH's older buildings are now seen as no longer fit for purpose because their out-dated dimensions and proportions cannot be reconfigured to meet modern needs optimally. This was recognised in the 2016 report from CQC:

*'Where the trust had completed a refurbishment or rebuild, the facilities were modern, extremely child friendly and conducive to excellent patient care and dignity. There remained some wards, not yet refurbished, rebuilt or relocated where the environment was less good.'*

### b. Current Cancer Facilities

GOSH currently delivers cancer day case, inpatient and outpatient services from a number of buildings located on the island site. There have been improvements to the clinical quality of other services through the delivery of previous phases of development. Phases 2 (cardiac and neuro services) and 3 (rare disease research) demonstrate GOSH's commitment to improving clinical quality for its patients.

However, further significant improvements are critical. Without them for example:

- Cancer services would remain fragmented over the existing site. A solution would need to be found for cancer day care (Safari ward) which is presently located in unsuitable accommodation in GOSH's oldest building, Southwood, built in 1938. Cancer inpatients are cared for in the Variety Club Building, opened in 1994. The connectivity between the cancer inpatient wards and Safari ward is poor. This prevents our clinicians from exploring innovative models of care and patient

pathways as well as resulting in clinical risks associated with the separation of cancer departments.

- Currently the iMRI is planned for a temporary and somewhat isolated facility in Southwood Courtyard but requires a permanent location where it is of optimum use and location for surgeons performing complex procedures safely.

This split between in-patient and day care accommodation causes staffing inefficiencies with two nursing teams working separately in two locations. Clinicians make the journey between the two locations in separate buildings many times a day. It hinders clinical collaboration and discussion. A patient's condition and treatment however necessitates moves between the two service locations. Capacity issues are already impacting on patient experience with clinicians short of space to have difficult and often emotional conversations with families about their child.

### c. Current Pharmacy Facilities

GOSH Pharmacy manufactures 3000 items a month and is involved in 240 trials. However, an independent external review of GOSH's pharmacy, was completed in October 2017 in response to MHRA inspection concerns and executive views that the environment and staffing levels were potentially unsafe. It found Pharmacy services are fragmented and scattered around various parts of the estate, operating from six geographically separate locations. MHRA has judged the main unit, where chemotherapy drugs are prepared, to be '*unfit for purpose'*. The layout of the pharmacy means an increased risk of errors. The 130 staff have the highest turnover in the Trust and the service is difficult to recruit to. Demand for pharmacy was noted as likely to grow given higher clinical activity since the opening of Premier Inn Clinical Building in 2017. The review notes '*space constraints potentially impacting on safe processing of prescriptions, both in dispensary and technical services'*.

### d. The Hospital School

The School's overarching aim is to minimise the interruption and disruption to children and young people's education so that academic progress and an interest in learning will continue as far as medical circumstances permit. As an integrated part of the Hospital it is essential that it is used to:

- support recovery and medical improvement
- minimise the risk of children falling behind their peers
- support patients to sit public exams if they are well enough to do so
- help patients continue a relationship with their 'home' school
- prepare patients for the life they will return to when they leave hospital

The Trust Board and Executive team have acknowledged that the current space is not fit for purpose. The School must provide its statutory service (section 19 of 1996 Education Act) to provide education for children and young people aged 3-18 and is facing increasing demand as the hospital continues to grow; the school schoolroom spaces have remained static and space is not sufficient.
Greater numbers of children of different ages are forced to work in an open plan space which hinders concentration and progress in their studies. The increasing demand on the wards means the teaching team has grown from 21 to 43 since 2011.

OFSTED (Office for Standards in Education) regularly feedback concerns about the lack of appropriate space.

### e. Quality and Entitlement

Another compelling reason for developing a cancer centre is the evidence that these buildings can be ground breaking in how the built environment is carefully designed and delivered to enhance the patient experience. A patient's experience is shaped by everything and everyone in the care environment. The paradigm is where the environment of care is considered as carefully as are the drugs or the surgery or the radiation.

Thus the quality of hospital buildings plays a fundamental role in patient safety, recovery, psychological well-being and the effectiveness of research and treatment. Poor environments impede recovery just as effectively as good environments support that recovery. The psychological wellbeing of people is impacted by lighting, acoustics, access to daylight, privacy and environmental conditions.

Through the implementation of The Children's Cancer Centre there will be a significant improvement to the quality of services by providing:

- a state-of-the-art international cancer centre, co-locating inpatients and outpatients' services for the first time in a nurturing environment and siting it next to intensive care. This will improve clinical quality through a reduced need to move patients across sites within the island site;
- 100% single bedrooms with controlled air quality to reduce the risk of cross-infection;
- consolidated pharmacy services in a Children's Medicine Centre on one site for safer medicines preparation and rectifying major regulatory compliance issues;
- the opportunity to support patients in their fundamental human right to education and play

### f. Capacity Modelling

The 2018 Capacity model has been re-based to reflect actual activity achieved 2018/19. It reflects the ONS data on population changes (1% for CYP in London) and NHS data on commissioning growth for cancer (also 1%) previously agreed with clinical teams.

| Bed type | Current capacity | Capacity required by 2035 | Capacity delivered by CCC |
|---|---|---|---|
| Inpatient | 50 | 65 | 64 |
| Day case | 20 | 24 | 24 |

It is recognised that the NHS will rationalise services to improve critical mass and outcomes, creating paediatric cancer research centres. GOSH will be at the forefront of these changes but must have the facilities to enable this to take place.

### g. Masterplan

The Masterplan 2015 was adopted by the Trust Board in February 2015. Masterplan 2015 provides a roadmap for further developing the site to meet rising demand, deliver increasingly complex care and offer a better patient experience. It allows services to be maintained on the existing site discounting the requirement to move away from WC1, consolidating resources and making best use of property assets, while still delivering on the aspiration to help children with complex health needs to fulfil their potential. It recognises that more than half of the island site has been redeveloped and limited options remain.

The key output of Masterplan 2015 is how the redevelopment programme could be completed in two further tranches. The Children's Cancer Centre (Phase 4) will develop the south of the site enabling in turn development of the Southwood and MNH buildings to the north. The delivery of future phases is dependent on the delivery of The Children's Cancer Centre – without this development, the masterplan for future phases cannot be realised.

**However, it is recommended that the Masterplan is refreshed in 2020-21 once town planning has been achieved for Phase 4.**

In summary:

The Children's Cancer Centre is required to deliver a dedicated, flexible facility to cope with future demands, capitalise on opportunities and promote innovation.

## 2. New Build Opportunity

Acknowledging that the EDA scheme cannot currently be supported in its totality by external funding the challenge has been to reduce the scheme without losing the vision and functionality of the Cancer Centre.

### a. Cost analysis and target area

Step one was to use the detailed cost analysis provided as part of the EDA works (and subsequently validated by the Trust Cost Consultant) to identify a target departmental area and therefore gross internal floor area.

Analysis showed that two different target areas can be established, driven by whether the Hospital or the Charity procure the scheme.

The targets are:

- Max 13,700 sqm for a hospital scheme
- Max 16,000 sqm for a charity scheme [1]

### b. Healthcare Planning

The Head of Healthcare Planning developed a draft functional content (list of depts.) and detailed Schedule of Accommodation which would generate a **minimum** footprint for each department and ward. From this came a draft stacking diagram which drives clinical adjacencies (within the scheme and with the remainder of the hospital).

This work was cross checked against the target area and the red line drawings (developable area) at each level and found to be within range.

### c. Building Form

The developable site is best described as the footprint of both Paul O'Gorman Building (POG) and the Frontage Building. The massing allows for careful development up to the Primrose Hill Viewing Corridor for St Paul's Cathedral.

The site sits within the Bloomsbury Conservation Area and POG is considered a heritage asset. Planning matters are considered later in the paper.

The EDA scheme occupied the site of both buildings and had 9 storeys above ground, including a set-back storey for both the school and plant space. The set-backs improved the experience from street level (building appears shorter).

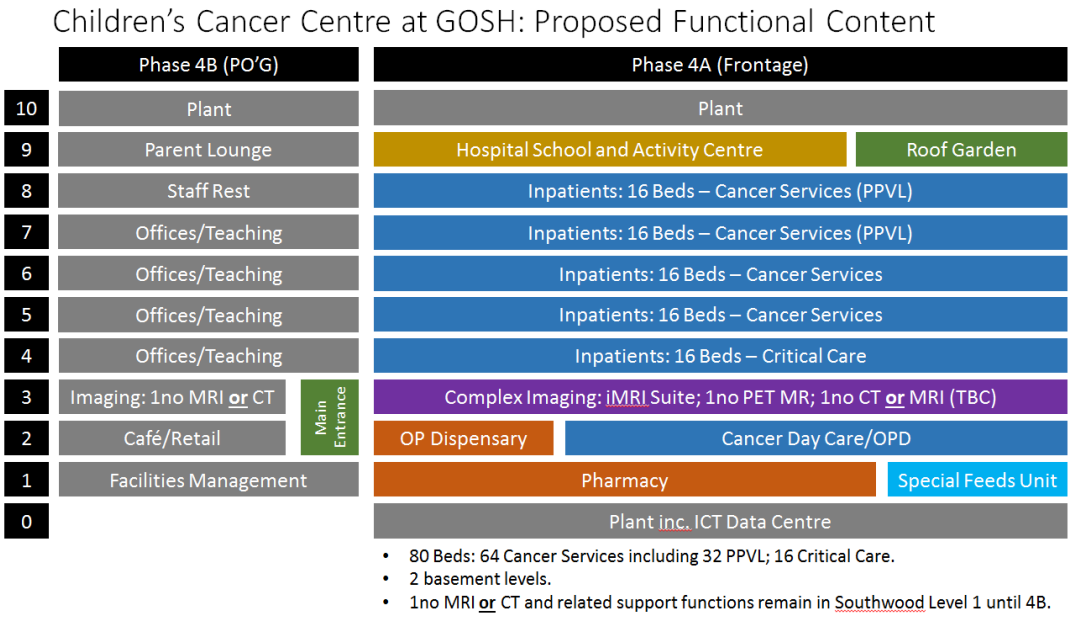
Below ground levels included plant and the medicines centre accommodation.

The Trust has been painstakingly implementing a 'horizontal platforms of care' model whereby particular depts. and the pathway experience for patients are delivered from specific levels across the site. (This is considered good practice but cannot be fully implemented at GOSH until Phase 5 completes.)

| Floor | Space | Examples |
|---|---|---|
| L5 and above | wards | |
| L4 | Critical Care | PICU, NICU |
| L3 | Theatres and complex imaging | Theatres, iMRI |
| Ground L2 | Ambulatory space / public space | Outpatients, imaging, lagoon |
| Below Ground L1 | FM and technical support space | Staff change; Imaging |

[1] EDA scheme was 23,603sqm new build.

This model of care; the available footprint and the schedules of accommodation drive a development of the Frontage site (without the need for POG) with the following stacking:




This option maximises the massing on site with Phase 4B on the POG site, as a re-model and extension project to complete the original vision for Phase 4.

### d. Flexibility and Adaptability

**Flexibility** is the potential for spaces to be used in a variety of ways without altering the **building** fabric**. Adaptability** is the potential for the fabric to be modified with relative ease to accommodate change. Truly adaptable hospital buildings come at a cost premium. The walls are over provided with building services such as water and waste. Service risers are over-sized for future plant.

The key to good healthcare planning is to create generic ward, clinic and theatre accommodation that can be used by any service (flexibility) and to include 'soft space, such as offices, ripe for future conversion to clinical space (adaptability).

Three of the 5 wards in the CCC have to be specialised spaces for either BMT (lobbied rooms) or critical care (larger rooms with no en-suites). The rest of the floors are also highly technical spaces and space is at a premium.

What has been determined through the design competition is that the ward floor could be adapted to increase / decrease the number of specialised beds and the overall beds were zoned such that air handling and other services could be switched out in cohorts of beds, allowing the ward to maintain operation.

### e. Technology – a forward look[2]

The most significant technologies (excluding ICT) are in the fields of imaging, laboratory medicine and robotics. The likely impact of technology over the next 15 years is well understood following extensive engagement with the clinical teams in late 2018.
Phase 4 represents a significant solution for imaging technology advances, cancer services and robotics. Service robots such as Tug and other AGVs are increasingly utilized in hospitals to transfer and deliver supplies, pharmaceuticals, patient food trays, and even trash throughout the hospital. Countless hours of repetitive labor are handled by these devices. Phase 4 is being designed for future implementation. The Pharmacy robot will be upgraded and it's use extended.
The most significant progress will be made in dual modality imaging. It is universally recognised that PET/MRI is the ideal hybrid imaging modality in paediatrics. in oncology, neurology and neurosurgery (epilepsy and brain tumours), infectious diseases (fever of unknown origin, monitoring of response to therapy of some infective conditions), rheumatology (vasculitis, connective tissue diseases), endocrinology (insulin secreting pancreatic tumours).

The equipment allowance within the project budget has allowed for the technology. Each asset is subsequently added to the asset register and its replacement planned into the Trust Wide Equipment Replacement Programme.

## 3. Next Steps

The principles for the revised scheme were approved by the Trust and Charity Board in May 2019 and the Hospital is now completing the Outline Business Case to support the next stage of investment for the CCC project. The principles established are that:

1) The Charity has committed to raise £250m to support the project.
2) The Hospital will contribute £8m towards design development.
3) The Hospital will manage any budget increase above the £258m described above.

The OBC is scheduled to go to the Trust Board and Board of Charity Trustees in September 2019. If approved the design development work on the CCC will re-commence in October. The work on the necessary projects to decant the Frontage Building will also start.
The design process and associated planning approvals are estimated to take approximately two years. The current programme will see the decant works completing mid-2022 with a start on site for the CCC planned for summer 2022. Completion will be early 2026.

[2] Review of New Technology and potential Impacts on the Masterplan: HCP advice note Oct 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

**Council of Governors**
**17th July 2019**

| **EPR Programme Update July 2019**<br><br>**Submitted by:**<br>R Collins - EPR Programme Director<br>H Vigne – EPR Programme Manager | **Paper No. Attachment D**<br>**EPR Programme Update July 2019**<br><br>**For Information** |
|---|---|

**Aims**

The aim of this paper is to provide the Council of Governors with a summary of the learnings and successes of the Electronic Patient Record (EPR) Programme following go-live on 19th April.

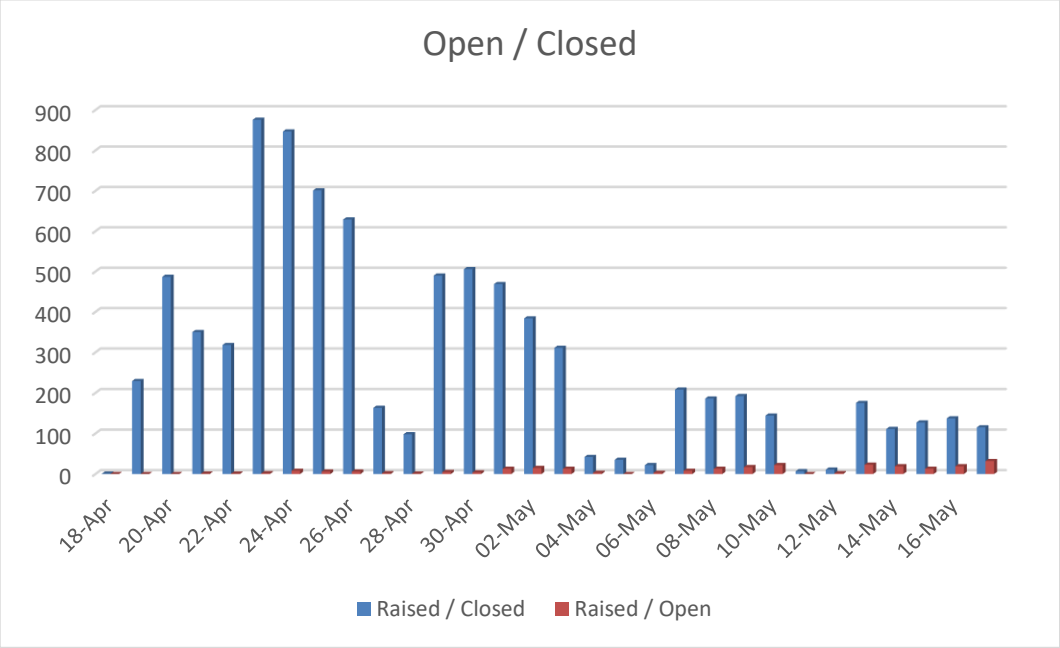
**Summary**

The EPR Programme went live, as planned, on 19th April 2019. The Programme has remained within the budget for the first two years (the 'Implementation' phase) and continues to track to time and budget for the 'Optimisation' phase which runs to October 2020.

There is broad agreement across the Trust (executive, leadership and staff) that the go-live has been successful. As predicted (and planned for) there have been a large number of issues raised since go-live with some key themes. There have also been a number of examples where some of the key patient and staff benefits have been evidenced; and whilst it is too early to empirically measure the impact of these, the anecdotal response suggests that the Programme has been effectively set up to start to deliver the benefits described in the EPR Full Business Case.

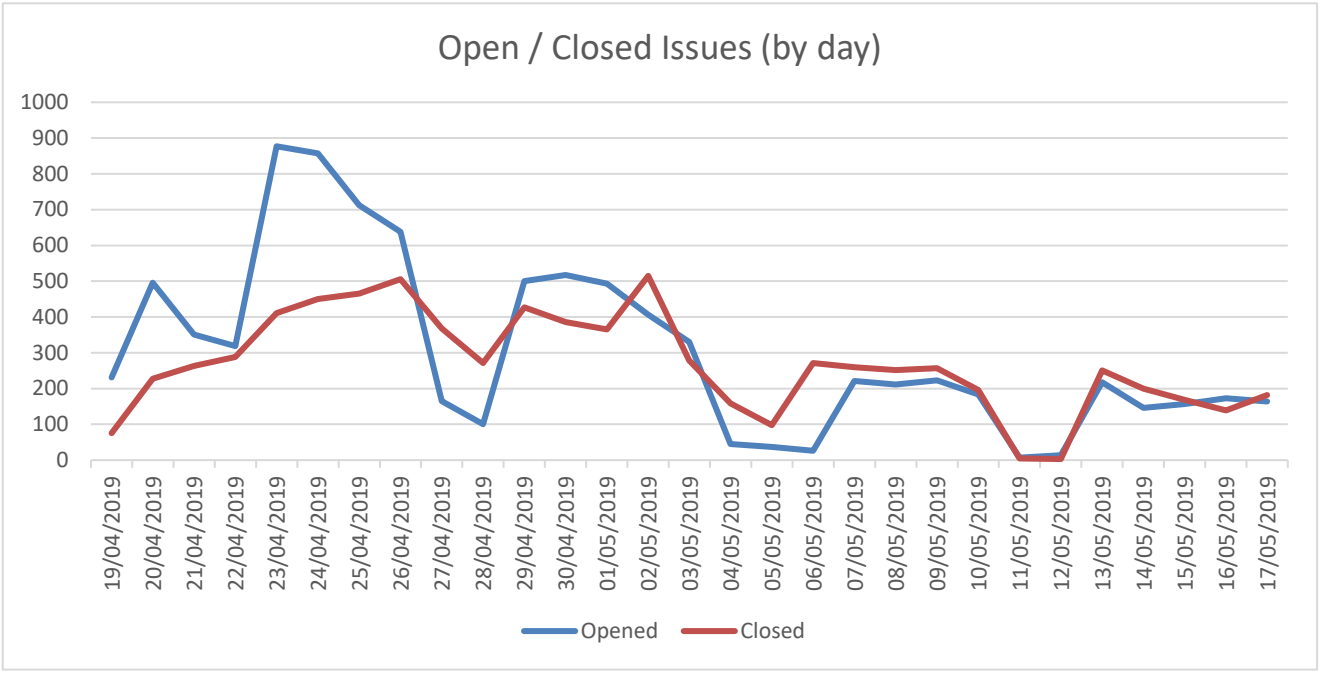
**Issues**

The graphs below show total number of issues raised and closed in the first four weeks following go-live. Whilst the total number of issues appears relatively high, the numbers are lower than was predicted by Epic, based on similar size and scope of implementations. The EPR analyst teams (both GOSH and Epic) prioritised the more severe or impactful issues but also looked to make small improvements to the system to ensure that it better supported workflow and experience. Other issues, which were requests for change, have been added to the Optimisation Log and will be prioritised with other optimisation requests which were identified prior to go-live.



The above shows the status of tickets that were raised on a particular day (i.e. a total of 221 calls were raised on 19th April and all have now been closed, whereas 847 calls were logged on 24th April of which 8 remain open).

The graph below shows total number of new issues raised each day and the total number of issues resolved each day. The EPR team is consistently closing more issues than are being raised on a daily basis, which is key to enabling them to focus on planning for optimisation activity and for the first major Epic upgrade, currently scheduled for September 2019.




To date, 11227 issues have been raised and 10537 issues have been closed.

**Themes**

The following are some of the key themes that have emerged since go-live:

Printing – largely relating to configuring the system to ensure staff could print to specific devices. Significant testing pre go-live reduced potential calls but there was still a high volume over the first few days.

Devices - the ICT and EPR Programme teams deployed or updated thousands of devices ahead of go-live. There were a number of different 'device' issues (largely now resolved), including:

- The upgrade required for certain devices within the ICUs could only be completed at cutover and this took longer and was more complex than predicted
- Insufficient numbers of some devices in certain clinical areas based on new ways of working

Scanning - Scanning (wristbands, sample labels and medication barcodes) is a key element of patient safety. There was a mix of scanning issues, which included issues with some barcodes. These were addressed urgently and workarounds introduced where appropriate.

Fluid Balance - Recording intake / output has changed with Epic and this has led to a number of unexpected difficulties both due to the change itself but also a need for nursing teams to take additional steps that were not required when using paper and legacy systems. The Chief Nursing Information Officer has worked with the nursing leadership to make changes to recording fluid balance which resulted in a more efficient process, although there are still some nursing teams who are more impacted than others. There is an optimisation project to link infusion pumps directly into Epic which should simplify this situation further (in addition to familiarisation).

Medications - The Epic system has introduced increased auditing of actions and patient safety (through closed loop medication administration). In order to configure the system to allow different nursing teams to both

prescribe and administer medications in accordance with their scope of practice, the system cannot be locked down by role. This has required ongoing education for nursing teams that staff should continue to work within their scope of practice as they would have done prior to Epic.

CIVAS - Changes to the way some medications are prescribed in Epic led to the CIVAS service changing the % of different medications produced. This had an unintended impact on nursing teams on some wards (where they were required to manufacture medications previously provided by CIVAS). In the short term, this was mitigated by providing additional nursing staff to these areas.

Pharmacy Stock - Stock conversion from JAC to Epic has highlighted some differences in how stock is reported (e.g. packs versus single items) which are being worked through and have required additional stock checks and build fixes. Overall there have been a number of issues affecting pharmacy (both inpatient and outpatient) and the General Manager / Chief Pharmacist are working with local teams and with the EPR team to provide some additional resource and focus to stabilise this area.

Phases of care - Moving patients through a single integrated system is a difficult concept to understand and there have been a number of examples where staff working in one area (e.g. theatres / interventional radiology) cannot 'see' the patient on their pathway, or cannot see documentation completed by staff in other areas (e.g. on the wards). The Programme team has resolved most of the access or workflow issues but this is an area where there is likely to be ongoing work required and in some instances, this is likely to require software development by Epic.

MyGOSH release of results - The MyGOSH patient portal has been well received by our patients / families (see below) but there have been some issues with the configuration of result message release which resulted in messages being sent to patients outside of the 9-5 planned time.

**Benefits**

The Trust selectively reduced some activity post go-live to ensure staff had the best opportunity to adopt and become more familiar with the system. Throughout the go-live period, the Trust has continued to deliver high class care to our patients; for example, on the day of go-live the Trust successfully operated on conjoined twins. One of the twins was the first new registration following go-live. The primary focus of the Trust leadership and EPR team over the first 4 to 6 weeks was to safely deliver go-live and respond to the issues identified by staff. However, there have been some good examples of improvements to workflows including:

- Two babies transferred from UCLH had records sent over through Care Everywhere – this demonstrates the benefit of shared patient records with other NHS organisations
- Clinical teams are already seeing data shared across teams giving a holistic summary (see below); the concept of 'Essence' was to give each clinical team a brief but informative overview of the current status of each child

**Essence: Last Filed per Specialty**

| | Value | Time | User |
|---|---|---|---|
| Cardiothoracic Transplant | Tacro level 15.2. No new changes. Level needed tomorrow am. | 23/4/2019 18:41 | Doxa KOTZIA, Clinical Fellow |
| Physiotherapy | Dry cough throughout bubble PEP. Needing encouragement++ to exercise. Physio community referral sent. | 23/4/2019 15:30 | Lee CARTER, PT |
| Nursing | Awake, playing. Settled. No complaints of pain. | 23/4/2019 21:19 | Hannah BURNS, RN |
| Social Work | Known to GOSH SW providing support during inpatient stay/will follow up in outpatient as necessary. | 23/4/2019 13:37 | Leah MOFFAT, SW |

- MyGOSH patient portal. 3,500 patients have already signed up. There has been feedback from one parent to a member of the patient experience team who has three children under our care and who already thinks MyGOSH will revolutionise how she communicates with the hospital. Once parent wrote in a note to their care team *"Thank you for looking after our son! I hope the new computer system goes to plan. I am now logged in and it's great so far. No hiccups this end. Thanks again for all your help."*
- In addition 867 patients have an updated 'fingerprint' in Epic which is personalized to them, showing things like favourite colours, likes and dislikes etc. Fingerprint enables our staff to engage with our patients on a more personal level
- Over the two weeks post go-live we had over 150 International super users supporting our staff. Many have reported how well the staff are coping with the change and how welcoming they have been. The investment in the international super users, aligned with our own staff, has been a real success and has made a huge difference to staff as they gained familiarisation during the initial two weeks of system use. The Epic leadership has been so impressed with the way that GOSH leveraged the relationships with other paediatric centres across the world that they have invited the Programme Manager to present to the annual Epic User Group meeting in August
- Melanie Hiorns, the Clinical Director of IPP and a Consultant Radiologist wrote "*Single most amazing thing about EPIC..... Suddenly out of nowhere, there is a little picture of the actual patient in the corner of our reporting template in Xray - transformational and psychologically very powerful - they are a real little person looking at us and saying 'please try really hard as you report our collection of black and white pixels in your darkened room*"
- The patient safety dashboards, showing key metrics such as adherence to closed loop medications administration and allergy checking have been made available to the Nurse in Charge and we witnessed improved compliance on a day by day basis for our key patient safety metrics quickly after go-live
- The number of user / security issues (where staff are unable to access elements of the system that they would expect based on their role) has been low. This is largely due to focussed efforts before go-live to review and update a large number of roles. The impact has also been reduced (where staff have had problems) by placing staff around the hospital who are able to resolve access issues quickly

**Lessons Learned**

Whilst there were a large number of lessons learned (and in many cases, applied) throughout the implementation of the EPR system, the following are those which are most relevant for subsequent phases of the EPR Programme and / or should be considered for similar programmes of work established by the Trust.

Effective engagement

The level of clinical and operational engagement throughout the implementation phase was significant and played a major part in ensuring that the system was configured to support the majority of staff for the majority of their key workflows. This included excellent representation by leaders from many areas through the Clinical & Operational Readiness (CORe) Group. There were some exceptions in terms of certain specialty teams who were less engaged than others and in most cases, these teams have found it harder to adapt to the new system. There is firm evidence to support appropriate investment in time from subject matter experts (SME) from all staff groups / directorates which may be impacted by a programme of this scale and complexity (i.e. this should continue throughout the optimisation phase of the EPR and should be factored into future programmes)

Dedicated nursing / medical input

In addition to the SME engagement, the EPR Programme invested in dedicated time from a number of Nursing Information Officers (NIOs) (led by the Chief Nursing Information Officer - CNIO) and Medical Information Officers (MIOs) (led by the Chief Clinical Information Officer – CCIO). These staff were all heavily invested in the EPR Programme and went over and above what was asked for to support the EPR team and initial implementation of the system. The benefits of the NIO / MIO involvement were multiple, including engaging effectively with their peers, translating / prioritising issues experienced by end users and guiding the EPR team throughout system design and subsequent end user training. Whilst the operational engagement (particularly in the six months leading up to go-live) was also excellent, the Programme recognises that there was a lack of equivalent 'administrative' representation to the same extent as provided by the clinical teams. Future phases and programmes should include dedicated time for other staff groups where appropriate

Governance

The programme was very thoughtful about governance at all levels, from the EPR Programme Board (which had strong executive input) down to sub-committees, which were all chaired by staff within leadership roles across the organisation (i.e. not formally part of the EPR team). This level of governance ensured that the programme team were appropriately held to account for delivery, but also provided strong links into the operational teams

Testing

The EPR team deliberately extended the scope of testing (i.e. over that suggested by the system supplier) to included complex 'end to end' clinical scenarios. This worked to an extent, but after go-live it was clear that further testing, particularly for pathways where patients were transitioning between different clinical areas (i.e. from ward to theatre), would have likely identified some of the issues that were not identified until after go-live. It is also true that many of these 'patient movement' issues were the result of 'upstream' actions in the system not being completed correctly. This requires a level of 'negative testing' (i.e. deliberately not following intended workflows). It is difficult to identify all likely scenarios before systems are in full use, but further consideration should be given to this going forwards.

User validation / end to end training scenarios

The EPR team encouraged (and supported) collaborative user scenarios where different staff groups came together to run through scenarios which they had developed; or spent considerable time in the system 'shadowing' actual clinical care in Epic. Teams that invested more heavily in this activity had fewer issues at go-live and the staff were far more confident using the new system. Whilst the EPR team promoted this activity, it was not mandated, as there was a difficult balance to be achieved between investment in time to prepare for Epic and maintaining the necessary level of clinical care for our patients in the weeks immediately preceding go-live. For future phases / programmes, the benefits evidenced by investing this additional time should be carefully weighed against any other (non-clinical) staff activity. This extends to 'playground' time and 'personalisation' following training, which was similarly encouraged but not mandated.

Investing in lessons learned elsewhere

Throughout the programme, teams visited other organisations, both in the UK and internationally, to study what had worked well and not so well on their programmes. The benefit of seeing systems 'in the flesh' and the impacts of certain decisions cannot be underestimated (as opposed to reading about lessons learned). The GOSH team (including operational / clinical leaders from outside the EPR programme team) made informed decisions which either allowed us to thrive in certain areas or avoid some of the more challenging issues experienced by others. The EPR Programme should continue to learn lessons from other organisations which are more advanced and other programmes should look for opportunities to learn from others in a meaningful way. The relationships developed during these site visits were also material in leading to the peer support (see below)

Peer support

The GOSH team either took advantage of existing, or created new relationships with peers from paediatric organisations across the world. Over 150 primarily clinical staff provided super users support to our staff during the first two weeks of go-live and this (above all other support offered by Epic and the EPR team) eased the initial adoption of the system. It provided users with the confidence to use the system knowing that there were experts available to them who use the system in very similar clinical scenarios; it also released time for some of the GOSH team (especially the MIOs and NIOs) to focus extended time on more complex issues

Go-live communication

The EPR team adopted Microsoft Teams as the mechanism for peer to peer communication. It is an application very similar in concept to WhatsApp which many people are familiar with, but had added security which meant that f any users inadvertently transmitted patient identifiable data, it was fully secure and in line with IG and GDPR. The super users made full use of the messaging and sharing capability of Teams to communicate issues, ask for help and post issue resolutions. This was far more immediate than logging calls with the helpdesk (also freeing up helpdesk capacity)

The EPR Programme team also held three time daily wash-up sessions with super users where issues were shared. The key learning from these sessions was that demonstration of preferred system use was significantly more effective than simply telling super users or sending updates on teams. This learning will be fed into future approaches for training and the roll-out of upgrades / large changes

Management of technical tasks

The EPR team was supported by colleagues from ICT for some of the technical elements of the programme, and in particular, the deployment and testing of new hardware. However, the structure of the teams (where resources were coming from EPR, Epic, ICT, Estates & Facilities and third party partners) and reporting of progress was confused and led to unnecessary delays / inefficiency. More thought in terms of setting the technical tasks up with a better shared understanding from the outset would have improved this.

Programme Structure

The overall structure of the EPR Programme (including 'non-EPR' staff supporting various activity) was effective in most areas. The team recognises that a more integrated approach to working with the Trust's information team should have been taken from the outset. Whilst the teams worked effectively together to deliver the key reports on time, this could have been better coordinated.

Supplier Management

The Trust developed a close relationship with the Epic team and there was a high degree of transparency throughout the programme. This led to a shared approach to issue resolution (i.e. avoiding a 'blame' approach which might have led to defensive behaviours on both sides). The Trust team has still held the supplier to account for delivering the agreed scope of service, but the collaborative working has led to a broadly successful go-live experience for the vast majority of staff.

Attachment E

Great Ormond Street Hospital for Children NHS Foundation Trust

# Council of Governors

## 17 July 2019

**Chief Executive Report – July 2019**

The purpose of this paper is to provide a summary of key work priorities and achievements since the 6 February 2019 report to the Council of Governors. The report includes:

- Executive summaries of: Month 2 Finance report and Integrated Quality and Performance Report – May 2019
- Trust Board update from 22 May 2019
- News stories
- GOSH appoints New Transformation Director
- GOSH Play Street!
- Launch of Speak up
- GOSH Strategy Engagement
- Opening of Zayed Centre for Research into Rare Disease in Children
- Other GOSH news
- Appendices
    - June 2019 Integrated Quality and Performance Report – Attachment Ei
    - Month 2 Finance report – Attachment Eii

**Governor action required:**

- Governors are asked to note the report and pursue any points of clarification or interest.

**Report prepared by:**

Paul Balson, Deputy Company Secretary, paul.balson@gosh.nhs.uk

**Report presented by:**

Matthew Shaw, Chief Executive

## Trust Board Executive summary: Month 2 Finance report

Key points for Governors to note include:

- The Trust is required to achieve an overall control total. The Trust is behind its control total in Month 2 by £0.5m. None of the £1.0m reserve has been released into the position.
- The Trust is behind its income target by £3.0m (excluding pass through) at Month 2. NHS Clinical Income that is not on block contract is behind plan by £0.4m. Private Patient income is also behind plan by £1.9m year to date due to lower levels of activity.
- Pay is underspent year to date by £1.9m due to the number of vacancies across the Trust that are not being covered by bank or agency staff.
- Non pay is £0.6m underspent year to date (excluding pass through). This predominantly relates to underspends on clinical supplies and drugs which are partially offset but non-delivery of non-pay better value schemes.
- Cash is higher than plan by £6.3m (£48.0m against a plan of £41.7m) in part due to higher than planned receipts from NHSE. The capital programme is currently £4.1m behind plan due to slippage on estates and Equipment projects. Overall, overdue Trust IPP debt has increased to £37.2m from £36.9m in Month 1.

At the April meeting of the Council of Governors the Council requested an update outlining the challenges of the changes to tariff and the action GOSH has taken. The Trust's finance team is currently working with the Children's Alliance and other national specialist Hospitals to influence 2020/21 tariffs onwards. More information will be forthcoming on this, with indicative tariffs due to be consulted on at the end of the calendar year as well as the impact of the new EPR systems impact on the Trusts coding and reporting. It is proposed that a workshop could be held at the November 2019 meeting of the Council of Governors to go through the latest position in more detail.

## Trust Board Executive summary: Integrated Quality and Performance Report – June 2019

The Integrated Performance Report (IPR) is focused on the key areas/ domains in order to be assured that the Trust's services are delivering to the level our patients & families, Trust Board and our commissioners & regulators expect. Key points for Governors to note include:

**Caring**

The Trust met the 25% FFT target in January, February and March 2019. A decrease in FFT responses was expected following a planned reduction of patient activity as part of EPIC launch. In May 2019 inpatient FFT response rate improved and is slightly below the Trust internal standard of 25% at 22.32%. Out of 3,051 patients eligible to respond, 667 patients completed the survey. It should be noted that Brain, Sight and Sound, Heart and Lung and IPP directorates have achieved the local standard. 96.25% of the 667 patients providing feedback would recommend the Trust. Positive comments received related to patient centred care and knowledgeable staff.

**Safe**

The Trust reported no incidents of MRSA in May 2019.

There was one incident of C-Diff reported in May 2019.

**Responsive**

90.51% of patients were waiting within 6 weeks for a Diagnostic test for May 19, 96 patients breached the standard with 76 attributable to Radiology including Cardiac MRI. The breaches are grouped into four categories, 70 due to reduced planned activity slot availability and administrative teams unable to provide reasonable offers to patients, 6 due to lack of capacity, 10 Trust processes

and 10 tolerance patients. The Trust has developed a recovery plan and trajectory with current forecast for compliance being end of September 2019

The Trust has underachieved against RTT Incomplete Pathway national standard at 88.25%. However, it was projected that a drop in performance due to EPIC Go-Live was to be expected due to the planned activity reduction. For May the Trust reported 6 patients waiting over 52 weeks.

**Well Led**

Appraisal rates remain a challenge. Action plans have been produced by directorates containing trajectories to improve the position.

**Effective**

Discharge summaries within 24hrs are below the national standard of 100%, at 45.27%. The Trust is currently undertaking a full data investigation and deep-dive into this metric to understand the impact of EPIC.

**Patient Advice and Liaison (PALS) cases**

PALS cases overall decreased in April in line with the reduction in appointments and procedures during EPIC go-live

There was an increase in complex cases (PALS cases which raise multiple questions and/or take more than 48 hours to resolve). The PALS team focus on review of cases to ensure timely follow up and appropriate categorisation of cases.

At the time of reporting, there were only two EPIC related cases. More widely, there were concerns related to communication which is hoped will be improved as patients sign up to MyGOSH and families are able to access information directly and communicate via the portal.

**Complaints**

Complaint numbers were consistent in March and April and lower overall than the monthly average

There was an increase in reopened complaints with complainants requesting meetings with staff and raising further questions prompted by the complaint investigation reports.

There are a number of overdue actions relating to red (high risk) complaints. The Complaints team are working with the directorates to address these.

## 22 May 2019 Trust Board update

The last meeting of the Trust Board was on 22 May 219. Highlights from this meeting that are not reported elsewhere within the Council of Governors' papers are summarised below.

**Patient story**

The Board received a patient story from ten year old Kai who had been a GOSH inpatient for nine weeks whilst he waited for a heart transplant. Key points from Kai's story were:

- He liked having the same school teacher each day.
- In general he liked the food as it was always hot, but was often not as well presented at weekends.
- Staff were sometimes overheard talking about his treatment. He would have preferred that conversations were either held with him, or out of earshot.
- He was unable to use the hospital's internet as he would at home.

- The teen room had been repurposed and the toys available in the play room were for very young children.
- Kai heard about EPR go-live through hearing nurses' discussions rather than through posters.
- Kai's mum had to leave the hospital to sign Kai up to My GOSH as the Wi-Fi was too poor in the hospital.

The Trust took these points into consideration and provided the following updates:

- The Chief Clinical Information Officer said that it was vital to manage patients' expectations around internet usage, adding that the reduced internet access was due to deliberate decision making around online safeguards. This would have affected Kai's perception that the Trust's Wi-Fi did not work.
- Work had taken place to review the usage of the teen room on Bear Ward.
- Consideration was being given to providing age appropriate games on the ward.
- The issue of the patient overhearing discussions about his treatment would be taken up with staff.

**GOSH Foundation Trust Annual Financial Accounts 2018/19 and Annual Report 2018/19**

The Board approved the following documents:

- Annual Accounts and Annual Report 2018/19*
- Annual Governance Statement
- Audit Committee Annual Report
- Draft Head of Internal Audit Opinion
- Representation letter
- The Quality Report 2018/19

*the Trust is waiting for the annual report and accounts to be laid before Parliament before publishing on our internet.

**Annual reports**

The Board also received and noted the following annual reports:

- Annual Freedom to Speak Up Report 2018/19
- Annual Health and Safety and Fire Report 2018/19
- Annual Sustainability Report 2018/19

**Compliance with the Code of Governance 2018/19**

The Company Secretary reported that the Board had applied the principles and met the requirements of the Code of Governance during 2018/19 with the exception of three provisions. Where necessary, alternative arrangements were explained.

**Compliance with the NHS provider licence – self assessment**

The Board agreed the Trust's response to the four conditions taking into account the views of the Governors.

**Quality Priorities 2019/20**

The Board approved the 2019 quality priorities based on both the national and local context. These priorities will inform the Trust's Quality Strategy.

**Revised Risk Management Strategy**

The Trust Risk Management Strategy had been updated to:

- reflect the new organisational structures.
- Clarify reporting lines for reviewing risks and the risk management roles and responsibilities of committees.

The Trust Board approved the Strategy requesting information on how risk inputs are identified at risk action groups and an explanation of how system wide and external risks are triangulated.

**Update on implementation of EPIC (with clinical team input)**

The EPR programme had gone live as planned on 19th April 2019 and there was broad agreement that the go-live had been successful. There had been a large number of issues raised since go-live but fewer than anticipated.

**Reports from the Board Assurance Committees**

The Board received reports from the Audit Committee, Quality, Safety and Experience Assurance Committee and Finance and Investment Committee.

**Accessing Board papers**

The full sets of papers, including those for the Trust Board meeting in May 2019 are uploaded here: https://www.gosh.nhs.uk/about-us/who-we-are/our-organisational-structure/trust-board/trust-board-meetings. If you would like to attend the Trust Board or have any queries please contact: Victoria Goddard, Trust Board Administrator Victoria.Goddard@gosh.nhs.uk

## GOSH news

**GOSH appoints New Director of Transformation**

I am pleased to report that Richard Collins, Programme Director for the EPR project has accepted the post of Director of Transformation. The Director of Transformation role is a 12-month secondment for someone to drive innovation and deliver projects that strengthen and refine the Trust.

I am sure that from myself and on your behalf we wish him all the best in his next GOSH chapter. He has now started his new role.

Richard said: "I'm delighted to have been given the opportunity to take on this exciting new role. We have delivered one of our core enablers with the Epic EPR. We know this will be a challenging year in terms of achieving our financial position but as well as delivering this key element, I look forward to working with you all to establish a firm platform for longer term transformational change across the Trust."

**GOSH Play Street!**

As Governors may be aware, in March 2019, GOSH and Global Action Plan launched the first ever Clean Air Hospital Framework (CAHF). The framework set out actions NHS trusts can take in key areas including procurement and supply chain, travel arrangements and staff training to create a healthier environment.

To mark Clean Air Day on 20th June 2019, in a collaborative project between GOSH and clean air campaigners, the street outside the hospital was closed to traffic for four hours and transformed into a rainbow themed play area, with a host of activities championing the therapeutic, emotional and psychological benefits of play, in a safe, clean-air environment.

The Clean Air Hospital Framework available for free on the Global Action Plan website.

## Speak Up programme

At GOSH we're committed to achieving zero preventable harm, Speaking Up for Safety training will help support and empower staff and volunteers to raise concerns, in the moment that could put others at risk.

On Monday 3 June, the Trust launched Speaking Up for Safety training. All staff are encouraged to sign up for the 1 hour training.

By Speaking up for Safety, all staff can help make GOSH a safer place for patients, visitors and colleagues.

Over 300 workshops are bring run by our GOSH Patient Safety Champions between June and December 2019. Our in-house trainers have been trained and accredited by the Cognitive Institute and Medical Protection Society, our partners for the project. During the first month over 30 per cent of GOSH staff and volunteers booked into or attended a workshop, so we are well on our way to achieving the 80 per cent attendance target.

**Strategy Engagement**

In May we launched a consultation to refresh the GOSH Strategy 'Fulfilling Our Potential', to develop a shared vision representing what our patients and families, staff and partners want GOSH to be like in 5 years' time.

During staff workshops we discussed some of the high impact transformational changes that staff want to see over the coming five years, including:

- Investment in our People: Supporting a culture of kindness and inclusivity, open communication, accountable leadership and continuous learning and improvement.
- Re-design of our services around what patients and families need: Focusing more on their lives, rather than on their conditions, co-ordinating their GOSH care better and being more present for them across the health and social care pathway.
- Investment in and promotion of the GOSH Learning Academy: Using GOSH's education offer as a mechanism to deliver a more fulfilling working life for staff, a better service for patients and to shape our place in the wider healthcare system.
- Developing and adopting technology: Empowering staff with insight, supporting safer and smarter decision-making and making GOSH a true healthcare innovator.
- Redefining our role in the system: increasing the focus on outreach and making the case for national policy that incentivises partnership and innovation.

**Opening of Zayed Centre for Research into Rare Disease in Children**

The Chairman and I were delighted to welcome HH Sheikh Theyab, son of the Abu Dhabi Crown Prince and guests to the opening events for the Zayed Centre for Research into Rare Disease in children on 1st and 2nd July 2019. The opening event was a wonderful opportunity to thank the Abu Dhabi Royal Family and the other donors for supporting our partnership with the GOSH Charity and UCL to create the world's first purpose-built centre dedicated to the scientific discovery and treatment of children's rare diseases.

Not only will the Centre act as a catalyst for global collaboration to diagnose, treat and cure more rare diseases worldwide – it also provides high quality, family-friendly outpatient facilities that will care for up to 200 children per day.

I'm really grateful not just to our donors but also to the clinical teams, inspirational scientists, researchers, artists, architects and engineers – and, of course, to the patients and families – that made this visit memorable for our guests.

## Other GOSH news

**Spina bifida team win BMJ award**


A team from University College London Hospitals (UCLH), UCL and Great Ormond Street Hospital (GOSH) won the clinical leadership team award in the BMJ awards, the UK's leading medical awards which promote excellence in healthcare and recognise the inspirational work of healthcare teams across the country.

The UCLH/UCL/GOSH team operates on the abnormally developed spinal cords of babies in the womb, in what are the first surgeries of their kind in the UK.

**First use of pioneering phage virus therapy to treat patient with cystic fibrosis**

A new treatment that uses a mix of naturally-occurring viruses to infect and destroy bacteria has been used for the first time to treat a fifteen year old patient at Great Ormond Street Hospital (GOSH).

Doctors at GOSH worked with US scientists from the University of Pittsburgh to develop a new therapy which uses bacteria-eating viruses called bacteriophages (phages) to fight bacterial infections.

**GOSH Charity and Sparks funding for child health research at ICH**

Four UCL Great Ormond Street Institute of Child Health researchers have been awarded research grants from Great Ormond Street Hospital Children's Charity and Sparks, the children's medical research charity as part of their annual National Call. These projects involve:

- Laboratory testing the pre-existing anti-parasitic drug (mebendazole) to treat children with a life-threatening form of leukaemia - acute myeloid leukemia (AML).
- Developing CAR-T cell therapy to treat a range of childhood cancers including sarcoma, neuroblastoma and brain tumours. CAR-T cells have previously been used successfully to treat blood cancers like leukaemia.

- Maximising the potential of a new stem cell treatment that could stop the toxic build-up of a molecule in the brains of children with Krabbe disease, reducing symptoms and improving life expectancy.
- Repurposing existing drugs to treat an aggressive childhood brain tumour, diffuse intrinsic pontine glioma (DIPG),
- Other successful projects include research into pioneering gene therapy for children with difficult-to-treat epilepsy, understanding the genetic causes of skeletal disorders in children and increasing understanding of the causes of inflammatory bowel diseases.

**Celebrating our Nurses and Operating Department Practitioners (ODPs)**

On 12 May 2018 GOSH were pleased to throw a day of joint celebrations, which recognised how GOSH nurses and ODPs work side-by-side during a patient's perioperative journey to deliver excellent care to the children and young people we look after.

**NHS treatment available for the first time for patients with a rare neuromuscular disorder**

Patients at Great Ormond Street Hospital (GOSH) and across the country are to benefit from a new drug on the NHS that targets the underlying cause of spinal muscular atrophy (SMA), which affects the nerves in the spinal cord, making muscles weaker and causing problems with movement, breathing and swallowing.

The approval of the drug, called Nusinersen or Spinraza, follows successful trials at GOSH and other centres around the world that have shown the drug can slow the effects of SMA in some cases, allowing babies and toddlers to develop stronger muscles and survive for longer without breathing support.

NHS England have negotiated a deal with the drug's manufacturer Biogen to be able to make the drug widely available.

**Mental Health Awareness Week at GOSH**

Between 13 – 19 May 2019, the hospital lit up some of its buildings with green light to support Mental Health Awareness Week.

The initiative was organised by the Mental Health Foundation as part of a range of activities put on across the hospital such as practical advice on 'Overcoming Fears & Phobias' and our GOSH Arts Temporary tattoo parlour for resilience, to support and mindfulness sessions for staff during this important week.

**Students get funding to study digital hi-tech for patient care**

Four medical students have been awarded £1000 each from a recently launched bursary that aims to advance the development of cutting-edge digital technology to improve patient care.

The Digital Health Bursary is a joint initiative between BCS, The Chartered Institute for IT and DRIVE, which is Great Ormond Street Hospital's Digital Research, Informatics and Virtual Environment unit.

**Awards Success for Disney Reef Collaboration**


The Disney Reef won the top prize for Best Collaborative Approach at the Corporate Engagement Awards on 12 June 2019, which recognise the most successful and innovative corporate partnerships and sponsorships.

The Disney Reef project was recognised for the successful partnership between the Walt Disney Company, Great Ormond Street Hospital Children's Charity and Great Ormond Street Hospital for Children.

**NHSX Launch**

NHSX officially launched on 1 July 2019 with the goal to drive digital transformation across the NHS and social care, giving patients and staff the technology they need. GOSH DRIVE hosted a launch event and we were pleased to welcome the Secretary of State for Health and Social Care the Rt Hon Matt Hancock and NHSX CEO Matthew Gould along with the wider NHSX team, NHS and social care leaders, colleagues from professional medical bodies and royal colleges, big tech companies, SMEs, charities and NHSX staff.

## Appendices

- Month 2 Finance report
- Integrated Quality and Performance Report – June 2019

Great Ormond Street NHS Hospital for Children
NHS Foundation Trust

# Integrated Quality & Performance Report
# June 2019
## (Reporting on May 2019 data)


**Sanjiv Sharma**
Medical Director

**Alison Robertson**
Chief Nurse

**Andrew Taylor**
Acting Chief Operating Office


Data correct as of: 3rd July 2019

The child first and always

Always
Welcoming Helpful Expert One Team

# CONTENTS



Performing well | Room for improvement | Significant improvement required | Direction of trend from previous month | Data not previously requested/available | TBC Parameter not needed/not agreed | * Potential data quality issues post EPIC. Caution to be taken in interpretation.

# June 2019 – Quality Focus

- Low rate of timely incident closures (slide 4, 7& 13)
- Decrease in WHO Checklist Compliance particularly in areas outside theatres (slide 4 & 7)
- Decline in FFT Performance (slide 7, 16, 21 & 22)
- Discharge Summary performance (slide 29)
- Mandatory training compliance at staff group/directorate level (slide 7 & 32)

* There are a number of metrics on the dashboards in the report which are marked with a red asterix. This is to draw to your attention to data which is being reported in a different way temporarily post EPIC, or which may be subject to a data quality query. Please exercise caution in interpretation.

# Well Led Overview

Duty of Candour compliance data demonstrates that performing well at having the initial duty of candour discussions with patients (100% of cases in April and May). There is really encouraging progress in sending the duty of candour letters, we are not yet meeting the 10 working day target routinely (40% for May 2019). Training in the new hospital Duty of Candour process was launched in June 2019, so we anticipate that this will help to support more timely completion of letters. Next month's report will also include compliance data on stage 3 of the process (sharing the outcome of our investigation with patients and families).

High risk monthly review performance has improved to 70% in May 2019 (from 56% in April). The Patient Safety Team will work closely with the RAGS to support improvement through in June. Directorate level data on risk review compliance will also be considered at the Directorate Performance Meetings from August 2019.

We have seen a positive improvement in the numbers of policies which are currently in date and available to staff. 67% of policies are in date for May 2019 compared to 58% in April 2019. There are 2 approval meetings scheduled for July and 1 being scheduled for August with a focus on high risk policies.

There are 6 open red complaint actions which link to one complex case. The action plan has been revised post EPIC (as planned), and will be presented to the July Closing the Loop meeting. Our lessons learned audit focussed on an SI from 2017 regarding a cardiorespiratory arrest secondary to aspiration of water from a ventilator tubing circuit. It found good evidence that we had implemented the key actions and a further refinement of the process has been recommended to ensure that there is clear evidence of training records in the department.

FOI performance with responses within timescale remain high (90% for May, which is slightly down from 94% in April) and there have been no requests for internal review or referrals to the ICO.

Email SARS performance for dealing with requests within timescales remains at 0% . One request was completed in May 2019, but not within timescale. It included the disclosure of 399 pages of emails.

Legal SARS performance has deteriorated significantly in April and May following introduction of EPIC. While the reported completion figure for May is 78%, there were 23 requests outstanding at the end of the month compared to 2 in April and 0 in May. The issues with data retrieval have been escalated to the EPIC team and a meeting has been organised with the CCIO to agree a plan to address these issues. An update on this plan will be provided in next month's report.

We have commissioned a new Trust Wide Quality Improvement Project to help improve the safety of urethral catheterisation. This aims to reduce harm associated with catheterisation, and will be rolled out Trust wide.

# Quality and Safety Overview

The Trust is seeing an increase in the percentage of incidents closed within timeframe however there is much more work to do to bring performance to the expected level. It is expected that Incidents that are reported on the Datix system are reviewed, investigated and closed within 45 working days. As of May 2019 we have only managed to achieve that in 52% of incidents closed. The IPP directorate have rolled out a weekly Datix Review Group led by a Consultant and the Nursing Education team, supported by the Q&S team, which identified 3 key learning points and ensures that the incidents are reviewed and updated on Datix on a weekly basis.

WHO checklist performance appears to have declined significantly following the introduction of EPIC. It had been anticipated that the system would support staff to complete and document the checks at the appropriate times during the procedure, however this has not materialised in all cases, but this is believed to be a training issue in theatres rather than a risk that the checklist is not being completed. In areas outside theatres, more work is being done to support clear pathways for completing the WHO checklist appropriately in addition to training on the EPIC system. This performance is being kept under very close review via the fortnightly Executive CQC meetings.

There are currently 335 open risks on the risk register which includes risks identified by Clinical teams, Corporate teams and Trust wide risks. In line with the Risk Management Strategy risks should be reviewed according to their grade (4 weeks for high, 8 weeks for medium and 12 weeks for low) currently the Trust is operating at 70-80% compliant with those timeframes. The Patient Safety team continue to support the Clinical Directorate's to ensure that the risks are reviewed and that the Datix system is updated to reflect the updated action.

The Quality Improvement team are working with the Pharmacy team and clinical directorates to improve the pathways for Controlled Drugs management and Total Parental Nutrition (TPN). The QI team are working with their colleagues in Clinical Audit and Patient Safety to identify other key work streams of Medication safety, a further update will be provided in the next IQR.

May saw the launch of the Quality Rounds, which is a peer to peer review of the clinical areas against the CQC's Key Lines of Enquiry (KLOE's). Over 50 volunteers were trained and took part in the rounds which has highlighted many areas of good and outstanding practice that is being shared with others and areas which we could do better. These include testing of electrical equipment and decontamination. The next Quality Round is planned for July 2019.

The Speaking up for Safety training programme has been rolled out Trust wide with a positive uptake on training dates.

# Emerging risks in Patient Safety

**Pharmacy Safety**

- An MHRA inspection in May 2019 has highlighted significant areas for improvement in our manufacturing processes, including delays with our quality managements system processes. There is a recovery plan in place which has been shared with the MHRA and other regulators, and is being closely supervised by the Chief Pharmacist, General Manager and Quality and Head of Special Projects for Quality and Safety. The BAF risk is being updated accordingly.
- The Pharmacy department is also experiencing challenges in workload and workflow post the introduction of EPIC. This had led at times to reduced ward presence of pharmacists.

**Follow up appointments**

- During the EPIC launch we reduced activity across the Trust and this has continued longer than anticipated in some areas post Epic Go Live. This has had an impact on patients being seen in a timely manner, although there have been no reports of harm caused. The patient safety concern raised via the risk action groups is that patients are not being seen for outpatient follow up within specific pathway timeframes post-operatively. A review of the scale of the problem, including an evaluation of the impact on patients will be undertaken.

**Line access**

- There have been a number of incidents reported around line management (inclusive of but not limited to central and peripheral lines) in May. This includes delays in lines being removed, delays in lines being inserted, and concerns around management of infected lines. The backlogs for line removal for haem-onc patients has been addressed through waiting list initiatives in May and June. However, the underlying causes contributing to these backlogs, which include, but are not limited to capacity in IR, which is a known risk in the organisation. The risk is being escalated to a Trust wide Risk which will be discussed at Operational Board to agree a clear action plan for addressing this issue at a hospital level.

# Hospital Quality Performance – June 2019 (May Data)

## Are our patients receiving safe, harm-free care?

| | Parameters | Mar 19 | April 19 | May 2019 |
|---|---|---|---|---|
| Patient Safety Incident Reporting * | R<60 A 61-70 G>70 | 62.8 | 480 | 582 |
| Incident Closure Rate (% of incidents closed in 45 working days) | R 0-64%A>65-75% G>76-100% | 45.9% | 47% | 52% |
| No of incidents closed | Trending | 564 | 341 | 624 |
| Average days to close (2018 - 2019 incidents) | R ->50, A - <50 G - <45 | 63.7 | 87 | 70 |
| Medication Incidents (% of total PSI) | TBC | 32.4% | 21.9% | 24.6% |
| WHO Checklist (overall) * | R<98% G>98-100% | 94.5% | 88.9% | 80.2% |
| WHO Checklist (Theatres) * | R<98% G>98-100% | | 95.98% | 96.9% |
| WHO Checklist(non-theatres)* | R<98% G>98-100% | | 80.3% | 60.09% |
| Near Miss reports (% of incidents reported) | R <8%, A 8-9%, G>10% | 6% | 8% | 9.1% |
| Serious Incidents | R >1, A -1 G – 0 | 0 | 2 | 1 |
| Overdue SI | R >1, A -1, G – 0 | 1 | 1 | 1 |
| Safety Alerts overdue | R- >1 G - 0 | 3 | 2 | 2 |
| Safeguarding Children's Reviews | New | 0 | 0 | 0 |
| | Open and ongoing | 6 | 6 | 6 |
| Safeguarding Adults Board Reviews | New | 0 | 0 | 0 |
| | Open and ongoing | 1 | 1 | 1 |

## Are we delivering effective, evidence based care?

| | Target | Mar 19 | April 19 | |
|---|---|---|---|---|
| Specialty Led Clinical Audits on Track | R 0- 69%, A>60-75% G>75-100% | 86% | 81% | 82% |
| Number of completed specialty led clinical audits per year | Aim =100 p.a G= YTD total at month end is on target | 131 | 10 | 24 |
| NICE guidance overdue for assessment of relevance | R=1+, G=0 | 0 | 0 | 0 |
| Relevant NICE national guidance without a gap analysis | R=1+, G=0 | 0 | 0 | 0 |
| Participation in mandatory relevant national audits | G=100% | 100% | 100% | 100% |

## Are our patients having a good experience of care?

| | Parameters | Mar 19 | April 19 | May 2019 |
|---|---|---|---|---|
| Friends and Family Test Recommend rate (Inpatient) * | G – 95+, A- 90-94, R<90 | 96.5% | 96% | 96% |
| Friends and Family Test Recommend rate (Outpatient) * | G – 95+, A- 90-94,R<90 | 94.1% | 91% | 91% |
| Friends and Family Test - response rate (Inpatient) * | 25% | 25.8% | 17% | 22% |
| PALS* | N/A | 165 | 135 | 182 |
| Complaints* | N/A | 7 | 7 | 9 |
| Red Complaints (%total complaints YTD) | R>12% A- 10-12% G- <10% | 7% | 8% | 9% |
| Re-opened complaints (% of total complaints YTD) | R>12% A- 10-12% G- <10% | 13% | 14% | 12% |

## Are our People Ready to Deliver High Quality Care?

| | Parameters | Mar 19 | Apr 19 | May 19 |
|---|---|---|---|---|
| Mandatory Training Compliance | R<80%,A-80-90% G>90% | 93% | 92% | 92% |
| PDR | R<80%,A-80-90% G>90% | 85% | 84% | 80.6% |
| Appraisal Compliance (Consultant) | R<80%,A-80-90% G>90% | 86% | 87% | 84% |
| Safeguarding Children Level 3 Training compliance | R<80%,A-80-90% G>90% | 85% | 82% | 77% |
| Safeguarding Adults L1 Training Compliance | R<80%,A-80-90% G>90% | 92% | 92% | 91% |
| Sickness Rate | R -3+% G= <3% | 2.5% | 2.4% | 2.4% |
| Turnover - Voluntary | R>14% G-<14% | 14.8% | 14.7% | 15.2% |
| Vacancy Rate – Contractual | R- >10% G- <10% | -0.15% | 8.2% | 8.5% |
| Vacancy rate - Nursing | | 3.4% | 7.2% | 0.5% |
| Bank Spend | | 5.8% | 4.4% | 4.6% |
| Agency Spend | R>2% G<2% | 1% | 0.9% | 0.59% |

# Well Led Dashboard

Great Ormond Street NHS Hospital for Children NHS Foundation Trust

## Is our culture right for delivering high quality care?

| | Target | Feb 2019 | March 2019 | April 2019 | May 2019 |
|---|---|---|---|---|---|
| High Risk Review (% reviewed within date) | R<80, A 81-90% G>90% | 71% | 68.5% | 55.7% | 70% |
| Serious Incident Actions (number of actions overdue) | R- >2 A- 1-2 G- 0 | Data collection will start for April data | | TBC | TBC |
| Red Complaints Action Plan Completion (no of actions overdue) | R- >2 A- 1-2 G- 0 | 2 | 9 | 6 | 6 |
| Duty of Candour Cases | N/A | N/A | | 6 | 5 |
| Duty of Candour Conversation (Stage 1) | R<75% A 75-90% G>90% | N/A | | 100% | 100% |
| Duty of Candour Letter (Stage 2) | R<75% A 75-90% G>90% | N/A | | 83% | 60% |
| Duty of Candour – compliance with 10 days | | N/A | | 50% | 40% |
| Policies (% in date) | R 0- 79%, A>80% G>90% | 56% | 58% | 58% | 67% |
| Fit and Proper Person Test Compliance (self assessment) | R - <90%A 90-99% G – 100% | 100% | 100% | 100% | 100% |
| Actions for Staff survey within timescale | TBC | N/A | N/A | N/A | N/A |
| Quality Improvement Led Projects – Trust Wide | Volume monitoring | 3 | 3 | 3 | 4 |
| Quality Improvement registered Projects – Local | Volume monitoring | 7 | 8 | 7 | 9 |
| Freedom to speak up cases | Volume monitoring | 8 | 8 | 6 | 7 |
| HR Whistleblowing - New | Volume monitoring | 0 | 0 | 0 | 0 |
| HR whistleblowing - Ongoing | open cases | 1 | 1 | 1 | 1 |
| New Bullying and Harassment Cases (reported to HR) | Volume | 0 | 2 | 1 | 0 |
| | 12 month rolling | New Metric | New Metric | New Metric | 9 |

## Are we managing our data?

| | Target | March 2019 | April 2019 | May 2019 |
|---|---|---|---|---|
| FOI requests | Volume | 47 | 56 | 49 |
| FOI % responded to within timescale | R- <65% A – 65-80% G- >80% | 95% | 94% | 90% |
| FOI - Number requiring internal review | R>1 A=1 G=0 | 1 | 0 | 0 |
| FOI Number referred to ICO | G=0 R=1+ | 0 | 0 | 0 |
| Information Governance Incidents | volume | 14 | 11 | 13 |
| IG incidents reported to ICO | volume | 0 | 0 | 0 |
| SARS (Medical Record ) Requests | | 108 | 90 | 106 |
| SARS (Medical Record) processed with 30 days | R- <65% A – 65-80% G- >80% | 100% | 97.8 % | 99% |
| SARS (Email) Requests | volume | 1 | 1 | 0 |
| SARS (Email) Requests released | volume | 2 | 2 | 1 |
| SARS (Email) Requests released within 90 days | R- <65% A – 65-80% G- >80% | 0% | 0% | 0% |
| SARS (Email) in progress | volume | 6 | 5 | 4 |
| SARS (Legal) Requests | volume | 55 | 78 | 65 |
| SARs (Legal) Compliance | R- <65% A – 65-80% G- >80% | 93% | 36% | 78.5% |

Great Ormond Street NHS Hospital for Children

# Are we delivering effective and responsive care for patients to ensure they have the best possible outcomes?

| Responsive Hospital Metrics | | Mar-19 | Apr-19 | May-19 |
|---|---|---|---|---|
| Diagnostics: patient waiting <6 weeks | R<99% G -99-100% | 97.48% | 90.79% | 90.51% |
| Cancer 31 day: referral to first treatment | R<85% G 85%-100% | 100% | 100% | 100% |
| Cancer 31 day: Decision to treat to First Treatment | R<96% G 96-100% | 100% | 100% | 100% |
| Cancer 31 day: Decision to treat to subsequent treatment - surgery | R<94% G94-100% | 100% | 100% | 100% |
| Cancer 31 day: decision to treat to subsequent treatment - drugs | R<98% G 98-100% | 100% | 100% | 100% |
| Cancer 62 day: Consultant upgrade of urgency of a referral to first treatment | - | 100% | 100% | 100% |
| Theatre Cancellation for non-clinical reason | - | 52 | Data under review | |
| Last minute non-clinical hospital cancelled operations - breach of 28 day standard | R 1+ G=0 | 7 | | |
| Urgent operations cancelled for a second time. | R 1+ G=0 | 0 | 0 | 0 |
| Same day/day before hospital cancelled outpatients appointments | - | 1.28% | 1.25% | 1.01% |
| RTT Incomplete pathways (national reporting) | 92% | 92.24% | 90.07% | 88.25% |
| RTT number of incomplete pathways <18 weeks | - | 6430 | 6683 | 6503 |
| RTT number of incomplete pathways >18 weeks | - | 541 | 737 | 866 |
| RTT Incomplete pathways >52 weeks Validated | R - >0, G=0 | 4 | 5 | 6 |
| RTT incomplete pathways >40 weeks validated | R - >0, G=0 | 28 | 31 | 35 |
| Number of unknown RTT clock starts – Internal Ref | - | 0 | 0 | 0 |
| Number of unknown RTT clock starts – External Ref | - | 231 | 465 | 521 |
| RTT: Total number of incomplete pathways known/unknown - <18 weeks | - | 6656 | 6587 | 7016 |
| RTT: Total number of incomplete pathways known/unknown - >18 weeks | - | 546 | 547 | 869 |

| Effective & Productivity Hospital Metrics | | Mar-19 | Apr-19 | May-19 |
|---|---|---|---|---|
| Discharge summary 24 hours | R=<100% G=100% | 79.00% | 56.38% | 45.27% |
| Clinic Letter– 7 working days | | 36.25% | 66.0% | |
| Clinic Letter– 14 working days | | 68.29% | 92.06% | |
| Was Not Brought (DNA) rate | | 8.45% | 7.28% | 8.67% |
| Theatre Utilisation – Main Theatres | R<77% G>77% | 66.80% | Data under review | |
| Theatre Utilisation – Outside Theatres | R<77% G>77% | 54.30% | | |
| Trust Beds | Bed Occupancy | 79.10% | Data under review | |
| | Beds available | 392 | | |
| | Avg. Ward beds closed | 35 | 32 | 32 |
| | ICU Beds Closed | 6 | 5 | 0 |
| Refused Admissions | Cardiac | 6 | 4 | 2 |
| | PICU/NICU | 14 | 3 | 9 |
| PICU Delayed Discharge | Internal 8-24 hours | 3 | 2 | 2 |
| | Internal 24h + | 13 | 4 | 3 |
| | External 8-24 hr | 4 | 2 | 0 |
| | External 24h+ | 7 | 7 | 3 |
| | Total 8-24h | 7 | 4 | 2 |
| | Total 24h + | 20 | 11 | 6 |
| PICU Emergency Readmission <48h | - | 1 | 1 | 1 |
| Daycase Discharges | In Month | 2,322 | 2,249 | 1,938 |
| | YTD | 28,667 | 2,249 | 4,187 |
| Overnight Discharges | In Month | 1,440 | 1,010 | 1,519 |
| | YTD | 16,707 | 1,010 | 2,529 |
| Critical Care Beddays | In Month | 972 | 836 | 1,170 |
| | YTD | 11,720 | 836 | 2,006 |
| Bed Days >100 days | No of Patients | 17 | 2 | 7 |
| | No of Beddays | 3,131 | 203 | 1,095 |
| Outpatient attendances (All) | In Month | 21,678 | 16,809 | 19,156 |
| | YTD | 266,187 | 16,809 | 35,965 |

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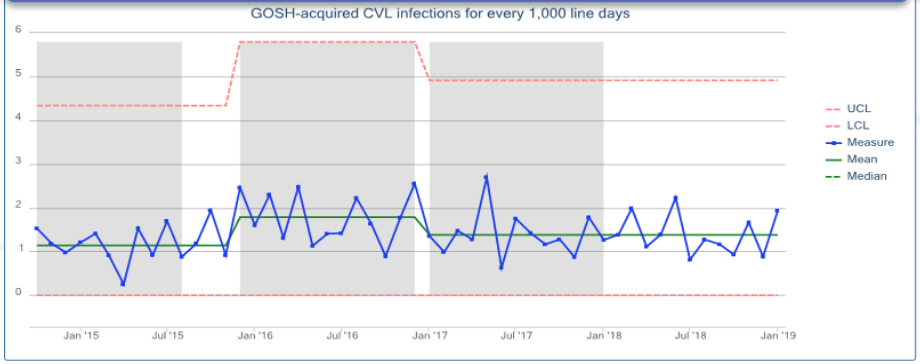
# Do we deliver harm free care to our patients?

## CVL Infections



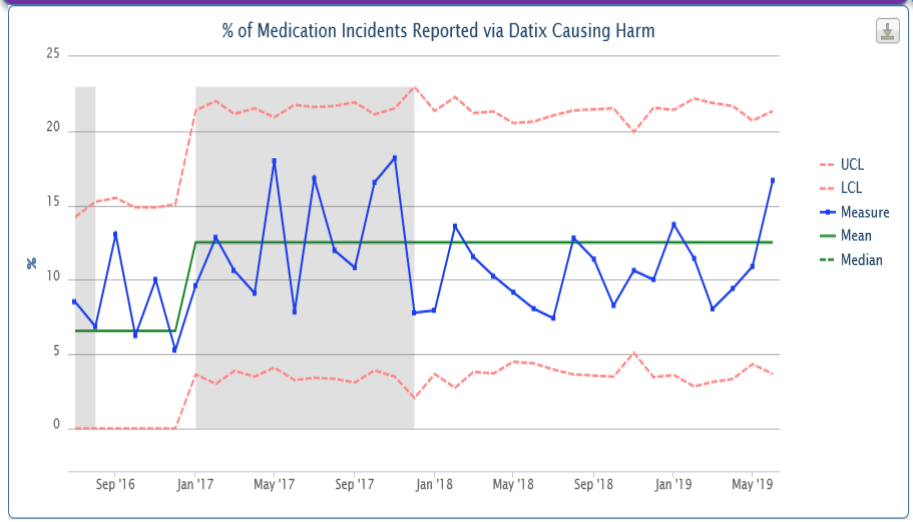

*updated chart not yet available pending rebuild of Quality Dashboards post EPIC

| | | Jan | Feb | March | April | May |
|---|---|---|---|---|---|---|
| Central Venous Line infections (per 1000 bed days) | Mean - 1.6 | 2.1 | 2.5 | 3.2 | 0.9 | 2.8 |

## Infection Control Metrics

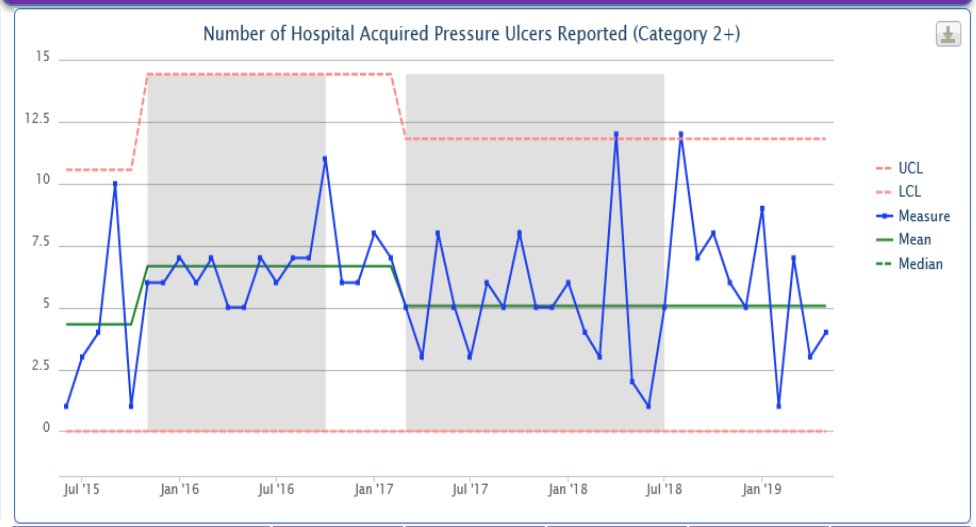
| Care Outcome Metric | Parameters | Feb 2019 | Mar 2019 | April 2019 | May 2019 |
|---|---|---|---|---|---|
| Bacteraemias (mandatory reporting – MRSA, MSSA, Ecoli, Pseudomas Klebsiella) | In Month | 7 | 5 | 5 | 9 |
| | YTD | 82 | 87 | 5 | 14 |
| C Difficile cases - Total | In month | 1 | 1 | 0 | 1 |
| | YTD | 6 | 7 | 0 | 1 |
| C difficile due to lapses (Considered Trust Assigned but awaiting confirmation from NHS E) | In Month | 1 | 0 | 0 | 1 |
| | YTD | 6 | 6 | 0 | 1 |

## Medication incidents causing harm




| | | Feb 19 | Mar 19 | Apr 19 | May 19 |
|---|---|---|---|---|---|
| % of reported medication incidents causing harm | Mean-12.5% | 14% | 9% | 11% | 17% |

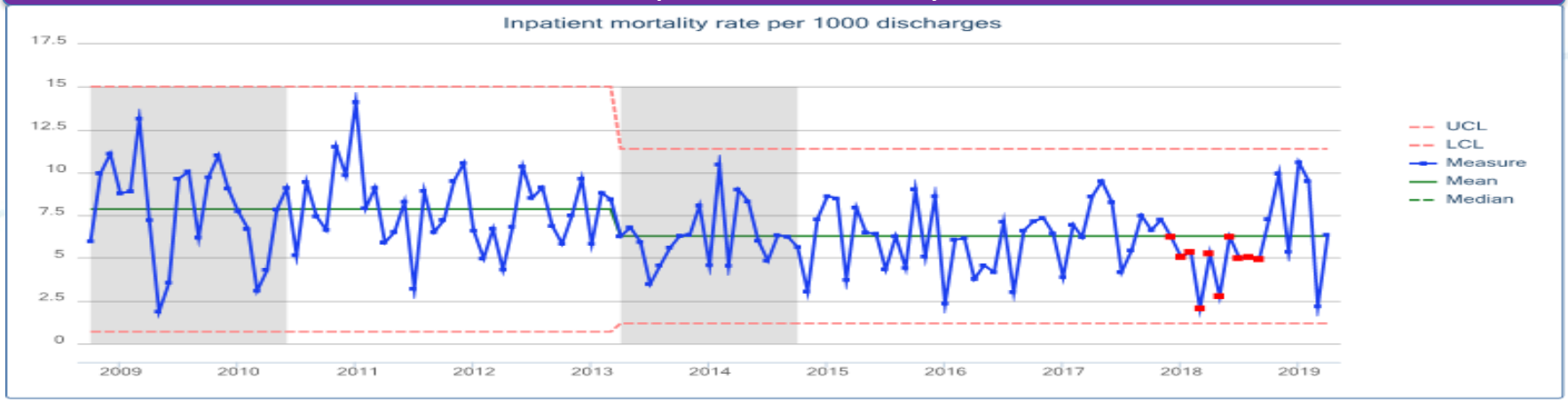
## Pressure Ulcers




| | | Feb | March | April | May |
|---|---|---|---|---|---|
| Hospital Acquired Pressure Ulcer (2+) | R – 12+, A 6-11 G =0-5 | 2 | 7 | 3 | 4 |

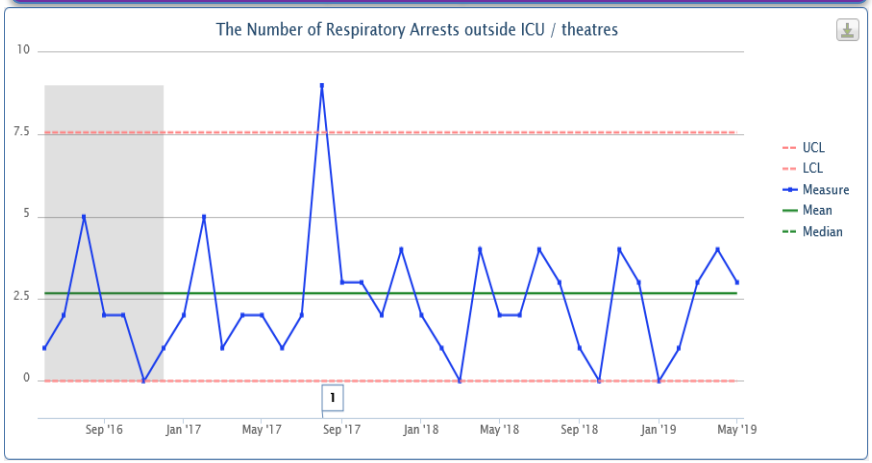
# Does our care provide the best possible outcomes for patients?

## Inpatient mortality

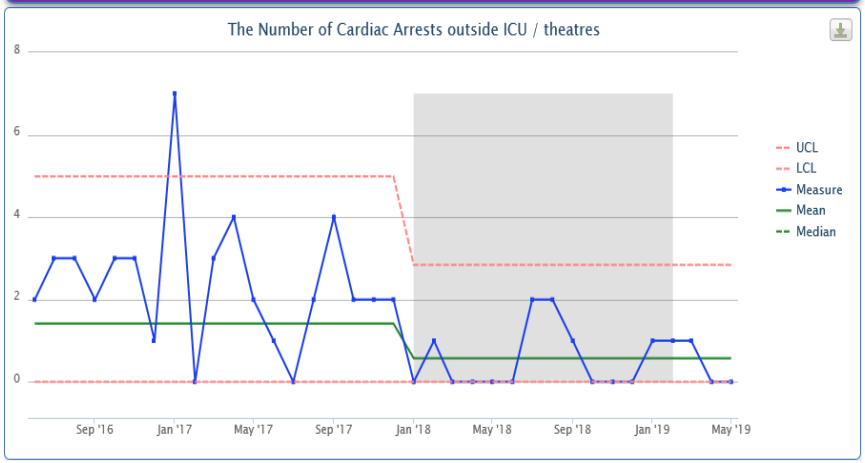



*updated mortality data not yet available pending update of Quality Dashboards post EPIC

## Respiratory Arrests




## Cardiac Arrests




The dashboards for respiratory arrest and cardiac arrest show volume this month, rather than rate, while we rebuild the quality dashboards Post EPIC

# Lessons Learned audit June 2019 - Cardiorespiratory arrest secondary to aspiration of water from a ventilator tubing circuit

Great Ormond Street Hospital for Children NHS Foundation Trust

## Background

As part of our governance and learning culture it is important that there we check our implementation of action and learning from past incidents, to identify if we have "closed the loop". A summary of SIs reported to PSOC from 2018 onwards 2018/19 have been reviewed by the Head of Special Projects for Quality and Safety and Clinical Audit Manager to identify actions where assurance about implementation would benefit from audit.

## The incident

This audit looks at an SI that occurred in 2017 on NICU

***Cardiorespiratory arrest secondary to aspiration of water from a ventilator tubing circuit***

***A neonate suffered a cardiorespiratory arrest following aspiration of excess water that had accumulated in the ventilator tubing circuit of the Fabian Optiflow model VN500.***

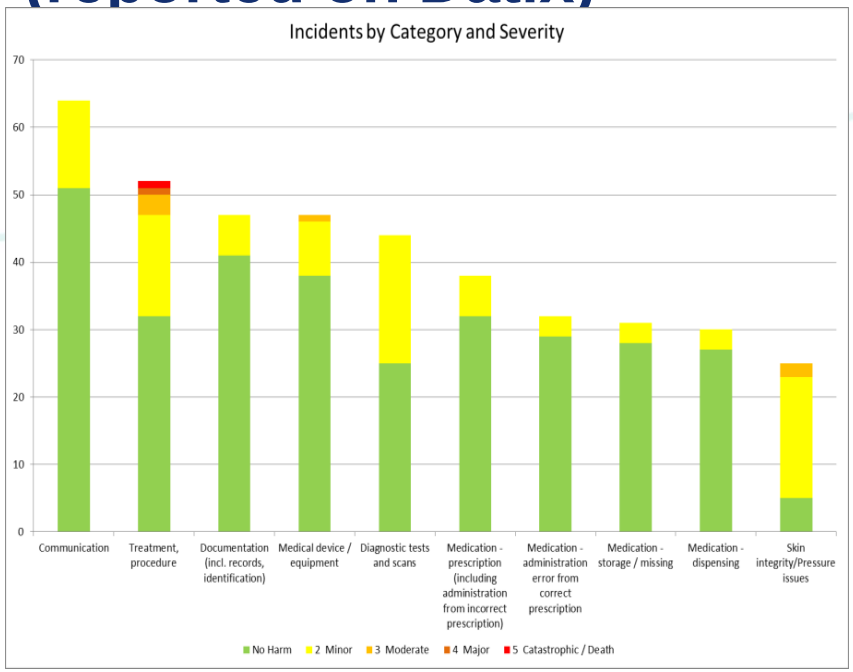
| Learning identified to be audited | Audit findings |
|---|---|
| **"The majority of ventilators in use on the unit have an auto fill function for the humidification systems. Staff on the unit are more familiar with the autofill function than a manual fill option .Whilst there is a written warning to staff on the Optiflow ventilator reminding them of the manual fill humidifier, after it was first employed this was removed. Thus no alert was visible to staff using the Fabian Optiflow on subsequent shifts "** | **Implemented**<br>**The Clinical Audit Manager reviewed this . On the 3rd May there were three patients on Optiflow on NICU . Confirmed with the Senior ITU Support Technician that there are no manual fill chambers in use in the trust.** |
| "The ventilator technicians offer ventilator training to all staff on induction. There is no attendance record or certificate and completion of training and so it is not possible to determine who has received training nor what this entailed." | Requires implementation<br>Confirmed with the Matron that staff are signed off as competent and records of competency are kept with the staff. Competencies for ventilation are done throughout the first 6 months and it is signed in the Nurse's own competency book. An improvement would be a system to evidence who has had training outside of individual records |

## Action agreed by PICU/NICU Matron and Head of Nursing for the Directorate

| Action | Action Lead | Date to be completed | Date to check this has happened |
|---|---|---|---|
| Records of all ventilator training given on induction to be recorded on the PICU local drive | Deborah Lees | Central records of these 6 month competencies will now be kept going forward | October 2019 |

**Andrew Pearson, Clinical Audit Manager , 26th June 2019**

# Patient Safety incidents (reported on Datix)



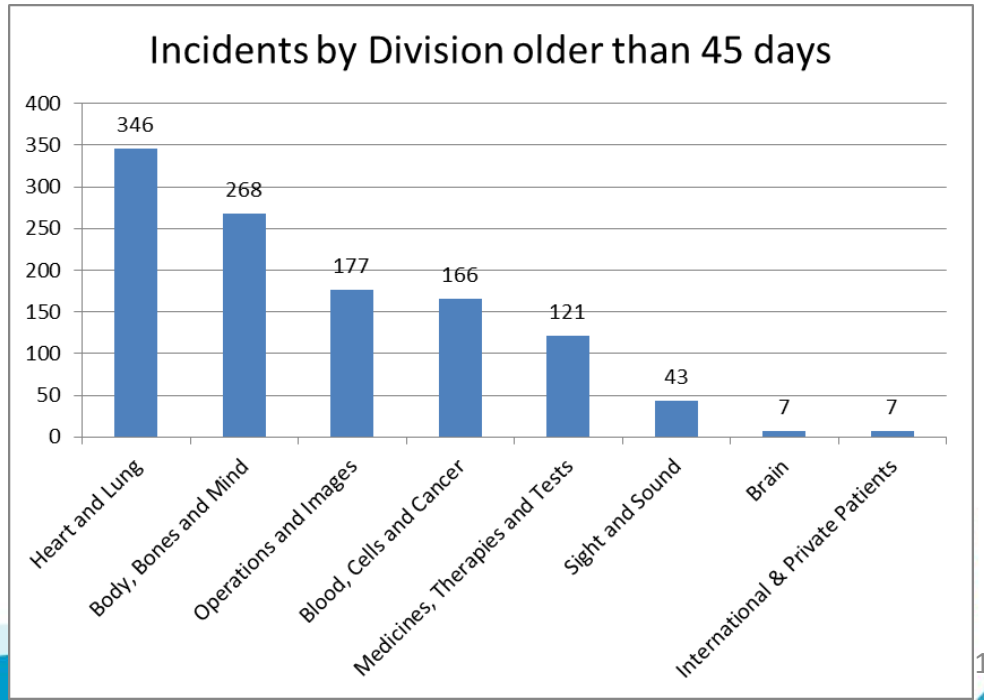

**Investigations for incidents should be completed within 45 days** for investigation, unless they are a Serious Incident (SI) in which case the timeframe is 60 days. For most incidents this is well within the timeframe an investigation will take.

On review, we found that many incident investigations had taken place but the results had not been uploaded onto DATIX. The Patient Safety team are always happy to meet with staff to review and close incidents, and this can be done on a regular basis to support timely closure.

In addition, many incidents are medical in nature, however comparatively few doctors use DATIX. It is important that as many doctors as possible sign up to review and manage incidents.

**Medication prescription and administration** errors were high in May, which is a known historically annual trend as many new doctor contracts start at this time. The other high point for these errors historically has been November. However what is interesting is that the focus of these errors has shifted. Whereas previously prescription errors were often due to unfamiliarity with local guidelines, currently the errors are largely down to in-built problems with EPIC, and with training on the new system. This suggests that long term EPIC's safety measures may help mitigate against this trend.

**Controlled drug storage** and management was another issue which was frequently reported in May. Common issues are wrong storage of patient's own medication, poor documentation and medication losses due accidental spillage. The plan to do a major trust-wide review of controlled drugs may also be acting to raise awareness around best practice in storage and encouraging reporting.



# Patient Safety Alerts

Great Ormond Street Hospital for Children NHS Foundation Trust

### Recently Closed Patient Safety Alerts

NHS/PSA/W/2018/009: Risk of harm from inappropriate placement of pulse oximeter probes (December 2018)

NHS/PSA/RE/2018/004: Resources to support safer modification of food and drink (April 2019)

NHS/PSA/D/2019/001: Wrong selection of orthopaedic fracture fixation plates. (Feb 2019)

### Overdue Patient Safety Alerts

NHS/PSA/RE/2017/004: Resources to support safe transition from the Luer connector to NRFit for intrathecal and epidural procedures, and delivery of regional blocks. **DUE: December 2017**

Latest update: It has been challenging identifying a product appropriate for use with the patient cohort in the Trust. However, a product has now been identified which is being assessed for suitability in theatres and potential trial.

**NHS/PSA/RE/2018/006:** Resources to support safe and timely management of hyperkalaemia (Aug 2018). This alert was due to close in May, but there was a delay of a week in closing while we arranged a fix for the intranet listing of policies to avoid confusion. This alert has now been closed.

### New and ongoing Patient Safety Alerts

NHS/PSA/RE/2019/002: **Assessment and management of babies who are accidentally dropped in hospital**

**Update:** The Trust is compliant with this alert as all steps are covered in the Patient Falls Policy. However it was decided to keep this open to explicitly include a section on carrying a child in the corridor, although this is not covered in the alert **Due:** Nov 2019

# Patient Safety – Serious Incident Summary

Great Ormond Street Hospital for Children NHS Foundation Trust

| New & Ongoing Serious Incidents | | | | |
|---|---|---|---|---|
| **Directorate** | **Ref** | **Due** | **Headline** | **Update** |
| Heart & Lung | 2019/8273 | 11/07/2019 | Retained arterial line | Timeline being drafted |
| Operations and Images | 2019/8826 | 17/07/2019 | Retained surgical instrument (never event) | Report being drafted |
| Estates and Facilities | 2019/10699 | 08/08/2019 | Staff collapsed on Trust premises. | Timeline underway. |
| Brain | 2019/11025 | 13/08/2019 | Delay in diagnosing renal failure | Timeline underway |
| Body, bones and mind | 2019/12525 | 30/08/19 | Unnecessary removal of Hickman Line | Timeline underway |

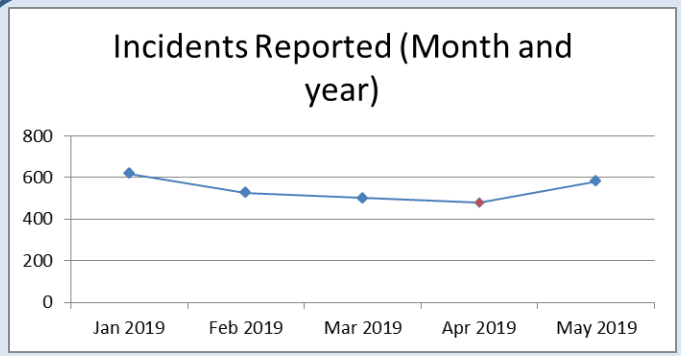
## New Serious Incidents

**2019/11025 –** a patient attended GOSH with end-stage renal failure. Reviewing clinical notes from a previous visit 2 years ago, it was identified that some blood results may have indicated the early stages of renal failure. It is not clear whether the outcome would have been different had this been identified.

**2019/12525 –** a patient attended with a suspected line infection. Removal in IR was booked in advance, and the line was checked daily for cultures (all negative). However the procedure was not cancelled and the line was removed. This will mean an additional procedure in 6 weeks to replace the line.

## Sharing Lessons Learned: SI 2018/24654

**Situation:** A patient had an elective cardiac catheter procedure for balloon dilation and implantation of a melody valve. During the procedure the conduit ruptured and the patient haemorrhaged and sadly died.
**Analysis:** The conduit had become calcified and brittle, and this is why it was more vulnerable to rupture.
**Recommendations:** This outcome was a known but unfortunate risk of the procedure. It has been referred to expert peer review to consider if there are any additional learning points for the team. No recommendations for change in practice have been identified to date.

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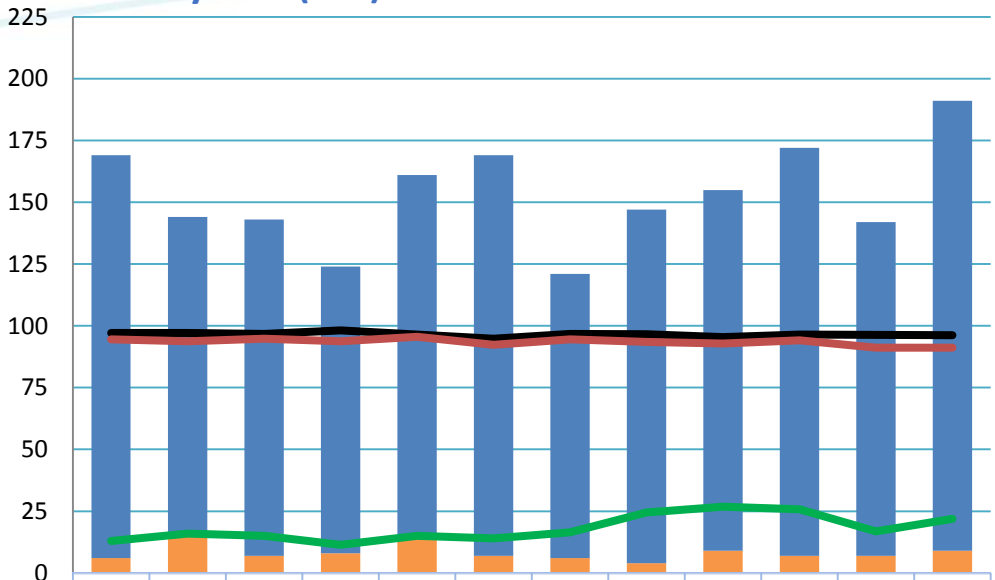
# Patient Experience Overview

## Are we responding and improving?

### Patients, families & carers can share feedback via PALS, Complaints & the Friends and Family Test (FFT).




| | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PALS | 163 | 129 | 136 | 116 | 146 | 162 | 115 | 143 | 146 | 165 | 135 | 182 |
| Formal Complaints | 6 | 15 | 7 | 8 | 15 | 7 | 6 | 4 | 9 | 7 | 7 | 9 |
| FFT recommendation rate - Inpatients % | 97 | 97 | 97 | 98 | 97 | 95 | 97 | 97 | 95 | 97 | 96 | 96 |
| FFT recommendation rate - Outpatients % | 95 | 94 | 95 | 94 | 96 | 92 | 95 | 94 | 93 | 94 | 91 | 91 |
| FFT % response rate | 13 | 16 | 15 | 11 | 15 | 14 | 17 | 25 | 27 | 26 | 17 | 22 |

**Integrated Patient Experience Commentary**

The Patient Experience teams have been closely monitoring feedback following the EPIC implementation. While there has been an increase in Pals cases in May, there were no specific concerns about EPIC.

There was an increase in concerns about communication (particularly in Pals cases). It is hoped that these issues will be reduced as families communicate via MyGOSH.

The Trust FFT response rate has increased from 17% in April to 22% this month. While the inpatient recommendation rate is consistent with previous months, outpatients has dropped since April. However, positively outpatient FFT responses have increased significantly.

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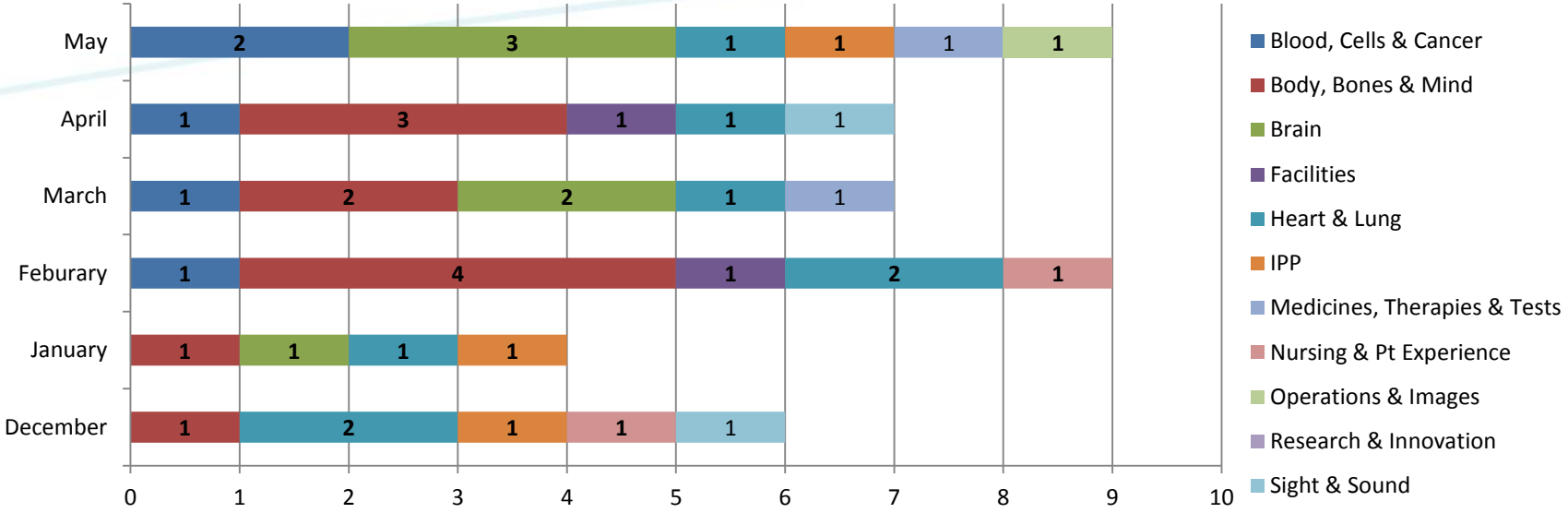
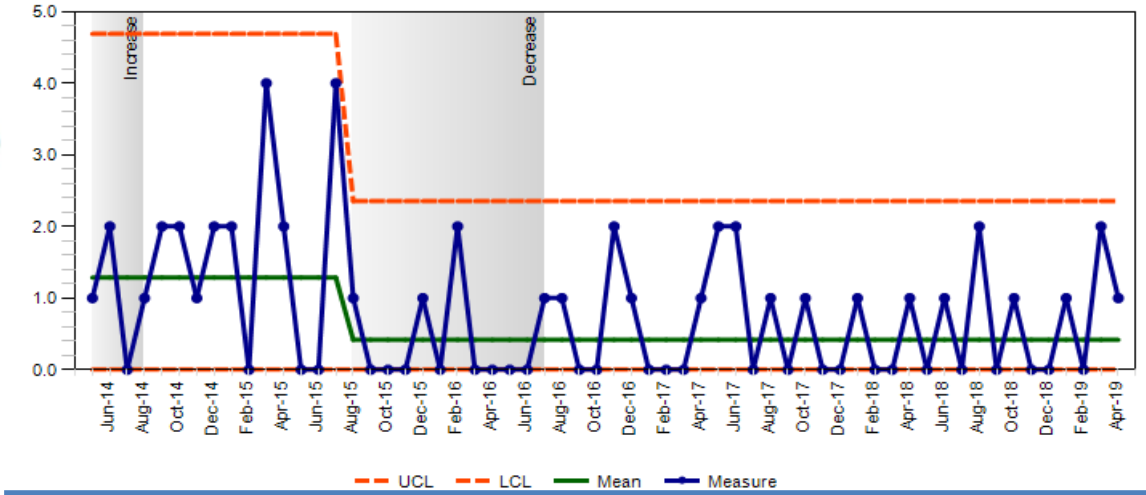
# Complaints: Are we responding and improving?




There were 9 new complaints received in May 2019 which related to concerns about/ that:

- delays in obtaining genetic test results from the clinical team
- the behaviour and attitude of a clinician. These concerns were raised in three complaints and related to three different specialities
- delays with dispensing medication in pharmacy
- two medication errors
- the decision not to prescribe a specific drug
- a clinic appointment was conducted insensitively
- the accuracy of the information given in clinic and within the medical records

# Red Complaints: Are we responding and improving?




| | |
|---|---|
| No of new red complaints this financial year 2019/20: | 2 |
| New Red complaints opened in May 2019 | 1 |
| No of re-opened red complaints this year 2019/20: | 0 |
| Open red complaints (new and reopened) as at 31/05/2019: | 3 |

**New red complaint**

| Ref | Opened Date | Report Due | Description of Complaint | Divisions Involved | Next Steps: |
|---|---|---|---|---|---|
| 19/010 | 10/05/19 | 22/07/19 | Parents are concerned that their child was not admitted to a specialist ward and therefore didn't receive the expert and urgent care required. They feel this led to permanent brain damage | IPP | Draft response has been received from the directorate and is with the complaints team for review |

There are 6 Red Complaint actions which remain open. This is partly due to the fact that some actions are no longer appropriate or required within EPIC. The action plan will be updated to reflect changes in processes and procedures post-EPIC. The clinical audit team have completed an audit of the current actions and a new audit plan will be agreed following the revised action plan.

# PALS – Are we responding and improving?

| Cases – Month | 05/18 | 04/19 | 05/19 |
|---|---|---|---|
| Promptly resolved (24-48 hour resolution) | 149 | 89 | 134 |
| Complex cases (multiple questions, 48 hour+ resolution) | 16 | 45 | 45 |
| Escalated to formal complaints | 0 | 2 | 2 |
| Compliments about specialities | 4 | 1 | 1 |
| *Special cases (e.g. large volume of contact following media interest) | 0 | 0 | 0 |
| **Total** | **171** | **137** | **182** |
| **Themes for the top five specialties** | | | |
| **Lack of communication** (lack of communication with family, telephone calls not returned; incorrect information sent to families) | 55 | 46 | 73 |
| **Admission/Discharge /Referrals** (waiting times; advice on making a NHS/ IPP referral; cancellations; waiting times to hear about admissions; lack of communication with families, accommodation) | 14 | 7 | 12 |
| **Staff attitude** (rude staff, poor communication with parents, not listening to parents) | 7 | 11 | 4 |
| **Outpatient** (cancellation; failure to arrange appointment; poor communication, franking of letters) | 40 | 36 | 45 |
| **Transport** (eligibility, delay in providing transport, failure to provide transport) | 10 | 4 | 7 |
| **Information*** (GOSH information, Health information, care advice, advice NHS, access to medical records, incorrect records, missing records, support/listening ) | 29 | 30 | 34 |

There has been an increase of Pals cases this month. This reflects the end of a planned period of reduced patient activity as part of the EPIC implementation.

Pals continue to monitor cases relating to EPIC. However, this month there have been no specific concerns raised about EPIC.

The implementation of MyGOSH (and specifically the function to contact clinical teams directly) is expected to improve communication. However, this will take some time as staff get used to the new system and MyGOSH sign up rates increase.

In May there was a significant increase in concerns about communication. Primarily these relate to the Brain (n=27) and Body, Bones and Mind (n=15) directorates.

*Pals have added data relating to information requests in order to more accurately capture the top themes of concerns raised.

# PALS – Are we responding and improving?

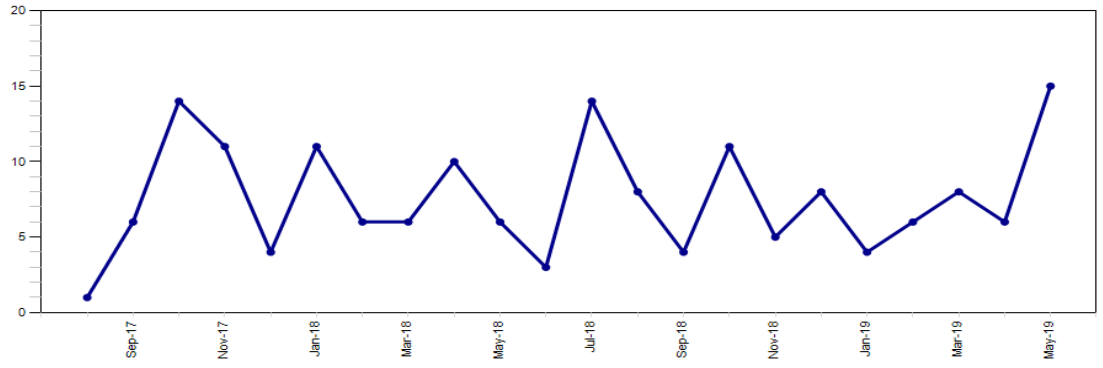
| Top specialities - Month | 05/18 | 04/19 | 05/19 |
|---|---|---|---|
| Neurology | 5 | 6 | 13 |
| Cardiology | 13 | 6 | 13 |
| Outpatients | 6 | 10 | 9 |
| ENT | 9 | 8 | 7 |
| Gastroenterology | 7 | 9 | 7 |

The main themes of **Neurology** cases related to communication (including concerns about delays in referrals, delayed test results, no responses to calls, explanation regarding a change in transport policy, how to raise questions about care following an appointment) as well as cancellations, accommodation provision and a request for a patient's notes.

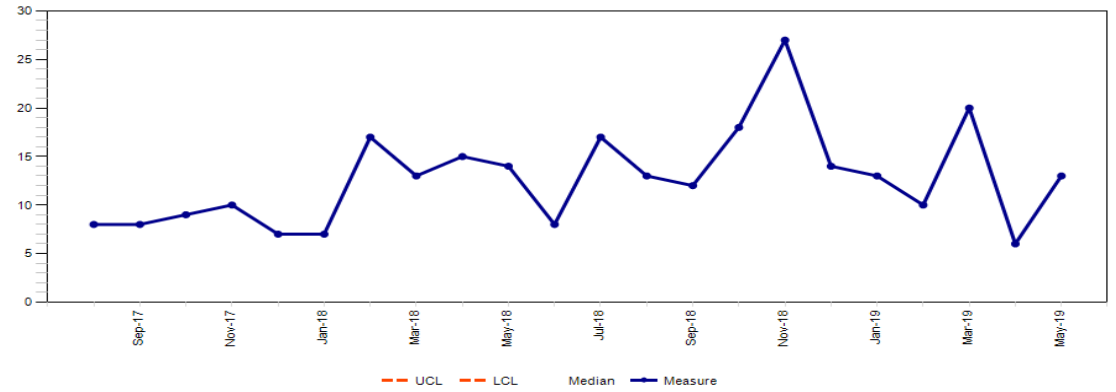
The Neurology team explained that many of these issues arose during a period of transition following EPR. Staff are being supported in their use of EPR and are continuing to promote MyGOSH.

**Cardiology*** cases in May also highlighted issues relating to communication. Specifically, delays in getting test results, unreturned phone calls and correspondence, delays in referrals and appointments, inadequate plans for a procedure, inadequate information about preparation for a procedure, and inaccurate information about a patient's condition.

## Neurology cases

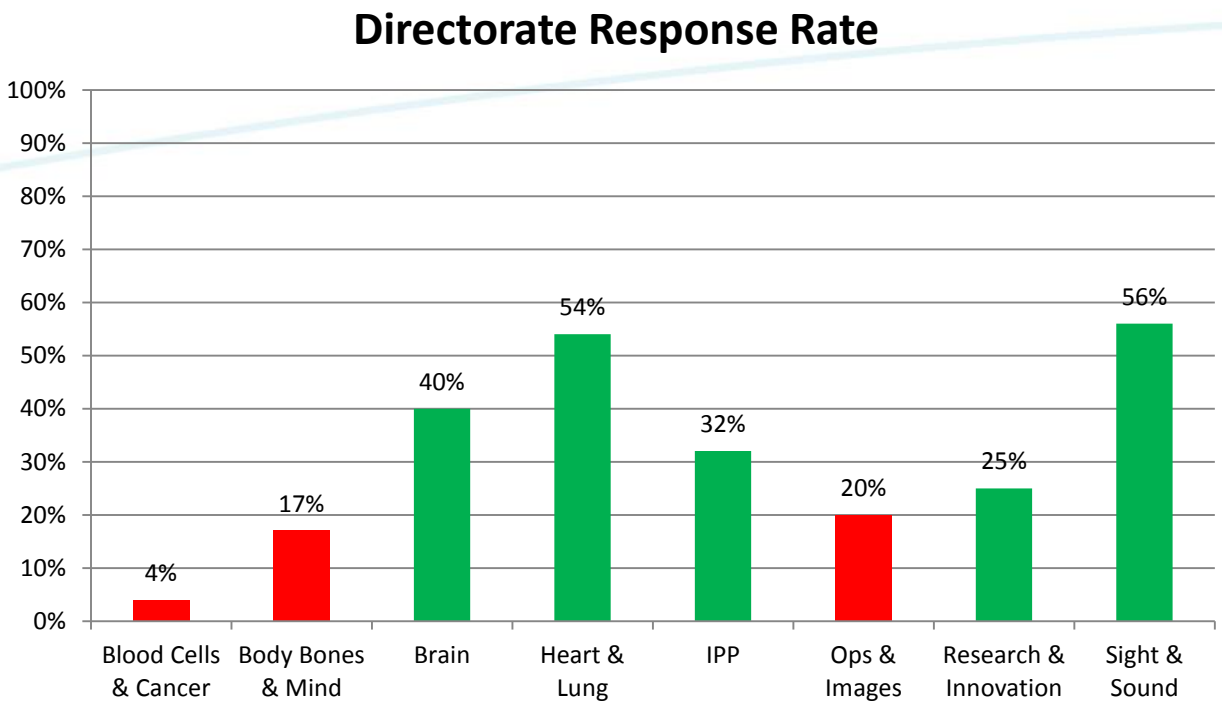



## Cardiology cases




**Pals are liaising with Cardiology for feedback regarding the increased cases and to better understand any contributing factors as well as actions to address this.*

# FFT: Are we responding and improving?




Following a reduction in the overall Trust FFT response rate in April (17%), this increased to 22% in May.

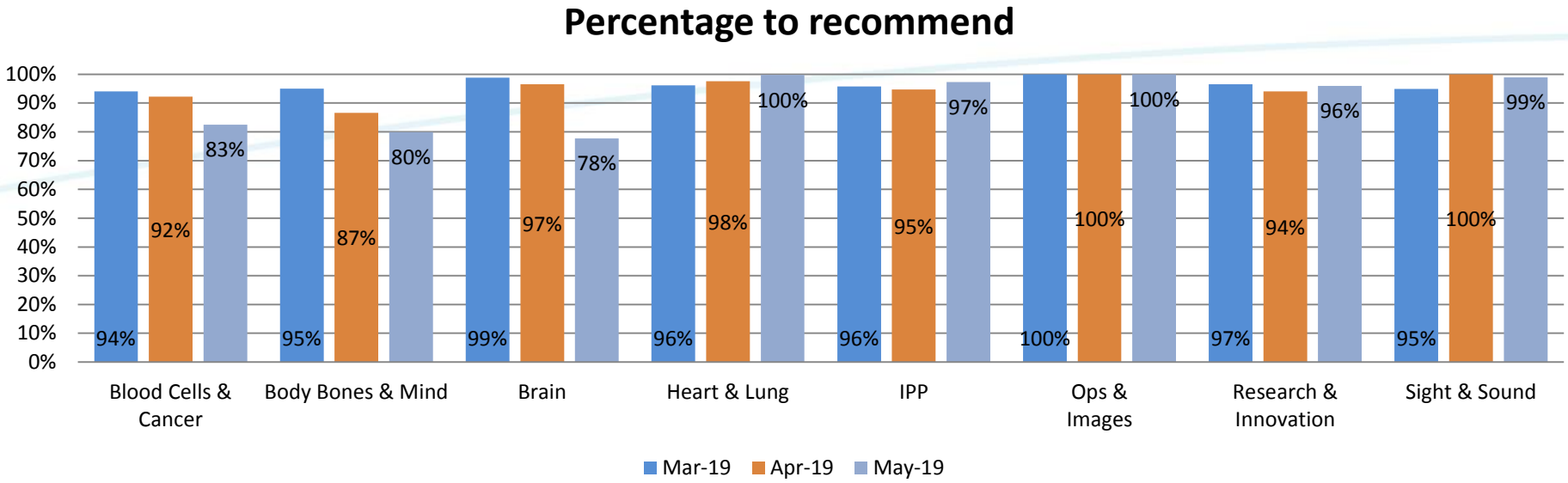
While the percentage to recommend score for inpatients has remained static at 96%, outpatients remains below target at 91%.

Five directorates met or exceeded the 25% Trust target for FFT responses in May.

There are some unresolved issues relating to discharge data from EPIC which has impacted FFT rates particularly at directorate level. Specifically, the Patient Experience team have identified discrepancies relating to incorrect discharges from theatres rather than ward areas which means that the above rates may be subject to marginal change. The Patient Experience team is working with EPR team to resolve these issues.

Additionally, changes since the EPIC implementation mean that some patients, previously booked as outpatients for procedures such as blood tests, are now recorded on EPIC as inpatient admissions. This is particularly relevant to Safari (part of the Blood Cells and Cancer directorate) and has contributed to the lower response rate.

# FFT: Are we responding and improving?

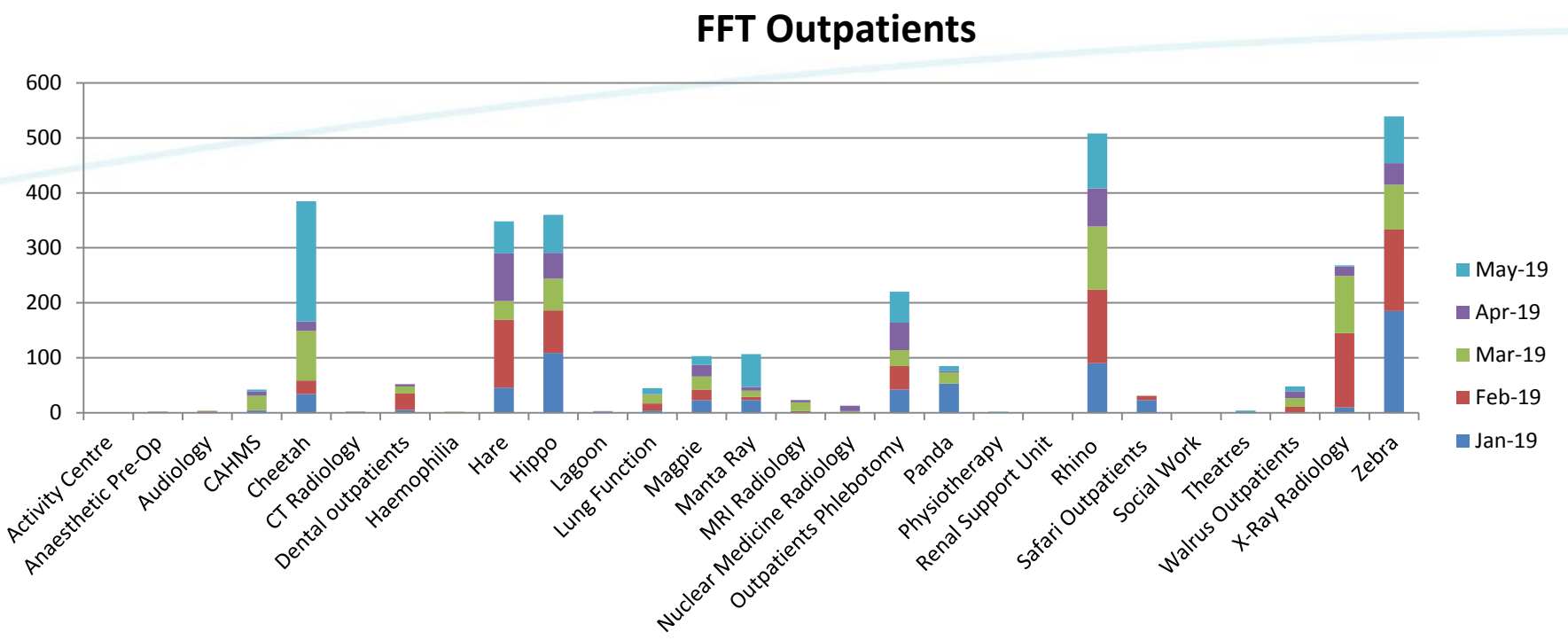



The inpatient recommendation rate overall was unchanged at 96%. However, at a directorate level, there were reductions in 4 of the eight directorates. In particular, the Patient Experience team are liaising with the Brain directorate and providing further data to aid analysis of the reasons for the reduced recommendation rate in May. This will be included in the June IQR.

| | Inpatient Comments | Outpatient Comments | IPP Comments | Total Feedback | % with qualitative comments (All areas) |
|---|---|---|---|---|---|
| Mar 19 | 876 | 673 | 48 | **1597** | **81.3%** |
| Apr 19 | 516 | 399 | 40 | **955** | **85.3%** |
| May 19 | 667 | 701 | 51 | **1419** | **79.4%** |

FFT comments from both inpatients and outpatients increased in May 2019. The percentage of qualitative comments remains high at 79%.
There were many positive comments on how the staff made patients and families feel welcome and in very safe hands. Negative comments during May have been varied and include pharmacy delays, procedure delays and communication issues between teams and departments.

# FFT: Are we responding and improving?




**The above chart outlines the number of the FFT responses within Outpatients. There is currently no Trust or NHS target for outpatient FFT feedback.**

**As expected, the number of responses have increased this month (percentage increase =75%) after the significant drop in April during the Epic go live. This still remains lower than average monthly responses received during Q1 2019.**

**The majority of negative comments within outpatients relate to waiting times for appointments.**

# FFT: Are we responding and improving?
# Qualitative Comments

Great Ormond Street NHS Hospital for Children NHS Foundation Trust

## Positive

*"When we were first admitted to GOSH, we were gutted and only expected the worst. The staff have given us the most incredible support from being there for a shoulder to cry on to giving us the best clinical advice. We are so lucky as a nation to have people like you watching over us!"* **– Giraffe Ward**

*"All staff are extremely friendly. The people at the front in yellow shirts who escort you are terrific and a great way to make patients feel welcome.* ***Hare Outpatients***

*"A very good experience from start to finish. All the staff were friendly and professional. Facilities are excellent"* **Nightingale Ward**

*"Staff are fantastic! Nothing is too much trouble and there is lots to do for children. Lots to play with and pass the time. Fantastic facilities"* **Outpatient Phlebotomy**

## Negative

*"We visit weekly for a 3 hour drug infusion. We travel 2.5 hours each way leaving home at 6.30am to arrive for 9am. Each time the nurses complete their tests in order for the drug to be made up within an hour of arrival. Every time there is a delay in the pharmacy providing the drug. It is currently 3.15pm and we still haven't got the drug to start the infusion. As we need 24 hour checks post drug it is likely we will not be home until approx. 11pm tomorrow creating child care issues, not forgetting the fact that my son is exhausted and usually has school the next day. He takes two days to recover from the experience. As his mother, I am drained also. CRF is also a very boring place to be waiting hours upon hours despite a fantastic play therapist. My son should not have to go through this".*
**Somers Clinical Research Facility**

A meeting took place on 14th June with relevant staff from Somers CRF, Pharmacy and Civas (who prepare the medication).
An action plan has been implemented to improve the waiting time for clinical trial drugs produced in Civas.

*Feedback is shared with the teams concerned. All negative comments are followed up with the families (subject to contact details being available).*

The child first and always

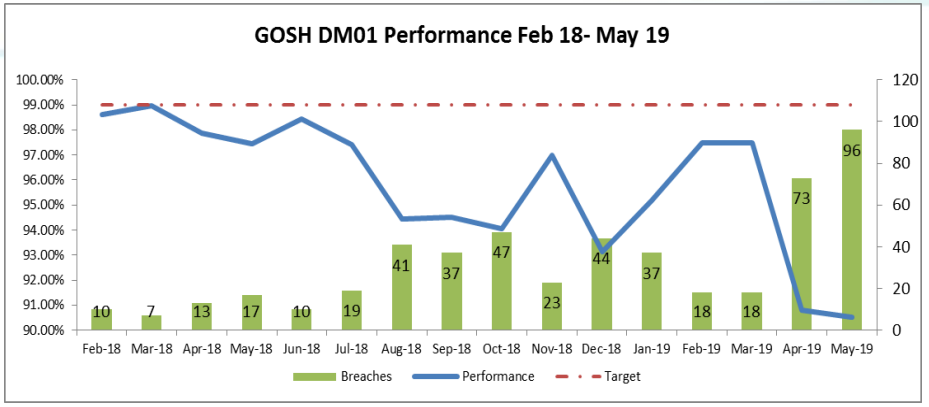
Always
Welcoming Helpful Expert One Team

# Responsive – Diagnostic Waiting Times

Great Ormond Street Hospital for Children NHS Foundation Trust

### May 2019 Summary

- The Trust continues to underachieve against the 99% national standard, reporting 90.81% of patients waiting within 6 weeks for the 15 diagnostic modalities
- The number of reported breaches has significantly increased to 96 compared to April when we reported 73.
- This is a further significant decline in performance compared to 18/19 due to a combination of the planned activity slot reduction over EPIC Go-live (21 lists down in MRI approx. 60 patient slots), tolerance patients and trust processes.




Of the 96 breaches, 76 are attributable to modalities within Imaging and the remaining 20 relate to Gastroscopy, ECHOs, Electrophysiology, Cystoscopy and Audiology diagnostic tests.

The breaches fall into four distinct themes; 70 due to reduced planned activity slot availability and administrative teams unable to provide reasonable offers to patients, 6 due to lack of capacity, 10 Trust processes (clinician unavailability, delay om protocolling scans, no ward bed available, patient booked into a wrong scanner), and 10 tolerance patients- failed sedation, patient unfit for scan, list overrun, unable to cannulate, scanner breakdown, and unable to complete urgent patient was a priority.

The Trust has developed a recovery plan and trajectory, however, it should be acknowledged that returning to an acceptable level of breaches is expected to take a number of months due to continued reduction in activity in May, loss of the CT scanner for a week in May and the planned MRI upgrade programme. The current trajectory forecasts compliance by end of September 2019.

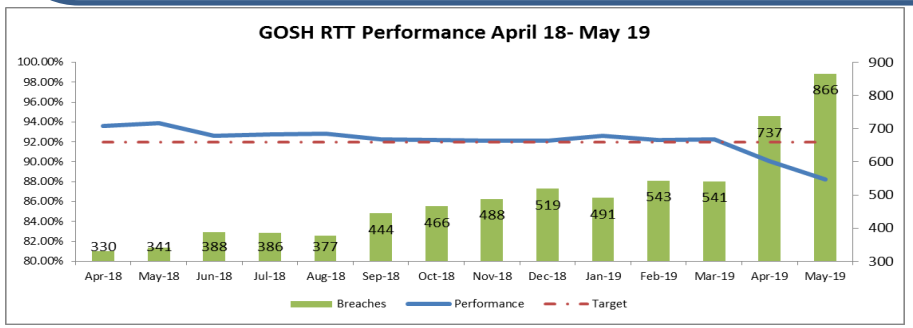
# Cancer Wait Times

At the time of writing the report for the month of April 2019, no breaches against the cancer standards attributable to the Trust were reported, with performance being at 100%. Indicative performance for May projects compliance against all standards.

# Responsive – Referral to Treatment

## May 2019 Summary

- The Trust did not achieve the RTT 92% standard, submitting performance of 88.25%, with 866 patients waiting longer than 18 weeks. However, it was projected that a drop in performance due to EPIC Go-Live was to be expected due to the planned activity reduction. The Trust is currently reviewing all under achieving specialties and working with services to produce recovery plans and trajectories. Trust compliance against this standard is expected by March 2020
- As previously described specialties which continue not to meet the standard are Plastic Surgery (sub-specialisation within the service), SNAPS (bed capacity), Dental and Maxillofacial Surgery (theatre capacity and consultant absence), ENT (inherited breach waits from other providers), Urology (complex patients and capacity) and Orthopaedics (bed capacity).
- Two of the seven NHS directorates have met the 92% standard
- The number of patients waiting 40 weeks+ has increased to 35 patients in May from 31 in April




## 52 Week Waits:

The Trust reported 6 patients waiting over 52 weeks in May. One in ENT, four in Dental & Maxillofacial Surgery and one in SNAPS. One of the Dental patients was seen in June and was discharged, whilst the other 2 patients have TCIs in July and August (patient choice) and the third one needs joint surgery with MaxFax and is currently awaiting a TCI. The ENT patient is a complex case and procedure needs to be coordinated with the dental team. The SNAPS patient was also a delayed referral (initial referral was never received by GOSH) and when received went to Urology first and on triage was transferred to SNAPS. The patient has a TCI in July.

## National Benchmarking:

For the month of April half of the patients on the Trusts incomplete PTL were waiting less than 7 weeks (nationally 7 weeks), and 92 out of every 100 patients were waiting less than 19 weeks (nationally 23 weeks) on a PTL size of 7,423 patients.

Contextually when comparing GOSH with other Children's Trusts or other London tertiary / specialist providers, the Trust is not an outlier with differential levels of performance. Nationally out of 184 providers reporting against the standard (NHS Trusts only) 76 in April were delivering 92% or better. 16 providers reported 90-92%, 72 at 80-90% and 19 reported <80%. 1 provider did not report.

Nationally, GOSH is ranked as the 92nd best performing Trust out of 183 providers. In London, GOSH is the 16th best performing Trust out of 28 Providers reporting RTT performance.

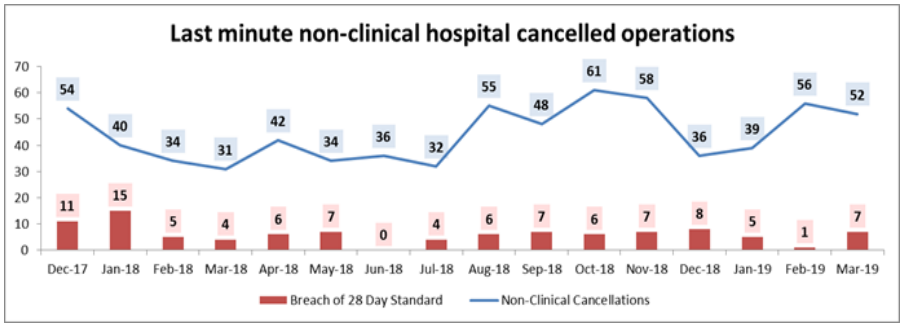
# Responsive – Last minute non-clinical hospital cancelled operations (and associated 28 day breaches)

**Last minute non-clinical hospital cancelled operations:**

At the time of writing, both April and May data was not available. The data is currently being reviewed and will be available in August 2019 due to this being a quarterly national submission.

Reported in the dashboard are the monthly breakdowns for this quarterly reportable indicator.

For month of March 2019, the Trust reported a decrease in the number of patients cancelled, with 52 patients cancelled compared to 56 in February. The areas contributing most to the monthly position are Cardiology/Cardiac Surgery (21), Radiology (9), Surgery (4), Neurosurgery (4), and ENT (4). The top three reasons recorded for the month are emergency/trauma patients taking priority (14), theatre list over run (10) & no ward staff (10).




**Last minute non-clinical hospital cancelled operations: Breach of 28 day standard**

The Trust reported 7 last minute cancelled operations not readmitted within 28 days in March, (compared to 1 in February). Two Neurosurgery patients, two Radiology patients, one Dental/Maxfax patients, one Orthopaedic surgery patient and one Cardiac Surgery patient

# Urgent operations cancelled for a second time

- This indicator has been added the Dashboard for 2018/19 following agreement with NHSE the content of Schedule 4 of the NHS Contract.
- Since the start of the new financial year the Trust has reported no patient being cancelled for an urgent operation for the a second time.

# Data Completeness – Mental Health Identifiers

**Mental Health Identifiers: Data Completeness**

The Trust is nationally required to monitor the proportion of patient accessing Mental Health Services that have a valid NHS number, date of birth, postcode, gender, GP practice and commissioner code. Within this area the Trust did not meet the 97% standard with 95.99% of patients having valid data in May. This is a result of EPIC Go live and the Trust is confident the standard will be met in upcoming months as staff get more familiar with the new system.

**Mental Health: Ethnicity Completion - %**

This indicator has been added the Dashboard for 2018/19 following agreement with NHSE the content of Schedule 4 of the NHS Contract.

The Trust has seen a decrease in collating ethnicity for patients accessing mental health services, with 67.53% (-2.43%) in May having a valid ethnic code. This is continues to be addressed with operational teams via weekly monitoring, refreshed training and focused Data Assurance work. Capture of this data is now completed within the EPIC system.

# Patients with a valid NHS Number

**% of patients with a valid NHS Number Inpatients and Outpatients**

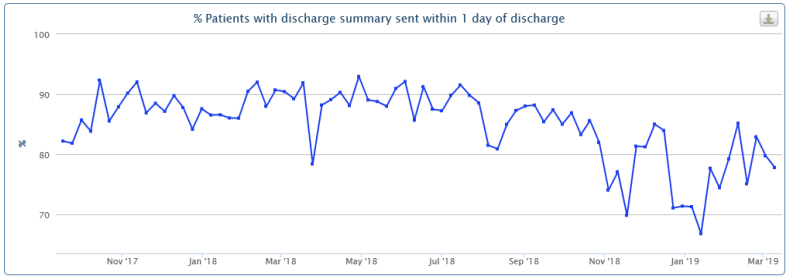
This indicator has been added the Dashboard for 2018/19 following agreement with NHSE the content of Schedule 4 of the NHS Contract.

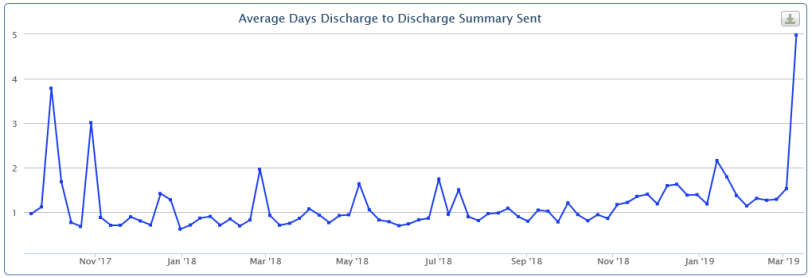
Nationally the Trust is monitored against achieving 99% of patients having a valid NHS Number across all services being accessed. As the report depicts for both Inpatients and Outpatients this is below the standard, nationally the average for both indicators is above 99%. Work is continues to improve collating our patient's NHS number.

# Effective – Discharge Summaries

## May 2019 Summary

- Performance within this metric continues to fluctuate and be challenging to directorates with May 2019 seeing 45.27% of discharge summaries being sent within 24 hours, which is a decline from April performance (56.38%).
- The Trust is currently undertaking a full data investigation and deep-dive into this metric to understand the impact of EPIC. Directorates have raised concerns regarding the information pulled into the discharge summary, reviewing the clinical workflow, identification of summaries in progress or not started and the flagging of whether a patient requires a discharge summary.
- Working groups have been initiated to focus on specific challenges experienced by services and ensure resolutions are agreed and transacted.
- Compliance for this standard is currently forecast by December 2019.




# Clinic Letter Turnaround Times

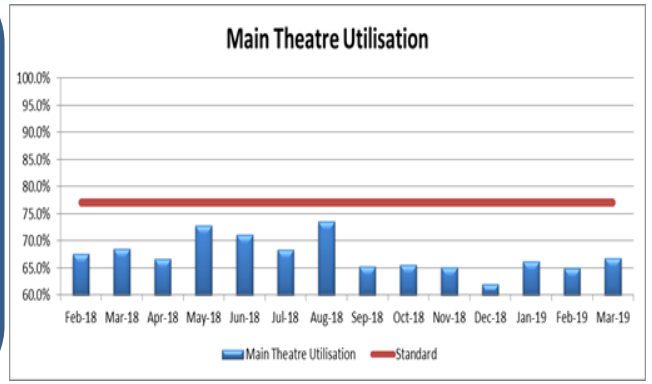
For April 2019 (as this indicator is reported a month in arrears), performance has significantly improved in relation to 14 day turnaround; 92.06% in April compared to 68.29% in March.

However, we will also be undertaking a deep dive into this metric to understand how the process in the EPIC system has impacted this process operationally; identifying where delays in the process reside within each specialty and implement actions. Some of the other actions to be taken include utilising the EPIC Report to monitor the volume of outstanding letters on a daily basis and target the area of delay, ensure clinic letter turnaround is part of monthly service reviews, extra admin time to work through the backlog of letters in specific areas and review the content and quality of the clinic letters.

# Productivity – Theatre Utilisation

Theatre utilisation for April and May remains unavailable at the time of reporting. This is due to reporting the indicator data from EPIC continues to be validated and utilisation logic application understood and signed off.

Work continues on targeting fully utilising lists and addressing delays with clerking and consenting of patients. However, it is expected that theatre utilisation will be impacted as EPIC stabilises and throughput returns to normal levels.




# Bed Occupancy and Closures

The metrics supporting bed productivity are to be improved for future months, however for now, reflect occupancy and (as requested) the average number of beds closed over the reporting period.

**Occupancy:** At the time of reporting, bed occupancy was unavailable for the reporting period of April and May. This indicator and methodology is currently under-review as part of the statutory returns work being completed to support EPR implementation.

**Bed closures:** The average number of beds closed in May (32) remained consistent with the number of beds closed in April. The reasons for closures are linked to staffing. This was mainly due to Sky having an average of 8 beds closed and both Bumblebee and Hedgehog having 5 beds closed. NICU/PICU have experienced an average of 3 beds closed

# Trust Activity

**Trust activity:** May activity for day case discharges are below the same reporting period for last year,. However outpatient attendances, critical care bed-days and overnight discharges are above the same reporting period last year. Further detail will be provided within the Finance Report.

**Long stay patients:** This looks at any patient discharged that month with a length of stay (LOS) greater than 100 days, and the combined number of days in the hospital. For the month of May, there were seven patients whose stay in hospital was over 100 days, accumulating 1,095 bed days in total.

# Productivity – PICU Metrics

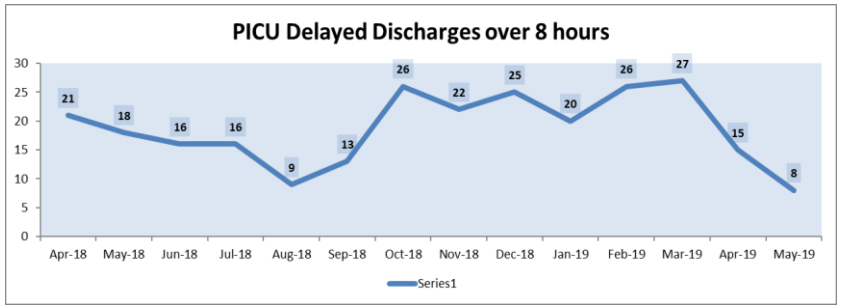
As previously reported the metrics supporting PICU shared in this month's IPR are the first iteration of KPIs. The KPIs have been agreed collaboratively with the Trusts PICU consultants and are designed to provide a triangulated picture of the service. Further analysis and intelligence will be added in future reports.

CATS PICU/NICU Refusals: The number of CATS referral refusals into PICU/NICU from other providers during May has increased to 9 from an April position of 3. The overall number of refusals for 2018-19 (189) were eight less than those in 2017-18 (197). During 2018-19 the Trust received 382 patients via the CATs retrieval service into PICU/NICU.

It should be noted that although The Trust has seen an improvement in the number of refusals, the Trust remains a national outlier. As part of the specialised services Quality Dashboard, a KPI is monitored on emergency admission refusals. It clearly shows the Trust refuses a higher percentage of patients than the national average, as demonstrated in the table below

**PICU Delayed Discharges:**

Delayed discharges over 8 hours from PICU can demonstrate the challenges being faced internally and externally with regards to capacity issues on accessing beds. May has seen eight patients delayed over 8 hours compared to 15 in April.




**PICU Emergency Readmissions:**

Readmissions back into PICU within 48 hours is one patient for the month of May, similar to April.

| Quarter | GOSH PICU/NICU/ CICU refusals | GOSH admission requests | GOSH % refused | National % refused |
|---|---|---|---|---|
| Q3 18/19 | 79 | 234 | 33.8 | 16.9 |
| Q2 18/19 | 45 | 127 | 35.4 | 8.09 |
| Q1 18/19 | 27 | 112 | 24.1 | 6.27 |
| Q4 17/18 | No Data | No Data | No Data | No Data |

# Are our people ready to deliver high quality care?

Great Ormond Street Hospital for Children NHS Foundation Trust

## Workforce Headlines

- **Contractual staff in post:** Substantive staff in post numbers in May were 4667 FTE which is a slight decrease from April (4609 FTE), however this is higher than the same month last year.

- **Unfilled vacancy rate:** The Trust vacancy rate for May increased to 8.53%, which while below target is well above the long term average. This is due to an increase in the budgeted establishment as well as a change to reporting of some unidentified Better Value costs. Trust vacancy rates have been below target since July 2017. The Nurse vacancy rate for May is 6.6% which is an increase from April (4.9%)

- **Turnover** is reported as voluntary turnover. Voluntary turnover increased to 15.2%, which is above target and the same month last year. HR has established a Recruitment & Retention group, linking in with colleagues across the Trust to develop a retention plan, aligned to the existing Nursing retention collaborative work. The most common leaving reasons are Relocation and promotion. Total turnover (including Fixed Term Contracts) decreased to 17.9% which is slightly above target. 2019/20 targets have been reduced to 13.75%/17.75% (Voluntary/Total) for Quarter 1. These targets will reduce to 13%/17% by the end of the year.

- **Agency usage** for May 2019 was 0.9% of total paybill, which is below the local stretch target, and is also well below the same month last year (1.2%). Human Resources Business Partners continue to work with the divisions and corporate areas to address local pockets of agency usage. The target for 2019/20 remains 2% of total paybill. Bank % of paybill was 4.6%.

- **Statutory & Mandatory training compliance:** In May the compliance rate across the Trust was 92%, which is above the target however 2 Directorates (Heart & Lung & Body, Bones & Mind) reported below target. Across the Trust there are 8 topics below 90% including Information Governance where the target is 95%.

- **Sickness absence** remains at 2.5%, and remains below target, and below the London average figure of 2.8%. The 2019/20 target remains 3%.

- **Appraisal/PDR completion** The non-medical appraisal rate has fallen to 81% with most Directorates below target. Consultant appraisals have reduced to 84%.

## Trust KPI performance May 2019

| Metric | Plan | May 2019 | 3m average | 12m average |
|---|---|---|---|---|
| Voluntary Turnover | 14% | 15.2% | 14.9% | 14.7% |
| Sickness (12m) | 3% | 2.4% | 2.4% | 2.4% |
| Vacancy | 10% | 8.5% | 5.5% | 2.8% |
| Agency spend | 2% | 0.6% | 0.8% | 1.0% |
| PDR % | 90% | 81% | 83% | 83% |
| Consultant Appraisal % | 90% | 84% | 83% | 86% |
| Statutory & Mandatory training | 90% | 92% | 92% | 92% |

**Key:**
Achieving Plan  Within 10% of Plan  Not achieving Plan

# Are our people ready to deliver high quality care?

Great Ormond Street NHS Hospital for Children NHS Foundation Trust

## Directorate (Clinical) KPI performance May 2019

| Metric | Plan | Trust | Blood, Cells & Cancer | Body, Bones & Mind | Brain | Heart & Lung | Medicine, Therapies & Tests | Operations & Images | Sight & Sound | IPP |
|---|---|---|---|---|---|---|---|---|---|---|
| Voluntary Turnover | 14% | 15.2% | 15.2% | 13.9% | 12.6% | 15.2% | 13.9% | 11.8% | 17.6% | 24.1% |
| Sickness (12m) | 3% | 2.4% | 2.% | 2.1% | 2.3% | 2.8% | 1.9% | 2.8% | 3.3% | 4.2% |
| Vacancy | 10% | 8.5% | -4.6% | 4.2% | 0.9% | 4.4% | -5.4% | 2.4% | 6.2% | 14.4% |
| Agency spend | 2% | 0.6% | 0.1% | 0.1% | 0.0% | 0.1% | 0.4% | -0.3% | 1.0% | 0.0% |
| PDR % | 90% | 81% | 85% | 78% | 90% | 81% | 81% | 76% | 90% | 91% |
| Stat/Mand Training | 90% | 92% | 92% | 89% | 93% | 89% | 92% | 91% | 92% | 93% |

Key:
Achieving Plan | Within 10% of Plan | Not achieving Plan

# Are our people ready to deliver high quality care?

Great Ormond Street NHS Hospital for Children NHS Foundation Trust

## Directorate (Corporate) KPI performance May 2019

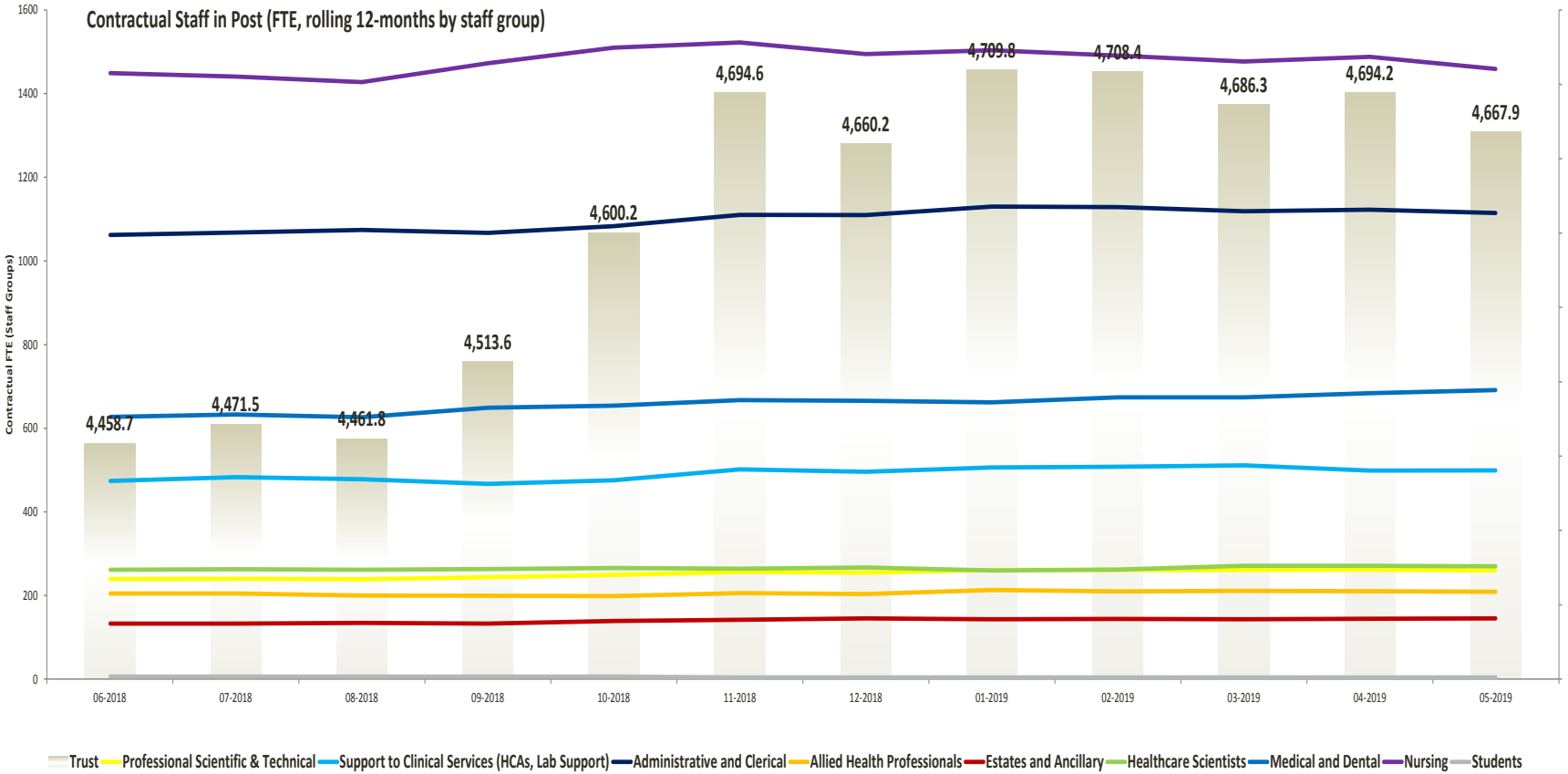
| Metric | Plan | Trust | Clinical Operations | Corporate Affairs | DPS | Finance | HR&OD | Medical Director | Nursing & Patient Experience | Research & Innovation |
|---|---|---|---|---|---|---|---|---|---|---|
| Voluntary Turnover | 14% | 15.2% | 18.9% | 14.6% | 12.5% | 13.1% | 19.5% | 19.0% | 15.4% | 32.2% |
| Sickness (12m) | 3% | 2.4% | 1.2% | 0.0% | 2.8% | 0.9% | 4.0% | 1.6% | 1.3% | 1.5% |
| Vacancy | 10% | 8.5% | 34.5% | 8.9% | 24.0% | 23.8% | 6.1% | 23.3% | -1.7% | -71.1% |
| Agency spend | 2% | 0.6% | 0.6% | -0.0% | 6.9% | 8.6% | -10.2% | 0.0% | 0.0% | 0.0% |
| PDR % | 90% | 81% | 79% | 79% | 84% | 93% | 92% | 86% | 80% | 75% |
| Stat/Mand Training | 90% | 92% | 95% | 93% | 94% | 100% | 96% | 92% | 96% | 96% |

Key:
Achieving Plan | Within 10% of Plan | Not achieving Plan

# Are our people ready to deliver high quality care?

Great Ormond Street NHS Hospital for Children NHS Foundation Trust

## Substantive staff in post by staff group



# Are our people ready to deliver high quality care?

Great Ormond Street NHS Hospital for Children NHS Foundation Trust

## Workforce: Highlights & Actions

**Sickness %**

- Monthly sickness absence reports distributed to managers from the HR Advisors to encourage a proactive approach to managing sickness absence.
- Regular meetings are held with Ward Sisters, service leads and departmental managers to discuss and provide support for sickness absence management.
- Health and wellbeing; a number of initiatives have been launched in order to support employees at work such as mental health awareness and healthy activities.
- HRBP undertook a refreshed deep dive into sickness for IPP with the General Manager in September, to be reviewed against one undertaken the previous year. Sickness in month of September was just over target, and the deep dive gave assurances that sickness was being reported accurately and managed appropriately.
- HRBP working with management teams to ensure sickness absence is being logged using the correct system so reporting can be accurate.
- Allocate HealthRoster is being rolled out across the Trust during 2018/19. The new system will enable more accurate reporting.

**Voluntary Turnover Rate**

- There has been a significant amount of work undertaken to better understand the broader turnover position - with specific focus on areas of low stability and high turnover. 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 Advisory Board.
- Developing B5s into vacant B6 roles helps to decrease turnover of B5s
- Analysis of exit surveys received and recommendations for improvements to the process have been presented to the Trust Operational Board and Education and Workforce Development Committee.
- HRBPs actively involved in undertaking exit interviews with leavers for their areas to get underneath the reasons for leaving, then working with the specific areas with lessons learned
- HR&OD are actively engaging with EU colleagues to advise them of support available with applications for the governments Settled Status scheme after Brexit.

## Workforce: Highlights & Actions

**Agency Spend**

- HRBPs continue to work within the Directorates to reduce agency usage. This includes converting individuals from agency to permanent or bank contracts.
- This work is inline with NHSI requirements to reduce agency and breaches of payrates and duration.

**PDR Completion**

- PDR reminders are now sent to managers on a monthly basis, flagging expired and upcoming PDRs.
- Simplifying the reporting process of PDRs has supported managers in working towards their PDR targets.
- HRBPs are continuing to support managers in identifying the PDRs that are required for completion, this includes consultant appraisals.
- PDR rates are a rolling agenda item for Performance Meetings within the Directorates.
- A Working group has been established to ensure changes to Agenda for Change are incorporated in to the PDR process from April 2019.

**Statutory & Mandatory Training Compliance**

- GOLD sends automatic reminders to staff and managers when they are due and overdue the training.
- L&D sends reminders to staff who are not compliant on the subjects that are currently below 90% overall Trust wide (excluding Resus) on a monthly basis.
- Improved visibility through LMS - staff encouraged to check their own records on GOLD
- Learning and Development & ER team work with managers to identify those who are non-compliant including further developments to the Trust GOLD LMS
- StatMan rates are a rolling agenda item for Performance Meetings within the Directorates.

# Local QI projects

The QI team provides a service offering QI mentoring and support to staff delivering local projects. The team also offers a process to register any QI work going on across the Trust. This helps capture and share learning and improvement, prevent duplication, and provides a platform to raise the profile of quality improvement.

| | Area of work | Project lead: |
|---|---|---|
| 1 | To reduce the number of unnecessary clotting samples in SNAPS | Sonia Basson, SNAPS SpR |
| 2 | To Improve the knowledge/ understanding for all new parents on the precautions and restrictions on Fox/ Robin from day one of their child's admission. | Robyn Newton (Ward sister) & Anna Sillett (Ward Sister) |
| 3 | Supporting the medication safety work stream of the Hospital Pharmacy Transformation Programme Board (HPTPB), by reviewing the management of Parenteral Nutrition (PN) at GOSH | Stephen Tomlin (Chief Pharmacist) |
| 4 | Supporting the implementation of Quality & Safety initiatives on Pelican ward | Carole Campbell (Ward Sister) & Emma Gilbert (Matron) |
| 4 | To improve and standardise the provision of Play at GOSH so that all children and young people receive the play support they require for their needs | Laura Walsh (Head of Play Services) |
| 5 | To implement Datix review rounds to improve the culture of learning from incident reporting in IPP | Deborah Zeitlan (Consultant General Paeds) |
| 6 | Decrease IR delays or cancellations in Blood, Cells and Cancer Directorate caused by patients not being ready / in IR on time | Anupama Rao (Haem/onc Consultant) & Beth Corley (Haem/onc Fellow) |
| 7 | Discharge summaries – IPP<br>Revising the provision of DS in IPP following EPIC to enable standardised documentation with additional safety measures | Sian Pincott (DCOS IPP), Tariq Chaudry (Fellow) |
| 8 | Mobile App Development Project<br>Develop a framework and process to oversee the development and implementation of Mobile Applications in the Trust | Louis Grandjean (ID Cons) |
| 9 | Improve handover quality and continuity of care for outlying patients in the cardiology service | Craig Laurence (Cardiac Fellow ) |

**If you have any improvement work going on in your area that you wish to share or would like to seek QI support, contact the team to discuss further or complete the Quality Improvement Project Notification Form and submit this to Gosh.QI@gosh.nhs.uk .**

**For more information, visit the QI intranet page (search 'quality improvement')**

# Quality improvement at GOSH

**The QI Team works to support, enable and empower teams to continuously improve the quality of care provided to patients across GOSH. The following maps where registered QI activity is taking place across the Trust:**



- Reduce unnecessary coagulation testing in SNAPS


- ZAPPP



- Reducing IR delays & cancellations
- Patient/ Family information
- Pelican Q&S initiatives



- Datix review meeting
- Discharge Summaries


- Standardise the provision of play
- HPTPB – PN

| Trust-wide projects |
| --- |
| Reducing incidences of extravasation harm and repeated cannulation |
| Reducing rejected laboratory samples |
| Improving Transition |
| Improving safety of urethral catheterisation |

**By Quality Improvement (QI), we mean a systematic approach to "making changes that will lead to better patient outcomes, better system performance, and better professional development"** *(Batalden and Davidoff, 2007)*

**At GOSH, we use the Model for Improvement as a framework for developing, testing, implementing and measuring change** *(Associates for Process Improvement)*


The child first and always

*Click links to open project dashboard

Great Ormond Street Hospital for Children NHS Foundation Trust

# Finance and Workforce Performance Report Month 2 2019/20

## Contents

# Trust Performance Summary for the 2 months ending 31 May 2019

## *KEY PERFORMANCE DASHBOARD*

Great Ormond Street Hospital for Children NHS Foundation Trust

## FINANCIAL PERFORMANCE

| | In month | | | Year to date | | | Full Year Forecast | |
|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | RAG | Plan | Actual | RAG | F'cst | RAG |
| **INCOME** incl. passthrough | £39.4m | £38.5m | | £77.4m | £75.7m | | £488.5m | |
| **PAY** | £24.3m | £23.0m | | £48.5m | £46.7m | | £289.2m | |
| **NON-PAY** incl. passthrough | £17.1m | £17.9m | | £34.1m | £34.7m | | £199.3m | |
| **CONTROL TOTAL** excl PSF | (£2.0m) | (£2.4m) | | (£5.2m) | (£5.7m) | | £0.0m | |

*RAG: on or favourable to plan = green, 0-5% adverse to plan = amber, 5%+ adverse to plan = red*

**AREAS OF NOTE:**

As at the end of Month 2, the Trust position is adverse to the planned control total (£0.5m). The Trust Income is behind plan YTD (£2.1m) due to activity levels and depth of coding. YTD pay costs are favourable to plan (£1.8m) due to the vacancies across the organisation not being covered by bank or agency staff. Non-pay is favourable to plan (£0.6m excl. passthrough) due to underspends relating to lower than planned activity. Below plan charitable income YTD (£0.4m) is offset by reduced pay and non pay expenditure due to timing of the projects expected to occur later in the year.

## INCOME BREAKDOWN RELATED TO ACTIVITY

| *Income breakdown Year to Date* | Plan (£m) | Actual (£m) | Var (£m) | RAG |
|---|---|---|---|---|
| **NHS & Other Clinical Revenue** | £46.2m | £45.8m | (£0.4m) | |
| **Pass Through** | £9.8m | £11.1m | £1.3m | |
| **Private Patient Revenue** | £11.2m | £9.3m | (£1.9m) | |
| **Non-Clinical Revenue** | £10.2m | £9.4m | (£0.8m) | |
| **Total Operating Revenue** | £77.4m | £75.7m | (£1.7m) | |

*RAG: on or favourable to plan = green, 0-5% adverse to plan = amber, 5%+ adverse to plan = red*

**AREAS OF NOTE:**

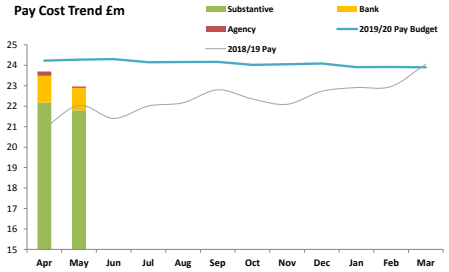
Operating revenue is adverse to plan (£3.4m excluding pass through) YTD. The Trust has entered into a block contract with NHSE and some of the CCGs for 2019/20; this is represented in the NHS income figures with the underperformance (£0.4m) arising from lower than planned levels of activity and depth of coding on those contracts that are not on block. Passthrough drugs remain on cost and volume and have over performed (£1.3m), offset by passthrough drug expenditure. Private patient income is below plan (£1.9m) due to lower levels of activity through the Ramadan period. Non-Clinical income underperformance (£1.2m) is due to lower levels of charitable contributions which will be achieved later in the year when expenditure is incurred.

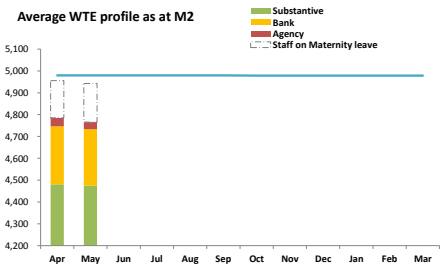
## PEOPLE

| | M2 Plan Av. WTE | M2 Actual Av. WTE | Variance |
|---|---|---|---|
| **PERMANENT** | 4,630.5 | 4,474.7 | 155.8 |
| **BANK** | 292.8 | 258.4 | 34.5 |
| **AGENCY** | 56.5 | 32.9 | 23.6 |
| **TOTAL** | **4,979.7** | **4,765.9** | **213.8** |

**AREAS OF NOTE:**

The pay costs have risen in absolute terms from last year due to the AfC pay award and one off non-consolidated AfC payments in M1. This is combined with increased costs associated with the Go live of EPIC which will reduce in future months. As part of Budget setting the establishment was reviewed and set in line with the Trust bed base. The WTE excludes 176.7 average contractual WTE's on maternity leave within the Trust. There are a number of vacancies across the Trust, and the plan set for bank and agency spend is currently below plan (and below the agency ceiling set by NHSI).



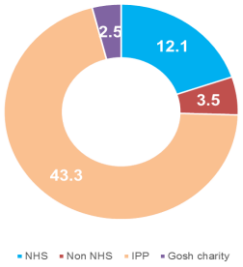

## CASH, CAPITAL AND OTHER KPIs

| *Key metrics* | Plan | Actual |
|---|---|---|
| **Cash** | £41.7m | £48.0m |
| **IPP Debtor days** | 120 | 233 |
| **Creditor days** | 30 | 32 |
| **NHS Debtor days** | 30 | 12 |

| *Capital Programme* | YTD Plan M2 | YTD Actual M2 | Full Year F'cst |
|---|---|---|---|
| **Total Trust-funded** | £4.6m | £3.6m | £21.8m |
| **Total Donated** | £9.5m | £6.5m | £46.7m |
| **Grand Total** | £14.1m | £10.0m | £68.6m |

| *NHSI metrics* | Plan M2 | Actual M2 |
|---|---|---|
| **CAPITAL SERVICE COVER** | 4 | 4 |
| **LIQUIDITY** | 1 | 1 |
| **I&E MARGIN** | 4 | 4 |
| **VAR. FROM CONTROL TOTAL** | | 3 |
| **AGENCY** | | 1 |
| **TOTAL** | 3 | 3 |

**Net receivables breakdown (£m)**




**AREAS OF NOTE:**

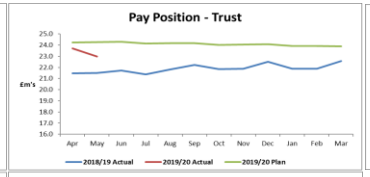
1. Cash held by the Trust is higher than plan by £6.3m of which £6.1m was received from NHS England ahead of plan.
2. The capital programme is behind plan by £4.1m at M02 due to slippage on several Estates, and Equipment projects.
3. IPP debtors days decreased in month from 243 days to 233 days largely as a result of higher than average receipts from Embassies .
4. Creditor days is increased slightly in month from 30 to 32 days.
5. NHS debtor days remained the same as M01 at 12 days which is in line with plan.
6. The NHSI metric for M2 is an overall value of 3 which is inline with the Trust plan. All metric are inline with plan with the exception of variance from control Total where the total is underperforming against the plan.

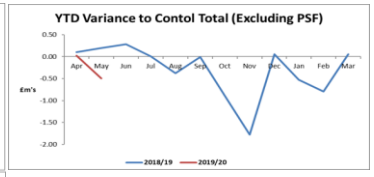
## Trust Income and Expenditure Performance Summary for the 2 months ending 31 May 2019

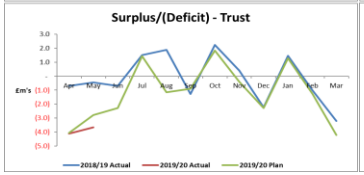
Great Ormond Street Hospital for Children NHS Foundation Trust

| 2019/20 | | | | | | | | | | | | 2018/19 | CY vs PY | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Annual Budget | Income & Expenditure | Month 2 | | | | Year to Date | | | | Rating | Notes | YTD Actual | Variance | |
| | | Budget | Actual | Variance | | Budget | Actual | Variance | | YTD Variance | | | | |
| (£m) | | (£m) | (£m) | (£m) | % | (£m) | (£m) | (£m) | % | | | (£m) | (£m) | % |
| 296.47 | NHS & Other Clinical Revenue | 23.51 | 23.55 | 0.04 | 0.17% | 46.23 | 45.83 | (0.40) | (0.87%) | A | 1 | 47.00 | (1.17) | (2.49%) |
| 59.94 | Pass Through | 5.02 | 5.55 | 0.53 | 10.56% | 9.79 | 11.09 | 1.30 | 13.28% | | | 9.90 | 1.19 | 12.02% |
| 69.76 | Private Patient Revenue | 5.73 | 4.39 | (1.34) | (23.39%) | 11.19 | 9.34 | (1.85) | (16.53%) | R | 2 | 9.70 | (0.36) | (3.71%) |
| 62.25 | Non-Clinical Revenue | 5.16 | 4.96 | (0.20) | (3.87%) | 10.16 | 9.39 | (0.77) | (7.58%) | R | 3 | 9.00 | 0.39 | 4.38% |
| **488.42** | **Total Operating Revenue** | **39.42** | **38.45** | **(0.97)** | **(2.46%)** | **77.37** | **75.65** | **(1.72)** | **(2.22%)** | R | | **75.60** | **0.05** | **0.07%** |
| (272.88) | Permanent Staff | (22.65) | (21.80) | 0.85 | 3.75% | (45.25) | (43.97) | 1.28 | 2.83% | | | (39.70) | (4.27) | (10.76%) |
| (3.48) | Agency Staff | (0.29) | (0.07) | 0.22 | 75.86% | (0.58) | (0.27) | 0.31 | 53.45% | | | (0.50) | 0.23 | 46.00% |
| (12.81) | Bank Staff | (1.34) | (1.10) | 0.24 | 17.91% | (2.68) | (2.42) | 0.26 | 9.70% | | | (2.70) | | 0% |
| **(289.17)** | **Total Employee Expenses** | **(24.28)** | **(22.97)** | **1.31** | **5.40%** | **(48.51)** | **(46.66)** | **1.85** | **3.81%** | G | 4 | **(42.90)** | **(3.76)** | **(8.76%)** |
| (13.80) | Drugs and Blood | (1.14) | (0.91) | 0.23 | 20.18% | (2.24) | (1.77) | 0.47 | 20.98% | G | | (2.20) | 0.43 | 19.55% |
| (44.13) | Other Clinical Supplies | (3.80) | (3.46) | 0.34 | 8.95% | (7.56) | (6.75) | 0.81 | 10.71% | G | | (7.30) | 0.55 | 7.53% |
| (62.50) | Other Expenses | (5.61) | (6.41) | (0.80) | (14.26%) | (11.42) | (12.06) | (0.64) | (5.60%) | R | | (9.80) | (2.26) | (23.06%) |
| (59.94) | Pass Through | (5.02) | (5.55) | (0.53) | (10.56%) | (9.79) | (11.09) | (1.30) | (13.28%) | | | (9.80) | (1.29) | (13.16%) |
| **(180.37)** | **Total Non-Pay Expenses** | **(15.57)** | **(16.33)** | **(0.76)** | **(4.88%)** | **(31.01)** | **(31.67)** | **(0.66)** | **(2.13%)** | R | 5 | **(29.10)** | **(2.57)** | **(8.83%)** |
| **(469.54)** | **Total Expenses** | **(39.85)** | **(39.30)** | **0.55** | **1.38%** | **(79.52)** | **(78.33)** | **1.19** | **1.50%** | G | | **(72.00)** | **(6.33)** | **(8.79%)** |
| **18.88** | **EBITDA (exc Capital Donations)** | **(0.43)** | **(0.85)** | **(0.42)** | **(98.13%)** | **(2.15)** | **(2.68)** | **(0.53)** | **(24.70%)** | R | | **3.60** | **(6.28)** | **(174.33%)** |
| (18.88) | Owned depreciation, Interest and PDC | (1.53) | (1.52) | 0.01 | 0.72% | (3.05) | (3.02) | 0.03 | 1.15% | | 7 | (2.58) | (0.44) | (16.98%) |
| **0.00** | **Control Total (exc. PSF)** | **(1.96)** | **(2.37)** | **(0.41)** | **(20.85%)** | **(5.20)** | **(5.69)** | **(0.49)** | **(9.52%)** | | | | | |
| 3.76 | PSF | 0.19 | 0.19 | (0.38) | (200.00%) | 0.38 | 0.38 | (0.38) | (100.00%) | | | | | |
| **0.00** | **Control total** | **(1.77)** | **(2.18)** | **(0.41)** | **(22.94%)** | **(4.82)** | **(5.31)** | **(0.49)** | **(10.18%)** | R | | **1.02** | **(6.33)** | **(620.98%)** |
| (13.07) | Donated depreciation | (1.01) | (1.06) | (0.05) | (5.07%) | (2.01) | (2.02) | (0.01) | (0.75%) | | | (1.82) | (0.20) | (11.10%) |
| **(13.06)** | **Net (Deficit)/Surplus (exc Cap. Don. & Impairments)** | **(2.78)** | **(3.24)** | **(0.46)** | **(16.47%)** | **(6.83)** | **(7.34)** | **(0.51)** | **(7.41%)** | | | **(0.80)** | **(6.54)** | **(817.00%)** |
| (5.50) | Impairments | 0.00 | 0.00 | 0.00 | 0.00% | 0.00 | 0.00 | 0.00 | 0.00% | | | 0.00 | 0.00 | 0% |
| 46.72 | Capital Donations | 5.60 | 2.36 | (3.24) | (57.86%) | 9.53 | 6.44 | (3.09) | (32.42%) | | 6 | 3.40 | 3.04 | 89.41% |
| **28.16** | **Adjusted Net Result** | **2.82** | **(0.88)** | **(3.70)** | **(131.13%)** | **2.70** | **(0.90)** | **(3.60)** | **(133.19%)** | | | **2.60** | **(3.50)** | **(134.46%)** |

| DIVISIONAL CONTROL TOTALS | | | | | | | | | | Rating |
|---|---|---|---|---|---|---|---|---|---|---|
| Plan Annual | | 2019/20 | | | | | | | | |
| | | Month | | | | Year to Date | | | | |
| | | Budget | Actual | Var | Var | Budget | Actual | Var | Var | |
| (£m) | Directorates | (£m) | (£m) | (£m) | % | (£m) | (£m) | (£m) | % | |
| (31.70) | Blood Cells & Cancer | (2.58) | (2.54) | 0.04 | 1.55% | (5.27) | (5.14) | 0.13 | 2.47% | G |
| (30.90) | Body Bones & Mind | (2.55) | (2.72) | (0.17) | (6.67%) | (5.14) | (5.16) | (0.02) | (0.39%) | G |
| (22.39) | Brain | (1.86) | (1.86) | 0.00 | 0.00% | (3.71) | (3.76) | (0.05) | (1.35%) | G |
| (45.88) | Heart & Lung | (3.82) | (3.81) | 0.01 | 0.26% | (7.71) | (7.68) | 0.03 | 0.39% | G |
| (26.05) | Medicines Therapies & Tests | (2.16) | (1.94) | 0.22 | 10.19% | (4.32) | (4.52) | (0.20) | (4.63%) | A |
| (32.74) | Operations & Images | (2.71) | (2.83) | (0.12) | (4.43%) | (5.43) | (5.60) | (0.17) | (3.13%) | A |
| (18.66) | Sight & Sound | (1.57) | (1.76) | (0.19) | (12.10%) | (3.10) | (3.28) | (0.18) | (5.81%) | R |
| 25.01 | International Private Patients | 2.05 | 0.76 | (1.29) | (62.93%) | 3.96 | 2.55 | (1.41) | (35.61%) | R |
| 2.80 | Research And Innovation | 0.22 | 0.24 | 0.02 | 9.09% | 0.45 | 0.48 | 0.03 | 6.67% | G |
| 180.52 | Corporate/Other | 13.02 | 14.09 | 1.07 | 8.22% | 25.07 | 26.41 | 1.34 | 5.35% | G |
| **0.00** | **Control total** | **(1.96)** | **(2.37)** | **(0.41)** | **(20.92%)** | **(5.20)** | **(5.70)** | **(0.50)** | **(9.62%)** | |



**RAG Criteria:**
Green Favourable YTD Variance
Amber Adverse YTD Variance ( < 5%)
Red Adverse YTD Variance ( > 5% or > £0.5m)

### Summary

- YTD the Trust is reporting an adverse position to the control total (£0.5m). Private patient income is below plan (£1.9m) while pay is underspent (£1.9m) and NHS activity not on a block is below plan (£0.4m). The Trust position includes PSF funding for months 1&2.

### Notes

1. NHS & other clinical revenue (excluding pass through) is adverse to plan YTD (£0.4m). This is driven by lower levels of activity across the organisation on non-block NHS income.
2. Private Patient income has fallen in month and is behind plan YTD (£1.9m) due to lower than planned activity across a number of specialties and due to lower demand across the period of Ramadan.
3. Non-clinical income is adverse to plan (£0.5m) due to timing of charity funded projects.
4. Pay is favourable to plan (£1.9m) due to vacancies across the Trust. The Trust has a full year plan for agency (£3.5m) and Bank (£12.8m) staffing which is also underspent at Month 2.
5. Non pay (excluding pass through) is underspent (£0.6m) YTD due to lower levels of activity across the organisation post EPIC go live and timing of charity funded projects.
6. Income from capital donations is lower than plan YTD due to slippage in capital projects (£3.1m).

## 2019/20 NHS Income for the 2 months ending 31 May 2019

Great Ormond Street Hospital for Children NHS Foundation Trust

| Organisation | Contract type | Annual plan £000s | Income plan £000's | Income actual £000's | Income variance £000's | RAG YTD Variance |
|---|---|---|---|---|---|---|
| NHS England | Block | £274,248 | £42,936 | £42,936 | £0 | G |
| | Pass through drugs | £51,747 | £8,453 | £9,806 | £1,353 | G |
| | Cost & volume | £795 | £118 | (£196) | (£314) | A |
| **Total NHS England** | | £326,790 | £51,507 | £52,546 | £1,039 | G |
| CCG contracts | Block | £13,010 | £1,922 | £1,922 | £0 | G |
| | Cost & volume | £0 | £0 | £46 | £46 | G |
| | Pass through | £3,828 | £625 | £448 | (£177) | A |
| **Total CCG contracts** | | £16,838 | £2,547 | £2,416 | (£131) | A |
| CCG non contract activity | Cost & volume | £6,255 | £958 | £1,082 | £124 | G |
| | Pass through | £1,218 | £199 | £120 | (£79) | A |
| **Total NHS Clinical Income** | | £351,101 | £55,211 | £55,991 | £953 | G |
| Non NHS | Cost & volume | £5,015 | £760 | £752 | (£8) | G |
| | Pass through drugs | £292 | £48 | £4 | (£44) | G |
| Private patients | Cost & volume | £69,759 | £11,189 | £9,337 | (£1,852) | R |
| **TOTAL CLINICAL INCOME** | | **£426,167** | **£67,208** | **£66,257** | **(£951)** | R |

**RAG Criteria:**
Green Favourable Variance to plan
Amber Adverse Variance to plan ( < 5%)
Red Adverse Variance to plan ( > 5% or > £0.5m)

**Summary**

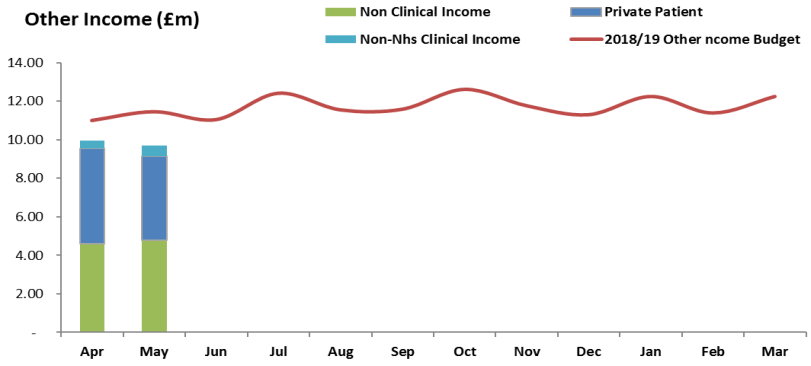
- Block contracts for activity have been agreed with NHS England for specialised commissioning and are in the process of being agreed with contracted CCG's. This approach was adopted to mitigate the risk from the implementation of the new patient administration system, EPIC.
- Pass through income is being charged on a cost and volume basis for all commissioners except NHS England where drugs only are on a cost and volume basis. There can be significant variability in these categories and therefore a block was not seen as appropriate due to the potential risk.
- The key driver of the adverse variance of £951k is the under-performance of £1,852 for private patients that is largely due to reduced activity as a result of the implementation of EPIC and Ramadan.
- This adverse variance is offset by increased pass through drugs income for NHS England. This value is currently based on an estimate for May and may be subject to change when refreshed in June.

# 2019/20 Other Income for the 2 months ending 31 May 2019

Great Ormond Street Hospital for Children NHS Foundation Trust

***Other Income Summary***

| | Annual plan £000's | Current month Plan £000's | Current month Actual £000's | Current month Variance £000's | Year to date Plan £000's | Year to date Actual £000's | Year to date Variance £000's | RAG YTD Variance |
|---|---|---|---|---|---|---|---|---|
| Private Patient | £69,759 | £5,731 | £4,386 | (£1,345) | £11,189 | £9,337 | (£1,852) | R |
| Non NHS Clinical Income | £4,887 | £378 | £529 | £151 | £742 | £925 | £183 | G |
| **Non-NHS Clinical Income** | **£74,646** | **£6,109** | **£4,915** | **(£1,194)** | **£11,931** | **£10,262** | **(£1,669)** | R |
| Education & Training | £8,005 | £668 | £626 | (£42) | £1,286 | £1,259 | (£27) | G |
| Research & Development | £26,282 | £2,193 | £2,099 | (£94) | £4,366 | £4,432 | £66 | G |
| Non-Patient Services | £1,001 | £83 | £57 | (£26) | £162 | £88 | (£74) | A |
| Commercial | £1,609 | £133 | £109 | (£24) | £260 | £232 | (£28) | G |
| Charitable Contributions | £10,716 | £877 | £980 | £103 | £1,724 | £1,336 | (£388) | A |
| Other Non-Clinical | £18,401 | £1,397 | £1,279 | (£118) | £2,737 | £2,419 | (£318) | A |
| **Non Clinical Income** | **£66,014** | **£5,351** | **£5,150** | **(£201)** | **£10,535** | **£9,766** | **(£769)** | R |




**RAG Criteria:**
Green Favourable YTD Variance
Amber Adverse YTD Variance ( < 5%)
Red Adverse YTD Variance ( > 5% or > £0.5m)

**Summary**

- Private patient income is adverse to plan YTD (£1.9m) due to lower than expected bed occupancy caused by referrals rates into the Trust. This is a further deterioration from Month 1 where this income was £0.5m lower than plan, bringing the YTD position to £1.9m adverse to plan.
- Charitable contributions are £0.4m adverse to plan due to timing of spend on approved projects.
- Other Non-Clinical income is adverse to plan YTD (£0.7m) due to underperformance on work for other Trusts and commercial funding schemes across the organisation.
- Project DRIVE is underperforming against its commercial income target (£0.2m).

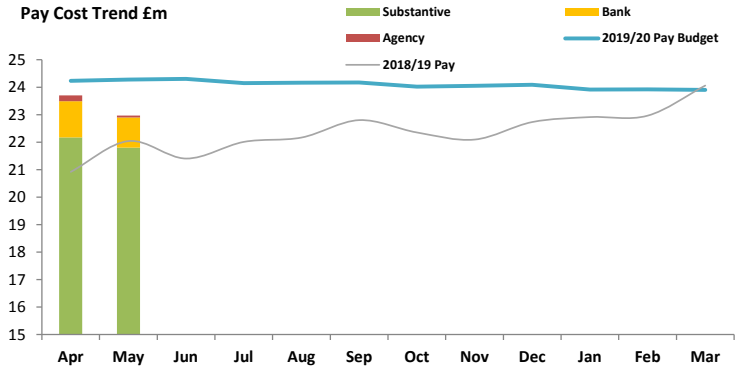
# Workforce Summary for the 2 months ending 31 May 2019

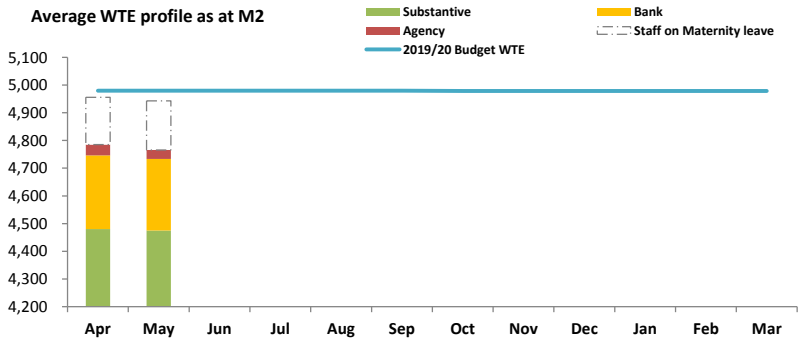
*WTE = **Worked WTE**, Worked hours of staff represented as WTE

Great Ormond Street Hospital for Children NHS Foundation Trust

| £m including Perm, Bank and Agency | 2019/20 plan | | | 2019/20 actual | | | Variance | | | | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Staff Group | YTD (£m) | YTD Average WTE | £000 / WTE | YTD (£m) | YTD Average WTE | £000 / WTE | YTD (£m) | Average WTE Vacancies | Volume Var (£m) | Price Var (£m) | £ Variance |
| Admin (inc Director & Senior Managers) | 9.9 | 1,214.2 | 48.7 | 8.4 | 1,131.9 | 44.8 | 1.4 | 82.3 | 0.7 | 0.8 | G |
| Consultants | 9.0 | 368.0 | 146.7 | 8.6 | 348.8 | 147.5 | 0.4 | 19.3 | 0.5 | (0.0) | G |
| Estates & Ancillary Staff | 0.8 | 146.8 | 33.4 | 0.7 | 129.2 | 33.5 | 0.1 | 17.6 | 0.1 | (0.0) | G |
| Healthcare Assist & Supp | 1.6 | 305.6 | 32.1 | 1.5 | 283.2 | 32.2 | 0.1 | 22.4 | 0.1 | (0.0) | G |
| Junior Doctors | 4.6 | 381.9 | 72.5 | 4.5 | 336.7 | 80.7 | 0.1 | 45.3 | 0.5 | (0.5) | G |
| Nursing Staff | 13.9 | 1,623.9 | 51.4 | 13.5 | 1,550.9 | 52.4 | 0.4 | 72.9 | 0.6 | (0.3) | G |
| Other Staff | 0.1 | 10.0 | 55.3 | 0.1 | 8.3 | 55.4 | 0.0 | 1.7 | 0.0 | (0.0) | G |
| Scientific Therap Tech | 8.5 | 948.4 | 53.6 | 8.8 | 944.0 | 55.8 | (0.3) | 4.4 | 0.0 | (0.3) | A |
| **Total substantive and bank staff costs** | **48.4** | **4,998.8** | **58.1** | **46.2** | **4,733.0** | **58.5** | **2.2** | **265.7** | **2.6** | **(0.3)** | G |
| Agency | 0.6 | 56.5 | 61.6 | 0.3 | 32.9 | 49.8 | 0.3 | 23.6 | 0.2 | 0.1 | G |
| **Total substantive, bank and agency cost** | **49.0** | **5,055.2** | **58.1** | **46.4** | **4,765.9** | **58.5** | **2.5** | **289.3** | **2.8** | **(0.3)** | G |
| Reserve* | (0.5) | (75.5) | 0.0 | 0.2 | 0.0 | 0.0 | (0.7) | (75.5) | (0.7) | 0.0 | R |
| **Total pay cost** | **48.5** | **4,979.7** | **58.4** | **46.7** | **4,765.9** | **58.7** | **1.8** | **213.8** | **2.1** | **(0.2)** | G |
| Remove Maternity leave cost | | | | (0.6) | | | 0.6 | | | 0.6 | G |
| **Total excluding Maternity Costs** | **48.5** | **4,979.7** | **58.4** | **46.1** | **4,765.9** | **58.0** | **2.4** | **213.8** | **2.1** | **0.3** | G |

*Plan reserve includes WTEs relating to the better value programme*




**RAG Criteria:**
Green Favourable Variance to plan
Amber Adverse Variance to plan ( < 5%)
Red Adverse Variance to plan ( > 5% or > £0.5m)

**Summary**

- YTD pay spend is £46.7m which is £1.8m favourable to plan. The key contributor to the underspend is the number of vacancies across the organisation that are currently not being backfilled by bank or agency; this can be seen by the volume variance (£2.1m).
- The Trust has put in a bank and agency budget alongside the permanent workforce budget in line with the NHSI reporting requirements. The agency budget has been set below the agency ceiling and is currently underspent.
- The table above does not include 176.7 average contractual WTE for staff on maternity leave which have cost £0.6m YTD. If this cost is excluded then the average cost per WTE is lower than plan by £0.4k per WTE.
- The reserve line contains the unidentified pay better value target and the plan for the apprenticeship levy which is offsetting part of the underspend within pay.
- We are not expecting to breach the agency ceiling set by NHSI and the Trust is currently below the agency ceiling.

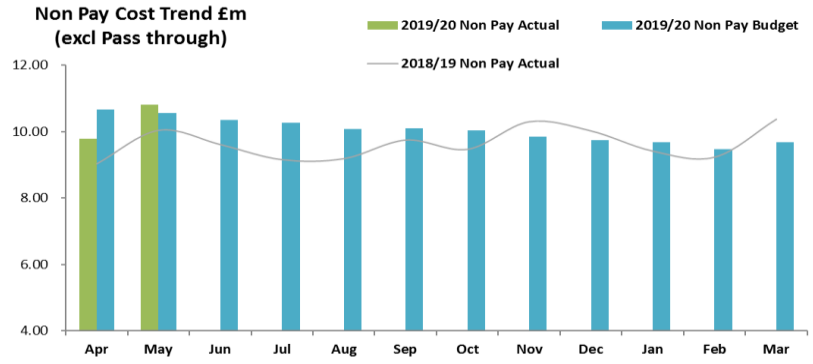
# Non-Pay Summary for the 2 months ending 31 May 2019

Great Ormond Street Hospital for Children NHS Foundation Trust

| Non-Pay Costs (excl Pass through) YTD | | | | |
|---|---|---|---|---|
| | Budget (£m) | Actual (£m) | Variance | RAG YTD Actual variance |
| Drugs Costs | 1.90 | 1.44 | 0.47 | G |
| Blood Costs | 0.34 | 0.33 | 0.01 | G |
| Business Rates | 0.70 | 0.70 | 0.00 | G |
| Clinical Negligence | 1.14 | 1.14 | 0.00 | G |
| Supplies & Services - Clinical | 7.56 | 6.75 | 0.81 | G |
| Supplies & Services - General | 0.87 | 0.76 | 0.12 | G |
| Premises Costs | 6.08 | 6.15 | (0.07) | A |
| Other Non Pay | 2.63 | 3.32 | (0.68) | R |
| **Total Non-Pay costs** | **21.22** | **20.57** | **0.65** | G |
| Depreciation | 3.78 | 3.78 | 0.00 | G |
| PDC Dividend Payable | 1.33 | 1.33 | (0.00) | G |
| **Total** | **26.33** | **25.68** | **0.64** | G |

| Top 5 YTD Clinical* Non Pay overspends by Speciality (£m) | | | | |
|---|---|---|---|---|
| | YTD 2019/20 Budget (£k) | YTD 2019/20 Actual (£k) | Variance (£k) | Trend |
| Haematology/Oncology | 482 | 599 | (117) | → |
| General Paediatrics | 17 | 81 | (64) | → |
| Medical Endocrinology | 173 | 219 | (46) | ↑ |
| Audiology | 274 | 314 | (40) | ↑ |
| Anaesthesia | 5 | 25 | (20) | → |

| Top 5 YTD Clinical* Non Pay underspends by Speciality (£m) | | | | |
|---|---|---|---|---|
| | YTD 2019/20 Budget (£k) | YTD 2019/20 Actual (£k) | Variance (£k) | Trend |
| Theatre | 1,402 | 1,181 | 222 | ↑ |
| Clinical Immunology | 344 | 203 | 141 | ↑ |
| Cardiac Serv & H&L Central Bud | 885 | 764 | 121 | → |
| Nephrology | 554 | 458 | 96 | ↑ |
| Pharmacy | 198 | 117 | 81 | → |




*Clinical non-pay excludes passthrough*

**Summary**

- YTD non-pay excluding pass through is favourable to plan (£0.6m). The key drivers behind this variance are the underspends on clinical supplies and drugs partially offset by the unidentified Better Value non-pay target.

**Top 5 clinical over/under spends**

The key areas with Non-pay overspends are:

- **Haematology/Oncology** – Non Pay budget includes the Blood Cells and Cancer unidentified better value target which is the main driver for the overspend variance.
- **General Paediatrics -** Majority of the overspend relates to chemical pathology recharges. A portion of this is following EPIC go-live and there is a review ongoing as to whether cost should relate to the admitting consultant specialities rather than General Paediatrics.
- **Medical Endocrinology -** Mainly due to the overspend on chemical pathology for recharges following EPIC go-live.
- **Audiology –** Overspend is on devices but in line with an over-performance on activity YTD.
- **Anaesthesia** - Additional costs associated with Pathology use across the speciality linked to activity.

The key areas of Non-pay underspends are:

- **Theatre -** Driven by low clinical supplies expenditure across theatres in month 1 and fewer theatre sessions during go live of EPIC
- **Clinical Immunology -** Lower activity levels have led to reduced spend on outpatient drugs
- **Cardiac and H&L central Budget-** Driven by drugs expenditure estimates post EPIC implementation being below plan
- **Nephrology** - Outpatient drugs underspent due to lower than expected activity post-EPIC
- **Pharmacy -** Waste and expired stock were lower than expected. Drugs are continuing to be counted and updated to endure accurate values post EPIC Go live.

**RAG Criteria:**
Green Favourable YTD Variance
Amber Adverse YTD Variance ( < 5%)
Red Adverse YTD Variance ( > 5% or > £0.5m)

# Better Value summary for the 2 months ending 31 May 2019

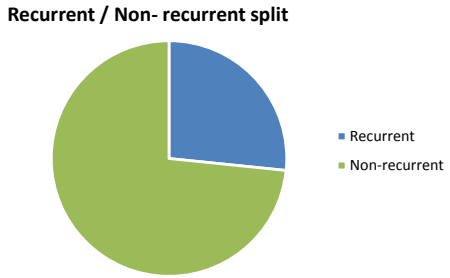
Great Ormond Street Hospital for Children NHS Foundation Trust

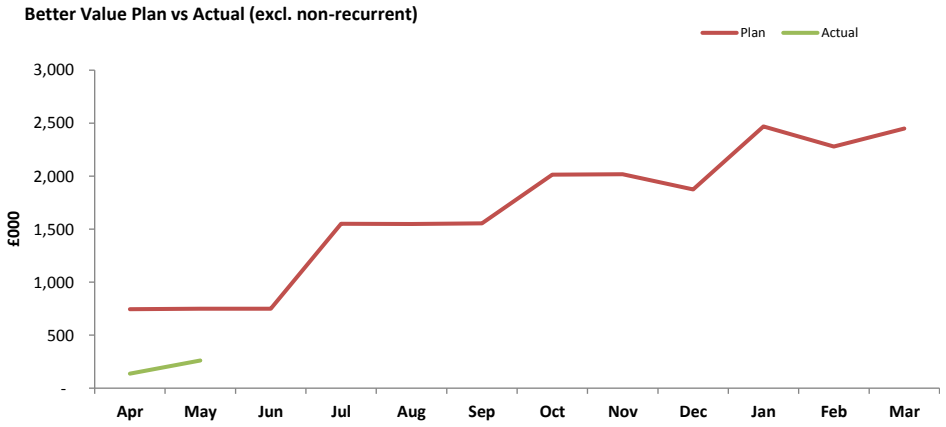
| Better Value Summary | | | | | | |
|---|---|---|---|---|---|---|
| DIRECTORATE | YTD performance £000's | | | Better Value Total £000's | | |
| | YTD plan | YTD delivery | YTD variance | Better Value target | Unidentified target | Schemes identified |
| Blood Cells & Cancer | 301 | 4 | (297) | 1,803 | (1,778) | 25 |
| Body Bones & Mind | 312 | 0 | (312) | 1,873 | (1,873) | 0 |
| Brain | 226 | 0 | (226) | 1,357 | (1,315) | 42 |
| Clinical & Medical Operations | 93 | 36 | (57) | 556 | 156 | 712 |
| Corporate Affairs | 21 | 1 | (20) | 127 | 28 | 155 |
| Finance | 48 | 50 | 2 | 289 | 152 | 441 |
| Genetics Laboratory Hub | 73 | 73 | 0 | 440 | 0 | 440 |
| Heart & Lung | 610 | 100 | (510) | 3,657 | 475 | 4,132 |
| HR | 48 | 29 | (19) | 290 | 8 | 298 |
| ICT | 112 | 0 | (112) | 671 | (39) | 632 |
| IPP | 157 | 0 | (157) | 944 | 0 | 944 |
| Medical Director | 29 | 0 | (29) | 173 | (173) | 0 |
| Medicines Therapies & Tests | 417 | 12 | (405) | 2,501 | (2,308) | 193 |
| Nursing and Patient Experience | 25 | 2 | (23) | 150 | (116) | 34 |
| Operations & Images | 376 | 8 | (368) | 2,257 | (1,907) | 350 |
| Estates and Facilities | 234 | 6 | (228) | 1,404 | (697) | 707 |
| Built Environment | 8 | 0 | (8) | 50 | 0 | 50 |
| Sight & Sound | 168 | 1 | (167) | 1,009 | (859) | 150 |
| Central | 75 | 75 | 1 | 447 | 0 | 447 |
| Better Value phasing | (1,838) | 0 | 1,838 | 0 | 0 | 0 |
| **Total** | **1,495** | **398** | **(1,097)** | **19,998** | **(10,246)** | **9,752** |
| Vacancies | | 1,097 | 1,097 | 0 | 0 | 0 |
| **Total Better Value** | **1,495** | **1,495** | **(0)** | **19,998** | **(10,246)** | **9,752** |

**Summary**

- The Better Value program is only currently delivering £0.4m of the £1.5m YTD target at month 2. The rest of the delivery is being covered by Pay vacancies across the organisation.
- The Trust has identified better value savings (£9.8m) that have been removed from the Trust budgets. Additional saving plans have been worked up (£5.0m), these require additional work to remove from the Trust plans on a recurrent basis.
- Without the Trust vacancies supporting the Trust better value program the program would be £1.1m behind target. With the staffing posts in the Trusts plans these savings can only be recognised on a non recurrent basis which will add pressure onto the 2020/21 finances of the Trust.
- The Better Value program phasing can be seen in the graph below. This shows that the Better Value target increases significantly each quarter. It is therefore important that the savings across the organisation increase to cover the increased targets in later months.
- Savings across the Trust have been phased according to directorate plans and so a delivery central phasing adjustment has been made.

| Recurrent / Non-recurrent | YTD 2019/20 Actual (£k) |
|---|---|
| Recurrent | 398 |
| Non-recurrent | 1,097 |
| **Total Better Value** | **1,495** |



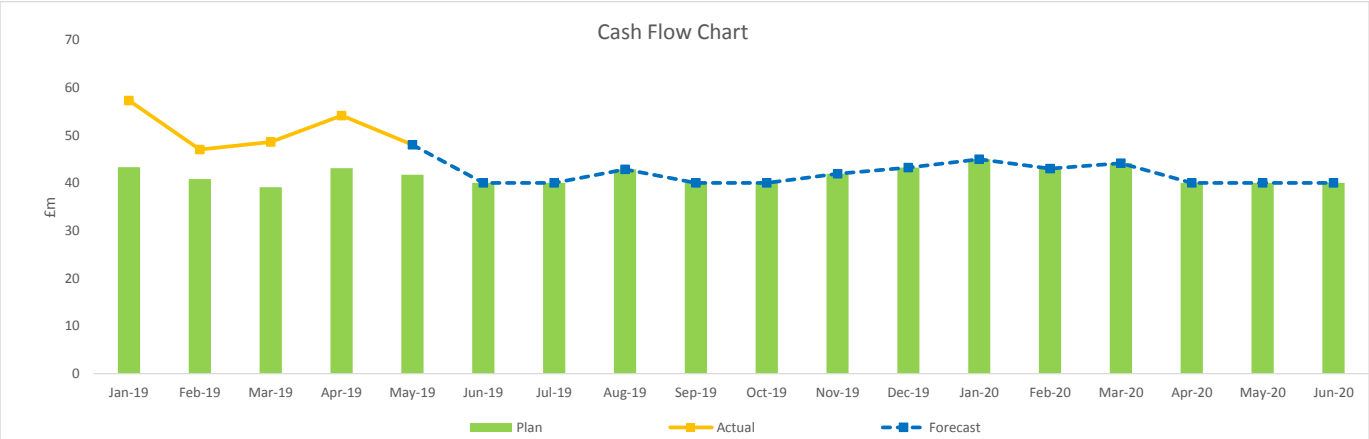



| 31 Mar 2019 Audited Accounts £m | Statement of Financial Position | Plan 31 May 2019 £m | YTD Actual 31 May 2019 £m | YTD Variance £m | Forecast Outturn 31 Mar 2020 £m | YTD Actual 30 Apr 2019 £m | In month Movement £m |
|---|---|---|---|---|---|---|---|
| 499.04 | Non-Current Assets | 508.71 | 505.70 | (3.01) | 538.60 | 504.33 | *1.37* |
| 103.55 | Current Assets (exc Cash) | 87.87 | 100.92 | 13.05 | 88.79 | 99.79 | *1.13* |
| 48.61 | Cash & Cash Equivalents | 41.74 | 48.00 | 6.26 | 44.11 | 54.17 | *(6.17)* |
| (74.89) | Current Liabilities | (62.46) | (79.47) | (17.01) | (66.27) | (82.24) | *2.77* |
| (5.01) | Non-Current Liabilities | (4.77) | (4.75) | 0.02 | (4.87) | (4.78) | *0.03* |
| **571.30** | **Total Assets Employed** | **571.08** | **570.40** | **(0.68)** | **600.36** | **571.27** | **(0.87)** |

| 31 Mar 2019 Audited Accounts £m | Capital Expenditure | Plan 31 May 2019 £m | YTD Actual 31 May 2019 £m | YTD Variance £m | Forecast Outturn 31 Mar 2020 £m | RAG YTD variance |
|---|---|---|---|---|---|---|
| 5.81 | Redevelopment - Donated | 3.99 | 3.44 | 0.55 | 35.25 | A |
| 9.06 | Medical Equipment - Donated | 3.49 | 1.00 | 2.49 | 9.30 | R |
| 9.78 | ICT - Donated | 2.05 | 2.05 | 0.00 | 2.17 | G |
| **24.65** | **Total Donated** | **9.53** | **6.49** | **3.04** | **46.72** | A |
| 6.99 | Redevelopment & equipment - Trust Funded | 1.44 | 0.95 | 0.49 | 8.90 | A |
| 1.61 | Estates & Facilities - Trust Funded | 0.74 | 0.20 | 0.54 | 3.06 | R |
| 4.73 | ICT - Trust Funded | 1.86 | 2.40 | (0.54) | 9.40 | A |
| 0.00 | Contingency | 0.55 | 0.00 | 0.55 | 0.47 | R |
| **13.33** | **Total Trust Funded** | **4.59** | **3.55** | **1.04** | **21.83** | A |
| **37.98** | **Total Expenditure** | **14.12** | **10.04** | **4.08** | **68.55** | A |

| 31-Mar-19 | Working Capital | 30-Apr-19 | 31-May-19 | RAG | KPI |
|---|---|---|---|---|---|
| 20.00 | NHS Debtor Days (YTD) | 12.0 | 12.0 | G | < 30.0 |
| 253.00 | IPP Debtor Days | 243.0 | 233.0 | R | < 120.0 |
| 36.70 | IPP Overdue Debt (£m) | 36.9 | 37.2 | R | 0.0 |
| 5.00 | Inventory Days - Drugs | N/A | N/A | | 7.0 |
| 94.00 | Inventory Days - Non Drugs | 92.0 | 92.0 | R | 30.0 |
| 34.00 | Creditor Days | 30.0 | 32.0 | A | < 30.0 |
| 43.6% | BPPC - NHS (YTD) (number) | 43.3% | 43.9% | R | > 90.0% |
| 80.3% | BPPC - NHS (YTD) (£) | 85.5% | 83.8% | R | > 90.0% |
| 85.5% | BPPC - Non-NHS (YTD) (number) | 89.3% | 86.4% | A | > 90.0% |
| 91.1% | BPPC - Non-NHS (YTD) (£) | 94.0% | 90.7% | G | > 90.0% |

**RAG Criteria:**
NHS Debtor and Creditor Days: Green (under 30); Amber (30-40); Red (over 40)
BPPC Number and £: Green (over 95%); Amber (95-90%); Red (under 90%)
IPP debtor days: Green (under 120 days); Amber (120-150 days); Red (over 150 days)
Inventory days: Green (under 21 days); Amber (22-30 days); Red (over 30 days)




**Comments:**

1. The capital programme is behind plan by £4.1m at M2, due to slippage on Estates (£0.5m), Redevelopment (Children's Cancer Centre £1.4m) and Equipment purchases (£2.5.m).
2. Cash held by the Trust is higher than plan by £6.3m. This is largely due to higher than planned receipts from NHS England (£6.1m)
3. Total Assets employed at M2 was £0.7m lower than plan as a result of the following:
   - Non current assets totalled £505.7m (£3.0m lower than plan)
   - Current assets excluding cash less Current liabilities totalled £21.4m (£3.9m lower than plan).
   - Cash held by the Trust totalled £48.0m (£6.3m higher than plan of which £6.1m was received from NHS England ahead of plan)
4. Overdue IPP debt increased in month to £37.2m (£36.9m in M1) however there was a reduction in total IPP debt as a result of higher than expected receipts from Embassies in month.
5. IPP debtor days decreased from 243 days to 233 days as a result of the overall decrease in IPP debt in month.
6. The cumulative BPPC for NHS invoices (by value) decreased in month to 83.8% (85.5% in M1). This represented 43.9% of the number of invoices settled within 30 days (43.3% in M1)
7. The cumulative BPPC for Non NHS invoices (by value) decreased in month to 90.7% (94.0% in M1). This represented 86.4% of the number of invoices settled within 30 days (89.3% in M1).
8. Creditor days increased in month to 32 days as a result of the increase in unpaid invoices in month which are not yet due.
9. Inventory days (drugs) cannot be calculated at month 2 because the value of Pharmacy inventory at 31 May 2019 is not available. Non-drug inventory days remained the same as M01 at 92 days.

ATTACHMENT N

Attachment N

Great Ormond Street Hospital for Children NHS Foundation Trust

# QUALITY, SAFETY AND EXPERIENCE ASSURANCE COMMITTEE

## Great Ormond Street Hospital for Children NHS Foundation Trust

GREAT ORMOND STREET LONDON WC1N 3JH

## A G E N D A

## Thursday 11th July 2019
## 2:00pm – 5:00pm

Great Ormond Street Hospital for Children NHS Foundation Trust

# QUALITY, SAFETY AND EXPERIENCE ASSURANCE COMMITTEE
## Thursday 11th July 2019 at 2:00pm – 5:00pm in the Charles West (Board) Room, Barclay House, Great Ormond Street Hospital for Children NHS Foundation Trust
## AGENDA

| | Agenda Item | Presented by | Attachment | Time |
|---|---|---|---|---|
| 1. | **Apologies for absence** | Chair | | **2:00pm** |
| 2. | **Minutes of the meeting held on 4 April 2019** | Chair | **A** | |
| 3. | **Matters arising/ Action point checklist**<br><br>**Action 49.4: Update on tissue viability** | Chair<br><br>Chief Nurse | **B**<br><br>**X** | **2:05pm** |
| | **QUALITY AND SAFETY** | | | |
| 4. | **Overview and Emerging clinical and risk issues – to focus the committee's attention on the areas under its remit of most concern** | All | **Verbal** | **2:10pm** |
| 5. | **Integrated Quality and Performance Report (May 2019)** | Medical Director/ Chief Nurse/ Acting Chief Operating Officer | **C** | **2:20pm** |
| 6. | **GOSH Quality Priorities 2019/20 – process of agreement** | Medical Director | **D** | **2:30pm** |
| | **RISK AND GOVERNANCE** | | | |
| 7. | **Assurance of compliance with Risk Management Strategy** | Head of Quality and Safety | **E** | **2:40pm** |
| 8. | **Board Assurance Framework Update** | Deputy Company Secretary | **F** | **2:50pm** |
| 9. | **BAF Deep Dive**<br>**Risk 14: Update on plans to respond to the MHRA inspection report** | Chief Pharmacist | **G** | **2:55pm** |
| 10. | **Health and Safety Update** | Director of HR and OD | **H** | **3:10pm** |
| 11. | **Whistle blowing update - Quality related cases** | Director of HR and OD | **I** | **3:20pm** |
| 12. | **Freedom to Speak Up Guardian Update** | Freedom to Speak up Guardian | **J** | **3:30pm** |
| 13. | **Update on quality impact of Better Value Schemes** | Programme Director | **K** | **3:40pm** |
| 14. | **Update on compliance with Duty of Candour** | Medical Director | **L** | **3:45pm** |

| | | | | |
|---|---|---|---|---|
| **15.** | **Freedom of Information Act Annual Report 2018/19** | Head of Quality and Safety | **N** | **3:55pm** |
| | **AUDIT AND ASSURANCE** | | | |
| **16.** | **Clinical Audit Update (January – June 2019) And Clinical Audit Workplan 2019/20** | Head of Clinical Audit | **P** | **4:00pm** |
| **17.** | **Palliative Care and Oncology Outreach Service** | Clarissa Pilkington, Chief of Service, Blood Cells and Cancer | **W** | **4:10pm** |
| **18.** | **Update from the GOSH Bioethics Service** | Chair of the Ethics Committee | **Q** | **4:20pm** |
| **19.** | **Compliance Update** | Head of Quality and Safety | **R** | **4:30pm** |
| **20.** | **Annual Complaints Report 2018/19** | Chief Nurse | **S** | **4:35pm** |
| **21.** | **Internal Audit Progress Report (April 2019 – June 2019)** | KPMG | **T** | **4:45pm** |
| **22.** | **Internal and external audit recommendations update** | KPMG | **U** | |
| **23.** | **Matters to be raised at Trust Board** | Chair | **Verbal** | **4:55pm** |
| | **FOR INFORMATION** | | | |
| **24.** | **Update from Audit Committee (April and May 2019)** | Deputy Company Secretary | **V** | |
| **25.** | **Any Other Business** | Chair | **Verbal** | |
| **26.** | **Next meeting** | **Thursday 17th October 2019 2:00pm – 5:00pm** | | |
| **27.** | **Terms of Reference and Acronyms** | **1** | | |

Attachment F

Great Ormond Street Hospital for Children NHS Foundation Trust

# Council of Governors

## 17 July 2019

**Reports from Board Assurance Committees:**

**Finance and Investment Committee (March and June 2019)**

**Summary & reason for item:** To provide an update on the March and June 2019 meetings of the Finance and Investment Committee.

The agendas for the two meetings are attached.

**Governor action required:** The Governors are asked to NOTE the report and pursue any points of clarification or interest.

**Report prepared by:** Paul Balson, Deputy Company Secretary

**Item presented by:** James Hatchley, Chair of the Finance and Investment Committee

**Purpose**

This report summarises the work of the Finance and Investment Committee's (FIC) since its last written report to the Council of Governors on 6 February 2019. The FIC held formal meetings on 25 March 2019 and 11 June 2019. Highlights from these meetings are covered below and the agendas included as appendices.

**Key issues for the Council of Governors' attention**

- The results of the Committee's survey of effectiveness stated that the Committee was performing well and identified a few areas for further enhancement in 2019/20.
- The Trust ended Month one of the 2019/20 financial year £0.1m behind its control total.
- Cash was higher than plan by £11.1m.
- Performance in Month aligned to the expected reduction agreed as part of the implementation plan for EPIC's EPR. Activity will increase over the remainder of the year to deliver the plan.
- The Trust was developing recovery plans for the Diagnostic waiting times and RTT incomplete pathway performance measures.
- There remained a £5.8m gap between the identified Better Value schemes and the £20m target which remains a significant concern and area of focus for the committee
- The Committee initiated reviews of all directorates. It reviewed Body, Bones and Mind Directorate, Research and Innovation Directorate in March and International and Private Patients in June.

**Assessment of effectiveness**

To inform its assessment of effectiveness, a survey was circulated to both Committee members and regular presenters. The results were discussed at the 11 June 2019 meeting.

In summary, members and presenters stated that the Committee was performing well against its terms of reference. In particular, the work undertaken to develop links with the GOSH Children's Charity was well received.

Key areas for consideration in 2019/20 included: how frequent certain reports are received, paper length and relevance to the Committee's terms of reference. The Committee would also be mindful of how consistently executives are challenged at the Committee.

**Performance and finance standing updates**

<u>Finance report 2019/20 Month one finance report</u>

At Month 1 the Trust was behind with its control total by £0.1m and behind its income target by £1.5m (excluding pass through).

Trust income had been reviewed in light of implementation of the new EPR system.

Pay was underspent by £0.5m in Month one.

Cash was higher than plan by £11.1m in Month one.

<u>Activity monitoring April 2019/20</u>

As part of the implementation plan for EPIC's EPR an agreement was made for a reduction in activity across inpatient and outpatient activity in April 2019. Performance in Month was as expected and the impact was expected to continue to have an effect into early May.

The Trust plans to make up the performance throughout the remainder of the financial year.

There were issues with coding of activity since implementation of EPIC which has led to an adverse impact on the depth of coding and income per spell. The total impact of the changes would be assessed.

Integrated Performance Report: April 2019 (Month 1)

The Trust was developing recovery plans for the Diagnostic waiting times and RTT incomplete pathway performance measures caused largely as a consequence of EPR delivery. Focus was placed on Cardiac MRI delays and continued underperformance in terms of theatre flow.

Staff appraisal rates remained challenging; however, improvement was seen in the rate of consultant appraisal and there are action plans for all other directorates.

The number of discharge summaries sent within 24 hours was below the national standard – again, part of this was due to EPR transition. The Trust has initiated a full data investigation into this metric.

Better Value Programme update

The Committee received a new-look Better Value Programme update report. The key item was that there remained a £5.8m gap between the worked up schemes and the £20m target. Whilst there is a palpable focus on organisational culture change and EPIC benefit realisation that would potentially increase the likelihood of the Trust being able to deliver the £20m target, the committee remains concerned about, and focused on the size of the gap. There was discussion and focus on step change initiatives. It was noted however, that there are a reduced number of other levers that could help the Trust deliver its control total given the block nature of the majority of revenue in 2019/20.

This is a major focus for 2019/20 and the agreed better value targets are extremely challenging.

NHS Contracts update

For 2019/20, the Trust agreed to a block contract with NHSE and with a number of CCGs. This was predominantly to safeguard the Trust against activity risk arising from EPIC implementation.

It was reported that the risks to income arising from coding difficulties and data capture post EPIC Go-Live were mainly mitigated by the block contract that is in place. However there could be an adverse impact on future contracts if not rectified quickly.

**Project updates / reviews**

GOSH Learning Academy

The Committee recommended some minor amendments to the Draft GOSH Learning Academy business case ahead of submission to the GOSHCC Grants Committee in June 2019. The GOSH Learning Academy would deliver the Trust's strategic priorities relating to education and training over the next five years.

Month 1 2019/20 Procurement Report

The Committee received an update on the Guys & St. Thomas Hospital Trust led "SmartTogether" shared procurement service activity. Key points reported included:

- Good feedback had been received from operational teams within the Trust, in particular there had been improvements in invoicing processing.
- To date, delivery against the Better Value programme had not been in line with expectations. Measures have been taken to address this further.
- A procurement Transformation Board has been established to oversee the contract and savings programme.

Directorate reviews

In March 2019 the committee conducted the first of its directorate reviews covering the new management structure. The first two directorates to present were:

- Body, Bones and Mind Directorate
- Research and Innovation Directorate

The Chair requested a follow-up from the Body, Bones and Mind Directorate on performance against its objectives and requested that future Directorate reviews include reporting on their objectives and associated KPIs. A template for the Directorate reviews had been created.

In June 2019 the committee conducted a review of the International and Private patients and discussed:

- The staffing differences between the IPP Directorate and the NHS Directorates.
- Effectiveness of debt retrieval.
- Strategies for retaining existing markets and the scope for attracting new markets.

The proposed review of the Brain Directorate was deferred due to unavoidable staff absence and will be covered in the next committee meeting.

EPIC update

The Committee was informed that the EPR Programme achieved the go-live criteria (agreed by Trust Board) and the Epic system was taken into full live use at approximately 3pm on Friday 19th April (as per plan).

DRIVE update

The Committee received an overview of DRIVE as an enabler and discussed several options for commercialisation, including the recruitment of information technology commercialisation expertise.

Major projects update

The Committee received a summary of progress made on several major development projects:

- Zayed Centre for Research into Rare Disease in Children
- Children's Cancer Centre
- Sight and Sound Centre
- IMRI

- A post implementation review of the Chillers upgrade was also presented and discussed and lessons learnt noted.

Sustainability key performance indicators (KPIs)

The Committee reviewed the key performance indicators that would be used to measure performance. These included: clean air hospital framework, green champions network expansion, recycling target, combined heat and power (CHP) engines, Co2 emissions from energy and the overall Trust carbon footprint. It was agreed that the Finance and Investment Committee would receive a quarterly sustainability report to monitor performance.

Evaluation of papers

At the end of each meeting throughout 2018/19, the Committee reviewed the quality of the papers it received. It was agreed that this would continue throughout 2019/20.

**End of report**

Attachment F

Great Ormond Street Hospital for Children NHS Foundation Trust

**FINANCE AND INVESTMENT COMMITTEEMEETING**
**Tuesday 11 June 2019**
**2.00pm to 5.00pm**
**Charles West Room**
**Great Ormond Street Hospital for Children NHS Foundation Trust**

**AGENDA**

| | Agenda Item | Presented by | Attachment | Time |
|---|---|---|---|---|
| 1 | Apologies for absence | Chair | Verbal | |
| 2 | Minutes of the meeting held 25 March 2019 | Chair | A | 2.00 |
| 3 | Matters arising, action checklist | Chair | B | |
| 4 | Annual Effectiveness Review | Deputy Company Secretary | C | 2.05 |
| | Performance & finance standing updates | | | |
| 5 | Month one activity monitoring | Acting Chief Operating Officer | D | 2.10 |
| 6 | Month one integrated performance report (IPR) | Acting Chief Operating Officer | E | 2.20 |
| 7 | Month one finance report | Chief Finance Officer | F | 2.35 |
| 8 | Month one productivity and efficiency (Better Value) report | PMO Programme Director | G | 2.45 |
| | Annual Business | | | |
| 9 | NHS Contract Status | Chief Finance Officer | H | 3.00 |
| 10 | Procurement update | Chief Finance Officer | I | 3.10 |
| 11 | Commercialisation | Chief Finance Officer / Director of Operations IPP | J | 3.10 |
| | | | | |
| 12 | International and Private Patients | Director of Operations IPP | K | 3.20 |
| 13 | Brain | Chief of Service | L | 3.30 |
| | Project Updates / Reviews | | | |
| 14 | EPIC update | Programme Director, EPR | M | 3.40 |

Great Ormond Street Hospital for Children NHS Foundation Trust

| | Agenda Item | Presented by | Attachment | Time |
|---|---|---|---|---|
| 15 | DRIVE project update | Chief Research Information Officer for DRIVE | N | 3.50 |
| 16 | Learning academy business case | Associate Director of Education, Nursing and Non-medical Education | O | 4.00 |
| 17 | Major Project updates<br>• ZCR<br>• Children's Cancer Centre<br>• DRIVE | Director of Development | P | 4.20 |
| 18 | Post implementation review<br>• DRIVE | Director of Development | Q | 4.30 |
| 19 | Chillers | Director of Development | R | 4.40 |
| 20 | Sustainability Key Performance Indicators | Director of Development / Head of Sustainability and Environmental Management, | S | 4.50 |
| | Other Business | | | |
| 21 | Evaluation of papers | Chair | - | 4.55 |
| | Close 5.00pm | | | |
| | Next meeting<br>25 July 2019 | | | |

Attachment F

Great Ormond Street Hospital for Children NHS Foundation Trust

**FINANCE AND INVESTMENT COMMITTEEMEETING**
**Monday 25 March 2019**
**3.00pm to 5.00pm**
**Charles West Room**
**Great Ormond Street Hospital for Children NHS Foundation Trust**

**AGENDA**

| | Agenda Item | Presented by | Attachment | Time |
|---|---|---|---|---|
| 1 | Apologies for absence | Chair | Verbal | |
| 2 | Minutes of the meeting held 1 February 2019 | Chair | A | 3.00pm |
| 3 | Matters arising, action checklist | Chair | B | |
| 4 | Finance and Investment Committee report for the Annual report | Deputy Company Secretary | To follow | 3.05pm |
| 5 | Annual Effectiveness Review | Deputy Company Secretary | To follow | 3.15pm |
| 6 | Review of terms of reference and work plan | Deputy Company Secretary | E | 3.25pm |
| | Performance & finance standing updates | | | |
| 7 | Activity monitoring through 'Magic numbers' 2018/19 | Acting Chief Operating Officer | F | 3.30pm |
| 8 | Integrated Performance Report | Acting Chief Operating Officer | G | |
| 9 | Finance Report Month 11 | Chief Finance Officer | H | 3.45pm |
| 10 | Better Value | PMO Programme Director | I | |
| | Directorate review | | | |
| 11 | Body, Bones and Mind | Allan Goldman – Chief of Service | J | 4.00pm |
| 12 | Research and Innovation | Deputy Director of Research and Innovation | K | |
| | Project Updates / Reviews | | | |
| 13 | EPIC update | Programme Director, EPR | L | 4.10pm |
| 14 | Children's Cancer Centre Update | Director of Development | M | 4.15pm |



Great Ormond Street Hospital for Children NHS Foundation Trust

| | Agenda Item | Presented by | Attachment | Time |
|---|---|---|---|---|
| 15 | National Cost collection approval process' | Chief Finance Officer | O | 4.45pm |
| | Other Business | | | |
| 16 | Evaluation of papers | Chair | | 4.55pm |
| | Close 5.00pm | | | |
| | **Next meeting**<br>11 June 2019 | | | |

ATTACHMENT M

Great Ormond Street NHS
Hospital for Children
NHS Foundation Trust

**People and Education Assurance Committee**

**Wednesday 10th July 2019**
**14:00 – 17:00**
**Charles West Boardroom 2 & 3**

**AGENDA**

| | Agenda Item | Presented by | Author |
|---|---|---|---|
| 1. | Apologies For Absence | Chair | Verbal |
| 2. | Declarations of Interest | | |
| 3. | Terms of Reference / membership | Chair | Attachment A |
| | **PEOPLE** | | |
| 4. | People Strategy | Caroline Anderson | Attachment B |
| 5. | Review & Repositioning the HR&OD function and HR Service Plan | Caroline Anderson | Attachment C |
| 6. | HR Performance Scorecard | Caroline Anderson | Attachment D |
| | **EDUCATION AND TRAINING** | | |
| 7. | Update on the Learning Academy | Alison Robertson | Presentation<br>Attachment E |
| | **STAFF ENGAGEMENT** | | |
| 8. | Staff Survey Action Plan | Caroline Anderson | Attachment F |
| | **RISK** | | |
| 9. | Board Assurance Framework and HR Specific Risks<br><br><u>PEAC assured BAF Risks</u><br><br>Risk 4: The risk that the organisation will be unable to recruit and retain sufficient highly skilled staff<br><br>Risk 17: Failure to embrace service transformation and deliver innovative, patient centred and efficient services<br><br>Risk 18: There is a risk that GOSH fails to develop its culture and levels of staff engagement and motivation in alignment with its strategy and values | Caroline Anderson<br><br><br><br>Alison Hall<br><br><br>Richard Collins<br><br><br>Alison Hall | Attachment G |
| **Any Other Business** | | | |
| **Next meeting**<br>The next meeting of People and Education Assurance Committee will be held on Wednesday 11th September, DRIVE Large Meeting Room, DRIVE Level 1, 40 Bernard Street, London WC1N 1LE | | | |

Attachment G

Great Ormond Street Hospital for Children NHS Foundation Trust

# Council of Governors

## 17 July 2019

**Young People's Forum Update**

**Summary & reason for item:** To provide an update of the activities of the Young People's Forum since the last Members' Council Meeting.

**Governor action required:** The Council is asked to NOTE the update.

3 key messages to take away from this report are:

1) The YPF are assisting the Trust to evaluate how young people are heard via the PALS and Complaints services. Patients tend not to use these services themselves, however, as a paediatric hospital the Trust is keen to make these services accessible to children and young people. PALS and Complaints visited YPF to explore why patients may not use these services currently. PALS and Complaints will revisit YPF in a future meeting to continue this work.

2) The YPF have had input into a puppet show which will tour hospitals nationally. Little Angel Theatre received funding to produce a show on patient journeys. Little Angel Theatre visited YPF to ask for their ideas on themes for the shows. Ideas included transition and mental health. Little Angel Theatre will visit YPF again in December and early 2020 to show the work-in-progress and to gain YPF approval before it goes on tour nationally.

3) Several YPF members attended the first Youth Voice Summit hosted by NHS England. The summit brought together young people and senior leaders in the NHS to co-create ideas and strategies around the 10 year plan and how they can be implemented.

**Report prepared by:** Amy Sutton, Children and Young People's Participation Officer.

**Item presented by:** Emma Beeden and/or Josh Hardy, Young People's Forum Governors.

Great Ormond Street Hospital for Children NHS Foundation Trust

YOUNG PEOPLE'S FORUM

# YPF activity – April 2019 to June 2019

The Young People's Forum (YPF) is a group of current patients and siblings aged 10-21 who have a strong voice in helping to improve the experiences of teenage patients. They use their own experiences to guide and support the hospital. There are six meetings a year, with ad hoc involvement opportunities between meetings.

The current total of membership: 65

Since the last report to the Council three monthly YPF newsletters have been circulated.
Examples of YPF member activities since the last report are:

- Three YPF members becoming Digital Health Ambassadors for London.
- YPF member, Ihsaan, taking part in the recruitment of the Medical Director post.

21 involvement opportunities were advertised during this period including working with Youth Access to design a tool to navigate the mental health service

**Meetings**
A YPF meeting took place in April with 22 young people in attendance. At the meeting:

- YPF members began work with the Pals and Complaints teams looking at how young people give feedback about their care and complain if required.
- YPF Governors, Emma and Josh, led a session to explore how to increase the youth membership of the Foundation Trust.
- The Trust's Strategic Partnerships Adviser to Chief Executive asked the YPF if they would like to be involved in developing the Trust's Strategy. The Chief Executive will be attending the July meeting to hold a workshop on this topic.
- The YPF took part in a puppetry workshop by Little Angel Theatre as they have received funding to produce a new show centred on patient journeys. The theatre company asked YPF members to help them generate ideas for their show.

Fig 1. YPF members discussing Trust membership

Fig 2. Puppetry workshop

**GOSH Teens Careers Festival**

**Update**

The dates for the next two GOSH Teens Careers Festivals have been set; these will take place on 15 October 2019 and 18 February 2020. Young people have requested advice on completing university applications - UCAS (The Universities and Colleges Admissions Service) and University College London have both agreed to attend the October event.

XTX Markets, who attended the last event, will be hosting eight GOSH patients for work experience on 10 July 2019.

**Nursing and Non-Medical Education**

**Update**

A third session was held with a new cohort of apprentice healthcare assistants in June. YPF member Rose, spoke to them about her experiences of being a teenage inpatient. The session scored 4.8 out of 5 making it the most popular session of the training day.

**Youth Voice Summit**

On Tuesday 23 April NHS England held the first Youth Voice Summit. Several YPF members attended, including Emma in a facilitating role. Transition is an important topic for adolescent patients and the 10 year plan shows that this is one of the priorities for the NHS. Emma facilitated a session about transition, asking other young people about their experiences of transition and what would make transition better. Emma fed back their comments to Simon Stevens, NHS Chief Executive, and Ruth May, Chief Nursing Officer.

**Schwartz Round**

Schwartz Rounds are monthly themed meetings to give staff from all disciplines, clinical and non-clinical an opportunity to reflect on the practical and emotional aspects of their work. In June the topic was *Moving on – Transitions from adolescent care* and for the first time ever a patient was invited onto the panel. YPF member Emma spoke about her recent experience of transitioning to adult care after being a GOSH patient since she was four years old and the impact this had on her emotionally.

Attachment H

Great Ormond Street Hospital for Children NHS Foundation Trust

# Council of Governors

## 17th July 2019

**Quality Report 2018/19**

**Summary & reason for item:**
The Quality Report is an annual report produced for the public by NHS healthcare providers about the quality of services they deliver. Its aim is to enhance accountability and engage leaders of NHS organisations in their quality improvement agendas. The Quality Report is a mandated document, which is laid before Parliament prior to being made available to patients, their families, and the public on the NHS website.

The production of the document is in line with Department of Health and NHS Improvement published requirements. One document has been produced, which meets the requirements of both.

Consulted in its preparation: contributors, Trust Board representatives, Council of Governors representatives, Audit Committee representatives, Quality, Safety, and Experience Assurance Committee representatives, Deloitte, commissioners, local Healthwatch and Health Scrutiny committees.

**Governor action required:**

To note, and to comment

**Report prepared by:**
Meredith Mora, Clinical Outcomes Development Lead

**Item presented by:**
Dr Sanjiv Sharma, Medical Director

NHS

Great Ormond Street Hospital for Children

NHS Foundation Trust

# Quality Report 2018/19

# Contents



Cover: **Eleanor**, is four years old. While she's at GOSH she loves tie dying and crafting, and visits the GOSH school with other patients on Squirrel ward.

# What is the *Quality Report*?

The *Quality Report* is an annual report produced for the public by NHS healthcare providers about the quality of services they deliver. Its aim is to enhance accountability and engage leaders of NHS organisations in their quality improvement agendas. The *Quality Report* is a mandated document, which is laid before Parliament before being made available to patients, their families, and the public on the NHS website.

## What does it include?

The content of the *Quality Report* includes:

- Local quality improvement information, which allows trusts to:
  - demonstrate their service improvement work
  - declare their quality priorities for the coming year and how they intend to address them
- Mandatory statements and quality indicators, which allow comparison between trusts
- Stakeholder and external assurance statements

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) has a long-standing reputation as one of the finest paediatric hospitals in the world. We are keen to share information publicly about the quality of our services and about our continuous improvement work.

## Understanding the Quality Report

We recognise that some of the information provided may not be easily understood by people who do not work in healthcare. So, for clarity, we have provided explanation boxes alongside the text.

**This is a 'what is' box**

It explains or describes a term or abbreviation found in the report.

**"Quotes from staff, patients and their families can be found in speech bubbles."**

**What is the NHS website?**

The NHS website is the UK's biggest health website. It provides a comprehensive health information service to patients and the public.

**What is a Foundation Trust?**

A Foundation Trust is a type of NHS trust in England that has been created to devolve decision-making from central government control to local organisations and communities. NHS Foundation Trusts provide and develop healthcare according to core NHS principles – free care, based on need and not on ability to pay. NHS Foundation Trusts have members drawn from patients, the public, and staff, and are governed by a board of governors comprising people elected from and by the membership base.

**Faridat** is six years old. She comes to Safari outpatients at GOSH with her mum and grandma to have treatment. While she's at the hospital, she enjoys playing with the toy kitchen and doing arts and crafts with the playroom.

# Our hospital

GOSH has
**62**
**nationally recognised specialties**

GOSH has
**19**
**highly specialised services for rare and complex conditions,**
the largest number of any NHS Trust in the UK

**97%**
**of inpatients would recommend the hospital**

GOSH employs
**5,045**
**hospital staff including doctors, nurses, allied health professionals and administrative staff**

Over
**1,300**
**research studies active in 2018/19**

**100%**
**of our clinical specialties collect data on outcomes of treatment**

GOSH had
**43,218**
inpatients and
**237,908**
outpatient appointments in 2018/19

# Fulfilling our potential.

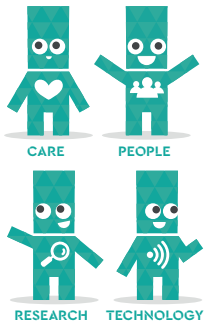
Our mission is to put the child first and always – this describes why GOSH exists.

**The child first and always**

Our vision has been updated to better describe what lies at the heart of the work we do at GOSH – to help the sickest children with complex health needs to fulfil their potential.

**Helping children with complex health needs fulfil their potential**

To turn our vision into goals we have defined four areas of focus around care, people, research, and technology.



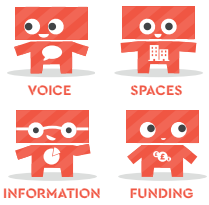

**CARE**
We will achieve the best possible outcomes through providing the safest, most effective and efficient care.

**PEOPLE**
We will attract and retain the right people through creating a culture that enables us to learn and thrive.

**RESEARCH**
We will improve children's lives through research and innovation.

**TECHNOLOGY**
We will transform care and the way we provide it through harnessing technology.

To deliver our work we need to have the right capabilities, resources, and programmes of work.




**VOICE**
We will use our voice as a trusted partner to influence and improve care.

**SPACES**
We will create inspiring spaces with state-of-the-art equipment to enhance care delivery and learning.

**INFORMATION**
We will provide timely, reliable and transparent information to underpin care and research.

**FUNDING**
We will secure and diversify funding so we can treat all the children that need our care.

*Our Always Values* are the guiding principles for everything we do and will help us deliver our ambition.

**Always welcoming**

**Always helpful**

**Always expert**

**Always one team**

# Our strategy – fulfilling our potential

Following a refresh and launch of Fulfilling Our Potential in 2017, our activities in 2018 continued to focus on creating a structure and engaging staff to embed our strategy as a plan for the Trust.

Alongside celebration of the work at GOSH to help children and young people with the most complex needs to fulfil their potential, this year's Open House event launched a new structure for clinical operations teams. The new organisational structure is designed to improve clarity on leadership and reduce the gap between Trust leaders and frontline services.

In December, staff came together for business planning events. Groups cut across departments and discussed how teams throughout the Trust can support one another to deliver Fulfilling Our Potential.

Other key achievements include delivery of the national Referral to Treatment target throughout the year, saving £12.3m through the Trust's 'Better Value' programme, and progress on the redevelopment programme to create inspiring **spaces** to deliver care and learning. In 2019/20, we plan to deliver savings of £20m.

Implementation of the Electronic Patient Record system will harness **technology** to transform care, and we are also working to improve recruitment and retention at GOSH, to ensure we have the right **people** in place to fulfil our potential.

We actively engage in a range of national and international collaborations to learn together and to share good practice across paediatric healthcare settings. Our collaborations include the UK Children's Alliance, and the European Children's Hospitals Organisation, for which we co-chair the Quality, Safety, Outcomes and Value working group. Read more about our collaborations in our 2018/19 Annual Report.

A number of our clinical projects from the past year are showcased in section 2A of this report.

Staff showcasing the GOSH Arts BloodQuest app, which aims to reduce anxieties before children and young people have blood tests

A special visit from Hoover to promote our wonderful GOSH Therapy Dog Programme

See the GOSH Annual Report 2018/19 for more on *Fulfilling Our Potential*, and the programmes that are delivering key elements.

FUTURE PROOF

ELECTRONIC
PATIENT RECORDS

# Electronic Patient Record programme

GOSH went live successfully with the Epic electronic patient record (EPR) system over the Easter weekend 2019, and this will be reported on in the 2019/20 Quality Report.

Our EPR vision is that every member of the team caring for a child can always access the information they need – rapidly, confidently and from a single source. Patients, parents and carers, as well as care providers in other hospitals and care settings will also be able to see relevant sections of the records and contribute information between visits to GOSH.

2018/19 has seen an iterative process of building, testing and reviewing the system, with hundreds of staff from every corner of the organisation involved in rigorously testing workflows. There were 127 Usability Sessions in 27 locations around the Trust, with almost 400 staff taking part. Our build of the Epic EPR system has been presented specialty wide, culminating in more than 13,000 hours of training to equip our staff for go-live.

Testing of hardware and software has taken place, with full 'technical dress rehearsals' across all wards, including every device that will be used with Epic. Devices for use in the event of downtime have been deployed in all clinical areas, alongside other new pieces of equipment such as workstations on wheels, barcode scanners and label printers.

After go-live, a period of stabilisation follows where the hospital gets used to the new ways of working. Then a phase of optimisation will allow for additional builds to the system to further utilise the capabilities of our EPR for patient care and reporting.

**Gabriel**, is eight years old has been coming to GOSH every week since November 2018, he loves singing and tickles from his Mum.


# Digital Research, Informatics, and Virtual Environment (DRIVE)

October 2018 marked the official launch of GOSH's new digital research and informatics unit, DRIVE, with the vision to become a world-leading clinical informatics unit focused on data analysis and the acceleration of research. Investment in infrastructure and a Digital Research Environment (DRE) mean that DRIVE is uniquely placed to focus on early phase evaluation of digital technologies.

GOSH's new Electronic Patient Record System, Epic, is now live and collecting the complex clinical data associated with GOSH patients. The DRE provides us with the platform we need to apply machine learning and artificial intelligence tools to our rich data and to be able to improve patient care and hospital efficiency through:

- prediction of outcomes/complications
- improving scheduling
- reducing variation in care
- improving patient experience using technology

We are developing a programme of engagement with patients, families and staff and will make the most of game-changing technologies, such as artificial intelligence, sensor technology and robotics to address the daily challenges they face. Examples of such technologies include:

- better monitoring of patients both in hospital and at home for earlier detection of complications through sensors and wearables
- use of robots and chatbots for improved patient experience
- development of remote consultation technology to prevent patients travelling to GOSH unnecessarily
- improved patient safety through computer vision and machine learning

DRIVE has established an important partnership with NHS Digital, which has provided significant funding to support the collaboration, alongside partnerships with a selection of global technology giants. DRIVE continues to work with the Industry Exchange Network (IXN) at University College London and their computer science students, who bring an impressive array of novel ideas to DRIVE.

DRIVE also aspires to grow a culture of entrepreneurship across the organisation and, together with Barclays' Digital Eagles programme, will be running a course for staff with the aim of fostering good ideas and encouraging digital innovation in line with NHS and Department of Health and Social Care (DHSC) priorities.

**What is the Department of Health and Social Care?**

The Department of Health and Social Care (DHSC) is a department of the UK government with responsibility for government policy for England alone on health, social care and the NHS.

**Mohammad**, is two years old. His favourite colour is red and he loves playing with water, especially outside in the rain.

# Making inclusivity a reality at GOSH

We know from research evidence that people perform better at work when they are valued, treated fairly, and feel comfortable to be themselves. We also know that discriminatory attitudes and behaviours, whether conscious or unconscious, perpetuate inequalities that prevent us from maximising the skills, talents and experience of our rich and diverse workforce[1].

In response to the 2017 NHS Staff Survey results, which indicated that GOSH had some work to do to ensure all our staff feel valued, we created staff inclusion forums. These forums are staff-led initiatives, supported by the Human Resources and Organisational Development department. Each forum has a sponsor who is a member of the Trust's executive team.

### Black, Asian and Minority Ethnic (BAME) Forum

The BAME Staff Forum launched in October 2018, with the purpose of empowering BAME staff to achieve their potential by creating a positive change and cultural shift in the Trust. Based on feedback from members, the Forum's Executive Team has defined three main focuses for 2019:

- Career development
- Leadership
- Social and networking opportunities

In addition to four main events throughout the year (based around major cultural and/or religious celebrations), there is a schedule of events including interview skills workshops and joint events with like-minded organisations. To date, two successful events have been held including the Forum Launch and a Welcome Breakfast, which boosted current membership to 150 staff.

Top left: The BAME Forum Executive Team

Top right: GOSH staff enjoying the crowds and sunshine at the Pride in London parade

[1] West MA and Dawson JF (2012) Employee engagement and NHS performance. London : Kings Fund


### LGBT+ and Allies Forum

GOSH launched its LGBT+ and Allies Forum in October 2018, which aims to ensure the Trust recognises and involves staff and volunteers who identify as lesbian, gay, bisexual, trans and non-binary (LGBT+), relationship diverse or as an LGBT+ ally. Its forum executive team has surveyed staff and identified forum priorities, which include: visibility and support of LGBT+ staff and families; policy input; training and education; mentoring; social and other events; and working closely with the other forums to recognise intersectionality, and to provide cross-forum support.

In 2018/19, the LGBT+ and Allies Forum:

- saw the first GOSH presence at the Pride in London parade
- celebrated LGBT+ History Month with events and activities, including the first raising of a rainbow flag at GOSH
- hosted forum breakfasts and evening events
- produced a regular newsletter for members and supporters
- prepared for the launch of its rainbow badge initiative in April 2019

Plans for 2019/20 include the roll out of the 'GOSH We're Proud' badge at GOSH, which gives our staff and volunteers a way to show that GOSH offers an open, non-judgemental and inclusive environment for patients and their families, staff and volunteers who identify as LGBT+.

### Women's Forum

To coincide with International Women's Day, the GOSH Women's Forum was launched on 8th March 2019. The Forum is currently setting their agenda of what they want to achieve, including working with colleagues across the organisation to explore a range of events and work streams to benefit women working at GOSH. The plans for 2019/20 include developing and promoting the forum across the Trust and engaging with staff to shape the agenda. Work streams will focus on how to support women working at GOSH. Initial suggestions have included menopause support, returning to work after having a baby, and career progression.

### Disability and Long-Term Health Conditions Forum

Launching later this year, this forum aims to create a safe, inclusive and diverse working environment that encourages and supports engagement from those members of our staff who are disabled or who are affected by a long-term health condition. Members will have the opportunity to influence relevant GOSH policies, strategies and work streams and engage with the Trust to promote awareness around specific issues affecting the membership. We hope that members will help shape our health and wellbeing plans as well as supporting us as we progress through the Disability Confident Employer Scheme. The forum will also support the Trust to develop positive work experiences at GOSH.

Top left: Making history: The rainbow flag flies for the first time at GOSH

Top right: Women's Forum launch

# Part 1:
# A statement on quality from the Chief Executive

It is widely accepted that research-based organisations have a culture of learning and that learning organisations tend to have better patient outcomes and patient experience.

Great Ormond Street Hospital is a standalone specialist children's hospital with a very strong academic partner, University College London. We are, therefore, very fortunate to be a research hospital where an emphasis is put on learning. That is, learning from when things go well and when they don't and fostering a culture where we continually seek to improve all we do. Our hospital has always depended on charitable support, and I'd like to thank GOSH Children's Charity and the thousands of donors it represents for its vital contribution to our research and across a wide range of projects.

This Quality Report is one way we can provide information on how we are improving our services and meeting a range of standards and expectations. While some standards are set externally, many of our quality improvement projects are informed by feedback from our patients, their carers and families, our commissioners and other stakeholders. Input from our staff is also vital as we identify and implement actions to improve the quality of the GOSH experience.

This report is divided into sections. In part two of this report we provide detail of a number of improvement projects aligned to our three quality priorities. In this same section we also provide a range of information that serves as reassurance from the Board as to the Quality of our services and information on how we are doing against core quality indicators. The final section includes our performance against key national targets.

Our improvement work should always link to our quality priorities. These are:

**Safety** - we are committed to reducing avoidable harm and improving patient safety as rapidly as possible. Our safety initiatives aim to ensure that each patient receives the correct treatment or action the first time, every time.

**Clinical effectiveness** - we seek to provide patient care that is amongst the best in the world and work with our patients to improve the effectiveness of our care through research and innovation.

**Experience** - we wish our patients and their families to have the best possible experience of our treatment and care. Measurement is important and we seek feedback from our patients, their families, and the wider public to improve the services we offer.

In the area of safety, this report highlights the very good work to improve the safety and experience of patients when venous access is needed. The introduction of a Vessel Health Preservation Framework (VHP) is important. Having a needle introduced to a vein can be an extremely distressing experience for our young patients, but prior to this work no framework existed for children and young people. The framework was carefully developed and tested with staff and children and young people, and the results are impressive: there has been a reduction in the number of unsuccessful cannulation attempts and a sustained reduction in the number of extravasation injuries.

The introduction and further development of the electronic Paediatric Early Warning System (PEWS) was a focus for our efforts to further improve clinical effectiveness. This tool, designed to recognise and respond to children and young people at risk of deterioration, is generated by combining scores from a selection of routine observations. This year we included sepsis risk triggers and alerts to the system and adapted the software for better adherence to full observation sets. Feedback from staff has been overwhelmingly positive and the percentage of completed observations has increased. The number of cardiac arrests outside ICU wards has also decreased and we are monitoring this sustained improvement to see if there is a direct correlation with the use of PEWS. I am also very pleased we are now working with other hospitals and NHS England to develop a national PEWS tool.

In the area of patient experience this year we have done further work to improve our transition support. As a specialist children's hospital we are very mindful of the need to prepare our young people for a transition into general adult or specialist adolescent or adult services, while recognising that the age and type of transition varies. To support our young people to be aware and develop the skills needed to engage with other centres, this year we rolled out the Growing Up Gaining Independence (GUGI) Tool. Feedback from young people and their parents about their experiences has been very good and over the next year we hope to further embed the framework as well as working with other children's hospitals to seek consistency of approach.

Looking forward to the next year, and following inputs from a wide range of stakeholders, including our Young People's Forum, three of the quality priorities we have set ourselves are: the introduction of a Trust wide programme that empowers staff to speak up for safety in the moment; an initiative to reduce the rejected samples for laboratory testing; and to further implement and develop a system that enables our families to give feedback in real time.

Audits are an important way we are able to gain assurance of the quality of our services. During this year we had a number of national audits and clinical outcome reviews, the results of which are found in the body of this report. GOSH staff also carried out a large number of local clinical audits. In order to underline the importance of this work and celebrate the teams that trailblaze in this area, this year we introduced a clinical audit prize, which was won by three exceptional teams.

The quality of our services is also assured by our regulator, the Care Quality Commission. At the beginning of this year, we published the report on our latest inspection which rated our services as good overall. However, we recognise that there are also many areas for improvement. So, during this year we have developed a post-inspection action plan that includes the introduction of a rolling schedule of peer-to-peer mock inspections. These inspections aim to create a cycle of continuous monitoring, learning and improvements as part of the day-to-day culture across the Trust.

The healthcare targets that are set nationally are an important way we can assess whether we are delivering timely and effective care. I am very pleased that after a huge piece of work to improve our systems and process for recording patient data, we were able to consistently meet the national standard of treating 92 per cent of our patients within 18 weeks of referral.

Feedback from our staff, our patients and their families is also essential to monitor and improve the quality of our services. One of the principal ways our staff give feedback is through the national NHS Staff Survey. This year the confidence our staff had in the quality of our services - measured through the percentage likely to recommend the hospital for their family and friends - improved and remained far above the national average. However, the feedback we had from staff about their experience at work was not as positive, with a higher than average proportion of staff saying they had experienced at least one incident of bullying, harassment or abuse at work. Understanding why this is the case and taking concrete steps to address this is a priority for the next year and one which will be addressed in our new People Strategy.

One of the richest sources of feedback comes from our patients and their families. One mechanism to capture this is the Friends and Family Test (FFT). In previous years we had struggled to achieve sufficient response rates. This year I am very pleased that the rate substantially increased, meeting our target in the last quarter, and that the percentage of families recommending the hospital remained very high. The improvements are a result of substantial efforts by our staff from across the Trust. I would also like to thank all the children, young people and their families who take time to give feedback and by doing so become partners in care - you are not only helping us to ensure the quality of care for your family but for all the families that use our services.

At GOSH we also strive to harness the latest technology to transform the care and experience we offer. Throughout this year, we have worked to prepare for the implementation of our Electronic Patient Record (EPR) known as Epic. This was launched successfully in April 2019 and offers enormous potential for further driving up quality. Throughout this report you will see references to how the Epic system is set to augment and improve how we deliver care. I look forward to sharing the impact this system has had in next year's Quality Report.

Of final note, the information provided in this report relies on good quality data. To this end, we have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported.

Matthew Shaw
Chief Executive

# Part 2a:
# Priorities for improvement

This part of the report sets out how we have performed against our 2018/19 quality priorities. These are made up of a combination of national priorities as well as local priorities identified by staff, patients and their families, and wider stakeholders such as referrers and commissioners. The quality priorities fall into three categories: safety, clinical effectiveness and experience. These categories were defined by Lord Ara Darzi in his 2008 NHS review for the Department of Health, in which he emphasised that quality should be a central principle in healthcare.


## Safety

We are committed to reducing avoidable harm and improving patient safety as rapidly as possible. Our safety initiatives aim to ensure that each patient receives the correct treatment or action the first time, every time.

## Clinical effectiveness

At GOSH, we seek to provide patient care that is amongst the best in the world. As a major academic centre, we work with our patients to improve the effectiveness of our care through research and innovation. We use national and international benchmarks to measure our effectiveness whenever possible, and we publish this outcomes data on our website and in renowned academic journals. To measure our effectiveness from the patient's perspective, we use Patient-Reported Outcome Measures (PROMS).

## Experience

We wish our patients and their families to have the best possible experience of our treatment and care. Therefore, we measure patient experience across the hospital and seek feedback from our patients, their families, and the wider public to improve the services we offer. We do this via:

- Membership, patient and member surveys
- Focus groups and events
- Social media
- Asking patients and families about their experience within 48 hours of discharge

# Reporting our quality priorities for 2018/19

**The six quality priorities reported for 2018/19 were:**

**Safety**

- Improving the safety and experience of our patients when venous access is needed for their care
- Reducing the rate of rejected samples for laboratory testing

**Clinical effectiveness**

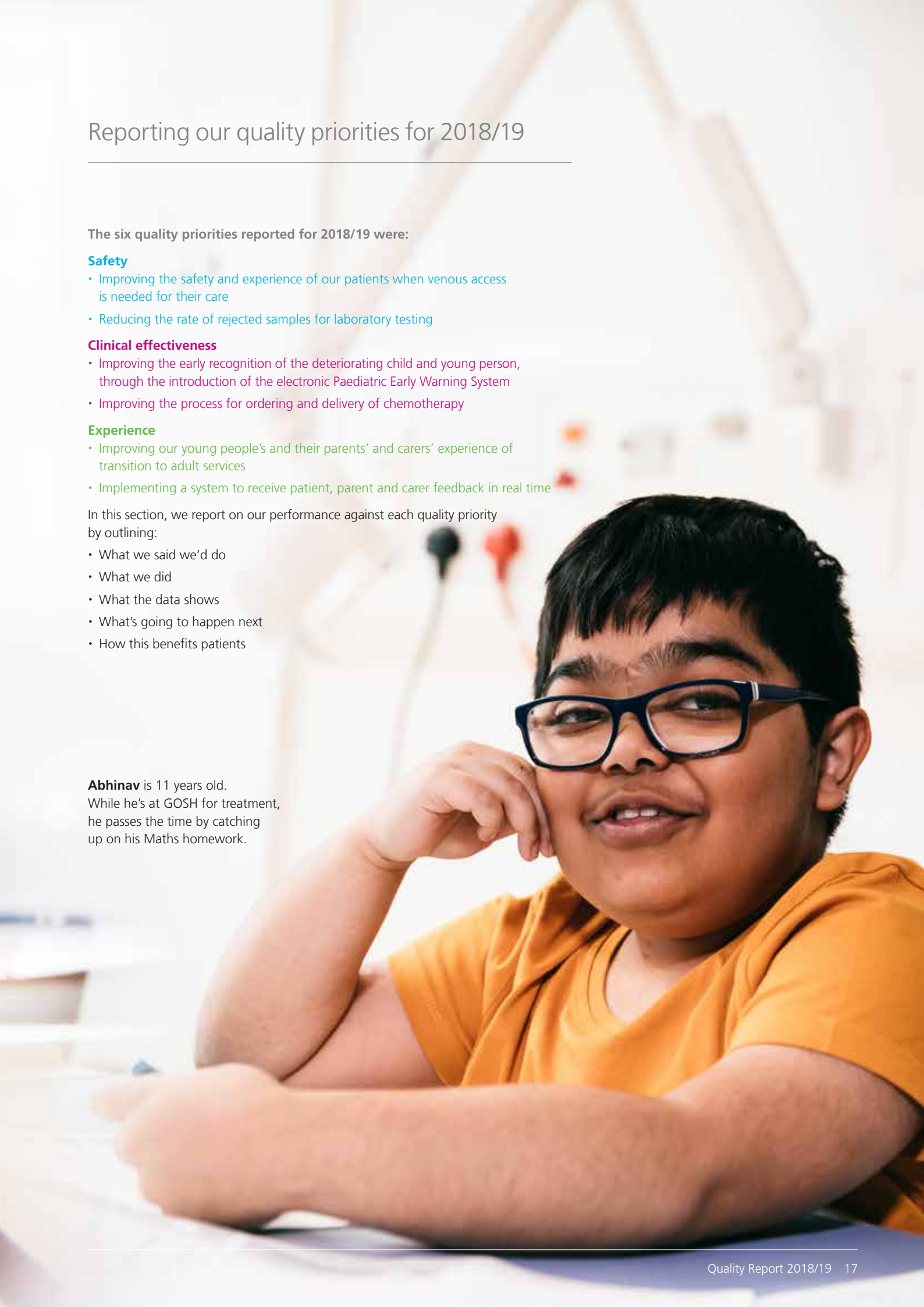
- Improving the early recognition of the deteriorating child and young person, through the introduction of the electronic Paediatric Early Warning System
- Improving the process for ordering and delivery of chemotherapy

**Experience**

- Improving our young people's and their parents' and carers' experience of transition to adult services
- Implementing a system to receive patient, parent and carer feedback in real time

In this section, we report on our performance against each quality priority by outlining:

- What we said we'd do
- What we did
- What the data shows
- What's going to happen next
- How this benefits patients



**Abhinav** is 11 years old. While he's at GOSH for treatment, he passes the time by catching up on his Maths homework.

## Improving the safety and experience of our patients when venous access is needed for their care

For many of the children who come to GOSH, a daunting experience of their stay is when a needle needs to be introduced into a vein to draw blood or give medication. This anxiety can lead to behavioural distress that further intensifies pain and can interfere with the procedure, and any future procedures required. If ongoing venous access such as a peripheral cannula is required, there is also a risk of extravasation.

### What we said we'd do

We said we would introduce a Vessel Health Preservation (VHP) framework that supports staff to:

- choose the right device
- make sure the right procedure is considered based on the child's individual needs
- help prepare the child and family for the procedure
- make sure the staff member with the right skills is performing the task

### What we did

Trusts across the UK use a VHP framework in adult care, where they grade the quality of veins before attempting venous access. However, such a framework did not exist in paediatric healthcare. We decided that to make progress with vessel health, we needed to develop a similar framework for children and young people.

We established a GOSH steering group, consisting of clinical and non-clinical leads including the Chief Nurse, anaesthetists, specialty leads, clinical site practitioners, infection control staff and quality improvement (QI) staff. We also regularly consulted with patients and families to understand their experiences of cannulation. Over a number of months, the group carefully developed a paediatric VHP framework, testing the framework on pilot wards to ensure it was fit for purpose for both staff and patients.

Once we had refined the framework, we held the 'Vessel Health Roadshow', an education and engagement event to raise awareness of the new framework across the hospital. This included teaching by members of the Play Team to promote how preparation of the child and family, positioning, and distraction techniques can help ease anxieties and lead to a more successful procedure.

To ensure early identification of patients where venous access may be more difficult to achieve due to vein condition, we added a section to our electronic Patient Status at a Glance (ePSAG) boards to document vein grade. This helps to highlight these patients to the whole ward team to ensure appropriate treatment plans are put in place at the outset. We have also worked with the team who are implementing Epic, our new electronic patient record system, to ensure that vein grading is supported in the new system.

We also reviewed and updated our education programme to ensure children and young people are cannulated by appropriately skilled clinicians. We developed a teaching and engagement video to ensure all existing and new staff are aware of the new framework, and share good practice in paediatric cannulation to reduce avoidable pain and distress. This is now embedded in the cannulation and venepuncture study day. We have also tested opportunities for junior doctors to gain additional skills and experience in paediatric cannulation through shadowing experts such as anaesthetists and vascular access facilitators, and are working to embed this into the junior doctors' education pathway.

### What is extravasation?

Extravasation is the inadvertent leakage of a medicine or fluid from its intended vein into the surrounding tissue. Extravasation has the potential to cause blisters or severe tissue injury.

### What is venepuncture?

Venepuncture is a common procedure that involves the insertion of a needle into the vein, to draw a blood sample or administer medication.

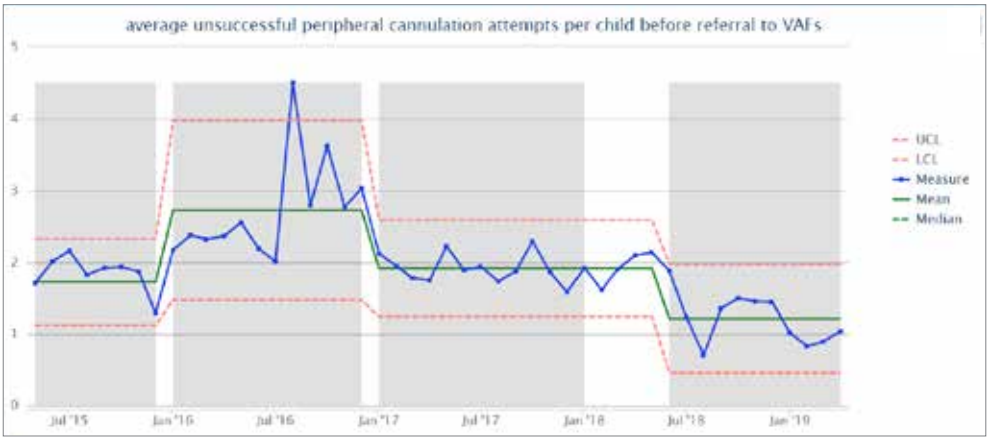
### What is cannulation?

Sometimes when intravenous treatment is required over a longer period of time, an intravenous cannula is inserted. This is a small, flexible tube inserted into a vein and secured. A syringe or infusion line can then be attached to the cannula to administer medication or fluids directly into the bloodstream.

## What the data shows

**1. The average number of unsuccessful cannulation attempts before a patient is referred to the Venous Access Team**

We have seen a reduction from an average of 1.9 attempts per child to 1.2 attempts prior to referral to Venous Access Facilitators (VAFs), indicating improvement in timely escalation of children whose vein condition requires additional expertise to achieve venous access.




**2. The number of extravasation injuries referred to the Plastics Team**

We have achieved and sustained a reduction in the number of extravasation injuries referred to the Plastics Team, decreasing from an average of 12 a month before the project commenced, to 5 a month.


## What's going to happen next?

We are updating our policy and guidelines to ensure the new framework is embedded as standard across the Trust. We are also developing an e-learning package incorporating the training video for all doctors to complete on induction.

The Trust is considering establishing a larger peripheral venous access team to improve out-of-hours access to expert practitioners in venepuncture and cannulation.

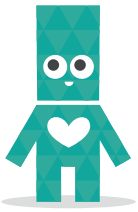
## How this benefits patients

The VHP framework benefits patients by ensuring:

- The most suitable type of venous access is consistently determined for the patient depending on the reason for access and the length of time for which it is required
- Venous access is attempted by a practitioner with the right level of skill. This reduces the likelihood of failure, improving patient safety and reducing distress
- Children and young people with difficult venous access are identified early, and additional support needed can be planned or booked without delay

Standardising our education, policies and guidelines has:

- Lessened variation in the insertion and management of peripheral cannulas across the hospital, helping to reduce the risk of extravasation injuries. This improves patient safety and reduces the risk of delayed treatment or discharge.


### What is a Statistical Process Control chart?

Statistical Process Control (SPC) charts are used to measure variation and improvement over time. Importantly, SPC takes into account natural variation of data, which, if acted upon without analysis, is an inefficient approach to improvement work. Upper control limits (UCL) and lower control limits (LCL) are calculated to help with data analysis. SPC methodology enables us to focus on 'special cause' variation, which identifies areas that require further investigation and action.

### What is a baseline period?

A baseline is the period of measurement to establish 'how things are' before changes are made to a process, to enable comparison 'before' and 'after'. An average (mean) of the data from the baseline period would be used for that comparison.

**"It helps prevent distress in children from excessive attempts at venepuncture."** Staff nurse, Bear Ward

**"It helps guide your management of a patient and tries to minimise the harm in those circumstances where there is known difficult access."** Staff nurse, Koala Ward

## Reducing the rate of rejected samples for laboratory testing

Approximately 70%[2] of clinical decisions are based on information derived from laboratory test results. In 2017, GOSH's laboratories received more than 400,000 samples and performed more than 1 million tests.

An audit in 2017 identified that approximately 4900 samples were rejected due to pre-analytical reasons over the year. When a sample is rejected, it usually means that the test needs to be repeated. We know that a delay in receiving a result can contribute to delays in diagnosis, treatment and discharge, as well as having a significant impact on patient experience.

### What we said we'd do

Early in 2018, the rejection of nasopharyngeal aspirate (NPA) samples due to container leaks was considered as an area for improvement. Issuing guidance for staff to send all of these samples through porters rather than via the pneumatic tube system ('chute') reduced the rejection rate.

After this 'quick win', we decided to explore other opportunities for improvement in sample collection practice and to implement solutions, with the overall aim of significantly reducing the number of sample rejections by the end of 2019. We said that we would investigate the reasons for sample rejection to understand the causes and identify ways to avoid them.

We identified four key work streams that were integral to achieving a quality sample:

Sample Collection Resources – focusing on the equipment and resources we use to collect patient samples to certify that they are adequate, compatible and do not hinder a quality sample being obtained.

Sample Transport – looking at the different routes, methods and timings for patient samples to get to the laboratory.

Training and Education – assessing the current availability and content of education and training opportunities related to sample collection and comparing it with best practice.

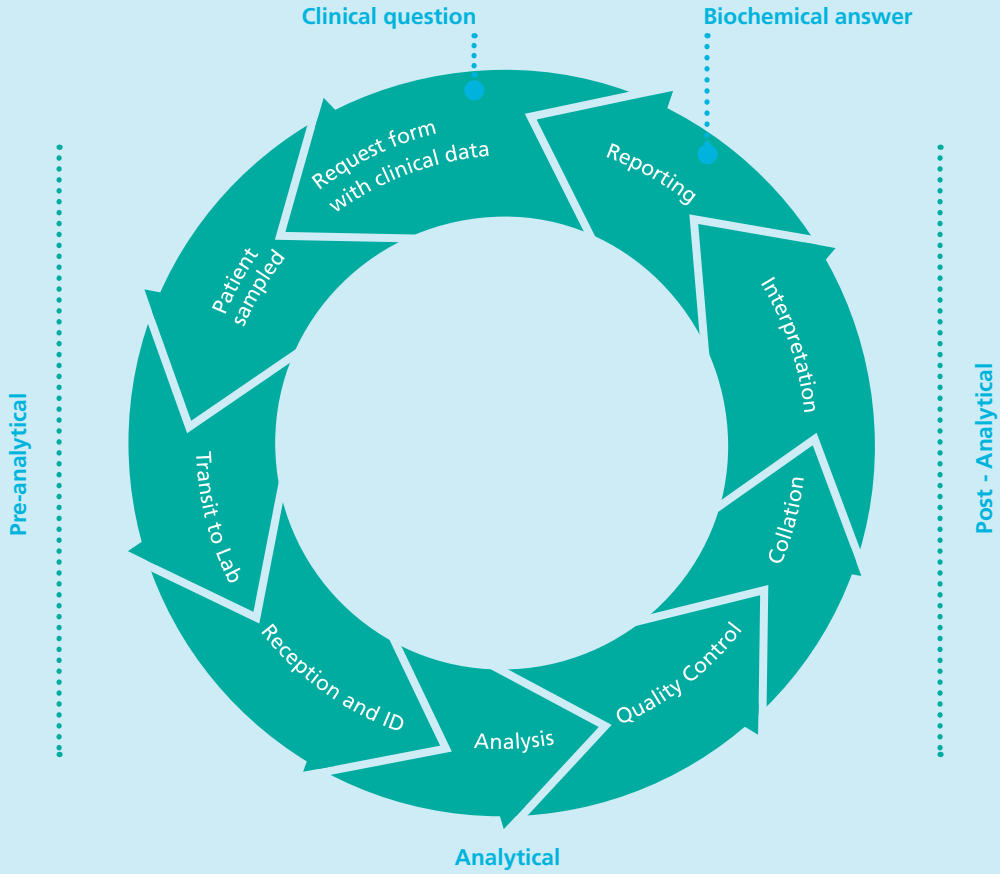
Policy and Guidelines – reviewing our policies and guidelines to ensure they are evidence based and support staff to obtain adequate samples.

### What is the pre-analytical phase?

The pre-analytical phase starts at the point of sample collection and test requesting by the medical team and ends when the sample arrives in the laboratory and is evaluated for errors before processing.

### What are blood cultures?

Blood cultures are blood samples to detect infections in the blood. If a blood culture test is positive, the bacteria causing the infection will be identified and testing will be done to find out which antibiotics will effectively treat the infection.




[2] Datta P (2004) *Resolving discordant specimens in clinical laboratory practice*. Medical Laboratory Observer. November. Accessed 19/02/2019.

## What we did

We set up a project team of clinical and non-clinical stakeholders from across the Trust, led by the Quality Leads for the laboratories. To understand the main reasons for rejection and where the greatest areas for improvement were, we developed a real-time report on the intranet using data from the laboratory information system. Data can be viewed at Trust and ward level and is accessible by all staff. From the data we were able to identify the most common reasons for rejection:

- Clotted coagulation test samples
- Insufficient/underfilled samples
- Labelling errors

The causes were identified as: incorrect technique when taking the sample (such as insufficient mixing or vigorous shaking), issues with the equipment (such as loss of vacuum, expired tubes or incompatible resources), or delays in transporting samples to the laboratory.

Delayed transport of blood cultures was identified as a frequent issue. It is important that blood cultures are sent to the laboratory as soon as possible so that any bacteria that might be present in the sample can grow, be detected and be treated. We developed visual guides to remind staff to send these samples via the chute for speed of delivery.

Blood must be drawn in a specific order to avoid cross-contamination between blood tubes. We found the collection sequence used at GOSH was different to the order recommended by the suppliers of the bottles, laboratory standards and the World Health Organisation. We have now changed our guideline, created new resources to reflect this, and shared the rationale with staff.

Epic, our new electronic patient record system, will change how tests are requested. When blood tests are requested on Epic, the clinician will be prompted to print a patient label for the tube and will also be reminded of the new sequence in which to take their samples. We therefore anticipate that labelling errors will decrease further from April 2019.

## What the data shows

**1. Percentage of rejected nasopharyngeal aspirate samples**

The weekly percentage of NPA samples rejected due to leakage has reduced from a mean of 1.79% to a mean of 0.3%. This improvement has been sustained since March 2018.


**2. Average blood culture transport time**

The weekly average transport time mean has reduced from 239 minutes (June 2017 to October 2018) to 169 minutes (November 2018 to February 2019). In March 2019 it reduced further to 146 minutes.


**3. Weekly rate of rejected samples**

Though we have not yet seen an improvement in the mean rejected samples for these laboratories, our project continues to strive for a decrease. We expect the implementation of Epic to aid this by the end of 2019, when the project is scheduled to end.


One Team INFORMATION

### What's going to happen next?

We're going to continue to develop and implement interventions to reduce the rate of rejection. We plan to develop a training strategy and practical best practice guide with quick tips for decreasing the likelihood of a sample being rejected.

We're going to continue to evaluate the products we use including trialling an alternative needle and an alternative coagulation tube for neonates with a reduced minimum volume requirement.

### How this benefits patients

- Reduced numbers of repeated sample collection procedures, which can be uncomfortable and distressing for patients and families.
- Fewer delays in medical teams receiving results, enabling fewer delays in diagnosis, treatment and discharge.

**"This has become a Trust-wide campaign. Clinical and non-clinical stakeholders across the hospital are involved in improving sample quality and reducing sample transport times. Despite all challenges, the staff engagement has been amazing! We are beginning to see very positive conversations and results already."** Quality Improvement Lead (Pre-analytical), Laboratory Medicine

**"The increased use of the pneumatic chute has seen a great improvement in the transportation of blood cultures from the ward to the laboratory. There are now very few blood cultures that are received with long delays in transport time. This means that blood cultures can be incubated quickly, which will reduce the time to detection of pathogens that cause sepsis and allow for quicker patient treatment and management."** Deputy Laboratory Manager, Microbiology

**"This initiative will help us reduce repeated blood draws, which will really help in reducing the distress to patients and also help us manage our workload effectively. I think the project will result in improved patient satisfaction, reduced treatment delays and hospital stays and of course reduced cost"** Venous Access Facilitator, Caterpillar Outpatients

**Harvey**, age three, recently had surgery to remove his tonsils and adenoids. He loves dinosaurs and blowing bubble in his bedroom. His mum says he's been a "very brave boy" since coming to GOSH.

## Improving the early recognition of the deteriorating child and young person, through the introduction of the electronic Paediatric Early Warning System

Early warning scores are designed to alert health professionals to the signs of clinical deterioration. They support staff by strengthening team communication and helping to deliver the best possible care to stabilise the child or young person.

### What we said we'd do

In the Quality Report 2017/18, we made a commitment to improve the early recognition of the deteriorating child and young person at GOSH, through the introduction of the electronic Paediatric Early Warning System (PEWS).

### What we did

The decision to replace our Children's Early Warning Score (CEWS) with PEWS was made after extensive national research and data modelling of over 1.5 million clinical observations showing PEWS to be a more sensitive tool in identifying paediatric patients at risk of deterioration.

A Quality Improvement project was initiated with the aim of implementing PEWS across GOSH by April 2018 and supporting wards to embed use of the new scoring system.

### Process Approach

In addition to the implementation of PEWS, sepsis risk factors, prompts and alerts were built into the electronic system. This provided clinical staff with the additional markers to improve the early recognition of clinical deterioration when completing their observations.

The recording of incomplete observations is possible within Epic. However, dashboards have been built to monitor this at ward level, so that any issues with observations completion can be addressed promptly.

### What is PEWS?

The Paediatric Early Warning System is a tool to recognise and respond to children and young people at risk of deterioration. It is generated by combining the scores from a selection of routine observations of patients including respiratory rate, heart rate, blood pressure, and blood oxygen saturation.

### What is sepsis?

Sepsis is a life threatening condition that arises when the body's response to an infection injures its own tissues and organs. Sepsis leads to shock, multiple organ failure and death, especially if not recognised early and treated promptly.
UK Sepsis Trust.

### What is a Clinical Site Practitioner?

A Clinical Site Practitioner (CSP) is a senior nurse in charge of the day-to-day operational management of the hospital.

### Training and Education

A comprehensive training package was created by the clinical education team, and rolled out using a 'Train-the-Trainer' approach. Key features included:

- Differences in the scoring between CEWS and PEWS
- A 'Back to Basics' campaign designed to improve the quality of observation taking
- Staff roles and responsibilities in response to PEWS, such as introducing agreed timeframes for staff to respond to a high PEWS alert

### Project Approach and Implementation

The PEWS was successfully launched at GOSH in March 2018, and an eight week post implementation review was completed in May 2018.

The main recurring theme in the initial period was alert fatigue. It became apparent that escalation alerts had been set at a level that caused a significant increase in the number of unnecessary alerts that nursing staff were required to action. We therefore worked to align the scores with more appropriate escalation triggers, ensuring appropriate reviews were undertaken by the right clinical staff member and at the right time.

### Early Warning Dashboard example

**Incomplete observations**

**75**

/ 425 total observations

**Sepsis 6 patients with no bundle / review**

**0**

/ 1 total triggering patients

**Chart types**

| Chart | Obs | Pts |
|---|---|---|
| PEWS | 414 | 17 |
| Doppler | 0 | 0 |
| NCA/PCA | 11 | 1 |
| Non-acute monitoring | 0 | 0 |

**Early warning score RAG**

| PEWS Score | Obs | Pts |
|---|---|---|
| Red (9+) | 2 | 2 |
| Amber (5-8) | 50 | 7 |
| Green (1-4) | 281 | 16 |
| Zero | 91 | 14 |
| No score | 1 | 1 |

The Quality Improvement data analysts built the Early Warning Dashboard, which combines specific PEWS and Sepsis measures in a user-friendly way, including the ability to view data at a hospital, ward and patient level.

The data provides assurance that the correct chart types are being used, patient observations are fully completed, and that when sepsis flags are triggered, decisions are made within agreed timeframes.

**What is cardiac arrest?**

Cardiac arrest is a term used to describe sudden loss of heart function. It can occur due to an electrical disturbance in the heart, but can also be caused by structural heart abnormalities that disrupt the heart's normal pumping action.

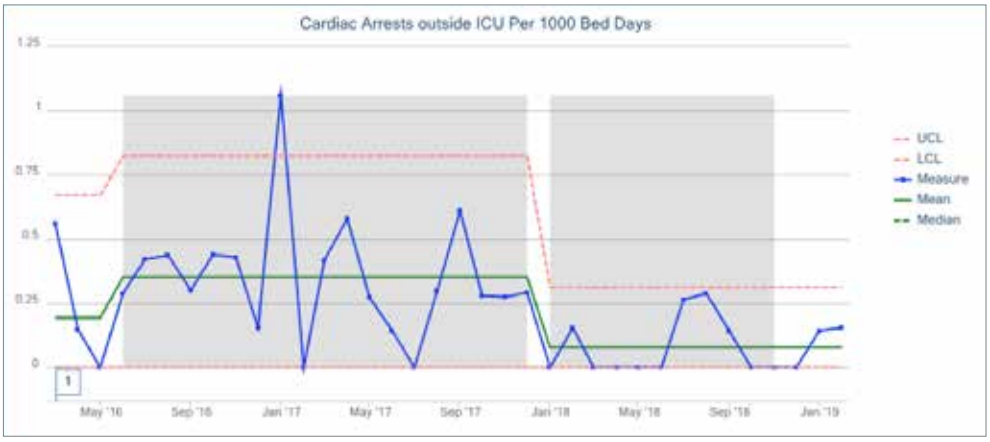
**What is 'Train the Trainer'?**

'Train-the-Trainer' is a cascading training model. PEWS subject matter experts intensively trained a number of staff on how to use PEWS appropriately. Those staff then trained others, and so on. This approach is often used within healthcare when a large number of staff must be trained but cannot all attend training at the same time, and peer learning is appropriate.

## What the data shows


**1. The percentage of observations where all parameters are completed (required to produce an Early Warning Score)**
CEWS prior to 07/03/2018, PEWS after this date. Since the launch of PEWS, the percentage of completed observations has increased from 62% to 75%.


**2. Cardiac arrests outside ICU wards/ theatres, per 1000 bed days**
Cardiac arrests per 1000 bed days have decreased from a mean of 0.35 to 0.08 from January 2018, and the reduction has been sustained. Though we cannot claim a direct causal link between the PEWS project and the reduction in cardiac arrests, the timings co-occur and we continue to monitor this improvement.




## What's going to happen next?

PEWS has been integrated within our EPR system, Epic, with no changes to the scoring or escalation algorithm.

Led by NHS England, GOSH is also working with other hospitals to develop a national PEWS tool. The initiative is designed to standardise the approach to managing deterioration in children and young people across the UK.

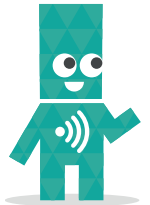
## How this benefits patients

- A safer environment
- Better outcomes for patients

**"'I'm a huge advocate of PEWS, especially when I'm the nurse in charge on the ward, as the system will automatically prompt me whenever one of our patients has a high PEWS score. I can then go and check in with the nurse and patient to see how they're getting on and put a plan in place if needed."** Staff Nurse

**"Since PEWS started we've noticed staff feel more confident in escalating concerns to the CSP team, even if their patient doesn't have a high PEWS score. For me this shows staff are using the system correctly, by using PEWS to support their clinical judgement, rather than replace it."** Clinical Site Practitioner (CSP)


Expert


TECHNOLOGY

## Improving the process for ordering and delivery of chemotherapy

The chemotherapy unit prepares 80 to 100 doses per day of bespoke chemotherapy for a range of patients in the hospital. Both inpatients and outpatients receive complex regimens of chemotherapy for the treatment of cancer. Specialised pharmacists oversee the process from prescribing, clinical verification, manufacture and administration of these high-risk drugs with numerous safety checks built into the process to prevent harm.

### What we said we'd do

Tracking preparation of these medicines had always been through a manual paper process that relied on access to a single sheet of paper per day, which would need to be kept up-to-date as changes occurred. Inevitably, the chemotherapy unit would receive numerous phone calls to receive updates about particular patients or from ward areas to enquire about the status of a patient's chemotherapy. These interruptions along with the labour intensive process of keeping the 'day planner' up-to-date led to inefficiencies and required specialist pharmacists to oversee this workflow. There was no visibility at ward level as to the status of chemotherapy, so the chemotherapy unit had limited ability to manage workload.

We decided to explore options for the development of an electronic solution to bring visibility of this information to both pharmacy and ward.

### What we did

We approached the Quality Improvement Team with a proposal to create a fully electronic tracking system for chemotherapy prescriptions from prescribing to collection. By identifying the process from start to finish, we provided a comprehensive plan to ensure that the system would bring visibility about chemo status at ward level and pharmacy, with safety mechanisms to ensure chemotherapy can be prioritised. After initial development, the system was tested and refined with the wider team, with additional features developed, such as clinical trial flags to help highlight trial medicines which may require additional steps. After running the system in parallel to the old system to validate it, Chemotracker was launched in February 2018.

The system:

- Allows ward-based pharmacists to update Chemotracker at ward level, without the need to call the chemotherapy unit
- Helps track preparation of chemotherapy through each stage of preparation providing real-time information from Pharmacy to ward areas
- Allows the technicians to prioritise workload based on when patients are due and provide better visibility on expected workload and tasks that need to be completed for the day, all of which help reduce any delays in preparation of chemotherapy

A significant benefit of introducing the system has been that due to the simplified processes in the chemotherapy unit, it has allowed the release of specialist pharmacist time away from the chemotherapy unit and into patient facing areas, making best use of our resources. This has allowed us to maintain specialist pharmacists in all haematology/oncology ward areas, providing a continued benefit in the quality of prescribing.

Prior to the launch of the tracker, ward nurses would call the chemotherapy unit with queries about chemotherapy or communications about patient investigation results. They now are directed to Chemotracker, which answers the majority of their queries. Where additional queries or communications are required they can now talk to their ward-based pharmacist, who knows the patient best and is more readily available on the ward due to the time saved by Chemotracker.

### What the data shows

We did a baseline audit in October 2018 of our paper-based system:

**October 2018**

**40-60 calls per day**
to the chemotherapy unit

After full implementation of Chemotracker:

**March 2019 onwards**

**0 calls per day**
to the chemotherapy unit

The chemotherapy unit phone now has a voicemail message to direct any, now occasional, callers to speak directly to their ward-based pharmacists as the authoritative and now routinely on-site source of information. Ward-based pharmacists communicate with the chemotherapy unit now using Chemotracker, and urgent messages can be called through to the chemotherapy unit manager.

**"Chemotracker has allowed us to concentrate on the tasks we need to do. It's a big improvement from the old system which was difficult to use and interpret. By reducing the number of phone calls, we can provide an environment free from interruptions to ensure the safe preparation of chemotherapy."** Chemotherapy unit manager

### What's going to happen next?

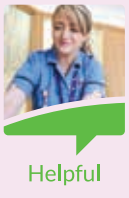
Chemotracker will be used in conjunction with Epic after go-live in April 2019, providing an ideal model to eventually develop in Epic itself.

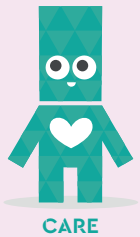
### How this benefits patients

- Reduced errors
- Reduced delays
- Nurses and doctors have access to specialist pharmacists on the ward at all times where they are best placed to help optimise patient care and support in the delivery of complex chemotherapy

**"It allows us as nurses to concentrate on the patients rather than needing to chase up where chemo is. We don't need to spend time calling to find out if chemo is ready and it is instantly visible to us. The pharmacist can update the tracker on the ward. Having the pharmacist around more on the ward means we can optimise patients' treatment better and resolve any queries much quicker."** Senior Staff Nurse Safari Day Care

**"It allows us as ward-based pharmacists to concentrate on being visible in ward areas, reducing the amount of time taken tracking prescriptions. It allows us to fully manage our patients' chemotherapy orders and reduce delays."** Specialist Haematology/Oncology Pharmacist



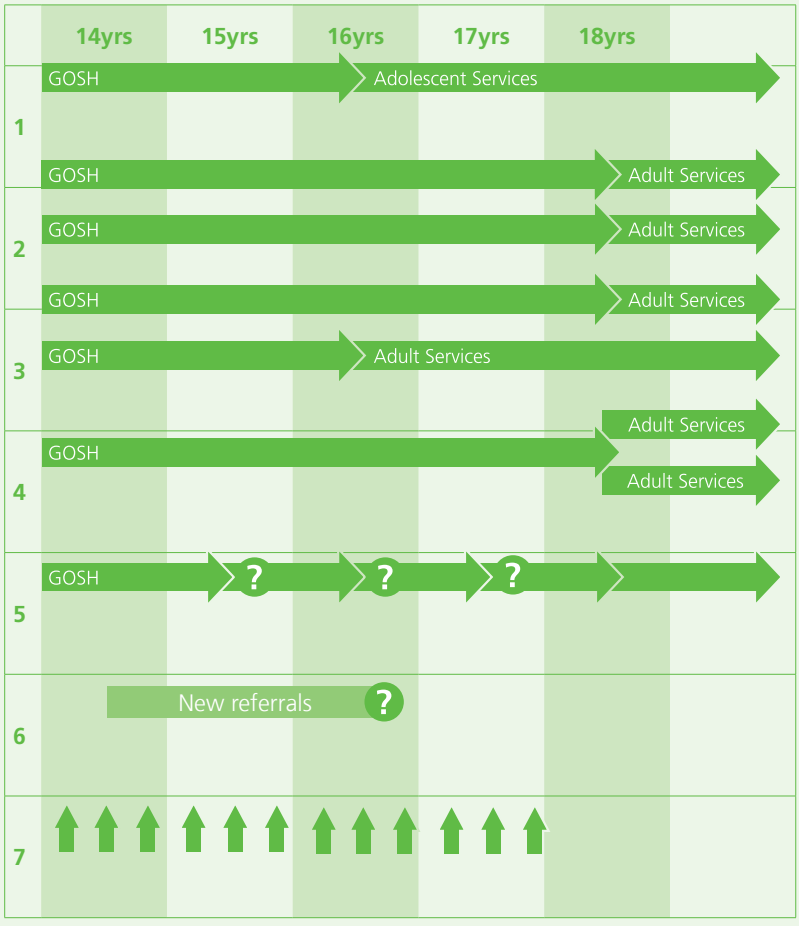
**Austin** is five years old. He's currently receiving treatment for Duchenne muscular dystrophy as part of a clinical research trial at GOSH. While at the hospital, he enjoys colouring with help from Play Worker Sian.

## Improving our young people's and their parents' and carers' experience of transition to adult services

The way young people and their families are prepared for the move from paediatric to adult health services has come under increasing scrutiny in recent years. NICE published the guidelines, *Transition from Children's to Adults' Services for Young People Using Health or Social Care Services* in 2016. One of the underlying principles in the guidelines is that young people should start to be prepared for adult health services (termed 'transition') by the age of 14 at the latest.

As a stand-alone paediatric hospital providing highly specialised care, this principle presents a challenge for GOSH. It is not always clear at this age whether transfer to specialist adult health services, and therefore transition, will be necessary. In addition, some young people move to dedicated adolescent services located in other Trusts. They encounter similar challenges as those who move straight to adult services (including different environments, procedures and personnel) and consequently have similar preparation needs. This is a situation unique to GOSH and is not addressed in the NICE Guidance.

Working jointly with young people and parents we developed the Growing Up, Gaining Independence (GUGI) framework at GOSH to enable us to both find solutions to the unique challenges our young people and their families face, and to comply with the NICE guidelines as closely as possible.




Variety of transition types and timings

### What is transition?

Transition is 'the purposeful, planned process of preparing young people under paediatric care and their families or carers for, and moving them to, adolescent- or adult-oriented healthcare'. GOSH, 2017, adapted from Blum et al, 1993[3].

### What is Pals?

The Patient Advice and Liaison Service (Pals) offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and carers, and are available in all NHS hospitals.

**The Growing Up Gaining Independence (GUGI) programme has been developed to:**

- Make all young people and their parents/carers aware of the skills and knowledge they need to engage with adult health care services
- Support the young person to develop these skills
- Prepare those who need to continue onto specialist adolescent or adult healthcare services

[3] Blum RW, Garell D, Hadgman CH et al. Transition from child-centred to adult health-care systems for adolescents with chronic conditions. A position paper of the Society for Adolescent Medicine. J Adol Health 1993: 14; 570-6.

## What we said we'd do

In last year's Quality Report, we said that in 2018/19, we would:

- Roll out the two part GUGI programme across the Trust and embed it as standard practice
- Start those older than 16 on GUGI Part Two, which is specifically designed to support those who will soon transfer into specialist adolescent or adult care from GOSH

## What we did

GUGI information folders are now available in all the clinic rooms in the Trust and on the Trust's internet. The information is also freely available on the external GOSH website[4] and on display outside the Patient Advice and Liaison (Pals) office. Information is available in a variety of formats including Easyread© for young people and parents with a learning disability.

Templates for GUGI part 2 information booklets are available, which teams can adapt as necessary. We are developing further supporting information in a variety of formats (written, audio and video). An additional project is underway with the GOSH Arts programme to produce a resource to help young people with the emotional impact of moving on from GOSH.

## What the data shows

A total of 21,899 (29%) of our patients were in the 12-19 age bracket in 2018/19. Not all of these patients will need to transition to specialist adult care but we recognise that the majority will need to engage with health services as adults. The numbers by each age are shown in the table below:

**1. Number of patients**

| Age | Number of patients |
|---|---|
| 12 | 3,991 |
| 13 | 4,162 |
| 14 | 4,051 |
| 15 | 3,860 |
| 16 | 2,989 |
| 17 | 1,915 |
| 18 | 669 |
| 19 | 262 |
| **Total** | **21,899** |

Another indication of volume is outpatient appointments. The table below shows the total number of appointments by age for people aged 12 -19 years in 2018/19.

**2. Number of appointments**

| Age | Number of patients |
|---|---|
| 12 | 12,228 |
| 13 | 12,696 |
| 14 | 12,129 |
| 15 | 11,790 |
| 16 | 8,942 |
| 17 | 5,561 |
| 18 | 1,519 |
| 19 | 550 |
| **Total** | **65,415** |

Anecdotal evidence so far suggests GUGI is making a positive difference by prompting young people and families to consider their independence preparation needs and making them aware of legal changes that occur at their 16th birthday. The launch of Epic is necessary for quantitative measures, such as number of transition plans in place two years prior to expected age of transfer.

## What's going to happen next?

The Clinical Nurse Specialist for Adolescent Health will continue the improvement programme and further develop and embed the GUGI framework, support teams to adapt resources, and ensure transition is an integral and early aspect of the care we provide to our young people.

We will undertake research and audit in 2019 to assess the impact of the GUGI framework on young people's preparation for the move to specialist adult care.

We have joined with other children's hospitals, including Alder Hey, Royal Manchester, Birmingham, Leeds, and Sheffield in a nurse-led National Transition Improvement Group to share challenges and good practice, make recommendations, and seek consistency of approach nationally where possible.

GOSH is also an active member of the National Transition Collaborative. Launching in May 2019, this joint NHS Improvement and NHS England initiative was established to help organisations develop their transition practices.

## How this benefits patients

- Helps promote young people's independence and helps them prepare for adulthood and for adult health services
- Provides practical advice for young people on how to prepare for clinic appointments and how to get the most out of them
- Makes families aware of health-related legal changes after the 16th birthday

**"Transition was always something that really scared me. I feel very fortunate that I have been able to help in the development of *Growing Up, Gaining Independence*. I really think this will give people a much smoother transition, make them better prepared and help to alleviate some of the fear."** Emma, 18

**"This has really opened my eyes – I simply hadn't thought about making sure my son knew how to make an appointment for himself. And I certainly didn't know he would be signing his own consent form once he is 16!"** Parent of 15 year old

**"Me and mum started talking about it on the train. Next appointment I want to go in and see the doctor on my own for a bit. And we're going to look at all my clinic letters when we get home. I didn't know you got sent a letter."** Ben, 13

Welcoming

INFORMATION

[4] gosh.nhs.uk/your-hospital-visit/growing-gaining-independence

## Implementing a system to receive patient, parent and carer feedback in real time

At GOSH, we think it is vital to use the feedback we get from children, young people and families to continually improve our services.

### What we said we'd do

We said that we would introduce new computer software to replace the Friends and Family Test (FFT) database that we developed in-house to initially implement the FFT here at GOSH. This would enable patients and families to enter feedback online, including via tablet or phone.

We wanted the new software to:

- expand the options for our patients and families in how they can enter feedback about their experiences
- enable us to act on feedback as quickly as possible, and ideally in 'real time'
- ensure tracking of any actions needed from feedback to ensure they are achieved in a timely manner
- enable central storage of all data received from the FFT (including paper cards)
- achieve streamlined reporting
- work alongside Epic
- reduce manual data input of feedback

We also wanted the software to be interactive to encourage children and young people to give feedback. None of the suppliers we reviewed met each of these requirements but one supplier was willing to work in partnership with GOSH to develop an interactive module for children and young people.

### What we did

We looked at companies that produce feedback software in the UK, North America and Canada. We also asked colleagues in North America and Canada for advice in integrating feedback software with Epic. After extensive evaluation, we selected a supplier at the end of 2017 that could deliver a reliable software solution and had the willingness and capability to work with us to develop new functionality. Work commenced on configuring the software to meet our needs in January 2018. The system was launched ahead of schedule on 5 June 2018.

### What the data shows

**15,000**

**the number of feedback comments received since we went live with the new software**

**271%**

**increase in the amount of feedback received online January to February 2019**

**11**

**the average number of days to respond to and resolve a negative comment received via a feedback card**

**2**

**the average number of days to respond to and resolve a negative comment received through the online system**

### What is the Friends and Family Test?

The Friends and Family Test (FFT) is a national patient feedback mechanism that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. FFT asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary questions, the FFT provides a mechanism to highlight both good and poor patient experience, to inform improvement.

## What's going to happen next?

Having implemented and rigorously tested the standard feedback software, we are now working with the software company and the GOSH Young People's Forum to develop an interactive surveying module. Our aim is to encourage more children and young people to tell us about their experiences at GOSH by providing an engaging and fun feedback module. This will initially be for children under eight years old, and will extend to other age groups in time.

We want our Heads of Nursing to manage the feedback for their areas of responsibility. The software allows customised dashboards for various job roles, which will give an overall impression of the feedback being received, but will also provide the facility to look deeper into specific issues. After this development, we will extend the dashboards to meet the needs of matrons and managers at all levels.

We will continue to promote the online feedback tool to give patients and families a range of feedback options. In addition to promotional materials, we are also aiming to send a link to the feedback page via a text message both in the reminder before an appointment and also afterwards.

## How this benefits patients

- Families can give us their feedback at any time that suits them
- Queries submitted online can be investigated and resolved quickly
- All feedback that requires action can be easily tracked and remains 'open' until resolution
- By analysing actions taken, themes for broader improvement can be identified and prioritised more effectively
- All feedback methods (cards and online) give respondents the option to record their disability, ethnicity and gender so that additional analysis can show whether experience varies as a result of these characteristics

### What is the Young People's Forum?

The Young People's Forum (YPF) is a group of young people aged 11 – 25 who are or have been patients, or siblings of patients, at GOSH. The mission of the YPF is to improve the experience of teenage patients at GOSH. The group meet formally six times a year, as well as participating in Trust projects and consultations, and meeting with the executive team and other key decision-makers.

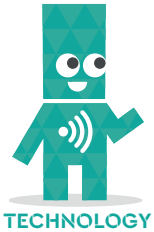
**We monitor the feedback and nominate members of staff for a GOSH Exceptional Member of Staff (GEMS) award. In March 2019, a Healthcare Assistant within our International Private Patients directorate has received a GEMS award as a result of the feedback received about her.**

A family were having problems contacting GOSH regarding their daughter's appointment. Action was taken by the Dermatology team and the child had an appointment booked the same day.

**"Thank you for your help. Although we were unhappy that we had to chase, we are very pleased with the outcome and quick response."**
Parent of dermatology patient

A parent wanted to pass on her thanks to the Learning Disability team:

**"From contacting the hospital to arrange support for our appointment to arriving on the day, I cannot praise [staff name] (who organised support) and [staff name] (who assisted on the day) enough. This service is a life saver to ourselves as parents and our son. To have someone by our side who understands and empathises with his needs is like a dream come true. We cannot thank you enough for this fabulous service."**

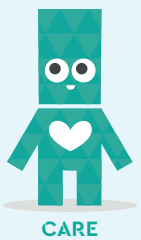



# Quality priorities for 2019/20

The following table provides details of three of the quality improvement projects that the Trust will undertake in 2019/20. These priorities were determined with input from staff, patients and their families, and commissioners. This input was sought through a range of mechanisms including a survey, consultation, and use of established meetings such as our Council of Governors, Young People's Forum, and Patient and Family Engagement and Experience Committee. The new quality improvement projects are in line with our strategic priority to provide the safest, most effective and efficient care, with the best possible outcomes.

## Safety

To eliminate avoidable harm.

| Improvement initiative | What does this mean and why is it important? | How will progress be monitored, measured and reported? |
|---|---|---|
| Implementing the Speak Up Programme<br><br>  <br>Expert<br><br>  <br> | GOSH is undertaking a transformational multi-year programme of work to build and sustain an outstanding culture of safety, reliability and openness.<br><br>The Speak Up Programme includes work undertaken with the Cognitive Institute and the Medical Protection Society UK, and involves us supporting our staff to take responsibility and be held accountable for behaviours and attitudes that create and build culture.<br><br>The programme includes `Speaking Up for Safety'™ and also encompasses NHS-wide work streams such as the Freedom to Speak Up Guardian and Ambassadors.<br><br>This is a Trust-wide programme focused on developing and sustaining a healthcare culture that enhances safety, reduces risk and promotes openness. | 1.Rate of incident reporting per 1000 bed days<br><br>2. Number of Serious Incidents reported<br><br>3. Percentage of staff who have witnessed errors, near misses or incidents that could hurt patients in the last month<br><br>4. Percentage of staff who reported the last error/near miss/incident seen that could hurt staff or patients<br><br>5. Number of staff who feel able to appropriately challenge where hand hygiene should have been performed<br><br>6. Number of grades 2, 3 and 4 pressure ulcers acquired in our hospital<br><br>Progress is monitored at monthly programme board. Reports are provided quarterly to Trust Board. |

## Clinical effectiveness

To consistently deliver excellent clinical outcomes, to help children with complex health needs fulfil their potential.

| Improvement initiative | What does this mean and why is it important? | How will progress be monitored, measured and reported? |
|---|---|---|
| Reducing the number of rejected samples for laboratory testing<br><br>  <br>One Team<br><br>  <br>INFORMATION | 70% of clinical decisions rely on laboratory test results. At GOSH, a high proportion of samples were rejected due to `pre-analytical' reasons - from sample collection methods and labelling through to transportation to the laboratory.<br><br>If a sample must be rejected, re-taking of the sample will often be needed. Consequences may include delay in diagnosis, treatment, and discharge, negative patient experience, and increased cost to the Trust.<br><br>This project is supported Trust-wide by stakeholders across the hospital. A real-time QI dashboard of measures displays sample rejection data as well as a table of reasons for rejections, so that the team can identify key aspects for improvement quickly. | 1. The number of rejected lab samples due to pre-analytical reasons<br><br>2. Percentage of blood cultures transported within 120 mins<br><br>3. Percentage of clotted anticoagulant tubes<br><br>4. Number of under-filled / insufficient samples<br><br>5. Percentage of rejected stool samples<br><br>Project progress is reported to and monitored at the Quality Improvement Committee. |

## Experience

To deliver kind and compassionate care, and communicate clearly to build confidence and ease.

| Improvement initiative | What does this mean and why is it important? | How will progress be monitored, measured and reported? |
|---|---|---|
| Implementing a system to receive patient, parent and carer feedback in real time<br><br>  <br>Helpful<br><br>  <br>TECHNOLOGY | Patients and their families told us that they would like to have choice in how they provide feedback to the Trust.<br><br>The online system allows families to give feedback at a time that suits them. In addition, this enables the Patient Experience Team to investigate and resolve any issues very quickly. By analysing the comments, themes for improvement can be identified and prioritised.<br><br>Children and young people have told us that they would be encouraged to feed back if the software was more interactive.<br><br>We will work with the system supplier and our Young People's Forum to develop the feedback software to encourage a higher percentage of online feedback from our patients. | 1. Number of feedback items received online and in paper form<br><br>2. Ongoing monitoring of the resolution time of negative comments<br><br>3. Number of feedback items we receive from our children and young people<br><br>Project progress will be reported and monitored at the Patient and Family Experience and Engagement Committee and the Quality, Safety and Experience Assurance Committee. |

**James**, is eleven months old and was diagnosed with Leukaemia on New Years' Day. He was rushed to GOSH when he was seven months old, here he is visiting Elephant Ward with Mum Faye.

# Part 2b:
# Statements of assurance from the Board

This section comprises the following statements:

- Review of our services
- Clinical audit
- Learning from deaths
- Participation in clinical research
- CQC registration
- Use of the CQUIN payment framework
- Data quality
- Priority clinical standards for seven-day hospital services
- Promoting safety by giving voice to concerns
- Reducing rota gaps for NHS doctors and dentists in training

## Review of our services

During 2018/19, GOSH provided and/or sub-contracted 62 relevant health services. The income generated by these services reviewed in 2018/19 represents 100 per cent of the total income generated from the provision of relevant services by GOSH for 2018/19. GOSH has reviewed all the data available to us on the quality of care in our 62 services.

In order to ensure that we maintain excellent service provision, we have internal processes to check that we meet our own quality standards and those set nationally. These processes include scrutiny by committee. One example is our Quality, Safety and Experience Assurance Committee, where there is a focus on improvements in quality, safety and patient experience. Assurance is provided through reports on compliance, risk, audit, safeguarding, clinical ethics, and performance. Patient stories are often presented to this forum and to the Trust Board.

As a matter of routine, key measures relating to the Trust's core business are presented to the Trust Board. These include measures of quality and safety, patient and referrer experience, and patient access to services.

The Trust's performance framework enables clinical divisions to regularly review their progress, to identify improvements and to provide the Trust Board with appropriate assurance. Our structure can respond to our improvement needs. For example, our recent NHS Staff Survey results have prompted the development of a comprehensive People Strategy and a new committee, the People and Education Assurance Committee to monitor its delivery.

# Clinical Audit

### Participation in national clinical audit

During 2018/19, 13 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 national audit / clinical outcome review programme | Cases submitted, as a percentage of the number of registered cases required |
|---|---|
| Cardiac arrhythmia (NICOR: National Institute for Cardiovascular Outcomes Research) | 162/162 (100%) |
| Congenital heart disease including paediatric cardiac surgery (NICOR: National Institute for Cardiovascular Outcomes Research) | 610/610 (100%) for surgical procedures<br>515/515 (100%) for catheters<br>18/18 (100%) for support procedures |
| Diabetes (Paediatric) (National Paediatric Diabetes Association) | 49/49 (100%) |
| Inflammatory Bowel Disease (IBD) Registry (British Society of Gastroenterology, The Royal College of Physicians, and Crohn's and Colitis UK via IBD Registry Ltd) | The IBD has 120 GOSH patients in the registry, and this is all eligible patients |
| Learning Disability Mortality Review Programme (LeDeR) | 6/6 (100%) |
| Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) | 17/17 (100%) |
| National Cardiac Arrest Audit (ICNARC: Intensive Care National Audit and Research Centre) | 11/11 (100%) |
| Use of Fresh Frozen Plasma and Cryoprecipitate in Neonates and Children (National Comparative Audit of Blood Transfusion Programme) | 21/21 (100%) |
| National Neurosurgical Audit Programme | Data is collected from mandatory national Hospital Episode Statistics |
| Seven Day Hospital Services Self-Assessment Survey (NHS England) | 10/10 (100%) |
| Paediatric Intensive Care Audit Network (PICANet) | 1896/1896 (100%) |
| Serious Hazards of Transfusion (SHOT) (UK National Haemovigilance Scheme) | 21/21 (100%) |
| UK Cystic Fibrosis Registry (Cystic Fibrosis Trust) | 191/191 (100%) |

**What is clinical audit?**

'Clinical audit is a way to find out if healthcare is being provided in line with standards, and lets care providers and patients know where their service is doing well and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients.'[5]

[5] www.england.nhs.uk/ourwork/qual-clin-lead/clinaudit/

### National clinical audit reports

The following national clinical audit reports with relevance to GOSH practice were published in 2018/19 from mandatory national audits:

| Name of national audit/clinical outcome review programme | Relevance to GOSH practice |
|---|---|
| Congenital heart disease including paediatric cardiac surgery (NICOR: National Institute for Cardiovascular Outcomes Research) | The 30-day survival rate for paediatric cardiac surgery is a nationally accepted benchmark that is used to judge outcomes. In the three years 2014 to 2017, there were 1885 cardiac operations performed at GOSH, of which 99.2% of patients survived to 30 days. The GOSH risk-adjusted survival rates for paediatric cardiac surgery are defined as 'much higher than predicted'. More information about this can be found on the Cardiothoracic clinical outcomes page[6] on the GOSH website. |
| Diabetes (Paediatric)<br><br>(National Paediatric Diabetes Association) | The 2017/2018 report focuses on measuring care for type 1 diabetes patients. GOSH does not have sufficient numbers of typical type 1 diabetes patients to allow comparison of performance. 18.7% of GOSH cases included in the audit have complex forms of Type 1 diabetes in comparison to 98.1% of standard Type 1 and Type 2 diabetes in other centres. 81.3% of GOSH cases included are rare forms of diabetes. |
| Inflammatory Bowel Disease Registry | No paediatric data has been published by the IBD Registry at the time of writing.<br><br>GOSH's Gastroenterology service participates in *Improve Care Now*, an international collaboration between paediatric gastroenterology centres. The collaboration benchmarks improvement in quality and monitors clinical outcomes for children with inflammatory bowel disease. As part of the *Improve Care Now* initiative, GOSH has routinely collected data since 2011 and monitors specific IBD outcome measures including disease remission rates, nutrition and growth for the children we treat.<br><br>More information about this can be found on the Gastroenterology clinical outcomes page[7] on the GOSH website. |
| National Cardiac Arrest Audit (NCAA)<br><br>(ICNARC (Intensive Care National Audit & Research Centre). | The NCCA 2017/18 audit report was published in 2018/19 and reports the incidence and outcome of in-hospital cardiac arrest in order to inform practice and policy. The annual audit report has been reviewed by Resuscitation Services.<br><br>The number of paediatric cardiac arrests nationally is approximately 250-300 per year.<br><br>The interpretation of the data for GOSH is:<br><br>• There were 24 in-hospital cardiac arrests in 2017/18.<br><br>• GOSH has a higher incidence of cardiac arrests per 1000 hospital admissions (0.6 per 1000) than the four other standalone paediatric centres who participate in NCCA. This data is not risk-adjusted, so it does not take into account the severity of illness.<br><br>• Overall data from NCAA since 2011 indicate that GOSH has an excellent rate of survival to discharge for patients who have had a cardiac arrest.<br><br>The actions that have been completed in the last year to support best practice in management of cardiac arrests were:<br><br>• Continued Clinical Emergency Team Simulation Training<br><br>• Re-organisation of the Clinical Emergency Team to improve efficiency and further embed quality cardiopulmonary resuscitation<br><br>• Increased numbers of resuscitation training places for all staff |

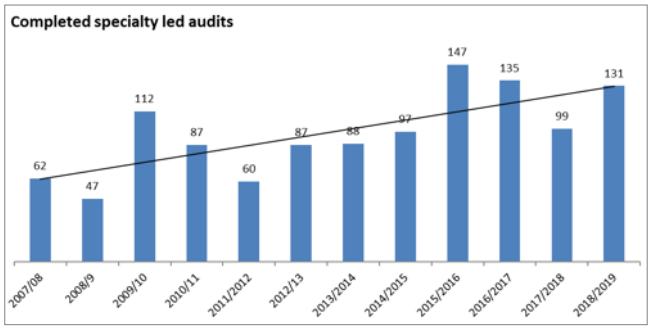
[6] www.gosh.nhs.uk/health-professionals/clinical-outcomes/cardiothoracic-clinical-outcomes
[7] www.gosh.nhs.uk/health-professionals/clinical-outcomes/gastroenterology-clinical-outcomes

| Name of national audit/clinical outcome review programme | Relevance to GOSH practice |
|---|---|
| Paediatric Intensive Care Audit Network<br><br>(PICANet) | The primary outcome measure used in Intensive Care Units (ICU) is the survival rate for patients, measured at the time when they are discharged. Raw survival/mortality rates may be challenging to interpret as patients admitted in a sicker condition are at greater risk, and therefore the outcomes need to be 'adjusted' to consider the level of severity of the patients in respect of case mix.<br><br>The most recent PICANET report compares Trusts' Standardised Mortality Ratio[8] for the calendar years of 2015-17.The data in this report shows GOSH mortality as well within the expected range, factoring case mix.<br><br>More information about this can be found on the Intensive Care Unit clinical outcomes page[9] on the GOSH website. |
| Cancer in Children, Teens and Young Adults: On the Right Course?<br><br>Child Health Clinical Outcome Review Programme (NCEPOD) | The Cancer in Children, Teens and Young Adults report identifies areas for improvement nationally in the care of children and young people who receive chemotherapy. A GOSH consultant is the national clinical lead for this study.<br><br>The recommendations in the report apply across care settings and care pathways. A GOSH Haematology/Oncology consultant is involved in the implementation of actions to achieve the recommendations with NHS England. |
| UK Cystic Fibrosis Registry (Cystic Fibrosis Trust) | The 2017 Cystic Fibrosis report was published in 2018/19 and includes data about individual cystic fibrosis centres, to help the centres benchmark themselves against their peers.<br><br>The data shows that GOSH results for key clinical outcomes are within the expected range. More information about this can be found on the Cystic Fibrosis clinical outcomes page[10] on the GOSH website. |

## Specialty-led clinical audit

131 clinical audits led by clinical staff were completed at GOSH during 2018/19. To promote the sharing of information, a summary of completed projects is published on the Trust's intranet and monthly reports of clinical audit activity are shared with the Patient Safety and Outcomes Committee.

Our long term data suggests we are encouraging a culture of sharing our specialty-led clinical audit activity.




A full list of clinical audits completed in 2018/19, and their impact on quality and safety at GOSH, can be obtained on request by contacting the Clinical Audit Manager on 020 7405 9200 ext 5892 or by emailing **clinical.audit@gosh.nhs.uk**.

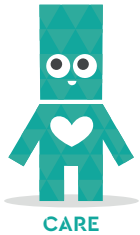
[8] Standardised Mortality Ratio (SMR)
The SMR is the ratio of observed deaths in the ICU compared to the expected number of deaths based upon the PIM2r score: the SMR is calculated periodically and is used as a method of benchmarking the outcomes between ICUs nationally via PICANet.
[9] www.gosh.nhs.uk/health-professionals/clinical-outcomes/intensive-care-unit-clinical-outcomes
[10] www.gosh.nhs.uk/health-professionals/clinical-outcomes/cystic-fibrosis-clinical-outcomes

## Clinical audit prize

The Clinical Audit team developed a clinical audit prize in 2018/19 to promote, value, and incentivise clinical audit in the Trust.

| 1 | 1 | 1 |
|---|---|---|
| **Dental and Maxillofacial**<br>Alveolar bone grafting in patients with a cleft lip and palate | **Kangaroo and Leopard Wards**<br>Ventilator prescriptions | **Urology**<br>Referral pathway for urodynamic requests |
| Audit highlighted excellent clinical outcomes.<br>*"This audit has demonstrated excellent treatment outcomes as well as effective and efficient patient care. As a department, we have learnt greatly from the audit results and will continue to persevere with maintaining and improving our current standards."* | Actions were taken to learn from incidents and to reduce risk. This is a nurse-led audit that resulted in clear improvements.<br>*"This has led to there being no clinical incidents surrounding ventilator prescriptions with inpatients. Nurses feel more empowered to be able to ask for a ventilator prescription if it is not present due to it being on the safety checklist. It is acknowledged amongst the medical team that every child on a ventilator must have a ventilator prescription and they have been more engaged in completing these as needed."* | Clear improvements were made to benefit patient experience and safety, and this audit 'closed the loop'.<br>*"We have achieved better resource utilisation and added multiple check-points, thus improving patient service and safety."* |

**"This idea of acknowledging audit work throughout the Trust is brilliant and am sure will encourage more good work."**
Urology Specialist Registrar

# Learning from deaths

Death in childhood is a rare event. Whenever a child dies, it is important to reflect and to learn if anything could be done differently in the future.

The GOSH Mortality Review Group (MRG) is a multidisciplinary group of senior clinicians that conducts routine, independent structured case record reviews of all deaths that occur at GOSH. The MRG has been in place since 2012.

The purpose of the MRG is to provide a Trust-level overview of all deaths to identify themes and risks, and take action as appropriate, to shape quality improvement activities in the Trust. This process is linked with local case reviews undertaken by specialty teams and provides an additional oversight of deaths in the Trust. The MRG reviews the patient care pathway to identify whether there are modifiable factors, and any learning for the Trust.

### Deaths in 2018 and case record reviews

| 2018 | Jan-Mar | Apr-Jun | Jul-Sep | Oct-Dec | Total |
|---|---|---|---|---|---|
| **Number of deaths** | 17 | 20 | 20 | 29 | **86** |
| **Modifiable factors** | 1 | 1 | 1 | 2 | **5** |

Between 1 January 2018 and 31 December 2018, 86 children died at GOSH. All of these deaths have been subject to a case record review as part of the investigative process of the MRG.

Five (5.8%) of the reviewed patient deaths had modifiable factors at GOSH that may have contributed to vulnerability, ill health or death.

No deaths in 2018 had modifiable factors at GOSH that provided a complete and sufficient explanation for death.

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- Five (5.8%) of the reviewed patient deaths had modifiable factors at GOSH that may have contributed to vulnerability, ill health or death. No deaths in 2018 had modifiable factors at GOSH that provided a complete and sufficient explanation for death.

*One death from 2017 was reported in the 2017/18 Quality Report as not being subject to a case record review, due to the case awaiting additional investigations before it could be reviewed. This case was reviewed in July 2018; no modifiable factors were identified

### Learning from clinical case reviews

The learning points from case record reviews are shared at the Patient Safety and Outcomes Committee, and at Trust Board. Modifiable factors identified outside of GOSH are shared with the Child Death Overview Panel (CDOP).

Where modifiable factors or other issues are identified about GOSH care, these are fed back to the relevant clinical team and/or directorate management team for action. The feedback mechanism will be determined based on the nature of the information to be shared, but could include a specialty case review meeting, email, and/or directorate management meeting.

Some key themes were identified, including the importance of clear communication between clinical teams, accurate documentation, and identification of the deteriorating patient in a timely manner.

In recognition of the Trust's commitment to promoting learning lessons from child deaths, a plan to enhance and embed the organisational learning culture has been agreed as a Trust Quality Priority for 2019/20. This includes the introduction of a forum that aggregates learning from a range of sources, including CDOPs. The forum will support timely operational action to:

- Address any immediate process/infrastructure problems
- Triage education and communication on lessons learned into the most appropriate pathways

It is anticipated that the introduction of the Epic EPR system in 2019/20 will help to improve the quality of the medical record and communication between clinicians.

A working group has been established to implement the Child Death Review Statutory Guidance, which aims to help strengthen links with referring hospitals and the CDOPs to identify modifiable factors to help prevent future deaths.

### What are modifiable factors?

Modifiable factors are defined as those factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

An influence score offers an interpretation of the extent to which a factor may have contributed to the death of the patient:
**0** – Information not available
**1** - No factors, or unlikely to have contributed to death
**2** - Factors may have contributed to vulnerability, ill health or death
**3** - Factors provide a complete and sufficient explanation for death.

### What is the Child Death Overview Panel (CDOP)?

The CDOPs are statutory bodies that review the deaths of all children who die in the UK. The death is reviewed by the CDOP where the child is resident, so GOSH liaises with multiple CDOPs.


## Participation in clinical research

As one of the leading children's research hospitals, children and young people are referred to GOSH from all over the world. They are often in need of treatment for the most complex and life threatening diseases. Working in partnership with the UCL Great Ormond Street Institute of Child Health (ICH), the hospital is the largest paediatric research and training centre in the UK and one of a very small number of internationally recognised centres of excellence in the field of child health.

The vision of GOSH as a research hospital is one where:

- Research is an integral part of the working lives of our staff and the patients and families we treat and see
- Research is fully integrated into every aspect of the hospital, to improve the treatment and outcomes for our patients
- We learn from every patient we see, using the knowledge gained to improve our patients' health and the health of future patients
- Staff, patients and families understand the opportunity and importance of research (research is seen to benefit and not compromise NHS clinical activity)
- We support, value and train all those involved in research, and research is considered as a core component when recruiting to leadership positions across the organisation
- We lead the way in involving patients and families in research design, delivery and strategy and continue to develop creative ways to ensure equitable involvement
- All clinical directorates and services develop and own their research agenda and are supported to do this.

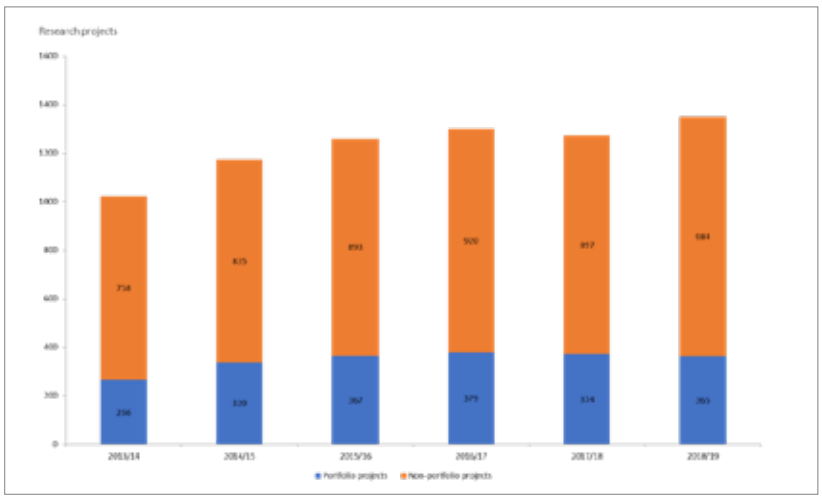
**Research activity**

During 2018/19, we have run 1,349 research projects at GOSH/ICH. Of these, 365 were adopted onto the National Institute for Health Research Clinical Research Network[11] (NIHR CRN) Portfolio, a prestigious network that facilitates research delivery across the NHS. Our already extensive research activity has grown with an ever increasing focus on high intensity, experimental research since our most recent NIHR Clinical Research Facility (CRF) and Biomedical Research Centre (BRC) awards began in April 2017. These studies account for over 40% of those supported by the CRF but for 65% of the total patient hours. The intensity of care in delivering these studies in paediatrics translates into increased clinical time to deliver each study, often requiring regular overnight visits.

[11]www.nihr.ac.uk/research-and-impact/nihr-clinical-research-network-portfolio/

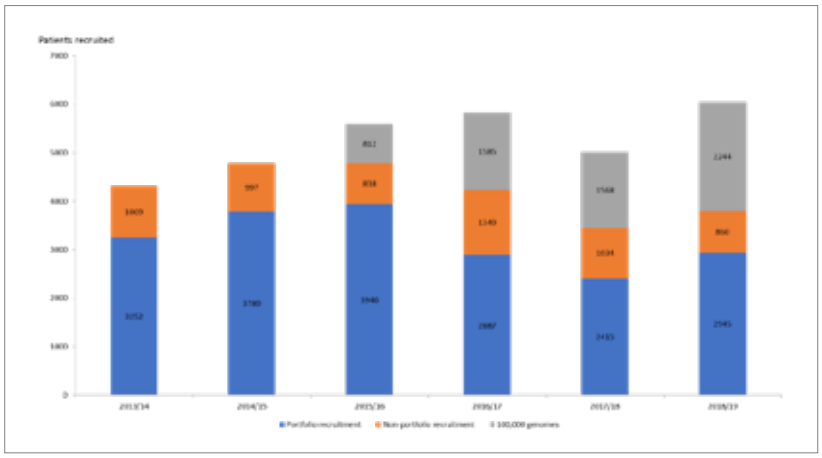
**Lacey** is 13 years old, but she's been coming to GOSH since she was a baby. Because she was born without intestines, she's had to have many procedures to help her absorb nutrients.

## Figure 1. Number of research projects taking place at GOSH/ICH, highlighting the high quality NIHR CRN Portfolio projects




In 2018/19, over 3,800 patients and family members took part in research at GOSH, approved by the Health Research Authority, including Research Ethics Committee and Medicines and Healthcare Products Regulatory Agency approval as appropriate. In addition, GOSH leads the North Thames Genomic Medicine Centre[12] (GMC), one of 13 regional centres that are responsible for coordinating the return of results for patients that were recruited to the 100,000 Genomes Project. This pioneering project aims to better understand and treat rare conditions and cancers and this year completed its recruitment phase. Over 23,000 genomes have been collected by the North Thames GMC (23% of all genomes collected nationally) including 5,674 rare disease and 296 cancer genomes collected at GOSH (2,244 in 2018/19). Across the North Thames GMC, we have completed the scientific analysis of over 1,200 reports for patients with rare disease (and their families) and over 500 reports for patients with cancer.

## Figure 2. Number of research participants recruited at GOSH/ICH, highlighting the high quality NIHR CRN Portfolio projects and those recruited to the 100,000 genomes project




The Trust is making considerable progress against its objective to obtain generic consent from patients, allowing us to use clinical data and excess tissue for research. The pilot completed its initial outpatient phase in September 2017, moving to the next phase (inpatients) in July 2018, with further areas beginning to consent in 2019. The pilot phase indicated that the principle for generic consent was generally accepted by patients and families but indicated the need for face-to-face discussion about the scheme. To assist our teams with this communication, the Trust has commissioned a short animation to explain to patients what happens to their samples, with input from both our Young Person's Advisory Group and Parent/Carer Research Advisory Group.

### What is a genome?

A genome is the complete set of genetic material present in a cell or organism. The study of genomes is called genomics.

[12] www.ntgmc.nhs.uk/

## Funding

This year we saw an overall 25% growth in our research income to £25 million, which supports research infrastructure and projects across the Trust. This has been in part due to a higher than anticipated growth in commercial income of 13%, through attracting an increased number and value of commercial studies to the Trust as well as extensive work to improve the effectiveness of commercial income recovery. 2018/19 was the second (out of five) year of our third funding term of the NIHR GOSH Biomedical Research Centre (BRC) and of our new NIHR Clinical Research Facility.

## Innovation

The Trust has established a GOSH Innovation Hub and an intellectual property (IP) oversight group to review our IP portfolio and make strategic recommendations to the Research and Innovation (R&I) Board for support of innovation with commercial potential. The Trust has a robust IP policy that supports the Trust's objective to encourage the creation and successful commercialisation of innovation by GOSH employees, ensuring that GOSH effectively manages its IP and that revenue share arrangements to incentivise employees are transparent and well-managed. The Trust works with third party organisations with appropriate expertise, for example technology transfer offices to support its innovation activities, including commercialisation of IP.

A dedicated Business Development Manager based within the Division of R&I enables regular on-site access to our university partner and facilitates shared learning in the translational research space.

The Trust launched the Digital Research Informatics & Virtual Environment[13] (DRIVE) in October 2018; a partnership with University College London (UCL) and leading industry experts in technology, artificial intelligence and digital innovation. The unit aims to revolutionise clinical practice and transform patient experience with new approaches to research and tailored care. This will be enhanced following the implementation of Epic, which has a specific research work stream with input from across R&I. This will allow much greater alignment across research and clinical practice, with clinical data extracted into the Trust's Digital Research Environment, linked to a high-performance analytical platform in collaboration with Aridhia.

## Journal Publications

With our academic partner, we publish over 1,000 papers a year; 700 from 1 April to 31 December 2018. In the five year period between 2012 and 2016, GOSH and ICH research papers together had the second highest citation impact of comparable international paediatric organisations.

## Research Highlights

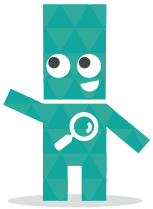
**1** A new, targeted treatment for a rare genetic form of rickets called X-Linked Hypophosphataemia (XLH) became available to NHS patients in January 2019, just three and a half years after the clinical trial first started. The new drug, known as burosumab, is the first to specifically target the root cause of the condition. In the trial, which recruited several GOSH patients, children experienced less pain and showed improved growth rates.

**2** GOSH and ICH researchers developed a sophisticated rapid genome sequencing technique that has helped quickly diagnose GOSH patients in intensive care. Results can be returned within four days. This enables doctors to make quicker decisions about treatment pathways and provide families with a diagnosis. It also reduces the time children have to spend in hospital and delivers savings by reducing the length of stays in our intensive care units.

**3** Following the success of the cell therapy research programme at GOSH and ICH, GOSH recently became one of only three UK hospitals commissioned to offer a cutting edge CAR-T cell therapy to NHS patients with acute lymphoblastic leukaemia. The first NHS patient was treated with the therapy, known as Kymriah, in January 2019.

**4** GOSH researchers grew the world's first oesophagus engineered from stem cells and successfully transplanted them into mice. Within a week the engineered tissue developed its own blood supply. It is hoped this research could pave the way for clinical trials of lab-grown food pipes for children with congenital and acquired gut conditions such as oesophageal atresia.

In the five year period 2012-2016, GOSH and ICH research papers together had the second highest citation impact[14] of comparable international paediatric organisations.





[13] www.gosh.nhs.uk/news/latest-press-releases/new-unit-opening-great-ormond-street-hospital-set-revolutionise-how-technology-used-hospitals

[14] GOSH citation impact = 1.997. The average citation impact is calculated from the number of citations for reviews and original papers normalised for research field and year of publication

### Supporting nurses and allied health professionals in research activity

GOSH also hosts one of the few centres dedicated to supporting nurses and allied health professionals in research activity: The Centre for Outcomes and Experiences Research in Children's Health, Illness and Disability (ORCHID). Professor Faith Gibson, Director of Research – Nursing and Allied Health, leads this centre, who along with Dr Kate Oulton, Dr Debbie Sell and Associate Professor Jo Wray, provides leadership to the Research and Clinical Academic Faculties within ORCHID.

This year has been another successful year with increased research and engagement activity, awards and capacity building as our team goes from strength to strength. Two of our allied health professionals (AHPs) were awarded prestigious Clinical Doctoral Fellowships from the National Institute for Health Research (NIHR). Speech and Language Therapist Alex Stewart and Physiotherapist Emma Shkurka will start their PhD studies in the summer, bringing our total number of NIHR funded Fellowships to seven, one of the highest of any NHS Trust in the country. One of our senior team members, Dr Kate Oulton, was awarded a place on the NIHR 70@70 Research Leadership Programme, for senior nurse/midwife clinical leaders with a record of developing existing practice and contributing to a research-rich environment. Furthermore, in conjunction with the Parent Support Group (the Cleft Lip and Palate Association, Ireland) the PLAT project, co-led by Dr Debbie Sell, which empowers parents to improve their child's speech at home, received the Social Entrepreneurs Award, Ireland.

Our research collaborations are far-reaching. In conjunction with the GOSH Biomedical Research Centre, we held a Clinical Academic Careers training weekend for 35 nurses/AHPs from 10 organisations across London and are in the process of establishing a Pan-London support network. The Heart of the Matter[13], a Wellcome Trust funded public engagement project, co-led by Associate Professor Jo Wray, culminated in an exhibition visited by more than 20,000 people across the country. Professor Faith Gibson leads a workstream within the NIHR funded study BRIGHTLIGHT[14]. Part of this work involved working with young people and a theatre company to co-produce a piece of performance art, 'There is a Light', performed to approximately 1600 people, with national and international coverage.

## CQC registration

GOSH is required to register with the CQC and is currently registered, without conditions, as a provider of acute healthcare services. GOSH has not participated in any special reviews or investigations by the CQC in 2018/19.

In January 2018, the Trust obtained a CQC rating of 'Good' overall following an unannounced inspection of two (surgery and outpatients) out of the eight core services provided at GOSH. An additional unannounced inspection for the Well Led aspect was also conducted in the same period. The report was published in April 2018.

An action plan has been developed for 2019/20 that focuses on areas that received ratings of 'Requires Improvement'. Oversight of progress against the actions is monitored through the directorates, and assurance is provided to the Board and Council of Governors. Executive directors and operational managers have been identified to respectively hold accountability and responsibility for achieving compliance with each element of the CQC registration standards. The Trust has commenced a programme of work to ensure overall compliance that is interlinked with quality, safety and experience as part of day-to-day culture across the Trust. This will be delivered through established programmes including:

- Weekly steering groups with Deputy Chiefs of Service
- In depth mock inspections (CQC Quality Rounds) in clinical directorates
- Directorate led self-assessments
- An assurance framework to provide sight of compliance performance from ward to board
- Gap analysis of information undertaken for the Routine Provider Information Return
- Reviews of potential areas/sources of learning, such as review of themes from CQC inspection and insight reports

Read more about our work on Well Led in our 2018/19 Annual Report.

**What is CQC?**

The Care Quality Commission (CQC) is the independent healthcare regulator for England and is responsible for inspecting services to ensure they meet fundamental standards of quality and safety.

[13] www.insidetheheart.org
[14] www.brightlightstudy.com/

## Use of the CQUIN payment framework

A variety of CQUINs have been undertaken by the Trust in 2018/19. Some of these are national indicators, which may also be undertaken by other trusts across the country, and some were locally defined in order to improve our individual performance. Due to the specialist nature of our care, some of the national CQUINs needed to be adapted to fit with the services we provide for our patients.

| CQUIN Reporting 2018/19 | |
|---|---|
| **CQUIN title** | **Overview** |
| Anti-Microbial Resistance/Sepsis | The aim of the project is to improve the timeliness of both identification and treatment of sepsis, as well as reducing inappropriate antibiotic usage within the Trust. |
| Child and Adolescent Mental Health Services – Long-Term Conditions | The aim is to establish screening and provision of mental health services for specialised paediatric inpatients with a chronic and severely disabling medical condition. |
| Cardiac Devices | This scheme seeks to ensure that device selection for patients remains consistent with the commissioning policy, service specification, and relevant NICE guidance. It also aims to ensure that contractual requirements are in place for providers while new national procurement and supply chain arrangements are embedded. |
| Critical Care - Paediatric Networked Care | This scheme aligns with the national Paediatric Intensive Care Service Review. It aims to gather information that allows the demand across the whole paediatric critical care pathway to be considered. |
| Haemtrack | This scheme intends to improve adherence, timeliness, and accuracy of patient data submissions to the Haemtrack patient reporting system. |
| Medicines Optimisation | This CQUIN scheme aims to support the procedural and cultural changes required to optimise use of medicines commissioned by specialised services. A number of priority areas for implementation have been identified nationally by clinical leaders, commissioners, Trusts, the Carter Review and the National Audit Office. |
| Neuroscience Network | The scheme aims to support the development of the North Thames Neurosciences Paediatric Network. |
| Enhanced Supportive Care | This scheme aims to better integrate the work of the disease-specific Clinical Nurse Specialists and Advanced Nurse Practitioners with the Paediatric Oncology Outreach Nurses in the Palliative Care Team. The aim is to review the cancer clinical pathways and identify where it would be expected for Palliative Care to be involved. |
| Severe Asthma | The Severe Asthma scheme aims to ensure that assessment and investigation of children with difficult-to-control asthma is completed within 12 weeks of referral. This is so that all eligible children have appropriate and timely intervention in order to improve asthma control, reduce hospital admissions and avoid inappropriate escalation of therapy including the initiation of expensive monoclonal antibodies. |
| Transition Planning | The aim is to increase the number of transition plans for young people aged 13 years and above that will be used across the Trust. |
| Univentricular Home Monitoring | This scheme involves implementation of home monitoring programmes for children following palliative cardiac surgery for patients with a primary diagnosis of: hypoplastic left heart syndrome, functionally univentricular heart or pulmonary atresia with intact ventricular septum. Collectively, these conditions are referred to as univentricular hearts or univentricular circulations. |

In 18/19 (as in 17/18), the total financial allocation for CQUINs was set at 2% of GOSH's NHS income (activity only). This equates to £4.9m for the 18/19 financial year. However, this value includes the Clinical Utilisation Review CQUIN, in which the Trust declined to participate (total value of £1.07m). The value of the individual CQUINs for the Trust ranged from £750,000 for Medicines Optimisation to £175,000 for Complex Device Optimisation. During Q1 to Q3 of the financial year, we reported high compliance against all our CQUIN indicator milestones. We expect to report approximately 98% compliance at year end. In 2017/18, our final monetary total for the CQUIN payment was £4 million.

## Data quality

Good quality data is crucial to the delivery of effective and safe patient care. Data is vital to enable us to run our services efficiently as well as to identify any care quality issues and predict trends in order to take early action.

In March 2018, the Data Quality Review group signed off an updated data quality action plan, which focused on the improvement work needed during progression towards going live with the Epic system in April 2019. A monthly EPR Existing Systems, Data and Reporting Readiness Group supports data quality improvement work and planning across the programme to ensure the Trust's position is robust in moving forward with Epic.

Highlights of the work completed in 2018/19 include:

**Information Services**

- Information Services reporting tools to support returns and internal monitoring dashboards
- Completion of the data warehouse audit
- Data warehouse standards have been defined
- Clear implementation of soft and hard stops for incomplete data and data entered outside of expected values where poor data quality affects reporting
- Establishment of multi-dimensional and comprehensive live data quality dashboard within the EPR system to flag data quality errors that drill down to patient level across the patient journey - referral, pathways, waiting list, outpatient and inpatient activities and patient demographics

**Data assurance**

- All members of the Data Assurance Team are trained as EPR super users within the key modules to support the EPR go-live period
- Links to training content and standard operating procedures (SOPs) are embedded within the EPR learning home dashboard and on the intranet
- Weekly and monthly targeted data quality training for front line users based on information from the data quality dashboard
- Establishment of data assurance audit methodology signed off by the Data Quality Review Group in September 2018
- Full validation of clock start information for all tertiary referrals received by the Trust means we now report less than 3% unknown clock starts as part of our referral-to-treatment pathway (RTT) data submissions
- Re-launch of RTT training in April 2018 and delivery of data quality principles as part of the course contents. We have now trained 97% of our core users
- Data Quality Review Group commissioned patient demographics training across the Trust in August 2018 to support data migration. We have trained 156 staff (September 2018 to January 2019). Patient demographics training content is now incorporated into EPR training materials and SOPs.

We have made good progress to improve our data quality to date, and work continues within the EPR project build to ensure safeguards are in place to minimise data quality risks.

The focus for 2019/20 is to continue to support front line staff on data quality in Epic and to ensure our clinical operational teams have access to timely and reliable information that will support business processes and decision making.


### What is data quality?

Data quality refers to the tools and processes that result in the creation of accurate, complete and valid data that is required to support sound decision making.

### What is an NHS Number?

Everyone registered with the NHS in England and Wales has their own NHS number, a unique 10-digit number that helps healthcare staff to find a patient's health records. The NHS number increasingly helps to identify the same patient between organisations and different areas of the country.

### What is the Secondary Uses Service?

Everyone registered with the NHS in England and Wales has their own NHS number, a unique 10-digit number that helps healthcare staff to find a patient's health records. The NHS number increasingly helps to identify the same patient between organisations and different areas of the country.

### What is NHS Digital?

NHS Digital is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.

**Secondary Uses Service**
As required by NHS Digital, GOSH submitted records during 2018/19 to the Secondary Uses Service (SUS) for inclusion in the national Hospital Episode Statistics. These are included in the latest published data.

The table below shows key data quality performance indicators within the records submitted to SUS.

| Indicator | Patient group | Trust score | Average national score |
|---|---|---|---|
| Inclusion of patient's valid NHS number | Inpatients | 92.7% | 99.4% |
| | Outpatients | 93.8% | 99.5% |
| Inclusion of patient's valid General Practitioner Registration Code | Inpatients | 99.5% | 99.9% |
| | Outpatients | 99.8% | 99.8% |

Notes:

- The table reflects data from January 2019 at month 10 SUS inclusion date.
- Nationally published figures include our international private patients, who are not assigned an NHS number. Therefore the published figures are consequently lower at 92.7% for inpatients and 93.8% for outpatients.
- Figures for accident and emergency care are not applicable as the Trust does not provide this service.

**Information governance**
The Trust is in the process of finalising its first submission against the re-launched Information Governance Toolkit, the Data Security and Protection Toolkit (DSPT). This new system will allow us to demonstrate our position against the General Data Protection Regulations (GDPR) 2018 and outline the key requirements to maintain status as a `Trusted Organisation' with regards to sharing NHS data.

While compliant with the mandatory requirements, some areas of improvement have been identified and an action plan is underway. Actions include:

- updating and embedding the process for accessing the privacy risks of proposed new uses of personal information (Data Protection Impact Assessments)
- ensuring the Trust has an accurate and up-to-date list of all personal information it holds and a review of the arrangements and checks for sharing personal information with external suppliers

**Clinical coding**
GOSH has a dedicated and highly skilled clinical coding team, which continues to maintain high standards of inpatient coding. The depth of coding continues to sit above the national average due to the complexity of our patients.

GOSH carries out quarterly internal specialty audits to ensure that accuracy and quality are maintained, that national standards are adhered to, and any training needs are identified.

The recent 2018/19 audit for the Data Security & Protection Toolkit (DSPT) showed results of over 98% accuracy for primary diagnostic coding, and 95% for primary procedure coding.

GOSH was not subject to a national Payment by Results clinical coding audit during the 2018/19 reporting period.

## Priority clinical standards for seven-day hospital services

The seven-day services programme is designed to ensure patients that are admitted as an emergency receive high quality consistent care, whatever day they enter hospital.

GOSH does not have an accident and emergency department and therefore our 'emergency' workload relates to non-elective patients admitted directly from other hospitals into our critical care units.

For these unplanned critical care admissions, we participate in the NHS England seven-day service audit and self-assessment framework. The audit measures whether patients admitted as an emergency are seen by a consultant within 14 hours of arrival, and whether patients are subsequently seen twice daily by a consultant. Our audit data for 2018/19 shows that we meet all required clinical standards.

**Vinnie**, who's two and a half, had surgery at GOSH earlier this year to remove a tumour from his brain. Since his operation, the physio team have been working with Vinnie to help him regain his balance and walk again. He loves playing with Lego™ and getting involved in music sessions in the playroom.

# Promoting safety by giving voice to concerns

## Speak Up Programme

One of GOSH's key priorities is to eliminate avoidable harm to patients in our hospital. In the coming year, we are launching two new initiatives to support our work on harm-free care.

**1. Speaking Up for Safety™ workshop**
A focused workshop is being delivered across the organisation to equip, empower and support every one of our staff to 'Speak Up for Safety'. The objective of the workshop is to develop staff insight and skills to respectfully raise issues with colleagues when concerned about a patient's safety. In conjunction with the Medical Protection Society, we have trained and accredited 22 internal Safety Champions to support the programme and deliver the workshops to all staff across the Trust. Once complete, the workshop content will become part of Trust induction for all new staff, so the knowledge in our workforce is embedded and sustained in a culture of safety.

**2. Promoting Professional Accountability™**
At all times, we aim to provide a considerate and respectful environment for our staff and patients. To assist us in doing this, we will be introducing the Promoting Professional Accountability programme. Promoting Professional Accountability works hand-in-hand with the Speaking Up for Safety message. It provides a platform for staff to give feedback on colleagues who have either championed or undermined our Trust values, to ensure that great team working is recognised and difficult behaviours are discouraged.

## Supporting staff to speak up

Being able to speak up about a concern in the workplace is an essential part of providing safe care for children and young people at GOSH. In line with other hospitals across the country, we have established a Guardian for the Freedom to Speak Up. This role is in conjunction with Freedom to Speak up Ambassadors, who work with the Guardian to provide support to any staff member across the hospital who wishes to raise a concern.

Support may be needed where a staff member wants to raise a concern about safety but doesn't know how, or doesn't feel comfortable to do so, or where a concern has been raised locally but the staff member feels it has not been taken seriously. The Freedom to Speak Up roles provide this additional layer of support to ensure that concerns are heard, explored, and any actions identified and acted upon.

## Whistleblowing protection

Most issues raised by employees are easily resolved. However, there are times when concerns are of a more serious nature. The Trust has a policy that has recently been updated in line with national guidance, which provides a clear and easily accessible route for raising these types of concerns known as qualifying disclosures (also known as whistleblowing concerns). The policy also outlines a range of people who employees can raise concerns with even if they don't fall under the definition of a whistleblowing concern, including the Freedom to Speak Up Guardians and Speaking Up for Safety™. The overarching aim of the policy is to demonstrate the Trust's commitment to openness and accountability through:

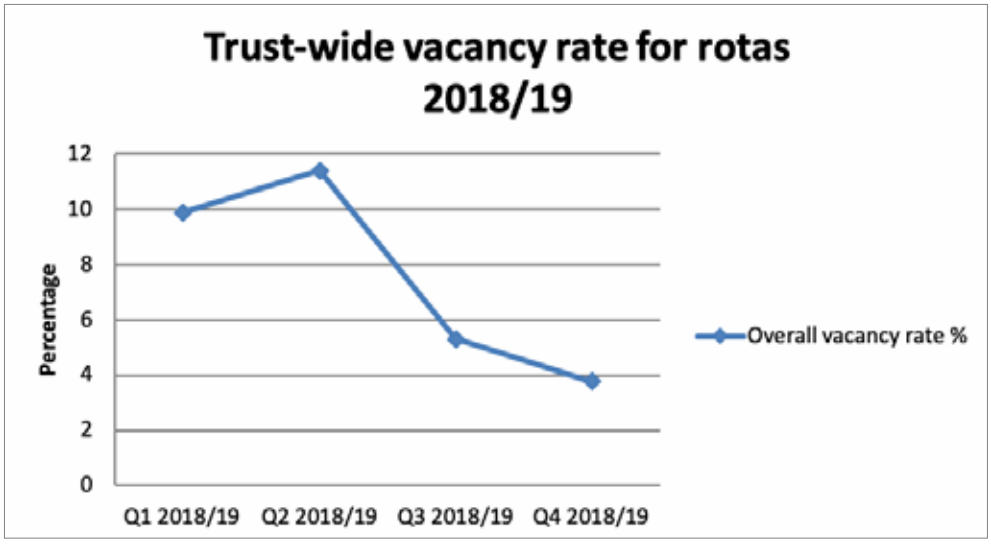
- The provision of a safe environment to raise concerns at work
- Reassurance of employees that it's safe and acceptable to speak up
- Reassurance of employees that they can raise a concern at an early stage and with clarity about the process

## Reducing rota gaps for NHS doctors and dentists in training

Vacancy rates and rota gaps are a constant area of change within the organisation. They reflect the end point of multiple workforce issues, including short term unplanned absence, delays in recruitment process and rotational pathways, alongside a national reduction in the medical paediatric workforce.

Rota gaps have been highlighted as an organisational pressure and measures are being taken to mitigate the situation at GOSH. The Modernising Medical Workforce Group has been established through the Medical Director's Office in direct response to the issues impacting the medical workforce at local and national level. The group is designed to assist the Board and Executive Team in the recruitment, support and retention of doctors, with a focus on the sustainability of the medical workforce. The goal of the group is to problem-solve and think innovatively about the Trust-wide challenges facing the medical workforce. Rota gap pressures for our junior doctors is a particular focus.

We have become aware of the requirement for centralised 'real time' continuous data collection regarding vacancy rates that reflect rota gaps. Therefore we are currently developing a mechanism to capture this data to ensure that there is consideration to both the immediate and medium term impact of rota gaps across the organisation. In parallel to this, we are creating a clear plan for the escalation process to support doctors on rotas that have short-and medium-term vacancies. Below are 2018/19 vacancy rates, by end-of-quarter census across the organisation.




It is our experience that the impact of rota gaps is specific to each department and is dependent upon multiple factors including the number of doctors available in day-time hours, the use of advanced clinical practice roles and the overall rota establishment. Although the average organisational vacancy rate percentage is a useful metric, we currently anticipate and consider the direct impact of rota gaps upon each department, with a review of medical work flow and work schedules when necessary.

**Maxwell**, is three years old. He has a Berlin Heart and has been on the transplant list since 2018. He loves football (like his dad!) and playing with the little kitchen in the GOSH playroom.

# Part 2c:
# Reporting against core indicators

## Performance against Department of Health and Social Care quality indicators

NHS trusts are subject to national indicators that enable the DHSC and other institutions to compare and benchmark trusts. Trusts are required to report against the indicators that are relevant to them. The table below shows the indicators that GOSH reports against on a quarterly basis to our Trust Board and also externally. Where national data is available for comparison, it is included in the table.

| Indicator | From local trust data | | | From national sources | | | | GOSH considers that this data is as described for the following reasons: | GOSH intends to take the following actions to improve this score, and so the quality of its services, by: |
|---|---|---|---|---|---|---|---|---|---|
| | 2018 | 2017 | 2016 | Most recent results for Trust | Best results nationally | Worst results nationally | National average | | |
| | | | | Source: NHS Staff Survey<br>Time period: 2018 calendar year | | | | | |
| The percentage of staff who would be happy with the standard of care provided by the organisation if a friend or relative needed treatment. | 88.2% | 86.1% | 90.4% | 88.2% | 94.8% | 77.5% | 89.7% | The survey is carried out under the auspices of the DHSC, using their analytical processes. GOSH is compared with other acute specialist trusts in England. | The key actions associated with addressing staff survey findings will be incorporated into the Integrated People Strategy – with its four pillars; Capacity, Infrastructure, Skills and Culture & Engagement.<br>The survey results indicate the need to prioritise the Culture & Engagement pillar. This workstream's purpose is to ensure all our people feel well led and managed, but also supported and empowered to do and be their best.<br>The key components of this pillar are: Visible Leadership, Corporate Strategy & Narrative, Creating an Employee Voice, Living Our Values, Creating Transparency & Promoting Dialogue, and Integrating Support Services & Networks. These are underpinned by Training & Development and Internal Communications. |
| Percentage of staff who agreed that care of patients is the organisation's top priority | 84.2% | 82% | 88% | 84.2% | 92.7% | 76.9% | 75.5% | | |
| Percentage of staff saying they experienced at least one incident of bullying, harassment or abuse at work from managers in last 12 months | 17.2% | 17.1% | 14.6% | 17.2% | 3.3% | 27.2% | 13.1% | | |
| Percentage of staff saying they experienced at least one incident of bullying, harassment or abuse at work from other colleagues in last 12 months | 22.1% | 20.8% | 18.6% | 22.1% | 10.3% | 28.4% | 18.7% | | |
| Percentage of staff who consider the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age | 78.8% | 81.3% | 84.6% | 78.8% | 94.3% | 60.8% | 83.4% | | |

| Indicator | From local trust data | | | From national sources | | | | GOSH considers that this data is as described for the following reasons: | GOSH intends to take the following actions to improve this score, and so the quality of its services, by: |
|---|---|---|---|---|---|---|---|---|---|
| | 2018/19 | 2017/18 | 2016/17 | Most recent results for Trust | Best results nationally | Worst results nationally | National average | | |
| Friends and Family Test (FFT) - % of responses (inpatient) | 18.9% | 24.6% | 23.8% | 18.9% | 37.3% | 12.4% | 24.5% (mean) | The rates are from NHS England<br><br>Time period:2018/19 financial year<br><br>Comparing: paediatric trusts* | We are promoting FFT at ward level, so every family is aware they can provide feedback and how. We advertise the online feedback on our weekly Feedback Friday slot on the @GreatOrmondSt Twitter feed, along with the feedback page link. Interactive feedback functions are being developed to encourage our children and young people to complete the FFT. |
| FFT - % of respondents who recommend the Trust (inpatient) | 96.7% | 97.1% | 98% | 96.7% | 98% | 93% | 96.5% (mean) | | |
| *Children's hospitals: Alder Hey; Birmingham; Bristol Royal; Evelina; GOSH; Leeds; Nottingham; The Alex; Royal Manchester; Southampton; The Great North | | | | | | | | | |
| Number of clostridium difficile (C.difficile) in patients aged two and over | 6 | 11 | 1 | 11 | 1 | 11 | 4.7 (mean) | The rates are from Public Health England.<br><br>Time period: 2017/18 financial year<br><br>Comparing: Stand-alone paediatric trusts† | Continuing to test stool samples for the presence of C.difficile, investigate all positive cases, implement isolation precautions and monitor appropriateness of antimicrobial use across the organisation. |
| Rate of C.difficile in patients aged 2 and over (number of hospital acquired infections/ 100,000 bed days) | 10.3 | 18.8 | 1.79 | 12.6* | 1.4 | 12.6 | 6.3 (mean) | | |
| Note: C.difficile colonisation is common in children and, while severe disease may occur at any age, it is rare. At GOSH, we test for C.difficile toxin in all diarrhoeal stool that 'conforms to the shape of the pot' (minimal national standard), as well as other stool where diarrhoea, fever or blood in stool was reported; where a request is made for enteric viruses; and as part of the surveillance programme in children with congenital immunodeficiency and undergoing bone marrow transplants. On agreement with our commissioners, we investigate all positive detections and report to Public Health England those aged 2 and above with diarrhoea (or a history of diarrhoea) where no other cause is present or, if another possible cause is present, clinical opinion led to treatment as a possible case. We report on the Healthcare Acquired Infection database according to a locally agreed paediatric modification of the national definition, to enable year-on-year comparison in our specialist trust. Our approach means we find more positive samples compared with the number of cases that we report.<br>* National report used estimated bed days at time of reporting. † www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data. | | | | | | | | | |

| Indicator | From local trust data | | | GOSH considers that this data is as described for the following reasons: | GOSH intends to take the following actions to improve this score, and so the quality of its services, by: |
|---|---|---|---|---|---|
| | 2018/19 | 2017/18 | 2016/17 | | |
| **Patient safety incidents reported to the National Reporting and Learning System (NRLS):** | | | | | |
| Number of patient safety incidents | 6,751 | 6,345 | 5,429 | GOSH uses electronic incident reporting to promote robust reporting and analysis of incidents. It is expected that organisations with a good safety culture will see higher rates of incident reporting year-on-year, with the severity of incidents decreasing. | Initiatives such as: Risk Action Groups, local training in root cause analysis, and "Learning from…" events and posters, improve the sharing of learning to reduce the risk of higher-graded incident recurrence. Initiatives are reported and monitored by the Patient Safety and Outcomes Committee. |
| Rate of patient safety incidents (number/100 admissions) | 14.9 | 14.2 | 12.4 | | |
| Number and percentage of patient safety incidents resulting in severe harm or death | 6 (0.1%) | 12 (0.2%) | 8 (0.1%) | | |

**Explanatory note on patient safety incidents resulting in severe harm or death**

It is mandatory for NHS trusts in England to report all serious patient safety incidents to the CQC as part of the CQC registration process. GOSH also reports its patient safety incidents to the NRLS, which runs a national database designed to promote learning.

There is no nationally established and regulated approach to reporting and categorising patient safety incidents. Different trusts may choose to apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. This judgement may, acceptably, differ between professionals. In addition, the classification of the impact of an incident may be subject to a lengthy investigation, which could result in the classification being changed. This complexity makes it difficult to do a formal comparison.

**What is a mean?**

The mean is the average of a set of numbers. It is calculated by adding up all the values and then dividing the answer by the total number.

# Part 3:
# Other information

NHS Improvement uses a limited set of national mandated performance measures, described in its *Single Oversight Framework*, to assess the quality of governance at NHS foundation trusts.

Performance is measured on an aggregate (rather than specialty) basis and Trusts are required to meet the appropriate threshold each month. Consequently, any failure in one month is considered to be a quarterly failure. The table below sets out the relevant national performance measures used to assess the Trust's quality governance rating.

**What is NHS Improvement?**

NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.

## Performance against key healthcare targets 2018/19

| Domain | Indicator | National threshold | GOSH performance for 2018/19 by quarter | | | | 2018/19 mean | Indicator met? |
|---|---|---|---|---|---|---|---|---|
| | | | Q1 | Q2 | Q3 | Q4 | | |
| Effectiveness | All cancers: 31-day wait from decision to treat to first treatment*** | 96% | 97.87% | 100% | 100% | 100% | 99.45% | Yes |
| Effectiveness | All cancers: 31-day wait for second or subsequent treatment, comprising:*** | | | | | | | |
| | · surgery | 94% | 100% | 93.33% | 90.91% | 100% | Indicative position: 95.65% | Yes for Q1&4. No for Q2&3 |
| | · anti-cancer drug treatments | 98% | 100% | 100% | 100% | 100% | 100% | Yes |
| Experience | Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway††***** | 92% | Apr: 93.62%<br>May: 93.64%<br>June: 92.59% | Jul: 92.76%<br>Aug: 92.85%<br>Sep: 92.24% | Oct: 92.19%<br>Nov: 92.15%<br>Dec: 92.09% | Jan: 92.59%<br>Feb: 92.18%<br>Mar: 92.24% | 92.60% | Yes |
| Experience | Maximum 6-week wait for diagnostic procedures*** | 99% | Apr: 97.87%<br>May: 97.45%<br>June: 98.43% | Jul: 97.43%<br>Aug: 94.44%<br>Sep: 94.53% | Oct: 94.07%<br>Nov: 96.98%<br>Dec: 93.14% | Jan: 95.19%<br>Feb: 97.54%<br>Mar: 97.48% | 96.21%†† | No |
| Experience | Certification against compliance with requirements regarding access to healthcare for people with a learning disability | Compliance against requirements* | Achieved | Achieved | Achieved | Achieved | Achieved | Achieved |

*Target based on meeting the needs of people with a learning disability, from recommendations set out in Healthcare for All (Department of Health, 2008)
†† Throughout the year, the Trust identified a number of poor administrative processes related to the booking of diagnostic tests, which resulted in an increase in the volume of breaches. Capacity has also been an issue. The Trust is currently working through a recovery plan to improve performance against this standard in 2019/20. ***Source: NHS Digital

**Additional indicators – performance against local improvement aims**

In addition to the national mandated measures identified in the above tables, the Trust has implemented a range of local improvement programmes that focus on the quality priorities as described in Part 2a. The table below sets out the range of quality and safety measures that are reviewed at each Trust Board meeting. Statistical Process Control (SPC) charts are used to measure improvements in projects over time and to identify areas that require further investigation (see definition on page 19). All measures remain within expected statistical tolerance.

| Domain | Indicator | GOSH performance for 2018/19 by quarter | | | | 2018/19 mean |
|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | |
| Safety | Central Venous Line (CVL) related bloodstream infections (per 1,000 line days) | 1.7 | 1.2 | 1.3 | 2.6 | 1.7‡ |
| Effectiveness | Inpatient mortality rate (per 1,000 discharges)‡‡† | 4.74 | 5.00 | 7.62 | 8.95 | 6.49 |
| Effectiveness | PICU discharges delayed by 8–24 hours | 19 | 13 | 16 | 17 | 16 |
| Effectiveness | PICU discharges delayed by more than 24 hours | 36 | 25 | 57 | 56 | 43 |
| Experience | Discharge summary completion time (within 24 hours) | 89.24% | 87.18% | 80.75% | 77.32% | 83.30% |
| Effectiveness | Last minute* non-clinical hospital cancelled operations‡ and breaches of 28-day standard: | | | | | |
| | · cancellations | 112 | 135 | 155 | 150 | 137 |
| | · breaches | 13 | 17 | 21 | 13 | 16 |
| Experience | Formal complaints investigated in line with the NHS complaints regulations*** | 18 | 30 | 27 | 20 | 95 (total) |
| Effectiveness | % of patients aged 0–15 readmitted to hospital within 28 days of discharge‡‡ | 1.63% | 2.72% | 2.24% | 1.58% | 2.04% |
| Effectiveness | % of patients aged 16+ readmitted to hospital within 28 days of discharge‡‡ | 0 | 0 | 1.53% | 0 | 0.38% |

## Performance against key healthcare targets 2017/18

| Domain | Indicator | National threshold | GOSH performance for 2017/18 by quarter | | | | 2017/18 mean | Indicator met? |
|---|---|---|---|---|---|---|---|---|
| | | | Q1 | Q2 | Q3 | Q4 | | |
| Effectiveness | All cancers: 31-day wait from decision to treat to first treatment*** | 96% | 100% | 100% | 100% | 100% | 100% | Yes |
| Effectiveness | All cancers: 31-day wait for second or subsequent treatment, comprising:*** | | | | | | | |
| | · surgery | 94% | 100% | 100% | 100% | 100% | 100% | Yes |
| | · anti-cancer drug treatments | 98% | 100% | 100% | 100% | 100% | 100% | Yes |
| Experience | Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway*** | 92% | Apr: 90.31%<br>May: 90.36%<br>June: 89.26% | July: 89.84%<br>Aug: 90.07%<br>Sept: 89.67% | Oct: 90.59%<br>Nov: 90.72%<br>Dec: 90.75% | Jan: 92.96%<br>Feb: 93.53%<br>Mar: 92.91% | 90.91% | Yes, for Q4 but not for Q1-3. Improvement work continued. |
| Experience | Maximum 6-week wait for diagnostic procedures*** | 99% | Apr: 97.44%<br>May: 97.49%<br>June: 97.73% | Jul: 97.77%<br>Aug: 97.49%<br>Sep: 98.09% | Oct: 98.69%<br>Nov: 99.02%<br>Dec: 98.93% | Jan: 99.51%<br>Feb: 98.60%<br>Mar: 98.98% | 98.28% | No |
| Experience | Certification against compliance with requirements regarding access to healthcare for people with a learning disability | Compliance against requirements* | Achieved | Achieved | Achieved | Achieved | Achieved | Achieved |

*Target based on meeting the needs of people with a learning disability, from recommendations set out in Healthcare for All (Department of Health, 2008)

**Additional indicators – performance against local improvement aims**

| Domain | Indicator | GOSH performance for 2017/18 by quarter | | | | 2017/18 mean |
|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | |
| Safety | CVL related bloodstream infections (per 1,000 line days) | 1.57 | 1.47 | 1.31 | 1.54 | 1.47 |
| Effectiveness | Inpatient mortality rate (per 1,000 discharges)‡†† | 8.8 | 5.7 | 6.7 | 4.2 | 6.3 |
| Effectiveness | PICU discharges delayed by 8–24 hours | †† | †† | 32 | 19 | 25 |
| Effectiveness | PICU discharges delayed by more than 24 hours | †† | †† | 43 | 54 | 48 |
| Experience | Discharge summary completion time (within 24 hours) | 87.8% | 87.1% | 88.1% | 88.1% | 87.7% |
| Effectiveness | Last minute* non-clinical hospital cancelled operations*** and breaches of 28 day standard: | | | | | |
| | · cancellations | 137 | 119 | 176 | 105 | 537(total) |
| | · breaches | 14 | 7 | 27 | 24 | 72 (total) |
| Experience | Formal complaints investigated in line with the NHS complaints regulations*** | 29 | 21 | 14 | 22 | 86 (total) |
| Effectiveness | % of patients aged 0–15 readmitted to hospital within 28 days of discharge‡‡ | 1.93% | 1.99% | 2.23% | 1.23% | 1.83% |
| Effectiveness | % of patients aged 16+ readmitted to hospital within 28 days of discharge‡‡ | 0% | 0% | 0.81% | 1.55% | 0.54% |

† Does not include day cases †† Reported to Board from October 2017 *** Source: NHS Digital ‡‡Source: Hospital Episode Statistics

* Last minute' is defined as: on the day the patient was due to arrive, after the patient has arrived in hospital, or on the day of the operation or surgery.

‡ Thirteen episodes come from one child with a serious gastrointestinal issue who had recurrent bacteraemias likely to have arisen from the gut but seeded the line. Removing these unavoidable 13 episodes (and the line days) gives an annual rate of 1.4.

†††Throughout the last year, the Trust continued work to improve the quality and robustness of our waiting list data, building on the work that had been completed over previous years. The principle focus for 2018/19 was maintaining compliance against the RTT standard as an organisation and focusing on speciality level compliance. In addition a significant focus has been placed on the build of the EPIC system to ensure we are able to robustly track and manage patients who are awaiting treatment, both within the EPIC system, as well as utilising Qlikview reporting to provide a patient targeting list (PTL) and booking reports for the operational teams. Throughout 2018/19, the Trust successfully delivered the 92% incomplete standard every month. This was a testament to the work completed by the clinical and operational teams. Following the completion of our audit of the Quality Accounts for 2018/19, a number of data quality issues were identified related to the small sample undertaken, although the significance of errors have reduced since last year's audit. While disappointing, the majority of the errors related to documentation management and late receipt / processing of referral information and thus were not material to the Trust's reported RTT position and as such this has led to a modified opinion by our auditor, Deloitte. This year's audit was completed using a cross section of waits on the PTL in addition to focusing on those waiting between 17 and 18 weeks. As such, the review highlighted a reduced quality of data across those pathways below 18 weeks, compared to those who have waited over 18 weeks as all of these pathways are validated as part of our RTT reporting processes in-line with processes completed. Those pathways under 18 weeks are randomly sample audited as part of our waiting times and data assurance processes on a weekly basis. Our previous patient administration system was not capable of tracking patients against an RTT pathway, so this had to be constructed and calculated outside of the system in a data warehouse environment. While much work has been completed to compensate for this, it allowed the user to enter pathway data and an outcome code regardless of the status of the pathway. The functionality provided by Epic will go some way to mitigate this, although this is unlikely to address all the issues identified as part of the audit. In addition, the initial concept of RTT was developed around the clinical model of simple surgical care, rather the complex tertiary and quaternary care that we offer at GOSH. As such, it remains a challenge to our clinicians and operational teams to apply the rules to the clinical pathways we have at GOSH. This is further compounded by the fact that 93% of the patients we receive at GOSH have been referred from another hospital setting and hence will have already waited for care at another organisation. This means that for each we have to source a minimum dataset, informing us of the current status of the patient together with their current waiting time. This vital information is often hard to source. However the Trust has completed a significant amount of work to reduce the volume of unknown clock starts from 894 in April 2018 to 231 in March 2019. Finally, although the number of errors was higher than the organisation expected, GOSH notes the context of other Foundation Trusts and their performance against this indicator. It is clear this is a significant challenge to the wider NHS.

# Annex 1: Statements from external stakeholders

## Statement from NHS England (London), Specialised Commissioning Team

NHS England would like to thank Great Ormond Street Hospital NHS Foundation Trust (GOSH) for the opportunity to review and provide a response to the 2018/19 Quality Account.

We continue to work together to address improvements in the quality of care and accessibility of services for those children whose healthcare needs are managed by GOSH.

NHS England reviews feedback from: patients and families, clinical quality review meetings and other external sources including the Care Quality Commission, Health Education England (North Central and East London), and Public Health England to inform decisions about where improvements are required. This year, the Trust itself has also undertaken to benchmark performance against some of its peers to identify opportunities for learning and improvement and we welcome this proactive reflection. Notable improvements include:

- A new system to replace the Friends and Family Test which has significantly improved the volume of responses received from service users
- Implementation of the PANDA system - designed to objectively assess the nursing dependencies and calculate safe nurse ratios for each ward area
- Improved recognition of deteriorating patients through implementation of Paediatric Early Warning System (PEWS)
- Better identification and management of children at risk of developing sepsis
- Improvements in the experience of patients requiring venous access
- The Growing Up Gaining Independence Programme, which addresses transition to adult services
- Reducing sample rejection rates in laboratories

The CQC report published in April 2018 identified two areas which require improvement; outpatients, and diagnostic imaging and surgery. NHS England will work with the Trust over the coming year to ensure that the action plans to address these priority areas are delivered. Whilst the Trust has made progress against the CQC Well-Led domain, this has been an area of significant discussion with NHS England and, it will remain as such so that the organisational changes that aim to improve the annual staff survey results are implemented.

The Trust has a busy year ahead; in addition to those mentioned above, priority areas include - assuring the stability of services following implementation of Epic, the electronic patient record which went live in April 2019; addressing any further improvements that may be identified following a scheduled review of surgery by the CQRG and, aligning processes with the new Child Death Overview Panel guidance.

Great Ormond Street Hospital is host to the newly established North Thames Paediatric Network and through the new leadership team, we are confident that this will enable stronger collaboration across Providers to improve the care of children and young people in the region.

## Statement from Camden Health and Adult Social Care Scrutiny Committee

**Disclaimer: The Health and Adult Social Care (HASC) Scrutiny Committee did not sit between the receipt of the draft quality report and the due date for comments. They could not therefore provide comments on the named quality report. The following statement was provided solely by the Chair of the HASC Scrutiny Committee, Cllr Alison Kelly, and they should not be understood as a response on behalf of the Committee.**

Thank you for sending us your 2018/19 quality report for comment. The report is comprehensive.

The Trust is to be congratulated on the progress made in 2018/19 and for the dedication of so many GOSH colleagues who ensured that this happened.

Other Trusts have a specific section on key achievements and exciting developments during the year. Perhaps the Trust should, succinctly, celebrate its achievements a bit more loudly early on in its report.

The report has not been the easiest to comment on as it is an early draft without a contents page, without a statement of quality from the chief executive, and without the priorities and actions for 2019/20, for example.

The following observations were made in accordance with a set of core governance principles which guide the scrutiny of health and social care in Camden.

**1) Putting patients at the centre of all you do**
The report makes clear that `fulfilling our potential' is the strategic focus of the Trust. `The child first and foremost' is the pinnacle. This is excellent.

**2) Focussing on a common purpose, setting objectives, planning**
Pages 6-13 under the heading `Our strategy' cover a range of important topics but it is not always immediately clear how the individual topics on these pages link to the Trust's strategic focus.

The Trust may want to consider how it initially describes its strategy to make clear that helping children and young people with the most complex needs to fulfil their potential is the absolute priority of the Trust.

The report contains six clear, patient focused priorities which were taken forward during 2018/19. The priorities are narrower and less strategic than in some other Trusts.

Action taken and progress made is detailed. As are the next steps, which is very helpful. However the Trust should give further consideration to the audience of the report as too much detail can get in the way of understanding.

Ideally the national audit and clinical outcomes review programme should be linked to priorities.

It is unclear what the priorities are for 2019/20. They may be included but are difficult to locate without a context page.

**3) Working collaboratively**
The Trust demonstrates that it takes seriously working with, listening to and learning from patients, their families and carers. The progress made is positive. The Trust may want to consider a more holistic approach, which encompasses cultural change, in future.

Following the disappointing 2018 staff survey result it is positive to see the steps the Trust is taking to improve clarity of leadership and reduce the gap between leaders and frontline services.

We know that GOSH takes seriously collaboratively working with Camden Council and across other local sectors to achieve the best possible outcomes and experience. Perhaps progress can be reported in the next quality account.

We also know that the Trust takes exceedingly seriously its work with national and international partners, and it is pleasing to read about the Trust's participation in clinical research. The report would benefit from reflection on any other areas where there is collaboration.

**4) Acting in an open, transparent and accountable way - using inclusive language, understandable to all - in everything it does**
The 2018 CQC inspection is mentioned in the section on CQC registration and in Annex 2 of the report. The inspectors rated services as outstanding - effective and caring. Many sincere congratulations indeed.

However, `Well Led' aspects which required improvement by CQC are not covered in the report. Only future processes to be followed are covered, which are not linked to the specific issue. Below average staff ratings in the quality indicators confirm the CQC results.

Some clearer actions are covered in the final column of the core indicators table, but the lack of clarity and transparency is disappointing and concerning.

There is some excellent practice in NCL in relation to these reports. It might be worth sharing good practice in this report and also learning from others.

We would like to finish by thanking GOSH for its huge commitment to putting the child first and always. And for all the hard work by so many, including volunteers, frontline staff, clinicians, the leadership team and board members. Your dedication is inspirational and hugely appreciated.

**Councillor Alison Kelly**

Chair of Health and Adult Social Care Scrutiny Committee

## GOSH response to statement from Camden Health and Adult Social Care Scrutiny Committee

The Trust wishes to thank Cllr Kelly for taking the time to give feedback. We are grateful for the recognition of our ongoing work to continuously improve the care we provide to our children and young people. The suggestions of improvements to the report are helpful and we have either applied these or will do so in forthcoming years. We respond below to specific topics referenced by Cllr Kelly:

**Strategy**
We are currently doing a piece of work to hone our strategy under the new leadership team, which includes workshops with staff and clarification of specific deliverables that map to our quality domains. Greater clarity about priorities should therefore be evident in the 2019/20 Quality Report.

**Leadership and staff experience**
We recognise from a range of feedback sources that staff engagement and wellbeing need to be improved. We are committed to addressing these issues and improving the experience of our staff, including their sense of being valued and supported.

The Trust is currently in the process of developing a comprehensive People Strategy, which will encompass engagement from a wide range of staff in different roles across the organisation. The strategy will aim to address cultural issues identified in the CQC report, staff survey and other staff feedback mechanisms.

The Chief Nurse and Medical Director are attending the Health and Adult Social Care Scrutiny Committee in July and will be pleased to present in more detail our progress with strategy and improving the experience of our staff. We will also report these in detail in the 2019/20 Quality Report.

## Statement from Healthwatch Camden

Healthwatch Camden thanks the Trust for the opportunity to comment on your Quality Accounts. It is always good to learn more about your important work. However, we are not making a formal comment on Quality Accounts this year. This decision should not be seen as any lack of interest in or support for your work. Pressure of other work in the context of falling core income and increased complexity in the local NHS means that we do not have the human resources to consider Quality Accounts in the detail that they deserve this year. We look forward to commenting in future years.

## Feedback from members of the Council of Governors

**Comments from Public governor, north London and surrounding area:**
An entire year has passed since I last reviewed the GOSH annual report and evidently much progress has been made. The delivery of the national Referral to Treatment target which has saved the Trust £12.3M is truly commendable. Plans to save over £20M the following year are also very reassuring to read, and something I trust will be followed through. The implementation of the EPR System is a great contributing factor to the technological advancement the Trust is currently experiencing. The initiatives taken by the Trust to ensure inclusivity of its staff is greatly appreciated and an area I hope progress continues to be made in. It is very heartening to read about the Trust's commitment to the quality priorities, which for this past year are significant, and the introduction of the PEWS system is noted and commended. The focus that has been placed on ordering and delivering chemotherapy more efficiently is also lauded and a priority that I hope will continue to be delivered upon.

The introduction of a paediatric VHP framework as promised is welcomed. The fear of venous access is often a major hindrance in the recovery of young patients and the Trust's emphasis on this has and will continue to improve the efficiency of treatment and patients' experience. The digital logging of relevant information on the ePSAG and Epic systems has improved efficiency and accessibility to data for all staff - a measure that supports efficient inter-departmental communication. The decrease in cannulation attempts from 1.9 attempts per child to 1.2 is a notable improvement, and a figure I'd like to see further improvement on the following year. There has been a significant decrease in the number of extravasation injury referrals from an average of 12 to 5 per month - an excellent improvement. The plans for standardisation of the new framework are also sensible - this will prove sufficiently informative when combined with the introduction of the e-learning package and training video for doctors.

Having commented on the effectiveness of the PEWS system in the previous year's report, it is reassuring to read that the Trust has followed through on its commitment to improve the early recognition of deteriorating condition, especially the early signs of sepsis. It is reassuring to read that PEWS was successfully launched and that training was well received. The accessibility of the Early Warning Dashboard to hospital, ward and patient is fundamental to increasing awareness at all levels. The increase in percentage of completed observations from 62% to 75% is heartening and a figure I anticipate will be greater in the following year, with the PEWS system in place. The Trust's work to develop a national PEWS tool is welcomed and will greatly impact the wider NHS.

The efficient administration of chemotherapy is vital to providing world class cancer care. The results of the baseline audit in October 2018 which indicate that the number of phone calls to the chemotherapy unit have decreased from 40-60 phone calls per day to 0 following the implementation of Chemotracker are truly commendable.

To conclude, the Trust has had another busy year with much success. The developments and standardisation of frameworks will continue to ensure the Trust works towards fulfilling its 'always' ethos, and it is incredibly heartening to read about the great progress made from last year particularly in technological implementation. On behalf of the governing body, I'd once again like to thank the Trust for its extensive, sustained efforts in providing outstanding care to its patients and its manifest commitment to putting the child 'first and always'.

**Comments from Staff governor:**
I am a new Governor in what has been an exciting time for GOSH.

2018/19 has been dominated by preparations for Epic, our new Electronic Patient Record (EPR) system. This is a massive project to build a unified IT system for all of our patient-related activity, replacing the large number of smaller systems which had previously been in place. The whole Trust has been involved, from the front line point-of-care teams, through to back office functions such as Finance.

The system will have everything in one place; where, in the past blood test reports would be on one system, with radiology reports in another, now our staff will have what they need in one place at the click of a mouse. This will improve safety (for example, reducing medication errors) and the service we provide to our families. It will also allow for efficiencies and automation, such as test results automatically being returned as a message to clinicians and filed under the patient's notes, rather than staff having to chase results.

From a Governor's perspective, I have been reassured to see the diligence and care that has gone into the preparations for the system's implementation. The team directly working on the project were a mix, with a large contingent being current staff who were seconded to the project. This meant there was a deep level of local knowledge and, crucially, strong input from our Nursing and Medical teams. Due to the vital nature of the project it is discussed at several assurance committees, as well as at Trust Board.

No implementation will be glitch free, but I am content that the Trust has done a great job in preparing for the next step in GOSH's mission to provide excellent care to its patients.

The other main issue I would identify is the work that the Trust is doing around staff engagement and the organisational culture. This year the Trust carried out a survey to get the views of staff. This was sent to every staff member. The results were not always what one might want to see and small pockets of inappropriate behaviour were identified.

It is sad that this has been the situation, but I am fully convinced that the Board, and especially the Chairman and Chief Executive are absolutely committed to remedy the situation and improve the working lives of staff in those areas and ensure that all of the hospital lives up to our Always Values at all times. The Council of Governors stands full square in support of this aim. A great deal of work has already gone in to improving the experience of staff, including the creation of staff forums, which you can read about on pages 12-13 of this report.

The final thing I will highlight is GOSH's focus on research and the future. The 100,000 Genomes project closed to recruitment this year. This large national research study hopes to unlock information coded into the human genetic makeup to inform management and treatment of a huge range of conditions. It will have particular impact on rare diseases, which GOSH specialises in. GOSH was the largest single recruiter of families to the project, something we can certainly be proud of.

This is in line with our aim to become a Research Hospital, where research is completely integrated with the care we provide, so that we can offer cutting-edge treatments to our patients and maximise clinical outcomes. To this end, we have opened the Digital Research and Informatics Unit (DRIVE), which brings together healthcare experts, researchers and other partners to develop exciting new devices and systems to advance the care provided to patients. This is an exciting initiative and I am sure that it will lead to many future developments.

To conclude, it has been a very busy year for the Trust, with a lot happening and a lot yet to do. We have an energised Board, showing great leadership and I think the coming year will be one where we see GOSH making excellent progress.

# Annex 2: Statements of assurance

## External assurance statement

**Independent auditor's report to the Council of Governors of Great Ormond Street Hospital for Children NHS Foundation Trust on the *Quality Report*.**

We have been engaged by the council of governors of Great Ormond Street Hospital for Children NHS Foundation Trust to perform an independent assurance engagement in respect of Great Ormond Street Hospital for Children NHS Foundation Trust's quality report for the year ended 31 March 2019 (the 'quality report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Great Ormond Street Hospital for Children NHS Foundation Trust as a body, to assist the council of governors in reporting Great Ormond Street Hospital for Children NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and Great Ormond Street Hospital for Children NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

### Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway; and
- Maximum waiting time of 31 days from decision to treat to first treatment for all cancers.

We refer to these national priority indicators collectively as the 'indicators'.

### Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the NHS Improvement Detailed guidance for external assurance on quality reports 2018/19; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with:

- board minutes for the period April 2018 to 23 May 2019;
- papers relating to quality reported to the board over the period April 2018 to 23 May 2019;
- feedback from Commissioners,
- feedback from governors,
- feedback from local Healthwatch organisations,
- feedback from Overview and Scrutiny Committee,
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009,
- the 2018 national staff survey,
- the 2017 national inpatient survey
- the Head of Internal Audit's annual opinion over the trust's control environment, dated 22 May 2019;
- the Care Quality Commission inspection report dated 6 April 2019; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

### Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000

(Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- reviewing the process flow of the indicator with management;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

## Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Great Ormond Street Hospital for Children NHS Foundation Trust.

## Basis for qualified conclusion

***Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period***

The "percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period" indicator requires that the NHS Foundation Trust accurately record the start and end dates of each patient's treatment pathway, in accordance with detailed requirements set out in the national guidance. This is calculated as an average based on the percentage of incomplete pathways which are incomplete at each month end, where the patient has been waiting less than the 18 week target.

Our procedures included testing a risk based sample of 20 items, and so the error rates identified from that sample should not be directly extrapolated to the population as a whole.

We identified a number of issues during testing (with some samples having more than one issue). We noted the following errors:

- Two instances of invalid pathways;
- One instance of an incorrect clock start being recorded and two instances of a clock stop being recorded incorrectly. Monthly reporting was affected in the case of one clock stop.
- One instance of the pathway being attached to the wrong specialty. Monthly reporting was unaffected.
- Two instances of insufficient support for the start date recorded due to missing date stamps on referral documents. For one sample we were able to confirm reporting is unaffected based on the earliest possible start date per referral letter, for the second we were unable to confirm whether reporting was affected; and
- Three further instances of incorrect reporting, whereby the number of active patients on the waiting list was over/ understated as a result of late processing of the clock stop/start dates.

As a result of the issues identified, we have concluded that there are errors in the calculation of the "maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway" indicator for the year ended 31 March 2019. We are unable to quantify the effect of these errors on the reported indicator.

The "Performance against key healthcare targets 2018/19" section on page 56 of the Trust's Quality Report details the actions that the NHS Foundation Trust is taking to resolve the issues identified in its processes.

## Qualified conclusion

Based on the results of our procedures, except for the matters set out in the basis for qualified conclusion section of our report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual';
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the NHS Improvement Detailed requirements for external assurance for quality reports 2018/19; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual' and supporting guidance.

Deloitte LLP

St Albans, United Kingdom

23 May 2019

## Statement of directors' responsibilities for the *Quality Report*

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

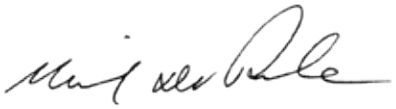
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the *Quality Report*.

In preparing the *Quality Report*, directors are required to take steps to satisfy themselves that:

- The content of the *Quality Report* meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2018/19* and supporting guidance *Detailed Requirements for Quality Reports 2018/19*.
- The content of the *Quality Report* is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2018 to May 2019
  - papers relating to Quality reported to the board over the period April 2018 to May 2019
  - feedback from commissioners dated 14/05/2019
  - feedback from governors dated 24/04/2019
  - feedback from Camden Healthwatch organisation dated 08/05/2019
  - feedback from Camden Health and Adult Social Care Scrutiny Committee dated 08/05/2019
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2019
  - National Paediatric Outpatient Survey 2016
  - Children and Young People's Inpatient and Day Case Survey 2016
  - the national NHS Staff Survey 2018
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 22/05/2019
  - CQC inspection report dated 06 April 2018
- The *Quality Report* presents a balanced picture of the NHS foundation trust's performance over the period covered.
- The performance information reported in the *Quality Report* is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the *Quality Report*, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the *Quality Report* is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The *Quality Report* has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the *Quality Report*.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the *Quality Report*.

By order of the board



22 May 2019

Chairman

22 May 2019

Chief Executive

# Great Ormond Street Hospital for Children NHS Foundation Trust

Great Ormond Street
London WC1N 3JH
020 7405 9200
**gosh.nhs.uk**

Designed and produced by Great Ormond Street Hospital Marketing and Communications.

Thank you to everyone who was interviewed for, or gave permission for their picture to be used in, this report, as well as the many members of Great Ormond Street Hospital staff who helped during its production.

The *Annual Report and Accounts* is available to view at www.gosh.nhs.uk.

Design Manager
Great Ormond Street Hospital
Fourth floor
40 Bernard Street
London WC1N 1LE
E design.work@gosh.org

Attachment I

Great Ormond Street Hospital for Children NHS Foundation Trust

# Council of Governors

## 17th July 2019

**Findings and Recommendations from the 2018/19 NHS Quality Report External Assurance Review**

**Summary & reason for item:** External Audit Report on Quality Report and External Audit Report on Financial Statements

**Governor action required:** No formal action required, for information only

**Report prepared by:** Deloitte – External Auditors

**Item presented by:** Deloitte – External Auditors

Deloitte.

Great Ormond Street Hospital for Children NHS Foundation Trust

# Great Ormond Street Hospital for Children NHS Foundation Trust

Findings and Recommendations from the 2018/19 NHS Quality Report External Assurance Review

# Contents

# Executive Summary

## Our work on the Quality Report is completed and we issued a modified limited assurance opinion

**Status of our work**

- We have completed our review, including validation of the reported indicators.
- The scope of our work is to support a "limited assurance" opinion, which is based upon procedures specified by NHS Improvement in their "Detailed Requirements for External Assurance For Quality Reports for Foundation Trusts 2018/19".
- We have signed a modified opinion for inclusion in your 2018/19 Annual Report. Our modification reflects our findings from our work on 18 Week Referral to Treatment Incomplete Pathways ("RTT").

| | 2018/19 | 2017/18 |
|---|---|---|
| Length of Quality Report | 65 pages | 56 pages |
| Quality Priorities | 6 | 6 |
| Future year Quality Priorities | 3 | 3 |

**Scope of work**

We are required to:

- Review the content of the Quality Report for compliance with the requirements set out in NHS Improvement's Annual Reporting Manual ("ARM").
- Review the content of the Quality Report for consistency with various information sources specified in NHS Improvement's detailed guidance, such as Board papers, the Trust's complaints report, staff and patients surveys and Care Quality Commission reports.
- Perform sample testing of three indicators.
  - The Trust has selected 31 Day Cancer ("31 Day") and 18 week referral to treatment times as the publically reported indicators, based on NHS Improvement's specified order of preference.
  - For 2018/19, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. The Trust has selected Number of PICU delayed discharges.
  - The scope of testing includes an evaluation of the key processes and controls for managing and reporting the indicators; and sample testing of the data used to calculate the indicator back to supporting documentation.
- Provide a signed limited assurance report, covering whether:
  - Anything has come to our attention that leads us to believe that the Quality Report has not been prepared in line with the requirements set out in the ARM; or is not consistent with the specified information sources; or
  - There is evidence to suggest that the 18 week referral to treatment waiting times and 31 day cancer indicators have not been reasonably stated in all material respects in accordance with the ARM requirements.
  - Provide this report to the Council of Governors, setting out our findings and recommendations for improvements for the indicators tested: 31 Day Cancer, 18 week referral to treatment waiting times and Number of PICU delayed discharges.

# Executive Summary (continued)

## We have issued a modified opinion in relation to 18 weeks RTT

### Content and consistency review

Review content → Document review → Interviews → Form an opinion

Our work on the content and consistency review of the Quality Report is complete. From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019 the Quality Report is not prepared in all material respects in line with the criteria set out in the ARM).

| | Overall conclusion |
|---|---|
| **Content** | |
| Are the Quality Report contents in line with the requirements of the Annual Reporting Manual? | 4 |
| **Consistency** | |
| Are the contents of the Quality Report consistent with the other information sources we have reviewed (such as Internal Audit Reports and reports of regulators)? | 4 |

### Performance indicator testing

Interviews → Identify potential risk areas → Detailed data testing → Identify improvement areas

NHS Improvement requires Auditors to undertake detailed data testing on a sample basis of three mandated indicators. We perform our testing against the six dimensions of data quality that NHS Improvement specifies in its guidance.

As in the prior year, our conclusion on the RTT indicator is qualified.

| | 31 Day | RTT | PICU |
|---|---|---|---|
| **Recommendations identified?** | 4 | 4 | 4 |
| **Overall Conclusion** | Unmodified Opinion | Modified Opinion | No opinion required |

**Summary of issues identified**

**RTT**

- Issues identified include invalid RTT pathways being included in reporting, incorrect clock starts and stops being recorded and cases where insufficient evidence is available to conclude on the accuracy of clock starts.

Please refer to the performance indicator testing section of this report for details and recommendations.

**31 Day Cancer**

- Issues identified include incorrect clock starts and stops being recorded and cases where insufficient evidence is available to conclude on the accuracy of clock starts.

Please refer to the performance indicator testing section of this report for details and recommendations.

# Content and consistency review

# Content and consistency review

## The Quality Report represents a clear and effective summary of the Trust's ongoing quality programme

**The Quality Report is intended to be a key part of how the Trust communicates with its stakeholders.**

**Although our work is based around reviewing content against specified criteria and considering consistency against other documentation, we have also made recommendations to management through our work to assist in preparing a high quality document. We have summarised below our overall assessment of the Quality Report.**

| Key questions | Assessment | Statistics |
|---|---|---|
| • Is the length and balance of the content of the report appropriate? | G | Length: 65 pages |
| • Is there an introduction to the Quality Report that provides context? | G | |
| • Is there a glossary to the Quality Report? | G | |
| • Is the number of priorities appropriate across all three domains of quality (Patient Safety, Clinical Effectiveness and Patient Experience)? | G | Patient Safety: 2<br>Clinical Effectiveness: 2<br>Patient Experience: 2 |
| • Has the Trust set itself SMART objectives which can be clearly assessed? | G | |
| • Does the Quality Report clearly present whether there has been improvement on selected priorities? | G | |
| • Is there appropriate use of graphics to clarify messages? | G | |
| • Does there appear to have been appropriate engagement with stakeholders (in both choosing priorities as well as getting feedback on the draft Quality Report)? | G | |
| • Does the Annual Governance Statement appropriately discuss risks to data quality? | G | |
| • Is the language used in the Quality Report at an appropriate readability level? | | |

**Deloitte view**

The Quality Report represents a clear and effective summary of the Trust's ongoing quality programme; the report contains engaging graphics which are particularly appropriate given that the key users of this report are expected to be children and their parents.

Areas of good practice include:

•The report is well written with clearly and logically presented priorities and related actions.

•Explanatory boxes are included throughout the report in order to explain technical terminology to the lay reader.

•Charts, diagrams and various other graphics are used appropriately throughout the report to clarify and explain technical information and ensure it is accessible to the lay reader.

# Performance and Indicator Testing

# 31 day cancer wait times

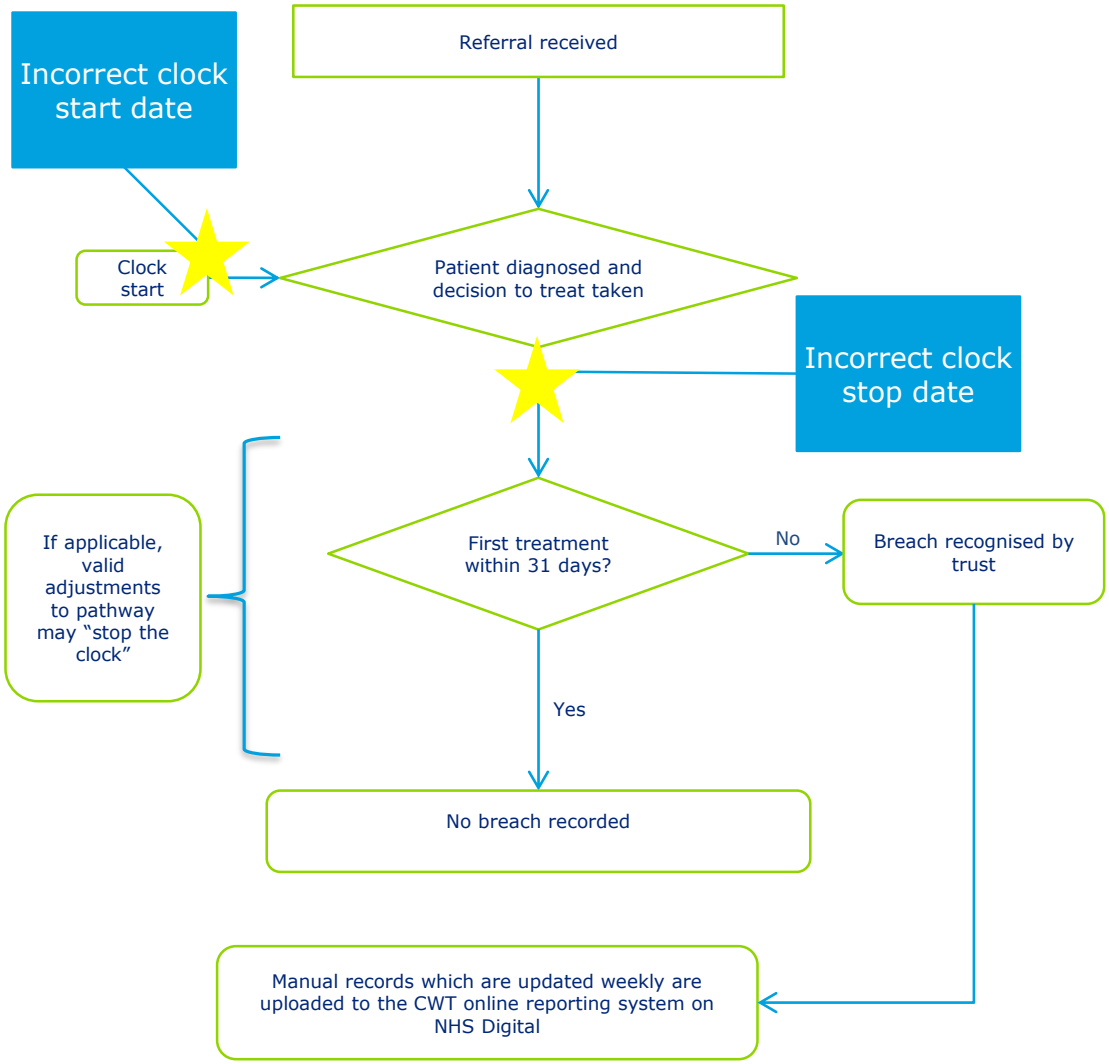
## Minor issues were identified in our testing

| | Trust reported performance | Target | Overall evaluation |
|---|---|---|---|
| 2018/19 | 99.45% | 96% | Unmodified opinion |
| 2017/18 | 100% | 96% | Unmodified opinion |
| 2016/17 | 98.9% | 96% | Unmodified opinion |

**Indicator definition**

**Definition:** "Percentage of patients receiving first definitive treatment for cancer within 31 days of decision to treat"

**Process flow**



# 31 day cancer waiting times (continued)

## Minor issues were identified in our testing

**Approach**

- We met with the Trust's lead for 31 day cancer waits to understand the process from decision to treat to the result being included in the Quality Report.
- We evaluated the design and implementation of controls through the process. We discussed with management and used analytical procedures to identify pathways which appear to be most at risk of error e.g. patients with manual adjustments, pathways close to the 31 day breach date together with a random sample of other cases.
- We selected a sample of 24 from 1 April 2018 to 31 March 2019 following patient records through until treatment. During our work we noted one instance where the evidence was insufficient to conclude on the sample's breach status; this finding led us to extend our sample by two.
- We recalculated the reported indicator in the quality report

**Findings**

We identified the following errors; more than one error may relate to a single sample:

- One instance where we could not conclude on the appropriateness of the reporting due to insufficient available evidence related to the clock stop and start dates; and
- Six instances of incorrect clock start/stop dates. In all cases, reporting and breach status were unaffected. As these errors did not affect breach status, they did not cause us to modify our opinion.

With regard to the sample described above for which the evidence was insufficient, we extended our sample by two at the final testing date and noted no errors. As these issues were not systemic throughout our sample, we concluded that this did not cause us to modify our opinion.

**Deloitte View:**

Despite the errors identified not impacting reporting or breach status, the Trust should ensure that appropriate controls are put in place to prevent future errors from occurring.

# 18 week Referral to Treatment times

## We have qualified our opinion with respect to this indicator

| | Trust reported performance | Target | Overall evaluation |
|---|---|---|---|
| 2018/19 | Monthly figures reported | >92% | Modified Opinion |
| 2017/18 | Monthly figures reported | >92% | Modified Opinion |
| 2016/17 | n/a | >92% | Modified Opinion |

### Indicator definition

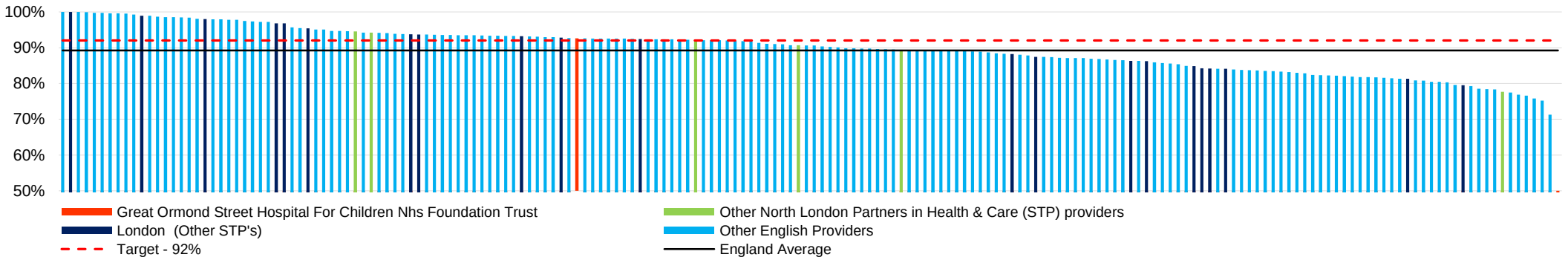
**Definition:** "The percentage of patients on an incomplete pathway who have been waiting no more than 18 weeks, as a proportion of the total number of patients on incomplete pathways," reported as the average of each month end position through the year.

The national performance standard for the incomplete Referral-To-Treatment (RTT) metric (92%) was introduced in 2012. This metric is about improving patients' experience of the NHS – ensuring all patients receive high quality elective care without any unnecessary delay.

### National context of performance

The chart below shows how the Trust compares to other organisations nationally for the first 11 months of 2018/19, the latest national data available.

**18 week Referral to Treatment incomplete pathway - 11 months to February 2019 (tested indicator)**




Source: Deloitte analysis of NHS Digital data

### National context of data quality

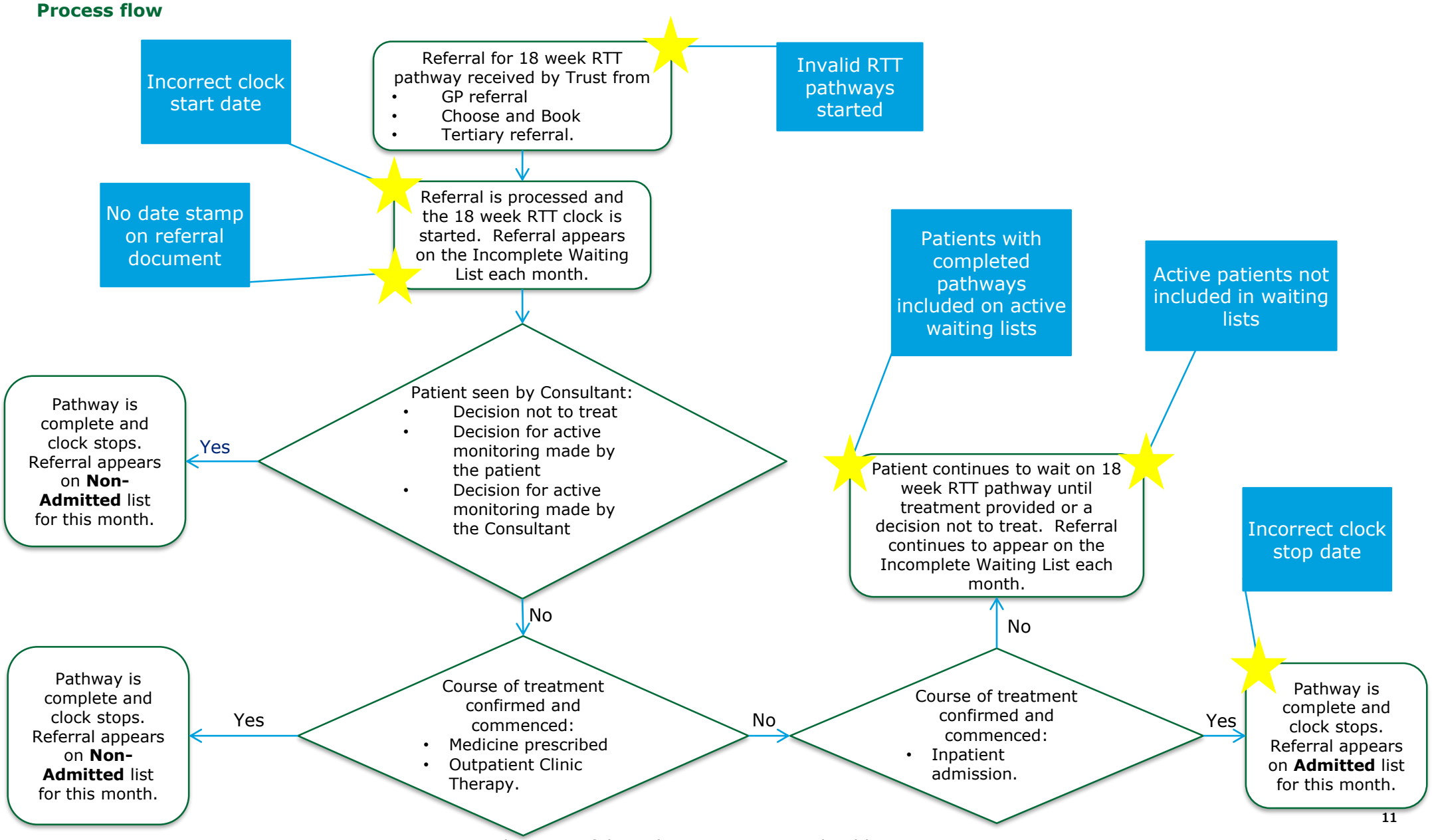
NHS Improvement mandated the 18 week RTT indicator for testing for the first time in 2014/15. Nationally, in the first year of testing only 41% of trusts subject to testing received a clean opinion. The indicator has continued to be mandated, with many trusts experiencing continued issues. Although some trusts were able to address issues relatively quickly (particularly where they related to data retention issues), with the number of qualifications falling form 61 in 2014/15 to 52 in 2015/16, the complexity and scale of RTT reporting mean that there were still 42 qualifications in 2017/18 nationally.

NHS Improvement have reviewed auditor reporting on this metric, and noted that of the qualifications, most relate to control environment and data testing issues, with common themes including clock stops and pauses, clock start dates, data retention, duplicated pathways for the same patient, system issues, and weaknesses in patient referral processes.

# 18 week Referral to Treatment times (continued)

## We have qualified our opinion with respect to this indicator

**Process flow**



# 18 week referral to treatment times (continued)

## We have qualified our opinion with respect to this indicator

**Approach**

- We met with the Trust's lead for the 18 week RTT metric to understand the process from patient referral to the result being included in the Quality Report.
- We evaluated the design and implementation of controls through the process. We discussed with management and used analytical procedures to identify whether there were any periods during the year or divisions within the Trust representing a greater risk that we should focus sample testing on. As a result we focused our testing on pathways within one week of the 18 week waiting period, as those are pathways where errors are most likely to impact the level of breaches reported by the Trust. We also included a random sample across the full population.
- We selected a sample of 20 from 1 April 2018 to 31 January 2019, following patient records through until treatment We identified a high error rate, as described in more detail to the right.
- Due to errors identified in the sample we did not extend our testing to cover the final three months of the year as additional testing would not alter our opinion.
- We recalculated the indicator reported in the quality report.

**Findings**

We identified the following errors; more than one error may relate to a single sample:

- Two instances of invalid pathways, whereby we could not be assured as to the validity of pathways included in the dataset provided for testing;
- One instance of an incorrect clock start being recorded and two instances of a clock stop being recorded incorrectly. Monthly reporting was affected in the case of one clock stop.
- One instance of the pathway being attached to the wrong specialty. Monthly reporting was unaffected.
- Two instances of insufficient support for the start date recorded due to missing date stamps on referral documents. For one sample we were able to confirm reporting is unaffected based on the earliest possible start date per referral letter, for the second we were unable to confirm whether reporting was affected; and
- Three further instances of incorrect reporting, whereby the number of active patients on the waiting list was over/understated as a result of late processing of the clock stop/start dates.

Due to the quantity of errors and the pervasive nature of some of the errors discovered, we are unable to quantify the effect of these errors on the reported indicator and have issued a modified opinion.

**Deloitte View:**

The high error rate in the current year continues to highlight the difficulties inherent in RTT pathway management and reporting; despite robust processes, the degree of manual input and individual judgment required by the current system result in making the reporting of this indicator a challenging task for the Trust, especially given the variety and complexity of RTT pathways.

The unsuitability of the Trust's patient administration system for this task was noted in our prior year's report, which leads us to highlight the Trust's planned migration to EPIC which is expected to improve future RTT reporting.

We note that, whilst high, the level of error identified in our sample is not outside the range of other Trusts we audit, and national trends continue to show significant levels of qualifications due to RTT, demonstrating the challenges faced by the sector in reporting the indicator.

Given the results of our testing we issued a modified opinion for 2018/19.

# Number of PICU delayed discharges

## This is the first year of review for this indicator

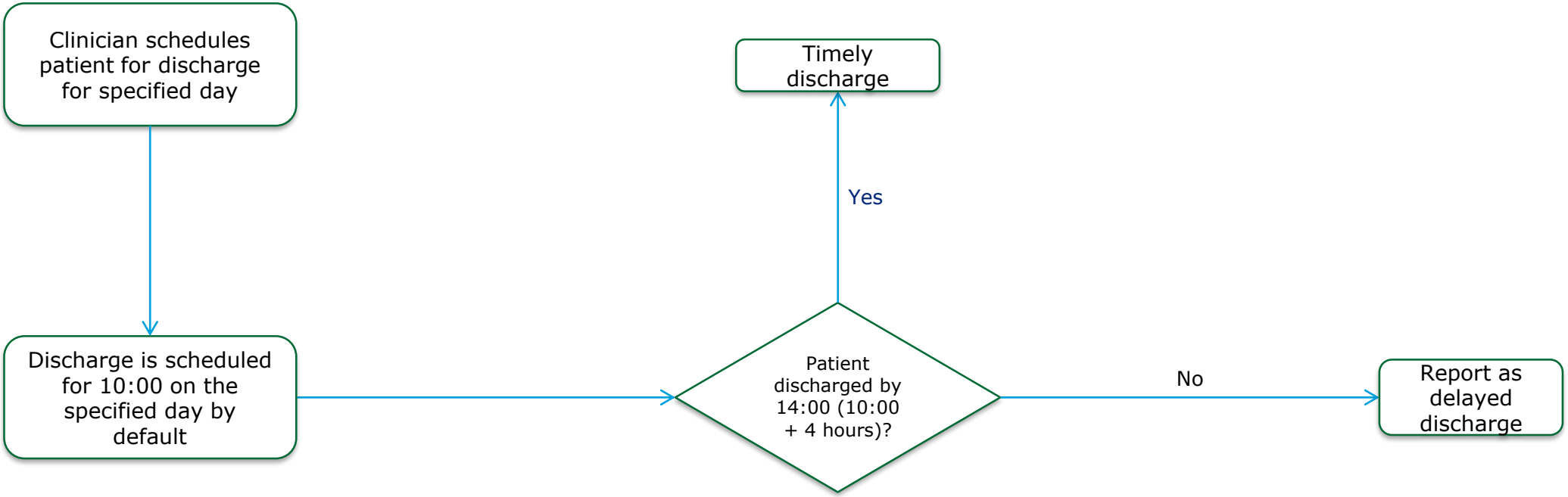
| | Trust reported performance | Target | Overall evaluation |
|---|---|---|---|
| 2018/19 | Between 8 and 24 hours - 16<br>More than 24 hours – 43 | n/a | No opinion required |

### Indicator definition and process

**Definition:** Discharges from the Paediatric Intensive Care Unit (PICU) must be completed within four hours from 10:00. Any discharges that take place after 14:00 are reported as delayed discharges. The indicator is reported as a simple total all the delayed discharges that took place during the year.

There is no national standard for this indicator. The indicator is monitored and reported internally by the Trust in order to ensure a smooth flow of patients into and out of the war, thereby avoiding admission delays and ensuring increased patient satisfaction.

### Process flow



# Number of PICU delayed discharges

## This is the first year of review for this indicator

### Approach

- We met with the Trust's leads to understand the process from identifying patients scheduled for discharge to identifying and recording delayed discharges, and to the overall performance being included in the Quality Report. There were no recommendations from the previous auditor's review of last year's Quality Report as this indicator was not part of the external assurance work.
- We selected a sample of 24 from 1 April 2018 to 31 March 2019. During our work we found no errors.
- We recalculated the indicator reported in the quality report.

### Findings

No errors or exceptions were noted as a result of our testing, however:

- It came to our attention that over the course of the year, the reporting team had received PICU information which was not presented in a manner consistent with its intended reporting goals. This issue did not affect our testing but has resulted in a finding with regard to the Trust's reporting process.

### Deloitte View

We did not identify any errors or exceptions as a result of our testing, however we did note miscommunication between the data extraction team and the team who were receiving this data in order to report it in the Quality Report. The final intended use of the information was not communicated clearly to the team extracting the information, which could have resulted in incorrect reporting as the PICU data was not necessarily separately identifiable from NICU data (Neonatal Intensive Care Unit delayed discharges) in the way it was presented to the reporting team. This issue was only identified after challenge of the data by Deloitte. We have included a recommendation with regard to this issue in order that the Trust may avoid similar future occurrences with this or other indicators, which could result in misreporting over the course of the year or at the end of the year.

# Future changes in reporting requirements

# Clinically-led Review of NHS Access Standards

## The NHS National Medical Director has issued an interim report on recommendations for updating and supplementing current targets

**Issue**

In 2018 Professor Stephen Powis, NHS National Medical Director, was asked to carry out a clinical review of standards across the NHS, with the aim of determining whether patients would be well served by updating and supplementing some of the older targets currently in use.

An interim report in March 2019 made a number of recommendations across elective care, urgent care, cancer and mental health, to replace and/or add to the existing clinical access standards. The standards are designed to support:

- shorter waiting times for a wider range of clinical services;
- more emphasis on standards that improve the quality of clinical care and outcomes;
- shorter waiting times for A&E and planned surgery, by tracking the entire wait for every patient; and
- standards that will enable trusts to modernise their care without being penalised.

The new standards are planned to be field-tested during 2019/20 and then implemented during 2020/21, with field testing to consider both the practicalities of adoption and also whether they:

- promote safety and outcomes;
- drive improvement in patient experience;
- are clinically meaningful, accurate and practically achievable;
- ensure the sickest and most urgent patients are given priority;
- ensure patients get the right service in the right place;
- are simple and easy to understand for patients and the public; and
- do not worsen inequalities.

The proposed indicators are set out on the next page. Dependant upon the final changes, this may affect the scope of Quality Report testing in from 2020/21.

**Deloitte View**

The choice of specific targets to measure often involves trade-offs in what is captured, or not captured, by the indicators selected, and in the behaviours that are incentivised.

There have been a variety of responses to the proposals, reflecting in part the changes in what would be emphasised (and deemphasised) relative to the current targets and indicators.

The intention of the new indicators is to measure what is most important clinically and to patients. As the implementation of new standards progresses, it will be important that organisations do not focus solely upon achievement of performance against the selected metric, and that there is continued focus on the overall quality and timeliness of care provided to service users.

We highlight that the implementation of new metrics will require process and potentially system changes, and it will be important for the Trust to consider controls over data quality as part of implementing any changes.

# Clinically-led Review of NHS Access Standards (continued)

## The NHS National Medical Director has issued an interim report on recommendations for updating and supplementing current targets

### Urgent care

The proposed standards would replace the current 4 hour wait target with a measure of the average waiting time, and a specific measure for treatment of the most critically ill patients.

- Time to initial clinical assessment in Emergency Departments and Urgent Treatment Centres (type 1 and 3 A&E departments). (The report does not include a specific target).
- Time to emergency treatment for critically ill and injured patients (complete a package of treatment in the first hour after arrival for life-threatening conditions).
- Mean waiting time in A&E (all A&E departments and mental health equivalents).
- Utilisation of Same Day Emergency Care. The aim is to complete all diagnostic tests, treatment and care that are required in a single day.
- Call response standards for 111 and 999.

### Mental health

A series of new indicators are proposed for testing, which would replace the current Early Intervention in Psychosis and Improving Access to Psychological Therapies targets. These would focus on faster access for mental health crises, with slower but timely targets for other support.

- Expert assessment within hours for emergency referrals; and within 24 hours for urgent referrals in community mental health crisis services.
- Access within one hour of referral to liaison psychiatry services and children and young people's equivalent in A&E departments.
- Four-week waiting times for children and young people who need specialist mental health services.
- Four-week waiting times for adult and older adult community mental health teams.

### Cancer

The proposed standards combine existing standards into simplified overall metrics:

- Faster Diagnosis Standard: Maximum 28 day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening.
- Maximum two-month (62-day) wait to first treatment from urgent GP referral (including for breast symptoms) and NHS cancer screening.
- Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.

### Elective care

The current 18 week RTT target may be revised, and a patient choice standard introduced.

- Maximum wait of six weeks from referral to test, for diagnostic tests (the current standard is to be retained).
- Defined number of maximum weeks wait for incomplete pathways, with a percentage threshold (current 18 week RTT threshold and maximum wait to be reviewed) **OR** Average wait target for incomplete pathways.
- 26-week patient choice offer (patients will be able to choose whether to access faster treatment elsewhere in a managed way).
- 52-week treatment guarantee.

# Appendices

# Appendix 1: Recommendation for improvement

## We have made the following recommendations

| Indicator | Deloitte Recommendation | Management Response |
|---|---|---|
| 31 day cancer | **Training for relevant staff**<br>We recommend that guidance and training should be made available regarding the correct documents on which the start and stop dates are to be based, as we noted numerous instances of the start and stop dates used being out of line with NHS guidance on this pathway. | The Trust will ensure that the importance of correct documentation for capturing pathway start and stop dates is incorporated into the standard operating procedure for the tracking pathways.<br>**Responsible Officer:** Peter Hyland, Director of Operational Performance and Information<br>**Timeline:** July 2019<br>**Process for updating Council of Governors:** Verbal |
| 31 day cancer | **Implement procedures to ensure proper audit trail**<br>We recommend that procedures be implemented to ensure the correct documents are produced and filed in order to allow relevant staff to properly determine the pathway start dates (decision to treat) and pathway stop dates (first treatment). Instances were noted where the proper documents were not available resulting in start and stop dates that could not be validated properly. | The functionality provided by the EPIC system will ensure that documents can filled within the system and linked to the relevant activity. The action above will ensure the process is known for the capturing of the necessary documentation.<br>**Responsible Officer:** Peter Hyland, Director of Operational Performance and Information<br>**Timeline:** Completed with EPIC<br>**Process for updating Council of Governors:** Verbal |
| 18 weeks RTT | **Implement procedures to ensure date stamped referrals**<br>We recommend that the Trust implement procedures to ensure that all referral letters are date stamped to properly evidence the pathway clock start. | This will be picked up as part of the standard operating procedure within the Outpatient Booking Centre.<br>**Responsible Officer:** Daniella Soar, General Manager – Sight and Sound<br>**Timeline:** July 2019<br>**Process for updating Council of Governors:** Verbal |

# Appendix 1: Recommendation for improvement (Continued)

## We have made the following recommendations

| Indicator | Deloitte Recommendation | Management Response |
|---|---|---|
| 18 weeks RTT | **Increased automation and reduced manual input**<br>Our recommendation in the prior year was to ensure additional automation or assurance controls were included in the new processes and workflows associated with the migration to EPIC EPR, in order to reduce the risk of human error. We are highlighting the same recommendation in the current year as this is a continuing issue, which is demonstrated by our findings in the current year. | With the introduction of our new EPIC EPR system, this provides a more automated process for the capturing of outcomes. The attendance outcome is derived based on other outcomes. However given that the RTT outcome is based on a clinical decision, the Clinician responsible for the patients care still needs to select the correct outcome and therefore is still prone to human error, which is something that cannot be changed. In parallel, training for EPIC has encompassed RTT outcome codes and tip sheets have been created to highlight the codes that need to be selected. In addition EPIC presents the most likely possible RTT outcomes for the patient based on their pathway status to date, with an aim to improve the quality of the pathway information.<br>**Responsible Officer:** Peter Hyland, Director of Operational Performance and Information<br>**Timeline:** Completed with EPIC<br>**Process for updating Council of Governors:** Verbal |
| PICU delayed discharges | **Clear communication of intended use of data**<br>During our testing we identified that there was an apparent lack of communication between the team extracting the data and the team that were responsible for analysing and reporting such data. The data being provided included not only PICU data but also NICU, and the data was provided in such a format that it was not easily identifiable.<br>We would recommend that the team providing the data is always made aware of its end-use, mitigating the risk of any potential misreporting. | The Information team will develop a presentation to provide an overview of what data is being collected and what it is used for all stakeholders in the process.<br>**Responsible Officer:** Sean Hession, Principal Analyst and Clinical Information Lead<br>**Timeline:** July 2019<br>**Process for updating Council of Governors:** Verbal |

# Appendix 2: Update on prior year recommendations

| Indicator | Prior year finding | Deloitte Recommendation | Current year status |
|---|---|---|---|
| 18 weeks RTT | We identified 2 samples whereby the patient should not have been included for RTT reporting as per RTT guidance. The process of admitting a patient requires manual input on PIMS to confirm if a patient is on an RTT relevant pathway, which creates a risk of manual error in the process. | **Reduction of manual data input**<br>We acknowledge the Trust is taking steps to re-train staff and that this step in the process is a limitation of the current PIMS system. The Trust will be considering the required processes and workflows needed for the move to EPIC EPR and as part of this should ensure that any additional automation or assurance controls can be added to reduce the risk of human error.<br>**Responsible Officer:** Peter Hyland - Director of Operational Performance and Information<br>**Timeline:** April 2019 | With the introduction of our new EPIC EPR system, this provides a more automated process for the capturing of outcomes. The attendance outcome is derived based on other outcomes. However given that the RTT outcome is based on a clinical decision, the Clinician responsible for the patients care still needs to select the correct outcome and therefore is still prone to human error, which is something that cannot be changed. In parallel, training for EPIC has encompassed RTT outcome codes and tip sheets have been created to highlight the codes that need to be selected. In addition EPIC presents the most likely possible RTT outcomes for the patient based on their pathway status to date, with an aim to improve the quality of the pathway information. |
| Great Ormond Street acquired CVC related bacteraemia (GOSACVCRB) | We identified that the data collection process for total line days relies on manual data input, and there is a risk of incomplete or inaccurate data being submitted. | **Completeness of Line day data**.<br>We recommend that the Trust consider if data collection could be automated or whether stronger controls could be implemented to check and remind staff to complete the dataset each day as required.<br>**Responsible Officer:** Peter Hyland - Director of Operational Performance and Information<br>**Timeline:** August 2018 | The collection of CV line information has now been automated within the EPIC system with the reporting completed through a feed into the RL system. |

# Appendix 3: Audit opinion

Below is an extract from our audit opinion:

**Basis for qualified conclusion**

***Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period***

The "percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period" indicator requires that the NHS Foundation Trust accurately record the start and end dates of each patient's treatment pathway, in accordance with detailed requirements set out in the national guidance. This is calculated as an average based on the percentage of incomplete pathways which are incomplete at each month end, where the patient has been waiting less than the 18 week target.

Our procedures included testing a risk based sample of 20 items, and so the error rates identified from that sample should not be directly extrapolated to the population as a whole.

We identified a number of issues during testing (with some samples having more than one issue). We noted the following errors:

- Two instances of invalid pathways;
- One instance of an incorrect clock start being recorded and two instances of a clock stop being recorded incorrectly. Monthly reporting was affected in the case of one clock stop.
- One instance of the pathway being attached to the wrong specialty. Monthly reporting was unaffected.
- Two instances of insufficient support for the start date recorded due to missing date stamps on referral documents. For one sample we were able to confirm reporting is unaffected based on the earliest possible start date per referral letter, for the second we were unable to confirm whether reporting was affected; and
- Three further instances of incorrect reporting, whereby the number of active patients on the waiting list was over/understated as a result of late processing of the clock stop/start dates.

As a result of the issues identified, we have concluded that there are errors in the calculation of the "maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway" indicator for the year ended 31 March 2019. We are unable to quantify the effect of these errors on the reported indicator.

The "Performance against key healthcare targets" section on page XX of the Trust's Quality Report details the actions that the NHS Foundation Trust is taking to resolve the issues identified in its processes.

# Responsibility statement

# Purpose of our report and responsibility statement

## Our report is designed to help you meet your governance duties

### What we report

Our report is designed to help the Council of Governors, Audit Committee, and the Board discharge their governance duties. It also represents one way in which we fulfil our obligations to report to the Governors and Board our findings and recommendations for improvement concerning the content of the Quality Report and the mandated indicators. Our report includes:

- Results of our work on the content and consistency of the Quality Report, our testing of performance indicators, and our observations on the quality of your Quality Report.
- Our views on the effectiveness of your system of internal control relevant to risks that may affect the tested indicators.
- Other insights we have identified from our work.

### What we don't report

- As you will be aware, our limited assurance procedures are not designed to identify all matters that may be relevant to the Council of Governors or the Board.
- Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.
- Finally, the views on internal controls and business risk assessment in our final report should not be taken as comprehensive or as an opinion on effectiveness since they will be based solely on the procedures performed in performing testing of the selected performance indicators.

### Other relevant communications

- Our observations are developed in the context of our limited assurance procedures on the Quality Report and our related audit of the financial statements.

We welcome the opportunity to discuss our report with you and receive your feedback.

**Deloitte LLP**

28 May 2019

This report is confidential and prepared solely for the purpose set out in our engagement letter and for the Board of Directors, as a body, and Council of Governors, as a body, and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent. You should not, without our prior written consent, refer to or use our name on this report for any other purpose, disclose them or refer to them in any prospectus or other document, or make them available or communicate them to any other party. We agree that a copy of our report may be provided to NHS Improvement for their information in connection with this purpose, but only the basis that we accept no duty, liability or responsibility to NHS Improvement in relation to our Deliverables.

Deloitte.

Attachment J

Great Ormond Street Hospital for Children NHS Foundation Trust

# Council of Governors

## 17 July 2019

### Update from the Constitution Working Group: Council of Governors' Effectiveness Review Survey

Background

The Code of Governance (B.6.5) states that the Council of Governors should periodically assess its performance. This gives the Council an opportunity to review its roles, structure, procedures and support requirements, taking into account emerging best practice.

The Council's 2019 assessment will be informed by questionnaires sent to both the Council of Governors, Non-Executive Directors, Chief Executive and Chief Finance Officer.

Attached for consideration by the Council of Governors are the Constitution Working Group's (CWG) proposed questions. These questions were informed by:

- Requirements in the Code of Governance (covering areas such as clarity of roles, Council composition, support to the Council, training, development and group dynamics).
- Previous GOSH Council of Governors' (Members' Council) surveys.
- GOSH Constitution.
- Other Foundation Trust surveys.
- Review by the Constitution Working Group on 3 July 2019.

This will be the first evaluation of the 2018 intake of Governors. Questions have been phrased so that they can be used in future evaluations and the results benchmarked to monitor progress. Some of the questions were used in previous Council of Governors' surveys.

The final report to the 26 November 2019 meeting of the Council of Governors' will provide comparison with previous questions where possible.

Timeline and next steps

Following amendment / approval by the Council, the questionnaire will be circulated via SurveyMonkey in the week commencing Monday 22 July 2019 with a deadline of Friday 6 September 2019.

The Trust will aim for a 100% return rate from Governors, the Non-Executive Directors, the Chief Executive and Chief Finance Officer.

The Constitution Working Group will meet before the end of October 2019 to review the results and propose recommendations. Where appropriate, the CWG will recommend immediate improvement measures to the Lead Governor and Deputy Lead Governor. A final report will then be presented to the 26 November 2019 Council of Governors' meeting.

Recommendation

1. Review and approve the questions for circulation to Governors and Directors.
2. Review and approve the timeline and next steps.

**Proposed questions**

Questions for Governors

The majority of the survey questions is for Governors.

| Area of focus | # | Question | Scale of measurement<br>• Agree<br>• Undecided<br>• Disagree<br>• Free text box<br>(Unless otherwise specified below) |
|---|---|---|---|
| 1. Governance, structure and composition of the Council of Governors | 1.1 | I have a good understanding of my role and responsibilities as a member of the Council of Governors including:<br>• holding the non-executive directors to account for the performance of the board,<br>• communicating with member constituencies and the public and transmitting their views to the board,<br>• Contributing to the development of the Trust strategy, annual report and accounts, etc. | |
| | 1.2 | I understand the difference between the role of the Council and the role of the Trust Board. | |
| | 1.3 | I understand the difference between the role of an Executive Director and Non-Executive Director. | |
| 2. Contribution of the Council of Governors | 2.1 | Are you aware of the Trust's Annual Plan? | Yes<br>No |
| | 2.2 | Governors are appropriately consulted on the development of the Trust's Annual Plan. | |
| | 2.3 | Governors are provided with sufficient information to know what the key risks and challenges facing the organisation are. | |
| | 2.4 | Governors are provided with sufficient guidance and background information when asked to make decisions. E.g. When making changes to the Constitution or appointing NEDs. | |
| | 2.5 | Governors are provided with sufficient opportunity to attend the Assurance Committees* in order for them to observe the Non-Executive Directors.<br>(*Audit Committee, Quality, Safety Experience Assurance Committee, People and Education Assurance Committee and Finance and Investment Committee). | |

| Area of focus | # | Question | Scale of measurement<br>• Agree<br>• Undecided<br>• Disagree<br>• Free text box<br>(Unless otherwise specified below) |
|---|---|---|---|
| | 2.6 | Governors are provided with the meeting papers for the Assurance Committees of the Trust Board sufficiently in advance. | |
| | 2.7 | Governors' are made to feel welcome at Assurance Committees. | |
| | 2.8 | Governors are given appropriate opportunity to engage, comment and participate appropriately at the Assurance Committee meetings. | |
| | 2.9 | Governors are provided with the opportunity to follow up issues arising from the Assurance Committees of the Trust Board with Non-Executive Directors. | |
| | 2.10 | Governors have appropriate access to the Chair, the Board and the Senior Independent Director (James Hatchley). | |
| | 2.11 | The Trust Board has regard for the views and contribution of the Council of Governors. | |
| 3. Management of the Council of Governors Meeting | 3.1 | Governors have the opportunity to influence the Council of Governors' meeting agenda. | |
| | 3.2 | The Council of Governors' papers provide the right amount of information. | |
| | 3.3 | The Council of Governors' papers are circulated with sufficient time for review. | |
| | 3.4 | Agree or disagree:<br>• Meetings are chaired effectively<br>• Agenda items are properly introduced<br>• Appropriate time is allocated to discuss agenda items fully<br>• Discussions are appropriately summarised at the meeting. | |
| | 3.5 | During a meeting, Governors are given the opportunity to bring up a topic or ask a question that is not on the meeting agenda. | |
| | 3.6 | Council of Governor actions are followed up and reported back on at the next meeting | |
| 4. Culture and behaviour | 4..1 | Meetings are not dominated by individual Governors. | |

| Area of focus | # | Question | Scale of measurement<br>• Agree<br>• Undecided<br>• Disagree<br>• Free text box<br>(Unless otherwise specified below) |
|---|---|---|---|
| | 4.2 | Do you feel you have sufficient opportunity to contribute to Council meetings?<br>If you have answered 'no' then what would assist you to contribute more? | Yes<br>No<br><br>Freetext |
| | 4.3 | The behaviour of all Governors is consistent with the Trust's 'Always Values': always welcoming, always helpful, always expert and always one team. | |
| | 4.4 | New Governors receive relevant and appropriate induction training to undertake their role.*<br>*This includes, where relevant the role of Lead Governor and Deputy Lead Governor. | |
| | 4.5 | Governors receive relevant and appropriate mandatory training and training at development sessions to undertake their role. | |
| | 4.6 | The private sessions between the Chair and Council are beneficial to Governors' role.<br>If you disagree, please state why. | |
| | 4.7 | What works well at Council of Governors' meetings? | Free text box |
| | 4.8 | Governors are provided with sufficient opportunities to get involved in other aspects of Foundation Trust Governance e.g. working groups, review of reports, inspections as appropriate. | |
| | 4.9 | The Governors' newsletter and online portal support Governors in their role.<br>What else could be implemented to support Governors? | |
| 5. Final comments | 5.1 | What other support would you like to receive in your role as Governor? | Free text box |
| | 5.2 | Do you have any other comments related to the effectiveness of the Council of Governors? | Free text box |

Questions for the NEDs Chief Executive and Chief Finance Officer

| Area of focus | # | Question | Scale of measurement<br>• Agree<br>• Undecided<br>• Disagree<br>• Free text box<br>(Unless otherwise specified below) |
|---|---|---|---|
| Governance, structure and composition of the Council of Governors | 1 | Governors understand the difference between the role of the Council and the role of the Trust Board. | |
| | 2 | Governors understand the difference between the role of an Executive Director and Non-Executive Director. | |
| | 3 | Governors direct their questions to the NEDs. | |
| Contribution of the Council of Governors | 4 | The Trust Board has regard for the views and contribution of the Council of Governors. | |
| Management of the Council of Governors Meeting | 5 | Agree or disagree:<br>• Council meetings are chaired effectively<br>• Council agenda items were properly introduced<br>• Appropriate time is allocated to discuss Council agenda items fully<br>• Discussions are appropriately summarised. | |
| Culture and behaviour | 6 | The behaviour of Governors is consistent with the Trust's 'Always Values': always welcoming, always helpful, always expert and always one team. | |
| Council of Governors' effectiveness | 7 | The Council is effective in performing its role in:<br>• holding the non-executive directors individually and collectively to account for the performance of the board of directors,<br>• communicating with member constituencies and the public and transmitting their views to the board of directors,<br>• Contributing to the development of the Trust strategy, annual report and accounts, etc. | |
| Final comments | 8 | Would you make any changes to the management or development of the Council of Governors to make it more effective in 2019/20? | Free text box |
| | 9 | Do you have any other comments related to the effectiveness of the Council of Governors? | Free text box |

**Appendix 1: B.6.5 of the Code of Governance**

B.6.5. of the code of g Led by the chairperson, the council of governors should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities, including their impact and effectiveness on:

- holding the non-executive directors individually and collectively to account for the performance of the board of directors.
- communicating with their member constituencies and the public and transmitting their views to the board of directors; and
- contributing to the development of forward plans of NHS foundation trusts.

Great Ormond Street Hospital for Children NHS Foundation Trust

## Attachment K

# Council of Governors

**17 July 2019**

**Reappointment of a Non-Executive Director (James Hatchley)**

**Summary & reason for item:**

The Council of Governors Nominations and Remuneration Committee recommends the reappointment of Mr James Hatchley, Non-Executive Director on the GOSH Trust Board.

**Council Action**

To consider and approve the recommendation.

**Presented by**: Anna Ferrant, Company Secretary

**Council of Governors**

**17 July 2019**

**Reappointment of a Non-Executive Director (James Hatchley)**

Introduction

Mr James Hatchley – NED and Senior Independent Director was appointed for a three year term on 1 September 2016. His current term expires on 31 August 2019 and under the Trust Constitution he is eligible for reappointment for another three years, subject to approval of the Council of Governors.

Mr Hatchley has expressed a wish to be reappointed for another three years and the Board fully supports this.

The Council of Governors' Nominations and Remuneration Committee considered the request for reappointment in relation to the number and balance of NEDs on the Board, their skill mix, the independence of Mr Hatchley as well as he is most recent appraisal.

Mr. Hatchley has provided a statement supporting his request to be reappointed at **Appendix 1**.

The committee considered the following information:

- Information from the most recent appraisal of Mr Hatchley including his attendance at Board and Board committees (**Appendix 2**)**.** Mr Hatchley has attended Council meetings throughout 2018/19.
- Information about Mr Hatchley's other commitments and his independence in his statement.
- Mr. Hatchley has declared that he meets the Fit and Proper Person's Test and will act in accordance with the Code of Conduct for Board directors;
- A Board skills, experience and knowledge audit was conducted in April 2018 to support and inform the search for relevant skills and experience for the appointment of a new NED to the Board. A refreshed audit will be conducted in Q2 2019/20 to support the work being conducted around the Board development programme and reflecting on the skills, knowledge and experience of the NEDs and executives.

The committee fully supported a recommendation to reappoint Mr James Hatchley for a further three years. The committee noted his commitment to the Trust and his informed, supportive and quality-focused approach to the role.

**ACTION REQUIRED:** The Council of Governors is asked to approve the recommendation from the Council Nominations and Remuneration Committee to reappoint Mr James Hatchley as a NED on the GOSH Board from 1 September 2019 to 31 August 2022, after which time he will stand down from the Board.

Attachment K

For information

Number of NEDs on the Board and tenures

As outlined in Monitor's "*Your Statutory Duties – A reference guide for NHS foundation trust governors*", the procedure for all reappointments to the Board must be formal, rigorous and transparent. As part of the process, governors should consider the relevant aspects of the NHS foundation trust's constitution and the *Code of Governance* as outlined below:

- **the requirements of the NHS foundation trust's constitution concerning the number of non-executive directors:**

The Trust Constitution states that the Board is made up of:

  - *a non-executive Chairman;*
  - *not more than 6 independent non-executive directors;*
  - *not more than 6 executive directors; and*
  - *at least half the board (excluding the Chairman) will comprise independent non-executive directors.*

For information, the table below shows the length of tenure for all non-executive directors on the GOSH Board, including their membership of Board assurance committees.

| **Name** | **Appointments to Board** | **Total tenure as at 30 June 2019** | **Subject to reappointment or stepping down?** | **Assurance committees** |
|---|---|---|---|---|
| Sir Michael Rake (Chair) | First appointed 1 November 2017 for 3 years | 1 year 7 months | Can request reappointment for further 3 years from 1 November 2020 (subject to CoG approval) | |
| Mr. Akhter Mateen, Deputy Chair | First appointed 28 March 2015 for 3 years<br><br>Reappointed from 29 March 2018 for 3 years | 4 years and 3 months | Steps down 28 March 2021 | Audit Committee (Chair)<br>Finance and Investment Committee (Member) |
| Professor Rosalind Smyth (UCL appointment) | First appointed 1 January 2013 for 3 years<br><br>Reappointed 1 January 2016 for 3 years<br>Reappointed 1 January 2019 for 1 year | 6 years 6 months | Reappointment to be confirmed prior to 1 January 2020 (noting requirement for annual review) | Quality, Safety and Experience Assurance Committee (Member) |

Attachment K

| Name | Appointments to Board | Total tenure as at 30 June 2019 | Subject to reappointment or stepping down? | Assurance committees |
|---|---|---|---|---|
| Mr. James Hatchley, NED and SID | First appointed 1 September 2016 for 3 years | 2 years and 10 months | Reappointment subject to review by the CoG in July 2019 | Finance and Investment Committee (Chair)<br>Audit Committee (Member)<br>People and Education Assurance Committee (Member) |
| Mr. Chris Kennedy, NED | First appointed 1 April 2018 for 3 years | 1 year and 3 months | Can request reappointment for further 3 years from 31 March 2021 (subject to CoG approval) | Finance and Investment Committee (Member)<br>Audit Committee (Member) |
| Lady Amanda Ellingworth, NED | First appointed 1 January 2018 for 3 years | 1 year 6 months | Can request reappointment for further 3 years from 31 December 2020 (subject to CoG approval) | Quality, Safety and Experience Assurance Committee (Chair)<br>People and Education Assurance Committee (Member) |
| Ms Kathryn Ludlow, NED | First appointed 1 September 2018 for 3 years | 10 months | Can request reappointment for further 3 years from 31 August 2021 (subject to CoG approval) | People and Education Assurance Committee (Chair)<br>Quality, Safety and Experience Assurance Committee (Member) |

Appendix C

**James Hatchley, Non-Executive Director, Senior Independent Director, Chair of the Finance and Investment Committee, Chair of the Remuneration Committee and Chair of the Joint GOSHCC/GOSH, Hospital Priorities Steering Group**

**Statement for consideration by the Council of Governors for reappointment to the GOSH Board**

I have been a Non-Executive Director of Great Ormond Street Hospital NHS Foundation Trust since September 2016. Prior to that, I served for 18 months as an independent member of the Audit Committee and the Quality and Safety Assurance Committee. I have also had direct experience of the hospital and its work as a parent of a child at GOSH. As my formal three year term comes to an end, I am seeking reappointment for a further three years.

I feel honoured to have fulfilled the above roles for some or all of the last three years. I have sought to make a direct contribution to outcomes across a number of initiatives over this term and have, I believe, offered both challenge and support to the executive team. Such roles are not without conflict from time to time and I embrace this and believe this is an important feature of effective governance.

Examples of key areas in which I believe I have played a significant governance role over the last three years have been:

- executive management change and transition
- the whistleblowing and freedom to speak up agenda
- questioning commercialization of research and other areas within the hospital
- focus on ways to meet the evolving financial challenges facing GOSH
- the prioritisation of charitable funding and effective communication between the GOSHCC and the Trust
- the implementation of EPR
- plans to undertake major expansion (phase 4/CCC); and
- focus and mitigation of key risks.

I also attend the majority of the GOSHCC Trustee meetings at their kind invitation as an observer, and spend significant additional time outside of my set role meeting with staff across the Trust. I am also an active fundraiser for GOSHCC and have first-hand experience of the challenges associated with, and the success of, our Charity partner.

I would be the first to acknowledge that GOSH is not perfect and I remain particularly disappointed when we fail to meet our own standards in areas which should be fixable and with the feedback received from our staff through the recent staff survey. There is of course amazing work done and incredible outcomes achieved at GOSH every day but I truly believe we can and must do better tomorrow than we do today even, and especially, in the face of an uncertain NHS funding backdrop.

To support my reappointment, I would like to highlight a number of specific areas where I believe I can continue to contribute significantly to GOSH if selected for reappointment.

**Governance:** I will continue to focus on effective challenge in relation to the formal governance posts I fill. I believe I am open to different views and perspectives, approachable and transparent in my work. I will continue to try to balance being supportive of management with being a challenging and critical friend. I will also continue to seek out and take on board independent reference points to ensure my perspective is not only derived directly from management.

Appendix C

**Cultural Change:** I remain humbled by the challenge of seeking to make significant cultural change across the Trust over the next few years. I believe the Board can provide critical leadership and decision making in this regard and I am personally committed to this journey and keen to see pressure remains on the executive team to prioritize this. My proposed role as a member of the newly formed People and Education Assurance Committee is an important way for me, and my NED colleagues, to specifically influence and track this agenda.

**Projects/joint prioritization of funding with the Charity**: making the most of our partnership with the Charity is fundamental for what we can deliver now and in the future to the children and families than need GOSH's services. This is particularly the case given the increasing financial uncertainty that NHS institutions live under. I am totally committed, particularly through my Chairmanship of the Finance and Investment Committee, to continuing to scrutinize the proposed CCC redevelopment that has the potential to have a transformational impact on the Trust. The relationships and experience I have across both the Charity and the hospital allow me to play an important role in how we make the most of the funding we have for the benefit of our staff and patients both today and for tomorrow.

**Commercialisation of Intellectual Property (IP) and research:** GOSH is an innovator and global leader across many areas. This follows from its emphasis and focus on research and from management leadership e.g. the investment and prioritization of the "Drive" initiative. I believe we can and need to do more to assist management in the commercialization of this IP for the benefit of GOSH itself and to give a greater chance of creating additional sustainable funding streams outside of the NHS. I look forward to continuing to use my experience to introduce contacts, help construct the right governance framework and skills to allow these initiatives to succeed.

I also look forward to continuing to be transparent and open with the Council of Governors as it relates to my areas of responsibility and to ensure that the relevant priorities of the Governors are considered and a close working relationship between Governors and NEDs is maintained. I see the following as continuing to be potentially important: Governor observation at Committees, informal meetings and/or buddying or other forms of getting together to promote communication and dialogue.

In addition to my roles at GOSH, I am the Group Strategy Director of 3i Group plc, a FTSE 100 listed private equity and infrastructure investment trust. This is a full time executive role. In this capacity, I am a member of the 3i Group Investment Committee that is responsible for all of the investments made by 3i Group. In addition, I am a Non-Executive Director and Chair of the Audit and Risk Committee of Scandlines, a leading Danish ferry business 35% owned by 3i Group. Prior to joining the 3i Group, I was the Chief Operating Officer of KKR in Europe and, before that, Co-CEO of Avoca Capital. I am a qualified Chartered Accountant and have over 20 years of experience as a corporate finance professional based in the City. Notwithstanding my full time executive role at 3i Group, I have given significant time to fulfilling my duties at GOSH over the last three years. It remains a high priority for me personally and I am confident that that I will continue to be able to provide an independent perspective in my NED role and continue to give the right level of commitment over the next three years.

I bring my executive experience together with a sense of how rewarding and hard it is to work at GOSH and how important GOSH is to its families and patients. It would be a privilege to continue to work with the Trust Board and Council of Governors and serve the Trust as a Non-Executive Director for a further three year term.

**James Hatchley**

Attachment L

Great Ormond Street Hospital for Children NHS Foundation Trust

# Council of Governors

## 17 July 2019

### Governance update

Summary & reason for item:

The purpose of this paper is to provide a summary of governance work undertaken related to the Council of Governors since the 6 February 2019 Council meeting. The report includes:

- Evaluation of buddying
- Proposed changes to 'Member Matters'
- Managing Council of Governors' declarations of interest and gifts and hospitality
- Governor statutory training update
- Governors' online portal update
- Annual General Meeting and Annual Members Meeting planning
- Membership statistics report as at 5 July 2019
- Revised Foundation Trust Membership Form
- Council of Governors' development session update
- Feedback from Governor training and education events

Key comments from the February and April meetings of the Membership Engagement, Recruitment and Representation Committee (MERRC) are included under relevant items.

Governor action required:

- Approve continuation of the buddying program, as well as the key principles and next steps
- Approve the consolidation of Trust news, updates and involvement opportunities into one regular, monthly email.
- Login and complete statutory training by 1 September 2019.
- To note the report and pursue any points of clarification or interest.

**Report prepared by:**

Paul Balson, Deputy Company Secretary, paul.balson@gosh.nhs.uk

**Report presented by:**

Paul Balson, Deputy Company Secretary

Attachment L

## Evaluation of buddying

Background

In July 2018, Governors were paired with NEDs based on their expressed interests, experiences, and committee interests. The Corporate Affairs team facilitated the first meeting of each buddying group and encouraged them to choose how often and in what format they met.

In February 2019 it was reported that the buddying programme would be evaluated and a report prepared for 17 July 2019 meeting of the Council of Governors. It was reported that dependent on feedback, buddying would either be continued or alternative arrangements considered.

On 13 June 2019 Governors and NEDs were sent a survey to inform this review.

- Three of five NEDs (60%) completed the survey (Kathryn Ludlow started after the first allocation of Buddying groups and was not sent the survey).
- 11 of 22 Governors (50%) completed the survey (Josh Hardy, Emma Beeden, Margaret Bugyei-Kyei and Carley Bowman started after the first allocation of Buddying groups and were not sent the survey).

Summary of results

The feedback received from both Governors and NEDs could be summarised as:

*Buddying has the potential to support both NEDs and Governors and while both groups broadly support it, more proactive engagement from both is required. To deliver on this potential, the program needs to be opt-in, the buddying objectives need to be refreshed with regular reminders circulated, larger buddying groups are required (E.g. two NEDs paired with a maximum of nine Governors) meeting in scheduled informal meetings and / or teleconferences.*

An analysis of the results and the full results are included at Appendix 1.

Recommendations

It is recommended to the Council that the Buddying Program be refreshed and continue with the following key principles:

1. The Buddying program will be made optional to Governors who will be asked to 'Opt in'.
2. The Non-Executive Directors will be paired together offering a range of skills and experiences to each buddying group.
3. A maximum of nine Governors will be matched with a pair of NEDs. Each Governor will be matched with a different NED buddy to the NED they were matched with in February 2019. This matching will last for a period of six months, after which Governors will join with another pair of NEDs.
4. NED pairings will last for 18 months, allowing all Governors to experience buddying in each group.

Next steps

If this approach is approved:

1. Governors will be asked to opt-in to the revised buddying program.
2. The Company Secretary will determine the pairings of NEDs.
3. Governors will be allocated to the new pairings, ensuring that all Governors are allocated to new NEDs.
4. Corporate Affairs Team will facilitate the first meeting of the new Buddying program (before October 31st) and provide ongoing support if rooms, teleconference facilities or other

support is required. The objective of the first meeting will be to formalise the aims and expectations of both Governors and NEDs of the buddying program.

5. Buddying groups then arrange subsequent meetings' style, format and frequency.
6. A further review of the effectiveness of buddying will take place in six months' time.

**Governor action required**

- Approve continuation of the buddying program
- Agree the principles and next steps

## Proposed changes to Member Matters

Background

Member Matters is the bi-annual (Spring and Autumn) 16-page publication sent to all members. The content of these magazines is tailored to benefit both our younger people and adult audiences with two versions produced:

- A youth edition for under 16s and,
- An adult edition for over 16s.

The magazine is sent to members either digitally or by post, depending on their registered communications preference. The content includes a variety of stories from across the hospital, from membership news and events to research breakthroughs, patient stories and 'behind the scenes' features. The Trust's Internal Comms team prepares the magazines, with contribution from the Patient Experience team, governors, and others stakeholders. The lead time for content is two months to allow for content scoping, writing, proofing, design and sign off.

At the April 2019 meeting of the Membership Engagement, Recruitment and Retention Committee (MERRC), members voiced concerns around:

- How well Member Matters serves the needs of the foundation trust, both in terms of the channel and the way people take on board information.
- Value for money and impact on the environment in printing and mailing multiple copies. At present 2,930 members have opted for a hard copy at a cost of c£2.5k.
- Its ability to include the most recent information. Producing a magazine twice a year means that content is generally out of date and is repurposed from other hospital and charity channels, often weeks or months before the magazine goes to print.
- Digital readership statistics are low and there is no ability to gauge readership of printed copies. See appendix 2 for the readership statistics.

Proposal

To maximise engagement with the membership, while allocating appropriate time and resources, it is proposed that:

- The Trust shift the way the membership takes on board information about the hospital by consolidating the news, updates and involvement opportunities into one regular, monthly email

The benefits of this will:

- Encourage a digital-first approach to communicating with our members.

- Enable us to share timely and relevant news features and opportunities for member involvement.
- Reduce cost for the trust (print and postage) and champion sustainability.
- Allow us to better track membership readership and engagement rates.

Next steps

If approved, the Trust will Inform members via the 'Member Matters' – Autumn edition and the August, September and October editions of 'Get involved' that the Trust will be moving to a paperless electronic monthly communication from November 2019.

**Action required by Governors**

- Approve the consolidation of Trust news, updates and involvement opportunities into one regular, monthly email.
- Approve the next steps.

## Managing Council of Governors' declarations of interest and gifts and hospitality

Background

As Governors will be aware, new guidance released by NHS England requested consistency and transparency in the way interests are managed across the NHS. The guidance asks Trusts to:

- Have clear management of declarations of interest within organisations.
- Ensure that all staff are aware of the revised policy.
- Certain staff (called decision making staff) will make annual mandatory declaration of interest and gifts and hospitality returns.

This guidance formed the basis of the soon to be approved GOSH policy: Management of declarations of interest and gifts and hospitality.

Who makes a declaration?

Under the GOSH policy, all staff must declare interests on appointment and within 28 days via a positive declaration to their organisation.

Some staff are more likely than others to have a decision making influence on the use of taxpayers' money in their role. These people are referred to as 'decision making staff' and need to make an annual declaration or 'nil' declaration. Within the GOSH Policy, the following staff have been agreed as 'Decision making staff':

- **Governors on the GOSH Council of Governors**
- Executive and non-executive directors
- Members of the Senior Leadership Team at GOSH
- All consultants and honorary consultants

Progress to date

To date, the Corporate Affairs team has:

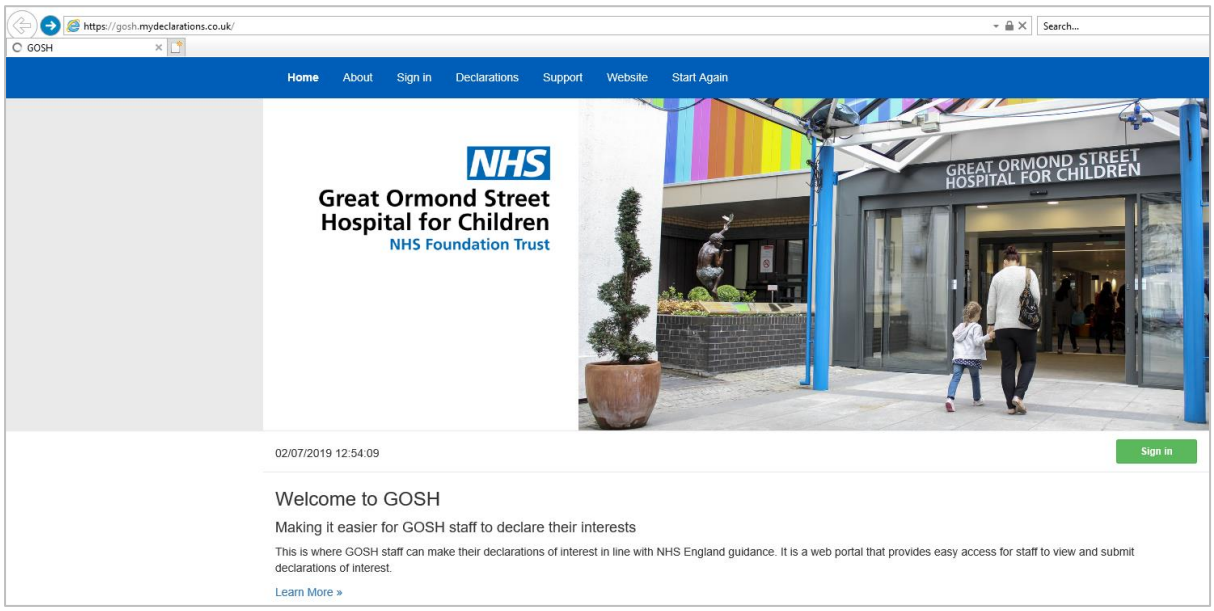
- Identified the Decision Making (DM) Staff.
- Requested that the decision making staff provide written declarations of interest forms.
- These forms are in the process of being uploaded to the internet

Attachment L

Next steps

To better manage the declarations of interest for the 550 individuals identified as decision makers, the Trust has purchased an online portal called MES Declare.

From 1 August 2019 all staff will be able to declare electronically on the website https://GOSH.mydeclarations.co.uk . Governors will be issued with usernames and passwords for the site before 1 August 2019. The website will look like the diagram below:




Governors will login with their username and password and make their declarations.

All declarations will then be reviewed by the Company Secretary. The declarations for all 'Decision Making Staff' will then be published on the Trust Website.

**Action required by Governors**

- Prepare to make declarations on the system from 1 August 2019.

## Governor mandatory and statutory training

Background

On the 24th July 2018 the Council of Governors received their last Council of Governors' induction session. This session included instructions on how to access the mandatory and statutory training. At this session, Governors were issued with usernames and passwords to access the GOLD website.

The statutory courses for governors are:

- Fire Safety
- Health and Safety
- Information Governance
- Infection Prevention & Control
- Prevent Level 2
- Safeguarding Adults Level 1
- Safeguarding Children Level 1
- Moving & Handling – non-clinical non-patient handler
- Counter Fraud
- Equality, Diversity & Human Rights

At the time of reporting, the level of Governor completion requires improvement.

It is acknowledged that some of the Governors started their terms after 24th July 2018 and were not issued with usernames or passwords.

Attachment L
The Corporate Affairs team have:

- Created new profiles for the Governors who have started after 24 July 2018.
- Refreshed the Governor profiles that expired (profiles that have not been logged into for more than 90 days are frozen and closed down).

The usernames, passwords and hyperlinks required to access the training will be issued to all Governors on 17 July 2019.

Action required

Governors should login to their email accounts and online training at their earliest convenience and complete the courses required of them by 1 September 2019.

The training is available online. Additionally, the Trust learning lab in Weston House has computers set up for the completion of training if required.

Governors should login to their profiles at least once every 90 days to ensure their accounts are not frozen by IT.

Any Governors having difficulty accessing the training should contact the Deputy Company Secretary

**Action required by Governors**

Login and complete statutory training by 1 September 2019.

Login at least once every 90 days.

Contact the Deputy Company Secretary paul.balson@gosh.nhs.uk if there are any difficulties in accessing the training.

## Governors online portal

To date seven of 26 Governors have access to the Governors' Portal which provides a range of documents and information to support Governors in their role.

All Governors who do not currently have access are encouraged to arrange this via the Deputy Company Secretary as soon as possible. For security purposes, the invite to join the portal expires after six days. Once access is granted it is easy to login and view the documents.

## Annual General Meeting and Annual Members meeting

At the April 2019 meeting of MERRC, members discussed the theme of the AGM and AMM on 1 October 2019, which will be 'Sustainability and Efficiency'. A number of proposals were made including the following

- Have a stand on social sustainability which would include an opportunity to appeal for more members from groups currently underrepresented in the membership.
- A stand on staff sustainability which would outline all the schemes human resources and organisational development have that contribute to staff health and wellbeing.
- The food provided should be (as far as practicable): vegan, sustainably sourced and have a low carbon footprint.
- Staff statistics on travel arrangements. E.g. how many staff cycle to work and what the Trust is doing to encourage it.
- Create a short video consisting of YPF members or young patients talking about what sustainability means to them e.g. what does a 'Green Hospital' look like and how does it compare with our plans?

- A few activities stands e.g. arts and crafts using recycled materials.
- The event should not use single use plastics.
- A robot demonstration from DRIVE
- Energy costs from annual report
- Key issues for the year ahead from the Chair.

These suggestions have been built into the AGM and AMM planning.

**Action required by Governors**

Governors are asked to:

- Make every effort to attend the AGM and AMM on Tuesday 1 October 2019.
- Contribute any further ideas for the 'Sustainability and efficiency' 2019 AGM and AMM to paul.balson@gosh.nhs.uk by 31 July 2019.

## Membership statistics and report as at 5 July 2019

Anyone living in England and Wales over the age of 10 can become a GOSH member, and the Trust strives for our membership to reflect the broad and diverse public communities we serve as well as patients, their families and carers, and staff.

This report provides a summary of our public, parent and carer and patient membership (it does not include staff membership).

Membership Engagement Services (MES) is our membership database provider and holds and manages our public and patient, parent and carer data. Statistical analyses were run within the database and the attached report produced to highlight key findings.

Targets for 2019/20

At the April MERRC meeting, the following targets for 2019/20 were approved:

- Increase public membership overall by 85 members.
- Increase patient, parent and carer membership overall by 208 members.

Targets are calculated using the closing figures of the previous financial year, subtracting 5% (owing to general attrition) and adding 8%. The table below details the calculations.

| Constituency | Membership at 31 March 2019 | 5% attrition | 8% growth | Net difference | Target membership for 2019/20 |
|---|---|---|---|---|---|
| **Public** | 2825 | 141 | 226 | 85 | 2910 |
| **Patient, Parent and Carer** | 6947 | 347 | 556 | 208 | 7155 |
| **Total** | 9772 | 489 | 782 | 293 | 10065 |

Specific demographic targets

Following a review of the public membership demographics, the Committee also agreed the following targets:

- Increase the number of 0-16 year old public members by 100% (37 to 72)
- Increase the number of 0-16 year old patient members by 100% (116 to 232)

Attachment L

Current membership figures

| Current positon as at 5 July 2019 | Performance against yearly projected target | Action required |
|---|---|---|
| Total membership<br>**9,772** | Total membership has remained the same since 31 March 2019. | To meet our target of 10,065 by 31st March 2020 we need to recruit 293 members. |
| Patient and Carer membership<br>**6947** | Although the total number of patient and carer members has remained the same since 31 March 2019, there were changes within the constituencies. | To meet our target of 7,155 by 31st March 2020 we need to recruit 208 patient, parent and carer members. |
| Public membership<br>**2,825** | Although the total number of Public members has remained the same since 31 March 2019, there were changes within the constituencies. | To meet our target of 2,910 by 31st March 2020 we need to recruit 85 public members. |

MERRC has discussed the targets and has set the following key actions for recruitment across both patient and carer and public membership:

- Define what the benefits of being a Foundation Trust member are and publicise these.
- Use the expertise of YPF to shape engagement approaches.
- Make better use of social media channels as advised by YPF members.
- Hold Member recruitment events in the Lagoon.
- Have Governor representation at Charity events to encourage the recruitment of new members.
- Print and share the revised membership form.

Public membership profile and analysis of eligible membership compared with percentage of base population

| | | # | % of membership | The number of people in the local area in each constituency | % of area | Index* |
|---|---|---|---|---|---|---|
| **Gender** | Male | 784 | 27.75 | 29,237,843 | 49.44 | 56 |
| | Female | 2009 | 71.12 | 29,894,538 | 50.56 | 141 |
| | Unspecified | 32 | 1.10 | 0 | 0.00 | 0 |
| **Age** | 0-16 | 35 | 1.24 | 12,038,823 | 20.32 | 6 |
| | 17-21 | 158 | 5.59 | 3,488,059 | 5.89 | 95 |
| | 22+ | 2,413 | 85.42 | 43,708,089 | 73.79 | 116 |
| | Not stated | 219 | 7.75 | 0 | 0.00 | 0 |
| **Ethnicity** | Asian | 337 | 11.93 | 4,213,531 | 7.51 | 159 |
| | Black | 238 | 8.42 | 1,864,890 | 3.33 | 253 |
| | Mixed | 118 | 4.18 | 1,224,400 | 2.18 | 191 |
| | White | 1,778 | 62.94 | 48,209,395 | 85.97 | 73 |
| | Other | 354 | 12.53 | 563,696 | 1.01 | 1,247 |

Attachment L

*Index: A value indicating how representative of the area is of the membership is. 100 is perfectly representative, <100 is underrepresented and >100 is over represented.

Analysis

The public membership is underrepresented in the following demographics:

- Males make up 49.44% of the eligible membership, but only represent 27.75% of our actual membership.
- 0-16 year olds make up 20.32% of the population, but only represent 1.24% of our actual membership.
- 17-21 year olds are only just underrepresented.
- Public members of White ethnicity make up 85.97% of the eligible membership but only represent 62.94% of our actual membership.

The public membership is overrepresented in the following demographics:

- Females make up 50.56% of the eligible membership, but 71.12% of the actual membership.
- Public members aged 22+ make up 85.42% of the population, but represent 85.42% of the actual membership.
- Public members of Asian ethnicity make up 7.51% of the eligible membership but represent 11.93% of the actual membership
- Public members of mixed ethnicity make up 2.18% of the eligible population but represent 4.18% of the actual membership.
- Public members of black ethnicity make up 3.33% of the eligible membership but represent 8.42% of the actual membership.

At the April meeting of MERRC, members requested more detail on the specific demographics that the Trust needed to recruit and how it could tailor specific recruitment strategies using the Trust's forums.

## GOSH Open Day: share your vision for future GOSH

Children, young people and families were invited to the Trust Open Day to learn more about how GOSH operates today and explore how the hospital could operate in 20 years' time.

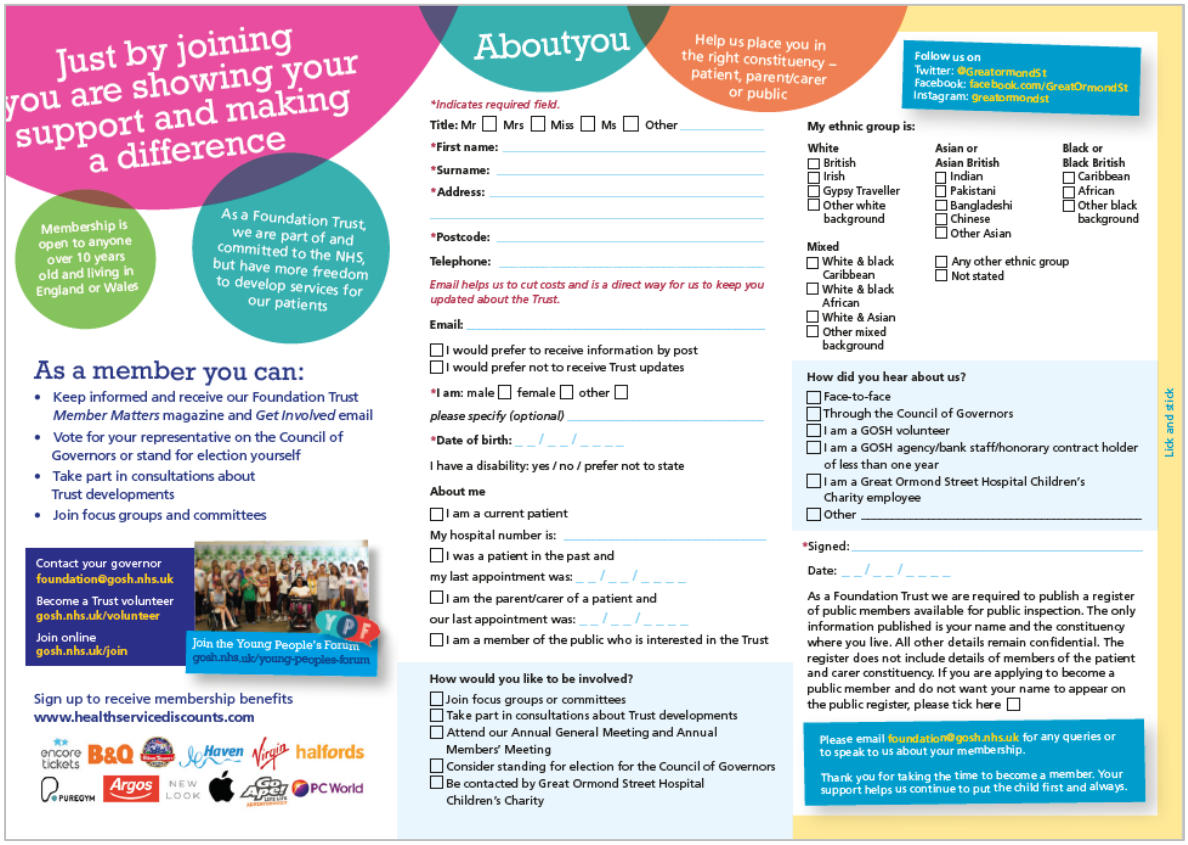
On 9 July, the Trust held a space themed Open Day for patients and families at the hospital on 9th July 2019 from 11 – 3pm to explore what they want from a future GOSH with fun activities for all ages. Governors were invited to support a stall for Foundation Trust membership.

Paul Gough – Staff Governor and Josh Hardy – YPF Governor supported the stall and recruited 37 new members at the event.

Attachment L

## Revised Foundation Trust Membership form

The MERRC approved the new Foundation Trust membership form for print. This has also been approved by the Information Governance Manager. Governors are asked to approve the form for printing.



Just by joining you are showing your support and making a difference

Membership is open to anyone over 10 years old and living in England or Wales

As a Foundation Trust, we are part of and committed to the NHS, but have more freedom to develop services for our patients

As a member you can:

- Keep informed and receive our Foundation Trust *Member Matters* magazine and *Get Involved* email
- Vote for your representative on the Council of Governors or stand for election yourself
- Take part in consultations about Trust developments
- Join focus groups and committees

Contact your governor
foundation@gosh.nhs.uk
Become a Trust volunteer
gosh.nhs.uk/volunteer
Join online
gosh.nhs.uk/join

Join the Young People's Forum
gosh.nhs.uk/young-peoples-forum

Sign up to receive membership benefits
www.healthservicediscounts.com

Aboutyou

Help us place you in the right constituency – patient, parent/carer or public

Follow us on
Twitter: @GreatOrmondSt
Facebook: facebook.com/GreatOrmondSt
Instagram: greatormondst

*Indicates required field.

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ____

*First name: ____

*Surname: ____

*Address: ____

*Postcode: ____

Telephone: ____

*Email helps us to cut costs and is a direct way for us to keep you updated about the Trust.*

Email: ____

☐ I would prefer to receive information by post
☐ I would prefer not to receive Trust updates

*I am: male ☐ female ☐ other ☐

*please specify (optional)* ____

*Date of birth: __ __ / __ __ / __ __ __ __

I have a disability: yes / no / prefer not to state

About me

☐ I am a current patient
My hospital number is: ____
☐ I was a patient in the past and
my last appointment was: __ __ / __ __ / __ __ __ __
☐ I am the parent/carer of a patient and
our last appointment was: __ __ / __ __ / __ __ __ __
☐ I am a member of the public who is interested in the Trust

How would you like to be involved?

☐ Join focus groups or committees
☐ Take part in consultations about Trust developments
☐ Attend our Annual General Meeting and Annual Members' Meeting
☐ Consider standing for election for the Council of Governors
☐ Be contacted by Great Ormond Street Hospital Children's Charity

My ethnic group is:

White
☐ British
☐ Irish
☐ Gypsy Traveller
☐ Other white background

Asian or Asian British
☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Chinese
☐ Other Asian

Black or Black British
☐ Caribbean
☐ African
☐ Other black background

Mixed
☐ White & black Caribbean
☐ White & black African
☐ White & Asian
☐ Other mixed background

☐ Any other ethnic group
☐ Not stated

How did you hear about us?

☐ Face-to-face
☐ Through the Council of Governors
☐ I am a GOSH volunteer
☐ I am a GOSH agency/bank staff/honorary contract holder of less than one year
☐ I am a Great Ormond Street Hospital Children's Charity employee
☐ Other ____

*Signed: ____

Date: __ __ / __ __ / __ __ __ __

As a Foundation Trust we are required to publish a register of public members available for public inspection. The only information published is your name and the constituency where you live. All other details remain confidential. The register does not include details of members of the patient and carer constituency. If you are applying to become a public member and do not want your name to appear on the public register, please tick here ☐

Please email foundation@gosh.nhs.uk for any queries or to speak to us about your membership.

Thank you for taking the time to become a member. Your support helps us continue to put the child first and always.

Lick and stick

**Action required by Governors**

- Approve the new membership form for printing

## Council of Governors' development session update

Background

Following the July 2018 Council of Governors' meeting, Governors were sent a template to help the Corporate Affairs team design a Council of Governors' development plan for the rest of 2018/19 and 2019-2021.

To date there have been three development sessions. The content and learning objectives have been:

| Date | February 2019 | April 2019 | July 2019 |
|---|---|---|---|
| **Title session 1** | How quality is measured at GOSH | Better Value | NHS Providers refresher<br>Presented by an external organisation. |
| **Objectives session 1** | How GOSH measures quality outcomes | This year's target and programme | Governance and the role of the Governor |

Attachment L

| | | | |
|---|---|---|---|
| | The standards GOSH benchmarks itself against<br>How GOSH uses Clinical Audit | Governance and reporting of Better Value<br>Four key Better Value priority themes<br>Benchmarking and best practice with other Foundation Trusts | The importance of listening and effective questions |
| **Title session 2** | Finance at GOSH | Sustainability and efficiency | |
| **Objectives session 1** | Tariffs and their impact<br>Research funding<br>International and Private Patients income<br>Relationship with the Charity | Health problems caused by air pollution.<br>How GOSH will lead the health sector response.<br>The Clean Air Hospital Framework<br>Longer term ambitions | |

Change to format of development sessions

Following a meeting between the Lead Governor, Deputy Lead Governor, Company Secretary and Deputy Company Secretary, it was agreed that:

- The format of the development sessions would be changed to allow for three topics to be covered rather than two.
- Time for Governors to meet and discuss issues in private would be scheduled.

From the November 2019 meeting onwards, the format of development sessions will be as follows:

| Time | Meeting | Comment |
|---|---|---|
| 11.15 to 1.30pm | Three varied 45 minute development sessions | These sessions will be selected dependent on the topics selected by Governors in August 2018 and topical developments at the Trust |
| 1.30pm to 2.15pm | Private Governor session with Lead Governor/ Deputy Lead Governor (with sandwich lunch) | This session will be led by the Lead Governor/ Deputy Lead Governor. |
| 2.15pm to 3.00pm | Private meeting between Council of Governors and Chair | These meetings will continue as before. |

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## Feedback from Governor training and education events

Governor focus conference 2019

Quen Mok – Staff Governor attended the Governor Focus conference in May 2019. The conference was a Governor-specific programme to help Governors explore how they can be best equipped to support their Trusts in delivering quality healthcare.

Two highlights selected by Quen as potential pieces of work to take forward include:

- Gloucestershire Hospitals NHS Foundation Trust – Building Governor confidence and capability. As part of a journey to a CQC 'outstanding' rating, the Trust created a comprehensive 18-month development plan. The first phase focused on building Governor capability and confidence, followed by two subsequent phases on raising the governor profile and engaging existing members, and finally recruiting new members. A product of the first phase was a pamphlet which provided a concise summary of Governor responsibilities, how members could contact their governor and other key points.
- Guy's and St Thomas' NHS Foundation Trust – Engaging members. The Governor's membership development and communications group implemented a new member newsletter called Listening line. The newsletter gives trust members a chance to directly engage with governors and aims to ensure that their voices are heard and responded to directly, as well as giving governors and clearer sense of member interests and concerns.
- A list of the showcased schemes' are presented at Appendix 4. The Membership Engagement Recruitment and Representation Committee will discuss and consider the schemes for implementation at GOSH.

GOVSEC's Government IT Security Conference

Josh Hardy - YPF Governor attended the GOVSEC's Government IT Security Conference in May 2019.

GOVSEC is run by Whitehall Media and aims to enable government to function effectively, safely and securely through improved IT and information security. The all-day conference explored how public sector organisations and professionals can make sense of securing their functions in a rapidly changing environment. Highlights from the conference included:

- 5G will enable humans to perform surgery via robots in 2020.
- The World Economic Forum global risk report highlights technological and biological risks as the fourth and sixth most demanding risks facing the World.
- The International Cyber Security Protection Alliance (ICSPA) Project 2020 suggests that there will be an increase in economic cyber espionage attacks on businesses, governments and individuals.
- It was predicted, that if not already, the global internet will separate into an entity per nation, region or political belief in 2020, which may cause disruption to GOSH's research and development.
- The UK's aim is to be a leading digital nation.
- Existing technology could enable GOSH to take care to the patient. Home management or hospital management apps allow monitors or implants to monitor anything from body temperature, heart rate and even gas, adjusting the climate, medication and the stove according to behavioural activity. This may be suitable for long term health conditions/disability's or advanced wards.

Recommendations from the conference (many of which are already in place at GOSH) included:

- Hold regular discussion at board level on cybersecurity

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- Develop and embrace a risk aware culture
- Assume that IT systems could be compromised from anywhere.
- Formalise contracts with suppliers so that they respond or assist to any identified vulnerabilities.
- Regular as well as spontaneous training.

Next steps

The future is exciting and it is clear that GOSH embraces technology. Josh recommends that there should be a consideration as to whether GOSH's cyber-security and AI could be enhanced. If so, this could increase human interaction, efficiency and our position in the healthcare sector. Vitally, this makes sure that patients and their families have shorter, interactive and high quality experiences at GOSH.

Please note: this topic could be scheduled for a Governor Development session in 2020.

National Share a Story Month

To celebrate National Share a Story Month, GOSH held a flash fiction writing competition for patients and staff. All participants wrote a story using the title 'Taking Flight' within 500 words.

The event was launched Wednesday 1 May at 2.00pm in the Staff Side of The Lagoon and closed on 31 May 2019. Mariam Ali – Parent and Carer from London Governor sat on a panel with three other judges on Tuesday 18 June 2019. There will be prizes in 4 categories (3 patient age groups, and one staff group) for a winning story that best captures the title's theme. The winners will be announced shortly.

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## Appendix 1: Buddying survey feedback

Key points from the survey

- 33% of Governors felt that buddying had supported them in their role as Governors. 33% felt it did not and 33% were neutral. The comments received indicated that while the Buddying program was a good idea, more proactive engagement from both NEDs and Governors would be required for it to work.
- One NED had found one-on-one meetings with Governors outside of the regular formal meetings and briefings before the formal meetings useful. Governor perspective as a parent / carer was also useful.
- Five of the 11 Governors felt that buddying had supported them in their role. Five were neutral and one disagreed. However, all Governors noted that the program had the potential to provide support.
- Four of 11 Governors agreed that buddying had met the objective of providing Governors with a direct contact with a NED to support them in their role. 4 of the 11 were neutral and 3 disagreed. The comments received indicated that buddying, was a good idea in principle but needed to be implemented properly.
- Four of 11 Governors agreed that buddying had met the objective of providing an opportunity for NEDs to highlight their role on the Board to Governors and flag the issues that they were interested in. Three were neutral and four disagreed. The comments indicates that not all governors were able to agree owing to varying levels of participation.
- The Buddying groups that did meet recommended informal telephone catch ups and clarification of roles to the other groups.
- Six of 11 Governors agreed that Buddying should continue, five were neutral. The comments under this question indicated the following:
    - Buddying should be optional for Governors.
    - The format, objectives and responsibilities (of both parties) need to be clarified.
    - Governors voted for the top three possible ways in which buddying could be enhanced. Overall, the top three suggestions were:
    - Create buddying groups with two NEDs.
    - Recommend that the Buddy groups meet up informally and undertake joint walkrounds of the Hospital.

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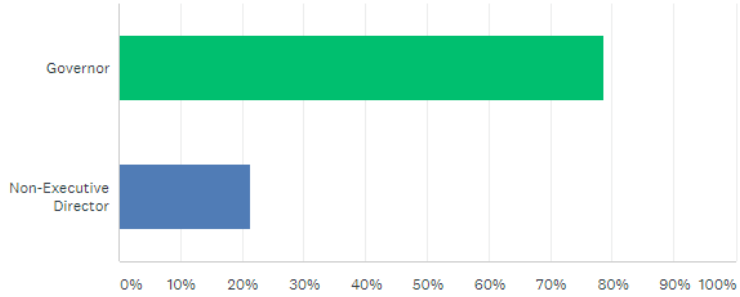
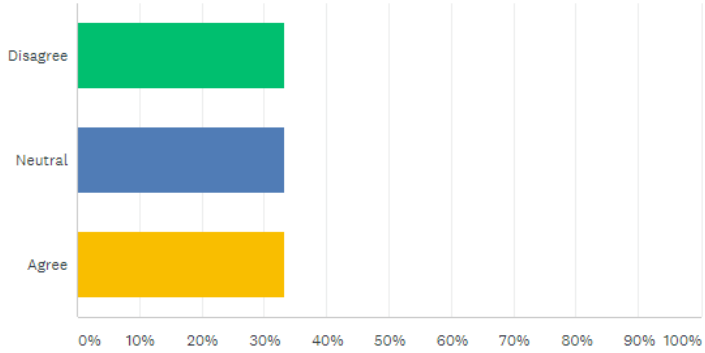
Q1: What is your role




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Governor | 78.57% | 11 |
| Non-Executive Director | 21.43% | 3 |
| TOTAL | | 14 |

Q2 To what extent do you agree or disagree that buddying has supported you in your role as a Governor? (Question was sent to Governors only)




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Disagree | 33.33% | 3 |
| Neutral | 33.33% | 3 |
| Agree | 33.33% | 3 |
| TOTAL | | 9 |

- Although I feel buddying is a good idea I don't feel we have been proactive enough for it to be beneficial
- The buddying needs to work better; currently it is failing due to lack of Governor engagement.
- It has proved virtually impossible to spend any time with the NED I am buddies with.
- Have only met buddy once
- I had one call with my NED, it was quite early after my appointment so I didn't have too many questions to start with

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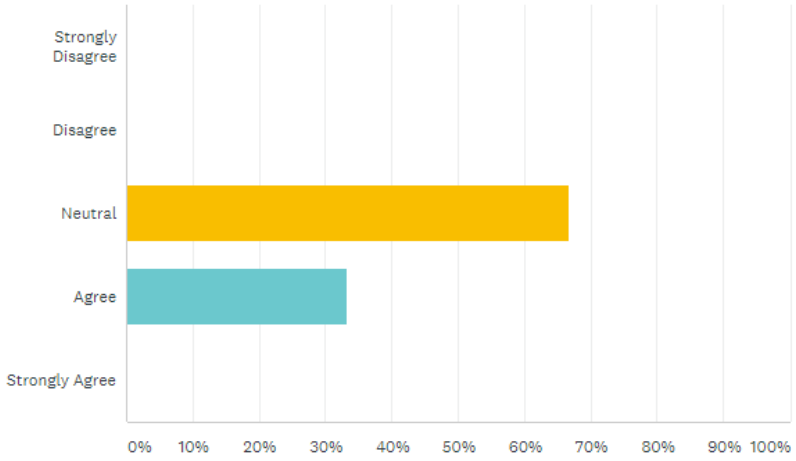
Q3: To what extent do you agree or disagree that buddying has supported you in your role as a Non-Executive Director? (Questions was sent to Non-Executive Directors only)




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Strongly Disagree | 0.00% | 0 |
| Disagree | 0.00% | 0 |
| Neutral | 66.67% | 2 |
| Agree | 33.33% | 1 |
| Strongly Agree | 0.00% | 0 |
| TOTAL | | 3 |

- Helpful to have the opportunity to speak to Governors one-on-one outside of the regular meetings schedule
- Only one gov wanted to participate. It was useful to meet her before each QSEAC as a way of prepping her for the meeting and she gave me her personal views as a parent of a patient rather than as a gov.
- Despite all efforts could not get to meet the entire group together. Over the year I have met with a couple of buddies on a one-to-one basis and these meetings have been very useful.

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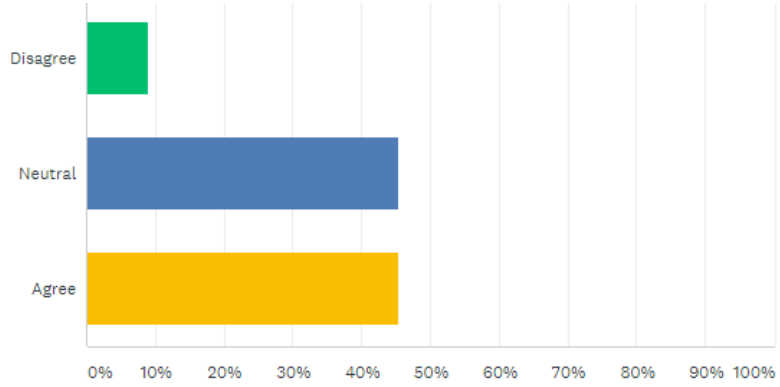
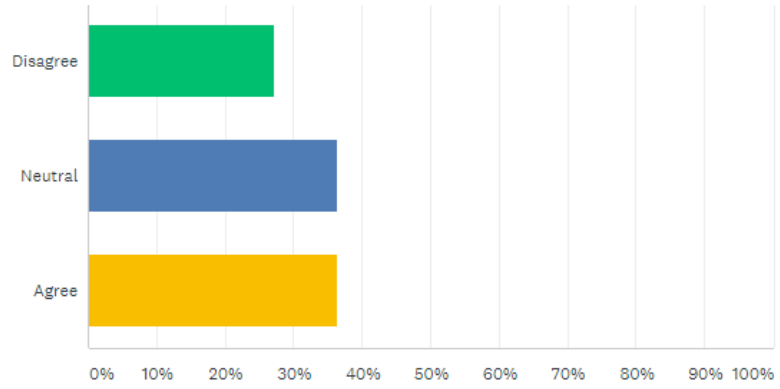
Q4: To what extent do you agree or disagree that buddying has created better working relationships between Governors and NEDs?




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Disagree | 9.09% | 1 |
| Neutral | 45.45% | 5 |
| Agree | 45.45% | 5 |
| TOTAL | | 11 |

- I do feel I know a little more about my 'buddy' NED and feel much more comfortable about approaching him if needs be.
- I'm not sure how good the working relationship was prior to the introduction of the buddying system but I can't say my relationship is better because of the buddying
- There has not been enough contact and this has frustrated NEDs and Governors.
- It is neither adding or subtracting would be my summary - potential for upside in establishing a more naturally flowing dialogue

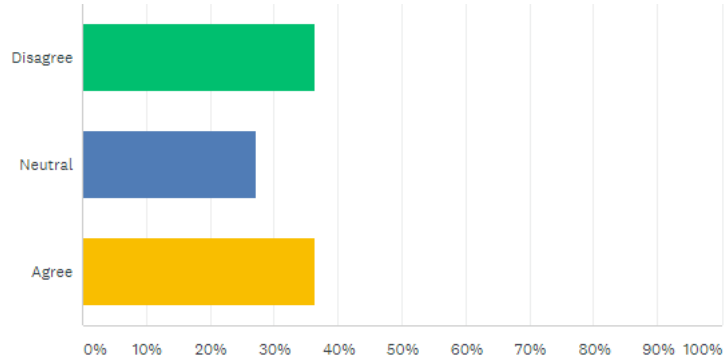
Q5: One of the objectives for the buddying program was to provide Governors with direct contact with a NED who can support their role and provide information and assurance on matters of interest or concern. To what extent do you agree or disagree that this objective was met?




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Disagree | 27.27% | 3 |
| Neutral | 36.36% | 4 |
| Agree | 36.36% | 4 |
| TOTAL | | 11 |

- I agree that there is now a line of communication for this to happen. But I haven't used it as such.
- haven't had cause to use this
- Suspect it is not part of the natural set of tools at the Governors disposal for the moment so whilst it is a good idea it has yet to really make a difference (YET - but we should continue with it)
- Had a very general discussion about the governor role with my NED buddy.
- for the one gov who participated
- I have their number but I think this would be too personal as a contact. It would've been useful to have an email address to contact for questions

Q6: One of the objectives of the buddying program was to provide an opportunity for NEDs to highlight their role on the Board to Governors and flag the issues that they are interested in.To what extent do you agree or disagree that this objective was met?




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Disagree | 36.36% | 4 |
| Neutral | 27.27% | 3 |
| Agree | 36.36% | 4 |
| TOTAL | | 11 |

- Not sure I can recall what interests by buddy has.
- Best for the NEDs to display their role through work on committees, at the Board and through other touch points within the hospital
- Not attended meetings with my NED buddy. Not sure who else is buddied with my NED, hence have not had a buddy group.
- haven't needed to do this
- for the one gov who participated.

Q7: Please list up to three specific features of your buddying group that you would recommend to other buddying groups? E.g. format of meetings, setting of meetings. If there were none, please enter 'n/a'.

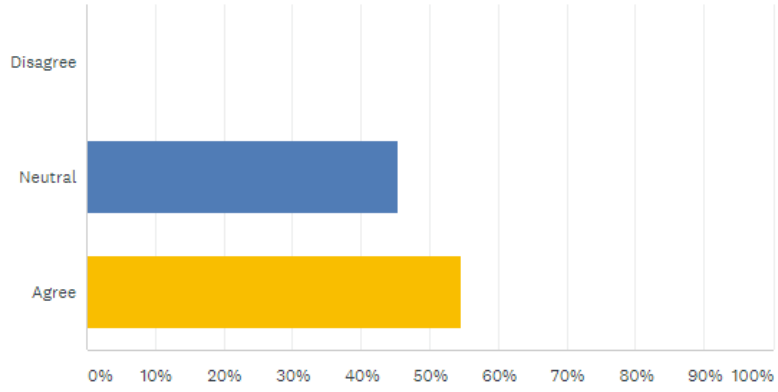
- informal telephone catch ups
- Flexibility
- meet before a QSEAC meeting they would attend to discuss papers
- A contact to go to for questions

- Supportive (non-judgemental)

Q8: What, if any, were the unintended effects from buddying (positive or negative)?

- I think Governors realise the NEDs are happy to be contacted. It has made that 'first contact' less daunting.
- In reality very little happened with relation to a buddying group
- Additional administration
- Objectives for buddying may need to be reiterated to NEDs
- Friendship
- i hope it helped the Gov let go of misconceptions and distrust a bit
- enhanced engagement

Q9: To what extent do you agree or disagree that buddying should continue?




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Disagree | 0.00% | 0 |
| Neutral | 45.45% | 5 |
| Agree | 54.55% | 6 |
| TOTAL | | 11 |

- Agree, but as long as we can make more use of the time/process
- It could be clarified where the responsibility sits for ensuring the system works sits. If it sits with the NED this could be used as an additional measure of their effectiveness i.e. are they offering opportunities to meet?
- I haven't particularly needed the buddying programme but if others report it has been useful then perhaps it should continue in the format that has best feedback
- I think it is a good idea in theory but it is probably should be optional would be my thought... If the objective is for the Governors to see how the NED executes his/her role I am not sure it is the right tool but as a way of exchanging views in an informal way I think it has and will continue to work...
- Objectives may need to be clarified for all concerned for it to be beneficial
- Im happy to if any of them want to. It can help to nip problems or misconceptions in the bud perhaps
- It is a good initiative but we need to rethink the format.

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Q10: Please rank the following possible ways buddying could be enhanced to achieve its objectives (1-6, 1 being good, 6 being poor)

| | TOTAL | SCORE |
|---|---|---|
| Joint buddy groups coffee morning style informal catch ups | 8 | 4.25 |
| Larger buddying groups with two NEDs (merging of buddying groups) | 7 | 4.14 |
| Walkrounds with NEDs | 9 | 3.67 |
| Scheduled conference calls with buddying groups | 10 | 3.10 |
| Tutorial style task and finish meetings on different subjects | 8 | 3.00 |
| Informal gatherings | 8 | 2.75 |

Q11: Do you have any additional comments on how the buddying program could be enhanced?

- I imagine experiences have varied by NED and by buddy group so it may be a good idea to try to standardise the best aspects and focus on theses
- It would be great if we could get this to work. Please continue it.
- table some form of informal time around existing Governor meetings (to make it as easy as possible to meet up)
- I think the objectives of the buddying may need to be revisited and clarified for all concerned
- It might be different for different govs, some are very busy and want no buddying, some only want phone calls to answer queries, others might want more face to face. Important it is kept to the Gov role and not stray into operational issues

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## Appendix 2: Member Matters readership statistics

Foundation Trust members can access *Member Matters*:

- By post – 2,930 members have opted for a hard copy
- Cost to post both adult and youth editions every six months: £2,344.52
- Through an email, which takes them to an online version at gosh.nhs.uk – roughly 6,500 members receive *MM* this way.

Email statistics and open rates

| Edition | Opens | Clicks | Sent to | Bounces |
|---|---|---|---|---|
| **2019** | | | | |
| Spring 2019 youth | 19% | 13% | 6,267 | 115 |
| Spring 2019 adult | 27.9% | 23.5% | 61 | 1 |
| **2018** | | | | |
| Autumn 2018 youth | 38.2% | 7.7% | 6,436 | 139 |
| Autumn 2018 adult | 31.1% | 21.7% | 74 | 2 |
| Summer 2018 youth | 25.2% | 0% | 111 | 1 |
| Summer 2018 adult | 23% | 7% | 6,495 | 107 |
| **2017** | | | | |
| Autumn 2017 youth | 22.2% | 11.5% | 117 | 1 |
| Autumn 2017 adult | 24.7% | 6.7% | 6,606 | 120 |
| Summer 2017 youth | 37.3% | 6.4% | 126 | 1 |
| Summer 2017 adult | 28.3% | 7% | 6,699 | 48 |

Google analytics for the period of January 2018 – June 2019

| Total page views | Unique page views | Avg. time on page | Bounce rate |
|---|---|---|---|
| 498 | 417 | 01:39 | 72.85% |

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ISSU statistics

ISSU.com is the website where *Member Matters* is uploaded for users to browse the publication via an online page turner

| Edition | Reads | Impressions | Average time spend reading |
|---|---|---|---|
| Member Matters Spring 2019: | 113 reads | 301 impressions | 02:21 |
| Member Matters Autumn 2018 | 75 reads | 809 impressions | 02:55 |
| Member Matters May 2018 (adult) | 55 reads | 1907 impressions | 02:46 |
| Member Matters May 2018 (youth) | 6 reads | 431 impressions | 08:12 |

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**Appendix 3: Good practice schemes from Governor Focus 2019**

| | |
|---|---|
| Torbay and South Devon NHS Foundation – Promoting membership for the next generation<br><br>In response to the realisation that their membership reflected an older age group, the team broadened their membership and reduced the minimum age from 16 to 14. | Frimley Health NHS Foundation Trust – Meaningful Engagement, hearing what really matters<br><br>Frimley Health NHS Foundation Trust have developed a more informal, but still informative, way of connecting with members, giving them the opportunity to raise issues and concerns in a comfortable environment. With over 80 people attending the first round table event, with a governor hosting each table, members felt listened to. |
| Lancashire Teaching Hospitals NHS Foundation Trust – Increase representation of diverse communities within membership<br><br>To better understand the needs of the diverse community surrounding the trust, the council of governors identified the need to increase representation. To do so, they developed an enagagement strategy that looked beyond the hospital into the community which it serves – therby engaging with those who face health inequalities. | South London and Maudsley – Membership Engagement – The smile bids schemes<br><br>The trust's council of governors wanted a way of engaging with members and giving them a real and tangible benefit of membership. Through their Smile bids scheme, the trust was able to spread awareness of mental wellbeing in the community and reduce the stigma of mental ill health, raise awareness of the trust's services and optimise the opportunity to increase the membership base. |