Great Ormond Street Hospital for Children NHS Foundation Trust

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST
MEETING OF THE MEMBERS' COUNCIL
Wednesday 29th June 2016
4:00pm – 6.30pm
Charles West Room, Paul O'Gorman Building

NO.	ITEM	ATTACHMENT	PRESENTER	TIME
1.	**Welcome and introductions**		Chairman	4:00pm
2.	**Apologies for absence**		Chairman	
3.	**Declarations of interest**		Chairman	
4.	**Minutes of the meeting held on 27th April 2016**	**A**	Chairman	
5.	**Matters Arising and action log**	**B**	Chairman	
	STRATEGY			
6.	**Quality Report 2015/16 including External Auditor Report 2015/16**	**C**	Dr Vinod Diwakar, Medical Director	4:15pm
	PATIENTS, FAMILIES AND MEMBERS			
7.	**Updates from the Membership and Engagement Committee**	**D**	Carley Bowman, Chair of MEC	4:25pm
8.	**Update from the Young Person's Forum (YPF)**	**E**	George Howell, Chair of YPF	4:40pm
9.	**Update from the Patient and Family Experience and Engagement Committee plus annual PALS report**	**F**	Juliette Greenwood, Chief Nurse	4:50pm
10.	**Councillor activities**	**Verbal**	All Councillors	5:00pm
	PERFORMANCE AND GOVERNANCE			
11.	**Chief Executive Report (Highlights and Performance)**	**G**	Dr Peter Steer, Chief Executive & Executive Directors	5:10pm
12.	**Update on discharge summaries**	**Presentation**	Dr Vinod Diwakar, Medical Director	5:25pm
13.	**Reports from Board Assurance Committees** • **Clinical Governance Committee (CGC) (May 2016)**	**H**	Mary MacLeod, Chair of the CGC	5:45pm

	• **Audit Committee Summary Report (March and May 2016)** • **Finance and Investment Committee Summary Report (March and May 2016)**	**I** **J**	Charles Tilley, Chairman of the Audit Committee David Lomas, Chairman of the F&I Committee	
14.	**Appointment of a NED on the GOSH Board**	**K**	Anna Ferrant, Company Secretary	5:55pm
15.	**Appointment of the Deputy Chairman**	**L**	Anna Ferrant, Company Secretary	6:00pm
16.	**Compliance and Governance Update**	**M**	Anna Ferrant, Company Secretary	6:10pm
17.	**Chairman and NED objectives**	**N**	Anna Ferrant, Company Secretary	6:15pm
18.	**Application of the Policy for non – audit work**	**O**	Anna Ferrant, Company Secretary/ Loretta Seamer, Chief Finance Officer	6:25pm
19.	**Any Other Business**	**Verbal**	Chairman	6:30pm
20.	**Meeting closes**			

ATTACHMENT A

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT MINUTES OF THE MEMBERS' COUNCIL MEETING
27th April 2016
Charles West Boardroom

Baroness Tessa Blackstone	Chair
Mr Matthew Norris	Patient and Carer Councillors: Parents and Carers from London
Ms Mariam Ali	
Mrs Lisa Chin-A-Young	
Ms Claudia Fisher	Patient and Carer Councillors: Parents and Carers from outside London
Mrs Carley Bowman	
Miss Sophie Talib	Patients from London
Mr Edward Green**	Patients outside London
Ms Rebecca Miller	Public Councillors: North London and surrounding area
Mr Trevor Fulcher	
Miss Mary de Sousa	
Mr Simon Hawtrey-Woore	
Mrs Gillian Smith	Public Councillors: South London and surrounding area
Mr Stuart Player	Public Councillors: The Rest of England and Wales
Ms Jilly Hale	Staff Councillors
Mr Rory Mannion	
Ms Clare McLaren	
Rev James Linthicum	
Professor Christine Kinnon	Appointed Councillor: UCL Institute of Child Health
Mr Muhammad Miah	Appointed Councillor: Great Ormond Street Hospital School

In attendance:

Mr Charles Tilley	Non-Executive Director
Mr David Lomas	Non-Executive Director
Ms Mary MacLeod	Non-Executive Director
Mr Akhter Mateen	Non-Executive Director
Professor Stephen Smith	Non-Executive Director
Professor Rosalind Smyth	Non-Executive Director
Dr Peter Steer	Chief Executive
Ms Nicola Grinstead	Deputy Chief Executive
Ms Loretta Seamer	Chief Finance Officer
Dr Vinod Diwakar	Medical Director
Ms Juliette Greenwood	Chief Nurse
Mr Ali Mohammed	Director of HR and OD
Mrs Claire Newton	Interim Director of Strategy and Planning
Mr Matthew Tulley	Director of Development
Mr Bill Boa	Interim Financial Advisor
Dr Anna Ferrant	Company Secretary

Ms Victoria Goddard	Trust Board Administrator
Ms Herdip Sidhu-Bevan	Assistant Chief Nurse Quality and Patient Experience
Ms Emma James	Patient Experience and Engagement Officer
Ms Elisabeth Crowe*	EPR Programme Director
Dr Shankar Sridharan	Chief Clinical Information Officer and Consultant Paediatric Cardiologist
Mr Trevor Clarke*	Director of IPP
Mr Chris Rockenbach*	General Manager, IPP

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

1.	**Apologies for absence**
1.1	Apologies were received from: Mr George Howell, Patient and Carer Councillor; Ms Susanna Fantoni Patient and Carer Councillor; Dr Camilla Pease, Patient and Carer Councillor; Mr David Rose, Public Councillor; Dr Prab Prabhakar, Staff Councillor; Miss Olivia Frame, Appointed Councillor; Cllr Jenny Headlam-Wells, Appointed Councillor and Ms Hazel Fisher, Appointed Councillor.
2	**Declarations of Interest**
2.1 2.2	No declarations of interest were received. The register of Councillors' Declarations of Interest for 2015/16 was noted.
3	**Minutes of the meeting held on 27th January 2016**
3.1	The minutes of the previous meeting were **approved** subject to the addition of Miss Sophie Talib's apologies.
4	**Matters Arising and action log**
4.1	The Council **noted** the actions that had been taken.
5	**Revised Members' Council Terms of Reference**
5.1 5.2	Dr Anna Ferrant, Company Secretary said that the Terms of Reference had been updated to reflect the approved changes made to the Constitution covering Councillors' duties. **Action:** The following amendments were agreed: • It was agreed that Paragraph 5 would be updated to clarify that it is referring to the Members' Council Nominations and Remuneration Committee. • Discussion took place about the inclusion of the words 'as a whole' in paragraph 2. It noted that this had been included to avoid a single issue driver of meetings however it was agreed that this would be removed but that the Council would continue to be mindful of this issue. • It was agreed that it would be noted that the Council should receive the

	agenda and minutes of both the public and confidential Trust Board sessions.
5.3	The Council **approved** the revised Terms of Reference subject to the above amendments.
6	**Revised Terms of Reference for the Members' Council Nominations and Remuneration Committee**
6.1	Dr Ferrant said that the Members' Council Nominations and Remuneration Committee had discussed the revisions along with the tenure of seats on the committee. It had been agreed that where possible Councillors in both first and second terms of office should be encouraged to join.
6.2	Dr Ferrant said that discussion had taken place around the chairperson of the committee. Monitor's (now NHS Improvement) Code of Governance states that "*chairperson or an independent non-executive director should chair the nominations committee*". The Code also mentions that at the discretion of the committee, a governor (councillor) can chair the committee in the case of appointments of non-executive directors or the chairman. It was acknowledged that that the Code left this to the discretion of the committee and that any committee meeting or appointment panel is made up of a majority of councillors. It was agreed that the Chairman would continue to chair the committee meetings and the Terms of Reference would remain unchanged in this respect.
6.3	The Council **approved** the Members' Council Nominations and Remuneration Committee revised Terms of Reference.
7	**Councillor appointment to the Members' Council Nominations and Remuneration Committee**
7.1	Dr Ferrant told the Council that four seats were up for election as outlined in the Terms of Reference:
7.2	• two councillors from the public constituency and/or the patient and carer constituency • one staff councillor and • one councillor from any constituency (patient and carer, public, staff or appointed).
7.3	The following Councillors had nominated themselves to sit on the Members' Council Nominations and Remuneration Committee: • Ms Mariam Ali, Patient and Carer Councillor • Mr Edward Green, Patient and Carer Councillor • Mr Trevor Fulcher, Public Councillor • Ms Rebecca Miller, Public Councillor • Ms Jilly Hale, Staff Councillor
7.4	Ms Hale, the only staff councillor nominee, was elected, unopposed, to the Committee.
7.5	The Council voted using the alternative voting system and the results were

	provided later in the meeting.
8	**Update on International and Private Practice (IPP) at GOSH**
8.1	Mr Trevor Clarke, Director of IPP gave a presentation on IPP work at GOSH. He said that work was taking place to explore new territories to work in and that a marketing strategy was in place which took a segmented approach, dividing identified territories into four tiers. Mr Clarke said and the team was working with overseas embassies in London to secure preferred hospital status.
8.2	Mr Clarke said that the aim was to become less dependent on the current 'tier one' countries and to expand and begin work with other, lower volume countries. He said that it was clear that the GOSH brand was vital to achieving good referral rates.
8.3	Mrs Lisa Chin-A-Young, Patient and Carer Councillor asked for a steer on the GOSH share of the London market. Mr Clarke said that information in this area was not sufficiently reliable and that GOSH's case mix for IPP work made benchmarking difficult as it was very different to other hospitals as a result of the decision not to enter the secondary care market.
8.4	Dr Peter Steer, Chief Executive said it was vital that GOSH encouraged its NHS consultants to undertake their private practice at the Trust rather than with other providers. He added that this required sufficient capacity to be confident that work could be accepted without adversely impacting NHS patients.
8.5	Mr Matthew Norris, Patient and Carer Councillor noted that IPP debtor days had increased significantly and queried the extent to which this was a concern.
8.6	Mr Chris Rockenbach, General Manager of IPP said that although debtor days had increased in relation to specific international contracts, there had been no debt write offs in relation to embassy debt. He said that IPP was working closely with finance to recover the debt.
8.7	Mr Charles Tilley, Non-Executive Director said that this matter had been discussed at the Audit Committee and Deloitte, the External Auditors had confirmed that GOSH was not in an unusual position. He reported that letters of guarantee were in place for over 90% of the debt.
8.8	The Council discussed the potential for GOSH developing a facility overseas. Mr Clarke said that this had previously been considered by the Board however no projects had been agreed. It was noted that there was a significant risk and challenge in staffing an overseas facility.
8.9	The Council agreed that they were generally supportive of IPP activity but continued to be concerned that there remained no adverse impact on NHS services. The Chairman confirmed that this was also the Board's expectation.
8.10	It was noted that there would be an increase in IPP beds on Hedgehog Ward in August 2016 and the Council queried how the additional capacity would be staffed in order to avoid negative impact on NHS services.
8.11	Mr Rockenbach said that during periods of extremely high NHS demand it had

	been possible to allocate IPP space to NHS patients, providing greater flexibility for the Trust as a whole.
9	**Update on progress with the Electronic Patient Record (EPR)**
9.1	Dr Shankar Sridharan, Chief Clinical Information Officer and Consultant Paediatric Cardiologist gave a presentation on the Trust's progress with implementing an EPR. He said that GOSH had heavily invested in ICT however this had previously been in local systems rather than strategically across the organisation. Dr Sridharan emphasised the transformative nature of the project and said that it was vital that it was managed as such rather than as an IT project.
9.2	It was noted that the first stage of implementation following planning and procurement would be in 2018 and following learning received from other Trusts it had been agreed that a support team would remain on site following implementation to ensure that the programme could be correctly adapted for local use.
9.3	The Council noted the governance structure of the EPR work and that updates would be reported to all the Board subcommittees and queried how the Council could be involved. Dr Vinod Diwakar, Medical Director said that the Members' Council were an important stakeholder and would be kept informed of progress. He said that the Young People's Forum had already been involved through a workshop run by Elisabeth Crowe, EPR Programme Director.
9.4	Ms Claudia Fisher, Patient and Carer Councillor said that it was clear that the project was vital to GOSH and was also closely linked to the Always Values but emphasised the importance of ensuring that the correct decisions were made at an early stage. Ms Fisher said that it was important that patients and families were represented in the discussion groups.
9.5	Ms Jilly Hale, Staff Councillor highlighted the commitment that would be required from the Trust to release suitably experienced staff from their roles to enable their engagement with the project. She emphasised the importance of ensuring that this input was in place. Dr Diwakar agreed that there was a balance to be struck between ensuring the timetable was adhered to, as well as receiving the correct input.
9.6	The Council acknowledged the transformative nature of the project in terms of patient experience and discussed the practicalities of using the system to allow patients and families access to their notes and to allow better communication between GOSH and local Trusts. They emphasised the importance of ensuring that the system had been tested by front line staff who would be required to use it on a daily basis.
9.7	Ms Crowe said that discussions would take place around how patients and carers would be able to access data but agreed that this had been an important component of programmes being used by other Trusts. Ms Crowe added that it was vital that engagement took place with front line staff around any challenges and how these should be overcome. Dr Diwakar said that a portal would enable other NHS organisations to access GOSH data where it was appropriate for sharing.

10	**Annual Plan Update and report on the results of the Survey of Members on the Annual Plan 2016/17**
10.1	Mrs Claire Newton, Interim Director of Strategy and Planning said that the results and responses received from the survey had been useful to the Trust and presented a paper which set out the actions which would be taken as a result of the survey. Mrs Newton said that the responses had also been discussed at the Patient and Family Engagement and Experience Committee (PFEEC) and the Membership and Engagement Committee (MEC).
10.2	It was reported that positive responses had been received around the Always Values however respondents were less positive around the 'One Team' aspect. Mrs Newton said that the Always Values Steering Group would take the responses into account in their work to promote the values.
10.3	Ms Fisher said that discussion had taken place at MEC around the definition of 'One Team' which was likely to be different for different stakeholders. She suggested that it would be helpful to consider this when setting behaviour expectations.
11	**Updates from the Membership and Engagement Committee including Update on Board and Council engagement work**
11.1	Mrs Lisa Chin-A-Young, Patient and Carer Councillor gave a presentation on the output of an MEC away day that had taken place in February 2016 and said that Councillors had collated case studies from the interactions they had had with patients and families in the Lagoon during recruitment events and undertaking the Annual Plan survey.
11.2	Ms Juliette Greenwood, Chief Nurse said that the Patient and Family Engagement and Experience Committee (PFEEC) had reviewed the case studies and work would take place with the new Assistant Chief Nurse for Patient experience and Quality to look at how the learning from the stories and themes will be incorporated into the approached to patient experience work.
12	**Update from the Patient and Family Experience and Engagement Committee (PFEEC)**
12.1	Ms Juliette Greenwood, Chief Nurse provided the update and said that it would be important to work with the MEC as one of the sources of intelligence and information to shape the delivery of the PFEEC work going forward.
13	**Update from the Young Person's Forum (YPF) (January and April 2016)**
13.1	Ms Sophie Talib, Patient and Carer Councillor and Member of the YPF said that the forum had discussed transition from patients' personal experiences and looked at running a 'take over day' to provide young people with insight into the work of various teams at GOSH.
14	**Councillor activities**
14.1	The following Councillor activities were noted:

	• Ms Mariam Ali worked with members of staff from the GOSH Children's Charity to talk to children at a London school about membership • Ms Rebecca Miller attended a Deloitte Governor Seminar • Ms Lisa Chin-A-Young connected with a potential GOSHCC donor through St Paul's Catherdral • Cllr Jenny Headlam-Wells and Dr Camilla Pease observed the Trust Board • Ms Claudia Fisher had attended a meeting of the food improvement group, the Quality Improvement Launch, observed the Audit Committee, attended a NHS Providers Governor Focus conference and attended a Lead Governor Group • A group of Councillors visited various examples of patient and family accommodation at GOSH • Mr Matthew Norris observed the Finance and Investment Committee.
15	**Chief Executive Report (Highlights and Performance)**
15.1	Dr Peter Steer, Chief Executive introduced Ms Nicola Grinstead, Deputy Chief Executive and Ms Loretta Seamer, Chief Finance Officer to the Council.
15.2	Dr Steer gave an update on the following matters: • Divisional restructure – developed to provide new core clinical leadership and reduce silo working across the organisation. • Junior Doctor strike action – The Trust's Junior Doctors had been communicating well with the Trust and other staff had been extremely supporting during the action. • End of financial year – The Trust had achieved its planned outturn for 2015/16 which was a considerable achievement when taking into account the competing priorities. • Referral to Treatment – Approximately 73,000 pathways had been validated and no harm caused by long waits had been identified.
15.3	The Council discussed the financial and other costs of not meeting targets. The Chief Executive emphasised that the Trust's highest priority was to safely treat all patients within a clinically appropriate timeframe. Dr Steer said that on average patients were referred to GOSH at 12 weeks of an 18 week pathway. He said that once the work to validate all pathways was complete, discussions around this would begin with commissioners.
15.4	It was noted that the Council had selected the local quality indicator for evaluation by the External Auditors as part of the Quality Report. The Council expressed some concern that this indicator had been selected previously however there had been limited improvement.
15.5	Dr Vinod Diwakar, Medical Director said that a quality improvement project had taken place which had improved the level of discharge summaries sent within 24 hours however since project had been wound down, achievement had deteriorated. Dr Diwakar said that over 90% of discharge summaries were sent within three days and heads of clinical service were continuing to investigate the issue.

15.6	Dr Steer said that this was a difficult problem and many other Trusts had similar issues. He added that GOSH currently had a large number of competing priorities and said that as the summaries were largely written by junior doctors who rotate hospitals on a 6 monthly basis it would be necessary to continue to highlight the issues.
16	**Reports from Board Assurance Committees**
16.1	Clinical Governance Committee (CGC) (January 2016)
16.2	Ms Mary MacLeod, Chair of the Clinical Governance Committee told the Council that Professor Stephen Smith, newly appointed Non-Executive Director would be joining the Committee following Ms Yvonne Brown's decision to step down from the Board at the end of February 2016. She said that the Committee's Terms of Reference had been revised and the Committee would now be known as the Quality and Safety Assurance Committee (QSAC).
16.3	**Action:** Ms MacLeod said that the committee had received a presentation on the Trust's Mortality Review Group which was an example of best practice nationally. It was agreed that the Members' Council would also receive this presentation.
16.4	Audit Committee Summary Report (January 2016 and April 2016)
16.5	Mr Charles Tilley, Chair of the Audit Committee gave a summary pf the meeting.
16.6	**Action**: The Terms of Reference had been updated and would be circulated to the Council for information.
16.7	Finance and Investment Committee Summary Report (25 January 2016)
16.8	Mr David Lomas, Chair of the Finance and Investment Committee said that the Committee considered the Trust's financial results and the drivers thereof, high value business cases, commercial matters and results forecasts.
17	**Appointment process for a NED on the GOSH Board**
17.1	Dr Anna Ferrant, Company Secretary presented the paper and confirmed that it had been recommended by the Members' Council Nominations and Remuneration Committee for approval.
17.2	The Council **approved** the process.
18	**Councillor appointment to the Members' Council Nominations and Remuneration Committee**
18.1	Following a vote by the Council it was confirmed that the following Councillors would take up seats on the Members' Council Nominations and Remuneration Committee: • Rebecca Miller • Edward Green

	• Mariam Ali • Jilly Hale
19	**Annual Endorsement of the Lead Councillor**
19.1	The Council **endorsed** the Lead Councillor with 19 endorsements from councillors received.
20	**Compliance and Governance Update**
20.1	Dr Anna Ferrant, Company Secretary presented the compliance update including the actions plans which had been submitted in response to the CQC report. The Council noted that there was work to be done around transition however there were areas of good practice in the Trust.
21	**Any Other Business**
21.1	It was noted that Ms Mary de Sousa had secured a permanent position at the Trust and therefore must step down as a public Councillor. The Council thanked Ms de Sousa for her input.

ATTACHMENT B

Attachment B

MEMBERS' COUNCIL - ACTION CHECKLIST
June 2016

Checklist of outstanding actions from previous meetings

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
78.5	25/11/15	It was agreed that the objectives would be reviewed following the January meeting of the Members' Council to ensure they were SMART, particularly around the 'measurable' criteria.	**AF**	**April 2016**	On agenda
83.2	27/01/16	It was agreed that the access improvement internal communications information would be provided to the Council by 29th January 2016.	**CM**	**January 2016**	To be emailed separately to councillors
85.10	27/01/16	It was agreed that the GOSH committee structure would be provided to the Council.	**Rachel Pearce**	**April 2016**	To be emailed separately to councillors
86.7	27/01/16	It was agreed that the draft CQC action plan that was being sent to the Trust Board would be circulated to the Members' Council.	**Rachel Pearce**	**April 2016**	To be emailed separately to councillors
5.2	27/04/16	The following amendments to the revised Members' Council Terms of Reference were agreed: • It was agreed that Paragraph 5 would be updated to clarify that it is referring to the Members' Council Nominations and Remuneration Committee. • Discussion took place about the inclusion of the words 'as a whole' in paragraph 2. It noted that this had been included to avoid a single issue driver of meetings however it was agreed that this would be removed but that the Council would continue to be mindful of this issue. • It was agreed that it would be noted that the Council should receive the agenda and minutes of both the public and confidential Trust Board	**AF**	**April 2016**	Actioned

Attachment B

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
		sessions.			
16.3	27/04/16	Ms MacLeod said that the Clinical Governance Committee had received a presentation on the Trust's Mortality Review Group which was an example of best practice nationally. It was agreed that the Members' Council would also receive this presentation.	**AF**	**September 2016**	To be arranged for September 2016 meeting
16.6	27/04/16	The Audit Committee Terms of Reference had been updated and would be circulated to the Council for information.	**AF**	**June 2016**	Circulated with the papers for the June Council meeting

Attachment C

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

29th June 2016

Quality Report 2015/16

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 Choices website.

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

Consulted in its preparation: working group and other staff and families, governors, contributors, Trust Board representatives, Audit Committee representatives, Clinical Governance Committee representatives, Members' Council representatives, Deloitte, commissioners, local Healthwatch and Health Scrutiny committees.

The external auditor assurance report 2015/16 is also attached for information.

Councillor action required:
To note, and to comment

Report prepared by:
Meredith Mora, Clinical Outcomes Development Lead

Item presented by:
Dr Vin Diwakar, Medical Director and Consultant Paediatrician

Great Ormond Street Hospital for Children
NHS Foundation Trust

Quality Report 2015/16

Contents

Cover: Tyler, age four, whilst on Badger ward.
This page: Essa, age 15, during one of his stays at the hospital.

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."

On the cover: GOSH patient Tyler, age four, whilst on Badger ward.
This page: Ava, age six, during one of her visits to the hospital.

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 Choices 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, and
  - 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.

What is NHS Choices?

NHS Choices 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.


GREAT ORMOND STREET
HOSPITAL FOR CHILDREN

99%

of parents and patients
would recommend
the hospital

67,377

patient visits

4,122

permanent and fixed-term staff

58

specialties

1,581

outpatient clinics

838

active research studies

19

highly specialised national services

Part 1:
A statement on quality from the Chief Executive

We strive to ensure that every patient and family that comes through the doors of Great Ormond Street Hospital receives care commensurate with the best in the world. This can only be delivered by a deliberate strategy to continually challenge, refine and improve the quality of care we provide. Our annual Quality Report sets out our current strategy by detailing our performance against our 2015/16 quality priorities and outlining the priorities we have set ourselves for the coming year.

They have not been developed in isolation. Our priorities for improvement have been determined by listening and responding to priority areas identified by patients and their families, staff and local stakeholders including our commissioners. They are also informed by national and international priorities and best practice.

Our quality priorities fall into three categories: safety, clinical effectiveness and experience.

Priority one - safety

To reduce all harm to zero

Priority two - clinical effectiveness

To consistently deliver excellent clinical outcomes, with the vision of being the leading children's hospital in the world.

Priority three - experience

To consistently deliver an excellent experience that exceeds our patents' families' and referrers' expectations.

Safety

Many of our initiatives to improve quality have been clinically led and co-designed with our patients and their families. One such project was the roll-out of electronic 'Patient Status at a Glance' (ePSAG) boards.

These are large, easy to read electronic whiteboards that display a range of real time patient information. They primary aim is to improve patient safety by reducing avoidable harm through improving the identification, escalation and care planning of patients at risk of deterioration.

They were developed by clinical teams and a parent representative who facilitated the involvement of more than 30 patients and three families. This was important as our families views' helped inform the level of information on display and identify the features that would be meaningful to parents and therefore also improve their experience. Instrumentally their involvement also led to the creation of 'watcher 'status which is applied to patients that do not trigger the more formal Children's Early Warning Scores (CEWS) but indicate where a family member or clinical staff member has a concern.

We set ourselves the ambitious target of rolling out the boards across all our wards by the end of the financial year with effectiveness measured by a number of pre and post rollout audits.

A delay to the ambulatory version of ePSAG meant the Trust wide-rollout has been slightly delayed and we are now on track to achieve roll out by May 31. Where the Boards have been installed they have had a significant impact. They have contributed to an increased awareness of CEWs and of the term 'watcher' patient. Data has also shown that they have reduced interruptions and improved the patient experience. They have also facilitated better communication between staff particularly at safety huddles - which is an element we will be focusing on in the next year along with work to further improve the monitoring and communication of the deteriorating child.

Improving flow is theme woven through this report. It was an outcome that was supported by the roll out of the of the ePSAG initiative and is the focus of our second safety priority. Here we set out to reduce delays in the journeys of patients leaving the intensive care unit and avoid the number of refusals and cancellations. The work aimed to improve the patient experience and also inform a wider programme of work to create more capacity across the Trust.

Following the introduction of a number of initiatives to improve flow and an in-depth analysis of our data, we saw some lengths of stay reduced and were able to identify that delay in discharge were, in part, a result of limited beds being available in other parts of the hospital or locally. We also found that the vast majority of patients booked by GOSH consultants to be transferred to ICU did not end up requiring intensive support. Over the coming year we will work to model the risk for all theatres cases to better judge and manage the need for ICU beds post surgery. We will also work with teams across the Trust to enable swifter discharges.

Clinical effectiveness

In my introduction to this Annual Report I spoke about the important work we are undertaking to ensure that all our patients receive treatment within a time appropriate to their clinical conditions and the challenges we face ascertaining exactly when their pathway of care began. Our work to resolve the issue of incomplete pathways features in the clinical effectiveness s section of the Quality Report. It gives some detail how we have worked with NHS experts to address the issues identified. This work to improve access is extensive and ongoing and is the reason why we are unable to report performance against some of our quality indicators linked to waiting times. It is an essential programme of work and remains a quality priority for 16/17.

Blood is an extremely precious resource and plays a vital role in saving lives at GOSH. We have a responsibility to use only where clinically needed and therefore ensure it is available to those children that need it wherever they are being treated. This year, as part of our 'no waste' strategy, we set out to reduce the amount of blood that is wasted. Through a number of work streams covering surgical ordering, education and training and improved inventory management we were able to dramatically cut blood wastage – almost 30 per cent compared to 2013/14.

Patient experience

As a specialist provider, our patients come to us from other hospitals often returning to these local hospitals before returning home. Ensuring the receiving hospitals have accurate and comprehensive information about the treatment received at GOSH is essential for a smooth transfer of care and is facilitated by the production of a discharge summary. In 2015/16 we undertook to improve the quality and timeliness of our discharge summaries using national guidance and local expertise. A key component of this work was moving their production to an electronic system that could pull in information from other systems including those capturing prescribed medicines.

This project has had some success with clinical areas such as rheumatology and specialist neonatal and paediatric surgery dramatically cutting the time between patients discharge and the production of a discharge summary. Trust-wide significant improvements were made in the first part of the year and there will be an ongoing programme of work to ensure that the improvements made are sustained.

The second quality priority aimed at improving the care experience of patients with learning disabilities. This programme of work continued the commitment we set out last year to do better for our many patients with learning disabilities.

It comprised continuing to: embed training and support to staff, use clinical alerts and promote the hospital passport. There was also an additional focus on improving partnership working.

Many elements of this work were praised in our CQC Report and last year it resulted in us doubling the number of patients with learning difficulties that we were able to identify before they came to hospital and therefore better plan their care at GOSH. Within this report we hear directly from a patent of a patient with a learning disability. Her words are extremely moving and serve as an important reminder of how we must tailor the care and experience we provide to each of our chidren's needs.

Many of our young people tell us that the transition from being treated at GOSH, where they have often been seen for many years, into adult services is not always a smooth one. This year we have decided to focus on improving young people's experience of transition to adult services by working with young people and the adult centres they will be treated to deliver a much better experience. We will in part measure progress by the number and percentage of Specialty Transition Leads established.

As this report shows, there are many areas over the last year where we have made significant improvements to the quality of the care and experience we provide. There are some areas where more improvement work is necessary and which require a renewed and deliberate focus. There are also some new areas of work which we have identified as requiring attention in order to improve the quality of care we provide. Many of these challenges cannot simply be solved within the walls of Great Ormond Street. It is imperative that we work with other healthcare providers and partners to achieve what we have set out to do in order to deliver the standards of care and experience our patients and their families deserve.

We are very mindful that much of the information we have provided in this report is dependent on the quality of the data we can obtain. In preparing the Quality Accounts, there are a number of inherent limitations which may impact the reliability or accuracy of the data reported. These include:

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year.
- Data is collected by a large number of teams across the trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might reasonably have classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.
- Where we have been unable to provide accurate data in relation to key healthcare targets it is clearly stated

The Trust and its executive team have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above.

Following these steps, to my knowledge, the information in the document is accurate.

Peter Steer
Chief Executive

Part 2a:
Priorities for improvement

This part of the report sets out how we have performed against our 2015/16 quality priorities. These have been determined by 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 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, year on year, and as rapidly as possible. Our Zero Harm initiatives aim to ensure that each patient receives the correct treatment or action the first time, every time.

Clinical effectiveness

At Great Ormond Street Hospital we seek to provide care for our patients commensurate with the best in the world. Furthermore, as a major academic centre we work with our patients to improve the effectiveness of this care. Wherever possible we use international and national benchmarks to measure our effectiveness and we publish this data on our website and in major international and national journals. To measure our effectiveness from the patient's perspective, we use Patient-Reported Outcome Measures (PROMS).

Our extensive research and innovation work is evidence of our dedication to delivering the most clinically effective care.

Experience

We wish our patients and their families to have the best possible experience of our care and treatment. Therefore, we measure patient experience across the hospital and we seek feedback from our patients, their families, and the wider public via our membership, patient and member surveys, focus groups, the use of social media, and asking patients and families about their experience within 48 hours of discharge. All of these sources of information we use to improve the services we offer.

After an extensive consultation and development period, we formally launched *Our Always Values* in March 2015. Since then, *Our Always Values* has been a visible representation of our commitment to our patients, families and staff.

Reporting our quality priorities for 2015/16

The six quality priorities for 2015/16 were:

Safety

- Roll-out of electronic 'Patient Status at a Glance' on the ward
- Improving flow through our intensive care units

Clinical effectiveness

- Referral to treatment (RTT): incomplete pathways
- Working smarter to reduce blood component wastage

Experience

- Improving discharge summary completion times
- Improving the care experiences of our patients with learning disabilities

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

Safety

Roll-out of electronic 'Patient Status at a Glance' on the ward

The traditional ward whiteboard provides clinical staff and families with an overview of the patients on the ward. The electronic Patient Status at a Glance (ePSAG) board is an in-house GOSH software development to deliver an electronic whiteboard system. Information is pulled from clinical hospital systems to ensure that what is displayed is up-to-date and relevant. Large touch screens and intuitive software design mean that the effort required to update the data is kept to a minimum.

What we said we'd do

In September 2015, we said we would install the electronic Patient Status at a Glance (ePSAG) boards in all of our wards by 30 April 2016 to make the updating and accessibility of patient overview information more efficient, and thereby improve safety.

What we did

A clinical user group was set up on each ward to look at the particular workflow in that area and design a template for ePSAG to support the ward's current working practices. The groups also looked for opportunities to improve their workflow as part of the project. Division-wide clinical user groups were set up to address the need for standardised elements of the board across the hospital and to manage individual requests for new alerts and functions to be added to the boards.

With the support of a dedicated parent representative, we consulted with over 30 patients and parents to gather their opinions on the purpose of ePSAG, the ideal level of information to display, and to learn about other features that were meaningful to them. A parent focus group was held to review this feedback and compile key themes to be carried forward and addressed by the steering group.

By 31 March, we had successfully rolled out the ePSAG board to all inpatient wards, and were on schedule to roll out to day-care units by 30 April.*

We approached the roll-out of ePSAG in four 'waves', beginning with wards that were already implementing safety huddles. On completion of these areas, we grouped long-stay wards into similar specialties and rolled ePSAG out to these areas in two phases before finally approaching the Day-care and Ambulatory units.

What the data shows

A delay to the development of the ambulatory version of ePSAG meant that we did not complete roll out to all day-care units by 30 April. We are now working to a 31 May deadline, and are on schedule to achieve this. In order to know whether an improvement had been made by the use of ePSAG, we carried out situational awareness audits in the weeks prior to installing the boards on each ward. We then returned to the wards two months after installation to assess staff awareness as a result of having the board and access to real-time data.

*A delay to the development of the ambulatory version of ePSAG meant that we did not complete roll out to all day-care units by 30 April. We are now working to a 31 May deadline, and are on schedule to achieve this.

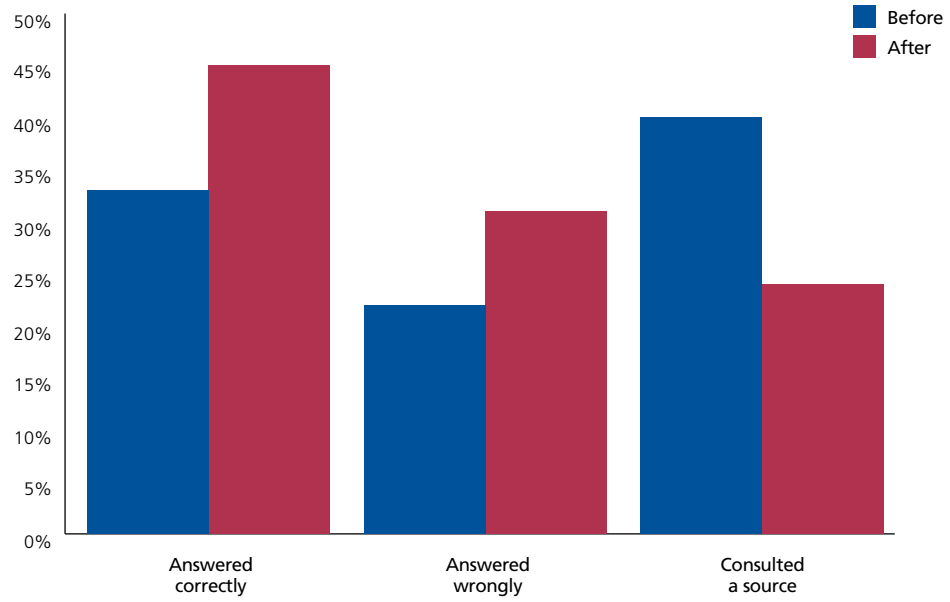
Situational awareness pre-project and post-project audit results (wave one)

Before the project, the range of sources checked when a staff member could not answer included: the handover document, electronic observation system, whiteboard, patient notes, or asking the nurse in charge.

After the project, the range of sources checked had reduced to one: ePSAG.

The results show the intended increase in staff awareness of the patients on their ward with CEWs of 3 or above. They also show a reduction in the number of sources consulted by staff when they need to find the answer. This increases efficiency, reduces the risk of error, and increases our confidence that staff know where to access information about patients' CEWs scores when needed

Chart one – Percentage of staff aware of patients with a CEWS of 3 or above currently on the ward



Children's Early Warning Score (CEWS) Action to be taken when a patient scores:	
0 – 2	No action needed Nurse/parental concern inform nurse-in-charge (NIC)
3 – 4	Report CEWS to nurse-in-charge (NIC) Repeat observations within 30 minutes, agree monitoring plan, consider adjusting parameters If no improvement after 30 minutes, inform the NIC and Registrar for review Follow escalation algorithm
5+	Inform nurse-in-charge (NIC), Registrar and CSP with recommendation (SBARD) to attend

If there is concern about the clinical condition of the patient at any time consider placing a 222 call regardless of the CEWs score

S Situation
I am *(your name and role)* in *(ward x or department x)*. What is the problem?

B Background
What is the background or context?
What has led up to this event?

A Assessment
What do I think is wrong?
How worried am I about this situation?

R Recommendation
What do I want to happen now?

D Decision
The receiver reads back the SBARD
What plan do we agree on?
Is there anything that I need to do now?

What is CEWS?

CEWS (Children's Early Warning Score) is a tool to support staff to recognise and respond to children who may be deteriorating (see left).

Early warning scores are generated by combining the scores from a selection of routine observations of patients including pulse, respiratory rate, blood pressure, oxygen saturation and consciousness level.

Chart two – Percentage of staff who understood the term 'watcher' patient

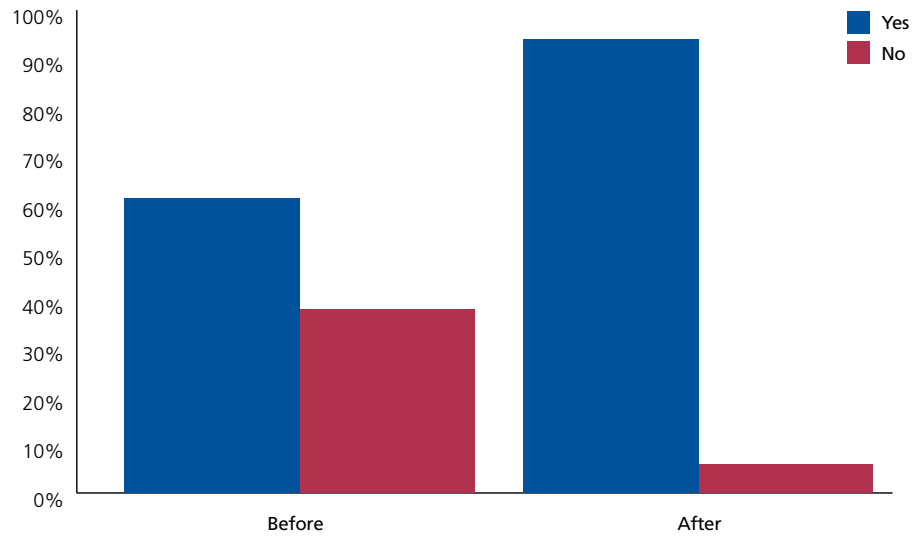
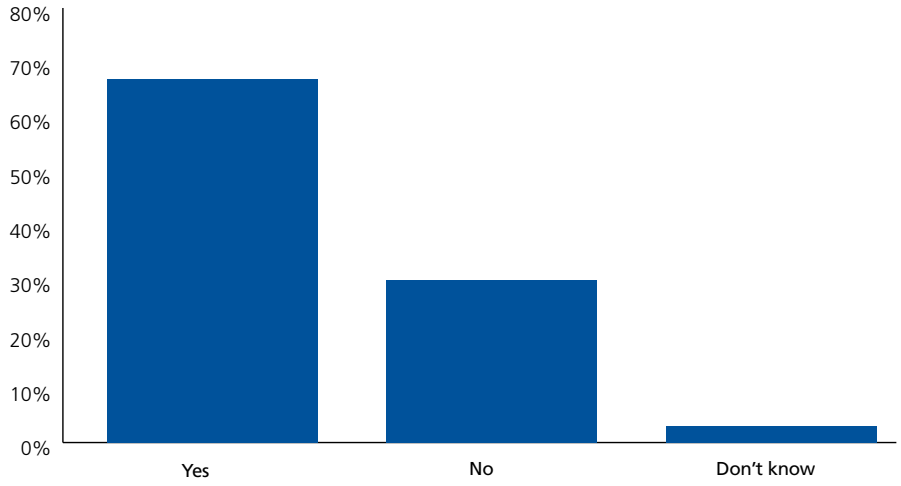


*Chart three – Percentage of parents and young people who felt ePSAG was helpful to them as a parent/patient**



*sample size: 27 individuals

The data shows us that ePSAG reduces interruptions, increasing time to care. It facilitates communication at daily safety huddles, handover and ward rounds, ensuring clinicians are always expert in their knowledge of and care for their patients and are always working as one team. ePSAG also helps with planning for discharge, bed management, and communication between staff and families.

The ePSAG boards have supported improvements in patient flow – on Puffin Ward, the board requires all essential fields to be completed before a child/young person goes to theatre, including: clerking, consent, and marking of the site for surgery. Getting the process right first time avoids delay and ensures that patients are consistently prepared for their operations.

In support of the Trust's Situation Awareness for Everyone (SAFE) project, ePSAG also improves situational awareness on wards by:

- clearly displaying Child Early Warning Scores (CEWS)
- flagging 'watchers'
- displaying other information relevant to identifying patients at risk of deterioration

Pre-project audits have also been completed for waves 2 and 3. We are currently undertaking the post-project audits for waves 2 and 3 to measure change from the implementation of ePSAG.

What is a 'watcher' patient?

The 'watcher' patient initiative at GOSH is a formalising of previously informal action. 'Watchers' are the patients whose CEWS do not trigger an alert, but where the patient's family/carer or a clinical member of staff has a concern.

These patients are formally monitored and reviewed on the basis of this concern.

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

What is a safety huddle?

'Patient safety team huddles' are daily, focused, group discussions by frontline staff to support identification and management of patients at risk of deterioration. The safety huddles not only ensure that refined escalation plans are in place for these patients, but that all staff are aware of the severity of patients under their care.

What's going to happen next?

The next steps for the ePSAG roll-out project will be:

1. Complete the design and roll-out of ePSAG to all day-care units by 31 May 2016.
2. Return to all recently installed areas and undertake situational awareness audits to measure change.
3. Integrate this work with the roll-out of safety huddles in order to fully realise the combined benefits of both interventions in improving the situational awareness of the whole team.

How this benefits patients

The use of ePSAG boards:

- Improves patient and family experience by making relevant information visible at all times, including estimated discharge date and the named nurse and doctor for each patient.
- Can reduce avoidable harm to patients on inpatient wards by improving the identification, escalation and care planning of patients at risk of deterioration.
- The introduction of the 'watcher' status empowers individuals to speak up and provides visual validation of parental concerns. It also enables clinicians to highlight patients for whom they have a concern or clinical 'gut feel', despite the observations remaining within normal parameters.
- Improves flow for theatre patients, which reduces avoidable delays and cancellations.
- Encourages earlier and better discharge planning, reducing delayed discharges for non-clinical reasons.

"I have been privileged to be part of the ePSAG group since last year. It has been wonderful to see that the foundation values the input of parents and allows them to contribute to how the hospital is constantly developing and evolving.

"ePSAG has given the parents a source of information which was never available with the traditional whiteboards and most importantly they can access details quickly and without having to disturb members of staff. The clarity and frequently updated information on the boards is also incredibly helpful and also reassuring to parents."

Parent, and Outpatients and Family Liaison Volunteer (Bear Ward)

Improving flow through our intensive care units

The smooth flow of patients through the Paediatric Intensive Care Unit (PICU) and Neonatal Intensive Care Unit (NICU) is vital to the effective running of the hospital.

What we said we'd do

We said we would collect data on delays, refusals and cancellations of elective admissions to understand the impact of our improvement work and further target our interventions.

What we did

The Intensive Care Units Flow project continued throughout 2015/16, focusing on five key areas of improvement:

Time of transfer to the wards

A new process was trialled, then introduced, at the daily Trust-wide bed management meeting, whereby all patients transferred from an intensive care area must be given a 'receiving time' by the accepting ward. This has improved the discharge planning process and reduced the risk of afternoon cancellations. Consultants within each specialty actively prioritise accepting children from intensive care to avoid delayed discharges from the intensive care units.

Electronic Patient Status at a Glance (ePSAG)

The development of the ePSAG board, an electronic version of the patient whiteboard, has improved both communication and situational awareness of staff members. The inclusion of real time information about the location and status of ventilators and other essential equipment on the board has also reduced time lost by clinicians to non-clinical issues. See page 12 for more information about ePSAG.

Intensive care units e-referral process

Though the earlier implementation of an electronic referral tool was very successful, a number of clinician-led changes have now been made to deliver further improvements. A new interface was created on ePSAG to display the status of all imminent PICU and NICU referrals in real time. The referral review process is incorporated into the ICU morning ward round, reducing delays and improving data quality. The PICU and NICU teams use the system dynamically to flex capacity within the context of current bed availability and external constraints. The ability to pre-empt potential cancellations and flex beds proactively improves patient experience and reduces unnecessary cancellations.

Trust-wide, the specialty teams have appreciated the new referral process, as they now have access to all current PICU and NICU referrals in the system. This offers greater transparency and choice to them when making their own referrals.

Identifying reasons for delayed discharges

A number of different methods were tested to determine why patients were delayed when being discharged from the intensive care units. While we know that the reasons for delays are variable and complex, we consider it worthwhile to test a coded analysis approach to aid understanding of flow.

Increasing the spread of elective work across the working week

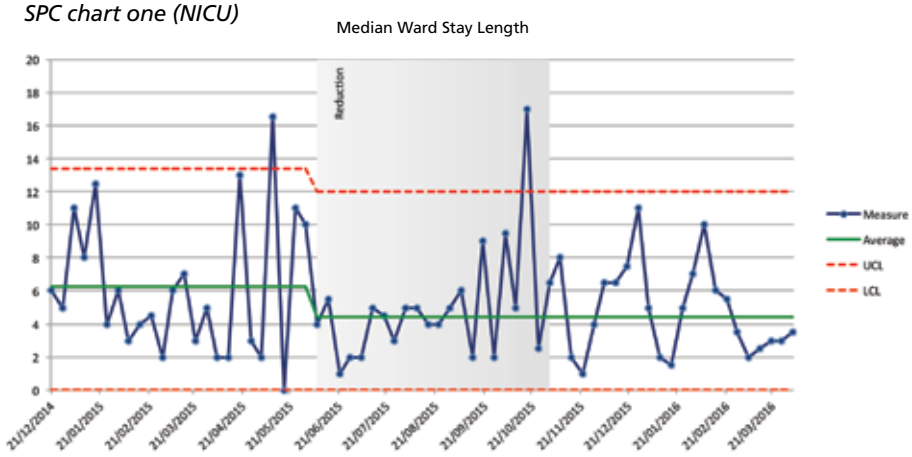
The PICU and NICU teams and the main surgical specialties that refer children into ICU have changed work practices to spread demand across the week. Previously, both of the two main specialties operated every Wednesday, with both teams trying to admit their patients for post-surgical intensive care at the same time. These lists are now spread over three days, thus increasing access to intensive care beds and reducing cancellations.

What the data shows

1. Length of stay in PICU and NICU

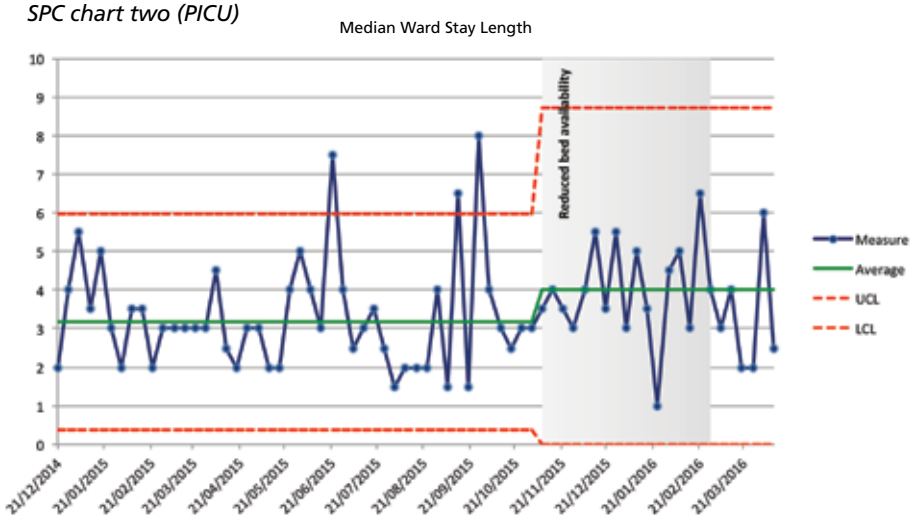
With improved flow, we expect to see reduced length of stay. The data shows a reduction in the median length of stay on NICU (SPC chart one) as compared with the 2015 baseline period. However, there has also been an increase in the median length of stay on PICU, as compared with the previous baseline period from 2014 (SPC chart two). We believe that the increased length of stay in PICU is related to a lack of ward beds internally and at local hospitals.

SPC chart one (NICU)



This chart uses SPC methodology and shows a sustained reduction in median length of stay on NICU.

SPC chart two (PICU)



Using SPC methodology, the dots highlight a reduction in median length of stay on PICU. However, this reduction was not sustained, and there has subsequently been a statistically significant increase. Work is ongoing in this area.

What is a Statistical Process Control chart?

Statistical Process Control (SPC) charts are used to measure variation and improvement over time.

SPC methodology takes into account the phenomenon of natural variation, 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 focus on the 'special causes' of variation, thus identifying 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 making up that baseline period would be used for that comparison.

What is the median?

The median is an average that is derived by finding the middle point in a sorted range of values. Unlike the mean average, which is the total divided by the number of values, the median provides an average that is not skewed by 'outlier' or extreme data points.

2. Number of cancelled elective admissions for PICU

While patients continue to be successfully admitted to our intensive care units from other specialties within the Trust via our electronic referral process tested on PICU (chart three), approximately 80 per cent of the accepted cases do not go to ICU despite being booked, because they are well enough to return to the surgical ward from theatre, or are cancelled for other patient-related reasons (chart four). Future work is planned on modelling the risk for all theatres cases to better judge the need for an ICU bed post-surgery.

Chart three – PICU electronic referrals

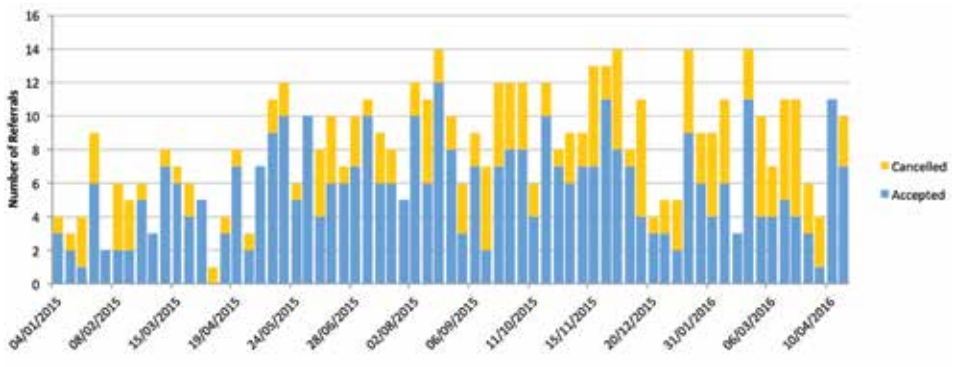
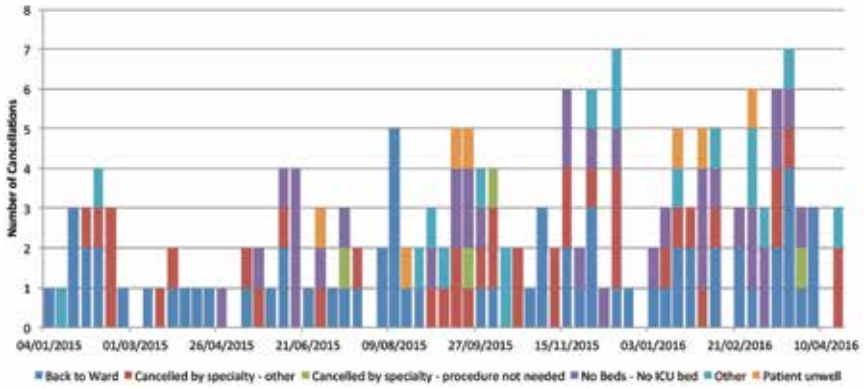


Chart four – PICU electronic cancellations



"When my daughter was medically fit to be discharged from PICU, there was no bed available for her on the ward. It was a battle to get her discharged several days later. The PICU staff were very helpful and in the end we were delighted to be discharged, but the process was very frustrating for us."

Mother, PICU patient

"I think we can now more clearly see the flow of elective patient bookings through PICU and NICU, which gives us greater flexibility to plan the timing of surgery, and reduce the likelihood of cancellation because of lack of capacity."

Mr. Joe Curry, Specialist Neonatal and Paediatric Surgery Consultant

What's going to happen next?

In 2016/17, the Intensive Care Units Flow project team will continue to work on improving flow through the intensive care areas, focusing on:

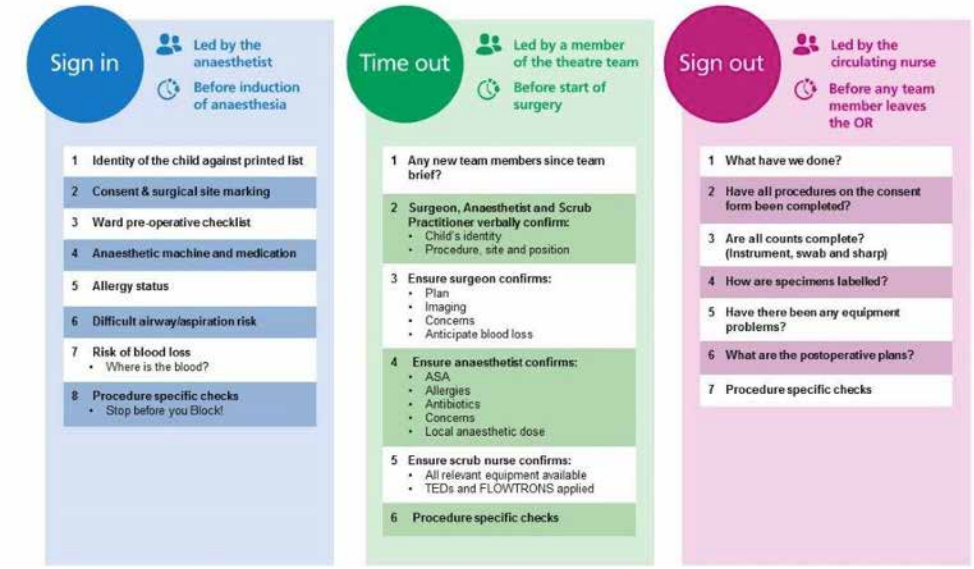
- Developing a robust and reliable method for capturing the multifaceted reasons patients may be delayed from intensive care.
- Developing reliable processes to ensure that patients can be discharged, without delay, to a ward bed.
- Working collaboratively with each surgical speciality team to identify areas for improvement in their current patient pathways.

How this benefits patients

Reducing delays in the patient journey and reducing the risk of cancellation improves patient care and experience.

Organisational engagement with the WHO Surgical Safety Checklist

The World Health Organisation (WHO) Surgical Safety Checklist is an intervention to improve safety culture in theatres.



Teams at GOSH had begun using the Checklist in 2008, and it was rolled out across the Trust in 2009. The National Patient Safety Agency mandated use of the WHO Checklist in a patient safety alert in 2009. The Trust has since collected data continually to monitor compliance with the three stages of the WHO Checklist. Our data indicates high levels of performance with recording that the WHO Checklist takes place. The mean average for completion of all three stages of the Checklist is 97 per cent. This means that 97 per cent of procedures are reported as having all three parts of the Checklist completed.

97%

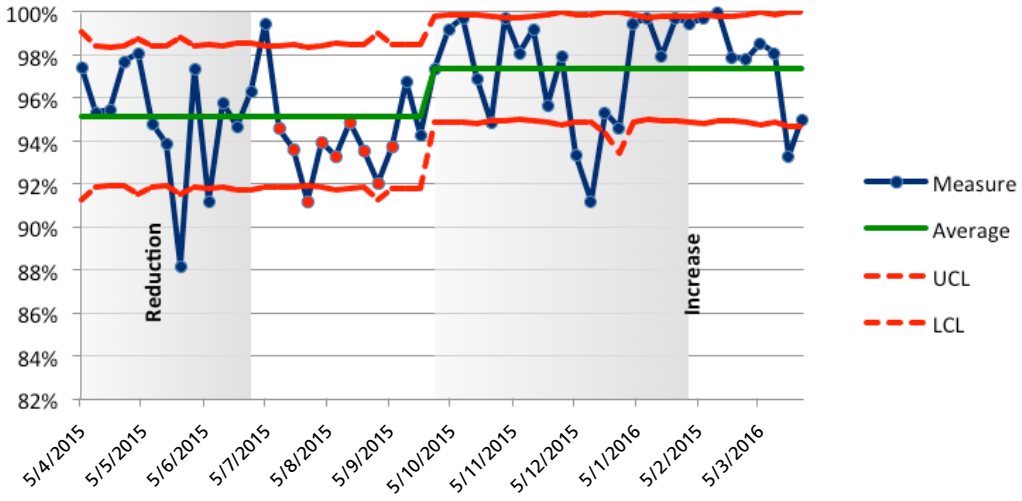
of procedures are reported as having all three parts of the Checklist completed

What is the WHO Surgical Safety Checklist?

"The Checklist is intended to give teams a simple, efficient set of priority checks for improving effective teamwork and communication and to encourage active consideration of the safety of patients in every operation performed. Many of the steps on the Checklist are already followed in operating rooms around the world; few, however, follow all of them reliably. The Checklist has two purposes: ensuring consistency in patient safety and introducing (or maintaining) a culture that values achieving it."

Safe Surgery Saves Lives, Implementation Manual WHO Surgical Safety Checklist 2008, World Health Organisation

Percentage Total WHO Checklist Completion (Sign In, Time Out & Sign Out)



In addition to monitoring the use of the WHO Checklist, it is important to know how well our teams are engaged in and participating in the Checklist process. This is part of our Clinical Audit work plan and we will report the outcome of this work at our Patient Safety and Outcomes Committee in quarter one of 2016/17.

GOSH will be reviewing how it intends to prevent Never Events in the operating theatre as part of its work for National Safety Standards for Invasive Procedures (NatSSIPs). An NHS Never Event is an error that should never happen, such as wrong site surgery.

What are the NatSSIPs?

The NatSSIPs bring together national and local learning from the analysis of Never Events, Serious Incidents and near misses through a set of recommendations that will help provide safer care for patients undergoing invasive procedures. This does not in any way replace the existing WHO Surgical Checklist, but rather enhances it by looking at additional factors such as the need for education and training.

The principle behind the NatSSIPs is that organisations will review their current local processes for invasive procedures and ensure that they are compliant with the new national standards. This will be done by organisations working in collaboration with staff to develop their own set of 'Local Safety Standards for Invasive Procedures' (LocSSIPs).

Source: https://www.england.nhs.uk/patientsafety/never-events/natssips/

Clinical effectiveness

Referral to treatment (RTT): incomplete pathways

Incomplete pathways are the care pathways of those patients who are still awaiting treatment for their condition. This is measured against the national 'Incomplete' standard, which states that 92 per cent of patients waiting at any point in time should be waiting less than 18 weeks from referral (the length of time defined as a patient's constitutional right). This measure ensures that patients on an RTT pathway are seen and treated within 18 weeks and thus receive timely care.

What we said we'd do

We chose to report on our RTT work in 2015/16 because we recognised that we needed to improve our processes and data management to ensure that we see all patients in a timely manner. As a tertiary and quaternary provider, we do not know when the 'clock' has been started for nearly 70 per cent of the referrals we receive. This is a considerable challenge for us, and other specialist providers, in meeting the 18 week RTT timescale. However, despite this challenge, we knew we needed to do better at determining exactly how long our patients on these pathways have been waiting to ensure that they are seen within 18 weeks. Limited assurance work by Deloitte in 2014/15 highlighted the problem.

What we did

Since May 2015, we have been working with the national Intensive Support Team (IST) for Elective Care, who are the national experts in supporting trusts in the management and reporting of waiting times and RTT.

A number of significant issues were identified by the IST, in addition to the challenges mentioned above. These mainly related to the data and information processes in place to manage and track patients robustly through their elective pathway. A number of problems with operational processes were also identified.

The Trust established an Access Improvement Programme, led by the Chief Operating Officer, to define, scope, and oversee the necessary improvements required across the elective care pathway. This work programme has been governed internally through a fortnightly Access Improvement Board and externally through a fortnightly tripartite meeting, which includes input from Monitor, NHS England and the Care Quality Commission (CQC).

Significant progress has been made over the course of the year to address the issues identified, including the establishment of robust processes for the management and tracking of RTT patients across the organisation and the training of staff in RTT rules and GOSH processes related to elective care.

While the review has not to date flagged any significant concerns with the clinical care received by patients, we are clinically reviewing our very long-waiting patients to make absolutely sure that they have been managed appropriately and are treated without further delay.

What the data shows

The prime measure for improvement for RTT is the national 'incomplete' standard of 92 per cent, as outlined above. While the Trust is presently unable to report against this standard, we expect to resume reporting from the end of September 2016.

What's going to happen next?

The work programme will continue into 2016/17 in line with the approach set out above until the problems are fully resolved.

How this benefits patients

The Access Improvement Programme aims to provide greater assurance and improved processes for patients accessing elective care at GOSH, ensuring they are treated within the most clinically appropriate timescales.

What is a care pathway?

A care pathway is an outline of anticipated care in an appropriate timeframe to treat a patient's condition or symptoms.

"Delivering high-quality and safe care in a timely fashion has to be our guiding principle. Good progress has been made this year to improve our systems and processes for tracking patients across their pathways and therefore reassuring them and us that they are being seen and treated within the most appropriate timescales. Over the next year, we are committed to further improving our systems and processes to ensure our data is robust and to maximise access for the children and young people who need our care."

Dr Vinod Diwakar, Medical Director

Working smarter to reduce blood component wastage

Blood and blood components are used at GOSH every day to save lives. The availability of blood components is due to the generosity of voluntary blood donors, so it is a precious resource that we should manage well, minimising wastage as well as unnecessary cost.

There will always be some discards of blood components, particularly fresh components with short expiry dates, which must be available immediately for clinical emergencies. This is inevitable and appropriate. However, there is a proportion of discards of blood components that can be avoided by better management of the system of blood availability.

What we said we'd do

In 2015, the Transfusion Team, supported by the Quality Improvement Team, undertook a project to eliminate avoidable blood component wastage as part of the 'No Waste' strategy. Our workstreams included:

- improved inventory management
- reduction in surgical ordering, despite a background of growing surgical activity
- education and training of staff handling blood components

What we did

We began by mapping blood management processes, to help us to understand where in the system improvements could be made, to enable reductions in issued and wasted components. The reasons and cost of blood component wastage were highlighted to staff involved in the transfusion process and it was noted that this varied between clinical divisions. We undertook the following actions:

- Review of the maximum surgical blood ordering schedule requirements for all surgical specialties, with a particular focus on cardiorespiratory care.
- Re-development of the blood components usage and wastage dashboard, with the addition of more measures to enable us to better use the data to inform the project.
- The reservation period for all blood was reduced to 24 hours.
- Review of availability and use of emergency O RhD negative blood (this is the blood group that is compatible with all other blood groups, so can be given to any patient).
- Education of staff to include the lifespan of components and storage requirements.
- Publication of a focus topic about the project for 'Blood Drops', the blood transfusion newsletter, which is available throughout the Trust.
- Support and empowerment of biomedical scientists to challenge orders that don't seem appropriate or necessary.
- Review of the age of red cell requirements to reduce overuse of the freshest components.

What the data shows

Data is collected monthly and shows that relatively inexpensive interventions have had a dramatic impact on blood component wastage, improving patient outcomes and offering savings to the Trust.

What's going to happen next?

The national picture from clinical audits consistently shows that blood components are sometimes used inappropriately. So, the next steps for the project to reduce blood component wastage are:

1. We will undertake an audit of appropriate use of blood to monitor and continue to improve practice.
2. We will maintain awareness of blood component wastage issues through ongoing education.

In addition, we will undertake the following blood management initiatives:

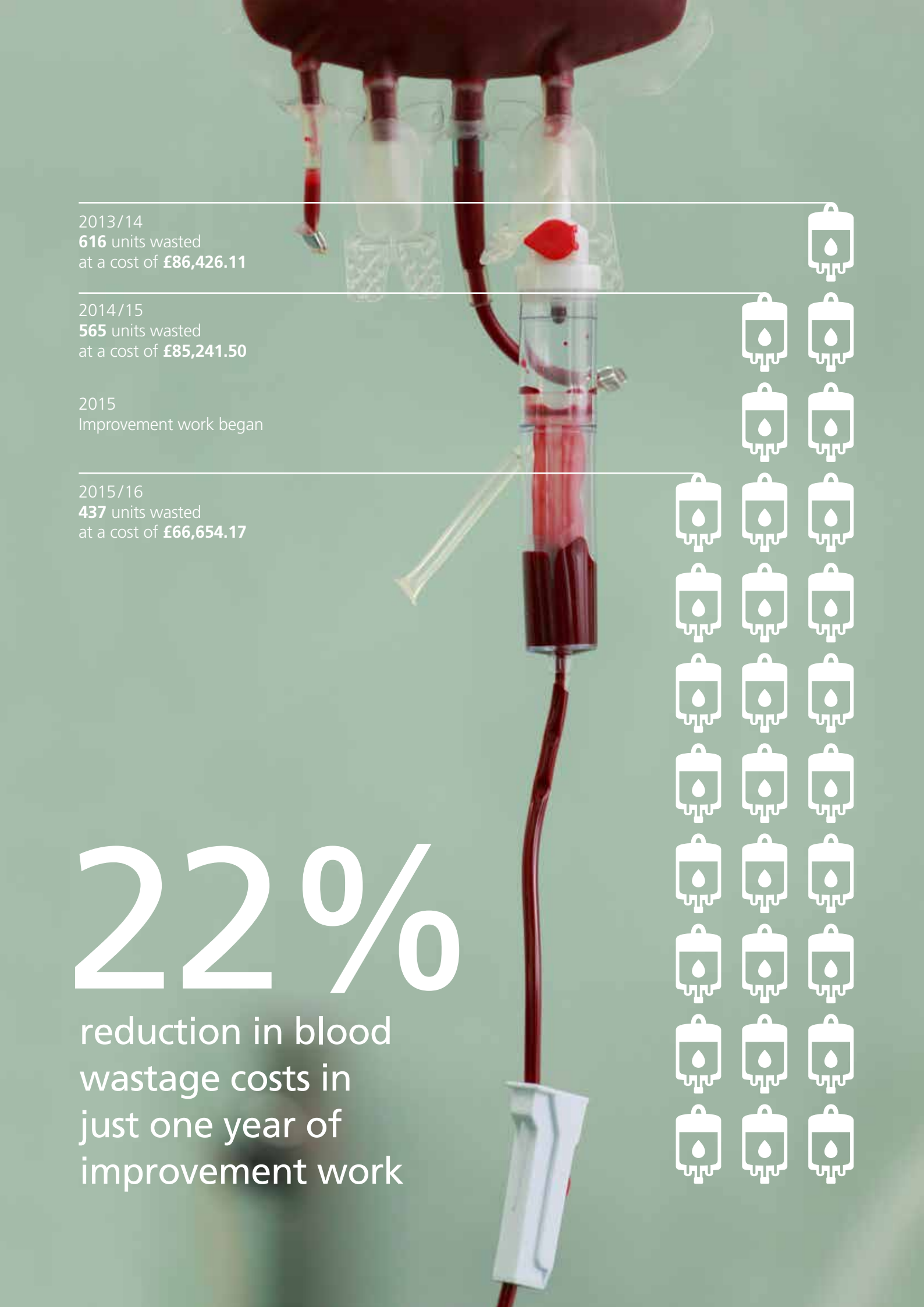
- minimise the volume of blood samples taken
- develop an anaemia pathway for investigating and treating patients undergoing elective surgery
- explore and educate our staff on alternatives to transfusion where appropriate

How this benefits patients

Reduction in wastage of blood components helps to ensure they are available where and when they are clinically needed. All blood management improvements by healthcare providers also contribute to the sustainability of the national blood supply in the future.

"Addressing blood wastage issues at our team days and knowing how we are performing as a team by reviewing timely data, has helped us to identify opportunities to improve. This could benefit all patients if blood that may have been wasted is available for another patient in clinical need and money saved can be diverted to other uses in the Trust."

Deborah & Maria, Practice Educators, PICU


2013/14
616 units wasted
at a cost of **£86,426.11**
2014/15
565 units wasted
at a cost of **£85,241.50**
2015
Improvement work began
2015/16
437 units wasted
at a cost of **£66,654.17**
22%
reduction in blood wastage costs in just one year of improvement work

Experience

Improving discharge summary completion times

When doctors refer children and young people to GOSH for inpatient care, they rely on us to provide them with information about that care once the child is discharged from hospital. This information is sent in a discharge summary.

What we said we'd do

We said we would improve the quality and timeliness of our discharge summaries, by rolling out an electronic system that we piloted from June 2013 to January 2015. We said we would introduce a standardised discharge summary template, using guidance from the Royal College of Physicians to inform the core content required in every summary. We also committed to develop the electronic system further, so it could pull in patient information from other hospital systems in order to reduce duplication and make the process of writing summaries more efficient for clinicians.

What we did

A package of implementation tools was developed, based on our work in the departments that piloted the system (Rheumatology, Dermatology and Specialist Neonatal and Paediatric Surgery). The tools included: the web system itself, a future state process map, dashboards, user guides, posters, and exclusion lists. All clinical specialties were approached via their general managers, who were asked to promote the project within their divisions, identify and engage clinical champions for each specialty, and provide management support for the work.

Uptake of the web system and use of the core content of the standardised discharge summary template was mandatory, but customisation of templates was also available. Requests for adjustments were prioritised and added to an ongoing development plan. At the same time, development of additional features for all users continued. Integration of completed documents into the electronic document management system and a near-live feed of medications from the Trust's e-prescribing system were made available to all clinical specialties in April 2015, after smaller-scale tests had been completed.

Twenty-five specialties across five clinical divisions were identified for roll-out. We established the project in each division through formal spread to one specialty, targeting either those with the greatest need or those who were most eager to be involved. By building our 'early majority' of adopters across the Trust, we were then able to create momentum as well as the spread of good practice through informal interactions between staff.

Our success in 'selling' the project to clinical teams relied on two key messages:

- Our interventions could reduce the overall time spent on discharge summaries as well as improving timeliness and quality.
- As development of our web system had been driven by the clinical team in Rheumatology, the end product had a greater degree of credibility with clinical teams in other areas. This was true even for teams whose clinical practice had little in common with Rheumatology.

By September 2015, all 25 specialties, except Intensive Care, had adopted the electronic system to produce their discharge summaries. In March 2016, the International and Private Patients division also adopted the system to begin writing discharge summaries for their patients.

What the data shows

Rheumatology achieved a statistically significant improvement in their discharge summary completion rate. Their average number of days from discharge of patient to discharge summary completion decreased from 6.1 days (March 2013) to 1.3 days (March 2016).

Specialist Neonatal and Paediatric Surgery has also achieved a reduction in average days from discharge of patient to discharge summary completion, from 4.2 days (May 2014) to 0.4 days (March 2016).

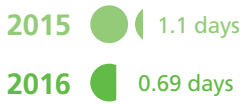
What is a discharge summary?

A discharge summary is a short clinical review of a patient's hospital stay. It lists any tests, procedures and medications the child received and gives instructions for follow-up care once they return home. To make sure there are no delays or problems with the patient's post-discharge care, it is important that discharge summaries are written promptly and contain all of the information the child's local doctor needs to continue their care.

There have also been improvements across the following clinical divisions:

- Neurosciences division has reduced their discharge summary completion time from 1.7 days (January 2015) to 0.4 days (March 2016).

- Surgery division has reduced their time from 1.1 days (January 2015) to 0.69 days (March 2016).



In September 2015, our overall discharge summary completion time was 0.8 days after patient discharge. This was sustained until December 2015 when delays began to reoccur across some clinical specialties.

What's going to happen next?

1. We will continue to smooth administration processes to improve the quality and timeliness of our discharge summaries.
2. We will update the Trust's policy on managing discharges, to include clear guidance on which patients require discharge summaries, and also to agree a clear process of roles and responsibilities in managing patients that are on a ward that is different from their admitting specialty.
3. We will also roll out the electronic system to the Intensive Care Units to complete its implementation across the organisation. This will allow the benefits of a Trust-wide standardised process to be fully realised.
4. We will continue to monitor completion times.

How this benefits patients

High-quality and prompt discharge summaries ensure a smooth and safe transfer of care of GOSH patients to other healthcare providers. This means that our patients receive the care they need when they need it because the right information is exchanged between care-givers at the right time.

"The teams have found the electronic system very helpful in terms of reducing unnecessary admin tasks (such as populating templates) and allowing better tracking of the progress on summaries. However, it was not simply the system that made the difference. Also key was the flexibility and engagement of the Quality Improvement Team to adapt the template for each specialty and work closely to support the administrative and clinical staff who actually compile these summaries."

Bryony, Service Manager (Immunology, Cancer and Infectious Diseases)

Improving the care experiences of our patients with learning disabilities

In last year's GOSH *Quality Report*, we explained our commitment to do better for our patients with learning disabilities. We described the work that had been undertaken across the Trust under the leadership of our Nurse Consultant for Intellectual (Learning) Disabilities and outlined the work we would be undertaking in the coming year.

What we said we'd do

For 2015/16, we said we would:

- Continue to deliver and embed training and support to staff, provided by senior learning disability nurses and the learning disability Link Leads.
- Continue to grow the use of clinical alerts.
- Promote our hospital passport.
- Improve our partnership working.

What we did

Training and support

We ran six educational programmes for all staff via our Post Graduate Medical Education department. The training was delivered in partnership with people with learning disabilities and their parents. The training we deliver is ever-evolving and expanding, based on the training needs identified from an ongoing programme of audits.

In addition, we respond to direct requests from staff for expert clinical advice and guidance in caring for our learning disabled patients. This support is provided by our nurse consultant and 45 staff trained to act as Learning Disability Link Leads.

Learning disability clinical alerts

In December 2014, we set up clinical alerts on our patient administration system to identify 780 of our patients with learning disabilities. By December 2015, this had grown to over 1,450, doubling the number of patients with learning disabilities that we were able to identify before they came in to hospital.

These alerts enable us to better plan for their attendance, to more pro-actively act to support their care and their experience of GOSH.

Hospital passport

Ongoing promotion of the hospital passport has meant that we know how to individually support more of our learning disabled patients when they come in to hospital, whether for an outpatient appointment, a ward attendance or an inpatient admission. The addition of 'Better Care – Healthier Lives', an information pack for staff, has maximised the effectiveness of the hospital passport.

x2

We were able to identify double the number of patients with learning difficulties before they came in to hospital

Partnership working

Our partnership working has continued within the hospital and externally:

- Within the hospital, we have worked in partnership with the complaints team to identify themes for complaints related to care of our patients with learning disabilities. In 2014, nine operations were cancelled on one day due to inadequate support of a patient with a learning disability who was due for surgery. Since implementation of the Learning Disability Protocol for Preparation for Theatre and Recovery in late 2014, there have been zero cancellations of operations related to a patient's learning disability. This has enhanced patient experience and outcomes as well as ensuring more efficient delivery of care. Our theatre protocol[1] has been implemented in Jersey General Hospital
- Externally, we have developed partnership working with Swiss Cottage School, Westminster College, British Institute of Learning Disabilities, Mencap, Bookts Beyond Words, Kingston University, St George's University, Jersey General Hospital and University College London Hospitals. These partnerships have enhanced patient care and experiences by sharing knowledge and expertise across organisations.

The Learning Disability Protocol for Preparation for Theatre and Recovery

- Discuss the patient's needs with them and their family/carer(s).
- Use 'comforters' to relax the patient pre op and recovery.
- Document and hand over to colleagues.

Wake up patients with learning disabilities slower than those without

a. Lower levels of noise and light
b. Place the patient in a quiet area within recovery
c. Ensure patient/carers are present and involved
d. Gradually recover observing how the patient is progressing.

If the patient is disturbed or distressed in Recovery:

1. Call an anaesthetist to use sedation to induce a relaxed, sleepier state
2. Increase levels of sedation as required.

The Care Quality Commission inspected GOSH in 2015 and in their 2016 report said the following about learning disability provision:

"The hospital had 'flagged' 459 of its patients as living with learning disabilities in the 12 months before our inspection. The hospital has a learning disability consultant nurse who is the lead for providing training, advice and support to other staff in the hospital. To support them, they had given enhanced training to 37 link learning disability staff."

"Approximately 40 per cent of children coming through Puffin Ward had a learning disability and Puffin had worked to improve meeting the needs of these children. All families were phoned the day before for confirmation of appointment and fasting times. If children had a learning disability, parents were asked what reasonable adjustments could be made such as the lighting being lowered in cubicles, not liking the surgical gowns and having a photo ID instead of wristbands. Preferences were also noted such as how close to stand to the child. 'Sing SIGN days' with Makaton took place (Makaton uses signs and symbols to help people communicate) and all staff had learned Makaton. The ward manager was due to present the Puffin Ward initiatives to a Royal College of Nurses conference later that month."

"On a recent visit to GOSH the staff had obviously read my daughter's personal passport and were aware of her complex needs and the best way in which to approach her. She is deafblind, has multi-sensory impairment and Down's syndrome amongst other things.

"The staff were aware of her sensory issues and were mindful of not overcrowding her and offered her a quiet space if that would make the whole experience both more accessible and more tolerable for her. The Consultant actually asked how close he needed to get so that she could see him talking to her! The first time her needs had been considered and addressed in such a pro-active way for many years. He also took time to listen to her questions and answered her rather than talk directly to me. This made her feel totally included and a valued part of the whole process, that she could make a decision about what was happening to her rather than simply being the person to whom things were done."

Parent of a patient with a learning disability

1 Where possible, staff are also applying these adaptations, such as lower levels of noise and light, for patients who do not have a learning disability.

What the data shows

Learning disability clinical alerts

Having an alert enables staff to know which patients with learning disabilities are in the hospital, where they are, and how they use the service, so that reasonable adjustments can be made to meet their individual needs.

Growth in the percentage of inpatients (Chart one) and outpatients (Chart two) for whom there was a learning disability alert has increased significantly in the past year. This demonstrates that as an organisation, we are increasingly able to identify children and young people with a learning disability in order to better support their care.

Chart one – Percentage of Inpatients with LD Alert - All Specialties

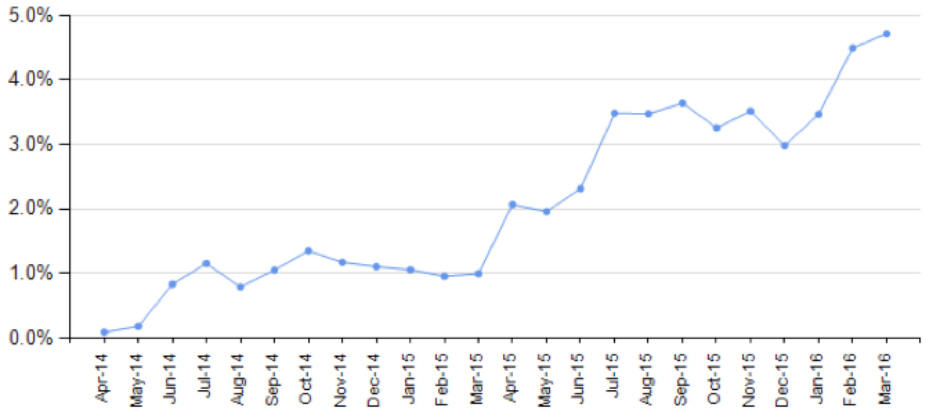
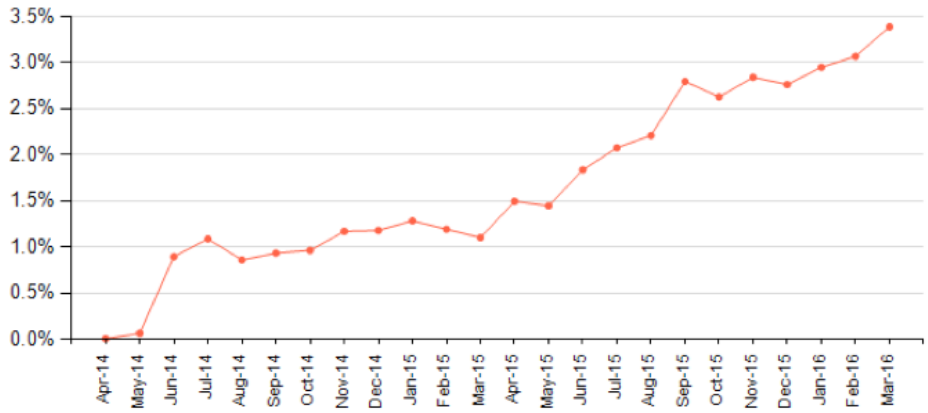


Chart two – Percentage of Outpatients with LD Alert - All Specialties

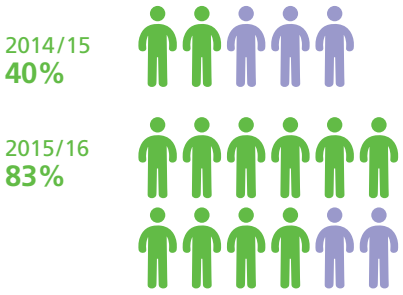


Reasonable adjustments

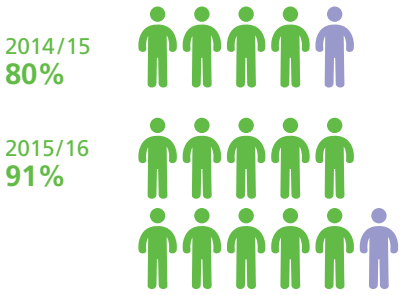
Reasonable adjustments are required to be made within services for people who have disabilities or impairments that fall within the Equality Act (2010).

In quarter three, we carried out an audit to find out how many of our patients had reasonable adjustments identified and documented in their patient record, and how many of the identified reasonable adjustments were met. Below are our figures for 2014/15 and 2015/16:

Reasonable adjustments that were identified and documented in patient notes:



Identified reasonable adjustments that were documented as having been met:



patient where this standard was met

patient where this standard was not met

What's going to happen next?

A steering group called 'Our Health, Our Hospital', made up of people with learning disabilities, families and staff has been set up. Under the group's guidance we will, in 2016/17:

1. Develop a more user-friendly clinic letter for patients with learning disabilities.
2. Establish Parent Support Volunteers so that parents of children and young people with learning disabilities (CYPLD) can be supported in clinics by other parents of CYPLD.
3. Engage in service evaluation and further teaching of staff across the hospital via Postgraduate Medical Education and other training opportunities.
4. Present at conferences and participate in research advisory groups to spread good practice.

How this benefits patients

- Reduced anxiety associated with hospital for patients with learning disabilities and their families.
- Improved experience of hospital.
- Genuine engagement with people who use the hospital to help us improve.

2016/17 Quality Priorities

The following table provides details of three of the quality improvement projects that the Trust will undertake on its services in 2016/17. These priorities were determined with input from staff, patients and their families, and commissioners. This input was sought through a range of mechanisms including survey, consultation, and use of established meetings such as our Members' Council, Young People's Forum, and Public and Patient Involvement and Experience Committee. All of our quality priorities are aligned with our strategic quality objectives, which in turn relate to the Trust vision of 'No waits, No waste, Zero harm'.

Safety

To reduce all harm to zero.

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Improve monitoring and communication of the deteriorating child	Ward teams alert the clinical outreach team about clinically deteriorating patients. We want to ensure that ward staff are effectively monitoring patients so they can identify early if a child's health is deteriorating and seek support when required to provide intervention to stabilise the child.	We will collect and analyse data on referrals to Clinical Site Practitioners and Intensive Care Outreach Network. The data will be published to our intranet dashboards, and reported to Trust Board.

Clinical effectiveness

To consistently deliver excellent clinical outcomes, with the vision to be the leading children's hospital in the world

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Referral to treatment (RTT): Reducing the number of patients with incomplete pathways at 18 weeks	Incomplete pathways are the RTT waiting times for patients whose RTT clock is still ticking at the end of the month. The national standard is 92 per cent of incomplete pathways are <18 weeks. This measure is a good indicator to ensure that patients on a RTT pathway are seen and treated within 18 weeks. Limited assurance work in 2015 confirmed that we had challenges with our 18 week pathway data, operational processes and capacity. This resulted in us taking a break from reporting 18 week data. In 2016/17 we will resume reporting, will launch new operational processes to ensure our waiting list management complies with national best practice, and will continue to work with commissioners to ensure sufficient capacity for the referrals received into the Trust.	In 2015, the Trust established an Access Improvement programme of work to define, scope and oversee the necessary improvements required across the elective care pathway, led by the Chief Operating Officer. This work programme is governed internally through a fortnightly Access Improvement Board and externally through a fortnightly tripartite meeting, which includes input from Monitor, NHS England and the CQC.

Experience

To consistently deliver an excellent experience that exceeds our patients', families' and referrers' expectations.

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Improve young people's experience of transition to adult services	Good transition experiences are associated with improved levels of independence and engagement with adult services, with consequently improved health in adulthood. NICE Transition Guidelines (NICE, 2016) recommend that every specialty should have a designated Transition Lead with responsibility for overseeing transition, the improvement of transition practices and compliance with national guidelines. The guidelines also recommend that a data set of young people who will transition to adult services is established by age and specialty to support better transition planning.	The following measures will be reported: 1. Number and percentage of Specialty Transition Leads established 2. Numbers of young people treated at GOSH, be specialty, in age bands: 15yrs, 16yrs, 17yrs, and 17+yrs.

GOSH patient Louie (R) and his twin brother Aiden, age nine.

Part 2b:
Statements of assurance from the board

This section comprises the following:

- Review of our services
- Participation in clinical audit
- Participation in clinical research
- Use of the CQUIN payment framework
- CQC registration
- Data quality
- Service review
- Implementation of the duty of candour

Review of our services

GOSH is commissioned by NHS England to provide 58 specialised, or highly specialised, paediatric services. These services account for approximately 90 per cent of the Trust's healthcare activity. The remaining 10 per cent of our activity is typically care which, although not specialist, is provided to patients with complex conditions and is commissioned by Clinical Commissioning Groups.

In order to ensure that we maintain excellent service provision, we have internal processes to check that we meet our own internal quality standards and those set nationally. 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 governance frameworks enable divisions to review regularly their progress, to identify improvements, and to provide the Trust Board with appropriate assurance.

The Trust's status during 2015/16 against Monitor's Governance Risk Assessment remains under review, as a consequence of the Trust's decision to commence non-reporting of referral to treatment (RTT) (Incomplete) target and the findings of a third party report, before deciding next steps.

The Trust is undertaking considerable work to rectify the identified data and systems issues in relation to RTT reporting, which have been a large focus during 2015/16 and will continue to be so during 2016/17. The Trust remains committed to the delivery of high quality, safe and effective specialist care for children.

What is Monitor?

Monitor is the independent regulator responsible for authorising, monitoring and regulating NHS Foundation Trusts.

Participation in clinical audit

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

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

What is clinical audit?

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

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

Learning from National Audit reports

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

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

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

Key learning from clinical audit in 2015/16

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

A selection of key findings is listed below:

Learning disabilities

Audit has taken place to support the improvement work on awareness and management of patients with learning disabilities (see page 26). The audit shows progress with documenting and meeting reasonable adjustments of care for children and young people with learning disabilities.

Surgical site marking

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

98%

of cases reviewed had appropriate site marketing arrangements in place

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

Learning from incidents

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

- An incident in January 2013 occurred when a patient's sutures were removed earlier than planned, which resulted in an additional general anaesthetic. The learning from the SI identified the need for clarity of post-operative instructions and communication at ward rounds. Completion of a re-audit this year showed that the recommended changes have been sustained.
- An SI occurred in May 2014 where a needle was retained in the patient. Audit showed that practice had changed in line with the recommendations of the investigation, but that further work is required to ensure that specific types of syringes are always used for closed cavity injections. As a result of this audit, a stock review of the specific syringes was undertaken and the location of the syringes was highlighted at relevant theatre handover. The audit results have been shared at a learning forum for all theatres staff, and changes made to the theatres care plan based around staff suggestions. This will be re-audited in 2016/17.
- In July 2014, an SI occurred where a child in a specialist chair slipped down and suffered positional asphyxiation. The findings of the audit this year showed good progress with the implementation of recommendations. As a result of the audit, staff have been offered additional training to ensure they are aware of the need for patients to be supervised in a specialist chair. We have also modified the instruction sheets that are kept at the patient's bedside when such chairs are used, to make the requirement for supervision clearer. This is currently being re-audited.
- Audit was prioritised to assess the implementation of learning following the unexpected death of a child who had been admitted for the insertion of a gastrostomy. The audit found that the recommendations made in the SI were implemented and no further actions were required.

Responding to national and local safety alerts

National patient safety alert

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

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

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

84%

of cases in May 2015 met the safety alert requirements

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

95%

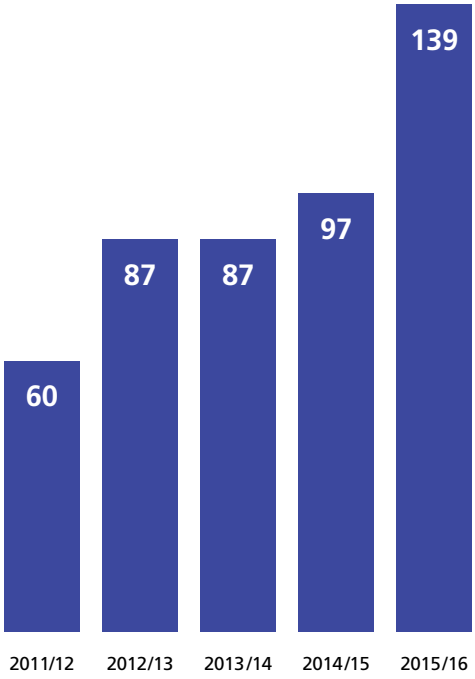
of cases in August 2015 met the safety alert requirements

This will be re-audited again in 2016/17 following additional practice changes agreed in one area of the hospital.

Local clinical audits

The summary reports of 139 completed local clinical audits were reviewed by clinical staff at GOSH during 2015/16. Our data shows we are improving our completion and sharing of local clinical audits over time.

Completed local clinical audits reported



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

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

Examples of actions intended to improve the quality of healthcare, or work that has made a difference as a result of local clinical audit are listed below.

Congenital hyperinsulinism feeding audit

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

"The safety alert and audit of blood glucose monitoring has improved the safety of our patients"

Clare Gilbert, Clinical Nurse Specialist, Hypoglycaemia

What is Model For Improvement?

Model For Improvement, shown by the diagram below, is a practical and systematic approach to change.

Learning from a complaint – Neurology team

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

Visual Infusion Phlebitis (VIP) scores on Koala Ward

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

Holding bay trial – Ocean Theatres

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

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

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

Participation in clinical research

At GOSH, we understand the immense importance to patients and their families of pushing the edges of medical understanding to make advancements in the diagnosis and treatment of childhood diseases. As a specialist hospital with strong academic links, many of our doctors are clinician-scientists who specialise in research and we are dedicated to harnessing opportunities for collaboration between clinicians and scientists, to deliver more research findings from 'bench to bedside' and 'bedside to bench'. In other words, medical research is a two-way process that allows us to offer the very latest treatments for our patients. Much of what we do is at the forefront of research in diseases of children and young people and we are also working to implement new evidence-based practice beyond GOSH, so that more patients can benefit in the UK and abroad.

GOSH's strategic aim is to be one of the top six leading children's research hospitals.

We are in the unique position of working with our academic partner, the University College London (UCL) Institute of Child Health (ICH), to combine enviable research strengths and capabilities with our diverse patient population. This enables us to embed research in the fabric of the organisation. In addition to ICH, GOSH has the benefit of access to the wealth of the wider UCL research capabilities and platforms.Together, GOSH and ICH form the largest paediatric research centre outside North America, and we host the only Biomedical Research Centre (BRC) in the UK dedicated to children's health. Our BRC status, awarded by the National Institute for Health Research (NIHR), provides funding and support for experimental and translational biomedical research. In addition to the BRC, the Division of Research and Innovation includes:

- The joint GOSH/ICH Research and Development Office.
- The Somers Clinical Research Facility (CRF), which is a state-of-the-art ward within GOSH for children taking part in clinical trials.
- Hosting research delivery staff funded through the Clinical Research Network: North Thames.

Our research activity is conducted with a range of national and international academic partners, and we work very closely with industry to support the development and introduction of new therapeutics, devices and diagnostics for the NHS.

Currently, we have 838 active research projects at GOSH/ICH. Of these, 212 have been adopted onto the NIHR Clinical Research Network (CRN) Portfolio, which is a grouping of high-quality clinical research studies. In total, 3164 of our patients were recruited in the past 12 months to participate in research.

838

research projects currently active at GOSH/ICH

Of these,

212

have been adopted onto the NIHR Clinical Research Network Portfolio

Some of our key research highlights in 2015/16 are described below.

- Our pioneering research teams, supported by the GOSH BRC, have developed a new treatment that uses 'molecular scissors' to edit genes and create designer immune cells programmed to hunt out and kill drug-resistant leukaemia. This form of gene therapy is promising for patients with particularly aggressive forms of leukaemia, where the cancer cells remain hidden or resistant to drug therapy. In addition to leukaemia, the teams continue to work together to develop gene therapy treatments for rare diseases, including Netherton syndrome, Fanconi anaemia and Wiskott Aldrich syndrome. The Gene and Cell Therapy Facility, which manufactures the modified cells, is funded through our BRC.
- GOSH has been successful in diagnosing the first patients through the 100,000 Genomes Pilot Study. These diagnoses have had a significant impact on the patients and their families. For the first patient, the genetic diagnosis resulted in a reduction of the patient's medication. In the second case, the diagnostic results indicated that the patient's condition was not inherited, but had arisen for the first time in the patient. Knowing that the chance of having a child with similar problems is very low, the parents now feel able to extend their family and have another child.

  The aims of the pilot were two-fold: to find out whether Whole Genome Sequencing would be a feasible diagnostic tool for patients in the NHS, and to test the pipelines and processes for patient recruitment and sample collection in anticipation of the main 100,000 Genomes Programme. Over 1,000 patient samples were provided by GOSH and our UCL partners, contributing to 22 per cent of the total samples included in the national pilot study.
- Children with a kidney cancer known as Wilms' tumour, who are at low risk of relapsing, can have their chemotherapy reduced. This finding, published in The Lancet, comes from a European-wide trial that studied a drug called doxorubicin. The 10-year study, led by BRC-funded Professor Kathy Pritchard-Jones, followed 583 children with stage II or stage III Wilms' tumour of intermediate risk type, which is the most common. The results showed that 96.5 per cent of children whose treatment included doxorubicin – which has been linked to irreversible heart problems later in life – survived for five years or more, compared with 95.8 per cent of children who did not receive the drug. Even though there was a slight increase in the risk of patients relapsing if they did not receive doxorubicin, such patients were successfully treated subsequently, meaning that overall survival rates were the same. The standard treatment for this type of Wilms' tumour has now been changed to no longer give doxorubicin. This means that the majority of these children now avoid the risk of long-term heart problems.
- The Dubowitz Neuromuscular Centre (DNC) at GOSH and ICH has been confirmed as a Centre of Paediatric Clinical and Research Excellence by Muscular Dystrophy UK. This is one of ten Centres of Excellence and the only paediatric centre selected. This award recognises centres with outstanding levels of specialist care for people living with muscle-wasting conditions. The status was awarded following a national audit carried out by Muscular Dystrophy UK, aimed at ensuring that high-quality care is provided to patients with muscle-wasting conditions. The DNC provides clinical assessments, diagnostic services and advice on treatment and rehabilitation alongside clinical trials. It also provides basic research focusing on causes of neuromuscular diseases in childhood and identifying novel therapeutic interventions. Professor Francesco Muntoni is Head of the DNC, and is the BRC Lead for the 'Novel Therapies for Translation in Childhood Diseases' theme.
- Promising findings from a trial for a new stem-cell based therapy for a rare skin condition have been published in the Journal of Investigative Dermatology. The clinical trial recruited 10 patients with recessive dystrophic epidermolysis bullosa, and was led by Professor John McGrath at King's College London and BRC-supported Principal Investigator Dr Anna Martinez at GOSH. The study involved intravenous injections of stem cells, and has led to an improvement in the quality of life for the subjects and their carers, including reports of improvement in skin healing, reduced pain, better sleep and reduced caring needs.

In addition, we are delighted to list recognitions and awards received:

- Professor Helen Cross received an OBE in the Queen's Birthday Honours for her services to children with epilepsy.
- Professor Waseem Qasim has been awarded a prestigious NIHR Research Professorship, one of only four awarded nationally this year. The posts are designed to support the country's most outstanding research leaders during the early part of their careers to lead research, to promote effective translation of research and to strengthen research leadership at the highest academic levels.
- Three academics associated with GOSH – Professor Helen Cross, Professor Francesco Muntoni and Professor Jane Sowden – were awarded NIHR Senior Investigator status. Professor David Goldblatt was successful in renewing his NIHR Senior Investigator status for a second term. These awards are made by the NIHR to outstanding research leaders.
- Two of our investigators – Dr Ri Liesner and Dr Anna Martinez – received awards from the NIHR CRN for their contribution to clinical research. Dr Liesner was recognised for recruiting the first global patient into a haemophilia study designed to evaluate the safety and efficacy of a recombinant fusion protein. Dr Martinez was recognised for recruiting the first European patient into a phase 3 epidermolysis bullosa trial.
- GOSH also hosts one of the few centres that brings together nurses and allied health professionals (AHPs) in a research setting, led by Faith Gibson, Professor of Child Health and Cancer Care, who holds a joint appointment between GOSH and the University of Surrey. Drs Kate Oulton, Debbie Sell and Jo Wray lead their own programmes of research from the centre, with success in NIHR funding, as well as funding from well-established charities. This team of researchers prioritise understanding the patient and family experience, helping to describe the care that families receive, and exploring both processes and outcome. Dr Kate Oulton is also the NIHR GOSH BRC Clinical Academic Programme Lead for Nursing and AHP research, and is leading the strategy to support and encourage nurses and AHPs to increase their research activity. Recent success includes an NIHR Clinical Doctoral Research Fellowship for Ms Lesley Katchburian, Clinical Specialist Physiotherapist and an NIHR Clinical Lectureship for Dr Elaine Cloutman-Green, Infection Prevention and Control Practitioner.

Use of the CQUIN payment framework

The Commissioning Quality and Innovation (CQUIN) payment framework makes up a proportion of NHS healthcare providers' income, conditional upon improvement. The framework aims to support a cultural shift by embedding quality and innovation as part of the discussion between service commissioners and providers, and constitutes 2.5 per cent of the Actual Contract Value between commissioner and provider.

In 2015/16 providers were given an option in relation to what tariff arrangement to implement (due to changes that were being made to how the tariff had been set nationally). The Trust (along with a number of other specialist tertiary service providers) chose to operate under the Default Tariff Rollover (DTR). By choosing the DTR (as opposed to the Enhanced Tariff Option), the Trust was ineligible to access CQUIN funding. As such, dedicated CQUIN schemes were not applicable during 2015/16

This arrangement was for one year only, and the Trust is now engaged with NHS England (its main commissioner) on CQUIN schemes for 2016/17.

CQC registration

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.

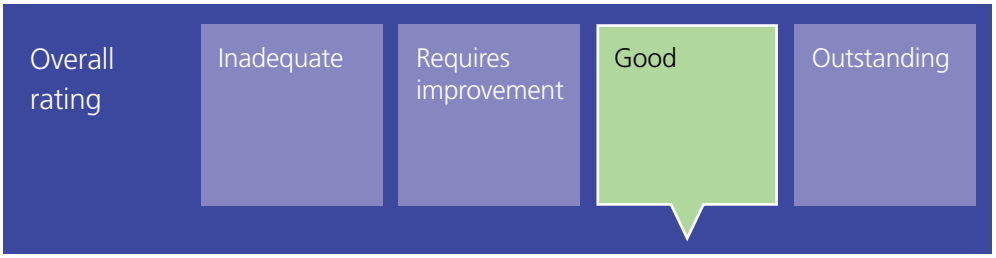
GOSH is required to register with the CQC and is currently registered, without conditions, as a provider of acute healthcare services. GOSH has not participated in any special reviews or investigations by the CQC in 2015/16.

In April and May 2015, as part of their announced rolling schedule of inspections, the CQC conducted a comprehensive inspection at GOSH. The ratings grid opposite demonstrates that the Trust was rated as "good" overall. As part of the assessment, it was rated 'outstanding' for being caring, mostly 'outstanding' for end-of-life care, and consistently 'good' for providing safe care.

What is CQUIN?

The Commissioning Quality and Innovation (CQUIN) payment framework makes a proportion of NHS healthcare providers' income conditional upon improvement. The framework aims to support a cultural shift by embedding quality and innovation as part of the discussion between service commissioners and providers.

Ratings grid



	Safe	Effective	Caring	Responsive	Well led	Overall
Medical care	Good	Outstanding ☆	Outstanding ☆	Good	Good	Outstanding ☆
Neonatal services	Good	Good	Outstanding ☆	Good	Good	Good
Transitional services	Good	Good	Outstanding ☆	Good	Requires improvement	Good
Surgery	Good	Good	Outstanding ☆	Requires improvement	Requires improvement	Requires improvement
Intensive/critical care	Good	Good	Outstanding ☆	Good	Requires improvement	Good
Services for children & young people	Good	Good	Outstanding ☆	Good	Good	Good
End of life care	Good	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆	Outstanding ☆
Outpatients	Good	Not rated	Outstanding ☆	Requires improvement	Requires improvement	Requires improvement

We were most concerned to be informed by the CQC that they sought to take enforcement action against GOSH during 2015/16. This was issued in relation to the Trust's management of referral to treatment (RTT) and associated data. This is reflected in the 'requires improvement' ratings for the responsive and well-led criteria in the surgery and outpatient services.

The Trust and its Board are committed to making the improvements to fully address the issues identified. An extensive transformation programme in the delivery of elective care is underway (see page 21), which will ensure that all patients will be treated in a more timely way in future, and that the systems and processes in place are robust. The Trust is aware of the effect these issues have had on patients' experience, and is working as quickly as possible to make the necessary improvements

Data quality

NHS managers and clinicians are reliant on information to support and improve the quality of services they deliver to patients. This information, or data, should be accurate, reliable, and timely. Some of this data is used to inform local decisions about clinical care and service provision. Some data is reported nationally, and enables comparison between healthcare providers.

The Secondary Uses Service (SUS) is a single source of specified data sets to enable analysis and reporting of healthcare in the UK. SUS is run by the NHS Health and Social Care Information Centre (HSCIC) and its reporting is based on data submitted by all provider trusts.

GOSH submitted records during 2015/16 to SUS for inclusion in the Hospital Episode Statistics, which are included in the latest published data. Performance is measured by examining the accuracy and completeness of data within the submissions to SUS and reported against local area and national averages.

The table below shows the percentage of records in the published data against specified indicators:

Indicator	Patient group	Trust Score	Average national score
Inclusion of patient's valid NHS number	Inpatients	98.2%	99.2%
	Outpatients	98.8%	99.3%
Inclusion of patient's valid General Practitioner Registration Code	Inpatients	99.9%	99.9%
	Outpatients	99.9%	99.8%

Notes:

- The table reflects the most recent data available as of 23 March 2016 (April 2015–January 2016 at month 10 SUS inclusion date).
- Percentages for NHS number compliance have been adjusted locally to exclude international private patients, who are not assigned an NHS number.
- Figures for accident and emergency care are not applicable as the Trust does not provide this service.

Clinical coding and data quality

GOSH was not subject to the Payment by Results clinical coding audit during the 2015/16 reporting period.

The Trust continues to carry out an internal clinical coding audit programme to ensure standards of accuracy and quality are maintained. As a result, for the second year in succession, the Trust has been shortlisted for the Data Quality Award (Specialist), one of only five specialist acute trusts across the UK to have excelled in a range of data quality indicators.

The award recognises the importance of clinical coding and data quality, and the essential role they play in ensuring appropriate patient care and financial reimbursement from commissioners.

The Trust has been shortlisted for this award based on performance against a range of data quality indicators including:

- depth of coding (not case mix adjusted)
- percentage of coded episodes with signs and symptoms as a primary diagnosis
- percentage of uncoded spells

The Trust has been shortlisted for the Data Quality Award

for the second year in a row

What is data quality?

Data quality refers to the tools and processes that result in the creation of correct, 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 NHS Health and Social Care Information Centre?

The NHS HSCIC is England's central, authoritative source of health and social care information.

Acting as a 'hub' for high-quality, national, comparative data for all secondary uses, they deliver information for local decision makers to improve the quality and efficiency of frontline care.

hscic.gov.uk

Information Governance Toolkit

Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The Information Governance Toolkit provides NHS organisations with a set of 45 standards, against which we declare compliance annually.

The Information Governance Toolkit overall score for GOSH in 2015/16 was 74 per cent. This represents a small decrease in performance against the score of 77 per cent reported in 2014/15.

For three of the 45 standards, our self-assessment was below a satisfactory level (level 2):

- Ensuring that all staff receive information governance training every year – only 84 per cent of staff completed the training in year.
- The use of NHS number in all outgoing correspondence – some areas of the Trust have not yet adopted this practice consistently.
- Conducting a recent audit of our corporate record practices.

To address these items, we have remedial action plans aimed at reaching the satisfactory level by June 2016. This includes:

- Communicating with all staff who have not completed their training.
- Introducing a new learning management system to support staff with their mandatory training.
- A project to ensure that all teams sending out correspondence include the NHS number.
- Carrying out a corporate records audit scheduled for completion by May 2016.

Improving data quality

GOSH will be taking the following actions to further improve data quality in the coming year:

- Ensuring that policies and processes regarding capturing of data on core IT systems are concise, complete and in a standard format.
- Development of online e-learning material available via the Trust intranet, giving staff immediate access to guidance when most needed.
- Assigning ownership at operational level of non-core data collection systems.
- Enhancing the data quality reporting suite, highlighting to service users missing or inconsistent data.

Part 2c:
Reporting against core indicators

NHS trusts are subject to national indicators that enable the Department of Health (DH) and other institutions to compare and benchmark trusts against each other. 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. The data is sourced from the Health and Social Care Information Centre, unless stated otherwise. Where national data is available for comparison, it is included in the table.

What is the Department of Health?

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

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:
	2015/16	2014/15	2013/14	Most recent results for Trust	Best results nationally	Worst results nationally	National average		
Domain 3: Helping people recover from episodes of ill health or following injury									
				Source: Health & Social Care Information Centre Time period: 2013/14 financial year					
Emergency readmissions to hospital within 28 days of discharge:									
– % of patients aged 0–15 readmitted within 28 days	1.78%	0.74%	2.5%	Not available from the HSCIC at the time of publication of this report.				The results are from the Hospital Episode Statistics (HES) and the Office of National Statistics (ONS).	Ensuring divisions and directorates develop and implement local action plans, which respond to areas of weakness.
– % of patients aged 16+ readmitted within 28 days	1.62%	0.6%	0.9%						
Domain 4: Ensuring that people have a positive experience of care									
				Source: NHS Staff Survey Time period: 2015 calendar year					
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends	88% (2015)	87% (2014)	87% (2013)	88%	93%	80%	91% (median score)	The survey is carried out under the auspices of the DH, using their analytical processes. GOSH is compared to other acute specialist trusts in England.	Ensuring divisions and directorates develop and implement local action plans, which respond to areas of weakness.
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	25% (2015)	24% (2014)	23% (2013)	25%	9%	49%	37% (median score)		
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	87% (2015)	89% (2014)	89% (2013)	87%	95%	81%	88% (median score)		

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 service, by:
	2015/16	2014/15	2013/14	Most recent results for Trust	Best results nationally	Worst results nationally	National average		
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm									
				Source: Department of Health (acute providers) Time period: 2014/15 financial year					
Number of clostridium difficile (C. difficile) in patients aged two and over‡	7	14	13	14	0	121	34		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 two and over (number of hospital acquired infections/100,000 bed days)*	8.3	12.2	11.9	12.2	0	62.2	15.1	The rates are from Public Health England†	
C.difficile is endemic in children and rarely pathogenic. 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 Health Care 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. ‡ Of the 7 cases of C.difficile attributed to GOSH for 2015/16, two were attributed to a lapse of care in line with guidance published by Monitor. Of the 14 cases of C.difficile attributed to GOSH for 2014/15, one was attributed to a lapse of care in line with guidance published by Monitor. Information on lapses of care was not determined in 2013/14. * Previously published rates for 2014/15 (12.7) and 2013/14 (14.8) were based on a different calculation. These have been recalculated in line with Department of Health methodology and re-published here. † https://www.gov.uk/government/collections/healthcare-associated-infections-hcai-guidance-data-and-analysis									
				From National Reporting and Learning Service (NRLS) Time Period: 01/04/2015 to 31/03/2016					
Patient safety incidents reported to the NRLS: Number of patient safety incidents	5,338	5,231	4,922	5,330	-	-	-	GOSH introduced electronic incident reporting (DatixWeb) in April 2011 to promote easier access to and robust reporting 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 to improve the sharing of learning to reduce the risk of higher graded incidents from recurring include learning events and a Learning, Implementation and Monitoring Board.
Rate of patient safety incidents (number/100 admissions)	15.32	12.82	10.28	-	-	-	-		
Number and percentage of patient safety incidents resulting in severe harm or death	11 (0.2%)	26 (0.5%)	27 (0.5%)	6	-	-	-		
There is a time lag between NHS Trusts uploading data to the NRLS (performed twice a month at GOSH) and the trend analysis reports issued by the NRLS.									

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 Care Quality Commission (CQC) as part of the CQC registration process. GOSH also reports its patient safety incidents to the National Reporting and Learning Service (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.

Part 3:
Other information

Monitor uses a limited set of national mandated performance measures, sourced from the NHS Operating 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.

Performance against key healthcare targets 2015/16

Domain	Indicator	Threshold/target	GOSH performance for 2015/16 by quarter				2015/16 total	Indicator met?
			Q1	Q2	Q3	Q4		
Safety	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia – meeting the MRSA objective	Monitor no longer includes MRSA in its governance indicators	N/A	N/A	N/A	N/A	N/A	N/A
Effectiveness	All cancers: 31-day wait from decision to treat to first treatment	96%	95.7%	100%	97.8%	100%	98.8%	Yes
Effectiveness	All cancers: 31-day wait for second or subsequent treatment, comprising:							
	· surgery	94%	94.4%	100%	92.3%	100%	96.1%	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%	2015/16 was a challenging year for the Trust related to delivery of the referral to treatment (RTT) standards, with a number of significant issues identified following an Elective Care Intensive Support team review in May 2015. As a result, GOSH has agreed with NHS England a pause in the reporting of its RTT figures until confidence in the data has been returned. The improvement work (see page 21) required to address the identified issues and return to compliance against the RTT Incomplete standard is ongoing, and we expect to resume reporting from the end of September 2016.					
Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance against requirements*	Achieved	Achieved	Achieved	Achieved	Achieved	Yes

* Target based on meeting the needs of people with a learning disability, from recommendations set out in *Healthcare for All* (Department of Health, 2008)

Performance against key healthcare targets 2014/15

Domain	Indicator	Threshold/target	GOSH performance for 2014/15 by quarter				2014/15 total	Indicator met?
			Q1	Q2	Q3	Q4		
Safety	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia – meeting the MRSA objective	Monitor no longer includes MRSA in its governance indicators	N/A	N/A	N/A	N/A	N/A	N/A
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%*	92.5%	92.2%	92.2%	94.4%	92.8%	Yes*
Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance against requirements‡	Achieved	Achieved	Achieved	Achieved	Achieved	Yes

* Work completed since last year has identified that the data quality of the Trust's RTT performance reporting was not of an appropriate standard. Therefore, we now know that the figures published last year (and included here) were not reflective of the Trust's position. A Trust Board decision was made to suspend RTT reporting while work is being completed to ensure that our processes are robust to report data that is an accurate reflection of the Trust's position.

‡ Target based on meeting the needs of people with a learning disability, from recommendations set out in *Healthcare for All* (Department of Health, 2008)

Performance against local improvement aims 2015/16

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 17). All measures remain within expected statistical tolerance.

2015/16

Domain	Indicator	Total 15/16 performance	2015									2016			Performance within statistical tolerance
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Safety	Number of serious patient safety incidents	18	3	4	1	1	2	1	1	1	1	3	0	0	Yes
Safety	CVL related bloodstream infections (per 1,000 line days)	1.4	0.3	1.5	0.9	1.7	1	1.2	1.9	0.9	2.5	1.6	2.3	1.3	Yes
Effectiveness	Hospitality mortality rate (per 1,000 discharges)	2.58	4.0	2.47	2.23	1.86	2.71	1.96	4.13	2.14	3.53	1.14	2.14	2.70	Yes
Patient Experience	RTT - Incomplete *	2015-16 was a challenging year for the Trust related to delivery of the RTT standards, with a number of significant issues identified following an Elective Care Intensive Support team review in May 2015. As a result, GOSH has agreed with NHS England a pause in the reporting of its RTT figures until confidence in the data has been returned. The improvement work (see page 21) required to address the identified issues and return to compliance against the RTT Incomplete standard is ongoing, and we expect to resume reporting from the end of September 2016.													
Patient Experience	Discharge summary completion time (within 24 hours)	81.8	78.7	81.0	83.4	80.2	79.4	82.9	82.6	82.3	73.0	74.5	76.6	79.4	N/A

2014/15

Domain	Indicator	Total 14/15 performance	2014									2015			Performance within statistical tolerance
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Safety	Number of serious patient safety incidents	23	1	2	2	3	2	1	2	2	3	0	1	4	Yes
Safety	CVL related bloodstream infections (per 1,000 line days)	-	1.1	2.3	0.5	1.3	1.5	1.8	1.5	1.2	1	1.2	1.4	1.3	Yes
Effectiveness	Hospitality mortality rate (per 1,000 discharges)	-	3.4	3.3	2.3	2	2.8	2.4	2.2	2.1	2.8	3.6	3.4	1.4	Yes
Patient Experience	RTT - Incomplete *	92.8%	92.8	92.2	92.6	92.0	92.2	92.2	92.0	92.1	92.7	94.6	93.9	94.7	Yes
Patient Experience	Discharge summary completion time (within 24 hours)	81.2%	82.2	81.1	85.1	84.9	77.7	80.6	83.4	81.2	78.8	80.3	79.0	80.2	N/A

Service review

To address issues with the Gastroenterology Service that had been reported via patient and parent complaints, PALS, and other internal rout es, the Trust commissioned an independent review and immediately took action upon receipt of early findings of the review.

Actions included:

- A review of all gastroenterology referrals by a multi-disciplinary team (MDT) chaired by the Medical Director.
- A revised approval process of procedure lists.
- A revised case review, diagnostic and treatment guidelines.
- Complex case review and management at MDT at which attendance was compulsory.

Implementation of these action plans is ongoing and is monitored closely by the executive team.

Implementation of the duty of candour

The Trust formalised its approach to openness and transparency in 2009 with the introduction of its Being Open Policy. This policy informed staff of the expectations of the Trust, that open and honest communication would take place with patients, parents and their families throughout all aspects of their care, including when patient safety events may have occurred.

The policy was updated to encompass the legal requirements that came into force on 1 April 2015, which described a legal responsibility to be open with patients and/or their families when a patient safety event caused harm graded as moderate, severe or death.

The Trust continues to engage in transparent communication with patients, parents and families and has robust processes to manage patient safety events that are reported at the Trust.

"The culture was very open and transparent. Parents and children were kept fully involved in their treatment. There was an evident commitment to continually improve the quality of care provided. Children and young people were involved in decision making as far as possible."

Quote from GOSH's CQC report, published January 2016

Annex 1: Statements from external stakeholders

Statement from NHS England (London), Specialised Commissioning Team

NHS England would like to thank Great Ormond Street Hospital for Sick Children for the opportunity to review and provide a response to the 2015/16 Quality Account.

NHS England is the Lead Commissioner and has a very positive relationship with the Trust. We continue to work together to consider improvements in the quality of care, taken up through contractual mechanisms, feedback from families and other stakeholders, clinical quality review meetings and through regular dialogue for example with Monitor and the Care Quality Commission which published its inspection report in January 2016.

We commend the Trust for the very positive feedback received and documented in the CQC report published in January 2016. The Trust received an overall rating of Good with a number of areas of outstanding practice. Two areas for improvement were identified in relation to Responsiveness and Well-led. A Requirement Notice was issued reflecting some necessary changes in the management of Referral to Treatment Targets (RTT) that were identified as a priority in the 2015/16 *Quality Report*. The Trust has undertaken extensive work in response to the issues raised, good progress has been made to date and work is planned to continue into 2016/17.

In 2015/16, NHS England established a Joint Strategic Change Programme and appointed a Project Manager to lead a programme of work that aims to improve paediatric care in London. GOSH clearly has a leadership role here. The *Quality Report* priority relating to "flow" particularly through paediatric intensive care and some service / pathway redesign which should have consequential benefits on RTT are key components of our joint work.

We acknowledge the areas of achievement reported this year. NHS England welcomes the ongoing focus of the following measures to address patient safety, clinical effectiveness and patient experience:

- To embed RTT processes (to include a better understanding of relative demand and capacity).
- To progress work to improve the care experiences of children and young people with learning disabilities.
- To focus on improving transition to adult services.
- To improve patient safety through better monitoring and communication of a child's deteriorating health.

More broadly, the new Executive team continues to review the governance processes in place across the Trust and has already made recommendations in relation to:

- Performance and turnaround of Serious Incident reports.
- Development of Ward to Board reporting.
- Prompt investigation of feedback from families point to concerns about clinical management warranting investigation.
- A wider review of data quality management processes.

We look forward to supporting the findings from these key pieces of work and building on the Trust's Always values to ensure continuous improvement for patients is delivered in 2016/17.

Response from Healthwatch Camden and Camden Health and Adult Social Care Scrutiny Committee

This report clearly sets out the continuing improvements at GOSH over the year. The results of the CQC inspection report were well deserved. We would like to congratulate the new leadership team on the way they have tackled the challenges they have faced. We are particularly pleased to see the excellent progress on supporting patients with learning disability.

GOSH has a demonstrable commitment to patient and family engagement. The caring ethos (rated as 'outstanding' by CQC) is evident in our contacts with GOSH staff.

We are concerned that data on referral to treatment (RTT) times is unreliable and hope that the trust is able to resolve the underlying issues, with a clear plan of action to share publicly, including with Camden's Health and Adult Social Care Scrutiny Committee in early autumn 2016.

Feedback from Members' Council councillors

Comments from patient councillor:

Overall, I am thoroughly impressed by the work performed at GOSH. It is always at the forefront and pioneering new medical treatments and practices, without compromising NHS care. The care I have received here and many others is world-class; it is extremely difficult to fault them.

GOSH is great at identifying problems early and responding to them rapidly, seen by their numerous audits and their reaction to improving flow through ICU. Getting clinicians, related staff members and families involved in the trials and development is essential to make the new system work. The implementation of ePSAG is wonderful and will provide real time information for everyone to access to enhance communication, which is always a concern and identify those at risk. The development of IT systems will really improve the workings of the hospital, especially the new EPRS in development. My only worry is that personal details are available to anyone that walks onto the wards and whether this is a breach of confidentiality.

I am pleased that GOSH responded to the RTT issue very promptly and have plans to resolve the current system and training. It is irritating to be waiting so long to receive treatment but in true GOSH spirit, they have not let significant harm come to anyone. GOSH have been open about this issue, adhering to their duty of candour.

Delayed discharges are inevitable at times, but are very frustrating as a patient and interfere with individual plans. I am glad work is being put into this to identify the reasons so this can be rectified, to free up beds and personal time. The use of ePSAG will really benefit this. No one likes to be on a ward unnecessarily.

Many patients at GOSH have chronic illnesses, and communication to their local services is fundamental for their care. The delay in discharge summary completion has been a concern for a while but I am pleased that work is being done to improve the completion time, as it will also free up time for clinicians. The development of a summary template will make it easier to complete and a system that is capable of connecting with other hospitals will revolutionise communication between GOSH and local teams. As a patient, duplicate copies are annoying but the communication once leaving hospital has always been difficult, tedious and can lead to delays in medical care. Looking at the outcomes of the intervention I am really impressed since they have notoriously been slow.

I am completely in agreement that there should be more support for those with learning difficulties. Hospital is a daunting place for anyone and everyone should be supported to meet their needs so they can get the best out of their treatment. The introduction of the hospital passport will make sure all departments are aware so they can improve the effectiveness of communication and the care they receive, making them feel as a valued individual.

What can be seen from the report is that staff engagement and support is vital to enhance the care they provide. This should be paramount to ensure they feel respected and valued in the work environment. The report shows staff likely to recommend the service to families and friends is lower than the national average, and those experiencing harassment (although both very high scores) could be improved. Whether they are provided equal opportunities for promotion is hard to say, as GOSH is a pioneering institution, so most people would be at the peak of their career.

I am particularly interested in Transition to Adult Services as this is something I have recently been through, however it is not executed particularly well and young people express very different experiences. It is an extremely difficult time to deal with in our lives and we have many questions and concerns. Preparation and support is key to this as is learning from other departments. By having a designated Transition lead in each department I hope that no-one will be missed. It means that young people know who to contact should they have any worries. Since transition in other departments is different we need a designated person in each department who understand the processes and knows when is an appropriate time to transition medically. It will hopefully mean that those under several specialities feel more relaxed as their transition leads can communicate with each other.

When I was treated at GOSH I was under the care of the gastroenterology team. I cannot fault them clinically however the service has been slow and communication was not always up to scratch. When waiting in outpatients, I never knew how long I would have to wait before being seen, and it would take me out of school for the whole day at times. Looking at PALS, they complain of a lack of care at times. I believe there is definitely room for improvement here, and I understand they are a large department with many patients to care for in an older part of the building. I think it is probably down to operational errors than anything else, however I am very satisfied that they are researching into this.

Comments from lead councillor:

GOSH is a world class tertiary paediatric hospital with an extraordinary reputation. This report highlights ongoing work to improve services and protocols as well as the incredible achievements of the hospital. Over the past 11 years GOSH care and expertise has saved my son's life on more than one occasion. I will always be grateful for this, so continue to work to improve services from the patient and parent perspective in the hope of improving the GOSH journey for others and in order to repay this debt.

I was pleased to read about the successful work to improve flow through intensive care, an important initiative. ePSAG is a welcome innovation that will help clinical treatment, save time, improve patient experience both trust wide and especially in relation to ICU. I am delighted that 'transparency and choice' are key concepts here; they are the way forward and will certainly improve patient and family experience and outcomes. It is refreshing to learn that a simple change in routine can make such a difference - it is so much more sensible to spread the load on ICU by simply changing operating days.

The 'watcher' facility now available through ePSAG is a fantastic new tool that will improve outcomes, reduce deteriorating child incidences and increase hugely patient safety and patient and family experience. I particularly applaud the ePSAG facility which allow parents' and staffs' concerns about a child's wellbeing to be recognised by flagging as 'watchers' whose CEWS don't trigger an alert. The benefits of ePSAG are clearly multifold and it is wonderful that the system can be built on and adapted according to specialist needs.

RTT issues are clearly very worry but it is reassuring to see that the situation is being dealt with carefully, thoroughly and efficiently. It is very good news that no patient harm has been discovered, I am confident that the 18 week window will be adhered to in the near future and that lessons learned will be beneficial to all areas of data management at GOSH.

It is good to read that there have been successful efforts to reduce the wastage of blood products as this is an expensive and valuable resource; it is clearly an area that needs continued monitoring.

Discharge summaries are a key local quality indicator that the Members' Council have selected as an item to include in this report annually since FT status was achieved in March 2012. This is because, as a Council, we recognise the importance role that discharge summaries play in the timely and safe discharge of patients. Not only does this improve patient and family experience, a timely and accurate discharge summary will also ensure a speedy return home and ensure that appropriate care is given by that patient's GP or local hospital on arrival. The Members' Council have been frustrated by the lack of improvement in discharge summary rates, so, while we applaud the work that has been done thus far, it clearly isn't enough as the job is not done. It is encouraging that the work that has been undertaken so far has resulted in significant improvement, but disheartening that the discharge summary times slipped so quickly after the end of the project. The Council hope to see a significant and sustained improvement in discharge summary rates for the 2016-17 Quality Report and are prepared to do whatever is necessary in supporting this.

The work around improving awareness and experience of patients with learning difficulties is wonderful, long may this continue. I do have concerns around the children and young people that do not fall into this category though, as this support is exclusive to patients with a significantly low IQ. This means that patients with a diagnosis of autism or Asperger Syndrome but with a higher IQ are not able to take advantage of the benefits offered through this facility. It is clearly a gap which needs closing as this group's needs are great too. Their experience and care would be vastly improved if they were able to access this service also.

I am pleased to see that 'Improving young people's experience of transition to adult services' is one of the three Quality Priorities for 2016/17, although I am concerned that the slant of this priority is on improving young people's experience rather than on significantly improving the transition provision. An experience is tenuous to measure, whereas a provision isn't. The transition provision at Great Ormond Street Hospital is sadly lacking, and this has been the case for many years. Often planned transition doesn't even happen. Young people become adults and they are moved on to adult hospitals with little support. There is certainly currently no standard protocol, so it is left to the specialities to work it out for themselves, resulting in a lack of consistency. The Members' Council have expressed concerns over this issue numerous times and we feel strongly that it needs tackling urgently. It isn't clear from this report whether the NICE guidelines for the provision of a Transition Lead for each specialty is going to be implemented trust wide.

Thorough auditing and learning from SI is clearly demonstrated by this report and is hugely reassuring and the extraordinary levels of medical innovation and excellence are heart warming to read. This is GOSH at its best. The 'molecular scissors' to edit genes and create designer immune cells is an example of this, as is the progress in diagnosis through the 100,000

Genomes Pilot Study. The list of extraordinary and groundbreaking new research and development in child health conducted at GOSH far too long to comment on individually but it is clearly something to be immensely proud of and to celebrate!

The CQC rating of 'Good' was very well deserved, the outstanding rating for caring and end of life care is a wonderful achievement and down to a set of people who do extraordinary things - every day. Clearly there is work still to be done in some areas, and the difficulties around RTT caused lower ratings that GOSH otherwise would have expected. But this is being dealt with and overall I am sure GOSH is very proud and deserving of its rating. GOSH is aware of, and proactive around, the issues in surgery and outpatients that need improvement. I am confident these will be tackled urgently. Data quality is a risk that the Trust is fully aware of and is working hard to improve. This is key to the delivery of a safe and effective service.

Issues with the Gastroenterology Service continue. I am pleased and reassured to hear that these complex issues are being monitored at Board level. It is an area where the Members' Council have expressed concern on several occasions in the past.

I am concerned by the minimal degree of reference to GOSH's 'Our Always Values' given in this report. These values were developed from the views of thousands of patients, parents and staff; they specify that GOSH aspires to be Always Welcoming, Always Helpful, Always Expert and Always One Team. I could find only one mention of these Values at any point through the document. It states that Our Always Values 'has been a visible commitment to our patients, families and staff' - while this is correct in that there are visible representations in the form of several posters and banners around the hospital and I know it is part of the recruitment policy, this minimal reference reflects my observation of many different GOSH departments and projects which either omit or keep to a minimum the utilisation of Our Always Values as a way of measuring and/or improving patient and family experience. The wholehearted adoption of Our Always Values by putting these values at the core of everything that GOSH offers and undertakes will inevitably lead to an improvement in all services, including clinical, and therefore will dramatically improve outcomes as well as patient and family experience. I trust this will improved in the 2016-17 Quality Report - because there will have been a significantly greater take up and awareness of the benefits of embracing 'Our Always Values' at the core of everything that GOSH does.

Nevertheless, overall I found this report interesting and enlightening. It has been carefully prepared and shows significant and heartening improvement in many areas. There are many achievements to celebrate and these are a testament to the extraordinarily hard, caring and dedicated work of thousands of people at GOSH who daily work together to make a positive difference to the sickest of children.

GOSH response to statements:

Confidentiality of ePSAG boards

We welcome the query about the confidentiality of the ePSAG boards. Throughout the implementation of ePSAG, which is installed only in swipe card access-controlled areas, all information that is added to the boards has been put through a formal information governance process. We have also consulted directly with patients and parents on the content of the boards. The feedback we have received is that the level of detail on the boards is appropriate and in fact, we found that parents welcomed the display of more information if it would increase the coordination and safety of care for their child. We continue to consult on and assess appropriateness of information as we make developments.

Discharge summaries

Discharge summaries are an important method of communication when a child or young person is discharged from hospital. We remain committed to improving timeliness by monitoring completion times, understanding why slips in performance happen, and targeting our improvement work accordingly. In 2016/17, we will focus on the remaining clinical areas that struggle to get their discharge summaries out in a timely fashion. Performance will be managed through our heads of clinical service, and we will undertake work in each poorly performing specialty to understand the reasons and learn from best practice in other areas.

Learning disabilities

Where appropriate and feasible, the principles underpinning aspects of the learning disabilities work stream are being modelled and mirrored for other children that would benefit from them.

Transition

The Trust is committed to achieving and consistently delivering all the required processes that underpin high quality transition for young people. In support of this, the Trust will be working to deliver the national CQUIN for Transition, the requirements outlined within the quality specification of the contract with commissioners, and the post-CQC GOSH Inspection Report (April 2015 inspection) action plan that focuses on improving the internal reporting of transition activity to the Board of Directors. Each specialty will provide a Transition Lead who, with their multi-disciplinary team, will be responsible for delivering the required process improvements such that every young person who requires transitioning from GOSH to a specialist adult service will receive this in a timely manner and as a positive experience. The delivery of this work across all of the pertinent specialties and consultants will be throughout 2016/17 and 2017/18.

Our Always Values – Always Welcoming, Always Helpful, Always Expert, Always One Team.

The contribution of our patients and families to the development of Our Always Values has been vital to them being embraced by staff (in our last Staff Friends and Family test, 97% of staff said they recognise Our Always Values). We welcome the continuing engagement of families in our work to embed the values, including the feedback provided here.

Having achieved high visibility of Our Always Values amongst staff, the next phase of work has been and continues to be the embedding of the values in our systems, processes and structures as well as in individual behaviours. Examples of this work in the last year include organisational redesign that has reduced the number of clinical divisions in part to reduce boundaries between specialist teams, supporting our 'One Team' value, and the commencement of a large piece of work to review the letters that we send to patients and families to ensure they are always clear and comprehensible, an example of our 'Helpful' value.

Major programmes of work are also underway, from building new patient care areas to delivering a new electronic patient record, which will allow us to further embed Our Always Values as 'business as usual'.

Jodie Irwin, Staff Nurse on Badger Ward at GOSH.

Annex 2: Statements of assurance

External assurance statement

Independent auditor's report to the Members' Council of Great Ormond Street Hospital for Children NHS Foundation Trust on the *Quality Report*

Text TBC 20 May 2016

Statement of directors' responsibilities in respect of 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.

Monitor 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 2015/16 and supporting guidance.
- 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 2015 to May 2016
  - papers relating to Quality reported to the board over the period April 2015 to May 2016
  - feedback from commissioners dated 27/04/2016
  - feedback from governors dated 20/04/2016 and 03/05/2016
  - feedback from local Healthwatch organisations dated 05/05/2016
  - feedback from Overview and Scrutiny Committee dated 05/05/2016
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated xx/05/2016
  - the first CQC commissioned National Children's inpatient survey 2014 (conducted for GOSH by Picker Institute Europe) – the second version of this survey is under development and is expected to be available to conduct in 2016
  - the independently commissioned Ipsos MORI outpatient experience survey 2014 (this survey is conducted every two years)
  - the national NHS Staff Survey 2015
  - the Head of Internal Audit's annual opinion over the trust's control environment dated 20/05/2016
  - CQC Intelligent Monitoring Report dated May 2015 and CQC *Quality Report* dated 8 January 2016
- 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 Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the *Quality Report* (available at www.monitor.gov.uk/annualreportingmanual).

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

20 May 2016

Chairman

20 May 2016

Chief Executive

Great Ormond Street Hospital for Children NHS Foundation Trust

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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.

This *Quality Report* is available to view at www.gosh.nhs.uk

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Great Ormond Street Hospital for Children NHS Foundation Trust

Findings and Recommendations from the 2015/16 NHS Quality Report External Assurance Review

Final report: 17 May 2016

the Distinctive audit

Contents

Executive Summary

We have completed our work pending resolution of differences in data tested and figures included in the draft Quality Report

Status of our work

- We have completed our field work in regards to validation of the reported indicators, however, there is currently a 0.1% difference between our calculation of the Cancer Waits indicator and the reported number. Work is ongoing to understand and this and whether it is indicative of reporting or data errors. We have completed our content and consistency review. We have still to receive the final signed Quality Report and letter of Representation, at which point we will issue our final report to the Council of Governors.
- The scope of our work is to support a "limited assurance" opinion, which is based upon procedures specified by Monitor in their "Detailed Guidance for External Assurance on Quality Reports 2015/16".
- We anticipate signing an unmodified opinion for inclusion in your 2015/16 Annual Report, subject to the satisfactory clearance of the points detailed above.

Q4 Governance Risk Rating: 'Under Review'

The Care Quality Commission inspected Great Ormond Street Hospital during the year and overall the Trust was rated "Good".

	2015/16	2014/15
Length of Quality Report	57 pages	53 pages
Quality Priorities	7	9
Future year Quality Priorities	3	10

Scope of work

We are required to:

- Review the content of the Quality Report for compliance with the requirements set out in Monitor's Annual Reporting Manual ("ARM").
- Review the content of the Quality Report for consistency with various information sources specified in Monitor'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 national priority indicators as mandated by Monitor for limited assurance testing for the year ended 31 March 2016 relevant to the Trust are:
    - Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
    - Maximum waiting time of 31 days from urgent GP referral to first treatment for all cancers
  - However, as detailed on page 46 of the Trust's Quality Report and page 94 of the Annual Governance Statement, the Trust has been unable to report upon the following indicator for the year:
    - Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
  - As the Quality Report does not include a figure for this indicator, Monitor guidance mandates an alternative national indicator for testing:
    - Emergency re-admissions within 28 days of discharge from hospital.
    - This is in addition to testing the 31 Day Cancer Indicator. We refer to these national priority indicators collectively as the 'indicators'.
  - For 2015/16, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. The Trust local indicator is 'the number of discharge summaries sent within 24 hours of discharge'.
  - 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 31 day cancer waits and 28 day re-admissions 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 waits, 28 day re-admissions and discharge summaries.

Executive Summary (continued)

We have completed our work pending resolution of minor differences in data tested and figures included in the draft Quality Report

Content and consistency review

Review content → Document review → Interviews → Form an opinion

We have completed our content and consistency review. From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016 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?	G
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)?	G

Performance indicator testing

Interviews → Identify potential risk areas → Detailed data testing → Identify improvement areas

Monitor requires Auditors to undertake detailed data testing on a sample basis of two mandated indicators and one local governors' indicator. We perform our testing against the six dimensions of data quality that Monitor specifies in its guidance.

From our work, pending resolution of reconciling differences between data tested and numbers reported, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016, the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the ARM and the six dimensions of data quality set out in the "Detailed Guidance for External Assurance on Quality Reports 2015/16".

Performance indicator testing (continued)

Please note that the below rating assumes satisfactory resolution of the differences identified between cancer performance recorded and our recalculation.

	31 day cancer waits	28 day re-admissions	Discharge summaries
Accuracy Is data recorded correctly and is it in line with the methodology.	B	B	A
Validity Has the data been produced in compliance with relevant requirements.	G	G	R
Reliability Has data been collected using a stable process in a consistent manner over a period of time.	G	B	A
Timeliness Is data captured as close to the associated event as possible and available for use within a reasonable time period.	G	G	A
Relevance Does all data used generate the indicator meet eligibility requirements as defined by guidance.	G	G	G
Completeness Is all relevant information, as specific in the methodology, included in the calculation.	G	G	A
Recommendations identified?	✓	✓	✓
Overall Conclusion	B Unmodified Opinion	B Unmodified Opinion	No opinion required

G No issues noted

B Satisfactory – minor issues only

A Requires improvement

R Significant improvement required

Content and consistency findings

the Distinctive audit

Content and consistency review findings

The Quality Report continues to be a clear and useful summary of the Trust's quality agenda

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, based upon the points identified in our NHS Briefing on Quality Accounts.

Key questions	Assessment	Statistics
• Is the length and balance of the content of the report appropriate?	G	Length: 57 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: 3 Clinical Effectiveness: 2 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?	A	Flesch reading score: 36 - Graduate (based on first draft received)

G No issues noted A Acceptable but could be improved R Significant improvements required

Deloitte view

Overall, the Quality Report at the Trust is in a clear format and consistent with stakeholder feedback and our understanding of the Trust.

Particular areas of good practice are;

- The report is well written; the logic behind the Trust's priorities are clear and the actions being taken behind them evidenced.
- A glossary is used in the format of "call-out bubbles" which allows the user to understand the terminology as they read through the report.
- The Trust has clearly disclosed where there have been data quality challenges around the RTT indicator, demonstrating the Trust's openness and transparency on quality issues.

Areas for improvement are;

- The Flesch reading score rates documents from 0-100 for ease of reading. A score of 36 means that the document is understandable to the average Graduate and indicates that the language and way in which the report is written could be simpler, which could improve accessibility for young patients and families.

Performance indicator testing

the Distinctive audit

31 day cancer waiting times

The Trust's process has been historically strong but we note there have been breaches during 2015/16

	Trust reported performance	Target	Overall evaluation
2015/16	98.8%	98%	B
2014/15	100%	98%	B
2013/14	100%	96%	B

Indicator definition

Definition: "Percentage of patients receiving first definitive treatment for cancer within 31 days of decision to treat"

This is a goal set by the NHS Cancer Plan. **As per Monitor guidance** -." For Trusts with cancer patients where the 62-day pathway does not apply or there are only a very small number of patients to whom this applies, the Trust may substitute this with a 31-day cancer wait indicator if desired."

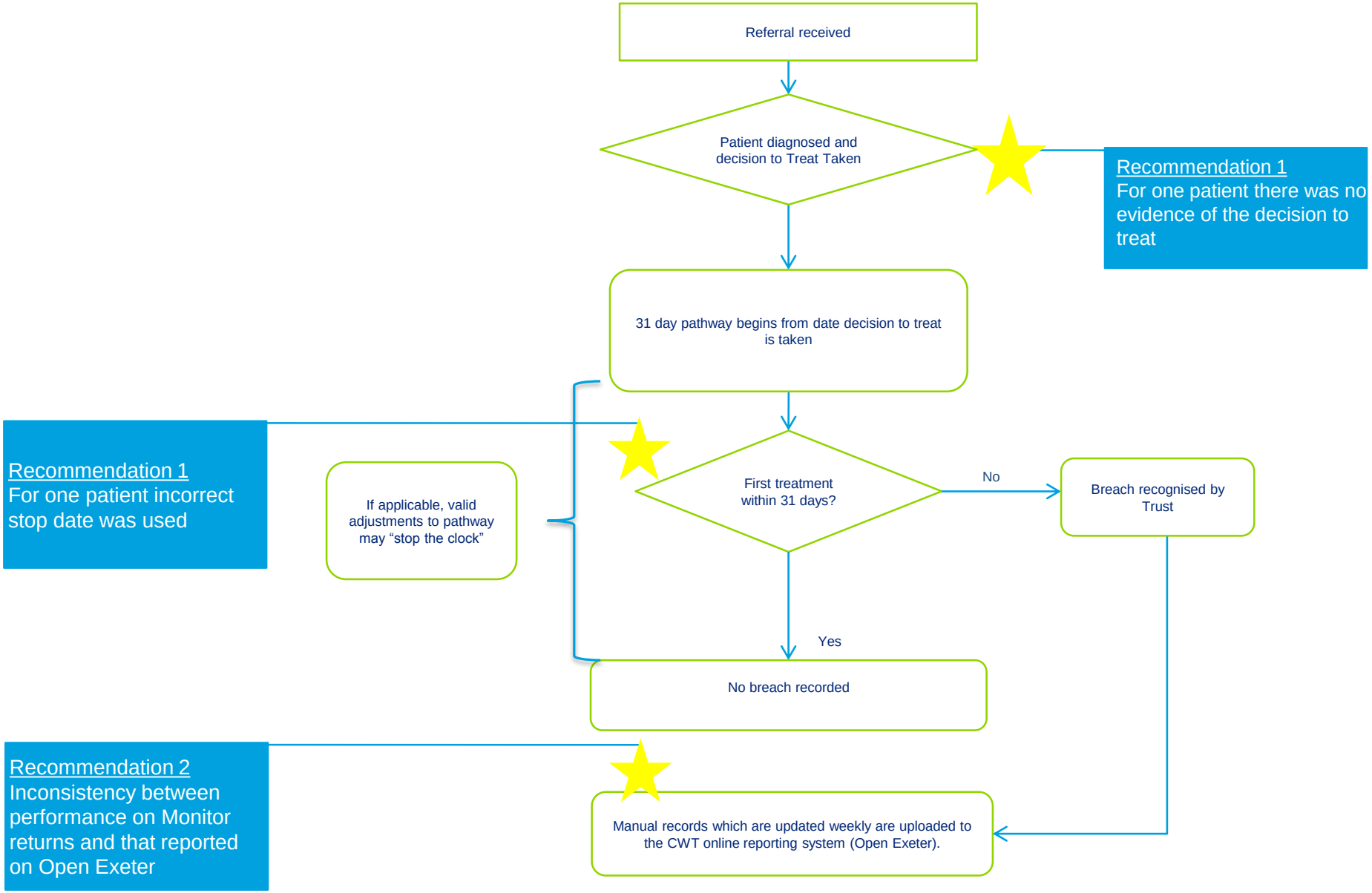
Approach

- We met with the Trust's lead for 31 day cancer waits to understand the process from an urgent referral to the Trust to the result being included in the Quality Report. There was one recommendation from the prior year to follow up on which we have concluded on below.
- We evaluated the design and implementation of controls through the process. We discussed with management and used analytical procedures to focus on pathways which appear to be most at risk of error e.g. patients with manual adjustments and pathways close to the 31 day breach date.
- We selected an initial sample of 24 from 1 April 2015 to 31 March 2016 including in our sample waiting times which were greater than 10 days as these represented highest risk of breach if found to be misstatements. During our work we found 2 issues, one where no evidence could be provided, and one where the dates recorded were incorrect; this error did not change the sample from a non-breach to breach. We therefore extended our sample to test whether this item was isolated. Our extended sampling raised no issues, gaining assurance these were isolated exceptions.
- We agreed our sample to supporting documentation.

31 day cancer waiting times (continued)

We have raised three recommendations

Process flow



31 day cancer waiting times (continued)

Findings

- Supporting evidence for decision to Treat - Recommendation 1 - For one patient there was no evidence of a decision to treat and therefore we are unable to conclude on whether this patient was included in the waiting lists in the correct months. We extended our testing in light of this with no further issues noted.
- Incorrect date used for first definitive treatment - Recommendation 1 - For one patient the incorrect stop date was used of Biopsy instead of Chemotherapy received. However, this did not result in a breach being incorrectly reported as the pathway remained under 31 days even when corrected.
- Inconsistency within the 31 day cancer waits performance between Monitor Returns and those reported on Open Exeter - Recommendation 2 - As noted in our interim report to the Audit Committee we found that there were two breaches in Q1 and Q3 respectively but GOSH had reported 100% performance of this target to Monitor in their quarterly returns. As per corroboration with management this was due to the fact that the patients were being validated as they had not concluded as to whether it was correct to include the patient on the pathway. We recommend that there is enhanced communication between the performance and cancer waits team.
- We identified an error in how the Trust had calculated the quarterly figures in the Quality Report. This meant that the indicator was misstated immaterially in the draft figures (reporting 98.8% rather than 98.9%) This did not impact whether the overall standard for the year was met or breached. At the date of our report discussions are ongoing to understand why this difference has arisen.

2014/15 audit findings

- Data input Errors
  We identified 7 instances where data was input incorrectly in client records, when compared to patient notes. These were manual data entry errors. None of these resulted in a patient being reported incorrectly in regards to whether they have breached, but do indicate there is a risk of inaccurate data recording.

Deloitte View:

The quality of the Trust's processes over reporting of this data has improved on prior year. During the 2014/15 31 day cancer waits testing we found 7 instances where there was a data input error compared to the two instances found during 2015/16 testing.

We have noted an inconsistency in regards to the Trust's reporting of the 31 day cancer waits metric in the Monitor Returns and those reported on Open Exeter. However, to conclude nothing has come to our attention that causes us to believe that this indicator has not been reasonably stated in all material respects within the Quality Report. The errors identified in relation to the accuracy of data input did not impact whether a breach had occurred or not and the final reported indicator does include those patients that had breached the indicator appropriately. Management should consider the controls in place to avoid future data-processing issues, reminding staff of the importance of careful documentation of relevant dates and information.

28 day emergency re-admissions

This is the first time this indicator has been tested at the Trust

	Trust reported performance		Target*	Overall evaluation
	Aged 0-15	Aged 16+		
2015/16	1.78%	1.62%	n/a	B
2014/15	0.74%	0.60%	n/a	Not selected
2013/14	2.50%	0.90%	n/a	Not selected

*There is no national target for this indicator as per NHS guidance.

Indicator definition and process

Definition: "Percentage of emergency admissions to a hospital that forms part of the Trust occurring within 28 days of the last, previous discharge from a hospital that forms part of the Trust."

The readmission rate can indicate early complications after discharge and how appropriate the original decision made to discharge was. Some re-admissions are to be expected from planned care pathways.

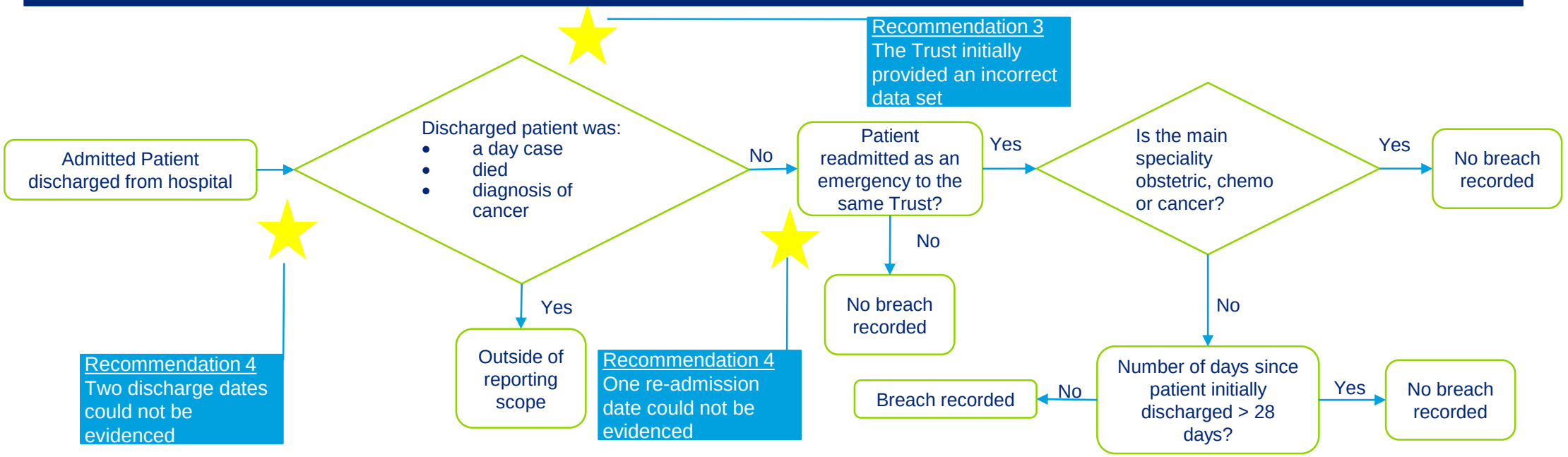
Approach

- We met with the Trust's lead for emergency re-admissions to understand the process from a patient being readmitted to the result being included in the Quality Report. This is the first year in which we have audited this indicator and therefore there were no recommendations from last year to follow up.
- 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 and decided to weight our sample to those which were near the 28 day point.
- The Trust initially provided us with a data set that incorrectly included cancer patients and international and private patients, which are outside the scope of the indicator. This has not led to any misreporting in current year as the Trust only reports the indicator at year end. As such a corrected data set as per the guidance for this indicator was extracted and used to calculate the year end indicator.
- On receipt of the correct data source, we sampled 24 patients across the year that had been re-admitted as well as a further 5 patients from the denominator as a test of completeness that no re-admissions were being excluded. We agreed discharge and re-admission dates to documentation from patient medical records. Owing to

28 day emergency re-admissions

This is the first time this indicator has been tested at the Trust

Process flow



Findings

- Provision of Incorrect Data - Recommendation 3 - The Trust initially provided us with data that was incorrect and included patients who should have been excluded. This did not impact reporting, as the Trust was able to extract the correct data and only report annually on this indicator, so could correct for year end. However, we recommend that the Trust consider other indicators, particularly those that are only reported annually, or for which the data requirements are complex, to ensure that the data sources used are appropriate.
- Discharge and Re-admission dates not supported by evidence - Recommendation 4 - In our sample testing we identified 2 patients in the numerator (those re-admitted) and 1 in the denominator (not re-admitted) for who we were unable to find documentary evidence (discharge summaries or documentation to support re-admission) to support the dates recorded. We extended our sample (with no further issues noted) and are satisfied that the issues are isolated.

Deloitte View:

We have tested a sample of patients for this indicator and although we identified some issues with completeness of evidence, we have been able to gain assurance that the 28 day emergency re-admissions figure reported by the Trust is materially correct.

Discharge Summaries

The Trust's process requires improvement

	Trust reported performance	Target	Overall evaluation
2015/16	81.8%	85%	n/a
2014/15	81.2%	85%	n/a
2013/14	83.0%	85%	n/a

Indicator definition and process

Definition: "Percentage of patients requiring discharge summaries for whom the discharge summary is sent within 24 hours of discharge"

All children who are discharged must have a discharge summary completed within 24 hours of discharge and primary care staff must be informed of the child's discharge. The Trust's target against this indicator is currently 85%

We do not issue a formal opinion on this indicator.

Approach

- We evaluated the design and implementation of controls through the process. We met with the Trust's lead in Information Services for this indicator to understand the systems and processes of recording results in the Quality Report.
- We reviewed progress against recommendations made in 2014/15 when we last tested the indicator. (See prior year recommendations section).
- We selected a sample of 24 patients from 1 April 2015 to 31 March 2016 from the Patient Information System ("PIMS") and agreed admission date, discharge date and date the summary was sent back to source documentation.
- We do not issue a formal opinion on this indicator.

Findings

- **Supporting evidence regarding the date the discharge summary was sent-** Recommendation 5. For 17 of our sample of 24 we were unable to agree the sample to a dated discharge summary, although the summaries did have a 'date last edited' figure which related to the date they were last edited on the system. Since this was not conclusive as to whether this corresponded to the sent date, and the discharge summaries do not tend to be dated as to when they are sent, we are unable to prove whether the summary was sent in line with the timings reported in the PIMS system. We recommend that the Trust implement a pro-forma summary, with a 'date sent' field, as documentary evidence to support the data. This will allow the Trust to gain further assurance over this publically reported indicator and the data that underpins it.
- **No date as per the discharge summary or date of last update on the system-** Recommendation 6 We found for 2 out of 24 samples, there was no discharge summary on file. We would therefore recommend that the Trust ensure that they have pro-forma discharge summary for all specialities which is dated.
- **Variance in Reported Figures and Underlying Data** We identified an error in the figures reported in the quality account compared to our tested figures. (Quality Report states 81.8% whereas the Deloitte recalculation of data tested recorded a figure of 82.7%). This is because of retrospective amendment of PIMS data. We have not performed any further work on the retrospective validation.

Discharge summaries (continued)

Progress on prior year findings

Findings continued

Prior year findings 2014/15

- **Evidencing the date discharge summaries are sent**

  We found that for 19 of our 25 samples, it was not possible to confirm the date the discharge summary was sent by reviewing patient records. The Trust does not routinely keep evidence to support the date the discharge summary was sent, and many discharge summaries are not dated. There is no standard pro-forma summary that includes a date.

  2015/16 update- We would still conclude that there is not a standard discharge summary pro-forma that includes a date sent. We have noted however that most discharge summaries are now scanned onto the EDM system which records patient correspondence and some patient notes but this is not yet a complete patient records system. While we have been able to use the EDM system for the majority of our testing the majority of our samples do not correlate to the PIMS system and we therefore believe that stronger links between the two systems need to be established.

- **Recording patient data correctly within PIMS**

  We identified one instance whereby a patient that should not require a discharge summary was included in the data reported from PIMS as having received one and one where a discharge summary was required and sent out correctly, but in PIMS they were recorded as not needing one. We also identified 2 occasions where the admissions or discharge dates were incorrectly recorded within PIMS. None of these instances led to a breach in the 24 hour target. The Trust can also make retrospective changes to PIMS data after it has been reported, but do not adjust their reported indicator to take account of this.

  2015/16 update- Our testing for 2015/16 has found further PIMS data input issues which are summarised on the previous page. We have however not found an issue in regards to the date the patient was discharged and there has therefore been an improvement in the process over this area. The main issue is concerning the date the discharge summary was sent as there is a clear lack of an audit trail in order for us to assess its accuracy.

Deloitte View:

In line with our findings in the prior year, we are still unable to follow a clear audit trail that demonstrates the date the discharge summary was sent. As per our recommendations on page 16 we recommend that the Trust adds a “date sent” field into their template summary letters, ensuring each letter has a clear indication of the date sent. We understand that the Trust is still in process of transferring data to the patient records system EDM and currently we believe that stronger links need to be made between PIMS and EDM for the quality of data input to improve for this indicator.

Recommendations for improvement

the Distinctive audit

Recommendations for improvement

Recommendation number	Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
1	31 day cancer waits	Supporting evidence for start and stop dates We would recommend that the cancer waits team implement appropriate controls to ensure that there is adequate supporting documentation for decision to treat and the clock stop for all patients when collating data each month.	The Trust implemented the Infoflex system on 29 March 2016 and completed the project plan to deliver the IST recommendations by 31 March 2016. The recent revisit by IST noted the significant improvement in this area **Responsible Officer:** Deputy Chief Executive **Timeline:** Immediate **Process for updating Council of Governors:** We will report progress against this recommendation plan at the members meeting	
2	31 day cancer waits	Inconsistency within 31 day cancer waits performance between Monitor Returns and those reported on Open Exeter As noted in our interim report to the Audit Committee we found that there were two breaches in Q1 and Q3 respectively but GOSH had reported 100% performance of this target to Monitor in their quarterly returns. As per corroboration with management this was due to the fact that the patients were being validated as they had not concluded as to whether it was correct to include the patient on the pathway. We recommend that there is enhanced communication between the performance and cancer waits team for each quarterly return and the monitor reporting is reconciled to the cancer data quarterly.	There is a national delay in the allocation of shared breaches between Trusts that can lead Quarterly returns requiring subsequent correction. The Trust is reviewing all external reporting to ensure consistent sign off of monitoring returns **Responsible Officer:** Deputy Chief Executive **Timeline:** September 2016 **Process for updating Council of Governors:** We will report progress against this recommendation plan at the members meeting	

Recommendations for improvement

Recommendation number	Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
3	28 day emergency re-admissions	Incorrect inclusion of incorrect patient types in reporting metric As per national guidelines the Trust should not be including patients who are readmitted who were previously diagnosed with cancer and also private patients. The Trust originally provided us with a data set that included these. The Trust was able to correct this and provide the correct data, and has based their year end indicator on correct populations. We recommend that the Trust considers the controls around other indicators and the data sources used to collate them, particularly those that are only reported annually, or for which the data requirements are complex, to ensure that the data sources used are appropriate and the figures are accurate.	The Trust amended the report and has confirmed the accuracy of the output. The measurement of 28 day emergency re-admissions is a commissioner reporting requirement and the Trust has agreed with commissioners that the metric is not readily applicable to the work the hospital undertakes. As a consequence the Trust is not required by Commissioners to report the metric. The report provided is therefore an ad hoc report. The content is nationally prescribed and while the relevance is limited for the Trust we have now ensured the report output is accurate. **Responsible Officer:** Deputy Chief Executive **Timeline:** Complete **Process for updating Council of Governors:** No further update required	
4	28 day emergency re-admissions	Evidence to support the date of discharge and re-admission For 3 samples, we were unable to locate evidence to support the discharge or re-admission dates recorded. We extended our sample and are satisfied this is not a material issue, but we recommend that the Trust review controls around ensuring patient notes are complete and accurate, and discharge and re-admission dates can be supported by documentary evidence.	The Trust has received an internal audit report on discharge management and will implement the detailed recommendations within that report, the recommendations within this report and the prior year actions into a single action plan for implementation this year. **Responsible Officer:** Deputy Chief Executive **Timeline:** December 2016 **Process for updating Council of Governors:** We will report progress against the consolidate action plan on a routine basis at Council member meetings	

Recommendations for improvement

Recommendation number	Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
5	Discharge summaries	All discharge summaries should be dated In order to ensure each discharge summary evidences the date sent, summaries should include a date box or there should be a requirement for this in EDM or the patient's notes (date stamp, copy of fax, email if possible). A pro-forma summary could be rolled out across the Trust, including a date sent box.	The Trust has received an internal audit report on discharge management and will implement the detailed recommendations within that report, the recommendations within this report and the prior year actions into a single action plan for implementation this year. **Responsible Officer:** Deputy Chief Executive **Timeline:** December 2016 **Process for updating Council of Governors:** We will report progress against the consolidate action plan on a routine basis at Council member meetings	
6	Discharge summaries	All discharges should be supported by a discharge summary For 2 of our samples, we were unable to agree the discharge to an appropriate discharge summary. We recommend that the Trust review controls to ensure that all discharges that require a summary have one, and this evidence is maintained either electronically or in patient notes.	The Trust has received an internal audit report on discharge management and will implement the detailed recommendations within that report, the recommendations within this report and the prior year actions into a single action plan for implementation this year. **Responsible Officer:** Deputy Chief Executive **Timeline:** December 2016 **Process for updating Council of Governors:** We will report progress against the consolidated action plan on a routine basis at Council member meetings	

Update on prior year recommendations

There is still work to be performed in regards to our prior year recommendations

Indicator	Prior year recommendation	Management Response	Current year status
18 weeks RTT	**1) Identification of unknown clock starts & RTT Pathways** We recommend the Trust review what procedures or processes can be implemented to earlier identify whether a patient is on a RTT pathway and then how best to capture start dates. As well as controls around training staff to correctly identify RTT pathways, a more detective control could be input, to review the nature of pathways included in the RTT indicator data.	We agree with the need to improve our reporting of unknown clock starts. However, this is an extremely challenging task given the number of different Trusts that we work with, the highly complex nature of our patients and the late stage we are in the patients' pathway. We also don't want to establish any solutions which could potentially compromise patient care and believe that our current processes pay due regard to the primary importance of the patients' health. We have invited in the national RTT intensive support team to assist us with a solution and we will work them to develop appropriate actions. **Responsible Officer:** Chief Operating Officer	We understand that the Trust is currently on a reporting break in regards to 18 weeks RTT. As per Monitor's quality accounts guidance we have therefore not performed a limited assurance review of this indicator during 2015/16.
18 weeks RTT	**2) Ensure clock stop dates are accurately recorded** Deloitte found 2 incorrect breaches due to the clock not being stopped correctly and 1 item where a breach should have been recorded but wasn't due to clock being paused. We recommend that GOSH review processes to ensure clocks are stopped accurately when the pathway is finished.	We have established a weekly pathway meeting which reviews on a patient by patient basis at a certain waiting trigger point. We will roll out training across the Trust and all Divisions should develop local SOPs. **Responsible Officer:** Chief Operating Officer	We understand that the Trust is currently on a reporting break in regards to 18 weeks RTT. As per Monitor's quality accounts guidance we have therefore not performed a limited assurance review of this indicator during 2015/16.

Update on prior year recommendations

Indicator	Prior year recommendation	Management Response	Current year status
18 weeks RTT	**3) Retrospective Data Changes** As a result of retrospective amendments made to data, we identified that for 6 months in the year, retrospective changes led to Trust position falling below the 92% threshold when the Trust had reported they had met the target. We recommend controls are put in place to ensure that the data reported each month is sufficiently reliable and validated prior to reporting.	We are in the process of implementing a system which clearly reports and sets in stone the monthly reported RTT figures. **Responsible Officer:** Director of Planning and Information	We understand that the Trust is currently on a reporting break in regards to 18 weeks RTT. As per Monitor's quality accounts guidance we have therefore not performed a limited assurance review of this indicator during 2015/16.
31 day cancer waits	**4) Recording data accurately** Although no material errors or breaches of the cancer waits or discharge summaries indicator were noted, we did identify several cases in both indicators whereby there were data recording errors. We recommend that the Trust considers the controls it has in place for ensuring data is recorded correctly around these two key indicators.	We will review our process and consider new controls as required. **Responsible Officer:** General Manager for ICT	From our current year testing it is clear that there have been improvements in regards to the accuracy of the data input as our error rate has improved on prior year. However, some discrepancies remain (see recommendation 1 for current year)

Update on prior year recommendations

Indicator	Prior year recommendation	Management Response	Current year status
Discharge summaries	**5)Ensure process around discharge summaries monitoring & reporting is clearly documented** In our testing we identified similar findings to those from our 2011/12 work. We would recommend that for this key Trust indicator that clear process and procedure notes are prepared which consider how best to address our findings and accelerate the Trust towards meeting its target in this area.	All Divisions need to develop local SOPs which comply with the Trust's discharge summary policy. We also need to work towards one Trust wide system which has an automatic recording on discharge summary completion date. **Responsible Officer:** Director of Planning and Information	We have identified similar issues during our current year review and therefore recommendation remains open.
Discharge Summaries	**6) Evidencing the date that discharge summaries are sent.** In order to ensure each discharge summary evidences the date sent, summaries should include a date box or there should be a requirement for this in EDM or the patient's notes (date stamp, copy of fax, email if possible). A pro-forma summary could be rolled out across the Trust, including a date sent box.	All Divisions need to develop local SOPs which comply with the Trust's discharge summary policy. We also need to work towards one Trust wide system which has an automatic recording on discharge summary completion date. **Responsible Officer:** Director of Planning and Information	This recommendation remains open and has been carried forward into the current year and remains open.

Responsibility statement

the Distinctive audit

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 under Monitor's Audit Code 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
Chartered Accountants

St Albans
17 May 2016

This report is confidential and prepared solely for the purpose set out in the contract under which this work is performed 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 Monitor for their information in connection with this purpose, but as made clear in the terms under which we are contracted, only on the basis that we accept no duty, liability or responsibility to Monitor in relation to our Deliverables.

Deloitte.

Attachment D

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

29th June 2016

Membership and Engagement Committee update

Summary & reason for item: To provide the Members' Council with an update on:

1. Update from Membership Engagement Committee meeting held on 22 June 2016
2. Membership Report as at 8 June 2016

Report prepared by: Deirdre Leyden, Membership and Governance Manager & Ross Johnson, Stakeholder Communications & Marketing Manager, GOSHCC.

Item presented by: Chair of the Membership and Engagement Committee and Deirdre Leyden, Membership and Governance Manager.

Councillor action required: To provide comment and note the report.

Attachment D

1. Membership Engagement Committee – Update from Meeting on 22 June 2016

1.1. Annual Membership report

This report is circulated at the Annual General Meeting and used for recruitment purposes. The committee agreed dates for feeding back on the draft report. They noted the importance of ensuring their work around the representation of members was included and that the report picks up the themes and progression made over the last year.

Action: The committee will be circulated dates for feedback and suggestion. The report will be available at this year's AGM.

1.2 Planning for the 2016 Annual General Meeting

The committee discussed the format for this year's AGM with a focus on increasing attendance. Incentives to attend, balancing constitutional obligations and membership engagement were discussed. The committee put forward several suggestions.The communications team at GOSHCC will support communications out to membership and the format for the meeting.

Action: Head of Internal Communications at GOSHCC will lead on the planning and further development of suggestions made. The Company Secretary will take suggestions to the Board.

1.3 Planning for Away Day 2

The second Away Day for the committee will be planned for September 2016. A revised terms of reference and a continuation of the workplan will be discussed to ensure that the work already begun is now becoming embedded.

Action: Membership and Governance Manager to set date and circulate agenda.

1.4 Database update

A test set of all data is now with Membership Engagement Services (MES) with first testing session to take place on 22 June. Testing will cover report running, basic functionality and communications. Links have already been made between the new provider and teams at the charity who currently run our communications out to membership. An updated membership form will also see changes for the online sign-up.

Action: Membership and Governance Manager to update at the next MEC meeting.

1.5 Electronic feedback methods for membership engagement

A meeting was held to discuss electronic methods for capturing feedback received by councillors which is used currently for case studies. The committee will need to look in more detail at what needs to be captured and how current systems already in use (e.g. electronic FFT) can be adapted.

Action: Membership and Governance Manager to investigate and feedback at next meeting.

1.6 Representing Members- case studies

So far the committee has taken six case studies to the Patient Family Experience and Engagement Committee (PFEEC) (circulated to councillors). The committee discussed the best ways to prevent duplication of patient experience stories. It was noted that the Members' Council receives a report

from the PFEEc at their meeting so that councillors can receive assurance that issues and themes arising are being considered alongside other patient experience data and information, themes identified and work programmes prioritised.

Action: The committee will present one case study at Members' Council on 29 June.

2. Membership Report as at 8 June 2016

2.1. Active Membership Total

The current membership stands at **9,242.**

2.2. Membership Profile and analysis of the overall membership statistics

2.2.1. Total Patient, Carer and Public membership

Table 1 below sets out the Patient, Carer and Public membership as at 8 June 2016.

Overview

The Council is asked to note comparison membership statistics since 1 April 2016.

Our overall membership number has increased by thirty-seven (37). We have seen a marginal decrease of six(6) members in the patient and carer segment and the greatest increase in the public segment by forty- three(43).
We undertook a face to face recruitment drive in May and accrued volunteer sign up in the last quarter. These efforts will result in 149 new joiners being reflected in our next membership statistics report in September.

Table 1: Patient and Carer and Public membership as at 8 June 2016.

Constituency	Number of members as at 1 April 2016	Number of members recruited in year**	Number of members leaving in year***	Number of members as at 8 June 2016
*Patient and Carer	6205	7	13	6199
Public	3000	53	10	3043
Total	**9205**			**9242**

Patient and Carer Constituency

** This constituency includes people who have received treatment as an inpatient or outpatient within six years of joining as a member. In the case of carers they must have attended the Trust with the patient within the six years immediately preceding the date of application. If a patient or carer has been a member for more than six years ago they are transferred to the public constituency. Public membership is limited to people who live in England and Wales. ** Note does not show members moving constituency *** 'Number of members leaving in year' includes members who have been suppressed i.e. 'gone- aways', general suppressions, deceased since April 2015.*

2.3. Membership breakdown by constituency

Table 2 sets out the Membership breakdown by constituency as at 8 June 2016.

Attachment D

Overview

The Council is asked to note comparison membership statistics since 1 April 2016.

During this reporting period we have seen a slight decrease of members in our Patient/carer constituencies. This may be due to duplicates being removed from the system or members leaving. We will continue to target our recruitment efforts in this constituency.
Of all public constituencies South London and surrounding areas has seen the highest increase. Other public constituencies have seen a small increase.

Table 2: Membership breakdown by constituency as at 8 June 2016

Breakdown by constituency	Number of members as at 8 June 2016
Patient and carer constituency	
Parent/carer in England and Wales	3211
Parent/carer in London	2048
Patient in England and Wales	486
Patient in London	454
Sub Total	6199
Public constituency	
Public in England and Wales	701
Public in North London	1587
Public in South London	755
Sub Total	3043
Grand Total	**9242**

2.4. Public Membership

Table 3 (see Appendix 1) sets out the Trust's public membership as at 8 June 2016, compared against the eligible membership in England and Wales.

Overview

The Council is asked to note comparison membership statistics since 1 April 2016

Age-Range :

- Our 10-16 age category is still under represented and we have seen movement from this category into the 17-21 bracket. We recognise that we need to concentrate our recruitment efforts in this category in the coming year and our projected membership target reflects this. All other age categories are over represented.

Attachment D

Ethnicity:

- Our new membership database will offer a wider breakdown of ethnicity choices. We are confident this will reduce the percentage of members stating " unknown" in this category which will help us to monitor our comparison data more effectively in this segment.
- We continue to see an over representation of our Asian or Asian British public members. 0
- Our Black or Black British public members have also increased resulting in an over representation.
- We are under represented in the White public members category.

Social and Economic status:

- Representation of social and economic status within our membership mirrors the demographics of the population of England and Wales. A high proportion of our public membership reside in London and the surrounding area. We take this into account when analysing the data and our new database will enable us to monitor this figure against the demographics of the population in this area.

2.5. Patient and carer eligible membership by age

Table 4 sets out the Trust's patient and carer membership by age as at 8 June 2016.

Overview

The Council is asked to note comparison membership statistics since 1 April 2016.

We have seen the highest increase in our 22+ category (380). We are aware that our membership is maturing and moving from the 10-16 and 17-21 age brackets. Our membership strategy states that our overall aim is to develop and marginally grow our membership community with a particular focus on young people aged 10-16 years and our patient population. We are mindful that over 58% of the patient population in GOSH is under three years of age and that this poses some challenges as eligible membership is open to children over the age of 10. We have therefore set realistic targets for this segment. We also aim to engage more with the patient population in the coming year.

Table 4: Patient and Carer eligible membership by age as at 8 June 2016.

Patient and Carer Constituency by age range	Total number of members	Percentage of membership
Total number of members	6199	100%
0-16	186	3.22%
17-21	550	9.53%
22+	4698	81.39%
Unknown	338	5.86%

2.6. Patient and carer breakdown by gender, ethnicity and social grade as compared to the hospital patient database (PIMs).

Table 5 (see Appendix 1)sets out the patient and carer breakdown by gender, ethnicity and social grade as at 8 June 2016 as compared to the hospital patient database (PIMs).

Overview

Gender:

- We have seen a slight increase in the male population but are still underrepresented in this segment. We note that on face to face recruitment sessions it is usually the female carer who joins for the family.

Attachment D

Social and Economic status:

- Representation of social and economic status within our patient and carer membership is comparable to the demographics of the patient population.

Ethnicity:

- Our new membership database will offer a wider breakdown of ethnicity choices. We are confident this will reduce thepercentage of members stating " unknown" in this category which will help us to monitor our comparison data more effectively in this segment.
- We are also very close to a perfect representation of Asian or Asian British segment and over represented in the other segments.

2.7 Projected versus actual membership figures for 2015/16

Table 6 below sets out our projected versus actual membership figures for 2015/16 as at 1 April 2016.

Overview

The Council is asked to note an update on projected versus actual membership figures for 2015/16.

- The Membership and Engagement Committee projected a 3% net growth membership target for 2015/16. We have met and exceeded this target . We are very marginally under our projected patient constituency target and are under our target in the parent carer constituency. We have met and exceeded our public membership target.

Table 6: Projected versus actual membership figures for 2015/16

Constituency	2015/16 projected	2015/16 Actual
Patient	943	938
Parent/Carer	5,374	5,267
Public	2,780	3,000
Total	9,097	9,205

2.8 Projected membership figures for 2016/17

Table 7 below sets out our projected membership figures for 2016/17.

Overview

The Council is asked to note our projected membership figures for 2016/17.

- The committee have set a 3% net growth with a membership target of **9,481** for 2016/17 which we feel is realistic and achievable.
- This will represent a growing membership with our focus being on increasing the 10-16 year membership segment in both patient and public constituencies and on increased engagement with these members.

Table 7: Projected membership figures for 2016/17

Constituency	2015/16 (final numbers)	Attrition Rate 5%	Recruitment Growth Rate 8%	2016/2017 (Predicted)	In Year Net Growth
Patient	938	47	75	966	28
Parent/Carer	5,267	263	421	5,425	158
Public	3,000	150	240	3,090	90
Total	9,205	460	**736**	9,481	276

Appendix 1

Table 3: Public membership by gender, ethnicity and social grade as compared against eligible membership in England and Wales as at 8 June 2016

Public Constituency	Total number of members	Percentage of membership	Catchment area profile (All of England and Wales (%)*)	Over or under representation (England and Wales)
Number of members	3043	100%		
Gender *				
Male	913	30.00%	48.90%	under
Female	2102	69.08%	51.10%	over
Unknown	28	0.92%	-	n/a
Age Range *				
10-16	96	3.15%	8.26%	under
17-21	290	9.53%	6.59%	over
22+	2432	79.92%	73.32%	over
Unknown	225	7.39%	-	n/a
Ethnicity *				
White	1878	61.72%	85.97%	under
Mixed	103	3.38%	2.18%	over
Asian or Asian British	272	8.94%	7.51%	over
Black or Black British	241	7.92%	3.33%	over
Other	68	2.23%	1.01%	over
Unknown	481	15.81%	-	n/a
Social Group *				
AB	884	29.04%	22.67%	over
C1	823	27.03%	27.36%	under
C2	478	15.72%	16.65%	under
DE	737	24.20%	24.98%	under
Unknown	122	4.01%	-	n/a

*Data true as of 2011 (ONS data).

- When percentages don't add up to 100% this is because certain categories are omitted i.e. age range 0-9.

Table 5:Patient and carer membership breakdown by gender, ethnicity and social grade as compared to the hospital patient database (PIMS) as at 8 June 2016

	Patient & carer	%	% of patients	Over or under represented
Gender				
Male	1888	30.46%	50.25%	under
Female	4285	69.12%	49.75%	over
Unknown	26	0.42%		n/a
Social Group				
AB	1907	30.76%	22.67%	over
C1	1735	27.99%	30.29%	under
C2	1055	17.02%	22.07%	under
DE	1421	22.92%	24.98%	under
unknown	81	1.31%	-	n/a
Ethnicity				
Asian or Asian British	480	7.74%	8.57%	under
Black or Black British	417	6.73%	5.8%	over
Mixed	193	3.11%	2.16%	over
Other	148	2.39%	3.06%	under
Unknown	556	8.97%	-	n/a
White	4403	71.06%	46.25%	over

ATTACHMENT D

Great Ormond Street Hospital for Children NHS Foundation Trust

MEETING OF THE MEMBERS' COUNCIL MEMBERSHIP AND ENGAGEMENT COMMITTEE

14th April 2016

Kingfisher Seminar Room

Attending:

Lisa Chin-A-Young (LC)	Patient and carer constituency
Carley Bowman (CB) (Chair)	Patient and carer constituency
Sophie Talib (ST)	Patient and carer constituency
Claudia Fisher (CF)**	Patient and carer constituency
Gillian Smith (GS)*	Public constituency
Simon Hawtrey-Woore (SHW)	Public constituency
Anna Ferrant (AF)	Company Secretary
Kevin Armstrong (KA)	GOSH Member
Emma James (EJ)	Patient Involvement and Experience Officer
Suzanne Collin (SC)	Patient Feedback Manager
Valerie Clyne (VC)	GOSH Volunteer
Victoria Goddard (VG)	Trust Board Administrator (minutes)
Claire Newton (CN)	Interim Director of Strategy and Planning
Graham Terry (GT)	Head of Planning and Performance

Apologies:

Camilla Pease (CP)	Patient and carer constituency
George Howell (GH	Patient and Carer constituency
Susanna Fantoni (SF)	Patient and Carer constituency
Olivia Frame (OF)	Appointed Councillor
Jamie Wilcox (JW)	Head of GOSH Volunteer Services
Kirsty Woodbridge (KW)	Stakeholder Communications and Marketing Manager
Gillian Smith (GS)	Public Constituency (South London and surrounding area)
Olivia Frame (OF)	Appointed constituency

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

1	**Welcome, Introductions and Apologies**	
1.1	LC welcomed everyone to the meeting. Apologies were noted.	
2	**February Away Day Output**	
2.1	CB said that there were many routes for patients and families to provide feedback within GOSH but it was important to ensure that there was a joined up route for the feedback to reach councillors and the themes were escalated to Board level. It had been agreed that the MEC would receive the consolidated feedback and would ensure that case studies were received at PFEEC. This would also help Councillors to engage with their constituencies.	

2.2	The Committee agreed that it was important to have a Patient Involvement and Experience Strategy and that sufficient time was allowed on the agenda for the required discussion around patient stories and case studies.	
2.3	**Action:** EJ said that she was working to collect more patient stories which would be shared throughout the Trust so that each team involved in a patient's pathway would be aware of the story. EJ said that she was developing a patient story form and this would be shared with the MEC.	**EJ**
2.4	**Action:** SC said that over 20,000 comments were received from the Friends and Family Test and it was agreed that work would take place to see if it would be possible to add a consent tick box to enable these comments could be used as patient story case studies.	**SC**
2.5	**Action:** Any feedback received from patients and families to be sent to LC and CF so it can be included in the log of case studies.	**ALL**
2.6	**Action:** It was agreed that a MEC away day would take place in June.	**DL & MEC**
3	**Annual Plan Survey**	
3.1	CN said that helpful comments had been received on the website and research. No comments or responses were received to indicate that the Trust should not continue with the priorities as set out in the annual plan. Good results were received in terms of the Always Values, however lower scores were received in terms of the 'Always One Team' aspect.	
3.2	GT said a listening event was being planned to take place before the end of the year but before this it was important to be clear on the key points that the Trust was engaging with people on.	
3.3	**Action:** GS said that it was important that to get more patient feedback and asked that consideration be given as to whether Councillors could go onto wards and into the school and activity centre. ST suggested getting the YPF involved in getting feedback from young people.	**DL**
3.4	**Action:** CN said that the survey would help to inform the workplan and AF said that it must be clear how the MEC would fit into the workplan. It was agreed that staff from the areas mentioned in the survey responses would be invited to MEC to report the work that was taking place as a result of the survey.	**DL**
3.5	CF said that it was likely that different stakeholder groups had differing ideas on what was meant by 'one team' and it was important that it was clearly defined. CN said that part of the aim of the divisional restructure was to encourage more joined up working and less of a silo approach. SHW said that work was taking place on the always values steering group to look at what the values meant to people rather than the definition.	

3.6	**Action:** It was agreed that the work would be summarised in Member Matters and would be put on the intranet. It would be included in the Annual Report which would be considered at the June Members' Council meeting,	**AF**
4	**Membership Update**	
4.1	The Committee discussed the support that the database would provide in identifying areas outside London with a large GOSH membership. This would indicate areas where engagement work could be valuable.	
5	**Database Update**	
5.1	AF said that there had been a delay in the implementation of the database and that currently data was being cleansed to ensure it matched the Trust's patient administration system.	
5.2	**Action:** AF said that when the constitution was being revised the six year rule for patient and carer councillors would also be considered.	**AF**
6	**AGM Membership Report**	
6.1	**Action:** The membership report to be sent to the MEC to be updated.	**DL and all**
6.2	**Action:** Consideration to be given to whether it is possible to live stream the AGM. GS, CB and ST to support this work.	**GS, CB&ST**
6.3	A high quality and interesting membership report to be a focus of the meeting.	
7	**Engagement Updates**	
7.1	**Action:** LC had made contact with a member of the Renaissance Foundation who had already made contact with members of GOSH staff. EJ to be the primary point of contact for this work and to update the MEC.	**EJ**
7.2	**Action:** RBC Race for the Kids – EJ and Fiona Jones to set up the membership stand and ST and KA to support. Councillors to let VG know if they available to support the event and recruit members.	**EJ, ST, KA and FJ**
7.3	**Action:** ST to circulate the video of her talking about her story at an engagement event.	**ST**
8	**Any other business**	
8.1	There were no items of other business.	

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

29th June 2016

Young People's Forum

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

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

Report prepared by: Fiona Jones, Children and Young People's Participation Officer

Item presented by: George Howell, Chair of the YPF

Attachment E

Young People's Forum (YPF):

The YPF has not met since the last member's council meeting.

Membership: one young member has left due to reaching 25 and will continue to engage with the Foundation Trust. At our meeting in July we are expecting 8 new members to attend.

Publicity

Figure 1. GOSH tweet about the YPF

YPF member, Pavan, wrote a blog on her highlights of the NHS England event, Cooking up a Youth Voice, that took place in March. This was published on the YPF page on the website and a link to the blog was shared via the Great Ormond Street Hospital (GOSH) twitter handle.

NHS England commissioned The Reporters Academy to capture the event on 5 March and carry out interviews with key influencers who were attending the day. The Reporters Academy have now posted the video from the day and also a video documenting 'The making of' and showing the four YPF members planning, filming and editing the video of the event. The videos are available at ttps://www.youtube.com/watch?v=FU-52Dxmf3q and https://youtu.be/a1wPhT5qRqA

The YPF page on the website now offers visitors the opportunity to download the visual minutes of previous meetings. This will allow interested children and young people to see exactly what goes on at a YPF meeting and the different activities that young people get involved with.

The group itself was also publicised on twitter during May with a link to the membership pages.

The YPF also featured a double page spread in the May edition of the staff newsletter, Roundabout. Please see below.

Figure 2. May 2016 edition of Roundabout

YPF Involvement Opportunities

During April and May 2016, one Opportunity Bulletin was sent to YPF members. There were also a number of advertisements for engagement activities placed on the Facebook group wall.

YPF members were offered opportunities to take part in:
- The consultation on the Disney Garden
- Providing feedback on imagery for adolescent information sheets

- Providing information on their experiences of being a Young Carer to our Children and Young People's Participation Officer
- A survey for the Royal College of Paediatric Health on young peoples (16 to 25) experiences of healthcare
- The NHS Youth Forum elections to sit on the nationwide NHS youth panel
- A new patient forum being set up by Health Education England's team for North Central and East London (HEENCEL)
- A tour around the new Premier Inn Clinical Building
- The Royal Bank of Canada's (RBC) Race for Kids

RBC Race for Kids

Two members of the YPF attended the RBC Race for Kids event on 15.5.16 to promote and recruit for the YPF and Foundation Trust (FT) membership. Over 7,500 people attended the event and over the course of the day they collected 74 application forms for FT membership, engaged with many children, young people and families and received high interest in the YPF.

The two young people were also interviewed live by the GOSH roving camera team. They were able to say what the YPF was, what they do and invited all current and ex-patients to visit them in the GOSH main tent.

Figure 3. YPF members being interviewed live on the screens at the RBC Race for Kids May 2016

Takeover Day 2016

Takeover will take place from 18 November. Advertisements have been placed in the Trust Monday E-Newsletter for teams to nominate themselves to be part of the events. The YPF currently have support from the Deputy Chief Executive, Catering and Redevelopment Teams to be taken over.

Cardiology Adolescent and Transition Clinical Nurse Specialist (CNS) interview

The Children and Young People's Participation Officer has supported the Cardiology Team to introduce a young person on the interview panel for a new Adolescent and Transition CNS.

It is hoped that with the support of a new Assistant Chief Nurse for Patient Experience and Nursing Quality, formal GOSH guidance and support will be created by the Patient Experience Team and Human Resources Department which will facilitate additional involvement in staff recruitment and selection. The Director of HR has been contacted to begin this project

Digital Badges

Figure 4. Digital Badge training

UPDATE: Currently the badges are being trialled with three inpatients, two YPF members and a further two patients who attended the PLACE inspections.

The Children and Young People's Participation Officer and a member of staff from Makewaves (the Digital Badge website) held a training session on the 19.5.16 for eight members of staff from the Play team, the Hospital School, GO Create! and the Clinical Research Facility.

Following this training, there will be engagement with a number of interested wards to identify one pilot area which will be supported by the Children and Young People's Participation Officer to roll out and further the digital badge scheme.

June 2016

Attachment F

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

29th June 2016

Update from the Patient and Family Experience and Engagement Committee (PFEEC)

Summary & reason for item:

This is the Patient and Family Experience and Engagement Committee report which demonstrates to the Members' Council how the Trust has been performing in relation to patient experience in the last quarter of the financial year.

Councillor action required:

To note the content of the report and the actions being addressed.

Report prepared by:
Herdip Sidhu-Bevan – Assistant Chief Nurse- Patient Experience and Quality

Item presented by:
Juliette Greenwood - Chief Nurse

Great Ormond Street Hospital for Children NHS Foundation Trust

Update from the Patient and Family Engagement and Experience Committee
June 2016

Complaints Annual Report

The key points identified from this report are:

- 151 formal complaints were investigated in 2015-2016 in line with the NHS complaints regulations, a 5% increase from the previous year.
- Twelve complaints were graded as red, a 25% decrease compared to the number of red complaints in 2014-2015.
- 60% of complaint responses closed between 1 April 2015 and 31 March 2016 were sent out within agreed timescales. 48% of draft reports were received by the complaints team on time from the lead investigator.
- The themes raised within complaints include a lack of communication with parents, the gastroenterology service and outpatient experience.
- Six investigations were completed by the Parliamentary and Health Service Ombudsman during the year, five were not upheld and one was partially upheld.

Spiritual Care Service

The Committee received a presentation from the Spiritual Care team; this included a list of services that they provide to GOSH. The Spiritual Care team requested that all divisional staffs ensure that it is noted on patient folders what their faith/religious background is so that the Chaplainry team can plan the support available in advance rather than last minute referrals. **Update – Jim Linthicum carrying out an audit, results due in July 2016.**

PALs Annual Report (Please see the attached PALs annual report)

PALs also reported on social media with regards to growth in social media and engagement is key because it is such a powerful tool. Social media cannot be controlled but can be used to campaign successfully through engagement

Nursing Key Performance Indicators

Zoe Egerickx presented her work to date around the development of nursing performance indicators. Zoe has done a number of workshops with staff and will also be engaging with parents and patients; this work is currently on-going.

Parent Accommodation Report

In the 2014 Care Quality Commission's (CQC) Annual Inpatient Survey, 75% of parents said that we provide good facilities for those who were staying overnight. The Trust has now carried investigations with parents through a range of channels to identify why 25% of parents felt we did not provide good accommodation. A further parent accommodation

survey in May 2016 by the Patient Experience team revealed that, out of the 23 parents that answered the question, how likely would you be to recommend our parent accommodation to your friends and family, if they were in a similar position, 87% of parents said they would be very or quite likely to recommend parent accommodation. This shows that whilst a large number of parents are happy, there is a level of dissatisfaction which resonates with the results of the 2014 CQC survey. A list of recommendations were made around the accommodation in alignment with a review of the parent accommodation strategy with the GOSH charity.

Patient and Family Engagement and Experience Report

Patient and family engagement activity is a key area that enables GOSH to demonstrate effective compliance with the requirement to engage and involve children, young people and their families in order to put patients and their carers at the heart of the NHS. Some of the current work/projects taking place are:

1. Digital Badges
2. Upopolis – communication tool
3. Organisation of the Listening Event
4. CYP participation officer organised for a young person to be on an interview panel
5. Awareness sessions for staff about Young Carers
6. Disney Garden involvement
7. Me First project
8. Nutrition and Hydration week
9. Take over day in November 2016
10. YPF stand at the RBC race for kids
11. Re-introduction of the youth club
12. YPF work featured in the May 2016 edition of Roundabout
13. EPR workshops with parents/patients (April 2016)
14. GOSH Sustainability Fair
15. Transition

PLACE Report

Patient-Led Assessments of the Care Environment (PLACE) inspections.
PLACE inspections took place on 15.4.16. There were 17 external assessors including patients, parents, volunteers, a YPF member and an assessor from Kingston Hospital. We have yet to receive the report

Volunteer Report

Volunteer Services continues to grow, with large numbers of people applying to volunteer and a steady flow of people being placed in volunteer roles that make a real difference to the patient and family experience.
With a small team of staff, we have been able to successfully manage larger numbers of volunteers at any one time completing their pre-volunteering training, checks and induction, thus ensuring the Trust has a large well-trained and prepared team of people

ready to support and assist in any duties that the Trust sees fit and appropriate. The new member of staff to Volunteer Services has freed up existing staff members to concentrate on managing volunteers on a day to day basis and to work with more wards and departments and ever increasing requests for volunteer support.
We have successfully increased the numbers of volunteers working in the Trust from 815 in last years' GOSH Charity Impact Report to 1,046; well above our predicted 950

Friends & Family Test/Real-time Feedback Report

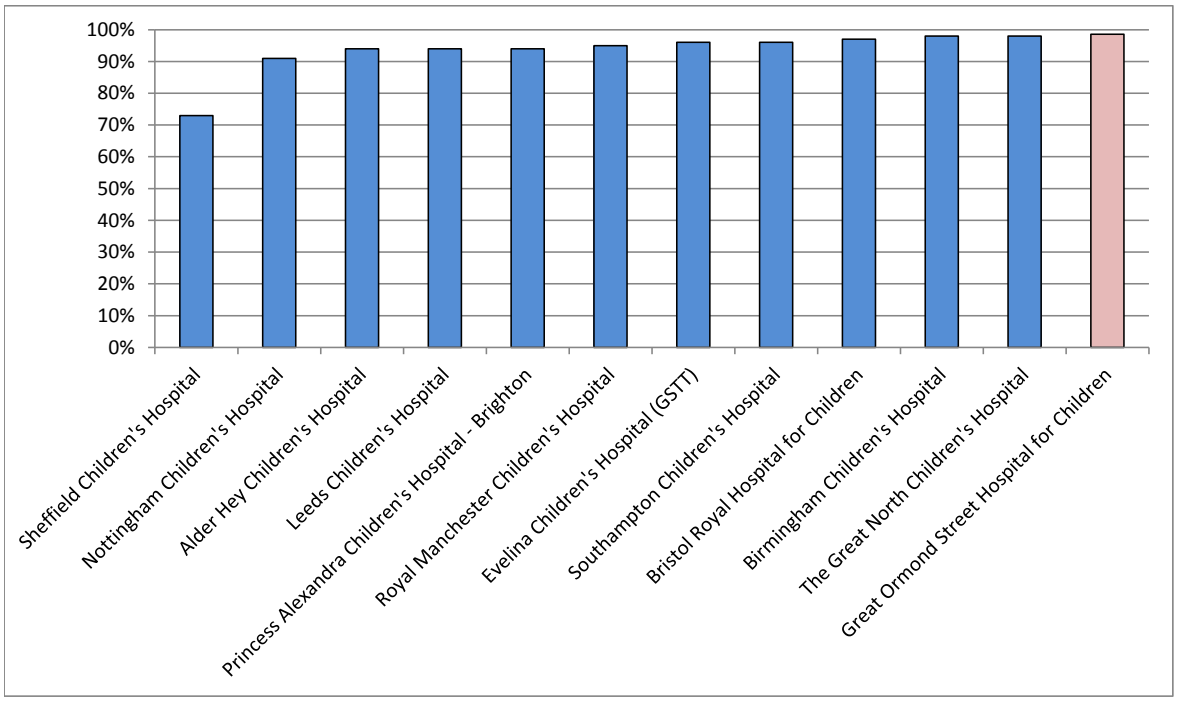
An amended submission of the Real-Time system was made in June 2016 and we are currently awaiting the outcome.

The Real-Time system provides an online option to input FFT results with hopefully increased response rates that create reports quicker with provide more detailed timely results. Real-Time system also increases accessibility to those with Learning Difficulties and who speak a foreign language. Discussions on exploring alternative methods of communications with patients and families were held.

The most recent report from our current FFT system: **We received 706 inpatient comments (23.6%) and 334 outpatient comments in April 2016 and 826 inpatient comments (27.5%) and 293 outpatient responses in May 2016.**

FFT Percentage to Recommend Rates Other Trusts

The trust had the highest percentage to recommend score compared with other like trusts.



Response rates obtained from NHS Choices – April 2016 data.

Patient Stories/Vignettes

Four patient stories have been presented in PFEEC over the past two months.
The stories are collated and presented by the Members Council parent representatives where any arising issues from the stories are appropriately referred to the relevant departments at PFEEC.

PFEEC

This committee will shortly be reviewing its Terms of Reference and its membership in alignment with the Trust restructure of the divisions.

Attachment F

Great Ormond Street Hospital for Children NHS Foundation Trust

Pals Annual Report
April 2015- March 2016

Highlights of this report

- Overall Pals activity for the year
- Key themes for the year
- Thematic analysis of cases by Division
- Thematic analysis of cases by top 5 specialities
- Cases formally escalated to Complaints or Risk teams
- Compliments for the teams across the Trust

1. Pals overall activity in 2014/15

- 3768 contacts and cases (decrease on previous 4074 in 2014/15)
- 2096 Information enquiries (decrease on previous 2536 in 2014/15)
- 1270 Promptly resolved cases (increase on previous 1186 in 2014/15)
- 283 Complex cases (decrease on previous 311 in 2014/15)
- 52 Escalated cases to Complaints (increase on previous 41 cases in 2014/15)
- 37 compliments for services across GOSH (increase on previous 30 cases in 2014/15)

In summary 77.3% of cases were resolved promptly, 17.1% were Complex and 3.2% were escalated to Formal Complaint. There has been a decline in information queries, however, there is a 7% increase in the number of promptly resolved cases from the preceding year, and the majority of Pals cases are resolved within a 5 day period. There is variation which can be explained by school holidays- this mirrors the Trust activity with a reduction in patients seen over the summer holidays and Christmas/ New Year period.

The key subjects were Outpatient Experience (32.1%); Admission and Discharge (16.1%) and Communication and Information (12.1%) and the main contributing reasons for these were lack of communication following outpatient appointments with families and lack of information about appointments and admissions being cancelled with no prior warning.

2.0 Key Themes for the year

2.1 Cancellations

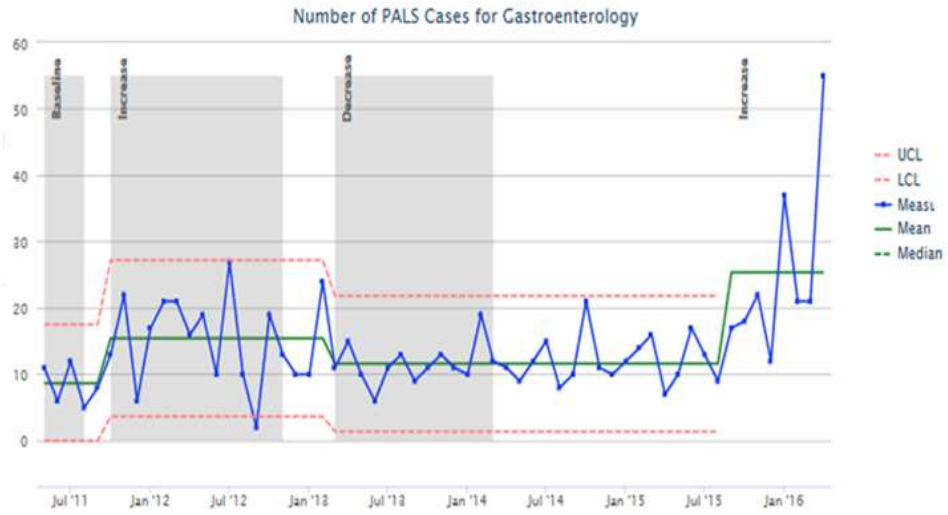
The case work in Pals relating to Cancellations has increased during the financial year 2015/2016 by 29% (152 cases about cancellations in 2014/15 increasing to 214 cases about cancellations in 2015-16). In the previous financial year it was not in the top 3 subjects for any directorates, but 2015/16 it has been in the top 3 for Surgery, MDTS, CCCR, Neurosciences and ICI. The top 5 specialities for 2015/16 for this subject are Cardiac Surgery (10.7%), Gastroenterology (10.7%), Neuroscience Medicine (8.9%), Cardiology (7.9%) and Ophthalmology (7.5%). Other changes that have occurred in Pals case work is compared to 2014/15 Dermatology have had reduction in cancellations. For admission/discharge and cancellations some of the reasons that were discussed were cancellations with no prior warning.

Pals works with colleagues in Outpatients and the admitting wards to provide support to those families arriving at GOSH without having been informed about their child's cancelled or rescheduled appointment or admission. In these cases Pals are able to work with the clinical team to arrange for support of their out of pocket expenses such as reasonable travel costs. Pals then work with the

clinical teams to identify how the cancellation occurred and to offer the family a replacement appointment or admission. In some cases, infrequently, the teams are able to make alternative arrangements and enable to child and family to be seen by an alternative clinician on the day of arrival. This is however not always possible or appropriate.

2.2 Gastroenterology

During 2015/16- 68.2% of Gastro cases were promptly resolved, 24.2% were complex cases and 3.3% of Pals cases were escalated to Formal Complaints.

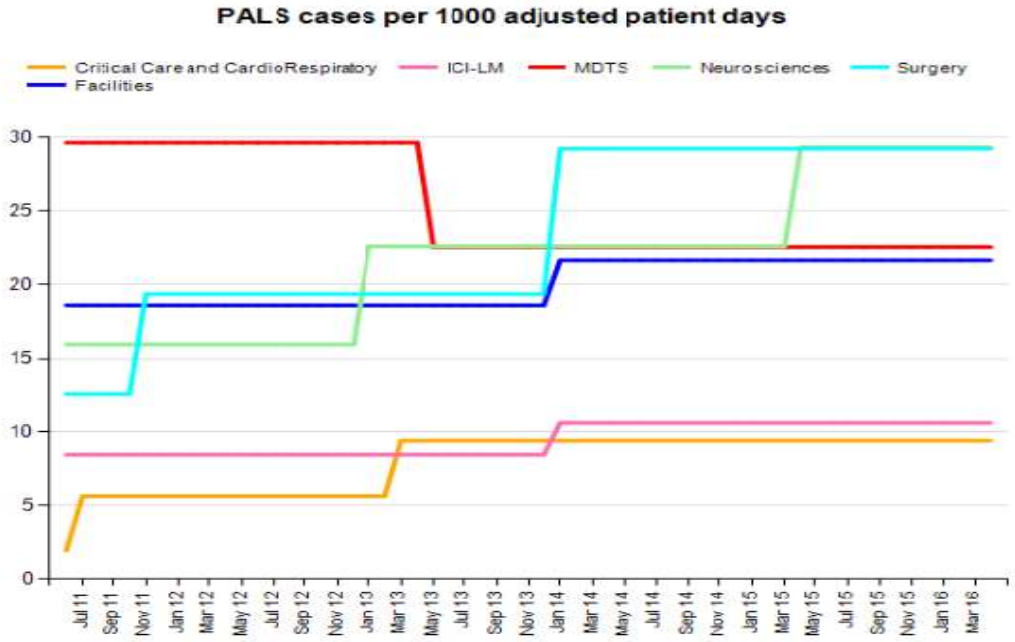


The above graph indicates that since August of 2015/16 the number of gastro cases for Pals have been increasing. This is not mirroring the previous financial years where there was variation around the mean and has resulted in an increase in the mean for gastroenterology. The reasons behind Pals attendances were: Outpatient experiences (28.9%); Communication/Information (20.4%) and Admission/Discharge (16.1%). Almost 50% of families coming to Pals have queries around communication issues and about 20% of the issues are around cancellations of outpatient appointments.

Team Explanation: The Trust is dedicated to listening to and learning from complaints and taking appropriate actions when gaps in our processes or themes have been identified. It is good practice to invite a review of services by other specialists in the same clinical area from other parts of the UK or internationally to help drive forward improvements and ensure best care. The Trust invited a review from the Royal College of Paediatric and Child Health of our Gastroenterology service.

Following the findings of the Royal College of Paediatric and Child Health, and taking the learning from the themes of the complaints received, a gastroenterology review group has been created which is led by a Programme Manager. This includes a review of how care is being managed and the themes detailed above will be reviewed as part of this work. In addition a new complaints co-ordinator has been recruited to support the service in fully investigating all complaints and in turn ensuring that families' questions are answered and concerns addressed.

3.0 Thematic analysis of cases by Division



3.1: Surgery- There was 401 surgery cases for Pals making up 24.4% of the Pals Case-work during 15/16. This was a decrease from the preceding year where Surgery made up 28.3% of Pals case-work.

The specialities with the highest Pals contacts were: Orthopaedics/Spinal (19.7%); Urology (19.7%) and General surgery (16.7%). These specialities were also the main reasons behind surgery referrals during 2014/15.

We carried out a thematic analysis of the above specialities and the themes attributed to the cases were: Outpatient Experiences (32.7%); Admission/Discharge (25.7%) and Communication / Information (9.2%).

Evaluation of the above themes elicited detailed insight about the most common subjects behind the above themes for Surgery. A lack of communication with families regarding appointments and admissions remains the most frequent reason for Pals case-work in Surgery. This is followed by a recent increase in families experiencing cancelations of appointments and admissions with little or no notice given.

3.2: Neurosciences- There was 336 Neurosciences cases for Pals making up 20.5% of Pals case work. This is an increase from 2014/15 when Neurosciences was 14.4% of all Pals work.

The specialities that contributed to the highest case load for Pals were: Neuroscience Medicine (25.3%); Ophthalmology (20.5%); and Reception fares and reimbursements (9.2%).

The key themes attributing towards this increase were: Outpatient Experience (40.2%); Communication and Information (13.7%) and Admission/Discharge (7.7%). From detailed analysis of these themes the following reasons emerged as being the most common subjects for attendance: support with liaising the team to book outpatient appointments, or arrange tests or admissions, support when customers experienced cancelled outpatient appointments and admissions especially with little noticed provided to the families, and advice regarding fare imbursement policy.

3.3: MDTS- There was 369 MDTS cases for Pals making up 22.5% of Pals case work. This is an increase from the preceding year when it contributed 19.5% of Pals case work.

The specialities with the highest Pals contacts were Gastroenterology (57.2%); Endocrinology (14.1%) and Nephrology (5.4%).

The key themes for Pals cases in MDTS were: Outpatient Experiences (24.7%); Communication and Information (17.3%) and Admission/Discharge (12.5%). An analysis of these themes highlighted the following common subjects; a lack of communication with families about their appointments/providing information relating to admission; customers feeling their speciality are not liaising with other teams, families requiring assistance with rebooking cancelled appointments and helping families get new admission dates after their attempts have not resulted in the desired outcome.

3.4: CCCR- There was 188 CCCR cases for Pals during the financial year making up 11.4% of Pals case work. In 2014/15 CCCR contributed 12.9% of Pals cased, therefore there has been a decrease in this financial year.

The top three specialities Pals case work related to were: Cardiology (38.3%); Cardiac surgery (21.8%); Critical care (20.2%).

A thematic analysis of the cases for the above specialities showed the principal reasons for CCCR customers coming to Pals were: Admission / Discharge (28.2%); Outpatient Experience (20.2%) and Inpatient Experience (14.4%). Analysis highlighted the following: customers found a lack of information relating to their admission/discharge arrangements was a concern. Another reason was related to the cancellation of outpatient and inpatient admissions, and more support was required for managing bereavement compared to the previous financial year.

3.5: ICI- There was 176 ICI cases making up 10.7% of all Pals case work. This is a decrease from the previous year where ICI had 12% of all Pals case load.

The top specialities are Rheumatology (41.5%); Immunology (10.8%) and joint third Dermatology and Oncology (10.2%).

Following a thematic analysis to obtain the main subjects for ICI Pals cases the findings showed: Outpatient experience (35.2%); Communication and Information (15.3%) and Admission/Discharge (13.1%). The analysis showed the most common themes families sought Pals support were related to assistance to communicate with the teams to ascertain information about their outpatient appointments or admissions, concerns relating to transport arrangements for outpatient appointments and discharges following a procedure and customers requiring support following cancellation of either outpatient appointments or and admissions.

3.6: Estates & Facilities- There were 92 cases for Estates and Facilities which attributes for 5.6% of Pals case load. This is a decrease from the previous year when 7.7% of Pals case load was for this division. The main departments are Accommodation and Patient transport (39%); Catering Kitchen (17.1%) and Catering Lagoon (12.2%). The themes for customers attending Pals about Estates and Facilities were: Inpatient experience (41.3%); Outpatient Experience (22.8%) and Admission/Discharge (12%). Thematic analysis showed the most frequent reason for customers attending Pals about the environment and facilities in inpatient accommodation and a need for support to receive information and communicate about accommodation.

3.7: IPP There were 20 IPP cases contributing to (1.2 %) for Pals during the financial year. 2014/15 there were 21 (1.1%).The top three reasons for Pals cases are Outpatient Experience (25%), Inpatient Experience (15%) and Referrals (15%). The main sub-subjects are Communication/Information; Medical records and Care advice.

4.0 Thematic analysis of cases by top 5 specialities

4.1 Gastroenterology (see above 2.2)

4.2 Neuroscience Medicine Themes

During 2015/16- 80% of cases were promptly resolved, 16.5% complex and 1.2% escalated to Formal Complaints. Thematic analysis revealed the main reasons customers attended Pals were:

- **Outpatient experience (36.5%)** - Analysis showed that Communication 38.7%; Cancellations 32.3% and Care advice 12.9% were the main subjects.
- **Communication/Information (16.5%)-** The main themes for why families attended Pals were: Lack of communication with families 64.3%; Telephone calls not returned 14.3% and lack of information between staff and teams 7.1%: and
- **Admission/Discharge (12.9%)** - the main contributing factors are: Communication 37.5%; Cancellations 25% and Care advice 18.8%. When comparing the information to 2014/15 it is noticeable that there is an increase in an almost 50% increase in queries across all subjects for this specialty.

Team Explanation: Centralisation of all referrals made to Neuroscience medicine across a small team of referral coordinators that we are looking to recruit/train existing staff. We are more strictly adhering to published referral criteria for a streamlined patient pathway to avoid unnecessary delays due to inadequate workup. Also, better acknowledgement of referrals received and their outcome of acceptance or rejection to both referrers and patients.

EDMD is under review with instruction to organise documents into folders according to date (week beginning) so older documents are more easily tracked and prioritised accordingly. KPIs for letters are being set between individual admin staff and consultant letter turnaround time reviewed on a monthly basis at review meetings.

Admin staff instructed that any amendment to appointments must be communicated with a telephone call, followed up with a clinic letter that is carefully selected from the various templates. Templates are being reviewed to include the correct clinic location and the text message service reviewed quarterly to ensure clinics are codes.

4.3 Orthopaedic/Spinal Themes

During 2015/16- 79.7% of cases were promptly resolved, 16.5% complex and 2.5% escalated to Formal Complaints. Thematic analysis revealed the main reasons for referral to Pals were:

- **Outpatient experience** (32.9%) and the main sub-subjects contributing to this were: (Communication 38.5%; Transport 23.1% and Cancellations 15.4%);
- **Admission/Discharge** (24.1%) and the main sub-subjects contributing to this were Communication 36.8%; Cancellations 31.6% and Care advice 26.3%)
- **Communication / Information** (10.1%) and the main subjects contributing to this were: Lack of communication with parents 75%; lack of communication between staff and teams 12.5% and incorrect information 12.5%.

Overall there is an improvement in the types of queries that have come to Pals and in each subject there was an over decrease compared to 2014/415 by as much as 1/3 for outpatients.

Team Explanation: We are looking at tighter referral criteria. We are looking to recruit specialist physiotherapist and to support pre and post op discharge and rehab. We are looking to recruit an additional spinal consultant and orthopaedic consultant that specialises in CF.

4.4 Urology Themes

During 2015/16- 74% of cases were promptly resolved, 20.5% were complex and 4.1% were escalated to Formal Complaints. Thematic analysis showed the top three subjects for referral were:

- **Admission/Discharge** (31.6%) Reasons for this are: Cancellations 28%; Communication and letters 28% and Care advice 20%
- **Outpatient experience** (30.4%) Reasons for these are: Communication/letters (58.3%; cancellations 12.5% and seeking care advice 12.5%
- **Communication/Information** (7.6%) Reasons for this are: the lack of communication with parents (50%) lack of information 33.3% and lack of correspondence being sent out 16.7%.

Comparing to the preceding year admission related communication has increased but the communication regarding outpatient appointments, such as clinic letters, have remained the same.

Team Explanation: We are reviewing urodynamic service model. We are looking to recruit and additional urology consultant. We are looking to locate urology inpatient to a ward location with specialist nurses to assist with co-ordination and communication.

4.5 Rheumatology Themes

During 2015/16- 72.2% of cases were promptly resolved, 22.8% were complex cases and 2.5% were escalated to Formal Complaints.

- **Outpatient experience (43.8%)** contributing reasons for this subject are lack of communication and letters about outpatients 53.1%; seeking care advice 15.6%; cancellations 12.5% and transport 12.5%
- **Admission/Discharge (19.2%)** Reasons contributing to this subject are: Lack of communication about admission (35.7%); Transport 21.4% and Accommodation 14.3%.
- **Communication/Information (9.6%)** contributing to this subject is a lack of communication with parents 42.9%; and Breach of confidentiality 28.6% and Lack of communication between staff 14.3%.

Comparing the subjects to 2014/15 there has been an over 50% increase in the number of Pals cases about admission/discharge. The number of cases around outpatient experiences has remained the same.

Team Response: We are working to address recurrent issues in Rheumatology around telecommunications within the administrative team. We are also working to strengthen and build our shared care arrangements with local Trusts to streamline patient care. We have a strong multi-disciplinary team, and continue to work towards ensuring that patient pathways are communicated clearly to set appropriate expectations with patients and families from the outset.

5.0 Thematic analysis of February's data

During February all cases were also analysed thematically as well as the standard assigning a primary subject and assisting with all supporting queries. It was noted that out of 155 cases in February, 87 cases had multiple subjects and that the majority of the cases related to lack of information with families/other teams. Cases were around the need for regular calls to be returned, additional support if there was a cancellation either to an outpatient appointment or admission. Failure to arrange new admissions following a cancellation was a key theme, and for families who attended PALS following a cancellation of their appointment or admission part of the action plan back to the team was to ensure that a new appointment / admission would be arranged.

6.0 Social Media

There have been 46 contacts via various social media outlets. This includes a mixture of positive and negative reviews. All those who contact us via social media receive a response. During Q4 there was a campaign led by family and friends for a patient waiting for a BMT- this resulted in over 70 separate

social media contacts about this case alone. All were responded to and the family were supported both by Pals and the clinical team.

7.0 Trust values

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

Value	Number	%
Helpful - Reliable	230	21.6
One Team - Communication	165	15.5
Helpful - Understanding	127	11.9
Expert - Professional	121	11.4
Helpful - Helps others	104	9.8
Expert - Safe	61	5.7
Expert - Improving	55	5.2
One Team - Open	42	3.9
Helpful - Patient	37	3.5
Welcoming - Reduce waiting	34	3.2
One Team - Listening	25	2.3
Expert - Excellence	22	2.1
One Team - Involve	17	1.6
Welcoming - Friendly	16	1.5
Welcoming - Respect	5	0.5
Welcoming - Smiles	3	0.3
Totals:	1064	100.0

8.0 Same Sex Accommodation:

There was one incidence of same sex accommodation when a 12 year old female a patient was put on a mixed ward. This was addressed by the staff who arranged for the young person who has a cubicle.

9.0 Cases formally escalated to Complaints

52 cases were escalated to Formal Complaints. The top five specialties referred to formal complaints are: Gastroenterology (13.5%); Ophthalmology (7.7%); Cardiology (5.85); Endocrinology (5.8%) and Rheumatology (5.8%). The top reasons for escalation to complaints are: Outpatient experiences (30.8%); Staff attitude (17.35) and Clinical care (13.5%). This is an increase in the previous year

10.0 Compliments top three specialties: 37 compliments were made to Pals about a range of services at GOSH. We have included these in the quarter reports but the "top five" by frequency are below.

	%
Cardiology	10.8
Gastroenterology	10.8
Cardiac Surgery	5.4
Ear Nose and Throat	5.4
Neurosciences - Medicine	5.4

The top subjects that the compliments are based up are Clinical care (56.8%), Inpatient experiences (18.9%) and outpatient experiences (13.5%). Some of the themes for the compliments were old patients complimenting staff who cared for them whilst they were children and appreciation of consultants/surgeons.

11.0 Pals Evaluation

Each family who contacts the Pals department receives a questionnaire with a stamp-addressed envelope asking them for feedback and/or concerns yet to be resolved. Pals do this for each family we open a Promptly Resolved Case, Complex Case or a case that needed to be escalated to Complaints.

Pals receive about 5% back in response. The majority are positive and those that are negative are asking for further assistance.

Pals has looked at the Trust ethnicity data and Pals cases, against the designations on PIMs show the service to broadly mirror the range of communities the Trust serves.

Pals continues to be committed to providing a good service to all communities and this year has worked with the Learning Disabilities Lead Nurse to improve our service to be more welcoming and accommodating to children and to family members with learning disabilities as well as hosting the weekly “drop in” for those with learning difficulty concerns.

Attachment G

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

29th June 2016

Chief Executive Report – June 2016

Summary & reason for item:

This performance highlight report covers the following areas:

- Chief Executive Highlights Report
- Performance Report (May 2016)
  - Quality and Safety
  - Targets and Activity
  - Workforce
  - Finance

Councillor action required:
Members' Council to note the highlights and performance for the period.

Report prepared by:
Peter Steer, Chief Executive.
Anna Ferrant, Company Secretary and Graham Terry, Head of Planning & Performance

Item presented by:
Peter Steer, Chief Executive and the Board

Attachment G

Chief Executive Report to Members' Council – June 2016

This report provides a summary of the issues and highlights of the Trust's performance since the previous report to the Members' Council in April 2016.

Chief Executive Highlights Report

World Hand Hygiene Day – 5th May 2016

Thursday 5 May was world hand hygiene day and the infection control team and GO Create! hosted events throughout the day to engage with children, young people and their families around the importance of hand hygiene. During this time GOSH was the starting point for a hand hygiene torch which set out to travel the country and Europe on its journey to promote hand hygiene.

Patients speak with Tim Peake, Astronaut

British astronaut Tim Peake called patients live from space. During the call, patients from across the hospital asked Tim questions and received a tour of the International Space Station. Five-year-old Maddison, who is recovering in isolation after a bone marrow transplant to treat her acute lymphocytic leukaemia, spoke to Tim and discovered she had many similarities with the astronaut, including being isolated from her family and needing a restricted diet.

New names for Royal London Hospital for Integrated Medicine (RHLIM) Outpatients

From Monday 27 June 2016, the GOSH Outpatient departments in the Royal London Hospital for Integrated Medicine building (RLHIM) will have new names. The first floor will be renamed Zebra Outpatients, the second floor Hare Outpatients and the fourth floor will become Hippo Outpatients. The clinics provided and all contact numbers will remain the same.

International Nurses Day

It was International Nurses Day on Thursday, 12 May, Florence Nightingale's birthday. As part of the celebrations at GOSH there was a stand, display and a range of activities in The Lagoon, followed by afternoon tea.

Chelsea Garden at GOSH

A courtyard garden designed by Chris Beardshaw for the RHS Chelsea Flower Show has been moved to GOSH. The Morgan Stanley Garden for GOSH has been designed as a private, reflective space for patients and families. The garden was replanted at the heart of the hospital on a disused, second floor rooftop, surrounded by ten storey buildings, in full collaboration with the Redevelopment team. As part of the garden move we have been given the exciting opportunity to appear on BBC One Series DIY SOS.

Chancellor of the Exchequer, George Osborne thanks staff

The Rt Hon George Osborne MP hosted a special reception at Number 11 Downing Street to celebrate the success of the *Evening Standard* and *Independent* newspaper's Christmas appeal 'Give to GOSH'. Chancellor of the Exchequer, George Osborne said "…*above all, I think we should thank the staff at Great Ormond Street who work so tirelessly and give so much of their own lives to the*

parents and the children who are fighting against the odds" Peter Steer also gave a speech praising the campaign that *"enabled us to tell the stories of our patients and staff in a thoughtful way*".

Performance Update – May 2016

Quality and Safety, Targets and Activity

Access Improvement Update

The Trust continues to make progress in regard to the Access Improvement Programme. Focus and effort continues to be on embedding systems and processes in readiness for the Trust to be in a position to re-report nationally. The expectation and plan is to be doing so in October 2016, reporting September's performance, against the national incomplete RTT standard of 92% of pathways are waiting less than 18 weeks.

The Trust has a number of challenging areas for which there is focus and engagement with Commissioners about how best to manage demand and capacity most appropriately, in line with the Trust's recovery trajectory to be delivery the necessary standard.

In April the Trust returned to reporting for diagnostic wait times nationally. For the first 2 months of this year (2016/17) the Trust has met the agreed recovery trajectory, which is profiled to deliver the national standard by September 2016 (which is that 99% of diagnostic tests from a defined basket of 15 are undertaken within 6 weeks).

Friends and Family Test (FFT)

Since FFT commenced at GOSH in April 2014 the number of responses has reached over 21,000. The response rate dropped significantly to 13.3% in September 2015 when day case patients were first included in FFT, however the response rate has recovered steadily, with a response rate of 27.5% in May 2016, inclusive of day-case patients.

FFT Response Rate for Inpatient Areas

Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016
27.8 %	28.3 %	28.1 %	29.7 %	16.6 %	13.3 %	18.1 %	21.0 %	18.6 %	22.8 %	23.7 %	26.1 %	23.6 %	27.5 %

Denominator derived from inpatient and day cases.

The Trust received 706 inpatient comments (23.6%) and 334 outpatient comments in April 2016 and 826 inpatient comments (27.5%) and 293 outpatient comments in May 2016.

The overall percentage of inpatients 'likely to recommend' for April & May (Q1 2016/17) is as follows:

- The inpatient percentage 'likely to recommend' has remained consistently above the Trust target of 95% with a score of 98.6% in April 2016 and 98.3% in May 2016.
- The outpatient percentage to recommend has also remained above the 95% Trust target with 95.5% in April and 95.9% in May 2016.

FFT Percentage to Recommend - Inpatient Areas

Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016
99.3	97.9	98.9	98.8	99.1	98.2	98.4	97.9	98.5	99.5	98.3	98.7	98.6	98.3

%	%	%	%	%	%	%	%	%	%	%	%	%	%

FFT Percentage to Recommend - Outpatient Areas

Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016
95.6 %	93.0 %	94.5 %	95.1 %	97.1 %	96.2 %	97.0 %	97.8 %	95.8 %	97.3 %	97.1 %	97.5 %	95.5 %	95.9 %

FFT Inpatient Themes

73% of responses contained qualitative data.

Theme	Total No. Comments	Positive Comments	Negative Comments
Access / Admission / Transfer / Discharge	18	6	12
Care	96	95	1
Catering / Food	16	11	5
Communication	4	3	1
Environment / Infrastructure	55	25	30
Equipment	2	1	1
Expert	17	16	1
General comment	84	84	0
Housekeeping / Cleanliness	28	27	1
Privacy and dignity	2	2	0
Safe	3	3	0
Staff behaviours	205	201	4
Treatment	17	14	3
Welcoming	63	63	0

FFT Response Rate for Inpatient Areas

The FFT response rate remains significantly below the Trust target of 60%, however the NHS England data (April 2016) confirms that the average response rate in similar Trusts equalled 24.2% with the highest response rate at 40.1%. The Trust was positioned seventh from a possible 12.

Hospital	% Response Rate
Royal Alexandra Children's Hospital - Brighton	15.4%
Royal Manchester Children's Hospital	13.2%
The Great North Children's Hospital	14.6%
Birmingham Children's Hospital	19.0%
Alder Hey Children's Hospital	19.2%
Southampton Children's Hospital	22.9%

Great Ormond Street Hospital for Children	23.6%
Evelina Children's Hospital (GSTT)	26.0%
Leeds Children's Hospital	30.0%
Sheffield Children's Hospital	30.7%
Bristol Royal Hospital for Children	35.2%
Nottingham Children's Hospital	40.1%

FFT Percentage to Recommend - Inpatient Areas

The FFT percentage to recommend remains above the Trust target of 95%. The NHS England data (April 2016) confirms that the average percentage to recommend at other similar Trusts equalled 94.4% with the highest percentage to recommend 98.6%. The Trust was positioned the highest from a possible 12 Trusts.

Hospital	% to Recommend
Sheffield Children's Hospital	73.0%
Leeds Children's Hospital	94.0%
Alder Hey Children's Hospital	94.0%
Royal Manchester Children's Hospital	95.0%
Royal Alexandra Children's Hospital - Brighton	96.0%
Southampton Children's Hospital	96.0%
Evelina Children's Hospital (GSTT)	96.0%
Nottingham Children's Hospital	97.0%
Bristol Royal Hospital for Children	97.0%
The Great North Children's Hospital	98.0%
Birmingham Children's Hospital	98.0%
Great Ormond Street Hospital for Children	98.6%

Number of complaints in period

The Trust received 4 formal complaints in April and 12 in May, with none of these being graded as a red complaint (in line with the Trust's complaints policy).

The Complaints team monitor all open complaints in order to ensure responses are sent in a timely manner. When actions are identified as a result of complaints the Complaints team monitor these to ensure they are completed and learning is shared across the Trust. In addition, the complaints team work with the clinical audit team to ensure there is assurance that actions are completed and effective.

Hospital Acquired Infections

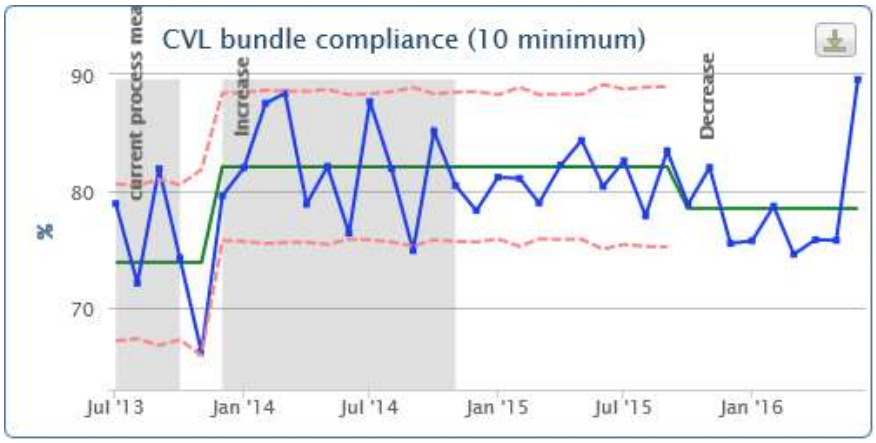
In May the Trust reported no cases of C.Difficile, assigned in patients aged two and over, tested on the third day or later, meaning the total year to date cases remains at one in 2016/17.

No cases of MRSA were recorded in April or May. All episodes of positive blood cultures are reported to the DH via the HCAI submission site as bacteraemias and each case is discussed in detail with NHS England.

Three cases of E. Coli were reported in May following 48 hours of admission, taking the year to date total onset in Hospital to 4 cases in 2016/17.

Three cases of MSSA was reported in March following 48 hours of admission, taking the year to date total onset in Hospital to 4 cases in 16/17.

Central Venous line bundle compliance

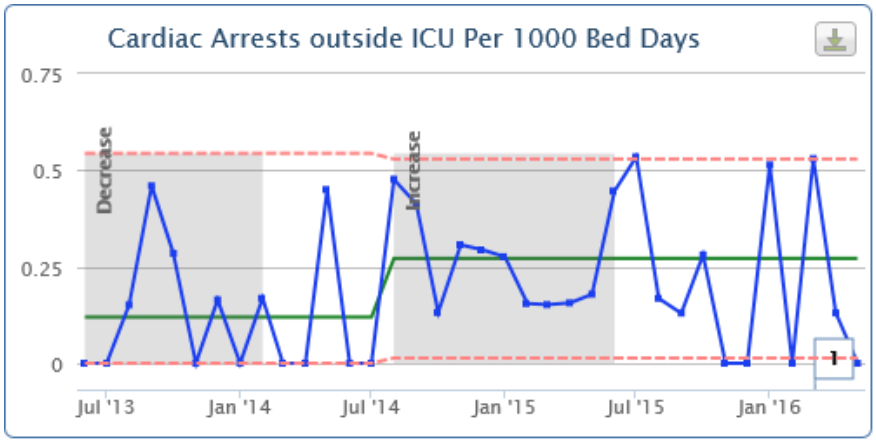


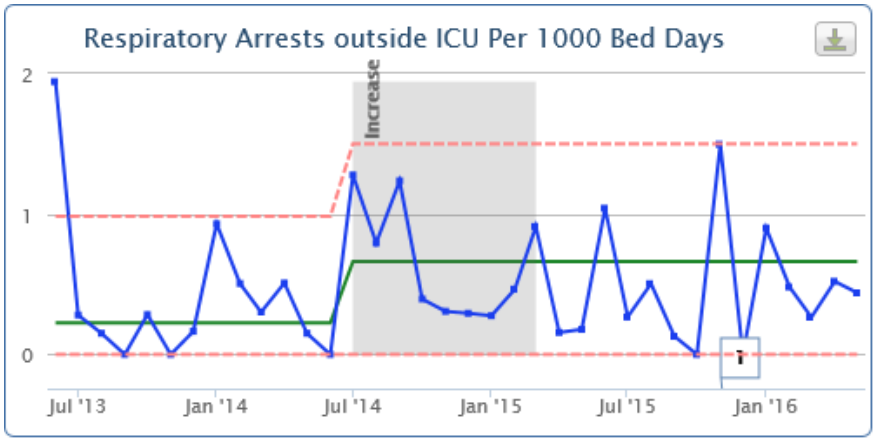
This month the CVL infections data is in normal variation whereas the bundle compliance has had special cause variation, which is being the focus of reporting this month.

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

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

Avoidable cardiac and respiratory arrests





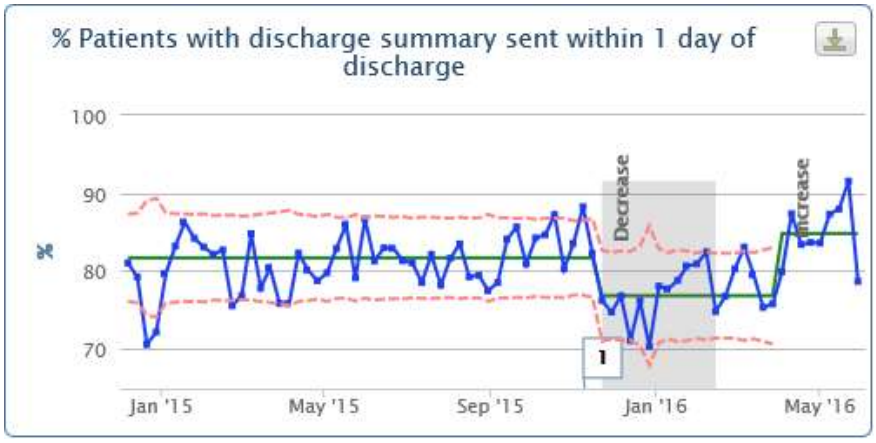
There were no cardiac arrests outside ICU in May

There were however 3 respiratory arrests. 2 calls were from the same patient on Miffy ; one due to a new tracheostomy tube which was difficult to re-insert and the second of unknown cause. The recovery was quick from both events and the patient remained on the ward. The other respiratory arrest was on Bear. The child had been discharged from CICU 4 hours previously and required re-intubation

Mortality

For this reporting period the Trust has not seen any notable exceptions or special cause variation against the mortality metric.

Discharge summary completion



May 2016 saw a significant improvement in performance overall with an increase of 6% more discharge summaries being sent within 24hrs from the previous month. It is acknowledged that continued support is required at an operation level to increase awareness and improvement in delivery. This is being undertaken via weekly reports and where applicable investigation into poor or deteriorating performance to understand challenges.

Discharge Summary Performance is included at specialty level within the new Divisional Performance Reports to be discussed at both Service Specialty and Divisional Performance Management Meetings. Action plans will be drawn up for failing areas, this work is to commence during the next month. Work has been requested to include IPP patients to ensure full coverage of

activity. Clinical teams are being sent reminder emails 24 hours following the patients discharge if no summary has been produced (with escalation to Division Directors after 48 hours).

Further update will be provided on Discharge Summaries on the agenda for this meeting.

Clinic Letter Turnaround

The Trust has traditionally identified this as an area of focus. This has now been recognised centrally as an indicator that should also be monitored (as per Discharge Summaries) and is now contained with the Standard NHS Contract for 2016/17. The operating standard that Trust are being asked to deliver in this financial year is 14 days from the date of the clinic. Indicatively for May 2016 the Trust turnaround on average was 7.27 days. This varies across the specialties and needs to be more fully reviewed and understood. This will be an on-going piece of work for this year.

Inpatient and outpatient activity

The Trust is currently reviewing how and what it reports in the regard to activity. This will be updated for the next Members Council.

NHS Improvement (formerly Monitor) rating

This is updated quarterly and so, quarter one for 2016/17 has not yet been updated. However as per the NHS I / Monitor most up to date position, the Trust is currently reporting, 2 for the financial sustainability risk rating score, and, "under-review" for the governance rating.

The financial sustainability risk rating is Monitor's view of the level of financial risk a foundation trust faces and its overall financial efficiency. A rating of 1 indicates the most serious risk and 4 the least risk.

The governance rating is Monitor's degree of concern about how the trust is run, any steps we are taking to investigate this and/or any action we are taking. We'll either indicate we have no evident concerns, that we have begun enforcement action, or that the foundation trust's rating is 'under review', which means we have identified a concern but not yet taken action.

Workforce

Contractual staff in post

GOSH increased its contractual FTE (full-time equivalent) figure by 13 in May to 3883 compared to April 2016.

Sickness absence

Sickness absence has decreased slightly to 2.4% (from 2.5%) and remains below the London average figure of 2.8%. Short-term sickness (STS) (episodes of sickness up to 4-weeks) has reduced slightly across the Trust at 1.3% whilst long-term sickness has remained at 1.1%.

Turnover & Vacancy Rate

Turnover is reported as voluntary turnover in addition to the standard total turnover. Voluntary turnover currently stands at 17.5% (a 0.3% increase from April 2016); this reported value excludes non-voluntary forms of leavers (e.g. dismissals, TUPE, fixed-term and redundancies). Total (voluntary and non-voluntary) turnover has increased slightly to 19.8% in May (+0.1% from April). The (unadjusted) London benchmark figure is 15.1% (which includes voluntary and non-voluntary leavers).

The unfilled vacancy rate across the Trust stands at 8%.

Agency usage

Agency usage for 2016/17 (year to date) stands at 3.67% of total paybill. The significant spend on agency staff (as percentage of paybill) is largely driven by the investment of validators to support the RTT improvement work and also a number of senior interims in the organisation. NHS Improvement have set an agency spend ceiling for all Trusts (3% for GOSH). The Trust is currently exceeding the agency ceiling for May due to RTT and the gastro review; however, Trust spend on business as usual (BAU) agency staff is significantly below the ceiling. The Trust also reports on the number of breaches against the agency rules (spend cap by shift and/or framework compliance and direct engagements); in May, 152 shifts (down from 502 shifts in April) breached the agency cap. Clinical & Medical Operations (Medical Director's Directorate & Operations Directorate) retains the highest spend on agency staff at 50% (down from 51% in April) of total paybill (slight decrease). Slight decrease to Finance & ICT agency spend (-0.3%).

PDR completion rates

The Trust overall appraisal rate stands at 73% - unchanged since April. Currently only one directorate is meeting the target of 95%, Human Resources & Organisational Development (at 98%). HR & OD are currently revisiting the PDR mechanism and will remove the PDR window and/or provide a simplified route of compliance to address the Trust's position of low completion across the organisation.

Statutory & Mandatory training compliance

The new GOLD LMS (Learning Management System) launched on 11 May 2016. During the go-live month, there has been a 3.4% increase to statutory and mandatory compliance across the Trust. Currently only directorate is meeting the 95% compliance requirement, Human Resource & Organisational Development.

Finance

The Trust ended the 2015/16 financial year with an outturn deficit of £11.1m, excluding capital donations.

The Trust is reporting a deficit of £1.2m, excluding capital donations, for the first two months of 2016/17, which is £2.3m better than the year to date plan (see appendix 3).

Earnings before Interest, Tax, Depreciation and Amortisation (EBITDA) for the 2 Months to the end of May are £3.0m. The year to date EBITDA is £2.2m better than plan and represents 4.5% of income. EBITDA in Month 2 is £1.9m better than plan.

The year to date positive variance is the net result of a number of positive and negative variances:

- NHS income (excluding pass through) YTD is above plan by £1.0m, however, has been offset by an adjustment to 2015/16 NHS Clinical Income of £1.0m representing the difference between estimated income when the accounts were produced and final chargeable income.
- Private patient income YTD is £1.6m above plan. This was delivered through increased activity and a high level of complex patients.
- Pay is £0.1m overspent in month; with agency spend £0.5m higher than plan. The agency spend is higher than the same period in 2015/16 due to the cost of RTT validation and the Gastro review.
- Non pay excluding pass-through drugs and devices YTD is £0.4m favourable to plan.
- Although the overall weighted monitor risk rating was a 3 for Month 2, the impact of the rating of 1 for the Variance I&E Margin to plan reduced the overall rating to 2. This was as a result of the capital donations being £5.4m less following delays in the Phase 2B redevelopment project building project. Further work is being undertaken to review the forecasts and cash flows for the project over the remainder of the year.

The Trust continues to forecast an outturn deficit of £9.5m for 2016/17.

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

The Trust is forecasting a Financial Sustainability Risk Rating (FSRR) of 3 by the end of the financial year.

Appendices:

1. Abridged Finance Report

NOTE: The Trust integrated Performance Report is being refreshed and will be shared with Members Council at the next meeting

Attachment G

Great Ormond Street Hospital for Children NHS FT - Trust I&E Financial Performance Summary. 2 Month to 31 May 2016

I&E GOSH	Current Month Budget (£m)	Current Month Actual (£m)	Current Month Variance (£m)	Current Year Year to Date Budget (£m)	Current Year Year to Date Actual (£m)	Current Year Year to Date Variance (£m)	Prior Year Year to Date Actual 2015/16 (£m)	Prior Year Year to Date Variance CY vs PY (£m)	RAG Rating Current Year Variance	Note
NHS & Other Clinical Revenue	20.3	21.4	1.1	41.2	41.2	0.0	37.8	3.5	G	1
Pass Through	4.9	4.4	(0.5)	9.6	9.1	(0.5)	8.2	0.9		
Private Patient Revenue	3.8	4.5	0.7	7.9	9.5	1.6	6.7	2.8	G	2
Non-Clinical Revenue	3.4	3.8	0.4	6.9	7.2	0.2	6.5	0.7	G	
Total Operating Revenue	**32.4**	**34.0**	**1.6**	**65.6**	**66.9**	**1.4**	**59.1**	**7.8**		
Permanent Staff	(18.9)	(17.6)	1.4	(37.7)	(34.7)	3.0	(32.9)	(1.8)		
Agency Staff	(0.3)	(0.9)	(0.5)	(0.7)	(1.4)	(0.7)	(0.6)	(0.8)		
Bank Staff	(0.1)	(1.1)	(0.9)	(0.2)	(2.6)	(2.4)	(2.2)	(0.4)		
Total Employee Expenses	**(19.4)**	**(19.5)**	**(0.1)**	**(38.6)**	**(38.7)**	**(0.1)**	**(35.7)**	**(3.0)**	A	3
Drugs and Blood	(1.0)	(1.3)	(0.3)	(2.0)	(2.0)	0.1	(1.4)	(0.6)	G	
Other Clinical Supplies	(3.4)	(3.6)	(0.2)	(6.9)	(6.6)	0.3	(5.8)	(0.8)	G	
Other Expenses	(3.8)	(3.4)	0.3	(7.7)	(7.6)	0.1	(7.8)	0.2	G	
Pass Through	(4.9)	(4.4)	0.5	(9.6)	(9.1)	0.5	(8.2)	(0.9)		
Total Non-Pay Expenses	**(13.1)**	**(12.7)**	**0.4**	**(26.1)**	**(25.2)**	**0.9**	**(23.2)**	**(2.0)**	G	4
EBITDA (exc Capital Donations)	**(0.1)**	**1.8**	**1.9**	**0.8**	**3.0**	**2.2**	**0.2**	**2.8**	G	
Depreciation, Interest and PDC	(2.2)	(2.2)	(0.0)	(4.3)	(4.2)	0.1	(4.0)	(0.2)		
Net (Deficit)/Surplus (exc Cap. Don. & Impairments)	**(2.3)**	**(0.4)**	**1.9**	**(3.5)**	**(1.2)**	**2.3**	**(3.8)**	**2.6**	G	
EBITDA %	**-0.2%**	**5.4%**		**1.2%**	**4.5%**		**0.3%**			
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Capital Donations	5.2	3.3	(1.9)	12.0	6.6	(5.4)	1.8	4.8		
Net Result	**3.0**	**2.9**	**(0.0)**	**8.5**	**5.5**	**(3.0)**	**(2.0)**	**7.4**		

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

NHSI Key Performance Indicators

KPI	Annual Plan	M2 YTD Plan	M2 YTD Actual	Rating	
Liquidity	4	4	4	G	
Capital Service Coverage	3	1	3	G	
I&E Margin	4	4	4	G	
Variance in I&E Margin as % of income	2	2	1	R	
Overall	3	3	3	G	
Overall after Triggers	3	2	2	A	5

Comments Key Areas:

- For Month 2 of the financial year 2016/17 the Trust has incurred an operating deficit (excluding capital donations) of £0.4m in month and YTD a deficit of £1.2m. The month 2 position is £2.0m favourable to plan and YTD is £2.3m Favourable to Plan.
- The Month 2 YTD EBITDA was a £3.0m surplus which is £2.2m favourable to plan and represents 4.5% of Income.

Notes:

1) NHS income (excluding pass through) YTD is above plan by £1.0m, which has been offset by the adjustment to 2015/16 NHS Clinical Income of £1.0m.
2) Private patient income YTD is £1.6m above plan. This was delivered through increased activity and a high level of complex patients.
3) Pay is £0.1m overspent in month, with agency spend £0.5m above plan. The agency spend is higher than the prior year due to the cost of RTT validation and the Gastro review.
4) Non pay excluding pass through YTD is £0.4m favourable to plan.
5) Although the overall weighted monitor risk rating was a 3 for Month 2, the impact of the rating of 1 for the Variance I&E Margin to plan reduced the overall rating to 2. This was as a result of the capital donations being £5.4m less following delays in the Phase 2B redevelopment project Building project.

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

29th June 2016

Clinical Governance Committee Summary Report
May 2016

Summary & reason for item: To provide an update on the May meeting of the Clinical Governance Committee. The agenda to the meeting is also attached.

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

Report prepared by: Victoria Goddard, Trust Board Administrator

Item presented by: Mary MacLeod, Chair of the Clinical Governance Committee

Great Ormond Street Hospital for Children NHS Foundation Trust

Update from the Clinical Governance Committee meeting held on 5th May 2016

Committee Terms of Reference

The Committee approved the revised terms of reference (see Appendix 1 for further information).

Internal Audit Progress Report

The Committee received the Internal Audit Reports for Education Strategy and Governance and IT Operations and Infrastructure which had both provided partial assurance with improvements required. Discussion took place around the importance of implementing an Education Strategy and it was noted that this was a complex area for many Trusts due to the number of funding streams and different staff groups.

Internal Audit Strategic and Operational Plan 2016-2019

The committee approved the internal audit plan and noted that the term 'aggregate risk' had been developed by KPMG to describe the level of priority given to an areas and the value that KPMG would be able to add.

Work of the Clinical Review Group (CRG)

The committee received an update on the work of the CRG and the programme of work to review patient notes. The Committee noted that the validation work would be completed at the end of August.

Risk 10: Access improvement programme

It was reported that the Access Policy had been developed with the Intensive Support Team and had been discussed with the relevant assurance committees and stakeholders. It was confirmed that it met the required standards and would be rolled out throughout the Trust. Reporting on cancer waits was planned to resume in May 2016 and RTT reporting in September 2016. Further work would be done on the demand and capacity mismatch.

Gastroenterology Review Update

It was reported that the key on-going risk was the capacity to review patients within the service rapidly with an independent gastroenterologist. It was confirmed that currently two clinicians external to the Trust were undertaking patient reviews. The Committee noted that so far no physical harm to patients had been identified. It was agreed that a process was required for the work that takes place in an organisation such as GOSH where clinicians are working at the forefront of knowledge in their specialty where there are limited standard protocols.

Update on out of hours medical cover

The Committee noted that Health Education North, Central and East London (HENCEL) had agreed to return trainees that had been removed and to return GOSH to routine quality assurance reporting.

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

An update was received on two Productivity and Efficiency Schemes: Neurosciences Administrative Workforce Review and Pharmacy (initial) Review and it was noted that there had been no adverse quality or safety impact as a result of the schemes. Discussion took place about the Quality Impact Assessment (QIA) process and the importance of ensuring it was not burdensome. Work would take place to consider the schemes that would require QIAs in the future and those that could be taken forward on a basis of 'business as usual'.

Annual Freedom of Information Update

The Committee expressed some disappointment at the reduction in FOI responses which had been issued with 20 days and welcomed the proposed improvement plan.

Compliance Update

It was reported that much of the CQC action plan had been completed. The Committee welcomed the progress.

Safeguarding update

The increase in safeguarding activity and social work referrals was noted and the committee welcomed the good work around honorary consultant safeguarding training. An internal safeguarding review had been undertaken which was currently going through factual accuracy and would be reported to the Clinical Governance Committee in due course.

Clinical Audit

Discussion took place around the Audit on hand washing, the results of which had not been as high as anticipated. It was reported that this had been discussed with the Director of Infection Prevention and Control and the Executive Team were satisfied that this was being taken seriously. It was agreed that it was vital that data such as this was provided alongside an evidence based explanation. The committee expressed disappointment that there had been a negative trend in the management of neonatal jaundice and emphasised the importance of this work. The Committee asked for a further update at the next meeting.

Matters to be raised at Trust Board

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

- RTT
- Gastroenterology
- Medical cover out of hours
- Timely responses by estates to health and safety issues
- Fire training
- The internal audit on IT

Attachment H

CLINICAL GOVERNANCE COMMITTEE
Thursday 5th May 2016 at 10:00am – 1:00pm in the Charles West (Board) Room, Great Ormond Street Hospital for Children NHS Foundation Trust

AGENDA

	Agenda Item	Presented by	Attachment	Time
1.	**Apologies for absence**	Chairman		**10:00am**
2.	**Minutes of the meeting held on 3rd February 2016**	Chairman	**A**	
3.	**Matters arising/ Action point checklist**	Chairman	**B**	
4.	**Revised Terms of Reference and Annual Report of the Clinical Governance Committee**	Company Secretary	**C**	
	RISK			
5.	**Board Assurance Framework Update** **Risk 10: Access improvement programme**	Company Secretary Deputy Chief Executive	**E** **F**	**10:25am**
6.	**Work of the clinical review group**	Medical Director	**H**	**10:35am**
7.	**Gastroenterology Review Update**	Medical Director	**I**	**10:45am**
8.	**Update on out of hours medical cover**	Medical Director	**Verbal**	**10:55am**
9.	**Update on quality and safety impact of Productivity & Efficiency (P&E) programme** **Revised Productivity and Efficiency QIA process**	Deputy Chief Executive	**3** **K**	**11:05am**
	COMPLIANCE			
10	**Compliance Update (including the CQC action plan)**	Company Secretary	**L**	**11:15am**
11.	**Quality Report 2015-16**	Medical Director	**M**	**11:25am**
12.	**Annual Freedom of Information Update**	FOI Coordinator	**N**	**11:35am**
	ASSURANCE			
13.	**Health and Safety Annual Report** **Revised January Health and Safety Report**	Director of HR and OD	**O** **2**	**11:45am**

	Camelia Botnar Labs Environmental Safety Update		**Z**	
14.	**Update from Patient Safety and Outcomes Committee**	Medical Director	**P**	**11:55am**
15.	**Research Governance Annual Update**	Director of Research and Innovation	**Q**	**12:05pm**
16.	**Quarterly Safeguarding Report (January 2016 – April 2016)**	Chief Nurse	**R**	**12:15pm**
17.	**Internal Audit Progress Report (January 2016 – April 2016)**	KPMG	**S**	**12:25pm**
18.	**Internal and external audit recommendations update**	Deputy Director of Finance	**T**	
19.	**Internal Audit Strategic And Operational Plan 2016-2019**	KPMG	**U**	
20.	**Clinical Audit update January 2016 – April 2016**	Clinical Audit Manager	**V**	**12:35pm**
21.	**Clinical audit plan 2016/17**		**W**	
	GOVERNANCE			
22.	**Matters to be raised at Trust Board**	Chair of the Clinical Governance Committee	**Verbal**	**12:45pm**
23.	**Clinical Ethics Committee Update**	Chair of the Clinical Ethics Committee	**X**	**12:50pm**
24.	**Performance Report – January 2016**	Deputy Chief Executive	**Y to follow**	
25.	**Audit Committee Summary – April 2016**	James Hatchley, Independent Committee Member	**Verbal**	
26.	**Any Other Business**	Chairman		
27.	**Next meeting**	**Wednesday 13th July 2016 2:00pm – 5:00pm**		
28.	**Terms of Reference and Acronyms**	**1**		

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

29th June 2016

Audit Committee Summary Report
April 2016 and May 2016

Summary & reason for item: To provide an update on the April and May meetings of the Audit Committee. The agendas for both meetings are attached.

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

Report prepared by: Victoria Goddard, Trust Board Administrator

Item presented by: Charles Tilley, Chair of the Audit Committee

Great Ormond Street Hospital for Children NHS Foundation Trust

Update from the Audit Committee meeting held on 18th April 2016

Board Assurance Framework

The Committee noted the position of the risks on the Board Assurance Framework (BAF) for 2015/16 and discussed the suggested BAF risks for 2016/17. It was agreed that any merging of risks should not divert focus from key areas which should continue to be specifically referenced within the risk description. The importance of being assured about the management of Trust Wide Risks was emphasised.

External Audit: Interim update report to the Audit Committee for the year ended 31 March 2016

Deloitte suggested that further work was required on the Trust's draft Annual Governance Statement which should include further information about the RTT issues in light of GOSH's reporting suspension. No risks had come to light as a result of Deloitte's substantive work and IPP debt would be considered again as large amounts of debt had been outstanding at month 9. The Committee discussed the disclosures that would be made around going concern in the annual report and Deloitte said that this should follow on from the disclosure made in 2014/15.

Risk Management Report

The Committee welcomed the Chief Executive taking the Chair of the Risk Assurance and Compliance Group to bring increased focus to the risk work within the divisions.

The Committee discussed the following high level risks:

- Risk 9: Research funding available to GOSH

It was noted that the process for applying for BRC and CRF funding was on-going and discussed the Trust's current level of commercial funding. The Committee welcomed the recent increase in levels of commercial funding and encouraged the continuation of this increase.

- Risk 10: Access Policy

The Committee noted that the Access Policy would be considered by the Policy Approval Group on 25th April and go live in the organisation from 1st May. The Intensive Support Team had confirmed that the policy was an example of best practice.

- Risk 12: Commissioners

The Committee discussed the two elements of the risk: a lack of commissioner strategy which would provide GOSH with the structure to prioritise services and future capacity, and the lack of differentiation in funding strategy between specialist paediatric services and others. It was noted that a gap remained between the funding offer made by NHS England and GOSH's proposal.

- Risk 15: Data Quality Risk and Data Quality Review Update

An action plan had been developed following the completion of the data quality review and the greatest challenges were around resources in operational teams and competing priorities within the organisation. Work was taking place to scope the additional resources required.

International and Private Patient (IPP) Debt Update 2015/16

The Committee discussed the levels of IPP debt which had risen along with the time taken to retrieve the debt. The Trust's external auditors confirmed that GOSH was not in an unusual position and the committee noted that the debt had been adequately provided for. Letters of guarantee were in place for over 90% of the debt.

Final report on generator test serious incident

The Committee received the report and noted that the learning would be shared with other Trusts.

Cyber activity at GOSH

It was reported that the priority was to complete the remediation and consolidation works to the network and servers and it was anticipated that this would take place within the next three months. As there were a large number of niche applications run by the Trust, these would take longer to consolidate. A significant work programme was underway which was being monitored by the IT Board.

Whistle blowing Update

It was reported that there was one open case being reviewed by the Trust's Counterfraud Manager. A lead GOSH investigator had been appointed as had two members of the finance team to support the investigation.

Losses and Comps (Debt Write off) and Aged Debtor/Creditors

Discussion took place around the write off of two key elements of debt, one of which had the possibility of being incorporated into a future contract. It was confirmed that this debt had been 100% provided for. Deloitte said it was vital that the revenue was not recognised twice, both in terms of having been written off and being recovered by a new contract. The Committee discussed the risk of treating self-paying patients following a clinician's estimate of the likely extent of the treatment.

Draft Head of Internal Audit Opinion for 2015-16

It was confirmed that the draft Head of Internal Audit Opinion had provided significant assurance with minor improvements required and that the core areas of the internal audit programme had provided green or amber green assurance throughout the year.

Internal Audit Strategic and Operational Plan: 2016-17

The Committee discussed the plan for 2016-17 and noted that a number of key areas would not be reviewed as part of the five year audit plan. It was agreed that the October meeting would review a robust internal control self-assessment programme that was being developed by the Chief Finance Officer.

Counter Fraud Workplan 2016/17

The Committee approved the Counter Fraud workplan for 2016/17.

Audit Committee Annual Effectiveness Survey Results

The Committee noted the results of the effectiveness survey and the key areas of concern which had been raised. The areas of improvement would be addressed during meetings.

Audit Committee Terms of Reference and workplan

The Audit Committee considered the proposed minor updates to the committee's terms of reference and approved the amendments. The terms of reference and workplan are attached at Appendix 1.

The Trust Board is asked to endorse the terms of reference.

Compliance with the NHS provider licence – self assessment

Areas of amber on the self-assessment showed where the Trust was in the process of addressing areas of non-compliance. KPMG confirmed that they were satisfied with this approach.

Procurement Waivers

The Committee requested that a deep dive be conducted into cases where it was not possible to issue procurement paperwork in the timescales available and to review the effectiveness of the process.

AUDIT COMMITTEE
Monday 18th April 2016 at 2:00pm, Charles West (Board) Room, Great Ormond Street Hospital for Children, Great Ormond Street, London WC1N 3JH
AGENDA

	Agenda Item	Presented by	Author	Time
1	**Apologies for absence**	Chairman		**2:00pm**
2	**Minutes of the meeting held on:** • **18th January 2016** • **23rd February**	Chairman	 **A** **B**	
3	**Matters arising and action point checklist**	Chairman	**C**	
	RISK			
4.	**Board Assurance Framework** • **2015/16** • **Strategy and suggested risks for 2016/17**	Company Secretary/ Interim Director of Strategy and Planning	**D**	**2:05pm**
5.	**Risk Management Report**	Head of Clinical Governance and Safety	**E**	**2:15pm**
6.	**Presentation of high level risks** **Risk 9: Research funding available to GOSH** **Risk 10: Access Policy** **Risk 12: Commissioners** **Risk 15: Data Quality Risk** **Data Quality Review Update**	 Deputy Director of Research & Innovation Deputy Chief Executive Interim Director of Strategy and Planning Director of Information Interim Director of Strategy and Planning and Director of Information	 **F** **G** **H** **I** **13**	**2:20pm**
7.	**Risks identified at and since last meeting:** **Final report on generator test serious incident** **International and Private Patient (IPP) Debt Update 2015/16**	Director of Development	**J** **12**	**2:45pm**
8.	**Insurance arrangements update & request to amend SFIs to address NHS Litigation Authority (NHSLA) Clinical Negligence Scheme for Trusts (CNST) Claims**	Interim Director of Strategy and Planning	**L**	**2:50pm**
9.	**Cyber activity at GOSH**	Interim Director of ICT	**M**	**2:55pm**
10.	**Productivity and Efficiency Update**	Deputy Chief Executive	**N**	**3:00pm**
11.	**Schedules for Review by Audit Committee as per SFI No 1:**	Chief Finance Officer	**P**	**3:10pm**

	• **Losses and Comps (Debt Write off)** • **Aged Debtor/Creditors** **Reference Cost Submission 2015/16**	Chief Finance Officer	**Q**	
12.	**Whistle blowing Update**	Deputy Director of HR and OD	**R**	**3:20pm**
	EXTERNAL AUDIT			
13.	**External Audit: Interim update report to the Audit Committee for the year ended 31 March 2016**	Deloitte LLP	**S**	**3:25pm**
	INTERNAL AUDIT AND COUNTER FRAUD			
14.	**Internal Audit Progress Report, Technical Update and Draft Head of Internal Audit Opinion for 2015-16**	KPMG	**V**	**3:45pm**
15.	**Draft Internal Audit Annual Report 2015/16**	KPMG	**W**	**3:55pm**
16.	**Internal Audit Strategic and Operational Plan: 2016-17**	KPMG	**U**	**4:05pm**
17.	**Internal and external audit recommendations – update on progress**	Chief Finance Officer	**X**	**4:15pm**
18.	**Counter Fraud Annual Report and Workplan 2016/17**	Counter Fraud Manager, TIAA	**Y**	**4:20pm**
	GOVERNANCE			
19.	**Audit Committee Annual Effectiveness Survey Results**	Chief Finance Officer	**Z**	**4:25pm**
20.	**Draft Annual Governance Statement 15-16**	Chief Finance Officer	**1**	**4:35pm**
21.	**Draft Audit Committee Report to be included in the Annual Report**	Chief Finance Officer	**2**	**4:45pm**
22.	**Revised Terms of Reference & Annual Workplan**	Company Secretary	**4**	**4:50pm**
23.	**Compliance with the NHS provider licence – self assessment**	Interim Director of Strategy and Planning	**5**	**4:55pm**
	ITEMS FOR INFORMATION			
24.	**Salary Overpayment Briefing**	Chief Finance Officer	**6**	**5:00pm**
25.	**Fire and Security Annual Report 2016**	Facilities Manager & Director of Estates	**7**	
26.	**Procurement Waivers –January 2016 to March 2016**	Chief Finance Officer	**8**	
27.	**Performance Report – Month 11 (2015-16)**	Deputy Chief Executive	**9**	
28.	**Finance and Investment Committee – Summary - January, February & March 2016**	David Lomas, Chair of the F&I Committee	**10**	
29.	**Clinical Governance Committee – Summary of meeting in January 2016**	Company Secretary/ James Hatchley	**11**	
30.	**Any Other Business**		**Verbal**	
31.	**Next meeting**	**Friday 20th May 2016, 10:00am – 1:00pm in the Charles West Room**.		

Great Ormond Street Hospital for Children NHS Foundation Trust

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

Internal Audit Progress Report

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

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

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

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

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

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

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

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

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

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

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

The Committee recommended the Quality Report for Board approval.

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

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

The Committee recommended the report for Board approval.

Board Assurance Framework 2016/17 including update from RACG

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

Clinical Negligence Scheme for Trust's outstanding claims

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

IT Programme Risk Update

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

Response to Reference Cost 2014-15 Audit Report by PWC

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

AUDIT COMMITTEE

Friday 20th May 2016, 9:30am, Charles West Room, Great Ormond Street Hospital for Children, Great Ormond Street, London WC1N 3JH

AGENDA

	Agenda Item	Presented by	Attachment	Time
1.	**Apologies for absence**	Chairman		**9:30am**
2.	**Minutes of the meeting held on 18th April 2016**	Chairman	**A**	
3.	**Matters Arising, Action point checklist**	Chairman	**B**	
	INTERNAL AUDIT			
4.	**Internal Audit Reports**	KPMG	**C**	**9:40am**
	ANNUAL ACCOUNTS AND ANNUAL GOVERNANCE STATEMENT			
5.	**Chief Financial Officer's review of the Annual Financial Accounts 2015/16, including the Going Concern assessment**	Chief Finance Officer	**D**	**9:50am**
6.	**Annual Financial Accounts 2015/16** **And** **GOSH Draft Annual Report 2015/16 (including the Annual Governance Statement)**	Chief Finance Officer Company Secretary	**E**	**10:05am**
7.	**Compliance with the Code of Governance 2015/16**	Company Secretary	**F**	**10:30am**
8.	**Quality Report 2015/16**	Meredith Mora, Clinical Outcomes Development Lead	**G**	**10:35am**
9.	**Internal Audit Annual Report 2015/16 including Head of Internal Audit Opinion 2015-16**	KPMG	**N**	**10:40am**
10.	**Final Report on the financial statement audit for the 12 month period ended 31 March 2016 and 2015/16 Quality Report Quality Assurance Review**	Deloitte	**I**	**10:50am**
11.	**Representation Letter in relation to the accounts and quality report for the year ended 31 March 2016**	Chief Finance Officer	**J**	**11:00am**

	Agenda Item	Presented by	Attachment	Time
12.	**Audit Committee Annual Report to the Trust Board for the financial year 2015/16**	Chief Finance Officer	**K**	**11:05am**
	RISK			
13.	**Board Assurance Framework 2016/17 including update from RACG**	Company Secretary	**L**	**11:15am**
14.	**Presentation of high level risks** **Data Quality Review Update (update against the action plan)**	 Interim Director of Strategy and Planning	 **M**	**11:30am**
15.	**Risks identified at/ since the last meeting** **Overview of Blood and Drugs Wastage** **IPP Debt Update** **Clinical Negligence Scheme for Trusts Outstanding claims** **IT Programme Risk Update**	 Chief Finance Officer Chief Finance Officer Interim Director of Strategy and Planning Chief Finance Officer	 **O** **P** **Q** **R**	**11:40am**
16.	**Response to Reference Cost 2014-15 Audit Report by PWC**	Chief Finance Officer	**S**	**12 Noon**
	GOVERNANCE			
17.	**Review of non-audit work conducted by the external auditors**	Chief Finance Officer	**T**	**12:10pm**
18.	**Update on raising concerns**	Deputy Director of HR and OD	**U**	**12:15pm**
	ITEMS FOR INFORMATION			
19.	**Local Security Manager Workplan 2016/17**	Local Security Manager	**V**	**12:20pm**
20.	**Any Other Business** This meeting is to be followed by a meeting of the Trust Board to approve the accounts.			
21.	**Next meeting**	**Monday 10th October 2016 – 2:00pm – 5:00pm**		
	FOR REFERENCE			
22.	**Minutes of subcommittees:** • **Summary report of the Finance and Investment Committee (May 2016)** • **Summary Report of the Clinical Governance Committee (May 2016)**	 Chair of F&I James Hatchley, Independent Member	 **Verbal** **X**	**12:25pm**

Attachment I

	Agenda Item	Presented by	Attachment	Time
23.	**Audit Committee Terms of Reference and Workplan**	Company Secretary	**1**	
24.	**Glossary of terms**		**2**	

Great Ormond Street Hospital for Children NHS Foundation Trust

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST

AUDIT COMMITTEE

TERMS OF REFERENCE

1. Authority

1.1. The Audit Committee is a non-executive committee of the Board of Great Ormond Street Hospital for Children NHS Foundation Trust (the Board), established in accordance with paragraph 36 of the Trust's Constitution and section 27 of the Board of Director's Standing Orders.

2. Remit

2.1.The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and financial and non-financial internal controls that supports the achievement of the organisation's objectives.

3. Authority

3.1. The Committee is authorised by the Board to:

a) investigate any activity arising within its terms of reference;

b) to seek any information it requires from any member of staff and all members of staff must co-operate with any request made by the Committee;

c) to request specific reports from individual functions within the Trust.

d) to obtain independent legal or professional advice; and

e) to request the attendance of individuals and authorities outside the Trust with relevant experience and expertise if it considers this necessary.

4. Membership

4.1. The Audit Committee shall be composed of at least three independent non-executive directors. The Chairman of the Trust shall not be a member of the Committee.

4.2. At least one of the committee members shall have recent and relevant financial experience. Two members shall constitute a quorum.

4.3. The Board may appoint an independent member of the committee in addition to the non-executive director members to bring in additional experience and expertise.

4.4. One of the non-executive members will be appointed as Chair of the Committee by the Board.

4.5. The independent member of the Audit Committee shall also sit as an independent member of the Clinical Governance Committee.

5. Attendance at meetings

5.1. The Chief Executive, Chief Finance Officer, Deputy Chief Executive, Head of Clinical Governance and Safety; representative of the external auditors; and the Head of Internal Audit shall normally be invited to attend meetings.

5.2. The external auditors and internal auditors shall meet annually with the Committee without executive directors present, or at the Auditor's or Committee's request.

5.3. The Company Secretary shall be the Secretary to the Committee.

5.4. The Committee may invite any member of GOSH staff or directors to attend a meeting of the Committee, should it be considered necessary.

6. **Frequency of meetings**

6.1. Meetings shall be held a minimum of four times a year at dates agreed to coincide with key stages in the accounting and audit cycle. The external auditors or Head of Internal Audit may request a meeting if they consider one is necessary.

6.2. Members are expected to attend a minimum of 3 meetings per year.

7. **Duties**

7.1. To discharge the Trust's duties for Audit, the Committee shall ensure that the business of the Trust is conducted fully in accordance with the principles of accountability and probity by undertaking the following duties:

8. **Governance, risk management and internal control**

8.1. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.

8.2. In particular, the Committee shall review the adequacy and effectiveness of:

8.2.1. All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to the endorsements by the Board.

8.2.2.The underlying processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of the principal risks and the appropriateness of the above disclosure statements.

8.2.3.The policies and strategies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.

8.2.4.The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by the Counter Fraud Service.

8.3. The Committee shall advise the chief executive on the effectiveness of the system of internal control.

8.4. The Assurance Framework will be used to guide the Committee's work and that of the audit and assurance functions that report to it.

8.5. The Committee shall review and make recommendations to the Board on the management of risk, and the resources required including the annual business plan.

9. **Internal Audit**

9.1.The Committee shall ensure that there is an effective internal audit function that meets mandatory Audit Standards in a Foundation Trust and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

9.1.1.consideration of the provision of the internal audit service, resourcing of the service, the cost of the audit and any questions of resignation and dismissal;

9.1.2.review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that it is consistent with the audit needs of the organisation as identified in the Assurance Framework;

9.1.3.consideration of the major findings of internal audit work (and management's response) and monitoring of the implementation of audit recommendations by management;

9.1.4.ensuring coordination between the internal and external auditors to optimise audit resources;

9.1.5.an annual review of the effectiveness of internal audit.

10. **External Audit**

10.1. The Committee shall review the work and findings of the external auditors and consider the implications and management's responses to their work.

10.2. Consideration of the appointment and performance of the external auditors will be conducted as outlined below:

10.2.1.1. The Committee will assess the external auditor's quality and value of work and the timeliness and reporting and fees on an annual basis and, based on this assessment, make a recommendation to the Members' Council with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards. To the extent that that recommendation is not adopted by the Members' Council, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

10.2.1.2. The Committee will make recommendation to the Members' Council about the remuneration and terms of engagement of the external auditor.

10.2.1.3. The Committee will oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years. It will agree with the Members' Council, the criteria for appointing, re-appointing and removing external auditors. The committee shall make a recommendation to the Members' Council with respect to the appointment of the auditor.

10.2.1.4. The Committee will develop,implement and monitor the policy on the engagement of the external auditor to supply non-audit services.

10.2.1.5. The Committee will consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal. Where the Members' Council puts forward a proposal to consider removing the auditor, the Audit Committee will investigate the issue, including allegations made against the auditor and report the findings to the Council.

10.1.2 Discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy

10.1.3 Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;

10.1.4 Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses and progress on implementation of the recommendations.

11 Other assurance functions

11.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust and consider the implications for the governance of the Trust.

11.2 The Committee will review the work of other committees in the Trust whose work can provide relevant assurance to the Audit Committee's scope of work. In particular, this will include the Clinical Governance Committee but may also include the Patient, Safety and Outcomes Committee and specific Risk Action Groups (RAGs).

11.3 The Committee will receive a report on the appropriateness of the evidence compiled to demonstrate the Trust's eligibility to hold the Monitor licence and its fitness to register with the Care Quality Commission (CQC)

11.4 The Committee will review the framework in place for managing, governing and monitoring data quality and information governance.

12 Counter Fraud

12.1 The Committee shall satisfy itself that the Trust has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

13 Raising concerns

13.1 The Audit Committee should review arrangements by which staff of the Trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.

13.2 The Audit Committee will monitor the arrangements in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. Through this work, the Audit Committee will ensure that:

13.2.2 safeguards for those who raise concerns are in place and operating effectively;
13.2.3 individuals or groups are enabled to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations
13.2.4 valid concerns are promptly addressed
13.2.5 processes reassure individuals raising concerns that they will be protected from potential negative repercussions

14 Financial reporting

14.1 The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's performance.

14.2 The Committee shall ensure that the systems for reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

14.3 The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

14.3.2 the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee;

14.3.3 changes in, and compliance with, accounting policies, practices and estimation techniques;

14.3.4 unadjusted mis-statements in the financial statements;

14.3.5 significant adjustments in preparation of the financial statements;

14.3.6 significant adjustments resulting from the audit.

14.3.7 letter of representation

14.3.8 qualitative aspects of financial reporting.

15 Standing Orders, Standing Financial Instructions and Standards of Business Conduct

15.1 On behalf of the Board of Directors, the Committee shall:

15.1.2 review the operation of, and proposed changes to, the Board of Directors and Members' Council standing orders; the standing financial instructions, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

15.1.3 review the scheme of delegation.

15.1.4 report to the Board of Directors on its findings and recommended amendments for approval.

16 Administration of the Committee

16.1 The Committee shall undertake an annual review of its effectiveness, which will be reported to the Board of Directors.

16.2 The Committee shall be supported administratively by the Company Secretary, whose duties shall include:

16.2.2 Agreement of the agendas with the Chair and collation of the papers;

16.2.3 Taking the minutes;

16.2.4 Keeping a record of matters arising and issues to be carried forward;

16.2.5 Advising the Committee on pertinent issues/ areas;

16.2.6 Enabling the development and training of Committee members.

16.3 The Committee shall review its terms of reference and work-plan on an annual basis and consult with the Members' Council on any revisions.

16.4 The Committee shall receive a summary of the minutes of the Risk, Assurance and Compliance Group and Clinical Governance Committee.

17 Reporting

17.1 A summary of the reports received by the Audit Committee is outlined in the work-plan attached at annex 1.

17.2 A summary of the minutes of the Audit Committee shall be submitted to a meeting of the Board of Directors.

17.3 The Chair of the Committee shall draw to the attention of the Board and the Member's Council any issue that requires disclosure to the full Board or requires action, making recommendations as to the steps to be taken.

17.4 The Committee will report to the Board at least annually on

17.4.2 its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework;

17.4.3 the completeness and extent to which the risk management framework is embedded across the Trust;

17.4.4 the completeness and extent to which the data quality framework is embedded;

17.4.5 the completeness and extent to which the information governance framework is embedded;

17.4.6 the integration of governance arrangements and the assurances sought of the robustness of the evidence demonstrating the Trust's eligibility to hold the Monitor licence and its fitness to register with the Care Quality Commission; and

17.4.7 the robustness of evidence demonstrating compliance with Monitor's Code of Governance, the Well Led Governance Framework and production of the Quality Report.

April 2016

Attachment J

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

29th June 2016

Finance and Investment Committee Summary Report
March 2016 and May 2016

Summary & reason for item: To provide an update on the March and May 2016 meetings of the Finance and Investment Committee. Agendas for March and May are attached.

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

Report prepared by: Neil Redfern, Financial Controller

Item presented by: David Lomas, Chair of the F&I Committee

Attachment J

Great Ormond Street Hospital for Children NHS Foundation Trust

Update from the Finance and Investment Committee meeting held on 24th March 2016

M11 results including Forecast Outturn
The Committee discussed the Trust's financial performance for M11 as well as the forecast for the year to March 2016.
Topics under discussion were:

- the latest position on the NHSE Specialised Commissioning proposed retention which has since reduced by 50%.
- Activity Volume variance on outpatients
- Kuwait education contract
- Bad debt provision and the increase in IPP debt

Procurement Plan
The Committee was advised that of the £2m of identified savings schemes, £1m had already been delivered through the full year impact of the outsourcing of Soft Facilities Management Services in 2015/16.

It was also noted that the PwC agenda included a review on the role of procurement and savings targets.

Productivity and Efficiency
The committee was advised that non recurrent savings were reported to Monitor which confirmed achievement of the CIP delivery plan, however this information was not included in internal reports.

It was confirmed that PwC are building a 3 year programme with 'quick wins' happening in year one and that PwC were remunerated on a fixed fee basis.

Capital Programme
The Committee agreed that it should review all business cases 12 months after initial approval

Productivity report
The Committee agreed to review proposed metrics which would include Workforce data.

Annual Effectiveness Review
The Committee agreed the proposed review questions and review of the outcomes.

Annual Work Plan 2016/17
The Committee discussed the content of the annual work plan which included review and finalisation of a 5-year plan and also agreed that 4 business cases (NICU/PICU, IPP Positioning, EPR and Phase 4 OBC) would be reviewed in the year.

Terms of Reference
The Committee reviewed the Term of Reference

Consultancy and Advisory costs 2015/16
The Committee discussed the year to date values as well as benchmarking against other Trusts for consultancy expenditure

Review of Annual Budgets 2016/17
The Committee reviewed the Annual budgets for 2016/17 and discussed the process for identifying CIPS targets for each division.

Three Year Financial Plan 2016/17 to 2018/19
The Three Year Financial Plan 2016/17 to 2018/19, which excluded the impact of the implementation of the Electronic Patient Record or cost pressure in relation to the Premier Inn Clinical Building, was reviewed and the Committee requested that this plan is finalised prior to signing off the Phase 4 outline business case.

Annual Plan narrative
The Committee discussed the rise in planned outpatient activity and changes to be made to the Annual plan narrative on the sections relating to Workforce and Quality. The Committee agreed to recommend the Annual Budgets to the Trust Board at its meeting on 1 April 2016. The Committee agreed to support the plan to delegate submission of the Annual Plan to the Executive Team.

Great Ormond Street Hospital for Children NHS Foundation Trust

Enc 0

FINANCE AND INVESTMENT COMMITTEE MEETING AGENDA

24th March 2016
15.30 to 18.00
Charles West Room

Members:

David Lomas (DL)	Chair NED
Akhter Mateen (AM)	NED
Dr Peter Steer (PS)	Chief Executive
Dena Marshall (DM)	Interim Chief Operating Officer
Bill Boa (BB)	Interim Chief Finance Officer
Claire Newton (CN)	Director of Strategy and Planning

Apologies:

In attendance:

All meeting

Andrew Needham (AN)	Deputy Finance Director
Neil Redfern (NR)	Financial Controller and Minutes

		Provisional time	Paper Ref	Accountable
1	Apologies for absence	**15.30**		**DL**
1.1	Minutes of the January and February meetings and action check list	**15.35**	**Enc 1.0** **Enc 1.1** **Enc 1.2**	**DL**
FOR INFORMATION AND DISCUSSION				
2	Financial activity board report M11 and Forecast to Year end Finance Report to February 2016	**15.40**	**Enc 2.0** **Enc 2.1**	**BB**
3	Procurement Plan update	**15.55**	**Enc 3.0**	**AN**
4	P&E Update	**16.05**	**Enc 4.0**	**DM**
5	Capital Programme update	**16.15**	**Enc 5.0**	**NR**
6	Productivity reports	**16.30**	**Enc 6.0**	**CN**
7	Annual Effectiveness Review	**16.45**	**Enc 7.0**	**DL**
8	Annual Work plan 2016/17	**16.50**	**Enc 8.0**	**DL**
9	Review of Terms of Reference	**16.55**	**Enc 9.0**	**DL**
10	Consultancy and Advisory Costs 2015/16	**17.00**	**Enc 10.0**	**AN**
11	Review of Annual Budgets 2016/17	**17.10**	**Enc 11.0**	**BB**
12	Three year Financial Plan 2016/17 to 2018/19	**17.50**	**Enc 12.0**	**BB**
13	Annual Plan narrative	**18.05**	**Enc 13.0**	**CN**
	AOB	**18.15**		
	Dates & times of next meetings: Wed 7th April 8.30-11.00 (Teleconference) Thursday 12th May 14.00-17.00 (Venue TBC) Monday 1st August 14.00-17.00 (Venue TBC) Monday 31st October 14.00-17.00 (venue TBC) Thursday 26th January 2017 14.00-17.00 (Venue TBC) Thursday 23rd March 2017 14.00-17.00 (Venue TBC) Thursday 6th April 2017 14.00-17.00 (Teleconference) Thursday 11th May 2017 14.00-17.00 (Venue TBC)			

Attachment J

Great Ormond Street Hospital for Children NHS Foundation Trust

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

Finance & Activity Report – M12 Outturn

The Committee reviewed the 2015/16 financial outturn.

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

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

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

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

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

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

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

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

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

Great Ormond Street Hospital for Children NHS Foundation Trust

FINANCE AND INVESTMENT COMMITTEE MEETING AGENDA
16 May 2016
9.00-12.00
Charles West Room

Members:

David Lomas (DL)	Chair NED
Akhter Mateen (AM)	NED
Dr Peter Steer (PS)	Chief Executive
Nicola Grinstead (NG)	Deputy Chief Executive
Loretta Seamer (LS)	Chief Finance Officer

Apologies: Charles Tilley

In attendance:

All meeting

James Corrigan (JC)	Interim Deputy Director of Finance
Neil Redfern (NR)	Financial Controller and Minutes

Attending to Present

Claire Newton (CN)	Interim Director of Strategy and Planning
Matt Tulley (MT)	Development Director
Sonal Parmar (SP)	Finance Manager

		Provisional time	Paper Ref	Accountable
1	Apologies for absence	**9:00**		**DL**
1.1	Minutes of the March meeting and action check list	**9:05**	**Enc 1.0** **Enc 1.1**	**DL**
STANDING ITEMS - FOR INFORMATION AND DISCUSSION				
2	Financial activity board report M12 outturn	**9:15**	**Enc 2.0**	**LS**
3	Contract Status Update • 2015/16 Outturn • 2016/17 Contract • Forward View – Commissioner Allocations	**9:25**	**Enc 3.0**	**CN**
4	Operational Performance Update	**9:55**	**Enc 4.0**	**NG**
GOVERNANCE				
5	Annual Effectiveness Review	**10:10**	**Enc 5.0**	**DL**
6	Committee Annual Workplan Update	**10:20**	**Enc 6.0**	**DL**
BUSINESS				
7	Service Line Reporting Update	**10:25**	**Enc 7.0**	**SP**
8	Strategic Outline Case – Phase 4	**10:40**	**Enc 8.0**	**MT**
9	Business Case - Inter Operative MRI	**11:10**	**Enc 9.0**	**LS**
10	Annual Review of Treasury Management	**11:20**	**Enc 10.0**	**NR**
11	Terms of Reference Amendment	**11:30**	**Enc 11.0**	**LS**
12	AOB	**11:40**		
13	***Dates & times of next meetings:*** Thursday 16th June from 12:00-15:00 Charles West Room Monday 1st August from 13:00-16:00 Charles West Room Monday 31st October from 13:00-16:00 Charles West Room Thursday 26th January 2017 from 14:00-17:00 Charles West Room Thursday 23rd March 2017 from 14:00-17:00 Charles West Room Thursday 6th April 2017 from 14:00-17:00 (Teleconference) Thursday 11th May 2017 from 14:00-17:00 Charles West Room			

Attachment L

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

29th June 2016

Appointment of the Deputy Chairman

Summary & reason for item:

In lieu of the departure of Mr Charles Tilley, Deputy Chairman and Non-Executive Director on the GOSH Board of Directors (as a result of reaching the end of his tenure on 31st August 2016), the Members' Council is asked to appoint one of the Non-Executive Directors as the Deputy Chairman from 1st September 2016.

Background

Paragraph 24 of the Constitution states that the Members' Council shall appoint one of the Non-Executive Directors as the Deputy Chairman. The Standing Orders for the Board of Directors (Annex 9 of the Constitution) and the Members' Council (Annex 8) state that the Deputy Chairman will chair the Board of Directors and the Members' Council meeting and members' meetings (Annex 10) should the Chairman be absent or, disqualified from participating due to a conflict of interest. The Deputy Chairman is also a member of the Members' Council Nominations and Remuneration Committee.

The Board of Directors recommends that Mary MacLeod is appointed as Deputy Chairman of the Trust for 6 months following Charles Tilley's departure (until 28th February 2016). Mary has a number of years' experience on the Board and is currently the Senior Independent Director (SID). She has a background as both a social worker and a lecturer in social work. She was a Director and then Deputy Chief Executive of ChildLine between 1991 and 1999, and founding Chief Executive of the Family And Parenting Institute. Mary is currently Deputy Chair of the Child and Family Court Advisory and Support Service (CAFCASS). The Board believes that she will bring the necessary independence, objectivity and knowledge to the role at a time when there are relatively new NEDs on the Board. Under section A.4.1 of NHS Improvement's Code of Governance, the SID can be the deputy chairperson.

At the January 2017 Council meeting, a recommendation will be made for another NED to take on the role from the end of February 2017, in light of Mary's impending departure in August 2017.

Councillor Action Required:

The Members' Council is asked to consider appointing Mary MacLeod as the Deputy Chairman of the Foundation Trust from 1st September 2016 until 28th February 2017.

Report prepared by:

Anna Ferrant, Company Secretary

Item presented by:

Baroness Blackstone, Chairman

Attachment M

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

29 June 2016

Compliance and Governance Update

Summary & reason for item:
To provide the Members' Council with an update on:

- implementation of formal and informal actions following the 2015 scheduled Care Quality Commission (CQC) inspection; and
- the NHS Improvement (previously called Monitor) Well-led assessment process.

CQC Update
Final action plans were submitted to the CQC on 18 March 2016, outlining the Trust's response to the formal requirement notice, 'must do' and 'should do' areas for improvement. These action plans were also circulated to all councillors. The Trust is required to provide the CQC with an update once all actions are completed; however, it is intended an interim update will be provided by correspondence from the Company Secretary (in her capacity as CQC Nominated Lead) in the coming weeks.

Requirement notice:
This requirement notice relates to the RTT and Access Improvement Programme. A detailed update on the progress of this programme will be provided under the Chief Executive's Report.

"Must do and should do" actions:
Of the 8 'must do' and 'should do' actions, all are in progress and either on track to deliver within agreed timeframes or with only minor delays.

Opportunities for improvement:
The Trust created a log of the critical comments made throughout the CQC's inspection report, and is monitoring these as informal opportunities for improvement, outside but in parallel to, the formal CQC monitoring process. These improvement initiatives are all in progress and either on track to deliver within agreed timeframes or with only minor delays.

Well-led Review Update
Under NHS Improvement's 'Risk assessment framework' and in line with the 'Code of Governance', NHS Foundation Trusts are required to carry out an external review of their governance, having regard to NHS Improvement's guidance "*Well-led framework for governance reviews: guidance for NHS Foundation Trusts*"

An independent assessor was appointed in May 2016 and the plan and timeline for the governance review has been agreed.

The Members' Council will be involved in the assessment as follows (and as detailed in an email on 17th June 2016 to the Council):

- contributing to a Members' Council focus group, including approximately 10 councillors (date to be confirmed);
- providing feedback via a survey which will be open from 22 June for approximately two weeks; and

- the Lead Councillor will participate in a 1 hour face to face interview with the assessors.

The purpose is to seek councillors views on various aspects of the Trust's governance arrangements, including engagement, visibility, and views on board effectiveness and leadership.

In addition to work with the Members' Council, the assessors will include:

- A document review
- One-on-one interviews with Board members and other key staff.
- Telephone interviews with external stakeholders.
- Observations of a number of Board and Committee meetings during July and August,
- Surveys of Board members and staff.

A summary of the findings from the assessment will be presented to the November Members' Council meeting.

Councillor action required:
To note the update provided.

Report prepared by:
Rachel Pearce, Compliance and Governance Manager
Anna Ferrant, Company Secretary and CQC Nominated Individual

Item presented by:
Anna Ferrant, Company Secretary

Great Ormond Street Hospital for Children NHS Foundation Trust

Appendix 1

Monitor's Well Led Assessment (Four domains and ten questions)

Outlined below is a headline mapping of the Monitor questions followed by the relevant CQC characteristics of 'good' well-led organisations.

Strategy and planning

Q1 Does the board have a credible strategy to provide high quality, sustainable services to patients and is there a robust plan to deliver?

- There is a clear statement of vision and values, driven by quality and safety. It has been translated into a credible strategy and well-defined objectives that are regularly reviewed to ensure that they remain achievable and relevant.

- The vision, values and strategy have been developed through a structured planning process with regular engagement from internal and external stakeholders, including people who use the service, staff, commissioners and others.

- The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place.

- Strategic objectives are supported by quantifiable and measurable outcomes which are cascaded through the organisation.

- Staff in all areas know and understand the vision, values and strategic goals.

Q2 Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?

- There is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks.

- Service developments and efficiency changes are developed and assessed with input from clinicians to understand their impact on the quality of care. Their impact on quality and financial sustainability is monitored effectively. Financial pressures are managed so that they do not compromise the quality of care.

Capability and culture

Q3 Does the board have the skills and capability to lead the organisation?

- The board has the experience, capacity and capability to ensure that the strategy can be delivered.

- The appropriate experience and skills to lead are maintained through effective selection, development and succession processes.

- The leadership is knowledgeable about quality issues and priorities, understands what the challenges are and takes action to address them.

Q4 Does the board shape an open, transparent and quality-focused culture?

- Leaders at every level prioritise safe, high quality, compassionate care and promote equality and diversity.

- Candour, openness, honesty and transparency and challenges to poor practice are the norm. Behaviour and performance inconsistent with the values is identified and dealt with swiftly and effectively, regardless of seniority.

- The leadership actively shapes the culture through effective engagement with staff, people who use the services, their representative and stakeholders. Leaders model and encourage co-operative, supportive relationships among staff so that they feel respected, valued and supported.

- Mechanisms are in place to support staff and promote their positive wellbeing.

- There is a culture of collective responsibility between teams and services.

- The leadership actively promotes staff empowerment to drive improvement and a culture where the benefit of raising concerns is valued.

Q5 Does the board support continuous learning and development across the organisation?

- Information and analysis are used proactively to identify opportunities to drive improvement in care.

- There is a strong focus on continuous learning and improvement at all levels of the organisation. Safe innovation is supported and staff have objectives focused on improvement and learning.

- Staff are encouraged to use information and regularly take time out to review performance and make improvements.

Process and structures

Q6 Are there clear roles and accountabilities in relation to board governance (including quality governance)?

- The board and other levels of governance within the organisation function effectively and interact with each other appropriately.

- Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.

- Quality receives sufficient coverage in board meetings and in other relevant meetings below board level.

Q7 Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance?

- The organisation has the processes and information to manage current and future performance.

- Performance issues are escalated to the relevant committees and the board through clear structures and processes.

- Clinical and internal audit processes function well and have a positive impact in relation to quality governance, with clear evidence of action to resolve concerns.

Q8 Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?

- A full and diverse range of people's views and concerns are encouraged, heard and acted upon. Information on people's experience is reported and reviewed alongside other performance data.

- The service proactively engages and involves all staff and assures that the voices of all staff are heard and acted on.

- Staff actively raise concerns and those who do (including external whistleblowers) are supported. Concerns are investigated in a sensitive and confidential manner, and lessons are shared and acted upon.

- The service is transparent, collaborative and open with all relevant stakeholders about performance.

Measurement

Q9 Is appropriate information on organisational and operational performance being analysed and challenged?

- Integrated reporting supports effective decision-making.

- Performance information is used to hold management and staff to account.

Q10 Is the board assured of the robustness of information?

- The information used in reporting, performance management and delivering quality care is accurate, valid, reliable, timely and relevant.

- In developing this framework, we consulted experts and reviewed board governance, leadership and quality governance documents alongside our own experience of foundation trust governance.

Attachment N

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

29th June 2016

Chairman and Non-Executive Director (NED) Objectives 2016

Summary & reason for item:

At the Members' Council in November 2015 during a discussion about the appraisal framework for the Chairman and NEDs, it was agreed that specific and measurable objectives would be drafted for consideration for the Chairman and NED appraisal process in December 2016.

A draft copy of the objectives is attached, mapped to the competencies for the Chairman and NED (these competencies were approved in 2015 by the Members' Council).

Councillor action required:
To consider and approve the Chairman and NED objectives for application in the 2016 Chairman and NED appraisal process.

Report prepared by:
Anna Ferrant, Company Secretary

Item presented by:
Anna Ferrant, Company Secretary

Appraisal of the Chairman and Non-Executive Directors 2016

Framework and competencies for Chairman and NEDs

The framework was updated and approved at the November 2015 Members' Council meeting:

- Trust Strategic Objectives
- Performance
- Quality and Risk Management
- People and effective leadership
- Accountability
- Promotion of NHS/Trust values and demonstration of behaviours in line with these values
- Other contributions

Appraisal of the Chairman and Non-Executive Directors

The Chairman and Non-Executive Directors have been appraised against the agreed framework and personal style/leadership competencies listed below. These have been reviewed against the recommendations arising from the Francis Report into the Mid Staffordshire NHS Foundation Trust.

1. Strategic direction (Contributes creatively and realistically to planning; can balance needs and constraints; debates cogently)
2. Intellectual flexibility (Can digest and analyse information; willing to modify own thinking; thinks creatively and constructively; sees the detail as well as the big picture)
3. Influencing and communication (Persuades with well-chosen arguments; uses facts and figures to support argument)
4. Independence and objectivity (Not influenced by personal feelings; opinions or involvement in other activities in considering and representing facts)
5. Openness and transparency (honest, open and truthful in all dealings with patients, the public, staff and stakeholders)
6. Holding to account (Accepts personal accountability; challenges constructively and effectively; contributes to effective governance)
7. Commitment (attends relevant meetings; demonstrates has read documents)
8. Patient and Stakeholder Focus (Understands local health issues; understands diversity of the patient and carer community and its differing viewpoints; engages with the Members' Council and other stakeholders)
9. Team working (Involves others in decision-making process; respects other team members; understands the Non-Executive and Members' Council role; shares expertise and knowledge freely)
10. Leadership style for chairing the Board of Directors and Members' Council (Chairman) or chairing Board committees, seeking assurance on behalf of the Board and escalating matters of significance to the Board (for the Audit Committee, Clinical Governance Committee and Finance and Investment Committee)(Non-executive directors)
11. Demonstrates a commitment to NHS/Trust values; promotes these values and acts in a way which is consistent with these values.

Attachment N

The following objectives are proposed for the 2016/17 appraisal process for the Chairman and the NEDs. The objectives have been mapped to the above approved competencies:

OBJECTIVE 1: Challenges made at Board during the past year are predominantly in relation to strategic matters and the management of corporate risks (competencies 1,2,3)
OBJECTIVE 2: Completes the relevant annual declarations and meets all requirements (annual declaration of interests form and raises any potential or actual conflicts at the beginning of a Board/ committee meeting; annual Fit and Proper Person Test declaration; and, the annual code of conduct declaration) (competencies 4,5)

OBJECTIVE 3: Follows up challenges (outside formal meetings when appropriate), to ensure that questions or concerns have been addressed satisfactorily (competency 6)

OBJECTIVE 4: Undertakes all relevant statutory and mandatory training in accordance with relevant timecales (competency 6)

OBJECTIVE 5: Regular attendance at Board and Board committee meetings and participation in a broad range of topics throughout the year. (competency 7)
OBJECTIVE 6: Attends external events and/or hospital visits and /or meetings with executives and Members' Council meetings during the year to gather information and inform viewpoints (competencies 8, 9)

OBJECTIVE 7: Chairs of the Board/ Board committees have reviewed the effectiveness of their Board/committees (on an annual basis) and the Chair has received reasonable feedback (competency 10)
OBJECTIVE 8: Are courteous to and supportive of other Board members (competency 11).

Attachment O

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

29th June 2016

Update on compliance with the policy on the engagement of the external auditors to undertake additional services

Summary & reason for item:

The Members' Council approved the current policy in June 2014 (attached at Appendix 1).

In the policy, delegated authority is given to the Chief Executive/ an Executive Director (amounts below £10k) and the Audit Committee (amounts above £10k) for commissioning additional services from the external auditor provided that the proposed services met certain criteria.

The audit committee oversees the relationship with the auditors and keeps the nature and extent of non-audit services under review. The audit committee must satisfy itself that the independence and objectivity of the auditor are not compromised by other work.

Application of the policy in 2015/16

During 2015/16, Deloitte did not undertake any non-audit work for the Trust on either a paid or pro bono basis.

In Q1 2016/17, Deloitte LLP was appointed, following an open competition to conduct a Well Led Governance Review at GOSH. An independent engagement partner and team will conduct the review and the Trust has been given assurances that there will be no consultation between the review team and the external audit team. The Audit Committee has reviewed the appointment (the amount to be paid is over £10k) and is satisfied that that the independence and objectivity of the auditor will not be compromised by this appointment and that the necessary safeguards are in place with the appointment of an independent engagement partner.

Councillor action required:

To note the report.

Report prepared and presented by:

Anna Ferrant, Company Secretary

Attachment O

APPENDIX 1

Policy on the engagement of the external auditors to undertake additional services

Section 2.12 of Monitor's Audit Code states that:

'*The auditor may, with the approval of the Board of Governors, provide the NHS Foundation Trust with services which are outside of the scope of the audit as defined within the code (additional services). The Trust shall adopt and implement a policy for considering and approving any additional services to be provided by the auditor*'.

Under the NHS Foundation Trust Code of Governance, it is the Audit Committee's (AC) role to develop and implement this policy, taking into account relevant ethical guidance regarding the provision of additional services by the external audit firm. It is also the AC's responsibility to report to the Members' Council, identifying any matters in respect of which it considers action or improvement is needed and making recommendations as to the steps to be taken.

Proposed Approval Process

The Audit Code makes it clear that the Members' Council's approval is required for the auditor to provide additional services.

In general, the Trust will seek to avoid the involvement of its external auditors in additional services.

There will be some circumstances, however, where such involvement is appropriate and, indeed, advisable, or a compelling case can be made for such involvement. Such circumstances include, but are not limited to, the following;

- Audit related services – not actually part of the agreed audit scope but closely related to it, including (but not limited to) assistance in reviews and tests of accounting control and related systems, assessments of the design and implementation of internal accounting controls, and undertaking due diligence.

- Other services where the use of the external auditor creates synergy in the form of efficiency or minimised disruption, provided independence is not impaired, i.e. VAT or tax consultancy work.

- Where the audit firm has skills and experience in their non-audit services which cannot be obtained from any similar organisation. It is only envisaged that there would be few instances where this would apply.

- *Where the audit firm has voluntarily offered to provide services involving the provision of specialist skills and experience on a pro bono basis in support of a strategic development of the Trust provided that these services do not relate to the development of financial systems or operational systems which provide information required for determining financial transactions.*

However, there are some services that are explicitly not to be provided by the Trust's external auditor, which include the following:

- Management of, or significant involvement in, internal audit services
- Secondments to management positions that involve any decision making.
- Any work where a mutuality of interest is created that could compromise the independence of the external auditor.
- Any other services which are defined as prohibited within relevant directives and guidance.

The Members' Council will be asked to delegate specific authority for commissioning additional services as follows:

- The Chief Executive and one other Executive Director will be responsible for considering and commissioning non-audit work by the auditors under £10k (excluding VAT).
- The Audit Committee will be responsible for considering and commissioning non-audit work by the auditors over £10k (excluding VAT).

Each decision will be taken on a case by case basis and in doing so, consider whether the Trust's External Auditors or any other organisation is best placed to provide the service. The decision will be based on relevant experience and expertise in that particular area and having regard to the circumstances described above.

Key factors to be considered in approving services include the following:

- whether, in the judgement of a reasonable and informed third party, the objectivity of the external auditor would be threatened by:
    - the nature of the service; or
    - the significance of the fee to the firm or to the audit partner
- the safeguards put in place by the external auditor to protect the objectivity and independence of the audit
- the extent to which business knowledge of the external auditor makes it more effective or cost-efficient to instruct them.

The Audit Committee will monitor the use of external auditors to carry out non-audit work on an annual basis and report this to the Members' Council.

For each and all individual elements of additional service work, the Trust will supply an Additional Services Engagement Letter, which will set out the detailed proposals for each and every specific area under review including the scope, timing, relevant responsibilities, cost and resource information along with the timescales for completing the work and reporting findings to the Trust.

This letter will also seek confirmation that the auditor will be able to safeguard their independence in each case and the specific steps it will take to assure the Audit Committee of this.

All external audit work, will, as a matter of course, be summarised in the External Auditor's Annual Audit Letter. This will include any work undertaken as part of any agreed additional services element of their Strategic Plan. The External Auditor will present this Letter to the Audit Committee, Board of Directors and the Members' Council.