Great Ormond Street Hospital for Children NHS Foundation Trust

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST
MEETING OF THE MEMBERS' COUNCIL
Wednesday 28th June 2017
4:30pm – 6.30pm
Charles West Room, Paul O'Gorman Building

NO.	ITEM	ATTACHMENT	PRESENTER	TIME
1.	**Welcome and introductions**		Mary MacLeod, Interim Chairman	4:00pm
2.	**Apologies for absence**		Interim Chairman	
3.	**Declarations of interest**		Interim Chairman	
4.	**Minutes of the meeting held on 26th April 2017**	**A**	Interim Chairman	
5.	**Matters Arising and action log**	**B**	Interim Chairman	
	PATIENTS, FAMILIES AND MEMBERS			
6.	**Update on implementation of the Always Values**	**C**	Ali Mohammed, Director of HR and OD	
7.	**Updates from the Membership Engagement, Recruitment and Representation Committee including** • **Membership Strategy update** • **Election Planning Update**	**D**	Carley Bowman, Chairman of MEC	4:25pm
8.	**Update from the Young People's Forum (YPF)**	**E**	George Howell, Councillor and YPF member	4:40pm
9.	**Update from the Patient and Family Experience and Engagement Committee**	**F**	Juliette Greenwood, Chief Nurse	4:50pm
10.	**Councillor activities**	**Verbal**	All Councillors	5:00pm
	PERFORMANCE			
11.	**Quality Report 2015/16 including External Auditor Report 2015/16**	**G**	Dr David Hicks, Interim Medical Director	4:15pm
12.	**Chief Executive Report (Highlights and Performance)**	**H**	Dr Peter Steer, Chief Executive & Executive Directors	5:10pm

	GOVERNANCE			
13.	**Reports from Board Assurance Committees** • **Quality and Safety Assurance Committee (April 2017)** • **Audit Committee (May 2017 and agenda) including:** ○ **external auditors' report 2016/17** ○ **request for extension to the External Auditor contract** ○ **application of the policy for non-audit work** • **Finance and Investment Committee Summary Report (May 2017 and agenda and verbal update on June meeting and agenda)**	**I** **J** **J1** **J2** **J3** **K**	Stephen Smith, Chair of the QSAC Akhter Mateen, Chair of the Audit Committee/ Loretta Seamer, Chief Finance Officer David Lomas, Chairman of the F&I Committee	5:45pm
14.	**Well Led Governance Review Update**	**L**	Anna Ferrant, Company Secretary	
15.	**MC Nominations and Remuneration Committee terms of Reference and nominations to sit on the Committee**	**M**	Anna Ferrant, Company Secretary	
16.	**Process for appointment of two NEDs**	**N**	Mary MacLeod, Trust Interim Chairman	5:55pm
	FOR INFORMATION			
17.	**Dates of Trust Board, Trust Board subcommittee and Members' Council meetings**.	**O**	Anna Ferrant, Company Secretary	6:30pm
18.	**Any Other Business**	**Verbal**	Chairman	
19.	**Meeting closes**			

ATTACHMENT A

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT MINUTES OF THE MEMBERS' COUNCIL MEETING
26th April 2017
Charles West Boardroom

Baroness Tessa Blackstone	Chair
Ms Fran Stewart	Patient and Carer Councillors: Parents and Carers from London
Mr Matthew Norris	
Ms Mariam Ali	
Ms Claudia Fisher	Patient and Carer Councillors: Parents and Carers from outside London
Dr Camilla Alexander-White	
Mr George Howell	Patient and Carer Councillors: Patients outside London
Ms Sophie Talib	Patient and Carer Councillors: Patients from London
Mr Simon Hawtrey-Woore	Public Councillors: North London and Surrounding area
Ms Rebecca Miller	
Mrs Gillian Smith	Public Councillors: South London and surrounding area
Mr Stuart Player	Public Councillor: The rest of England and Wales
Ms Jilly Hale	Staff Councillors
Mr Rory Mannion	
Rev Jim Linthicum*	
Dr Prab Prabhakar	
Professor Christine Kinnon	Appointed Councillor: UCL Institute of Child Health
Cllr Jenny Headlam-Wells	Appointed Councillor: London Borough of Camden
Ms Lucy Moore	Appointed Councillor: self management UK

In attendance:

Ms Mary MacLeod	Non-Executive Director
Mr James Hatchley	Non-Executive Director
Mr David Lomas	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
Ms Juliette Greenwood	Chief Nurse
Mr Matthew Tulley	Director of Development
Mr Ali Mohammed	Director of HR and OD
Dr David Hicks	Interim Medical Director
Dr Anna Ferrant	Company Secretary
Ms Victoria Goddard	Trust Board Administrator
Ms Deirdre Leyden	Membership and Governance Manager

Ms Herdip Sidhu-Bevan	Assistant Chief Nurse Quality and Patient Experience
Ms Bridgette Williams	Senior Internal Communications Officer
Ms Janine Smith	Independent Leadership and Governance Practitioner
Mr Peter Hyland*	Director of Operational Performance and Information
Professor Neil Sebire*	Professor of Paediatric and Developmental Pathology
Mr Richard Collins*	EPR Programme Director
Ms Sarah Trewella*	Deputy Director of ICT
Ms Faiza Yasin*	Chair of the Young People's Forum
Dr Tim Liversedge*	Consultant Anaesthetist
Professor Andrew Taylor*	Professor of Cardiovascular Imaging and Co-Chair of the West Division

**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 Edward Green, Patient and Carer Councillor; Mrs Carley Bowman, Patient and Carer Councillor; Mr David Rose, Public Councillor; Ms Clare McLaren, Staff Councillor; Ms Hazel Fisher, Appointed Councillor; Mr Muhammad Miah, Appointed Councillor; Mr Trevor Fulcher, Public Councillor; Ms Teskeen Gilani, Public Councillor.
2	**Declarations of Interest**
2.1 2.2	The register of Councillors' interests was noted. No specific declarations of interest were received for the April meeting.
3	**Minutes of the meeting held on 1st February**
3.1	Minute 84.1 to be revised to make it clear that the Constitution Working Group is being re-established rather than has been 'reformed'.
4	**Matters Arising and action log**
4.1	Minute 73.2 – It was agreed that the schedule of matters reserved for the Trust Board and Members' Council would be circulated outside the meeting.
5	**Updates from the Membership Engagement, Recruitment and Representation Committee including Membership Strategy update**
5.1 5.2	Mrs Gillian Smith, Public Councillor said that the Membership Engagement, Recruitment and Representation Committee (MERRC) had discussed the AGM with a theme of 'One GOSH'. The Committee had discussed the minimum age for membership which was currently 10 years and were broadly in favour of reducing this but it was agreed

	that further work was required to consider the resourcing implications of communicating with very young members.
5.3	It was reported that the Council was taking forward the skills matrix work which would be helpful for succession planning and had welcomed the reinstatement of walkrounds.
5.4	The Committee emphasised the importance of Councillors completing their mandatory training.
5.5	**Action:** It was noted that a proposed date of 14th September 2017 had been identified for the GOSH AGM and it was agreed that Dr Anna Ferrant, Company Secretary would email the Council to ensure it was suitable.
6	**Update from the Young People's Forum (YPF)**
6.1	Mr George Howell, Patient and Carer Councillor and member of the YPF said that following a workshop which had taken place on phase 4, two YPF members had taken part in the interview process for bidders in the design competition.
7	**Update from the Patient and Family Experience and Engagement Committee (PFEEC)**
7.1	Ms Juliette Greenwood, Chief Nurse presented the report and highlighted the widespread of the issues which where categorised under 'communication' for the purposes of PALS contacts and complaints.
8	**Councillor activities**
8.1	Councillors reported their participation in the following activities: • Mr Edward Green, Patient and Carer Councillor attended a Governor seminar run by Deloitte around Sustainability and Transformation Plans and cyber security • **Action:** Councillors had attended information displays for the evaluation of phase 4 and provided feedback. It was agreed that updates would continue to be provided on progress with phase 4 at Council meetings.
9	**Update on progress with the Well Led Governance Review action plan CQC action plan**
9.1	Dr Anna Ferrant, Company Secretary said that the Trust had completed 17 of the recommendations from the Well Led Review. Work continued on areas of the Board development programme, implementing a cultural barometer and taking forward 360 degree appraisals.
9.2	Ms Mary MacLeod, Non-Executive Director gave an overview on the work that was taking place on the recommendation about the relationship between the Board and Council. The Well Led Review Group had met three times and recruited Ms Sue Rubenstein and Ms Janine Smith who were Independent Leadership and Governance Practitioners to facilitate the work. Ms MacLeod noted that it was proving challenging to agree a date for the first engagement session. Six Board Members and seven Councillors would be interviewed by

	telephone prior to the engagement session and it had been agreed that Councillors being interviewed would take forward the views of any Councillors who felt they had additional issues to raise that would not already be covered under current arrangements.
9.3	It was agreed that it was unlikely that all Councillors would be present at the engagement workshop. Ms MacLeod and Ms Claudia Fisher, Patient and Carer Councillor and Lead Councillor had agreed to put in place a buddying arrangement both before and after the workshops.
9.4	Councillors expressed concern at the decision not to use webex or dial-in technology to enable those who could not attend the meeting in person to participate. It was noted that attendance was often particularly difficult for those Councillors who did not live in London. Ms Mary MacLeod, Non-Executive Director said that it was important that challenging matters were discussed face to face and highlighted that the session would be a workshop and was therefore not likely to be suited to individuals who were not present in person. Mr Stuart Player, Public Councillor said that there were systems available to enable engagement from offsite. The Board and Members' Council welcomed the number of Councillors who were keen to take part in the workshop.
9.5	It was agreed that although the Trust would not be able to support the use of webex or dial in for the workshops, the use of the buddy system would ensure that people who were able to attend one of the two sessions would be able to receive feedback and provide input to both.
9.6	**Action:** Ms Fisher noted that Friends and Family Test posters had been provided to all wards areas and the listening event had taken place in response to recommendation 22. She queried what was being done for staff and asked for assurance that actions would be on-going. Dr Ferrant said that there were a number of feedback routes for staff such as staff friends and family test, breakfast meeting with the Chief Executive and members of the Executive Team and all staff forum events. It was confirmed that this work was on-going and it was agreed that these details would be added to future reports.
9.7	Dr Ferrant reported that there was only one outstanding recommendation from the CQC report which was around mandatory training and this was being completed in line with the action plan.
9.8	Ms Fisher highlighted the recommendation that the contribution of nurses should be fully reflected in the hospital's vision and asked how this had been done. Dr Peter Steer, Chief Executive said that the Trust was clear that nursing recruitment and retention was a critical risk and there was significant activity taking place to ensure that the matter was at the forefront of GOSH's work.
10	**Update on the GOSH Refreshed Strategy and annual plan 2017/18**
10.1	Mr Peter Hyland, Director of Operational Performance and Information presented the refreshed strategy and confirmed that it had been approved by the Trust Board, subject to some minor amendments, at its April meeting.
10.2	Discussion took place about the references to children rather than children and young people and it was agreed that young people should be fully embedded in

	the strategy.
10.3	The Council noted that there had been growth in International Private Patient revenue and Mr Matthew Norris, Patient and Carer Councillor asked for a steer on the drivers and constraints of this growth. Ms Loretta Seamer, Chief Finance Officer said that the opening of a new IPP ward had been a key driver of growth in the previous year and the full year effect would be felt in the current financial year. Dr Anna Ferrant, Company Secretary reminded the Council that the previous cap that had existed on IPP work had been lifted and the Council had a duty to review IPP activity in the event that there was growth in non-NHS activity of 5% of the Trust's total income.
10.4	**Action:** Ms Claudia Fisher, Patient and Carer Councillor said that the Council was very clear that NHS patients should not be disadvantaged as a result of IPP work and it was agreed that the IPP working group would be re-established and would develop a format for reports to the Members' Council which would be received on a biannual basis.
10.5	Dr Peter Steer, Chief Executive emphasised that that Board was clear that NHS patients should not be disadvantaged by IPP work but highlighted the important and significant contribution that this activity made to support NHS work. He added that the Trust should provide clear reports to the Members' Council to evidence the work that was being done to ensure NHS patients were not disadvantaged.
10.6	<u>Digital Roadmap</u>
10.7	A presentation was provided on the development and implementation of a digital roadmap at GOSH including the implementation of the Electronic Patient Record (EPR).
10.8	Ms Rebecca Miller, Public Councillor noted the scale of the EPR project and asked whether other Trusts in the UK had undertaken this to a similar extent. Mr Richard Collins, EPR Programme Director said that Cambridge University Hospital NHS Foundation Trust were the most similar project in the UK which had also implemented the Epic system. Work had taken place with Cambridge to learn lessons from their implementation.
10.9	Ms Sophie Talib, Patient and Carer Councillor highlighted the importance of ensuring that GOSH systems were able to communicate with those operated by local hospitals and GPs. Ms Sarah Trewella, Deputy ICT Director confirmed that alongside this being crucial area for patients, a key part of the NHS England Digital Maturity scoring was around the ability to share information and therefore it was vital for Trusts to be able to do this.
10.10	Ms Fisher emphasised the importance of considering the family experience alongside that of the patient. It was confirmed that a parent representative had been part of the governance processes and Dr Tim Liversedge, Consultant Anaesthetist said that it had been clear from visits to other organisations that the use of the patient portal had not been fully optimised. He said that GOSH had ensured that this would be implemented in the initial phase to allow time to optimise the system.
10.11	Dr Prab Prabhakar, Staff Councillor asked for a steer on what had been seen to

	be key points of a successful implementation at other sites. Mr Collins said that Executive support and ownership of the programme as well as engagement with staff around the transformation had been extremely important. He confirmed that over 200 members of staff had been involved in the project so far and work was taking place with other organisations to learn from them. Ms Faiza Yasin, Chair of the Young People's Forum provided an overview of the way in which the Trust's Always Values had been considered in the development of the Full Business Case.
10.12	Mr Matthew Norris, Patient and Carer Councillor asked how the Finance and Investment Committee had been assured that the process had been and would continue to be subject to sufficient scrutiny. Mr David Lomas, Chairman of the Finance and Investment Committee confirmed that an update was received at each meeting and discussions had been held around vendor selection, change management and learning from other organisations. Mr Akhter Mateen, Chairman of the Audit Committee confirmed that the project was discussed by the Audit Committee from a point of view of self-assurance on a regular basis and would be subject to a further internal audit in due course. Mr Collins confirmed that external assurance was sought at each gateway point.
10.13	**Action:** It was agreed that a cyber security update would be provided at the next meeting.
10.14	<u>Congenital Heart Disease Consultation in England</u>
10.15	Professor Andrew Taylor, Professor of Cardiovascular Imaging and Co-chair of the West Division gave a presentation on the consultation that was taking place on the outcome of the Safe and Sustainable review into Congenital Heart Disease services for children and adults. It was reported that there was potential for GOSH to take on additional work if the outcome of the review was carried forward and GOSH was taking part in the NHS England nursing workstream to look at recruitment and retention to support the Trust in this work.
10.16	**Action:** It was agreed that an email would be circulated to the Council giving the details of the public consultation. If further information was available about the public meetings which had been affected by purdah, this would also be included.
11	**Update on work of the Members' Council Nominations and Remuneration Committee**
11.1	<u>Chairman Recruitment Process</u>
11.2	Ms Mary MacLeod, Non-Executive Director said that the Committee had agreed a shortlist of five very strong candidates and a stakeholder meeting was taking place on 3rd May. A training session was being held for councillor interview panel members and an extraordinary Members' Council meeting would be called to approve the Committee's recommended candidate.
11.3	<u>Chairman and NED Objectives 2017</u>
11.4	Dr Anna Ferrant, Company Secretary presented the proposed Chairman and NED objectives which would be in place until a review would be undertaken by the new chairman and following the introduction of 360 degree appraisals.

	The following amendments were agreed: • Link objective 9 to a competency • Include mention of families in competencies 5 and 8.
11.5	Subject to the above amendments, the Council **approved** the objectives.
11.6	<u>Appointment process for a NED on the GOSH Board</u>
11.7	Dr Ferrant said a NED was being sought to replace Ms Mary MacLeod who would be stepping down at the end of October 2017. She confirmed that the papers had been considered by the Members' Council Nominations and Remuneration Committee and it was proposed that the Trust used recruitment consultants as recommended by the Well Led Review Group. The Council was informed that the Board had endorsed the costs. It was also proposed that Harvey Nash was used as they were familiar with the organisation and had previously been successful in searching for high calibre candidates for GOSH.
11.8	A person specification would be considered by the Board and the Council subcommittee. Approval for the person specification would be sought at the extraordinary Members' Council meeting which would be called to approve the Chairman.
11.9	The Council discussed the terms and conditions of the role, particularly the time commitment required of 2.5 days per month. They expressed concern that the time required would be greater than this and suggested that this should be clearly expressed.
11.10	Mr David Lomas, Non-Executive Director highlighted the importance of attracting suitable individuals who would be committed to GOSH. He said that it was vital not to deter potential high calibre candidates with an overly burdensome time commitment. Dr Ferrant confirmed that 2.5 days per month was standard across the NHS. Mr James Hatchley, Non-Executive Director agreed and said that the expectations of the role would be clear following discussion with head hunters and key GOSH individuals.
11.11	**Action:** Mr George Howell, Patient and Carer Councillor suggested that patients and young people should be involved in the recruitment. It was agreed that work would take place to look at how this would be taken forward.
11.12	<u>Chairman and NED remuneration</u>
11.13	Dr Ferrant said that the Members' Council Nominations and Remuneration Committee had discussed the matter and proposed the following: • maintain the level of remuneration of the Chairman and Non-Executive Directors and not apply a cost of living uplift for 2017/18 • benchmarking of salaries and the application of a cost of living allowance to be undertaken on a three yearly basis • Ms MacLeod to take on the Chairman salary on a pro rata basis for the time during which she is Interim Chairman.
11.14	The Council **approved** the proposals.

12	**Appointment of Deputy Chairman and Senior Independent Director at GOSH**
12.1	The Council **approved** the appointment of Mr Akhter Mateen as Deputy Chairman and Mr James Hatchley as Senior Independent Director from 1st May 2017.
13	**GOSH Constitution Working Group**
13.1	The Council noted that one vacancy remained on the Constitution Working Group and one nomination had been received from Ms Gillian Smith, Public Councillor. The Council **endorsed** Ms Smith's appointment to the group.
14	**Reports from Board Assurance Committees**
14.1	Quality and Safety Assurance Committee (April 2017 agenda)
14.2	Ms Mary MacLeod, Chair of the Quality and Safety Assurance Committee said that the Committee had welcomed the appointment of a new substantive Named Doctor for Safeguarding following a period where an interim had been in place. She said that this was particularly important in light of the increase in safeguarding work at the Trust in line with national increases.
14.3	Dr Prab Prabhakar, Staff Councillor emphasised the importance of ensuring that the Named Doctor role was sufficiently well supported.
14.4	Audit Committee (April 2017 agenda)
14.5	Mr Akhter Mateen, Chair of the Audit Committee said that the Committee had discussed the Board Assurance Framework risks concerning financial sustainability and International Private Patients (IPP). He said that there had been considerable positive work around financial sustainability however the significant productivity and efficiency targets required focus. There had been some improvement in IPP debtor days but this remained high.
14.6	Four internal audit reports were received which all had provided significant assurance with minor improvement potential as had the draft Head of Internal Audit Opinion for 2016/17. The Committee had approved the 2017/18 internal audit plan.
14.7	Finance and Investment Committee Summary Report (March 2017) (and agenda)
14.8	Mr David Lomas, Chair of the Finance and Investment Committee highlighted the end of year results for 2016/17 and the significant achievement of the Executive Team in exceeding the control total. He added that the budget for 2017/18 was very challenging.
15	**Chief Executive Report (Highlights and Performance)**
15.1	Dr Peter Steer, Chief Executive gave an update on the following matters: • GOSH had returned to RTT reporting and was almost at the national target. The Trust was an exemplar for the NHS in this area. Dr Steer commended the staff involved for their work. • Over 700 people provided feedback on the designs for the phase 4

	competition. • Significant publicity had been received around one of the Trust's ICU patients. Work was taking place to support staff and GOSH was working as constructively as possible with the parents given the very difficult circumstances.
16	**Appointment of an Interim Deputy Lead Councillor**
16.1	Dr Anna Ferrant, Company Secretary said that one nomination had been received from Ms Mariam Ali, Patient and Carer Councillor. Ms Ali was unanimously endorsed as Interim Deputy Lead Council until the end of her term.
	<u>Endorsement of the Lead Councillor</u>
16.2 16.3	The Council unanimously endorsed the continuation of Ms Claudia Fisher, Patient and Carer Councillor as Lead Councillor until the end of her term.
17	**For information**
17.1	The Council noted the dates of Trust Board, Trust Board subcommittee and Members' Council meetings for the rest of 2017.
17.2	A video which had been developed by the GOSH Children's Charity and was available on the Trust's website was played.
18	**Any other business**
18.1	It was noted that it was Baroness Blackstone, Chairman last Members' Council meeting before stepping down on 30th April 2017. Ms Mary MacLeod, Non-Executive Director thanked Baroness Blackstone on behalf of the Trust for eight years of outstanding leadership.
18.2	Ms Claudia Fisher, Patient and Carer Councillor thanked Baroness Blackstone on behalf of the Members' Council for her commitment to GOSH.

ATTACHMENT B

Attachment B

MEMBERS' COUNCIL - ACTION CHECKLIST
June 2017

Checklist of outstanding actions from previous meetings

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
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**	**June 2017**	A draft calendar of presentation topics to be developed for consideration by the Council – September 2017
73.2	07/12/16	It was agreed that further updates to the schedule of matters reserved for the Trust Board and Members' Council would be circulated with tracked changes to show the updates that had been made.	**AF**	**June 2017**	Circulated to councillors by email with the MC Papers
5.5	26/04/17	The Company Secretary to circulate the preferred date for the 2017 AGM to the Council to ensure that it was a suitable date.	**AF**	**May 2017**	Actioned and in Councillor outlook calendars
9.6	26/04/17	It was agreed that the next update on the well led recommendations would outline the work that was taking place with staff to hear their views and to be clear that work was on-going.	**AF**	**May 2017**	On agenda
10.4	26/04/17	It was agreed that a biannual update on IPP work would be considered by the Council. The IPP working group to be re-established and develop a format for the Council update.	**TC** **TC**	**September 2017**	The working group will be re-established in July 2017 and an update provided to the September and April meetings of the Council

Attachment B

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
10.13	26/04/17	It was agreed that a cyber security update would be provided at a future meeting.	**NG**	**September 2017**	Not yet due - A draft calendar of presentation topics to be developed for consideration by the Council – September 2017
10.16	26/04/17	Professor Andrew Taylor agreed to circulate an email to Councillors including the link to the public consultation on the outcome of the Safe and Sustainable Review into Congenital Heart Disease services. If further information was available around the public meetings which had been affected by purdah this would also be included.	**Andrew Taylor**	**May 2017**	To follow
11.4	26/04/17	The following amendments to the Chairman and NED objectives were agreed: • Link objective 9 to the competencies provided • Include families in competency 5 • Add a patient and family focus under point 8	**AF**	**June 2017**	Actioned

Great Ormond Street Hospital for Children
NHS Foundation Trust

Our Always Values

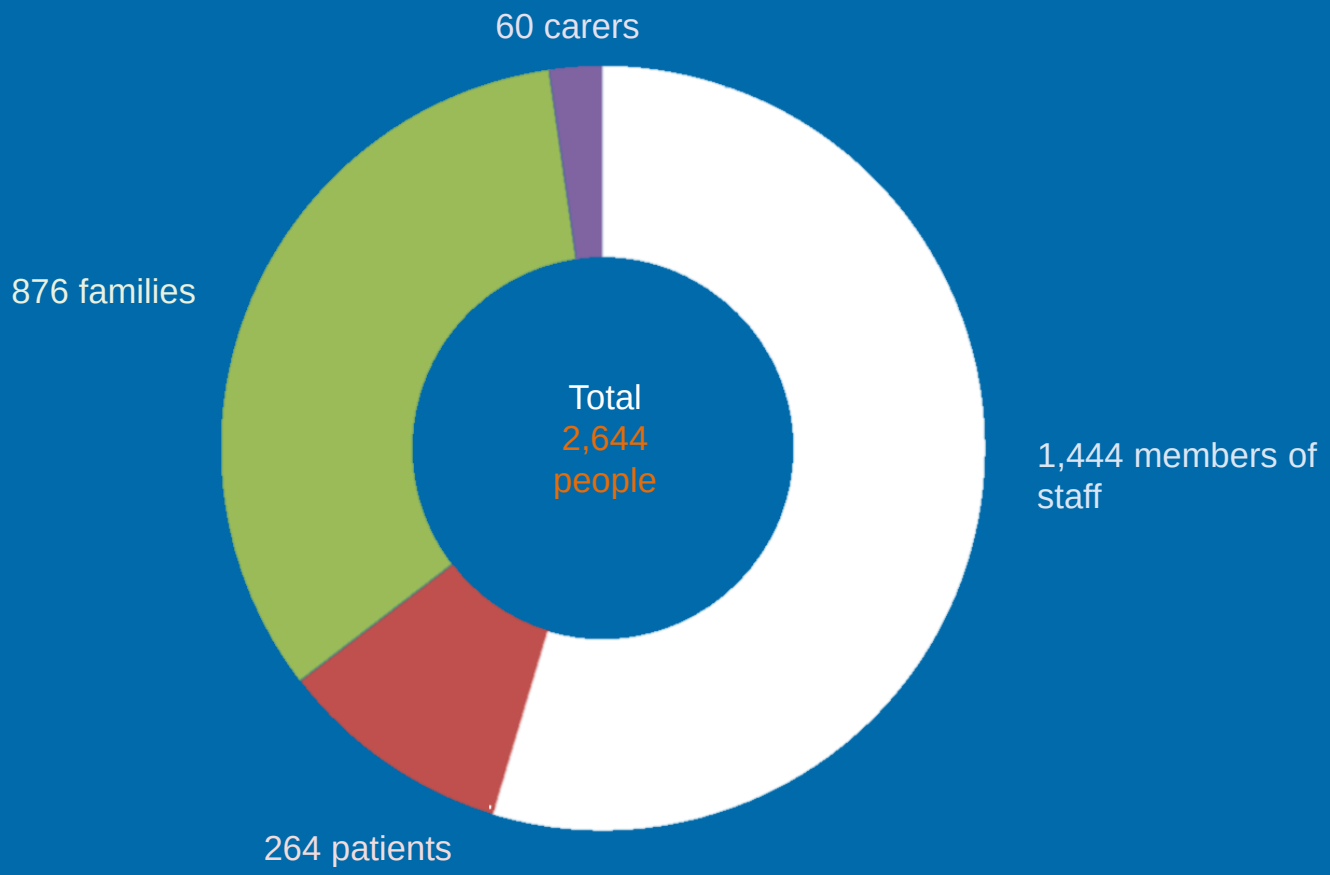
June 2017

The child first and always

History of Our Values

Great Ormond Street Hospital for Children NHS Foundation Trust

Over 2500 people defined our values through comments they presented to the Trust at an event.



The child first and always

Great Ormond Street Hospital for Children
NHS Foundation Trust

Why values?

We asked patients, families and carers about their experience at GOSH, this is what they said.

Always

Welcoming

Helpful

Expert

One Team

Governance Arrangements for Launching and Embedding Values

Steering Board includes the Chief Executive and several other Directors

Organisational Development Delivery Group is a multi-professional group which successfully launched the values in March 2015 and has continued to work to embed the values in the Trust.

Parents are included in both groups.

Embedding the Values in the Trust

Great Ormond Street Hospital for Children NHS Foundation Trust

Developing our people and meeting the challenges of the Well-Led domain of CQC

- Values-based leadership and management development, this includes the recently launched Band 6 and Matron development programmes
- All programmes will focus on development of our leaders as role models
- Values will be integrated into Board development and 360 degree feedback for Board members
- Values are currently integrated into recruitment & selection, PDR's/appraisals and Induction
- There is alignment with actions around equality, diversity and inclusion

Embedding the Values in the Trust

Great Ormond Street Hospital for Children NHS Foundation Trust

Key projects and developments of the Trust include engagement with groups such as YPF, PFEEC, LNC and SPF.

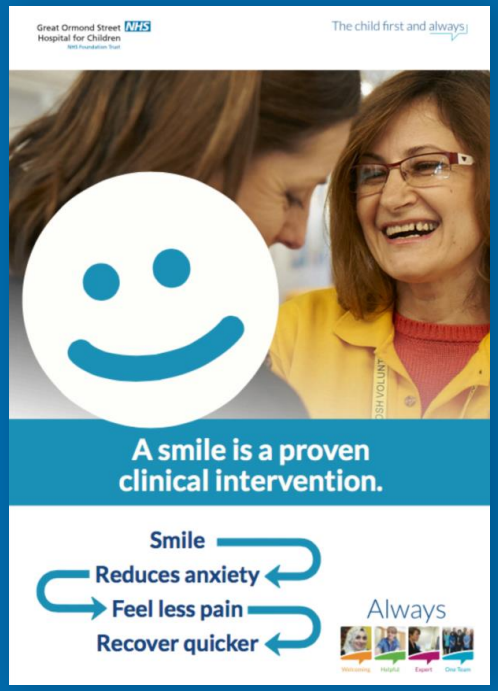
For example:

- The design exhibition for Phase 4. Over 300 feedback forms were received. Specific sessions were also held for GOSHCC, Patient Experience, Member's Council and the Clinical Reference Group.
- 200 staff plus patients and families involved in setting the requirements for EPR
- Values are linked in to the 360 degree appraisal process for consultants
- Working with local partners to develop apprenticeships with over 75 last year and 100 planned for this year.
- Project Search-allowing people with Learning Disabilities to work at GOSH
- Developing children and young peoples' involvement in recruitment and selection

Embedding the Values in the Trust

Embedding ‘Always Welcoming’

- Staff involved in developing ‘welcoming’ by the use of role play and practice scenarios.
- Launching ‘SHOW’ to patients to involve them to improve welcoming throughout the department.
- A trial of an outpatient route map will be included.
- ‘SHOW’ week in September
- Activities to encourage children to get involved.



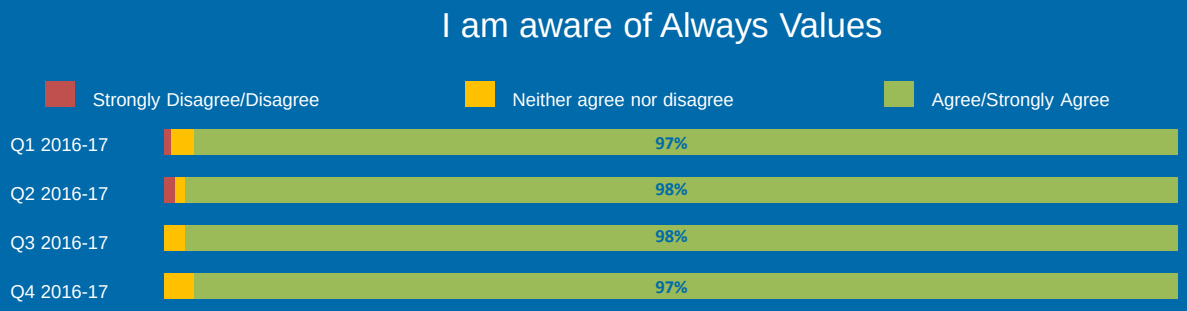
Our Always Values

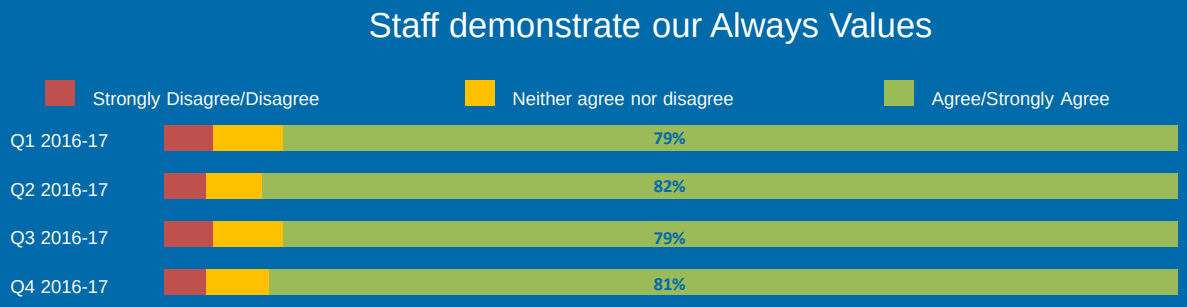
Promotional Material

Recognition & Demonstration of values

Great Ormond Street Hospital for Children NHS Foundation Trust

Staff Friends and Family Test





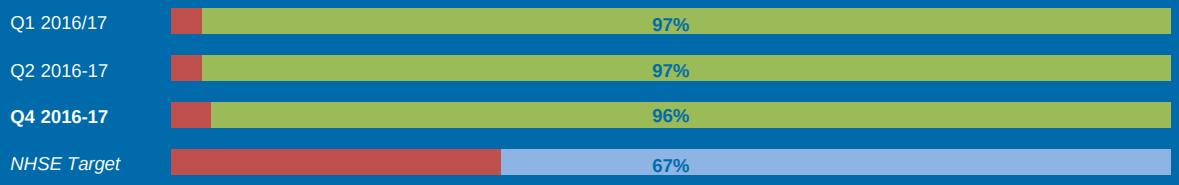
The child first and always

Recognition & Demonstration of values

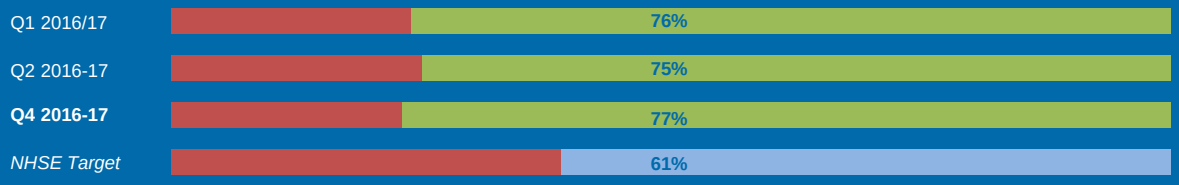
Great Ormond Street Hospital for Children NHS Foundation Trust

Staff Friends and Family Test - Response rate (Q4) 655 staff

How likely are you to recommend this organisation to friends and family if they needed care or treatment?



How likely are you to recommend this organisation to friends and family as a place to work?



The child first and always

Analysis of free text

Friends and Family Test Comments

- The extreme satisfaction I feel from working at GOSH is second to none. It really feels like everyone works as a team as all our goals are the same, to make children better.’
- ‘Kind, patient people, always there to help you.’
- ‘I think the values are excellent and generally espoused. I think the one lacking is Always One Team.’

Staff Awards

Great Ormond Street Hospital for Children NHS Foundation Trust

Each year a staff awards evening is hosted with winners from across the hospital. This year we are celebrating over 250 people who have received a qualification over the last 12 months. We also celebrate those who have received long service awards, 98 x 10 year, 35 x 20 year, 18 x 25 year, 6 x 30 year , one 35 year and one 40 year.

The categories are;

- Improvement Champion
- Colleague of the Year
- Team of the Year
- Leader of the Year
- Child and Family Award
- Research Champion
- Volunteer of the Year
- Staff Development Champion
- The Gwen Kirby Award donated by the Nurses League
- Apprentice of the Year
- Mentor of the Year
- Preceptor of the Year
- Student Nurse of the Year
- Practice Educator of the Year
- Vanessa Garside Award

Staff Awards

Dr. Clarissa Pilkington and Eagle Ward

GEMS

Great Ormond Street Hospital for Children NHS Foundation Trust

GEMS stands for Great Ormond Street Hospital Exceptional Members of Staff and were introduced in 2014. The process includes staff , parents and previous winners get involved in selecting the next winners.

The categories are compiled of;

- GEMS Team of the Month
- GEMS Clinical Individual of the Month
- GEMS Non-Clinical Individual of the Month

There have been 98 GEMS winners across the hospital since the awards began. That is 41 teams and 57 individuals. All winners receive a presentation by Director of HR&OD, who comes to their place of work to notify them of the win and are then presented at the All Staff Talk by the Chief Executive.

Resuscitation and Clinical Site Practitioners

April 2017 Team Winners


Great Ormond Street
Hospital for Children
NHS Foundation Trust
NHS
Thank
You

Thank you

Attachment D

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

28 June 2017

Updates from the Membership Engagement Recruitment and Representation Committee held on 7 June 2017 including Membership Strategy update (as at 1 June 2017)

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

1. Membership Engagement Recruitment and Representation Committee held on 7 June 2017
2. Membership Strategy update including statistics as at 1 June 2017 – (on power point presentation format)

Report prepared by: Deirdre Leyden, Membership and Governance Manager

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

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

Attachment D

Membership Engagement Recruitment and Representation Committee Update from Meeting held on 7 June 2017

1.1 2017 AGM – planning

Date now confirmed as 14 September, 6pm-7:30pm, venue: Weston House Lecture Theatre. Costing options for using periscope as a live streaming and high light filming option was discussed further. The Trust Board will need to approve any arrangements. The event is an opportunity to launch the Trust's refreshed strategy – Fulfilling our Potential. Patient stories will feature throughout the strategy launch.

1.2 A review of joining age for foundation trust members

The committee considered the need for a Trust-wide plan for patient and public involvement in engaging with the under 10 age bracket in preparation for a review of the membership age in the future. An overview of the discussion and a way forward was communicated to all committee members post-meeting to keep them updated.

1.3 Members' Council elections 2017/18 - update on communication materials and Councillor involvement

An overview of progress made so far was given. A call out for involvement in filming election vox pops from each constituency will be made.

1.4 Update on Members' Council Skills Matrix

Councillor involvement in the restructuring and updating of the matrix was noted. This will be on the agenda for the September committee meeting to discuss further.

1.5 Project Identity Update - GOSHCC

A feedback survey will be issued to all councillors to help support this project- to review the GOSH brand. As the Members' Council is a key stakeholder it is important the Trust has their views.

1.6 Membership Statistics and report as at 1 June 2017

Continued growth in overall membership figures was noted. Membership figures stand at **9,552.** 101 Out of Trust members have been reassigned to their correct constituencies in preparation for the forthcoming Members' Council elections.

1.7 MERRC Walkabouts update

Committee members have been offered slots on PFEEC walkabouts. Dates and times have been planned for July, September and November 2017.

1.8 Any Other Business

The committee were informed as to how media coverage of GOSH will be communicated out to the Members' Council and the timeliness of such communications.

Attachment D

Great Ormond Street Hospital for Children NHS Foundation Trust

MEETING OF THE MEMBERS' COUNCIL MEMBERSHIP ENGAGEMENT RECRUITMENT AND REPRESENTATION COMMITTEE

5 April 2017
11:00pm-1:00pm

Projects Meeting Room, Level 4, Barclay House

Attending:

Simon Hawtrey-Woore (SHW)	Public constituency
**Claudia Fisher (CF)	Patient and carer constituency
**George Howell (GH)	Patient and carer constituency
Gillian Smith (GS)	Public constituency
Kevin Armstrong (KA)	GOSH FT member and GOSH Volunteer
* Anna Ferrant (AF)	Company Secretary
Deirdre Leyden (DL)	Membership and Governance Manager
Emma James (EJ)	Patient Involvement and Experience Officer
Bridgette Williams (BW)	Senior Internal Communications Officer, GOSHCC Communications
Georgina Day (GD)	Internal Communications Manager, GOSHCC Communications
*Jamie Wilcox (JW)	Head of GOSH Volunteer Services

Apologies:

Stephen McCulloch (SMC)	Head of Internal Communications, GOSHCC Communications
Sophie Talib (ST)	Patient and carer constituency
Fran Stewart (FS)	Patient and carer constituency

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

18	**Welcome, Introductions and Apologies**	
18.1	GS introduced herself as Chair for the meeting and welcomed everyone. Apologies were noted.	
19	**Minutes of the Meeting held on 12 January 2017 and Action Log**	
19.1	Minutes were approved with no amendments.	
19.2	4.5 Draft template of Skills Matrix- JW and AF will follow up by next meeting workload permitting. In the meantime the previous version will be circulated to those councillors who have been discussing this item to help shape the framework for an updated skills matrix. AF stressed that the Trust needs to have opportunities in place for making best use of councillor's skill sets.	
19.3	**Action:** Original Members' Council Skills Matrix to be circulated to those councillors for feedback	**DL**
20	**2017 AGM – planning**	
20.1	The committee discussed: 1. Filming options 2. Live streaming options 3. Engagement with the wider membership and the theme for the event	

	1. The committee agreed that filming of the event is a beneficial form of engagement to reach out to members outside of London and those who could not attend in person. It can also serve as a promotional tool for next year's AGM, sent as a link with bespoke email invites and could become part of the online GOSH events library. With between 10-20 views only on most film segments it was a costly exercise with filming costing approx. £25 per view. As this was the first year trialling this engagement method the committee felt that it could only gain momentum and that perhaps the event this year could be one film with highlights instead of being in segments. Of note was that the CEO segment was viewed by 40 people. It was agreed that the event be filmed again this year with the possibility of a highlights film (similar to the approach taken with the Listening Event). It was thought that those highlights must include the CEO talk, Lead councillor and Patient story. Other highlights would be to film the market place and interactions with members. 2. It was thought that a live streaming option was very expensive however GH raised the option of 'periscope' a live video streaming app which is free, however can only be viewed for a set amount of time and the implications for information governance need to be explored. 3. GH felt that the theme must have resonance with all membership. He proposed a theme around "One GOSH" incorporating the idea that everyone's voice is listened to, that the Trust wishes to hear everyone's opinion. CF thought that any theme would need the full backing of the Board and AF agreed saying that the theme would be come through the updated Trust strategy in relation to patient experience.	
20.2	**Action:** - contact Tony Anstis and look at the implications for information governance for live streaming using periscope - investigate the cost for additional editing needed to make a highlights film of the event - the committee to reflect on the proposed theme and feedback to DL outside the meeting any other themes they might propose.	**GOSHCC** **GOSHCC** **MERRC**
21	**A review of membership constituencies**	
21.1	DL introduced the two areas for discussion- removal of the six year rule and age of joining for members. DL outlined the reasons behind proposing the removal of the six year rule for patient and carer constituencies: - inaccurate data when matching against PIMS- (full breakdown of this in Appendix A of the paper) - A large number from constituency would be transferred to the Public constituencies if the rule were enforced which will have an effect in terms of nominations and voting numbers in the forthcoming elections - Query as to why a patient carer view would not still be relevant post six years and the fact that members may return to this constituency anyway if their child has appointments in the future	
21.2	Six year rule: AF outlined the history to establishing the Patient carer constituency and the rationale behind the six year rule when the Trust gained Foundation Trust status.	

	The Trust wished to adhere to a six year rule for members in this constituency as they would have the most recent experiences of Trust services from which to feedback views. AF was of the opinion that having been seen in the hospital post six years does not invalidate that view; a patient carer perspective is still relevant at any time. AF stressed that a decision needs to be reached on the makeup of this constituency for the purposes of the forthcoming elections in terms of nominations and voting purposes. AF stressed that if we were to remove the six year rule we would still run our in house checks against PIMS for internal auditing and to check against deceased members. We could still segment data and send targeted communications to those patient carer members with most recent experiences of Trust services if necessary.	
21.3	SHW felt that the numbers falling if members were to be moved into public needed to be recognised. He also thought some parents may feel their experiences are still relevant post six years and that they would want to remain in the patient carer constituency.	
21.4	EJ received reassurance that we would still be involving and engaging with this constituency to hear their views if we were to remove the six year rule. The new database enables us to segment data according to last seen date if required.	
21.5	DL clarified the procedure for removing the six year rule and that if it was approved it would be enforced for those members from the date of approval onwards, not retrospectively.	
21.6	The committee were in agreement that a proposal to remove the six year rule be brought to the April Members' Council and Trust Board meetings for voting and approval. DL outlined the next steps: - Proposed changes to membership constituencies require an amendment to the Trust constitution and would need to be raised at the Constitution Working Group - If approved by the Members' Council and Trust Board the proposed change would need to be brought to the 2017 Annual General Meeting for voting by the membership	
21.7	Age for joining: The committee discussed at length the age of joining the Trust. GS felt this should be the lowest age possible. KA agreed and thought that this would also adhere with the GOSH vision of 'the child first and always'. DL highlighted the issue of consent and costings attached to tailored communications for a third membership age segment also that numbers recruited to this age segment would be extremely low and that considerations needed to be made when thinking of the costings involved; there was still the facility to sign up members under 10 and keep them in the quarantine section of the database until they turned 10. EJ felt that there would be long term benefits to making resources available now to make the change. She felt that the Trust should be innovative and engaging with the youngest age group we can – starting at 5 years old and suggested engagement materials such as 'I'm a member stickers'. EJ remarked that YPF were currently reviewing the age ranges for their membership and looking at opening membership to those younger than 11. They were looking at having a stall in the Lagoon to engage with the young patient population. CF agreed with GS and EJ and that stated that the communications materials needed to be adapted. BW queried whether membership was the best way to engage with the five year age group. JW suggested a 'Peter Pan Club' of membership for this age. DL felt that resources to recruit to this age range were limited and that membership would need support to undertake this. AF suggested	

	that there would be more work needed for looking into this and changes would not be made before the upcoming Members' Council elections and that age of joining could be brought to the Constitution Working Group.	
21.8	**Action:** Provide the committee with further information on the additional costs/resources required to implement an age change.	**DL**
22	**Members' Council Elections 2017/18 communications planner and materials and councillor involvement (Agenda Items 5&6)**	
22.1	The committee reviewed communications plans and materials for use in the recruitment and engagement of members for the purposes of the Members' Council elections at the end of 2017. It was agreed which councillor's would be approached for involvement in the review of materials and the filming of promotional videos. It was agreed that the Members' Council role description would not be finalised until after the planned facilitated Away day.	
22.2	**Action:** DL to contact those councillors identified for involvement and begin work on draft elections communications materials.	**DL**
23	**Members' Council Walk rounds**	
23.1	CF outlined the arrangement for parent walk rounds which take place as part of PFEEC and how Members' Council case studies feed into these. CF informed the meeting that there has been a pause on gathering case studies whilst the Well Led Review is being carried out. CF found the last walk rounds on Lion and Woodpecker Wards and Outpatients to be very useful. The plan was to have four different parents go on walk rounds. The April PFEEC meeting has been cancelled but the May meeting is going ahead with availability dates needed for walk rounds. CF told the meeting that the PFEEC walkrounds were being expanded to include MERRC. GH asked was it being extended to MC- No just to MERRC CF thought that the arrangement meant that walk rounds be extended to all parents on MERRC but that she would clarify this with Juliette Greenwood as both ST and GH are patient councillors and KA is a volunteer member of MERRC. EJ remarked that there was a similar Walk round pilot scheme for young people called 'You're Welcome' which has already begun on Mildred Creek Unit and in PALS. GOSH is the first hospital in the country to have completed their assessment.	
23.2	**Action:** CF to clarify with JG on the makeup of MERRC members to attend Walk rounds. EJ to liaise with those MERRC members to work out availability dates and coordinate them- these may be pm and/or weekends.	**CF & EJ**
24	**Membership statistics and report as at 31 March 2017 and projected membership targets 2017/18**	
24.1	DL presented the last quarter's membership statistics. DL informed the committee that although membership numbers have exceeded projected targets it was by a relatively small margin so this needs to be taken into account when setting 2017/18 projected membership targets (projected target of 9,481 was met and exceeded by 45).	
24.2	The committee discussed the proposed membership targets for 2017/18 as laid out	

	in the paper and agreed them. They also discussed engagement methods for patients to include the use of the patient bedside screens, contacting Scouts and Guides group at GOSH (DL has had no response so far)	
24.3	**Action** : DL to follow up Scouts and Guides contact through JW. : DL to follow up on patient bedside communications with Martin Nightingale.	**DL**
25	**Any Other Business**	
25.1	Members' Council GOLD training – a reminder will be sent to all councillors in their April eBulletin that a 1pm-2pm slot has been allocated to support councillors complete their training.	
25.2	EJ said that she had begun to map and track patient and parent representatives involvement across the Trust and that this work was well over due. With this information she will be setting up a patient experience page on the website. Once a full list has been gathered, annual training will be offered and email updates will be sent to those parents and patients involved- similar to Vbytes	

Membership Strategy Update

1 June 2017

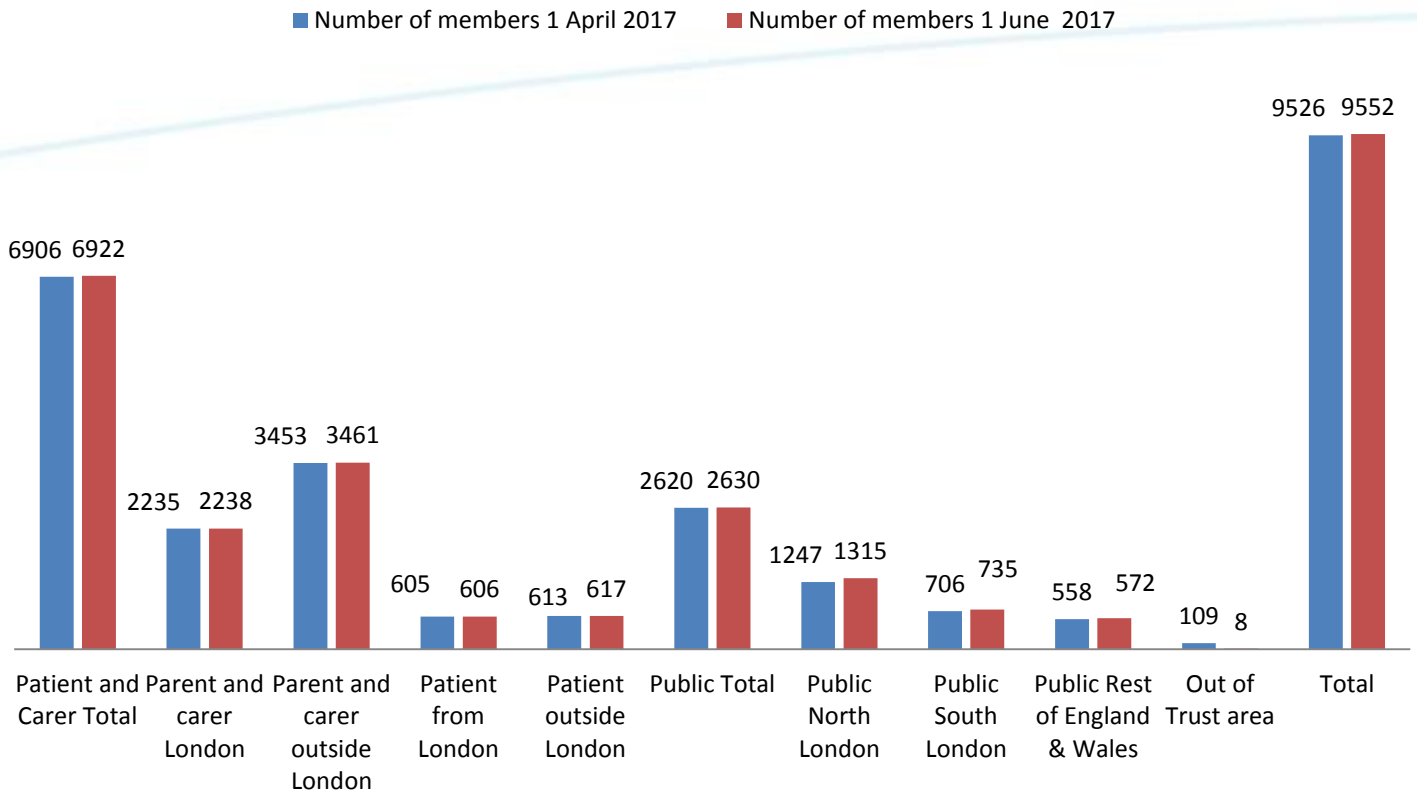
Membership Strategy

Recruit

Great Ormond Street Hospital for Children NHS Foundation Trust

Objectives	Report provided
To maintain and develop membership achieving marginal growth in overall membership numbers (c.3%)	**Total membership comparison figures (1 April 2017 - 1 June 2017)** **Patient and Parent Carer membership split**
To maintain and develop a membership that is representative of the communities the Trust serves and to increase the membership of patients	**Projected membership targets 2017/18**
To maintain and develop a membership that is representative of the communities the Trust serves including demographic, ethnic minority and socio economic representation	**Public membership profile as at 1 June 2017**

Total membership figures comparison

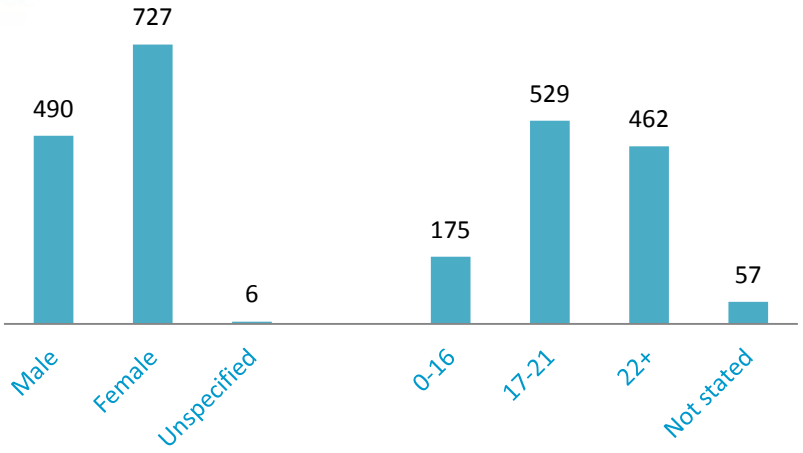


* Out of Trust area: Our membership database is populated by Royal Mail's Postcode Address Files (PAF). New addresses can take a period of time to get updated by Royal Mail, thus defaulting these addresses to Out of Trust area. This figure could also include people who live outside of our constituencies.

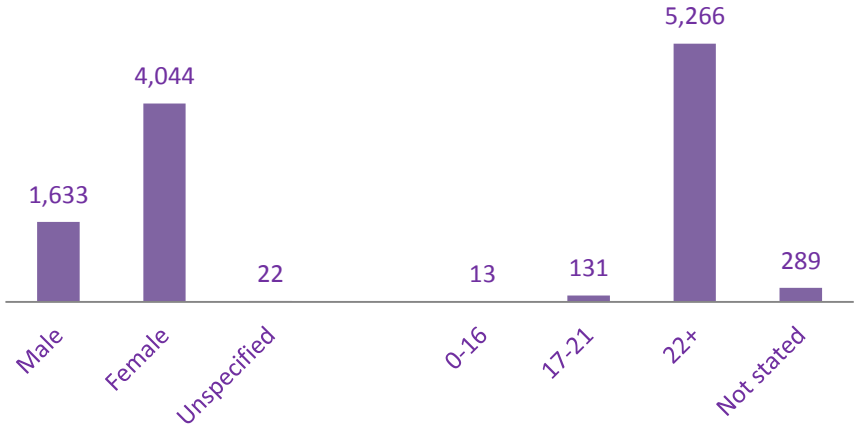
Patient and Parent Carer membership split

Great Ormond Street Hospital for Children NHS Foundation Trust

Patient Constituency



Parent and carer constituency



Patient and Parent and Carer Constituencies

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 parents and 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 should be transferred to the public constituency.

Projected membership targets 2017/18

Great Ormond Street Hospital for Children NHS Foundation Trust

<table>
<tr><th>Current position as at 1 June 2017</th><th>Performance against yearly projected targets</th><th>Note</th><th>Forward plan</th></tr>
<tr><td>Total membership 9,552</td><td>Total membership figure has increased by 26 since March 31, 2017 reporting.</td><td>Our 2017/18 projected total membership target is 9,812.</td><td>To meet our total projected membership target by 31/03/2018</td></tr>
<tr><td>Total Patient and Carer membership 6,922</td><td>Increase by 16 since March 31, 2017 reporting. (+5 patients , +11 Parent carers)</td><td>• Snapshot recruitment :
• Additional 18 Volunteers joined – numbers will be reflected in September 2017 reporting

<table><tr><th>Date</th><th>Activity</th><th>Number</th></tr><tr><td>26/04/17</td><td>Face to face- pre Members' Council Meeting- (councillor Gillian Smith)</td><td>15</td></tr><tr><td>April 2017 post reporting</td><td>Online sign up</td><td>4</td></tr><tr><td>May 2017 pre reporting</td><td>Online sign up</td><td>12</td></tr></table></td><td>Report quarterly *PIMS check outcome at September 2017 Members' Council meeting as issue with ICT for June reporting.

Continue to concentrate recruitment efforts in under-represented segments (10-16 patient)
• Hospital and Outpatients for next quarter</td></tr>
</table>

**Patient Information Management System (PIMS) - running quarterly checks against all data.*

Projected membership targets 2017/18

Great Ormond Street Hospital for Children NHS Foundation Trust

Current position as at 1 June 2017	Performance against yearly projected targets	Note- (since 31 March 2017 reporting)	Forward plan
Public membership total **2,630**	Total Public membership has increased by **20** since March 31 , 2017 reporting. Our projected 2017/18 Public membership target is **2,699**	• 101 (of 109) 'Out of Trust ' members have been reassigned to their correct constituencies. • North London has seen an increase of 68 members • South London has seen an increase of 29 members • Rest of England and Wales has seen an increase of 14 members • Under representation in 10-16 year age bracket. • Awaiting recent Volunteer signups at time of reporting.	• Promoting membership via FT Get Involved email - member to recruit member. • Communications team at GOSHCC to support recruitment efforts. • Autumn community events to support recruitment.

**Patient Information Management System (PIMS) - we will be running quarterly checks against all data.*

Public membership profile and analysis of eligible membership compared against percentage of base population North London and surrounding areas

Great Ormond Street Hospital for Children NHS Foundation Trust

Gender		% of Membership	% of Area	Index
Unspecified	7	0.53	0.00	0
Male	363	27.60	49.69	56
Female	945	71.86	50.31	143
Age				
0-16	54	4.11	21.47	19
17-21	147	11.18	5.76	194
22+	1,037	78.86	72.76	108
Not stated	77	5.86	0.00	0
Ethnicity				
White	732	55.67	70.01	80
Black	149	11.33	8.07	140
Mixed	63	4.79	3.66	131
Asian	214	16.27	15.64	104
Other	157	11.94	2.62	455
ONS/Monitor Classifications				
AB	382	29.05	27.27	107
C1	394	29.96	32.53	92
C2	212	16.12	17.55	92
DE	313	23.80	22.65	105

Overview

Total: 1,315
Increase of **68** since 1 April 2017

Age Profile:
- Under represented in 10-16 age bracket
- Over represented in other age brackets

Gender Profile:
- Over representation of female members
- Under representation of male members

Ethnicity Profile:
- Broadly representative of Asian and White
- Over represented in other ethnic groups
- Under represented in White

ONS
Social and economic status is broadly representative of the demographics of this constituency

% of Area — The percentage of people in the local area in that constituency.

Index — A value indicating how representative of the area our membership is in comparison to that population.
(100 is perfectly representative, <100 is underrepresented and >100 is over represented)

Public membership profile and analysis of eligible membership compared against percentage of base population South London and surrounding areas

Great Ormond Street Hospital for Children NHS Foundation Trust

Gender				
Unspecified	4	0.54	0	0
Male	193	26.26	49.02	54
Female	538	73.2	50.98	144
Age				
0-16	7	0.95	20.39	5
17-21	37	5.03	5.65	89
22+	630	85.71	73.96	116
Not stated	61	8.30	0.00	0
Ethnicity				
White	495	67.35	82.28	82
Black	60	8.16	6.77	121
Mixed	32	4.35	3.18	137
Asian	62	8.44	6.62	127
Other	86	11.70	1.14	1,022
ONS/Monitor Classifications				
AB	235	31.97	28.30	113
C1	225	30.61	33.48	91
C2	121	16.46	18.34	90
DE	149	20.27	19.88	102

% of Area — The percentage of people in the local area in that constituency.

Index — A value indicating how representative of the area our membership is in comparison to that population.
(100 is perfectly representative, <100 is underrepresented and >100 is over represented)

Overview

Total: 735
Increase of 29 since 1 April 2017

Age Profile :
- Under represented in 10-16 age bracket
- Under represented in 17-21 age bracket
- Over represented in 22+ age brackets

Gender Profile:
- Over representation of female members
- Under representation of male members

Ethnicity Profile:
- Good representation across all ethnicities except White but over representation of Other in comparison to local population

ONS
Social and economic status is broadly representative of the demographics of this constituency

Public membership profile and analysis of eligible membership

Rest of England and Wales

Great Ormond Street Hospital for Children NHS Foundation Trust

	Total	% of membership
Gender		
Unspecified	15	2.62
Male	193	33.74
Female	364	63.63
Age		
0-16	6	1.04
17-21	31	5.42
22+	457	79.9
Not stated	78	13.64
Ethnicity	**572**	
Asian	30	5.24
Black	20	3.5
Mixed	5	0.9
Other	97	17
White	420	73.43
ONS/Monitor Classifications	**569**	
AB	159	27.8
C1	165	28.85
C2	118	20.63
DE	127	22.2

Overview

Total: 572

Increase of 14 since 31 March 2017

Age Profile :

- Under represented in 10-16 age bracket
- Highest representation in 22+ age bracket

Gender Profile :

- Higher representation of female members
- Lower representation of male members

Ethnicity Profile :

- Highest representation in White segment

ONS

Social and economic status is evenly spread.

We do not compare our membership to the Rest of England and Wales as the number of members within this constituency is so small that it cannot be held to be an accurate microcosm of the population within it.

Membership Strategy

Communicate

Great Ormond Street Hospital for Children NHS Foundation Trust

Objective	How we are meeting our strategic aims	What are our future plans?
Provide appropriate information to members and the Members' Council 	• Spring *Member Matters* – reached 6,825 members electronically. • May *FT Get Involved* email to membership reached 6,839 members • Website election pages have been set up – are hidden at present until Election campaign begins. Generating content at present • Intranet pages for staff have been updated. • *Vfocus* article on Members' Council Elections- due out late June 2017 <u>Members' Council</u> • Councillors to receive June Members' Council ebulletin and all relevant papers and meeting dates. • Delivery of online GOLD training modules continues- as at 02/06/17 , 7 councillors have completed all modules.	• *Member Matters* Autumn 2017 editorial meeting planned for July 12 , 2017. • Preparation for July 2017 *FT Get Involved* email to membership. (June email will have landed by time of reporting) • Updated *Welcome Pack* for new members will be issued in August2017. • Updated Members' Council photo board for display in the hospital and to be issued with updated *Welcome Packs* • Continue work plan from election communications planner to prepare our membership communities for the 2017/18 Members' Council elections . • June e bulletin to councillors will contain relevant information to support them in their role and training seminar. • Councillors training to be streamlined with GOSH volunteer and NED training . Councillors to complete online training

Membership Strategy

Communicate

Great Ormond Street Hospital for Children NHS Foundation Trust

Objective	How we are meeting our strategic aims	What are our future plans?
Communicate the benefits of membership and create new engagement opportunities	• April and May *FT Get Involved* email advertised involvement opportunities including attendance at GOSHCC events. • Updated *Welcome Packs* ready for distribution in August 2017. • Membership sign up and elections news to be made available on Patient Bedside Education and Entertainment System' (PBEE).	• Continue to request more opportunities for members through GOSH staff newsletter and by engaging with new teams across the Trust. • Plan for more bespoke emails to members for key Trust events.
Build more awareness, communication, and interaction between councillors and their constituents	• A councillor engaged with members and the hospital community pre Members' Council meeting in April. • Lead councillor has reached out to members interested in possibly standing for election.	• Continue to advertise Members' Council meetings in *FT Get Involved* email. • Councillors identified for letters and welcome articles for Autumn 2017 *Member Matters* • Activity Centre have invited councillors to have a stall outside any day of the week. • Queries made to Scouts and Guides at GOSH. • Possible stall at Esher Sixth Form college.

Membership Strategy

Engage

Objective	How are we meeting our strategic aims ?	What are our future plans ?
Harness the experience, knowledge and skills of our membership community and actively engage them in the development of the Trust and its activities.	• Members' Council continue to engage with members pre Members' Council meetings and at Trust events • Reaching out to those members who have expressed an interest in running for election and offering opportunity to them to attend Members' Council meetings as observers and to meet the Lead councillor. • Membership forms distributed at Research Awareness Week event.	• To work in collaboration with the Patient Experience team to engage with our members at events in the future. • To continue to engage with young members who may wish to stand for election in 2017 Members' Council election. • To engage with members at the AGM in September and at pre election information sessions.
Support the Trust's Patient & Public Involvement work and enable a single view of Trust, Partnership Organisations and Charity-wide engagement opportunities.	Our *FT Get Involved* emails have advertised opportunities for: - Young People's Advisory Group - Membership stories - Patient Experience Volunteers - GOSHCC events and campaigns	Continue to engage with GOSH staff to advertise more opportunities to FT members.
Encourage a partnership approach between the Trust, its membership, and other likeminded organisations	• GOSHCC to advertise Race for the Kids and Run the Royal Parks in *FT Get Involved* and *Member Matters* Magazine • Reached out to Scouts and Guides Group at GOSH	Continue to look for opportunities to engage in partnership work.

Projected membership targets for 2017/18

Attrition Rate >	5.00%
Growth Rate >	8.00%

Constituency	2016/17 (final numbers)	Attrition	Growth	2017/18 (Predicted)	In Year Net Target
Patient	**1,218**	61	97	**1,255**	**37**
Parent/Carer	**5,688**	284	455	**5,859**	**171**
Public	**2,620**	131	210	**2,699**	**79**
Total (excluding staff)	**9,526**	476	762	**9,812**	**286**

Attachment D

Election planning update.

1.0 Introduction

On 14th November 2017 the Trust will give notice that it will hold an election to the Members' Council for **22** seats in the following constituencies:

Patient and carer Constituency	
Class	Number of seats for election
Parents and Carers from outside London	3
Parents and Carers from London	3
Patients from outside London	2
Patients from London	2

Public Constituency	
Class	Number of seats for election
North London and Surrounding Areas	4
South London and Surrounding Areas	1
Rest of England and Wales	2

Staff Constituency
Number of seats for election
5

Elections are run on the Trust's behalf by an independent election company, Electoral Reform Services and conform to the Department of Health model election rules (which are included in the Trust Constitution). These rules enable online nominations and voting.

2.0 Election Timetable

The election timetable has been set to enable the newly elected/re elected Members' Council to receive Induction training in February 2018 in preparation for their first Members' Council meeting.

ELECTION STAGE	**TIMETABLE**
Nomination materials and nomination data to be provided by Trust to ERS	Tuesday, 31 Oct 2017
Notice of Election / Nominations open	Tuesday, 14 Nov 2017
Nominations deadline	Tuesday, 12 Dec 2017
Summary of valid nominated candidates published	Wednesday, 13 Dec 2017
Final date for candidate withdrawal	Friday, 15 Dec 2017
Electoral materials and electoral data to be provided by Trust to ERS	Monday , 18 Dec 2017
Notice of Poll published	Thursday, 4 Jan 2018
Public and Patient carer Voting packs despatched Staff voting packs arrive Staff voting packs despatched	Friday, 5 Jan 2018 Wednesday 3 Jan 2018 Thursday 4 and Friday 5 January 2018
Close of election	Tuesday, 30 Jan 2018
Declaration of results	**Wednesday, 31 Jan 2018**

3.0 Elections Communications Planning

The Membership Engagement Recruitment and Representation Committee have been provided with an Elections Communication Planner in preparation for key messaging about the election to membership and the public. Committee members have also provided input on some of the elections materials and face-to-face engagement.

Below outlines the key communications channels which will be used to promote the elections to the GOSH membership , hospital community and the wider public.

Communications channel	**Members' Council input**
<u>Publications and Design:</u>	
Members' Council Election Factsheet	Young councillor perspective
Spring *Member Matters* Magazine – Elections special	Q&A with a councillor
Annual Membership Report	MERRC Chair and Deputy Chair input
V Focus Volunteering Newsletter - Summer and Autumn features	n/a
Roundabout Staff Newsletter – monthly features (from August 2017)	Staff councillor input
Autumn Welcome Pack for new members- refresh with elections information and updated Members' Council photo board	Lead councillor welcome letter
Refresh of Elections Pop up banners	n/a
Refresh of Elections Posters	n/a
<u>Online communications:</u>	
Bespoke membership emails split by constituency - call to nominate and reminder to vote	Councillor representative by constituency
Bespoke emails to members who have expressed an interest in running for election or who have nominated in previous elections	Request Lead councillor to sign email
Patient Bedside Education and Entertainment System' (PBEE) - join online advert and link to Elections website page.	n/a
Staff- Intranet- refreshed pages and advertisement banners	staff councillor input
Refreshed website elections pages - updated to integrate with campaign recruitment and election messaging at key points during the election	n/a
Monthly FT Get Involved membership email- updates throughout the election with links to elections website pages and events page	n/a

Attachment D

GOSH Staff weekly electronic newsletter	Staff councillor input
Members' Council Vox Pops	Councillor representative by constituency for filming
Twitter and Facebook- GOSHCC to update	n/a
<u>Events and face-to-face engagement:</u>	
Annual General Meeting and Annual Members' Meeting	Members' Council engagement stall
Election Briefing Sessions for staff, membership and the public (two evening sessions)	Councillor representation
Pre Members' Council meeting engagement sessions in the Lagoon and Outpatients- June and September 2017	Councillor representation

Attachment E

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

Wednesday 28 June 2017

Young People's Forum Update

Summary & reason for item: To provide an update of the activities of the Young People's Forum for the past year

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

Report prepared by: Fiona Jones, Children and Young People's Participation Officer and Faiza Yasin, Chair of the YPF.

Item presented by: George Howell, Members' Councillor.

Attachment E

YPF activity – April 2016 to April 2017

The Young People's Forum (YPF) have had another active year, taking part in Trust activities and advising on matters affecting young people. The group has developed and grown throughout the year, with an increase in membership, a larger team of staff and volunteers to facilitate meetings and support young people in the group.

Membership

- Increase of 60 per cent from January 2017
- Total of 47 members
- Good representation of current and past patients, many with long term conditions
- Wide range of representatives from non-White British backgrounds, and a wide range of medical conditions
- Ages range from 11 to 25 years. young people's ages span the full range

- Increase in attendance at meetings
  - March 2017 meeting had 28 young people attending
- Link with Members' Council
  - All YPF members asked if they would like to join Foundation Trust membership
  - Two YPF members are currently Members' Councillors

Meetings

- All meetings are planned using a structured approach to support attendees as well as staff supporters
- From September 2016, all meetings are evaluated by attendees , results are used to plan the following meeting
- Communication in between meetings is also standardised
  - Short email every two weeks with opportunities to get involved in projects
  - Detailed online newsletter every month with opportunities, updates on projects and member news stories

Elections

- These take place annually in September
- Young people standing for election create a biography
- Chair and Vice Chair then elected through two consecutive online voting periods

Key projects

Cooking up a youth voice – March 2016

- Collaboration with NHS England and GOSH to hold an event for over 140 colleagues from across the UK
- Aim was to encourage and support engagement with children and young people by sharing good practice

- NHS England commissioned the Reporters' Academy to capture the event – in return, four YPF members received training to cover future events

Takeover Challenge – November 2016

- Twenty-seven young people took over 10 staff teams for a day

Listening event – November 2016

- Young people formed a planning group, convening via teleconference to guide the planning of the Listening Event
- Young people attended the event and participated in the topic discussions, as well as speaking to attendees about the YPF

Publicising the YPF

- Commonwealth Service at Westminster Abbey - March 2016
- Race for Kids event – May 2016
- Interviewing staff members for publication - June 2016
- Feedback on mood boards for new YPF publicity materials July 2016
- Photo shoot for publicity materials – September 2016
- Queen's Birthday, Hallowe'en and Christmas parties
- Attendance at the 2016 GOSH Staff Awards
- The YPF Chair took part in Judging an award and the YPF will distribute thank cards at the Staff Awards 2017
- GOSH Annual General Meeting – Two young people attended and addressed the audience with their experiences of being a patient at GOSH
    - Weekly Teen Café run by YPF Chair – started February 2017
- Meeting and presenting to Operating Theatres Team and Human Resources Team - May 2017

Involvement in staff recruitment

- The YPF took part in two sessions to learn about recruitment and selection of staff at GOSH – September and December 2016
- One young person participated in the recruitment process for the Adolescent Clinical Nurse Specialist for Cardiology – June 2016
- The YPF chair was involved in the recruitment process for the Trust Chair, and formed part of a welcoming party, welcoming candidates and providing feedback on each candidate – May 2017
- The YPF created a set of questions which will be included in all interviews later in 2017

Catering

The YPF regularly provide feedback on the food served at the hospital and maintain and good relationship with the Catering Team who regularly ask for advice

- Feedback on tray designs for Catering – March 2016

- Feedback on names for Sandwiches – March 2016

Feedback and involvement on Trust initiatives

- Transition to adult services – ongoing discussion at YPF meetings and representatives on the new Transition Steering Group
- Digital badges – participation in a digital badges scheme, YPF members can earn 'badges' related to their involvement
- Patient-Led Assessment of the Care Environment (PLACE) inspections – YPF members have been involved in 2016 and 2017
- Pay More Attention study for Centre for Outcomes and Experience Research in Children's Health, Illness and Disability (ORCHID) at GOSH – July and December 2016
- London South Bank University student nursing open day at GOSH YPF members attended and spoke with students looking to have placements at GOSH, to discuss their experience of being an adolescent patient – September 2016
- Discussing the play needs of young people in hospital
- Clean Air project – YPF members gave feedback to the Clean Air Day team on how to get Clean Air messages to patients and parents – January 2017
- GOSH Arts tattoo project – the YPF took part in an activity which was to be rolled out to teenage inpatients – January 2017
- a YPF member became the voice of the ICT service desk, recording the welcoming statement and various messages to direct staff – January 2017

Redevelopment – plans of new buildings

The YPF Have maintained a good working relationship with the redevelopment team, following on from being heavily involved in creating the design brief for Phase four, the YPF have;

- contributed ideas for the Disney Garden - May 2016
- toured the Premier Inn Clinical Building site – June 2016
- welcomed Deputy Director of Development and Property Services to the YPF to provide an update on redevelopment – December 2017
- 28 young people took part in providing feedback for the Phase Four design competition entries – March 2017
- two young people were part of the formal interview process with the Phase Four architect teams April 2017

Electronic Patient Records

- Welcomed the Electronic Patient Record (EPR) team to the YPF to discuss contents for the Patient Portal aspect of the EPR – July 2016
- YPF members attended a workshop to hear from potential providers – September 2016

Summary

The YPF is a well-used platform for staff to hear patient perspective on projects and raising

awareness of adolescent patients and their health needs. The YPF are keen to 'close the feedback loop' to hear how their ideas and opinions have affected a project or created improvement in the hospital, this sometimes is a challenge to receive formal feedback from teams or evidence of direct influence, often due to the work being long term or ongoing.

Key improvements/ changes influenced by the YPF

- Regular food tasting has enable the catering team to make changes to food immediately based on young people's feedback
- Young people have been involved in the whole process of Phase four redevelopment, from design brief to recommendation for the preferred architect
- There are now activities for young people at all inpatient parties and a regular Teen Café opportunity for teenage inpatients
- The young persons preferred candidate employed for Cardiac CNS position
- ORCHID study adapted resulting from feedback from the YPF – feedback will also inform future research studies
- Electronic Patient Record design influenced by the YPF and young people involved in the formal evaluation of potential suppliers

YPF member's feedback regularly that being involved in the YPF gives them support, confidence and the chance to 'give back'.

'It helps to change the hospital for the better, its great fun and I love getting to meet so many people and make new friends. It has been life changing for me.' – YPF Member

'The opportunities afforded to [YPF Member] have really opened up his world, meeting people outside his community at home, challenging his self-confidence issues, and has helped him face some of his fears'. – Parent of YPF member.

Future ambitions

As noted with our membership numbers, representation and involvement in a wide variety of projects, the YPF is growing and evolving at a steady rate. Some of the projects and challenges the group look forward to are;

- **Takeover Challenge 2017**
  The YPF look forward to the Takeover Challenge 2017 and hope to offer opportunities to more children and young people to experience different roles

- **National YPF Event**
  The YPF have been successful in a bid for funding from the GOSH Children's Charity to host a national convention of hospital and health Young People's Forums.
  The Event is hoped to become an annual event hosted by other trusts in the following years. The YPF are leading on the planning and facilitation of the event and are engaged at YPF meetings and via Telephone Conferences

- **Involvement in recruitment and selection**
  The YPF look forward to establishing regular involvement in the recruitment and selection of staff.

Attachment F

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

28th June 2017

Update from the Patient and Family Experience and Engagement Committee

Summary & reason for item: To update the members' council on the Patient and Family Experience and Engagement Committee.

Councillor action required: To receive and note the report

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

Item presented by: Juliette Greenwood, Chief Nurse

PATIENT AND FAMILY EXPERIENCE AND ENGAGEMENT COMMITTEE (PFEEC)

Herdip Sidhu-Bevan
Assistant Chief Nurse

(Members' Council June 2017 Report)

Friends and Family Test (FFT)

Top Three Positive Themes

- Welcoming
- Expert
- Housekeeping / Cleanliness

Top Three Negative Themes

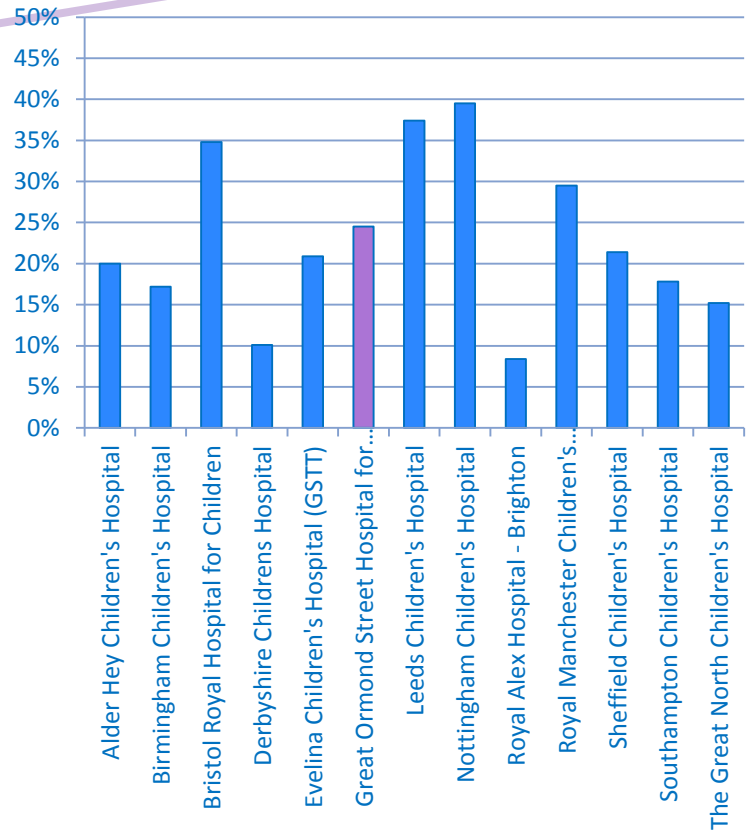
- Access, Admission, Discharge & Transfer
- Staffing Levels
- Environment & Infrastructure

FFT Comparison Chart

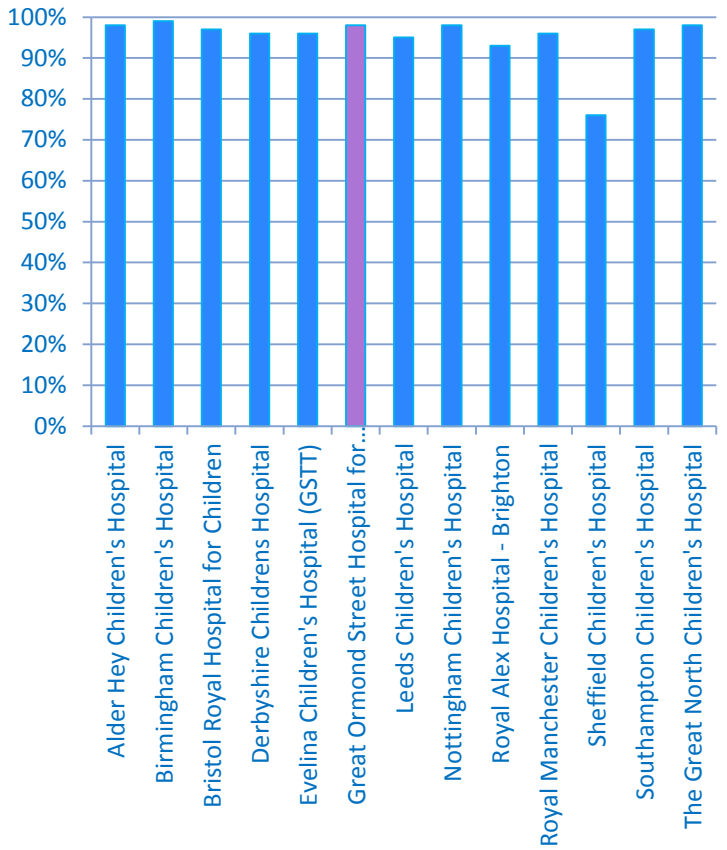
Great Ormond Street Hospital for Children NHS Foundation Trust

*Based on NHS Choices Data – Feb 2017

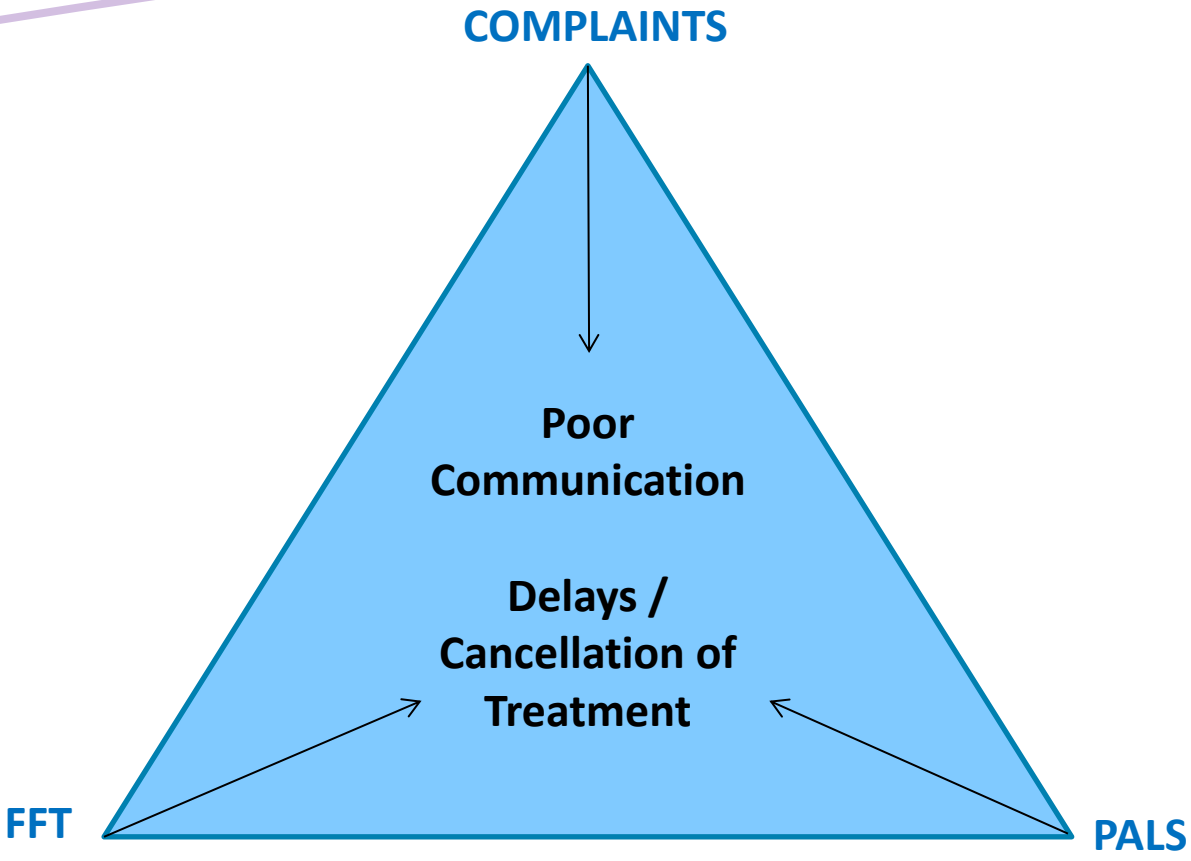
Response Rates



Percentage to Recommend



FFT / PALS / Complaints Common Themes



FFT Percentage to Recommend

Great Ormond Street Hospital for Children NHS Foundation Trust

Inpatients

Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
99.3%	97.9%	98.9%	98.8%	99.1%	98.2%	98.4%	97.9%	98.5%	99.5%	98.3%	98.7%

Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
98.6%	98.6%	97.5%	97.0%	98.5%	98.8%	97.9%	99.0%	97.3%	97.9%	98.0%	97.0%

Outpatients

Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
95.6%	93.0%	94.5%	95.1%	97.1%	96.2%	97.0%	97.8%	95.8%	97.3%	97.1%	97.5%

Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
95.5%	95.9%	96.4%	82.4%	94.8%	91.2%	95.6%	92.3%	91.0%	94.5%	92.5%	94.8%

Real Time Feed Back

- RL Solutions will be the company working with GOSH to introduce the system
- Steering group to be set up over the next month
- Working collaboratively with RL Solutions to devise paediatric friendly feedback systems

Parent Walkabout

- It has been decided that there will be parent walkabouts commencing and the feedback will be organised in line with the PFEEC meetings. The dates of the walkabouts will be: Thursday July 13th 1.30pm to 4.30pm, Tuesday September 12th 5.30pm to 8.30pm, Saturday November 4th 9.30am to 12.30pm. A member of the patient experience team will be present on these walkabouts

- Feedback will be addressed with the relevant departments/divisions to make necessary changes and to communicate these changes.

Patient Story (April 2017 Trust Board)

- This film showcases the story of two adolescent patients who took part in Takeover Week 2017.
- Demi Dawson and Niamhie Smith are both aged 12. The pair met during Takeover Week 2017 when they participated in taking over Radio Lollipop.
- Demi was in the middle of a six week stay, being in hospital for four weeks at the point of Takeover; she is under the care of rheumatology at GOSH and ophthalmology at Moorfields. Niamhie was an inpatient for a week, which coincided with our Takeover challenge; she is under the care of Endocrinology. Following their inpatient stays, the girls continue to visit GOSH for outpatient appointments.
- Demi and Niamhie's story is poignant as the girls overcame personal challenges. Both patients had not met others who were of the same age as themselves; this had led to them feeling isolated. Therefore an event which brought patients of the same ages together, across the Trust was of great importance for them.
- Furthermore, Niamhie is Autistic and struggled to feel comfortable in a ward environment due to the large amount of activity, she experienced sensory overload and often stayed in her bed, under the covers, with the curtain drawn. Outside of the hospital, Niamhie struggles to make friends and particularly has been unable to find the confidence to use/answer telephones.
- The event encouraged her to leave the ward; this then enabled her to meet a fellow patient who she has since become close friends with. In addition, during the radio show Niamhie surprised her mother and the Radio Lollipop team by answering the studio phone, unprompted, live on air.
- Whilst Takeover Week, helps to teach participants about specific roles and activities in the hospital, staff were also able to learn from patients who willingly shared their experiences and opinions on their care and treatment at GOSH.
- Therefore, this video captures more than the girl's experience of taking over Radio Lollipop, it also portrays an insight of their stay and their ambitions for the future of the hospital.
- Their story highlights the importance of the provision of play, the role of the Children and Young People's Participation Officer in being able to coordinate events such as Takeover. It also demonstrates the value of engagement and involvement, not only for the participants but for staff.

Listening Event – Video Booth

Video booth

- The Patient Engagement and Experience Officer (PEEO) has been working with the Communications Team to set up a page on the staff intranet so that once uploaded, all videos with specific feedback for individuals, wards/departments/teams can be seen and shared widely.

- In addition the PEEO has created a video montage of positive clips which will be available on the staff intranet and is in discussions with the Human Resources department regarding where else the video could be shared e.g. the Annual Staff Awards.

- The PEEO has also made a montage of videos for comments regarding improvements so that these can also be shared with the teams responsible for these areas e.g. comments on food for the Catering Team.

Attachment G

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

28 June 2017

Quality Report 2016/17

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: contributors, Trust Board representatives, Members' Council representatives, Audit Committee representatives, Quality and Safety Assurance Committee representatives, Deloitte, commissioners, local Healthwatch and Health Scrutiny committees.

Deloitte have provided a 'qualified conclusion' due to only one quarter of reporting of the RTT indicator for the year. This is a result of the Trust's RTT reporting break in quarters 1-3 2016/17 (see page 53 of the report).

Councillor action required:
To note the report.

Report prepared by:
Meredith Mora, Clinical Outcomes Development Lead

Item presented by:
Juliette Greenwood, Chief Nurse

Great Ormond Street Hospital for Children
NHS Foundation Trust

Quality Report 2016/17

Contents

Cover: Erin, age three, has a complex combination of symptoms and no diagnosis for her condition. Erin loves Power Rangers and dinosaurs and her bright personality has made her lots of friends across the hospital.

Baby Hope has been at GOSH with her twin sister Maria for the eight months of their life.

Understanding the *Quality Report*

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

This is a 'what is' box
It explains or describes a term or abbreviation found in the report.

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

What is the *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
  - 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.

Our hospital

98%
of parents and patients (inpatient) would recommend the hospital

296,252
admissions and appointments

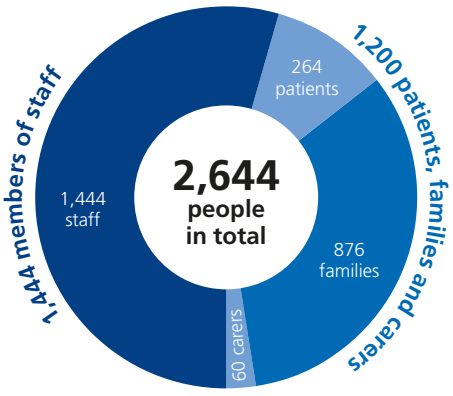
58
specialities

1299
research projects active in 2016/17

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

Our Always Values

We consulted very widely with staff, patients and families to derive our values:



After an extensive consultation and development period on values and the behaviours that demonstrate them, 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. These logos appear throughout the report where work described reflects *Our Always Values*.

Always

Part 1:
A statement on quality from the Chief Executive

At GOSH we are committed to continual improvement in everything we do. The *Quality Report* details our performance in the year's key improvement projects aligned to our three quality priorities, which are:

- **Safety** – to eliminate avoidable harm
- **Clinical effectiveness** – to consistently deliver excellent clinical outcomes, with the vision to be the leading children's hospital in the world
- **Experience** – to deliver kind and compassionate care, and communicate clearly to build confidence and ease

Areas for improvement are spotlighted in a number of ways. Issues may be flagged via internal or external audit or review, or via any of the gamut of ways through which we invite feedback from our patients and their families.

As detailed in Part 2c and Part 3, we have performed well against quality indicators set by Department of Health and met nearly all of our reportable healthcare targets set by NHS improvement. An urgent overhaul of our processes and systems for data collection and handling means we have been unable to report referral to treatment (RTT) for 2016/17. We are back on track to have complete waiting time data for 2017/18.

I am particularly proud of the further progress made this year to prevent and identify deterioration in our young patients (see below). Over recent years this programme of work has brought together a wide range of initiatives – from new technology and better equipment, to staff training and awareness raising – to deliver the excellent quality of care our patients deserve.

Safety

A new protocol was introduced at GOSH, and supported by staff training, to increase timely recognition and treatment of sepsis, which is a life-threatening condition that can arise as a result of infection. Swift action is vital in sepsis, so it is very encouraging that in the first few months of the protocol being rolled out hospital-wide, nearly 70% of actions were taken within one hour – far in excess of the international average.

Work was also undertaken this year to cut preventable cardiac and respiratory arrests. By reviewing our monitoring systems, improving staff's preparedness for a clinical emergency and bringing in new equipment, potentially preventable arrests reduced substantially over the 12 months.

Finally, we built on last year's introduction of electronic Patient Status at a Glance (ePSAG) boards, by establishing safety huddles into the daily routine of inpatient wards. These short meetings of clinical staff take place at the ward ePSAG. They ensure that all staff understand each patient's status, and that there is collective awareness of those children that may be at risk of deterioration.

An audit of neonatal care at GOSH spotlighted some areas for safety improvement that we intend to address in the coming year. This work will focus on three main areas: bloodspot testing for early detection of serious conditions, identification and evidence-based treatment of neonatal jaundice, and management of neonatal intravenous fluids.

Clinical effectiveness

In 2015 the quality of our referral-to-treatment data began to cause concern. It was failing to accurately reflect waiting times, so we were unable to keep track of our performance against national targets. Over the past year a great deal of time and hard work has gone in to transforming the quality of our data and systems so they are now viewed as among the best in the sector. We recommenced reporting in 2017, and the first few months of data put us well ahead of our recovery trajectory. This gives me great confidence that in all but a handful of sub-specialties we'll meet the national standard in 2017/18 – that 92% of patients should wait less than 18 weeks from referral to treatment.

To be truly world-leading in our practice it is crucial we care for the whole child, rather than treating a patient's condition in isolation. Evidence shows that people with long-term conditions are at high risk of mental health problems, so this year we proactively, but unintrusively, increased our psychological support services across four clinical areas. Mental health screening – in the form of a questionnaire offered to families – confirmed that our patients with long-term conditions do exhibit a higher rate of mental health difficulties than children in the general population. Our psychological services staff followed up every patient whose screening caused concern. Going forward, we plan to refine and establish mental health support as part of the patient journey in high risk clinical areas at GOSH.

In 2017/18 we will bring clinical outcomes to the forefront. Currently, Trust-wide access to teams' outcome data is patchy. We will take a consistent approach to collecting and reporting outcome information internally through the Clinical Outcomes Hub. This will enable teams to more readily use this evidence in decision-making and service improvement.

Experience

The views of our patients and families are paramount in informing the continual improvement of clinical and support services across GOSH. We place the results from the NHS Friends and Family Test (FFT) in high regard, and have worked hard to make it easy for more of our patients and parents to tell us what they think. It is encouraging to see a 7% increase in comments received this year. Crucially, we have established practices to ensure teams throughout the Trust use the feedback to recognise their achievements as well as understand where improvement is needed.

The FFT results from inpatients have this year exceeded our own ambitious target of a 95% rate of recommendation for the hospital, but for outpatients it stands at 93%. Work continues to address this shortfall in outpatient responses, and we will soon begin a demographic analysis of FFT results. This will help us to identify and address any differences in the quality of experience at GOSH according to ethnicity, age and additional needs.

Many of GOSH's patients have conditions that persist beyond their time in our care. We therefore have a duty to ensure that the transition from paediatric to adult services is as positive as it can be. It's a complex challenge, and an area that GOSH patients and parents have told us needs improvement. This year we laid the foundations of our trust-wide Transition Improvement Project. This work included the identification of a doctor in each specialty who will be the transition lead, and an audit of relevant data and information about our transitioning or near-transition patients. There is a great deal of work to do now to improve the experience of transition, and the project will remain a priority in the coming year and beyond.

Accuracy of data

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

Hassan, age five, having treatment at GOSH for leukaemia.

Part 2a:
Priorities for improvement

This part of the report sets out how we have performed against our 2016/17 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 as rapidly as possible. Our safety initiatives aim to ensure that each patient receives the correct treatment or action the first time, every time.

Clinical effectiveness

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

Experience

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

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

Reporting our quality priorities for 2016/17

The six quality priorities reported for 2016/17 are:

Safety

- Improving the monitoring and escalation of the deteriorating child
- Implementing safety huddles

Clinical effectiveness

- Reducing the number of patients with incomplete pathways at 18 weeks
- Implementing mental health screening in children and young people with long-term physical health conditions

Experience

- Improving young people's experience of transition to adult services
- Utilising Friends and Family Test data for improvement

This section reports 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

In this section, we also provide information about other ways we have sought the views of our patients and families in 2016/17.

Improving the monitoring and escalation of the deteriorating child

What we said we'd do

We said we would further improve the monitoring of patients on the ward to ensure early identification every time when a child's health is deteriorating. Effective monitoring means staff can seek support early on to provide intervention to stabilise the child. The improvement work had two strands:

1. Improving sepsis awareness
2. Preventing cardiac and respiratory arrests

1. Improving sepsis awareness

What we did

Since a national report in November 2015[1], sepsis awareness has grown as an NHS priority to avoid preventable health problems or death through early detection and treatment. Research shows that for every hour of delay in treatment of a septic patient, mortality increases by 7%. We've always been conscious of the risk of sepsis, but this report has influenced us to further our efforts to identify these cases early.

As part of our improvement workstream on the deteriorating child, we developed and implemented a new sepsis protocol in 2016/17 to increase timely recognition and treatment of sepsis in our patients.

In July 2016, a project team was set up to implement the 'Sepsis 6' protocol at GOSH. The steering group was led by a specialist neonatal and paediatric surgeon and had representation from intensive care units (ICU), resuscitation services, clinical site practitioners, frontline nursing and medical teams and the Quality Improvement team. The GOSH Sepsis 6 protocol was adapted from the national Paediatric Sepsis 6, developed by the UK Sepsis Trust.

[1] National Confidential Enquiry into Patient Outcome and Death (2015). Just Say Sepsis! A review of the process of care received by patients with sepsis. London: NCEPOD

What is sepsis?

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

UK Sepsis Trust

What is 'Sepsis 6'?

Sepsis 6 is a list of six actions that can double the chances of survival, if applied within the first hour of presentation. The actions are:

1. Provide high flow oxygen
2. Obtain intravenous (into vein)/intraosseous (into bone marrow) access and take bloods (gas, lactate and blood cultures)
3. Give intravenous/ intraosseous antibiotics
4. Consider fluid resuscitation
5. Involve senior clinician early
6. Consider inotropic support early (medicines that change the force of heart contractions)

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.

The protocol was piloted on Squirrel (surgical) Ward and then rolled out to Elephant, Lion and Giraffe (haematology and oncology) Wards. The pilot included:

- Ward-based training for nursing and medical teams
- A hotline for support to staff implementing the sepsis care protocol
- Data collection on the timeliness of delivery of the protocol

Following the positive results of the pilot, the Sepsis 6 protocol was rolled out Trust-wide at the end of January 2017. Sepsis champions were recruited from all clinical specialties and participated in a train-the-trainer programme. A Sepsis Awareness Week was held in the hospital to promote knowledge among all staff, parents and patients about the signs of sepsis. This was delivered through lunchtime lectures, information stands and simulation exercises on the wards.

What the data shows

The current international average for completing the Sepsis 6 protocol within one hour is 47%[2]. *Figure 2* demonstrates compliance with the protocol significantly above the international average now that it has been rolled out to all inpatient areas.

These early results are encouraging. In addition, staff reported that they felt empowered by the protocol and that it facilitated fast response to deterioration and good communication across the multidisciplinary team.

What's going to happen next?

We will continue to make improvements within our system to facilitate early recognition of the signs of sepsis and fast delivery of the protocol. Next steps are:

- Ensure all first-line antibiotics are stocked on every ward so that they can always be delivered within the first hour
- Incorporate an automated alert for sepsis into our electronic patient observation system, which will guide staff through to an electronic Sepsis 6 tool when a patient triggers against the flag signs for sepsis
- Provide further education to ward areas to overcome specific challenges in delivering the Sepsis 6 protocol in one hour
- Raise greater awareness among parents through leaflets given post-surgery and in outpatients, and via general communications on the hospital website

One Team

"Sepsis 6 means that I don't need to ask permission to do what I know is right. I can take the bloods and start treatment without waiting to ask someone. We could never have delivered the treatment so quickly before this protocol. It is so clear and makes it really easy to do the right thing."

Senior Staff Nurse, Squirrel Ward

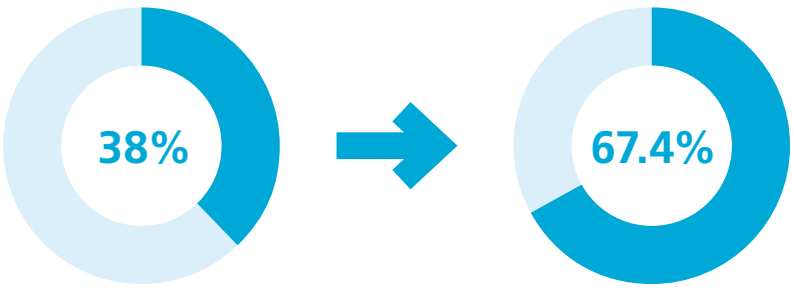


Figure 1: Sepsis 6 protocols completed within one hour in the pilot areas (Squirrel, Elephant, Lion and Giraffe Wards) from September 2016 to January 2017.

Figure 2: Sepsis 6 protocols completed within one hour in all inpatient areas (including ICUs) from January to March 2017.

[2] Levy MM et al (2014). Surviving Sepsis Campaign: association between performance metrics and outcomes in a 7.5-year study. Intensive Care Medicine 40(11) pp 1623-33.

2. Preventing cardiac and respiratory arrests

What we did

Cardiac and respiratory arrest is sometimes inevitable in the care of very sick patients. However, we want to ensure any arrest that could be prevented is prevented. We divided this workstream into three projects:

- Evaluation of Early Warning Score systems to determine the best scoring system for our patients
- Establish Just-in-Case training to prepare in advance for predicted clinical emergencies
- Roll out new defibrillators (devices that deliver electric current to the heart to correct life-threatening cardiac rhythms)

Early Warning Score: We undertook an in-depth evaluation of the Childrens' Early Warning Score (CEWS) that we use at GOSH to identify patients at risk of deterioration. We compared it with the Bedside Paediatric Early Warning Score (B-PEWS) developed by SickKids, the children's hospital in Toronto, Canada. By the assessment parameters, B-PEWS was found to be superior to CEWS for identifying clinical deterioration in children. We are now planning our replacement of CEWs with B-PEWS.

Just-in-Case training (JIC): We implemented a JIC training programme on non-ICU wards that look after the highest number of very sick children. Using the safety huddles and the clinical emergency team brief, the sickest patients are identified on these wards and the bedside nurses are trained to prepare for a clinical emergency, enabling them to be specifically equipped, whether the child deteriorates or not.

New technology in defibrillators: Supported by the GOSH Charity, we installed new defibrillators across the Trust. Two styles were introduced:

- A top-specification defibrillator with full advanced life support features. This was installed in areas of high clinical risk such as theatres, interventional labs, ICUs and high dependency areas
- A first-responder defibrillator, which may be used in either automated external defibrillation or manual mode for all age groups. This was installed in all other clinical areas including outpatients, and in public areas around the Trust with high footfall

The higher-specification defibrillator has been used to help clinical staff in the recognition and management of the acutely unwell by being used early in an arrest event. The technology of the defibrillator enables us to monitor the quality of ventilation and chest compressions by the defibrillator. It also provides real-time feedback to the resuscitating team.

What the data shows

We reviewed all respiratory and cardiac arrests outside ICU and theatre, using a classification system devised to reflect the complexity of our patients and the degree of certainty we can have about whether an arrest could have been prevented. We use the term 'probably' to show a level of certainty greater than 50%, and the term 'potentially' to show a level of certainty less than 50%.

This simple classification of three categories seeks to identify any practice that could be improved in relation to a cardiac or respiratory arrest at GOSH:

1. Probably not preventable
2. Probably not preventable but with modifying factors
3. Potentially preventable

The 'probably not preventable but with modifying factors' category enables us to identify improvements we can make to the process, even where it wouldn't have changed the outcome. Modifying factors are defined as:

1. Mismanagement of deterioration
- Failure to act on or recognise deterioration
- Failure to give ordered treatment/support in a timely way
- Failure to observe

2. Failure of prevention
- For example, healthcare associated infections, pressure sores, etc

3. Deficient checking and oversight
- Medication error
- Misinterpretation or mishandling of test results

4. Dysfunctional patient flow
- Inappropriate discharge
- Poor/inadequate handover
- Unavailability of ICU beds

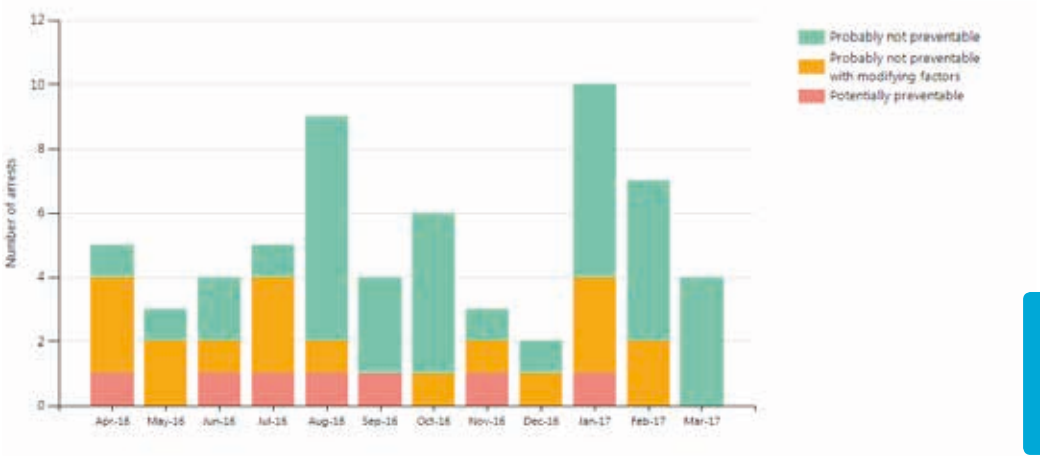
5. Equipment-related errors
- Necessary equipment failed or faulty
- Necessary equipment misused or misread by practitioner
- Necessary equipment not available

6. Other
- Other modifying factor specified

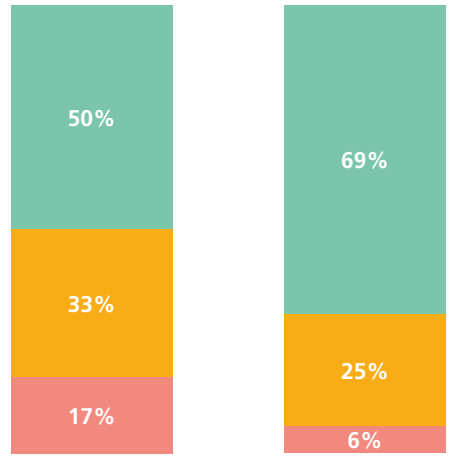
What is cardiac and respiratory arrest?
Cardiac and respiratory arrest, also known as cardiopulmonary (heart and lungs) arrest, is a term used to describe the sudden loss of heart function, breathing and consciousness. It can occur due to an electrical disturbance in the heart, but can also be caused by structural heart abnormalities that disrupt the heart's normal pumping action. This loss of function stops blood flowing to the rest of the body and stops lung function.

What is an Early Warning Score?
There are several Early Warning Score tools available in paediatrics to support staff to recognise and respond to children who may be deteriorating. 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.

All cardiac and respiratory arrests outside ICU and theatres – by review category:



2016/17 shown in 6-month blocks:



"It's been great to recap my skills and be better prepared for any event."
Nurse on JIC training

"The metronome helps keep me to the right compression rate."

"Quality CPR feedback from the defibrillator pads is amazing."

"It is very clear, no confusion."

Staff on defibrillator training

Expert

Every event that we determine as potentially preventable undergoes a comprehensive process that includes a root cause analysis. Potentially preventable arrests have reduced over the last 12 months, as have arrests that are probably not preventable but with modifying factors.

The higher number of arrests in August 2016 and January 2017 is due to a small number of extremely sick children in these months having multiple events. This is not reflective of the hospital-wide trend.

We continue to review and monitor this data closely. This enables us to use the findings in our work to eliminate potentially preventable arrests and to address modifying factors, where they are present in arrests that are probably not preventable.

What's going to happen next?

Preventing cardiac and respiratory arrests:

- Implement the B-PEWS at GOSH by the end of September 2017
- Continue to roll out JIC training across the Trust
- Further develop our dashboard of measures to identify issues in escalation of the deteriorating child
- Work with the high-specification defibrillator manufacturer to improve the accuracy of its clinical feedback for paediatric patients as part of an international study

How this benefits patients

Earlier detection of patients who deteriorate means:

- Better outcomes
- A safer environment
- Better communication and clarity between families and medical teams in the delivery of end-of-life care

Implementing safety huddles

Over the past two years, GOSH has been involved in a national programme called Situational Awareness For Everyone (SAFE), a joint initiative between the Royal College of Paediatrics and Child Health and the Health Foundation. The purpose of SAFE was to increase the ability to recognise and manage the deteriorating patient. As part of the programme, the Quality Improvement team rolled out electronic Patient Status at a Glance (ePSAG) boards in 2015/16 to enable staff to access clear, accurate and real-time patient information. The new 'watcher' category was also introduced on the ePSAG boards for monitoring. 'Watchers' are patients whose Early Warning Scores do not trigger an alert, but where the patient's family/carer or a clinical member of staff has a concern.

What we said we'd do

As part of the situational awareness programme, we also committed to implement safety huddles across all GOSH inpatient wards.

The first safety huddle took place in October 2012. But without the visual aid of electronic patient boards, traction was difficult on our busy wards. The safety huddle workstream was relaunched in September 2015, after the implementation of the ePSAG boards. This meant staff were better able to access in real time the clinical information they needed to inform their safety huddle discussions.

What we did

In 2016/17, safety huddles were successfully rolled out to every inpatient[3] ward using a staggered approach. The project steering group included clinical leads from each division to ensure local champions were engaged from the outset. Key figures such as matrons, practice facilitators and nursing leads were also identified to ensure the overarching strategy for rollout was clear. Ward staff were trained and key departmental meetings were attended for dissemination of information about the project before the intervention was fully implemented. Spread was facilitated by the Quality Improvement team and medical leads.

The analysts/developers in the Quality Improvement team also created a number of tools and documents to improve the success of the project:

- A 'huddle attendance' monitoring tool was provided to assist in assessing the attendance and timeliness of the huddles
- A reflection tool helped us analyse different aspects of the huddle to support the embedding of the practice
- An education and situational awareness video provided accurate and succinct information for all new clinicians during their induction at GOSH
- A four-week training package was developed and distributed to all ward managers as part of the implementation. The documentation provides all information necessary to commence, test and sustain the huddles at a ward level

What are safety huddles?

At GOSH, a safety huddle is defined as a five-minute daily gathering at the ePSAG board at a specified time. They are attended by all nurses on the ward, the lead doctors and any other appropriate staff members to discuss all patients' Early Warning Scores and escalation plans, and to identify the sickest patient on the ward and identify any 'watchers'.

"I feel the safety huddles have made my ward more organised with better team work and awareness."

Medical Registrar

"I think that nurses' confidence in raising their concerns has improved since the introduction of the huddle, especially the more junior nurses."

Ward Manager

"As long as I am around at GOSH I will always be looking at the ePSAG boards, or watching a huddle, and feeling a deep sense of pride that I was able to work with you all and to contribute freely."

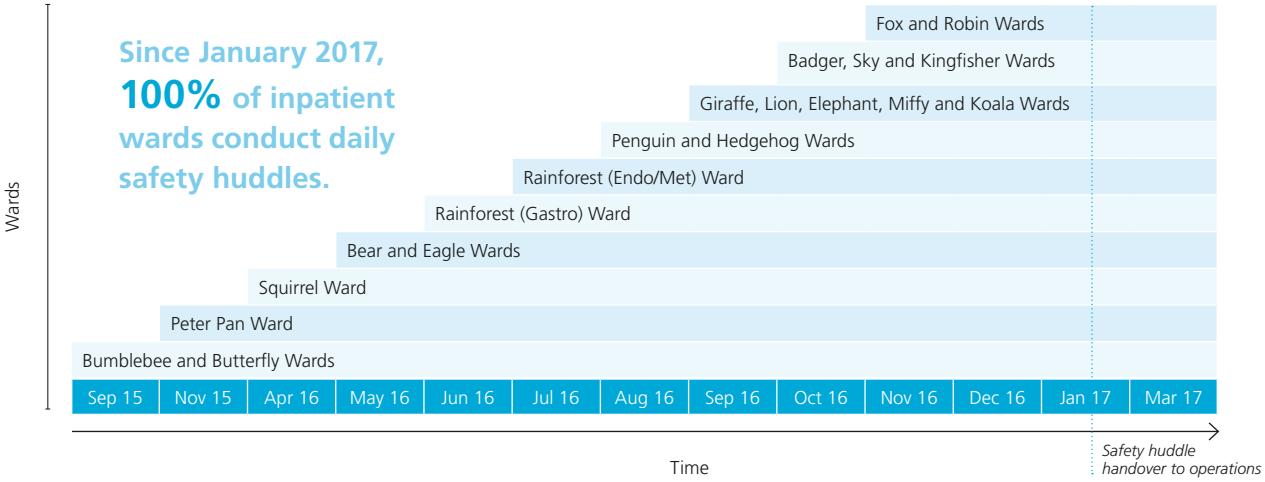
Parent representative on the project group

One Team

[3] Except intensive care units, which already have specific safety procedures embedded as part of their 1:1 care.

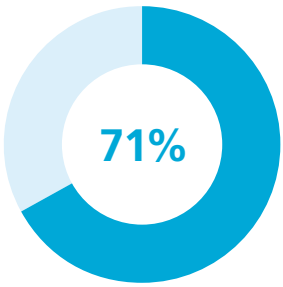
What the data shows

1. Inpatient wards that have daily safety huddles:



The project team is currently handing over the formal management of the safety huddles to operational staff to ensure sustainability of practice.

2. Inpatient wards currently fulfilling all of the 'gold standard' huddle criteria:



The GOSH 'gold standard' huddle takes place daily using an agreed script, with medical and nursing attendance. The multidisciplinary team identifies all patients with an elevated EWS and/or who fit the 'watcher' definition, and agree an escalation plan. The remaining 29% of wards (six wards) perform safety huddles daily but do not always have the wider multidisciplinary team in attendance. Local clinical managers are working with these wards to achieve consistent attendance by the full multidisciplinary team.

What's going to happen next?

To support a smooth transition from project status to 'business as usual' throughout 2017/18, we will:

- Develop a more sensitive safety indicator dashboard, devised in partnership with clinicians, which will focus on key indicators of timely intervention and avoidance of preventable deterioration in a child's condition
- Give a 'watcher' leaflet to all parents and families of children admitted to GOSH
- Finalise and include the situational awareness content in both the junior doctor induction programme and the Trust induction programme
- Hand over to wards the monitoring of their huddles for frequency and quality, so that they are locally owned and proactively sustained

How this benefits patients

- Early detection of deterioration
- Accurate and timely escalation of concerns
- Shared decision-making and contingency planning to mitigate risk of child deterioration
- Improved safety culture and staff confidence

"Safety huddles improve patient safety and communication between the team. They also help us to acknowledge who may be at risk of deteriorating and to consider patient dependency. If we do identify someone as a watcher it helps us to think about whether to share information with the CSPs, if we have not already done so."

Practice Educator

"Being up to date with all patients on the ward has definitely improved the safety culture, as we are now all aware of each other's concerns about patients."

Staff Nurse

Clinical effectiveness

Reducing the number of patients with incomplete pathways at 18 weeks

Incomplete referral-to-treatment (RTT) 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% 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

Having paused our reporting of RTT incomplete pathways in August 2015 in order to address issues with our data and processes, we committed to resuming reporting in this financial year. To achieve this, we said we would launch new operational processes to ensure our waiting list management complies with national best practice, and continue to work with commissioners to ensure sufficient capacity for the referrals that we receive into the Trust.

Part of this work included the roll out of the electronic Clinic Outcome Form system (eCOF) to support the timely and accurate capture of outcomes related to the patient pathway.

What we did

A considerable amount of improvement work has been completed by the organisation over the last year in relation to the delivery of elective care. The Trust returned to reporting against the incomplete RTT standard in January 2017, almost at target with a performance of 91.2% for the month and above the Trust's recovery trajectory that was agreed with our commissioners.

We established a clinical review process for all our children and young people who had waited longer than they should have, which was chaired by the Trust's Medical Director. Following the completion of our transformation work, we have reviewed this and formalised a process for review of any child who waits longer than their constitutional right of 18 weeks.

We entirely rewrote our processes, from data handling through to management and reporting of RTT to ensure it was robust and in line with national guidance. The new reporting system tracks all elective care patients across all parts of the elective care pathway to ensure total transparency. An external review of the reporting solution was completed by the NHS Improvement Intensive Support team, who endorsed the product as "best practice".

Particular focus has been placed on receiving complete information from referring organisations about the length of time patients have already waited prior to their referral to GOSH. As a specialist centre, 85% of our patients are first seen at a local hospital before being referred to us for more complex care. The date the patient was originally referred to their first hospital is known as the 'clock start'. In April 2016, we had an 'unknown clock start' position for 78% of all patients on the incomplete waiting list. Despite this being a difficult problem to influence directly, we sent communications to our many referrers to ensure they understood the importance of providing this information to us when they refer.

In order to improve the accuracy and completeness of outcome codes, the eCOF system was designed and implemented. Appointment outcomes and follow-up appointment requests were historically recorded by clinicians on paper and taken by patients to reception staff. We found that paper forms were not always returned, creating a risk of losing patients to follow-up and challenges in being able to track where a patient was in their RTT pathway.

eCOF was developed for clinicians to record RTT outcomes and request follow-up appointments electronically at the time of the appointment, eliminating paper forms and providing real time information on incomplete outcomes and outstanding follow-up requests for administration. Patient experience is improved as patients are now more likely to have their follow-up booked before they leave the hospital.

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.

"Much better system."

"Faster than paper."

"Recording outcomes is easier."

Clinicians

"Good way of tracking patients."

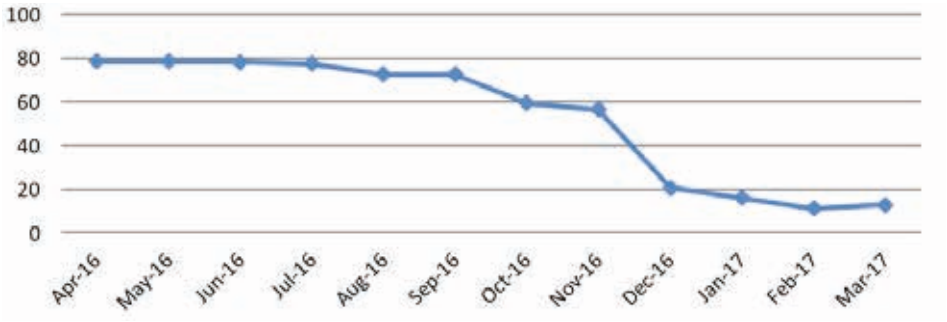
Specialty administrative staff

"This should stop the follow-ups being missed."

Outpatients department reception staff

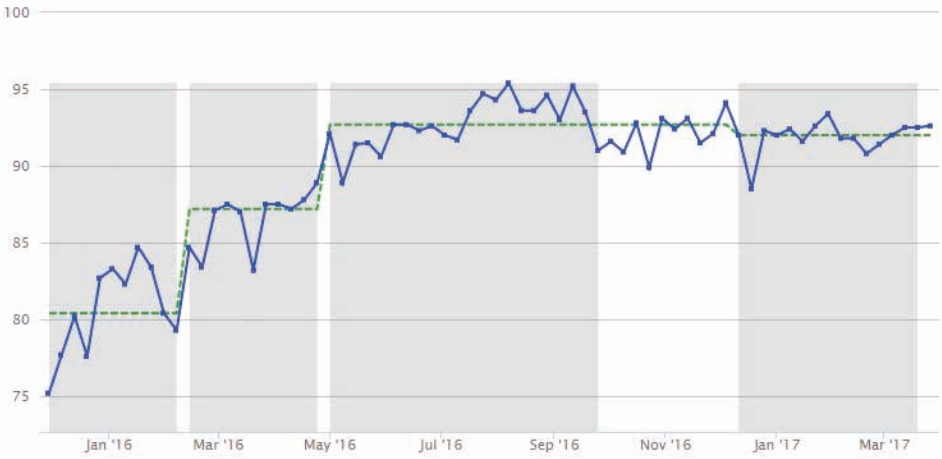
What the data shows

1. Percentage of unknown clock starts on RTT pathways:



After working hard with our many referrers to reduce 'unknown clock starts', much progress has been made in receiving referrals that have complete information to enable us to know how long the patient has already been waiting.

2. Percentage of appointments with RTT outcome within five working days:



eCOF has been fully implemented and the improvement has sustained as the chart above shows. Outpatient appointment outcomes were recorded within five days for 80.4% of appointments in January 2016. In March 2017, we recorded 92.6% of appointment outcomes within five days.

Any remaining outcomes and appointments that are outstanding are booked through weekly outpatient performance meetings, which will in future form part of the permanent Trust Patient Tracking List meetings.

3. RTT incomplete pathways:

As we only returned to reporting against the RTT standard in January 2017, we are continuing to monitor our position. However, 91.2% is a very encouraging return position against the 92% standard, with 91.6% achieved in February 2017 and 91.85% achieved in March 2017.

What's going to happen next?

The RTT standards work is now focused on a number of dedicated areas to embed good practice and sustain improvement. This includes the establishment of the Data Assurance team, who will focus on the prevention and correction of errors at source. This team will also be responsible for the establishment of training in the processes to support delivery of elective care, including RTT, cancer pathways, eCOF, and discharge summaries.

Finally, the Trust will return to compliance with the 92% incomplete pathway standard in 2017/18.

How this benefits patients

Improving our processes for elective care and strengthening assurance of our data means that patients can be seen within the most clinically appropriate timescales.

"Providing timely access to care for all GOSH patients is one of the organisation's key priorities and I am immensely proud of the improvement work completed over the last year. The Trust has not only returned to reporting, but we have been cited as a "best practice" organisation related to the tracking and managing of our patients through their pathway with absolute transparency across all aspects of care.

"We have now a solid foundation established and the future focus needs to be on making our processes sustainable to ensure that we provide timely elective care for all our patients going forward."

Nicola Grinstead, Deputy Chief Executive

Helpful

Implementing mental health screening in children and young people with long-term physical health conditions

Introducing a standardised mental health screening tool as part of routine clinical practice is in line with the government's strategy to improve the mental health and wellbeing of the nation and to improve outcomes for people with mental and physical health problems. Physical health and mental health are related, with a compelling body of evidence highlighting that people with long-term conditions (LTCs) are particularly vulnerable to mental health problems.

"Great to see that all patients have their outcomes completed on the eCOF."

Outpatients department reception staff

Expert

At GOSH, we have well-established psychosocial services offering a good level of support related to specific physical conditions, which includes adjustment to illness and adherence to treatment regimes. However, we wanted to improve our recognition and treatment of mental health problems, such as depression and anxiety, where these co-occur with physical health problems. Ultimately, our aim is to strive for optimal holistic care of children, young people and their families and to be leaders in the field.

What we said we'd do

We said we would introduce and then embed routine mental health screening and linked provision of mental health input across four identified LTC areas: Nephrology, Metabolic Medicine, Cardiology and Cleft/Craniofacial. Over the year we wanted to increase the number of inpatients offered the Strengths and Difficulties Questionnaire (SDQ) as part of routine care. The SDQ is a robust, well-validated, standardised screening measure that identifies children and young people at risk of significant mental health problems.

We also wanted to introduce a standard pathway to follow up those patients whose scores indicated they were likely to be experiencing mental health difficulties. This approach would enable us to initiate treatment as required with our trained paediatric mental health professionals.

What we did

Firstly, we worked across clinical, administrative and management staff groups to introduce routine screening to supplement our existing provision. With the help of colleagues in our Quality Improvement team, we were able to offer families the option of completing the SDQ electronically with support by nurses and other clinical staff on the ward as needed. This was easier for patients and families, more efficient for us, and allowed us to keep careful track of which children and young people needed a follow-up conversation and support from our psychological services staff. Over the year we were slowly able to build up the number of patients screened. We successfully followed up every screened patient who flagged as being at risk of mental health problems.

What the data shows

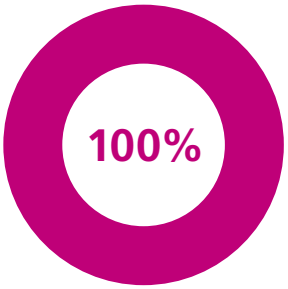
1. Number of children under a physical health specialty who received a mental health screening:

9%	14.5%	45%
Quarter 2 48 screened out of 532 eligible	**Quarter 3** 46 screened out of 318 eligible	**Quarter 4** 170 screened out of 379 eligible

2. Number of mental health-screened children, who scored above the SDQ threshold:

Of the total of 264 individuals offered the SDQ, 30 scored above the SDQ threshold. In quarter four, which was most representative, 17% of Metabolic Medicine patients screened, 13% of Nephrology patients screened, and 12% of Cardiology patients screened scored above the SDQ threshold. National research indicates that one child in 10 in the UK has a diagnosable mental health problem[4]. So, the figures are slightly higher than the general population, as we expected. This indicates a significant opportunity to attend to our patients' mental health as well as their physical healthcare needs.

3. Number of mental health-screened children, who scored above the SDQ threshold, who were followed up by a member of the Psychological Services team:



Of the 30 patients who scored above threshold, all were followed up.

"This initiative allows patients to be assessed in a way that does not rely on staff judgement or opinion. The family do not have to approach the team to vocalise their need for help and it helps to avoid waiting for crisis before intervention. Children and their families at GOSH will be aware of our views on the importance of an integrated physical and mental health approach to improve their health-related quality of life."

Carly, Matron, Barrie Division

What's going to happen next?

While we want to ensure that we identify mental health problems so we can offer intervention or support, we want to be careful that we offer screening at a time that is appropriate for families. We are exploring the best ways to do this, including the commencement of screening before children reach the stage of admission to an inpatient bed. Over the coming year we aim to:

- Commence screening earlier in the patient journey
- Increase our screening rates further
- Develop further the protocol for assessment type after a child scores 'above threshold'
- Standardise our approach across screening areas
- Develop a shared protocol for assessing the value of our mental health interventions and support to children, young people and their families

How this benefits patients

- Improved care of our patients through an integrated mental and physical health approach
- Increased opportunities to improve wellbeing of patients and their families

[4] Green H et al (2005). Mental health of children and young people in Great Britain, 2004. Basingstoke: Palgrave MacMillan.

Improving young people's experience of transition to adult services

How young people with long-term conditions and their families are prepared for their move from paediatric to adult services has come under increasing scrutiny nationally. In 2016, NICE published the guidelines, *Transition from Children's to Adults' Services for Young People Using Health or Social Care Services*. The CQC also started to include transition in their inspections.

At GOSH, transition to adult care has long been a challenge that we have sought to improve in different ways. More recently, transition was raised as an area that required attention by our Young People's Forum and by parents at the GOSH Listening Event held in November 2016.

What we said we'd do

We said we would commence a Trust-wide transition improvement project, led by the Assistant Chief Nurse for Patient Experience and Quality and coordinated by a full-time transition improvement manager.

In accordance with NICE recommendations, we said we would identify a transition lead in every clinical specialty at GOSH, with the intention of building consistency of approach within and across teams.

To understand the scope of the project ahead of us, we said that we would determine the number of young people being treated by each specialty aged 13, 14, 15, 16 and 17+. To understand the complexity of coordination required, we also said we would identify the percentage of young people in this data set who were being cared for by three or more clinical specialties.

What we did

The Chief Nurse is the executive lead for transition and has overall responsibility for transition and the transition improvement project.

Transition lead

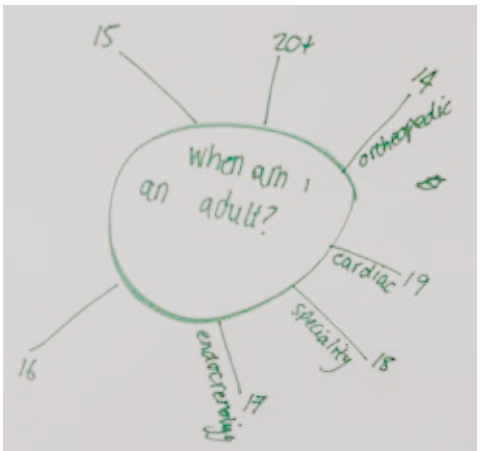
We have confirmed a doctor in every specialty to take forward the leadership role of medical transition lead for their specialty. We are currently working on the reporting requirements to meet national guidance.

Data and feedback

We completed a data snapshot in August 2016 on:

- The number of young people aged 13, 14, 15, 16 and 17+
- The specialty of first open referral received
- The consultant to whom the first open referral was made
- The number of these young people under the care of three or more specialties
- The number of these young people with a future inpatient admission or outpatient appointment

We ran a discussion group with our young people as part of the GOSH Listening Event in November 2016. The group explored the many challenges of transition from paediatric to adult health services. This diagram created by the young people during the discussion demonstrates how complex transition can be, especially for those who are cared for by multiple specialties.



What is transition?

Transition is 'the purposeful, planned process of preparing young people under paediatric care and their families or carers for, and moving them to, adolescent- or adult-oriented healthcare'

GOSH, 2017, adapted from Blum et al, 1993[5]

What is the National Institute for Health and Care Excellence?

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care in England and the rest of the UK.

What is the Care Quality Commission?

The Care Quality Commission (CQC) is the independent regulator of health and social care in England.

Helpful

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

Comments gathered at the listening event also helped us to understand the experience of our young people and their families in transition to adult services. This feedback helps us to prioritise our next steps in getting transition right at GOSH:

"It happens at different times in different departments. You may still be treated at GOSH even if you have transitioned in other departments. This is confusing – am I an adult or not?"

"GOSH is a bubble – there is an outside world. You can feel lost when you leave GOSH – no-one should be lost in the system or be transitioned without a bye."

"I'm just so scared. We've been coming to GOSH since he was a baby – he knows everyone and everyone knows him and what he's like. GOSH is like our second home."

In addition, our Transition Improvement Manager visits our transition clinics to support staff, to gather examples of good practice to learn from, and to identify improvement opportunities. The following comments were from transition clinics:

"It was really good, really reassuring. We had the chance to meet the other team and they seem really nice. It feels good knowing who we'll be seeing."
Parent after Gastro Transition Clinic appointment

"It was different. Better. I was scared at first, but one thing they did – they talked to me, it felt like it was my appointment. At GOSH they always talked to my mum. I really felt they were treating me like an adult."
18 year old, after attending first adult appointment

Understanding current practice

We also undertook an audit of all transition information and Transition Plans developed and currently used by specialties in the Trust. The Transition Improvement Steering Group, working with young people and parents/carers, is reviewing the information to ensure that processes and information are of a consistently high quality that meets the needs of young people and their parents/carers.

What the data shows

1. A data snapshot from August 2016 shows the numbers of young people aged 13 years and above:

Age	Total
13 year olds	903
14 year olds	826
15 year olds	876
16 year olds	552
17 and over	3,592

By examining the data, we found that the higher number of 13-year-old patients is because many attended GOSH for diagnosis only or second opinion. The majority of these patients return to their local services for treatment and support, so do not need a GOSH transition plan.

The higher figure for those aged 17+ years old was examined in detail. This has allowed us to identify services and groups for whom transition is not relevant so that these can be excluded from subsequent data sets. For example, our Clinical Genetics Service provides testing and advice for people of all ages, and the Cardiac Foetal Heart Service is a service for parents-to-be.

We are refining our data use to further inform the order of project priorities. We know that focusing on our young people who are 17+ is the first priority.

2. Of the patients in table 1, these are the numbers receiving care under three or more specialties:

Age	Total	As a % of total
13 year olds	467	37%
14 year olds	209	16%
15 year olds	189	15%
16 year olds	165	13%
17 and over	240	19%

The higher number of 13 year olds was expected, as young people aged 14 and 15 are more likely to be referred directly to adolescent services. The Trust generally does not accept initial referrals for 16 year olds and over. The higher number in the 13-year-old group also helps us to understand more about the complexity of transition planning for our young people whose health problems require them to be seen across multiple specialties.

The care of patients accessing three or more specialties is complex, and there are conditions treated at GOSH for which there is no equivalent adult specialist service. The challenge of identifying appropriate services often causes delayed transfer to adult services, resulting in slightly higher numbers in the 17+ age group. The transfer of some young people is also delayed until the course of treatment, such as those involving multiple surgeries, is completed.

What's going to happen next?

We aim to:

- Define and set standards for Transition Plans
- Focus on putting Transition Plans in place for young people aged 16 and over in 2017/18, and from 14 and over in 2018/19
- Work in partnership with Barts Health NHS Trust and University College London Hospitals NHS Foundation Trust to improve support for young people with learning disabilities or additional needs
- Build IT infrastructure to better support planning and documentation of transition

The Transition Improvement Project is anticipated to continue for a minimum of three years and we will report the coming year's progress in next year's *Quality Report*.

How this benefits patients

Well-coordinated transition empowers young people to be as involved in their future health and healthcare as they are able, and supports them to develop to their full potential.

Utilising Friends and Family Test data for improvement

We began to use the national Friends and Family Test (FFT) at GOSH in April 2014, starting with inpatient areas before extending to outpatient and day care areas six months later. Since then, we have collected nearly 33,000 pieces of feedback from patients and their families.

What we said we'd do

Initially, the NHS FFT programme required feedback from adult patients and service users. We said we wanted to extend the use of the FFT to children and young people too, because we need to hear their voices to have a full picture of experience here at GOSH.

We said we wanted to collect demographics on all FFT cards so that we can better understand experience and determine if there are any differences in quality of experience by ethnicity, age, and additional needs.

We also said we wanted to make sure that the data collected from the FFT was used throughout the Trust to inform service improvement work.

The core component of FFT is the percentage of respondents to recommend the hospital. For this, we set ourselves an ambitious target of 95%.

What we did

After conducting focus groups with patients and their families and consulting with our Young People's Forum in late 2015/16, we had information that could guide us. Our young people told us that they were happy to complete the adult cards, but felt that child-friendly feedback cards were needed. In 2016/17, we used a combination of their input and NHS England guidance to produce our own feedback cards for children eight years and under. We began using our new cards for children from July 2016. By 31 March 2017, 1,028 cards had been completed by children and young people, giving us a unique view of their experience as patients.

Inpatient (above) and outpatient (right) feedback cards for young children.

We have also increased awareness of FFT among children, young people and families at GOSH through high visibility feedback stations in all areas.

We worked with the Quality Improvement team to design and implement a new FFT database to enable collection of additional demographic information and improve reporting. We began collecting demographic data in December 2016. Once we have enough data, we will begin to look for trends so that we can target improvements in the equity of services and experience.

All the data and comments received are reported back to the areas they concern on a monthly basis. Positive comments about individual members of staff are passed to their manager and used to support nomination for staff awards. We also provide word clouds of comments to boost staff morale.

Word cloud of feedback about Eagle Ward, April 2016.

Now that we hold so much experience data, teams have been encouraged to review this before undertaking other surveys. In addition, FFT data has been used to support workstreams at GOSH, including development of the patient portal for the Electronic Patient Record programme, support of nurse revalidation, and use of *Our Always Values*. FFT data was also used to inform the topics discussed at our listening event in November 2016.

What is FFT?

The Friends and Family Test is a national feedback tool for NHS service users to provide feedback on their experience of the care they receive.

What is the Young People's Forum?

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

Helpful

Welcoming

"The food is very repetitive."

Parent – Badger Ward

The catering team has now amended the menu cycle from weekly to three weekly, so it is less repetitive for long-stay patients.

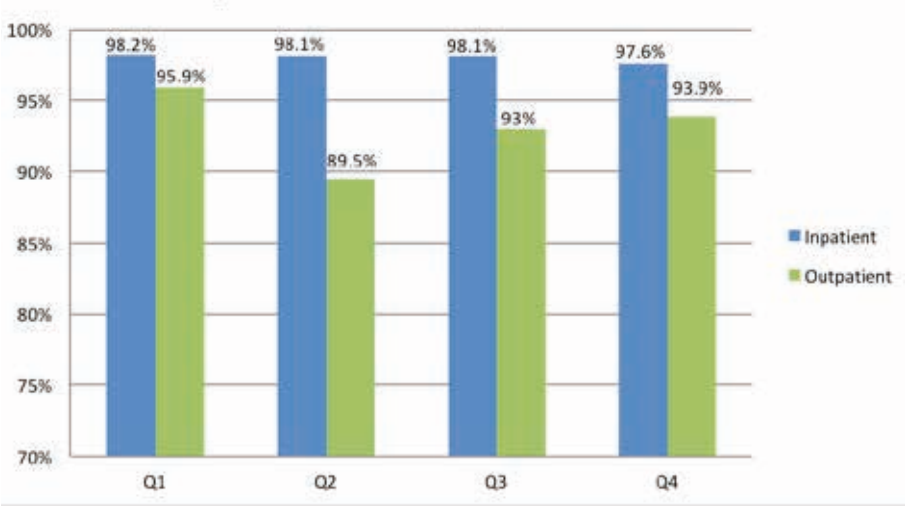
What the data shows

1. Response rate:

Feedback through FFT has increased from around 6,300 comments in 2014/15 to more than 13,000 in 2016/17. In the last year, the number of comments received has increased by 7%. We have a total response rate of 24% (inpatient) for 2016/17. While our response rate is lower than our challenging chosen target of 40%, it is broadly similar to the response rates of other children's hospitals. We continue to widely promote the FFT cards to patients and families, while being sensitive to the complex and, at times, difficult circumstances for families with a sick child.

2. Percentage of respondents to recommend the Trust:

The percentage of inpatients to recommend GOSH has remained above 97% throughout 2016/17. The percentage of outpatients to recommend GOSH has been slightly lower at an average of 93%, and we have used these responses to define an improvement project in outpatients that is currently underway.



3. Percentage of feedback that is provided to departments:

100% of feedback that specifies wards, specialties or individuals is fed back to managers in those areas for sharing with staff, to encourage with the positive feedback and to target improvement through feedback about what could be better.

What's going to happen next?

We will start to analyse demographic data for experience trends, to enable us to better understand differences and target improvement work to achieve greater equity in our service delivery.

As FFT is currently delivered in paper form, we are exploring ways to provide it electronically to improve ease and accessibility, and increase uptake.

In 2017/18 we plan to implement a real-time feedback system, which will enable comment at any time throughout a patient's stay or visit using mobile phones and tablet computers. This will enable staff to respond to negative feedback and/or problems in a much timelier manner. We want the system to be interactive, with separate modules for different ages, as well as adaptations to enable feedback from non-English speakers and those with additional needs.

How this benefits patients

- Listening to the experience of our children, young people and families helps us improve the services we provide – according to what matters to them
- The 'percentage to recommend' measure gives the Trust a broad view of patient experience, but the qualitative comments allow further analysis to target improvements where needed
- The data also allows us to monitor positive themes, so that we can celebrate individual wards and departments who provide an excellent experience

"Lynne was fantastic. With her bubbly personality, she made all of us feel at ease. It was my son's first cannula and she made it a positive experience, highly recommended."

Parent – Walrus Ward

Lynne, Senior Healthcare Assistant, was nominated for a GOSH GEMS award as a result of many comments like this. Lynne successfully won the individual GEMS award in January 2017. Read Lynne's story on page 18 of the Annual Report.

"The only thing that needs improving is the Wi-Fi. We rely on technology while our child is in hospital."

Parent – Bumblebee Ward

The GOSH ICT department are working closely with a mobile telecommunications company to install Wi-Fi boosters across the site to tackle the Wi-Fi signal weak spots.

"The staff were very open and professional, and communicated really well with us and responded to all of our questions/ needs. There was always a nurse available, which is so important to help with feelings of anxiety in hospital. Thank you.

Parent – Penguin Ward

This feedback was communicated to the Matron and Penguin team to celebrate their excellent approach and compassionate manner.

Other ways that we listen to our patients and families

Listening event
On Saturday 19 November 2016, GOSH held an outer-space-themed listening event where patients and parents shared their ideas and experiences of the hospital.

The day centred on four topics identified through FFT feedback and social media. The key areas chosen by the children, young people and parents were: communication, food, transition and outpatients.

A range of senior members of staff attended the day, including the Chief Executive, Deputy Chief Executive, Medical Director and Chief Nurse.

There was also a marketplace area so families could meet a number of our teams and learn about other projects taking place at the hospital. There were representatives from the following teams: Chaplaincy, Charity, Digital, Electronic Patient Records programme, GOSH Arts, Hospital School, Patient Advice and Liaison (PALS), Redevelopment, Research, Sustainability, Volunteers and Learning Disabilities.

Everything we learned about the four topics during the day was themed to help us understand what matters most to our patients and families. The themes included:

Communication
- Face-to-face communication
- Staff-to-staff communication
- Fewer and more comprehensive letters, and more use of text and email

Food
- More information on ingredients
- More variety of meals
- Flexible mealtimes

Transition
- Clearer communication
- Transition spoken about sooner
- More support when going through transition

Outpatients
- Advising of delays
- Staff to introduce themselves to children and young people more
- More things for older children to do while waiting
- Appointments requested at early mornings or weekends

The themes that emerged from our listening event have been shared with families. Staff are working on short- and long-term actions, which will also be shared with families as we progress.

Breakout room for children and young people to discuss the four chosen topics.

Peter Steer, Chief Executive, receiving feedback from children and young people on the topic of communication.

Ruth Evans, Involvement and Engagement Officer for Research, teaching attendees about research at GOSH and biology.

Video booth
As there is no 'one size fits all' when it comes to feedback, GOSH piloted a video booth to allow families who may not want to fill out surveys or attend focus groups, to share their experiences at the hospital.

The video booth was placed in the GOSH entrance for four days in November, with the Patient Experience team and PALS supporting booth use by answering questions and offering outer space props!

Inside the video booth, the screen displayed a series of steps to record a message if the participant provided their name and email address. There was a disclaimer that if anyone had any specific questions or urgent worries they should speak to a member of staff, as the booth was for non-urgent messages.

In four days (17–21 November), 101 videos were recorded and 175 people took part. One hundred of those (57%) were children and young people and the other 75 (43%) were adults.

91%

of comments were positive and all were themed to inform our improvement work.

A wide variety of people left messages, ranging from patients to their siblings, aunts, uncles, cousins, other family members and friends. A range of ethnicities was represented by contributors. Feedback was also collected from two people who had not felt able to engage in other feedback mechanisms – one adult who could not read or write and one child whose multiple health conditions meant a video recording made giving feedback more achievable.

Following the video booth pilot, videos that contained specific staff, ward, or team feedback (whether praise or comments about what can be improved) were collated. Consent was obtained so that the films could be shared with staff, and a compilation video is due to be completed shortly. Any concerns raised (eg comfort of parent beds) were shared with the teams responsible.

A number of individuals have also been offered the opportunity to share their experience as part of our patient story programme.

GOSH's space station-themed video booth.

2017/18 Quality priorities

The following table provides details of three of the quality improvement projects that the Trust will undertake in 2017/18. These priorities were determined with input from staff, patients and their families, and commissioners. This input was sought through a range of mechanisms including a survey, consultation and use of established meetings such as our Members' Council, Young People's Forum, and Patient and Family Engagement and Experience Committee. The new quality improvement projects are in line with our strategic priority to provide the safest, most effective and efficient care, with the best possible outcomes.

Safety

To eliminate avoidable harm.

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Improving the quality and safety of care for inpatient neonates/small infants – this work will focus on three main areas: bloodspot screening, neonatal jaundice and intravenous fluid management. This work is to act upon a need for improvement that was identified through an audit of neonatal care.	Bloodspot testing, which is part of the national newborn screening programme, ensures early detection and treatment for nine rare but serious conditions. It is essential that all newborn babies at GOSH receive bloodspot screening if this has not already happened prior to their admission. We also want to ensure that ward staff are able to effectively identify and manage the treatment of neonatal jaundice in line with evidence-based practice. We have developed a Trust guideline for the management of neonatal intravenous fluids with speciality, pharmacy and neonatal leads. We will be working to implement this and raise awareness of the importance of neonatal fluid management – both in terms of safety and to ensure that we are able to provide a standardised approach for all babies.	1. By the number of blood spot screening tests carried out 2. By the number of blood spot tests not taken within the appropriate timeframe 3. By the number of blood spot tests that could have been avoided 4. Audit compliance with neonatal jaundice guidelines 5. Audit compliance with the neonatal intravenous fluid management guidelines The data will be published on our intranet dashboards, and reported to the Quality Improvement Committee.

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?
Developing Trust-wide access to outcomes data through the Clinical Outcomes Hub.	Clinical outcomes are broadly agreed, measurable changes in health or quality of life that result from our care. Here at GOSH, every speciality collects outcomes and many teams have published outcomes to the Trust website. But, we need greater visibility of that data internally to enable teams to more readily use outcomes data in decision-making, to notice trends, and in service improvement. By working closely with the specialties, the Clinical Outcomes Hub will display effectiveness data in ways the clinical teams find most informative.	1. By the number of specialities with a dashboard of outcome measures published on the Hub 2. By the total number of outcome measures published on the Hub 3. By the number of patient-reported outcome measures collected via an electronic survey tool linked from the Hub Progress will be reported monthly to the Quality Improvement Committee.

Experience

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

Improvement initiative	What does this mean and why is it important?	How will progress be monitored, measured and reported?
Improving young people's and parents'/carers' experience of transition to adult services.	Good experiences of transition from paediatric to adult healthcare services are associated with improved levels of independence for young people with long-term conditions. A good transition also increases engagement with adult services, improving health in adulthood. **Features of a good transition include:** • Ongoing incremental preparation, from the age of 14 at the latest • Use of a Transition Plan to inform a programme of education and support including the opportunity to meet the adult service(s) prior to the transfer of care • Good communication between the paediatric team, local primary care services and the receiving team • Consistency of approach, especially for young people who are under the care of multiple specialties	1. By the numbers of young people aged 16 and over with a Transition Plan in place, identifying specialty and consultant initially referred to (for focused improvement work in 2017/18) 2. By the numbers of young people aged 13 and over under three or more specialties, identifying specialties and consultants involved (for continuing to enhance our understanding of our population of young people) Monthly reports will be sent to the Specialty Transition Leads and Divisional Boards. In addition, the Transition Improvement Steering Group will report to the Quality Improvement Committee and the Patient and Family Engagement and Experience Committee on a monthly basis.

Sadie, age one, is on Miffy Ward while her mum learns to use the ventilator equipment before they can go home.

Part 2b:
Statements of assurance from the Board

This section comprises the following statements:

- Review of our services
- Participation in clinical audit
- Participation in clinical research
- Use of the Commissioning for Quality and Innovation (CQUIN) payment framework
- Care Quality Commission (CQC) registration
- Data quality
- 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% of the Trust's healthcare activity. The remaining 10% 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 processes to check that we meet our own internal quality standards and those set nationally. These processes include scrutiny by committee. One example is our Quality, Safety and Assurance Committee, where there is a focus on improvements in quality, safety and patient experience. Assurance is provided through reports on compliance, risk, audit, safeguarding, clinical ethics, and performance. Patient stories are often presented to this forum and to the Trust Board.

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

The Trust's performance framework enables clinical divisions to regularly review their progress, to identify improvements, and to provide the Trust Board with appropriate assurance.

Expert

One Team

Participation in clinical audit

During 2016/17, 12 national clinical audits and clinical outcome review programmes covered the NHS services that GOSH provides. The Trust has participated in them all and data submissions are outlined below.

Name of national audit/clinical outcome review programme	Cases submitted, expressed as a percentage of the number of registered cases required
Cardiac arrhythmia – National Institute for Cardiovascular Outcomes Research (NICOR)	100% (186/186)
Congenital heart disease including paediatric cardiac surgery – NICOR	100% (1,372/1,372)
Diabetes (paediatric) – National Paediatric Diabetes Association	100% (34/34)
Inflammatory bowel disease – Royal College of Physicians	100% (34/34)
Maternal, Newborn and Infant Clinical Outcome Review Programme – Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK)	100% (18/18)
Medical and Surgical Clinical Outcome Review Programme – National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Cases have been submitted for the three outcome reviews that cover GOSH services. The deadlines for submissions are in 2017/18.
National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (NCISH)	No clinical reviews were identified for GOSH in 2016/17.
National Cardiac Arrest Audit – Intensive Care National Audit and Research Centre (ICNARC)	100% (33/33)
National Neurosurgical Audit Programme	Data is taken from national Hospital Episode Statistics rather than submitted by the Trust.
Paediatric Intensive Care Audit Network	100% (1,881/1,881)
Renal replacement therapy – UK Renal Registry	100% (197/197)
UK Cystic Fibrosis Registry – Cystic Fibrosis Trust	100% (183/183)

The following national audit reports have been published during 2016/17, which are relevant to GOSH practice:

- Cardiac Rhythm Management Audit Report 2015/16
- Congenital Heart Disease (CHD) Audit Annual Report 2012–2015
- Inflammatory Bowel Disease Programme: Biological Therapies Report 2016
- National Cardiac Arrest Report
- National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (NCISH) Annual Report 2016
- National Neurosurgical Audit Programme: Continuous Outcome Data
- National Paediatric Diabetes Audit Report 2015/16
- Paediatric Intensive Care Audit Network (PICANET) Annual Report 2016
- Pulmonary Hypertension Audit Report 2016
- UK Cystic Fibrosis Registry Annual Data Report 2015

GOSH has a process to ensure that all national audit reports are reviewed by appropriate professionals within the organisation. The process includes assurance that any relevant data or recommendations are discussed by the clinical teams and any actions identified.

The Congenital Heart Disease Annual Report highlights excellent clinical outcomes reported at GOSH for paediatric cardiac surgery. This also highlights the outstanding work of the Clinical Information team for the West Division, which maintains systems that have allowed high-quality data to be reviewed as part of this registry.

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

What is clinical audit?

"Clinical audit is a way to find out if healthcare is being provided in line with standards, and lets care providers and patients know where their service is doing well and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients. Clinical audits can look at care nationwide (national clinical audits) and local clinical audits can also be performed locally in trusts, hospitals or GP practices."

NHS England[6]

"It is also noteworthy and reassuring to families that five centres have results with an overall risk-adjusted survival at 30 days higher than predicted level, one of whom (Great Ormond Street Hospital) at a much higher than predicted level."

Congenital Heart Disease Annual Report

Key learning from clinical audit in 2016/17

The Clinical Audit team sits within the Quality and Safety team 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 and patient complaints, and to investigate areas for improvement in quality and safety. A selection of this work is highlighted below.

Quality of World Health Organization (WHO) Surgical Safety Checklist

The Trust collects data continuously on WHO checklist completion. The mean average for completion of all three stages of the checklist across the Trust is 94%. While the data is useful, we also wanted to understand how *effectively* the checklist is being used to promote quality and safety in the operating theatres.

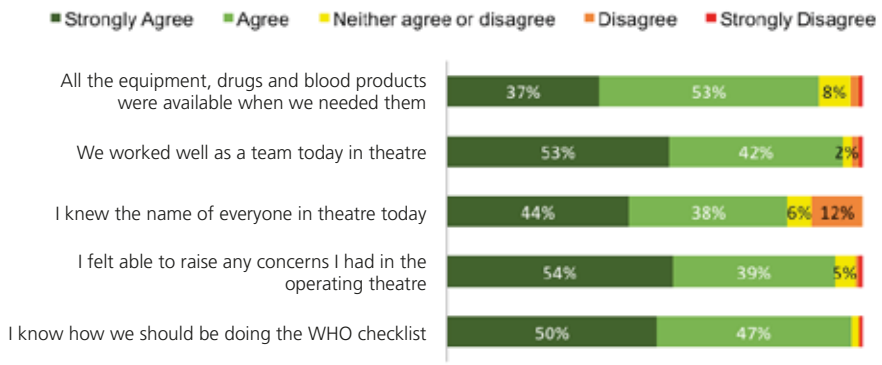
The following audit helps to answer the question: 'How well are we doing the checklist?'

What is the WHO Surgical Safety Checklist?

The WHO Checklist is a three-stage set of documented safety checks that are performed by clinical staff in the operating room to enhance safety practices and ensure communication and teamwork.

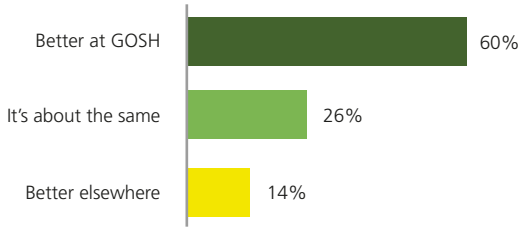
Key findings

Theatres checklist culture



GOSH compared with other centres

"How well are the team briefs and the WHO checklist observed at Great Ormond Street Hospital compared with where else you currently practice, or have practised in the last three months?"



The audit shows good engagement in the team brief and WHO Checklist, and a positive safety checklist culture. An area for improvement that the audit highlighted was that checks should always be performed with reference to the checklist rather than at times performed from memory.

Action taken

- Theatre staff were asked to identify solutions as to how the checklist can be better used for each case. This took the form of an electronic suggestion box to engage staff energy and ideas for improvement
- The Lead Nurse for Theatres has introduced an additional minute into the morning theatres handover for communication with the sisters about using the checklist each day

Clinical emergency trolley audit

Background

Resuscitation services audited the contents of emergency trolleys across the Trust in January 2017.

Results

84% of trolleys reviewed met the required quality standard. This is a 24% increase on the 2016 results. All trolleys not meeting the standard were corrected as part of the audit and later re-audited.

How have we improved?

- Ownership from the ward staff to ensure their trolley is safe and well-maintained
- Nursing Visible Leadership programme included the raising of awareness about emergency trolleys
- New defibrillators were introduced, requiring extra training that included highlighting with staff the importance of their emergency equipment

One Team

Helpful

Expert

Bereaved parent survey

Aim

The purpose of this audit is to learn from the experience of bereaved parents and carers whose children have died in hospital and to evaluate the support offered.

Key findings

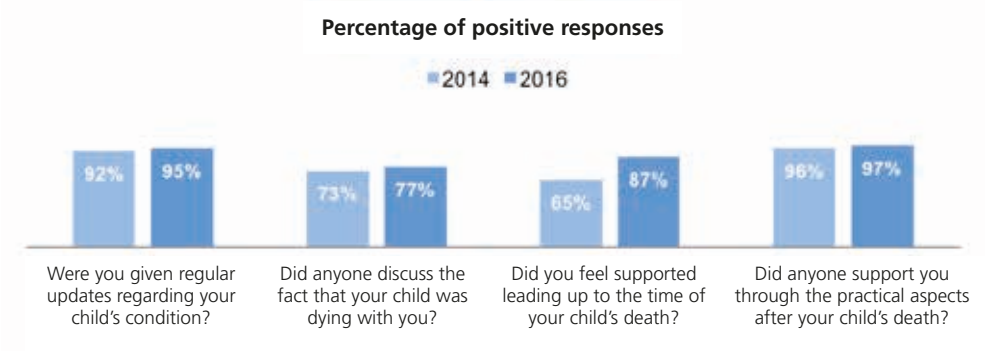
The audit demonstrates the excellence of the support that is provided to children and their families. The feedback from parents highlights the high praise and esteem that our staff have received for the support they provide to families:

98%

of respondents who answered the question reported that they had been contacted by bereavement services since their child had died.

Have you been contacted by your child's medical team and offered a follow-up meeting?

Improvements have been noted in a number of key measures when compared with results from 2014.



Recommendations for improvement included:

- Developing and improving the hospital information available to families
- Delivering training opportunities for staff in communicating with families about the death of their child, particularly on our ICU
- Delivering training opportunities for doctors to feel more comfortable and confident in discussing post-mortem examinations with families
- Ensuring that families are contacted by the medical team within 6–8 weeks following their child's death

These recommendations have been reviewed by the End of Life Care Committee and by the Patient and Family Experience and Engagement Committee. Actions will be taken forward by the Bereavement Services Manager.

Learning from complaints

As part of the complaint investigation process, lessons learnt and areas for service improvement are identified and actions plans are devised. This section of the report shows a selection of completed audits in 2016/17 to assess the implementation and effectiveness of learning from patient complaints.

Background

Multiple attempts at cannulation (insertion of a thin plastic tube into a vein for blood sampling and giving of medicines and fluids) were made on a patient who was difficult to cannulate.

What we said we would do

We said we would identify whether the complaint reflected a wider patient safety issue.

What did the audit tell us?

The data showed an increased prevalence over time of patients having multiple attempts at cannulation, contrary to our escalation policy.

Actions

Learning from the audit was circulated as a Trust Safety Message of the Week. The data shows challenges with cannulae and is being used to inform a Quality Improvement project to reduce extravasation, a particular kind of harm associated with cannulae.

Background

A patient was discharged without blood tests being reviewed and subsequently deteriorated.

What we said we would do

Improve the process of requesting urgent blood tests and improve the recording of the correct contact details on the blood test request form on one inpatient ward.

What did the audit tell us?

100% of standards to minimise the risk of this event from reoccurring had been implemented.

Background

A variation in a patient's DNA was incorrectly transcribed onto a report. This single variation altered the interpretation of the result.

What we said we would do

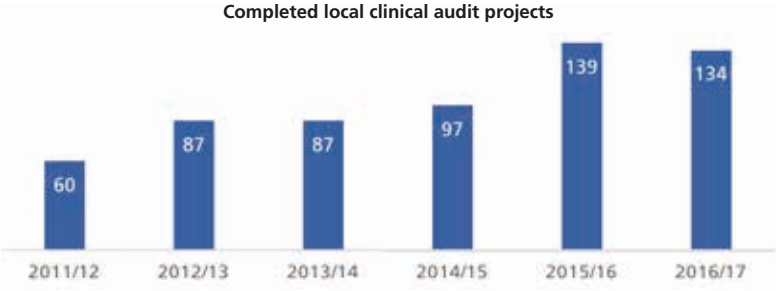
Improve the process of checking DNA variants forms, by changing the protocol to include an additional level of review by an independent reviewer.

What did the audit tell us?

In 98% (98/100) of cases variant forms were independently reviewed. 98% of cases (98/100) were correctly transcribed onto the report. Actions have been taken to reinforce the process of independent reviews, and to implement an automated report to reduce human error. A re-audit is planned.

Local clinical audit

The summary reports of 134 completed clinical audits by clinical staff were reviewed at GOSH during 2016/17. Our data shows we are improving our completion and sharing of local clinical audit:



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.

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:

Audit name	Key findings	How did the clinical audit help patients and staff
Oxygen levels in children with severe lung disease in the Paediatric Intensive Care Unit	Children with severe lung disease are unable to maintain their oxygen levels without intensive care support. Current guidelines based on adult evidence suggest that patients with severe lung disease should have oxygen saturations (measure of how much oxygen is carried by the blood) between 88–94%. We examined the amount of time spent by patients with the most severe lung disease at different levels of oxygen saturation. Overall, children spent over 40% of the time with oxygen saturations above 97%.	While a lack of oxygen is not good for patients, emerging research suggests that high levels of oxygen may also not be good for patients. This piece of work helped us obtain a GOSH Children's Charity grant to study the impact of different oxygen saturations in children in a randomised controlled trial. The trial will test feasibility for a larger-scale trial and is currently underway in three UK paediatric intensive care units. We believe that the knowledge gained from this wider work will improve the care given to children on intensive care units at GOSH and worldwide.
Indications for use of parenteral nutrition in bone marrow transplant patients	Earlier nutrition intervention via tube feeding may help reduce the number of patients starting intravenous nutrition. This would cut overall costs, reduce line infection risk, and potentially reduce the length of hospital stay.	This has provided the team with a greater awareness when considering intravenous nutrition and greater confidence to encourage earlier tube feeding wherever possible.
Time to clinical remission in juvenile idiopathic arthritis (JIA) patients commencing on etanercept and adalimumab (biologics)	Area of improvement identified to achieve the standard of regular review after starting biologic treatment.	Plan to set up shared care with local hospitals in order to review JIA patients after commencing new biologics.
Continuous assessment of basic gastrostomy care in the Trust	Higher levels of confidence were reported in: • Determining why a gastrostomy may be required • Identifying gastrostomy devices • Providing basic care • Escalating concerns	There was significant improvement across the Trust.
Trends in obesity amongst patients undergoing general anaesthesia	A significant proportion of patients were found to be obese (12.9%), which represents an immediate risk during operations.	Development of a perioperative protocol for the management of the obese child undergoing general anaesthesia.
Use of cuff pressure manometers and review of cuff pressures during anaesthesia	We used this audit to identify that we could reduce the risk to patients in theatre associated with cuffed airway devices.	More cuff pressure monitors have been purchased following these results.
Review of the feeding outcomes of children with a diagnosis of posterior laryngeal cleft	The audit enabled better understanding of the type of swallowing problems children with a laryngeal cleft have pre- and post-surgery, their feeding prognosis and the need for ongoing support and/or intervention.	It helped to inform parents, children and the multidisciplinary team about feeding problems and resulted in refinement of the clinical care pathway.

Clinical Audit Heroes

As part of National Clinical Audit week in November 2016, the Healthcare Quality Improvement Partnership launched 'Clinical Audit Heroes' to celebrate individuals who make a positive difference in audit and quality improvement across the NHS. Of 25 NHS staff members nominated nationally, three nominees were GOSH staff. This signals our commitment to clinical audit here at GOSH, and the integration of audit with quality improvement, outcomes and research. It also demonstrates the peer support of colleagues in their work to improve the care of our children.

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 a leading children's research hospital. We are in the unique position of working with our academic partner, the University College London (UCL) Great Ormond Street 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 benefits from 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. Continued investment in research infrastructure is critical, with current examples including:

- The National Institute for Health Research (NIHR) GOSH Biomedical Research Centre has been awarded a further five-year term of funding. A total of £37m has been awarded, which will drive forward translational research into rare diseases in children. The successful application is part of our ongoing partnership with ICH as the UCL Great Ormond Street Institute of Child Health
- For a period of five years, £3m has been awarded by the NIHR to support our Somers Clinical Research Facility (CRF). The CRF is a dedicated space for children taking part in clinical trials at GOSH. This funding will allow the CRF to support more complex early phase research for some of the rarest childhood conditions
- The Trust together with GOSH Children's Charity invested £1.2m into research infrastructure posts, which underpin the work of our leading research teams
- The Trust also received £1.9m from the NIHR Clinical Research Network to support key research delivery posts

GOSH also hosts one of the few centres dedicated to supporting nurses and allied health professionals in research activity. This team of researchers prioritises understanding the patient and family experience, helping to describe the care that families receive, and exploring both processes and outcome.

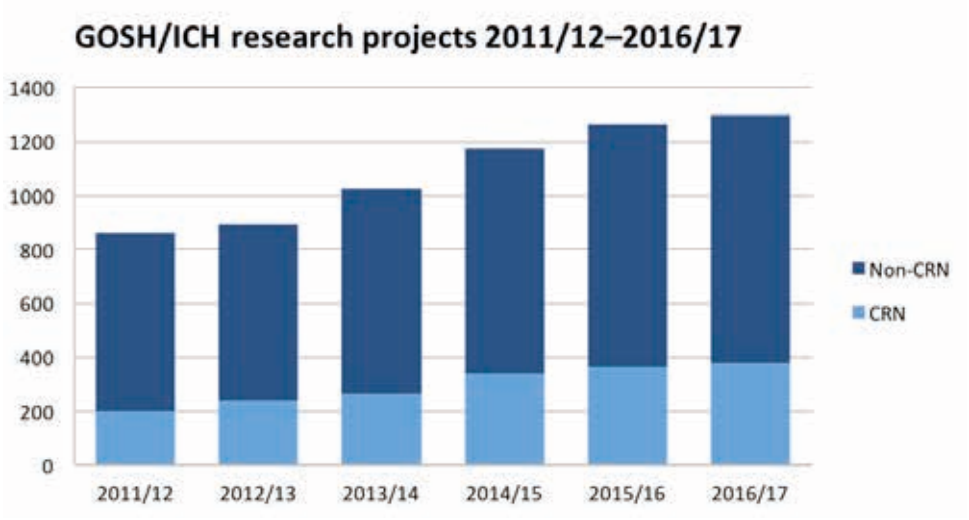
Together, GOSH and ICH form the largest paediatric research centre outside North America.

Research activity

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.

During 2016/17, we ran 1,299 research projects at GOSH/ICH. Of these, 379 were adopted onto the NIHR Clinical Research Network (CRN) Portfolio, a prestigious network that helps deliver research across the NHS. In the first three quarters of 2016/17, more than 4,000 patients and family members took part in research studies. In addition to these, GOSH is the lead trust for the North Thames NHS Genomic Medicine Centre (GMC), which is sequencing patient genomes for the 100,000 Genomes project for rare diseases. The North Thames GMC has recruited 5,200 participants, making up around 28% of those recruited nationally.

Our already extensive research activity has consistently increased year on year. The chart below shows the numbers over time of all our research, including the CRN portfolio projects:



Year	CRN	Non-CRN	Total
2011/12	199	662	**861**
2012/13	239	653	**892**
2013/14	266	758	**1,024**
2014/15	339	835	**1,174**
2015/16	367	898	**1,265**
2016/17	379	920	**1,299**

Note: These figures may differ from those previously reported due to a change in the measure of research activity from 'Number of active research projects at year end' to the more representative 'Number of research projects active within a financial year'.

Journal publication

In addition to high levels of research activity, we also have high citation impact. This means that our published research papers are often referenced in others' research. An analysis by Thomson Reuters of our publication output for the five years to 2014 showed that GOSH and ICH has the highest citation impact of the top children's hospitals we compared ourselves with internationally. This analysis is undertaken periodically and is currently underway for the five years to 2016. We will report the result in next year's *Quality Report*.

Research highlights include

Researchers at GOSH and ICH have discovered a new genetic mutation that causes a rare form of epilepsy. The faulty gene was identified in seven out of 32 children with a rare strain of vitamin B6-dependent epilepsy who are unresponsive to standard anti-epilepsy drugs. These findings are extremely important as they will allow easier identification of patients who will benefit from treatment with vitamin B6.

A study has identified a set of 614 genetic markers that can be used to speed up diagnosis of suspected neurometabolic disease. Currently, patients can undergo extensive and often invasive testing, and delays or difficulties in establishing a diagnosis are commonly encountered. A GOSH team showed that testing for defects in 614 different genes could at least partially diagnose neurometabolic conditions in up to 89% of cases. This powerful tool could assist timely diagnosis in many patients, meaning that crucial treatment can begin more quickly.

We've seen promising results in a pilot project at GOSH to test whether genome sequencing of patients' blood samples can be used as a diagnostic tool in the clinic. The project aimed to test 10 patients (and their parents) from GOSH's Paediatric Intensive Care Unit whom consultants suspected may have a rare genetic disease. For five of the first eight patients, definite or possible genetic causes of the disease were returned within five days, helping clinicians to take rapid and appropriate action to treat these patients.

Pharmaceutical company BioMarin has pre-released promising results from a novel trial testing a new treatment for CLN2 disease. CLN2 disease is a subtype of the fatal neurodegenerative condition called Batten disease, which is caused by a genetic mutation that results in reduced activity of the CLN2 protein. In this trial, an active copy of the protein was administered directly into patients' brains. One year after treatment, affected patients showed an 80% reduction in the progression of the disease. It is expected that BioMarin will now look to implement an early access programme to enable additional CLN2 patients to have access to this novel treatment.

In collaboration with the University of Cambridge, researchers at GOSH/ICH have identified a new genetic cause of complex early-onset dystonia. Dystonia is a movement disorder, characterised by abnormal body movements and postures. The condition affects around 70,000 people in Britain. However, for a large proportion of children with childhood-onset dystonia, the underlying cause remains unknown. This research demonstrated that children with the faulty gene could be treated using 'deep brain stimulation' – a new therapy where electric impulses are delivered to specific areas of the brain.

Use of the CQUIN payment framework

A variety of CQUINs have been undertaken by the Trust in 2016/17. Some of these are national indicators, which may also be undertaken by other trusts across the country, and some were locally defined in order to improve our individual performance. Due to the specialist nature of our care, some of the national CQUINs needed to be adapted to fit with the services we provide for our patients.

CQUIN schemes 2016-17	Overview
National schemes	
Clinical Utilisation Review system	The Clinical Utilisation Review is a pilot to improve the flow of patients through GOSH. This CQUIN involves the procurement, installation and implementation of a system, and the reporting of results and evaluation of the pilot.
Antimicrobial resistance – Part 1 (20%)	To increase the number of patients' antibiotic prescriptions that are reviewed in hospital, in order to prevent overuse of antibiotics.
Antimicrobial resistance – Part 2 (80%)	To reduce the use of specific antibiotics when they are no longer needed.
HAEMTRACK	The HAEMTRACK system is a patient-reported record of usage of self-managed blood and blood-product home therapy. The aim of the CQUIN is to encourage patients to record their treatment at home, on a device that enables viewing from a central system. In turn, the necessary drugs are delivered straight to the patient's home.
Optimal devices (Cardiac)	The optimal devices scheme relates to the maintenance and improvement in optimisation of cardiac device usage, while the service is moving to a centralised national procurement and supply chain arrangement.
Critical care	This CQUIN is for collection of information about bed utilisation on our paediatric ICU. The aim of this is to obtain a better understanding of potential flow issues and how these could be improved, for example to support optimal scheduling of surgical patients.
Difficult asthma	This CQUIN scheme aims to ensure assessment and investigation of children with difficult-to-control asthma, by a multidisciplinary team, within 12 weeks of referral.
Univentricular home monitoring	This CQUIN scheme implements home monitoring programmes for children following palliative cardiac surgery. These are aimed at patients with certain primary diagnoses that collectively are referred to as univentricular hearts or univentricular circulations.
Child and Adolescent Mental Health Service (CAMHS) – long-term conditions	This CQUIN is to support the screening of patients aged 2–17 with one or more of four specified long-term conditions, when they are admitted as inpatients. The screening tool used, the Strengths and Difficulties Questionnaire (SDQ), enables the identification of patients who may have mental health needs. Once identified, the swift initiation of additional support is facilitated, as well as input from psychological and mental health services as appropriate.
CAMHS – pathways	This CQUIN concerns the implementation of good practice regarding the involvement of family and carers through a CAMHS journey to improve longer-term outcomes.

What is CQUIN?
The Commissioning for 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 schemes as part of the discussion between service commissioners and providers, and constitutes 2.5% of the Actual Contract Value between commissioner and provider.

CQUIN schemes 2016-17	Overview
NHS staff health and wellbeing	
Introduction of staff health and wellbeing initiatives (30%)	• Introducing a range of physical activity schemes for staff • Improving access to physiotherapy services for staff • Introducing a range of mental health initiatives for staff
Healthy food for NHS staff, visitors and patients (30%)	The aim of this indicator is to change the organisational behaviour and culture towards the food and drink sold on NHS premises. This is to be achieved by focusing on making healthier food and drink more widely available.
Improving the uptake of 'flu vaccinations for frontline staff (40%)	61% or more of frontline healthcare workers to have received the flu vaccine by 31 December 2016.
Internal schemes	
Patient access improvement – complaints	To increase the number of complaint responses sent out within agreed timescales, and to reduce the number of concerns relating to lack of communication with parents.
Patient access improvement – discharge summaries	To measure the content of the discharge summaries against best practice standards, and to improve the timescales for the dispatch of summaries from the Trust.
Patient access improvement – clinic letters	To measure the content of the clinic letters against best practice standards, and improve timescales for the dispatch of summaries from the Trust.
Patient access improvement – cancelled operations	To review the Trust's processes for recording cancelled operations, along with the implementation of an agreed improvement plan to reduce cancellations.
Patient access improvement – consultant-to-consultant referrals	To reduce unnecessary consultant-to-consultant referrals by producing a Standard Operating Procedure (SOP) of consultant-to-consultant referrals, and undertaking a clinical audit of three specialties to test against the SOP.
Cryopyrin-Associated Periodic Syndrome (CAPS), haemophilia, factor VIII bloods	To deliver more efficient utilisation of pass-through drugs and blood products.
Telemedicine	To pilot the replacement of physical outpatient attendances, where appropriate, with virtual contact through telephone calls, video calls or other technology-facilitated methods.
Transition to adult services	To design a clear transition pathway for young people aged 13 years and above that will be used across the Trust.

In 2016/17, 2% of GOSH's NHS income (activity only) was conditional upon achieving CQUIN goals agreed with NHS England for the above schemes. If the Trust achieves 100% of its CQUIN payments for 2016/17, this will equate to £4.8 million.

During Q1 to Q3 of the financial year, we reported high compliance against all our CQUIN indicator milestones. We expect to report approximately 95% compliance at year end.

CQC registration

GOSH is required to register with the CQC and is currently registered, without conditions, as a provider of acute healthcare services. GOSH has not participated in any special reviews or investigations by the CQC in 2016/17.

The CQC visited the Trust as part of its rolling schedule of inspections in April 2015. The report was published in January 2016 and services were rated as 'good' overall and 'outstanding' for being caring and for being effective. The report identified concerns about the Trust's management of referral-to-treatment (RTT) and associated data and required action to be taken via a Requirement Notice. The Trust and the Board is committed to making the improvements to fully address the issues identified. Our efforts in 2016/17 and the improvements achieved can be read about on pages 16–17.

What is the CQC?
The Care Quality Commission (CQC) is the independent healthcare regulator for England and is responsible for inspecting services to ensure they meet fundamental standards of quality and safety.

Data quality

Good quality data is crucial to the delivery of effective and safe patient care and to the running of GOSH. Data is vital to enable us to run our services efficiently as well as to identify any care quality issues and predict trends in order to take early action.

In the past year, we have embarked on an improvement programme to enhance the provision of good quality data. We have also introduced data quality 'kitemarking' for key metrics used by senior managers so they can at a glance see how reliable and robust the information used for decision-making is.

In early 2017/18, GOSH will take the following actions to improve data quality:

- We will establish a dedicated Data Assurance team who will work closely with staff to improve data quality. This will be achieved through improved training and coaching as well as tailored initiatives to target common problem areas.

Secondary Uses Service

As required by NHS Digital, GOSH submitted records during 2016/17 to the Secondary Uses Service (SUS) for inclusion in the national Hospital Episode Statistics. These are included in the latest published data.

The table below shows key data quality performance indicators within the records submitted to SUS:

Indicator	Patient group	Trust score	Average national score
Inclusion of patient's valid NHS number	Inpatients	99.1%	99.4%
	Outpatients	99.6%	99.5%
Inclusion of patient's valid General Practitioner Registration Code	Inpatients	99.9%	99.9%
	Outpatients	100%	99.9%

Notes:

- The table reflects the most recent data available (April 2016–January 2017 at month 10 SUS inclusion date)
- Nationally published figures include our international private patients, who are not assigned an NHS number. These published figures are consequently lower at 91.4% for inpatients and 93.6% for outpatients
- Figures for accident and emergency care are not applicable as the Trust does not provide this service

Clinical coding

GOSH has a dedicated and highly skilled clinical coding team which continues to maintain high standards of inpatient coding. Due to the complexities of our patients, each inpatient stay tends to have a higher than average number of codes applied. GOSH carries out internal audits to ensure that accuracy and quality are maintained. The most recent audit showed results of over 96% accuracy for all of the areas audited. GOSH was not subject to the Payment by Results clinical coding audit during the 2016/17 reporting period.

Information governance

The Information Governance Toolkit* provides NHS organisations with a set of 45 standards, against which we declare compliance annually. GOSH's Information Governance Assessment Report overall score for 2016/17 was 76% and was graded red. This means that we did not meet minimum standards in two out of the 45 standards: to train all staff every year in information governance, and to log and include information governance clauses in all supplier contracts. To address these shortfalls in the coming year, we will:

- Communicate directly with staff who have not completed their training and also underscore the importance of this training via managers
- Include as a mandatory part of the procurement logs an assessment of whether there is any information sharing and if the relevant terms have been included within contracts. Guidance will be provided to the procurement department to enable them to make this assessment

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.

*More information about the Information Governance Toolkit can be viewed at www.igt.hscic.gov.uk.

What is data quality?
Data quality refers to the tools and processes that result in the creation of accurate, complete and valid data that is required to support sound decision-making.

What is NHS Digital?
NHS Digital is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.

What is the Secondary Uses Service (SUS)?
The SUS is a single source of specified data sets to enable analysis and reporting of healthcare in the UK. SUS is run by NHS Digital and its reporting is based on data submitted by all provider trusts.

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.

"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."

Quotes from GOSH's CQC report, published January 2016

Eight-year-old Abdal comes to GOSH twice a week for dialysis.

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 NHS Digital, 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 (DH) is a department of the UK government with responsibility for government policy for England alone on health, social care and the NHS.

Performance against Department of Health quality indicators

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:
	2016/17	2015/16	2014/15	Most recent results for Trust	Best results nationally	Worst results nationally	National average		
Domain 4: Ensuring that people have a positive experience of care									
				Source: NHS Staff Survey Time period: 2016 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	90% (2016)	88% (2015)	87% (2014)	90%	95%	87%	90% (median score)	The survey is carried out under the auspices of the DH, using their analytical processes. GOSH is compared with other acute specialist trusts in England.	Ensuring that divisions and directorates develop and implement local action plans that respond to areas of weakness.
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	25% (2016)	25% (2015)	24% (2014)	25%	17%	30%	25% (median score)		
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	85% (2016)	87% (2015)	89% (2014)	85%	94%	81%	86% (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 services, by:
	2016/17	2015/16	2014/15	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: Public Health England Time period: 2015/16 financial year					
Number of clostridium difficile (C.difficile) in patients aged 2 and over‡	1	7	14	7	0	139	33.5	The rates are from Public Health England.†	Continuing to test stool samples for the presence of C.difficile, investigate all positive cases, implement isolation precautions and monitor appropriateness of antimicrobial use across the organisation.
Rate of C.difficile in patients aged 2 and over (number of hospital acquired infections/100,000 bed days)	1.79	8.3	12.2	8.5*	0	66	14.9		
Note: C.difficile colonisation is common in children and, while severe disease may occur at any age, it is rare. At GOSH, we test for C.difficile toxin in all diarrhoeal stool that 'conforms to the shape of the pot' (minimal national standard), as well as other stool where diarrhoea, fever or blood in stool was reported; where a request is made for enteric viruses; and as part of the surveillance programme in children with congenital immunodeficiency and undergoing bone marrow transplants. On agreement with our commissioners, we investigate all positive detections and report to Public Health England those aged 2 and above with diarrhoea (or a history of diarrhoea) where no other cause is present or, if another possible cause is present, clinical opinion led to treatment as a possible case. We report on the Healthcare Acquired Infection database according to a locally agreed paediatric modification of the national definition, to enable year-on-year comparison in our specialist trust. Our approach means we find more positive samples compared with the number of cases that we report. ‡ One case of C.difficile was attributed (due to onset after third day of admission) to GOSH for 2016/17, but was not classed as a lapse of care in line with guidance published by NHS Improvement. Of the seven cases of C.difficile attributed to GOSH for 2015/16, two were attributed to a lapse of care, and of the 14 cases of C.difficile attributed to GOSH for 2014/15, one was attributed to a lapse of care. * National report used estimated bed days at time of reporting. † www.gov.uk/government/collections/healthcare-associated-infections-hcai-guidance-data-and-analysis									
Patient safety incidents reported to the National Reporting and Learning System (NRLS):				**Source: National Reporting and Learning Service (NRLS) Time Period: 1/04/2016 to 31/03/2017**					
Number of patient safety incidents	5,429	5,338	5,231	5134	-	-	-	GOSH uses electronic incident reporting to promote robust reporting and analysis of incidents. It is expected that organisations with a good safety culture will see higher rates of incident reporting year on year, with the severity of incidents decreasing.	Initiatives to improve the sharing of learning to reduce the risk of higher-graded incident recurrence. Initiatives are reported and monitored by the Patient Safety and Outcomes Committee.
Rate of patient safety incidents (number/100 admissions)**	12.40	12.50	12.83	-	-	-	-		
Number and percentage of patient safety incidents resulting in severe harm or death	8 (0.1%)	11 (0.2%)	26 (0.5%)	5	-	-	-		
Note: 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. ** An inaccuracy in the rate calculation reported in 2015/16 was detected and has been corrected here.									

Explanatory note on patient safety incidents resulting in severe harm or death

It is mandatory for NHS trusts in England to report all serious patient safety incidents to the CQC as part of the CQC registration process. GOSH also reports its patient safety incidents to the NRLS, which runs a national database designed to promote learning.

There is no nationally established and regulated approach to reporting and categorising patient safety incidents. Different trusts may choose to apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. This judgement may, acceptably, differ between professionals. In addition, the classification of the impact of an incident may be subject to a lengthy investigation, which could result in the classification being changed. This complexity makes it difficult to do a formal comparison.

What is 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.

Part 3:
Other information

NHS Improvement uses a limited set of national mandated performance measures, described in its *Single Oversight Framework*, to assess the quality of governance at NHS Foundation Trusts.

Performance is measured on an aggregate (rather than specialty) basis and trusts are required to meet the appropriate threshold each month. Consequently, any failure in one month is considered to be a quarterly failure. The table below sets out the relevant national performance measures used to assess the Trust's quality governance rating.

What is NHS Improvement?
NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.

Performance against key healthcare targets 2016/17

Domain	Indicator	National threshold	GOSH performance for 2016/17 by quarter				2016/17 mean	Indicator met?
			Q1	Q2	Q3	Q4		
Effectiveness	All cancers: 31-day wait from decision to treat to first treatment	96%	97.5%	97.9%	100%	100%	98.9%	Yes
Effectiveness	All cancers: 31-day wait for second or subsequent treatment, comprising:							
	· surgery	94%	95%	100%	100%	100%	98.8%	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%	Following the identification in 2015/16 of challenges with delivery of the RTT standards, GOSH agreed with NHS England a pause in the reporting of its RTT figures until confidence in the data had been returned. The improvement work (see pages 16–17) has progressed and reporting resumed in February 2017.			Jan: 91.2% Feb: 91.6% Mar: 91.85%	N/A as the indicator is a snapshot at a given census date.	No
Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance against requirements*	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved

Additional indicators – performance against local improvement aims
In addition to the national mandated measures identified in the above tables, the Trust has implemented a range of local improvement programmes that focus on the quality priorities as described in Part 2a. The table below sets out the range of quality and safety measures that are reviewed at each Trust Board meeting. Statistical Process Control charts are used to measure improvements in projects over time and to identify areas that require further investigation. All measures remain within expected statistical tolerance.

Domain	Indicator	GOSH performance for 2016/17 by quarter				2016/17 mean
		Q1	Q2	Q3	Q4	
Safety	Central Venous Line (CVL) related bloodstream infections (per 1,000 line days)	1.7	1.8	1.7	1.4	1.65
Effectiveness	Inpatient mortality rate (per 1,000 discharges)‡	4.2	5.6	7.0	5.7	5.6
Experience	Friends and Family Test (FFT) – % of responses (inpatient)	25.4%	17.7%	26.0%	26.2%	23.8%
Experience	FFT – % of respondents who recommend the Trust (inpatient)	98.2%	98.1%	98.1%	97.6%	98%
Experience	Discharge summary completion time (within 24 hours)	87.4%	88.7%	86.6%	89.9%	88.2%
Effectiveness	Last minute non-clinical hospital cancelled operations: Breach of 28-day standard					
	· cancellations	197	191	157	180	725 (total)
	· breaches	32	32	23	25	112 (total)
Experience	Formal complaints investigated in line with the NHS complaints regulations	33	22	26	18	99 (total)
Effectiveness	% of patients aged 0–15 readmitted to hospital within 28 days of discharge	1.73%	1.67%	1.86%	1.39%	1.66%
Effectiveness	% of patients aged 16+ readmitted to hospital within 28 days of discharge	1.35%	1.60%	0.68%	3.91%	1.80%

Performance against key healthcare targets 2015/16

Domain	Indicator	National threshold	GOSH performance for 2015/16 by quarter				2015/16 mean	Indicator met?
			Q1	Q2	Q3	Q4		
Effectiveness	All cancers: 31-day wait from decision to treat to first treatment^	96%	97.1%	100%	98%	100%	98.8%	Yes
Effectiveness	All cancers: 31-day wait for second or subsequent treatment, comprising:							
	· surgery^	94%	94.9%	100%	90.9%	100%	96.5%	Not in Q3
	· 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 RTT standards, with a number of significant issues identified following an Elective Care Intensive Support team review in May 2015. As a result, GOSH agreed with NHS England a pause in the reporting of its RTT figures until confidence in the data had returned.					
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

Additional indicators – performance against local improvement aims

Domain	Indicator	GOSH performance for 2015/16 by quarter				2015/16 mean
		Q1	Q2	Q3	Q4	
Safety	CVL related bloodstream infections (per 1,000 line days)	0.9	1.3	1.8	1.7	1.4
Effectiveness	Inpatient mortality rate (per 1,000 discharges)‡‡	7.0	5.0	7.3	5.0	6.0
Experience	FFT – % of responses (inpatient)	28.1%	19.9%**	19.2%**	24.2%	22.8%
Experience	FFT – % of respondents who recommend the Trust (inpatient)	98.7%	98.7%	98.3%	98.8%	98.6%
Experience	Discharge summary completion time (within 24 hours)	81.0%	80.8%	79.3%	76.8%	79.5%
Effectiveness	Last minute non-clinical hospital cancelled operations: Breach of 28-day standard††					
	· cancellations	11	39	17	309	376 (total)
	· breaches	0	0	0	52	52 (total)
Experience	Formal complaints investigated in line with the NHS complaints regulations	36	44	32	39	151 (total)
Effectiveness	% of patients aged 0–15 readmitted to hospital within 28 days of discharge	1.82%	1.83%	1.77%	1.69%	1.78%
Effectiveness	% of patients aged 16+ readmitted to hospital within 28 days of discharge	0.93%	0.56%	4.32%	0.76%	1.62%

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

‡ Does not include day cases.

† 'Last minute' is defined as: on the day the patient was due to arrive, after the patient has arrived in hospital, or on the day of the operation or surgery. The Trust is working to minimise its level of last-minute cancelled operations for non-clinical reasons and the 'Better Value' work over the next year will help to provide more clarity on what expected levels should be.

^ Reporting corrections from 2015/16 *Quality Report* included.

‡‡ Does not include day cases, thus producing higher figures than the previous Hospital Mortality Rate. This new definition provides a more accurate measure of inpatient mortality.

** Percentage dropped as a result of Trust including from Q2 all ward discharges in the denominator, including frequently returning patients who had previously been excluded from the figures as per the national definition.

†† As part of the Trust's ongoing review of submissions and returns, an issue was identified with the methodology used to capture data items related to cancellations and 28-day breaches. The Trust developed a robust methodology for the capture and reporting of the standard, which was supported through a CQUIN programme of work in 2016/17.

Annex 1:
Statements from external stakeholders

Statement from NHS England (London), Specialised Commissioning Team

NHS England would like to thank Great Ormond Street Hospital NHS Foundation Trust for the opportunity to review and provide a response to the 2016/17 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 and accessibility for those children whose healthcare needs are ideally managed by GOSH.

We continually reviewed feedback from families and other stakeholders, clinical quality review meetings and other external sources including the Care Quality Commission, Health Education North Central and East London, and Public Health England to inform decisions about where improvements can be delivered; notable examples this year include the gastroenterology and spinal surgery services.

We commend the Trust for the considerable work undertaken to improve access to elective care, to return to national reporting during 2016/17 and we note that the development of a reporting solution which has been identified as best practice by the NHS Improvement Intensive Support team. The Trust will continue to manage its patient tracking processes and will embed clinical harm reviews as business as usual. We are confident that the Trust will also continue to work with referring hospitals to improve the positon with unknown clocks and that it has a plan in place to achieve the national standard for diagnostic waits.

We acknowledge the areas of achievement reported this year which includes the implementation of the Sepsis 6 superheroes and the focused work to prevent and manage cardiac arrests, both of which will continue into the coming year.

There are a number of areas where work to facilitate the improvements outlined in the quality account are underway, that is:

- Good transition of children and young people to adult services
- Improving the quality and safety of care for inpatient neonates/ small infants
- Developing Trust-wide access to outcomes data
- More broadly, the Trust is also focusing on improvements with:
  - Late cancellation of operations
  - Patient flow and productivity with some changes in capacity occurring with the opening of the Premier Inn Clinical Building
  - Sustaining better staff appraisal and statutory and mandatory training rates

We look forward to considering these areas of work and values to ensure continuous improvement for patients are delivered in 2017/18.

Statement from Healthwatch Camden, incorporating comments from Camden Health and Adult Social Care Scrutiny Committee

The draft *Quality Report* is commendable. Although only a small percentage of GOSH's patients are Camden residents, Healthwatch Camden has always found the Trust to be open and welcoming of our input. Camden Health and Adult Social Care Scrutiny Committee also welcomes the Trust's Quality Accounts. We would have liked to have seen further detail about collaborating with, and reaching out to, North Central London councils to share learning about working with and supporting vulnerable children and families.

We have some specific comments on the report.

We commend the 'safety huddles' and particularly incorporating the parents' concerns in the 'watchers' list. We note the very positive feedback from the patient representative. 29% of wards are not yet at 'gold standard' and we would welcome more specific information on actions to get all wards to the gold standard most wards are already at.

Although significant improvements have been made to reach the 92% national target for referral-to-treatment (RTT) pathways, we note the last result was still below 92%. We suggest feedback from parents be built into the process to gain insight from this key group to further support improvements.

Friends and Family Test (FFT) data for inpatients was above the 95% target, but for outpatients it was below the target. Some commentary in the final report as to why the outpatients result was below target would be welcome, as would some brief indications of what specific actions to improve the figure are being undertaken. We would imagine direct input from patient groups could well provide useful input into this. The way GOSH went about gathering the FFT information to engage patient feedback was highly innovative and impressive (the child friendly forms, listening event and video booths clearly demonstrate this). Some more detailed analysis (beyond the themes on page 24), with specific actions against each identified area would be welcome additions to the report.

With regard to the engagement quality improvement project around transition to adult services that the Trust will undertake in 2017/18, we feel some further and ongoing direct feedback from young adults themselves into proposed improvements would be helpful. The Patient and Family Engagement and Experience Committee could give guidance on how this might occur.

The data from the Bereaved Parent Survey was positive. This surely must be the most challenging of areas, so the training identified to support staff is welcome. We note the data showed that 77% responded yes to "Did anyone discuss the fact that your child was dying with you", so 33% would have responded no. Perhaps this might be one of the areas where additional staff training might be targeted. We presume the End of Life Care Committee, the Patient and Family Experience and Engagement Committee and the Bereavement Services Manager would be able to feed into what this training might entail.

GOSH's Information Governance Assessment Report overall score for 2016/17 was 76% and was graded red. We suggest a quality improvement project around this could be something to consider for 2017/18.

There does seem to be an excellent learning culture with GOSH that looks to people's real experiences of the Trust, and some excellent engagement of both parents and children. We would encourage even more of these innovative and excellent engagement processes, but also encourage more openness of the actual results and particularly what actions will be undertaken as a result of the feedback. We would encourage parents and patient groups to be involved in the analysis of the feedback as well as disseminating of the outcomes and resultant actions.

Feedback from Members' Council councillors

Comments from patient councillor:
It is clear to see the outstanding work that GOSH carries out daily to improve services for children and young people. Furthermore, the innovative research the Trust has undertaken demonstrates how GOSH is at the forefront of advancements in medical treatments. Having been a patient at GOSH, and now representing patients outside of London, it has been extremely heartening to read how a significant amount of work has been undertaken over the last year to improve the safety, clinical effectiveness and experience of patients and parents at GOSH.

Safety:
The work the Trust has done to improve the awareness of sepsis is fantastic. As detailed in this report, the variety of events undertaken by the Trust, such as the Sepsis Awareness Week and the creation of Sepsis Champions has all helped to raise awareness of what sepsis is, and the protocol to follow at GOSH. It is noted that staff feel empowered by GOSH's Sepsis Protocol, and that work has been undertaken to raise awareness of sepsis with parents and carers. Furthermore, the classification system for respiratory and cardiac arrests outside ICU and theatre appears to be effective in steadily reducing the number of arrests on a monthly basis. It is reassuring to have read that a detailed analysis is undertaken on arrests that are 'probably not preventable but with modifying factors' and arrests that are classed as 'potentially preventable', thus helping to improve patient safety.

Additionally, the successful implementation of the daily safety huddle across every inpatient ward is pleasing. It is of vital importance to get nurses, lead doctors and other relevant staff members together as one team to help reduce deteriorating child incidences. The aid of the electronic Patient Status at a Glance boards appear to be pivotal in ensuring that staff members have relevant and timely information on patients, thus helping to inform the huddle discussions. Of particular note is the 'watcher' category, which enables parents'/carers' concerns to be recognised and listened to, even if the Children's Early Warning Score doesn't trigger an alert. Next year, I would hope to see 100% of inpatient wards fulfilling all of the GOSH 'gold standard' huddle criteria.

Clinical effectiveness:
The issues surrounding referral to treatment at GOSH has been an area that the Members' Council has taken a keen interest in, and it is something that we have regularly been briefed on. The hard work, persistence and dedication shown by GOSH staff in investigating this issue, looking at processes and rewriting guidance is outstanding. I am delighted that this has been reflected not only by the fact that GOSH is back reporting ahead of recovery trajectory, but that GOSH has also been referred to as a "best practice" organisation. Many congratulations to all who have been involved in this significant area of work.

It is good to see the proactive approach that GOSH has taken to introduce a standardised mental health screening tool for patients. This approach helps to ensure that mental health is not neglected and patients feel able to talk about it, thus helping recognition and treatment of mental health problems. There has been a significant increase in the number of children and young people who received a mental health screening, from 9% in Quarter 2 to 45% in Quarter 4, which is brilliant. However, I hope that work will be ongoing to ensure that all eligible patients are screened. The use of the Strengths and Difficulties Questionnaire, and the ability to complete it electronically, with face-to-face support from clinical staff, is welcome. It is encouraging to see that the hard work that has gone into this project is having a great benefit for patients and families.

Experience:
I have read with interest the work that GOSH has undertaken to improve young people's experience of transition to adult services. Having recently been through this process, and having spoken to other young people who have recently been through transition, feedback has varied from poor to excellent. It is important to recognise that this is an extremely challenging area to get right, as there is no one correct way to transition a patient, as every patient is unique. I strongly welcome the work that the Trust has undertaken to introduce a 'Transition Lead' in each specialty, and the involvement of young people in the Transition Improvement Steering Group. I am confident that this will lead to a more 'joined-up' approach to transition. However, as the figures in the *Quality Report* detail, with thousands of patients between 13–17 years old, I am concerned whether there is enough resource being put behind this project with one transition improvement manager. I trust that the Chief Nurse, in her role as executive lead for transition, will actively drive forward this vital area of improvement work. The section has been largely focused on the perspective of the patient, which I am really pleased to see. However, it is important not to neglect the views of parents as it can often be a worrying time for them as well.

A significant amount of work has also been undertaken with regards to the Friends and Family Test (FFT). It is vital that patients and parents feel able to give honest feedback, and the increase in response rate highlights that this is the case. The introduction of feedback cards for patients aged eight or under is fantastic, as this ensures that the Trust is able to capture feedback in an age-appropriate manner. Over the next year, I hope to see the use of technology in capturing patient and parent/carer feedback, which will help to increase accessibility and may help to increase the number of patients responding to the FFT. The percentage of those who recommend the Trust has remained extremely high, and is a testament to the many dedicated staff at GOSH who go above and beyond every day, making a difference to very sick children and young people.

The listening event, held in November 2016, was a great success as it enabled patients and parents to discuss four key topics. It is clear that the Trust was able to get a lot out of the day and it is vital that there is ongoing communication with the attendees as to the improvements made following their feedback. Thanks must go to all the staff who made this event a great success.

Other comments:
I am concerned that the GOSH Information Governance Assessment score for 2016/17 has remained at red. I hope to see an improvement in the grading and overall score in next year's *Quality Report*.

Whilst there has been a change in methodology, I have noted that the mean number of last minute non-clinical hospital cancelled operations has increased from 94 in 2015/16 to 181 in 2016/17. This is disappointing to have read; however, it is good that GOSH has recognised that this figure is higher than it would like and it is actively undertaking work to reduce the number of hospital cancelled operations. I look forward to seeing this figure decline over the next year as last minute cancellations can cause significant inconvenience for families.

Many of the strands of work covered in the 2016/17 GOSH *Quality Report* are ongoing. It would be useful to have a reflection on how these areas have further improved in the 2017/18 *Quality Report*, as well as having an update on the quality priorities detailed in the 2015/16 *Quality Report*.

The exciting medical innovations detailed at length in this *Quality Report* are far too many to comment on in this brief statement, but they highlight that GOSH continues to be a world-leading research hospital, which is something that everyone should be incredibly proud of.

In conclusion, I have found this *Quality Report* extremely interesting and informative. It clearly demonstrates that there are many achievements to celebrate. One must pay tribute to all the dedicated members of staff who have worked so hard to implement these improvements, all whilst delivering outstanding care to patients. I believe that this *Quality Report* can be summed up by simply saying that in everything GOSH does, it puts 'the child first and always'.

Comments from parent councillor:
GOSH is an internationally recognisable institution with dedicated staff serving some of the most ill children and young people and providing support to their families and carers. The research that GOSH does is vital for the continued understanding of child ill health and improvement in treatment. The annual *Quality Report* provides an excellent opportunity to explain and highlight the quality of services delivered over the past 12 months against predetermined criteria (safety, clinical effectiveness and experience), whilst giving a foretaste of the priorities for the current year. As a parent of two children who have received treatment at GOSH and now a Council Member, I am pleased to add my own contribution to this *Quality Report*.

Reading the 2015/16 *Quality Report* as part of the preparation to write this piece, I was delighted to see certain priorities such as electronic patient status and referral-to-treat incomplete pathways, also featuring in this current year's *Quality Report* albeit with further progress made in each. It would be helpful in each year's report if a brief reference could be made to progress or developments occurring in each of the previous year's priorities. They ought to be embedded into the 'normal' work of the hospital and/or are a necessary precursor to enable other developments to occur.

The reintroduction of 'safety huddles' adds another dimension of clinical awareness regarding the patients on that ward and utilises the capabilities of the electronic Patient Status at a Glance boards. The 'watcher' category also recognises the role parents and other family members can play in spotting a change in their child's health. The proposal to develop this further during 2017/18 with a 'watcher' leaflet provided to all parents and families of children admitted to GOSH is welcome. Similarly, the commitment to include this situational awareness content in junior doctor induction and Trust induction programme is a positive step towards gaining ownership and emphasising the importance of the 'safety huddle' practice to the six wards and staff yet to be fully persuaded of its role.

The return to reporting in January 2017 against the incomplete referral-to-treatment pathways national 'incomplete' standard marked a huge step forward for GOSH after the difficulties previously uncovered in data and processes. The amount of work undertaken to prepare and introduce new processes, create sufficient capacity to manage referral demand, improve communication from referring organisations and ensure compliant data recording systems has been enormous. It is to the credit of all those involved in this work that from a dire situation in 2015/16 the reporting system implemented by GOSH is now cited as demonstrating "best practice" by the NHS Improvement Intensive Support team. The benefit to patients and families in terms of more transparency and certainty over care provided and planned is obviously welcome and should assist in reducing worry over potentially missing appointments and follow-ups.

The transition from child to adult care is fraught with difficulties at the best of times. For young people with long-term conditions who may have only known GOSH as 'their' hospital it can be particularly stressful and uncertain. For parents/carers 'letting go' and seeing your child as an adult who is now meant to be capable of making decisions over their care is a real concern. The vignettes from the listening event cited in the report aptly capture this level of uncertainty and loss. It is vital that GOSH take these comments and others from the Young People's Forum on board over the next 12 months and actively determine, across all specialisms, the age when, as part of each patient's consultation, discussion turns towards planning for leaving GOSH and how this transition can be made as painless as possible. The inclusion of transition as a 2017/18 priority is a positive step.

The report is full of examples where developments in technology and data collection have been harnessed to improve patient care, improve service and receive feedback such as:

- Automatic alerts for sepsis in the electronic patient observation system
- Timeliness of delivery of the sepsis protocol
- Use of defibrillators with built-in feedback which prompt a change in use to facilitate better outcomes
- Introduction of electronic completion of questionnaires for mental health screening for those with long-term physical health conditions

This work is essential not least as the patients GOSH treats are tech savvy and expect technology to be used as a matter of course, both in their treatment and as a means of recording their views, booking appointments, communicating etc. To continue to attract and retain the best staff and stay at the forefront of medical research through keeping pace with the data world whilst maintaining security of systems is an ongoing challenge for GOSH, but one they have to both succeed and invest in. The commitment to improving accessibility to outcomes data during 2017/18 and to establish a dedicated Data Assurance team is welcome.

GOSH launched the *Our Always Values* in March 2015; Always: Welcoming, Helpful, Expert, One Team. These values are "a visible representation of our commitment to our patients, families and staff". The *Quality Report* contains excellent examples of these values being upheld such as:

- GOSH Listening Event November 2016: 'Welcoming'
- Participation in all 12 national clinical audits and clinical outcome review programmes, clinical research and contributing to journals: 'Expert'
- Learning from complaints: 'Helpful'

and provides some direct reference to the Values themselves and linking of the work described to the Values. It was however disappointing that in the Surgical Safety Checklist survey of theatre staff 12% of staff respondents disagreed with, and 6% neither agreed nor disagreed with the statement that 'I knew the name of everyone in theatre today'. Having said that, the same survey did show that 95% of respondents considered "they had worked well as a team today in theatre".

Specific reference was made by the Lead Councillor in her comments on the 2015/16 *Quality Report* about the limited coverage of these Values in that document and how the wholesale adoption of these Values could improve services, including clinical, improve outcomes and patient and family experiences. The current report has sought to positively respond to this comment with visual signifiers included where particular initiatives in each priority accord with one or more of the 'Always Values'. Although a step in the right direction, there can be no resting on laurels. During 2017/18 more has to be done to fully embed these 'Values' into the working of the hospital and behaviours of all those working in and associated with GOSH.

The report touches on the work of the Quality Improvement team and that of the GOSH Charity during 2016/17. This is appreciated as the Quality Improvement team have been instrumental in developing and supporting the implementation of a range of initiatives to assist with patient care. The charity raises significant funds for the hospital each year and provides a mechanism for supporters of GOSH to get involved and put something tangible back.

The report is, I think, a fair assessment of the progress made against the identified priorities and provides statements of assurance from the Board as well as details of the wider engagement by GOSH, both within the NHS and internationally. There is much to be proud of and to celebrate. Thank you to all the staff at GOSH for continuing to try your best and to push the boundaries in the care and treatment of our children and young people.

GOSH response to statements

Here, we provide more information on points in response to statements from our stakeholders.

GOSH Listening Event
At the listening event, we made sure that an executive and a professional in the subject area were at each table, listening to parents and patients. The discussion and feedback drawn from the day was summarised in a report and sent to the teams involved in the four subject areas. Staff from these areas of work will report to the Patient and Family Engagement and Experience Committee in July on actions agreed after time spent investigating and costing ideas that were proposed on the day.

Friends and Family Test
Our response rate within outpatients has always been lower compared to inpatients. Though similar to other Trusts' rates, it is something we have tried to address. We have:

- Deployed our survey volunteers in the outpatient areas on an *ad hoc* basis. This human interaction (and the provision of a pen) often increases the number of responses we receive on a short-term basis but we are not able to deploy volunteers permanently to this as they are needed in other areas too
- Asked for staff in the reception teams to hand out feedback cards to the patients and their families on arrival
- Attend regular huddles held for the outpatient staff, so we will continue to do this to emphasise the importance of FFT being a team effort

From our informal conversations with families, we have found that regular attenders are understandably reluctant to complete a card on every outpatients visit. Families have also told us that now they can book their follow-up appointment through the electronic Clinic Outcome Form (eCOF), they can leave without waiting so no longer have the reminder at reception.

We will continue dialogue with patients and their families and seek to improve response rates in our outpatients department.

Transition
The figures in the report do not represent the numbers of young people who will need to have transition plans. Each age group includes those attending GOSH for diagnosis or second opinion, those who will be referred back to local services for treatment, and those whose treatment will be completed prior to their 18th birthday.

The Trust fully recognises the anxiety that the prospect of leaving GOSH and paediatric services can cause to young people and their families. The definition of transition developed by the Trust goes beyond that used in the NICE Transition Guidelines (NICE, 2016) and explicitly acknowledges the preparation needs of families and carers as well as our young people. We are collaborating with representatives from both groups to ensure their needs will be included in any transition plans. We firmly believe that preparation for adult services and adulthood should be a partnership between professionals, parents/carers and young people that relies on the transition process starting as early as reasonably possible.

Referral to treatment
We provided updates to our Members' Council on the work to improve the 18-week pathways and took on board their suggestions and feedback on the approach that we were taking to reduce our waiting times and improve our processes.

Information governance tookit
We will report on our information governance improvement work in the *Quality Report* next year.

Annex 2: Statements of assurance

External assurance statement

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

We have been engaged by the council of governors of Great Ormond Street Hospital for Children NHS Foundation Trust to perform an independent assurance engagement in respect of Great Ormond Street Hospital for Children NHS Foundation Trust's quality report for the year ended 31 March 2017 (the '*Quality Report*') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Great Ormond Street Hospital for Children NHS Foundation Trust as a body, to assist the council of governors in reporting Great Ormond Street Hospital for Children NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Great Ormond Street Hospital for Children Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the national priority indicators as mandated by NHSI:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- Maximum waiting time of 31 days from decision to treat to first treatment for all cancers

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the *Quality Report* in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance issued by NHSI.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the *Quality Report* is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the *Quality Report* is not consistent in all material respects with the sources specified in section 2.1 of the NHS Improvement 2016/17 Detailed guidance for external assurance on quality reports; and
- the indicators in the *Quality Report* identified as having been the subject of limited assurance in the *Quality Report* are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the *Quality Report* and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the *Quality Report* and consider whether it is materially inconsistent with:

- board minutes for the period April 2016 to March 2017;
- papers relating to quality reported to the board over the period April 2016 to March 2017;
- feedback from the Commissioners dated May 2017;
- feedback from the governors dated May 2017;
- feedback from local Healthwatch organisations, dated May 2017;
- feedback from Overview and Scrutiny Committee, dated May 2017;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2017;
- the national patient survey August 2016;
- the national staff survey dated May 2016;
- Care Quality Commission reports; and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2016.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance to the categories reported in the *Quality Report*; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the *Quality Report* in the context of the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Basis for Qualified Conclusion

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

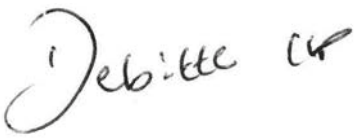
As set out in the Review of Quality Performance section on page 16 of the Trust's *Quality Report*, the Trust went on a reporting break in the prior year in respect of the referral to treatment within 18 weeks for patients on incomplete pathways indicator, as a result of known data quality issues with the indicator. The Trust took steps to address the issues and has implemented new process and controls, recommencing reporting in January 2017.

Since the Trust are reporting a figure in the *Quality Report*, NHSI guidance mandates that we test that indicator. However, as the Trust do not have reported data for the first three quarters of the year, the reported indicator is incomplete. As a result, there is a limitation upon the scope of our procedures which means we are unable to complete our testing and are unable to determine whether the indicator has been prepared in accordance with the criteria for this period.

Qualified Conclusion

Based on the results of our procedures, except for the effect of the matters set out in the basis for qualified conclusion paragraph, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the *Quality Report* is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the *Quality Report* is not consistent in all material respects with the sources specified in 2.1 of the NHS Improvement 2016/17 Detailed requirements for quality reports for Foundation Trusts 2016/17; and
- the indicators in the *Quality Report* subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.



Deloitte LLP
Chartered Accountants
St Albans

25 May 2017

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.

NHS Improvement has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support the data quality for the preparation of the *Quality Report*.

In preparing the *Quality Report*, directors are required to take steps to satisfy themselves that:

- The content of the *Quality Report* meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual* 2016/17 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 2016 to May 2017
  - Papers relating to Quality reported to the board over the period April 2016 to May 2017
  - Feedback from commissioners dated 18 May 2017
  - Feedback from governors dated 9 May 2017 and 10 May 2017
  - Feedback from local Healthwatch organisation dated 12 May 2017
  - Feedback from the Health and Adult Social Care Scrutiny Committee dated 12 May 2017
  - The Trust's annual complaints report 2016/17 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - The CQC-commissioned National Paediatric Outpatient Survey 2016
  - Data from the CQC-commissioned Children and Young People's Inpatient and Day Case Survey 2017 is being collected currently and is not available for this report
  - The national NHS Staff Survey 2016
  - The Head of Internal Audit's annual opinion of the Trust's control environment dated 25 May 2017
  - CQC inspection 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 NHS Improvement'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*

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

25 May 2017

Chairman

25 May 2017

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.

The *Annual Report and Accounts* is available to view at www.gosh.nhs.uk.

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Deloitte.

Great Ormond Street Hospital for Children NHS Foundation Trust

Great Ormond Street Hospital for Children NHS Foundation Trust

Findings and Recommendations from the year ended 31 March 2017 NHS Quality Report External Assurance Review

Contents

Executive Summary

We have completed our Quality Report testing and are in a position to issue our limited assurance opinion.

Status of our work

- We have completed our review, including validation of the reported indicators. We are in the process of completing 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 Governors.
- The scope of our work is to support a "limited assurance" opinion, which is based upon procedures specified by NHS Improvement in their "Detailed Requirements for External Assurance on Quality Reports for Foundation Trusts 2016/17".
- We anticipate signing a qualified opinion for inclusion in your 2016/17 Annual Report as a result of the Trust being on a reporting break for the RTT indicator for the first 9 months of the year.

	2016/17	2015/16
Length of Quality Report	54 pages	57 pages
Quality Priorities	7	7
Future year Quality Priorities	3	3

Scope of work

We are required to:

- Review the content of the Quality Report for compliance with the requirements set out in NHS Improvement's Annual Reporting Manual ("ARM").
- Review the content of the Quality Report for consistency with various information sources specified in NHS Improvement's detailed guidance, such as Board papers, the Trust's complaints report, staff and patients surveys and Care Quality Commission reports.
- Perform sample testing of three indicators.

  The national priority indicators as mandated by NHS Improvement for limited assurance testing for the year ended 31 March 2017 relevant to the Trust are:

  - Percentage of incomplete pathways within 18 weeks at the end of the reporting period
  - Maximum waiting time of 31 days from decision to treat to first treatment for all cancers

  For 2016/17, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. The Trust has selected 'last minute cancelled operations for non-clinical reasons and breaches of the 28 day readmission standard'.

  The scope of testing includes an evaluation of the key processes and controls for managing and reporting the indicators; and sample testing of the data used to calculate the indicator back to supporting documentation.
- Provide a signed limited assurance report, covering whether:
  - Anything has come to our attention that leads us to believe that the Quality Report has not been prepared in line with the requirements set out in the ARM; or is not consistent with the specified information sources; or
  - There is evidence to suggest that the 18 weeks RTT incomplete pathways and 31 day cancer waits 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: 18 weeks RTT,31 day cancer waits and last minute cancelled operations for non-clinical reasons and breaches of the 28 day readmission standard.

Executive Summary (continued)

We will issue a qualified opinion in relation to 18 weeks RTT

Content and consistency review

Review content → Document review → Interviews → Form an opinion

We in the process of finalising our content and consistency review. From our work so far (pending receipt of remaining outstanding documents), nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017 the Quality Report is not prepared in all material respects in line with the criteria set out in the ARM).

	Expected 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

NHS Improvement requires Auditors to undertake detailed data testing on a sample basis of three mandated indicators. We perform our testing against the six dimensions of data quality that NHS Improvement specifies in its guidance.
From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017, 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 Requirements for External Assurance on Quality Reports for Foundation Trusts 2016/17".

Performance indicator testing (continued)

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

G No issues noted B Satisfactory – minor issues only

A Requires improvement R Significant improvement required

*rating reflects Trust's reporting break for part of the year

Content and consistency findings

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: 54 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	

Deloitte view

Overall, the Quality Accounts at the Trust are 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 makes good use of diagrams, charts and other visual information to make the document accessibe
- The Trust has clearly disclosed where there have been data quality challenges around the RTT indicator, and progress to address this in the year, demonstrating the Trust's openness and transparency on quality issues.

Performance and Indicator Testing

18 week Referral to Treatment times

The Trust was on a reporting break until January 2017

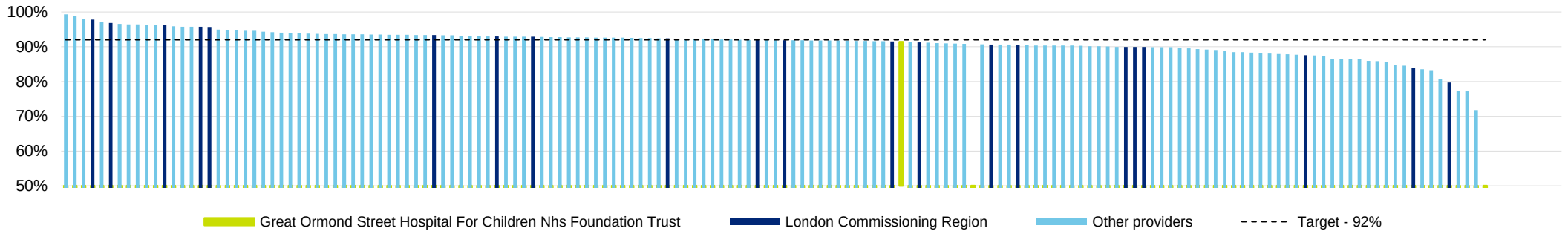
	Trust reported performance	Target	Overall evaluation
2016/17	Jan: 91.2% Feb: 91.6% March: 91.9%	>92%	A
2015/16	Not reported	>92%	n/a

Indicator definition

Definition: "The percentage of patients on an incomplete pathway who have been waiting no more than 18 weeks, as a proportion of the total number of patients on incomplete pathways," reported as the average of each month end position through the year.

The national performance standard for the incomplete Referral-To-Treatment (RTT) metric (92%) was introduced in 2012. This metric is about improving patients' experience of the NHS – ensuring all patients receive high quality elective care without any unnecessary delay.

18 week Referral to Treatment incomplete pathway - April 2016 to Feb 2017 (tested indicator)



Source: Deloitte analysis of Health and Social Care Information Centre data

National context of data quality

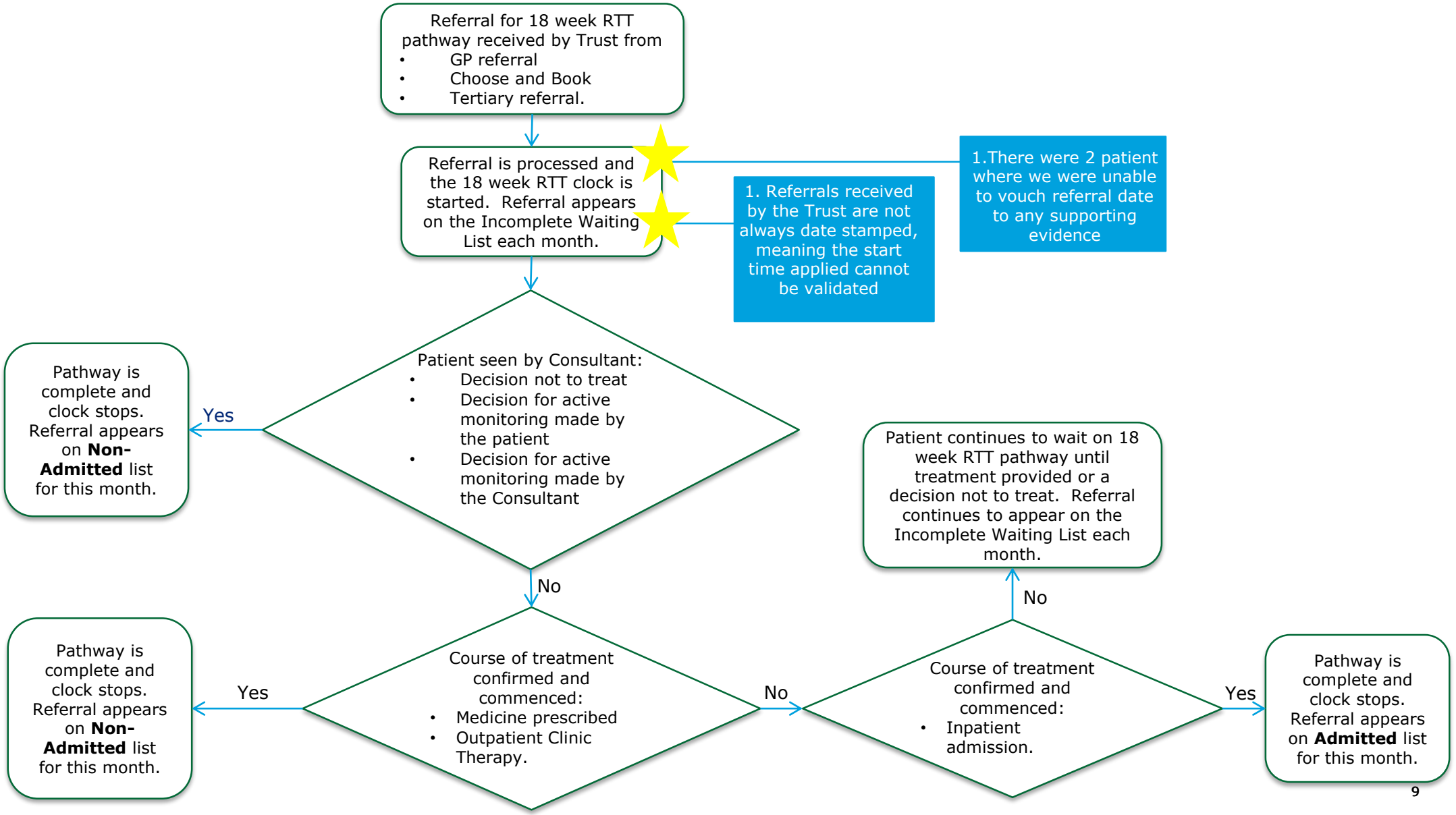
NHS Improvement mandated the 18 week RTT indicator for testing for the first time in 2014/15. Nationally, only 41% of trusts subject to testing received a clean opinion. NHS Improvement have reviewed auditor reporting on this metric, and noted that of the qualifications, 71% were due to control environment and data testing issues, 10% due to a planned failure to report the metric, 8% as monthly reports were not retained, and 11% due to a combination of issues. Themes identified among the specific causes included clock stops, clock start dates, data retention, duplicated pathways for the same patient, system issues, and weaknesses in patient referral processes.

The indicator continued to be mandated for 2015/16, with many trusts experiencing continued issues. Although there was some improvement where trusts had opportunities for "quick wins" or addressing data retention type issues, there were still 52 qualifications of Foundation Trust quality reports in 2015/16 compared to 61 in 2014/15.

18 week Referral to Treatment times

The Trust's process for monitoring and reporting the 18 weeks RTT indicator was not in place for the full year

Process flow



18 week referral to treatment times

The Trust has not reported for the full year and we anticipate issuing a qualified conclusion

Approach

- We met with the Trust's lead for the 18 week RTT metric to understand the process from patient referral to the result being included in the Quality Report. This process is newly established in response to the Trust's historic RTT issues and reporting break.
- We enquired of management to understand how the Trust process addressed previous failings in the system that were uncovered before the Trust went on reporting break.
- We evaluated the design and implementation of controls through the process.
- We selected a sample of 14 from 1 January 2017 to 31 March 2017, following patient records through until treatment.

Findings

- We identified 1 pathway in our sample where the referral had been received by the Trust, but not date stamped. As such we were not able to validate whether the start date recorded by the Trust was correct - [Recommendation 1]
- We identified 2 pathways where we were unable to trace patient start times to supporting patient records. [Recommendation 1]
- All of the issues above are audit trail deficiencies, rather than fundamental issues with the Trust's process that are indicative of factual error.

Deloitte View:

The Trust has been through a detailed exercise to address previously identified issues with its data quality in regards to the 18 weeks RTT indicator. This work was completed in year and the Trust recommenced reporting in January 2017.

Our overall conclusion for the 2016/17 period is **qualified**, due to the fact that the Trust does not have a complete data set for the year due to the reporting break. We have, however, performed limited testing on data from January to March 2017, in order to give the Governors, Management and the Audit Committee some early assurance over the Trust's redesigned process and controls, prior to a full years reporting in 2017/18.

We considered how the Trust's new process and controls address the historic issues identified in RTT reporting and were satisfied the Trust has taken steps to address these in its process.

Though our sample was limited to 14 items, we identified findings (outlined above) whereby there was not appropriate audit trail for us to conclude on samples. The testing did not identify any factual errors, and walkthrough of the process suggested it was appropriately designed and implemented. However, in order to be able to issue an unmodified opinion over the indicator, it is important that auditors are able to validate pathway start and stop times to supporting evidence. We have raised recommendations to this effect.

31 day cancer wait times

The Trust's process has been historically strong and we identified no issues in our testing for 2016/17

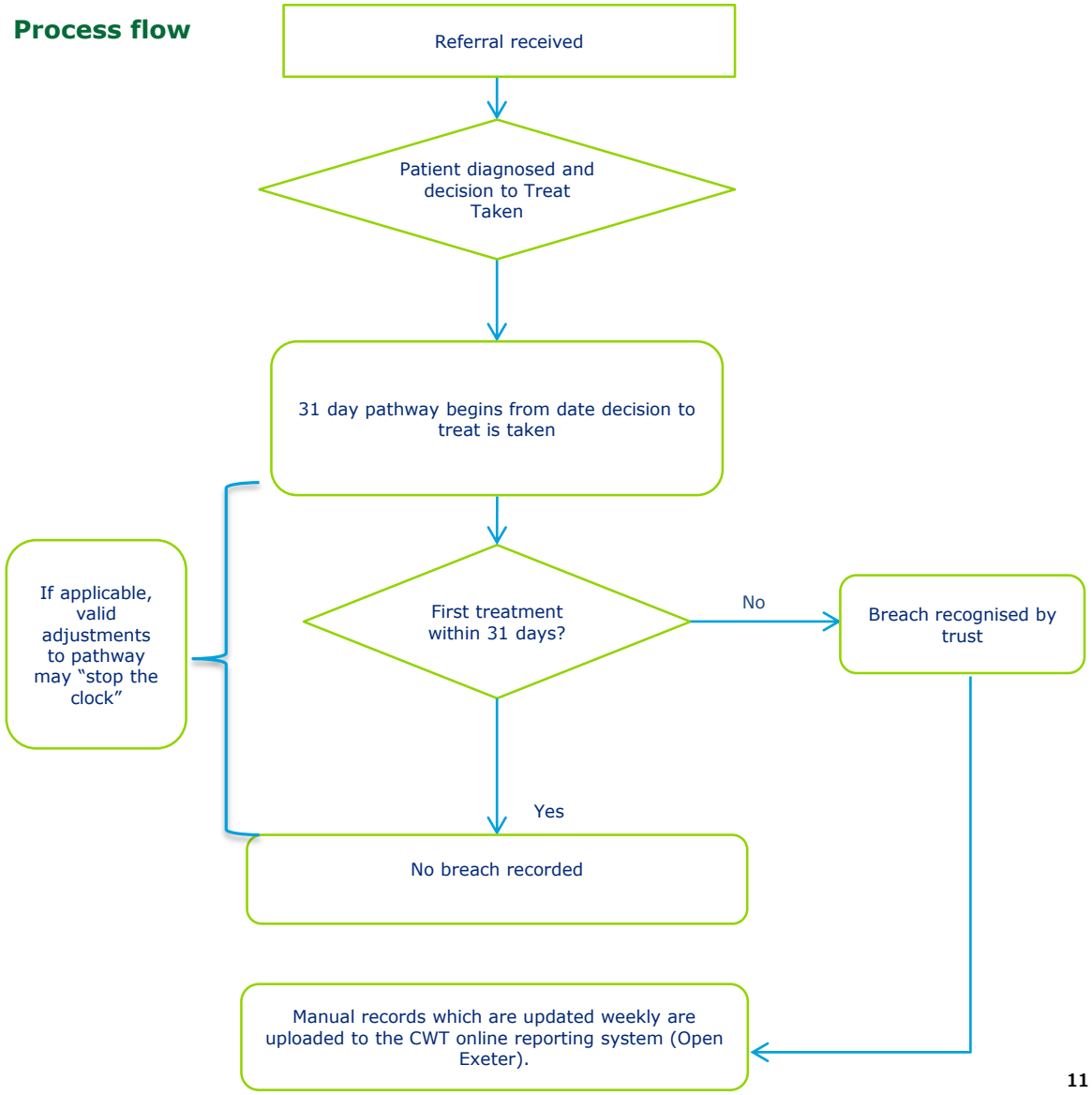
	Trust reported performance	Target	Overall evaluation
2016/17	99.0%	98%	G
2015/16	98.8%	98%	B
2014/15	100%	98%	B

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 NHS Improvement 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."

Process flow



31 day cancer waiting times (continued)

The Trust's process has been historically strong and we identified no issues in our testing for 2016/17

Approach

- We met with the Trust's lead for 31 day cancer waits to understand the process from decision to treat to the result being included in the Quality Report.
- We evaluated the design and implementation of controls through the process.
- We selected a sample of 24 from 1 April 2016 to 31 March 2017 including in our sample a mixture of cases in breach and not in breach of the target.
- We agreed our sample of 24 to supporting documentation.
- We recalculated the reported indicator in the quality report

Findings

- We did not identify any errors in our sample of 24.

Deloitte View:

The quality of the Trust's processes over reporting of this data has improved on prior year. During the 2015/16 31 day cancer waits testing we found 2 instances where there was a data input error compared to no instances found during 2016/17 testing.

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.

Local Indicator – Cancelled Elective Operations

We identified a number of findings

	Trust reported performance (cancelled operations)	Breaches of 28 day cancelled operation guarantee	Overall evaluation
2016/17	**725**	**112**	n/a
2015/16	376	52	Not tested

Figures above show the sum of 4 quarters data we have agreed each quarter and the total to underlying data for 2016/17.

Approach

- We met with the Trust's leads to understand the process from identifying cancellations to the overall performance being included in the Quality Report. There were no recommendations from the previous auditor's review of last year's Quality Report as this indicator was not part of the external assurance work.
- We selected a sample of 24 from 1 April 2016 to 31 March 2017 including in our sample 12 items that were taken from the non-clinical cancellations list (to test accuracy) and 12 items from list of patients cancelled for clinical reasons (to test completeness and ensure the Trust are picking up all non-clinical cancellations).

Indicator definition and process

Definition: The indicator is the absolute number of patients whose operations are cancelled for non-medical reasons at the last minute and also the absolute number of patients who have not received another binding date within a maximum of the next 28 days (the cancelled operations standard).

Last minute is defined as cancellation on the day the patient was due to arrive, after the patient has arrived in hospital or on the day of the operation or surgery.

Findings

- We identified 1 error whereby the Trust had incorrectly recorded a clinical cancellation as a non-clinical cancellation, thus overstating the reported indicator. - [Recommendation 2]
- We identified 8 pathways where we were unable to trace the Trust's reported data to supporting evidence in the patient notes- [Recommendation 2]

Deloitte View:

As outlined above, for a number of cancellations, we were unable to obtain appropriate audit trail to validate the Trusts reported figure. Documentation explaining non-clinical cancellations was not formalised within patient information for a number of samples.

We identified 1 error whereby the Trust had incorrectly recorded a clinical cancellation as a non-clinical cancellation, thus overstating the reported indicator.

We have made recommendations to improve the overall control environment in regards to the indicator. We note the manual nature of the current process due the limitations of the Trust's current PAS system, which inherently makes reporting the indicator more complex for the Trust. The EPR system should provide an opportunity for the Trust to streamline and improve controls and processes and the Trust should consider this in their planning for the change.

Recommendation for improvement

Recommendation for improvement

We have made the following recommendations

No.	Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
1	18 Weeks RTT Incomplete Pathways	**Audit Trail** We recommend that the Trust implement controls to ensure that appropriate audit trail is retained for start and stop times for 18 week RTT pathways, allowing for the data to be validated for assurance purposes. This includes ensuring referral letters are held on file and date stamped to clearly evidence their receipt into the organisation and the patients potential clock start.	Recommendation accepted. The Trust will reiterate to all teams who receive and register referrals the importance of following the standard operating procedure (SOP) to ensure the patients clock start is reflective of their wait and to ensure that all referral letters and other associated documentation are uploaded to EDM and attached to the patient record. Accuracy and compliance against this will be monitored via the Data Assurance team through regular audit with any concerns fed back to the relevant service. **Responsible Officer:** Peter Hyland, Director of Operational Performance and Information **Timeline:** 31 July 2017 **Process for updating Council of Governors:** Update to be provided to Members Council	Medium
2	Cancelled Elective Operations	**Audit Trail** We recommend that the Trust implement controls to ensure that appropriate audit trail is retained for cancellations, and the reasons for cancellation are clearly documented in patient records. This will ensure there is adequate audit trail for assurance purposes and also help to ensure cancellations are categorised correctly in the dataset.	Recommendation accepted. The Trust will reiterate to all clinical teams the need to ensure that the patients records details around cancelled procedures, including reasons why and plans to reschedule the procedure. This needs to apply to cancellations for both clinical and non-clinical reasons. Accuracy and compliance against this will be monitored via the Data Assurance team through regular audit with any concerns fed back to the relevant service. **Responsible Officer:** Divisional Chairs & Peter Hyland, Director of Operational Performance and Information **Timeline:** 31 July 2017 **Process for updating Council of Governors:** Update to be provided to Members Council	Medium

Responsibility statement

Purpose of our report and responsibility statement

Our report is designed to help you meet your governance duties

What we report

Our report is designed to help the Council of Governors, Audit Committee, and the Board discharge their governance duties. It also represents one way in which we fulfil our obligations to report to the Governors and Board our findings and recommendations for improvement concerning the content of the Quality Report and the mandated indicators. Our report includes:

- Results of our work on the content and consistency of the Quality Report, our testing of performance indicators, and our observations on the quality of your Quality Report.
- Our views on the effectiveness of your system of internal control relevant to risks that may affect the tested indicators.
- Other insights we have identified from our work.

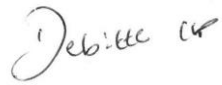
What we don't report

- As you will be aware, our limited assurance procedures are not designed to identify all matters that may be relevant to the Council of Governors or the Board.
- Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.
- Finally, the views on internal controls and business risk assessment in our final report should not be taken as comprehensive or as an opinion on effectiveness since they will be based solely on the procedures performed in performing testing of the selected performance indicators.

Other relevant communications

- Our observations are developed in the context of our limited assurance procedures on the Quality Report and our related audit of the financial statements.

We welcome the opportunity to discuss our report with you and receive your feedback.



Deloitte LLP
Chartered Accountants

19 May 2017

This report is confidential and prepared solely for the purpose set out in our engagement letter and for the Board of Directors, as a body, and Council of Governors, as a body, and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent. You should not, without our prior written consent, refer to or use our name on this report for any other purpose, disclose them or refer to them in any prospectus or other document, or make them available or communicate them to any other party. We agree that a copy of our report may be provided to Monitor for their information in connection with this purpose, but as made clear in the terms under which we contracted, only on the basis that we accept no duty, liability or responsibility to Monitor in relation to our Deliverables.

Deloitte.

Attachment H

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

28 June 2017

Chief Executive Report – April 2017

Summary & reason for item:

This purpose of this report is to provide a summary of key work priorities and achievements since the 26 April 2017 report to the Members' Council. The report includes:

- **Chief Executive Highlights Report** – Peter Steer, Chief Executive – See **Appendix 1**

- **Integrated Quality Report (April 2017)** (Juliette Greenwood, Chief Nurse and David Hicks, Interim Medical Director) – **See Appendix 2**

The Integrated Quality report provides information on whether patient care has been safe in the past, safe at the present time and what the organisation is doing to ensure that we are implementing and monitoring identified learning from our data sources (PALS, complaints, incidents, SIs).

The report also highlights areas of good practice identified through clinical audit and assurance that our systems and processes are reliable in the areas identified.

- **Integrated Performance Report (April 2017)** (Nicola Grinstead) **– See Appendix 3**

The attached Integrated Performance Report and supporting narrative (and appendices) provides an overview of the Trust as at Month 1 2017/18 – April 2017.

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

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

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

The IPR additionally includes further indicators and metrics with regard to Our Money (Finance) and Productivity. These indicators are those that have been recommended by the Trust Board, Clinical Divisions and other relevant parties.

- **Workforce Report** (Ali Mohammed, Director of HR and OD) **– see Appendix 4**

This report provides an updated position of a number of workforce metrics, together with a

summary of interventions for those areas of concern.

- **Finance Report** (Loretta Seamer, Chief Finance Officer) **– see Appendix 5**

This report provides an update on progress as at 30 April 2017 against the Trust financial plan for 2016/17.

The Trust is reporting a year to date deficit of £2.5m (excluding capital donations and impairments); this is in line with plan. At the end of Month 1 the Trust is forecasting that it will achieve the NHSI Plan that was submitted for 2017-18.

Councillor action required:

To note and discuss where required

Report prepared by:

Executive Teams

Item presented by:

Peter Steer, Chief Executive (and Executive Leads for their respective element of the report)

Appendix 1

Chief Executive Report to Members' Council – 26 April 2017

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 2017.

Further information will be provided at the Council meeting.

New Chairman Announcement

The Trust announced on 12 June 2017 that Sir Michael Rake has been appointed as the new Chairman of Great Ormond Street Hospital for Children NHS Foundation Trust and will take up the position in November 2017.

Sir Michael Rake said: "*I am honoured to be given this opportunity to serve such a well-loved organisation which makes a dramatic difference to the lives of children with rare diseases in the UK and elsewhere.*

"It will be a great privilege to work with leading clinicians and researchers who deliver world-class care and pioneering research in collaboration with key partners."

National clean air day

GOSH has joined forces with organisers of National Clean Air Day to raise awareness of the health impacts of air pollution, share information about minimising exposure and promote behaviour changes that will improve air quality. The event was held on June 15 in the Lagoon. Further information can be found here: https://www.cleanairday.org.uk/

GOSH Leadership Event: Freedom to Speak Up on 5 June 2017

Held on Monday 5 June, this event was aimed at leaders, managers and those in leadership positions across GOSH. It was a thought provoking exploration of the issues facing leaders when staff raise concerns. How should leaders react? What should they do? Who can they turn to for advice? How do they handle any conversations with staff at the time and subsequently?

Update on International Private Practice (IPP) at GOSH

Finance and activity

IPP income is behind the plan for 2017/18 but above the same time last year. The annual plan for IPP income for 2017/18 includes growth which is delivered within dedicated private wards, via business case investment in NHS speciality wards and Better Value schemes.

The majority growth in IPP income is generated through the full year effect of opening Hedgehog ward (September 2016).

Bed day activity for 2017/18 is behind plan but this has been more than off-set by providing treatment to NHS patients on private wards.

Debt

Debt levels remain high and whilst this is not at peak levels, is above desired debt holding. The vast majority of this debt is 'guaranteed' by governments of referring countries and we therefore have high confidence in collecting. There are two significant debts totalling £2.7m for which we have a concern but these are fully provided for. Finance and the IPP credit control team have been refining a number of practices to enable the Trust to refocus on debt collection.

Future growth

There are opportunities in phase 2B-Premier Inn Clinical Building (PICB) that enable further NHS speciality bed growth but currently there are no further plans to develop dedicated private wards prior to phase 4. IPP are working with the Charles West and JM Barrie division to consider how the additional capacity in the PICB can contribute to the further growth required to achieve the IPP strategy and contribute to future GOSH financial stability.

Health and Social Care Act 2012 compliance

The 2017/18 plan and future growth projections do not breach the control measures for non-NHS income.

Members' Council

The IPP division will continue to engage members' council with updates and involvement in future strategy, and to this end a follow-up meeting of the Members' council IPP strategy sub-group is being planned for July 2017 to enable a refresh of the IPP strategy document approved in September 2014.

GOSH in the news

Update on Charlie Gard

An update will be provided in the meeting.

Animating genome sequencing

Great Ormond Street Hospital (GOSH) and UCL Great Ormond Street Institute of Child Health have created an animation for young people coming to the hospital to have their genome sequenced.

GOSH is recruiting patients with rare diseases and their families as part of the 100,000 Genomes Project.

The aim of the project is to identify the underlying genetic cause for some rare diseases as well as create a new genomic medicine service for the NHS.

The animation compares a genome sequence to a robot's computer code and shows how 'glitches' in the code can sometimes cause health problems.

Attachment H

Drug derived from cannabis could spell the end of seizures for children with epilepsy

A drug derived from cannabis could have a life changing effect for thousands of people living with epilepsy, according to new research published today by Great Ormond Street Hospital (GOSH).

A trial of 120 children conducted in Europe and the USA has shown that cannabidiol – derived from cannabis but with the psycho-active elements removed – reduces seizures by nearly 40% in children with a form of drug resistant epilepsy, known as Dravet syndrome. It also has the potential to provide relief to the thousands of children with other strains of epilepsy who live with debilitating seizures.

Professor Helen Cross, Consultant in Paediatric Neurology at GOSH and joint lead author of the study, said: “The results of this study are significant and provide us with firm evidence of the effectiveness of cannabidiol. This drug could make a considerable difference to children who are living with Dravet syndrome and currently endure debilitating seizures.”

Great Ormond Street Hospital for Children NHS Foundation Trust

Integrated Performance Report

Nicola Grinstead, Deputy CEO

April 2017

(updated for Members Council)

The child first and always

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Great Ormond Street Hospital for Children NHS Foundation Trust

Executive Summary

Great Ormond Street Hospital for Children NHS Foundation Trust

APRIL 2017 (MONTH 1 2017/18)

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

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

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

The IPR additionally includes further indicators and metrics with regard to Our Money (Finance) and Productivity. These indicators are those that have been recommended by the Trust Board, Clinical Divisions and other relevant parties. The IPR is attached as an appendix to this supporting narrative. The narrative is continuing to be revised, in accordance with the update to the last Trust Board. This report and narrative should continue to be looked at in conjunction with other Trust Board reports (i.e. the Quality and Safety (appended), HR & OD and Finance).

2017/18 provides the Trust with a number of exciting opportunities and challenges, whilst looking to maintain the delivery of excellent patient care and to improve in a number of areas (e.g. continued EPR procurement, Better Value Programme, returning to the delivery of the national Referral to Treatment Time standard of 18 weeks, as a well as to continue to develop and improve services and patient & family experiences).

Caring

(to be reviewed alongside the Integrated Quality and Safety Report)

Great Ormond Street Hospital for Children NHS Foundation Trust

Friends & Family Test (FFT)

Headlines via the Performance Report for these measures are:

- Continued very positive recommendation responses for those undertaking the Inpatient FFT (97.7% for April 2017)
- The rate (%) of those responding (for Inpatients) remains below the local 40% standard set by the Trust, at 27.2% (for April 2017)

A comprehensive over-view and assessment of the Inpatient FFT delivery is provided in the Integrated Quality and Safety Report, tracking response rates over time and also in comparison to other organisations. This is reviewed and assessed in the relevant Trust Committees, and Divisional Nursing leads provide regular updates at their monthly Divisional Performance meetings.

Access to Healthcare for people with Learning Disabilities

The Trust continues to report compliance with this requirement against the measure outlined in the supporting appendix which provides an over-view of the definitions for each indicator.

Safe

(to be reviewed alongside the Integrated Quality and Safety Report)

Great Ormond Street Hospital for Children NHS Foundation Trust

Serious Incidents and Never Events

As confirmed in the Performance Dashboard and in the Quality & Safety Report, the number of reported incidents for April 2017 are:

- Serious Incidents = 2
- Never Events = 0

These are further detailed in the Quality and Safety Report

Healthcare Associated Infections (HCAIs)

Incidents of C. Difficile

As reported the Trust has seen 3 incidents of C Difficile in April, all of which are assigned to the Trust (in comparison with 4 reported and 1 assigned to the Trust for the whole year). These cases continue to be investigated as to whether they resulted from a lapse of care (the Trust last year reported no lapses of care following review with Commissioners).

Incidents of MRSA

The Trust reported no incidents in April 2017 (which is a continuation of the trend from the last few months, and where only 3 cases were reported in 2016/17)

CV Line Infections

These have returned to the required levels in April 2017, having risen in March 2017. The increase in incidents have been investigated by the lead nursing staff with involvement from the Infection Control team.

WHO Surgical Checklist Completion (> 98%)

The last 3 months have shown a steady improvement in the completion rate of the WHO Surgical Checklist, up to 95.1% in April (towards the target pf 98%). In main theatres, the drive is to ensure there is a sustained level of completion rates, following the NatSIPPs programme. Outside of main theatres, the focus have been on Dermatology where significant improvements have been seen in April (with the recent review of process and updating the checklist to be more fit for purpose)

Responsive

Great Ormond Street Hospital for Children NHS Foundation Trust

Diagnostics (99% < 6 weeks)

As per the April 2017 (M1 17/18) position the Trust continues to see improvements in this area, as it moves towards delivery of the 99% standard for the 15 diagnostic modalities reported against. For April the reported position was 97.44% (up from 96.62% last month)

From the table opposite which shows performance by modality, the main are of focus currently not delivering the standard is Audiology. Due to the volumes reportable for GOSH (in a typical month) any more than 5-6 patients waiting longer than 6 weeks, means the Trust is outside the 99% requirement. In April the Trust reported 15 > 6 weeks, of which 7 were in Audiology (the others in imaging, cystoscopy and gastroscopy where predominantly associated with patient choice or were complex cases).

The issues previously raised in regard to Audiology are being progressed and the infrastructure changes for the inclusion of an additional sound-proof booth, are being finalised, with the service aiming for compliance in May.

The standard remains challenging for the service with regard to the complexity of some tests that are undertaken, and the associated specialist resourcing required. Additionally, across the whole range of modalities where patient's choosing the be seen greater than 6 weeks presents a constant challenge. Services though are ensuring reasonable appointments are offered to all patients and families.

Modality	% <6 weeks
Audiology - Audiology Assessments	91.46%
Barium Enema	100.00%
Colonoscopy	100.00%
Computed Tomography	95.45%
Cystoscopy	85.71%
Gastroscopy	92.86%
Magnetic Resonance Imaging	98.78%
Neurophysiology - peripheral neurophysiology	100.00%
Non-obstetric ultrasound	98.21%
Urodynamics - pressures & flows	100.00%
Respiratory physiology - sleep studies	100.00%
Trust Total	**97.44%**

Cancer Wait Times

The Trust continues to report delivery of the Cancer Wait time standards applicable to the Trust.

Responsive

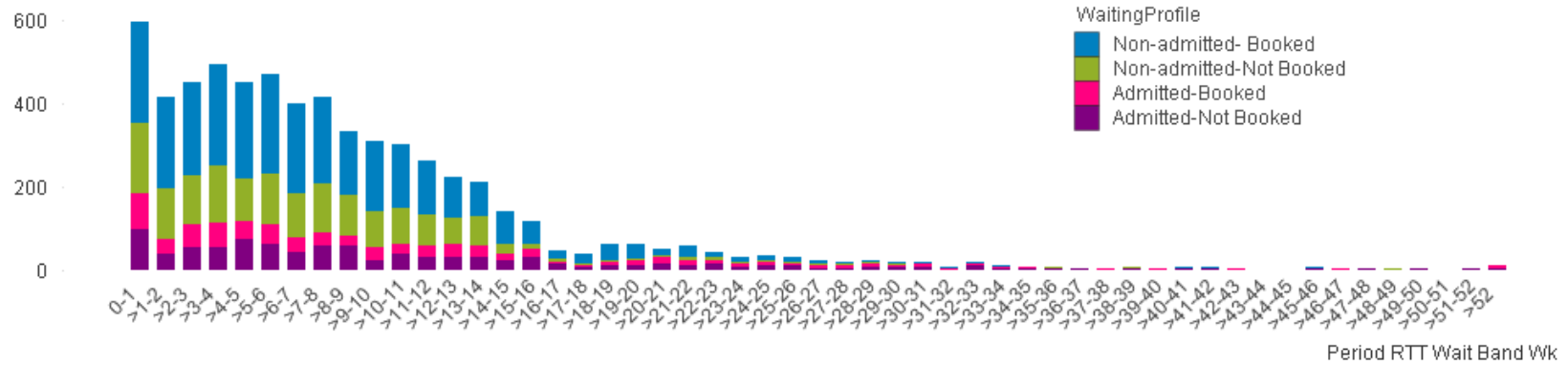
Great Ormond Street Hospital for Children NHS Foundation Trust

Referral to Treatment Time (incomplete standard > 92%)

Since returning to reporting the Trust continues to make good progress against the agreed improvement trajectory. As at April the Trust's performance against the 92% incomplete pathway standard was 90.31% (a slight reduction on last month), and in excess of the trajectory of 87.67% for the same period.

The areas contributing most to the non-delivery of the standard are those previously highlighted pressure specialties (Orthopaedics, Spines, Plastics, Urology and SNAPs). Plans are in place and being revisited to ensure clarity remains on when these services are expected to become compliant. Much of the delivery are associated with change projects across the Trust and with PICB opening.

The graph below provides an overview of the distribution of the Trust's RTT wait times (for those with known clock start pathways). As is evident a high proportion of pathways are booked early on in their wait, with those remaining un-booked reducing appropriately over time (reflecting good booking practice).



52 week waits:

For April the Trust reported 12 pathways waiting in excess of 52 weeks (which is a deterioration on the previous month of 2). Some of these resulted from an inherited waiting time from another provider (and this has been taken up directly with the provider concerned) and as a consequence of patient choice (having been able to treat < 52 weeks). However 8 of the 12 are from within the Rheumatology service. The reasons are being investigated and will be reported on more fully next month.

Unknown clocks starts:

As at April the proportion of pathways with an unknown clock start (i.e. referred to the Trust without confirming the start date of the pathway) was 14%. This is broadly in line with previous months and a significant improvement on historic levels, following the change in process and resource to target these referrers.

Responsive

Great Ormond Street Hospital for Children NHS Foundation Trust

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

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

For Quarter 4 (2016/17) the Trust reported the following (the full year is provided for completeness). The April figure (within the report) is an indicative assessment of M1 (to be contained within the Q1 position that will be submitted). This positively shows much lower levels than the last few months.

As is evident from the data, the Trust has seen an improvement from the start of the year, however the downturn seen in Q3 has not been sustained into Q4. Positively however 28 day breaches (i.e. those rebooked after a non-clinical last minute hospital cancellation) have been maintained at the Q3 levels, and the indicative April figures would suggest this has continued if not improved.

Focused work is underway within key areas to build on the improvements in year, and where there are further opportunities. The on-going balance between urgent / emergency cases versus elective bed capacity remains a challenge. Certain specialties are additionally being reviewed (e.g. Radiology), and further escalation steps are being put in place with operational senior management teams

2016/17	Last minute Non-clinical cancellations	28 day breaches
Q1	197	32
Q2	191	32
Q3	157	23
Q4	180	25

Analysis is currently underway to propose an appropriate level of cancellations for Trust (i.e. as a proportion of the elective work load of the Trust), and how this is comparable to other specialist paediatric hospitals. From the reported levels by the likes of Birmingham Children's, Alder Hey and Sheffield Children's, the Trust's volumes are higher (however this could be down to how those providers also record and report these – which is being investigated).

Well-Led

(to be reviewed alongside the Workforce Metrics & Exception Report)

Great Ormond Street Hospital for Children NHS Foundation Trust

Turnover Rate (Total & Voluntary)

As per the Performance Dashboard and reported on in the Workforce report, for April 2017 this stood at 15.7% for voluntary and 18.8% for standard. Which is a marginal increase in the rate from March to April

Trust wide efforts are underway to reduce turnover and there is a separate work stream overseen by the Nursing Workforce Programme Board specifically targeted at reducing turnover of nurses.

Appraisal (PDR) rate

The Trust this month has achieved the total appraisal rate of 90%

Considerable effort and focus has been given to achieving this requirement– which has been delivered in the following areas: West Division, IPP, Nursing & Patient Experience, Development & Property Services and Research and Innovation.

This needs to be sustained and for those areas not at 90% yet to be so in future months.

Mandatory Training

The compliance for Statutory and Mandatory training in April was 90%, as confirmed in the Workforce report, this is being delivered across the Trust (with the exception of one area).

Agency Spend

As at April this was 2.3% of the total pay bill. Further information is contained within the Workforce report

Vacancy Rate

At the time of writing this information was not available for M1, for the contracted rate.

For Nursing specifically, this is at 8.4%, which is an improvement on the last few months.

Effective

Great Ormond Street Hospital for Children NHS Foundation Trust

Discharge Summaries

Over the course of the last year there has been an improvement in the turn around time for Discharge Summaries being sent within 24 hours of discharge (as can be seen in the SPC chart below). Unfortunately there was a slight down turn in March (89.5%) and this has continued into April 2017 (86.9%).

The Clinical Divisions throughout the year have been focusing on particular specialties, with action plans in place to improve these turnaround times.

In JM Barrie Division these include: Gastroenterology, Nephrology , Dental MaxFac, Neurology / Epilepsy and Neuro-disability

In C West: Oncology, BMT, infectious diseases and Rheumatology.

The plans have included piloting different systems and approaches, reviewing roles & responsibilities , and appropriate escalation.

An audit was carried out during Q3 of 2016/17 with regard to the quality of the content of the discharge summaries, assessing these across a range of specialties against best practice standards. The results were positive evidencing good practice across the Trust. These findings were presented to the Patient & Safety Outcomes Committee and with Commissioners.

Clinic Letter Turnaround times

Much like the above, the Trust has seen modest improvements in this area over the course of the last year, reporting in April 2017 against 14 days 75.53%.. Key specialties are again being targeted to ensure there is sustained improvements.

Positively again however, following an audit in 2016/17, of key specialties (which provided a cross section across the breadth of services) using the a tool developed by the Royal College of Paediatrics and Child Health (RCPCH) known as the Sheffield Assessment Instrument for Letters (SAIL). Overall the audit showed the letters being produced at GOSH are of a high quality

Productivity

Great Ormond Street Hospital for Children NHS Foundation Trust

Theatres

As updated for the last Trust Board, the Performance Report now includes the total number of theatres alongside the utilisation metric.

For utilisation – over the last few months there has been an improvement with April showing indicative utilisation of 75.5% (for main theatres).

As part of the Better Value work streams, theatres is one of the major programmes of work and as such increased focus on process and systems is underway. In support of this programme a new theatres dashboard is being developed, and the way in which utilisation is being reviewed. This will provide increased transparency on theatre productivity in future months.

Beds

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

Occupancy: For the month of April 2017 has dropped from the levels shown in March to 82.8%. Further analysis will be required with regard to day and overnight occupancy levels, and what the range of occupancy is across the Trust, whether this can be understood because of the case mix and patients using those beds, and where opportunities exist to improve.

This indicator and methodology is currently under-review as part of the statutory returns review, and as such the metrics should be used as a guide at this time, pending completion of this exercise

Activity

Across the 3 main points of operational delivery (inpatients – discharges, Critical Care bed-days and outpatients) a comparison is provided looking at year on year differences, cumulatively YTD and individual month on month.

As at Month 1 (April 2017) Day Case and Outpatient Attendances are down on the same month last year (however there were fewer working days over this period). Overnight IPs and Critical Care Beddays are showing a slight increase.

Our Money

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary

This section of the IPR includes a year to date position up to and including April 2017 (Month 1). In line with the figures presented, the Trust has a deficit of £2.4m at Month 1, which is in line with plan.

- Clinical Income (exc. International Private Patients and Pass through Income) is £0.3m lower than plan
- Non Clinical revenue is £0.8m lower than plan
- Private Patients income is £0.1m higher than planned
- Staff costs are £0.4m lower than plan
- Non-pay costs (excluding pass-through costs) are £0.6m lower than plan.

Trust Board Dashboard - April 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

Caring

	Feb	Mar	Apr	Trend	Plan	NHS Standard
Access to Healthcare for people with Learning Disability						
% Positive Response Friends & Family Test: Inpatients	98.00%	97.36%	97.69%			95%
Response Rate Friends & Family Test: Inpatients	24.46%	25.90%	27.24%		40%	
% Positive Response Friends & Family Test: Outpatients	92.55%	94.74%	89.94%			95%
Mental Health Identifiers: Data Completeness	99.38%	99.12%	99.31%			97%

Safe

		Feb	Mar	Apr	Trend	Plan	NHS Standard
Serious Patient Safety Incidents	In-month	0	1	2			
	YTD	10	11	2			
Never Events	In-month	0	0	0			0
	YTD	1	1	0			0
Incidents of C. Difficile	In-month	1	0	2			1
	YTD	4	4	3			
C.Difficile due to Lapses of Care	In-month	0	0	0			1
	YTD	0	0	0			
Incidents of MRSA	In-month	0	0	0			0
	YTD	3	3	0			0
CV Line Infection Rate (per 1,000 line days)		0.99	1.68	1.28		1.6	
WHO Checklist Completion		92.11%	93.05%	95.10%		98%	
Arrests Outside of ICU	Cardiac Arrests	0	3	4		5	
	Respiratory Arrests	6	1	2			
Total hospital acquired pressure / device related ulcer rates grade 3 & above		0	0	0		0	

Responsive

		Feb	Mar	Apr	Trend	Plan	NHS Standard
Diagnostics: Patients Waiting >6 Weeks		95.73%	96.62%	97.44%			99%
Cancer 31 Day: Decision to Treat to First Treatment		100%	100%	100%			96%
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Surgery		100%	100%	100%			94%
Cancer 31 Day: Decision to Treat to Subsequent Treatment - Drugs		100%	100%	100%			98%
Last Minute Non-Clinical Hospital Cancelled Operations		60	67	37			
Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard		8	7	4			0
Same day / day before hospital cancelled outpatient appointments		1.11%	1.25%	1.14%			
RTT: Incomplete Pathways (National Reporting)		91.57%	91.85%	90.31%			92%
RTT: Number of Incomplete Pathways (National Reporting)	<18wks	5494	5723	5696			-
	>18wks	506	508	611			-
RTT: Incomplete Pathways >52 Weeks - Validated		7	2	12			0
Number of unknown RTT clock starts	Internal Referrals	29	23	13			-
	External Referrals	705	867	1023			-
RTT: Total Number of Incomplete Pathways Known/Unknown	<18 weeks	6205	6588	6669			-
	>18 weeks	529	533	674			-

Trend Arrow Key (based on 2 most recent months' data)

- Improvement
- Consistent trend
- Deterioration
- On / above target
- Below target
- No target

People, Management & Culture: Well-Led

		Feb	Mar	Apr	Trend	Plan	NHS Standard
Sickness Rate		2.27%	2.23%	2.18%		3%	
Turnover	Total	18.8%	18.6%	18.8%		18%	
	Voluntary	14.5%	15.4%	15.7%		14%	
Appraisal Rate		82%	85%	90%		90%	
	Consultant	83%	83%	84%			
Mandatory Training		87%	86%	90%		90%	
% Staff Recommending the Trust as a Place to Work: Friends & Family Test			77%			61%	
Vacancy Rate	Contractual	3.1%	0.1%	TBC		10%	
	Nursing	12.8%	13.0%	8.4%			
Bank Spend		6.0%	6.1%	5.4%			
Agency Spend		3.78%	3.90%	2.34%		2%	

Effective

		Feb	Mar	Apr	Trend	Plan	NHS Standard
Discharge Summary Turnaround within 24hrs		90.43%	89.56%	86.99%			100%
Clinic Letter Turnaround within	7 working days	46.19%	48.71%				
	14 working days	73.61%	75.53%	77.61%		100%	
Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)		6.86%	7.29%	7.71%		8.36%	

Productivity

			Feb	Mar	Apr	Trend	Plan	NHS Standard
Main Theatres	Theatre Utilisation		67.6%	70.7%	75.5%			77%
	No. of theatres		12	12	12			
Outside Theatres	Theatre Utilisation		55.1%	57.1%	55.7%			77%
	No. of theatres		TBC	TBC	TBC			
Trust Beds	Bed Occupancy		82.6%	85.7%	82.8%			
	Number of Beds		TBC	TBC	TBC			
Average number of beds closed		Wards	9.5	11.3	10.8			
		ICU	0.1	0.2	0.0			
Refused Admissions	Cardiac refusals		1	3	2			
	PICU / NICU refusals		14	19	9			

Activity

			Feb	Mar	Apr	Trend	Plan	NHS Standard
Daycase Discharges (YOY comparison)		In-month	1,936	2,174	1,789		2,082	
		YTD	22,507	24,681	1,789		2,082	
Overnight Discharges (YOY comparison)		In-month	1,556	1,733	1,509		1,540	
		YTD	17,358	19,091	1,509		1,540	
Critical Care Beddays (YOY comparison)		In-month	1,099	1,272	1,086		1,169	
		YTD	12,649	13,921	1,086		1,169	
Excess Bed Days	No. of patients		TBC	TBC	TBC			
>=100 Days	No. of beddays		TBC	TBC	TBC			
Outpatient Attendances (All) (YOY comparison)		In-month	21,073	23,084	18,339		19,891	
		YTD	229,380	252,464	18,339		19,891	

Our Money

	Feb	Mar	Apr	Trend	YTD Target	YTD Variance
Net Surplus/(Deficit) v Plan	(2.5)	(1.1)	(2.5)		(2.5)	0.0
Forecast Outturn v Plan	(6.3)			#VALUE!	0.2	0.0
Better value	0.5	0.5	1.0		0.0	0.0
Pay Worked WTE Variance to Plan	(213.2)	(228.0)	TBC		0.0	0.0
Debtor Days (IPP)	194.0	182.0	183.0		120.0	63.0
Quick Ratio (Liquidity)	1.80	1.90	1.88		1.73	0.2
NHS KPI Metrics	2.0	2.0	3.0		3.0	0.0

Great Ormond Street Hospital for Children NHS Foundation Trust

Integrated Quality Report

Dr David Hicks, Interim Medical Director
Juliette Greenwood, Chief Nurse

May 2017

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Great Ormond Street Hospital for Children NHS Foundation Trust

Safety

Care/ Experience

Outcomes/ Effectiveness

Improvement

Has patient care been safe in the past?

Measures where we have no concerns

Great Ormond Street Hospital for Children NHS Foundation Trust

This slide contains an overview of some of the key measures monitored within the Trust; these will be considered by exception. Where there are measures/trends of concern, a slide containing a deep dive of that information will be included in the report.

Measures for self reporting systems do not always have a direct correlation between the data and safety; e.g. an increase in reporting may not always be a result of an unsafe environment but instead as a result of a good reporting culture which in turn can improve safety via learning.

Please see appendix 1 for the methodology used for the measures below.

Measure	Comment
Never Events	The last never event was in June 2016 (more than 320 days ago) and performance remains stable at an average of 220 days between never events; this is within normal variation and is not statistically significant. Work is on-going to complete the actions from the investigation; these are in line with the agreed timescales for completion.
Non-2222 patients transferred to ICU by CSPs** ** patients should be transferred to ICU before they have an arrest where possible which would indicate the early identification of a deterioration prior to an arrest.	Performance remains stable at an average of 8 per month; this is within normal variation and is not statistically significant. The data has been reviewed and no trends or themes were identified at this time; the data will continue to be monitored.
Cardiac and respiratory arrests** **The figures within the Integrated Quality Report includes arrests within all areas outside of ICUs (including day case Wards, day units, outpatient areas and non-clinical areas e.g. main reception) whilst the Safe Staffing Report arrest data only refers to arrests on in-patient Wards . The data will therefore differ between the two reports as the Integrated Quality Report includes additional areas.	Overall, performance remains stable for both measures at 2 cardiac arrests per month and 2.7 respiratory arrests per month; this is within normal variation and is not statistically significant.

	Cardiac arrests outside of ICU	Respiratory Arrests outside of ICU
March 2017	**3** (Badger x2, Walrus)	**1** (Giraffe)
April 2017	**4** (Badger x3, Robin)	**2** (Squirrel (SNAPS), Koala)

Mortality	Performance remains stable at 6.3 deaths per 1000 discharges; this is within normal variation and is not statistically significant.
Serious Incidents** ****by date of incident not declaration of SI**	The data has shown a reduction in serious incidents reported per month from 1.2 to 0.63 however further data is required before it can be established if this is a sustained change.
Hospital acquired pressure ulcers reported (grades 2+)	While the increase in pressure ulcers previously reported has been sustained in March and April and currently averaging 6.7 per month, this is within normal variation and is not statistically significant. There have been no new grade 3 or 4 pressure ulcers since the last report. There is now an electronic referral process to inform the Tissue Viability team when there is a pressure ulcer. An RCA process for the review of pressure ulcers has been developed and is being piloted.

Has patient care been safe in the past?

Serious Incidents and Never Events

Great Ormond Street Hospital for Children NHS Foundation Trust

Serious Incidents and Never Events March- April 2017

No of new SIs declared in March-April 2017:	3	No of new Never Events declared in March-April 2017:	0
No of closed SIs/ Never Events in March- April 2017:	1	No of de-escalated SIs/Never Events in March- April 2017:	1

New SIs/Never Events declared in March-April(3)

STEIS Ref	Incident Date	Date Report Due	Description of Incident	Divisions Involved	Senior Responsible Officer (SRO)	Patient Safety Manager	Executive Sign Off	Divisional Contact
SI 2017/ 9747	06.04.17	10/07/17	Preventable aspiration cardiac arrest secondary to ventilator operation	JM Barrie	Associate Medical Director- Quality, Safety and Patient Experience	Lead Patient Safety Manager	Interim Medical Director	Divisional Chair, JM Barrie
SI 2017/ 10146	Identified on 07/04/17	13/07/17	Human tissue sent to incorrect location	Charles West	Deputy Medical Director/ Caldicott Guardian	Patient Safety Manager	Interim Medical Director	Divisional Co-Chair, Charles West
SI 2017/ 10169	13/03/17	13/07/17	Migrated needle during cardiac procedure	JM Barrie and Charles West	Associate Medical Director- Quality, Safety and Patient Experience	Lead Patient Safety Manager	Chief Nurse	Divisional Assistant Chief Nurse, JM Barrie

Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Great Ormond Street Hospital for Children NHS Foundation Trust

Learning from closed/de-escalated SIs in March-April 2017 (2):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
SI 2016/31065 (de-escalated 17/03/17)	The patient was referred to this centre for shared care management of an aortic coarctation with the local hospital in Cambridge, Addenbrookes. The patient underwent a series of screening investigations and subsequent multidisciplinary reviews where the consensus opinion was to proceed to surgical repair. The patient was admitted to theatre but the procedure was not completed as the surgeon with the support of a senior cardiology colleague felt the degree of aortic narrowing evident on macroscopic inspection was not sufficiently severe to justify surgical repair. Although the repair was not carried out, the patient underwent surgery and required post-operative management on cardiac intensive care and then the cardiac ward for three days ahead of discharge. It is possible that a coarctation repair may still be required in the future.	The findings from the pre operative serial echocardiograms and MRI were not supported by the intraoperative clinical findings and it was thus felt there was potentially more risk associated with proceeding with a modified surgical procedure than would be gained by not undertaking a modified repair.	• Divisional Director to discuss with consultant body, who chair the JCC, to ensure that a summary of all the discussion is outlined to the designated recorder and not just the outcome of the discussion. • Senior management team to propose and plan the consent clinic with the appropriate support, resources and membership. • Complete the consent audit on the cardiac day care unit and collate the data. • Present the data to the cardiac services in appropriate forums e.g.: Cardiac Board , consultants meeting, M&M • Review the information provided to families ahead of admission for elective procedures, how it is presented to them and when it is presented to them.	Staff should ensure that there is consistent recording of any discussions, not just outcomes, held at multi-disciplinary meetings to ensure that the decision process and rationale is clear to all.
SI 2016/33178 (closed 19/04/2017)	Information Governance Breach- information was sent to the birth parents of a patient where a court order was in place restricting information from being shared with them.	The PIMS record with contact details for the patient's birth parents was not amended once the Trust became aware that ongoing information should not be shared with them.	• PIMS alert for care orders to ensure that potential issues are flagged to all staff reviewing the patient record a) Create PIMS alert which would signify there is a relevant care order b) Create process for ensuring these are regularly reviewed (ongoing process) c) The member receiving information about a change in care details should be directly responsible for checking that PIMS information is updated accordingly. • Review all the records of all patients with a 'secure address' on PIMS for the last 2 years, to ensure that there are no other patients for whom we hold contact details on PIMS of parties who should no longer receive information about the child a) Collate list of those with secure address from Information Services b) Review information held on PIMS alongside information held by social work team • A new tab has been created on EDM (Electronic Document Management System for care orders to be uploaded and stored in.	If a patient has a secure address staff should be more vigilant. Demographic details to be checked at each visit and please ask for help from a manager if unsure

Are we delivering high quality care today?

Trust measures for Complaints

This slide contains an overview of some of the key measures monitored within the Trust; these will be considered by exception. Where there are measures/trends of concern, a slide containing a deep dive of that information will be included in the report.

Measures for self reporting systems do not always have a direct correlation between the data and safety; e.g. an increase in reporting may not always be a result of an unsafe environment but instead as a result of a good reporting culture which in turn can improve safety via learning.

Please see appendix 1 for the methodology used for the measures below.

Measure	Comment
All complaints	The number of complaints has reduced from 11 per month to 7.6 (This is a sustained reduction)
Red complaints	Performance remains stable at 0.4 per month
Amber complaints	Performance remains stable at 2.3 per month Note: the last 3 months are all below the process mean. Although too early to say this is an improvement we remain optimistic (we look for 7 consecutive months all above or below the mean)
Yellow complaints	Performance remains stable at 6.8 per month. Note: the last 4 months are all below the process mean. Although too early to say this is an improvement we remain optimistic (we look for 7 consecutive months all above or below the mean)

Are we responding and Improving?

Patient and Family Feedback: Red Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust

Red Complaints in March-April 2017

No of new red complaints declared in March- April2017:	1	No of re-opened red complaints in March- April 2017:	0
No of closed red complaints in March-April 2017:	2		

Learning from closed red complaints in March-April 2017 (2):

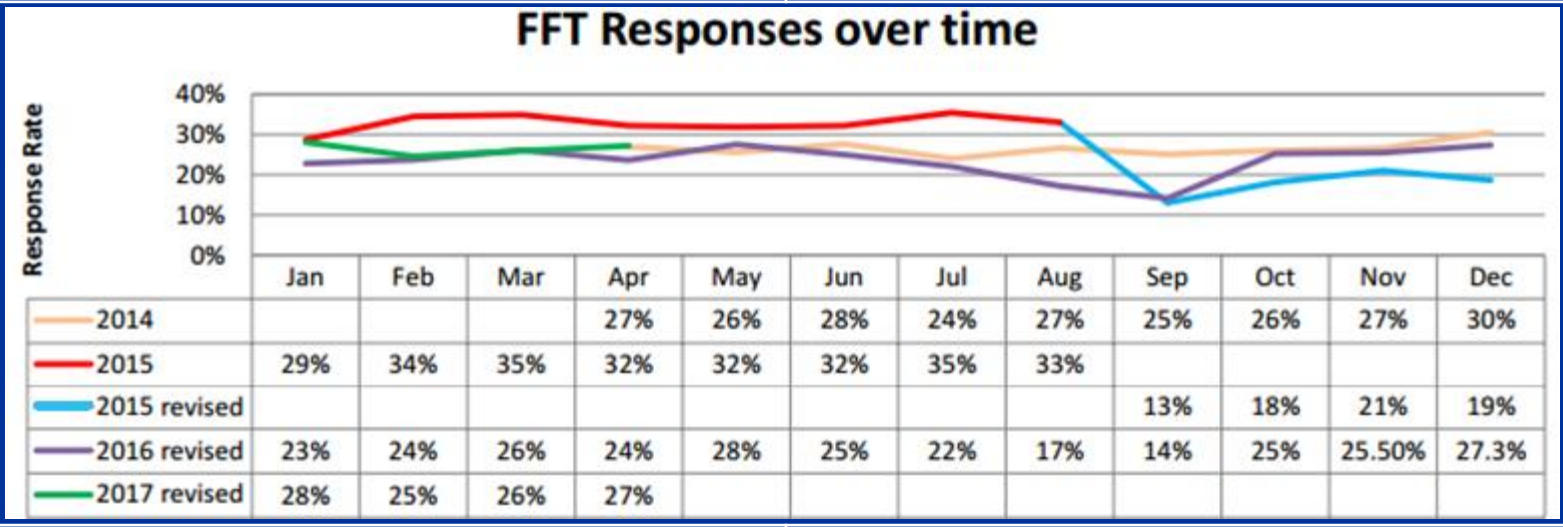
Ref:	Summary of complaint:	Outcomes/Learning:
16/075	The complainant raised concerns regarding the decision making regarding the need for a surgical repair for aortic narrowing and the consent process. The complainant also raised concerns that the patient received an unnecessary procedure as the surgical repair was not undertaken as it was found to be not clinically needed during the procedure and therefore not undertaken.	This complaint was linked with a serious incident investigation (SI 2016/ 31065 de-escalated 17/03/17); the complaint was answered via the serious incident root cause analysis report. The learning from the SI can be found on slide 5.
16/079	The complainant raised concerns that there were complications post procedure including septic shock and heart failure. Concerns were raised regarding the procedure undertaken, consent and post operative care provided.	A full investigation was undertaken and a report was shared with the family on completion. The report provided a detailed explanation for the care and management provided and the rationale for the clinical decisions made.

Are we responding and improving?

Learning from Friends and Family Test- Inpatient Data

Great Ormond Street Hospital for Children NHS Foundation Trust

Inpatient Results March 2017	Inpatient Results April 2017
March 2017 Overall FFT Response Rate = 25.9% Overall % to Recommend = 97.3%	**April 2017** Overall FFT Response Rate = 27.2% Overall % to Recommend = 97.7%



Q4 2016/17 Top 3 Themes			April 2017 Top 3 Themes		
Positive Themes:	**No +ve comments**	**Total comments**	**Positive Themes:**	**No +ve comments**	**Total comments**
Always Helpful (Understanding, Helps Others, Patient, Reliable)	771	779	Always Helpful (Understanding, Helps Others, Patient, Reliable)	242	243
Always Welcoming (Respect, Smiles, Friendly, Reduce Waiting)	537	555	Always Expert	190	198
Always Expert	648	700	Always Welcoming (Respect, Smiles, Friendly, Reduce Waiting)	136	141
Negative Themes:	**No -ve comments**	**Total comments**	**Negative Themes:**	**No -ve comments**	**Total comments**
Access / Admission / Transfer / Discharge	50	76	Staffing Levels	2	2
Staffing levels	13	26	Access / Admission / Transfer / Discharge	11	17
Environment & Infrastructure	117	393	Catering	7	21

Are we responding and improving?

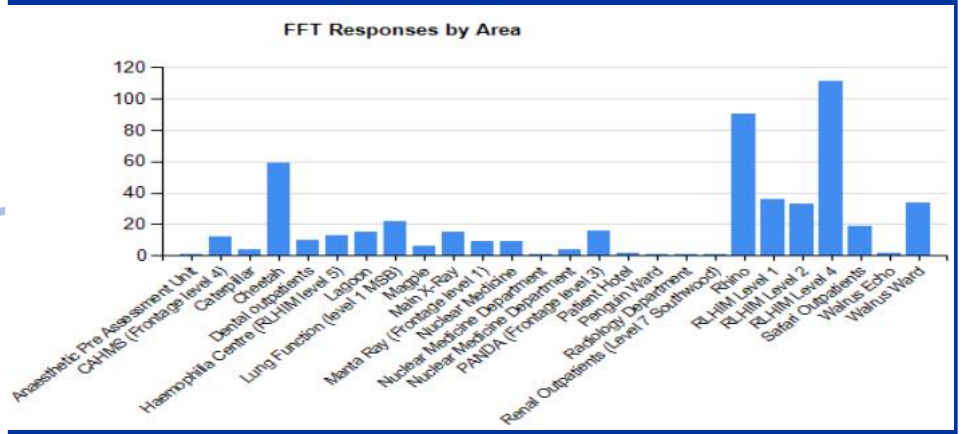
Learning from Friends and Family Test- Outpatient Data

Great Ormond Street Hospital for Children NHS Foundation Trust

Outpatient Results March 2017

March 2017

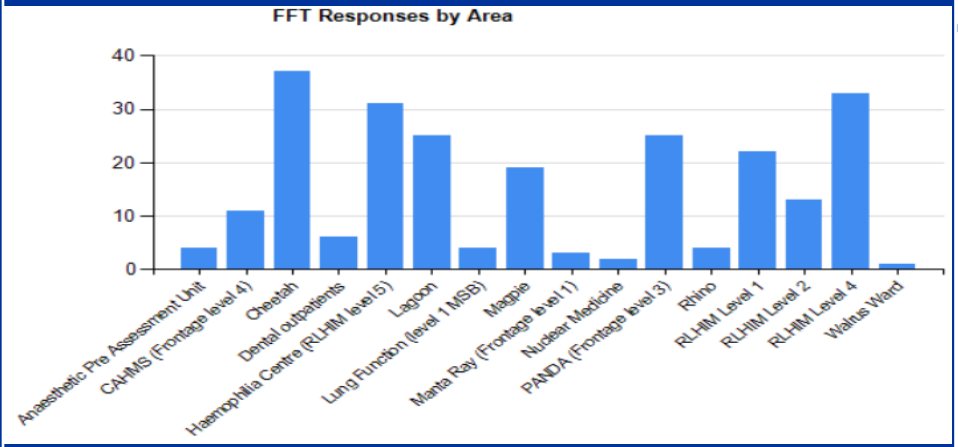
Overall % to Recommend = 94.5%



Outpatient Results April 2017

April 2017

Overall % to Recommend = 89.9%



Q4 2016/17

The average percentage to recommend for Outpatient in Q4 2016/17 was 93.93%.

The decrease in percentage to recommend has been reviewed by the team and established that the primary reason is due to waiting times in clinic.

(Other data is not available at the time of report completion due to data issues resulting from the NHS cyber attack).

Are we responding and improving?

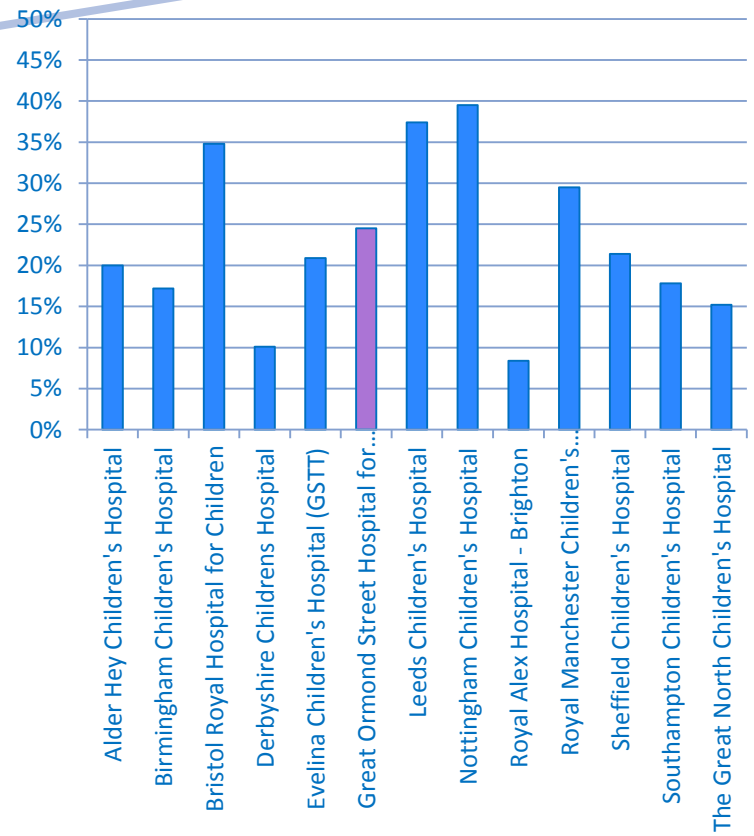
FFT Updates / Benchmarking

Great Ormond Street Hospital for Children NHS Foundation Trust

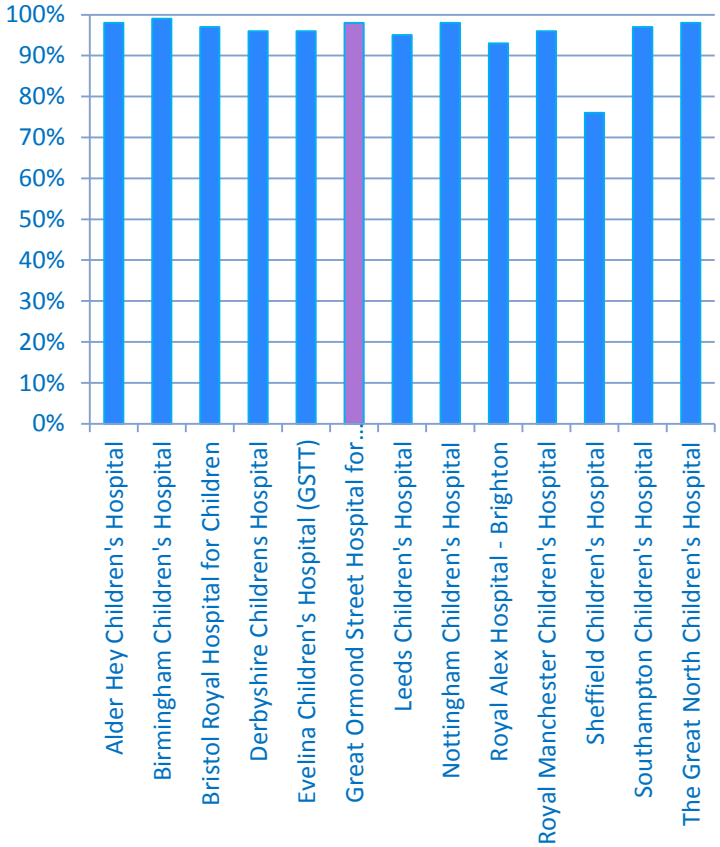
- FFT comments feature in roundabout each month.
- Real Time Feedback supplier has been chosen.

*Based on NHS Choices Data – Feb 2017 (this is the most current data available at report production)

Response Rates



Percentage to Recommend



Are we responding and improving?

Learning from Friends and Family Test- Positive Feedback

Great Ormond Street Hospital for Children NHS Foundation Trust

Below is a snapshot of some of the positive received via FFT during the reporting period. Positive feedback is shared with the relevant teams for dissemination.

Patient Feedback

Our son is highly anxious. He attended his first appointment at GOSH, which he found to be very traumatic such that he has refused to come for his follow up appointment or to attend the hospital again. The first appointment did not cater for the extremeness of his needs as he was bombarded with questions and we his parents were in front of him. The whole appointment was very clinical, impersonal and terrifying for our son.
CAMHS

Doctor was very polite. Information was given clearly. I felt comfortable at all times. Very good environment

Good care, Friendly, Less stress because of the welcome environment, encouragement, good explanation.

Parent/Carer Feedback

Everything was fantastic we are so grateful for the incredible expertise care, compassion we have received whilst as GOSH The nurse are exceptional very special people what an incredible hospital doing such am amazing work. THANK YOU our baby was born at UCLH and the connect to GOSH care fluidity was exceptional. a template for all other hospitals"

I have been extremely impressed by the endless patience and caring of the nurses and staff. Nothing is ever too much trouble. We feel lucky to be looked after by such wonderful professionals.

Everyone is so friendly and makes you feel welcome, they do anything to help.

Are we responding and improving?

Learning from Friends and Family Test- 'You Said, We Did' Feedback

Great Ormond Street Hospital for Children NHS Foundation Trust

Below is a snapshot of some of the negative feedback received via FFT during the reporting period and the subsequent actions taken. There is a process in place for the management of negative feedback to ensure that this is acted upon appropriately.

'You Said'

We did

"We do see the negative effects of the short staffing and turnover of nurses. New nurses take about six months to be trained and agency nurses from other wards often do not give the same quality of care. They are not used to the work load and urgency/ timing that is so important on this ward. we have spent a few weeks on other wards such as Penguin & Elephant and the nurses there were also kind, but not used to the "difficult" patient that my son is and were overwhelmed/ stressed despite being clearly less busy (based on time spent on lunches and the desk chatting).
The Fox nurses need incentive + more compensation for the heavy work load they have to increase retention and drive the work on such an intense ward. Our care is usually worse and filled with anxiety if we have an agency nurse that is not from Fox or Robin originally"

The Ward Sister has reviewed the concerns raised:
The dependency of complex patients on the Ward is higher than other wards in ICI. Nurses external or new to this speciality can require additional support as they become familiar with the area which is given as needed. Vacancies have been highlighted and recommendations for higher staffing levels have also been discussed. The positive feedback within the e-mail has been well received by the Ward.
The email will be shared with the Ward Managers on Elephant Ward and Penguin Ward to investigate the issues with long breaks and chatting at the desk.

This has been escalated to ICT and the Manager responsible for Patient Bedside Entertainment to review.

"No TV, no entertainment."

"The treatment area is the waiting area - It is hugely overcrowded, Dirty. Patient treatment chair/beds are not cleaned before or after patients are treated in them. Patient's relatives and other patients are crowded around giving no privacy to patients being treated. Supplies of medical equipment are out of stock (sticky plasters removing gel) Staff opened a window while wearing examinations gloves and then proceeded to examine/treat my daughter without changing them. Chairs are broken - it is awful to be a patient on this ward - truly terrible."

The e-mail has been received by the Ward Sister and the matter is being reviewed as a matter of urgency.
Regarding the overcrowded infusion room, this has been ongoing issue but staff on the Ward always try to ensure the privacy policy is adhered to . Examination of patients are always carried out in the cubicles. In the treatment room, there are 3 recliner chairs which enables staff to administer infusions to 3 patients at a time.
Regarding the staff not following infection control guidance with regards to use of gloves, this will be discussed will all of the clinical team on the Ward to remind them the importance of following guidelines for infection control.
This particular shift was busy due to staff sickness; we are sorry that this had an impact on patient experience.

"Not allowed go outside the room. No Wii games. Baby programme repeated movies (the jungle book), hurting doctor."

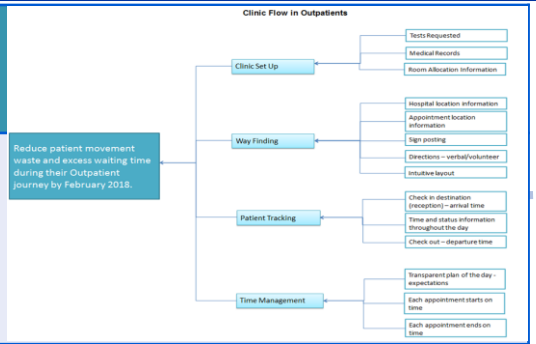
The Ward Sister and Play team have been informed of the comments and are reviewing the support in place.
The lack of Wii Games and lack of suitable programmes/movies has been escalated to ICT and the Manager responsible for Patient Bedside Entertainment to review.

Are we responding and improving?

Featured Project: Outpatient Clinic Flow

Great Ormond Street Hospital for Children NHS Foundation Trust

Project aim:
To reduce excess movement waste and waiting times for patients and families in the Outpatients Department by February 2018.



The Outpatient Clinic Flow Project seeks to improve patient waiting times in Outpatient clinics by addressing physical and process issues within the department. It was developed from the final arm of the closed 'Access to Outpatients' programme of work (paused in 2015) in response to growing concerns around patient waiting times highlighted from patient surveys and listening events. The project is led by the multidisciplinary nursing and administrative OP team, including medical representatives from specialties and Quality Improvement support. The project works closely with the OP Space project, which seeks to move clinics into specialty grouped zones.

Expected Benefits of the Project:

- Patients to be seen at their booked appointment time
- Apply LEAN principles to prioritise value adding clinical tasks during clinic and maximise clinic prep
- Improved visibility for staff and patients of the patient journey on appointment day, and the patient's progress through this
- Clear signage to support easy wayfinding for families
- Agreed resources available to ensure clinics start on time
- Clinicians to receive required patient information in a timely manner
- Standardise practice across the main Outpatient areas to support equity of care and rotation of Outpatient staff

Primary Drivers

- Clinic Set Up
- Wayfinding
- Patient Tracking
- Time Management

Measures for Improvement:

Audit and survey data will be used to measure results of the project.

Outcome measures:

- Time in mins of global avoidable patient waiting time to see clinician
- Distance travelled by patient during Outpatient journey
- Patient experience (surveys)

Process measures:

- % Missing health records
- Time in mins patients wait for H&W measurement
- Time in mins of lag between H&W and appointment time
- % of pts requiring signposting assistance

Balancing measure:

- Clinic slot utilisation

Progress to date:

- New Outpatient Clinic Flow Project Team established
- Process mapping session and feedback from patient and families used to inform the project
- New project scope agreed by QIC in January 2017
- Spread planned in tandem with the OP Space project (clinic moves)
- Manta Ray (first area) audit and patient/family survey completed
- Manta Ray area working group established to formalise PDSA ideas
- Cheetah Reception working group established to improve patient access and patient flow, seating changed, await new desk
- New blood room established to reduce patient journey, audits underway

Next Steps:

- Finalise and share the audit analysis of Manta Ray and Rhino with the project team and parent rep
- Diagnostics and process mapping with the Neurodisability, Ophthalmology and OP teams, involving health records to identify issues and ideas
- PDSA practice changes in Manta Ray and Rhino
- When ENT move to Manta Ray, H&W service to be established
- New desk to be repositioned in Cheetah – PDSA waiting area to maximise patient access and flow
- Ongoing audits across the Outpatient areas according to planned spread, working with specialties and the Outpatient team to identify issues for improvement

Are we responding and improving?

Quality Improvement Project Status Update (with Executive sponsorship)

Great Ormond Street Hospital for Children NHS Foundation Trust

Project	Project Aims	Project Leads	Project Timescales and Progress
Nursing Quality Measures	To demonstrate Ward Nursing Quality Measures	Executive Sponsor- **Chief Nurse** Clinical Lead- **Assistant Chief Nurse**	Progress to date: • Development will continue through to 30th June 2017. • While progress has been made in identifying the metrics the project is delayed against the timeframes agreed. The delay is due to: • Access to PANDA and LMS data. • Difficulties in linking the national safety thermometer data with the dashboard. • Challenges around displaying real time information. As a first step the QI team are going to pull through all the current measures that are accessible into the QI Nursing quality measures dashboard site. The is will enable ward sister to view considerably more of their ward metrics in one place. • Visits have been made to Salford, UCLH and Birmingham children's hospitals to share practice and learn from others.
Neonates	To improve the quality and safety of care within inpatient neonates/small infant* at GOSH by 1 June 2017 [*<28 days or 4kg]. The three areas of focus are to: • Reduce the number of avoidable bloodspot test repeats • Increase the recognition and management of neonatal jaundice • Improve documentation and delivery of IV fluid management	Executive Sponsor- **Chief Nurse** Nursing Lead- **Neonatal Nurse Advisor** Medical Lead- **Head of Clinical Service**	June 2017 Progress to date: • Neonatal Intranet section in development • Presenting project at the IHI GOSH Experience Day • Developed e-learning for bloodspots, jaundice and fluids – working with Learning and Development team to develop GOLD packages • Neonatal fluid management guideline developed and due to be published • Reviewed and updating neonatal information sheets provided to families • Currently testing process and access to NHS Spine for ICU Ward Admins to identify and complete missing NHS numbers on PiMS for neonatal admissions to reduce avoidable bloodspot repeats • Developing and testing Neonatal Standard of Care, to replace birth History form • Updating and testing neonatal information folders on NICU

Are we responding and improving?

Quality Improvement Project Status Update (with Executive sponsorship)

Great Ormond Street Hospital for Children NHS Foundation Trust

Project	Project Aims	Project Leads	Project Timescales and Progress
Transition	Specialties are working on the short-term requirements of the Transition CQUIN and work is on-going on longer-term improvement strategies with specialties to ensure the Trust meets the recommendations of the NICE Transition Guidelines.	Executive Sponsor- Chief Nurse	On-going project Progress to date: • Q4 CQUIN submitted (target achieved but will need confirmation from Commissioners) • 6 young people have now joined Steering Group • Minimum standards for a Transition Plan being agreed • Project underway with UCLH and Barts to improve transition for YP with an LD or additional needs- 1st draft of joint information leaflet • Pilot underway of dedicated Transition tab on PIMS showing which YP have a Transition Plan in place • Pilot of Consultant alert list showing date of next appointment and frequency of appointments for YP over 16 Next steps: • Finalise minimum standards that must be met in any specialty-specific Transition Plans • Revision of Trust Transition Policy
Extravasation	To reduce the incidence of extravasation injury at GOSH	Executive Sponsor- **Chief Nurse** Clinical Lead- **Consultant Anaesthetist**	Progress to date: • Six work streams underway • VHP Framework & Tool – currently on Koala, Eagle & Bumblebee wards, commencing on Bear ward in April 2017. • Discussions are underway for roll out on Peter Pan and Hedgehog Wards. • VHP Tool – Feedback survey underway for Staff and Families • Communication group started – Soft Focus day planned for June 17 • Training video – storyboard agreed and filming due to commence April 2017 pending funding

Appendix 1

Methodology for key Trust measures

Great Ormond Street Hospital for Children NHS Foundation Trust

Measure	Methodology	
Never Events	Note that the most recent data point indicated the number of days since the most recent never event. Never events are defined here - https://www.england.nhs.uk/ourwork/patientsafety/never-events/	
Non-2222 patients transferred to ICU by CSPs**	Unplanned non-2222 patient transfers to ICU, admitted as deteriorating patients from ward areas by the CSP team. Parameterised by ward (May 2015 onwards).	
Cardiac and respiratory arrests	**Cardiac arrests outside of ICU:** The monthly number of cardiac arrests outside of ICU wards (recorded from calls made to the 2222 Clinical Emergency Team). Cardiac arrests are defined by any patient requiring cardiac compressions and/or defibrillation. Cardiorespiratory arrests count towards the cardiac arrests total, not the respiratory arrests total.	**Respiratory arrests outside of ICU:** The monthly number of respiratory arrests outside of ICU wards (recorded from calls made to the 2222 Clinical Emergency Team). Respiratory arrest is defined by any patient requiring bag mask ventilation. (Previous to May 2013 this was defined as any patient requiring T-piece and/or Bag Valve Mask.) Cardiorespiratory arrests count towards the cardiac arrests total, not the respiratory arrests total.
Mortality	The inpatient mortality rate per 1000 discharges. The numerator is the number of patients who die whilst inpatients at GOSH. The denominator is the number of inpatients who are discharged each month. Day case admissions (as specified by a patient classification of 2 or 3) are excluded from the denominator. CATS patients who are not admitted to GOSH are excluded from this measure.	
Serious Incidents	This is the monthly count of serious incidents (SIs), by date of incident (as opposed to date incident was reported). A serious incident is defined as an incident that occurred in relation to care resulting in one of the following: • Unexpected or avoidable death of one or more patients, staff visitors or members of the public. • Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm • Allegations of abuse • One of the core sets of 'Never Events' http://www.england.nhs.uk/ourwork/patientsafety/serious-incident/	

Appendix 1

Methodology for key Trust measures

Measures for self reporting systems do not always have a direct correlation between the data and safety; e.g. an increase in reporting may not always be a result of an unsafe environment but instead as a result of a good reporting culture which in turn can improve safety via learning.

Measure	Methodology
All complaints	All complaints added together (red, amber and yellow).
Red complaints	A count of all red complaints per month. Red complaints are defined as severe harm to patient or family or reputation threat to the Trust.
Amber complaints	A count of all amber complaints per month. Amber complaints - lesser than severe but still poor service, communication or quality evident.
Yellow complaints	A count of all yellow complaints per month. Yellow complaints - issues or difference of opinion rather than deficient service.
Number of PALS cases	A simple count - the number of PALS cases.

TRUST BOARD WORKFORCE METRICS & EXCEPTION REPORTING – APRIL 2017

Introduction

This suite of workforce reports includes:

- Voluntary turnover and total turnover;
- Sickness absence;
- PDR appraisal rates;
- Statutory & Mandatory training compliance;
- Temporary staffing usage as a percentage of paybill (split by bank and agency).

Each report shows divisional and directorate performance and an exception report that indicates the cost centres which are the most statistically significant outliers against average performance. Where data exists to provide an external comparator (London trusts) this is indicated on each graph.

Headlines

Contractual staff in post GOSH decreased its contractual FTE (full-time equivalent) figure by 11 in April to 4105 compared to February 2017 (4116).

Sickness absence has decreased to 2.2% and is below the London average figure of 2.8%. Short-term sickness (STS) (episodes of sickness up to 4-weeks) has decreased to 1.26% across the Trust whilst long-term sickness has also decreased to 0.92%.

Unfilled vacancy rate: The Trust's unfilled vacancy rate is currently unavailable as the 2017/18 budgets have not yet been confirmed.

Agency usage for 2017/18 (year to date) stands at 2.3% of total paybill. The Trust has established a Better Value Scheme scrutinising all agency spend. Significant progress has already been made in converting agency staff to either permanent contracts or bank. All RTT validators will be converted by the end of May and the Trust has extensive recruitment campaigns underway for specific target staff groups in order to reduce agency further. NHS Improvement (NHSI) have set an agency spend ceiling for all Trusts (3% for GOSH, £6.525 million) and the Better Value Scheme aims to achieve overall savings of £250K.

Agency Measure	Spend YtD (April 2017)	Shifts breaching agency cap
RTT agency staff	*£176k*	*0*
Gastro review agency staff	*£0*	*0*
Business as usual agency staff	*£467k*	*740*
Total agency staff	*£643k*	740
Agency ceiling	*£7,068k*	

PDR completion rates The Trust overall appraisal rate stands at 90% - an increase of 6% since February 2017. Areas meeting the in-year target of 90% are West Division, IPP, Human Resources & OD, Nursing & Patient Experience, Development & Property Services and Research and Innovation.

Statutory & Mandatory training compliance: In April the compliance across the Trust remained at 90%. Currently, all but one of the directorates/divisions are meeting the in-year 90% compliance requirement, with the exception of West (at 89%). The significant improvements to StatMan compliance has been driven by:

- A Trust-wide focus to drive up compliance at all levels (accessibility of information, publicity via screensavers);
- Specific challenge to the appropriateness of training requirements per post within the training needs analysis.

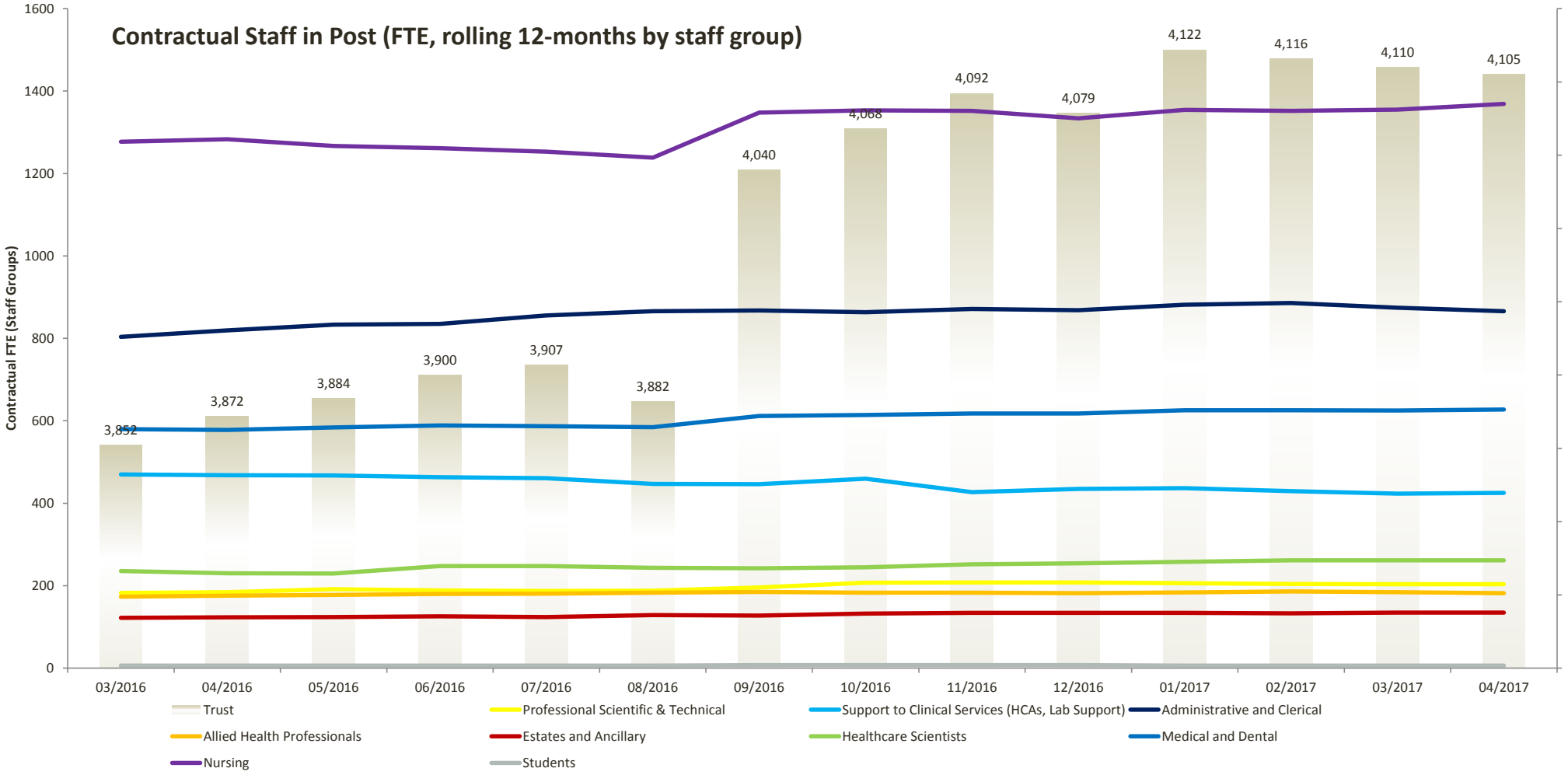
These reviews will continue over the forthcoming weeks including modelling supply and demand of training to ensure capacity is available and reviews to the methods of training to best fit demand and quality requirements

Turnover is reported as voluntary turnover in addition to the standard total turnover. Voluntary turnover currently stands at 15.7%; this reported value excludes non-voluntary forms of leavers (e.g. dismissals, TUPE, fixed-term and redundancies). Total (voluntary and non-voluntary) turnover has remained at 18.8% in April 2017. The (unadjusted) London benchmark figure is 15.1% (which includes voluntary and non-voluntary leavers).

Trust wide efforts are underway to reduce turnover and there is a separate work stream overseen by the Nursing Workforce Programme Board specifically targeted at reducing turnover of nurses.

HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2017 REPORT

Division	**Contractual Staff in Post (FTE)**	**Voluntary Turnover Rate (%, FTE)** (voluntary leavers in 12-months in brackets, 14% green)	**Total Turnover Rate (%, FTE)** (number of leavers in 12-months in brackets, 18% green)	**Sickness Rate (%)** (0-3% green)	**PDR Completion (%)** (target 90%)	**Statutory & Mandatory Training Compliance (%)** (target 90%)	**Agency (as % of total paybill, £)** (Max 0.5% Corporate, 2% Clinical)	**Bank (as % of total paybill, £)** (target 8%) (RAG TBC)
West Division	1640	16.0% (262.2)	18.8% (277.9)	2.3	93%	89%	1.0%	5.7%
Barrie Division	1661	14.0% (231.6)	17.5% (259.5)	1.8	86%	90%	0.6%	4.5%
International	199	18.8% (37.4)	21.8% (39.4)	3.4	96%	98%	-0.2%	15.1%
Corporate Affairs	8	12.5% (1.0)	22.7% (2.0)	0.1	75%	91%	1.7%	0.0%
Clinical Operations	112	15.0% (16.8)	17.7% (16.8)	2.9	86%	92%	5.8%	10.1%
Human Resources & Organisational Development	78	23.9% (23.5)	31.4% (25.5)	2.9	90%	98%	0.0%	3.6%
Nursing & Patient Experience	81	7.4% (6.0)	13.2% (9.8)	1.7	94%	94%	0.0%	-0.5%
Medical Directorate	45	10.1% (4.6)	12.7% (5.0)	2.1	78%	93%	0.0%	2.0%
Finance	37	43.1% (16.0)	40.8% (19.0)	2.6	82%	100%	41.9%	2.9%
Development & Property Services	147	12.9% (18.9)	13.9% (19.9)	2.9	97%	95%	-2.5%	5.0%
Research & Innovation	95	24.8% (23.6)	26.6% (23.6)	1.8	91%	94%	1.3%	5.2%
Trust	4105	**15.7%▲ (643.6)**	**18.8%► (698.3)**	**2.2%▼**	**90.0▲**	**90.0% ►**	**2.3%▼**	**5.4%▼**


Contractual Staff in Post (FTE, rolling 12-months by staff group)
Contractual FTE (Staff Groups)
1600
1400
1200
1000
800
600
400
200
0
3,852
3,872
3,884
3,900
3,907
3,882
4,040
4,068
4,092
4,079
4,122
4,116
4,110
4,105
03/2016
04/2016
05/2016
06/2016
07/2016
08/2016
09/2016
10/2016
11/2016
12/2016
01/2017
02/2017
03/2017
04/2017
Trust
Professional Scientific & Technical
Support to Clinical Services (HCAs, Lab Support)
Administrative and Clerical
Allied Health Professionals
Estates and Ancillary
Healthcare Scientists
Medical and Dental
Nursing
Students

HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2017 REPORT

Highlights & Actions

Sickness Rate

Actions

- Continued support to encourage line managers to attend the ER Bitesize training sessions, and bespoke sessions within the Divisions. On a monthly basis the Er team continue to report on the Bradford triggers for those staff that have reached the trigger. Regular meetings are held with Ward Sisters to discuss sickness management. Health and wellbeing; a number of initiatives are being launched in order to support employees at work such as mental health awareness and healthy activities over the next month.
- IPP - Regular meetings held with managers in IPP to discuss employees with sickness concerns which has improved over recent months. This is predominantly made up of short term sickness as they have a very low long term sickness rate.
- Regular meetings set up with service leads to provide additional support in managing sickness cases.

Agency Spend

Actions

- HRBPS are working within the Divisions to reduce agency usage by converting individuals from agency to permanent or bank contracts. This work is inline with NHSI requirements to reduce agency and breaches of payrates and duration.

Voluntary Turnover Rate

Actions

- There has been a significant amount of work undertaken over the past few months to better understand the broader turnover position - with specific focus on areas of low stability and high turnover. Whilst this is work in progress, there have been developments in also understanding the reasons why people leave and where they go. In addition, the work around nurse recruitment and retention is now a focused project under the Nursing Workforce Programme Board.
- A retention survey is on-going to obtain feedback from staff after they have been in post for 3 months
- Developing B5s into vacant B6 roles helps to decrease turnover of B5s
- Focus groups have been held and feedback is being reviewed from Band 6 nurses to support retention

PDR Completion

Actions

- Simplfiying the reporting process of PDRs has supported managers in working towards their PDR targets. The HRBPs are continuing to support managers in identifying the PDRs that are required for completion.
- Performance management via divisional reviews continues.
- PDR rates now regularly reported and accessible via the intranet. Significant increases across all divisions
- Continued reminders to individuals and line managers

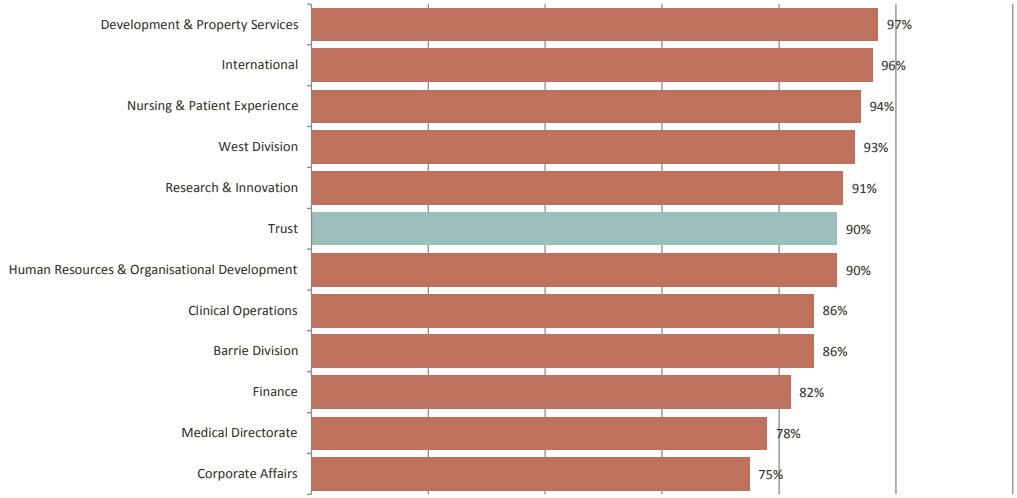
Statutory & Mandatory Training Compliance

Actions

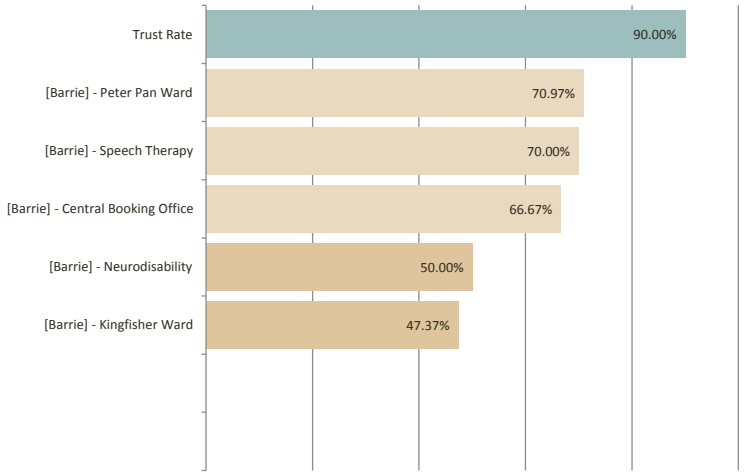
- More visibility through LMS
- Learning and Development & ER team will work with managers to identify those who are non-compliant including further developments to the new LMS
- Additional face to face sessions have been run for DPS staff. Information sheets sent out for online courses.
- Simplicity in reporting process to improve compliance

HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2017 REPORT

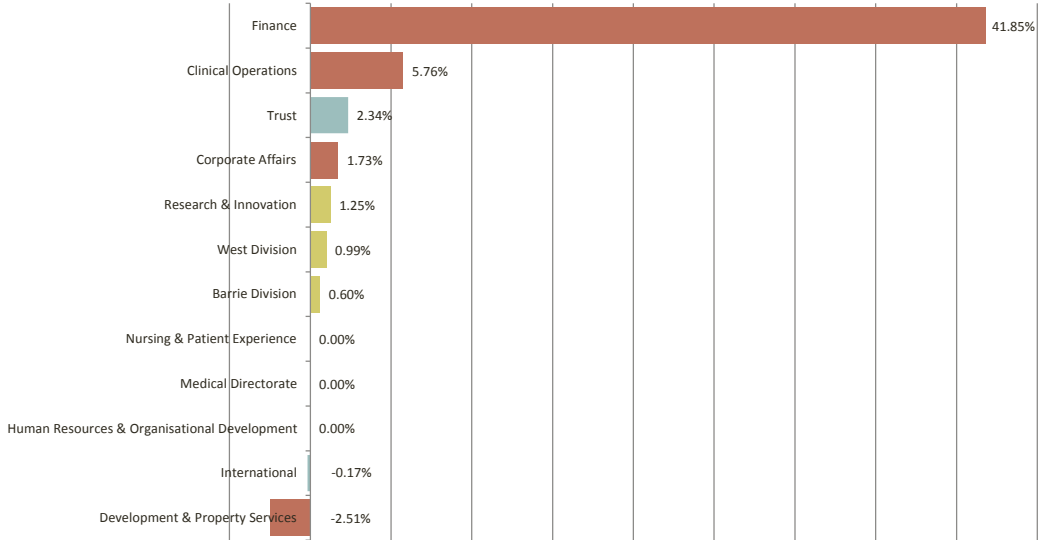
Divisional PDR (Target 90%)



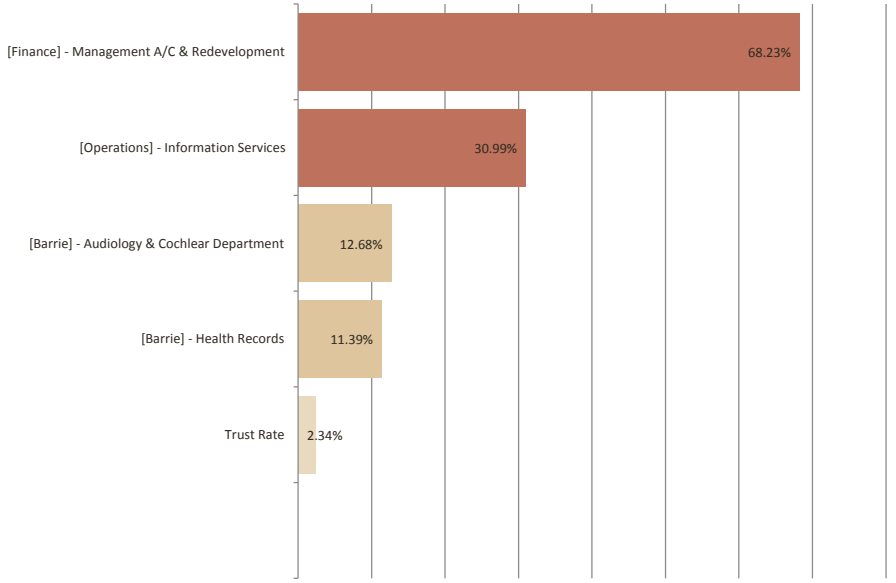
Exception Reporting PDR



Divisional Agency as % of paybill

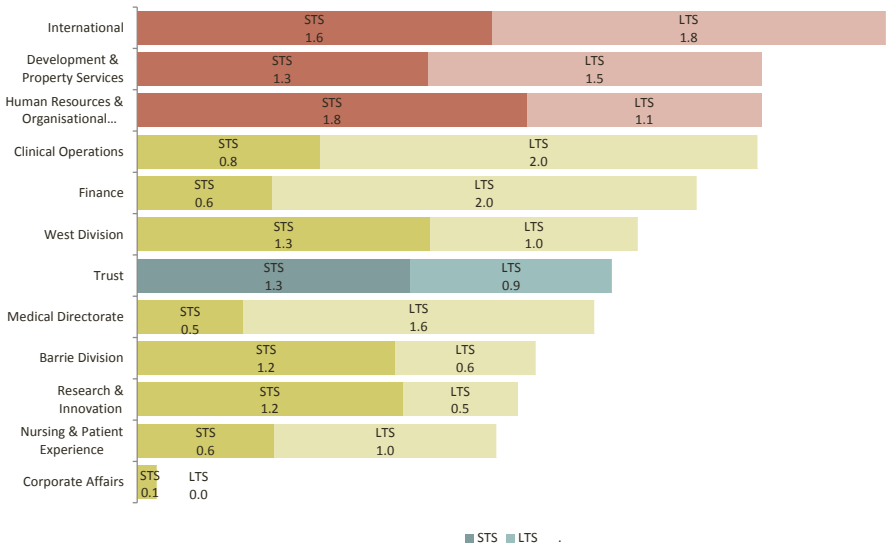


Exception Reporting Agency as % of Paybill

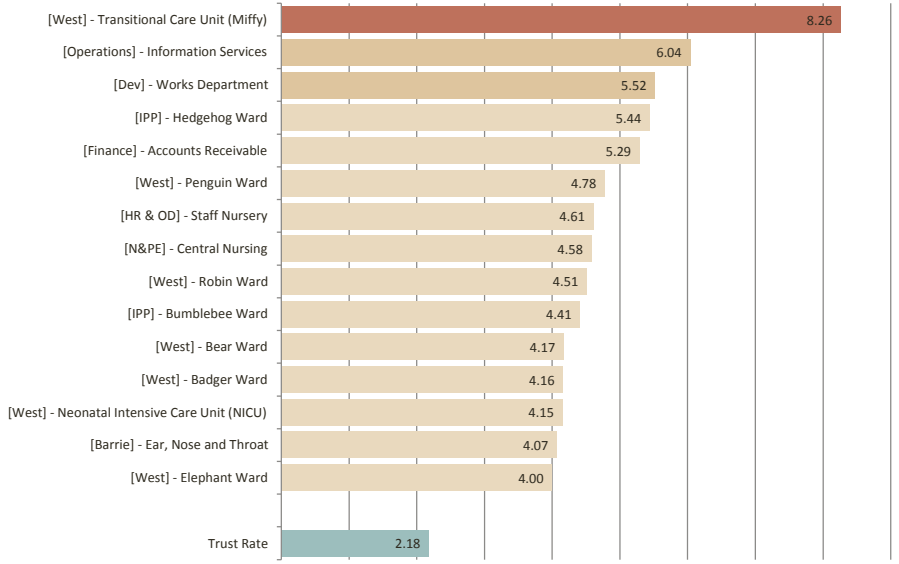


HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2017 REPORT

Divisional Sickness

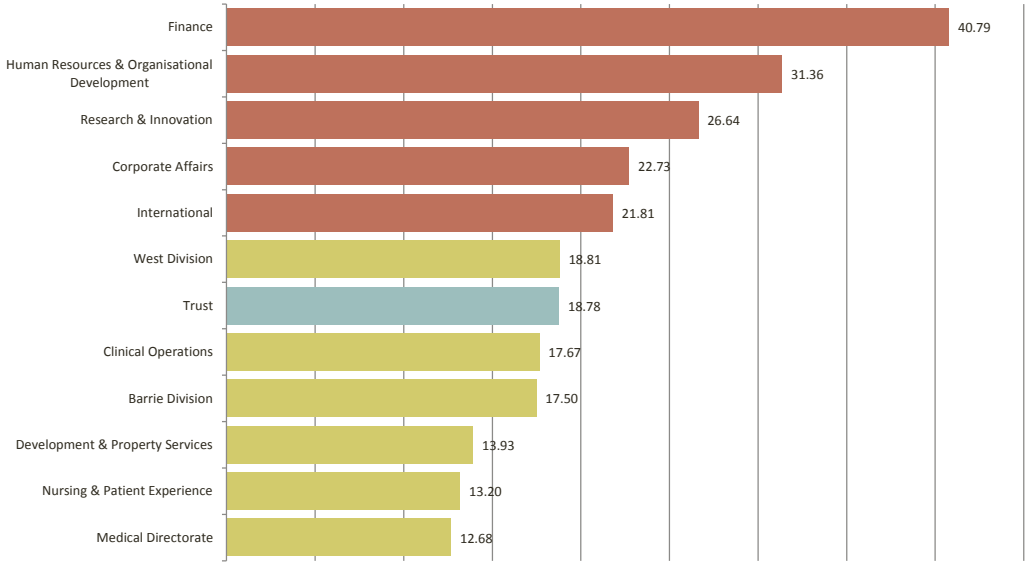


Exception Reporting Sickness

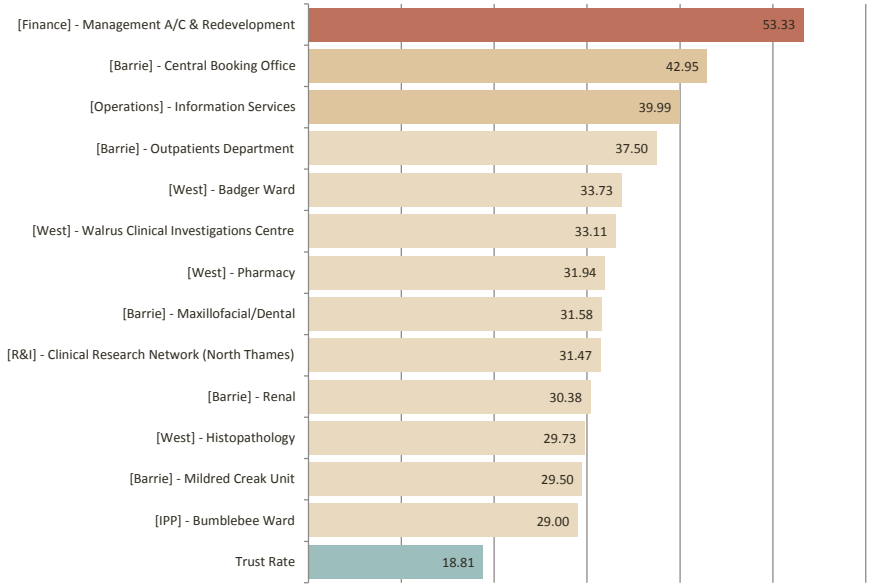


HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2017 REPORT

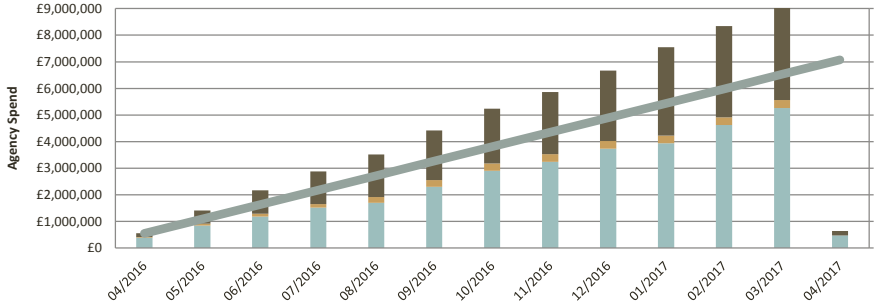
Divisional Turnover (Voluntary & Non-Voluntary)



Exception Reporting Turnover

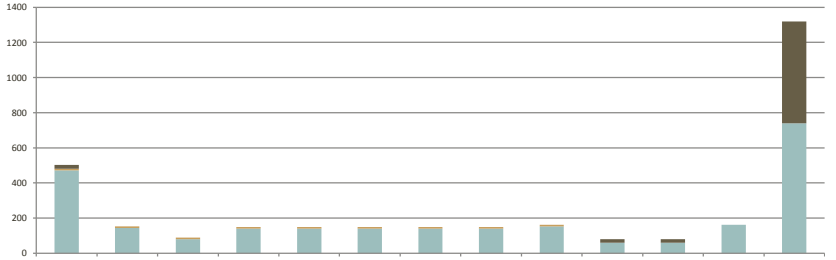


Agency Spend Ceiling (NHS Improvement Directive, Cumulative)



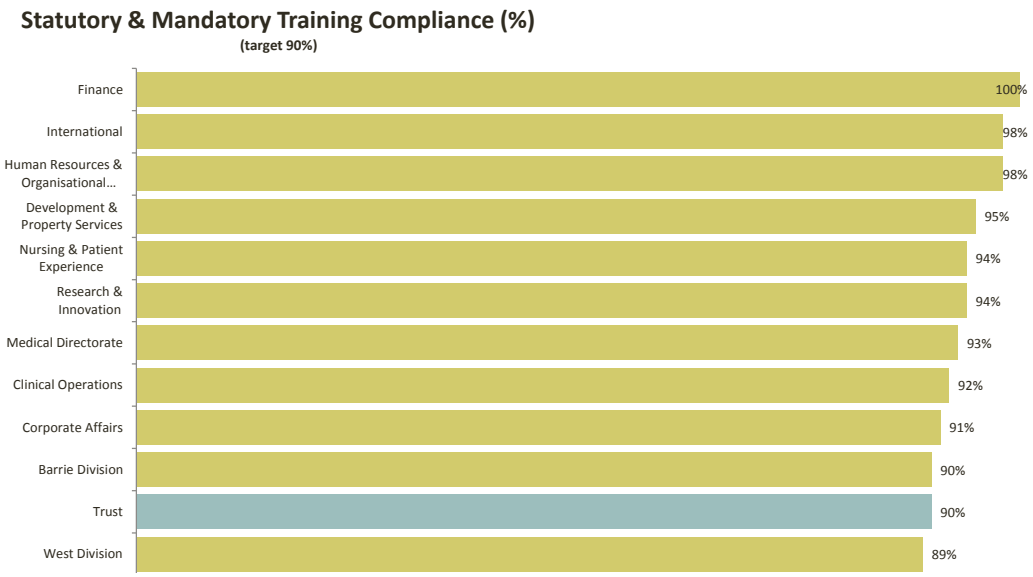
	30/04/2016	31/05/2016	30/06/2016	31/07/2016	31/08/2016	30/09/2016	31/10/2016	30/11/2016	31/12/2016	31/01/2017	28/02/2017	31/03/2017	30/04/2017
RTT	£153,012	£499,693	£873,238	£1,222,238	£1,601,238	£1,872,000	£2,056,000	£2,327,206	£2,647,649	£3,323,868	£3,435,807	£3,727,017	£176,196
Gastro Review	£27,447	£66,513	£110,233	£134,029	£214,638	£249,747	£278,685	£288,186	£290,176	£290,176	£290,176	£290,176	0
Agency BAU	£378,796	£845,945	£1,179,401	£1,516,005	£1,694,201	£2,297,941	£2,898,875	£3,243,474	£3,734,751	£3,934,848	£4,618,715	£5,266,128	£467,340

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

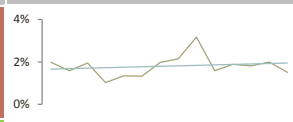
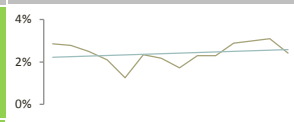
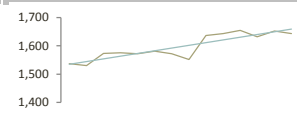
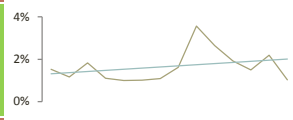
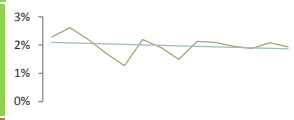
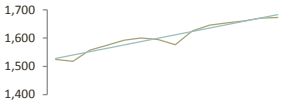
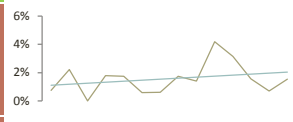
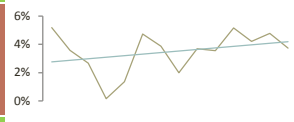
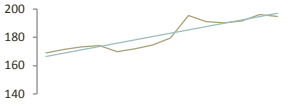
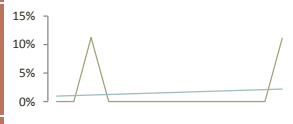
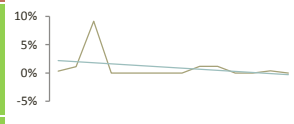
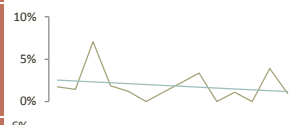
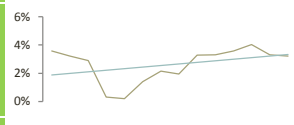
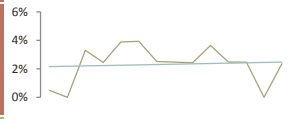
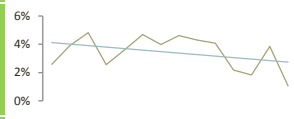
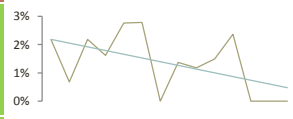
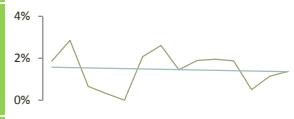
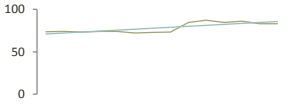
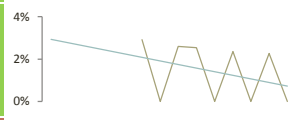
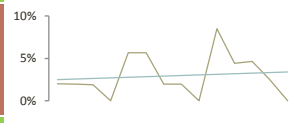
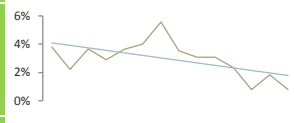
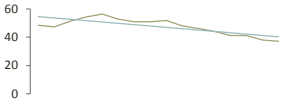
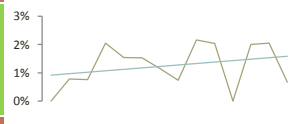
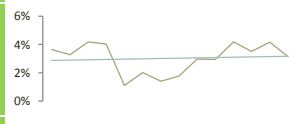
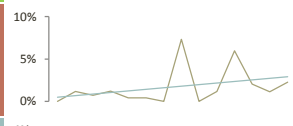
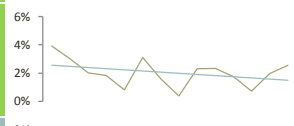
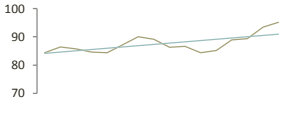
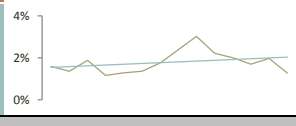
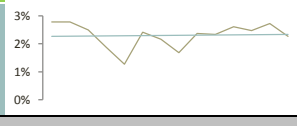
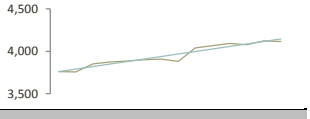


	30/04/2016	31/05/2016	30/06/2016	31/07/2016	31/08/2016	30/09/2016	31/10/2016	30/11/2016	31/12/2016	31/01/2017	28/02/2017	31/03/2017	30/04/2017
Shifts breached per month RTT	21	0	0	0	0	0	0	0	0	20	20	0	580
Shifts breached per month Gastro Review	9	8	8	8	8	8	8	8	8	0	0	0	0
Shifts breached per month BAU	472	144	80	140	140	140	140	140	153	60	60	161	740

HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2017 REPORT



HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT
WORKFORCE METRICS EXCEPTION REPORTING - APRIL 2017 REPORT

Division	Total Turnover Rate (%, FTE) (number of leavers in 12-months in brackets, <18% green)	Total Turnover Rate (%, FTE) Monthly variation trend over 12 months	Sickness Rate (%) (0-3% green)	Sickness Rate (%, FTE) Monthly variation trend over 12 months	Contractual Staff In Post Trend (FTE) Monthly variation trend over 12 months excludes temporary staff
West Division	18.8% (277.9)		2.4		
Barrie Division	17.5% (259.5)		1.8		
International Division	21.8% (39.4)		3.4		
Corporate Affairs	22.7% (2.0)		1.0		
Clinical Operations	17.7% (16.8)		2.9		
Human Resources & OD	31.4% (25.5)		2.9		
Nursing & Patient Experience	13.2% (9.8)		1.7		
Medical Directorate	12.7% (5.00)		2.1		
Finance	40.8% (19.0)		2.6		
Development & Property Services	13.9% (19.9)		2.9		
Research & Innovation	26.6% (23.6)		1.8		
Trust	**18.8%► (698.0)**		**2.2%▼**		

The scale varies per division to enable a trend view for 12-month with sufficient detail (blue line). The red 'direction of travel' indicates the overall direction of travel across each of the 12-months. The 'total turnover rate' approximates to the total of each individual's months' turnover rate.

Great Ormond Street Hospital for Children NHS Foundation Trust

Finance and Activity Performance Report
Month 1 – 2017/18

19 May 2017

Summary Reports

Great Ormond Street Hospital for Children NHS Foundation Trust

Finance Scorecard

Our Money	April	YTD Target	Variance
Net Surplus/(Deficit)	(2.5)	(2.5)	0.0
Forecast Outturn	0.2	0.2	0.0
*P&E Delivery	TBA	TBA	
Pay Worked WTE Variance to Plan	TBA	TBA	
Debtor Days (IPP)	183.0	120	(63.0)
Quick Ratio (Liquidity)	1.9	1.7	0.2
**NHSI KPI Metrics	3.0	3.0	0.0

NHSI Key Performance Indicators				
KPI	Annual Plan	M1 YTD Plan	M1 YTD Actual	Rating
Liquidity	1	1	1	G
Capital Service Coverage	1	1	2	R
I&E Margin	1	4	4	A
Variance in I&E Margin as % of income	1	1	2	R
Agency Spend^^	1	1	1	G
Overall	1	2	2	G
Overall after Triggers	1	3	3	A

Comments

- For Month 1 (month ending 30 April 2017) the Trust is reporting a £2.5m deficit, excluding capital donations which is £3.1m less than plan due to lower capital expenditure on Charity funded projects (refer to page 6).
- The overall weighted NHSI rating for Mth1 was a 3. The main driver of the NHSI score is the I&E margin which the plan had anticipated as a deficit in month driven by the reduced working days in April that would lead to a reduced level of overall income.
- The IPP debtor days increased by 1 day from March 2017.

Trust Income and Expenditure Performance Summary
Year to Date for the 1 month ending 30 April 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

2017/18												2016/17	CY vs PY	CY vs PY
Annual Budget (£m)	Income & Expenditure	Month 1 Budget (£m)	Month 1 Actual (£m)	Month 1 Variance (£m)	Month 1 Variance %	Year to Date Budget (£m)	Year to Date Actual (£m)	Year to Date Variance (£m)	Year to Date Variance %	Rating Current Year Variance		YTD Actual (£m)	Variance (£m)	Variance %
277.7	NHS & Other Clinical Revenue	20.6	19.9	(0.7)	-3.4%	20.6	19.9	(0.7)	-3.4%	R	1	19.8	0.1	0.5%
67.8	Pass Through	5.4	5.5	0.1	1.9%	5.4	5.5	0.1	1.9%			4.7	0.8	17.0%
60.7	Private Patient Revenue	4.9	4.8	(0.1)	-2.0%	4.9	4.8	(0.1)	-2.0%	A	2	5.0	(0.2)	-4.0%
47.9	Non-Clinical Revenue	3.8	3.3	(0.5)	-13.2%	3.8	3.3	(0.5)	-13.2%	R		3.4	(0.1)	-2.9%
454.1	**Total Operating Revenue**	**34.7**	**33.5**	**(1.2)**	**-3.5%**	**34.7**	**33.5**	**(1.2)**	**-3.5%**			**32.9**	**0.6**	**1.8%**
(248.4)	Permanent Staff	(20.2)	(18.4)	1.8	8.9%	(20.2)	(18.4)	1.8	8.9%			(17.1)	(1.3)	-7.6%
(0.2)	Agency Staff^	(0.1)	(0.5)	(0.4)	0.0%	(0.1)	(0.5)	(0.4)	0.0%	R		(0.6)	0.1	16.7%
(0.2)	Bank Staff^	(0.2)	(1.2)	(1.0)	0.0%	(0.2)	(1.2)	(1.0)	0.0%			(1.5)	0.3	20.0%
(248.8)	**Total Employee Expenses**	**(20.5)**	**(20.1)**	**0.4**	**2.0%**	**(20.5)**	**(20.1)**	**0.4**	**2.0%**	G	3	**(19.2)**	**(0.9)**	**4.7%**
(12.4)	Drugs and Blood	(1.0)	(0.6)	0.4	40.0%	(1.0)	(0.6)	0.4	40.0%	G		(0.7)	0.1	14.3%
(36.9)	Other Clinical Supplies	(3.1)	(3.0)	0.1	3.2%	(3.1)	(3.0)	0.1	3.2%	G		(3.0)	0.0	0.0%
(60.1)	Other Expenses	(5.1)	(4.8)	0.3	5.9%	(5.1)	(4.8)	0.3	5.9%	G		(4.1)	(0.7)	17.1%
(67.8)	Pass Through	(5.4)	(5.5)	(0.1)	-1.9%	(5.4)	(5.5)	(0.1)	-1.9%			(4.7)	(0.8)	-17.0%
(177.1)	**Total Non-Pay Expenses**	**(14.6)**	**(13.9)**	**0.7**	**4.8%**	**(14.6)**	**(13.9)**	**0.7**	**4.8%**	G	4	**(12.5)**	**(1.4)**	**-11.2%**
(425.9)	**Total Expenses**	**(35.1)**	**(34.0)**	**1.1**	**3.1%**	**(35.1)**	**(34.0)**	**1.1**	**3.1%**	G		**(31.7)**	**(2.3)**	**-7.3%**
28.2	**EBITDA (exc Capital Donations)**	**(0.4)**	**(0.5)**	**(0.1)**	**25.0%**	**(0.4)**	**(0.5)**	**(0.1)**	**25.0%**	R		**1.2**	**(1.7)**	**-141.7%**
(28.0)	Depreciation, Interest and PDC	(2.1)	(2.0)	0.1	-4.8%	(2.1)	(2.0)	0.1	-4.8%			(2.0)	0.0	0.0%
0.2	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**(2.5)**	**(2.5)**	**0.0**	**0.0%**	**(2.5)**	**(2.5)**	**0.0**	**0.0%**	G		**(0.8)**	**(1.7)**	**-212.5%**
6.2%	**EBITDA %**	-1.2%	-1.5%			-1.2%	-1.5%					**3.6%**	**-5.1%**	**-140.9%**
0.0	Impairments	0.0	0.0	0.0	0.0%	0.0	0.0	0.0	0.0%			0.0	0.0	0%
72.1	Capital Donations	4.8	1.7	(3.1)	-64.6%	4.8	1.7	(3.1)	-64.6%		5	3.3	(1.6)	-48.5%
72.3	**Net Result**	**2.3**	**(0.8)**	**(3.1)**	**-134.8%**	**2.3**	**(0.8)**	**(3.1)**	**-134.8%**			**2.5**	**(3.3)**	**-132.0%**

^Agency ceiling for 2017/18 is £6.5m

^^This is measured against the agency ceiling of £6.5m

Notes

1. NHS income (excluding pass through) YTD is adverse to plan by £0.7m.

2. Private patient income YTD is £0.1m adverse to plan.

Note: a detailed NHS income and activity breakdown is provided on Page 9.

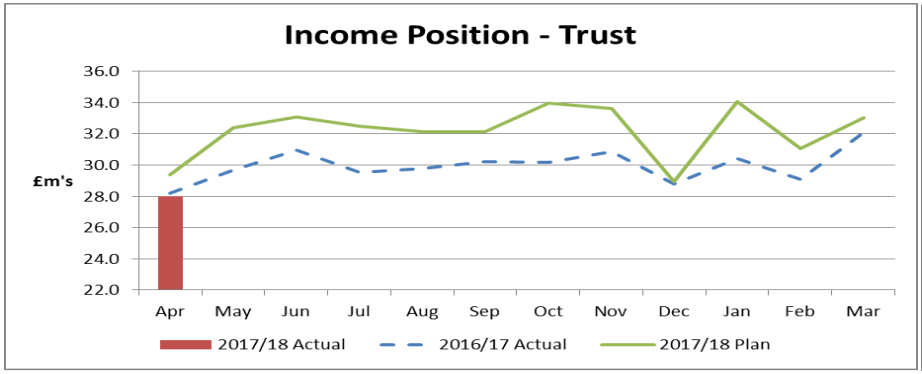
3. Pay is favourable to plan in Month 1 by £0.4m, with agency spend below the agency NHSI ceiling.

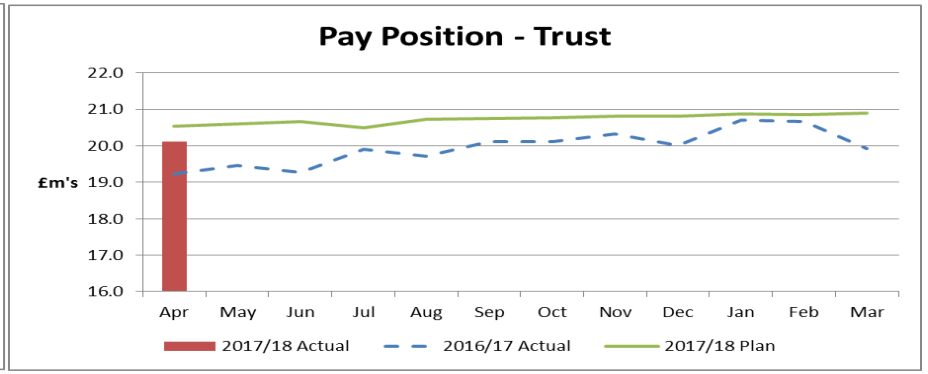
4. Non pay excluding pass through in Month 1 is £0.8m favourable to plan.

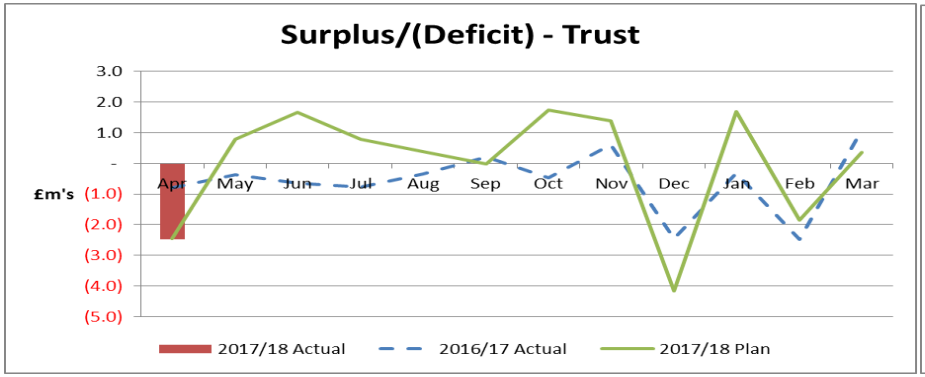
5. Capital Donations of £1.7m in Month 1 which was £3.1m lower than plan.

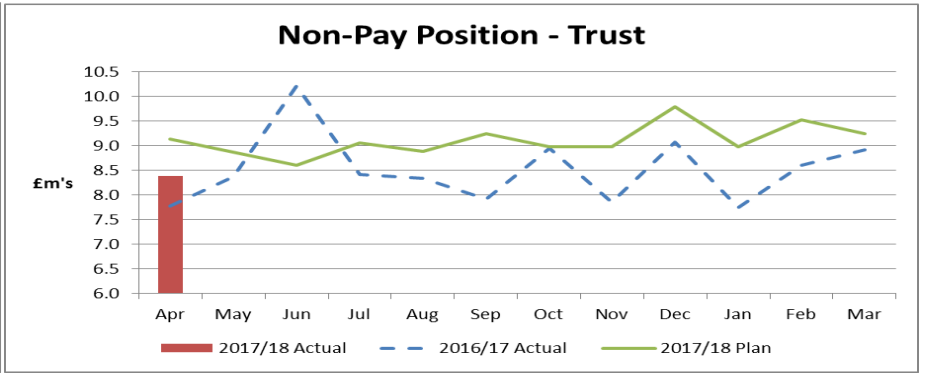
Trust Income and Expenditure Performance Summary
Year to Date for the 1 month ending 30 April 2017

Great Ormond Street Hospital for Children NHS Foundation Trust









Income

- Private Patient income in Month 1 is £0.1m behind plan largely due to revised bad debt provision (£0.6m).
- NHS & Other Clinical Revenue is £0.7m behind plan due to the reduced working days in April 2017 and therefore reduced activity although income targets have been phased to reflect this. This reduced activity includes SNAPS cancellation and Neurosurgery (£0.7m) The main drivers of this are the phasing of RTT growth and the impact of the HRG4+ casemix..

Pay

- For Month 1 the pay spend is £0.7m favourable to plan. There was a reduction of pay spend in PICU/NICU as the expansion nursing posts are still in the process of recruitment.
- The Trust pay budget profile assumes no agency RTT validation staff. The pay relating to PICB opening is phased from Month 5.

Non Pay

- For Month 1 the non pay spend is £0.8m favourable to plan due to the reduced activity in Month 1.

Surplus/Deficit

- In Month 1 the surplus is on plan with the reduced operating income offset by decrease pay and non pay spend**.**

Trust Income and Expenditure Performance Summary
Year to Date for the 1 month ending 30 April 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

Statement of Financial Position	31 Mar 2017 Actual £m	30 Apr 2017 Plan £m	30 Apr 2017 Actual £m
Non-Current Assets	430.2	475.7	432.7
Current Assets (exc Cash)	74.4	82.9	77.8
Cash & Cash Equivalents	42.5	42.2	40.9
Current Liabilities	(56.1)	(67.7)	(58.7)
Non-Current Liabilities	(5.8)	(5.7)	(5.7)
Total Assets Employed	**485.2**	**527.5**	**487.0**

Capital Expenditure	Annual Plan £m	30 Apr 2017 Plan £m	30 Apr 2017 Actual £m	YTD Variance £m
Redevelopment – Donated	37.8	1.9	0.9	1.0
Medical Equipment – Donated	19.1	2.2	0.8	1.4
Estates – Donated	0.0	0.0	0.0	0.0
ICT – Donated	15.2	0.7	0.0	0.7
Total Donated	**72.1**	**4.8**	**1.7**	**3.1**
Redevelopment & equipment - Trust Funded	11.1	0.9	0.4	0.5
Estates & Facilities - Trust Funded	3.7	0.4	0.1	0.3
ICT - Trust Funded	7.2	0.3	0.4	(0.1)
Contingency	1.0	0.1	0.0	0.1
Total Trust Funded	**23.0**	**1.7**	**0.9**	**0.8**
Total Expenditure	**95.1**	**6.5**	**2.6**	**3.9**

Redevelopment donated

There was a reduced spend in Development – Donated against plan due to a time slippage in the following projects:

- Bernard Street 1st floor (may become Trust-funded) £0.2m
- IMRI £0.5m
- Phase 4 £0.3m

Medical Equipment – Donated

There was a reduced spend against plan due to Phase 2B equipment delivery needing re-phasing due to building project delays (£0.8m). There was also a delivery slippage in NICU/PICU (£0.2m)

Bridge M1 Cash Plan to Actual (£m)

Cash
The closing cash balance was £40.9m, £1.3m lower than plan. This was largely due to higher than planned EBITDA (£1.8m); lower than planned trust funded capital expenditure (£0.8m); and the movement on working capital (£3.9m).
The movement on working capital (£3.9m) largely relates to lower than planned non capital payables (£6.4m); Capital payables (£2.6m);
In addition, trade receivables were £5.1m lower than plan.

NHS Debtor Days
There was slight decrease to debtor days which still remains within target at 14 days.

IPP Debtor Days
IPP debtor days decreased in month to 183.

Creditor Days
Creditor days decreased in month to 28 days.

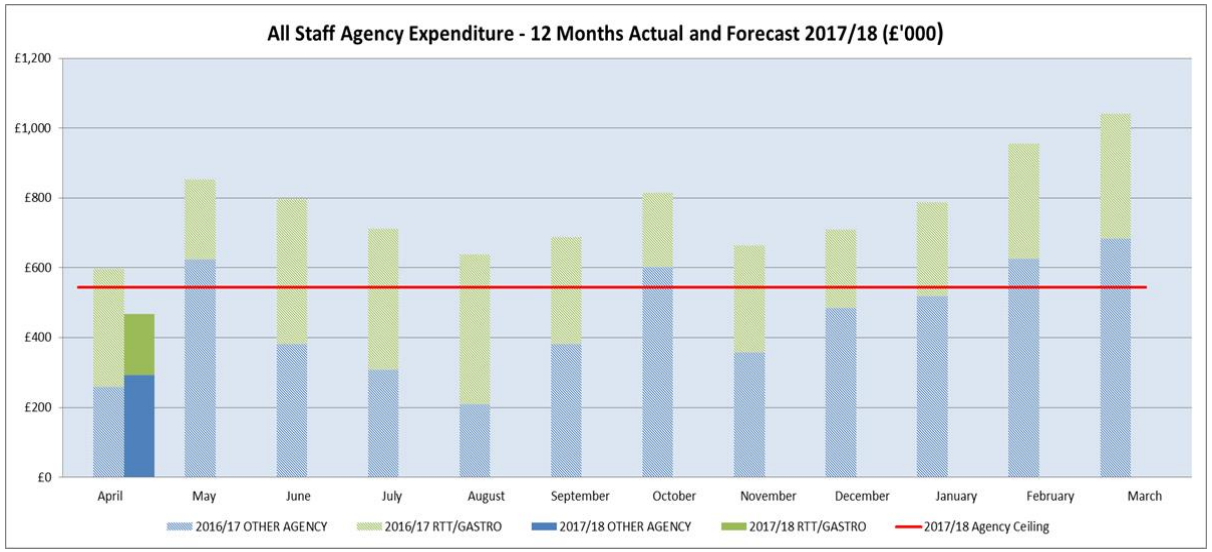
Non-Current Assets
Non-current assets increased by £1.2m in month, the effect of capital expenditure of £2.6m less depreciation of £1.4m. The closing balance is £43.0m lower than plan. This is largely due to the opening balance for the year being £39.2m less than plan of which the movement on buildings valuation represents £36.9m and the remainder (£2.3m) being capital expenditure slippage compared to the forecast on which the plan was based. In addition M1 YTD capital expenditure was less than plan by £3.9m and depreciation less than plan by £0.2m. The expenditure variance is analysed on the capital expenditure schedule.

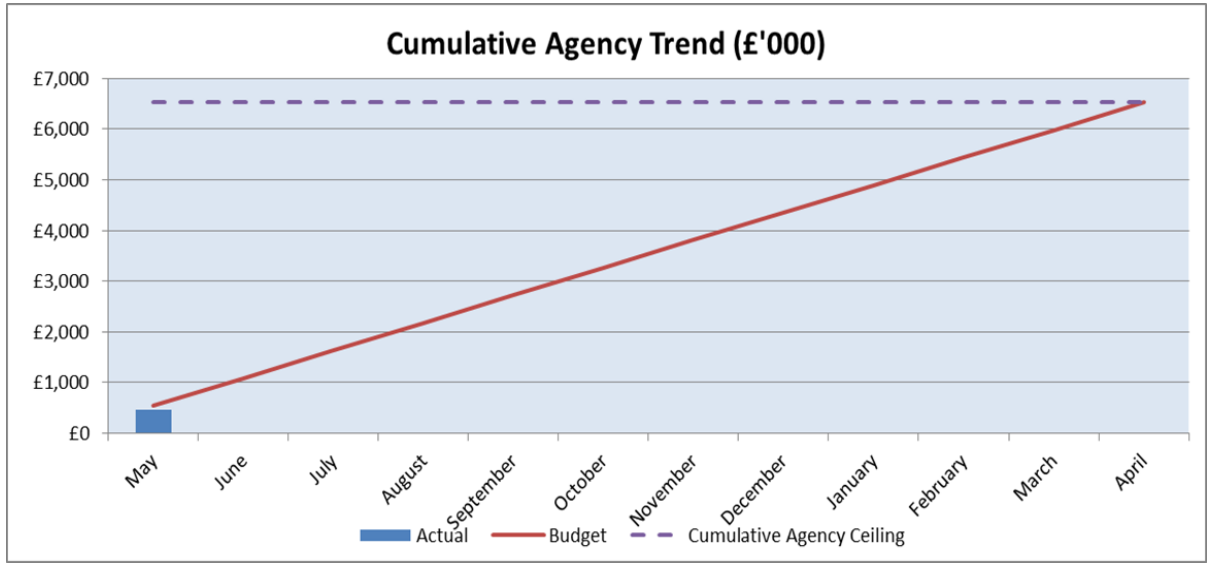
Inventory Days
Drug inventory days increased in month to 8.
Non-Drug inventory days decreased in month to 62 days largely due to the level of inventory held for Audiology stock (42% increase); and Haemophilia stock (26% decrease)

Working Capital	31-Mar-16	31-Mar-17	30-Apr-17	RAG
NHS Debtor Days (YTD)	11.8	19.4	14.8	G
IPP Debtor Days	197.1	182.0	183.0	R
IPP Overdue Debt (£m)	13.0	22.5	24.2	R
Inventory Days - Drugs	6.0	4.0	8.0	G
Inventory Days - Non Drugs	51.0	63.0	62.0	R
Creditor Days	35.0	34.5	28.7	G
BPPC - Non-NHS (YTD) (number)	85.2%	82.3%	88.8%	R
BPPC - Non-NHS (YTD) (£)	87.8%	87.8%	91.6%	R

Trust Income and Expenditure Performance Summary
Year to Date for the 1 month ending 30 April 2017

Great Ormond Street Hospital for Children NHS Foundation Trust





- As at 30 April across the Trust, there are approximately 22 agency staff still working on RTT, (compared to 65 agency staff at 31 December 2016)
- In Month 1 the Trust is currently running below its NHSI notified cost ceiling for agency staff.

Trust Income and Expenditure Performance Summary
Year to Date for the 1 month ending 30 April 2017

Great Ormond Street Hospital for Children NHS Foundation Trust

	2017/18 YTD								2016/17 YTD					
	Income				Activity				Income			Activity		
	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan	Actual *	Variance	Variance %	Actual £'000	Variance 16/17 to 15/16 £'000	Variance 16/17 to 15/16 %	Actual	Variance 16/17 to 15/16	Variance 16/17 to 15/16 %
Day case	**1,873**	**1,730**	**(143)**	**-7.6%**	**1,565**	**1,290**	**(275)**	**-17.6%**	**2,149**	**(419)**	**-19.5%**	**1,730**	**(440)**	**-25.4%**
Elective	4,247	4,870	623	14.7%	1,390	885	(505)	-36.3%	4,603	267	5.8%	1,074	(189)	-17.6%
Elective Excess Bed days	213	20	(193)	-90.5%	545	38	(507)	-93.0%	299	(278)	-93.2%	540	(502)	-93.0%
Elective	**4,460**	**4,890**	**430**	**9.6%**					**4,902**	**(11)**	**-0.2%**			
Non Elective	1,399	1,024	(375)	-26.8%	421	113	(308)	-73.1%	859	165	19.2%	123	(10)	-8.1%
Non Elective Excess Bed Days	167	4	(163)	-97.6%	416	6	(410)	-98.6%	196	(192)	-98.0%	412	(406)	-98.5%
Non Elective	**1,565**	**1,028**	**(537)**	**-34.3%**					**1,056**	**(27)**	**-2.6%**			
Outpatient	**2,847**	**2,677**	**(170)**	**-6.0%**	**11,425**	**10,479**	**(946)**	**-8.3%**	**3,056**	**(379)**	**-12.4%**	**11,903**	**(1,424)**	**-12.0%**
Undesignated HDU Bed days	396	269	(126)	-31.9%	585	209	(376)	-64.3%	426	(157)	-36.8%	414	(205)	-49.5%
Haem/Onc Other	0	0	0	0.0%	0	0	0	0.0%	0	0	0.0%	0	0	0.0%
Non Consortium HDU Bed days	0	0	0	0.0%	0	0	0	0.0%	0	0	0.0%	0	0	0.0%
Picu Consortium HDU	214	242	28	13.2%	289	243	(46)	-15.9%	273	(30)	-11.1%	286	(43)	-15.0%
HDU Beddays	**610**	**512**	**(98)**	**-16.1%**	**874**	**452**	**(422)**	**-48.3%**	**699**	**(187)**	**-26.8%**	**700**	**(248)**	**-35.4%**
													0	
Non Consortium ITU Bed days	0	0	0	0.0%	0	0	0	0.0%	0	0	0.0%	0	0	0.0%
Picu Consortium ITU	2,590	2,836	246	9.5%	924	1,025	101	10.9%	2,199	637	29.0%	915	110	12.0%
PICU ITU Beddays	**2,590**	**2,836**	**246**	**9.5%**	**924**	**1,025**	**101**	**10.9%**	**2,199**	**637**	**29.0%**	**915**	**110**	**12.0%**
Ecmo Bedday	80	58	(22)	-27.3%	15	11	(4)	-26.7%	54	4	7.2%	10	1	10.0%
Psychological Medicine Bedday	93	102	9	9.3%	231	253	22	9.5%	84	18	21.1%	212	41	19.3%
Rheumatology Rehab Beddays	124	92	(32)	-26.0%	217	161	(56)	-25.8%	94	(3)	-2.8%	168	(7)	-4.2%
Transitional Care Beddays	238	223	(15)	-6.2%	164	154	(10)	-6.1%	246	(23)	-9.2%	172	(18)	-10.5%
Total Beddays	**535**	**475**	**(60)**	**-11.2%**	**627**	**579**	**(48)**	**-7.7%**	**479**	**(3)**	**-0.7%**	**562**	**17**	**3.0%**
Packages Of Care Elective	**(615)**	**(671)**	**(57)**	**9.2%**					**581**	**(1,252)**	**-215.6%**			
Highly Specialised Services (not above)	2,416	2,398	(18)	-0.7%					2,204	194	8.8%			
Other Clinical	3,236	2,879	(357)	-11.0%					2,107	772	36.7%			
Outturn adjustment	0	0	0	0.0%					0	0	0.0%			
STF Funding	0	0	0	0%					0	0	0%			
Pricing Adjustment	248	383	136	54.8%					0	383	0%			
Non NHS Clinical Income	646	815	169	26%					386	429	111%			
NHS and Other Clinical Income	**20,411**	**19,952**	**(459)**	**-2.2%**					**19,816**	**136**	**0.7%**			

*Activity = Billable activity
*Activity is an extract from SLAM taken at Day 1 and is subject to changes following coding completion

Elective/Non Elective
- Bone Marrow Transplant income has increased in Month 1 with 9 transplants in month of which 5 were unrelated donor's.

Day case
- There was reduced day case activity in Month 1 due to the reduced working days in Month.

Outpatients
- There is currently a better value scheme (£0.3m) being held centrally however this will be allocated in year.

Bed Days/ITU bed days
- Critical care had one of its strongest performing months for bed days.

Other Clinical
- This includes income for CQUIN and the target for the local pricing review.
- CQUIN income is below plan to take account of risk to full delivery.

Total Trust Inpatient and Outpatient Activity
Year on Year trend analysis

Great Ormond Street Hospital for Children NHS Foundation Trust

Prior Year 2016/17													Activity Analysis	Year 2017/18			
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD		Apr	Total YTD	Change YOY	%Change YOY
													Inpatients				
													Number of Discharges				
2,082	2,061	2,229	2,040	2,162	2,031	1,972	2,075	1,800	2,129	1,949	2,205	24,735	Day Case	1,787	1,787	(295)	-14.2%
													Overnight:				
1,155	1,153	1,256	1,248	1,170	1,177	1,101	1,195	1,064	1,083	1,142	1,269	14,013	Elective	1,086	1,086	(69)	-6.0%
64	67	65	63	59	75	62	71	75	75	51	74	801	Non Elective	73	73	9	14.1%
164	175	178	152	158	169	156	188	214	197	163	159	2,073	Non Elective (Non Emergency)	171	171	7	4.3%
157	171	182	188	181	180	165	186	159	194	189	204	2,156	Regular Attenders	177	177	20	12.7%
3,622	3,627	3,910	3,691	3,730	3,632	3,456	3,715	3,312	3,678	3,494	3,911	43,778	Total Discharges	3,294	3,294	(328)	-9.1%
													Beddays				
760	733	841	760	829	847	736	748	651	793	703	774	9,175	Day Case	639	639	(121)	-15.9%
0.37	0.36	0.38	0.37	0.38	0.42	0.37	0.36	0.36	0.37	0.36	0.35	0.37	Day ALOS	0.4	0.4	(0)	-2.0%
													Overnight:				
4,686	5,197	5,577	5,565	5,470	5,456	5,680	5,478	5,174	5,447	5,398	5,503	64,632	Elective	5,447	5,447	761	16.2%
561	713	610	494	526	687	808	668	668	589	606	710	7,639	Non Elective	709	709	148	26.5%
2,133	2,267	2,044	2,324	2,181	2,033	2,160	2,218	2,395	2,453	2,229	2,330	26,767	Non Elective (Non Emergency)	2,185	2,185	52	2.5%
0	1	1	1	1	4	1	2	1	22	100	101	235	Regular Attenders	105	105	105	105.0%
7,380	8,178	8,232	8,383	8,178	8,180	8,649	8,366	8,238	8,511	8,333	8,645	99,273	Total Overnight Beddays	8,446	8,446	1,066	14.4%
4.79	5.22	4.90	5.08	5.22	5.11	5.83	5.10	5.45	5.49	5.39	5.07	5.2	Overnight ALOS	5.6	5.6	0.4	17.0%
													Midnight Census (ON Bed days)				
4,452	4,853	4,543	4,785	4,557	4,472	4,523	4,866	4,192	4,330	4,243	4,904	54,720	Elective	4,587	4,587	135	3.0%
643	557	494	428	424	373	425	403	458	508	559	757	6,029	Non Elective	636	636	(7)	-1.1%
1,891	1,973	1,980	2,040	2,105	1,928	2,076	1,854	2,011	2,059	1,766	1,762	23,445	Non Elective (Non Emergency)	1,999	1,999	108	5.7%
			1									1	Regular Attenders		0	0	0.0%
6,986	7,383	7,017	7,254	7,086	6,773	7,024	7,123	6,661	6,897	6,568	7,423	84,195	Total	7,222	7,222	236	3.4%
233	238	234	234	229	226	227	237	215	222	235	239	231	Average ON Beds Utilised	241	241	10	4.4%
													Critical Care Beddays				
359	397	299	337	346	345	327	474	368	446	414	497	4,609	Elective	345	345	(14)	-3.9%
196	132	82	90	120	63	62	71	80	162	163	233	1,454	Non Elective	200	200	4	2.0%
482	468	596	575	582	612	627	487	625	509	415	428	6,406	Non Elective (Non Emergency)	563	563	81	16.8%
1,037	997	977	1,002	1,048	1,020	1,016	1,032	1,073	1,117	992	1,158	12,469		1,108	1,108	71	6.9%
35	32	33	32	34	34	33	34	35	36	35	37	34		37	37	2	6.9%
													Outpatients				
19,890	19,858	21,229	20,293	20,176	22,067	21,050	23,342	18,434	22,013	21,130	24,047	253,529	Outpatient Attendances (All)	17,573	17,573	(2,317)	-11.6%
3,821	3,872	4,125	3,880	3,839	4,169	3,913	4,304	3,340	4,109	3,970	4,352	47,694	First Outpatient Attendances	3,393	3,393	(428)	-11.2%
16,069	15,986	17,104	16,413	16,337	17,898	17,137	19,038	15,094	17,904	17,160	19,695	205,835	Follow Up Outpatient Attendances	14,180	14,180	(1,889)	-11.8%
4.2	4.1	4.1	4.2	4.3	4.3	4.4	4.4	4.5	4.4	4.3	4.5	4.3	New to Review Ratio	4.2	4.2	(0.0)	-0.6%

Inpatients:
The total number of inpatients discharged year on year by 9.1%. This has been offset by the increased overnight beds in particular non elective patients 5.7%.
Total Overnight bed days have increased by 14.4% Year on Year due to the growth in inpatient elective activity.

Outpatients:
The total number of outpatients has decreased by -11.6%.

* Note that this is all Trust activity

Attachment I

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

28th June 2017

Quality and Safety Assurance Committee Summary Report
April 2017

Summary & reason for item: To provide an update on the April meeting of the Quality and Safety Assurance Committee. The agenda for the meeting is 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, Chairman of the Quality and Safety Assurance Committee

Attachment I

Quality and Safety Assurance Committee Summary
12th April 2017

Integrated Quality and Safety Update

The Committee discussed the number of complaints that were related to communication issues. It was noted that a wide variety of communication problems were grouped together and it was agreed that consideration should be given to categorising these separately. The importance of benchmarking complaints' data with other Trusts was highlighted. The Committee welcomed the decrease in the total number of complaints but emphasised the importance of ensuring that it was clear to patients and their families how to raise a complaint.

Quality Report

The Committee discussed the draft version of the Quality Report and noted that the auditors would be reviewing the following indicators: 31 day cancer waits, 18 week incomplete pathways (RTT), and cancelled operations (the local indicator selected by the Members' Council).

Quarterly Safeguarding Report (January 2017 – March 2017)

The Committee noted that the newly appointed Named Doctor for Safeguarding was now in post. The appointment was welcomed and it was agreed that Dr Steele would attend future Committee meetings to provide updates.

Discussion took place around the significant increase in case conferences and it was noted that this echoed the increase in the number of child protection cases nationally. It was agreed that discussions should take place with the Named Doctor about the best and most transparent way to present the safeguarding data.

Workforce and OD update (quality related issues)

Work had taken place to ensure that there were sufficient numbers of staff in the correct roles on the correct shift and it was confirmed that the Trust had met its safe staffing and Royal College standards.

Following work which had been undertaken to understand the reason for staff leaving the Trust, it was noted that one in nine staff members reported that this was due to relationships with colleagues and managers. Listening events for staff were taking place in May 2017 and Non-Executive Directors were welcome to attend.

It was noted that 90,000 episodes of training were required from the Trust as a whole annually. The Committee emphasised the importance of ensuring training was delivered as efficiently as possible.

Nurse Recruitment and Retention

The Committee emphasised the importance of this risk to the Trust and noted that the highest number of posts had been offered. Deep dives into the reasons for nurses leaving and staying at the Trust had provided some areas of good practice to be built on but there remained some areas with very high turnover. Discussion took place around innovative steps which would be used to increase recruitment and retention.

Update on quality issues in pharmacy (action from October 2016 QSAC meeting)
The Committee reviewed the Terms of Reference for a review of the pharmacy service. Discussion took place around the prioritisation of customer experience and whether or not it was appropriate to benchmark the GOSH pharmacy with busy pharmacies which were not in hospitals. The Committee emphasised that it was important to include someone on the review panel who was able to 'future scope' the service.

QSAC Annual Report
The Committee reviewed the report and said that it would be used as a starting point for the review of the effectiveness of the committee. It was agreed that work would take place to the review the report against those of other Trusts. Discussion took place about whether the report should highlight the cutting edge and aspirational nature of GOSH's work.

Board Assurance Framework Update
The Committee endorsed the recommendations of the Executive Team to amend the net risk scores of some risks. It was agreed that risk 8: GOSH Strategy Position would be discussed at the July risk meeting to consider whether this should also be a QSAC owned risk.

Update on Compliance with Risk Management Strategy
The Committee discussed the report and the way in which the committee could receive assurance on the Trust Wide Risk Register. It was agreed that this would be further discussed outside the meeting along with the value that QSAC could add to the process.

Compliance Update
It was reported that all actions arising from the CQC inspection had been closed with the exception of one around mandatory training which remained on target.

Risk Management Benchmarking
The Committee noted the Internal Audit view that the number and level of risks captured on the Board Assurance Framework was an area of good practice when benchmarked against other organisations.

Internal and external audit recommendations update
Discussion took place around the number of recommendations which were overdue and the way in which the committee could differentiate the actions for which an appropriate new deadline had been negotiated from those which remained outstanding and required focus from assurance committees.

Internal Audit Progress Report (January 2017 – March 2017) and Strategic Operational Plan 2017-18
The Committee welcomed the outcome of the review of data quality which had provided significant assurance with minor improvement potential. The plan for 2017/18 was approved.

Update on quality and safety impact of Fit for the Future programme (linked to BAF risk 2: Productivity)

It was reported that, of 76 anticipated Project Outline Documents the majority had been either completed or were underway. The PMO was working to verify the number of schemes which would require a Quality Impact Assessment.

Clinical Audit update January 2017 – March 2017 including clinical audit workplan for 2017/18
The Committee welcomed the outcome of the social work audit and the clear value that families received from the service.

Health and Safety Annual Report 2016-17
It was reported that positive work on sharps compliance was taking place and a draft policy had been developed which was in the process of being approved and included a risk assessment tool. There remained some gaps, however good engagement had been generated across the organisation.

A large number of audits had taken place through walkrounds and helpful suggestions to issues had been provided by staff.

Discussion took place about the target of ensuring that 95% of staff had completed all mandatory training and whether this target was set at the correct level. It was proposed that 90% would be a more appropriate target. It was reported that the London Fire Brigade had reviewed the Trust's Fire Safety training and had been satisfied with the work. Mock evacuations took place for newly developed wards before they were open and existing wards undertook a table top exercise.

Whistle blowing update - Quality related whistle blowing cases
The Committee noted that staff concerns were being taken forward with HR and ambassadors were supporting staff to speak with line managers in the first instance however if a pattern or theme emerged a more formal route would be taken.

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

- Safeguarding
- Nurse retention
- Quality Impact Assessments of productivity and efficiency schemes
- Pharmacy Service Review
- Internal Audit Plan

Attachment I

Great Ormond Street Hospital for Children NHS Foundation Trust

QUALITY AND SAFETY ASSURANCE COMMITTEE
Wednesday 12th April 2017 at 2:00pm – 5:00pm in the Charles West (Board) Room, Great Ormond Street Hospital for Children NHS Foundation Trust
AGENDA

	Agenda Item	Presented by	Author	Time
1.	**Apologies for absence**	Chairman		**2:00pm**
2.	**Minutes of the meeting held on 18th January 2017**	Chairman	**A**	
3.	**Matters arising/ Action point checklist**	Chairman	**B**	
	QUALITY AND SAFETY			
4.	**Integrated Quality and Safety Update**	Interim Medical Director	**C**	**2:10pm**
5.	**Draft Quality Report 2016/17**	Interim Medical Director	**D**	**2:20pm**
6.	**Quarterly Safeguarding Report (January 2017 – March 2017)**	Chief Nurse	**E**	**2:30pm**
7.	**Workforce and OD update (quality related issues)**	Director of HR and OD	**F**	**2:40pm**
8.	**Nurse Recruitment and Retention**	Chief Nurse	**G**	**2:50pm**
	RISK AND GOVERNANCE			
9.	**QSAC Annual Report**	Company Secretary	**H**	**3:00pm**
10.	**Update on quality issues in pharmacy** (*action from October 2016 QSAC meeting*)	Chief Pharmacist	**I**	**3:10pm**
11.	**Board Assurance Framework Update**	Company Secretary	**J**	**3:20pm**
12.	**Update on Compliance with Risk Management Strategy**	Interim Medical Director	**K**	**3:30pm**
13.	**Compliance Update**	Company Secretary	**Verbal**	**3:40pm**
14.	**Health and Safety Annual Report 2016-17**	Director of HR & OD	**M**	**3:50pm**

15.	**Whistle blowing update - Quality related whistle blowing cases**	Assistant Director of Employee Relations	**N**	**4:00pm**
	AUDIT AND ASSURANCE			
16.	**Update on quality and safety impact of Fit for the Future programme (linked to BAF risk 2: Productivity)**	Deputy Chief Executive	**O**	**4:10pm**
17.	**Internal Audit Progress Report (January 2017 – March 2017) and Strategic Operational Plan 2017-18**	KPMG	**P**	**4:20pm**
18.	**Risk Management Benchmarking**	KPMG	**T**	
19.	**Internal and external audit recommendations update**	KPMG	**Q**	
20.	**Clinical Audit update January 2017 – March 2017 including clinical audit workplan for 2017/18**	Clinical Audit Manager	**R**	**4:40pm**
21.	**Update from Audit Committee (January 2017)**	James Hatchley, NED	**S**	**4:50pm**
22.	**Matters to be raised at Trust Board**	Chair of the Quality and Safety Assurance Committee	**Verbal**	**4.55pm**
23.	**Any Other Business**	Chairman	**Verbal**	
24.	**Next meeting**	**Wednesday 12th April 2017 2:00pm – 5:00pm**		
25.	**Terms of Reference and Acronyms**	**1**		

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

28th June 2017

Audit Committee Summary Report
May 2017

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

Under this item, the Audit Committee Chairman will also highlight the following for consideration (and approval were necessary – please see separate papers):

- **external auditors' report 2016/17**
- **request for extension to the External Auditor contract**
- **application of the policy for non-audit work**

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

Report prepared by: Victoria Goddard, Trust Board Administrator

Item presented by: Akhter Mateen, Chairman of the Audit Committee

Attachment J

Update from the Audit Committee meeting held on 25 May 2017

Chief Financial Officer's review of the Annual Financial Accounts 2016/17, including the Going Concern assessment

The Committee noted the change in the valuation of fixed assets as a result of engaging a valuer with a more robust methodology in line with Deloitte's recommendation. It was noted that income had increased by 7.9% and operating costs before impairment of fixed assets had increased by 6.1% including the costs that had been incurred as a result of RTT. Income from charitable donations remained in line with the previous year.

It was confirmed that the accounts had been prepared on a going concern basis.

Annual Financial Accounts 2016/17 and GOSH Draft Annual Report 2016/17 including Annual Governance Statement Annual Audit Committee Report

The Committee discussed the number of off payroll engagements which had been in place over the year. Given the Trust's focus on moving staff onto permanent contracts, discussion took place as to whether to provide further information on the progress that had been made since the end of the reporting period. It was agreed that this would be done if the change was considered to be material.

Discussion took place around including a potential additional disclosure around aged debt and it was noted that a significant proportion was overdue by 6 – 12 months the proportion aged over 12 months was minimal. It was agreed that as both GOSH and Deloitte believed that sufficient provisions had been made however the risk of default was not regarded as high, this additional disclosure was not required.

Quality Report 2016/17

The Committee welcomed the Quality Report and noted that feedback had already been incorporated into the document from a variety of areas including members of the Board and Members' Council.

Discussion took place about the programme of Kitemarking that was being undertaken for performance metrics and it was noted that it was important to prioritise the areas where Kitemarking was required due to the resource intensive nature of the process.

Internal Audit Annual Report 2016/17 including Head of Internal Audit Opinion 2016/17

It was confirmed that the Head of Internal Audit Opinion remained unchanged at 'significant assurance with minor improvement potential'. The Committee discussed this outcome in the context of the audit that had been undertaken on the implementation of the EPR programme which had provided a rating of no assurance. The Committee noted that the recommendations of that audit had all been implemented and KPMG were satisfied with the work that had taken place since the review.

Final Report on the financial statement audit for the 12 month period ended 31 March 2017 and 2016/17 Quality Report Quality Assurance Review

The Trust's external auditors confirmed their intention to issue an unmodified opinion on GOSH's true and fair statement and also on the value for money statement. They had no concerns regarding any inconsistencies in the Annual Report. Nothing of concern had been noted in the management override of controls.

It was confirmed that an unmodified opinion would be issued on 31 day cancer waits. A qualified opinion would be issued on 18 weeks RTT as the Trust had not reported for the full year however the significant improvements made in this area was noted.

Discussion took place around cancelled operations and it was noted the Deloitte had identified a number of pathways where they had not been able to trace the Trust's reported data to supporting evidence in patients' notes. It was confirmed that an increased focus on this indicator continued at the Quality and Safety Assurance Committee and a deep dive would take place at its next meeting.

Board Assurance Framework at 31 March 2017

The Committee discussed risk 2: Productivity and agreed that sufficient work had been done to enable the likelihood score to be reduced. It was noted that further work was required for risk 4: recruitment and retention and therefore it was recommended that the net risk score remained unchanged.

The Committee received an update on the following high level risks:

- Risk 9: Unreliable data

The most recent internal audit had provided significant assurance with minor improvement potential. The net risk score had moved from 16 to 9 and the aim was to reduce the score to 6 or below.

- Risk 13: Business Continuity

GOSH benchmarked highly in terms of national performance, particularly in terms of incident preparedness over business continuity. The net risk score was felt to be reflective of the current situation. Discussion took place about the likelihood score and it was agreed that if the Trust felt that the likelihood score could not be positively changed by the programme of work taking place, the risk appetite score should be reconsidered.

Risks identified at/or since the last meeting:

- IR35 Compliance

It was noted that of 66 individuals who were affected by the change in regulations, issues with only two remained outstanding.

- Cyber security incident

It was confirmed that GOSH was unaffected by the global cyber attack as a result of disconnecting access to external emails and internet. No patients had been cancelled, however some delays were experienced.

Review of non-audit work conducted by the external auditors

The committee noted that Deloitte had carried out two pieces of non audit work: The Well Led Governance Review and provision of business rates advice.

Attachment J

Assurance of compliance with the Bribery Act 2011

The Committee approved the statement to be published on the GOSH website.

Update on raising concerns

There had been one whistleblowing incident since the last meeting which was being managed in the appropriate way. The national freedom to speak up guardian had visited the Trust to raise the profile of raising concerns.

Matters to be raised at Trust Board

- Annual accounts, annual report and annual statements
- External auditors review of year end documents
- Head of Internal Audit Opinion
- Board Assurance Framework
- Cyber Security
- Whistleblowing

Great Ormond Street Hospital for Children NHS Foundation Trust

AUDIT COMMITTEE
Thursday 25th May 2017, 9:00am, 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		**9:00am**
2.	**Minutes of the meeting held on 18th April 2017**	Chairman	**A**	
3.	**Matters Arising, Action point checklist**	Chairman	**B**	
4.	**Minutes of subcommittees:** • **Finance and Investment Committee (May 2017)** • **Quality and Safety Assurance Committee (April 2017)**	Chair of F&I James Hatchley, NED	**1** **2**	**9:10am**
	ANNUAL ACCOUNTS AND ANNUAL GOVERNANCE STATEMENT			
5.	**Chief Financial Officer's review of the Annual Financial Accounts 2016/17, including the Going Concern assessment**	Chief Finance Officer	**C**	**9:20am**
6.	**Annual Financial Accounts 2016/17 and GOSH Draft Annual Report 2016/17 including** • **Annual Governance Statement** • **Annual Audit Committee Report**	Chief Finance Officer and Company Secretary	**D**	**9:30am**
7.	**Quality Report 2016/17**	Meredith Mora, Clinical Outcomes Development Lead	**E**	**10:00am**
8.	**Internal Audit Annual Report 2016/17 including Head of Internal Audit Opinion 2016/17**	KPMG	**F**	**10:15am**
9.	**Final Report on the financial statement audit for the 12 month period ended 31 March 2017 and 2016/17 Quality Report Quality Assurance Review**	Deloitte	**G**	**10:30am**
10.	**Representation Letter in relation to the accounts and quality report for the year ended 31 March 2017**	Chief Finance Officer	**H**	**11:00am**
	RISK			

Attachment J

	Agenda Item	Presented by	Attachment	Time
11.	**Board Assurance Framework at 31 March 2017**	Company Secretary	**J**	**11:10am**
12.	**Presentation of high level risks** **Risk 9:** Failure to manage data recording and data management processes in a way which supports timely, relevant, accurate, consistent and appropriate reporting, billing and decision making across all segments of the Trust. **Risk 13**: The trust is unable to deliver normal services and critical functions during periods of significant disruption.	Director of Operational Performance and Information Deputy Chief Executive/ Divisional Director (TBC)	**Verbal** **Verbal**	**11:15am**
13.	**Local Security Manager Work-plan 2017/18**	Local Security Manager	**K**	**11:30am**
14.	**Risks identified at/or since the last meeting:** • **IR35 Compliance** • **Cyber security incident**	Director of HR and OD Deputy Chief Executive	**L** **Verbal**	**11:35am**
	GOVERNANCE			
15.	**Review of non-audit work conducted by the external auditors**	Chief Finance Officer	**M**	**11:45am**
16.	**Assurance of compliance with the Bribery Act 2011**	Chief Finance Officer	**N**	**11:50am**
17.	**Update on raising concerns**	Deputy Director of HR and OD	**O**	**11:55am**
18.	**Matters to be raised at Trust Board**	Chairman	**Verbal**	**12 Noon**
19.	**Any Other Business** This meeting is to be followed by a meeting of the Trust Board to approve the accounts.			
20.	**Next meeting**	**Tuesday 24th October 2017 – 2:00pm – 5:00pm**		
	FOR REFERENCE			
21.	**Audit Committee Terms of Reference and Workplan**	Company Secretary	**3**	
22.	**Glossary of terms**		**4**	

Attachment J1

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

28 June 2017

Auditor Opinion on financial accounts

Summary & reason for item:

The external auditor (Deloitte) has issued an unqualified audit opinion to the Members' Council and Trust Board on the Trust's financial statements for 2016/17. In their opinion, the financial statements give a true and fair view of the Trust's affairs as at 31 March 2017 and that they are free from material misstatement.

The following audit concerns were raised and are described in detail within the audit report; Deloitte satisfied themselves that in each of the areas the Trust's accounting treatment and estimates were appropriate.

Recognition of unsettled NHS revenue

There are significant judgements in identifying the level of income from the treatment of NHS patients because the level of outstanding debt at the year-end tends to be large. Deloitte reviewed the Trust's judgements and concluded that income and provision for debt which may become uncollectible were appropriate.

Management override of controls

Due to the increasingly tight financial circumstances of the NHS in 2016/17, Deloitte considered that there was a heightened risk across the NHS that management may be tempted to fraudulently manipulate financial statements. As a result they planned their testing to ensure that there was no manipulation of accounting estimates or journal entries. Deloitte satisfied themselves that journal entries and accounting estimates were reasonable.

Valuation of land and buildings

If Land and Buildings are over or under valued, this can significantly affect the Trust's accounts. Deloitte questioned the reason why the value changed but as explained in the report, this was due to changes in approach and no concerns arose.

Appropriate capitalisation of costs in relation to capital projects

The Trust had a high level of spend on capital projects in the year; these largely related to development of new clinical buildings and the new Electronic Patient Records system. If this expenditure is inappropriately capitalised then it means that the I&E position is inappropriately overstated. Deloitte tested invoices relating to capital expenditure and satisfied themselves that expenditure had been recognised appropriately.

Attachment J1

Recoverability of overseas private patient debt

The Trust has a significant IPP practice and as a result had a high level of IPP debt at the end of the financial year. There is a risk that this debt is not collectible and as a result the I&E may be overstated. Deloitte reviewed the assumptions around provisions for bad debt and satisfied themselves that income, debtors and provisions had been recognised appropriately.

A copy of the report is attached.

Councillor action required:

To note the content of the report.

Report prepared by:

Tom Burton, Deputy Chief Finance Officer

Item presented by:

Loretta Seamer, Chief Finance Officer

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST

Opinion on financial statements of Great Ormond Street Hospital for Children NHS Foundation Trust

In our opinion the financial statements:

- **give a true and fair view of the state of the Trust's affairs as at 31 March 2017 and of its income and expenditure for the year then ended;**
- **have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and**
- **have been prepared in accordance with the requirements of the National Health Service Act 2006.**

The financial statements that we have audited comprise:

- the Statement of Comprehensive Income;
- the Statement of Financial Position;
- the Statement of Cash Flows;
- the Statement of Changes in Equity; and
- the related notes 1 to 26.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Summary of our audit approach

Key risks	The key risks that we identified in the current year were: • Recognition of unsettled NHS revenue • Management override of controls • Valuation of land and buildings • Appropriate capitalisation of costs in relation capital projects • Recoverability of overseas private patient debt
Materiality	The materiality that we used in the current year was £6.8m (2015/16: £4.0m) which was determined on the basis of 1.5% of revenue (2015/16: 0.9%).
Scoping	The Trust is a single entity. Audit work was performed at the Trust's head offices directly by the audit engagement team
Significant changes in our approach	In the current year, we have separated our key risk into two risks, Valuation of land and buildings and appropriate capitalisation of costs in relation to capital projects. In the prior year these were combined in our audit plan, though both were addressed as key risks. We have also removed Going Concern as a key risk.

Going concern

We have reviewed the Accounting Officer's statement contained within the Performance Report on page 20 that the Trust is a going concern.

We confirm that:

- **we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and**
- **we have not identified any material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern.**

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Trust's ability to continue as a going concern.

Independence

We are required to comply with the Code of Audit Practice and Financial Reporting Council's Ethical Standards for Auditors, and confirm that we are independent of the Trust and we have fulfilled our other ethical responsibilities in accordance with those standards.

We confirm that we are independent of the Trust and we have fulfilled our other ethical responsibilities in accordance with those standards. We also confirm we have not provided any of the prohibited non-audit services referred to in those standards.

Our assessment of risks of material misstatement

The assessed risks of material misstatement described below are those that had the greatest effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team.

Recognition of unsettled NHS revenue

Risk description

There are significant judgments in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners due to:

- the complexity of the Payment by Results regime and other locally set tariffs for specialised services, in particular in determining the level of overperformance; and
- the judgemental nature of provisions for non-payment, including in respect of outstanding overperformance income for quarters 3 and 4; and
- the risk of revenue not being recognised at fair value due to adjustments agreed in settling current year disputes and the status of agreement of future year contracts and tariff arrangements.

The majority of the Trust's income from patient care activities of £374.2m (2015/16; £349.6m) is commissioned by NHS England, increasing the

	significance of associated judgements. The Trust also works with numerous disparate Clinical Commissioning Groups ('CCGs') on a smaller scale which increases the complexity of agreeing a final year-end position. The settlement of income with NHS England and Clinical Commissioning Groups continues to present challenges, leading to delays in the agreement of year end positions. The year-end NHS debtors balance per Note 14.1 of the financial statements is £19.7m (2015/16: £9.8m). See also note 1.4 to the financial statements, Critical accounting judgements and key sources of estimation uncertainty, note 2, Revenue from patient care activities and note 14.1, Trade and other receivables.
How the scope of our audit responded to the risk	We tested the design and implementation of key controls in relation to revenue recognition, including how the IT systems feed through from activity being carried out to income being billed. We performed detailed substantive testing on a sample basis of unsettled overperformance, non-contractual and other unsettled NHS income items. We evaluated the results of the agreement of balances exercise, testing a sample of mismatches to validate the Trust position. We agreed STF income to award letters from the Department of Health.
Key observations	We are satisfied that revenue and provisions have been recognised appropriately.
Recovery of overseas private patient debt	
Risk description	The Trust has a significant private patient and overseas (non-reciprocal) patient practise, accounting for £55.1m of revenue in 2016/17 (2015/16: £47.9m in 2015/16). As at 31 March 2017, the Trust has receivables of £31.9m (2015/16: £26.8m) in regards to this revenue. The year-end debtor in relation to international private payment debt is contained within the £36.3m of other receivables disclosed in Note 14.1. Due to the nature of the debt (predominantly embassy or privately funded) amounts typically take longer to recover than NHS amounts and can be individually large and hence judgement is required to determine the level of provision required. See also note 1.5 to the financial statements, Critical accounting judgements and key sources of estimation uncertainty and note 14.1, Trade and other receivables and the Audit Committee's Report on page 88.
How the scope of our audit responded to the risk	We evaluated the design and implementation of controls over recognition and collection of overseas, private patient and non-NHS revenue. We traced a sample of debtors at an interim date to subsequent cash receipts and performed roll forward procedures to year-end balance. We tested a sample of patients to confirm the validity of the revenue. We also tested new debt arising since the interim date on a sample basis. We tested the mechanical accuracy of the bad debt provision and challenged assumptions made to assess the adequacy of the provision, including reviewing aging of the debts, write-offs in the year and analysing the impact of changes in the provisioning approach on the valuation of the balance.

	Where there was no evidence of cash receipts, the prior payment history was assessed relevant correspondence reviewed and we challenged management in relation to their judgement around recoverability to assess whether payments will be made. We agreed a sample of debtors to letters of guarantee to support recoverability. The provisions were also assessed to determine whether individual balances were overstated by considering the historical accuracy of the provision.
Key observations 	We are satisfied that revenue, receivables and provisions have been recognised appropriately.
Valuation of land and buildings	
Risk description 	The Trust holds Land, Building and Dwellings within Property, Plant and Equipment at a modern equivalent use valuation of £304.9m (2015/16 £339.3m). The valuations are by nature significant estimates which are based on specialist and management assumptions (including the floor areas for a Modern Equivalent Asset, the basis for calculating build costs, the level of allowances for professional fees and contingency, and the remaining life of the assets) and which can be subject to material changes in value. There has been an overall reduction in valuation of £36.9m, of which £24.7m is reduction in the Trust's revaluation reserves, whilst there is a £12.2m impairment in the Statement of Comprehensive Income. Further details on the associated estimates are included in notes 1.5 and 11 to the financial statements and the Audit Committee's Report on page 89
How the scope of our audit responded to the risk 	We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Trust to the valuer. We used Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the Trust's properties, including through benchmarking against revaluations performed by other Trusts at 31 March 2017. We have reviewed the disclosures in notes 1.5 and 11 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation. We assessed whether the valuation and the accounting treatment of the impairment were compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.
Key observations 	We are satisfied that the Trust assumptions and valuation methodology are appropriate and are not indicative of management override or manipulation to achieve a preferred outcome.

Appropriate capitalisation of costs in relation to capital projects	
Risk description 	The Trust has £32.7m (2015/16: £35.9m) of additions to assets under construction as per note 11.1 of the financial statements, primarily in relation to the development of new clinical buildings. The Trust has also begun to capitalise costs in relation to a new Electronic Patient Records System (EPR). Determining whether expenditure should be capitalised can involve significant judgement as to whether costs should be capitalised under International Financial Reporting Standards, and when to commence depreciation. In addition, previously capitalised works that are being replaced or refurbished need to be appropriately written down. Further details on the associated estimates are included in note 11 to the financial statements.
How the scope of our audit responded to the risk 	We have tested the design and implementation of controls around the capitalisation of costs. We have tested spending on a sample basis to confirm that it complies with the relevant accounting requirements, and that the depreciation rates adopted are appropriate. We have reviewed the status of individual projects to evaluate whether they have been depreciated from the appropriate point. We have challenged the treatment of capitalised costs in regards to the Trust's EPR programme, ensuring that such costs (mainly professional fees and project team staff costs) are directly attributable to the asset and that the project is sufficiently advanced for capitalisation to commence.
Key observations 	We are satisfied that capital expenditure has been recognised appropriately.

Management override of controls	
Risk description 	We consider that in the current year there is a heightened risk across the NHS that management may override controls to fraudulently manipulate the financial statements or accounting judgements or estimates. This is due to the increasingly tight financial circumstances of the NHS and the incentives to meet or exceed control totals to receive STF funding. All NHS Trusts and Foundation Trusts were requested by NHS Improvement in 2016 to consider a series of "technical" accounting areas and assess both whether their current accounting approach meets the requirements of International Financial Reporting Standards, and to remove "excess prudence" to support the overall NHS reported financial position. The areas of accounting estimate highlighted included accruals, deferred income, and partially completed patient spells, bad debt provisions, property valuations, and useful economic lives of assets. Details of critical accounting judgements and key sources of estimation uncertainty are included in note 1.4.

How the scope of our audit responded to the risk 	**Manipulation of accounting estimates** Our work on accounting estimates included considering each of the areas of judgement identified by NHS Improvement. In testing each of the relevant accounting estimates, engagement team members were directed to consider their findings in the context of the identified fraud risk. Where relevant, the recognition and valuation criteria used were compared to the specific requirements of IFRS. We tested accounting estimates (including in respect of NHS revenue and provisions and property valuations discussed above), focusing on the areas of greatest judgement and value. Our procedures included comparing amounts recorded or inputs to estimates to relevant supporting information from third party sources. We evaluated the rationale for recognising or not recognising balances in the financial statements and the estimation techniques used in calculations, and considered whether these were in accordance with accounting requirements and were appropriate in the circumstances of the Trust. **Manipulation of journal entries** We used data analytic techniques to select journals for testing with characteristics indicative of potential manipulation of reporting focusing in particular upon manual journals. We traced the journals to supporting documentation, considered whether they had been appropriately approved, and evaluated the accounting rationale for the posting. We evaluated individually and in aggregate whether the journals tested were indicative of fraud or bias. We tested the year-end adjustments made outside of the accounting system between the general ledger and the financial statements. **Accounting for significant or unusual transactions** We considered whether any transactions identified in the year required specific consideration and did not identify any requiring additional procedures to address this risk.
Key observations 	We are satisfied as to the reasonableness of the journal entries posted by Management and Management's accounting estimates, and are satisfied that the financial statements are not materially misstated due to management override of controls

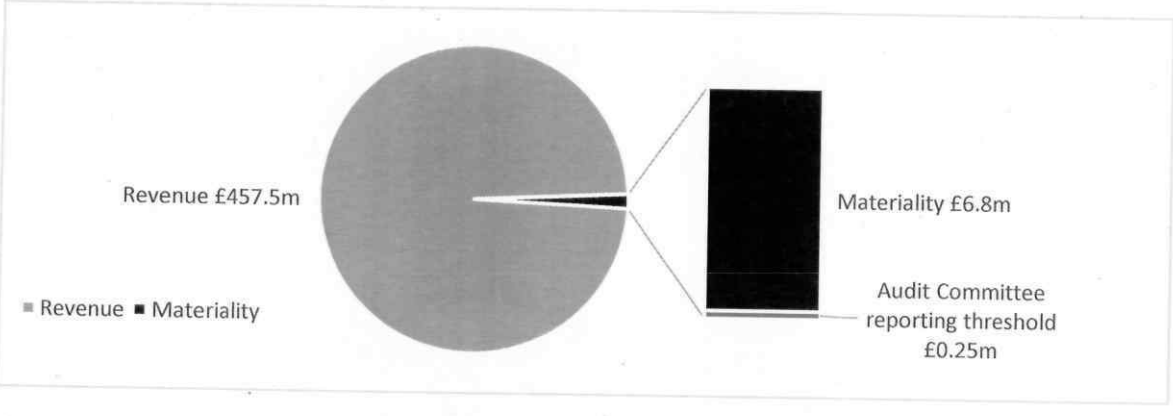
These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Materiality	£6.8m (2015/16: £4.0m)
Basis for determining materiality	1.5% of revenue (2015/16: 0.9% of revenue) We reassessed the percentage used in the context of our cumulative knowledge and understanding the audit risks at the Trust and our assessment of those risks for this year.
Rationale for the benchmark applied	Revenue was chosen as a benchmark as the Trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.



We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £250k (2015/16: £198k), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our audit was scoped by obtaining an understanding of the entity and its environment, including internal control, and assessing the risks of material misstatement. Audit work was performed at the Trust's head offices in London directly by the audit engagement team, led by the audit partner.

The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and Information Technology systems.

Data analytic techniques were used as part of audit testing, in particular to support profiling of populations to identify items of audit interest.

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Directors' Remuneration Report and staff report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Annual Governance Statement, use of resources, and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Our duty to read other information in the Annual Report

Under International Standards on Auditing (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements; or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we are required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable and whether the annual report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed.

We confirm that we have not identified any such inconsistencies or misleading statements.

Respective responsibilities of Accounting Officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the

financial statements in accordance with applicable law, the Code of Audit Practice and International Standards on Auditing (UK and Ireland). We also comply with International Standard on Quality Control 1 (UK and Ireland). Our audit methodology and tools aim to ensure that our quality control procedures are effective, understood and applied. Our quality controls and systems include our dedicated professional standards review team.

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Great Ormond Street Hospital for Children NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Heather Bygrave FCA (Senior statutory auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
St Albans, United Kingdom
25 May 2017

Attachment J2

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

28 June 2017

Request for an extension to the External Audit contract

Summary & reason for item:

The Trust external auditor contract (Deloitte LLP) commenced on 1 April 2014 with an expiry date of 31 March 2017 unless an extension period had been agreed by both parties (to terminate no later than 31 March 2019).

The Code of Governance states that:

C.3.6. The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust. The current best practice is for a three- to five-year period of appointment.

The Members' Council is asked to consider and approve an extension to the current contract for two years until 31 March 2019 (i.e. for a five year period in total). In 2018, the Council will be asked to consider and approve the process and appointment of a new auditor from 31 March 2019.

The Audit Committee has reviewed the performance of Deloitte in their role as the Trust's external audit for the last three financial years and concluded that they are satisfied with the service that has been provided and have recommended that the contract should be extended to 31 March 2019. A number of points were considered in reaching this conclusion with respect to the engagement letter that was issued originally for them to provide services to the Trust:

- The core audit service has been delivered efficiently and seamlessly in each of the three years with the audit completed and the accounts signed off in advance of the national timetable.

- The Trust welcomes Deloitte's high level of challenge in the audit process and recognises this as effective scrutiny of its due process.

- Deloitte are a significant provider of audit and other services to London Foundation Trusts, this allows them to provide invaluable insight from areas of benchmarking as well as enabling them to contribute to other areas of the agenda in Audit Committee meetings.

- Auditors must carry out their work with independence and objectivity. Deloitte has maintained independence throughout the contract and as a result of the current Deloitte Partner having lead the external audit contract at GOSH for 10 years as at May 2017, a new audit Partner has been appointed to ensure that this independence remains.

- Deloitte provide services at a reasonable cost and therefore the current contract is considered to be value for money.

Communication has been very effective in terms of both the planning stages and reporting to the Audit Committee with the lead Audit Partner for the Deloitte contract having attended and presented at Audit Committee and Trust Board meetings as required. Additionally, Deloitte has been commissioned to implement a small selection of non-financial audits (appropriately approved under the Non-Audit Work Policy) on behalf of the Trust which they have completed on time and to typically high standards.

Councillor action required:
The Audit Committee recommends that the Members' Council approve the extension of the external audit contract with Deloitte until 31 March 2019 on the same terms of engagement.

Report prepared by:
Tom Burton, Deputy Chief Finance Officer

Item presented by:
Loretta Seamer, Chief Finance Officer

Attachment J3

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

28 June 2017

Review of non-audit work carried out by the external auditors for the Trust

Summary & reason for item:

The purpose of this paper is to inform the Members' Council of non-audit work carried out by Deloitte, the Trust's external auditor in the financial year 2016/17.

- Well Led governance review (£42k). - An independent review against the Monitor Well Led Governance Framework (incorporating elements of the quality governance framework) was conducted by Deloitte in June 2016. None of the engagement team undertook any external audit work at the Trust in the previous three years. The appointment was approved by the Chairman of the Audit Committee and NHS Improvement is aware that Deloitte are the Trust's external auditors and were undertaking this non-audit work.

- Business rates advice (£2k).

The Audit Committee has approved the non-audit work detailed above and in their opinion this did not compromise the independence and objectivity of the auditor.

Councillor action required:

To note the content of the report.

Report prepared by:
Tom Burton, Deputy Chief Finance Officer

Item presented by:
Loretta Seamer, Chief Finance Officer

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

28th June 2017

Finance and Investment Committee Summary Report
May 2017 and verbal update on June 2017 meeting

Summary & reason for item: To provide an update on the May meeting of the Finance and Investment Committee. The agenda for the meeting is attached.

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

Report prepared by: Victoria Goddard, Trust Board Administrator

Item presented by: David Lomas, Chair of the Finance and Investment Committee

Great Ormond Street Hospital for Children NHS Foundation Trust

Summary of the Finance and Investment Committee held on 11th May 2017

Matters arising

The Committee discussed a number of actions which had arisen from a discussion on the timetable of phase 4. It was noted that a number of areas which required decisions were interlinked but the committee requested early discussions on the Trust's debt capacity.

Discussion took place around workforce productivity metrics in the context that activity remained broadly flat year on year and whole time equivalents grew by approximately 5%. The Committee noted that each area of the hospital would have diverse staffing requirements with some fixed components and some based on activity. The Committee requested that consideration be given to the indicators to support productivity metrics.

Annual Effectiveness Review

The committee discussed the outcome of the survey and agreed that there was currently not sufficient time given to the consideration of strategic matters. Consideration would be given to making links with the Chair of a Finance and Investment Committee from another Trust and inviting relevant individuals from divisions.

Phase 4 Outline Business Case Update

The Trust have been in discussions with ITFF regarding the information required to assess their lending capacity for phase 4 project. It was noted that the ITFF would also undertake an independent assessment of the Trust's debt capacity.

Overview of Trust Property Portfolio

A presentation was provided on current mix of properties within the portfolio of the Trust and Charity including an overview of the current use and ownership. Usage of buildings included clinical, office space, staff and parent/patient accommodation. Utilisation rates for accommodation was requested as additional information but it was noted there is a high occupancy rate for staff, patient and family accommodation. Consideration was being given to the way in which Barclay House and the Italian building would be used to support phase 4.

Rare Diseases Centre – Progress Report

The project is being built and managed by the Charity. The Committee noted that the project development costs were over the original estimates and requested the causes were taken into account for future development projects. However it was noted that a different procurement process of contractor led design was used for phase 4 to ensure there would be less likelihood that the project would overrun.

Better Value Programme Update 2017/18 Plan

It was reported that there had been substantial progress from the same point in 2016/17. The Committee welcomed the progress that had been made and recommended continuing to identify additional schemes to increase the likelihood that the overall target would be met. It was noted that

a conservative view had been taken on the risk based approach to whether or not a scheme was likely to be realised. A deep dive was undertaken into the schemes in procurement.

2016/17 Month 12 Final Performance Scorecard

Discussion took place around the Trust's agency spend. It was confirmed that once the remaining RTT validators were moved onto permanent contracts within teams GOSH would no longer be in breach of its agency cap. A key risk around agency spend was the opening of the Premier Inn Clinical Building and the substantial number of additional nurses that would be required. Work was taking place in the performance team to ensure that if any indicator deviated from the target, a deep dive review took place.

2016/17 Month 12 Final Finance report

GOSH had exceeded its control total at the end of 2016/17 but had not met the activity target. A pound for pound incentive payment had been received as well as a bonus payment from unallocated STP funds. It was agreed that a benchmarking exercise would take place against both comparable Trusts and the NHS as a whole on revenue, contribution and contribution less IPP income.

Trust Activity Summary 2016/17 Month 12

The Committee discussed activity data and suggested additional narrative on the reasons for the changes in activity trends.

NHS Contract Status Update Final 2016/17 & 2017/18

It was reported that the Trust had achieved significant over performance in 2016/17.

NHSI Governance Standards and FSRR

The Committee noted that the only change to the regulatory requirements had been the removal of the requirement to provide quarterly in year governance statements and the introduction of Board Assurance Statements which were only required when the Trust was reporting an adverse change to the forecast outturn.

Review of LTFM 3 year Plan

The revised LTFM includes the NHSI base plan, the EPR business case. The Committee reviewed the Long Term Financial Model and agreed that amendments would be considered on a biannual basis. It noted that the benefits had been included for the EPR project. The committee also reviewed and discussed the movements in working capital assumptions and noted the IPP debt did not reduce significantly considering the income growth.

Great Ormond Street Hospital for Children NHS Foundation Trust

FINANCE AND INVESTMENT COMMITTEE
11th May 2017 2:00pm – 4:40pm
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	Verbal	2:00pm (10 mins)
2.	Minutes of the meeting held on 23rd March 2017	Chairman	A	
3.	Matters Arising, Action point checklist	Chairman	B	
4.	Annual Effectiveness Review	Chairman	C	2.10pm (10 mins)
	Redevelopment			
5.	Phase 4 Outline Business Case Update	Director of Development/Chief Finance Officer	Verbal	2:20pm (10 mins)
6.	Overview of Trust Property Portfolio	Director of Development	J	2:30pm (15 mins)
7.	Rare Diseases Centre – Progress Report	Director of Development	L	2:45pm (15 mins)
	Performance and Finance			
8.	2016/17 Month 12 Final Performance Scorecard	Deputy Chief Executive	D	3:00pm (15 mins)
9.	2016/17 Month 12 Final Finance report	Chief Finance Officer	E	3.15pm (15 mins)
10	Trust Activity Summary 2016/17 Month 12	Chief Finance Officer	F	3.30pm (10 mins)
11.	NHS Contract Status Update Final 2016/17 & 2017/18	Deputy Chief Finance Officer	G	3.40pm (10 mins)
12.	Better Value Programme Update 2017/18 Plan	Deputy Chief Executive/ Programme Office Director	H	3.50pm (25 mins)
	Annual Planning and Approval			
13.	NHSI Governance Standards and FSRR	Chief Finance Officer	I	4.15pm (5 mins)
14.	Review of LTFM 3 year Plan	Chief Finance Officer	K	4:20pm (15 mins)

	Agenda Item	Presented by	Attachment	Time
	OTHER BUSINESS			
15.	**Any other business**	**Chairman**	**Verbal**	**4.35pm** (5 mins)
16.	**Next meeting** The date of the next meeting will be 21st June, 2:00pm-5:00pm in the Charles West Room.			

Great Ormond Street Hospital for Children NHS Foundation Trust

FINANCE AND INVESTMENT COMMITTEE
21st June 2017 2:00pm – 4:15pm
Levinsky Room, UCL GOS Institute of Child Health, 30 Guilford St, London WC1N 1EH.

AGENDA

	Agenda Item	Presented by	Attachment	Time
1.	Apologies for absence	Chairman	Verbal	2:00pm (10 mins)
2.	Minutes of the meeting held on 11th May 2017	Chairman	A	
3.	Matters Arising, Action point checklist	Chairman	B	
	PRESENTATIONS			***2:10pm (55mins)***
4.	Productivity and Efficiency Review 2017/18 Plan	Programme Office Director	C	(15 mins)
5.	Phase 4 – Health Service Plan	Deputy Chief Executive/ Director Operational Performance and Information	Presentation	(20 mins)
6.	International Private Patients Capacity Growth Business Case – Post Implementation Review	Director of IPP	E	(20 mins)
	PERFORMANCE & FINANCE UPDATES			***3:05pm (40 mins)***
7.	Finance Report 2017/18 Month 2	Chief Finance Officer	F Noting Only	(- mins)
8.	Review overall WTE profile actual 16/17, Budgeted 17/18, explore drivers of actual and planned annual changes Deep dive into profile of admin staff; actual and Budgeted growth in WTE 16/17 and 17/18 and drivers; and proportion of total workforce	Deputy Chief Executive / Director of HR&OD	G	(25mins)
9.	Review of aged debt profile over 181 days	Deputy Chief Finance Officer	H	(5 mins)
10.	Initial approach and agreement of bench marking to other paediatric Trusts	Deputy Chief Finance Officer	I Noting Only	(- mins)

	Agenda Item	Presented by	Attachment	Time
11.	**Activity Review 2017/18 Month 2**	**Deputy Chief Finance Officer**	**J**	(10 mins)
12.	**NHS Contract Update 2017/18**	**Deputy Chief Finance Officer**	**K Noting Only**	(-mins)
13.	**Procurement Update including dashboard**	**Chief Finance Officer**	**L Noting Only**	(- mins)
14.	**Capital Programme Update**	**Chief Finance Officer**	**M Noting Only**	(- mins)
	ANNUAL REVIEWS			**3:45pm** (20mins)
15.	**Patient/Reference Cost Annual Submission**	**Deputy Chief Finance Officer**	**N**	(10 mins)
16.	**Service Line Reporting – 2016/17 summary**	**Deputy Chief Finance Officer**	**O**	(10 mins)
17.	**Annual Review of Treasury Management**	**Deputy Chief Finance Officer**	**P Noting Only**	(- mins)
	BUSINESS CASE REVIEWS/UPDATES			
18.	**Chiller & Mortuary Business Case** *Update only*	**Director of Development**	**Verbal**	**4.05pm** (5mins)
19.	**EPR Update** *Update on Programme Progress*	**EPR Director**	**Q Noting Only**	**4.10pm** (- mins)
	OTHER BUSINESS			**4:10pm**
20.	**Any other business** • **Matters to be raised to the Trust Board**	**Chairman**	**Verbal**	(5 mins)
	CLOSE			
21.	**Next meeting** The date of the next meeting will be 7 September, 11:00am-2:00pm in the Charles West Room.			

Attachment L

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

28 June 2017

Well Led Governance Review Action Plan Update

Summary & reason for item: To provide the Members' Council with a regular update on progress with implementation of the Well Led Governance Review.

Councillor action required: To note the progress with the Well Led Governance Review recommendations including those relevant to the role and responsibilities of the Members' Council.

Report prepared by: Anna Ferrant, Company Secretary

Item presented by: Mary MacLeod, Interim Chairman/ Anna Ferrant, Company Secretary

Well Led Governance Review Action Plan Update

Following the independent Well Led Governance Review at GOSH, an action plan to deliver the recommendations has been developed. Progress with the actions is regularly reported to the Executive Management Team and the Trust Board. The Trust Board retains overall responsibility for ensuring that the recommendations are acted upon in a timely manner and agree any required changes to stated actions or timescales, where appropriately evidenced.

Twenty-three (23) of the 36 recommendations have been completed. Eleven (11) of the remaining 13 recommendations are in progress. Two of the recommendations (11 and 31) refer to external assessment of progress with the recommendations and the timetable for this work will be in Q3 of 2017/18, to allow actions to 'bed-in'. The new substantive Chairman will also be in post from 1 November 2017.

A summary of progress with the recommendation is detailed below. Many of the recommendations are linked or co-dependent. A copy of the action plan is available on request.

Recommendations and action progress update

Recommendations	Actions and progress update
1 (Update the strategy); 2 (align KPI reporting to the Board to the strategy); 3 (prioritise and refresh the key enabling strategies); 4 (improve communication on the strategy); 5 (align the divisional KPIs to the strategy); Monitor each service against key performance; 34 (ensure that each service at the Trust is monitored and managed against key performance indicators)	A high level overview of the strategic objectives was presented to the Board in March 2017. This was followed by a detailed review of the actions to deliver the objectives at the April Board meeting where the strategy was approved. The Trust Board workplan has been refreshed (approved at March Board) and includes regular review of progress with delivery of the strategy. The strategy has been renamed 'Fulling our potential' COMPLETED The communication plan for Fulfilling our Potential has now been developed and the communications team is working with the strategy team to deliver it. Messaging is going to leaders within the organisation and an event is being planned to engage further. A formal launch to all staff is taking place on 30 June and 3 July with case studies and publications to bring it to life. Communications channels alongside business planning and other documents are also being redeveloped to align with the new strategy. An intranet hub is being developed and next stages for continuous staff engagement are being discussed. (In progress) The new performance dashboard was introduced in July 2016 and has been updated every month since. This is subject to on-going development and review and includes alignment with the current strategic plan and regulatory frameworks. COMPLETED For 2017/18, divisional operational plans and objectives will be linked to the refreshed strategy and divisions will report to the Board twice a year on rotation. COMPLETED Divisional Boards review service level and divisional level performance indicators. Executives attend divisional performance reviews and scrutinise and challenge performance and offer support where required. COMPLETED

Recommendations	Actions and progress update
6 (Strengthen the Board Assurance Framework)	A quality risk has been agreed and controls and assurances identified and documented. The risk was reviewed at the January QSAC meeting. COMPLETED The assurance committees will continue to receive an overview of all BAF risks (on the summary chart). Each committee will receive detailed information about their relevant risks at every meeting. Deep dives into the relevant risks will move from once a year to twice a year, but will be subject to flexibility on a risk based basis. COMPLETED The Board calendar has been subject to a review and this has included alignment with committee workplans. The Board calendar was approved at the March 2017 Trust Board COMPLETED. Work has already started to reference alignment of Board and committee items to strategic risks and will continue. COMPLETED
7, 8 and 9 (Strengthen sign off of QIAs assurance reporting and engagement with staff to enhance P and E); 33 (enhance reporting on P&E to Board)	A formal sign off process has being implemented. The QIA process is based upon best practice and learning from other organisations and aims to strike a balance between minimising bureaucracy and providing the required level of assurance to enable schemes to proceed with confidence. All schemes that involve a change to skill mix and/or headcount; service redesign; and/or change to a business process or service delivery are required to complete a QIA. The sign-off process depends on whether the scheme has a quality impact on other Divisions or parts of the hospital; poses any Trust-wide quality risks; contains an individual quality risk with a net 5x5 score of 12 or above or, for schemes from corporate areas, has potential clinical quality or patient safety impacts. Divisions have ensured that teams are involved in the design of savings schemes and this approach will be strengthened going forward. COMPLETED In order to support continuous learning, the central QIA Panels meet bi-monthly and audits selected QIAs reviewed at Divisional level. The QIA Panel also agrees a programme and appropriate dates for post implementation reviews of schemes, depending upon potential impacts identified through the QIA process. This programme will include schemes approved by the Panel and also some approved within Divisions, with the aim of encouraging a virtuous cycle of feedback, informing the future QIA approval process. COMPLETED The 2017/18 ‘Better Value’ programme was launched as part of the Trust’s work on its refreshed strategy (‘Fulfilling our Potential’) including updates to the Senior Management Team and an associated awayday session attended by approx. 100 staff. Local Better Value schemes have been developed with frontline staff by local management teams within divisions and

Recommendations	Actions and progress update
	key frontline staff have also been engaged in the development of the cross cutting work programme, especially areas pertaining to flow. A new communications strategy has been developed for the Better Value programme and will include a mix of enhanced intranet presence, use of newsletters and other initiatives (eg 'Dragons' Den') to encourage the generation of new ideas from all staff. COMPLETED The work of QIA panels and specific quality impact analysis on two schemes a quarter are reported to QSAC and from there to Board. COMPLETED
10 (Commission an on-going Board development programme); 14 (formal succession planning for the Board); 15 (assessment of successes and risks for GOSH)	Board members assessment of development priorities have been requested and feedback/discussion scheduled for Board Seminar - 28 June 2017. This will include a review of assessment of success and risks for GOSH. (In progress) The MC Nominations and Remuneration Committee will review succession planning for NEDs as part of its usual annual work programme and in collaboration with the new substantive Chairman. This work is ongoing with consideration of the appointment of 2 NEDs to replace MM and DL over the next 6 months. ONGOING
12 (Use of headhunters for NED positions); 13 (360 appraisal process); 29 (commission an independent facilitated programme of development between the Board and Council); 30 (engage with other FTs that have good levels of engagement between councillors and Board)	The Board and Council has approved the use of headhunters for all NED appointments. The Board will consider the cost of headhunters to ensure value for money. Both the Board and Council agreed to sign off the use of headhunters for each NED appointment. COMPLETED It has been agreed that: • A draft proposal for seeking 360 feedback for NEDs together with proposed timetable will be shared at the June Board. This is based on the NHS Leadership Academy Healthcare Leadership Model and national 360 degree scheme. (In progress) • The Well Led Governance Review Working Group has agreed to appoint Sue Rubenstein to run the facilitation programme (covering roles and responsibilities and behaviours). Facilitation dates will be sought ensuring as many councillors and Board members can attend. (In progress) • The Well Led Governance Review Working Group representatives have met with 5-6 other trusts to find out how engagement works between board and councils. The findings from this work will be fed in to the facilitation exercise (In progress)
16 (Align the code of conduct)	For delivery at the June Board and Council. (In progress)

Recommendations	Actions and progress update
17 (Implement a formal programme of NED/ Board walkrounds); 23 (formal NED committee chair meetings)	A schedule of formal NED/ Board walkrounds has been drawn up and implemented. COMPLETED. The first formal NED committee chairman meeting took place in January and will be held again later in the year to share information, leaning and ensure effectiveness between committees. COMPLETED
18 (introduce regular patient stories and Board and QSAC); 19 (introduce a rolling programme of divisional team presentations to QSAC); 24 (introduce assurance based reporting cards from committees to Board); 25 (update committee ToR); 26 (introduce improvements to Board/ committee administration); 27 (clarify the committee responsible for performance); 32 (deliver a fully integrated Board performance report)	The Board receives patient stories at every public meeting (subject to availability of the individual patient). Different formats are being tested including videoed patient stories. Three stories have been reported to Board so far. The QSAC will follow up on matters arising from these stories. COMPLETED The Trust Board workplan has been updated and divisional teams will start to report to the Board from June 2017 onwards. COMPLETED The assurance committee chairman have agreed that summary reports to the Board will remain but be drafted so as to be clear about the level of assurance received by the committees and to document any concerns raised. COMPLETED The assurance committee chairman have considered the workplans of the committees and removed duplication of reporting. The ToR for the Audit Committee has been revised accordingly, including reference to counterfraud attending the meeting and councillors observing the meetings. COMPLETED Restructure of team will commence once the new Compliance and Governance Manager has started in post (10 July) and the temporary Membership Manager has started in post (26 June). Funding for a deputy company secretray or equivalent has been approved for 2017/18. Once this post has been appointed to, a review of the duties and workload of the team will be conducted to ensure we are fit for purpose for 2018/19 (In progress) The Finance and Investment Committee is responsible for performance and the workplan now reflects this COMPLETED A revised and integrated scorecard was reported to the Board in May 2017 COMPLETED.
20 (Explore the culture of GOSH); 21 (introduce a culture barometer)	The new Head of OD will be tasked to implement this. This will need to be congruent and consistent with the Board and wider leadership development needs analysis - both of which are now underway and should be completed by September. (In progress).
22 (feedback on learning from patient/staff feedback)	Friends and Family Test posters have been provided to all ward areas and the Trust Listening Event was held in November 2016. COMPLETED.
28 (improve internal staff	Team members continue to be recruited. A new intranet has

Recommendations	Actions and progress update
communication);	been agreed and our intranet manager is in liaison with agencies - development is expected to take a few months. New newsletter software is also being purchased to provide statistics on open rates, which will in turn lead to a better understanding of our digital channels. All channels are being assessed as part of an internal communications deep-dive which will result in new rules and ways of working for each channel. New comms channels will also open as a part of this. Planning is underway to improve engagement up, down and across the organisation for programmes of work. (In progress)
35 (update the data quality strategy o clearly define the Executive post holder responsible for data quality and the Board Committee accountable for receiving assurance reporting in this area.); 36 (Re-visit the action plan produced in response to the external data quality review)	The accountable executive is the DCEO. The Audit Committee receives assurance on data quality and this is reflected in the AC Terms of Reference. Following a restructure, there is now a new post of Director of Planning and Information and also a Chief Information Officer appointed. A data quality dashboard is being procured to enhance reporting to the Data Quality Committee and Audit Committee. COMPLETED The action plan has been updated and reviewed at the January Audit Committee COMPLETED

Attachment M

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

28 June 2017

Revised Committee Terms of Reference and Councillor appointment to the Members' Council Nominations and Remuneration Committee

Summary & reason for item:

The Members' Council Nominations and Remuneration Committee's Terms of Reference has been subject to its annual review by the Committee.

Councillors are invited to nominate themselves to sit on the Committee.

Councillor action required:

To consider the recommendation from the Committee to approve the proposed amendment to the Terms of Reference.

To **note** the process for appointing members to the Committee and elect Councillors to sit on the Committee.

Report prepared by: Anna Ferrant, Company Secretary

Item presented by: Anna Ferrant, Company Secretary

Attachment M

Revised Committee Terms of Reference

The Members' Council Nominations and Remuneration Committee reviewed its Terms of Reference in June 2017. The committee was informed that the Terms of Reference (ToR) were assessed against Monitor's Code of Governance in April 2016. The Code of Governance was last updated in July 2014 and there have been no changes to the Code since that time.

The committee has recommended one administrative amendment to the ToR (please see tracked changes) for the purposes of simplifying the wording around the length of tenure of councillor members on the committee.

The Council is asked to **approve** the proposed amendment to the Terms of Reference.

Councillor appointment to the Members' Council Nominations and Remuneration Committee

The current one year term of office of the existing members of the Members' Council Nominations and Remuneration Committee has ended. Under the terms of reference, the committee is comprised of the following seats to be filled by Councillors:

- 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).

Committee members are required to attend a minimum of one meeting a year (in person or by telephone). The term of office of the elected councillors is for one year and as agreed at the April Council meeting, Councillors may be a member of the Committee for a total of three years and where possible, Councillors in both first and second terms of office are encouraged to join.

As requested by the Committee, the table below provides information on the tenure of those individuals serving on the Committee since March 2012, when the Trust was authorised as an FT.

All councillors, except Edward Green (who has served 2 years and 10 months in total on the Committee) can re-nominate themselves to serve on the Committee until end February 2018, noting that nominations will reopen at the April 2018 Members' Council meeting.

Name	Dates of tenure on Committee	Total length of time on Committee
Edward Green	July 2012 – November 2014 January 2017 - Present	2yrs 4 months + 6 months. **Total** 2 yrs 10 months
Matthew Norris	April 2014 – April 2016	**Total** 2 yrs
Jilly Hale	March 2015 - Present	**Total** 2yrs 3 months
Rebecca Miller	March 2015 - Present	**Total** 2yrs 3 months
Mariam Ali	January 2017 - Present	**Total** 6 months
Christine Kinnon	January 2013 – November 2014	**Total** 1yr 10months

Clare McLaren	April 2014 – November 2014	**Total** 8 months

Nominations and where there are more expressions of interest than seats available

Councillors are asked to nominate themselves to sit on the Committee for consideration at the meeting.

If more expressions of interest are received than positions available, the positions will be selected by a vote of councillors in attendance at the Members' Council meeting on 27th April 2016. Councillors may use the dial in or webex facilities to attend this meeting and vote.

To support councillors in reaching a decision about who to vote for, each nominee will be asked to make a one minute statement at the meeting stating why they should be elected to the committee. This process will be chaired by the Trust Interim Chairman.

Voting will be conducted via the alternative voting system on the day of the meeting.

A ballot of councillors attending the meeting in person or by telephone or webex will be held and councillors asked to vote in order of preference (1, 2, 3 etc.) (Webex and telephone councillors will need to send their completed ballot papers by email to the Company Secretary - anna.ferrant@gosh.nhs.uk on the day). If no one receives over 50% of the votes, the lowest number of 1st choice votes will be redistributed on the basis of 2nd choices. This process will be repeated until a nominee has received over 50% of the votes. If two candidates are tied with the same number of votes, lots will be drawn.

Councillors are asked to **note** the process for appointing members to the Committee and consider putting themselves forward to sit on the Committee.

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council Nominations and Remuneration Committee

Terms of Reference

The members' council nominations and remuneration committee is authorised by the members' council to act within its terms of reference. All members of staff are requested to co-operate with any reasonable request made by the members' council nominations and remuneration committee.

1. Nominations role

1.1 The members' council nominations & remuneration committee will:

- Periodically review the balance of skills, knowledge, experience and diversity of the non-executive directors on the board and make recommendations to the board of directors with regard to the outcome of the review.
- Give consideration to succession planning for the chair and non-executive directors in the course of its work, taking into account the challenges and opportunities facing the NHS foundation trust and the skills and expertise needed on the board of directors in the future.
- Keep the leadership needs of the foundation trust under review at non-executive level to ensure the continued ability of the NHS foundation trust to operate and compete effectively in the health economy.
- Keep up to date and fully informed about strategic issues and commercial changes affecting the NHS foundation trust and the environment in which it operates, having regard to any relevant legislation and requirements of the independent regulator.
- Agree with the members' council a clear process for the nomination of a chair and non-executive directors.
- Take into account the views of the board of directors on the qualifications, skills and experience required for each position.
- Prepare a description of the role and capabilities required for an appointment of non-executive directors, including the chair.
- Interview and nominate candidates as non-executive directors for approval by the members' council respectively, ensuring that candidates are eligible for appointment under the Constitution.
- Ensure that a proposed chair's or non-executive director's other significant commitments are disclosed to the members' council before appointment and that any changes to their commitments are reported to the members' council as they arise.
- Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

- Ensure that on appointment non-executive directors including the chair receive a formal letter of appointment setting out clearly what is expected of them in terms of time commitment, committee service and involvement outside board of directors meetings.

- Review the results of the performance evaluation process for the chairman and non-executive directors.

- Review annually the time requirement for non-executive directors.

- Advise the members' council in respect of re-appointment of any non-executive directors in relation to a term beyond six years (in accordance with paragraph 7, annex 9 of the Constitution and Monitor's Code of Governance).

- Advise the members' council in regard to any matters relating to the removal of office of a non-executive director including the chair (in accordance with Annex 7 of the Constitution).

2. Remuneration role

1.1 To decide and review the terms and conditions of office of the foundation trust's non-executive directors in accordance with all relevant foundation trust policies, including:

• Salary, including any performance-related pay or bonus;

• Provisions for other benefits, and allowances.

1.2 To adhere to all relevant laws, regulations and policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate non- executive directors whilst remaining cost effective.

1.3 To advise upon and oversee contractual arrangements for non-executive directors, including but not limited to termination payments.

3. Request for advice

3.1 The members' council nominations and remuneration committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3.2 The committee is authorised, subject to funding approval by the company secretary, to request professional advisors and the attendance of individuals and authorities from outside the foundation trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise its functions.

4. Membership

4.1 The members' council nominations and remuneration committee will comprise the chairman of the trust, the deputy chairman, 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). Each member of the committee shall have one vote.

4.2 The committee will normally be chaired by the NHS foundation trust chairman. Where the chairman has a conflict of interest, for example when the committee is considering the chairman's re-appointment or salary, the committee will be chaired by the deputy chairman.

4.3 When the chairman is being appointed or reappointed, the deputy chairman shall take his or her place, unless he or she is standing for appointment, in which case another non-executive director shall be identified and agreed prior to the meeting to take his or her place.

4.4 Councillor members will nominate themselves on an annual basis to sit on the Committee. The total length of tenure on the committee for a councillor will normally be 3 years.

4.5 Where the number of councillors prepared to serve on the committee is greater that the number of places available, then committee members will be selected by election by their councillor peers. Wherever possible, a mix of nominations will be sought from councillors within their first and second term on the Council.

4.6 A quorum shall be five members, including the chairman or deputy chairman and at least one councillor from the public constituency or the patient and carer constituency.

5. Attendance

5.1 Meetings of the committee may be attended at the invitation of the chairman by the chief executive; head of human resources (operations); the company secretary; and any other person who has been invited to attend a meeting by the committee so as to assist in deliberations.

6. Frequency of meetings

6.1 Meetings shall be held as required, but not less than once a year.

7. Minutes and reporting

7.1 The minutes of all meetings of the committee shall be formally recorded.

7.2 The nominations and remuneration committee will report to the members' council after each meeting. The chair of the committee will be required to brief the board of directors.

7.3 The nominations and remuneration committee shall ensure that board of directors benefits are accurately reported in the required format in the foundation trust's annual report.

7.4 Members of the committee will be required to attend the annual general meeting to answer questions from the Foundation Trust members and the wider public.

8. Review

8.1 The terms of reference of the committee shall be reviewed by the members' council and the board of directors at least annually.

Attachment M

June 2017

Attachment N

Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council

28 June 2017

Process for the appointment of two non-executive directors at Great Ormond Street Hospital for Children NHS Foundation Trust

Summary & reason for item:

To update the Council on the appointment process for two non-executive directors on the GOSH Trust Board, as recommended by the Members' Council Nominations and Remuneration Committee**.**

Councillor action required:

To **note** that the April 2017 Members' Council approved the appointment process for one NED and at the extraordinary May Council meeting agreed to simultaneously advertise for two NEDs for the purposes of replacing both Mary MacLeod (by 31 October 2017) and David Lomas (by 28 February 2018). It was agreed that this would be an efficient and effective way to conduct the search and offer both stability and coherence to the selection process to ensure the substantive Chairman is able to conduct Board team building from the outset.

The Committee recommends that the Council approves the following:

- The person specifications for the new NED roles.
- Minor amendments to the NED terms and conditions of service and role description.
- Amendments to the appointment process - inclusion of:
    - a young person stakeholder panel and tour of the hospital as part of the appointment process and
    - the incoming substantive Chairman joining the short-listing and interview panel as a non-voting member.

Author: Dr Anna Ferrant, Company Secretary

Presented by: Mary MacLeod, Interim Chairman/ Dr Anna Ferrant, Company Secretary

Attachment N

PROCESS FOR THE APPOINTMENT OF TWO NON-EXECUTIVE DIRECTORS ON THE GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST BOARD

1. PURPOSE

This paper outlines the proposed approach for the appointment of two non-executive directors on the Board of Great Ormond Street Hospital for Children NHS Foundation Trust (FT).

Appendices to this paper are provided in a separate pack.

2. BACKGROUND

2.1. Reason for the appointments

The tenure for Mary MacLeod OBE, Interim Chairman will end on 31st October 2017. Mary will have served 5 years and 8 months on the FT Board (the maximum tenure for a NED on an FT Board is 6 years). Previous to this, Mary served 3 years and 4 months as a NED on the GOSH NHS Trust Board.

The tenure for David Lomas, Non-Executive Director will end on 28th February 2018. David will have served 6 years on the FT Board. Previous to this, David served 4 months as a NED on the GOSH NHS Trust Board.

The plan is to finalise the appointments by end September 2017 for approval at an extraordinary meeting of the Council in October 2017.

2.2. Composition of the Board and review by the Board of Directors

Currently the Trust Board includes the Chairman, five Non-Executive Directors (noting that Mary MacLeod has stepped up from a NED to Interim Chairman) and five Executive Directors, plus the Chief Executive.

The Code of Governance (July 2014) states that "*When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position."*

In June 2016, the Trust appointed an independent assessor, Deloitte, to conduct a Well Led Governance Review. In the report, Deloitte stated:

There is a wealth of experience amongst the EDs (executive directors), including previous Board experience in either the NHS or other healthcare systems.

The Board has a full complement of NEDs. The NEDs bring substantial experience to the Board and come from a range of professional backgrounds, including: higher education, local authority, business and healthcare.

The Members' Council Nominations and Remuneration Committee noted and accepted the findings of the independent review and requested detail of the experience and knowledge of the Board as a whole.

The results of the refreshed experience and knowledge audit were reviewed by the Committee in April (via email) (**Appendix 1**) and used these findings to inform consideration of the draft person specifications (see below).

At its April meeting, the Committee agreed that the self-assessment question about experience/ knowledge of working with IT should be amended to experience/ knowledge of working with large scale transformational projects. This proposed amendment will be taken forward in discussions with the substantive chairman about the use of the self-assessment tool in the future.

2.3. Draft person specification for two new NEDs

Mary Macleod NED replacement

In April, the Committee noted that Mary MacLeod has considerable experience working with children and families and advocating on their behalf at the highest levels of service development and policy-making. Throughout her career, Mary has worked as a social worker, academic, service manager and policy adviser, culminating in 10 years as the CEO of the Family and Parenting Institute. She has sat as Deputy Chairman of Cafcass (the child and family court service); Chair of Gingerbread; Trustee of Columba 1400 (a youth leadership charity in Scotland); Vice Chair and now Chair of Ethics at the Internet Watch Foundation; Member of the Family Justice Council; and, Non-executive Director of the Video Standards Council. The breadth of her experience has been invaluable in maintaining an informed and measured scrutiny of quality and safety matters at GOSH.

Following a review of the results from the skills and knowledge evaluation highlighted above, the Committee proposed by email that additional skills/ experience should be added to the 'desirable' criteria in the person specification:

- Property skills/estate management experience
- Working with IT experience
- Corporate/social responsibility experience
- Sustainability experience

The Board reviewed the proposed person specification and additional skills and experience proposed by the Committee at its April meeting and agreed that it was essential to search for a candidate with strong background and understanding of quality and safety matters within the NHS and a professional career in children's services or other similar advocacy work. However, the Board felt that the additional desirable skills and experience listed by the committee were more attune to the person specification for the replacement NED for David Lomas. In addition, the Board agreed that Akhter Mateen already brought IT change management experience to the Board.

The Committee reviewed and agreed with the comments from the Trust Board and recommends that the Council approve the person specification for the NED replacing Mary MacLeod. The person specification is attached at **Appendix 2**.

David Lomas NED replacement

David Lomas is a qualified accountant and Chief Financial Officer at Achilles. Prior to joining Achilles in 2015, David was Chief Financial Officer of Elsevier, part of a FTSE 100 company Reed Elsevier. He has previously held a number of posts at BT plc including CEO of Multi-Media; COO at ESAT BT; CFO of the Enterprise Division and Head of Mergers and Acquisitions. David has also worked at Wassall plc and KPMG. David brings significant financial management experience to the Board and the breadth of his experience has been invaluable in challenging financial management at the Trust and developing an informed focus on productivity and efficiency.

In light of the findings of the experience and knowledge evaluation outlined above, as well as the drive to deliver services efficiently, remain financially healthy and implement considerable organisational change, the Committee proposes that the Trust advertises for a Non-Executive Director with strong business and financial acumen and with considerable experience in a senior/ Board level financial or accounting role for a large/complex/changing organisation. Experience of procurement/funding of large-scale transformational infrastructure projects is also essential. Experience in management of sustainability and implementation of corporate social responsibility would be desirable. The Trust Board will review the person specification at its meeting on 28 June 2017 and report back any comments via the Interim Chairman at the Council meeting.

The Committee recommends that the Council approve the person specification for the NED replacing David Lomas (subject to consideration of comments received from the Trust Board on 28 June 2017). The person specification is attached at **Appendix 3**.

The incoming substantive Chairman has received copies of both person specifications for the purpose of providing an opportunity to have an overview of the NED team prior to him taking up his role in November 2017.

2.4. NED Terms and conditions of service

The terms and conditions of service for a NED position were approved by the Member's Council in April 2017. At its April meeting, the Committee proposed a minor amendment to the terms:

- To add a reference to the Members' Council statutory duty to hold the non-executive directors individually and collectively to account for the performance of the Board. This has been added as paragraph 6.2 in the terms and conditions of service.

The Committee recommends that the Members' Council approves the amendment to the terms and conditions of service. An updated version of the terms and conditions is provided at **Appendix 4** (with tracked changes).

2.5. NED role description

The NED role description was approved by the Member's Council in April 2017. At its April meeting, the Committee proposed a minor amendment to the role description:

- To strengthen the statement about maintaining effective communication between the Board and the Council and require NEDs to work positively and collaboratively with the Members' Council to promote the success of the Trust.

The Committee recommends that the Members' Council approves the amendment to the NED role description. An updated version of the NED role description is provided at **Appendix 4** (with tracked changes).

2.6. Use of recruitment consultants

The April 2017 Members' Council approved the appointment of Harvey Nash to conduct the search for both NED appointments.

3. APPOINTMENT PROCESS

The appointment of both Non-Executive Directors will be made on merit, based on objective criteria following open competition. The process will be formal, rigorous and transparent and in line with the above provisions. The initial NED appointment process was approved at the April Members' Council meeting.

At its April meeting, the Committee recommended that the NED recruitment process provides an ideal opportunity for young people to engage with the process and bring their perspective of the services offered and experienced at GOSH. The Committee noted that work is underway (involving Councillors and representatives from the Young People's Forum) to look at establishing a young person's stakeholder group, made up of 4 young people who will meet shortlisted candidates for both positions on the same day and provide them with an opportunity to enquire about GOSH and find out what it is like to be a patient here. A short tour of the hospital with a current or ex-patient will also be provided.

Following a discussion, the committee recommended that the incoming substantive Chairman join the interview panels as a non-voting member, so as to provide an opportunity for Sir Michael to meet candidates for both positions. As such, the interview panel will comprise the following members:

- Interim Chairman of the Board, Members' Council and the Members' Council Nominations and Remuneration Committee (voting)
- A NED (voting)
- Three members of the Members' Council Nomination & Remuneration Committee (voting).
- Incoming substantive Chairman (non-voting)

The Company Secretary will be in attendance for advice.

The Committee recommends that the Members' Council approves the amendments to the NED appointment process (see **Appendix 6**).

A draft appointment timetable is attached at **Appendix 7**. The Council is asked to note that the dates for short-listing and interviews will be agreed over the next few weeks, with the intention of finalising the appointments by end September 2017 for approval at an extraordinary meeting of the Council in October 2017.

Results of the 2017 Experience and Knowledge Audit

H = High / considerable M = Medium / some N = None

Appointee	Finance Experience/ knowledge in a large and complex organisation	Governance experience / knowledge in a large and complex organisation; bringing experience of strategic planning, risk management / identification, auditing (clinical and non-clinical)	Experience of working in a healthcare setting	Experience / knowledge of working with patients: in the voluntary sector or community – for example experience of working with disadvantaged groups, patient advocacy, working with children and carers in health and other settings	Leading within a large, complex organisation	Strategy and planning	Quality Improvement systems	Operational management/ performance management	Property development/ estate management/ facilities management	Partnership/ stakeholder relationship building	Mergers & acquisitions	Research in clinical or non-clinical settings	Education and training in clinical or non-clinical settings	Human Resources/ employee relations	Organisational Development/ Change Management	Project management/ Contract management	Working with IT	Experience of improving customer service	Acting independently as a Director and/or NED in another organisation	Corporate Social Responsibility	Sustainability	Productivity and efficiency management
NON EXECECUTIVE DIRECTORS																						
Michael Rake	H	H	N	N	H	H	H	H	H	H	H	M	M	H	H	H	H	H	H	H	H	H
Mary MacLeod	M	H	N	H	H	M	H	M	N	H	N	M	H	M	H	M	M	H	H	M	L	M
Akhter Mateen	H	H	N	N	H	H	H	H	M	H	H	M	H	H	H	H	H	H	H	H	H	H
David Lomas	H	H	N	N	H	H	H	H	M	H	H	M	H	H	H	H	H	H	M	M	M	H
Rosalind Smyth	M	H	H	H	H	H	H	H	M	H	M	H	H	H	H	H	M	H	H	H	M	H
Stephen Smith	H	H	H	H	H	H	M	M	N	M	H	H	H	N	M	N	M	N	H	M	M	N
James Hatchley	H	H	N	M	M	H	M	H	M	H	H	M	M	H	M	M	M	M	H	M	M	M
Peter Steer (V)	H	H	H	H	H	H	M	H	M	H	M	H	H	M	H	M	M	H				
Nicola Grinstead (V)	H	H	H	H	H	H	M	H	M	H	N	N	N	M	H	H	M	M				
Loretta Seamer (V)	H	H	H	M	H	H	H	H	H	H	H	M	M	M	H	H	H	M				
Ali Mohammed (V)	M	H	H	M	H	H	H	H	M	H	H	M	H	H	H	H	M	M				
David Hicks (Interim) (V)	M	H	H	H	H	H	H	H	M	H	H	H	H	H	H	H	H	H				
Juliette Greenwood (V)	M	H	H	M	H	H	H	H	N	H	M	M	H	M	H	M	M	H				
Matthew Tulley (NV)	H	H	H	M	H	H	M	M	H	M	M	M	N	M	M	H	M	M				
Trevor Clarke (NV)	H	M	H	M	H	H	M	H	N	M	M	N	N	M	M	M	M	H				
David Goldblatt (NV)	M	M	M	M	H	M	N	N	N	M	N	H	M	N	M	N	N	H				

Attachment N

Appendix 2

DRAFT Non-Executive Director (Advocacy NED post)

Great Ormond Street Hospital for Children NHS Foundation Trust

Person Specification

The candidate should have a strong focus on strategic development and implementation and a grasp of the three cornerstones of GOSH's strategy:

- safe, effective patient care, experience and outcomes;
- world leading paediatric research; and
- an excellent place to work and learn.

We are looking for a candidate who will champion effective, safe services and an excellent patient and family experience. You will be personally influential and demonstrate intellectual ability with the capacity to analyse and master complex information and handle differing views in a flexible way.

Essential criteria

- Substantial experience of working at Board level in either the public, voluntary or private sector.
- A distinguished professional career in children's services or similar advocacy work.
- Experience of delivering and/ or improving patient, family, service user, client or customer services.
- Demonstrate a strong commitment to excellent paediatric healthcare, the principles of the NHS and the Trust's Always Values.
- Ability to contribute to the hospital's strategic development and challenge constructively across all areas of the business
- The diplomacy and empathy to engage, promote and sustain relationships with internal stakeholders (Board members, Members' Councillors and staff members).
- Excellent communication skills and awareness of the sensitivity of the services GOSH provides.
- Uphold the highest standards of conduct, displaying the principles of selflessness, integrity, objectivity, accountability, openness, honesty, and leadership.
- Qualified to be a member of the NHS Foundation Trust with a home within one of its public constituency boundaries.

Desirable criteria

- Understanding of quality governance and safety matters within the NHS.

Attachment N

Appendix 3

DRAFT Non-Executive Director (Finance NED post)

Great Ormond Street Hospital for Children NHS Foundation Trust

Person Specification

The candidate should have a strong focus on strategic development and implementation and a grasp of the three cornerstones of GOSH's strategy:

- safe, effective patient care, experience and outcomes;
- world leading paediatric research; and
- an excellent place to work and learn.

We are looking for a candidate who will champion effective, safe services and an excellent patient and family experience. You will be personally influential and demonstrate intellectual ability with the capacity to analyse and master complex information and handle differing views in a flexible way.

Essential criteria

- Strong business and financial acumen, with considerable experience in a senior/ Board level financial or accounting role for a large/complex/changing organisation.
- Experience of procurement/funding of large-scale transformational infrastructure projects.
- Experience of delivering and/ or improving patient, family, service user, client or customer services.
- Demonstrate a strong commitment to excellent paediatric healthcare, the principles of the NHS and the Trust's Always Values.
- Ability to contribute to the hospital's strategic development and challenge constructively across all areas of the business
- The diplomacy and empathy to engage, promote and sustain relationships with internal stakeholders (Board members, Members' Councillors and staff members).
- Excellent communication skills and awareness of the sensitivity of the services GOSH provides.
- Uphold the highest standards of conduct, displaying the principles of selflessness, integrity, objectivity, accountability, openness, honesty, and leadership.
- Qualified to be a member of the NHS Foundation Trust with a home within one of its public constituency boundaries.

Desirable criteria

- Experience in management of sustainability and implementation of corporate social responsibility.

Great Ormond Street Hospital for Children NHS Foundation Trust

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST

TERMS AND CONDITIONS FOR NON EXECUTIVE DIRECTOR

These are the terms and conditions under which your appointment has been made. These are the standard terms and conditions for a Non-Executive Director (NED) of Great Ormond Street Hospital for Children NHS Foundation Trust (the "Foundation Trust"). It is important that you read these carefully and contact the Company Secretary should you have any queries. Please indicate your acceptance of these terms and conditions by signing one copy and returning to the Company Secretary.

1. Statutory basis for appointment

1.1. Non-Executive Directors hold a statutory office under the National Health Service Act 2006. The appointment and tenure of office are governed by the requirements of the Act and the Foundation Trust's Constitution. Your appointment is made by the Members' Council. It does not create any contract of employment. This document is a contract for services and not a contract of employment between you and the Foundation Trust.

2. Tenure of office

2.1. The length of appointment will be determined by the Members' Council in accordance with the requirements of the Foundation Trust Constitution and the NHS Foundation Trust Code of Governance. Your appointment tenure will be set out in your letter of appointment. Your continued tenure of appointment is contingent on your satisfactory performance and will be subject to annual appraisal by the Chairman in accordance with a process agreed by the Members' Council**.** The tenure of appointment shall be for an initial period of three years commencing on DATE and ending on DATE subject to the termination provisions set out at paragraph 7.

3. Appointment

3.1. Your appointment is subject to the Foundation Trust's Constitution. Nothing in these terms and conditions shall be taken to exclude or vary the terms of the Constitution as they apply to you as a Non-Executive Director of the Foundation Trust. Your appointment is also subject to the Job Description approved by the Members' Council and to the Foundation Trust's Code of Conduct as amended from time to time.

4. Employment law

4.1. Appointments are not within the jurisdiction of Employment Tribunals. Neither is there any entitlement for compensation for loss of office through employment law.

5. Fit & Proper Person Test (Health & Social Care Act 2008 (Regulated Activities) law

5.1. All providers are required to demonstrate that appropriate processes are in place to confirm that directors are of good character, hold the required qualifications and have the competence, skills and experience required which may include appropriate communication and leadership skills, as well as a caring and compassionate nature.

5.2. The fitness of directors will be regularly reviewed on appointment and thereafter. In addition, non-executive directors have a responsibility to report any mismanagement or misconduct issues to the Chairman of the Foundation Trust Board.

5.3. You warrant that you are a fit and proper person as defined by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended or supplemented from time to time) to hold a Board level appointment within the Foundation Trust.

5.4. You understand that there is an on-going duty to advise the Foundation Trust immediately if you become aware of any facts or circumstances that may mean you are no longer a fit and proper person to hold the role of Non-Executive Director of the Foundation Trust and agree to do so.

5.5. You understand that all directors have a collective and individual responsibility to help ensure the Foundation Trust complies with its obligations under this law. You also understand that there is an on-going duty to advise the Foundation Trust immediately if you become aware of any facts or circumstances that may mean another Executive or Non-Executive Director of the Foundation Trust is no longer a fit and proper person to hold the position which they hold within the Foundation Trust and agree to do so.

5.6. You understand that in the event the Foundation Trust has reason to believe at any time that you may not be a fit and proper person then it may suspend you from any or all of your duties pending investigation, the outcome of which may result in your removal from your role.

6. Role and responsibilities

6.1. Your role and responsibilities are set out in the job description attached to these terms and conditions of service**.**

6.2. You understand that the Members' Council has a statutory duty to the non-executive directors individually and collectively to account for the performance of the Trust Board.

6.3. You will be expected to perform your duties, whether statutory, fiduciary or common-law, faithfully, efficiently and diligently to a standard commensurate with both the functions of your role and your knowledge, skills and experience.

6.4. You will exercise your powers in your role as a Non-Executive Director having regard to relevant obligations under prevailing law and regulation, including the NHS Foundation Trusts Code of Governance, the Foundation Trust Constitution, the Role Description approved by the Members' Council and any relevant Codes of Conduct and Foundation Trust or Department of Health guidance (or similar) in force from time to time, including the Department of Health's Code of Conduct & Accountability for NHS Boards.

6.5. You will have particular regard to the general duties of Directors, set out in the Foundation Trust Constitution, including the duty to promote the success of the Trust so as to maximise the benefits for the general public and the Foundation Trust's members.

7. Time commitment

7.1. You will be expected to devote such time as is necessary for the proper performance of your duties. You should be prepared to spend a minimum of 2.5 days a month (and as required) on Foundation Trust business. A Non-Executive Director who is also the Deputy Chairman and Committee Chairman or Senior Independent Director will need to spend additional time on these duties. By accepting this appointment, you confirm that you have sufficient time to undertake your duties and have informed the Foundation Trust of your existing significant commitments prior to taking up the position. Any future changes to your other significant commitments should be reported to the Company Secretary.

7.2. The nature of the role makes it impossible to be specific about the maximum time commitment, and there is always the possibility of additional time commitment in respect of preparation and ad hoc matters which may arise from time to time, and particularly when the Foundation Trust is undergoing a period of increased activity. At certain times it may be necessary to convene additional Board, committee or Members' Council meetings.

8. Remuneration

8.1. The annual fee rate as at the date of this document is £14,000 gross per annum, paid in arrears on the last working day of each working month by direct credit (exceptions may apply when the last working day falls on a Bank Holiday).

8.2. You are only entitled to receive remuneration in relation to the period in which you hold office. This fee covers all duties, including service on any Board committee.

8.3. All fees will be paid through PAYE and are subject to income tax and other statutory deductions.

8.4. There is no entitlement to compensation for loss of office. In accordance with the

Constitution, remuneration for the Non-Executive Director will be set by the Members' Council and is subject to periodic review.

8.5. In line with the requirements of the Health & Social Care Act, information on Directors' remuneration must be included in the Trust's Annual Report & Accounts.

9. Expenses

9.1. You are eligible to claim the reasonable and properly-documented travel and other expenses you incur in performing the duties of your office at the rates set by the Foundation Trust and in accordance with Foundation Trust policy and procedure.

9.2. In line with the requirements of the Health & Social Care Act, information on Directors' remuneration must be included in the Trust's Annual Report & Accounts.

10. Eligibility for NHS Pension

10.1. As a Non-Executive Director of the Foundation Trust, you are not eligible to join the NHS Pension Scheme.

11. Induction

11.1. After the commencement of your appointment, the Trust will ensure you receive a formal and tailored induction.

12.Reappointments

12.1. The Foundation Trust Constitution requires the Chairman and other Non-Executive Directors to be appointed following a process of open competition. You are eligible to stand for reappointment for a further three years appointment (to a maximum of 6 consecutive years), subject to satisfactory appraisals during your initial term and meeting all relevant requirements of the Foundation Trust Constitution.

12.2. There is no automatic right to be reappointed and any decision will be made by the Members' Council in accordance with the process set out in the Foundation Trust's Constitution**.** The Members' Council will consider performance during the initial term, the knowledge, skills and experience required by the Trust Board, the requirements and interests of the Foundation Trust and the requirements of the NHS Foundation Trust Code of Governance in relation to maximum tenure. Any re-appointment is subject to your continued eligibility under the criteria set out in the Foundation Trust's Constitution.

12.3. If the Members' Council does not re-appoint you at the end of your term, your appointment shall terminate automatically, with immediate effect and without compensation.

13. Confidentiality

13.1. All information acquired during your appointment is confidential to the Foundation Trust and should not be released, communicated or disclosed to third parties or used for any reason other than in the interests of the Foundation Trust, either during your appointment or following termination (by whatever means), without prior clearance from the Trust Board.

13.2. Your attention is also drawn to the requirements under both legislation and regulation as to the disclosure of inside information. Consequently you should avoid making any statements that might risk a breach of these requirements without prior clearance from the Foundation Trust Board.

13.3. You acknowledge the need to hold and retain Foundation Trust information (in whatever format you may receive it) in line with Trust policy.

13.4. You hereby waive all rights arising by virtue of Chapter IV of Part I of the Copyright Designs and Patents Act 1988 and moral rights in respect of all copyright works created by you in the course of performing your duties hereunder.

13.5. For the avoidance of doubt, nothing in this agreement restricts or otherwise affects your ability to make a protected disclosure under the Public Interest Disclosure Act 1998 and your attention is drawn to the Foundation Trust's whistleblowing policy which is available from the Company Secretary.

14. Public speaking

14.1. On matters affecting the work of the Foundation Trust, a Non-Executive Director should not normally make political speeches or engage in other political activities. In cases of doubt, the guidance of the Company Secretary or Director of Communications should be sought.

15. Independent Legal Advice

15.1. In some circumstances you may consider that you need professional advice in the furtherance of your role and it may be appropriate for you to seek advice from independent advisors. The Company Secretary will provide information on instructing solicitors.

16. Conflict of interest

16.1. All Non-Executive Directors are required to comply with and adhere to the relevant provisions on conflicts of interest as set out in the Foundation Trust Constitution. The Foundation Trust Constitution requires Board Directors to declare any pecuniary, personal or family interest, whether that interest is direct or indirect, in any

proposed contract or other matter which is under consideration or is to be considered by the Trust Board. Further details can be found in Annex 9 of the Trust Constitution.

Further guidance on the relevance of an interest is available from the Company Secretary.

17. Gifts and inducements

17.1. It is an offence for you to accept any gifts or consideration as an inducement or reward for:

- doing, or refraining from doing, anything in your official capacity; or
- showing favour or disfavour to any person in your official capacity.
- You may only receive hospitality which is line with the Trust Policy and free of any impropriety.
- Any hospitality received must be declared and entered into the Hospitality Register.
- You will at all times comply with and notify the Foundation Trust with any breaches or potential breaches of the Bribery Act 2010 as amended from time to time.
- You are required to comply with the Foundation Trust's Declaration of Interest and Gifts and Hospitality Policy.

18. Resignation

18.1. You may resign at any time by giving at least three months' notice in writing to the Chairman and Company Secretary.

19. Termination of appointment

19.1. The Trust may terminate your term of office if:

19.1.1. You have been adjudged bankrupt or your estate sequestrated and (in either case) you have not been discharged.

19.1.2. You have made a composition or arrangement with, or granted a trust deed for, your creditors and have not been discharged in respect of it.

19.1.3. Within the preceding five years you have been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on you.

19.1.4. You have been required to notify the police of your name and address as a result of being convicted or cautioned under the Sex Offenders Act or other relevant legislation or whose name appears on the Protection of Children Act List;

19.2. Further provisions as to the circumstances where your terms of office may be terminated are outlined in Annex 7 of the Trust Constitution. Other examples of matters which may indicate to the Trust that it is no longer in the interests of the Health Service and/or the Foundation Trust that an appointee continues in office are provided at Annex 1 of this document.

19.3. Any removal of a Non-Executive Director will be carried out in accordance with the Foundation Trust Constitution.

20. Indemnity

20.1. The Foundation Trust will indemnify you against personal civil liability which you may incur in whilst carrying out your Board functions, providing that at the time of incurring the liability, you were acting honestly and in good faith, and not recklessly.

20.2. The Foundation Trust has directors' and officers' liability insurance in place and it is intended to maintain such cover for the full term of your appointment.

21. Disclosure and Barring Service (previously CRB)

21.1. You agree at the request of the Foundation Trust to undergo a Disclosure and Barring Service (DBS) check, to provide any relevant information to the DBS and to submit any necessary documentation to the DBS to enable such a check to be made. This obligation extends to processing any requests for criminal record checks, enabling the DBS to decide whether it is appropriate for you to be placed on or removed from a barred list or placing you on or removing you from the DBS children's barred list and adults barred list for England, Wales and Northern Ireland.

21.2. You must promptly respond to any communications from the DBS and provide the Company Secretary with a copy of any correspondence of such nature as soon as it is received. The Chairman will deal with such matters in confidence and with a view to ascertaining whether it may indicate that you may not be a fit and proper person for your post when dealing with the DBS.

21.3. This process is carried out on appointment and is repeated every 3 years or when required.

21.4. You are required to report any police caution or conviction that may occur at any time during your appointment. The Foundation Trust reserves the right to withdraw any offer of appointment made on the basis of the outcome of a DBS check.

22. Trust Property

22.1. On request and in any event on termination of your office for any reason you are required to return to the Foundation Trust all Foundation Trust property which may be in your possession or under your control including but not limited to your security pass and all keys, computer hardware and software provided by the Foundation Trust and you shall not retain any copies thereof.

22.2. All documents, equipment, manuals, hardware and software provided to you by the Foundation Trust, and any data or documents (including copies) produced, maintained or stored on the Foundation Trust's computer systems or other electronic equipment (including mobile phones), remain the property of the Trust.

23.Data protection

23.1. By signing this document you consent to the Trust holding and processing information about you for legal, personnel, administrative and management purposes and in particular to the processing of any sensitive personal data (as defined in the Data Protection Act 1998) including, as appropriate:

23.2. information about your health or condition in order to monitor sickness levels and take decisions as to your fitness to carry out your duties; or

23.3. information about you that may be relevant to ensuring equality of opportunity and treatment in line with the Foundation Trust's Equality and Diversity obligations and in compliance with equalities legislation; or

23.4. information relating to any current criminal proceedings or unspent convictions in which you have been involved in order to comply with legal requirements and obligations to third parties; and,

23.5. You consent to the Trust making such information available to any of its Officers, Committees, those who have an appropriate reason to access this information including payroll administrators, regulatory authorities, potential or future employers, governmental or quasi-governmental organisations.

23.6. You will comply at all times with the Foundation Trust's Confidentiality policy.

24.Rights of third parties

24.1. The Contracts (Rights of Third Parties) Act 1999 shall not apply to this document. No person other than you and the Foundation Trust shall have any rights under this agreement and the terms of this agreement shall not be enforceable by any person other than you and the Foundation Trust.

25.Law

25.1. Your engagement with the Foundation Trust is governed by and shall be construed in accordance with the laws of England and your engagement shall be subject to the jurisdiction of the courts of England.

25.2. This letter constitutes the entire terms and conditions of your appointment and no waiver or modification thereof shall be valid unless in writing and signed by the parties hereto.

I agree to accept the post on the terms and conditions as set out above

.....
Signed

.....
Dated

Draft March 2017

Annex 1

The following list provides examples of matters which may indicate to the Trust that it is no longer in the interests of the Health Service and/or the Foundation Trust that an appointee continues in office. This list is not intended to be exhaustive or definitive and the Foundation Trust will consider each case on its merits, taking account of all relevant factors.

- If you no longer enjoy the confidence of the Members' Council.
- If you no longer enjoy the confidence of NHS Improvement.
- If you fail to ensure that the Foundation Trust Board governs the performance of the Foundation Trust in an effective way.
- If you fail to deliver work against pre-agreed targets incorporated within your annual objectives.
- If you lose the confidence of the public or local community in a substantial way.
- If there is a terminal break down in essential relationships e.g. between you and the rest of the Foundation Trust Board and/or the Members' Council.
- If you fail to meet the requirements of the Fit and Proper Person Test.

Great Ormond Street Hospital for Children NHS Foundation Trust

Non-Executive Director
Great Ormond Street Hospital for Children NHS Foundation Trust
Role Description

GOSH profile

Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) is a national centre of excellence in the provision of specialist children's health care, currently delivering the widest range of specialist care of any children's hospital in the UK. It is the only specialist Biomedical Research Centre for paediatrics, the largest centre in the UK for children and young people with heart or brain problems, and the largest centre in Europe for children and young people with cancer. It works in partnership with the UCL Institute of Child Health (ICH), part of University College London, and together they form the largest paediatric research and teaching centre in the UK.

The population of children and young people served by the hospital is characterised by those with multiple disabilities and/or health problems and rare and congenital (present at birth) conditions. Many children and young people need the help of different specialist teams and some children live with a chronic condition and are patients of the hospital throughout their childhood.

Our strategic plan sets out a programme of work to enable us to achieve our vision of being the leading children's hospital in the world and be recognised as such. It takes in to account the changing political and economic landscape and seeks to define areas where the Trust can explore taking a more deliberate leadership role locally, regionally and nationally.

Key facts

The hospital receives over 255,000 patient visits (inpatient admissions or outpatient appointments) a year, and carries our approximately 18,800 operations each year.

The hospital has 383 patient beds. Many of the children and young people on our wards require high dependency care or are classed as ward intensive care, requiring one-to-one nursing.

Around 4,100 full-time and part-time staff work at the hospital. The ICH has around 600 staff. Many senior staff have roles in both organisations.

The hospital has approximately 50 paediatric specialties, the widest range of any hospital in the UK, which uniquely enables it to diagnose and pioneer treatments for children and young people with highly complex, rare or multiple conditions. It has 19 highly specialised national services.

1. Trust Values and Expected Behaviours

The Trust has developed the Always Values with our staff, patients and families. The Values characterise all that we do and our behaviours with our patients and families and each other in support GOSH's ethos 'the child first and always'. Our Always Values are that we are:

- Always Welcoming
- Always Helpful
- Always Expert
- Always One Team

Each value is underpinned by behavioural standards and all staff, directors and councilors are expected to display these behaviours at all times.

2. Job Summary

Non-executive directors work alongside other non-executives and executive directors as an equal member of the Board. A NED at GOSH plays a crucial role in bringing an independent perspective to the Board in addition to any specific knowledge and skills.

The Board is collectively responsible for the success of the Trust, including delivering high standards of clinical and corporate governance, responsibility for financial viability, using resources effectively in line with financial controls and ensuring value for money.

3. General responsibilities

- Support the Chairman, Non-Executive Directors and Executive Directors in setting the strategic direction of the Trust;

- As a member of the Board, set the Trust's values and standards. Uphold the Always Values of the Trust and champion an open, honest and transparent culture within the Board and the Trust;

- Ensure the Trust complies with the Terms of Authorisation, the Constitution and any other applicable legislation and regulations, including the maintenance of mandatory services and retention of property;

- Ensure that the organisation promotes human rights and equality and diversity for all its patients, staff and other stakeholders;

- ~~Maintain effective communications between the Board and the Members' Council;~~

- Work positively and collaboratively with the Members' Council to promote the success of the Trust.

- Set challenging objectives for maintaining and improving performance of the Trust and ensure effective implementation of the Board decisions by the Chief Executive and the senior management team;

- Hold the Chief Executive to account for the effective management and delivery of the organisation's strategic aims and objectives, including achieving the Trust's commitment to

patients by improving the quality of care, patient and family experience and meeting targets for treatment;

- Ensure that quality and financial controls and systems of risk management are robust and that the Board is kept fully informed through timely and relevant information;

- Ensure, through the leadership of the Chief Executive, that reporting lines and accountabilities are robust and support the effective oversight of the organisation including the development of effective risk and performance management processes

- Safeguard the good name and reputation of the Trust and be an ambassador for the Hospital. Represent the Trust with international, national, regional or local bodies or individuals, to ensure that the views of a wide range of stakeholders are considered;

- Ensure that the Board, and the organisation, observe the Secretary of State's and other government policies and priorities, including regulatory requirements and the Code of Governance and Codes of Conduct and Accountability;

4. <u>Board activities</u>

- Ensure the appropriate delegation of authority from the Board to the senior management team;

- Support and challenge, where appropriate, the Chief Executive and other directors to ensure that the Board conforms to the highest standards of corporate governance and makes appropriate decisions;

- Meet periodically with the Trust Chairman in the absence of Executive Directors to discuss issues of interest or concern;

- With the Board nomination committee, initiate change and succession planning for executive director appointments which can meet the needs of the Foundation Trust.

- With the Board remuneration committee, determine appropriate levels of remuneration for Executive Directors;

- Participate in the appointment and where necessary the removal of the chief executive and other executive directors, as appropriate;

- Participate in any board induction, training and evaluation identified as an individual and as part of the Board or committee;

- Work with the senior independent director on the annual performance evaluation of the chairman, in line with the process agreed by the Members' Council and reporting back to the Members' Council appropriately,

- Undergo an individual and board performance appraisal and attend any additional training highlighted as a result of the evaluation process.

- Take opportunities to develop and refresh knowledge and skills and remain well informed of the main areas of the NHS Foundation Trust's activity.

5. Members' Council activities

- Build and maintain close relations between the foundation trust's constituencies, and stakeholder groups to promote the effective operation of the trust's activities;

- Attend Members' Council meetings and maintain regular contact with Councillors to understand their issues and concerns, feeding back these comments/ concerns to the Board;

6. Review

This job description will be subject to review by the Trust Board and Members' Council as appropriate.

7. Other information

Great Ormond Street Hospital for Children NHS Foundation Trust is a dynamic organisation, therefore changes in the core duties and responsibilities of this role may be required from time to time. These guidelines do not constitute a term or condition of employment.

8. Confidentiality

On appointment you may be given access to confidential information which must only be disclosed to parties entitled to receive it. Information obtained during the course of employment should not be used for any purpose other than that intended.

Attachment N

Appendix 6

1. Advertisement

The post will be advertised on the following websites:

- Public Appointments website http://publicappointments.cabinetoffice.gov.uk/.
- Great Ormond Street Hospital for Children NHS Foundation Trust website www.gosh.nhs.uk
- The recruitment consultant website.
- The Sunday Times Website.

An advert will be drafted and circulated to committee members for approval on behalf of the Council. The position will be advertised for a minimum of 4 weeks.

A draft timetable is attached at **Appendix 7**.

2. Long-list

The recruitment consultant will analyse the applications and discuss and agree the long list with interview panel members. Harvey Nash will hold assessment interviews with long list applicants.

3. Shortlist

Following the long list assessment interview process, the recruitment advisers will present a report on the most suitable candidates as assessed against the role description and person specifications and taking into account the findings of the long list assessment interview process (covering quality aspects, candidate interests) and any information pertinent to the fit and proper persons test.

The interview panel will shortlist and identify those candidates that should be invited for interview. Barring an exceptional number of high calibre candidates, the Committee should aim to select for interview no more than 4-5 candidates per post.

4. References

If possible, two references will be provided for shortlisted candidates.

5. Shortlisted Candidates

There will be an opportunity for shortlisted candidates (if they wish) to speak to the Chairman of the Trust and/or another NED.

6. Stakeholder Panel and Tour (TBC)

Set up a young person's stakeholder group, made up of 4 young people who will meet shortlisted candidates for both positions on the same day and provide them with an opportunity to enquire about GOSH and find out what it is like to be a patient here. A short tour of the hospital with a current or ex-patient will also be provided.

7. Interviews

At interview, candidates will be asked questions to assess whether they can demonstrate the required skills and expertise required for the NED role. The selection process will ensure that the interview panel tests all relevant criteria.

Each interview will last approximately 45 minutes.

8. Decision and Recommendation of appointee

The Interview Panel will seek to arrive at an agreed decision on a preferred candidate for each position at the conclusion of the final interview process. Any provisional offer will be subject to a range of appropriate checks including two detailed references (in writing), a DBS check and assessment against the Fit and Proper Person assessment criteria, which may include qualification checks. The offers will also be subject to endorsement by the Members' Council Nominations and Remuneration Committee and the full Members' Council.

9. Interview Panel

The role of the panel is to make a recommendation to the Members' Council for a preferred candidate to be appointed to the roles of NED. As outlined in Monitor's Governors' Guide (2013), councillors make up a majority of the votes on the interview panel.

The interview panel will comprise the following members:

- Interim Chairman of the Board, Members' Council and the Members' Council Nominations and Remuneration Committee (voting)
- A NED (voting)
- Three members of the Members' Council Nomination & Remuneration Committee (voting).
- Incoming substantive Chairman (non-voting) (TBC)

The Company Secretary will be in attendance for advice.

Prior to the interviews, the Interview Panel will decide on a series of questions and areas for discussion with candidates, ensuring that the interviews are consistent, fair and transparent. Documentation will be provided to panel members to ensure all agreed criteria are fairly assessed.

Appendix 7

Great Ormond Street Hospital for Children NHS Foundation Trust

NED Appointment Process (Two Non-Executive Directors)

Indicative Milestones

Date	Activity
10/07/2017	Begin market mapping, develop a micro-site to support the searches
17/07/2017	Microsite goes live
23/07/2017	Advert to appear in Sunday Times
18/08/2017	Closing date for applications
w/c 21/08/2017	Analyse applications and dispatch to the Trust
w/c 28/08/2017	Harvey Nash assessment interviews with candidates
w/c 11/09/2017 (TBC)	Agree final shortlist with Trust
w/c 18/09/2017 (TBC)	Final interviews
27/09/2017	Members' Council Approval (subject to pre-employment checks)

ATTACHMENT O

Attachment O

Great Ormond Street Hospital for Children NHS Foundation Trust

Meetings Councillors are welcome to observe 2017

Date	Meetings and times	Councillor names
Wednesday 12th July	2:00pm – 5:00pm QSAC	Camilla Alexander-White Carley Bowman
Friday 21st July	From approximately 12 Noon: Trust Board	Gillian Smith
Thursday 14th September	6:00pm: AGM 7:15pm Reception	
Thursday 7th September	11:00am – 2:00pm Finance and Investment Committee	Gillian Smith
Wednesday 27th September	From approximately 12 Noon: Trust Board	Rebecca Miller Simon Hawtrey-Woore
Wednesday 18th October	2:00pm – 5:00pm QSAC	Carley Bowman
Tuesday 24th October	2:00pm – 5:00pm Audit Committee	Fran Stewart
Monday 20th November	1:00pm – 4:00pm Finance and Investment Committee	
Wednesday 29th November	Trust Board (from approximately 12 Noon)	
Tuesday 12th December	1:00pm – 4:00pm Finance and Investment Committee	

Members' Council meeting dates:

28th June 2017

27th September 2017

29th November 2017