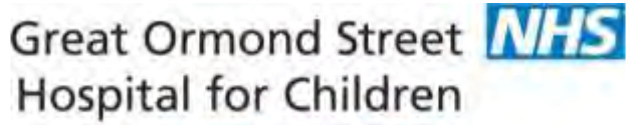


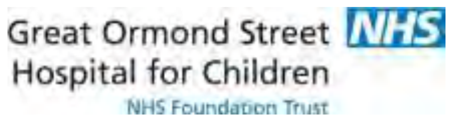
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST
MEETING OF THE MEMBERS' COUNCIL
Wednesday 25 April 2018
5:00pm – 6:30pm
Charles West Room, Paul O'Gorman Building

NO.	ITEM	ATTACHMENT	PRESENTER	TIME
1.	Welcome and introductions		Michael Rake, Chairman	5:00pm
2.	Apologies for absence		Michael Rake, Chairman	
3.	Declarations of interest	A	Michael Rake, Chairman	
4.	Minutes of the meeting held on 7 February 2018	B	Michael Rake, Chairman	
5.	Matters Arising and action log	**C**	Anna Ferrant, Company Secretary	
	GOVERNANCE			
6.	The Council and Board working together	**D**	Michael Rake, Chairman	5:05pm
7.	Update on the work of the Constitution Working Group including • Nominations to sit on the Constitution Working Group • Draft Lead Governor (and Deputy Lead Governor)Role Description	**E**	Anna Ferrant, Company Secretary	5:15pm
8.	Nominations for appointment to: • Council of Governors Nominations and Remuneration Committee • Membership Representation, Recruitment and Engagement Committee (MERRC)	**F** **G**	Anna Ferrant, Company Secretary	5:30pm
9.	Process for the appointment of a Non-Executive Director	**H**	Anna Ferrant, Company Secretary	5:40pm
10.	Non-Executive Director Appraisal process	**P**	Anna Ferrant, Company Secretary	5:50pm
	PERFORMANCE			
11.	CQC report and actions in response to recommendations	**I and presentation**	Matthew Shaw, Medical Director	6:00pm
12.	Reports from Board Assurance Committees • Quality and Safety Assurance	**J**	Stephen Smith, Chairman of the QSAC	6:20pm

	Committee (January 2018 agenda) • Audit Committee (April 2018 agenda) • Finance and Investment Committee (March 2018 agenda)	 **K** **L**	 Akhter Mateen, Chairman of the Audit Committee James Hatchley, Chairman of the F&I Committee	
13.	**Any Other Business**	**Verbal**	Chairman	6:30pm

	FOR INFORMATION			
1.	Chief Executive Report (Highlights and Performance) including integrated quality report and finance report	M	Peter Steer, Chief Executive	
	PATIENTS, FAMILIES AND MEMBERS			
2.	**Update from the Young People's Forum (YPF)**	**N**	Emma James, Patient Involvement and Experience / Faiza Yasin, Chair of the YPF	
3.	**Update from the Patient and Family Experience and Engagement Committee (PFEEC) including Q4 2017/18 PALS Report**	**O**	Alison Robertson, Chief Nurse	

Attachment A



Council of Governors

25 April 2018

Declarations of interest - Council of Governors'

Summary & reason for item:

The purpose of this paper is to present the Council of Governors' register of Interests 2018/19 and inform Governors of their responsibilities to declare interests.

Governor action required:

- To note what constitutes an interest
- Ensure that all interests have been declared with Victoria Goddard, Trust Board Administrator, Victoria.Goddard@gosh.nhs.uk
- To note the content of the register.
- To declare any additional interests that may arise or change in circumstance affecting the Council of Governors' register of interests.

Report prepared by:

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

Report presented by:

Sir Michael Rake, Chairman/ Anna Ferrant, Company Secretary

Attachment A

Declarations of interest - Council of Governors'

All Governors are required to inform the Company Secretary whether they have any personal or family interests as soon as they are elected or appointed. Governors should also declare whether their spouse or partner has any interests.

The Constitution also requires Governors to declare any pecuniary, personal or family interest in any proposed contract or matter that is to be considered by the Council of Governors at a meeting.

If there is a conflict of interest then the Governor may not be able to receive the pertinent papers, participate in the discussion, or vote on that particular issue. The conflicted Governor should also withdraw from meeting whilst the item is discussed.

The Trust Constitution currently states:

Councillors[1] shall declare any pecuniary, personal or family interest[2], whether that interest is direct or indirect[3], in any proposed contract or other matter which is under consideration or is to be considered by the Members' Council. A family interest will include those of a Councillor's spouse[4] or partner. Any Councillor appointed subsequently shall declare such interests on appointment or election.

Such interests include (without limitation):

- *directorships, including non-executive directorships held in private companies, public limited companies or public benefit corporations (with the exception of those of dormant companies);*
- *ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;*
- *majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;*

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[1] Now named 'Governors'

[2] "family" shall include a councillor's close family, for example, domestic partner, children, children of domestic partner, dependants, dependants of domestic partner

[3] This includes a transfer of resources, services or obligations between related parties, regardless of whether a price is charged.

[4] "spouse" shall include any person who lives with another person in the same household

- *a position of trust or fiduciary duty in a charity or voluntary organisation in the field of health and social care;*
- *any connection with a voluntary or other organisation contracting for NHS services; or*
- *any other commercial interest in the decision before the meeting.*

The following exceptions shall not be treated as interests:

- *an employment contract with the Trust held by a staff councillor;*
- *an employment contract with the National Commissioning Board held by a National Commissioning Board councillor;*
- *an employment contract with a local authority held by a Local Authority councillor;*
- *an employment contract with a partnership organisation held by a partnership councillor.*

Any declared interests are entered onto a Register of Governors' Interests and made publicly available in order to avoid Governors being influenced or appearing to be influenced by their private interests in the exercise of their duties as a councillor. Failure to declare an interest could lead to a Governor breaching the code of conduct and being excluded from their position.

Governors are asked that over their tenure should their circumstances change, specifically:

- Declared interests expire or in some other way become no longer valid and/or
- New or additional personal or family interests are identified,

they should declare these changes to the Company Secretary as soon as possible. Where an interest is relevant o an item discussed at a meeting, this interest should be declared prior to the item being discussed. The Chairman will agree how the matter will be managed to avoid any conflict.

Governor action required:

Governors are asked:

1. To note the content of the register attached at appendix 1.
2. To note the requirement to declare any future interests that may arise.

Attachment A

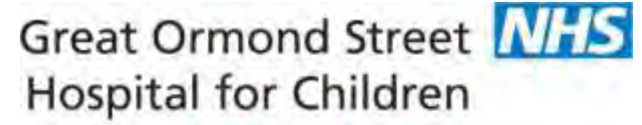
Great Ormond Street Hospital for Children NHS Foundation Trust

Members' Council Register of Interests 2017-18

Constituency	Name	Declared Interests
Patient and Carer Councillors		
Patients from outside London	Faiza Yasin	None
	Alice Rath	None
Patient from London	Elena-May Reading	None
	Zoe Bacon	None
Parents and carers from London	Mariam Ali	None
	Stephanie Nash	None
	Emily Shaw	I am an NHS employee (not GOSH). Adult doctor in infectious diseases and general medicine at UCL. My husband and I run 'The Little Jimmy Brighter Future Fund', a fund within Great Ormond Street Hospital Charity.
Parents and carers from outside London	Lisa Allera	GOSH Patient Experience Committee GOSH (PALS) Volunteer GOSH Research Parent Advisory Group Steering Committee – Cardiac Post Surgical Morbidity Study Husband – member of Corporate Partnerships Board for GOSH Charity
	VACANT	
	Claire Cooper-Jones	None
North London and surrounding area	Simon Hawtrey-Woore	None
	Theo Kayode-Osiyemi	None
	Simon Tan	None
	Teskeen Gilani	Declaration not received
South London and surrounding area	Fran Stewart	None

Constituency	Name	Declared Interests
The rest of England and Wales	Colin Sincock	None
	Julian Evans	None
Staff	Sarah Aylett	Visiting Consultant Paediatric Neurologist to the Children's Trust, Tadworth.
	Michael Glynn	None
	Nigel Mills	None
	Paul Gough	None
	Quen Mok	Appointed as Trustee for Tushinskaya Trust. This is a UK registered charity set up in 1988 by the previous Medical Advisor to the British Embassy in Moscow. The aim of the charity is to improve the health and welfare of sick Russian children in hospitals. Young Russian doctors or nurses are selected for The Diana, Princess of Wales memorial scholarships to spend 12 weeks in Great Ormond Street Hospital as clinical observers. I have been on the selection panel since 2005 and was appointed as Trustee in 2011.
London Borough of Camden	Lazarro Pietragnoli	Declaration not received
University College London, Institute of Child Health	Jugnoo Rahi	Employed by UCL Roles within a number of committees of Royal College of Ophthalmologists (not remunerated).
Great Ormond Street Hospital School	VACANT	
Expert Patient Experience Programme	Lucy Moore	Declaration not received
NHS England	Hazel Fisher	Declaration not received

ATTACHMENT B



DRAFT MINUTES OF THE COUNCIL OF GOVERNORS MEETING
7th February 2018
Charles West Boardroom

Sir Michael Rake	Chairman
Mr George Howell	Patient and Carer Councillor: Patients outside London
Ms Sophie Talib	Patient and Carer Councillor: Patients from London
Ms Fran Stewart	Patient and Carer Councillors: Parents and Carers from London
Mr Matthew Norris	
Ms Claudia Fisher	Patient and Carer Councillors: Parents and Carers from outside London
Mrs Carley Bowman	
Mr Simon Hawtrey-Woore	Public Councillors: North London and surrounding area
Mrs Gillian Smith	Public Councillors: South London and surrounding area
Ms Jilly Hale	Staff Councillors
Rev Jim Linthicum	
Professor Christine Kinnon	Appointed Councillor: UCL Institute of Child Health
Cllr Jenny Headlam-Wells	Appointed Councillor: London Borough of Camden
Mr Muhammad Miah	Appointed Councillor: Great Ormond Street Hospital School

In attendance:

Mr James Hatchley	Non-Executive Director
Mr David Lomas	Non-Executive Director
Professor Rosalind Smyth	Non-Executive Director
Dr Peter Steer	Chief Executive
Ms Loretta Seamer	Chief Finance Officer
Ms Helen Jameson*	Interim Chief Finance Officer from 1st March 2018
Dr Andrew Long	Interim Medical Director
Ms Polly Hodgson	Interim Chief Nurse
Mr Ali Mohammed	Director of HR and OD
Mr Matthew Tulley	Director of Development
Ms Herdip Sidhu-Bevan	Deputy Chief Nurse
Ms Emma James	Patient Involvement and Experience Officer
Mr Peter Hyland*	Director of Operational Performance and Information
Dr Anna Ferrant	Company Secretary
Ms Victoria Goddard	Trust Board Administrator

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

***Denotes a person who was present by telephone*

95	**Apologies for absence**
95.1	Apologies for absence were received from: Mr Edward Green, Patient and Carer Councillor; Ms Mariam Ali, Patient and Carer Councillor; Dr Camilla Alexander-White, Patient and Carer Councillor; Ms Rebecca Miller, Public Councillor; Ms Teskeen Gilani, Public Councillor; Mr Stuart Player, Public Councillor; Mr David Rose, Public Councillor; Ms Clare McLaren, Staff Councillor; Dr Prab Prabhakar, Staff Councillor; Ms Hazel Fisher, Appointed Councillor and Mrs Lucy Moore, Appointed Councillor.
96	**Declarations of Interest**
96.1	No declarations of interest were received.
97	**Minutes of the meeting held on 4th December**
97.1	The Council of Governors **approved** the minutes.
98	**Matters Arising and action log**
98.1	The actions taken since the last meeting were noted.
99	**Update from the Membership Engagement, Recruitment and Representation Committee (MERRC)**
99.1 99.2	Dr Anna Ferrant, Company Secretary reported that the recent Council of Governor election had filled all seats. Electoral Reform Services had communicated with all elected Governors and Dr Ferrant confirmed that she would begin communicating with the new Council about induction. She added that discussion had taken place about including a set of FAQs from former Governors as part of the induction programme. Mrs Carley Bowman, Chair of MERRC said that the Committee had discussed the 2018 AGM and had agreed it would be held in Staff Side Lagoon and take lessons from the successful 'Open House' strategy week. The theme would be the 70th anniversary of the NHS. Discussion had also taken place on the potential to develop a secure Governor portal and how to include Governors in hospital walkrounds.
100	**Update from the Young People's Forum (YPF)**
100.1 100.2	Mr George Howell, Patient and Carer Councillor said that due to the substantial growth in the number of members of the Young People's Forum it was now possible to hold separate sessions for older and younger members to ensure activities could be directed appropriately. Mr Howell added that a number of current or former members of the Young People's Forum had been elected to the Council of Governors. **Action:** The YPF had received a useful session on Clinical Ethics and it was agreed that this should also be presented to the newly elected Council at an upcoming meeting.

100.3	Mr Matthew Norris, Patient and Carer Governor noted the consultation that had taken place with the YPF around the visiting policy and queried the reasons for making any changes. Ms Herdip Sidhu-Bevan said that visiting times around the Trust were currently used as guidelines and thoughts were being scoped about making this uniform across the Trust. No changes were currently planned.
101	**Update from the Patient and Family Experience and Engagement Committee (PFEEC) including Q3 2017/18 PALS Report**
101.1 101.2	Ms Polly Hodgson, Interim Chief Nurse reported that the Trust had met the target of 95% likely to recommend GOSH for both inpatients and outpatients in the Friends and Family Test and the key positive themes were around 'Always helpful'. Negative themes were around staffing levels and discharge. An increase in the number of PALS contacts had led to a positive decrease in the number of cases which were escalated to complaints.
102	**NED reappointment**
  102.1 102.2 102.3	*Mr Akhter Mateen left the meeting.* Sir Michael Rake, Chairman presented the paper and confirmed that the Council of Governors' Nominations and Remuneration Committee had recommended Mr Akhter Mateen for reappointment as Non-Executive Director. Sir Michael said that the Board also supported the reappointment. The Council **approved** the re-appointment of Mr Mateen. *Mr Akhter Mateen rejoined the meeting.* Sir Michael proposed that Mr David Lomas, Non-Executive Director remain on the Board for one additional month, until 31st March 2018 in order to support the hand-over to Mr Chris Kennedy, newly appointed Non-Executive Director. The Council **approved** this proposal.
103	**Draft Lead Councillor Job Description**
103.1 103.2	Dr Anna Ferrant, Company Secretary said that following recent recommendations made by the Council of Governors it had been agreed that the Lead Governor role description would be revised. She said that DAC Beachcroft had supported the work, considering role descriptions used by other Trusts and being mindful of best practice. Dr Ferrant confirmed that the constitution working group would take this forward. **Action:** The Council of Governors discussed the role description and agreed that the role was significant and consideration should be given to the simple document that had been circulated by Ms Claudia Fisher, Patient and Carer Councillor outside the meeting. Consideration would also be given to whether the role could be shared by more than one individual.
104	**Reports from Board Assurance Committees**
104.1	Quality and Safety Assurance Committee (January 2018 agenda)

104.2	Professor Stephen Smith, Chair of the Quality and Safety Assurance Committee said that the committee had agreed to revise the wording around Never Events in the Integrated Quality Report to be clear that GOSH was responsive and learnt from these events. The Committee had discussed transition and its complexities and welcomed an update on the pharmacy review.
105	**Selection by Councillors of a Local Quality Indicator for external data testing and inclusion in the Quality Report 17/18**
105.1 105.2	**Action:** Mr Peter Hyland, Director of Operational Performance and Information presented the three indicators from which the Council of Governors could choose one for external data testing. It was confirmed that Councillors should email Alissa Angelova with their choice of indicator. Mr Matthew Norris, Patient and Carer Councillor noted that focus of the selection was not on performance, rather data quality and accuracy however he queried whether any additional emphasis would be placed on performance throughout the period. Ms Nicola Grinstead, Deputy Chief Executive confirmed that all the indicators which could be chosen were part of existing work programmes. Mr Akhter Mateen, Non-Executive Director said that scrutiny should be provided to indicators on an on-going basis however it was important to receive periodic external assurance about the quality of the data being scrutinised.
106	**Reports from Board Assurance Committees**
106.1 106.2 106.3 106.4 106.5 106.6 106.7	<u>Audit Committee (January 2018 agenda)</u> Mr Akhter Mateen, Chair of the Audit Committee said that the Committee had considered the process around the Board Assurance Framework and undertaken a deep dive into four risks. There had been no adverse movement in any of the risks reviewed. Mr Mateen said that a number of risks had a net score which was higher than the appetite and further work would take place to look at this. The Committee continued to review IPP debt which had reduced in the last report but remained an area of risk, and the committee had considered whether additional provisioning was required. Mr Matthew Norris, Patient and Carer Councillor who had observed the committee said he felt that thorough and robust discussions had taken place and highlighted a discussion which had taken place around HR and payroll systems and an issue of incompatibility. Mr Mateen said that this was an additional review which had been undertaken by the internal auditors at the request of the executive team on annual leave payments, the outcome of which would be monitored by the Finance and Investment Committee. Mr Mateen said that the external auditor engagement would end in March 2019 so a tender would be conducted with Governor involvement as this was an area of statutory responsibility. <u>Finance and Investment Committee Summary Report (January 2018 and agenda)</u> Mr David Lomas, Chair of the Finance and Investment Committee said that the committee had noted the year to date results and highlighted that currently the Trust was performing better than or equal to budget in financial terms however Mr Lomas emphasised that the current position was due in large part to the support

	provided by the GOSH Children's Charity and IPP revenue.
107	**Chief Executive Report (Highlights and Performance) including integrated quality report**
107.1 107.2 107.3 107.4 107.5	Dr Peter Steer, Chief Executive welcomed Dr Andrew Long, Interim Medical Director and Ms Polly Hodgson, Interim Chief Nurse to the Executive Team. He reported that Ms Loretta Seamer, Chief Finance Office would be leaving the Trust at the end of February 2018 and introduced Ms Helen Jameson, Interim Chief Finance Officer. Dr Steer highlighted the cultural change work which was taking place with the Cognitive Institute and confirmed that it had been well received by clinical and non-clinical leaders throughout the Trust. Mr George Howell, Patient and Carer Councillor requested an update on RTT and the work on unknown clock starts. Ms Nicola Grinstead, Deputy Chief Executive said that following a period of non-reporting, GOSH had been working to a recovery trajectory which had been agreed with NHS Improvement, NHS England and CQC. Ms Grinstead said GOSH had now met the 92% target and she was confident that the Trust was now in a position to continue to do this consistently. This performance was amongst the best nationally. Mr Howell noted that the staff vacancy rate was within target however he queried how this triangulated with the Friends and Family Test which had received negative feedback about staffing levels. Mr James Hatchley, Non-Executive Director said that this had been discussed at the Quality and Safety Assurance Committee and it had been noted that following the opening of the Premier Inn Clinical Building where patients were in cubicles, the perception of staff presence on wards was likely to have changed. Dr Steer confirmed that the Trust operated a high nurse to patient ratio in comparison to other organisations and added that care hours per patient per day had increased. Mr Matthew Norris, Patient and Carer Councillor highlighted the red rated theatre utilisation metrics and the number of last minute cancelled operations per month. He emphasised the impact that cancelled operations would have on families and asked for assurance that work was taking place to minimise this as far as possible. Dr Steer said that it was made clear throughout the organisation that last minute cancellations were unacceptable and considerable work was taking place around flow and ensuring that all options had been explored before it was possible to cancel a patient. Discussion took place about whether it should be highlighted that there was a possibility that procedures could be cancelled however Dr Steer said it was important to have a culture where the expectation was that a booked procedure would take place.
108	**Dates of Trust Board, Trust Board subcommittee and Members' Council meetings**
108.1	**Action:** It was agreed that meeting dates for the rest of 2018 would be confirmed following discussions.
109	**Any other business**
109.1	There were no items of other business.

ATTACHMENT C

Attachment C

MEMBERS' COUNCIL - ACTION CHECKLIST
April 2018

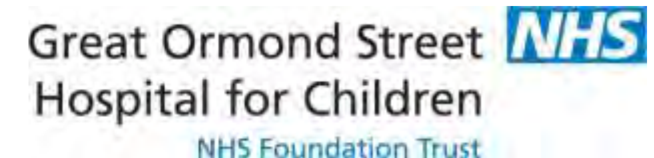
Checklist of outstanding actions from previous meetings

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**	**July 2018**	Not yet due: A draft calendar of presentation topics to be developed as part of the Council induction programme for 2018/19, in consultation with the Council, Chairman and NEDs.
10.13	26/04/17	It was agreed that a cyber security update would be provided at a future meeting.	**NG**	**July 2018**	Not yet due: A draft calendar of presentation topics to be developed as part of the Council induction programme for 2018/19, in consultation with the Council, Chairman and NEDs.
83.2	04/12/17	Mr Matthew Norris, Patient and Carer Councillor said that he had visited GOSH for a weekend clinic appointment and felt this was an excellent use of resources and convenient for families. He queried how far weekend working was being considered in order to increase capacity. He noted from the performance report that 4% of beds had been closed and asked whether there was a particular issue which drove the closure of beds. Mr Norris expressed concern at the 8% of families who did not attend their appointment and suggested that text messaging could improve this. He highlighted the good quality of text messaging from Guys and St Thomas' NHS Foundation Trust and it was agreed that the team would look at the number of people who did not attend their appointments at that hospital.	**NG/ Peter Hyland**	**February 2018**	Verbal update

Attachment C

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
87.1	04/12/17	It was agreed that an update on the Board development programme would be provided at a future meeting.	**AM**	**April 2018**	Update on agenda under The Board and Council working together
100.2	07/02/18	The YPF had received a useful session on Clinical Ethics and it was agreed that this should also be presented to the newly elected Council at an upcoming meeting.	**AL/MS**	**April 2018**	Not yet due: A draft calendar of presentation topics to be developed as part of the Council induction programme for 2018/19, in consultation with the Council, Chairman and NEDs
103.2	07/02/18	The Council of Governors discussed the role description and agreed that the role was significant and consideration should be given to the simple document that had been circulated by Ms Claudia Fisher, Patient and Carer Councillor outside the meeting. Consideration would also be given to whether the role could be shared by more than one individual.	**AF**	**April 2018**	On agenda
105.1	07/02/18	It was confirmed that Councillors should email Alissa Angelova with their choice of indicator.to be audited by Deloitte for data quality and accuracy purposes.	**All Councillor**	**March 2018**	CV lines indicator was selected. The testing is due to commence shortly.
108.1	07/02/18	Confirmation of meeting dates for the rest of 2018 to be provided to the Council following discussions.	**AF**	**April 2018**	Update on agenda under The Board and Council working together

Attachment D



Council of Governors

25 April 2018

GOSH Trust Board and Council of Governors Working Together

Purpose

The purpose of this paper is to summarise the key points raised at the joint meeting of the Trust Board and Council of Governors (previously known as the Members' Council) in February 2018. The aim of the meeting was discuss how both bodies can work together effectively.

It included a presentation on the different roles and responsibilities of the Board, Council, directors and councillors. It also highlighted the information gathered from other trusts by members of the GOSH Well Led Working Group on how Boards and Councils work together. Feedback from the meeting has been used to inform the following proposals for effective working between the Council and Board. The Board has reviewed and approved these proposals.

Governor action required:

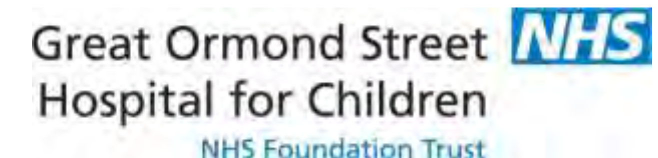
- Note the report and pursue any points of clarification or interest.
- Endorse the recommendation regarding the Lead Governor.
- Note the Trust Board and Council of Governors' meeting dates in 2018 and early 2019

Report prepared by:

Anna Ferrant, Company Secretary

Report presented by:

Michael Rake, Chairman



GOSH Trust Board and Council of Governors Working Together

The Trust Board and Council of Governors (previously known as the Members' Council) held a joint meeting in February 2018 to discuss how both bodies can work together effectively, taking in to account the recommendations in the Well Led Review report from October 2016 and learning from the independent investigation.

It included a presentation from Mr Giles Peel, a chartered secretary who highlighted the different roles and responsibilities of the Board, Council, directors and councillors. It also highlighted the information gathered from other trusts by members of the Well Led Working Group on how Boards and Councils work together.

Feedback from that meeting has been used to inform the following proposals for effective working between the Council and Board.

Change of name of the Council

At the joint meeting, all participants agreed that there was an appetite to change the name of the Council and role title of councillor. The purpose was to ensure clarity of the role of the Council and members of the Council as well as to align the Council name with the NHS Act. The Council and the Board jointly agreed that the Members' Council will be renamed 'Council of Governors' and the role title of councillor changed to 'Governor'.

Interim Lead Governor

With the recent turnover of Governors and the gap between the start date of new Governors and the first meeting of the new Council on 25 April, the Trust needs to ensure that that the role of Lead Governor is covered for the interim period. Sir Michael Rake, Chairman of the Board and Council has approached the previous Deputy Lead Governor, Mariam Ali and asked her to stand as Interim Lead Governor for a period of 12 months. Mariam has kindly agreed to take up this interim position. Mariam has previous experience in the deputy role and has also sat on the Council for 3 years, so provides continuity for the Council.

Recommendation: The Council is asked to endorse the appointment of Mariam Ali as Lead Governor for 12months from April 2018. The revised job descriptions for Lead Governor and Deputy Lead Governor are on the Council agenda for consideration. Appointment of Deputy Lead Governor will be made at the July Council meeting.

Governor Induction Programme

The Governor Induction programme is under way. It takes the form of a number of sessions aimed at introducing new Governors to the hospital and its place in the wider NHS; the role of the Board and Council; and their role of governor. There will also be a focus on team building and communication skills as well as presentations from NEDs and staff members so as to provide interactive learning about the Trust and individuals'' roles and responsibilities.

The first session was held on 14 March and the second on 25 April, with future dates to be booked. The intention is to move from induction to a development programme where Governors have the

opportunity to access relevant information and training (internally and externally provided) to support them in their role.

A review of statutory and mandatory training is underway for Governors to ensure that they receive the appropriate level of training relevant to their role.

Governor Portal and provision of GOSH emails to Governors

One of the requests from past Governors has been for the establishment of a Governor Portal where key information can be uploaded and accessed by Governors at any time. Work will commence on development of the portal in May 2018.

Governors have requested a GOSH email and this will be implemented between the April and July Council of Governor meetings. The email will be able to be used to encourage communication with, and feedback from, constituency members, using the membership database to support targeted correspondence.

Board and Council meetings

The Chairman is keen to ensure that the Board and Council operate within an effective governance framework, one that supports both bodies to fulfil their duties to maximum effect.

Previously Board and Council meetings have been held on the same days. This has proven difficult in ensuring all items have sufficient time to be considered and has meant that Board members are sitting in meetings for several hours at a time. Board and Council dates have been reviewed and revised, taking in to account the following:

- Existing meeting dates already in diaries
- The agreed principle that Council and Board dates should held on separate dates
- Four Council of Governor meetings per year to support quarterly reporting
- Chairman/Governor meetings prior to each Council meeting.

It is proposed that the Board and Council will meet as follows:

- 7 Formal Confidential/Public Trust Board Meetings each year (B = Board)
- 4 Council Meetings each year (CoG = Council of Governors) February, April, July and November

Please see revised meeting schedule at **Appendix 1** below.

Chairman meetings with Governors

The Chairman has agreed to hold regular meetings with Governors prior to each Council meeting to foster effective working relations and listen to any concerns or issues Governors have (related to the papers for the meeting or other matters). These pre meetings have been built in to the revised meeting schedule at **Appendix 1**.

The Chairman has also agreed to meet with the Lead Governor and Deputy lead Governor once a month either face to face or by telephone to provide an opportunity for matters to be raised between Council meetings. These meetings will be established from March onwards.

Buddying system for Governors

The Chairman is keen to ensure that Governors feel supported in their role and outwith the administrative support provided by the Executive Office, have an identified NED that they can seek support and assurance from as they start in their role.

It is proposed that each NED will be allocated a small group of named Governors for whom they will maintain contact with and provide support and advice. It will also provide an opportunity for NEDs to highlight their role on the Board and the issues that they are interested in. NEDs may wish to meet their Governors during the year and/or maintain regular email communication. Buddying will commence from June 2018. Prior to this Governors will be asked about their interests and allocated to relevant NEDs. NEDs will work with Governors and discuss how they wish to engage.

Council agendas and attendance at Council meetings by executives

Noting the move to four Council meetings a year (timed to support quarterly reporting) the Chairman proposes that the Council agenda is revised as follows:

- A presentation from the Chief Executive on current performance and other significant matters. This will include covering quality, operational and finance performance and will be supported as required by the relevant executive director for that particular item;
- A quarterly report from QSAC to the Council, including an update on complaints and PALS;
- A six monthly report from the Audit Committee and the Finance and Investment Committee (alternate Council meetings);
- A presentation on a matter agreed by the Council.

Executive directors will not normally be required to attend Council meetings unless requested for specific items. NEDs will be encouraged to attend Council meetings, where possible.

Governor attendance at assurance committee meetings

The Chairman has proposed that Governors are identified to attend assurance committee meetings as observers based on their relevant skills and background. This will provide continuity from the Council and allow Governors to build an understanding of the work of the committee and the role of the NEDs on that committee. Governors will receive the agenda and papers for the assurance committee two working days before the meeting, via encrypted email.

The meeting dates for the assurance committees in 2018 are as follows. The Finance and Investment committee dates are being agreed with the new Chairman, Mr James Hatchley. The 2019 dates will be set in June 2018.

Wednesday 9th May 2018	**4:00pm – 7:00pm Quality, Safety and Assurance Committee**
Friday 20th July 2018	**2:00pm – 5:00pm Quality, Safety and Assurance Committee**
Thursday 11th October	**2:30pm – 5:30pm Quality, Safety and Assurance Committee**
Thursday 18th October	**9:00am – 12:00pm Audit Committee**

Attachment D

Hospital Walkrounds

The Chairman is keen that a review of walkrounds is conducted with the aim of preventing numerous groups of Board members, Governors and external stakeholders from visiting clinical areas and potentially disrupting care. It has been proposed that joint executive, NED and Governors walkrounds be established 3-4 times a year and work is underway to develop a protocol.

Appendix 1: Revised Trust Board and Council of Governors' meeting dates 2018 and early 2019

No.	Date	Meetings and times	Notes
CoG 2 2018	**EXISTING COUNCIL DATE Wednesday 25th April**	**3:15pm-3:45pm Private meeting of Chairman and Governors 4:00pm – 6:30pm: Council of Governors**	**For reporting Q4 data**
B3.	**EXISTING BOARD DATE Wednesday 23rd May**	**9:00am – 12:00pm Audit Committee 12:30pm – 5:00pm: Trust Board**	**QSAC – 19 July 2018**
CoG 3 2018 BD	**NEW COUNCIL DATE Tuesday 24th July**	**2:15pm-2:45pm Private meeting of Chairman and Governors 3:00pm – 5:30pm: Council of Governors**	**For reporting Q1 data**
B4.	**EXISTING BOARD DATE Wednesday 25th July**	**9:00am – 10:0am Chairman and NED meeting 10:00am – 3:00pm: Trust Board (private and public)**	
	August –no meetings		
B5.	**NEW BOARD DATE Thursday 27th September**	**10:00am – 11:00am Chairman and NED meeting 11:00am – 4:00pm: Trust Board (private and public)**	
AGM	**Tuesday 2nd October 2018**	**5:00pm-7:00pm**	
CoG 4 2018 BD	**NEW COUNCIL DATE Wednesday 7th November**	**3:15pm-3:45pm Private meeting of Chairman and Governors 4:00pm – 6:30pm: Council of Governors**	**For reporting Q2 data**
B6.	**NEW BOARD DATE Thursday 8th November**	**9:00am – 10:00am Chairman and NED meeting 10:00am – 3:00pm: Trust Board (private and public)**	

Attachment D

No.	Date	Meetings and times	Notes
B7.	**NEW BOARD DATE** **Wednesday 5th December**	**12:30pm - 5:00pm Trust Board (private and public)**	
CoG 1 2019	**6 February 2019**	**2:15pm-2:45pm Private meeting of Chairman and Governors** **3:00pm – 5:30pm: Council of Governors**	**For reporting Q3 data**
B1.	**7 February 2019**	**9:00am – 10:0am Chairman and NED meeting** **10:00am – 3:00pm: Trust Board (private and public)**	
B2	**End March 2019 (TBC)**	**12:30pm - 5:00pm Trust Board (private and public)**	
CoG 2 2019	**End April 2019**	**3:15pm-3:45pm Private meeting of Chairman and Governors** **4:00pm – 6:30pm: Council of Governors**	**For reporting Q4 data**

Attachment E

Council of Governors

25 April 2018

Update on the work of the Constitution Working Group and Draft Lead Governor Role Description

Summary & reason for item:

Constitution Working Group – appointment of members

The Constitution is an organisation's governing document. It is a set of fundamental principles and processes according to which the foundation trust is governed.

The Trust's Constitution Working Group has been set up as a short life working group to complete a review of the Constitution and proposed amendments where appropriate. **Appendix 1** sets out the agreed Terms of Reference for the group. The Group is made up of a mix of Governors, Board and Trust staff. Small amendments to the ToR are proposed in red text.

The Constitution was last revised in September 2014. A copy of this current Constitution has been circulated to all Governors by email. The Group has met three times between January and March 2018 and has agreed a workplan (please see **Appendix 2**). Copies of the minutes of the Group are attached for information (**Appendix 3)** along with decision log for the Group (**Appendix 4**).

Five governors from across all the constituencies (patient and carer, public, staff and appointed) sit on the Group. It has been agreed for purposes of continuity that Fran Stewart, Parent and Carer Governor should remain on the Group (in her second term as a Governor). George Howell, a past Patient Governor has also been asked to remain on the group for similar reasons and to ensure a patient perspective is provided – his membership does not take up a governor seat.

Noting the Lead Governor now takes one seat on the Group (see Appendix 1), there are three vacancies and governors are asked to consider if they wish to get involved. A governor does not need to have any specialist skills or knowledge in the area, just a commitment to reading the Constitution and meeting to discuss how it can effectively support the Council and Board to discharge its duties.

The Group will hold its next meeting in May 2018 and it is envisaged that it will meet about 3-4 times between May and July 2018 (meetings last approximately 2 hours and governors can dial in). The Group was originally keen to try and have a draft revised Constitution ready by end June 2018. Unfortunately, with some slippage in setting up meetings, it is envisaged that the work will be completed by mid-July in time for the July Council meeting.

A revised Constitution will be recommended by the Group for approval at meetings of the Trust Board and Members' Council.

Draft Lead Governor Role Description

Every Foundation Trust is required to appoint a Lead Governor from the existing Council membership. Whilst limited, guidance is included in the Code of Governance (July 2014) and the Governor's Guide (2013) – see **Appendix 5.**

As part of the work of the group, the draft Lead Governor Role Description was reviewed and discussed at the February 2018 CWG meeting. It was agreed that the document needed to be short, succinct and clear. A copy of the role description is attached for consideration (see **Appendix 6)** by the Council. It is proposed that the Deputy Lead Governor position is appointed in July 2018 to allow new Governors to gain more information about the role and the role of Governor.

Governor action required:

- To receive the update from the CWG.
- Approve the revised terms of reference for the Group
- Governors are asked to consider nominating themselves to sit on the Group and to inform the Deputy Company Secretary of their interest by email (paul.balson@gosh.nhs.uk) prior to the meeting (by Tuesday 24 April at 4.00pm). If more nominations than seats are received, a secret ballot will be held at the Council meeting.
- Governors are asked to consider and approve the draft Lead Governor Role Description.

Report prepared by:
Anna Ferrant, Company Secretary
Item presented by:
Anna Ferrant, Company Secretary and Nicola Grinstead, Deputy Chief Executive and Chairman of the Group

FINAL Constitution Working Group
Terms of Reference

1. Authority

The Constitution Working Group is set up as a short life working group to complete a review of the Constitution and propose amendments where appropriate.

The Constitution Working Group is authorised by the Trust Board and Members' Council to take any decisions which fall within its' Terms of Reference.

The Constitution Working Group will acknowledge the requirements for amending the Constitution:

The Trust may make amendments of its constitution only if –

- *More than half of the members of the Members' Council of the Trust voting approve the amendments, and*
- *More than half of the members of the Board of Directors of the Trust voting approve the amendments.*

Where an amendment is made to the constitution in relation the powers or duties of the Members' Council (or otherwise with respect to the role that the Members' Council has as part of the Trust):

- *At least one member of the Members' Council must attend the next Annual Members' Meeting and present the amendment, and*
- *The Trust must give the members an opportunity to vote on whether they approve the amendment.*

If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

2. Duties

2.1. To review the Constitution and appendices to ensure its compliance with the Health and Social Care Act 2012.

2.2. To review the Constitution and appendices in light of:

2.2.1. best practice guidance including that set out in the Foundation Trust Code of Governance (July 2014)
2.2.2. changes to strengthen governance arrangements for the membership, Members' Council and Trust Board.
2.2.3. changes to the structure of the Members' Council or Trust Board.
2.2.4. Relevant recommendations and resolutions arising from internal reviews and reports to the Members' Council and Trust Board.

2.3. To make recommendations to the Trust Board and Members' Council on changes to the Constitution and appendices.

3. Membership

3.1. The members of the working group are:

- Deputy Chief Executive (Chair)
- Company Secretary (Deputy Chair)
- Programme Director
- 1 Non-Executive Director
- 5 councillors from across the constituencies (public, patient and parent/carer (including a young councillor), appointed and staff councillors) including the Lead Governor (Deputy Lead Governor may attend in the place of the Lead Governor).

3.2. Meetings will be chaired by the Deputy Chief Executive. The Company Secretary will be the Deputy Chair of the Working Group.

3.3. Other members may be co-opted as required.

3.4. Deputies may attend with the prior agreement of the Chair of the Working Group.

3.5. Papers will be sent out at least four working days before the meeting.

3.6. Secretariat support for the Group will be provided by the Company Secretary.

3.7. Dial in facilities will be available for members' participation at meetings if required.

4. Quorum

4.1. The quorum will be made up of the Chair or Deputy Chair of the Working Group, the Programme Director or Non-Executive Director plus three Councillors.

5. Frequency of Meetings

5.1. Meetings will be held as required. The group will work towards completing a review of the Constitution by end ~~June~~ July 2018, for reporting to the Board and Council for approval and the Annual General meeting in 2018.

6. Reporting

6.1. The Working Group reports to the Trust Board and Members' Council. A revised Constitution will be recommended for approval at both meetings of the Trust Board and the Members' Council.

April 2018

GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST
CONSTITUTION WORKING GROUP

SUGGESTED CONSTITUTION CHANGES – WORK PLAN

KEY

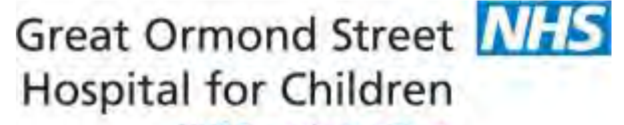
Working group to consider further
Options to be prepared for Group
To address when re-drafting constitution

	Suggested change	Next steps	Responsibility
Changes on which there was Working Group consensus			
1.	Change name of Members' Council to Council of Governors and title of councillors to governors.	When revisions to the constitution are made, ensure names are amended accordingly.	DACB
2.	Have a standing constitutional review committee.	To consider whether this needs to be drafted into the constitution. The only Members' Council committee referred to in the constitution currently is the nomination and remunerations committees. Annex 8 para 5.3 gives the Members' Council the power to appoint committees, which can be used to appoint a constitutional review committee, without needing to amend the constitution.	Working Group
3.	Ensure there are no conflicts between the main body of constitution and the standing orders and other annexes.	Once revisions to the constitution have been made, check that there are no conflicts between various parts of the constitution.	DACB / Working Group
4.	Clarify terminology around members meetings / AGM.	Check terminology and propose any necessary amendments to the wording.	DACB
5.	Update list of definitions.	To do throughout review process where other changes necessitate amendments to the definitions. Final sweep at the end of the constitution review process to ensure no unused defined terms and all changes reflected.	DACB / Working Group
6.	Remove parts of the constitution that are no longer relevant, for example the appointment of the initial Chairman and Chief Executive, or are not relevant to GOSH, for example, the requirement for an executive director to be a registered medical practitioner or a registered dentist.	Remove such parts of the constitution from a working draft.	DACB

Changes on which there was Working Group consensus in principle but further consideration of details required			
7.	Keep in principle but update Annex 6, para 4.3.2, which sets out when a Councillor will cease to hold office for non-attendance at Members' Council meetings.	Consider whether to keep the provisions as they currently are, that is: a councillor will cease to hold office if he/she misses two meetings in a year unless: (a) he/she has reasonable cause; (b) he/she will be able to start attending meeting of the Trust within such a period as the Members' Council considers reasonable. Proposals included: • Keeping provision as is, but defining what a reasonable cause is. • Changing the requirements so that a councillor ceases to hold office if he/she misses two consecutive meetings or three in a year, for whatever reason.	Working Group to consider further and finalise suggested change.
8.	Remove six year rule for the patient and carer constituency.	Consider what should replace the six year rule. Proposals included: • having an upper age limit for the patient classes of the constituency; and • not having any limit The NHS Act 2006 requires that there the constitution specifies a period within which individuals have attended the hospital as a patient or carer – consider whether an upper age limit would satisfy this requirement.	DACB / Working Group
9.	Stagger councillor elections.	Draw together examples of how other Trusts stagger elections to be considered at the next Working Group meeting.	DACB / Working Group
10.	Increase young people's voice / representation by way of an increased connection with the Young People's Forum.	Consider in more detail how this would work including what decisions the YPF should have input into and the process for how that input would be provided.	Working Group
11.	Review age limit for membership	Consider lowering the age limit from 10 to lower age.	Working Group
12.	Establish a process for the investigation of complaints about governors.	Further consideration required as to what this process should look like.	Working Group
13.	Establish a process for evaluating councillors to check they are fulfilling their role.	Consider what such a process would look like. Consider legal requirements / governance standards around this.	Working Group DACB
14.	Include a process for what happens when something that isn't provided for in the constitution occurs.	Working Group to consider what such a process would look like.	Working Group
15.	Removal/ suspension of councillors	To consider further. Ensure clarity. Look at what other trusts have in place	Working Group
16.	Voting requirements	Ensure clarity and consistency of voting requirements	Working Group

Changes on which there were differing views, views were not discussed or further legal advice required			
17.	Tenure of councillors.	Further discussion regarding options for length of tenure. Look at what other Trusts do and what corporate governance guidance suggests.	DACB / Working Group
18.	Review number of governors elected from the North London and South London classes of the public constituency.	Review proportion of patients that come from north London boroughs versus south London boroughs.	Company Secretary
19.	Committees established by the Board.	Consider the extent to which these should be referred to in the constitution. Consider how best to clarify councillors' roles on those committees, for example, whether councillors are entitled to papers in advance of the meetings. Consider whether this is something best done in the constitution or the terms of reference for those committees.	Working Group
20.	Consider the structure of the constitution including: (a) moving dispute resolution provisions into the main body of the constitution; and (b) more logical ordering of membership and constituency provisions.	To be done when a revised draft of the constitution is produced.	DACB
21.	Clarification of certain terms within constitution, for example "serious breach" [of the code of conduct].	Make a list of terms that the Working Group feels need clarifying.	Working Group
22.	Review role description and election process for Lead Governor and Deputy Lead Governor.	This is on the agenda for the 7 February Members' Council meeting for consultation with councillors	DACB / Members' Council
23.	Consider whether anything could be included in the constitution that would assist staff governors with the conflicting position they sometimes find themselves in.	To consider further. This is most likely not a matter for the constitution but for development with staff governors or a basic protocol.	Working Group
24.	Clarify whether meetings of councillors outside formal members' council meetings are allowed.	To consider further.	Working Group
25.	Have a young person representative on the appointment committee for Board members (executives and NEDs)	Consider whether this is something that would be more appropriate to include in the terms of reference for those appointments committees.	Working Group
26.	Clarify what the Nolan Principles and Code of Conduct mean in practice.	Consider whether this is something that would be better dealt with outside of the constitution, for example, within the code of conduct itself.	Working Group
27.	Consider the role of the charity with respect to membership, conflicts and councillors.	To consider further.	Working Group
28.	Consider whether the standing orders should be separate documents.	Consider legality and practicality of this	DACB

29.	Use of telephone and webex	Clarify where this should be stated and expectations around telephone etiquette	Working Group
30.	Role of Chairman in dispute resolution	Clarify the role in particular in those instances where the Constitution is silent.	DACB



FINAL MINUTES OF THE MEETING OF THE MEMBERS' COUNCIL
CONSTITUTION WORKING GROUP
24 January 2018
Charles West Room, Paul O'Gorman Building

Attending:

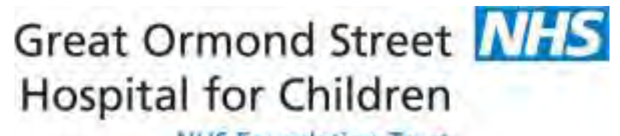
Nicola Grinstead (NG)	Deputy Chief Executive (Chairman)
Gillian Smith (GS)	Public constituency
Claudia Fisher (CF)	Patient and carer constituency
George Howell (GH)	Patient and carer constituency
Rebecca Miller (RM)	Public Constituency
Ahkter Mateen (AM)	Deputy Chairman
Jon Shick (JS)	Director, Programme Management Office
Anna Ferrant (AF)	Company Secretary (minutes)
Giles Peel (GP)	Beachcrofts
Alastair Robertson (AR)	Beachcrofts
Stephanie Needleman (SN)	Beachcrofts

Apologies:

Fran Stewart	Patient and carer constituency

1	**Welcome, Introductions and Apologies**	
1.1	Apologies were noted from Fran Stewart, Patient and carer councillor.	
1.2	Nicola Grinstead, Chairman requested introductions and stated that the purpose of this meeting was to consider the areas under the Constitution that required review, including comments on what has worked well and not so well and agree a workplan for the Group.	
1.3	The Group agreed that the Constitution was a key document, one that new councillors should be familiar with from induction onwards. It provided a framework for establishing effective relationships between the Council and the Board.	
2.	**Draft Terms of Reference**	
2.1	The draft terms of reference were reviewed. It was agreed that: • the number of councillors making up the quorum should be raised to three councillors. • The terms of reference should note the timescale that the group intended to complete the work – by June 2018, so as to provide sufficient time for consideration and approval by the Board and Council and preparation for any voting at the Annual General Meeting.	
2.2	It was noted that the ToR allowed for individuals to be invited to attend the group for advisory purposes, including a past councillor representative on relevant issues to aid transition.	
3.	**Beachcrofts – overview of the purpose of the Constitution**	
3.1	Giles Peel from Beachcrofts provided a reminder of the NHS governance framework. He said that the Constitution provided a framework for a dialogue between a Board and Council and was based upon a collective approach by both bodies. In some places, the	

	Constitution is dictated by the NHS Act and in others, guided by the Code of Governance and other guidance from NHSI.	
4. 4.1 4.2 4.3 4.4 4.5 4.6	**Review of the matters requiring change** **Action**: The group discussed the matters in the Constitution that require change or simple updating. A list was produced and it was agreed that this list would be used to establish a work programme for the group. The group discussed how to approach the different matters raised. It was noted that some were very easy to agree on and reach consensus, whilst some required more detail and examples from other trusts and others were more complex, with differing views on the changes required. The list produced would be framed according to these three groups and considered at the next meeting. **Action**: At the meeting, the Group reached a consensus on the change of name of the Council from 'Members' Council' to 'Council of Governors'. It was felt that this would enhance the identity and role of new people joining the Council and also streamline the name with most other Councils. A recommendation would be put to the Board and Council. The Group also discussed staggering the Council elections. There was a consensus that this was the right thing to do so as to avoid the situation that had occurred this year, with such a high volume turnover of councillors on the Council in one go. It would provide support for new councillors and ensure continuity for the Council and the Board as a whole. **Action**: Beachcrofts agreed to provide options for staggering elections and Claudia Fisher said that she would share some examples with the group as well. The Group discussed the make-up of councillors from different constituencies of the Council. It was agreed by all that the Trust should retain a Patient and Carer Constituency. **Action**: The Group discussed the age limit for a member to remain as a patient in this constituency. It was noted that the 6 year rule was very difficult to administer and track patients via PIMS (the patient database at GOSH). It was agreed to look at an option of having a top age limit for all patient members of 25 years old. At 25 years of age, a member would be moved in to the relevant public constituency. Under this age limit, any patients having being treated at the Trust more than 8 years ago could also be moved to the relevant public constituency. Rather than relying on a PIMS check, this would be administered by regularly asking members to update their membership information through regular requests and communications. It was agreed that Beachcrofts would review this option with any other possible options and report back to the next meeting of the Group.	 **Beachcrofts and AF** **To be raised at MC on 0702018** **Beachcrofts and CF** **Beachcrofts**
5. 5.1	**Next meeting of the Group** The Group agreed that it would consider the following matters at its next meeting: • First version of the Group workplan • Staggering elections • Options for the Patient/ Parent and Carer Constituency • Lead councillor and deputy lead councillor role description. • Non-attendance by councillors at Council meetings. • The process of removal of councillors from the Council • Formalising relationships with the YPF.	**AF**
6. 6.1	**Any Other Business** The next meeting will be held on Thursday 15 February at 10:00am – 12 Noon.	



DRAFT MINUTES OF THE MEETING OF THE MEMBERS' COUNCIL CONSTITUTION WORKING GROUP

15 February 2018

Charles West Room, Paul O'Gorman Building

Attending:

Nicola Grinstead (NG)	Deputy Chief Executive (Chairman)
Gillian Smith (GS)	Public constituency
Claudia Fisher (CF)	Patient and carer constituency
Ahkter Mateen (AM)	Deputy Chairman
Jon Shick (JS)	Director, Programme Management Office
Anna Ferrant (AF)	Company Secretary (minutes)
Graham Lawrence (GL)	Beachcrofts
Stephanie Needleman (SN)	Beachcrofts

7	**Introductions and Apologies**	
7.1	Apologies were noted from George Howell, Patient and Carer Councillor and Rebecca Miller, Public Councillor.	
7.2	The Group welcomed Mr Graham Lawrence, from Beachcrofts to his first meeting of the Group.	
8.	**Minutes of the meeting held on 24 January 2018**	
8.1	The minutes of the meeting were approved as an accurate record subject to one amendment – the replacement of the word 'would' with 'could' under minute 4.6.	
9.	**Draft workplan for the Group**	
9.1	The Group considered the workplan and approved it as a working document subject to the following: • A standard operating procedure (SOP) would be drafted outlining the expected availability and use of telephone, webex, portal and internet access for governors and including etiquette in using these media. • The word 'allowed' be replaced with the word 'constitutional' under item 23 of the workplan	
10.	**Staggering Elections**	
10.1	The Group discussed options for staggering elections. The following was recommended: • Staggering of election is essential to ensure the Council is refreshed regularly whilst at the same time preventing a large-scale change of governors at one time. • A mix of 2 year and 3 year terms should be used (a 1 year term was too short a time for a governor to get to know the Trust and effectively discharge their duties and anything longer than a 3 year term is not allowed under the Act).	

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The Trust should aim for approximately a third of councillors coming up for election each year. It was noted that this would have resource implications for the Trust (staff time and election costs)
Action: Beachcrofts would work up different options for staggering election based on:

Wait for next round of elections in 2021 and advertise for 3 or 2 year tenures
Take action now based on the voting turn-out at the recent election and agree that those with the most votes remain on 3 year tenures and those with the least votes, move to a 2 year tenure
Take action now and extend some governor terms by 1-2 years for a transitional period only, reverting back to two three year terms once the staggered election framework is in place.

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Options for the Patient, Parent and Carer Constituency – review of the 6 year rule

GL advised the Group that the NHS Act states that in retaining a patient and carer constituency, the Trust must specify a time period by which a member remains a patient or carer member (currently 6 years after the last health appointment with the Trust).

The Group discussed various options and recommended the following:

Recent experience of the Hospital as a patient or carer is key
The views of young people are particularly important and any revision to the criteria should support this principle
The 6 year rule should be amended to a 10 year rule as it was felt that such an extension continued to support the principle of capturing recent experience of Hospital services
Members would be asked to verify they can be placed in the patient /carer constituency on joining the FT. Reminders would also be sent out during the year asking members to update their personal details. Any members applying to be a councillor would also be asked at the nomination phase.

Action: It was agreed that options for the patient and carer constituency would be worked up for consideration at the next meeting.

Action: It was agreed that the lower age limit of members should be added as a workstream to the Group workplan.
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Non-attendance by governors at Council meetings

The Group discussed how non-attendance would be managed going forward and recommended the following:

The Chairman, Lead Governor and Company Secretary should consider whether the reasons for non-attendance by a governor is ‘reasonable’;
The number of meetings required for attendance will remain at 3 out of 5 meetings a year
Examples of accepted reasons for non-attendance should be drafted
Changes to meeting dates at short notice would not be counted for the purposes of non-attendance monitoring
The Company Secretary would contact a governor to request reasons for on-going non-attendance.

Action: A set of principles regarding governor non-attendance at meetings would be
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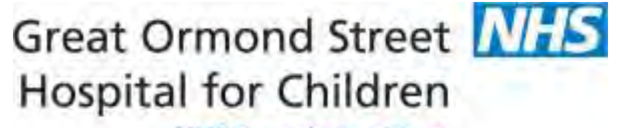
	drafted for the next meeting.	
13. 13.1 13.2	**Lead governor and deputy lead governor role description** The Group considered the various drafts of the Lead Governor role description and recommended a simpler version is developed. **Action**: The Group worked through one of the examples and agreed amendments to the wording. A revised version would be considered at the next meeting of the Group with a draft Deputy Lead Governor role description.	
14. 14.1 14.2	**Transitional arrangements going forward** NG reminded the Group that Fran Stewart had been re-elected to the Council and would therefore remain on the Group going forward. NG had also asked George Howell to remain working with the Group after the end of his tenure as a governor, as a young person representative. New governors would also join the Group. FS suggested that going forward, CF and GS could provide input on specific governance matters. NG stated that this matter would be reviewed by the new Group once appointed.	
15. 15.1 15.2	**Next meeting of the Group** The Group agreed that it would consider the following matters at its next meeting: • Establish a process for the investigation of complaints about governors and removal of governors. • Establish a process for evaluating the Council of Governors. • Include a process for what happens when something that isn't provided for in the constitution occurs • Voting requirements • Lead Governor and Deputy Lead Governor Role Description • Governor Non-attendance at meetings – principles • Staggering elections • Options for the Patient, Parent and Carer Constituency. **Action**: It was agreed that another meeting of the Group would take place over the next two weeks. Dates would be sought for an evening meeting.	



DRAFT MINUTES OF THE MEETING OF THE MEMBERS' COUNCIL CONSTITUTION WORKING GROUP

12 March 2018

Chairman's Office, Paul O'Gorman Building

Attending:

Nicola Grinstead (NG)	Deputy Chief Executive (Chairman)
George Howell (GH)	Patient and carer constituency
Claudia Fisher (CF)	Patient and carer constituency
Fran Fosher (FF)	Patient and carer constituency
Ahkter Mateen (AM)	Deputy Chairman
Jon Shick (JS)	Director, Programme Management Office
Anna Ferrant (AF)	Company Secretary (minutes)
Graham Lawrence (GL)	Beachcrofts
Stephanie Needleman (SN)	Beachcrofts

16	**Introductions and Apologies**	
16.1	Apologies were noted from Gillian Smith, Public Councillor and Rebecca Miller, Public Councillor.	
16.2	The Group welcomed Mr Graham Lawrence and Stephanie Needleham from Beachcrofts.	
17.	**Minutes of the meeting held on 15 February 2018**	
17.1	**Action**: It was noted that the minutes had not been circulated with the papers and would be emailed to members after the meeting.	**Anna Ferrant**
18.	**Phased elections**	
18.1	The Group considered the paper from Beachcrofts and the options presented on phasing of governor elections.	
18.2	The Group agreed the following: • That that subject to any by-elections, one third of the seats on the CoG should be subject to election every year. This would make it easier to administer and plan • The Council would need to decide on whether to implement the phasing in 2018 or wait until 2020 and the next election. By implementing phasing in 2018, this would mean a number of governors (approximately a third) would need to volunteer to reduce their current tenure from 3 to 1 year (the Group felt that a 1 year tenure was very short). Another third would need to agree to reduce their tenure to 2 years. Selection could be made through asking for volunteers or by number of votes received at the last election (although it was felt by the Group that this may not be very fair on governors who were new). • By waiting until the next election in 2020, the phasing could be implemented upfront and members nominating to be a councillor would be aware of the	

18.3	phasing which would be openly based on votes received. In-between now and 2020, any governor stepping down from the role would be replaced by holding an election instead of going to the next highest polled candidate in that constituency (as currently allowed under the Constitution). **Action**: A discussion would take place at the next CWG about the length of tenure of a governor on the CoG (6 years v 9 years) and this would inform further advice on the phasing options.	**Beachcrofts**
19. 19.1 19.2 19.3	**Options for the Patient, Parent and Carer Constituency** Beachcrofts reminded the group that he Constitution provides that an individual who has attended the Trust's hospitals either as a patient or as a carer of a patient within the last six years may become a member of the Patient and Carer Constituency of the Trust. At the last CWG meeting it was agreed that the group would recommend that this time period was increased to 10 years to try to balance the dual aims of (i) ensuring that individuals who were treated as relatively young children at the hospital would still be able to stand for election as governors in the Patient and Carer Constituency; and (ii) a desire that members of this constituency should have had a relatively recent experience of care at the Trust. Following a discussion of the proposed options, the Group agreed the following: • Noting the challenges with checking whether individuals are in the correct patient/ carer/ public constituency, the Trust should rely on self-declarations and regular requests for conformation of constituency from members • **Action**: That patient and carer consistencies determined by location should remain but the rationale for the make-up of the Council in terms of number of these governors should be re-run against the residence of patients treated at GOSH. • **Action**: The proportion of public governors should be mapped to the above data. • **Action**: A proposal would be brought to the Group on the total number of governors on the CoG, ensuring that the CoG remains representative.	**Anna Ferrant** **Anna Ferrant** **Anna Ferrant**
20. 20.1 20.2 20.3	**Process for the investigation of complaints about governors and removal of governors** Beachcrofts highlighted two elements: removal of a governor and investigating complaints into an alleged breach by a governor. The Group discussed the criteria for removal of a governor and agreed: • **Action**: That the current criteria for removal (a breach of the code of conduct; acting in a manner detrimental the interests of the Trust; or if it is not in the Trust's best interests for him/her to continue as a governor) should be added to, using examples of serious/ material breaches from the other trusts cited in the paper. • The Council should continue to vote on the removal of a councillor - the ¾ majority should be retained for governors present and voting with the need for a public councillor majority as is the case now. The Group then discussed investigating complaints into an alleged breach by a governor and agreed the following: • Depending on the seriousness of the breach, mediation should always be sought where appropriate	**Anna Ferrant**

	• The Code of Conduct needs to be reviewed ad updated to include reference to dealing with complaints • Managing complaints that are not material or serious should be aligned with the Trust policy as close as possible. • **Action**: The need for clarity about how a suspension is invoked is needed. In some cases suspension of an individual may be necessary to allow investigations to be conducted or if the matter is a serious breach, resulting in dismissal. There should be clarity about how and when suspension will be invoked and who will give the final approval, with reporting back to the Council on the rationale for the suspension. A standard operating procedure should be drafted for consideration. • **Action**: Where an investigation is proposed, a monitoring panel should be established (the Chairman, SID and Lead Governor). The panel could review the breach, propose the terms of reference of the investigation and timelines and report back to the Council on the rationale for and progress with the investigation. A standard operating procedure should be drafted for consideration.	**Beachcrofts** **Beachcrofts**
21. 21.1	**Next meeting** The Group agreed that the remaining items would be discussed that the next meeting of the Group (date TBC): • Process for evaluation of Council of Governors • Process to address a matter on which the Constitution is silent • Guidance on non-attendance at Council meetings.	

Attachment E Appendix 4

Appendix 4

Decision Log from Constitution Working Group – January – March 2018

Date	Minute	Decision
24-Jan-18	1.3	The Group agreed that the Constitution was a key document, one that new councillors should be familiar with from induction onwards. It provided a framework for establishing effective relationships between the Council and the Board.
24-Jan-18	2.1	The draft terms of reference were reviewed. It was agreed that: • the number of councillors making up the quorum should be raised to three councillors. • The terms of reference should note the timescale that the group intended to complete the work – by June 2018, so as to provide sufficient time for consideration and approval by the Board and Council and preparation for any voting at the Annual General Meeting.
15-Feb-18	9.1	A standard operating procedure (SOP) would be drafted outlining the expected availability and use of telephone, webex, portal and internet access for governors and including etiquette in using these media.
15-Feb-18	10.1	**Staggering elections**: • Staggering of election is essential to ensure the Council is refreshed regularly whilst at the same time preventing a large-scale change of governors at one time. • A mix of 2 year and 3 year terms should be used (a 1 year term was too short a time for a governor to get to know the Trust and effectively discharge their duties and anything longer than 3 years was not allowed under the Act). • The Trust should aim for approximately a third of councillors coming up for election each year. It was noted that this would have resource implications for the Trust (staff time and election costs)

15-Feb-18	11.1	**Patient and carer constituency:** • Recent experience of the Hospital as a patient or carer is key • The views of young people are particularly important and any revision to the criteria should support this principle • The 6 year rule should be amended to a 10 year rule as it was felt that such an extension continued to support the principle of capturing recent experience of Hospital services • Members would be asked to verify they can be placed in the patient /carer constituency on joining the FT. Reminders would also be sent out during the year asking members to update their personal details. Any members applying to be a councillor would also be asked at the nomination phase.
15-Feb-18	12.1	**Phased elections:** • The Chairman, Lead Governor and Company Secretary should consider whether the reasons for non-attendance by a governor is 'reasonable'; • The number of meetings required for attendance will remain at 3 out of 5 meetings a year • Examples of accepted reasons for non-attendance should be drafted • Changes to meeting dates at short notice would not be counted for the purposes of non-attendance monitoring • The Company Secretary would contact a governor to request reasons for on-going non-attendance.
12-Mar-18	18.2	The Group agreed the following: • That that subject to any by-elections, one third of the seats on the CoG should be subject to election every year. This would make it easier to administer and plan • The Council would need to decide on whether to implement the phasing in 2018 or wait until 2020 and the next election. By implementing phasing in 2018, this would mean a number of governors (approximately a third) would need to volunteer to reduce their current tenure from 3 to 1 year (the Group felt that a 1 year tenure was very short). Another third would need to agree to reduce their tenure to 2 years. Selection could be made through asking for volunteers or by number of votes received at the last election (although it was felt by the Group that this may not be very fair on governors who were new). • By waiting until the next election in 2020, the phasing could be implemented upfront and members nominating to be a councillor would be aware of the phasing which would be openly based on votes received. In-between now and 2020, any governor stepping down from the role would be replaced by holding an election instead of going to the next highest polled candidate in that constituency (as currently allowed under the Constitution).

12-Mar-18	19.3	**Options for the Patient, Parent and Carer Constituency** • Noting the challenges with checking whether individuals are in the correct patient/ carer/ public constituency, the Trust should rely on self-declarations and regular requests for conformation of constituency from members • That patient and carer consistencies determined by location should remain but the rationale for the make-up of the Council in terms of number of these governors should be re-run against the residence of patients treated at GOSH. • The proportion of public governors should be mapped to the above data. • A proposal would be brought to the Group on the total number of governors on the CoG, ensuring that the CoG remains representative.
12-Mar-18	20.2 and 20.3	**Process for the investigation of complaints about governors and removal of governors** The Group discussed the criteria for removal of a governor and agreed: • Action: That the current criteria for removal (a breach of the code of conduct; acting in a manner detrimental the interests of the Trust; or if it is not in the Trust's best interests for him/her to continue as a governor) should be added to, using examples of serious/ material breaches from the other trusts cited in the paper. • The Council should continue to vote on the removal of a councillor - the ¾ majority should be retained for governors present and voting with the need for a public councillor majority as is the case now. The Group then discussed investigating complaints into an alleged breach by a governor and agreed the following: • Depending on the seriousness of the breach, mediation should always be sought where appropriate • The Code of Conduct needs to be reviewed ad updated to include reference to dealing with complaints • Managing complaints that are not material or serious should be aligned with the Trust policy as close as possible. • Action: The need for clarity about how a suspension is invoked is needed. In some cases suspension of an individual may be necessary to allow investigations to be conducted or if the matter is a serious breach, resulting in dismissal. There should be clarity about how and when suspension will be invoked and who will give the final approval, with reporting back to the Council on the rationale for the suspension. A standard operating procedure should be drafted for consideration. • Action: Where an investigation is proposed, a monitoring panel should be established (the Chairman, SID and Lead Governor). The panel could review the breach, propose the terms of reference of the investigation and timelines and report back to the Council on the rationale for and progress with the investigation. A standard operating procedure should be drafted for consideration.

Appendix 5

Role of the Lead Governor (from the Code of Governance July 2014).

The lead governor has a role to play in facilitating direct communication between Monitor and the NHS foundation trust's council of governors. This will be in a limited number of circumstances and, in particular, where it may not be appropriate to communicate through the normal channels, which in most cases will be via the chairperson or the trust secretary, if one is appointed.

It is not anticipated that there will be regular direct contact between Monitor and the council of governors in the ordinary course of business. Where this is necessary, it is important that it happens quickly and in an effective manner. To this end, a lead governor should be nominated and contact details provided to Monitor, and then updated as required. The lead governor may be any of the governors.

The main circumstances where Monitor will contact a lead governor are where Monitor has concerns as to board leadership provided to an NHS foundation trust, and those concerns may in time lead to the use by Monitor's board of its formal powers to remove the chairperson or non-executive directors. The council of governors appoints the chairperson and non-executive directors, and it will usually be the case that Monitor will wish to understand the views of the governors as to the capacity and capability of these individuals to lead the trust, and to rectify successfully any issues, and also for the governors to understand Monitor's concerns.

Monitor does not, however, envisage direct communication with the governors until such time as there is a real risk that an NHS foundation trust may be in significant breach of its licence. Once there is a risk that this may be the case, and the likely issue is one of board leadership, Monitor will often wish to have direct contact with the NHS foundation trust's governors, but at speed and through one established point of contact, the trust's nominated lead governor. The lead governor should take steps to understand Monitor's role, the available guidance and the basis on which Monitor may take regulatory action. The lead governor will then be able to communicate more widely with other governors.

Similarly, where individual governors wish to contact Monitor, this would be expected to be through the lead governor.

The other circumstance where Monitor may wish to contact a lead governor is where, as the regulator, we have been made aware that the process for the appointment of the chairperson or other members of the board, or elections for governors, or other material decisions, may not have complied with the NHS foundation trust's constitution, or alternatively, whilst complying with the trust's constitution, may be inappropriate.

In such circumstances, where the chairperson, other members of the board of directors or the trust secretary may have been involved in the process by which these appointments or other decisions were made, a lead governor may provide a point of contact for Monitor.

Accordingly, the NHS foundation trust should nominate a lead governor, and to continue to update Monitor with their contact details as and when these change.

Governors Guide (2013)

Lead governor

Monitor has asked all NHS foundation trusts to nominate a "lead governor". This individual will liaise between Monitor and the council of governors where, for example, we have concerns about the leadership provided to an NHS foundation trust or in circumstances where it would be inappropriate for the chair to contact us, or vice versa (for example, regarding concerns about the appointment or removal of the chair).

However, the term "lead governor" has created some confusion. Monitor did not intend the person holding this role to "lead" the council of governors or assume greater power or responsibility than other governors. We recognise that many NHS foundation trusts have broadened the original intention of this role and given greater responsibility or power to their lead governor. Every trust can decide how best to structure its own council; we continue to require only that the lead governor act as a point of contact between Monitor and the council of governors when needed. Directors and governors alike should always remember that the council of governors as a whole has the responsibilities and powers in statute, and not individual governors.

Where NHS foundation trusts choose to broaden the lead governor's role, directors and the council of governors should agree what it should and should not include. The council of governors should vote on or otherwise decide who the lead governor will be; directors (including the chair) should not be involved in this process.

Having a lead governor does not, in itself, prevent any other governor from making contact with Monitor directly if they feel this is necessary. The Independent Panel for Advising Governors can provide advice if the council approves the submission of a question to it (see Chapter 3).

Communication from Monitor to governors will, as a matter of course, be disseminated by trust secretaries.

DRAFT LEAD GOVERNOR ROLE DESCRIPTION

Principal responsibilities

- To support the Chairman in facilitating a continuing good relationship between the Council of Governors (CoG) and the Board of Directors (the Board).[1]
- To bring to the Chairman's attention any material issues from the Governors.
- To work towards the effectiveness of the CoG and its subcommittees, including supporting the Chairman and Company Secretary in organising any evaluation of the CoG.
- Contribute to the induction process for newly appointed or elected Governors.
- To act as the point of contact between the Governors and NHS Improvement[2].

Specific Lead Governor tasks

- To chair the CoG pre-meeting as required and to ensure that any material matters discussed there are brought to the attention of the CoG and the Chairman.
- To chair meetings of the COG that cannot be chaired by the Chairman, Deputy Chairman or another Non-Executive due to a conflict of interest or any other absence.
- To be a member of the Nominations & Remunerations Committee and any other committees established by the CoG.[3]
- In accordance with the process approved by the CoG, to collate the input of Governors for the senior independent director of chairman for the Non-Executive Directors' and Chairman's annual appraisals.
- To liaise with the Company Secretary/ Deputy Company Secretary as and when concerns are raised by Governors.
- Be involved with setting the agendas for the Council of Governors;
- Support the Chair in acting to remove a Governor due to unconstitutional behaviour.

The Person Specification

To be able to fulfil this role effectively, the Lead Governor will:

- Have integrity in accordance with the Nolan Principles (*The 7 Principles of Public Life*), the Code of Conduct for Governors and be committed to the values of the Foundation Trust.

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[1] To include: Where requested by the Chairman, supporting him/her in contacting the CoG or groups of Governors, or in understanding Governors' views on any matter and where approved by the COG and the Chairman, speaking for and represent the COG at the Trust's Annual Members' Meeting or any other occasion.

[2] The Lead Governor may only contact NHS Improvement (NHSI), the organisation which includes Monitor, after authorisation from the Council of Governors (COG) and only when all reasonable efforts have been made to resolve the matters that are of concern to the COG. The Lead Governor may only act as a contact between the Governors and NHSI when the normal channels of communication are unavailable.

[3] The COG may agree that the Lead Governor must share this responsibility with the Deputy Lead Governor.

- Enjoy the confidence of the CoG and the Chairman.

- Have an understanding of the statutory duties of Governors, the Trust's Constitution and how the Trust is influenced or regulated by other organisations including the role of and basis that NHS Improvement may take action.

- Have the ability to chair meetings in a manner that works in the best interests of patients and of the Foundation Trust in accordance with the Code of Conduct for Governors.

- Have a willingness to challenge constructively and the ability to influence, negotiate and present a well-reasoned argument.

- Be able to commit the time necessary to represent the position and wishes of Governors in a manner that has their confidence.

- Maintain the confidentiality of information.

Conditions of appointment and Term of Office

- A Governor will nominate themselves (including an outline of the relevant experience) and be appointed or elected by the CoG by a 'show of hands' or by a secret ballot as determined by the relevant Council meeting.

- The Lead Governor (and the Deputy Lead Governor) must be elected governors. A staff governor may only be appointed as Lead or Deputy in a situation where he/ she will serve with a publicly appointed governor. Thus a staff governor may stand for election as Deputy only if the Lead is a publicly elected governor.[4]

- The tenure is one financial year with the option for re-election annually in accordance with due process, for up to the full tenure period of the elected Governor's 'appointment' (subject to removal from office, removal as a Governor or member or any resignation)

- The Lead Governor will be supported and deputised for by a Deputy Lead Governor whose appointment will follow the same procedure above. It is anticipated, where terms of office accord, that the Deputy Lead Governor will put themselves forward for Lead Governor position when that position becomes vacant, remaining subject to the appointment process above.

- Requirements for removal of any Governor from the Lead Governor role will be determined as part of the review of the Constitution.

Approval and review of this document

This document will be reviewed not less than annually.

<u>Deputy Lead Governor</u>

The role of the Deputy Lead Governor is to support the Lead Governor and deputise for him or her when necessary.

[4] Where the Lead Governor is a staff governor, in any situation where the Lead Governor's position as an employee of the Trust gives rise to a position of potential conflict, the Deputy Lead shall act as Lead until the next meeting of the Council, when the situation shall be considered and a decision made as to how it shall be handled.

Attachment F

Council of Governors

25 April 2018

Process for election to the Council of Governors' Nominations and Remuneration Committee

Summary & reason for item:

The purpose of this paper is to:

- provide the Council of Governors with an overview of the Council of Governors' Nominations and Remuneration Committee including its role within a Foundation Trust, the remit, responsibilities and meeting frequency; and
- invite four Governors to nominate themselves to become members of the Committee. Where more than four Governors nominate themselves, a secret ballot will be held at the meeting.

Governor action required:

- Express an interest to join the Committee by **Tuesday 24 April at 4.00pm (emailing Paul.balson@gosh.nhs.uk)**
- Approve the revised terms of reference for the committee (amendments in red text)

Report prepared by:

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

Report presented by:

Anna Ferrant, Company Secretary

Background

The NHS Foundation Trust Code of Governance (the Code) is guidance that helps NHS foundation trusts to deliver effective corporate governance.

One statutory duty within this document is for: *the council of governors to hold the non-executive directors individually and collectively to account.*

The Council of Governors are able to accomplish this through approving:

- Non-Executive Director appointments, and
- Non-Executive Director remuneration

The Code of governance requires that these tasks are carried by a Committee. Great Ormond Street Hospital Foundation Trust has one Committee, to determine both Non-Executive Director nominations and remuneration.

Remit of the Council of Governors Nominations and Remuneration Committee (the Committee)

For full details of the remit, responsibilities, membership, and frequency of meetings please refer to the terms of reference for the committee, included as Appendix 1. This section of the report provides a top level summary.

As noted above, the remit of the Committee is split between: a nominations role and a remuneration role.

Nominations role

The committee reviews the balance of skills, knowledge, experience and diversity of the non-executive directors on the board; both in terms of its ability to address immediate and future challenges and opportunities. It makes recommendations as appropriate, following these periodical reviews.

The committee agrees and carries out a process for the interviewing, nomination and selection of a chairman and non-executive directors when appropriate.

Remuneration role

The committee decides and reviews the terms and conditions of office of the foundation trust's non-executive directors in accordance with all relevant foundation trust policies (including remuneration).

Support

The Committee receives full support from the Corporate Affairs Division to deliver its functions. Additionally, it is authorised to request internal advice or attendance of professional advisors from outside the foundation trust with relevant experience and expertise, if it considers this necessary.

Membership

Membership and voting rights are as follows:

- Chairman of the Trust (Chair of Committee)
- Deputy chairman
- Lead Governor (this is a new addition to the Committee as proposed by the Constitution Working Group and included in the attached terms of reference)
- Two Governors from the public constituency and/or the patient and carer constituency,

- One staff Governor
- One Governor from any constituency (patient and carer, public, staff or appointed).

Each member of the committee shall have one vote.

Each Governor member nominates themselves to be a member of the Committee for one year, up to a total of three years.

Meeting frequency

The Committee meets mostly as and when a nomination or remuneration decision is required. However, the Committee will meet not less than once a year.

Summary

In summary, the Committee works to consider skills and experience required in our Non-Executive Directors, nominates, interviews and appoints our Non-Executives, monitors the output from the appraisal process and then determines their remuneration while in post.

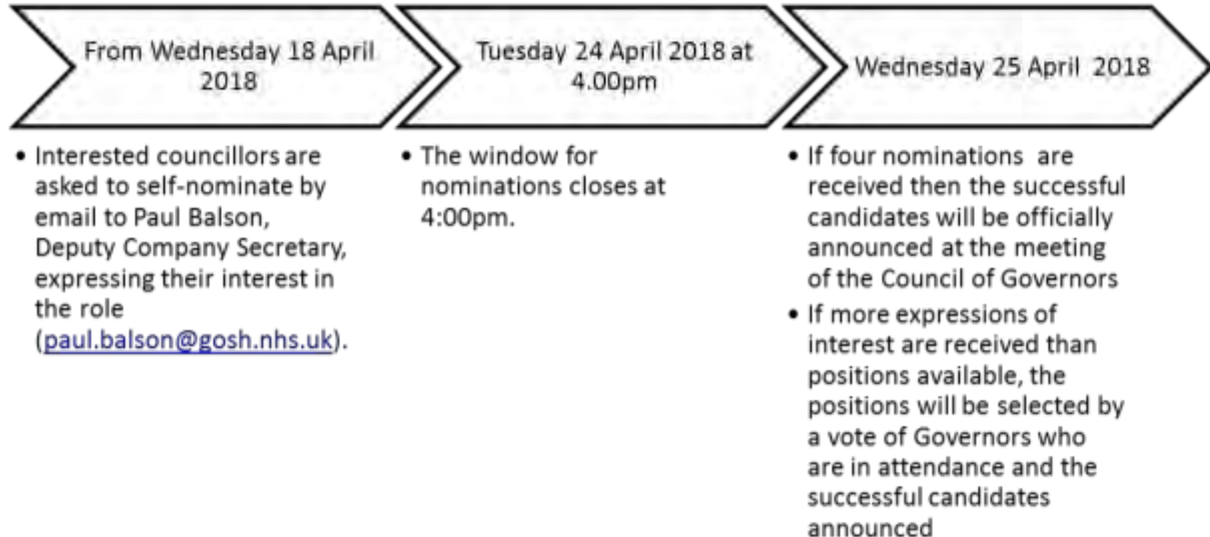
Being a member of this Committee is an important, interesting and varied role.

Nomination/appointment process

As the purpose of this paper stated, the Committee requires four Governors to nominate themselves to become members. Wherever possible, a mix of nominations will be sought from Governors within their first and second term on the Council. In addition to the Chairman, Deputy Chairman and the Lead Governor of the Trust, the Committee requires:

- two Governors from the public constituency and/or the patient and carer constituency
- one staff Governor and
- one Governor from any constituency (patient and carer, public, staff or appointed).

The process for nominations will be as follows:



The voting process will be overseen by the Chair of the Trust (and Chair of the Committee)

Appendix 1

Council of Governors Nominations and Remuneration Committee

Draft Terms of Reference

The council of governor's nominations and remuneration committee is authorised by the council of governors to act within its terms of reference. All members of staff are requested to co-operate with any reasonable request made by the council of governor's 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

2.1 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.

2.2 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.

2.3 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 Council of Governors nominations and remuneration committee will comprise the chairman of the trust, the deputy chairman, the lead governor, two Governors from the public constituency and/or the patient and carer constituency, one staff Governor and one Governor 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 Council of Governors will nominate themselves on an annual basis to sit on the Committee. The total length of tenure on the committee for a Governor will normally be 3 years.

4.5 Where the number of Governors prepared to serve on the committee is greater that the number of places available, then committee members will be selected by election by their Governor peers. Wherever possible, a mix of nominations will be sought from Governors within their first and second term on the Council of Governors.

4.6 A quorum shall be five members, including the chairman or deputy chairman and at least one Governor 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.

April 2018

Council of Governors

25 April 2018

Nominations for appointment to the Council of Governors Membership Representation, Recruitment and Engagement Committee

Purpose

The purpose of this paper is to:

- provide the Council of Governors with an overview of the Council of Governors' Membership Representation, Recruitment and Engagement Committee including its role within a Foundation Trust, the remit, responsibilities and meeting frequency; and,
- invite expressions of interest from the Council of Governors in serving on the committee for its 2018-21 term;
- To note the process for election to the role of Chair to the Committee.

Governor action required:

- consider nominating themselves to sit on the Group and to inform the Deputy Company Secretary of their interest by email (paul.balson@gosh.nhs.uk) prior to the meeting.
- Express an interest to join the Committee by **Tuesday 24 April at 5.00pm**
- Approve the revised terms of reference for the committee (only change has been the correction of 'Members' council' to 'Council of Governors'.

Report prepared by:

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

Report presented by:

Anna Ferrant, Company Secretary

Remit of the Council of Governors Membership Representation, Recruitment and Engagement Committee

For full details of the remit, responsibilities, membership, and frequency of meetings please refer to the terms of reference for the committee, included as Appendix 1. This section of the report provides a top level summary.

The purpose of the Committee is to oversee the recruitment and retention of members and maximise engagement opportunities for the members. It achieves this through:

- Developing, monitoring and reviewing the 'Membership and Engagement Strategy', 'Recruitment Plan' and associated action plans.
- Identifying and developing engagement opportunities and actions for growing a representative membership.
- Considering the requirements of Governors in communicating with their constituencies, between themselves and with the Board of Directors.

Support

The Committee will receive full support from the Corporate Affairs Division to deliver its functions with additional support from the Patient Experience Team and Volunteering Team as necessary.

Membership

The Membership Representation, Recruitment and Engagement Committee is made up of the following members:

- Ten Governors (at least six Governors are from the Patient and Carer or Public Constituencies)
- Head of Volunteer Services
- PPI and Patient Experience Officer
- Junior Membership Marketing Manager
- Senior Retention Manager
- Company Secretary
- Deputy Company Secretary

The Chair of the Committee will be elected from the Governor members.

Meeting frequency

The Committee will meet on a quarterly basis allowing timely reporting to the Council of Governors

Summary

In summary, the Committee works to identify innovative ways to attract, retain and how to best utilise members from the various constituencies. There are no specific skills required to sit on the committee, just an interest

Being a member of this Committee requires a specific and inventive skill set.

Nomination / appointment process

Governors are advised to read the full terms of reference at appendix 1 prior to considering nominating themselves.

Interested councillors are asked to self-nominate by email to Paul Balson, Deputy Company Secretary, expressing their interest in the role (paul.balson@gosh.nhs.uk).

Successful candidates will be officially announced at the meeting of the Council of Governors on 25 April 2018

Election to the role of Chair

Nominations for election to the role of Chair of the committee will be invited at the first meeting of the Membership Representation, Recruitment and Engagement Committee.

Appendix 1

Membership Representation, Recruitment and Engagement Committee. Committee

Terms of Reference

1. Authority and Scope

The Membership and Engagement Committee is a subcommittee of the Council of Governors of Great Ormond Street Hospital NHS Foundation Trust and is chaired by a public or patient/carer Governor.

The Committee has delegated authority from the Council of Governors to make decisions on behalf of and be accountable to the Council of Governors for recruiting and engaging with the Trust's membership and representing the interests of the patients, carers, families and the general public in the areas served by the Trust.

2. Purpose

The purpose of the Committee is to oversee the recruitment and retention of members and maximise engagement opportunities for the members.

3. Duties

Membership

3.1 Review the Membership and Engagement Strategy and Recruitment Plan

3.2 Develop a work programme and action plan and review and monitor progress.

3.3 Consider actions for growing a representative membership.

3.4 Identify and develop engagement opportunities and events, working alongside the Patient Experience Team and Volunteering Team.

3.5 Agree the promotion and involvement required from Governors to ensure appropriate support at all recruitment and engagement events.

3.6 Review the membership profile against the demography of the population to inform decisions on future membership strategy and activities.

3.7 Review the effectiveness of the annual recruitment activities and engagement events.

3.8 Present an annual report on the Membership and Engagement Strategy at the annual members meeting.

Communication

3.9 Develop communication tools to support implementation of the Membership and Engagement Strategy and Recruitment Plan that are of use to all membership and the wider public (regardless of age or language).

3.10 Consider the requirements of Governors in communicating with

- their constituencies
- between themselves and
- with the Board of Directors
- and recommend tools to aid communication.

3.11 Develop quality monitoring systems for Foundation Trust membership and communications and provide assurance to the Council of Governorsthat the Foundation Trust membership is being appropriately communicated with.

3.12 Review membership recruitment material and the welcome and introduction pack for members.

3.13 Review communication methods for members. These will include:

- Newsletter (Members' Matters)
- Volunteers Newsletter
- E mail communications (including with staff)
- Regular contributions in the Roundabout
- Communication via the internet

3.14 Oversee content/production of Members' Matters' Newsletter

3.15 Work closely with the Communications & Marketing Team to maximise opportunities for positive public relations using the media and other fora to promote the Trust.

4. Reporting

4.1 The Committee will report to the Council of Governors on a quarterly basis. This will be in the format of a submission of minutes and summary report.

<u>Membership</u>

4.2 The Membership and Engagement Committee is made up of the following members:

- Ten representatives of the Council of Governors of which at least six representatives are from the Patient and Carer or Public Constituencies;
- Head of Volunteer Services
- PPI and Patient Experience Officer
- Junior Membership Marketing Manager
- Senior Retention Manager
- Company Secretary

4.3 Additional members may be invited to attend the Committee as appropriate.

4.4 The Chair of the Committee will be elected from the Governor representatives.

4.5 For a quorum, there must be a minimum of seven members present, including at least three Patient/Carer or Public Governors, the Company Secretary or the Head of Volunteer Services

5. Meetings

5.1 Meetings will be held on a quarterly basis allowing timely reporting to the Members' Council.

5.2 Members will be expected to attend a minimum of two meetings out of four meetings per year.

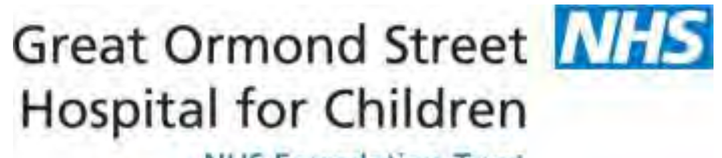
5.3 Papers will be sent out at least four working days before the meeting.

5.4 Secretariat support for the Committee will be provided by the Company Secretary/ Trust Board Administrator.

6. Monitoring

The Committee shall review its terms of reference on an annual basis.

April 2018



Council of Governors

25 April 2018

Process for the appointment of a non-executive director at Great Ormond Street Hospital for Children NHS Foundation Trust

Summary & reason for item:

To outline the proposed appointment process for a non-executive director.

Councillor action required:

To approve the process, including the person specification, amended terms and conditions of service and draft timetable for the appointment.

Author: Dr Anna Ferrant, Company Secretary

Presented by: Dr Anna Ferrant, Company Secretary

PROCESS FOR THE APPOINTMENT OF A NON-EXECUTIVE DIRECTOR ON THE BOARD OF DIRECTORS OF GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST

1. PURPOSE

This paper outlines the proposed process for the appointment of a non-executive director 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 appointment

Professor Stephen Smith, non-executive director (NED) and Chairman of the Quality and Safety Assurance Committee has been appointed as Chairman of the East Kent Hospitals Foundation Trust from 1 March 2018. Professor Smith was appointed to the FT Board on 1 March 2016. It was agreed for the purposes of effective Board stewardship (handover in his role as chairman of a Board assurance committee) and noting the limited opportunity for conflict for Professor Smith or the Trust, that Professor Smith would remain on the GOSH Board until the end of May 2018.

The plan is to finalise the NED appointment by end June 2018, advertising the position in during May 2018 (see Appendix 4 for the draft timetable).

2.2. Composition of the Board and review by the Board of Directors

Currently the Board of Directors includes the Chairman, six Non-Executive Directors 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 January 2018, the CQC conducted a routine, scheduled Well Led Governance Review. In the report, CQC stated that “*The trust had an experienced leadership team with the skills, abilities, and commitment to provide high-quality services*.”

In the last 12 months, the Council has appointed two new NEDs: Lady Amanda Ellingworth (with a social worker background) and Mr Chris Kennedy (with an accountancy background). Both positions were agreed by the Council to complement the skills and experience necessary to balance the Board membership and deliver the current strategy.

When considering the appointment of a new NED to the Board it is important to consider the experience and knowledge of the Board as a whole (NEDs and executive directors). Every 12-18 months, the Board refreshes the experience and knowledge audit (see **Appendix 1**). Following review of the findings of this self-assessment audit, a draft person specification for a new NED on the Board is proposed.

2.3. Person specification for a new NED

Professor Smith has considerable experience within the healthcare sector, both in this country and internationally as both a clinician and a healthcare leader (Stephen was Dean of Medicine at Imperial College and Chief Executive of Imperial College Healthcare NHS Trust from 2007-2011 and most recently Dean of the Faculty of Medicine at the University of Melbourne and Chair of the Melbourne Academic Centre for Health until October 2015. His knowledge and experience have informed chairing the Quality and Safety Assurance Committee (an assurance committee of the Board).

The Board is fortunate enough to have appointed Amanda Ellingworth to the Board from January 2018. Amanda was a senior social worker focusing on children and families before moving into Board level role. Amanda is Chair of Plan International UK and Deputy Chair of Barnado's, the major children's charity. She will take over chairing the QSAC from end May 2018.

Findings from the experience and knowledge audit reveal:

Almost all NEDS and executives assessed themselves as having a high or medium level of experience and knowledge in the following areas:

- leading a large complex organisation (finance and governance experience) across private, academic and public sectors;
- strategy and planning;
- quality improvement systems;
- operational management/ performance management;
- partnership and stakeholder building;
- education and training in clinical and non-clinical settings
- research in clinical or non-clinical settings
- organisational development/ change management;
- project management and contract management;
- working with IT ;
- human resources and employee relations;
- experience of improving customer service.

Almost all NEDS assessed themselves as having a high or medium level of experience and knowledge in the following areas:

- Acting independently as a director/ NED in another organization
- Corporate social responsibility
- Sustainability
- Productivity and efficiency

All of the above areas are the fundamental building blocks of the framework for the Trust strategy and provide assurance that the Board is sufficiently experienced and informed to implement, deliver and monitor the strategy going forward.

It is also noted:

- There is extensive governance experience at executive and non-executive roles in the private, public, academic and voluntary sectors
- There is a good level of experience and knowledge in property development and undertaking mergers and acquisitions, and this can be viewed as sufficient for the purposes of delivery of the refreshed Trust strategy (independent professional advice would inevitability be sought in such situations).

- There is an extremely high level of experience and knowledge in healthcare settings amongst executive members (covering the key areas of the strategy on clinical outcomes, education and research) and a lower level of experience and knowledge amongst NEDs, which is to be expected and is appropriate when considering the complex healthcare and commercial landscape the Trust operates in. Professor Rosalind Smyth, James Hatchley and Lady Amanda Ellingworth have high and medium levels of experience and knowledge in these areas and provide robust scrutiny of quality and safety matters at the Quality and Safety Assurance Committee.
- There is a very low level of experience and knowledge in the area of law across executive and NED Board members.

Taking account of the complexity of the NHS landscape, the ever increasing legal and regulatory burden placed on the Trust, and the need for scrutiny of extensive transaction management and integrity of the Trust's processes, it is proposed that the Trust advertises for a Non-Executive Director with a strong background and understanding of corporate law. The role description is attached at **Appendix 2a** which was previously approved by the Council and Board. A draft person specification is attached at **Appendix 2b** which highlights the need for knowledge of some of the following areas: corporate/public law, collaborations and business partnerships, joint ventures, company law, corporate governance, commercial and business law and contracts and procurement (including EU requirements). Professional scrutiny and assurance from a NED with this background and knowledge will support the Board to deliver the strategy with particular reference to complex future commercial and redevelopment plans.

Terms and Conditions of Service

The NED terms and conditions of service was previously approved by the Council in April 2017. With one minor change to reference to the General Data Protection Regulations, the Council is asked to approve the document (**see Appendix 3**).

2.4. Use of recruitment consultants

The Trust plans to use recruitment consultants, Harvey Nash to support the NED appointment and conduct the search.

Harvey Nash has conducted the Chairman and recent NED searches for the Trust and has been professional and responsive throughout these processes. The company appreciates the importance of the Trust's profile and reputation as an NHS Foundation Trust and international centre of excellence for paediatric healthcare. It recognises the importance of the relationships with GOSH's key stakeholders and the stature and significant experience required of a candidate to undertake the role at GOSH. This includes experience of having led similar originations of scale and complexity and possession of exceptional engagement and stakeholder management skills.

3. APPOINTMENT PROCESS

The Code of Governance provides a high level overview of the principles of an effective NED appointment process. Details are provided at **Appendix 4.**

The appointment of a Non-Executive Director 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 (see below for further detail).

The following process is proposed for appointment of a NED at GOSH:

3.1. 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.

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 5**.

3.2. Long-list

The recruitment consultant will analyse the applications and provide a long list of suitable candidates against the person specification.

3.3. Shortlist

The recruitment advisers will hold assessment interviews with short-listed list applicants and present a report on the most suitable candidates as assessed against the person specification and taking into account the findings of the assessment interview process (covering quality aspects, candidate interests) and any information pertinent to the fit and proper persons test.

The Council Nominations and Remuneration Committee will finalise the 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 3-4 candidates.

3.4. References

If possible, two references will be provided for shortlisted candidates.

3.5. 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.

3.6. 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.

3.7. Decision and Recommendation of appointee

The Interview Panel will seek to arrive at an agreed decision on a preferred candidate 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 will include qualification checks. It will also be subject to approval by the Council of Governors.

3.8. Interview Panel

The role of the panel is to make a recommendation to the Council for a preferred candidate to be appointed to the role 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:

- Chairman of the Board, Council of Governors and the Council Nominations and Remuneration Committee (voting)
- A NED (voting)
- Three (out of the five) members of the Members' Council Nomination & Remuneration Committee (voting).

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.

4. RECOMMENDATION

The Council is asked to approve the following:

- The job description for the new NED position at GOSH.
- The amended terms and conditions of service for a non-executive director
- The proposed appointment process.
- The proposed draft timetable for the appointment.

Attachment H

Appendix 1: Results of the 2018 Experience and Knowledge Self-Assessment

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;	Experience of working in a healthcare setting	Experience / knowledge of working with patients: in the voluntary sector or community	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	Corporate law	Acting independently as a Director and/or NED in another organisation	Corporate Social Responsibility	Sustainability	Productivity and efficiency management
NON-EXECUTIVE DIRECTORS																							
Michael Rake	H	H	N	N	H	H	H	H	H	H	H	M	M	H	H	H	H	H	M	H	H	H	H
Akhter Mateen	H	H	N	N	H	H	H	H	M	H	H	M	H	H	H	H	H	H	M	H	H	H	H
Rosalind Smyth	M	H	H	H	H	H	H	H	M	H	M	H	H	H	H	H	M	H	N	H	H	M	H
James Hatchley	H	H	N	M	M	H	M	H	M	H	H	M	M	H	M	M	M	M	M	H	M	M	M
Amanda Ellingworth	M	H	M	H	H	H	H	M	N	H	M	N	M	M	H	M	N	H	N	H	H	M	H
Chris Kennedy	H	H	N	N	H	H	M	H	M	H	H	N	N	M	H	H	H	H	M	H	M	M	M
EXECUTIVE DIRECTORS																							
Peter Steer (V)	H	H	H	H	H	H	M	H	M	H	M	H	H	M	H	M	M	H	M				
Nicola Grinstead (V)	H	H	H	H	H	H	M	H	M	H	N	N	M	M	H	H	M	M	N				
Helen Jameson (Interim) (V)	H	H	H	M	H	H	H	H	M	H	M	M	H	M	H	H	H	H	M				
Ali Mohammed (V)	H	H	H	M	H	H	M	H	M	H	H	M	H	H	H	H	M	H	M				
Matthew Shaw (V)	M	H	H	H	H	H	H	H	M	H	M	H	H	M	H	M	H	M	N				
Alison Robertson (V)	H	H	H	H	H	H	H	H	M	H	N	M	H	H	H	H	M	H	N				
Cymbeline Moore (NV)	M	M	H	M	H	H	M	M	M	H	M	M	M	M	M	M	M	M	M				
Matthew Tulley (NV)	H	H	H	M	H	H	M	M	H	M	M	M	M	M	M	H	M	M	M				
David Goldblatt (NV)	M	M	M	M	H	M	N	N	N	M	N	H	M	N	M	N	N	H	M				

*Professor Stephen Smith (NED) is stepping down and so is not included in this assessment

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;

- 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. Board activities

- 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.

Non-Executive Director

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 (partner)/ Board commercial law role within a large/complex/changing organisation.
- Comprehensive knowledge of corporate/public law including areas such as collaborations and business partnerships, joint ventures, company law, corporate governance, commercial and business law, contracts and procurement (including EU requirements).
- 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, Governors 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 of delivering and/ or improving patient, family, service user, client or customer services.

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 General Data Protection Regulations) 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 April 2018

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 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 you fail to meet the requirements of the Fit and Proper Person Test.

Appendix 4: Code of Governance

B.2.a There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. Directors of NHS foundation trusts must be "fit and proper" to meet the requirements of the general conditions of the provider licence.

B.2.b The search for candidates for the board of directors should be conducted, and appointments made, on merit, against objective criteria and with due regard for the benefits of diversity on the board and the requirements of the trust.

B.2.c The board of directors and the council of governors should also satisfy themselves that plans are in place for orderly succession for appointments to the board, so as to maintain an appropriate balance of skills and experience within the NHS foundation trust and on the board.

B.2.1 The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the NHS foundation trust and the skills and expertise required within the board of directors to meet them.

B.2.2. Directors on the board of directors and governors on the council of governors should meet the "fit and proper" persons test described in the provider licence. For the purpose of the licence and application criteria, "fit and proper" persons are defined as those without certain recent criminal convictions and director disqualifications, and those who are not bankrupt (undischarged). Trusts should also abide by the updated guidance from the CQC regarding appointments to senior positions in organisations subject to CQC regulations.

B.2.3 ….The nominations committee(s) should regularly review the structure, size and composition of the board of directors and make recommendations for changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge and experience on the board of directors and, in the light of this evaluation, prepare a description of the role and capabilities required for appointment of both executive and non-executive directors, including the chairperson.

B.2.4 The chairperson or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chairman.

B.2.5 The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors. Once suitable candidates have been identified the nominations committee should make recommendations to the council of governors.

B.2.6 Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors.

B.2.7. 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.

B.2.9 An independent external adviser should not be a member of or have a vote on the nominations committee(s).

Appendix 4

Great Ormond Street Hospital for Children NHS Foundation Trust

Non-Executive Director Appointment Process

Indicative Milestones

Date	Activity
26 April 2018	Begin market mapping, develop a micro-site to support the searches
27 April 2018	Micro-site goes live
29 April 2018	Advert to appear in chosen media – (Sunday Times)
29 May 2018	Closing date for applications
4 June 2018	Analyse applications and dispatch to the Trust
w/c 4 June 2018	Council of Governors' Nominations and Remuneration Committee to agree short-list and interview panel
w/c 11 June 2018	Harvey Nash assessment interviews with short listed candidates
w/c 18 June 2018	Agree final shortlist with Trust and hold an information session for Governor interview panel members
w/c 25 June 2018	Final interviews
25 July 2018	Council of Governor's Approval (subject to checks)

Attachment P

Council of Governors

25 April 2018

Appraisal of the Non-Executive Directors 2018

Summary & reason for item:

To present the process for Chairman and NED appraisal in 2018.

Councillor action required:

To consider and approve the process.

Presented by: Michael Rake, Chairman/ Anna Ferrant, Company Secretary

Appraisal of the Non-Executive Directors 2018

1. **Introduction**

1.1 The purpose of this paper is to outline the process for appraising the Chairman and Non-Executive Directors (NEDs) in 2018.

1.3 **Appendix 1** provides a summary of the guidance on chairman and NED appraisals, outlined in Monitor's *Your statutory duties; A reference guide for NHS foundation trust governors' – August 2013* and in Monitor's *Code of Governance* (July 2014).

The Council of Governors agrees the process for appraising the Chairman. **The focus of the Chairman's appraisal is his performance as chair of the board of directors.**

The Council of Governors and the Chairman agree a process for evaluating the non-executive directors.

Governors have an opportunity to provide soundings on the performance of the Chairman and the NEDs. Theses soundings, along with other information, are used to inform the output of the appraisals. The evaluations are shared with the Council for agreement.

Appraisal process

The Chairman individually appraises each non-executive director. To inform this process:

- The Chairman collates soundings from the Governors on the performance of each of the NEDs. A process will be agreed to collate these soundings (please see below). The Chairman will also provide an opportunity for Governors to report directly to him with their comments in a private meeting of Governors prior to the November 2018 Council meeting.
- The Chairman will collate soundings from the Chief Executive who will canvass views about each NED from the executives.

The Senior Independent Director (SID) appraises the Chairman. To inform this process, the SID will collate soundings from the NEDs, the executive directors (through the Chief Executive) and the Governors.

An appraisal proforma will be completed during the appraisal. A rating will be agreed to describe the overall contribution of the individual. Should any disagreement arise between the Senior Independent Director/ Chairman or the Chairman/ Non-Executive Director on the rating, the Chairman/Senior Independent Director will provide a written summary of the difference which will be presented to the Council of Governors' Nominations and Remuneration Committee and reported to the Council for noting.

A summary report will be submitted to the Council of Governors' Nominations and Remuneration Committee and a report presented to the Council for approval.

Collation of soundings

Over the next few months, Governors will have the opportunity to meet the Chairman and NEDs and get to know them individually and their role and how they work. The following opportunities will be available:

- NEDs attend the Council meetings and provide reports on the work of the assurance committees and respond to questions raised by Governors on the performance of the Board.
- Governors are invited to observe the work of the NEDs in the Board assurance committees and at Board meetings during the year.
- Governors will be given the opportunity to have a NED allocated as a buddy and meet them in-between Council meetings during the year.
- The Chairman will meet with Governors prior to every Council meeting in a private session.
- The Chairman will speak with the Lead Governor and Deputy lead Governor on a monthly basis and issues fed back to Governors via the LG/DLG.

In 2016, the independent assessment of the Board against the Well Led criteria recommended the following:

Introduce 360 degree feedback for Executive Directors and NEDs from Board colleagues and from Councillors to improve the quality of appraisal discussions.

A 360 degree appraisal process based on the NHS Leadership Academy Healthcare Leadership Model and national 360 degree scheme is being rolled out for executive director appraisal in 2018. This tool will be reviewed for relevance and application to the Chairman and NED appraisal process. An update will be provided at the July 2018 Council meeting on how this will work.

Focus of appraisals

The Council has previously approved the framework for the appraisal process for the Chairman and Non-Executive Directors. This is attached at **Appendix 2.** It is proposed that this framework is used for the 2018 appraisal process for the Chairman and NEDs.

Timetable for Board Appraisal Process for 2018

Taking into account the two new NEDs who joined the Board since January 2018 and the majority of new Governors who have not yet had the opportunity to meet or get to know the Chairman or the NEDs, it is proposed that the Chairman and NED appraisal process will be conducted as follows:

- July 2018: Process for collating soundings from Governors to be approved at the July 2018 Council meeting
- October 2018: Collation of soundings from the Governors
- November 2018: Private meeting of Chairman with Governors to consider comments and collate further soundings in person
- December 2018: Chairman conducts appraisals of NEDs in November 2018
- January 2019: Council of Governors' Nominations and Remuneration Committee meets to discuss and approve findings to the Council
- February 2019: Council considers outputs from the process for approval.

Recommendation

The Council is asked to consider and approve the appraisal process for the Chairman and NEDs, including the appraisal framework (as previously approved by the Council) and the timescales for conducting the appraisal process in 2018.

Appendix 1

Extract from 'Your statutory duties; A reference guide for NHS foundation trust governors' – August 2013.

Annual performance appraisals

Conducting an appraisal of the candidate's past performance at the NHS foundation trust, with particular regard to delivery of the role's objectives, will help the council of governors significantly in performing its statutory duties, particularly when considering the reappointment or removal of the chair or other non-executive directors.

- *For the chair: the council of governors should take the lead on determining what the process will be for evaluating the chair. The senior independent director would be expected to lead the actual appraisal (although one or more governors may also play a significant role) and confirm to the governors whether, following formal performance evaluation, the performance of the chair continues to be effective and demonstrates commitment to the role. The focus of the chair's appraisal will be his or her performance as chair of the board of directors. Since the primary aim of the chair's work will be to lead the directors in executing the trust's forward plan, the appraisal should consider carefully the chair's performance against pre-defined objectives supporting that aim.*

- *The fact that the focus of the chair's appraisal will be his or her performance as chair of the board of directors does not mean that appraising the chair's performance as the chair of the council of governors is not a highly relevant part of the appraisal. Rather, it reflects the 2006 Act, which states that the chair of the board of directors also chairs the council of governors (and not the other way around), and the fact that it is for the governors to appoint, and remove, the chair and the other non-executive directors. That said, the appraisal process should still be used to evaluate all relevant performance issues, including those relating to the council of governors, but these should not be the main issues for consideration in relation to reappointment of the chair, in their capacity as a non-executive director.*

- *The outcome of the evaluation should be discussed and agreed with the council of governors. Where an NHS foundation trust has already developed its own processes for evaluating the chair, the council of governors should periodically review the effectiveness of the process.*

- *For the other non-executive directors: the council of governors and the chair should agree a process for evaluating the non-executive directors. The evaluation should carefully consider their performance against pre-defined objectives that support the execution of the trust's forward plan. The chair of the council of governors will lead on setting objectives for the non-executive directors and carrying out the appraisals. The chair should confirm to the governors that, following formal performance evaluation, the performance of the individual non-executive director proposed for reappointment continues to be effective and demonstrates commitment to the role. The governors should then agree the outcome of the evaluations.*

Commitments

Any changes in the candidate's other significant commitments will be relevant. The governors should assess the candidate's availability against the time required for the role of chair or non-executive director.

Attachment

Extract from Monitor's 'Code of Governance' (July 2014)

B.4.2.The chairperson should regularly review and agree with each director their training and development needs as they relate to their role on the board.

B.6.c The council of governors, which is responsible for the appointment and re- appointment of non-executive directors, should take the lead on agreeing a process for the evaluation of the chairperson and the non-executives, with the chairperson and the non-executives. The outcomes of the evaluation of the non-executive directors should be agreed with them by the chairperson. The outcomes of the evaluation of the chairperson should be agreed by him or her with the senior independent director. The outcomes of the evaluation of the non-executive directors and the chairperson should be reported to the governors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chairperson.

B.6.f Individual evaluation of directors should aim to show whether each director continues to contribute effectively and to demonstrate commitment and has the relevant skills for the role (including commitment of time for board and committee meetings and any other duties) going forwards.

B.6.g The chairperson should act on the results of the performance evaluation by recognising the strengths and addressing the weaknesses of the board, identifying individual and collective development needs, and, where appropriate, proposing new members be appointed to the board or seeking the resignation of directors.

B.6.h The focus of the chairperson's appraisal will be his/her performance as leader of the board of directors and the council of governors. The appraisal should carefully consider that performance against pre-defined objectives that support the design and delivery of the NHS foundation trust's priorities and strategy described in its forward plan.

B.6.1. The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted, bearing in mind the desirability for independent assessment, and the reason why the NHS foundation trust adopted a particular method of performance evaluation.

B.6.3.The senior independent director should lead the performance evaluation of the chairperson, within a framework agreed by the council of governors and taking into account the views of directors and governors.

B.6.4. The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members.

Appendix 2

Appraisal of the Chairman and Non-Executive Directors 2018

The Chairman and each NED will be appraised against the following framework, mapped to the approved competencies (see below):

1: Challenges made at Board during the past year are predominantly in relation to strategic matters, the management of significant clinical and corporate risks and impact on quality and safety, clinical outcomes, and patient experience (competencies 1,2,3)

2: Completes the relevant annual declarations and meets all requirements (annual declaration of interests form and raises any potential or actual conflicts at the beginning of a Board/ committee meeting; annual Fit and Proper Person Test declaration; and, the annual code of conduct declaration) (competencies 4,5)

3: Follows up challenges (outside formal meetings when appropriate), to ensure that questions or concerns have been addressed satisfactorily, including delivery of the Well Led Governance Review Recommendations (competency 6)

4: Undertakes all relevant statutory and mandatory training in accordance with relevant timescales (competency 6)

5: Regular attendance at Board and Board committee meetings and participation in a broad range of topics throughout the year (competency 7)

6: Attends external events and/or hospital visits and /or meetings with executives and Council meetings during the year to gather information and inform viewpoints (competencies 8, 9)

7: Chairs of the Board/ Board committees have reviewed the effectiveness of their Board/committees (on an annual basis) and the Chairman has received reasonable feedback (competency 10)

8: Are courteous to and supportive of other Board members and Councillors (competency 11).

9: Actively engages with the Council of Governors (competency 6)

<u>Chairman and Non-Executive Directors personal style/leadership competencies</u>

1. Strategic direction (Contributes creatively and realistically to planning; can balance needs and constraints; debates cogently)
2. Intellectual flexibility (Can digest and analyse information; willing to modify own thinking; thinks creatively and constructively; sees the detail as well as the big picture)
3. Influencing and communication (Persuades with well-chosen arguments; uses facts and figures to support argument)

4. Independence and objectivity (Not influenced by personal feelings; opinions or involvement in other activities in considering and representing facts)
5. Openness and transparency (honest, open and truthful in all dealings with patients, families, the public, staff, councillors and stakeholders)
6. Holding to account (Accepts personal accountability; challenges constructively and effectively; contributes to effective governance)
7. Commitment (attends relevant meetings; demonstrates has read documents)
8. Patient and Stakeholder Focus (Understands local health issues; understands diversity of the patient, family and carer community and its differing viewpoints; engages with the Council and other stakeholders)
9. Team working (Involves others in decision-making process; respects other team members; understands the Non-Executive and Council role; shares expertise and knowledge freely)
10. Leadership style for chairing the Board of Directors and Council (Chairman) or chairing Board committees, seeking assurance on behalf of the Board and escalating matters of significance to the Board (for the Audit Committee, Clinical Governance Committee and Finance and Investment Committee)(Non-executive directors)
11. Demonstrates a commitment to NHS/Trust values; promotes these values and acts in a way which is consistent with these values and the Nolan principles.

Council of Governors

25 April 2018

CQC Inspection Report and Actions in response to recommendations

Summary & reason for item:

In January 2018, the CQC conducted a scheduled unannounced inspection of two services (surgery and outpatients) and an announced inspection against the well led criteria. The report was published in April 2018. The Trust was rated 'Good' overall. An action plan is in development to respond to the recommendations, which includes a requirement notice related to accessibility of clinical information for staff planning to undertake procedures.

At the meeting, the Medical Director, Mr Matthew Shaw will provide a summary of the findings and themes arising out of the report.

Governor action required: To consider and note the report and actions underway to respond to the recommendations.

Report prepared by: Anna Ferrant, Company Secretary

Item presented by: Mr Matthew Shaw, Medical Director

Great Ormond Street Hospital for Children NHS Foundation Trust

Inspection report

Great Ormond Street Hospital
Great Ormond Street
London
WC1N 3JH
Tel: 0207 405 9200
www.gosh.nhs.uk

Date of inspection visit: 09 Jan to 11 Jan 2018
Date of publication: This is auto-populated when the report is published

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Good
Are services safe?	**Good**
Are services effective?	**Outstanding**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

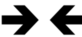
Background to the trust

Great Ormond Street Hospital for Children NHS Foundation Trust was established in 1852 in the London Borough of Camden and was the first hospital providing in-patient beds specifically for children in England. Great Ormond Street Hospital for Children NHS Foundation Trust is one of four dedicated children's hospital trusts in the UK. The trust achieved foundation trust status on 1 March 2012.

The trust operates from a single site in central London. The hospital has approximately 482 beds, and is registered with CQC for caring for children (0 - 18yrs year olds). Great Ormond Street Hospital and the UCL Institute of Child Health form the UK's only academic biomedical research centre specialising in paediatrics.

The trust is the largest paediatric centre in the UK for intensive care, cardiac surgery, neurosurgery, cancer services, nephrology and renal transplants. There are 63 different clinical specialties at GOSH. Children are also treated from overseas in the international and private patients' wing (IPP). Great Ormond Street Hospital received 252,389 outpatient visits and 43,778 inpatient visits in 2016/17. The trust mostly cares for children that are referred from other hospitals throughout the UK and overseas. More than half of their patients come from outside of London.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Good 

What this trust does

The trust runs services at Great Ormond Street Hospital site (GOSH). It provides surgery, medical care, critical care, end of life care, outpatients services, and children and young people's services. The hospital has 482 beds including 47 open intensive care beds and eight beds used by the clinical research facility.

It is the only specialist biomedical research centre for paediatrics, the largest centre in the UK for children with heart or brain problems, and the largest centre in Europe for children with cancer. The hospital is the only specialist children's hospital in the UK that does not have an accident and emergency department and only accepts specialist referrals from other hospitals and community services. In the trust 45% of patients are from London and over 55% are from outside of London, including 7% from overseas. The population of children served by the hospital is characterised by those with multiple disabilities and/or health problems and rare and congenital conditions (present at birth). The hospital receives over 260,000 patient visits a year (inpatient/day-case admissions or outpatient attendances), and carries out approximately 18,800 surgeries each year.

The Mittal children's medical centre which includes the Premier Inn clinical building was officially opened on 17 January 2018. The centre has 240 beds, spans two connecting wings, including the new Premier Inn clinical building. The centre has brand new, modern wards with ensuite bedrooms where parents can stay with their child overnight.

The trust leads the North Thames Genomic Medicine Centre, one of 13 regional centres which is responsible for coordinating recruitment of more than 100 patients a month. The project aims to help doctors better understand, and ultimately treat, rare and inherited diseases and various cancers.

GOSH is one of only two centres in the world developing the thymus tissue treatment. The thymus gland produces several hormones, closely associated with the immune system and serves a vital role in the training and development of T-lymphocytes (T cells) which is an important type of white blood cell. The thymus tissue treatment involves removal of thymus tissue as a standard from children undergoing cardiac surgery for congenital heart defects in order to allow the surgeons to perform the heart procedure.

Summary of findings

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We last inspected Great Ormond Street Hospital for Children NHS Foundation Trust in April 2015. All core services were inspected (medical care, neonatal services, transitional services, surgery, critical care, services for children and young people) this included child and adolescent mental health services), end of life care and outpatients.

All core services were rated as good or outstanding with the exception of Surgery and Outpatients Departments (OPD) which were rated as requires improvement (RI).

Between 9 and 11 January 2018 we inspected two core services at Great Ormond Street Hospital for Children NHS Foundation Trust. These were outpatients department and surgery.

We decided to inspect OPD and surgery as during the previous inspection we rated those services as requires improvement (RI). The trust informed us that they had made necessary changes to both services to rectify issues raised within the report published in January 2016. There had been sufficient time for the trust to act upon the findings and we decided that re-inspecting would allow us to asses changes implemented by the trust.

We decided not to inspect the other core services at this time as they were previously rated as 'Good' or 'Outstanding'; the decision was made on a risk based approach under the new methodology not to inspect at this time. Other concerns raised within these core services are continually monitored at quarterly regulatory meetings with the trust.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question for the trust overall. What we found is summarised in the section headed 'Is this organisation well-led?'

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as good because:

- We rated effective and caring as outstanding, well-led as requires improvement, safe and responsive as good.
- We rated two of the trust's eight core services as outstanding, five as good and one as requires improvement. In rating the trust, we considered the previous ratings of the six services not inspected this time.
- We rated well-led for the trust overall as requires improvement.

Summary of findings

Are services safe?

Our rating of safe stayed the same. We rated it as good because:

- There were systems in place to manage patient safety incidents well. Staff knew how to report incidents and we saw evidence of incidents investigation and learning.
- The trust controlled infection risk well and provided staff with the use of Personal protective equipment.
- The trust had clearly defined systems and processes to keep patients safe and safeguard them from abuse. Staff had access to the clinical site practitioners and safeguarding lead nurses who provided dedicated safeguarding support and additional training.
- The trust planned for emergencies and we noted that staff understood their roles if an emergency should occur.
- During the previous CQC inspection, we noted that the equipment used to transport patient records between departments was frequently not fit for purpose. During this inspection we saw that these had been replaced with patient record trollies on wheels which had a key pad system and were easy to move from area to area.
- During the previous inspection, we were told that a significant number of referrals from other NHS trusts and embassies did not include adequate medical or clinical information. During this inspection, staff told us they had since adapted a robust approach to this which had resulted in significantly improved quality of referral information.

However:

- Medicines were not appropriately managed and prescription pads were not stored appropriately and were left out on staff desks.
- The trust did not always meet their target for completion of mandatory training.

Are services effective?

Our rating of effective stayed the same. We rated it as outstanding because:

- The trust provided care and treatment based on national professional standard, national guidelines and evidence based practice to achieve the best patient outcomes.
- Staff we spoke to understood their roles and responsibility to adhere to the Mental Health Act 1983 and the Mental Capacity Act 2005.
- We saw evidence of very good multidisciplinary working between departments in the hospital and other hospitals and external agencies such as GPs and community teams to provide holistic care.
- The trust ensured staff were competent and supported for their roles.

Are services caring?

Our rating of caring stayed the same. We rated it as outstanding because:

- Staff showed compassion and respect to patients and their loved ones.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Patients and their relatives told us staff showed empathy and were sensitive to their needs when breaking bad news and offered reassurance when needed.
- Staff provided emotional support to patients to minimise their distress.

Summary of findings

- The trust recently developed a pilot project where a learning disability link nurse did a home visit to a patient who persistently refused to come to their appointments. The nurse used communication aids to prepare the patient for their next appointment and ensured they were on duty to welcome them into the department.

Are services responsive?

Our rating of responsive improved. We rated it as good because:

- The trust planned and provided services in a way that met the needs of the patients from the local area, country and abroad.
- The trust took account of patient's individual needs when planning and delivering care.
- The trust provided an extensive translation and interpreting service in recognition of the wide range of languages spoken by their patients and families.
- Staff used a hospital passport system to help them understand and communicate with young people where they presented with complex communication needs.
- Carers who travelled by car to the hospital were given a parking voucher for use in the area surrounding the hospital, the length of which depended on the nature of their visit. In addition, where the patient had a number of appointments over the course of more than one day, they were offered hotel accommodation close to the hospital.
- During the previous CQC inspection in May 2015, we recorded concerns over the reliability of referral to treatment (RTT) data reporting of which was suspended after our inspection. Various measures were put in place since then to address the problem and the trust returned to reporting in January 2017 in agreement with commissioners. Dedicated specialists in data collection, analysis and validation worked with clinical colleagues to ensure data was accurate and high quality. A demand and capacity model for all specialty services was in place and senior teams used this to improve waiting times.

Are services well-led?

Our rating of well-led stayed the same. We rated it as requires improvement because:

- The trust had an experienced leadership team with the skills, abilities, and commitment to provide high-quality services. However, there had been frequent executive leadership changes which affected staff morale. Since the previous CQC inspection in 2015 most of the executive and non-executive directors had changed. The trust had an interim medical director for approximately 12 months with a further temporary change made at the end of 2017. There was an interim chief and deputy chief nurse in post and the chief finance officer was leaving their post in February 2018.
- Staff told us they felt divisional structures were overly complicated. Staff felt it did not allow for clear lines of accountability and for cross divisional learning. Staff we spoke with on the wards were not clear who their divisional leaders were. The percentage of staff reporting good communication between senior management and staff was much worse than the national average in the NHS staff survey. Trust leaders did not appear to be aware of the wide concerns raised with the inspection team by nursing staff about leadership and morale.
- Nurses felt they lacked leadership and they did not feel retention of nursing staff had been addressed by trust's leaders. Staff were not aware of the trust's approach to future workforce decisions and how they mitigated the long-term risks associated with workforce planning.
- The trust had not fully demonstrated their commitment to support the freedom to speak up. They did not fully comply with recommendations set in freedom to speak up guidance issued by the National Guardian's Office. No trust guardian had been appointed.

Summary of findings

- Some staff we spoke to were unable to describe learning implemented in relation to serious incidents. There was limited evidence of shared understanding of key learning issues throughout the trust. For example, surgeons we spoke with were unaware of the never event which took place in another surgical speciality. Learning from incidents, never events and clinical reviews were not shared widely.
- The trust missed opportunities for engagement with some of the local stakeholders. The trust does not demonstrate open and positive relationships with key stakeholders. It was not sharing information promptly and was often defensive when challenged on performance and safety.
- The trust missed opportunities for engagement with some of the local stakeholders. The trust does not demonstrate open and positive relationships with key stakeholders. It was not sharing information promptly and was often defensive when challenged on performance and safety.

However:

- Research was well established within the hospital and there were robust policies and processes to promote innovation and safeguard patients taking part in trials and receiving innovative treatment. Staff were encouraged and supported to undertake research projects.
- Risk registers and the board assurance framework were reviewed regularly by the executive management team and board committees. They were reflective of risks facing the organisation and clearly listed all control measures set out to manage risks and what means of assurance were in place. Documents were informed by divisional risks registers and highlighted both strategic and operational risks. The risk management framework allowed staff to effectively escalate risks and their concerns.
- All staff were proud to work at Great Ormond Street Hospital. The trust scored above the England average for recommending the trust as a place to receive care from October 2016 to September 2016.
- Following the suspension of reporting its referral to treatment (RTT) waiting times, the trust completed a significant amount of work relating to the RTT access standards. The additional work has led to the improvement of the quality of the data, with staff re-trained to correctly manage RTT data.

Ratings tables

The ratings tables show the ratings overall and for each key question for each service, and for the whole trust. They also show the current ratings for services not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in surgery and outpatients.

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including one breach of legal requirements that the trust must put right. We also found areas that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve the quality of services.

For more information, see the 'areas for improvement' section of this report.

Summary of findings

Action we have taken

We issued one requirement notice to the trust. Our action refers to breaches of Regulation 17 which relates to good governance requirements, related to one service: Surgery

For more information on action we have taken, see the sections on 'areas for improvement' and 'regulatory actions'.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

In Outpatients:

- Staff told us the wide ranging and innovative measures introduced to improve the experience of patients with a learning difficulty enhanced their practice.
- The hospital was known to treat patients with the rarest of diseases and conditions from around the world. This enabled staff to develop skills and expertise in areas previously untreatable. Clinicians told us they shared this expertise with colleagues around the world for the advancement of medicine.
- Planning for transitional care from paediatric to adult care began when the child was 12 and followed trust policy which included regular contact and training as appropriate with the adult service to which the child would move.

In Surgery:

- The clinical site practitioner (CSP) team provided a multidisciplinary and highly responsive service to all specialties and disciplines. This team undertook specialty training in safeguarding and child protection and meant all ward teams had access to senior support for deteriorating patients at any time. The CSPs had developed a system of peer review within the team to develop standards of best practice and learn from the most complex care cases.
- The Woodpecker ward team had established a teaching and education system that engaged each staff group. This involved a group planning a topic of the month and delivering a training session to their colleagues, including the multidisciplinary team. In January 2018 the nominated team had chosen Makaton as their topic and were preparing to deliver a teaching and learning session.
- Fox ward had been recognised with a 'GOSH Gold' award by the trust for the team's work in improving mandatory training and supervision. This reflected significant work across the hospital by the practice education team to engage staff with training and improved development opportunities.
- The hospital had an extensive range of non-clinical, holistic services in place to help patients' recovery and to improve their experience whilst an inpatient. A team of volunteers worked across all clinical specialties seven days a week. This team provided relief for parents, such as looking after or playing with children while they had a coffee break. Transition specialists provided a wide range of activities with patients of all ages, including teenagers. The hospital also hosted regular social events for young people, such as a teenager café on a Wednesday and an in-hospital school was available.
- A clinical nurse specialist had been recognised for their work in emergency paediatric tracheostomy support by the National Tracheostomy Safety Project. They provided specialised, one-to-one care and treatment support to babies and children with a tracheostomy and had sourced information for parents in Greek and Arabic as well as providing a podcast for deaf mothers.

Summary of findings

- Surgical clinical teams were research active and as of January 2018, 37 research projects were active. Research projects represented multiple surgical areas including cardiothoracic surgery and neurosurgery and represented an international clinical practice profile that clinical teams used to drive improvement and innovation. Clinicians led research projects that aimed to understand the experience of patients in addition to clinical treatment and outcomes. For example, one project explored the decision-making process of young people who were due to have orthognathic surgery and another project considered the mental health and emotional needs of children with ophthalmological needs.
- There was a culture of reflection, assessment and audit amongst teams and services who led projects to improve patient care. For example, before relaunching a new nutrition pathway the dietetics team completed an audit of patient documentation. As part of a quality of documentation week, the clinical audit lead had engaged with staff across the trust to secure 88 pledges for quality improvement. The ear, nose and throat team had a significant track record of reviewing service experiences with patients and their parents. Examples such as these were evident across the hospital.
- The tracheal team had established the service as leading-edge in innovation and the provision of evidence-based, research-led surgical development. This included a quality of life assessment for physical and psychosocial factors post-procedure, which was the first of its kind internationally. The team worked with national and international multidisciplinary partners to measure patient clinical outcomes and share learning at international meetings.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve

We told the trust that it must take action to bring services into line with legal requirements.

In Surgery:

- The trust must establish safe systems of working for access to medical records and patient medical histories. This must result in surgeons and other clinicians always having access to past medical notes prior to a planned procedure.

Action the trust SHOULD take to improve

We told the trust that it should take action either to comply with minor breaches that did not justify regulatory action, to avoid breaching a legal requirement in future, or to improve services.

In Outpatients:

- Improve staff hand hygiene and adherence to bare below the elbows.
- Consider the use of disposable tourniquets.
- Ensure procedure rooms are clutter free and not used to store staff clothing.
- Ensure there is consistent fridge temperature monitoring and actions taken where temperatures are regularly outside of the recommended range.
- Ensure patient identifiable information is kept confidential and secured at all times.

Summary of findings

In Surgery:

- The trust should improve opportunities for engagement and communication between the executive team and clinical teams.
- The trust should ensure the transfer processes for patients moving from or to IPP inpatient wards continue to improve to ensure transfers are always led by a medical fellow.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our assessment of well-led at the trust-wide level included trust board and executive-level leadership and governance, the effectiveness of non-executive directors, the overall organisational vision and strategy, organisation-wide governance and management, and organisational culture and engagement (with patients, staff, stakeholders and so on).

We took account of what we found in all the core service inspections. We explored the flow of information, assurance, and governance from 'ward to board and board to ward', and how trust-wide strategies and leadership were reflected in services. We considered cross-trust systems and processes alongside local and service-level leadership, systems and processes.

We rated well-led at the trust as requires improvement because:

- The trust had an experienced leadership team with the skills, abilities, and commitment to provide high-quality services. However, there had been frequent executive leadership changes which affected staff morale. Since the previous CQC inspection in 2015 most of the executive and non-executive directors had changed. The trust had an interim medical director for approximately 12 months with a further temporary change made at the end of 2017. There was an interim chief and deputy chief nurse in post and the chief finance officer was leaving their post in February 2018.
- Nurses felt they lacked leadership and they did not feel retention of nursing staff had been addressed by trust's leaders. Staff were not aware of the trust's approach to future workforce decisions and how they mitigated the long-term risks associated with workforce planning.
- The trust had not fully demonstrated their commitment to support the freedom to speak up. They did not fully comply with recommendations set in freedom to speak up guidance issued by the National Guardian's Office. No trust guardian had been appointed.
- Staff told us they felt divisional structures were overly complicated. Staff felt it did not allow for clear lines of accountability and for cross divisional learning. Staff we spoke with on the wards were not clear who their divisional leaders were. The percentage of staff reporting good communication between senior management and staff was much worse than the national average in the NHS staff survey. Trust leaders did not appear to be aware of the wide concerns raised with the inspection team by nursing staff about leadership and morale.

Summary of findings

- Some staff we spoke to were unable to describe learning implemented in relation to serious incidents. There was limited evidence of shared understanding of key learning issues throughout the trust. For example, surgeons we spoke with were unaware of the never event which took place in another surgical speciality. Learning from incidents, never events and clinical reviews were not shared widely.
- The trust missed opportunities for engagement with some of the local stakeholders. The trust does not demonstrate open and positive relationships with key stakeholders. It was not sharing information promptly and was often defensive when challenged on performance and safety.
- The trust did not proactively engage and lead on paediatric care and treatment locally. Senior leaders stated the sustainability and transformation plans model (STP) did not directly correlate with the trust's tertiary services model which extended both across London but also throughout England. The chief executive told us the trust maintained an "observer role" on the STP. It was not clear how they were planning to become a system leader in the UK and international children's alliance as described in the trust strategy as there was no evidence of clear objectives, or measures of success and deliverables set out in the strategy.
- Staff did not always feel engaged or that they had a say in decisions taken by senior leaders of the organisation. Staff said that major decisions were made by the board and then communicated to them to implement. There was no clear strategy for staff engagement and organisational development.
- Pharmacy services did not report any key performance indicators directly to the board meaning there was a limited accountability or oversight of this service.
- The trust did not provide assurances that all incidents were being properly recorded in a central database of patient safety incident reports and shared with external partners. The trust did not resolve an issue with uploading information into the central system which was brought to their attention as early as August 2017.
- Staff felt learning from high profile cases had not always been implemented or sufficiently considered by the trust leaders. High profile cases often impacted on day to day service oversight and the trust's leaders did not always fully plan for additional operational pressures nor implement prevention mechanisms to minimise this impact.
- The trust was in a process of addressing findings from an independent review of their governance framework which took place in 2016. They were still to complete work required to facilitate improvements in relationships between trust's board and members' council, as well as ensure inclusivity and address potential concerns of the members council. Evidence from the well-led inspection indicated that there had not been a dynamic pace of change in the past and additional support from the board is required to achieve this.

However:

- Research was well established within the hospital and there were robust policies and processes to promote innovation and safeguard patients taking part in trials and receiving innovative treatment. Staff were encouraged and supported to undertake research projects.
- Clinical audits were shared across specialities and had positive impact on quality. There was a central clinical audit plan where work was prioritised to provide assurance and to review implementation of learning and identify areas for improvement.
- Risk registers and the board assurance framework were reviewed regularly by the executive management team and board committees. They were reflective of risks facing the organisation and clearly listed all control measures set out to manage risks and what means of assurance were in place. Documents were informed by divisional risks registers and highlighted both strategic and operational risks. The risk management framework allowed staff to effectively escalate risks and their concerns.

Summary of findings

- All staff were proud to work at Great Ormond Street Hospital. The trust scored above the England average for recommending the trust as a place to receive care from October 2016 to September 2016.
- The trust's financial performance had been consistently strong with cash and revenue plans being delivered broadly in line with plans in 2015/16, 2016/17 and 2017/18 year to date.
- The trust had established appropriate processes to support delivery of elective care including the establishment of governance structures to support delivery of the RTT standards as well as improved patient flow across the elective care pathway. This was a significant improvement on the previous inspection.
- There were effective systems to identify and learn from unanticipated deaths, serious incidents and complaints.
- The board reviewed performance reports that included data about the services. The information provided was reliable and sufficiently detailed to support informed decision making. The trust had developed clear operational performance quality indicators and had effective monitoring systems to allow reporting and support better understanding at divisional and board levels. The trust regularly shared performance data with staff.
- The trust had identified the strategic priorities for pharmacy services. There were systems of accountability for medicines via the trusts drug and therapeutics group.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good →← Jan 2018	Outstanding →← Jan 2018	Outstanding →← Jan 2018	Good ↑ Jan 2018	Requires improvement →← Jan 2018	Good →← Jan 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for Great Ormond Street Hospital for Children NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Apr 2015	Outstanding Apr 2015	Outstanding Apr 2015	Good Apr 2015	Good Apr 2015	Outstanding Apr 2015
Surgery	Requires improvement ↓ Jan 2018	Good →← Jan 2018	Good ↓ Jan 2018	Good ↑ Jan 2018	Requires improvement →← Jan 2018	Requires improvement →← Jan 2018
Critical care	Good Apr 2015	Good Apr 2015	Outstanding Apr 2015	Good Apr 2015	Requires improvement Apr 2015	Good Apr 2015
Neonatal services	Good Apr 2015	Good Apr 2015	Outstanding Apr 2015	Good Apr 2015	Good Apr 2015	Good Apr 2015
Transition services	Good Apr 2015	Good Apr 2015	Outstanding Apr 2015	Good Apr 2015	Requires improvement Apr 2015	Good Apr 2015
Services for children and young people	Good Apr 2015	Good Apr 2015	Outstanding Apr 2015	Good Apr 2015	Good Apr 2015	Good Apr 2015
End of life care	Good Apr 2015	Outstanding Apr 2015	Outstanding Apr 2015	Outstanding Apr 2015	Outstanding Apr 2015	Outstanding Apr 2015
Outpatients	Good →← Jan 2018	Not rated	Outstanding →← Jan 2018	Good ↑ Jan 2018	Good ↑ Jan 2018	Good ↑ Jan 2018
Overall*	Good →← Jan 2018	Outstanding →← Jan 2018	Outstanding →← Jan 2018	Good ↑ Jan 2018	Requires improvement →← Jan 2018	Good →← Jan 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Great Ormond Street Hospital

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Key facts and figures

Great Ormond Street Hospital (GOSH) was established in 1852 in the London Borough of Camden and was the first hospital providing in-patient beds specifically for children in England. The hospital has been dedicated to children's healthcare and to finding new and better ways to treat childhood illnesses.

In partnership with the University College London (UCL) Institute of Child Health, GOSH forms academic biomedical research centre specialising in paediatrics. The hospital is the only specialist Biomedical Research Centre for paediatrics, the largest centre in the UK for children with heart or brain conditions, and the largest centre in Europe for children with cancer. Its status as a Specialist Children's Hospital means that most of the children treated are referred from other hospitals or overseas. GOSH receives 252,389 outpatient visits and 43,778 inpatient visits every year (figures from 2016/17). The hospital has 482 beds including 47 open intensive care beds and eight beds used by the clinical research facility. There are 63 different clinical specialties at GOSH. The hospital has the UK's widest range of specialist health services for children on one site.

We inspected surgery and outpatients over three unannounced inspection days to enable us to observe routine activity between 9 and 11 January. We returned between 30 January and 1 February to undertake an inspection of the trusts leadership team.

We spoke with members of staff including doctors, nurses, allied health professionals, administrative and other staff. We spoke with members of the divisional leadership teams as well as local service leads and senior managers. We reviewed patient records and spoke with patients, their parents and carers.

Summary of services at Great Ormond Street Hospital

Good

Our overall rating of services stayed the same. We rated surgery as requires improvement and outpatients as good.

Surgery

We rated safe and well-led as requires improvement, and effective, caring and responsive as good. The rating of responsive improved while outstanding for caring went down since our last inspection. Our overall rating of this service stayed the same. We rated it as requires improvement because:

- Insufficient staffing in some clinical areas had led to delays in treatment and prescribing and the closure of some inpatient beds.

Summary of findings

- There was inconsistent management of risks related to medicines management.
- Clinical governance, risk management and incident investigation systems did not follow a coherent or effective structure in which learning was shared between teams and specialties. Although there was local evidence of improvements in practice as a result of incidents and morbidity and mortality meetings, shared learning was not evident outside of the immediate specialty or service.
- Between August 2016 and September 2017, the trust took an average of 59 calendar days to investigate and close complaints; which was significantly longer than the target of 25 days.
- There was a disconnect between specialty and divisional teams and the senior trust and executive team. A cross-section of 14 clinical staff, including senior clinicians, said the senior team was difficult to communicate and engage with and they did not feel listened to. Although the executive team demonstrated efforts to engage with staff, very few of the individuals we spoke with had been able to participate. The senior team had a track record of high levels of staff turnover, which service-level staff told us meant there was little consistency.
- There was limited evidence risks were regularly scrutinised or reviewed in a timely manner. We found the highest risk to clinical treatment related to the medical records system, which resulted in surgeons and anaesthetists sometimes carrying out treatment without access to the patients' medical history.

However:

- There were established safeguarding procedures appropriate to patient age groups. Although nurse and medical staff teams did not meet the trust's 90% standard, at 75%, for completion of safeguarding children level 3, specialists across the hospital provided dedicated support and training opportunities.
- The trust had significantly improved the use of the World Health Organisation surgical safety checklist in theatres. Quality and safety staff had audited the work to improve this safety tool, which resulted in a demonstrable trajectory of better practice.
- Staff used a range of systems to monitor and care for patients whose condition was deteriorating. This included electronic calculation of early warning scores and automatic escalation to senior clinical staff.
- An electronic monitoring system was in place across all clinical areas which enabled staff to monitor and track their patients throughout their care and treatment pathway.
- Some teams and services, such as ear, nose and throat and clinical site practitioners, had implemented peer reviews or audits to assess their service and improve care for patients with complex needs.
- Staff had access to extensive training and development opportunities and dedicated support from a practice education team. This team worked across the hospital and provided targeted, specialised training to staff. This was alongside simulation training and leadership development opportunities.
- All surgical areas scored consistently well in the NHS Friends and Family Test, with all recommendation scores at 90% or above in 2017.
- We saw an embedded culture of staff involving patients and parents when planning care and treatment. Staff took time to explain options and risks and patiently took time to answer questions.
- Substantial work had been completed in relation to delivery of referral to treatment times (RTT) following a suspension prior to 2016. Dedicated data, clinical and quality teams worked together to improve data quality and reporting.

- The trust had a target of full compliance with RTT national standards and no 52 weeks breaches by January 2018. Each specialty had a recovery trajectory aimed at achieving this. There was evidence of sustained improvements in the RTT with 29 of 49 recorded specialities achieving the RTT standard in December 2017 and 39 achieving it in January 2018.
- There was evidence of effective, inclusive leadership at service level. Staff in all departments, wards and clinical services spoke positively of the support and leadership they received and said this contributed to a very welcoming culture.

Outpatients

We rated safe, responsive and well-led as good and caring as outstanding. The rating of responsive and well-led had improved since our last inspection. Our overall rating of this service improved. We rated it as good because:

- We saw evidence of the use of national clinical guidelines and a culture of evidence based practice in the specialties we observed in outpatients.
- The service made sure staff were competent for their roles. All nurses in the outpatients department had an appraisal within the last year. Staff told us they found it of benefit to take time out and reflect on their work and possible career development.
- Staff cared for patients with compassion. We saw several examples of staff from all disciplines being supportive and kind to patients and their relatives. We saw staff comforting patients and carers and a high level of engagement with children and young people.
- Patients and their relatives felt included in their plan of care. Patients told us nurses and clinicians spoke directly with them rather than just to their parents and carers. They felt included in discussions about their treatment and staff took time to ensure they understood what was discussed.
- The service took account of patients' individual needs. There were link nurses for patients with a learning disability, who staff and patients could contact for advice and support. Reasonable adjustments were made to provide a better patient experience for learning disabled patients.
- The department supported people to be as engaged in their own health and wellbeing as possible. For example, speech and language therapists ran a group once a month for parents of children who recently had a cleft palate repair. Advice and information was shared about speech development, good oral hygiene and diet.
- Staff we spoke with were very positive about the current leadership team and told us their biggest strength was their honesty and visibility. Staff told us there was good teamwork and they felt valued and got recognition for their work.
- There was general consensus amongst managers and staff about what the departments' top risks were. These included increasing demand on services and capacity in clinics, as well as the unplanned for arrival of inpatients from other hospitals to the outpatients department. Staff told us risks were discussed at staff meetings and managers shared information about what was being done to mitigate these risks.
- Leaders developed a business strategy which was designed to increase the efficiency of the department and enhance patient experience. For example, providing extra space for clinics that had become too full.
- The trust returned to reporting referral to treatment times in January 2017 in agreement with commissioners with noticeable improvements to the quality of the data. This showed that the trust's referral to treatment time (RTT) for non-admitted pathways was similar to the England overall performance. Data on RTT for admitted pathways showed that 91% of patients were seen within 18 weeks with the between August and December 2017.

However:

Summary of findings

- We observed inconsistent adherence to infection prevention and control practice and recent hand hygiene results were poor. Hand hygiene audits from January to December 2017 demonstrated that the average compliance rate was 78%, with results varying between 50% and 96%. We observed doctors were not always ‘bare below the elbow’.
- We noted there were no single use tourniquets in use which increased the possibility of infection.
- We found inconsistencies in fridge temperature monitoring; we also saw that ambient temperature monitoring was not taking place in areas where medicines were being stored. There was no action plan in place to address this issue.
- Patient identifiable information was left unattended in consulting rooms. This created the risk of private patient information being accessed inappropriately.

Surgery

Requires improvement

Key facts and figures

Surgery services at Great Ormond Street Hospital are provided within three divisions; JM Barrie, Charles West and International and Private Patients. There are 12 surgical specialties represented within the hospital and provided across 14 operating theatres and a range of surgical inpatient wards, a pre-operative assessment unit and a day case ward. Theatres one to six include a nine-bedded recovery and infectious patient bay. A 24-hour emergency theatre and anaesthetic bay room are always available and the inpatient wards are equipped to provide care for patients who need high dependency care.

The trust had 11,058 surgical admissions from August 2016 to July 2017. Emergency admissions accounted for 668 admissions (6%), 5,032 (46%) were day cases, and the remaining 5,358 (48%) were elective. Across the 13 specialties, 32% of procedures were carried out in urology, 16% in ear, nose and throat and 12% in general surgery. Other proportions ranged from 8% in plastic surgery to fewer than 0.5% (six procedures) in day case anaesthetics.

During our inspection we visited the main theatres, Ocean theatres and all inpatient wards that provide care to NHS, international and private surgical patients. In addition, we spent time in the pre-surgery assessment unit, the discharge lounge and the anaesthetic pre-operative assessment unit. A CQC pharmacist inspector visited Sky ward, Hedgehog ward, Panther ward and Bumblebee ward.

To come to our ratings we spoke with 39 members of staff across clinical areas and services and management teams. We spoke with 24 patients and/or their parents and looked at 19 patient records. We also reviewed over 80 additional documents.

We last inspected surgical services at Great Ormond Street Hospital in April 2015 and May 2015. At that inspection we rated the service as requires improvement. Applicable to surgery, we told the trust they must:

- Resume World Health Organisation checklist audits in surgery
- Ensure referral to treatment time (RTT) data is robust
- Ensure greater uptake of mandatory training

At this inspection we found significant work had been completed to make demonstrable progress in the implementation of consistent surgical safety checklists and improvements in RTT data. However mandatory training compliance remained variable.

Summary of this service

We rated safe and well-led as requires improvement, and effective, caring and responsive as good. The rating of responsive improved and while outstanding went down since our last inspection. Our overall rating of this service stayed the same. We rated it as requires improvement because:

- Short staffing in some clinical areas had led to delays in treatment and prescribing and the closure of some inpatient beds.
- There was inconsistent management of risks in medicines management.

Surgery

- Clinical governance, risk management and incident investigation systems did not follow a coherent or effective structure in which learning was shared between teams and specialties. Although there was local evidence of improvements in practice as a result of incidents and morbidity and mortality meetings, shared learning was not evident outside of the immediate specialty or service.
- Between August 2016 and September 2017, the trust took an average of 59 calendar days to investigate and close complaints; which was significantly longer than the target of 25 days.
- There was a disconnect between specialty and divisional teams and the senior trust and executive team. A cross-section of 14 clinical staff, including senior clinicians, said the senior team was difficult to communicate and engage with and they did not feel listened to. Although the executive team demonstrated efforts to engage with staff, very few of the individuals we spoke with had been able to participate. The senior team had a track record of high levels of staff turnover, which service-level staff told us meant there was little consistency.
- There was limited evidence risks were regularly scrutinised or reviewed in a timely manner. We found the highest risk to clinical treatment related to the medical records system, which resulted in surgeons and anaesthetists sometimes carrying out treatment without access to the patients' medical history.

However:

- There were established safeguarding procedures appropriate to patient age groups. Although nurse and medical staff teams did not meet the trust's 90% standard, at 75%, for completion of safeguarding children level 3, specialists across the hospital provided dedicated support and training opportunities.
- The trust had significantly improved the use of the World Health Organisation surgical safety checklist in theatres. Quality and safety staff had audited the work to improve this safety tool, which resulted in a demonstrable trajectory of better practice.
- Staff used a range of systems to monitor and care for patients whose condition was deteriorating. This included electronic calculation of early warning scores and automatic escalation to senior clinical staff.
- An electronic monitoring system was in place across all clinical areas which enabled staff to monitor and track their patients
- Staff had access to extensive training and development opportunities and dedicated support from a practice education team. This team worked across the hospital and provided targeted, specialised training to staff. This was alongside throughout their care and treatment pathway.
- Some teams and services, such as ear, nose and throat and clinical site practitioners, had implemented peer reviews or audits to assess their service and improve care for patients with complex needs.
- simulation training and leadership development opportunities.
- All surgical areas scored consistently well in the NHS Friends and Family Test, with all recommendation scores at 90% or above in 2017.
- We saw an embedded culture of staff involving patients and parents when planning care and treatment. Staff took time to explain options and risks and patiently took time to answer questions.
- Substantial work had been completed related to the delivery of the referral to treatment times (RTT) following a suspension prior to 2016. Dedicated data, clinical and quality teams worked together to improve data quality and reporting.

Surgery

- The trust had a target of full compliance with RTT national standards and no 52 weeks breaches by January 2018. Each specialty had a recovery trajectory aimed at achieving this. There was evidence of sustained improvements in the RTT with 29 of 49 recorded specialities achieving the RTT standard in December 2017 and 39 achieving it in January 2018.
- There was evidence of effective, inclusive leadership at service level. Staff in all departments, wards and clinical services spoke positively of the support and leadership they received and said this contributed to a very welcoming culture.

Is the service safe?

Requires improvement

Our rating of safe went down. We rated it as requires improvement because:

- Completion rates of mandatory training varied from 58% to 100% and neither medical nor nursing staff met the trust's 90% completion rate in all subjects. However there was extensive evidence of programmes to improve this by the end of 2018.
- Nursing and medical staff groups met the trust's standards for the completion of safeguarding adults level 1 training but not for safeguarding children level 3 training, in which compliance was 74%.
- Between April 2016 and March 2017, surgical wards reported three cases of hospital-acquired MRSA. Results from the Saving Lives audit in 2017 indicated 88% overall compliance with a wide variance in individual results.
- Persistent short-staffing of nurses on Sky ward and clinical fellows in Bumblebee ward had led to delays in treatment and prescribing.
- Risks relating to medicine management were not always mitigated on each ward. For example, we found inconsistent medicines management on inpatient wards, such as unlocked storage areas and a lack of temperature monitoring. Risk action groups and specialty review meetings reviewed medicines risks on a monthly basis and so it was not evident why this had not resulted in more consistent ward practices.
- Learning from serious incidents and never events was limited to specialist clinical areas and there was very little sharing of learning or outcomes between specialties and services.
- Clinical staff had identified a serious potential risk to patient safety relating to access to medical histories and patient notes. This occurred as the trust moved to an electronic patient record system, which meant staff accessed previous patient records from a range of different sources. There were delays in this interim system, which meant procedures sometimes took place without clinicians having a full picture of the patient's medical history. This risk had remained on the trust risk register for over 12 months and multiple senior clinical staff we spoke with said escalating the risk had not resulted in improved practice or safety mechanisms. After our inspection the trust provided details of a trial project that would improve the scanning and availability of patient notes, which was due to be launched in April 2018 ahead of the full electronic system in April 2019.

However:

- There was a significant improvement in the use of the World Health Organisation surgical safety checklist in theatres. We saw evidence of this from observing practice, speaking with staff and reviewing progress audits the trust had completed.

Surgery

- Clinical site practitioners and safeguarding lead nurses provided clinical teams with dedicated safeguarding support and additional training. This reflected an overall comprehensive approach to safeguarding that included the recognition of radicalisation and multidisciplinary working with social workers, psychologists and the security team.
- Staff demonstrated consistently good standards of infection prevention and control, including when caring for patients who were isolated due to infectious conditions.
- Staff on inpatient wards demonstrated detailed knowledge of emergency procedures relating to fire and evacuation. Some staff had completed scenario-based evacuation simulations and could demonstrate how this applied to the specific needs of their patients.
- The biomedical engineering, facilities and estates teams managed a programme of planned and preventative maintenance for theatres. All maintenance was up to date or planned on schedule.
- Clinical staff used the child early warning scores (CEWS) system to monitor patients whose condition was deteriorating. This was an electronic system that escalated care needs to senior clinicians. In addition staff used an electronic patient monitoring board on each ward and daily safety huddles to provide additional risk monitoring for patients. These systems ensured patients at risk of increasing medical needs received timely and appropriate care.
- Staff vacancy, turnover and sickness rates were all significantly better than trust targets.
- Staff were confident in reporting incidents and we found evidence of improvements in practice as a result of incident investigations.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good because:

- The clinical audit team reviewed updates to national clinical guidance and quality standards on a monthly basis. This included a review of all hospital policies and protocols to identify where updates were needed.
- The hospital participated in national and international benchmarking, including as part of an international network for surgical interventions in patients living with epilepsy.
- A tracheostomy nurse specialist had led a range of improvements to patients who needed tracheostomy care. This included, targeted specialist training for nurses, the implementation of nurse link roles and remote reviews for patients after discharge.
- Staff in the ear, nose and throat specialty recognised a need for better benchmarking of care and treatment and had established clinical groups to drive this forward.
- The clinical site practitioner team had implemented a peer review system as a strategy to discuss complex cases and identify areas for improvement in care.
- Staff used evidence-based tools to monitor nutrition and hydration and ensure patients received appropriate support. Dieticians were available in the hospital and the gastroenterology service had recruited a food allergist as part of a new feeding pathway.
- Staff had reviewed starving times and implemented new care protocols for patients that enabled them to have a drink before surgery.
- A specialist pain control team was available 24-hours a day, seven days a week.

Surgery

- From July 2016 to June 2017, patients at the trust had a lower than expected overall risk of readmission for elective admissions.
- Effective discharge processes were in place in inpatient wards and consultants always provided discharge summaries for patients to take away with them and sent a copy to the patient's GP.
- A dedicated team of practice facilitators and practice educators provided specialist training, simulations, ad-hoc support and facilitated learning across all surgical areas.
- Patients were cared for by coordinated teams of clinicians who worked with therapies and rehabilitation staff and met regularly to review care planning. Multidisciplinary working was clearly embedded in all clinical pathways such as through consultants working cross-specialties and a team of psychologists reviewing patients in all inpatient wards.
- The child and family information group worked with clinical teams to develop health promotion materials and strategies to help patients and their parents during their stay and after discharge.
- An extensive range of non-clinical services and teams worked together to provide holistic care to patients and their relatives. This included a school with teachers who visited wards, a team of volunteers and dedicated play specialists. Staff in each team adapted their service to the age of patients and there was a demonstrable focus on improving facilities and services for adolescents.
- Play specialists had worked with the infection control and nurse teams to ensure they could use recreational resources with young people who were treated in isolation due to infectious risks.

However:

- Between April 2016 and March 2017, 85% of staff within surgery at the trust had received an appraisal compared to a trust target of 90%.
- Staff told us they did not routinely receive training in the Mental Capacity Act (2015) and there was limited understanding of mental capacity in some teams and departments. However after our inspection the trust told us this was included as part of their safeguarding level 1 mandatory training.
- Although multidisciplinary working was clearly embedded in services, this did not extend to the wider trust. This was because there was a lack of learning between services, departments and specialties.

Is the service caring?

Good

Our rating of caring went down. We rated it as good because:

- The results of the NHS Friends and Family Test (FFT) indicated people scored surgery services consistently well for recommendation rates. Several areas had a track record of achieving 100% recommendation rates from respondents.
- The trust had adapted the FFT questionnaire into a child-friendly format so that children could contribute their thoughts.
- During all of our observations, staff spoke to patients, parents and visitors with kindness and respect.
- Staff demonstrated understanding of the principles of privacy and dignity and adapted care to the age and needs of their patients.
- Staff in theatres offered children visits to theatres ahead of planned treatment as a strategy to reduce anxiety.

- A chaplaincy and spiritual care team provided emotional support to parents and children of all faiths or no faith.
- There was a culture of involving patients and parents in care planning and decision-making. We saw this demonstrated by staff in all specialties and roles. Parents and patients we spoke with persistently cited this as a positive aspect of their interactions with staff.

Is the service responsive?

Good

Our rating of responsive improved. We rated it as good because:

- The hospital benchmarked length of stay times for surgical specialties with three other specialist children's hospitals. Between April 2016 and September 2017, the average length of stay was 6.6 days, which was comparable to or better than similar hospitals.
- Staff used a hospital passport system to help them understand and communicate with young people where they presented with complex communication needs.
- Sensory rooms were available and activities rooms were located on each ward. Age-specific activities and relaxation spaces were provided and play specialists ensured they were 'safe spaces' away from medical procedures and medication administration.
- In 2016, the trust resumed reporting referral to treatment (RTT) times following a suspension to review data quality processes. Dedicated specialists in data collection, analysis and validation worked with clinical colleagues to ensure data was accurate and high quality. A demand and capacity model for all specialty services was in place and senior teams used this to improve waiting times and there was significant evidence of improvement, including 100% compliance with national standards in eight sub-specialties in December 2017 and January 2018.
- Work was ongoing in each specialty to address waiting lists and this involved improving recruitment to administrative roles and involving matrons in planning.
- In the second quarter (Q2) of 2017/2018, the trust cancelled 119 surgeries, 94% of which were treated within 28 days.

However:

- Some clinical specialties, including spinal surgery, were not expected to achieve the trust's RTT targets until 2019/20 due to persistent gaps in staffing and demand higher than capacity.

Between August 2016 and September 2017, there were 31 complaints in surgical specialties. The trust took an average of 59 calendar days to investigate and close complaints; which was not in line with the complaints policy standard of 25 days.

Is the service well-led?

Requires improvement Same rating

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Divisional structures were operating according to an interim model. This meant fewer senior staff provided oversight to increasing areas, including the director of operations who was responsible for five sub-divisions and all 52 specialties and services. We received consistently negative feedback about the functioning of senior executive teams from senior clinical staff.

Surgery

- Staff told us they did not understand the trust senior teams' roles or purpose and said efforts to engage were often very challenging because they were timed to conflict with their clinical responsibilities.
- Understanding of the trust's vision and strategy was variable amongst staff. Some teams had developed their own local vision to enable staff to work towards a common purpose.
- Some specialties had limited systems in place to ensure risk management and learning was shared amongst the whole team.

However:

- Divisional risk registers were regularly scrutinised, reviewed and updated. This included in relation to significant patient safety risks relating to poor records access control and management.
- All of the staff we spoke with said they were supported at a local level by their immediate supervisors and managers.
- Clinical governance systems at specialty level demonstrated leadership to improved practice and safety.
- Ward managers, senior nurses and doctors were empowered to develop the working culture in their respective areas of work. This led to high levels of job satisfaction, which contributed to highly dedicated patient care.
- Staff said good working relationships enabled them to develop professionally and work effectively with colleagues in a culture that rewarded good work and facilitated positive learning from mistakes.
- A clinical audit manager worked with staff to embed safety culture into theatres in a way clinicians thought was meaningful. This formed part of a quality improvement and engagement exercise to develop safety systems.
- A young people's forum operated for patients from age 11 and provided them with a voice within the trust to ensure their' needs were catered for.

Outstanding practice

We found an example of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Outpatients

Good

Key facts and figures

Great Ormond Street Hospital for Children NHS Foundation Trust is one of four dedicated children's hospital trusts in the UK. The trust operates from a single site in central London and provides outpatient clinics to children funded by the NHS and privately funded patients from overseas and the UK. It is the largest paediatric centre in the UK for intensive care, cardiac surgery, neurosurgery, cancer services, nephrology and renal transplants and has more than 50 different clinical specialties. Great Ormond Street Hospital forms the UK's only academic biomedical research centre specialising in paediatrics in conjunction with another hospital. Outpatient services are provided in various settings throughout the main hospital and across three floors in an adjoining building that is on the main hospital site but managed by another London trust.

There were 255,651 first and follow up outpatient appointments between August 2016 and July 2017 compared with 104,581,336 for the whole of England in the same period. This was an increase of over 20,000 patients seen between July 2013 and June 2014 (233,462) as recorded at the previous CQC inspection in June 2015.

We inspected the service over three unannounced inspection days, 9 to 11 January 2018.

During our inspection, we visited a range of clinical areas including Cheetah, Hippo, Rhino, Manta Ray, Caterpillar, Hare and Zebra. We spoke with staff and patients in a range of clinics; for example cardiology, endocrinology, gastroenterology, rheumatology, ophthalmology, neuro-disability and speech and language therapy. We spoke with 37 members of staff including doctors, nurses, allied health professionals, administrative and other staff. We spoke with the director of operations and clinical director for the ICSU as well as the head of nursing and operational lead for the service. We reviewed four patient records and spoke with 12 children and young people and 18 relatives.

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

Summary of this service

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

We rated safe, responsive and well-led as good. The rating of responsive and well-led had improved since our last inspection. Our overall rating of this service improved. We rated it as good because:

- We saw evidence of the use of national clinical guidelines and a culture of evidence based practice in the specialties we observed in outpatients.
- The service made sure staff were competent for their roles. All nurses in the outpatients department had an appraisal within the last year. Staff told us they found it of benefit to take time out and reflect on their work and possible career development.
- Staff cared for patients with compassion. We saw several examples of staff from all disciplines being supportive and kind to patients and their relatives. We saw staff comforting patients and carers and a high level of engagement with children and young people.

Outpatients

- Patients and their relatives felt included in their plan of care. Patients told us nurses and clinicians spoke directly with them rather than just to their parents and carers. They felt included in discussions about their treatment and staff took time to ensure they understood what was discussed.
- The service took account of patients' individual needs. There were link nurses for patients with a learning disability, who staff and patients could contact for advice and support. Reasonable adjustments were made to provide a better patient experience for learning disabled patients.
- The department supported people to be as engaged in their own health and wellbeing as possible. For example, speech and language therapists ran a group once a month for parents of children who recently had a cleft palate repair. Advice and information was shared about speech development, good oral hygiene and diet.
- Staff we spoke with were very positive about the current leadership team and told us their biggest strength was their honesty and visibility. Staff told us there was good teamwork and they felt valued and got recognition for their work.
- There was general consensus amongst managers and staff about what the department's top risks were. These included increasing demand on services and capacity in clinics, as well as the unplanned for arrival of inpatients from other hospitals to the outpatients department. Staff told us risks were discussed at meetings and managers shared information about what was being done to mitigate these risks.
- Leaders developed a business strategy which was designed to increase the efficiency of the department and enhance patient experience. For example, providing extra space for clinics that had become too full.
- The trust returned to reporting in January 2017 in agreement with commissioners with noticeable improvements to the quality of the data. This showed that the trust's referral to treatment time (RTT) for non-admitted pathways was similar to the England overall performance. Data on RTT for admitted pathways showed that 91% of patients were seen within 18 weeks with the between August and December 2017.

However:

- We observed inconsistent adherence to infection prevention and control practice and recent hand hygiene results were poor. Hand hygiene audits from January to December 2017 demonstrated that the average compliance rate was 78%, with results varying between 50% and 96%. We observed doctors were not always 'bare below the elbow'.
- We noted there were no single use tourniquets in use which increased the possibility of infection.
- We found inconsistencies in fridge temperature monitoring; we also saw that ambient temperature monitoring was not taking place in areas where medicines were being stored. There was no action plan in place to address this issue.
- Patient-identifiable information was left unattended in consulting rooms. This created the risk of confidential patient information being accessed inappropriately.

Is the service safe?

Our rating of safe stayed the same. We rated it as good because:

- Nursing staff were 100% compliant with safeguarding children level 3 training and were confident about how to escalate any concerns they had about the safety of the child.
- Medicines were stored securely and resuscitation trolleys in all areas we visited were in line with the Resuscitation Council's recommendations. Trolleys had been checked daily and these checks were recorded. All trolleys were situated in areas without obstruction and could be easily accessed.

- Staff told us they were confident to report any identified risks and log incidents without any fear of blame.
- There were hand washing facilities including hand wash basins and hand gel sanitisers widely available around general areas of the department and within the clinical areas.
- Staff were able to demonstrate in detail how they decontaminated isolation rooms after each use. We observed a morning handover, which identified patients who required isolation.
- There was a robust system in place to ensure toys in play areas were decontaminated after use. We were told that parents were encouraged to bring the child's own toys if they had to go into an isolation room to reduce the possibility of cross-contamination.
- During the last CQC inspection, we noted the equipment used to transport patient records between departments was frequently not fit for purpose. During this inspection we saw that these had been replaced with patient record trollies on wheels which had a key pad system and were easy to move from area to area.
- During the previous inspection, we were told that a significant number of referrals from other NHS trusts and embassies did not include adequate medical or clinical information. During this inspection, staff told us they had since adapted a robust approach to this which had resulted in significantly improved quality of referral information.

However:

- The most recent hand hygiene audit showed there was just 57% compliance. We observed good hand hygiene by all staff when they were examining patients, which was confirmed by parents we spoke with.
- There were times when demand for isolation rooms was between 16 and 35 cases per day for five rooms.
- The trust reported a 25% turnover of nursing staff which was higher than the trust average was 16%.
- Hospital-only outpatient prescription pads were left out on desks in all consulting rooms we visited. This was not in line with the NHS security of prescription forms guidance (updated August 2015).

Is the service effective?

We do not rate this domain.

- We found a culture of evidence-based practice in the specialties we inspected in outpatients. Clinicians told us of an audit which was now accepted National Institute for Health and Care Excellence (NICE) based practice.
- Many clinical services provided outcomes data to national or international registries. These registries monitored incidence of disease, clinical management of conditions and treatment outcomes.
- Data collected on patients with inflammatory bowel disease in May 2017 showed that 73% of registered patients were in remission. This was a significant improvement from 46% when the last data was collected in March 2011.
- The 2016-17 patient-related outcome measurement related to Osteogenesis imperfecta (OI), also known as brittle bone disease, showed that 100% of parents and 75% of young people understood the answers given to their questions. 100% of both parents and young people felt involved in decisions taken which related to their care.
- The speech and language department held monthly groups to support parents of patients who had recently undergone a cleft palate repair. Information was shared about ways in which to improve speech and maintain good nutrition and oral hygiene. Speech therapists told us there was positive feedback from parents about the efficacy of this group.

Outpatients

- Staff told us how training provided by the trust enhanced their ability to do their job well. For example, we were told how training in conflict resolution recently enabled them to diffuse a situation with a parent and therefore avoided the need to call the police.
- Volunteers were trained to enable them to provide a service to parents and patients who we observed to be helpful and informative.
- Appraisal rates for qualified nursing staff, healthcare assistants and administrative staff were 100% compliant with trust standards.
- We saw evidence of multidisciplinary working between the department and the rest of the hospital as well as with other hospitals and outside agencies such as GPs and community-based healthcare teams.
- Play workers engaged with patients in the waiting areas and a play therapist was frequently asked to provide distraction for distressed children during their appointment.
- The trust had a 'Transition to Adult Care' policy, which we saw was initiated on some patient records we reviewed.
- Staff we spoke with were clear about their responsibility to adhere to legislation and trust policy in relation to consent. We saw how a clinician applied the trust policy with regard to telephone consent which was clearly documented in patient records.

However:

- Trust data showed that turnaround time of discharge summaries within 24 hours varied between 85% and 89% between April and November 2017, which was below the NHS standard of 100%.

Is the service caring?

Outstanding

Our rating of caring stayed the same. We rated it as outstanding because:

- We received only positive comments from patients or their carers about staff throughout this inspection. They told us of the sensitivity demonstrated by staff when breaking bad news. They said they could, and frequently did, ring staff when they needed reassurance.
- Parents told us doctors and nurses made them feel like partners in their child's care. They told us they felt that when their views were sought, this was not just a token exercise and they were really taken into consideration.
- Young people told us how staff asked for their opinions and gave them the opportunity to speak without their parents present. They told us they were treated in a respectful way and made to feel their views were valued and taken into consideration when discussing their treatment plans.
- We observed many occasions when staff showed tremendous understanding and sensitivity towards patients and their carers. They anticipated situations which had the potential to be upsetting and provided distraction to the patient.
- Parents told us how staff were discreet and sensitive when they had to break bad or unexpected news to them. They told us they appreciated the way in which they were taken to a private area away from busy areas to absorb the information shared with them.
- Parent and carers of children with special needs told us how staff adapted their service in order to ensure the best possible experience. This included consistency of staff whom they saw on return visits.

Outpatients

- A pilot project had been developed where a learning disability link nurse did a home visit to a patient who persistently refused to come to their appointments. The nurse used communication aids to prepare the patient for their next appointment and ensured they were on duty to welcome them into the department.
- A professional carer told us they were given comprehensive information by doctors about the patient which they included in the person's residential care plan in order to better support their healthcare needs.
- We saw medical, nursing and administrative staff greet all patients and carers, many by their name and welcome them into clinics. We also saw that staff went to great lengths to ensure that treatment plans and medicine regimes were fully understood by patients and carers before leaving the department.
- The trust proactively sought to improve the service. There were numerous comments boxes throughout the department which encouraged people to leave their feedback on the service.
- A young people's forum operated for patients aged 11 to 25, and provided them with a voice within the trust, and to ensure all patients were catered for, regardless of their age.

Is the service responsive?

Good

Our rating of responsive improved. We rated it as good because:

- During the previous CQC inspection in May 2015, we recorded concerns over the reliability of referral to treatment (RTT) data. Various measures were put in place since then to address the problem and the trust returned to reporting in January 2017 in agreement with commissioners.
- Measures put in place included a clinical harm review of patients on the waiting list, the re-training of staff in the management of RTT and the RTT guidelines and embedding necessary processes to ensure the organisation was robustly tracking and managing its patients, in line with the standards.
- From January to September 2017, the trust's referral to treatment time (RTT) for non-admitted pathways and admitted pathways was similar to the England overall performance.
- Data submitted to CQC showed improvements to call handling performance and a reduction in the number of abandoned calls.
- Patients and carers told us they found the booking system to be efficient and flexible. They were given a follow-up appointment without having to pursue it and it was simple to arrange appointments which fitted in with their work pattern or their child's school schedule.
- The trust provided an extensive translation and interpreting service in recognition of the wide range of languages spoken by their patients and families.
- There was an extensive support system in place for patients living with a learning difficulty. This included a nurse consultant and link nurses who were available to patients, carers and staff. They worked collaboratively to ensure that reasonable adjustments were made to make the patient's hospital experience as positive as possible.
- There was publicly available information on health related matters including epilepsy, diabetes, autistic spectrum disorder, living with visual impairment and healthy eating.
- Carers who travelled by car to the hospital were given a parking voucher for use in the area surrounding the hospital, the length of which depended on the nature of their visit. In addition, where the patient had a number of appointments over the course of more than one day, they were offered hotel accommodation close to the hospital.

- Certain specialties offered telemedicine to patients who lived far away. This allowed clinicians to make an assessment of their patients over the telecommunications infrastructure and reduced the frequency with which the patient was required to attend the hospital in person.

However:

- Complaints to the outpatient departments took on average 42 calendar days to investigate and close, which exceeded the trust target of 25 calendar days.

Is the service well-led?

Good

Our rating of well-led improved. We rated it as good because:

- Following the suspension of reporting its referral to treatment (RTT) waiting times, the trust completed a significant amount of work relating to the RTT access standards. The additional work has led to the improvement of the quality of the data, with staff retrained to correctly manage RTT data.
- There were robust governance systems in place for identifying risk and monitoring quality against national standards. Local audits informed actions required to continuously improve service delivery.
- There was consistency in what staff raised as concerns and what were recorded as risks. The senior leadership team identified risks which staff also identified, including unplanned for arrival of inpatients from other hospitals to the outpatients department and capacity in clinics. We saw that risks were reviewed regularly and actions identified to address them.
- Staff were very positive about the local leadership of the outpatients department. They told us they were visible, supportive and had an open door policy.
- The departmental leadership team had a vision for the department and an improvement plan put in place to achieve this.
- Staff told us they felt valued and their views were listened to. They described the department as a good place to work where strong teamwork ensured good service delivery to patients.
- Staff said equality and diversity training, which was mandatory, helped them to offer better support to patients from diverse backgrounds.
- The trust developed an action plan in response to aspects of the 2016 staff survey which scored significantly worse than the rest of the trust.

However:

- Many staff told us they were unfamiliar with those members of the leadership team above departmental sisters and matrons and most did not know the names of board members and told us they would not recognise them.
- We were told that the frequent changes to the organisational structure were confusing and some staff told us they were not made fully aware of the reasons for them.
- The outpatient's staff survey scored worse than the rest of the trust in certain areas. For example, 24% of outpatient staff reported experiencing physical violence from patients, relatives or the public in last 12 months against a trust-wide rate of 7%. In addition, 60% of outpatient staff felt able to contribute towards improvements at work against a trust rate of 76%.

- We found patient-identifiable information on view in offices, including a patient identifiable letter on an unlocked computer screen and clinic lists with patient names on desks in three consulting rooms.

Outstanding practice

We found an example of outstanding practice in this service. See the Outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Our inspection team

Amanda Stanford, Deputy Chief Inspector and Nicola Wise, CQC Head of Hospital Inspection chaired this inspection. David Harris, CQC Inspection Manager took the lead for both parts of the inspection and was supported by Klaudiusz Zembrzuski, CQC Inspector.

The core service inspection team included nine CQC Inspectors, six specialist professional advisors (SPAs), two experts by experience (Exbyex) and one inspection planner.

The well-led inspection team included three inspectors, four SPAs, one executive reviewer and one inspection planner.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.

Attachment J

Council of Governors

25th April 2018

Quality and Safety Assurance Committee Summary Report
January 2017

Summary & reason for item: To provide an update on the January meeting of the Quality and Safety Assurance Committee. The agenda for the meeting is also attached.

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

Report prepared by: Victoria Goddard, Trust Board Administrator

Item presented by: Stephen Smith, Chairman of the QSAC

Update from the Quality and Safety Assurance Committee meeting held on 5th February 2018

Matters arising

The Committee discussed 7 day-working and patient safety out of hours. It was confirmed that Trusts had been asked to look at weekend working and safety during this time and GOSH had been satisfied that there were no concerns. The Committee requested information that could be triangulated to reach a view about safety out of hours such as PALS reports, serious incident reports and claims.

The Committee requested an update on sharps at the next meeting to include assurance that the Trust was compliant with the safer sharps regulations.

Update on Transition

Significant progress had been made in this complex area and a consultation had taken place with young people, families and staff. Patients with complex conditions were transitioned to several organisations for their adult care. The Committee requested that any learning was gathered from other paediatric hospitals and it was agreed that an update would be provided on progress against the milestones set out in the Quality Report.

Integrated Quality and Safety Update

Discussion took place about the wording that had been used in the report around Never Events and it was agreed that this would be reviewed. The Committee discussed the way in which trend data was presented and it was noted that the CQC had done work on this and had a suggested list of ways to present the data. It was confirmed that GOSH used Statistical Process Control (SPC) which was considered best practice.

Compliance with Risk Management Framework

The Committee noted that the number of risks of the Trust Wide Risk Register had reduced from 70 to 40 in quarter three as a result of scrutinising the risks' descriptions and the progress made. Work was taking place to ensure there was a standardised process for reviewing risks across the Trust. The Committee agreed that red risks that had been open for some time were the priority for the QSAC.

Whistle blowing update - Quality related whistle blowing cases

A lead Freedom to Speak Up (FTSU) Guardian had been appointed and work was taking place to look at reporting on a more regular basis to the Senior Independent Director and the Board. As part of the work taking place with the Cognitive Institute, two patient safety champions would be appointed and consideration was being given to how they would interact with the FTSU ambassadors.

Quarterly Safeguarding Report (October 2017 – December 2017)

The updated safeguarding policy had been approved by the Policy Approval Group and there had been additional resources put into the team; it was anticipated that the new posts would be filled by March 2018. Work was taking place to expand general paediatrics' cover of safeguarding out of hours which currently fell under the remit of the Clinical Site Practitioners. Patients on child protection protocols were being flagged on PIMS in advance of the implementation of the Electronic Patient Record.

Board Assurance Framework Update

An internal audit report on the Board Assurance Framework had provided a rating of 'significant assurance with minor improvement potential'. Recommendations had been around reporting to assurance committees and the work had been started prior to the report. Discussion took place around the way in which the BAF and the Trust Wide Risk Register (TWRR) worked together and it was confirmed that executive director risk owners were responsible for ensuring they were aware of anything on the TWRR which would impact a BAF risk. The importance of being responsive in this area was emphasised.

Compliance Framework Update

Substantial work was taking place to reduce the number of out of date policies. Processes around national safety standards for invasive procedures (NatSSIPs) were being developed and a governance process would be rolled out to divisions.

Update on implications for GOSH from national guidance on learning from deaths (Trust Board action May 2017)

The Committee noted that GOSH's processes around learning from deaths benchmarked well against other organisations' with the mortality review group having been in place since 2012. The CQC had been positive about GOSH's processes.

Update on learning from patient stories

The Committee noted the update and it was confirmed that a project was taking place around the patient menu.

Pharmacy Review

It was reported that recommendations arising from the review were covered under six themes and the committee welcomed the excellent work that had taken place. A number of positives had also been highlighted around the commitment of staff and their level of expertise. Discussion took place around the anticipated outcome of the work on the recommendations which included a reduction in medication errors. The Committee requested a further update in six months' time.

Update on quality and safety impact of Fit for the Future programme (linked to BAF risk 2: Productivity)

The Committee welcomed the reduction in the use of agency staff and requested an update on the work that was taking place around a theatre utilisation data issue. Two better value scheme post implementation reviews were noted which did not show any negative impact in terms of quality and safety.

Internal Audit Progress Report (October 2017 – December 2017)

The Committee noted the internal audit report on business continuity which had provided a rating of significant assurance with minor improvement opportunities.

Clinical Audit update October 2017 – December 2017

It was noted that the report made reference to an under resourcing in the Clinical Audit team and the committee emphasised the important of this function.

Matters to be raised at Trust Board

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

- Freedom to Speak Up
- Pharmacy review
- Actions arising from patient stories
- Compliance with the risk management framework.

QUALITY AND SAFETY ASSURANCE COMMITTEE
Monday 5th February 2018 at 12:00pm – 3:00pm in Number 45 Great Ormond Street, Great Ormond Street Hospital for Children NHS Foundation Trust

AGENDA

	Agenda Item	Presented by	Attachment	Time
1.	**Apologies for absence**	Chairman		**12:00pm**
2.	**Minutes of the meeting held on 17th October 2017**	Chairman	**A**	
3.	**Matters arising/ Action point checklist**	Chairman	**B**	
	QUALITY AND SAFETY			
4.	**Update on Transition**	Chief Nurse	**D**	**12:10pm**
5.	**Integrated Quality and Safety Update**	Associate Medical Director/ Interim Chief Nurse	**E**	**12:25pm**
6.	**Quarterly Safeguarding Report (October 2017 – December 2017)**	Interim Chief Nurse	**G**	**12:35pm**
	RISK AND GOVERNANCE			
7.	**Board Assurance Framework Update**	Company Secretary	**H**	**12:45pm**
8.	**Compliance Framework Update**	Company Secretary	**I**	**12:55pm**
9.	**Compliance with Risk Management Framework**	Head of Quality and Safety	**J**	**1:05pm**
10.	**Health and Safety Update**	Director of HR & OD	**Verbal Update**	**1:15pm**
11.	**Whistle blowing update - Quality related whistle blowing cases**	Assistant Director of Employee Relations	**L**	**1:20pm**
12.	**Update on implications for GOSH from national guidance on learning from deaths (Trust Board action May 2017)**	Associate Medical Director	**M**	**1:30pm**
13.	**Update on learning from patient stories**	Interim Chief Nurse	**N**	**1:40pm**

14.	**Pharmacy Review**	Dr Allan Goldman	**O**	**1:50pm**
	AUDIT AND ASSURANCE			
15.	**Update on quality and safety impact of Fit for the Future programme (linked to BAF risk 2: Productivity)**	Deputy Chief Executive	**P**	**2:05pm**
16.	**Internal Audit Progress Report (October 2017 – December 2017)**	KPMG	**Q**	**2:15pm**
17.	**Internal and external audit recommendations update**	KPMG	**R**	
18.	**Clinical Audit update October 2017 – December 2017**	Clinical Audit Manager	**S**	**2:25pm**
19.	**Matters to be raised at Trust Board**	Chair of the Quality and Safety Assurance Committee	**Verbal**	**2:35pm**
20.	**Any Other Business**	Chairman	**Verbal**	
21.	**Next meeting**	**Wednesday 9th May 2018 at 4:00pm – 7:00pm**		
22.	**Terms of Reference and Acronyms**	**1**		

ATTACHMENT K

Attachment K

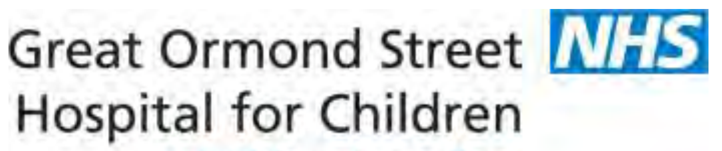
AUDIT COMMITTEE

The Great Ormond Street Hospital for Children NHS Foundation Trust

GREAT ORMOND STREET LONDON WC1N 3JH

A G E N D A

Monday 16th April 2018
2:30pm – 5:30pm



AUDIT COMMITTEE

Monday 16th April 2018 at 2:30pm, Charles West Boardroom, Paul O'Gorman Building

AGENDA

	Agenda Item	Presented by	Attachment	Time
1.	**Apologies for absence**	Chairman		**2:30pm**
2.	**Minutes of the meeting held on 23rd January 2018**	Chairman	**A**	
3.	**Matters arising and action point checklist**	Chairman	**B**	
4.	**Finance and Investment Committee –- January and March 2018 Draft Minutes**	James Hatchley, Chairman of the F&I Committee	**C**	
5.	**Quality and Safety Assurance Committee –January 2018 Draft Minutes**	James Hatchley, NED	**D**	
	RISK			
6.	**Board Assurance Framework Update**	Company Secretary	**E**	**2:45pm**
7.	**Presentation of high level risks** **Risk 8:** 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 9:** The Trust may not be able to provide the required level of research infrastructure or leverage additional research income if core research funding streams are reduced **Risk 13:** Inadequate planning or management of infrastructure redevelopment may result in poor VFM or failure to deliver expected business benefit.	Director of Performance and Information Director of Research and Innovation Director of Development	**F** **G** **H**	**2:50pm**
8.	**Update on Cyber Security**	Deputy Chief Executive	**I**	**3:20pm**
9.	**Update on GDPR Preparation**	Director of Planning and Information/ Company Secretary	**J**	**3:30pm**
10.	**Changes to accounting policy – IFRS 15**	Interim Chief Finance Officer	**K**	**3:45pm**
11.	**Valuation of Trust's Estate**	Interim Chief Finance Officer	**L**	**3:55pm**

	EXTERNAL AUDIT			
12.	**External Audit: Interim update report to the Audit Committee for the year ended 31 March 2018**	Deloitte LLP	**M**	**4:05pm**
	INTERNAL AUDIT AND COUNTER FRAUD			
13.	**Internal Audit Progress Report, Technical Update and Draft Head of Internal Audit Opinion for 2017-18**	KPMG	**N**	**4:15pm**
14.	**Internal and external audit recommendations – update on progress**	KPMG	**O**	**4:30pm**
15.	**Internal Audit Strategic and Operational Plan: 2018-19**	KPMG	**P**	**4:40pm**
16.	**Counter Fraud Annual Report and Counter Fraud Workplan 2018/19**	Counter Fraud Manager, TIAA	**Q**	**4:50pm**
17.	**Whistle blowing and Freedom to Speak Up Ambassador update**	Deputy Director of HR and OD	**R**	**5:00pm**
	GOVERNANCE			
18.	**Draft Annual Governance Statement 2017/18**	Interim Chief Finance Officer / Company Secretary	**S**	**5:05pm**
19.	**Draft Audit Committee Report to be included in the Annual Report**	Interim Chief Finance Officer	**T**	**5:15pm**
20.	**Process for appointment of external auditor, internal auditor and counterfaud service**	Interim Chief Finance Officer	**U**	**5:25pm**
	ITEMS FOR INFORMATION			
21.	**Performance Report – Month 11 (2017/18)**	Deputy Chief Executive	**V**	
22.	**Any Other Business**		**Verbal**	
25.	**Next meeting**	**Wednesday 23rd May 2018, 10:00am – 1:00pm in the Charles West Room**.		

ATTACHMENT L

FINANCE AND INVESTMENT COMMITTEE

Meeting

The Great Ormond Street Hospital for Children NHS Foundation Trust

CHARLES WEST ROOM
GREAT ORMOND STREET
LONDON WC1N 3JH

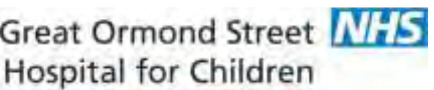
A G E N D A

Tuesday 20th March 2018 at 1:00pm – 3:00pm

FINANCE AND INVESTMENT COMMITTEEMEETING
Tuesday 20th March 2018 1:00 pm – 3.00pm
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	1:00pm (10 mins)
2	Minutes of the meeting held in Jan 2018	Chairman	A	
3	Matters Arising, Action checklist	Chairman	B	
	Performance & Finance Standing Updates			1:10pm
4	Finance Report 2017/18 Month 11	Interim Chief Finance Officer	C	*10 mins*
5	Performance Scorecard Month 10	Deputy Chief Executive	D	*Noting*
6	Activity Trends 2017/18 Month 11	Deputy Chief Executive	E	*Noting*
7	NHS Contract Update 2017/18 Month 11	Deputy Chief Finance Officer	F	*Noting*
8	Better Value Monthly Update	Deputy Chief Executive	G	*Noting*
9	Standard Template for Divisional Review Divisional Review – JM Barrie • 2017/18 Outturn v Plan v Last Forecast	Deputy Chief Executive	Presentation	*Noting* *20 mins*
10	Workforce Analysis	Interim Chief Finance Officer	I	*10 mins*
	Annual Planning			1.50pm
11	2018/19 NHSI Annual Plan Update	Deputy Chief Executive/ Chief Finance Officer	J	*10 mins*
12	2018/19 Draft Budget Review	Interim Chief Finance Officer	K	*20 mins*
13	2018/19 Capital Plan	Interim Chief Finance Officer	L	*10 mins*
14	Financial Trends – Update paper from previous meeting	Deputy Chief Finance Officer	M	*5 mins*
	Project Updates/ Reviews			2.35pm
15	EPR Programme Update	EPR Programme Director	N	*5 mins*



	Agenda Item	Presented by	Attachment	Time
16	**Post Implementation Review – Southwood Imaging Suite**	**Director of Development**	**O**	*15 mins*
	<u>Other Business</u>			**2.50pm**
17	**Any other business** - **2018 Meeting Dates**	**Chair**		*10 mins*
	Close 3.00pm			
18	**Next meeting** The date of the next meeting will be 17 May 2018 2:00pm - 5:00pm in the Charles West Room.			

[followed by Confidential meeting]

Attachment M

Council of Governors

25 April 2018

Chief Executive Report – April 2018

The purpose of this paper is to provide a summary of key work priorities and achievements since the 7th February 2018 report to the Council of Governors. The report includes:

- Welcome to the Trust Chief Nurse, Medical Director and new Non-Executive Director
- Trust Board update
- News stories:
    - Jeremy Hunt - Secretary of State for Health and Social Care visit
    - Al-Khair Foundation pledge to support prayer and reflection space
    - Other news items
- Appended to this report are quality, performance and finance reports.

Governor action required:

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

Report prepared by:

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

Report presented by:

Peter Steer, Chief Executive Officer

Welcome to the Trust Chief Nurse

I'm delighted that Alison Robertson officially started her role on Monday 9 April 2018 as the new Chief Nurse for Great Ormond Street Hospital.

Alison trained and worked at GOSH at the beginning of her career. Fast forward to today, and she brings a wealth of experience, including from her Chief Nurse role at one of the leading hospital providers in the Middle East, as well as experience in leading nursing and midwifery professions and providing direction to the quality, safety and experience agenda.

We will be looking for opportunities to introduce you to her over the coming weeks. One of her priorities as referenced in our recent CQC report, is to look at ways to develop a strong nursing voice within the Trust. We look forward to working with her on this. In the meantime, our thanks go to Polly Hodgson for filling the Chief Nurse role in the interim and who will now take up the role of Deputy Chief Nurse. An updated nursing team structure will be shared with Governors in due course.

Welcome to the Medical Director

Matthew Shaw took up his post as Medical Director on Friday, 2 March 2018 and is the Trust's lead for patient and staff safety and clinical quality. He provides professional leadership to the medical body and is also responsible for postgraduate medical education and training for doctors, medical workforce development and partnership services.

Matthew attends the Quality and Safety Assurance Committee.

Welcome to the new Non-Executive Director

Chris Kennedy, Non-Executive Director officially started his role on Monday 16 April 2018 as the new Non-Executive Director for Great Ormond Street Hospital.

Chris is a qualified accountant and currently chief financial officer of Micro Focus, one of the largest pure-play software companies in the world.

Prior to this Chris was CFO of ARM Holdings plc, the UK's largest listed technology company. He has spent the last 20 years in senior global, financial and commercial roles in a variety of sectors including five years at EasyJet. Chris spent 17 years at EMI as COO of EMI International running both the commercial and finance functions together with the growing digital music business, and later became CFO of the Group. Chris holds a degree in electrical sciences from Cambridge University.

Attachment M

An updated organogram detailing both our board members and our executive team is available here: https://www.gosh.nhs.uk/about-us/who-we-are/our-organisational-structure/trust-board

Attachment M

Trust Board update

The Trust Board met on 28 March 2018. The full set of papers for the Trust Board can be found on the Trust website here: https://www.gosh.nhs.uk/about-us/who-we-are/our-organisational-structure/trust-board/trust-board-meetings

A precis of discussions is below.

National Institute for Cardiovascular Outcomes Research (NICOR)

The National Institute for Cardiovascular Outcomes Research (NICOR) noted that GOSH outcomes were higher than the national average for the 2nd reporting cycle in a row. Staff were congratulated for this achievement.

NICOR collect clinical information (audits and comparison of patient outcomes) from UK hospitals with the aim of helping the NHS, the government and regulatory bodies improve quality of care.

North Thames specialist paediatric planning

GOSH has been approached by both the three North London Sustainability and Transformation Partnerships (STPs) with the aim of working together on specialist paediatric planning. The Trust has acknowledged the invitation and is enthused about working together on the project.

Quality and Safety Assurance Committee (QSAC) highlight report

In response to the 'Freedom to Speak Up' report the Head of PALS has been appointed as the Trust's Freedom to Speak up Guardian. The 'Freedom to Speak up' report set out 20 principles and actions which aim to create the right conditions for NHS staff to speak up, share what works right across the NHS and get all organisations up to the standard of the best and provide redress when things go wrong in future). For more information see: http://freedomtospeakup.org.uk/

The Board were also assured that all 'Patient Stories' presented to the Trust Board, were fully reviewed by the Quality and Safety Assurance Committee (a committee of the Board) for issues that require follow -up action.

Finance and Investment Committee highlight report

The Committee reviewed the processes for signing off budgets during the commissioning cycle. It proposed constructing a financial model that fully considered all long term assumptions. To assist this review, the Committee considered historical capital expenditures and how they performed financially, in terms of efficiency. One proposal considered, was a revision of the business case template.

Draft Annual Business Plan 2018/19 including operational and finance plan

The Board were informed of the highlights with the report submitted to NHS Improvement (our financial regulator) as part of the 2018-19 annual planning round, including:

- the draft Financial Plan and assumptions and risk assessment of assumptions used in the development of the two-year plan.
- that adequate governance measures were are in place to ensure the accuracy of information included within the plans.

It is my role as CEO to sign-off the final version of these submissions by 30 April 2018 with delegated authority from the Board.

Safety and Reliability Improvement Programme

In January 2018, the Trust partnered with the Cognitive Institute as the first UK partner in their Safety and Reliability Improvement Programme (SRIP). This contributed to our commitment to achieving zero preventable harm and delivering the best possible outcomes through providing the safest, most effective and efficient care.

As of March 2018, the programme's governance was established, inclusive of a project board with clinical leadership and a Senior Responsible Officer. The next step is to select 18 'Safety Champions' from across the organisation and train them in June 2018. The Board welcomed the work to improve the culture of the Trust, but noted that culture change in large organisations requires time and commitment from senior leaders. An update on progress with this work will be provided to the Council later in the year.

Sight and Sound Centre - Full Business Case

The Board approved the business case for the Sight and Sound Centre, which aims to provide a high quality patient environment for a group of patients that often have specific sensory needs and for whom a visit to a busy, low quality environment can be stressful. The Board requested regular assurances that the project would be delivered on time, in full and on budget.

Great Ormond Street Hospital news

Care Quality Commission inspection

Overall CQC Summary Report for GOSH 2018 rated us as 'Good'.

The full report and summary report are on the Trust and CQC website. The Trust's comprehensive action plan to address the issues is on the agenda.

Update on the review into the Gastroenterology Service at Great Ormond Street Hospital

A verbal update on steps the Trust has taken and will continue to take to improve the gastroenterology service will be provided at the meeting.

Jeremy Hunt - Secretary of State for Health and Social Care visit

Secretary of State for Health and Social Care, Jeremy Hunt, visited Great Ormond Street Hospital (GOSH) on Thursday 29 March to talk to staff on the topic of patient safety, outlining his ambition to ensure the NHS is the safest healthcare system in the world.

Mr Hunt spoke to staff from across the organisation, including consultants, nurses and healthcare assistants, and acknowledged the huge amount of hard work that takes place across the Trust every day striving for the highest standards of safety.

The visit was an opportunity for Mr Hunt to hear directly about how the hospital continued to improve patient safety by fostering a culture of transparency and a focus on quality. We showcased some of our current patient safety improvement programmes.

The visit came as part of a series of visits the Secretary of State is making to NHS Trusts across the country.

Al-Khair Foundation pledge to support prayer and reflection space

The Muslim Prayer Room and Contemplation Space will be supported by a £300,000 pledge from the Al-Khair Foundation, a humanitarian charity which has its headquarters in Croydon.

The charity has donated the sum to transform an area into a cherished space for patients, families and staff. The space will become an essential part of the hospital helping to improve the social and spiritual well-being of young patients and their families.

The prayer room and reflection space are due to open in September 2018.

The extended Nature Trail at GOSH

The Trust's nature trail, art work commissioned by GOSH Arts in 2012 for the Morgan Stanley Clinical Building, has been extended into the newly opened Premier Inn Clinical Building. The Nature Trail follows the patient journey to the operating theatre. This journey can present a difficult and anxious time for patients and their families and this artwork offers a pleasant distraction to improve their experience.

Rare Disease Day

On 28 February 2018, Great Ormond Street Hospital (GOSH), along with GOSH Children's Charity and Sparks, joined hundreds of organisations from all over the world in marking Rare Disease Day 2018.

The Trust created hands-on activities in the Lagoon for patients to help raise awareness of how research helps find treatments and cures for rare conditions. Patients had the chance to make a family tree to learn about genetic research and look at muscle cells under a microscope to find out about the causes of rare conditions.

In addition, GOSH's contribution to treating rare disease was featured in national press. The Guardian Rare Disease supplement ran an article by Professor Bobby Gaspar, an immunology expert at GOSH, who shared how gene therapy can be an effective method to treat rare diseases, such as severe combined immunodeficiency (SCID). In The Times, David Cameron shared how his son Ivan was born with an extremely rare neurological disorder called Ohtahara syndrome. His story highlighted how specialist research centres such as GOSH helped to find cures to treat incurable conditions.

Other news

Cancer drugs could transform the lives of children with serious disfigurements

Drugs normally used to treat cancer could reduce the disfigurements of thousands of children born with life-threatening blood vessel defects, according to research led by Great Ormond Street Hospital (GOSH) and its academic partner, the UCL Great Ormond Street Institute of Child Health (ICH).

Attachment M

Following DNA testing, scientists have been able to pinpoint the group of genes responsible for causing blood vessel defects in arteriovenous malformation (AVM). For the first time, they have identified drugs which could target the underlying cause of the condition.

In AVM, which affects hundreds of thousands of people across the globe, abnormalities in blood vessels lead to painful facial or other disfigurements, life-threatening bleeding and increased risk of complications like stroke. Until now, effective treatment options have been severely limited, with the only options being embolisation or surgery to try to stop growth, or reduce the swellings. However, these treatments often lead to the blood vessels growing back.

This research has now opened the door for highly personalised medical treatment for children with this debilitating condition.

The study is one of over 1000 research projects being carried out at GOSH as part of their pioneering research programme, which aims to develop treatments and cures for rare and complex childhood conditions.

Animating the Brain - Theatre Rites and GOSH Arts

A project using a robot puppet to ignite children's fascination with their brain and creatively engage people with neuroscience and neurology visited Great Ormond Street Hospital (GOSH). The project met with patients and families.

During their two-week project at GOSH, the Theatre Rites creative team ran workshops on Koala Ward – the neuroscience ward – with patients and families, who were introduced to their robot puppet, 'LabBoy'. The result of two years of research with neuroscientists from King's College London, LabBoy was a great hit with everyone he met.

In one-to-one sessions, children made their own symbolic 'brain' which allowed them to celebrate things that were important to them. In some cases, they playfully and physically represented the regions of their brain that caused their illness.

Theatre Rites' creative team also met with clinical staff who work in the field of neurology. The sessions helped Theatre Rites to understand more about the expertise that staff use and the ethical and social issues that they tackle when trying to repair acquired brain injuries or manage non-typical brain developments in children.

Theatre Rites recorded their conversations with the neurology teams and, alongside the ideas gathered during workshops with families, will use them to inform the development of Animating the Brain over the next year.

AI bodysuit trial launched to help treat Duchenne muscular dystrophy

A new artificially intelligent (AI) bodysuit to help understand how mobility is affected in boys with Duchenne will be trialled in a collaboration between researchers at Great Ormond Street Hospital (GOSH) and Imperial College London.

The study could help doctors make better treatment decisions for the condition. The trial will be led by Imperial researchers who will work with GOSH to develop and test a body suit that measures movements through everyday life in a number of boys with and without Duchenne.

Duchenne muscular dystrophy is a genetic muscle wasting disease that begins in childhood and mainly affects boys. It usually results in patients being unable to walk by age 12, and carries an average life expectancy of around 30 years. In the UK, 2,500 people currently live with the disease, and despite significant recent developments in treatment options, there is no cure for Duchenne.

The funding will support a clinical trial lasting 12 months, during which time the children will wear the suit on selected days, allowing it to measure how their body interacts with the world around

them. Patients will also wear fitness tracker bracelets throughout the trial which will collect data on everyday movements.

Appendices

- Integrated Quality Report (covering January – February 2018) – Appendix 1
- Integrated Performance Report (Month 10 and 11 2017/18) – Appendix 2a
- Trust Board Dashboard – February 2018 – Appendix 2b
- Finance and Activity Performance Report (Month 11 2017/18) – Appendix 3

Integrated Quality Report

Dr Andrew Long, Interim Medical Director
Polly Hodgson, Interim Chief Nurse

March 2018

(covering January- February 2018)

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Outcomes/ Effectiveness

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Improvement

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Has patient care been safe in the past?

Measures where we have no concerns

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.

Data Quality Kite-mark	Measure	Comment
Accuracy, Validity, Audit, Exec Director Judgement, Reliability, Relevance, Timeliness	**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.	The data remains stable, with a current process mean of 7 patients transferred to ICU per month by CSPs. There were 9 such incidents in January, and 12 in February – both within expected limits. The process is currently in normal variation; there have been no runs, trends or recent outliers identified.
Accuracy, Validity, Audit, Exec Director Judgement, Reliability, Relevance, Timeliness	**Cardiac arrests****	Overall, the data remains stable for this measure at 2 cardiac arrests per month; this has remained stable since 2015 with the exception of one outlier in January 2017. There were 2 cardiac arrests outside ICU in both January and February 2018. The process is currently in normal variation at GOSH; there have been no runs, trends or recent outliers identified.
	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.	The data remains stable for this measure at 3 respiratory arrests per month; this has remained stable since June 2015 (when there was a decrease) with the exception of an outlier in November 2015 and August 2017 (both high). The most recent 3 months indicate no change – there were 2 respiratory arrests outside ICU in January and 1 in February. The process is currently in normal variation at GOSH; there have been no runs, trends or recent outliers identified, though there has recently been a reduction in the number of respiratory arrests classified as preventable.
	Cardiac arrests outside of ICU	**Respiratory Arrests outside of ICU**
January 2018	2 (IR and Theatres)	2 (Panther ENT and Chameleon)
February 2018	2 (IR and Kangaroo)	1 (Panther Urology)

Has patient care been safe in the past?

Measures where we have no concerns

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

Data Quality Kite-Mark	Measure	Comment
Accuracy, Validity, Reliability, Timeliness, Relevance, Audit, Exec Director Judgement	**Never Events**	The last Never Event was on 20th October 2017. The mean time between never events is unchanged at 220 days. The baseline for this data is from 2010 until 2014. The Never Event declared in October 2017 is for wrong site surgery while the previous Never Event was due to a retained object.
Accuracy, Validity, Reliability, Timeliness, Relevance, Audit, Exec Director Judgement	**Serious Incidents**** ****by date of incident not declaration of SI**	The number of serious incidents remains stable, with a mean of 0.76 per month. This mean is based on a baseline between September 2016 and January 2018, and is a statistically significant reduction compared to the previous mean (taken from a baseline ending in August 2016, which was also a reduction compared to the previous baseline). There were no SIs reported in January or February. If we look at a more sensitive measure (days since previous SI) then we see that SIs have become less frequent. Before August 2016 we would expect an SI to be reported every 13 days, since then we have had an SI reported every 33 days
Accuracy, Validity, Reliability, Timeliness, Relevance, Audit, Exec Director Judgement	**Mortality**	The data remains stable at 6.3 deaths per 1000 discharges; the process is in normal variation and has been since 2014. The rate for January was 6.25 per 1000 discharges, and 5.35 per 1000 discharges in February. There have been no runs, trends or outliers identified. Over 80% of GOSH inpatient deaths are on ICU, and ICU deaths must be risk adjusted to properly determine a trend. Raw survival/mortality rates do not take account of severity of illness and case mix so outcome data needs to be adjusted to take these factors into account. All ICU data is submitted, after risk adjustment, to the national Paediatric Intensive Care Audit Network (PICANET). This process will allow any trends or outlier performance to be determined. Internal monitoring of Variable Life Adjusted Plots (VLAD) from January – June 2017 showed an increase in the number of deaths on PICU compared to expected. A comprehensive internal review of cases did not suggest any obvious patterns or concerns about the quality of care in PICU/NICU, and no single cause that could explain the trend. GOSH has been informed by PICANET it will not be a statistical outlier for 2017 and the full PICANET data for the calendar year 2017 is due to be published on 31 March 2018. The most recent VLAD data suggests that the negative trend has not continued.

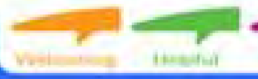
Has patient care been safe in the past?

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.

Data Quality Kite-Mark	Measure	Comment	
Accuracy, Validity, Audit, Exec Director Judgement, Reliability, Relevance, Timeliness	**Hospital acquired pressure ulcers reported (grades 2+)**	Performance remains within normal variation at 6.67 per month.	
		January 2018	**February 2018**
	Grade 2 hospital acquired pressure ulcers	**6**	**4**
	Grade 3 hospital acquired pressure ulcers	**0**	**0**
	Grade 4 hospital acquired pressure ulcers	**0**	**0**
Accuracy, Validity, Audit, Exec Director Judgement, Reliability, Relevance, Timeliness	**GOSH-acquired CVL infections**	We have identified a reduction in the measure of CVL infections per 1000 line days. This reduction started in January 2017 and has been sustained – the current baseline mean from January 2017 to January 2018 shows a rate of 1.38 CVL infections per 1000 line days, compared to a previous mean of 1.42 CVL infections per 1000 line days. (The figures for January and February 2018 are 1.27 and 1.38 CVLS per 1000 line days respectively.)	
Accuracy, Validity, Audit, Exec Director Judgement, Reliability, Relevance, Timeliness	**The number of PALS cases**	The number of PALS cases reported per month remains stable, with an average of 149. Since the outliers in summer 2017 (June and July), the process is currently in normal variation; there have been no runs, trends or recent outliers identified. There were 193 cases in January 2018 and 195 in February 2018, but despite being higher than the mean these are both within expected limits based on previous baseline data.	



Has patient care been safe in the past?

Learning from closed Serious Incidents and Never Events

Serious Incidents and Never Events January - February 2018

No of new SIs declared in January - February 2018:	**0**	No of new Never Events declared in January - February 2018:	**0**
No of closed SIs/ Never Events in January - February 2018:	**1**	No of de-escalated SIs/Never Events in January - February 2018:	**0**

Learning from closed/de-escalated SIs/Never Events in January – February 2018 (1):

Ref:	Summary:	Root Cause:	Action to Remedy Root Cause:	Trust Wide Learning:
2017/ 26155	**A patient was electively admitted for extraction of six teeth. During this procedure, an incorrect molar tooth was extracted.** The patient had an incorrect molar tooth removed. It has not been necessary for the tooth originally planned for removal to be removed at this time and the patient has not needed an additional procedure. The patient will be monitored to observe the progress of this tooth which may need to be removed at a later stage.	The root cause was identified as a failure to identify the correct tooth for removal by the maxillofacial SpR. This failure was due to the retention of the LRE which was confused with the LR6	A dedicated surgical safety checklist for maxillofacial surgery will ensure that a second check of all teeth for removal is implemented as well as identifying which equipment is necessary for the tooth removal. This will reinforce the use of imaging during team brief and the procedure itself. a) Implementation of a safety checklist for use prior to maxillofacial procedures. b) Use of checklist to be audited to ensure this is embedded for use by the maxillofacial and theatres teams. **Action Update: Checklist devised.** It is necessary to raise awareness to all dental, maxillofacial and theatres staff of this type of incident and actions which need to be taken to prevent recurrence. a) Internal safety alert to be devised and disseminated to staff. **Action Update: Complete.** Whilst the responsibility of identifying and removing the correct tooth lies with the surgical team, education of the theatre nurses regarding tooth counts and types of equipment required will empower them to query surgical decisions should this be necessary. a) Education sessions to be organised for relevant theatres nurses. Please note this action isn't due for completion until 01/04/2018, however we have requested an update and are awaiting details.	There may be a need for dedicated safety checklists for specific types of surgery to improve planning and communication amongst surgical teams.

Are we responding and Improving?

Patient and Family Feedback: Red Complaints

Great Ormond Street Hospital for Children NHS Foundation Trust NHS

Red Complaints in January - February 2018

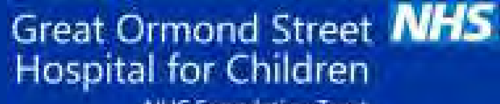
No of new red complaints declared in January-February 2018:	1	No of re-opened red complaints in January-February 2018:	0
No of closed red complaints in January-February 2018:	2		

New red complaints (1)

Ref	Opened Date	Report Due	Description of Complaint	Divisions Involved	Exec Lead	Division Lead
17/069	23/01/18	27/02/18	Father raises concerns regarding the nursing care provided to his child on Eagle Ward prior to the child's death. He believes that had certain symptoms been further investigated it may have prevented his child's deterioration. The complaint is currently under investigation, led by JM Barrie division	JM Barrie	Interim Medical Director	General Manager- JM Barrie

Are we responding and Improving?

Patient and Family Feedback: Learning from Red Complaints

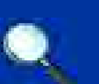


Learning from closed red complaints in January – February 2018 (2):

Ref:	Summary of complaint:	Outcomes/Learning:
17/002	During cardiac surgery a needle was left inside the patient, which necessitated the patient's chest being reopened to remove it. The patient did not leave the theatre between the two procedures. This was investigated as a Serious Incident. The Social Worker on behalf of the local authority raised concerns, and the outcome is identified in the Outcomes/Learning section.	There were a number of actions from this complaint: - A review has taken place of the surgical count policy to ensure the first surgical count is completed and signed before the chest is closed - The way information is recorded in the peri-operative careplan will be reviewed by the Theatres matron and the learning disseminated via newsletter, email, staff meetings and noticeboard In addition it is noted that the planned Trust partnership with the Cognitive Institute may lead to the implementation of a universally recognised safety language to improve safety culture within theatres.
17/040	Patient raises concerns that a complication during renal surgery as a teenager may have had an effect on her fertility and ability to conceive as an adult.	The investigation found that there was a complication during surgery in 2005, however it is unlikely that this would have any effect on the patient's long term fertility. Her underlying condition and the medicine used to manage it can reduce fertility and this was the likely cause. Due to the time that has passed processes have changed a great deal and there was no change to practice as a result of the complaint.

Are we responding and improving?

Learning from Friends and Family Test- Inpatient Data

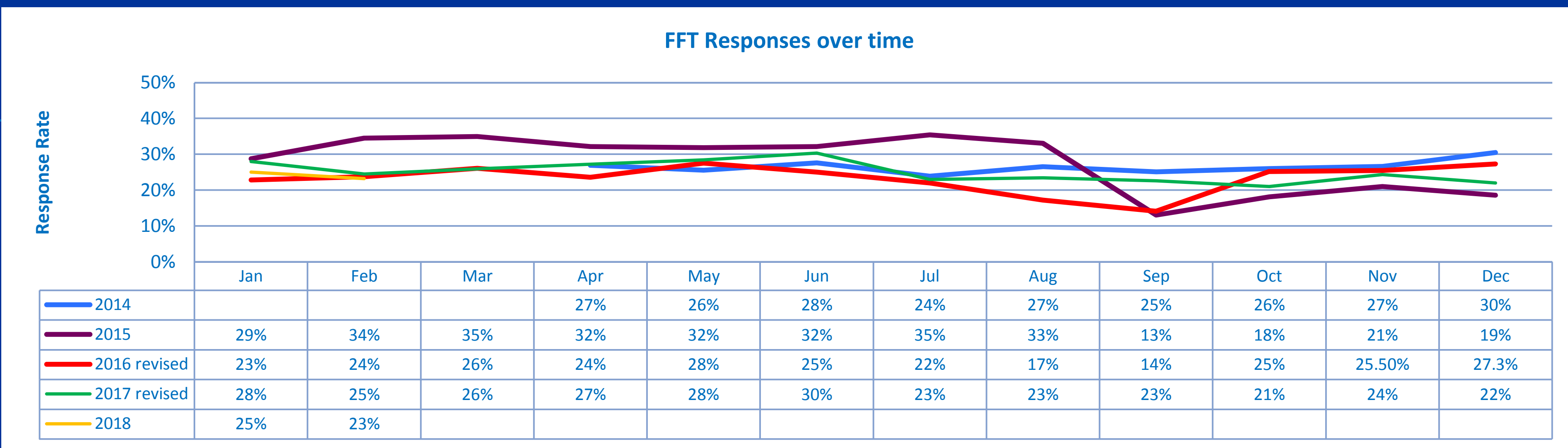


Great Ormond Street Hospital for Children NHS Foundation Trust

Data Quality Kite-Mark	Inpatient Results January 2018	Inpatient Results February 2018

January 2018
Overall FFT Response Rate = 25.1%
Overall % to Recommend = 97.4%

February 2018
Overall FFT Response Rate = 23.2%
Overall % to Recommend = 97.0%



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2014				27%	26%	28%	24%	27%	25%	26%	27%	30%
2015	29%	34%	35%	32%	32%	32%	35%	33%	13%	18%	21%	19%
2016 revised	23%	24%	26%	24%	28%	25%	22%	17%	14%	25%	25.50%	27.3%
2017 revised	28%	25%	26%	27%	28%	30%	23%	23%	23%	21%	24%	22%
2018	25%	23%										

January 2018 Top 3 Themes (by %)

Positive Themes:	No +ve comments	Total comments
Always Helpful	291	298
Always Expert	191	204
Always Welcoming	177	189
Negative Themes:	**No -ve comments**	**Total comments**
Staffing Levels	11	12
Access / Admission / Discharge / Transfer	20	23
Always One Team	9	29

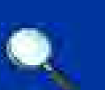
February 2018 Top 3 Themes (by %)

(Not all comments had been themed a time of report production, however the order will not be affected)

Positive Themes:	No +ve comments	Total comments
Always Helpful	288	294
Always Welcoming	125	135
Always Expert	61	75
Negative Themes:	**No -ve comments**	**Total comments**
Access / Admission / Discharge / Transfer	5	5
Staffing Levels	4	4
Catering / Food	6	18

Are we responding and improving?

Learning from Friends and Family Test- Outpatient Data



Data Quality Kite-Mark

Accuracy
Validity
Audit
Exec Director Judgement
Reliability
Relevance
Timeliness

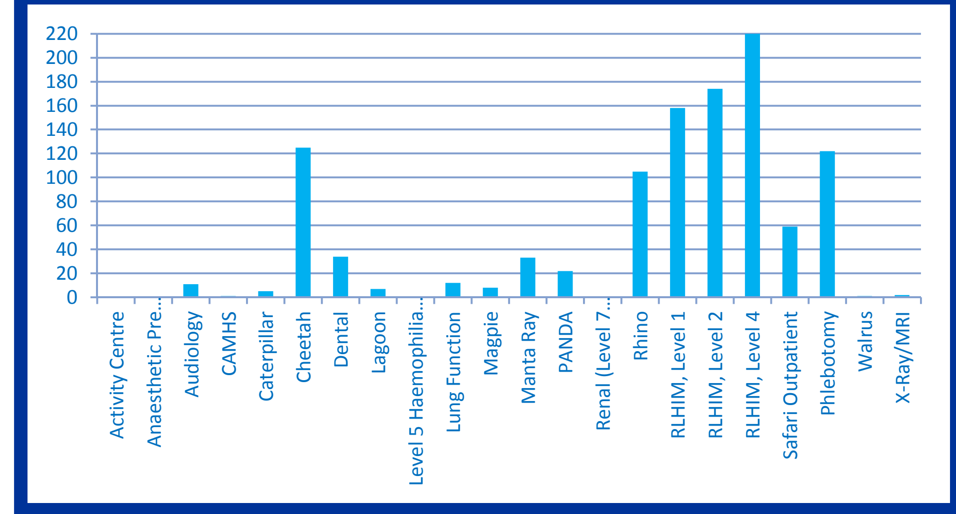
Narrative:

The average percentage to recommend for Outpatients reduced to 92.4% in February. The total number of cards collected within Outpatients was significantly lower for this month (n= 566) but there were also 2881 fewer attended appointments due to the severe weather conditions.

Outpatient Results January 2018

January 2018

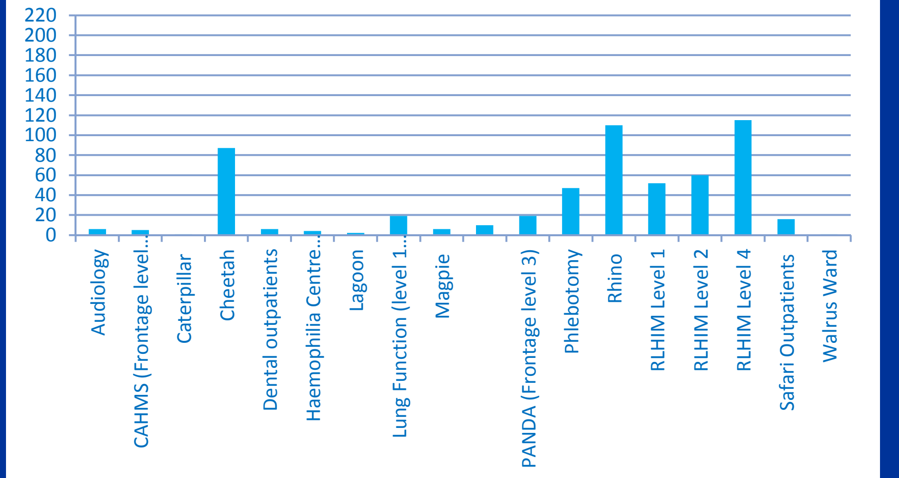
Overall % to Recommend = 93.7%



Outpatient Results February 2018

February 2018

Overall % to Recommend = 92.4%

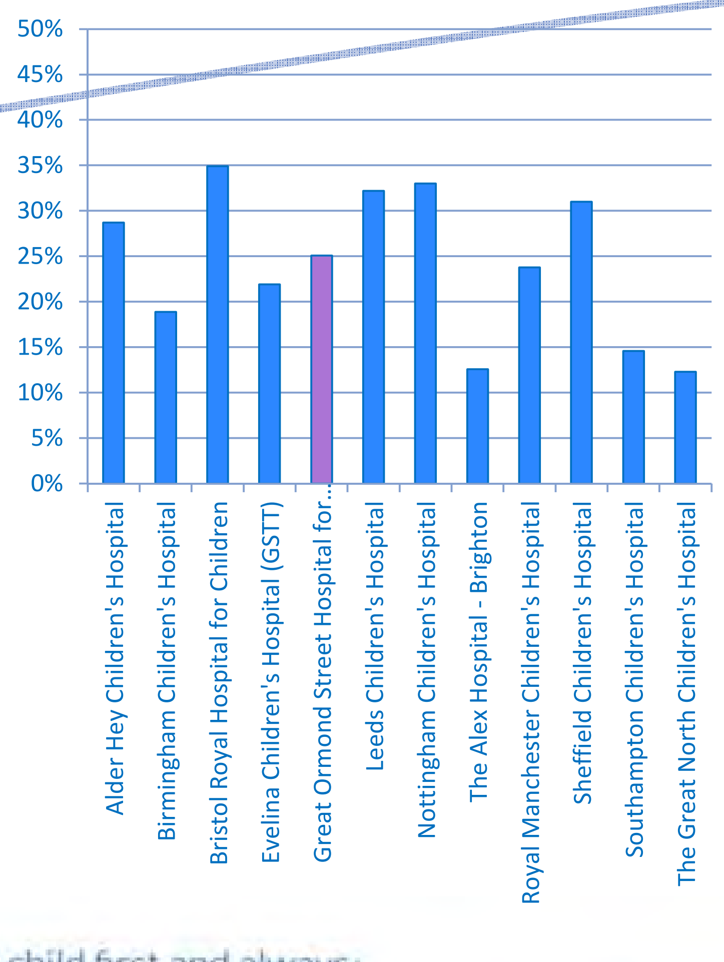


Are we responding and improving?

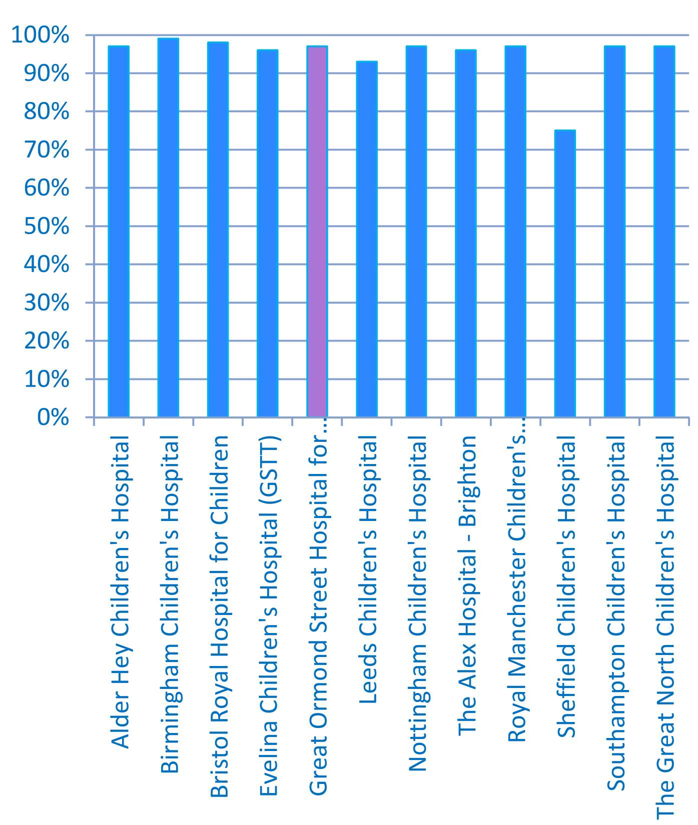
Benchmarking

Data from NHS Choices – January 2018

Response Rates



Percentage to Recommend



Are we responding and improving?

Learning from Friends and Family Test

Great Ormond Street Hospital for Children NHS Foundation Trust

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

Patient Feedback

All the nurses on elephant ward are lovely. They look after me very well! :-)

I liked the team that came to look after me and that they are very happy, smiley and friendly. I hope to see this friendly team again on my next visit. I like the team a lot.

The Care, professional and thoughtful nursing team do an incredible job. Miracle workers.

My room is really nice and comfy!

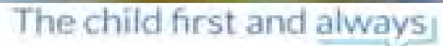
Parent/Carer Feedback

I would just say a couple of small issues - we were initially left for 4 hours in our room, weren't shown around despite a list in the room that should be ticked saying we've been told everything.

The staff can be the best and most professional individuals but unless there is enough of them, they are unable to do a good job. There needs to be more clinical staff on the wards for care to be good.

I was disappointed by the poor communication from the consultant. There was no discussion on the day regarding on-going follow up and then a week later we received an appointment in the post for follow up in 1 year! This should have been discussed face to face.

However seems to be an ongoing communication problem between the departments - phones are unanswered and delays occur - this is probably due to a shortage of staff.



Are we responding and improving?

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

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

All different professionals played their part extremely well such as nurses and anaesthetic. However everyone, including ourselves, were let down by the first doctor that came to assess my child. Very unprofessional of her to fail to get the consent form completed, causing a 4-hour delay and leaving my child to the back of the queue when he was meant to be the first one. No need to mention that he didn't have food for several hours, causing more distress. She was chased quite a few times unsuccessfully and at the end they had to get a different doctor to complete her job. As a doctor she should have a duty of care. Also a little bit more communication if she was going to skip my child in the queue. Please ensure that she doesn't do it to other families.

Ward Manager for Nightingale responded:
This patient was under the audiology team and the ENT team are responsible for getting these patients ready for their procedure.
We often have difficulties in getting these patients clerked and consented and I have brought this up many times with these teams.
Patient Experience have sent the comment to the ENT Team, currently awaiting a response.

No food menu all over the weekend. Some amount of food suppled of the trolley. Out of what was left. I had to provide food for my son while he was in hospital.
Feel forgotten with no consistent care, no bed bath, clean sheets etc.

Ward Manager for Sky Ward responded:
To try and ensure that patient menus aren't forgotten about, we are going to introduce a system whereby on Thursdays the menus for pre op patients are taken to the pre op ward and completed there as this has been a previous issue. We have had recent study days on the ward with the staff and basic care has been highlighted as key area for development and staff are being reminded that this needs to happen.

PEWS (Paediatric Early Warning System)

Project aim:

To implement PEWS across all inpatient wards at GOSH by April 2018.

Project Initiation and Leadership:

Project Initiated in May 2017, currently led by Interim Chief Nurse (Polly Hodgson)

Background:

Professor Mark Peters presented research comparing the predictive performance of 18 paediatric track and trigger systems to the Out of Hours Steering Group in 2017. On the basis of the research, the Steering Group chaired by the Medical Director, recommended that the Trust change to PEWS.

THE PEWS TOOL

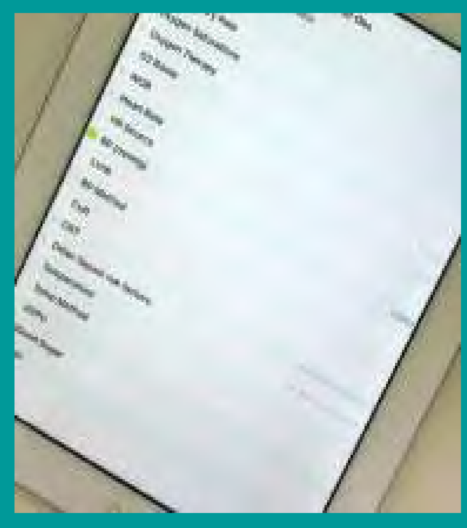
CEWS	PEWS
Temperature	X
Respiratory rate	✓
Sp02	✓
Heart rate	✓
Systolic blood pressure	✓
AVPU	X
	Oxygen
	Capillary Refill
	Work of Breathing
Additional Elements: (no score attached)	Sepsis Criteria Watcher Status

PEWS is a validated scoring system designed to identify potential deterioration in children and young people using a combination of factors such physiological findings, escalation responses and a strong communication framework.

- There are **7** PEWS parameters . All of which must be recorded **every time** an observation is required, for every patient.

There are Four Special Circumstance charts (Nervecentre);

1. **Non-acute monitoring -** For patients who do not require constant monitoring
2. **End of Life Care** – Observations to be agreed between the child's nursing / medical teams and with the child and family.
3. **PCA / NCA Chart** - For CYP on an NCA or PCA
4. **Doppler Chart** - This chart has BP split into systolic and diastolic pressure, with diastolic as a non-mandatory field



Measurements

- The 'Deteriorating Patient Dashboard' combines the measures for cardiac / respiratory arrests, 2222 calls and unplanned ICU transfers across the Trust, broken down by ward / location. http://qst/dashboards#/dashboards/dashboard/GetDashboards/125

Project Milestones

- 7th March 2018 PEWS launch
- 26th March 2018 Post PEWS implementation review
- 1st June 2018 Project closure

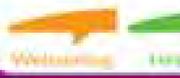
Next Steps

- Continuing to embed the new scoring system within GOSH to support the detection and escalation of the deteriorating child.
- Listening to staff feedback regarding the recent Nervecentre and CareVue PEWS changes and making any appropriate adjustments.
- To conduct a post project review to identify any key learnings that could support future Trust -wide projects .

Are we responding and improving?

Quality Improvement Project Status Update (with Executive sponsorship)

Project	Project Aims	Project Leads	Project Timescales and Progress
Neonates	To improve the quality and safety of care within inpatient neonates/ small infants* at GOSH by January 2018[*<28 days or 4kg]	Executive Sponsor- **Chief Nurse** Nursing Lead- **Neonatal Nurse Advisor** Medical Lead- **Head of Clinical Service**	Progress to date: • Project closure and sustainability recommendations due to be presented at February QIC
PEWS	To replace the Children's Early Warning System (CEWS) with the Paediatric Early Warning System (PEWS) for wards across GOSH by January 2018	Executive Sponsor- **Chief Nurse** Medical Lead- **Consultant Intensivist** Nursing Lead- **Clinical Site Practitioner**	Progress to date: • PEWS is set go live on 7th March 2018 • Nervecentre have completed the configuration of PEWS into the test system – currently with GOSH for software testing. • Clinical testing is due to be signed off Friday 23rd February • CareVue have completed the changes required to enable PEWS scores to be calculated and flagged as per the algorithm. • Sepsis alerts have been added to both systems, but there will be no automatic alert from the calculations – clinicians will need to observe for amber and red flags and escalate accordingly. • PEWS Nursing Education package currently being rolled out • The PEWS communication strategy being rolled out • GOLD Training has been updated



Are we responding and improving?

Quality Improvement Project Status Update (with Executive sponsorship)

Project	Project Aims	Project Leads	Project Timescales and Progress
Transition	To enable clinicians to start all young people a Transition Plan by the age of 14 in line with NICE recommendations 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: • Growing Up, Gaining Independence (GUGI) programme developed and being presented to teams to ensure works with all specialties • SOPs developed for 4 main outcome pathways • Link between PiMS and eCOF in test phase • Developing/refining process for Medical Director/Chief Nurse approval to accept referral/admit patient ≥ 16 yrs • Audit of ages of subspecialties are transferring majority of patients to adolescent, adult or Primary Care services to be repeated due to lack of engagement Next steps: Currently under development : • Getting feedback on YP/parent/carer information produced • 1st session to film YP for information videos 22.2.18 (joint project with NHSE) • Letter templates for over 16s (as part of OPD Improvement)
Extravasation	To reduce the incidence of extravasation injury at GOSH by 31st July 2018	Executive Sponsor- **Chief Nurse** Clinical Lead- **Consultant Anaesthetist**	Progress to date: • VHP Framework & Tool - now in use on Eagle, Bumblebee, Koala, Bear, Walrus, Butterfly, Giraffe, Lion, Hedgehog wards. • Implementation plan developed for roll out Trust-wide by July 2018 • Adaptions made to Arezzo and Endoscopy Care Pathway to incorporate vein grade and cannulation attempts information. • Completed testing phase of 'new' IV record chart, incorporating sticker elements - going to IP&C Committee for final sign off. • Training video incorporated into IV Study Day & Cannulation/ Venepunture Course • Planning underway for awareness event in May 2018. • Comparison work underway between plastics referrals and Datix. • Development underway of VAF system to log referrals to VAF team and enable prioritization and oversight from CSP team. • Acyclovir study now supported by QI data analyst using data from EP.

Integrated Performance Report

Nicola Grinstead, Deputy CEO
March 2018
(Month 10 & 11 2017/18)

The child first and always

Index

Great Ormond Street Hospital for Children
NHS Foundation Trust

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Appendix II:	Data Quality – Overview	Attached
Appendix III:	Definitions	Attached

The child first and always

Executive Summary

December 2017 (Month 9 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. As per previously for other elements his report and narrative should continue to be looked at in conjunction with the Quality and Safety Report and Finance Report.

At the time of writing the Trust Board report, Month 11 (February 2018) data was available, with key national submissions deadlines being met and data reviewed in time for inclusion.

Expert

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 positive recommendation responses for those undertaking the Inpatient FFT (97.39% in January and 95.68% in February)

- The rate (%) of those responding (for Inpatients) has seen fluctuation over the last six months with average response rate of 23.04%, and January performance at 25.11% and February 23.24%. There remains variability across the three Divisions and the wards. The IPP division returned to compliance in January, and sustained performance in February at 56.9%. The West division has improved from the December position of 19.60%, however, not sustained the performance seen in January (24.83%) with February being 21.15%. Barrie division has continued to improve its position since December (24.02%), achieving 25.53% and 26.30% in January and February respectively. An action plan is in place in both divisions to improve the response rate. Following the discussion regarding the target response rate being reviewed to assess if it can be more in line with other Trusts and Peers it has been agreed that a target will be set for non-frequent flyer wards and frequent flyer wards shown separately.

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)

Serious Incidents and Never Events

As confirmed in the Performance Dashboard and in the Quality & Safety Report, there were no serious incidents reported in January and February. The YTD positions are:

- Serious Incidents = 12
- Never Events = 2

Further detail is provided in the Quality and Safety report.

Healthcare Associated Infections (HCAIs)

Incidents of C. Difficile

The Trust has reported five additional incidents of C Diff during January (one) and February (four), taking the Trust YTD position to 18 (at M11). Eleven out of the eighteen cases of C Diff were trust acquired i.e. they occurred on or after the fourth day of the patients' admission. At this time, none of these have been found to have resulted in lapses of care, and these will be reviewed with Commissioners. The Trust's total allowance for 2017/18 is 15 cases, as set nationally.

Incidents of MRSA

The Trust reported one incident of MRSA in January on Butterfly ward, and RCA is being produced and further details will be provided in the Quality & Safety Report. It should be noted that three cases were reported in 2016/17.

CV Line Infections

The Trust has improved compliance against the standard in January and February (1.27 and 1.38 respectively against 1.6 per 1000 line days). All incidents have or will be investigated by the lead nursing staff with involvement from the Infection Control team. As per the Quality & Safety report, the ongoing trend / position over time is within expected levels showing no sustained outlying behaviour.

WHO Surgical Checklist Completion (> 98%)

The Trust continues to not deliver against the 98% standard as seen from November (97.45%) compliance in January and February was 97.81% and 93.33%, respectively. Work continues within divisions to understand reasons as to why checklists aren't fully completed for some specialties.

Hospital Acquired pressure / device related ulcer: Grade 3 & above

The Trust reported one grade 3 pressure ulcer in February, which occurred in Sky ward. An RCA is being completed to understand why this occurred.

Welcoming Helpful Expert One Team

Responsive

Great Ormond Street Hospital for Children
NHS Foundation Trust

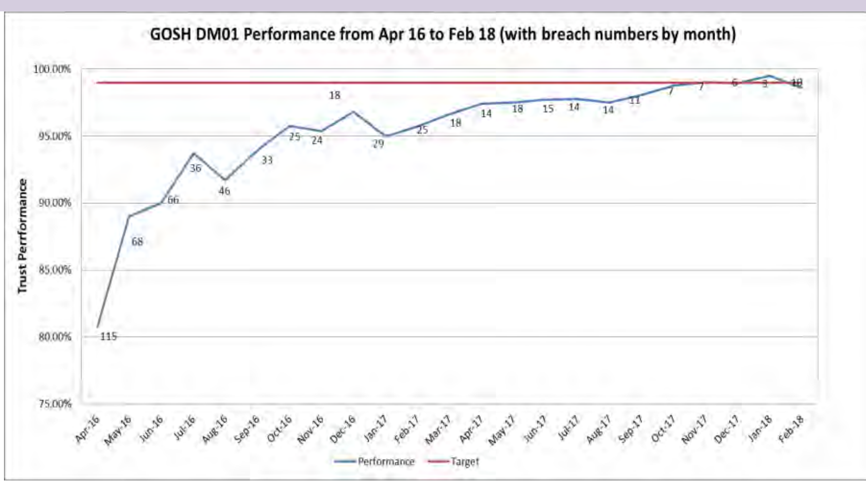
Diagnostics (99% < 6 weeks) – December 2017 position

In February, the Trust underachieved against the standard of 99% for patients accessing the 15 diagnostic modalities within 6 weeks of referral / request at 98.60%. Unfortunately, the Trust was unable to sustain the performance in January having achieved 99.51%, which illustrates the volatility in the denominator and breach numbers. Despite the Trust aiming to continue to reduce the number of patients waiting in excess of 6 weeks, February has seen an increase to ten patients.

As shown in the table opposite, the overall number of breaches for February was ten (increase of seven from January). Breaches occurred in MRI (4), Non Obstetric Ultrasound (5) and CT (1).

Five of the ten breaches could potentially have been prevented: four breaches were due to process / booking issues and one remaining breach occurred due to delay in request form. Three breaches occurred due to failed sedation and two patients are only the BBS highly specialised pathway that has limited capacity.

The breach reasons are currently undergoing a deep dive and any resulting actions will be addressed by the services.



Diagnostic Test	Breach	No Breach	Grand Total	Performance
Audiology - Audiology Assessments		34	34	100.00%
Barium Enema		9	9	100.00%
Colonoscopy		2	2	100.00%
Computed Tomography	1	62	63	98.41%
Cystoscopy		6	6	100.00%
DEXA Scan		12	12	100.00%
Gastroscopy		27	27	100.00%
Magnetic Resonance Imaging	4	246	250	98.40%
Neurophysiology - peripheral neurophysiology		37	37	100.00%
Non-obstetric ultrasound	5	154	159	96.86%
Respiratory physiology - sleep studies		91	91	100.00%
Urodynamics - pressures & flows		23	23	100.00%
Grand Total	**10**	**703**	**713**	**98.60%**

Contextually when comparing GOSH with other Children's Trusts or other London tertiary / specialist providers, the Trust is not an outlier with differential levels of performance. Nationally out of 362 providers reporting against the standard (NHS and Independent sector) 261 in January were delivering 99% or better (it must be noted that 98 of these trusts reported a waiting list of less than 100 and a number are also providers just offering certain specific diagnostics, rather than a full range). 31 providers reported 98-99%, 16 at 97-98%) and 54 reported <97%.

Cancer Wait Times

For the reporting period up to January 2017, there have been zero patient pathway breaches reported against the Cancer Wait time standards applicable to the Trust.

Referral to Treatment Time (incomplete standard > 92%) – February 2018

For the months of January and February the Trust has met the RTT 92% standard submitting performance of 92.96% and 93.54% respectively. January was the first time since returning to reporting that the Trust has met the standard. Significant improvements have been made across a number of specialties with Orthopaedics, ENT and Neurology meeting 92% standard. Specialties which continue not to meet the standard are Plastic Surgery (sub-specialisation within the service), SNAPS (bed capacity) and Urology (complex patients and capacity).

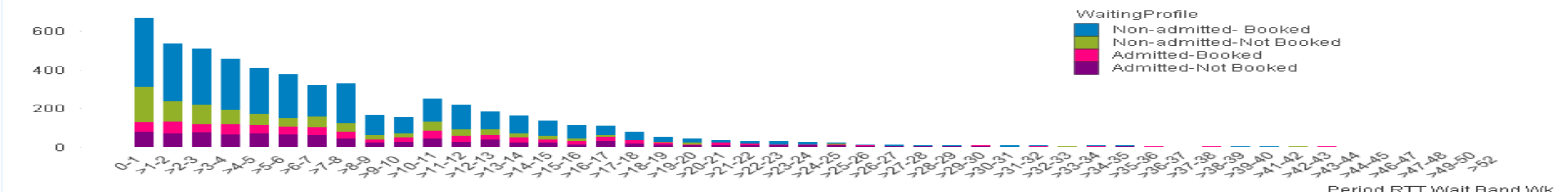
Revised improvement trajectories have been submitted by specialty and these continue to be monitored weekly via the Deputy Chief Exec led Weekly RTT Meeting which is attended by Director of Operations, General Managers, Heads of Clinical Service and Performance Team. The meeting enables in depth discussion to be undertaken on challenged specialties, early warning of potential risks to delivery and plans in place to meet the agreed trajectory.

The number of patients waiting 40 weeks+ has further decreased since the start of the financial year. We reported 43 patients waiting over 40 weeks in April and in February, there were 13 patients waiting over 40 weeks.

Contextually when comparing GOSH with other Children's Trusts or other London tertiary / specialist providers, the Trust is not an outlier with differential levels of performance. Nationally out of 145 providers reporting against the standard (NHS Trusts only) 53 in January were delivering 92% or better. 22 providers reported 90-92%, 62 at 80-90% and 8 reported <80%.

Nationally, GOSH is ranked as the 26th best performing Trust out of 145 providers. In London, GOSH is the 7th best performing Trust out of 21 Providers reporting RTT performance.

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 the number of long waiters >52 weeks continues to improve.



The Trust reported three waiting 52+ weeks in January 2018, two of the three patients have been treated during February. One 52+ week wait will be reported at the end of February 2018, a Urology patient who has a treatment date in March. A full RCA and action plan has been developed by the division to mitigate any future instances of this error.

Unknown clocks starts:

The number of pathways with an unknown clock start (i.e. referred to the Trust without confirming the start date of the pathway) has decreased in January and February, in comparison to what we reported in December. Divisions have been asked to further push in engaging with referring Trusts and escalate where necessary.

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 January 2018, the trust reported an improvement in performance in this area. There were 41 last minute non-clinical hospital cancelled operations, compared to 54 in December 2017, and 69 in November 2017. The areas contributing most to this are Radiology, Cardiac Surgery, Dermatology, General Surgery and ENT. Some of the reasons for cancellations were theatre lists overrunning, and cancellations due to emergency patients.

The Trust reported a deterioration in rebooking last minute cancelled operations within 28 days of the cancellation, 14 (compared to 11 in December 2017 and 9 in November 2017). There are plans to set up a joint working group for both divisions on cancelled operations where processes around cancelling and rebooking operations will be reviewed.

Workforce Headlines

- **Contractual staff in post:** Substantive staff in post reduced to 4458.29 FTE (full-time equivalent) in February. This is 342.2FTE (8.3%) higher than the same month last year.
- **Unfilled vacancy rate:** The Trust's unfilled vacancy rate has reduced to 2.63% from 4.6% in December. The vacancy rate remains below target and lower than February (8.5%)
- **Turnover** is reported as voluntary turnover in addition to the standard total turnover. Voluntary turnover currently stands below target at 13.9%; this reported value excludes non-voluntary forms of leavers. Total (voluntary and non-voluntary) turnover reduced further to 17.4%, which is below target and is lower than the same month last year (18.8%)
- **Agency usage** for 2017/18 (year to date) stands at 1.8% of total paybill, which is below the local stretch target, as well as below the NHS I target for GOSH 2017/18 of 3% (£6.5 million). Spend is also well below the same month last year (3.78%). The Trust has established a Better Value Scheme scrutinising all agency spend.
- **Statutory & Mandatory training compliance:** In February the compliance across the Trust was 90%. Currently, three directorates/divisions are not meeting the in-year 90% compliance requirement.
- **Sickness absence** remains below target at 2.3% and below the London average figure of 2.8%. During 2018, the Trust will implement an integrated rostering system. The system will support improvements in the accuracy of absence reporting, which may lead to fluctuations in reported rates.
- **Appraisal/PDR completion** The non-medical appraisal rate has reduced to 88% which is below the Trust target, however the Trust continues to benchmark well and is above it's long term average. Consultant appraisal rates have increased in recent months and now stands at 87%.

Well-Led

Great Ormond Street Hospital for Children NHS Foundation Trust NHS

Trust KPI performance February 2018

Metric	Plan	Feb 2018	3m average	12m average
Voluntary Turnover	14%	13.9%	14.1%	15.0%
Total Turnover	18%	17.4%	17.7%	18.4%
Sickness (12m)	3%	2.3%	2.3%	2.3%
Vacancy	10%	2.6%	3.4%	6.2%
Agency spend	2%	1.8%	1.8%	2.3%
PDR %	90%	88%	89%	88%
Statutory & Mandatory training	90%	90%	90%	90%

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

Substantive staff in post by staff group

Contractual Staff in Post (FTE, rolling 12-months by staff group)

Contractual FTE (Staff Groups)

1600
1400
1200
1000
800
600
400
200
0

4,110 4,105 4,130 4,128 4,115 4,099 4,272 4,372 4,349 4,313

Mar-17 Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18

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

Workforce: Highlights & Actions

Sickness %

- Monthly sickness absence reports distributed to managers from the HR Advisors to encourage a proactive approach to managing sickness absence.
- Regular meetings are held with Ward Sisters, service leads and departmental managers to discuss and provide support for sickness absence management.
- Health and wellbeing; a number of initiatives have been launched in order to support employees at work such as mental health awareness and healthy activities. Nutrition and Hydration week at GOSH is taking place between 12th – 16th March 2018;
- HRBP working with management teams in Finance and ICT to ensure sickness absence is being logged using the correct system so reporting can be accurate.

Voluntary Turnover Rate

- There has been a significant amount of work undertaken to better understand the broader turnover position - with specific focus on areas of low stability and high turnover. There have been developments in also understanding the reasons why people leave and where they go. In addition, the work around nurse recruitment and retention is now a focused project under the Nursing Workforce Programme Board.
- Developing B5s into vacant B6 roles helps to decrease turnover of B5s
- All Nurses within R&I on fixed term contracts have been transitioned over to permanent contracts to support retention of Nurses

Workforce: Highlights & Actions

Agency Spend

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

PDR Completion

- PDR rates now regularly reported and accessible via the intranet with continued reminders to individuals and line managers
- Simplifying the reporting process of PDRs has supported managers in working towards their PDR targets.
- HRBPs are continuing to support managers in identifying the PDRs that are required for completion, this includes consultant appraisals.
- PDR rates are a rolling agenda item for Performance Meetings within the Divisions / Directorates.

Statutory & Mandatory Training Compliance

- Improved visibility through LMS - staff encouraged to check their own records on GOLD
- Learning and Development & ER team work with managers to identify those who are non-compliant including further developments to the Trust GOLD LMS
- Simplicity in reporting process to improve compliance
- StatMan rates are a rolling agenda item for Performance Meetings within the Divisions / Directorates.

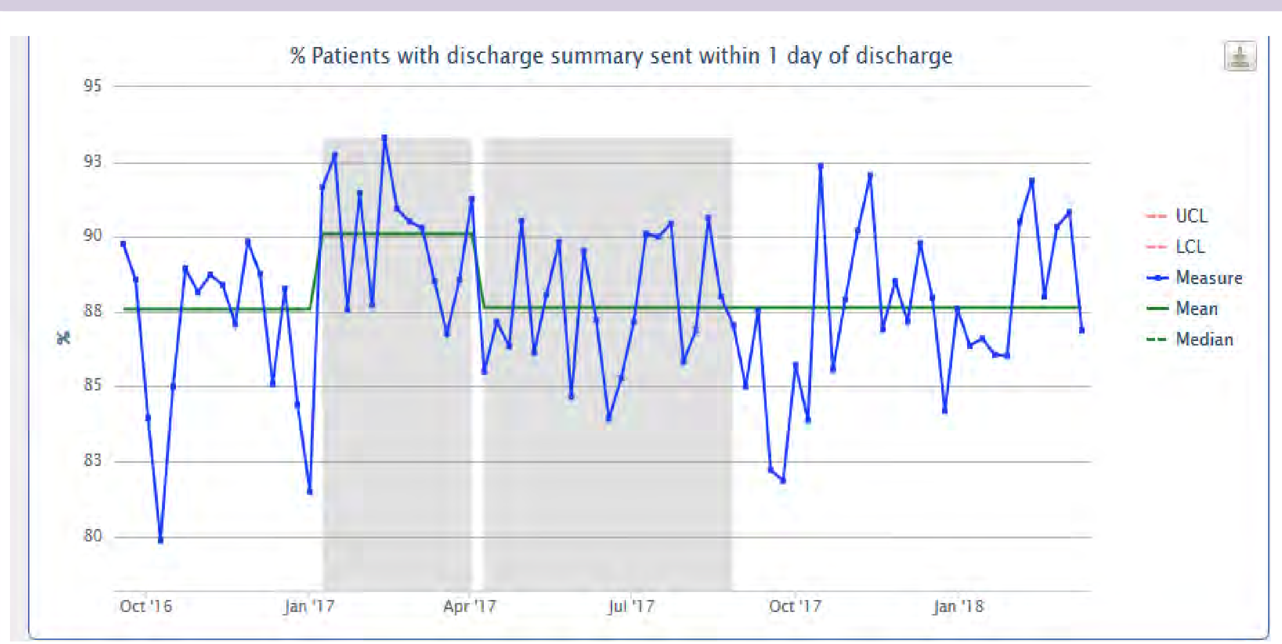
Effective

Discharge Summaries

As is evident from the SPC chart and the dashboard, performance in this area continues to fluctuate. For January and February 2018, the position was 87.00% and 89.26% sent within 24hrs of discharge, which is a slight improvement from December's performance. As per definitions of this metrics, the expectation for the Trust is to send all discharge summaries within 24 hours.

The Clinical Divisions continue to keep this as an areas of focus, and reported into their monthly performance meetings.

Some of the on going actions in place in divisions include daily reminders to HoCS/SM/fellows to complete the DS within 24 hours, weekly reports generated by the Data Assurance Team, sent to the Service and Ward Clerks, ensure discharges flagged as exclude are clinically validated, documented, and presentation for the Junior Doctors local induction on discharge summaries. Long term plans include introducing an automated system to send discharge summaries to GPs in real time.



Clinic Letter Turnaround times

For January (as this indicator is reported a month in arrears), there has been some deterioration in performance in relation to 14 day turnaround, 72.2% from 74.0% in December. For those sent within 7 working days, performance has also deteriorated, 42.5% from 43.2% in December. As with the above, specific specialties are being targeted by the service management teams to ensure turnaround is improved. Some of the actions in place in divisions include weekly reminders for clinical teams to sign of letters, providing remote access to clinicians so they can sign off letters electronically, create and administer a robust monitoring system for administrators to be used on a weekly basis to check the upload and downloading of letters, weekly reminders for clinical team to sign off letters and extra admin time to work through the backlog of letters in specific areas.

Productivity

Great Ormond Street Hospital for Children
NHS Foundation Trust

Theatres

Reporting in this area has now migrated and is based on the newly implemented Trust Theatres Dashboard. The reported positions have changed marginally, however remains largely in line. The dashboard, now provides theatres and operational teams with much more accessible and detailed information on their usage of Trust theatres.

The identification of the data anomaly reported in January has now been rectified. Utilisation of main theatres has dropped in February to 67.6% from 70.6% (January). Contributing factors to the decrease in utilisation are the adverse weather conditions seen in February, along with a high number of procedures cancelled on the day due to contraindication. JM Barrie division has maintained 70% utilisation across both months, whilst Charles West has seen a dip in performance to 57.4% (February) from 61.1% (January). Particularly affected specialties are Craniofacial (57.6%), Urology (67.3%), Cardiology (47.6%) and Cardiac Surgery (57.1%).

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 reporting periods of January and February occupancy has increased from the previous levels to 84.8% and 84.6% respectively, this is expected following the Christmas and New Year period.
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.

Bed closures: There has been a significant increase in the average number of beds closed in February (20) compared to 14 in January. This was mainly due to staffing shortages, Norovirus outbreak on Rainforest for 4 days with 3 beds closed per day and emergency works. Sky, Fox, Mildred Creek and Robin wards have had bed closures for the whole of February.

Productivity

PICU Metrics

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

PICU/NICU Refusals: The number of CATS referral refusals into PICU/NICU from other providers during February has decreased to seven from a January position of nineteen. The YTD position for refusals during 17/18 is 172 compared 238 in 16/17, a reduction of 66 (-27%) refusals.

PICU Delayed Discharges: Delayed discharges over 8 hours from PICU can demonstrate the challenges being faced internally and externally with regards to capacity issues on accessing beds. February saw an improvement in the total number of delays with 19 reported compared to 35 in January. Over the last 5 months 47% of patients have been delayed due to accessing another Provider, and 53% accessing a bed internally within the hospital.

PICU Emergency Readmissions: Readmissions back into PICU within 48 hours remains low with only 1 patient in February and zero patients in January. This indicator illustrates patients being safely discharged from the unit by the clinical teams.

Activity

YTD activity across day case discharges, overnight discharges, outpatient attendances critical care bed days are below the same reporting period for last year (i.e. up to M11). Further details will be provided within the Finance Report.

Long stay patients: This looks at any patient discharged that month with a length of stay (LOS) greater than 100 days, and the combined number of days in the hospital. For February, the Trust had nine patients discharged that had amassed a combined LOS of 1656 days. Most of the long stay patients were Bone Marrow Transplant patients. As reported previously, the West division looked at a sample of patients who had an excess stay of > 100 days, and found the reasons for their stay were clinically appropriate due to many having complex conditions and comorbidities warranting that LOS.

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 February 2018 (Month 11). In line with the figures presented, the Trust has a YTD surplus of £0.2m which is £0.4m ahead of plan. The Trust is currently £0.3m ahead of the control total.

- Clinical Income (exc. International Private Patients and Pass through Income) is £4.8m higher than plan
- Non Clinical revenue is £4.0m higher than plan
- Private Patients income is £3.0m lower than plan
- Staff costs are £1.8m higher than plan
- Non-pay costs (excluding pass-through costs) are £6.3m higher than plan

Appendices

Great Ormond Street Hospital for Children
NHS Foundation Trust

Appendix I – Integrated Performance Dashboard

Please see attached covering all the domains in line with this supporting narrative

Appendix II – Data Quality Kite-Marking

Please find attached the supporting DQ Kite-marking for each of the reportable indicators within the Trust Board report

This is in line with previous updates provided to the Board and Trust Audit Committee, which assesses each of the indicators for:

- Accuracy
- Validity
- Reliability
- Timeliness
- Relevance
- Audit
- Executive Judgement

Any areas where there is insufficient assurance an action plan is needed or is in place, approved and signed off for the relevant SRO / Executive lead for that metric. These will then be monitored by the SRO and then re-assessed at a set point in the year.

A more detailed summary is provided as part of the dashboard.

Appendix III – Definitions

Please see attached the supporting definitions and methodologies for each of the metrics reported upon

Trust Board Dashboard - February 2018

Caring

Measure		Dec	Jan	Feb	Trend	Plan	NHS Standard
Access to Healthcare for people with Learning Disability					→		
% Positive Response Friends & Family Test: Inpatients		95.48%	97.39%	95.68%	↓		95%
Response Rate Friends & Family Test: Inpatients		21.95%	25.11%	23.24%	↓	40%	
% Positive Response Friends & Family Test: Outpatients		95.14%	93.72%	92.40%	↓		95%
Mental Health Identifiers: Data Completeness		99.11%	99.19%	99.16%	↓		97%

Safe

Measure		Dec	Jan	Feb	Trend	Plan	NHS Standard
Serious Patient Safety Incidents	In-month	2	1	1	→		
	YTD	12	13	14			
Never Events	In-month	0	0	0	→		0
	YTD	2	2	2	→		0
Incidents of C. Difficile	In-month	0	1	4	↓		
	YTD	13	14	18	-		
C.Difficile due to Lapses of Care	In-month	0	0	0	→		
	YTD	0	0	0	→		15
Incidents of MRSA	In-month	0	1	0	↑		0
	YTD	0	1	1	→		0
CV Line Infection Rate (per 1,000 line days)		1.78	1.27	1.38	↓	1.6	
WHO Checklist Completion		95.87%	97.81%	93.33%	↓	98%	
Arrests Outside of ICU	Cardiac Arrests	3	2	2	→	5	
	Respiratory Arrests	3	2	1	↑		
Total hospital acquired pressure / device related ulcer rates grade 3 & above		1	0	1	↓	0	

Responsive

Measure		Dec	Jan	Feb	Trend	Plan	NHS Standard
Diagnostics: Patients Waiting <6 Weeks		98.93%	99.51%	98.60%	↓		99%
Cancer 31 Day: Referral to First Treatment							85%
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%
Cancer 62 day: Consultant Upgrade of Urgency of a referral to first treatment		100%	100%	100%	→		
Last Minute Non-Clinical Hospital Cancelled Operations		54	40	34	↑		
Last Minute Non-Clinical Hospital Cancelled Operations: Breach of 28 Day Standard		11	14	6	↑		0
Same day / day before hospital cancelled outpatient appointments		1.30%	1.09%	1.37%	↓		
RTT: Incomplete Pathways (National Reporting)		90.75%	92.96%	93.53%	↑		92%
RTT: Number of Incomplete Pathways (National Reporting)	<18wks	4992	5127	5154	↑		-
	>18wks	509	388	356	↑		-
RTT: Incomplete Pathways >52 Weeks - Validated		1	3	1	↑		0
RTT: Incomplete Pathways >40 Weeks - Validated		31	22	14	↑		0
Number of unknown RTT clock starts	Internal Referrals	1	2	0	↑		-
	External Referrals	1005	941	842	↑		-
RTT: Total Number of Incomplete Pathways Known/Unknown	<18 weeks	5970	6063	5986	↓		-
	>18 weeks	537	395	366	↑		-

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

Arrow	Meaning	Colour	Meaning
↑	Improvement	Green	On / above target
→	Consistent trend	Red	Below target
↓	Deterioration	White	No target

People, Management & Culture: Well-Led

Measure		Dec	Jan	Feb	Trend	Plan	NHS Standard
Sickness Rate		2.25%	2.30%	2.28%	↑	3%	
Turnover	Total	18.2%	17.6%	17.4%	↑	18%	
	Voluntary	14.5%	13.8%	13.9%	↓	14%	
Appraisal Rate		90%	90%	88%	↓	90%	
	Consultant	80%	85%	87%	↑		
Mandatory Training		91%	90%	90%	↑	90%	
% Staff Recommending the Trust as a Place to Work: Friends & Family Test						61%	
Vacancy Rate	Contractual	4.6%	3.1%	2.6%	↑	10%	
	Nursing	1.1%	1.1%	1.1%	→		
Bank Spend		5.9%	5.9%	5.9%	↓		
Agency Spend		1.89%	1.85%	1.79%	↑	2%	

Effective

Measure		Dec	Jan	Feb	Trend	Plan	NHS Standard
Discharge Summary Turnaround within 24hrs		86.83%	87.00%	89.26%	↑		100%
Clinic Letter Turnaround within	7 working days	43.18%	42.54%		↓		
	14 working days	72.16%	72.16%	69.02%	↓	100%	
Was Not Brought (DNA) Rate NHS (exc Telephone Contacts)		8.18%	8.34%	7.32%	↑	8.36%	

Productivity

Measure		Dec	Jan	Feb	Trend	Plan	NHS Standard
Main Theatres	Theatre Utilisation	66.3%	70.6%	67.6%	↓		77%
	No. of theatres	14	14	14			
Outside Theatres	Theatre Utilisation	53.7%	57.6%	54.2%	↓		77%
	No. of theatres	7	7	7			
Trust Beds	Bed Occupancy	80.3%	84.8%	84.7%	↓		
	Number of available beds	412	411	406	↓		
Average number of trust beds closed	Wards	13.8	14.7	20.2	↓		
	ICU	1.9	0.5	1.3	↓		
Refused Admissions	Cardiac refusals	7	6	7	↓		
	PICU / NICU refusals	36	19	7	↑		
Number of PICU Delayed Discharges	Internal 8 - 24 hours	4	6	7	↓		
	Internal 24 hours+	3	17	6	↑		
	External 8 - 24 hours	6	4	1	↑		
	External 24 hours+	14	8	5	↑		
	Total 8 - 24 hours	10	10	8	↑		
	Total 24 hours+	17	25	11	↑		
PICU Emergency Readmissions < 48 hours		1	0	1	↓		

Activity

Measure		Dec	Jan	Feb	Trend	Plan
Daycase Discharges (YOY comparison)	In-month	1,889	2,319	1,978	↓	1,949
	YTD	18,534	20,853	22,831		22,527
Overnight Discharges (YOY comparison)	In-month	1,381	1,457	1,390	↓	1,355
	YTD	13,190	14,647	16,037		15,382
Critical Care Beddays (YOY comparison)	In-month	1,082	1,113	1,004	↓	990
	YTD	9,664	10,777	11,770		11,311
Bed Days >=100 Days	No. of patients	5	2	9	↓	
	No. of beddays	737	268	1,656	↓	
Outpatient Attendances (All) (YOY comparison)	In-month	17,811	22,688	19,701	↓	21,167
	YTD	190,557	213,245	234,145		229,544

Our Money

Measure	Dec	Jan	Feb	Trend	YTD Target	YTD Variance
Net Surplus/(Deficit) v Plan	(2.3)	0.3	(1.8)	↓	(0.2)	0.4
Forecast Outturn v Plan	1.9	0.4	0.0	↓	0.2	(0.2)
Better value	1.3	1.3	1.2	↓	13.8	0.0
Pay Worked WTE Variance to Plan						
Debtor Days (IPP)	216	219	205.0	↑	120	(85.0)
Quick Ratio (Liquidity)	1.70	1.70	1.7	→	1.60	0.1
NHS KPI Metrics	1.0	1.0	1.0	→	1.0	0.0

Board
Finance and Activity Performance Report

Month 11 - 2017/18

(February 2018)

Summary Reports

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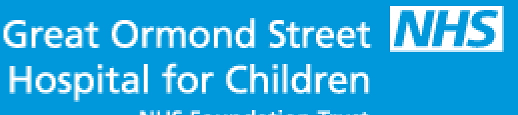


Finance Scorecard

TRUST Our Money	December	January	February	Trend	YTD Target	Variance
Net Surplus/(Deficit)	(2.3)	0.3	(1.8)	↓	(0.2)	0.4
Forecast Outturn	1.9	0.4	0.0	↓	0.2	(0.2)
P&E Delivery	1.3	1.3	1.2	↓	13.8	0.0
Debtor Days (IPP)	216	219	205	↓	120	(85)
Quick Ratio (Liquidity)	1.7	1.7	1.7	→	1.6	0.1
**NHSI KPI Metrics	1	1	1	→	1	0

Key Performance Indicators

KPI	Annual Plan	M11 YTD Plan	M11YTD Actual	Rating
Liquidity	1	1	1	G
Capital Service Cover	1	1	1	G
I&E Margin	1	1	1	G
I&E Margin Distance from Plan	1	1	1	G
Agency Spend	1	1	1	G
Overall	**1**	**1**	**1**	**G**
Overall after Triggers	**1**	**1**	**1**	**G**

Key Highlights

- In February 2018 there was a Net deficit (before capital donations and impairments) of £1.8m which was £0.1m favourable to plan. Year to date the Trust has a Net surplus of £0.2m which is £0.4m favourable to plan.
- The Trust is reporting year to date a £0.3m favourable position against the control total.
- The overall weighted NHSI rating for Month 11 is Green (Rating 1) which is on plan.
- The debtor days for IPP decreased from last month by 14 days.
- Cash is £6.7m below plan, liquidity remains strong with cash on hand of £59.9m.
- The Trust is forecasting to be £0.2m (before capital donations and impairments) adverse to the annual plan and on target at Control Total level.

Trust Income and Expenditure Performance Summary
Year to Date for the 11 months ending 28 February 2018

Great Ormond Street Hospital for Children NHS Foundation Trust

Annual Budget	Income & Expenditure	2017/18 Month 11 Budget	Month 11 Actual	Month 11 Variance	Month 11 Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Year to Date Variance	Rating Current Year Variance	Notes	2016/17 YTD Actual	CY vs PY Variance	CY vs PY Variance
(£m)		(£m)	(£m)	(£m)	%	(£m)	(£m)	(£m)	%			(£m)	(£m)	%
272.4	NHS & Other Clinical Revenue	21.75	22.31	0.56	2.57%	249.09	253.89	4.80	1.93%	G	1	232.50	21.39	9.20%
67.80	Pass Through	5.36	5.44	0.08	1.49%	62.17	60.21	(1.96)	(3.15%)			58.20	2.01	3.45%
60.67	Private Patient Revenue	4.89	3.52	(1.37)	(28.02%)	55.53	52.52	(3.01)	(5.42%)	R	2	49.90	2.62	5.25%
53.26	Non-Clinical Revenue	4.41	5.37	0.96	21.77%	48.66	52.69	4.03	8.28%	G		45.30	7.39	16.31%
454.13	**Total Operating Revenue**	**36.41**	**36.64**	**0.23**	**0.63%**	**415.45**	**419.31**	**3.86**	**0.93%**			**385.90**	**33.41**	**8.66%**
(244.42)	Permanent Staff	(20.47)	(19.68)	0.79	3.86%	(223.64)	(210.34)	13.30	5.95%			(195.60)	(14.74)	(7.54%)
(1.68)	Agency Staff^	(0.14)	(0.27)	(0.13)	(92.86%)	(1.54)	(4.11)	(2.57)	(166.88%)			(8.30)	4.19	50.48%
(2.68)	Bank Staff	(0.25)	(1.33)	(1.08)	(432.00%)	(2.71)	(15.25)	(12.54)	(462.73%)			(15.60)	0.35	2.24%
(248.78)	**Total Employee Expenses**	**(20.86)**	**(21.28)**	**(0.42)**	**(2.01%)**	**(227.89)**	**(229.70)**	**(1.81)**	**(0.79%)**	R	3	**(219.50)**	**(10.20)**	**(4.65%)**
(12.35)	Drugs and Blood	(1.03)	(1.22)	(0.19)	(18.45%)	(11.32)	(11.23)	0.09	0.80%	G		(11.40)	0.17	1.49%
(38.92)	Other Clinical Supplies	(3.24)	(2.99)	0.25	7.72%	(35.68)	(39.72)	(4.04)	(11.32%)	R		(36.70)	(3.02)	(8.23%)
(58.05)	Other Expenses	(5.25)	(5.13)	0.12	2.29%	(53.08)	(55.42)	(2.34)	(4.41%)	R		(45.80)	(9.62)	(21.00%)
(67.80)	Pass Through	(5.36)	(5.44)	(0.08)	(1.49%)	(62.17)	(60.21)	1.96	3.15%			(57.60)	(2.61)	(4.53%)
(177.12)	**Total Non-Pay Expenses**	**(14.88)**	**(14.78)**	**0.10**	**0.67%**	**(162.25)**	**(166.58)**	**(4.33)**	**(2.67%)**	R	4	**(151.50)**	**(15.08)**	**(9.95%)**
(425.90)	**Total Expenses**	**(35.74)**	**(36.06)**	**(0.32)**	**(0.90%)**	**(390.14)**	**(396.28)**	**(6.14)**	**(1.57%)**	R		**(371.00)**	**(25.28)**	**(6.81%)**
28.23	**EBITDA (exc Capital Donations)**	**0.67**	**0.58**	**(0.09)**	**(13.43%)**	**25.31**	**23.03**	**(2.28)**	**(9.01%)**	R		**14.90**	**8.13**	**54.56%**
(28.01)	Depreciation, Interest and PDC	(2.54)	(2.38)	0.16	6.30%	(25.46)	(22.83)	2.63	10.33%		6	(22.80)	(0.03)	(0.13%)
0.22	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**(1.87)**	**(1.80)**	**0.07**	**3.74%**	**(0.15)**	**0.20**	**0.35**	**233.33%**	G		**(7.90)**	**8.10**	**102.53%**
6.22%	**EBITDA %**	**1.84%**	**1.58%**			**6.09%**	**5.49%**					**3.86%**	**1.63%**	**42.25%**
(8.00)	Impairments	0.00	0.00	0.00	0.00%	0.00	0.00	0.00	0.00%			0.00	0.00	0%
72.11	Capital Donations	8.31	0.65	(7.66)	(92.18%)	63.79	22.16	(41.63)	(65.26%)		5	31.00	(8.84)	(28.52%)
64.33	**Net Result**	**6.44**	**(1.15)**	**(7.59)**	**(117.86%)**	**63.64**	**22.36**	**(41.28)**	**(64.86%)**			**23.10**	**(0.74)**	**(3.20%)**

Footnotes:

^ The Trust has only set bank and agency budgets for planned short term additional resource requirements.

Notes

1. NHS & other clinical revenue (excluding pass through) year to date is favourable to plan by £4.8m. This was mainly driven by increases in complex cases, increased tariffs and coding benefits.

2. Private Patient income year to date is £3.0m adverse to plan due to under-delivery in IPP, JM Barrie and the Trust Better value commercial scheme. The recent trend in IPP income has been for a significant downturn in income and this continues in M11.

3. Pay is adverse to plan year to date by £1.8m with agency spend of £4.1m which is below the cumulative NHSI notified agency cost ceiling of £6.0m.

4. Non pay (excluding pass through) year to date is £6.3m adverse to plan.

5. Year to date income for capital donations is £41.6m less than plan due to lower capital expenditure on donated assets.

6. Depreciation YTD is favourable to plan due to reduced capital expenditure, predominately due to slippage against large scale projects including PICB.

Trust Income and Expenditure Performance Summary
Year to Date for the 11 months ending 28 February 2018

Full Year Actual 2016/17 (£m)	Income & Expenditure	Annual Budget (£m)	Internal Forecast Full-Yr (£m)	Variance to Plan (£m)	Variance to Plan %	Rating Current Year Variance	Notes
	28 February 2018						
259.60	NHS & Other Clinical Revenue	272.40	277.40	5.00	1.80%	G	1
63.80	Pass Through	67.80	65.70	(2.10)	-3.20%		
55.10	Private Patient Revenue	60.67	57.00	(3.67)	-6.44%	R	2
47.00	Non-Clinical Revenue	53.26	55.80	2.54	4.55%	G	
425.50	**Total Operating Revenue**	**454.13**	**455.90**	**1.77**	**0.39%**		
(213.10)	Permanent Staff	(244.42)	(228.70)	15.72	-6.87%		
(9.30)	Agency Staff	(1.68)	(4.40)	(2.72)	61.82%		
(17.00)	Bank Staff	(2.68)	(16.50)	(13.82)	83.76%		
(239.40)	**Total Employee Expenses**	**(248.78)**	**(249.60)**	**(0.82)**	**0.33%**	R	3
(11.50)	Drugs and Blood	(12.35)	(13.60)	(1.25)	9.19%	R	
(41.20)	Other Clinical Supplies	(38.92)	(42.10)	(3.18)	7.55%	R	
(49.50)	Other Expenses	(58.05)	(59.40)	(1.35)	2.27%	R	
(63.80)	Pass Through	(67.80)	(65.70)	2.10	-3.20%		
(166.00)	**Total Non-Pay Expenses**	**(177.12)**	**(180.80)**	**(3.68)**	**2.04%**	R	4
(405.40)	**Total Expenses**	**(425.90)**	**(430.40)**	**(4.50)**	**1.05%**	R	
20.10	**EBITDA (exc Capital Donations)**	**28.23**	**25.50**	**(2.73)**	**-10.71%**	R	
(25.00)	Depreciation, Interest and PDC	(28.01)	(25.50)	2.51	-9.84%		5
(4.90)	**Net (Deficit)/Surplus (exc Cap. Don. & Impairments)**	**0.22**	**0.00**	**(0.22)**	**-633.33%**	R	
4.72%	**EBITDA %**	**6.22%**	**5.59%**		**0.00%**		
(12.10)	Impairments	(8.00)	(8.00)	0.00	0.00%		
32.00	Capital Donations	72.11	27.28	(44.84)	-164.38%		6
15.00	**Net Result**	**64.33**	**19.28**	**(45.06)**	**-233.75%**		

Summary

- The Trust is forecasting to be £0.2m adverse to plan though the Trust is forecasting to be on plan against the control total. This represents a reduction in Month 11 from prior months due principally to a downturn in IPP activity assumed in the previous forecast. A detailed review has been undertaken of the IPP year to date and FOT and we are comfortable the revised FOT is realistic.

Notes

1. NHS & other clinical revenue (excluding pass through) based on forecast outturn will be £5.0m favourable to plan. The favourable variance is due to higher tariffs associated with more complex cases and strong performance against plan in recent months expected to continue to year end.
2. Private patient income based on forecast outturn will be £3.7m adverse to plan. Key drivers are low activity in Butterfly, temporary closure of Hedgehog ward in Month 6 and lower activity in PICU across large parts of the year.
3. Pay based on forecast outturn will be £0.8m adverse to plan due to bank and agency staff being used to cover vacancies in the Trust at a premium. There is increased pay spend in the second half of the year due to PICB opening and newly qualified nurses who needed additional support and training.
4. Non pay (excluding pass through) is forecast to be £6.0m adverse to plan to match the increased activity forecast and additional cost of premises.
5. Depreciation is forecast to be £2.5m favourable to plan. This is due to slippage in the capital programme and the reduction in the opening carrying value of assets driven by the annual revaluation exercise.
6. Capital donations are forecast to be £44.8m adverse to plan due to slippage in the capital programme and therefore a reduction in the charitable donations funding in the programme is forecast.

Trust Income and Expenditure Trends
Year to Date for the 11 months ending 28 February 2018

Income Position - Trust

38.0
36.0
34.0
32.0
£m's 30.0
28.0
26.0
24.0
22.0

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

2016/17 Actual 2017/18 Actual 2017/18 Plan

Pay Position - Trust

23.0
22.0
21.0
20.0
£m's 19.0
18.0
17.0
16.0

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

2016/17 Actual 2017/18 Actual 2017/18 Plan

Surplus/(Deficit) - Trust

3.0
2.0
1.0
-
£m's (1.0)
(2.0)
(3.0)
(4.0)
(5.0)

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

2016/17 Actual 2017/18 Actual 2017/18 Plan

Non-Pay Position - Trust

12.0
11.0
10.0
£m's 9.0
8.0
7.0
6.0

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

2016/17 Actual 2017/18 Actual 2017/18 Plan

Financial Position and Capital Expenditure
Year to Date for the 11 months ending 28 February 2018

The following table summarises the net assets and liabilities:

31 Mar 2017 Audited Accounts £m	Statement of Financial Position	YTD Plan 28 Feb 2018 £m	YTD Actual 28 Feb 2018 £m	YTD Variance £m
431.56	Non-Current Assets	537.60	449.19	(88.41)
75.64	Current Assets (exc Cash)	83.24	84.48	1.24
42.49	Cash & Cash Equivalents	53.20	59.93	6.73
(56.09)	Current Liabilities	(80.13)	(78.10)	2.03
(5.81)	Non-Current Liabilities	(5.15)	(5.34)	(0.19)
487.79	**Total Assets Employed**	**522.20**	**510.16**	**(78.59)**

Annual Plan £m	Capital Expenditure	YTD Plan 28 Feb 2018 £m	YTD Actual 28 Feb 2018 £m	YTD Variance £m
37.76	Redevelopment - Donated	33.30	5.59	27.71
19.09	Medical Equipment - Donated	17.51	7.83	9.68
0.00	Estates - Donated	0.00	0.00	0.00
15.26	ICT - Donated	12.99	8.75	4.24
72.11	**Total Donated**	**63.80**	**22.17**	**41.63**
11.06	Redevelopment & equipment - Trust Funded	12.56	6.34	6.22
3.70	Estates & Facilities - Trust Funded	2.07	1.75	0.32
7.18	ICT - Trust Funded	6.72	3.89	2.83
1.00	Contingency	0.85	0.00	0.85
22.94	**Total Trust Funded**	**22.20**	**11.98**	**10.22**
95.05	**Total Expenditure**	**86.00**	**34.15**	**51.85**

Capital Expenditure Update

Redevelopment donated

- £1.0m Bernard St 1st floor to be funded by the Trust
- £7.7m Southwood Courtyard (IMRI) slippage
- £2.0m Mortuary project paused
- £12.3m Phase 4 project slippage
- £1.2m Italian Hospital slippage
- Phase 2B £0.2m underspend
- £2.5m CICU donated equipment included in Phase 2B.

Redevelopment trust funded

Expenditure was less than plan due to slippage on the following projects:

- £0.9m Barclay House office refurb slippage
- £1.5m chillers slippage
- £1.3m CICU slippage

Medical Equipment – Donated

Expenditure was less than plan due to the following:

- Phase 2B equipment procurement delayed due to delays in construction £3.2m
- IMRI equipment £1.4m (to be procured later)
- Other equipment £1.7m (awaiting outcome of full replacement review)
- £1.5m Cath lab equipment delivery awaiting building works completion

ICT – Donated

- £4.2m EPR implementation costs less than planned schedule.

Estates and Facilities – Trust Funded

Expenditure was less than plan due to slippage on the following projects:

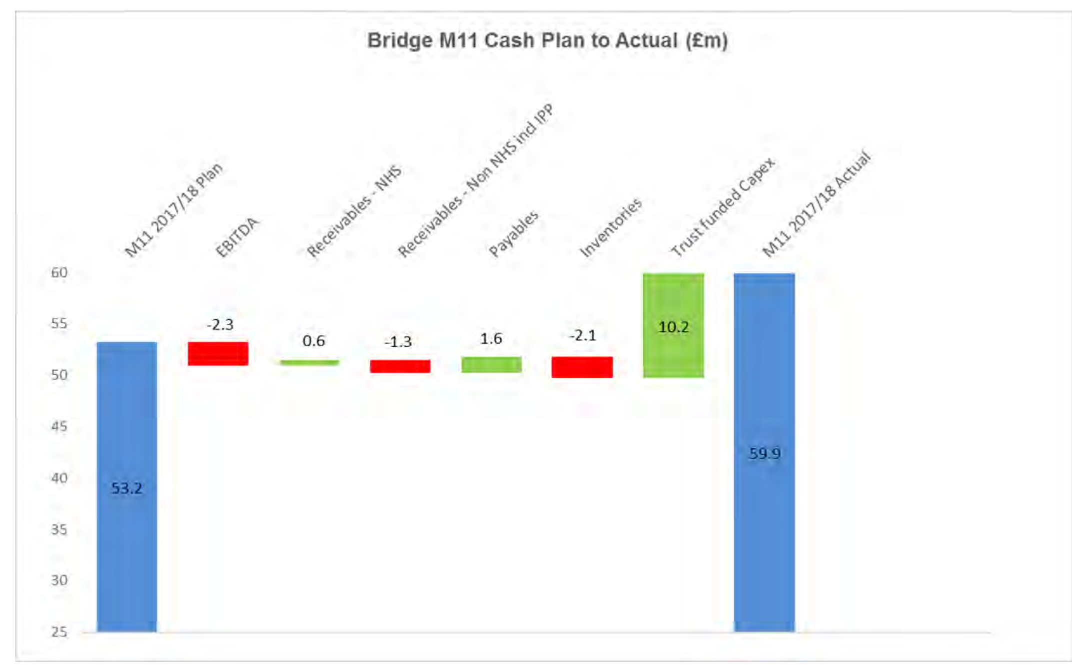
- Decontamination washer suite £1.5m

ICT – Trust Funded

Expenditure was less than plan due to delay in commencing the following projects:

- Vendor neutral archive and network hardware £1.0m
- GMC infrastructure £0.2m
- E-rostering £0.4m
- £0.5m Cybersecurity additional spend

Cash and Working Capital Summary
Year to Date for the 11 months ending 28 February 2018



31-Mar-17	Working Capital	31-Jan-18	28-Feb-18	RAG
19.40	NHS Debtor Days (YTD)	15.0	12.4	G
182.00	IPP Debtor Days	219.0	205.0	R
22.50	IPP Overdue Debt (£m)	27.7	26.5	R
4.00	Inventory Days - Drugs	8.0	8.0	G
63.00	Inventory Days - Non Drugs	69.0	78.0	R
34.50	Creditor Days	29.4	30.0	G
0.82	BPPC - Non-NHS (YTD) (number)	83.7%	83.6%	A
0.88	BPPC - Non-NHS (YTD) (£)	88.0%	88.5%	A

Cash
The closing cash balance was £59.9m, £13.1 higher than the previous month. This includes £10.1m received from GOSH Charity; £5.8 received for various IPP debtors; £2.0m received for over-performance invoices and is offset by £4.4m paid to Epic for the EPR project.

NHS Debtor Days
Debtor days decreased in month to 12 days which remains within target.

IPP Debtor Days
IPP debtor days decreased in month from 219 days to 205 days.

Creditor Days
Creditor days increased in month to 30 days which is broadly in line with last month.

Inventory Days
Drug inventory days remained the same as previous month at 8. Non-Drug inventory days increased in month from 69 days to 78 days. The methodology for calculating inventory days is based upon stock level and stock usage in month so, despite the stock level remaining broadly in line with previous month, the lower than average usage results in a higher number of inventory days.

Workforce Summary
For the 11 months ending 28 February 2018

2016/17 Actual (£m)	2017/18 Annual Plan (£m)	£m including Perm, Bank and Agency Staff Group	2017/18 Month 11 Budget (£m)	Month 11 Actual (£m)	Month 11 Variance (£m)	Month 11 Variance %	Year to Date Budget (£m)	Year to Date Actual (£m)	Year to Date Variance (£m)	Year to Date Variance %
38.05	48.24	Admin (inc Director & Senior Managers)	4.04	3.66	0.38	9.36%	44.20	38.38	5.82	13.17%
46.62	47.44	Consultants	3.98	4.10	(0.12)	-3.11%	43.44	44.36	(0.92)	-2.12%
3.59	3.99	Estates & Ancillary Staff	0.34	0.27	0.07	19.17%	3.65	3.19	0.46	12.66%
8.83	9.46	Healthcare Assist & Supp	0.86	0.71	0.15	17.14%	8.66	8.04	0.61	7.06%
24.19	25.73	Junior Doctors	2.19	2.10	0.09	4.12%	23.53	22.67	0.86	3.67%
69.54	73.61	Nursing Staff	6.15	6.50	(0.36)	-5.79%	67.39	68.39	(1.00)	-1.48%
0.28	0.36	Other Staff	0.03	0.02	0.01	28.78%	0.33	0.27	0.06	17.26%
39.52	43.70	Scientific Therap Tech	3.72	3.54	0.19	5.01%	39.98	39.52	0.47	1.17%
230.60	**252.52**	**Total substantive and bank staff costs**	**21.31**	**20.91**	**0.40**	**1.86%**	**231.19**	**224.83**	**6.36**	**2.75%**
9.32	1.68	Agency	0.14	0.27	(0.13)	-92.05%	1.54	4.10	(2.56)	-166.14%
239.92	**254.21**	**Total substantive, bank and agency cost**	**21.44**	**21.18**	**0.26**	**1.20%**	**232.67**	**228.94**	**3.75**	**-163.39%**
0.00	(6.04)	Better Value Scheme	(0.50)	0.00	(0.50)	100.00%	(5.54)	0.00	(5.54)	100.00%
(0.48)	(0.26)	Reserve	(0.07)	0.10	(0.17)	240.31%	(0.13)	0.76	(0.89)	693.73%
0.00	0.87	PICB reserves	(0.01)	0.00	(0.01)	100.00%	0.88	0.00	0.88	100.00%
239.44	**248.78**	**Total pay cost**	**20.86**	**21.28**	**(0.42)**	**-2.01%**	**227.89**	**229.70**	**(1.81)**	**-0.79%**

2016/17 Average WTE	2017/18 Annual Plan Average WTE	WTE Including Perm, Bank and Agency Staff Group	2017/18 Month 11 Budget WTE	Month 11 Actual WTE	Month 11 Variance WTE	Month 11 Variance %	Year to Date (average WTE) Budget WTE	Year to Date Actual WTE	Year to Date Variance WTE	Year to Date Variance %
948.53	1,080.04	Admin (inc Director & Senior Managers)	1,081.68	1,022.31	59.37	5.49%	1,079.89	997.59	82.30	7.62%
305.38	346.39	Consultants	346.15	318.14	28.01	8.09%	346.41	313.95	32.46	9.37%
117.95	132.36	Estates & Ancillary Staff	132.56	102.97	29.59	22.32%	132.34	108.77	23.57	17.81%
295.84	314.70	Healthcare Assist & Supp	316.54	284.46	32.08	10.13%	314.53	292.29	22.24	7.07%
311.29	333.18	Junior Doctors	333.18	319.51	13.67	4.10%	333.18	317.32	15.86	4.76%
1,405.15	1,542.61	Nursing Staff	1,543.87	1,601.68	(57.81)	-3.74%	1,542.50	1,516.30	26.20	1.70%
5.46	7.60	Other Staff	7.60	5.12	2.48	32.63%	7.60	5.20	2.40	31.64%
736.59	826.96	Scientific Therap Tech	827.01	790.44	36.57	4.42%	826.96	755.30	71.65	8.66%
4,126.19	**4,583.84**	**Total substantive and bank staff**	**4,588.59**	**4,444.63**	**143.96**	**3.14%**	**4,583.41**	**4,306.72**	**276.69**	**8.66%**
105.20	33.90	Agency	33.90	68.07	(34.17)	-100.80%	33.90	85.61	(51.71)	-152.54%
4,231.40	**4,617.74**	**Total substantive, bank and agency**	**4,622.49**	**4,512.70**	**109.79**	**2.38%**	**4,617.31**	**4,392.33**	**224.97**	**-143.88%**
0.00	(116.08)	Better Value Scheme	(112.79)	0.00	(112.79)	100.00%	(116.37)	0.00	(116.37)	100.00%
0.00	0.00	Reserve	0.00	0.00	0.00	0.00%	0.00	0.00	0.00	0.00%
0.00	0.00	PICB reserves	0.00	0.00	0.00	0.00%	0.00	0.00	0.00	0.00%
4,231.40	**4,501.66**	**Total Staff**	**4,509.70**	**4,512.70**	**(3.00)**	**-0.07%**	**4,500.93**	**4,392.33**	**108.60**	**2.41%**

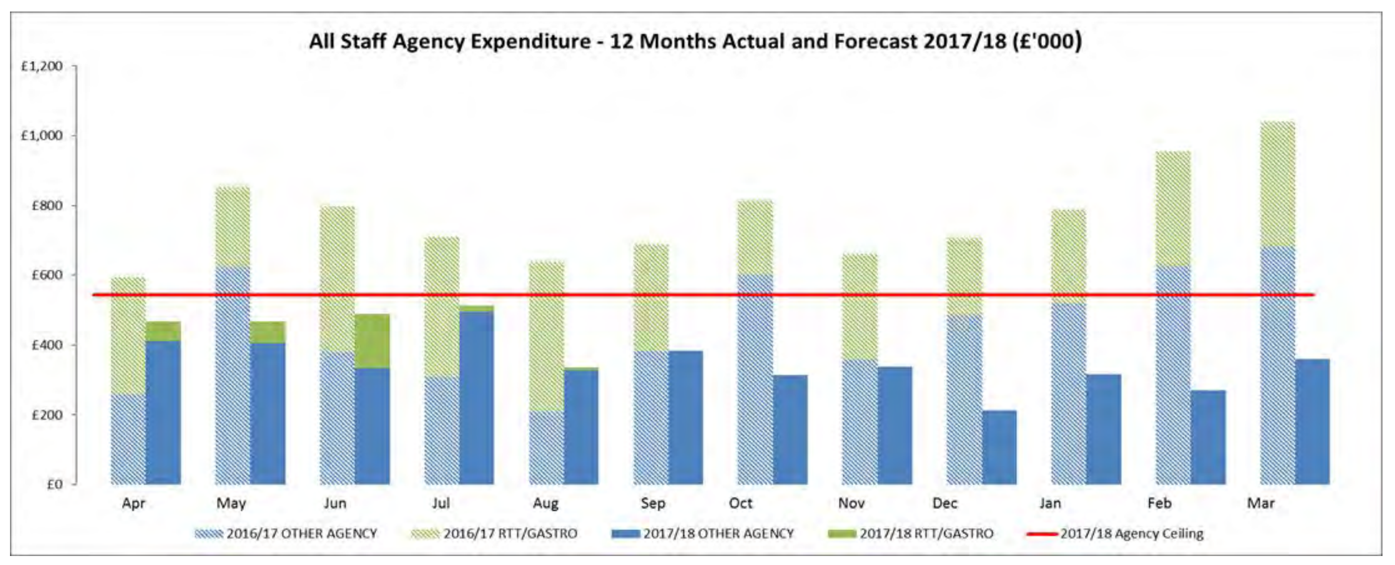
Summary

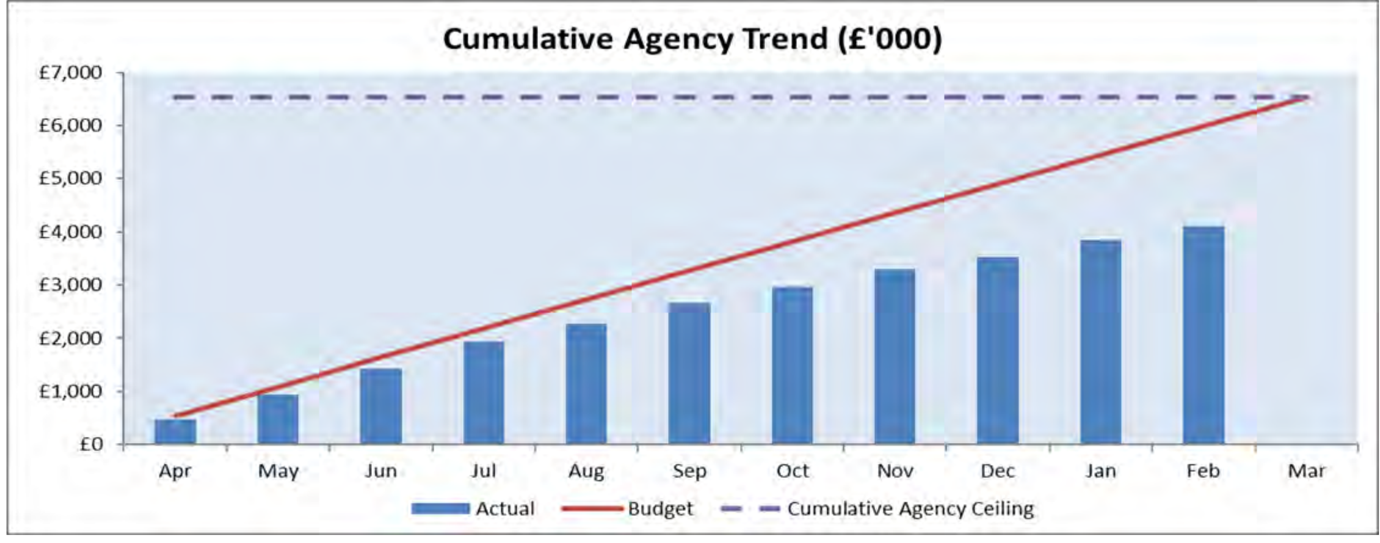
- In Month 11 pay spend is £21.3m which is £0.4m adverse to plan.
- Year to date, pay spend for substantive and bank staff is £6.4m favourable to plan due to numerous vacancies across the Trust.
- In Month 11, agency workers covered 68 of the in month vacancies. The agency spend in Month 11, £0.3m is below the NHSI monthly notified cost ceiling of £0.5m.
- Year to date, the Trust has spent £4.1m on agency workers. This is below the cumulative NHSI notified cost ceiling of £6.0m.

The Better Value Scheme annual plan £6.0m is made up of the following:

Cross Cutting Scheme	
Theatres	£1.0m
Bed Flow	£1.0m
Outpatients	£0.2m
Workforce	£1.3m
ICT Enabled	£0.3m
Agencies & VAT	£0.6m
Local Schemes/Vacancy Factor	
JM Barrie	£1.0m
Charles West	£0.6m
Total	**£6.0m**

Agency Expenditure Summary
Year to Date for the 11 months ending 28 February 2018





- In Month 11 the Trust is currently running below its NHSI cost ceiling for agency staff.

Trust NHS and Other Clinical Income Summary
Year to Date for the 11 months ending 28 February 2018

	2017/18 YTD								2016/17 YTD					
	Income				Activity				Income			Activity		
	Plan £'000	Actual £'000	Variance £'000	Variance %	Plan	Actual *	Variance	Variance %	Actual £'000	Variance 17/18 to 16/17 £'000	Variance 17/18 to 16/17 %	Actual	Variance 17/18 to 16/17	Variance 17/18 to 16/17 %
Day case	**22,945**	**22,644**	**(301)**	**-1.3%**	**19,170**	**18,829**	**(341)**	**-1.8%**	**21,353**	**1,291**	**6.0%**	**16,265**	**2,564**	**15.8%**
Elective	57,990	54,413	(3,577)	-6.2%	12,868	12,577	(291)	-2.3%	49,633	4,780	9.6%	11,790	787	6.7%
Elective Excess Bed days	2,699	2,421	(278)	-10.3%	4,793	4,327	(466)	-9.7%	2,983	(563)	-18.9%	5,970	(1,643)	-27.5%
Elective	**60,689**	**56,834**	**(3,855)**	**-6.4%**					**52,616**	**4,217**	**8.0%**			
Non Elective	15,565	16,866	1,301	8.4%	1,476	2,540	1,065	72.1%	12,327	4,540	36.8%	1,451	1,089	75.1%
Non Elective Excess Bed Days	1,853	2,445	592	32.0%	3,202	4,078	876	27.4%	1,619	826	51.0%	3,244	834	25.7%
Non Elective	**17,418**	**19,312**	**1,894**	**10.9%**					**13,946**	**5,366**	**38.5%**			
Outpatient	**35,899**	**36,202**	**304**	**0.8%**	**145,003**	**146,026**	**1,023**	**0.7%**	**35,698**	**504**	**1.4%**	**139,568**	**6,458**	**4.6%**
Undesignated HDU Bed days	4,641	5,063	422	9.1%	4,444	4,844	400	9.0%	4,306	757	17.6%	4,126	718	17.4%
Picu Consortium HDU	3,520	2,865	(655)	-18.6%	3,698	2,902	(796)	-21.5%	3,183	(318)	-10.0%	3,297	(395)	-12.0%
HDU Beddays	**8,161**	**7,928**	**(233)**	**-2.9%**	**8,141**	**7,746**	**(395)**	**-4.9%**	**7,489**	**439**	**5.9%**	**7,423**	**323**	**4.4%**
													0	
Picu Consortium ITU	32,126	29,087	(3,039)	-9.5%	11,093	10,110	(983)	-8.9%	25,117	3,970	15.8%	10,300	(190)	-1.8%
PICU ITU Beddays	**32,126**	**29,087**	**(3,039)**	**-9.5%**	**11,093**	**10,110**	**(983)**	**-8.9%**	**25,117**	**3,970**	**15.8%**	**10,300**	**(190)**	**-1.8%**
Ecmo Bedday	889	1,048	159	17.9%	162	196	34	20.7%	704	344	48.9%	129	67	51.9%
Psychological Medicine Bedday	1,040	942	(99)	-9.5%	2,576	2,332	(244)	-9.5%	1,115	(173)	-15.5%	2,763	(431)	-15.6%
Rheumatology Rehab Beddays	1,377	1,645	268	19.5%	2,421	2,755	334	13.8%	1,236	409	33.1%	2,176	579	26.6%
Transitional Care Beddays	2,650	2,106	(545)	-20.5%	1,828	1,452	(376)	-20.5%	2,363	(257)	-10.9%	1,631	(179)	-11.0%
Total Beddays	**5,956**	**5,741**	**(215)**	**-3.6%**	**6,987**	**6,735**	**(252)**	**-3.6%**	**5,418**	**323**	**6.0%**	**6,699**	**36**	**0.5%**
Packages Of Care Elective	**6,760**	**7,621**	**862**	**12.7%**					**6,863**	**759**	**11.1%**			
Highly Specialised Services (not above)	27,614	27,304	(310)	-1.1%					27,189	114	0.4%			
Other Clinical	22,070	30,627	8,557	38.8%					33,858	(3,231)	-9.5%			
Outturn adjustment	0	(119)	(119)	0.0%					(808)	688	-85.2%			
STF Funding	4,756	4,756	0	0.0%					0	4,756	0.0%			
Pricing Adjustment	6,510	6,510	0	0.0%					0	6,510	0.0%			
Non NHS Clinical Income	2,945	4,202	1,258	42.7%					3,715	488	13.1%			
NHS and Other Clinical Income	**253,849**	**258,648**	**4,800**	**1.9%**					**232,454**	**26,194**	**11.3%**			

*Activity = Billable activity
*Activity is an extract from SLAM taken at Day 1 and is subject to changes following coding completion

Day case
Day case is behind plan YTD by 341 which is primarily driven by reduced activity in Urology due to having lower staff numbers than plan to perform activity and a lower than anticipated demand level in 2017/18 against 2016/17.

Elective
Elective YTD is below plan due to lower activity in a number of specialty areas but particularly within Urology (for the same reason as above) and Haematology/Oncology (activity significantly ahead of plan in Other NHS clinical, Non-Elective and Outpatients).

Outpatients
YTD there has been an increase in outpatient activity due to Cardiac (cross cover between consultants to ensure avoidance of clinic cancellation due to annual leave), ENT (telephone clinics) and Psychosocial Services.

HDU beds
HDU activity is behind plan in Cardiac services driven by the cancellation of the Chest Wall service. This is partially offset by higher than plan HDU activity within Medical Metabolic due to complex long stay patients.

ITU Bed Days
PICU/NICU activity YTD remains broadly on trend from 16/17 levels. The year to date adverse variance is due to the PICU business case to open 4 additional beds that has been built into the 2017/18 annual plan, not delivering to the original planned levels.

Trust Inpatient and Outpatient Activity
Year on Year trend analysis

NHS and IPP Activity (Combined)								NHS Activity			IPP Activity		
Prior Year 2016/17				Current Year 2017/18									
Mth 11 Feb	Total 16/17	YTD Mth 11 16/17	Activity Type	Feb	Total YTD	Change YOY	% Change YOY	NHS YTD 17/18	Change YOY	% Change YOY	IPP YTD 17/18	Change YOY	% Change YOY
			Inpatients										
			Number of Discharges										
1,949	24,729	22,526	Day Case	1,978	22,841	315	1.4%	21,833	214	1.0%	1,008	101	11.1%
189	2,156	1,952	Regular Attenders	169	2,023	71	3.6%	2,019	78	4.0%	4	(7)	-63.6%
			Inpatient:										
1,141	14,010	12,741	Elective	1,151	13,021	280	2.2%	11,979	78	0.7%	1,042	202	24.0%
51	800	727	Non Elective	78	836	109	15.0%	738	110	17.5%	98	(1)	-1.0%
163	2,074	1,914	Non Elective (Non Emergency)	161	1,997	83	4.3%	1,966	95	5.1%	31	(12)	-27.9%
3,493	43,769	39,860	Total Discharges	3,537	40,718	858	2.2%	38,535	575	1.5%	2,183	283	14.9%
			Beddays										
704	9,178	8,403	Day Case	526	7,112	(1,291)	-15.4%	6,747	(1,316)	-16.3%	365	25	7.4%
0.36	0.37	0.37	Day ALOS	0.27	0.31	(0.06)	-16.5%	0.31	(0.06)	-17.1%	0.36	(0.01)	-3.4%
121	1,313	1,195	Regular Attenders	103	1,190	(5)	-0.4%	1,188	(1)	-0.1%	2.0	(4.0)	-66.7%
			Inpatient:										
5,197	66,583	60,635	Elective	5,354	61,540	905	1.5%	48,787	(543)	-1.1%	12,753	1,448	12.8%
622	6,842	5,984	Non Elective	444	6,152	168	2.8%	5,281	308	6.2%	871	(140)	-13.8%
1,854	25,639	23,732	Non Elective (Non Emergency)	1,996	24,594	862	3.6%	23,600	651	2.8%	994	211	26.9%
7,673	99,064	90,351	Total Overnight Beddays	7,794	92,286	1,935	2.1%	77,668	416	0.5%	14,618	1,519	11.6%
5.66	5.87	5.87	Overnight ALOS	5.61	5.82	- 0.05	-0.9%	5.29	- 0.08	-1.4%	12.5	- 0.9	-6.4%
8,498	109,555	99,949	All bed days	8,423	100,588	639	0.6%	85,603	- 901	-1.0%	14,985	1,540	11.5%
6,045	81,559	74,683	All bed days with LOS < 90 days	7,211	78,297	3,614	4.8%	69,898	1,609	2.4%	8,399	2,005	31.4%
			Midnight Census (ON Bed days)										
4,241	54,697	49,807	Elective	4,400	50,899	1,092	2.2%	39,204	(165)	-0.4%	11,695	1,257	12.0%
559	6,022	5,271	Non Elective	384	5,486	215	4.1%	4,693	338	7.8%	793	(123)	-13.4%
1,687	23,310	21,577	Non Elective (Non Emergency)	1,842	22,531	954	4.4%	21,586	745	3.6%	945	209	28.4%
0	1	1	Regular Attenders	2	1	0	0.0%	2	1	100.0%	1	1	100.0%
6,487	84,030	76,656	Total	6,628	78,917	2,261	2.9%	65,485	919	1.4%	13,434	1,344	11.1%
209	230	279	Average ON Beds Utilised	214	287	8	2.9%	196	3	1.4%	41	5	13.8%
			Critical Care Beddays (NICU|PICU|CICU)										
413	4,610	4,112	Elective	351	4,114	2	0.0%	3,141	89	2.9%	973	(87)	-8.2%
162	1,453	1,220	Non Elective	84	948	(272)	-22.3%	908	(192)	-17.5%	40	(80)	-66.7%
415	6,404	5,979	Non Elective (Non Emergency)	569	6,708	729	12.2%	6,469	563	9.5%	239	166	227.4%
990	12,467	11,311	Total CC Beddays	1,004	11,770	459	4.1%	10,518	1,290	14.0%	1,252	(1)	0.0%
31.9	34.2	41.1	Average CC Beddays	32.4	42.8	1.7	4.1%	31.5	3.9	14.0%	3.7	(0.0)	0.0%
			Outpatients										
21,167	253,717	229,552	Outpatient Attendances (All)	19,701	234,145	4,593	2.0%	217,312	3,818	1.6%	16,833	775	4.8%
3,976	47,751	43,362	First Outpatient Attendances	3,788	43,300	(62)	-0.1%	36,547	(258)	-0.7%	6,753	196	3.0%
17,191	205,966	186,190	Follow Up Outpatient Attendances	15,913	190,845	4,655	2.5%	180,765	4,076	2.3%	10,080	579	6.1%
4.3	4.3	4.3	New to Review Ratio	4.2	4.2	(0.1)	-1.5%	4.9	0.1	2.1%	1.5	0.0	3.0%

Comments on key changes to prior year:

Day Cases
Overall Day cases show an increase of 1.4% compared with the same period in 16/17, with a proportionately greater increase in IPP activity (11.1%). Urology continues to report a reduction compared to 16/17 (378 cases; 16%) - due to a combination of staff sickness and a reduction in waiting list initiatives compared to 16/17. Radiology has also decreased mainly due to allocation changes resulting from the new National tariff arrangements (119 cases; 15%). The YTD decrease caused by these is being offset by increases in other areas - for example, Haematology & Oncology (338 cases; 12%), due to some increase in demand but also linked to the allocation changes in relation to Radiology, and Rheumatology (223 cases; 6%), due to utilisation of additional rehab capacity to clear a backlog.

Inpatient
Inpatient spells YTD have increased by 472 (3.0%) compared to 16/17 with the most significant factors being NHS non-elective (increase of 110; 17.5% change) and IPP elective activity (increase of 202). The NHS non-elective increase mainly relates to Nephrology (increase of 42) and Cardiology (increase of 115). IPP elective activity has increased in a number of area, but particularly Respiratory, Haematology/Oncology and Neurology.

Critical care
Critical care bed days YTD have increased by 4.1% compared to 16/17. This represents activity below planned levels - 4 additional PICU/NICU beds were planned to be opened but there have been issues with both demand and staffing.

Attachment N

Council of Governors

25 April 2018

Young People's Forum Update

Summary & reason for item: To provide an update of the activities of the Young People's Forum since the last Members' Council Meeting since February 2018.

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

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

Item presented by: Any Young People's Forum Member who is also a Governor.

Young People's Forum (YPF) activity – February 2018 to April 2018

The YPF is a group of current and ex patients aged 10-25 who have a strong voice in helping to improve the experiences of teenage patients. They use their own experiences to guide and support the hospital. There are six meetings a year, with ad hoc opportunities between meetings.

The current total of membership: 73

Meetings
There were meetings in January and March; 38 young people attended in January and 30 were present at the March session.

January meeting
The January agenda differed from previous months as there were two main items for exploration, rather than a number of topics.

1) The architect and building team that won the Phase 4 Development bid presented updated designs and asked for feedback on a range of key issues such as: the adequacy of their privacy safeguards, the importance of relaxation and social spaces, where the Peter Pan statue should be relocated.

Fig 1. YPF members giving feedback on Phase 4 designs

Duncan from John Sisk & Son, the Phase 4 building contractor, said;

"The afternoon was very inspiring with lots of good ideas, in fact putting many of my adult clients to shame with the level of understanding, vision and your [the young people's] communication with the designers.

"The lack of selfishness from the YPF was a lesson for us all.

"In some ways you [YPF members] have made our role easier but in other ways, you [YPF members] have made it much harder as we know the levels we have to achieve!"

2) The second team who presented were from the suppliers of the planned electronic patient feedback system. The company flew over especially from Canada to meet the YPF and put the following questions to them: How should GOSH collect feedback from patients (making sure those with communication difficulties – not everyone can read or write-are included)?, How should GOSH tell those who give feedback what happened with it?

Fig 2. YPF member suggestions on how to gain feedback from patients

March meeting

10 young people attended a tour of the Zayed Centre for Research with Skanska.

The agenda had the following presentations, workshops and updates:

- a YPF member who had raised funds for the YPF
- ideas on how to improve the Adolescent Waiting Room in the Hippo outpatient department
- engagement opportunities with the Post Graduate Medical Education Team e.g. help with junior doctor exams
- the Assistant Manager for Catering
- the Lead Nurse for Infection Prevention and Control
- Healthy London Partnership, who developed the NHS Go app
- the Hospital Pyjamas company who requested feedback about a range of loungewear for teenagers that they are developing

Fig 3. YPF group photo at the March 2018 meeting

Takeover Challenge 2018 – with Premier Inn
As a result of a very successful Takeover Challenge which took place in November, a decision was made to approach a GOSH Charity corporate partner to pilot a Takeover outside of the Trust.

A trial week was planned with Premier Inn during the 2018 February half-term. Five YPF members "took over" their local Premier Inns via roles from Restaurant Supervisor to Hotel Manager. YPF member, Ihsaan, said: "I recommend it to everyone that has a spare day and wants to do some work for caring and friendly organisations."

Fig 4. YPF member, Ihsaan, at Premier Inn

Catering Review
The first Catering Review meeting took place in February and the Vice Chair of the YPF attended. A YPF member was also invited to the March meeting but was unable to attend. This group will be looking at the results of the independent catering review which is taking place and will provide feedback on any of the report's recommendations, before they go to the Trust Board.

The YPF were also pleased to see their suggestions to make the Lagoon more child friendly and the introduction of a salad bar become reality in early 2018.

Chief Finance Officer (CFO) Interviews

A panel of 6 young people was selected by The Interim Children and Young People's Participation Officer and the Head of Resourcing from the 11 YPF members who expressed an interest

The CFO candidates were asked to plan and facilitate a 10 minute ice-breaker session with the YPF panel. The YPF also had their own challenges to test teamwork, communication, problem-solving and leadership of candidates. Sessions ended by YPF members asking the CFO candidates questions.

The Deputy Chief Executive Officer helped support the YPF panel, however, a YPF member acted as chair and spokesperson for the panel and gave feedback to the formal interview panel.

Teen Café
Update
A review into the Teen Café pilot found that in the last year:

- 118 young people met and engage with others their age
- The average age attending was 14
- The highest attendance for one session was nine
- There have been 14 sibling attendances

The Teen Café will continue to run with the support of the Patient Experience and Volunteer Teams.

National YPF
Update
A comprehensive document outlining the details of planning of the National YPF has been shared with the hosts of the Big Meet Up 2018 (Derby and Nottingham hospitals). The GOSH team has also held a conference call with staff at these hospitals and introduced them to a number of key contacts.

A brief report and PowerPoint has been circulated to all 14 of the attending hospitals to share with their forums and to consider any actions in light of the issues raised on the day.

Artwork of the day has also arrived at the Trust and will be circulated to all attendees.

Additional YPF publicity

Two monthly YPF newsletters have been circulated.
Examples of YPF member activities during February and March are:

- Five members attended an engagement meeting with the Royal Collage of Paediatric Health Care
- Six members were part of a Virtual Reality focus group and how this could help train health professionals at GOSH
- One member was invited to be part of a “Dragons Den” panel at GOSH to decide on funding for innovative ideas.

There were also 15 involvement future opportunities advertised.

On the Horizon

The YPF will continue to support larger Trust projects such as the Transition Improvement Project and the Phase 4 Redevelopment team will be returning to providing updates on plans in the August 2018 meeting.

Council of Governors

Wednesday 25th April 2018

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.

Governor action required: To receive and note the report

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

Item presented by: Alison Robertson Chief Nurse

Patient Family Experience and Engagement Committee

April 2018

FFT Summary – Q4 2017/18

- **March 2018 FFT Response Rate, 24.1%**
- **February 2018 FFT Response Rate, 23.2%**
- **January 2018 FFT Response Rate, 25.1%**
- **Q4 Average FFT Response Rate, 24.1%**

  (⇧1.7% Q3)(Trust Target, 40%)

- **March 2018 FFT Percentage to Recommend, Inpatients, 96.1%**
- **February 2018 FFT, Percentage to Recommend, Inpatients, 95.7%**
- **January 2018 FFT Percentage to Recommend – Inpatients, 97.4%**

  (⇩0.2% from Q3) Q4 results were 96.4% (Trust Target, 95%)

- **March 2018 FFT Percentage to Recommend, Outpatients, 93.1%**
- **February 2018 FFT, Percentage to Recommend, Outpatients, 92.4%**
- **January 2018 FFT Percentage to Recommend, Outpatients, 93.7%**

  (⇩1.2% from Q3)(Q4 results were 93.1%) (Trust Target, 95%)

FFT Response Rate

Great Ormond Street Hospital for Children NHS Foundation Trust

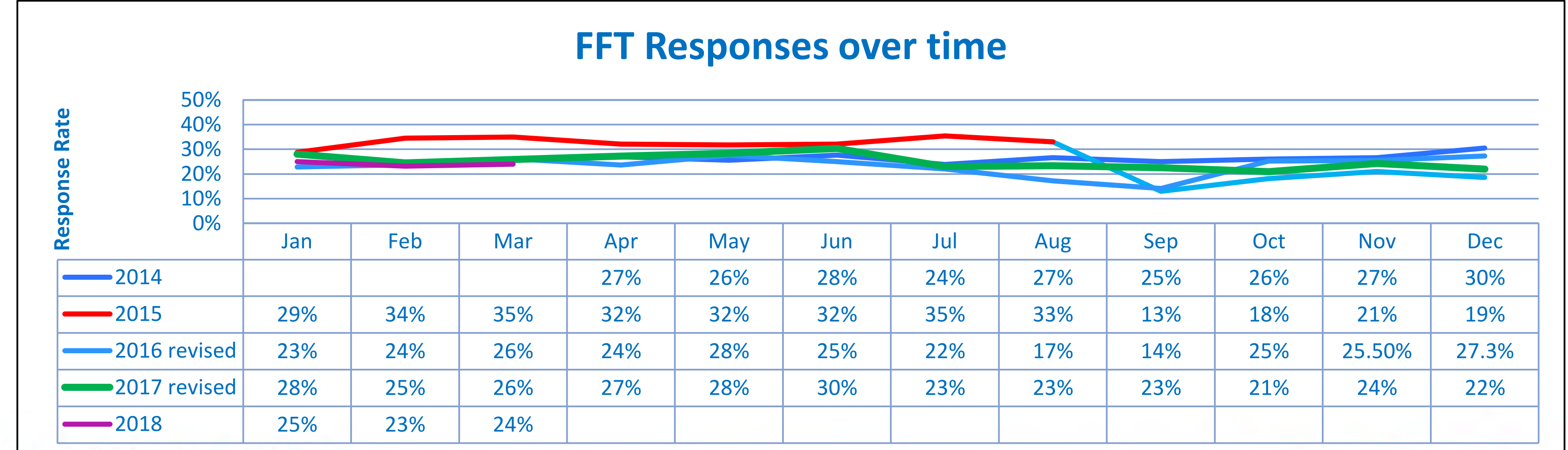
Inpatients

Average Response Rate in 16/17 = **23.8%**

Average Response Rate in 17/18 = **24.6%**

Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
23.6%	27.5%	25.0%	22.0%	17.0%	14.0%	25.2%	25.5%	27.3%	28.4%	24.5%	25.9%

Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
27.2%	28.4%	30.3%	23.3%	23.4%	22.6%	21.0%	24.3%	22.0%	25.1%	23.2%	24.1%



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2014				27%	26%	28%	24%	27%	25%	26%	27%	30%
2015	29%	34%	35%	32%	32%	32%	35%	33%	13%	18%	21%	19%
2016 revised	23%	24%	26%	24%	28%	25%	22%	17%	14%	25%	25.50%	27.3%
2017 revised	28%	25%	26%	27%	28%	30%	23%	23%	23%	21%	24%	22%
2018	25%	23%	24%									

FFT Themes

Great Ormond Street Hospital for Children NHS Foundation Trust

*Calculated by Percentage

Top Three Positive Themes*

January 2018	February 2018	March 2018
Always Helpful	Always Helpful	Always Welcoming
Always Expert	Always Welcoming	Always Helpful
Always Welcoming	Housekeeping/Cleanliness	Always Expert

Top Three Negative Themes*

January 2018	February 2018	March 2018
Staffing Levels	Staffing Levels	Access / Admission / Discharge / Transfer
Access / Admission / Discharge / Transfer	Access / Admission / Discharge / Transfer	Catering / Food
One Team	Catering / Food	Staffing Levels

The child first and always

Real Time Feedback System Update

- Configuration of the Real Time Feedback system i.e. Reports and Alerts is progressing in accordance with the Project Timelines.
- 95% of On-Line FFT form which will flow directly into the system has been completed.
- 90% of training guides completed for proposed roll out date in June 2018

CQC National Patient Survey

- **Run by the CQC**
- **First paediatric survey in 2014**
- **Second in 2016**

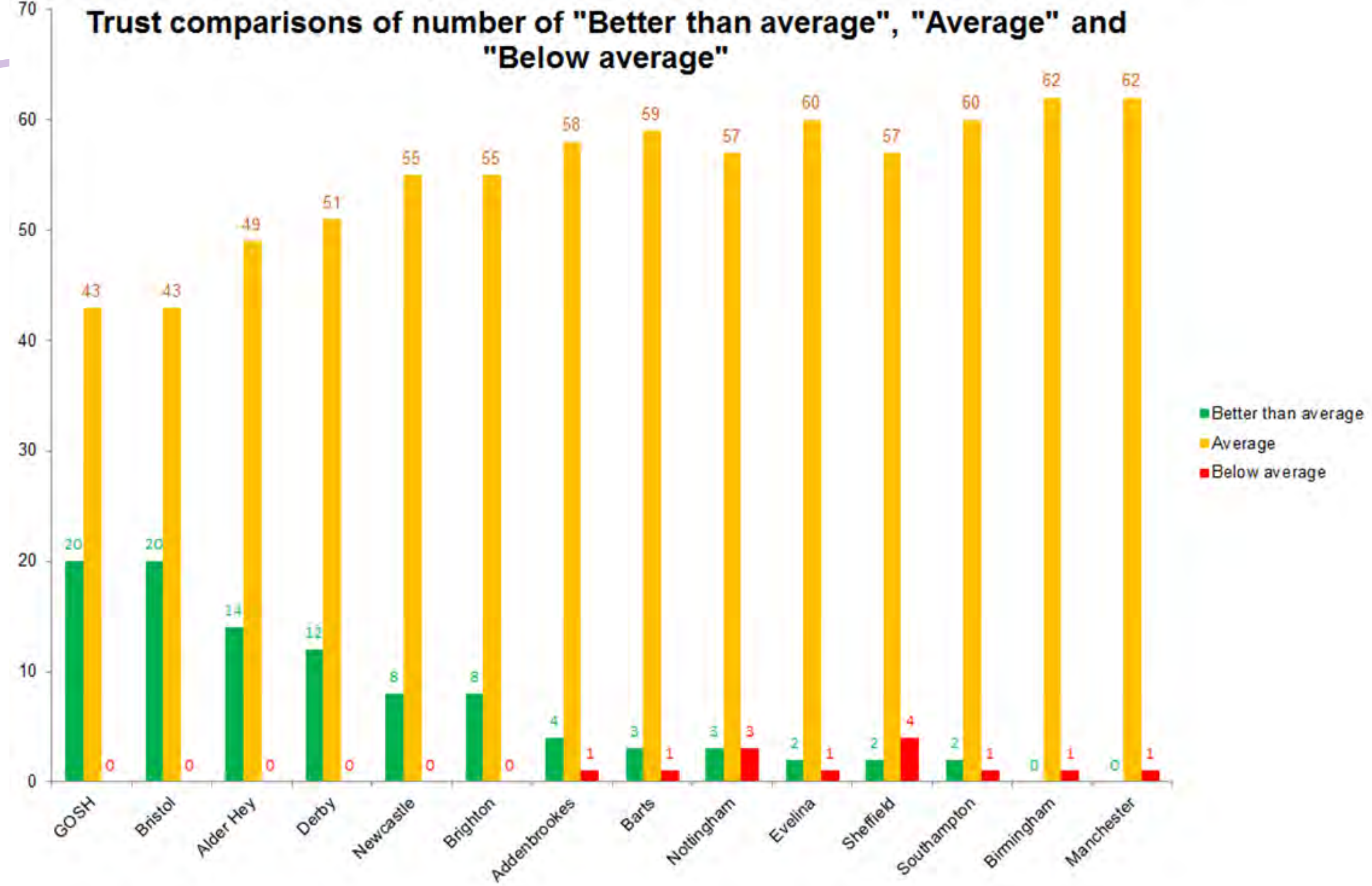
- Questions were based on topics related to coming into hospital e.g. the ward
- Sample - October, November and December 2016
- Administered by paper during Feb - April 2017
- Scoring of questions ranged from 0 poor to 10 excellent

Results

- 30% response rate (5% above national average) 1238 sent 372 returned
- 66% of returned questionnaires were young patients' questionnaire
- In 2016, patients rated care experience as 9.3 out of 10. In 2014 it was 8.5
- In 2016 parents also gave the score of 9.30 out of 10. In 2014 it was 8.7

National Comparisons

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust



Detailed Presentation

Appendix 1 provides a more detailed presentation of the CQC Patient Survey results.

Patient Story

The Patient Experience team continues to collate Patient Stories for Trust Board.

Each story is shared with the Trust staff members and in particular to the departments/staff/services raised.

The stories support on-going improvements and developments and actions are addressed as required.

Great Ormond Street Hospital for Children NHS Foundation Trust NHS

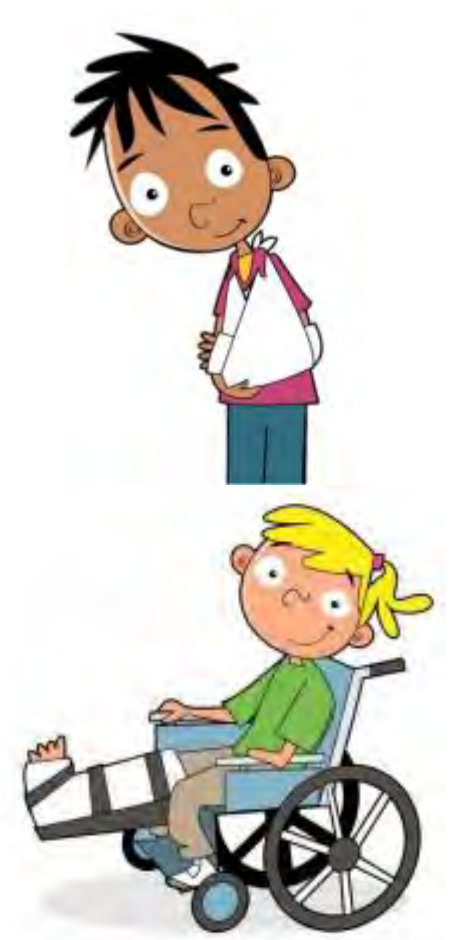
CQC National Children's Inpatient Survey Results 2016

Background

- Run by the CQC
- First paediatric survey in 2014
- Second in 2016

The survey

- Questions were based on topics related to coming into hospital e.g. the ward
- Sample - October, November and December 2016
- Administered by paper during Feb - April 2017
- Scoring of questions ranged from 0 poor to 10 excellent



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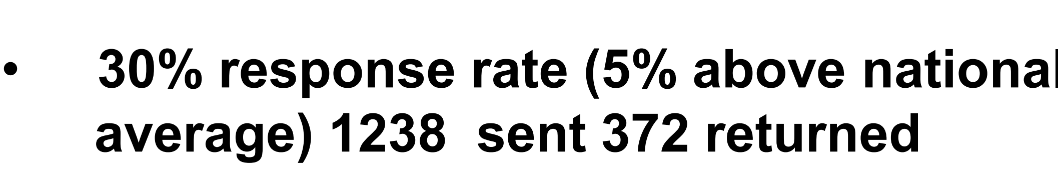
Results



- 30% response rate (5% above national average) 1238 sent 372 returned

- 66% of returned questionnaires were young patients' questionnaire

- In 2016, patients rated care experience as 9.3 out of 10. In 2014 it was 8.5

- In 2016 parents also gave the score of 9.30 out of 10. In 2014 it was 8.7

GOSH results

	From Patients	From parents
In the top three performing questions	96% felt they were able to ask questions	95% of parents felt they were given enough information on how to use medicines
	95% felt staff answered their questions	95% of parents felt they were given an explanation of what would be done in operations/procedures
	92% felt they were given explanations of what was to happen in operations/procedures	95% of parents felt that prior to an operation/procedure they received answers to their questions in a way that they could understand
In the bottom three performing questions	Only 56% felt there was enough things for them to do whilst in hospital	Only 64% of parents felt there was enough things for their child to do whilst in hospital
	Only 55% felt they were involved in decisions about their care and treatment	Only 59% of staff were aware of their child's medical history
	Only 50% liked the hospital food	Only 38% of parents reported that they were given a choice of admission dates

National comparisons

20/63 questions - GOSH scored “better than average”

47/63 questions - GOSH scored “about the same”

GOSH identified as performing “better than expected” for the 0-7 age group compared to other Trusts within the survey

“Better than average” in the topics below :

- **Hospital wards**
- **Hospital staff**
- **Leaving hospital**

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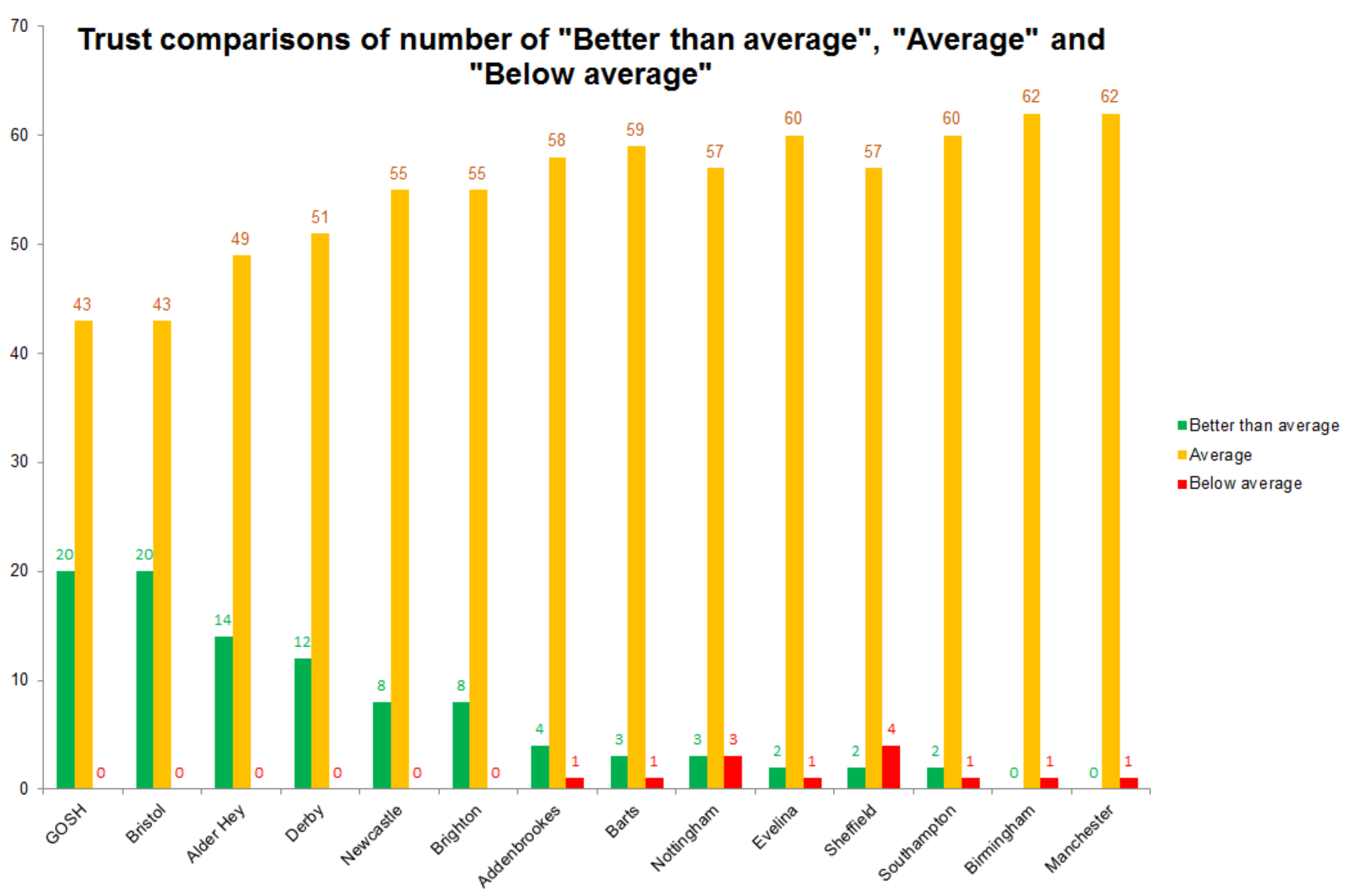
National comparisons 2016



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Always Values Consideration

Positives

Clear communication with health professionals shows the Trust can be *one team, helpful and expert* with our patients and parents.

Negatives

- **Ensuring parents have a choice of admission dates, where possible (*one team, welcoming, helpful)***
- **Improving the hospital food *(expert, helpful, welcoming*)**
- **Ensuing children and young people feel involved in decisions about their care and treatment *(expert, helpful, welcoming, one team)***
- **Having enough things for children and young people to do whilst in hospital *(expert, helpful, welcoming, one team)***
- **Ensuring staff are aware of patients medical history *(expert, helpful, one team)***

Limitations of this data

- **It was collected in early 2017, from patients who stayed in GOSH during October-November 2016 – results received on 28 November 2017**

- **16+ and above were not eligible for this survey, as dictated by the CQC**

Next steps

- Present at PFEEC and other relevant committees
- Share results with all staff via communications such as Roundabout
- Review existing work streams to identify whether any additional actions related to survey feedback can be incorporated. An action plan will be developed for all other areas not covered by existing work streams