Great Ormond Street Hospital for Children
NHS Foundation Trust
NHS

Meeting of the Trust Board
30th May 2012

Dear Members

There will be a public meeting of the Trust Board on Wednesday 30th May 2012 commencing at **1:30pm** in the **Charles West Room, Paul O'Gorman Building,** Great Ormond Street, London, WC1N 3JH.

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

AGENDA

	Agenda Item **STANDARD ITEMS**	Presented by	Authors
1.	**Apologies for absence**	Chair	
Declarations of Interest The Chair and members of this meeting are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must, as soon as practicable after the commencement of the meeting disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.			
2.	**Minutes of Meeting held on 25th April 2012**	Chair	**A**
3.	**Matters Arising / Action point checklist**	Chair	**B**
4.	**Chief Executive's Update** • ICU Review • Members' Council Development Sessions Update • Work-plan for 2012/13 • Update on development of annual plan • Update on Safe and Sustainable Reviews	Chief Executive	**Verbal**
	ITEMS FOR APPROVAL		
5.	**NHS Trust Final Accounts and Annual Report including** • Annual Governance Statement and • Head of Internal Audit Opinion **NHS Foundation Trust Final Accounts and Annual Report including** • Annual Governance Statement • Head of Internal Audit Opinion	Audit Committee Chair/ Chief Finance Officer	**C&D** **E&F** **In separate pack**
6.	**Quality Account 2011/12**		**G in separate pack**
7.	**Annual Report of Audit Committee 2011/12**	Chief Finance Officer	**H in separate pack**
8.	**Draft Schedule of Reservation and Delegation of Powers**	Company Secretary	**I in separate pack**

	UPDATES		
9.	**Quality, Safety & Transformation Update**	Co-Medical Director (ME)	**J**
10.	**Performance Report (April 2012)**	Chief Operating Officer	**K**
11.	**Finance and Activity Report** • **End of year 2011-12**	Chief Finance Officer	**L**
12.	**Update on progress with Education and Training Strategy**	Chief Nurse and Director of Education	**N**
13.	**Audit Committee** • **Final minutes from February 2012** • **April 2012 (Summary report)**	Company Secretary/ Chair of Audit Committee	**O** **P**
14.	**Clinical Governance Committee** • **Final minutes from March 2012** • **April 2012 (Summary Report)**	Company Secretary/ Chair of Clinical Governance Committee	**Q** **R**
15.	**Management Board** • **Final minutes from March 2012**	Chief Executive	**S**
16.	**Trust Board Members' Activities**	Chair	
	FOR RATIFICATION		
17.	**Consultant Appointments**	Chair	
18.	**Any Other Business** (Please note that matters to be raised under any other business should be notified to the Company Secretary before the start of the Board meeting.)		
19.	**Next meeting** The next Trust Board meeting will be held on Wednesday 27th June 2012 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London, WC1N 3JH.		

ATTACHMENT A

Great Ormond Street Hospital for Children
NHS Foundation Trust

DRAFT Minutes of the meeting of Trust Board held on 25th April 2012

Present

Baroness Tessa Blackstone	Chairman
Dr Barbara Buckley	Co-Medical Director
Ms Yvonne Brown	Non-Executive Director
Professor Andy Copp	Non-Executive Director
Dr Jane Collins	Chief Executive
Ms Fiona Dalton	Chief Operating Officer
Mr David Lomas	Non-Executive Director
Ms Mary MacLeod	Non-Executive Director
Mrs Liz Morgan	Chief Nurse and Director of Education
Mrs Claire Newton	Chief Finance Officer
Mr John Ripley	Non-Executive Director
Mr Charles Tilley	Non-Executive Director

In attendance

Dr Anna Ferrant	Company Secretary
Miss Victoria Goddard	Trust Board Administrator
Dr John Hartley	Consultant, Bacteriology
Ms Caroline Joyce	Assistant Chief Nurse, Quality, Safety and Patient Experience
Mr William McGill	Director of Redevelopment
Ms Grainne Morby	Head of PALS and Patient Experience

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

396 Apologies for Absence

396.1 Apologies were received from Professor Martin Elliot, Co-Medical Director.

397 Declarations of Interest

397.1 No declarations of interest were received.

398 Minutes of the Meeting Held on 29th February 2012

398.1 The minutes of the Trust Board meeting held on 29th February 2012 were received and **approved** with the following amendments.

- Minute 365.3 to be amended to read "The Board approved the nomination of Ms Mary MacLeod as Senior Independent Director, to be ratified by the Members' Council.

399 Action checklist

399.1 It was agreed that action 17.4 would continue with the Members' Council. Therefore this action was closed.

399.2 Minute 332.3 – The Chairman asked for some clarity around the completion

of the action as the two committees remained in operation and meetings remained at 10 per year.

399.3 Mrs Liz Morgan, Chief Nurse and Director of Education reported that parent representatives had requested that the meetings continue at the same frequency.

399.4 Ms Grainne Morby, Head of PALS and Patient Experience added that meetings for the year ahead had been reduced to 6. She noted the large workload of the committees which had made parent representatives cautious to merge committees.

399.5 Baroness Blackstone stressed that a large number of staff were involved with the committees and that Trust Board had resolved to reduce the number of meetings and committees which took place.

399.6 It was agreed that the Patient and Public Involvement and Experience Committee would meet no more than 6 times per year and any additional business would be conducted electronically outside of meetings. The Family Equality and Diversity Committee would meet no more than three times per year.

399.7 Mrs Morgan reported that the work of the two committees would be built into the Clinical Unit reports which were received annually in order to embed the work into Clinical Units.

399.8 The Chairman asked that a paper be brought to the next meeting to consider the ways in which meetings and committees could be streamlined.

399.9 **Action:** A paper to be brought to the next meeting to consider the ways in which meetings and committees could be streamlined.

399.10 Minute 335.4 – Dr Barbara Buckley, Co-Medical Director reported that transport was being prioritised for school aged children. She added that a review was conducted to ensure that no issues were missed.

399.11 It was confirmed that minute 368.8 would be carried over to the meeting in May.

399.12 Minute 372.8 – Ms Claire Newton, Chief Finance Officer reported that a baseline would be developed beginning at the start of the financial year 2012/13.

400 Chief Executive's Update

400.1 Dr Jane Collins, Chief Executive Officer provided a verbal update to the Board on the following areas:

400.2 <u>ICU Review</u>

400.3 Dr Collins reported that the ICU review had not yet been received. She confirmed that a telephone call would be taking place after the meeting with the Co-Medical Directors, the Chief Operating officer and the Chief Executive to discuss timescales for the report.

400.4 Safe and Sustainable

400.5 Dr Collins reported that a judicial review had found in favour of Safe and Sustainable. Outcomes for Cardiac surgery and respiratory patients were not yet clear and a meeting would be convened in June / July to discuss this.

400.6 Research

400.7 It was confirmed that the research income received by the Trust during 2012/13 would be reduced. Dr Collins reported that a positive meeting had taken place with Sally Davies and that work would not be completed until a new director of ICH had been appointed.

400.8 Media Attention

400.9 Dr Collins noted the recent media coverage and the potential distress caused to staff and families.

400.10 Actions to take forward over the death of child JR

400.11 It was reported that appropriate professionals at ICH, nationally and internationally would be convened to develop an action plan around congenital rickets given that it can be thought of as a non accidental injury. It had been agreed that Dr Barbara Buckley would ask Kling Chong, Consultant Radiologist to review working together.

400.12 Morgan Stanley Clinical Building (MSCB

400.13 It was confirmed that the formal opening of the MSCB would take place in July with three events. Invitations would be sent shortly.

400.14 Baroness Blackstone asked that she receive an attendance list for the opening and an agenda for the day.

400.15 **Action:** Baroness Blackstone to receive an attendance list for the opening and an agenda for the day.

401 Quality, Safety and Transformation Update

401.1 It was reported that there were no statistically significant changes in the zero harm report. Ms Fiona Dalton, Chief Operating Officer added that all specialities had identified two or three clinical outcomes and a benchmarking project was beginning with leading Children's Hospitals throughout the world.

401.2 Baroness Blackstone asked why Neurosciences had been unable to publish any of their measures on the GOSH website.

401.3 Ms Dalton reported that parents had requested a number of changes in order to make the report more user friendly which had resulted in a delay.

401.4 Ms Mary MacLeod, Non Executive Director indicated that she was pleased with the level of detail on the website and the way it related to the impact on children.

401.5 Professor Andy Copp suggested that feedback be collected from patients

and families during outpatient appointments.

401.6 The Board **noted** the update.

402 Trust Wide Patient Survey

402.1 Caroline Joyce, Assistant Chief Nurse presented the results of the Trust wide patient survey which had been independently compiled by Ipsos MORI.

402.2 She reported that at least 100 patients had been surveyed from each Clinical and the 'very satisfied' response had been increased by 2% while the number of issues of dissatisfaction had reduced in relation to last year's responses.

402.3 A new question had been asked around PALS as a result of a challenge from Monitor. The survey results showed that non English speaking families and those using services from particular clinical units were less likely to know about PALS.

402.4 Ms Joyce noted the disappointing results relating to food as work had been ongoing around food and nutrition. She added that there had been issues with catering at the time of the survey.

402.5 Mr David Lomas, Non Executive Director noted that 23% of people surveyed strongly agreed that the discharge process took a long time. He asked whether this was correct.

402.6 Dr Barbara Buckley reported that in some cases issues did arise. She added that discharge was being broken down into different types of problems that may arise such as waiting for medication or transport.

402.7 Mrs Liz Morgan added that a number of discharge projects were ongoing.

402.8 Baroness Blackstone asked how confident Ms Joyce was that caterers and servers were able to respond to criticisms.

402.9 Ms Joyce confirmed that she was confident as a lot of work was ongoing in this area in particular the timings of meals being delivered. This had been process mapped and those who required food very quickly from a food hygiene perspective received their meals sooner and older patients received meals later. Feedback cards on meal trays were being piloted.

402.10 Mr John Ripley, Non Executive Director asked whether Ipsos MORI could provide benchmarking information.

402.11 It was confirmed that different Trusts measured patient experience in varying ways making it difficult to benchmark the data in a meaningful way.

402.12 The Board **noted** the results of the survey.

403 Sustainability Development Management Plan

403.1 Mr William McGill, Director of Redevelopment presented the annual Sustainability Development Management Plan Update. He reported that the plan must demonstrate a commitment to carbon reduction which should be

approved at Board level.

403.2 Mr McGill reported that the opening of the Morgan Stanley Clinical Building had improved the Trust's use of energy as it had been possible to achieve the lowest energy use for the new building whilst meeting comfort issues, clinical needs and best value. The Trust achieved an 'excellent' rated score in this area.

403.3 It was noted that the Trust would be installing energy meters across the site to give an overview of energy use in different areas.

403.4 Mr McGill reported that the Trust had vastly reduced its CO_2 emissions in the last seven years in line with its commitment and from 16,000 organisations the Trust was in the top 1,500 in terms of its CO_2 emissions.

403.5 Mr Charles Tilley, Non Executive Director suggested that the plan should be more closely linked with the hospital's overall strategy as once published it may be considered as a stand alone document. He added that baseline assessment results in the 'good corporate citizenship' model in the area of workforce appeared to be low.

403.4 Mr McGill confirmed that HR had been heavily involved in sustainability and in driving HR policies in a sustainable way

403.5 It was agreed that Mr McGill would provide an update at the next Trust Board meeting as to why workforce scores were low.

403.6 **Action:** The Director of Redevelopment to provide an update at the next Trust Board meeting as to the reason for low workforce scores in baseline assessment results of the good corporate citizenship model.

403.7 The Board **approved** the Sustainable Development Management Plan.

404 PALS and Patient Experience Report

404.1 Mrs Liz Morgan, Chief Nurse and Director of Education explained that the newly designed report included updates on the outcomes of cases.

404.2 Ms Grainne Morby reported that Gastro continued to generate a disproportionate number of enquiries and as a result reoccurring issues were brought to the attention of clinicians. PALS had been provided with a response from Gastro around how issues were being moved forward.

404.3 It was confirmed that a new Patient Experience Officer was in post and positive projects were now ongoing to work more closely with hard to reach groups, in particular Orthodox Jewish families and patients with an Autistic Spectrum Disorder.

404.4 Mr David Lomas confirmed that the report had been helpful and asked that in future colour copies be provided.

404.5 **Action:** Colour copies of PALS and Patient Experience report to be provided to the Board.

404.5 Dr Barbara Buckley reported that a big piece of work was ongoing with the

Gastro team in order to support them to provide better services to families.

404.6 Ms Mary MacLeod suggested that it would be helpful to know which red rated PALS enquiries were related to GOSH clinical issues. She asked that in future reports these issues be highlighted.

404.7 **Action:** Future PALS and Patient Experience reports to separate red rated issues that arise from GOSH clinical issues from other enquiries.

405 Infection Prevention and Control Update

405.1 Dr John Harley, Consultant (Bacteriology) highlighted infection control arrangements taking place in Clinical Units. He reported that with the exception of two units, Clinical Units had produced ICP plans and had regular meetings. The Trust ensured that teams have the correct competencies in place through the use of practice educators.

405.2 It was noted that the estates team had worked hard to ensure theatres were up to date and Ms Fiona Dalton reported that next year two theatres would not be in use for the purposes of maintenance.

405.3 It was noted that there was a large financial consequence to the Trust when completing works on theatres which were in use.

405.4 Dr Hartley reported that hand hygiene was a nursing KPI and an area in which all units had made significant progress.

405.5 Baroness Blackstone expressed some concern that the staff survey had found that a number of staff felt that there weren't suitable hand washing facilities provided.

405.6 It was confirmed that this result related to corporate areas of the Trust and that contact cards were being placed in hand washing areas to enable staff to inform the cleaning contractors when it was necessary to refill soap or alcohol gel dispensers.

405.7 The Board **noted** the update.

406 Performance Report (March 2012)

406.1 Ms Fiona Dalton, Chief Operating Officer reported that work was ongoing to develop KPIs for 2012/13. She explained that, taking into account Board feedback, the aim was for fewer KPIs to be in place.

406.2 Mr David Lomas queried whether or not there was an equivalent statistic for outpatients which could be monitored as timeliness of discharge summaries was for inpatients. He added that it would be helpful to view inpatient waiting lists by Clinical Units in order to highlight those Units with red rated waiting lists.

406.3 Ms Dalton confirmed that there was a link between clinical appointments on PIMS and the timeliness of appointment letters which could be monitored as a KPI.

406.2 The Board **noted** the report.

407 Update on achievement of the PDR rate by end of financial year

407.1 Mrs Liz Morgan, Chief Nurse and Director of Education reported that the current PDR rate target had been identified to ensure that staff received feedback and training needs were identified. It was noted that in order to achieve NHSLA level 3, a PDR completion rate of 95% was required. Mrs Morgan added that achieving a target of 95% would require the combined effort of the education team and management.

407.2 Mrs Morgan confirmed that learning would be taken from the way mandatory Information Governance training had been implemented. A report would be taken to Management Board showing who had not undertaken the training.

407.3 Mr Charles Tilley stressed the importance of ensuring the data was correct and did not incorporate information which would skew results.

407.4 Baroness Blackstone, Chairman asked what impact, if any, would the inclusion of medical appraisals have on figures.

407.5 Mrs Morgan confirmed that this had already been included and had not had a significant impact.

407.6 It was agreed that a paper on revalidation of Doctors should be considered by Trust Board.

407.7 **Action:** A paper on revalidation of Doctors to be brought to the May meeting of the Trust Board.

407.8 Dr Jane Collins stressed the personal responsibility involved in ensuring PDRs had been completed and suggested it would be possible to withhold incremental salary increases until PDRs had been completed.

407.9 Ms Mary MacLeod, Non Executive Director queried whether it was possible to carry out PDRs in a way which was not face to face.

407.10 Mrs Morgan agreed to confirm whether there were no issues with this from a HR or NSHLA perspective.

407.11 **Action:** Mrs Liz Morgan to confirm whether it is acceptable to carry out PDRs which are not face to face, both from a HR and NHSLA perspective.

408 Finance and Activity

408.1 It was noted that the end of year report would be considered at the May meeting of the Trust Board.

409 Head of Nursing Report

409.1 Mrs Liz Morgan, Chief Nurse and Director of Education explained that it was intended for the Head of Nursing report to be considered quarterly by the Trust Board as it contained KPIs that were not reported in other areas.

409.2 Dr Anna Ferrant, Company Secretary agreed to ensure that the frequency of

papers was minimised while still meeting the duties of the HCAI Act.

409.3 **Action:** The Company Secretary to ensure that the frequency of papers are minimised while still meeting the duties of the Act.

409.4 It was agreed that the Board would delegate authority to receive Head of Nursing reports to the Clinical Governance Committee (CGC) and that this paper would be considered at the next CGC meeting.

409.5 **Action:** The Company Secretary to ensure that the Head of Nursing Report is considered at the next meeting of the Clinical Governance Committee.

410 Annual Safeguarding Report

410.1 Mrs Liz Morgan, Chief Nurse and Director of Education presented the Annual Safeguarding Report. She explained that the report demonstrated that the Trust achieved all key actions in 2011/12 and met the three CQUIN targets which had been set by local commissioners. She added that in future these targets would be incorporated into contracts.

410.2 Mrs Morgan noted that safeguarding scorecard was now being rolled out across North Central London.

410.3 The Board discussed the red, amber and green rating system used by the Child Protection Team. It was noted that the definitions of each colour were different to those used in RAG rating.

410.4 **Action:** The Child Protection Group to bring rating system in line with those used in RAG ratings.

410.5 The Board **ratified** the report.

410.6 *It was agreed that in order to make more effective use of Trust Board meeting time the Board would move straight to questions for each agenda item.*

411 Care Quality Commission Update

411.1 The Company Secretary reported that no outcomes had been rated as either amber or red however 8-10 items listed under the outcomes had been rated as ‘tending towards worse than expected’.

411.2 It was agreed that the action plan for these items should include timescales and the Board agreed to delegate the follow up of this action plan to the Clinical Governance Committee.

411.3 **Action:** The Company Secretary to ensure that the action plan for the outcomes resulting in ‘tending towards worse than expected’ is reviewed by the Clinical Governance Committee.

411.4 The Board **noted** the update.

412 2011 Staff Survey Results

412.1 Ms Fiona Dalton, Chief Operating Officer reported that the Trust’s staff survey results had indicated that a greater than average number of staff

suffered with work related stress and worked additional hours. She explained that the Trust had recently changed the provider of staff counselling services to one which was available 24 hours a day, online and over the telephone.

412.2 Baroness Blackstone, Chair expressed some concern around the score GOSH received for 'percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month' which was 14% higher than the national average. She added that there was a concern that these results would give the wrong impression.

413.3 Dr Jane Collins, Chief Executive explained that the Trust had a high reporting culture and staff would recognise an incident or near miss.

413.4 Mr John Ripley, Non Executive Director suggested the development of a focus group to look at reporting issues, ensuring that the Trust was focussing on issues resulting from the staff survey.

413.5 The Board **noted** the report.

414 Trust Wide Risk Register Summary

414.1 It was agreed that the Company Secretary would ensure that the frequency with which the Risk Register summary was received by the Trust Board was was not being over reported.

414.2 **Action:** The Company Secretary to confirm the frequency with which the Risk Register Summary must be reviewed by the Trust Board.

415 Register of Interests

415.1 Mr David Lomas, Non Executive Director queried the tax implications of consultants paying their income through private companies.

415.2 It was agreed that this would be investigated to ensure the Trust could not be reputationally disadvantaged by these actions.

415.3 **Action:** The Chief Finance Officer to investigate the administration of payment of amounts due to consultants for their private patient practice through a private company to ensure the Trust's reputation would not be disadvantaged by these actions.

415.4 Baroness Blackstone, Chair queried why the list of staff interests was incomplete. She asked that the Company Secretary to remind all members of staff who had not responded to requests to declare conflicts.

415.5 **Action:** The Company Secretary to remind all staff members who had not responded to emails querying declarations of interest.

416 Audit Committee – February 2012

416.1 Mr Charles Tilley, Non Executive Director and Chair of the Audit Committee reported that in addition to the summary provided, the Audit Committee had met on 23rd April 2012. He explained that the committee had received a presentation around the IT strategy to ensure there was a real understanding of what was being trying to be achieved.

416.2 Mr Tilley explained that the Committee had been assured of the lessons learned from an incident where cables were stolen.

416.3 It was reported that the Draft Head of Internal Audit Opinion had offered reasonable assurance overall. Mr Tilley added that four internal audits had reported limited assurance but these were not thought to be material.

416.4 The Board **noted** the summary report from the February 2012 meeting of the Audit Committee.

417 Clinical Governance Committee

417.1 Ms Mary MacLeod, Non Executive Director and Chair of the Clinical Governance Committee reported that the addition of a meeting in April meant that any business matters which had slipped as a result of the cancelled January meeting had now been completed.

417.2 The Board **noted** the March 2012 minutes from the Clinical Governance Committee.

418 Management Board

418.1 The Board **noted** the minutes from the February 2012 meeting of the Management Board.

419 Members' Council Report from March meeting

419.1 The Board **noted** the summary of the March Members' Council meeting.

420 Trust Board Members' Activities

421.1 There were no Trust Board members' activities to report.

422 Consultant Appointments

422.1 Baroness Blackstone informed the Board of the names of the consultants appointed since the last meeting in February:

Dr Timothy Liversedge – Consultant, Anaesthesia
Dr Stuart Grant – Consultant, Anaesthesia

422.2 The Board **ratified** the appointments.

423 Any Other Business

423.1 There were no other matters of business.

424 Date of the Next Meeting

424.1 It was **noted** that the next meeting would take place on Wednesday 30th June 2012.

ATTACHMENT A

Attachment B

TRUST BOARD - ACTION CHECKLIST
May 2012

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
254.3	21/12/11	The Chair noted the number of subcommittees reporting to Management Board and suggested that a further review of its governance arrangements was conducted post Foundation Trust authorisation. Dr Jane Collins explained that some of the committees were established under statute, but that there was scope for further consolidation of subcommittees. The Company Secretary to conduct a further review of the subcommittees reporting to Management Board post Foundation Trust authorisation.	AF	June 2012	Not yet due
327.7	25/01/12	The Chief Executive to report back to Board on the formal plan for implementing a list of prioritised work in March 2012.	JC	Deferred to May 2012	Under Chief Executive Update on agenda
336.5	25/01/12	Mr Sven Bunn to report back to the Board in 6 months time on the implication of Deloitte's recommendations to improve the basis and assurance for the board statement on quality governance.	SB	July 2012	Not yet due
368.8	29/02/12	Some concern was expressed around the wider issue of appraisals. It was noted that the Trust had struggled to meet the target of 80% for some time. Appraisal data to be analysed in terms of number of people due to have an appraisal.	FD and BB	May 2012	An action plan to improve appraisal rates across the Trust has been approved by MB and TB. In addition, Education representatives s have been invited to sit on Unit & Corporate Boards to ensure appraisal and statutory training rates are monitored and supported.
399.9	25/04/12	A paper to be brought to the May Trust Board meeting to consider the ways in which PPIEC meetings and	LM	May 2012	Following a review, there will now be 6 meetings a year of the

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
		committees could be streamlined.			PPIEC with membership of the committee reduced by a third.
400.15	25/04/12	Baroness Blackstone to receive an attendance list for the Morgan Stanley Clinical Building opening and an agenda for the event.	AF	May 2012	To be confirmed
403.6	25/04/12	The Director of Redevelopment to provide an update at the next Trust Board meeting as to the reason for low workforce scores in baseline assessment results of the good corporate citizenship model of the Sustainability Management Plan.	WM	May 2012 – deferred to June 2012	To be discussed at the Sustainable Development Committee on Monday 28th May 2012. An update to be provided at the June Board meeting.
404.5	25/04/12	Colour copies of PALS and Patient Experience reports to be provided to the Board in future.	LM	May 2012	Noted for future reports
404.7	25/04/12	Future PALS and Patient Experience reports to separate red rated issues that arise from GOSH clinical issues from other enquiries.	LM	May 2012	Noted for future reports
407.7	25/04/12	A paper on the revalidation of Doctors to be brought to the May meeting of the Trust Board	BB	May 2012	To be considered at the June 2012 meeting
407.11	25/04/12	Mrs Liz Morgan to confirm whether it is acceptable to carry out PDRs which are not face to face, both from a HR and NHSLA perspective.	LM	May 2012	PDR process recently reviewed and streamlined. Best HR practice in HR management advocates the one-to-one meeting between manager and staff member which should take no more than one hour once per year forming part of the line manager's regular interactions with their staff. Other parts of the appraisal process can be conducted remotely, specifically the written review and

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
					confirmation of objectives. The Trust study leave policy is being revised to prevent access to non-mandatory study leave without a current PDR and Managers with low PDR rates will be performance managed.
409.3 409.5	25/04/12	The Company Secretary to ensure that the frequency of papers (Head of Nursing Report) are minimised while still meeting the duties of the Act. The Company Secretary to ensure that the Head of Nursing Report is considered at the next meeting of the Clinical Governance Committee.	AF	May 2012	The Head of Nursing Report added to Clinical Governance Committee (CGC) work-plan and due to report at the July meeting
410.4	25/04/12	The Child Protection Group to bring its performance rating system in line with those used in RAG ratings.	LM	May 2012	Noted for future reports
411.3	25/04/12	The Company Secretary to ensure that the action plan for the CQC outcomes resulting in 'tending towards worse than expected' is reviewed by the Clinical Governance Committee.	AF	July 2012	Added to CGC agenda for July 2012
414.2	25/04/12	The Company Secretary to confirm the frequency with which the Risk Register Summary must be reviewed by the Trust Board.	AF	May 2012	The RR summary to be reviewed annually by the Board. The CGC and AC already see regular reports on the number of risks and themes arising. Under the Code of Governance, the Board is required to "*conduct, at least annually, a review of the effectiveness of the NHS foundation trust's system of internal control and should report to members that they*

Attachment B

Paragraph Number	Date of Meeting	Issue	Assigned To	Required By	Action Taken
					have done so. The review should cover all material controls, including financial, clinical, operational and compliance controls and risk management systems."
415.3	25/04/12	The Chief Finance Officer to investigate the administration of payment of amounts due to consultants for their private patient practice through a private company to ensure the Trust's reputation would not be disadvantaged by these actions.	CN	June 2012	Not yet due
415.5	25/04/12	The Company Secretary to remind all staff members who had not responded to emails querying declarations of interest.	AF	May 2012	Work underway with PGME department to identify staff and further email to be sent out to all staff

ATTACHMENT B

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

Trust Board 30th May 2012	
NHS Trust Final Accounts and Annual Report including Annual Governance Statement and Head of Internal Audit Opinion **and** **NHS Foundation Trust Final Accounts and Annual Report including Annual Governance Statement and Head of Internal Audit Opinion** **Submitted on behalf of** Chief Finance Officer/ Company Secretary	**Paper No:** ATTACHMENT C **Considered by the Audit Committee on 30th May 2012**
Aims / summary The Trust is required to publish an NHS Trust annual report for the 11 months ended 29th February 2012 and a Foundation Trust annual report for the one month (1st March – 31st March 2012). The text of both annual reports and accounts is attached. Each annual report includes an annual governance statement (previously referred to as the Statement on Internal Control). This can be found on page 96 of the Foundation Trust and page 85 of the NHS Trust. A copy of the Head of Internal Audit Opinions (HOIA) and the external auditors' opinions are also included in both reports (pages 109-115 in the Foundation Trust Report and pages 94-100 in the NHS Trust Report). The Foundation Trust annual report and accounts will be submitted to Monitor on 31st May 2012 and then submitted to the Department of Health at the end of June, for presenting to Parliament. It will be published in time for the Annual General Meeting in September 2012. The NHS Trust annual report and accounts published on-line in time for the Annual General Meeting in September 2012. **To note: Audit Committee members have received all of the papers referred to here as part of their Audit Committee packs. The HOIA opinions are included as part of the Internal Auditor Annual Report 2011/12 in the Audit Committee pack.*	
Action required from the meeting To receive comments from the Trust Board and approve the draft report.	
Contribution to the delivery of NHS / Trust strategies and plans Covers all Trust objectives	

Financial implications None
Legal issues None
Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? N/A
Who needs to be told about any decision N/A
Who is responsible for implementing the proposals / project and anticipated timescales No proposals included
Who is accountable for the implementation of the proposal / project No proposals included
Author and date Claire Newton/ Anna Ferrant May 2012

ATTACHMENTS C & D - Draft NHS Trust Final Account and Annual Report including Annual Governance Statement and Head of Internal Audit Opinion – TO FOLLOW

ATTACHMENTS E & F – Draft NHS Foundation Trust Final Accounts and Annual Report including Annual Governance Statement and Head of Internal Audit Opinion – TO FOLLOW

Great Ormond Street Hospital for Children
NHS
NHS Foundation Trust

ATTACHMENT G

Trust Board 30 May 2012	
Quality Account 2011-2012 **Submitted on behalf of** Professor Martin Elliott, Co-Medical Director	**Paper No: Attachment G**

Aims / summary

A quality account is a report about the quality of services provided and is made available to the public via NHS Choices. This is the third annual Quality Account produced by GOSH. It details the areas in which we will focus quality improvement in 2012/2013 and provides information on the progress we have made in improving the quality of our services since our last Quality Account.

The National Health Service (Quality Accounts) Regulations 2010 specify the requirements for all Quality Accounts. A Quality Account must have:

- A statement on quality from the Chief Executive
- At least three priorities for improving quality in 2012/13
- Mandatory statements as set out by the regulations
- Review of our quality priorities and performance in 2011/12
- Statements from our commissioners, Camden Council and Local Improvement Networks (LINks).

In the first Quality Account, we introduced the following three broad priorities which we felt were important to improving the quality of care for patients treated at GOSH:

- Safety – to reduce all harm to zero
- Clinical effectiveness – to consistently deliver clinical outcomes that place us among the top five children's hospitals in the world
- Patient experience – to consistently deliver an excellent experience that exceeds our patients', families and referrers' expectations

Following feedback from parents we identified specific and measureable improvement initiatives in each of our priority areas to ensure that we make progress in achieving these priority areas.

The new improvement initiatives that we have identified this year in each priority include:

Safety - to reduce all harm to zero:

- Improve the effective monitoring and communication of the deteriorating child by making a 50% reduction in the number of cardiac and respiratory arrests for patients outside of intensive care units and theatres
- Improve skin viability of our patients by reducing the number of pressure ulcers that are developed within the hospital which are graded from two to four by 20%

Clinical effectiveness – to consistently deliver clinical outcomes that place us among the top five children's hospitals in the world:

- Learn from why children die by reviewing mortality cases and sharing the learning across the organisation
- Developing clinical outcome measures to evidence our effectiveness by

identifying a third clinical outcome measure for each speciality

Experience – to consistently deliver an excellent experience that exceeds our patients', families' and referrers' expectations:

- Improve the way we manage and use our hospital beds by reducing the number of patients that we can't admit for unplanned treatment
- Improve the experience of our adolescent patients by reviewing our services against the Department of Health's You're Welcome quality criteria and identifying priorities for improvement.

We reviewed the improvement initiatives and aims that were stated in last year's Quality Account. We achieved or improved our performance in 13 out of the 15 improvement areas. The two areas where we didn't improve were in relation to:

- Patient/parent satisfaction with the quality and variety of food and patient/parent's knowing how to complain and offer feedback;
- Communication – we aimed to reduce the number of complaints we received regarding communication with families but the number of complaints increased over the last year. We also aimed to improve the timeliness and quality of our discharge summaries but the percentage of discharge summaries that we have sent within 24hours is 79% (our aim was 80%).

We received statements of assurance from our commissioners and LINks which are provided in the Annex of the document.

We underwent an independent audit on the data quality of three of the indicators in the Quality Account by Deloitte. The indicators selected where two of the mandated indicators of MRSA performance and 31 day cancer waiting time. The third indicator was selected by the Members Council which was the discharge summary performance of sending summaries within 24 hours. The data quality testing on the mandated indicators was satisfactory. However when testing the discharge summary performance information it was clear there were a few data quality issues and as a result only half of the records tested could be confirmed as accurate. The issues demonstrated that we do not always have the paper records to support the electronic recording of discharge summaries and that the current minimum data standards for discharge summaries does not include documenting the data a discharge summary is sent out. This made it difficult to undertake data testing and confirm that the overall performance of 79% is accurate. A formal report will be received by Deloitte in the Audit Committee.

The Quality Account will be proof read and final amendments made prior to being published on NHS Choices and the GOSH website at the end of June 2012.

Action required from the meeting
To review the document and approve in preparation for publication at the end of June 2012

Contribution to the delivery of NHS Foundation Trust strategies and plans
All NHS Trusts have been required to produce an annual Quality Account since 2010. This requirement was set out in the National Health Service (Quality Accounts) Regulations 2010. Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda.

Financial implications
NA

Legal issues NA
Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place? We have engaged with staff, patients, parents, volunteers and commissioners to ensure that the Quality Account gives an insight into the organisation and reflects the priorities that are important to all. The proposed template of the content of the Quality Account and draft versions of the Quality Account were circulated internally for comment and addition. Following feedback from the Clinical Governance committee, information regarding the project on benchmarking clinical outcomes and the referrer's improvement programme was included. Whilst it was agreed that patient and parent stories are important and should be included; the patient and public involvement and engagement team advised that the guidance on collecting and using stories has not been approved. Unfortunately we did not have a story that had been consented and could be used in the document at the time of preparation. We will strive to use at least one story next year instead. However we did attempt to use quotes and feedback from parents, volunteers and staff in the document to illuminate the content. As per the regulations a draft was also sent externally to our commissioners; Local Involvement Network and Camden Council Overview and Scrutiny Committee. Comments were received which included changes to make the account easier to read and understand and clarification on some of the measurements for improvement to make the data more meaningful. An overview of the Quality Account and priorities were presented to the Members Council in March. The Members Council selected the discharge summaries being sent within 24 hours as the indicator to be tested for data quality by the external auditor Deloitte.
Who needs to be told about any decision? Lisa Davies, Clinical Outcomes Development Lead
Who is responsible for implementing the proposals / project and anticipated timescales? Lisa Davies, Clinical Outcomes Development Lead
Who is accountable for the implementation of the proposal / project? Professor Martin Elliott, Co-Medical Director
Author and date Lisa Davies, Clinical Outcomes Development Lead 18th May 2012

Great Ormond Street Hospital for Children
NHS Foundation Trust

COVER IMAGE TO BE INSERTED

Quality Account 2011/12

The child first and always

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Cover: Three-year-old Kacie is an oncology patient on Elephant Ward. She loves anything pink and so she was very happy when the Easter Bunny visited her in hospital and gave her a pink rabbit.

Part one

A statement on quality from the Chief Executive

Great Ormond Street Hospital (GOSH) is an international centre of excellence in children's healthcare. Every year, GOSH treats thousands of children and young people from many different parts of the UK and abroad. Our staff are dedicated to making sure that the service we give children and their families is the best it can be.

This is the third annual Quality Account produced by GOSH. This account details the areas in which we want to focus on quality improvement in 2012/13 and provides information on the progress we have made in improving the quality of our services since our last Quality Account.

In the first Quality Account, we introduced the following three broad priorities, which we felt were important to improving the quality of care for patients treated at GOSH:

Priority one – safety
To reduce all harm to zero.

Priority two – clinical effectiveness
To consistently deliver clinical outcomes that place us among the top five children's hospitals in the world.

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

These priorities are embodied in our hospital's core objectives. This ensures that our commitment to delivering high quality patient care is at the very heart of all we do.

Great Ormond Street Children's Hospital believes completely in its motto, 'the child first and always'. Everything the Trust does is devoted to improving the health of children and to the support of their families during what we know are difficult times. GOSH has always been at the forefront of developments in children's health care, and the Trust has engaged actively in developing new ways to deliver both higher quality and greater safety. We emphasise the importance the Trust places on quality and safety, embedding it deeply in our culture and making it top of our agenda.

This year we became a Foundation Trust, which was really important to keep our independence. This will help in our ambition to strive to be in the top five children's hospitals in the world and to keep quality and safety at the centre of all we do. To support this, we have developed roles in teams across the hospital to provide clinical leadership for quality and safety improvement. We have also developed a quality training programme for junior doctors.

We have made good progress in our zero harm programme over the last year and have seen some statistically significant improvements in reducing infection rates such as central venous catheter line infection rates. We have also improved the use of the World Health Organisation surgical checklist across the hospital and ward staff are routinely using the Children Early Warning Score to monitor patient's health and are communicating effectively using a standardised technique. I am really proud of these improvements, but our priority must to be to continue to improve care, focusing on quality and safety. We have set ambitious targets to achieve zero harm and not all of these have been achieved in the last year. However, I am confident that we will continue to aim for improvement over the next year. We know we need to focus on reducing medication errors across the hospital, and a new specialist improvement role will help to focus attention on where it is required to make the biggest impact and share learning across the organisation.

We have continued to use measures and publish information that evidences clinical outcomes on our website and worked with parents to make this information meaningful for them. We know we need to develop further measures to show the results of all the services we provide and, in particular, keen to show how we compare with others. I am excited at the prospect of working with other leading children's hospitals around the world to do this and to learn from national campaigns in the next year.

I am delighted that our most recent annual independent survey results show that we have maintained a 96 per cent overall satisfaction rate from our patients and their parents that have needed to stay at GOSH in the last year. We have also trialled other methodologies to get valuable feedback from patients and parents on where we need to make improvements. I know there is more work to be done to make improvements in the quality and variety of food to ensure equal access and experience for all of our patients. We really value all of the parent representatives that are supporting our improvement projects and providing helpful advice. Our new Members' Council will help to focus on what matters most to our key stakeholders and I am keen to hear more from our adolescent patients on where we need to improve.

This year, we also held a referrer's open day which ended with a really helpful discussion and feedback session on areas where we need to make improvements. For example, making it easier to transfer a patient to GOSH.

In 2012/13, we will continue to focus improvement across our key priority areas and have identified specific improvement initiatives in each area which are set out in this Quality Account. I hope that you will find this information helpful and that it gives you the confidence that we are dedicated to ensuring the highest quality of care for all of our patients.

I, Jane Collins, confirm that, to the best of my knowledge, the information in this document is accurate

Jane Collins

Dr Jane Collins
Chief Executive

About the Quality Account

Why are we producing a Quality Account?

All NHS trusts have been required to produce an annual Quality Account since 2010. This requirement was set out in the *Next Stage Review* in 2008[1].

A quality account is a report about the quality of services provided and is avaliable to the public. Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda.

Great Ormond Street has a long-standing reputation as one of the finest paediatric hospitals in the world. We are keen to share information about the quality of our service, and our plans to improve even further, with patients and families.

What are the required elements of a Quality Account?

The National Health Service (Quality Accounts) Regulations 2010 specify the requirements for all Quality Accounts. We have used the requirements as a template around which our account has been built.

The Quality Account is laid out as follows:

Part one

- A statement from the Chief Executive (see page 03)
- About the Quality Account
- Brief summary of how we have done since our last Quality Account and the new improvement initatives we have identified for 2012/13.

Part two

- Priorities for improvement in 2012/13 – this section identifies our three priority areas for improving the quality of our services and the new improvement initiatives for 2012/13
- Mandatory statements, as set out in the National Health Service (Quality Accounts) Regulations 2010.

Part three

- Review of our quality priorities and performance in 2011/12, and case studies to illustrate improvement
- Statements from our Commissioners, Camden Council and Local Improvement Network (LINKs).

How did we produce our Quality Account?

We have used the Department of Health's Quality Account toolkit as the basic template for our Quality Account and included all the mandatory elements of the account.

We have engaged with staff, patients, parents, volunteers and commissioners to ensure that the account gives an insight into the organisation and reflects the priorities that are important to us all. Following feedback on our Quality Account last year, we have identified specific and measurable improvement initiatives in each of our priority areas. These initiatives will support improvement in our three priority areas.

We consulted a parent on the design and content of the Quality Account last year and we received feedback from Camden Council and LINKs. This stated that our Quality Account would benefit from a brief summary at the beginning detailing briefly and simply what we plan to do to improve quality and how we have done since the last Quality Account.

Feedback from parents also told us that they preferred to see quotes from patients, families or staff to explain or illustrate projects and performance.

We are also trying to use patient stories more frequently to aid understanding and impact of improvement across the organisation. While there is not a specific patient story in this year's Quality Account, we will aim to include at least one next year. In the last couple of months, we have been writing specific guidance on the development of patient stories which ensures that we have consent from the families before using stories in the hospital.

We have also reduced the number of new improvement initiatives that are detailed going further to make the content easier to understand. We still continue to focus on the improvement work detailed last year and there is lots of quality improvement work going on in the organisation but we selected a few that represent projects that are meaningful to our stakeholders.

We appreciate that some of the language used may be difficult to understand if you don't work in healthcare. This year we have spent more time on providing explanation and understanding around issues and more detail on how and who we report progress too. We continue to include a glossary at the end of our Quality Account to explain some of the words that we use within this document.

We are keen to ensure that the account is a useful document which helps patients, families and the public to understand the priorities we have for delivering quality care to our patients. If you have any suggestions for next year's Quality Account, or any queries regarding this year's document, please contact us at enquiries@gosh.nhs.uk

[1] Darzi. *Next Stage Review*, June 2008, Department of Health. This document was published to coincide with the 60th anniversary of the NHS. It developed a vision of how the NHS would continue to serve the needs of the public in the 21st century.

Summary of our Quality Account

What are our quality priorities?

At Great Ormond Street Hospital (GOSH), we are committed to providing the highest quality of care to the patients that we treat. We have identified three main priorities which will help us continuously improve the quality of services we provide. These priorities reflect the core dimensions that define quality: safety; effectiveness and experience.

Our three priorities for improving quality at GOSH are detailed as follows:

Safety
To reduce all harm to zero

Clinical effectiveness
To consistently deliver clinical outcomes that place us among the top five children's hospitals in the world

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

We have developed improvement initiatives with specific focus and aims that can be measured each year to ensure that we make progress in achieving these priority areas.

Summary of our Quality Account
continued

How have we improved on these priorities in the last year?

The following table shows the improvement areas and aims that we stated in our Quality Account last year, and an indicator of the progress we have made so far.

Safety

Zero harm – reducing all harm to zero

Improvement area and aim in 2011/12	What does this mean and why is it important?	How did we do?
Reduce infections by reducing central venous catheter (CVC) line infection days by 50 per cent	A central venous catheter is a line that is inserted into a patient's vein to give them fluid or medication. Because the skin is broken, it can allow infection to enter the blood stream. Infection can be controlled by applying best practice principles such as ensuring staff and visitors wash their hands. An infection may cause harm to a patient by making them sicker and may increase the length of time they need to stay in hospital	We have made a 24 per cent reduction in the number of CVC line infection days, which is an improvement but not met our target
Reduce infections by reducing surgical site infections by 50 per cent for: • cardiac surgery • spinal surgery • urology surgery	A surgical site infection is an infection at the place where a patient's skin has been cut to carry out a surgical procedure. Infection can be controlled by applying best practice principles such as ensuring staff and visitors wash their hands. An infection may cause harm to a patient by making them sicker and may increase the length of time they need to stay in hospital. We want to be able to reduce infections across all surgical specialities. Therefore we need to set up systems that can identify and record infections	We have reduced the rate of surgical site infections for cardiac surgery and urology surgery. The rate of surgical site infections has increased slightly for spinal surgery
Establish surveillance of surgical site infections in further surgical specialities		We have established surgical site infection surveillance in thoracis and tracheal; cochlear implant; plastic surgery; general and neonatal surgery and orthopaedics
Reduce infections by reducing or maintaining the number of methicillin-resistant staphylococcus aureus (MRSA) infections	MRSA is a type of bacterial infection that is resistant to a number of widely used antibiotics. This means it can be more difficult to treat than other bacterial infections. An infection may cause harm to a patient by making them sicker and may increase the length of time they need to stay in hospital	We had four MRSA infections this year although review of these shows that only one was avoidable. While this is an increase from last year we are still within our contractual target level
Reduce infections by reducing or maintain the number of Clostridium difficile-associated (C. difficile) diarrhoea infections	C. difficile are bacteria that are present naturally in the gut of around two-thirds of children and three per cent of adults. C. difficile does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C. difficile bacteria can multiply and produce toxins (poisons), which cause illness such as diarrhoea and fever. Infection can be controlled by applying best practice principles such as ensuring staff and visitors wash their hands. We want to be able to reduce infections across all surgical specialities. An infection may cause harm to a patient by making them sicker and may increase the length of time they need to stay in hospital	We reported eight C. difficile infections this year, which is lower than the 10 we reported last year
Ensuring all ward staff use the Children Early Warning Scores (CEWS) and SBARD (Situation, Background, Action, Result and Decision) when monitoring and communicating concerns about a deteriorating child	CEWS are used to identify, record and report signs of deterioration in patients when they are in hospital by using a simple scoring system based on clinical observations. A score above a certain level means that the patient must be referred to senior staff to ensure intervention where required. SBARD is a universal communication tool that was implemented to improve the safety, efficiency and effectiveness of patient care. It ensures that important information is communicated in a standardised and consistent way	We have improved the percentage of patients where CEWS were reported from 83 per cent to 94 per cent, and increased the use of SBARD from 71 per cent to 84 per cent
All relevant teams to use and record the World Health Organisation (WHO) surgical safety checklist in every procedure.	A Safe Surgery Checklist was developed by the WHO to help prevent deaths in surgery. A checklist coordinator must confirm that the surgery team has completed the listed tasks before it proceeds with a operation. It is estimated that at least half a million deaths per year would be preventable with effective implementation of the WHO Surgical Safety Checklist worldwide	We have increased the number of completed checklists from 60 per cent to 92 per cent
Reduce the number of medication errors by reducing the clinical prescribing errors per bed day in the Paediatric Intensive Care Unit and Cardiac Intensive Care Unit by 25 per cent	Medication errors are patient safety incidents in which there has been an error in the process of prescribing, dispensing, preparing, administering, monitoring, or providing medicine advice, regardless of whether any harm occurred. This is a broad definition and the majority of medication errors do not result in harm. However, some do have the potential to do harm and are often termed 'near misses'. A medication error may cause harm to a patient by making them sicker, which could increase the length of time they need to stay in hospital	We have made a 30 per cent reduction in prescribing errors in the Cardiac Intensive Care Unit, but we have not made a reduction in prescribing errors in the Paediatric Intensive Care Unit
Staff to record incidents when they happen, to maintain high levels of incident reporting and implement the National Patient Safety Agency's national framework for serious incidents	Patient safety involves the identification, analysis and management of patient-related risks and incidents, to make patient care safer and minimise harm to patients. Within the NHS a patient safety incident is defined as any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS-funded healthcare	We have increased the number of incidents reported by five per cent this year, but the level of actual harm has reduced to two per cent
Improve safeguarding by: • improving the quality of record-keeping • implementing group child protection supervision and ensure that at least 50 per cent of referrals receive supervision • ensuring that 40 per cent of the relevant staff have Level 3 training	Safeguarding and promoting the welfare of children is defined as: • protecting children from abuse and neglect • preventing impairment of their health or development and • ensuring that they receive safe and effective care… so as to enable them to have optimum life chances. We are responsible for having the sound processes and structures to support any child where there are safeguarding concerns	We have improved the quality of record-keeping and in the latest audit the records were scored as excellent. 90 per cent of child protection referrals received supervision. 50 per cent of the relevant staff have undergone Level 3 safeguarding

Clinical effectiveness

To consistently deliver clinical outcomes that place us among the top five children's hospitals in the world

Improvement area and aim in 2011/12	What does this mean and why is it important?	How did we do?
Publish clinical outcome information on the Great Ormond Street Hospital (GOSH) website in a further nine specialities.	We have developed measures to reflect some of the results of the treatments provided at GOSH. Parents have told us that they would like to see this information on our GOSH website for each of our specialties	We have published result information on the GOSH website for a further nine specialities
Using and developing patient-reported outcome measures in cystic fibrosis; epilepsy surgery; neurodisability; dermatology; adolescent medicine and orthopaedics	We want to use measures that reflect results of treatment from the patient or parent's perspective. These are often referred to as patient reported outcome measures (PROMs). This ensures that we understand and can measure if treatment is successful from the point of view of the patient and the results help to inform clinical care and further treatment	We have implemented PROMs in these specialties and also identified PROMs in other services
Benchmarking outcomes against other comparable organisations in cardiology and cardiothoracic surgery; cardiac and paediatric intensive care; cystic fibrosis; renal; adolescent medicine; gastroenterology; haemophillia; infectious diseases and ophthalmology	We want to use measures that show our results compared to other organisations. Parents have told us this helps them to understand if our results are good and what to expect when coming to Great Ormond Street Hospital	We have submitted outcome information to the relevant networks and registries, and identified further specialities where we can benchmark

Experience

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

Improvement area and aim in 2011/12	What does this mean and why is it important?	How did we do?
Maintain at least 90 per cent overall patient and parent satisfaction with our service in our annual inpatient telephone survey	Patient and parent feedback on their experience of Great Ormond Street Hospital (GOSH) is really important to us. Each year an independent telephone survey takes place on a sample of patients who need to stay in hospital. The survey asks a number of questions regarding experience of GOSH and in particular we compare the overall satisfaction results to determine how well we are doing	We achieved a 96 per cent overall satisfaction rate in this year's survey
Improve overall agreement for 'I knew how to complain or offer feedback' in our annual inpatient telephone survey	In our previous annual survey, 74 per cent of families agreed they knew how to complain or offer feedback. We want to ensure that we listen to all families to understand what matters most to them and make improvements where necessary. It is important that all families know how to give us feedback or complain	We maintained a 74 per cent agreement from families responding to this question
Improve overall satisfaction with the quality and variety of hospital food in our annual inpatient telephone survey	In our previous annual survey, 60 per cent of families were satisfied were the quality and variety of our hospital food. Nutrition is an important part of a patient's care when in hospital and we want to ensure we improve the quality and variety of hospital food	Satisfaction in the quality and variety of food dropped to 54 per cent this year

Improvement area and aim in 2011/12	What does this mean and why is it important?	How did we do?
Capture and record regular local feedback through trialling electronic systems	While our annual survey gives us valuable feedback for the whole of the hospital we wanted to explore using surveys on the wards and in outpatients to capture feedback when families are still in our hospital. We wanted to trial this using an electronic hand held device such as an ipad. This would allow us to understand issues when they happen and allow ward staff to have more local information regarding their patient's experience in the hospital	We trialled three different ways of capturing local feedback through using both electronic and paper systems
Reduce the number of complaints regarding our communication with parents	Feedback from parent's last year told us that at times we are not good at communicating with them. The main theme of the complaints we receive is also about our communication. Communication covers a broad remit but is important for the safety, effectiveness and experience of a patient's care. We are keen to improve this and act on parent's feedback	The number of complaints relating to communication with parents increased this year from 51 to 65
Improve the timeliness and quality of our discharge summaries	After a patient stays in hospital, a summary of the treatment they received, medication given and the recommendations for future management is sent to the patients local doctor (this could be a GP or a doctor at a local hospital to the patient). This is important to ensure that the doctor's involved in the patients care know what happened last to the patient and if additional treatment or support is needed. Feedback from these local doctors has told us that we need to improve the time it takes us to send these discharge summaries to them	Seventy-nine per cent of discharge summaries were sent within 24 hours of a patient's discharge
Identify patients with a learning disability and ensure that reasonable adjustments are made to enable them to access our services	Last year, an external independent review told us that we needed to review our services and put in place actions to improve these for patients with learning disabilities. One of the initial key actions required was the ability to develop a system that can identify if patients have a learning disability so that staff can provide the relevant information and access to our services. We wanted to develop a process to ensure that if a patient has a learning disability this is recorded in the patient's notes	We have developed a system to identify if patients have a learning disability and aim to implement this is 2012/13. We have also developed information in the right format
Maintaining timely access to services by ensuring that our waiting times are within the national standards	We understand that when a child is ill and needs medical attention the waiting time to be seen by a doctor is really important and families want to be seen as quickly as possible. The government has set national standards to ensure that patients are treated in any hospital in England within a maximum waiting time from referral. There are different waiting time targets set but the main one that is referenced is 18 weeks from referral to treatment	We have met all of the national waiting time standards

What additional improvement initiatives are we planning to focus on in 2012/13?

The following section briefly summarises the new improvement initiatives and aims we have identified to focus on in 2012/13 in each of the priority areas.

Safety

Zero harm – reducing all harm to zero

What additional things are we going to improve and what do we aim to do in 2012/13?	What does this mean and why is it important?
Improve the effective monitoring and communication of the deteriorating child by making a 50 per cent reduction in the number of cardiac and respiratory arrests for patients outside of intensive care units and theatres	A crash call is a call made to alert emergency staff when a child goes into cardiac arrest. We want to ensure that ward staff are effectively monitoring children so they can identify if a child's health is deteriorating and provide intervention before an onset of a cardiac arrest. This will improve the outcome and experience of a child's care
Improve skin viability of our patients by reducing the number of pressure ulcers that are developed within the hospital which are graded from two to four by 20 per cent	A pressure ulcer is sometimes known as a bedsore and is a type of injury that affects areas of skin and underlying tissue. Critically ill children are more at risk of getting pressure ulcers because their condition makes it difficult to move their body. Pressure ulcers are graded from one to four depending on degree of injury to the skin with higher grades being more severe. Pressure ulcers can cause pain and discomfort to a patient, and increase the time needed to stay in hospital while it heals

Clinical effectiveness

To consistently deliver clinical outcomes that place us among the top five children's hospitals in the world

What additional things are we going to improve and what do we aim to do in 2012/13?	What does this mean and why is it important?
Learn from why children die by reviewing mortality cases and sharing the learning across the organisation	Death in childhood remains a rare event but recent national research and confidential enquiries have highlighted and given evidence that some deaths could be avoidable and hospitals can learn from reviewing events. While individual teams at Great Ormond Street Hospital review their own cases, a hospital wide review will help to share learning across all teams and put in place best clinical practice
Developing clinical outcome measures to evidence our effectiveness by identifying a third clinical outcome measure for each speciality	A clinical outcome measure is a way to assess the results of clinical treatment. We have worked hard to identify clinical outcome measures in each of our specialities but feedback from parents this year has told us that we need to ensure that measures are reflective of the main conditions treated

Experience

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

What additional things are we going to improve and what do we aim to do in 2012/13?	What does this mean and why is it important?
Improve the way we manage and use our hospital beds by reducing the number of patients that we can't admit for unplanned treatment	While we don't have an emergency department, patients that are in local hospitals sometimes need to be admitted to Great Ormond Street Hospital for unplanned treatment. To do this we need to have a spare bed. We want to ensure that patients get the care that they need when they need it and improve the use of our beds so that we can admit patients when required
Improve the experience of our adolescent patients by reviewing our services against the Department of Health's You're Welcome and identifying priorities for improvement	We treat children and young people of all ages to 18. Feedback from our adolescent patients tell us that they should be treated as an individual. The You're Welcome quality criteria were developed by the Government to help ensure that hospitals like Great Ormond Street Hospital provide the best standards of care for adolescent patients. We want to ensure the services we provide reflect the needs of our adolescent patients and put in place improvements where needed

Part two

Priorities for improvement in 2012/13

This section details each of the priority areas for improvement and information on how we identify improvement work. It then details the new improvement initiatives that we will be focusing on in 2012/13.

Safety priority

Zero harm – reducing all harm to zero

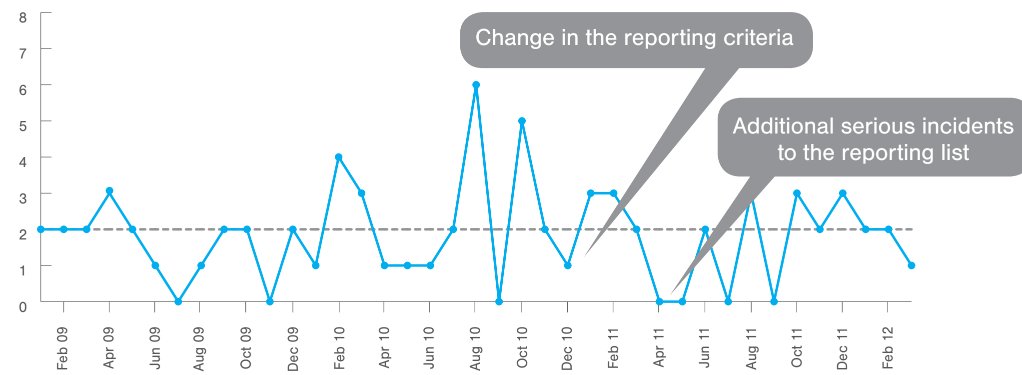
Over the last few years, Great Ormond Street Hospital (GOSH) has been committed to reducing avoidable harm for patients treated at the hospital. We have a responsibility to ensure the safety of the patients we treat and also learn from times when treatment doesn't go as initially planned. To achieve this we developed a zero harm programme with the aim to ensure that every patient receives the correct treatment or action the first time every time and to reduce harm to patients. Avoidable harm can include for example the development of infections whilst a patient is in hospital; complications after a patient has had surgery or errors when providing medications.

At GOSH, we have a team that is responsible for facilitating and implementing transformation change in the organisation. Transformation means thinking differently and implementing solutions in areas which need improving. The transformation programme is focused around three goals of improvement, 'zero harm, no waste and no waits'. Zero harm focusing on making improvement to the safety of the services we provide at GOSH. The progress on this priority is therefore monitored by the Transformation Board. Board meetings are established to hold teams to account and monitor objectives and aims. The Transformation Board is led by the chief executive and the members include not only transformation and clinical staff but also parent representatives.

In order to reduce harm we need to understand what types of harm happen and when these happen to patients. Within the NHS a patient safety incident is defined as any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS-funded healthcare. This is also sometimes referred to as an adverse event/incident, mistake or clinical error, and includes near misses.

At GOSH, we have an established system in the hospital to encourage staff to report and record every incident. All incidents are reported into a central database in the organisation and are reviewed by a central patient safety team and graded on the level of severity and cause of harm. This allows us to monitor the number of incidents and types of incidents. Every three months a formal report is taken to a quality and safety committee where senior clinical and management representatives from all teams across the hospital review the themes and actions required. The number of the most serious incidents is also reported on a monthly basis to the Trust Board. The following graph shows the number of serious incidents reported on a monthly basis, the grey dotted line represents the average. We aim to reduce the number of serious incidents.

The number of reported serious incidents that take place each month at Great Ormond Street Hospital (GOSH)



Data source: Incident Reporting Datix Database

Definition: A serious patient safety incident is defined as an incident that occured in relation to care resulting in one of the following:

- Unexpected or avoidable death of one or more patients, staff visitros or members of the public
- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm
- Allegations of abuse
- One of the core sets of 'Never Events'

We also report the more serious incidents externally to our commissioners who are responsible for providing external scrutiny. All serious incidents are reviewed using a root cause methodology, which means that the whole case of the patient is reviewed to identify what factors contributed to the harm in an attempt to learn lessons to avoid the incident happening again. Together with our reporting database, we can identify themes and areas for improvement, informing our zero harm programme.

We have introduced the Paediatric Trigger Tool (PTT) which helps staff to measure and understand the nature of any harm that takes place in the hospital. We use this tool to review the medical records of a sample of 20 patients each month to identify any events that resulted in harm or had the potential to cause harm. This is a structured review and focuses on a number of treatment events including medication. A rate of harm is then calculated and the themes of harm identified help to inform the zero harm programme.

The co-medical director from Sheffield Children's Hospital visited GOSH in February 2012 and reviewed how the PTT integrated with our governance and safety work, interviewed key staff and observed the PTT review. He concluded that the GOSH PTT system is a robust process for objectively quantifying the degree of harm resulting to patients. In addition, it was stated that the governance structure around the process ensures that findings are acted on rapidly where appropriate.

The zero harm programme is also informed by national and international safety reports. For example we aim to implement the principles of the Patient Safety First Campaign. We also work closely with Cincinnati Children's Hospital in the United States, who are recognised leaders in ensuring patient safety and compare ourselves against them to indicate how we currently perform and identify new measures of quality or areas for improvement. We reflect on feedback from staff, patients, parents and commissioners to inform the zero harm programme.

The summary of the review stated:

There is clear evidence that the introduction of the Paediatric Trigger Tool has been associated with a reduction in harm and that the findings from the reviews influence the Trust's workstreams and policy-making process.

Last year we identified a number of improvement projects and aims that would help us work to reduce harm to our patients and achieve zero harm. These included:

We have made improvement in all of these improvement initiatives over the last year and part three shows the details of this improvement. Our zero harm programme is built on the principles of continuous improvement. We will aim for year-on-year improvement on all of our initiatives and continue to improve our systems of measurement, monitoring and change. Therefore we will continue to seek improvement in all of these areas in the following years.

In addition, one of the improvement initiatives we described last year was on improving how ward staff communicate when a child's health is deteriorating so that they receive the right intervention at the right time. This year we are extending this improvement work with an additional indicator on the number of crash calls outside of an intensive care unit and this is detailed below.

GOSH is committed to expanding the list of safety improvement initiatives which are identified from analysis of incidents and complaints; clinical audit; national and international safety reports and feedback from staff, patients, parents and commissioners to ensure we focus improvement on areas that can help to achieve zero harm. This year, we have identified a further improvement initiative with our commissioners regarding reducing the number of patients that develop pressure ulcers whilst in hospital.

Both of these improvement initiatives are detailed in this section.

Safety improvement initiative one

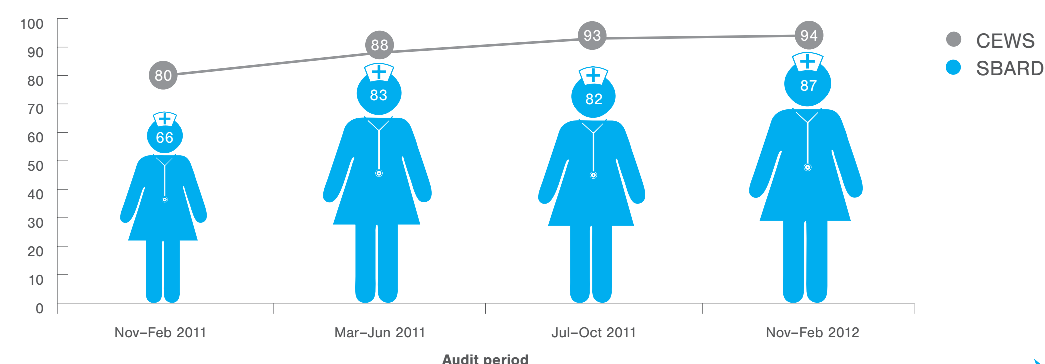
Effective monitoring and communication of the deteriorating child
Last year, we identified that we wanted to improve the way our ward staff communicate information about a patient when their health is deteriorating and urgent clinical support is required. Effective communication is fundamental to managing the safety of these patients by helping to make informed clinical decisions.

To monitor improvement in this area we have been recording the number of calls that have been made to our senior nursing team, the clinical site practitioners (CSP) using the technique of SBARD. SBARD stands for Situation, Background, Action, Result and Decision. It is a universal communication tool that is intended to improve safety, efficiency and effectiveness of patient care by ensuring information is structured and standardised.

We have also been monitoring the use and reporting of the Children's Early Warning Score (CEWS) in calls to the CSP. CEWS are used to identify, record and report signs of deterioration in patients by using a simple scoring system based on vital sign observations. For example, pulse and blood pressure.

Last year our aim was to ensure that 100 per cent of calls to the CSP's used SBARD and reported the most recent CEWS for the patient. The following graph shows the improvement we have achieved so far:

Percentage of calls to CSPs where CEWS were given and information was communicated using SBARD



Data source: CSPs callsheets

CEWS and SBARD are an important part of our work on improving the care of the deteriorating child, but we recognised that we needed a more effective way to monitor our progress and spread good practice. We have therefore developed a new improvement initiative to continue to concentrate on improving the care of the deteriorating ward patient. For instance it is important that when a child's condition deteriorates that this is communicated and managed appropriately. This usually involves assessment of the child, emergency treatment and possible transfer to a ward such as intensive care to ensure the right level of support is provided to reduce the likelihood of further deterioration. In the past cardiac and respiratory arrests were considered to be unexpected emergency events that we could do little to prevent. Nowadays, it is recognised that many of these events are preceded by clinical signs that are either not recognised or not acted upon by staff. We are keen to review cardiac and respiratory arrests that happen outside of intensive care units and theatres to learn lessons and reduce the likelihood of them happening in the future.

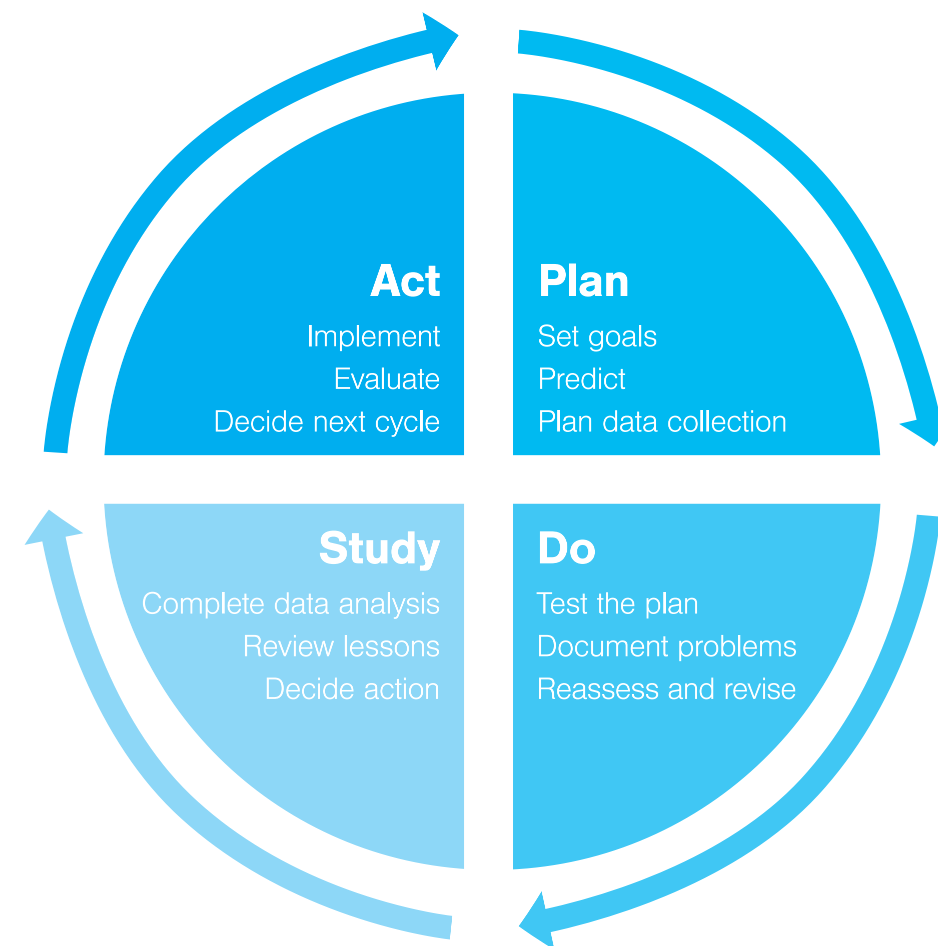
> Preventing arrests is important because even if the child received prompt resuscitation, many children die either immediately or later in intensive care. Cardiac and respiratory arrests also cause considerable distress not only to the child's family and friends, but also to the staff caring for them.
>
> **Sue Chapman, Nurse Consultant**

What do we aim to improve in 2012/13?
We aim to reduce cardiac and respiratory patient arrests outside of intensive care and theatres by 50 per cent.

How do we plan to improve in 2012/13?
A multi-professional group has been developed with representation from all clinical units and key services such as resuscitation and transformation. This group will review data on clinical emergency team calls, cardiac and respiratory arrests, and unplanned transfers from the ward to intensive care.

They also identify areas where improvements might be made, advise on data that would allows us to track our progress and monitor our success.

The focus in 2012/13 is on improving the quality of vital sign observations and we will continue to monitor and review the use and accuracy of CEWS scores. We are also exploring innovative ways of capturing and recording vital sign observations, such as electronic hand-held devices which allow vital signs recorded at the bedside to be simultaneously viewed by other professionals. Change will be implemented using the plan-do-study-act (PDSA) improvement methodology. This approach is recommended by the Institute for Healthcare Improvement and the NHS Institute for Innovation and Improvement. Each PDSA cycle 'tests out' an idea on a small scale to identify quickly what works and what doesn't. It also engages front-line staff in the change process and promotes innovation to focus improvement in this area.



Priorities for improvement in 2012/13
Safety priority continued

The group will follow the cycle:

Plan – the group plan to review the data on the number of cardiac and respiratory arrests outside intensive care and identify the three wards who are at the highest risk due to the complexity and severity of the child's illness.

Do – the group will undertake a review of patients medical records and the CEWS scoring to understand what caused the cardiac and respiratory arrest or what, if anything, could have been done to prevent it happening.

Study – the group will study the results taken from the "do" phase and compare to see if there are common themes or indicators that can be used with future patients or other causes for the cardiac and respiratory arrests

Act – the group will then implement recommendations from the study phase which may include training and education to try to improve performance.

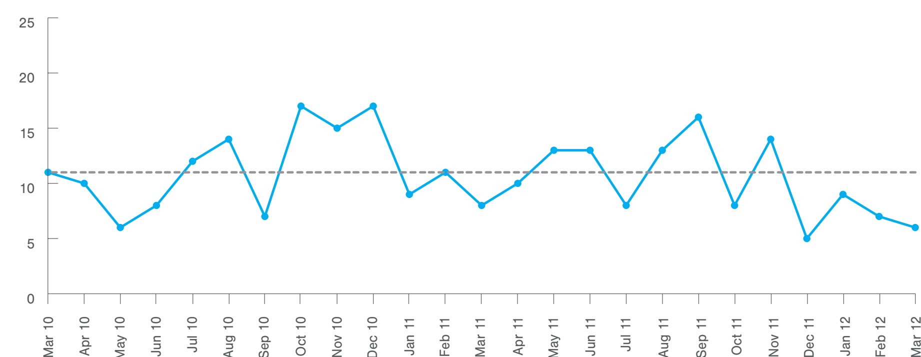
The concept of the PDSA cycle will continue throughout this work and after the initial actions are implemented the situation will be reviewed again and action identified accordingly. This will also enable the approach and solutions to be rolled out across other wards.

The clinical unit teams have recently developed specific roles within their teams to support with improving safety and quality in practice. Every clinical unit now has a patient safety officer (PSO) and a clinical improvement lead (CIL). PSOs and CILs are clinical staff who have expertise in improvement and patient safety and can support local improvement initiatives. We plan to develop a quality collaborative with their support to engage front line staff in identifying innovative ways to protect children against cardiac and respiratory arrests.

How will we measure and monitor performance in 2012/13?
We will use the number of cardiac and/or respiratory arrests outside of intensive care and theatres to measure improvement in this area. The data will be broken down at ward level to focus on the areas where action is put in place.

The data is collected by the resuscitation team and entered into a database. As well as being submitted to a national database, this data is also reviewed and monitored internally through our online dashboards. The following graph shows the monthly number of crash calls outside of intensive care and theatres, the grey line represents the average. Our aim is to reduce the number of crash calls.

The monthly number of crash calls outside intensive care and theatres



Data source: Clinical Emergency Team 2222 Database

This improvement initiative is also monitored by our Transformation Board. Board meetings are established to hold teams to account and monitor objectives and aims. The Board is led by the chief executive and the members include not only transformation and clinical staff but also parent representatives.

The findings of this work will be shared with our commissioners, as this improvement initiative is part of our contract with them to ensure that we focus on areas to improve quality. They will monitor our progress and if we do not fulfil the requirements agreed, there will be a financial penalty to the organisation.

Who is responsible for this improvement initiative?
The nurse consultant for acute and high dependency care is responsible for overseeing and directing the actions required to deliver this improvement. This improvement initiative is overseen by the co-medical director, who is the executive lead for quality and safety at Great Ormond Street Hospital.

Safety improvement initiative two

Improving patient's skin viability

Pressure ulcers, also sometimes known as bedsores or pressure sores, are a type of injury that affects areas of the skin and the underlying tissue. They are caused when the affected area of skin is placed under too much pressure. The extra pressure disrupts the flow of blood through the skin. Without a blood supply, the affected area of skin becomes starved of oxygen and nutrients. It begins to break down, leading to the formation of an ulcer.

Infants, children and young people in hospital who have restricted mobility are at higher risk of pressure ulcers because their condition makes it difficult for them to move their body. If children are continuously able to adjust their posture and position so that no part of their body is subjected to excessive pressure a pressure ulcer is less likely to occur. There is evidence that critically ill children are more at risk of pressure ulcers than the other children in hospital. Pressure ulcers can develop in different places compared to those common in adults such as on the back of the head, ears and their nose.

Pressure ulcers can cause considerable harm to patients and may lead to increased hospital costs and length of stay. Pressure ulcers can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle. When a child or young person is admitted to hospital, nurses check their skin, and staff on the ward ensure that a patient that is at risk of developing a pressure ulcer is moved regularly with the correct equipment. All beds in the hospital have special mattresses to try to prevent the development of pressure ulcer.

If a pressure ulcer is noted, it is graded by the degree of injury to the skin. There are four grades of pressure ulcers, ranging from grade 1 (skin discoloration) to grade four (deep tissue damage with bone involvement).

Patients have told us that pressure ulcers can be very painful and parents have observed that pressure ulcers cause a lot of discomfort to their child. We are therefore committed to ensuring that as far as possible we provide the right support to prevent our patients getting pressure ulcers.

Unfortunately, over the last two years, the number of pressure ulcers developed in the hospital has increased, causing harm to our patients. We have discussed this issue with our commissioners and developed aims to reduce the number of pressure ulcers for our patients.

Priorities for improvement in 2012/13
Safety priority continued

What do we aim to improve in 2012/13?
We aim to reduce the number of pressure ulcers per 1,000 bed days that are developed within the hospital, which are graded from two to four, by 20 per cent by March 2013. Reducing from 0.71 pressure ulcers per 1,000 bed days, to 0.57 per 1,000 bed days.

How do we plan to improve in 2012/13?
Preventing pressure ulcers involves firstly identifying patients that are more of risk of getting pressure ulcers and then secondly implementing prevention strategies for those patients who are identified as being at risk. The focus of this improvement will be to identify areas of good practice to spread across the hospital.

The hospital plans to implement a new pressure ulcer risk assessment which will be completed for all patients that require a hospital stay at Great Ormond Street Hospital. A risk assessment helps staff to determine the likelihood that the patient could develop a pressure ulcer by using a standard set of questions and a grading score for every patient.

Where patients are deemed to be at medium or high risk of developing pressure ulcers, the ward staff will monitor them frequently using a full skin assessment document and preventative measures will be used, for example ensuring the patient is frequently moved as far as feasible.

In the event that a patient develops a pressure ulcer, a specialist plastic surgery nursing team can also provide support, management and advice to the patient and the ward to minimise the impact of the ulcer.

The specialist plastic surgery nursing team will be supported by a new nursing quality practice educator who will provide education, training and support to clinical teams on the wards. This will involve training in practice on the ward to ensure that ward staff are capable and comfortable in identifying and monitoring patients at risk of pressure ulcers.

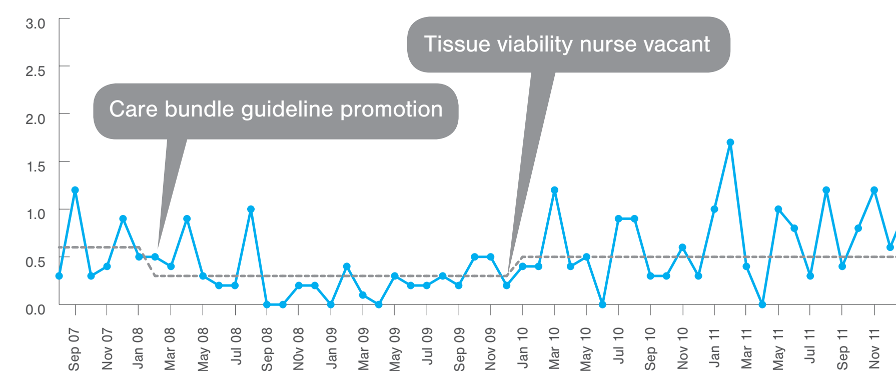
In addition training is provided for new members of clinical and allied health staff on our corporate induction days. This training content will be built upon and new interactive teaching models have been purchased for teaching purposes.

It is important to involve families where possible in the prevention of pressure ulcers. There is a leaflet explaining what pressure ulcers are and how best to prevent them whilst in hospital. This will be made widely available and tools such as charts for parents to tick when they have picked their child up or moved them to make them more comfortable will help the nurse and carer work together.

How will we measure and monitor performance in 2012/13?
We will use the number of pressure ulcers by 1,000 bed days recorded each month to measure the performance of this improvement work.

Ward staff notify the specialist plastic surgery nursing team when a patient develops a pressure ulcer who confirms the grading. The number and grading of pressure ulcers is then reported into a central database. The number of pressure ulcers is divided by the number of bed days to identify the number of pressure ulcers per 1,000 bed days. This rate is recorded and monitored internally using the graph illustrated right. The dotted grey line represents the average and our aim is to reduce the number of pressure ulcers per 1,000 bed days.

The number of reported hospital-acquired pressure ulcers per 1,000 bed days graded two to four



Data source: Tissue Viability Database

The number of pressure ulcers developed in the hospital has increased over the last year as the dedicated staff post became vacant. The hospital has reviewed the way to provide this support and therefore aims to reduce the number of pressure ulcers with a new structure over the next year. The new team will also be reviewing the case notes of patients who had pressure ulcers during the last year to try to identify any patterns and areas to focus improvement on first.

Pressure ulcers that are graded three and four are also reported to our commissioners as a serious incident. A root cause analysis is undertaken to explore the principle cause and enables lessons to be learnt and implemented.

A working group with representation of nursing, doctors and practice educators will be established to oversee and support the improvement work. This group will meet monthly and monitor the agreed steps and actions for improvement. The progress of this improvement work with then be fed back to the nursing senior management team via a Nursing Quality Forum.

The findings of this work will be shared with our commissioners every three months as this improvement initiative is part of our contract with them to ensure that we focus on areas to improve quality. They will monitor us and if we do not fulfil the requirements agreed there is a financial penalty to the organisation.

Who is responsible for this improvement initiative?
The nursing quality practice educator is responsible for the education, advice and teaching on the prevention of pressure ulcers and the plastic surgery clinical nurse specialists are responsible for pressure ulcer management, grading and advice. This improvement initiative is overseen by the chief nurse and director of education.

Clinical effectiveness priority

Consistently deliver clinical outcomes that place us among the top five children's hospitals in the world

Delivering effective care is, and always has been, the primary focus of Great Ormond Street Hospital (GOSH). Over the last couple of years we have been trying to evidence the effectiveness of our care and all specialities have been identifying measures that demonstrate the results of the treatment they provide. This means understanding success rates from different treatments for different conditions. This could include clinical measures such as survival rates, complication rates or measures that demonstrate clinical improvement. Just as important is measuring the effectiveness of care from the patient's own perspective through the use of patient-reported outcome measures (PROMs).

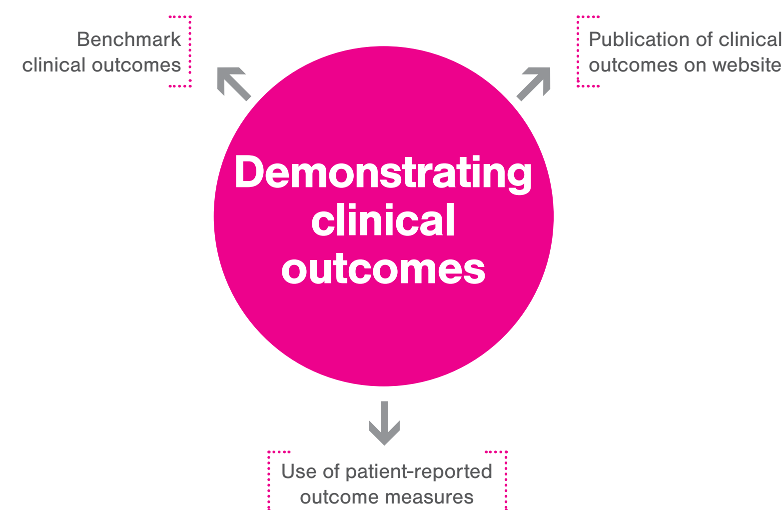
Alongside our internal work to demonstrate effectiveness there is also a national drive from the Government to use clinical outcome measures to demonstrate the results and quality of treatment. The difficulty for us is that a lot of the initial new clinical outcome measures that are proposed are focused more for general hospitals and involve the measurement of the outcome of adult care and are not applicable or suitable for use at GOSH.

Wherever possible we are using established national or international measures that allow us to benchmark our results with other services. However some specialities find this difficult due to the unique nature of many of the conditions we treat and at times are the only service in the UK providing treatment for rare conditions. Where it is more difficult we have encouraged specialities to develop local measures to demonstrate their results and aim to compare these measures over time.

To ensure that we make progress in demonstrating clinical outcomes that place us among the top five children's hospitals in the world we have established a clinical outcome programme. This programme supports specialities in the development of clinical outcome measures and identifying comparable organisations and measures to benchmark against. It also monitors the development of measures across specialities and reviews the information that is produced. Every three months, clinical teams are required to give updates on progress and provide examples of clinical outcomes to the senior management team in performance reviews.

Feedback from parents, patients and referrers over the last couple of years has told us that they want more information on the results of treatment to make more informed choices and have better understanding of treatment options. We recognise that there are many forms of information currently available on the worldwide web but not all of this is accurate or reflective of our current medical practice and could be misleading. We therefore feel that we need to take responsibility for providing our own information to inform our families and be open and transparent about our results.

Last year we identified three improvement initiatives that would help us achieve our priority of consistently delivering clinical outcomes that place us among the top five children's hospital. These included:



We have made improvement in all of these areas and more detail is provided in part three of this account.

We are keen to continue to improve in these areas and in particular are keen to use our experience and knowledge from the clinical outcomes programme in the last couple of years and reflect some of the new initiatives that are developing nationally. We have written to leading children's hospitals around the world to seek their interest in a collaborative study in regards to sharing clinical outcome measures and considering services that we provide to see if they are comparable.

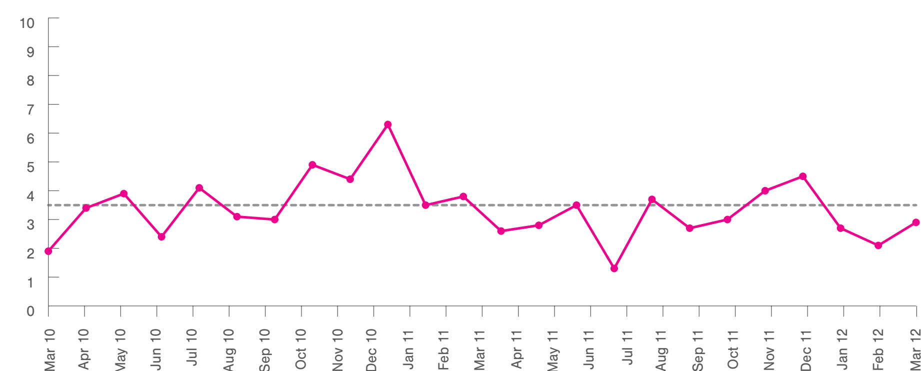
Therefore from feedback from parents; staff and commissioners we have developed two new improvement projects to help us to continue to make progress in this priority. The first is in relation to reviewing the survival outcomes of patients that are treated at GOSH and the second will focus on extending the current number of clinical outcomes identified for specialities to three.

Clinical effectiveness improvement initiative one

Monitoring and learning from why children die

In previous Quality Accounts, we have identified that the hospital standardised mortality ratio used previously by many hospitals in the UK to demonstrate outcomes is not applicable to paediatric care. Similarly the new summary hospital-level mortality indicator is not calculated for children's hospitals either. These tools are useful for providing an indicator of where mortality outcomes may need further attention and understanding by comparing performance against expected outcomes. At Great Ormond Street Hospital (GOSH), while we don't have the same ability to compare expected outcomes to actual outcomes, we do monitor the number of deaths each month. This is monitored by reviewing the mortality rate of patients per 1,000 discharges and this is shown in the graph below. The dotted grey line represents the average mortality rate per 1,000 discharges. We aim to reduce the mortality rate.

The mortality rate per 1,000 discharges



Data source: GOSH Patient Information Management System

Death in childhood remains a rare event, but evidence shows us that the care children and their families receive leading up to and around the time of death warrants particular attention. Recent national research and confidential enquiries have highlighted and given evidence that some deaths could be avoidable and hospitals can learn from reviewing the the Confidential Enquiry into Maternal and Child Health report, *Why Children Die,* 2008, and the 2011 National Confidential Enquiry into Patient Outcome and Death report, *Are We There Yet.*

This research and evidence suggests that establishing a system to review the medical records of patients who die is an effective way of identifying if any areas need improvement across the hospital. Within GOSH, clinical teams hold frequent meetings to discuss cases when children die or complications arise in their care to discuss the reasons and to learn lessons for future management. An example of where this happens is in the Cardiorespiratory Unit. This unit compromises clinical teams that treat and operate on children with cardiac and respiratory conditions. For example, cardiac surgery or providing treatment for cystic fibrosis patients. The unit holds weekly Friday morning meetings which review patient outcomes of recent operations and enables a forum to discuss unexpected outcomes and learning. Performance is compared against previous time periods. All staff in the unit, both clinical and non-clinical, are invited and attendance is strong.

At GOSH, we also have extensive experience of using a structured review of harm by using the paediatric trigger tool. This tool helps staff to measure and understand the nature of any harm that takes place in the hospital by reviewing the medical records of patients after they have been discharged. The team that are involved represent different areas across the organisations and the medical records are selected to represent all areas of the trust to provide a system wide approach to monitoring harm. This approach could also be applied to reviewing the medical records of patients who die, it offers the opportunity to identify organisation learning and implement good practice across the trust to help improve the outcomes for other patients. By taking this approach the ultimate aim would be to reduce the number of avoidable deaths across the hospital.

What do we aim to improve in 2012/13?

In the first three months we will establish a mortality review group and in the following nine months the group will review the medical records of 60 per cent of patients that have died and share the learning with staff across the organisation.

How do we plan to improve in 2012/13?

We will identify clinicians to form a mortality review group who will be representative of staff and teams across the hospital. This group will agree a process for undertaking reviews and establish a tool to use to ensure the reviews are carried out in a standardised and consistent way. This tool will reflect the best practice process learnt from the use of the paediatric trigger tool and examples of tools used to review mortality at other hospitals.

The group will make use of the NHS Institute 2x2 matrix to provide an initial analysis of the patient's death. The NHS Institute 2x2 matrix is a way to categorise for each patient that died whether there was an intensive care admission and whether the patient was receiving palliative care. It is demonstrated as follows:

		Intensive Care Unit admission	
		Yes	No
Receiving palliative care	Yes	1	2
	No	3	4

The matrix was established by the NHS Institute as a tool for hospitals to review the death of patients and to focus on identifying health and care system problems with the intention of improving the quality of care for patients. By using the NHS institute 2x2 matrix those patients that are in category four will be a particular focus of the review.

It should be noted that a number of children who die in the trust do so as part of planned end of life care. The palliative care team, who support these patients, have developed an end of life care pathway tool, and the case notes will also be assessed with reference to how this tool has been used.

Between July and April 2013, every three months the mortality review group will review the medical records of 60 per cent of patients who have died and conclude with a report of any services issues.

Priorities for improvement in 2012/13
Clinical effectiveness priority continued

How will we measure and monitor performance in 2012/13?
We will measure the performance of this improvement initatives by monitoring the number of case note reviews that have been completed every three months and identifying what actions are needed to make improvements in the future

The findings of the mortality review group will be fed back across all levels of the organisation. For example each clinical unit team has identified specific individuals who can lead on patient safety and provide clinical leadership within their local teams. The findings of this mortality review work will be shared with these individuals to ensure that learning is disseminated and actions can be implemented at local level to help improve the quality of care for patients.

To monitor quality and safety for patients at GOSH, we have a organisation wide committee meeting called the Quality and Safety Committee. This Committee is responsible for all matters that effect quality and safety for patients and is attended by a representative of all clinical units and corporate teams. It is chaired by the most senior medical post in the organisation, the co-medical director. The findings of the mortality review group will be reported to this Quality and Safety Committee. It enables a system-wide response to learning and the committee is able to ensure that actions are implemented where required.

The Quality and Safety Committee reports to the Trust Board which will monitor that the actions are being implemented and challenge performance if required.

To ensure that learning is disseminated across the whole hospital it is proposed that an annual meeting is held to report the findings to clinical staff.

The findings of this work will be shared with our commissioners as this improvement initiative is part of our contract with them to ensure that we focus on areas to improve quality. They will monitor us and if we do not fulfil the requirements agreed there is a financial penalty to the organisation.

Who is responsible for this improvement initiative?
A consultant in the anaesthetic department is responsible for overseeing and directing the actions required to deliver this improvement. The improvement initative is overseen by the co-medical director, who is the executive lead for quality and safety at GOSH.

Clinical effectiveness improvement initiative two

Development and use of clinical outcome measures for each speciality
Over the last few years each of our clinical specialties have been identifying at least two clinical outcome measures to demonstrate the effectiveness of the care that they provide. A clinical outcome is defined as ‘the change in the health of an individual, group of people or population which is attributable to an intervention or series of interventions’. For example, we use clinical outcome measures such as survival rates, complication rates or measures that demonstrate clinical improvement. We also try to measure the effectiveness of care from the patient’s own perspective through the use of patient-reported outcome measures (PROMs).

Specialities have been working to collect the information to measure their results and over the last year we have developed a section of the Great Ormond Street Hospital (GOSH) website to detail the results from 18 of our specialities. We have worked with parents to make this information available and found their input and recommendations really valuable to informing our priority to demonstrate clinical outcomes. In particular parents recognised that some of our specialities treat a number of conditions and use different procedures. Therefore some of the results that are currently on the website only reflect one part of a speciality and other condition or treatment results are not currently available. For example, Infectious Diseases has provided information on the results of treatment for patients with human immunodeficiency virus (HIV), but the specialty also treats other conditions and these results are not currently available.

Our parents were keen that we continue to develop clinical outcome information to reflect the results of the main part of the speciality for the conditions treated and make it clear on the website the targets and timeframes we have set to making this information available on the website.

Feedback from these parents also told us that the information would be more powerful and aid understanding if there was some form of comparator to understand the performance.

Since starting this programme we have gained experience and knowledge about developing clinical outcome measures and we also have a better understanding of how to produce information that can be understood by parents. We are therefore keen to develop further clinical or patient reported outcome measures for each speciality.

What do we aim to improve in 2012/13?
We aim to increase the number of clinical outcomes that we have for each speciality to three in 2012/2013 and to ensure that the outcome measures used are reflective of a speciality’s main work.

How do we plan to improve in 2012/13?
From the experience of identifying clinical and parent reported outcome measures over the last two years, we have more knowledge to identify a measure that is representative of the result of treatment.

To support the identification of the third clinical outcome measure we will use criteria to guide and inform decision making and agreement from our specialities.

I’m pleased that GOSH has asked for parents’ views when revamping their website. It is really important that parents are able to easily access and understand information which affects their children, particularly in a hospital. Well done GOSH for listening to parents and providing some excellent information.

Graham Manfield,
Parent Representative

This criteria is reflective of best practice guidance that is available on developing outcome measures and includes assessment of the following:

- Proxy power – whether the measure describes something which is reflective of the specialty's treatment objective.
- Data power – whether the data required to measure outcomes is of interest to the service and available and reliable.
- Good communication power – whether the measure clearly communicate to others what you are trying to achieve.

We are also currently writing to other leading national and international children's hospital to scope a collaborative piece of work to share clinical outcome measures that are used. This will help us to understand if the services we provide are comparable elsewhere in the longer term and could give us an opportunity to consider sharing data for comparisons. We hope the response to this proposal is positive and would give us valuable information on how other similar organisations are measuring the results of treatment and potential other measures to consider.

Since the introduction of the NHS Outcomes Framework, there has also been a lot of work in the development of quality dashboards which include clinical outcome measures that demonstrate effectiveness. Over the next year more specific speciality dashboards that are relevant to GOSH are being proposed and considered for implementation. We will implement the dashboards which are relevant to our specialities to ensure that we can start reporting on these measures in 2013/14.

The clinical outcomes development lead will meet with specialities across the hospital to discuss new measures together with feedback from the benchmarking work and the quality dashboards. We will also take the opportunity to get feedback from specialties of their views on effectively benchmarking with other organisations.

How will we measure and monitor performance in 2012/13?
We have a central list of specialities and clinical outcome measures agreed to date. This list will be updated by the clinical outcomes development lead when specialities have confirmed a third clinical outcome measure.

We will measure the number of specialities and associated clinical outcomes that are identified. The development of the third clinical outcome measure will be monitored by the clinical unit action plans which identify the next steps for measuring and publishing clinical outcomes

Progress in the development, measurement and publication of these clinical outcomes is reviewed and monitored on a monthly basis by the Clinical Outcomes Board. This Board oversees and directs the clinical outcome programme and is led by the most senior medical position in the organisation, the co-medical director.

Each clinical unit is required to present information on its progress and provide examples of clinical outcomes to the senior management team every three months at performance reviews.

Who is responsible for delivering this improvement initiative?
The clinical outcomes development lead is responsible for overseeing and directing the actions required to deliver this improvement. This improvement initiative is overseen by the co-medical director, who is the executive lead for quality and safety at GOSH.

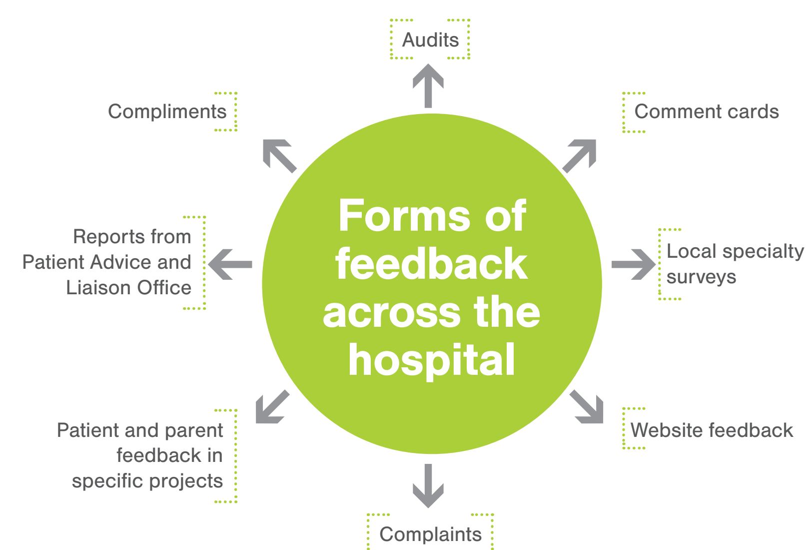
Experience priority

Consistently deliver an excellent experience that exceeds our patients', families' and referrers' expectations

We recognise that the memories and perceptions that patients and families have of Great Ormond Street Hospital (GOSH) are heavily influenced by the quality of their experience. GOSH seeks to provide the best possible services to patients and their families who come from diverse backgrounds and from all parts of the UK and abroad. We therefore need many ways to find out about, and improve patient and family experience. We do this best by involving and engaging our patients, their families and members in shaping health care at GOSH so it is appropriate to their needs and by making the best use of the knowledge and skills of our staff.

We have identified in our previous Quality Account that we use a variety of ways to get feedback from patients and parents regarding their experience at GOSH including an annual telephone survey as well as more local survey's at speciality or ward level. While the results of these surveys offer as valuable information and responses to set questions, we also have invested time this year in getting more detailed feedback from parents in the form of focus groups. These events help to illuminate the main themes of information we gather from surveys and give us more depth to areas that need improvement. For example, we had a focus group of parents to review the spinal surgery pathway for patients. We have also gained valuable feedback from having parent representatives on specific project groups, for example on the clinical outcomes on the website parent reference group. Their input has been very valuable and has often helped to make decisions and focus staff on the matters that mean the most to patients and families. By gaining Foundation Trust status this year we have also newly elected Members Council. This gives us a great opportunity to work in closer partnership with patient, parent, public and staff representatives, and members as well as local community agencies and representatives of patient groups over the next year.

To ensure we continue to focus on the priority of exceeding the experience of our patients and their families, we have established a committee called the Patient and Public Involvement and Engagement Committee. This Committee reviews the various forms of feedback that we get from patients' and families as illustrated below:



Priorities for improvement in 2012/13
Experience priority continued

The Committee is led by the assistant director of nursing for quality and safety and has representatives from across the hospital from clinical teams as well as representatives from groups that provide services across the hospital, for example accommodation and food. It also has five parent representatives. The purpose of this committee is to set a plan of work to ensure we focus on the needs of our patients and their families and to ensure that the responsible teams deliver on the relevant actions to improve experience

Last year we identified the following improvement initiatives that would help us achieve our priority of delivering an excellent experience. These included:

We have made improvements in all of these areas and more detail is provided in part three of this Quality Account. We are keen to continue to improve in these areas. We recognise that we need to work more on gaining feedback from patients and making improvements that matter most to them and this year we are keen to involve our adolescent patients in reviewing our hospital and helping to inform recommendations for improvement.

We also keen to ensure that doctors that refer their patients to us for further treatment also have the best experience of GOSH. This is important for a number of reasons but most importantly to ensure that the patient's care is as seamless and effective as possible.

Over the last couple of years, we have developed an improvement programme informed by a telephone survey undertaken with our referrers. We have a specific project group that is focused on making improvement work following this feedback from our referrers. This is led by the most senior medical post in the hospital, the co-medical director, and involves representation from teams across the hospital. In last year's Quality Account we focused on the work that we were doing to improve the timeliness and quality of our correspondence with the doctors that refer patients. The progress of this work is detailed in part three. This year we held a referrer's open day which was well attended and we received some valuable feedback during a question and answer session at the end of the day.

Experience improvement initiative one

Exceeding the experiences of our adolescent patients

Great Ormond Street Hospital (GOSH) is committed to improving the patient journey for children, young people and their families. However, we recognise, like other hospitals, catering for the needs of all age groups can be difficult, for example 70 per cent of our patients that required a hospital stay in 2010/11 were under the age of 10. There is a tendency to communicate with the parents of patients rather than directly with the young person, especially when patients have been under our care for a number of years.

Engagement work in recent years with our adolescent patients told us that they, quite rightly, want to be treated as individuals. To support this work a group of our adolescent patients developed a video about how they would like to be treated when in hospital. This video now forms part of the GOSH induction programme and is shown to every new member of staff. This video outlines the standards that the young people expect. These include:

- to be listened to and taken seriously
- to be given information by doctors in a way which makes it understandable
- to be involved in decisions regarding treatment
- to be given somewhere private when treated or examined
- to have access to enough toys, games and things to do on the ward.

Teenagers have strong views on what 'to be listened to, and taken seriously' means to them – they want to be talked to as individual patients and not via their parents; they want to feel they are a person and not a disease and they want 'to be believed'. Two additional satisfaction features are of particular note – the ability to maintain contact with school, and a plea to staff 'to smile and be positive'.

Over the last couple of years we have carried out an annual telephone survey with the families of patients that have needed to stay in hospital here. Patients over the age of 10 are asked to take part in this survey. These responses show us that patients compared to their parents are more likely to say that:

- they knew how to complain or offer feedback
- they could complain or offer feedback, and that this feedback would be taken seriously
- doctors or nurses asked questions about how they were feeling
- they were scared in the hospital, but also that staff helped deal with these fears
- had enough privacy when doctors/nurses talked about their treatment
- that they were kept awake at night by noise
- they were satisfied with the quality and variety of food
- the process of leaving hospital was easy.

Patient satisfaction was high across a number of key areas including involving them with decisions about their care and giving an explanation about treatment or tests and answering questions. Two areas where satisfaction was lower was in response to what extent do you agree or disagree that the ward was well designed for children of your age and you were kept awake at night by noise.

More local surveys have also been used and together have highlighted some of the issues for young people including communication with professionals, privacy and dignity, and transition to adult care.

The Department of Health developed the You're Welcome quality criteria to improve service delivery for adolescents. These criteria aim to give young people a voice in the NHS to ensure that their experience and contribution to the overall health of the nation is valued. They were developed following recognition that patterns of health related behaviour laid down in adolescence impacts on long term health behaviours. The first set of criteria was developed in 2005, and has been updated in 2011. They are based on examples of effective local practice with young people aged under 20. The updated version sets out established principles that enable health care professionals working in hospitals like GOSH to improve services by making them more accessible to young people.

Priorities for improvement in 2012/13
Experience priority continued

What to we aim to improve in 2012/13
We aim to review the services at GOSH to see if they meet You're Welcome quality criteria and identify and prioritise five areas for improvement for 2013/2014

How do we plan to improve in 2012/13
At GOSH we have an adolescent medicine service led by a consultant nurse working with a clinical nurse specialist. This team leads on the review of the quality criteria in services offered at GOSH. The quality criteria cover ten topic areas which are detailed as follows:

- accessibility
- publicity
- confidentiality and consent
- environment
- staff training, skills, attitudes and values
- joined-up working
- young people's involvement in monitoring and evaluation of patient experience
- health issues and transition for young people
- sexual and reproductive health services
- specialist child and adolescent mental health services (CAMHS).

The adolescent team has adapted the You're Welcome assessment tool for reviewing services at GOSH. They are working to develop a programme for roll out of the tool across the hospital and its services.

The team have started to recruit adolescent patients to help with the assessment of services and get feedback on how to improve services to better meet the needs of young people.

The results of the assessment will be reviewed with young people and analysed to identify the areas that most need improvement. They will be prioritised by reviewing the evidence and continuing to work closely with young people throughout the process.

The team will also be comparing the process and results obtained with other hospitals to see if lessons and actions can be shared. This will also help with the prioritising of what improvements need to be made first.

How will we measure and monitor performance in 2012/13?
The number of assessments and the results of the assessments will be used to measure performance in 2012/13.

To ensure we continue to focus on the priority of exceeding the experience of our patients and their families, we have a committee called the Patient Involvement and Engagement Committee. This committee has representatives from across the hospital from clinical teams as well as representatives from groups that provide services across the hospital, for example accommodation and food. It also has five parent representatives. The purpose of this committee is to set a plan of work to ensure we focus on the needs of our patients and their families and to ensure that the responsible teams deliver on the relevant actions to improve experience. The You're Welcome forms part of this improvement work and progress and performance will be reported back to this committee every three months, so to ensure that the results are shared across the organisation.

We will also consider the best way to feed back to our adolescent patients on what we are doing and what improvements we are going to make.

The findings of this work will be shared with our commissioners as this improvement initiative is part of our contract with them to ensure that we focus on areas to improve quality. They will monitor us and if we do not fulfil the requirements agreed there is a financial penalty to the organisation.

Who is responsible for this improvement initiative?
The clinical nurse specialist and consultant nurse in adolescence medicine are responsible for overseeing and directing the actions required to deliver this improvement. This improvement initiative is overseen by the chief nurse and director of education.

Experience improvement initiative two

Ensuring timely access to our services
In last year's Quality Account, we described the work we had started to gain feedback from our referrers, who are mainly consultant doctors in other hospitals. We are keen to understand what these doctors thought of the service we provided to them and their patients, and where they felt we needed to improve. One of the areas that they highlighted for improvement was in regards to our communication to them. A number of the patients we treat at Great Ormond Street Hospital (GOSH) are also cared for at other hospitals and when patients get ill they may first go to their local hospital for treatment before being transferred to GOSH if further specialist support is required. The patients may also be routinely seen at local hospitals in outpatient clinics. Therefore, it is important that our communication is effective so that local hospitals are made aware when the patient was last at GOSH, what care the patient received and what their future treatment plans are. Over the last year, we have focused on improving the time it takes to send discharge summaries to local hospital teams following the discharge of a patient. Importantly we have also been reviewing the content of these summaries to ensure that all the relevant information is included. Our performance in this is detailed in part three of this Quality Account.

In the last year, we have also held a referrers open day. This involved presentations from teams at GOSH and some focused work with specific services. This included reviewing how patients access services and proposed guidelines for referral to GOSH for specific treatments. The day was well attended and ended with a question and answer session with a panel of GOSH staff including our chief executive. Feedback from our referrers was really helpful and one area noted was that referrers found that it was very difficult to transfer a patient under their care at a local hospital to GOSH due to limited availability of beds and access to clinical teams. We obviously want to ensure that as far as possible we can provide a bed for a child that needs our specialist care.

What do we aim to improve in 2012/13?
We aim to reduce the number of times we are unable to admit a patient needing to be transferred from another hospital to GOSH due to insufficient bed availability by 25 per cent.

How do we plan to improve in 2012/13?
For patients that do not require an intensive care bed, there are two routes in which a local hospital could use to discuss the transfer of a patient to GOSH. We have a bed management team made up of two full time staff who explore all possible routes of admission for patients during normal working hours. This responsibility is handed over to the clinical site practitioner team out of hours. Local hospitals can also contact specific known wards and speak to staff on duty to see if there are beds available and enable the transfer of the patient and their care.

Priorities for improvement in 2012/13
Experience priority continued

Our first task to improve this patient pathway was to agree the criteria for admitting a patient for each of our specialities. This is important to ensure that beds are utilised by patients who genuinely require support from these specialist services. It was important to be clear and consistent with this information so local hospitals knew when they could transfer a patient if required. This guidance is now available on the GOSH website under the 'Health professionals refer a patient' section. This information will help guide local doctors to the different services provided and conditions treated at GOSH as well as the timeframe that patients should be admitted. It is hoped that this will help local doctors to manage their own and their patients' and families' expectations. It will also help GOSH clinicians and the Bed Management team by informing them of the agreed criteria and aid in the decision making when to admit a patient that needs care.

We have also updated our Admission and Bed Management Policy which governs the systems and processes in the hospital to manage the number of beds we have in the most effective way. This states that no patient should be refused admission to GOSH unless agreed with the bed manager. This team will endeavour to find a suitable bed for the patient when the preferred specialty ward is full. From reviewing and updating this policy, we have achieved full engagement and collaboration of all teams involved, and put in place actions to learn from best practice.

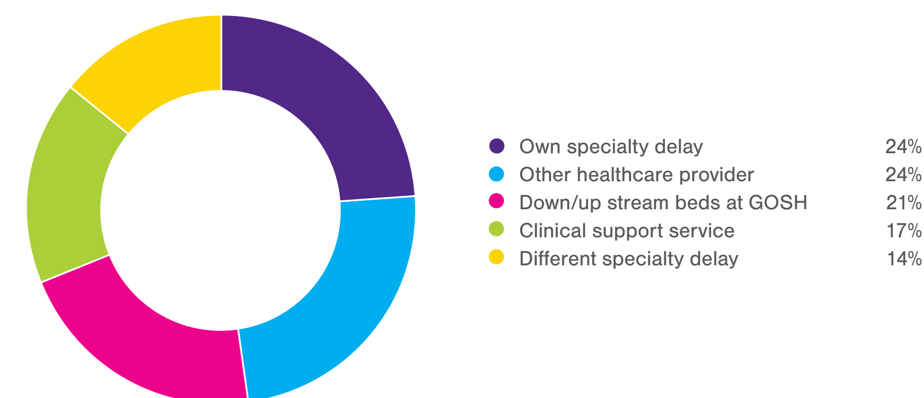
To support the effective use of our beds, we will be introducing an electronic real-time bed management system which will present accurate and transparent information about bed availability across the hospital. It will also display information about patients that are ready to leave the intensive care units and who are waiting for a bed on the ward. This will help the bed management team to facilitate moving patients into the environment that best meets their clinical needs and accept requests from local hospitals for patients that need to be transferred.

Engagement sessions with key staff are underway to ensure that the required cultural and process changes are identified and embedded across the organisation when the new system is implemented.

During 2012/13, we will be increasing the number of beds in our hospital across many specialities and this should also assist in decreasing the number of patient transfers that we are unable to admit. Like all organisations we have an absolute number of beds in the hospital and if these are all full we won't be in a position to exceed capacity. However, it is also recognised that at times, patients that are in hospital are waiting for internally provided services. For example, waiting for scans, which places extra demand for beds and increases patient length of stay. Over the last year, we have established a Health Care Delay Audit Group which on a fortnightly basis, review a ward to understand if there are any internal delays experienced by ward patients. A delay is defined as healthcare action not occurring in a timely manner which has the potential to either cause harm or increase the patient's length of stay in hospital by at least one night.

The group consists of a core team of staff and is led by the deputy chief operating officer. The results from this work have been collated and themed. They reveal that in this sample of 205 patients, 20 per cent of patients are delayed waiting for services. The reason for these delays is as follows:

Reasons for delay in healthcare



However the analysis shows that there isn't a common theme or team that we can easily approach to improve this situation. A real time bed management system would be crucial for improving the delays for patients and identifying where action is needed.

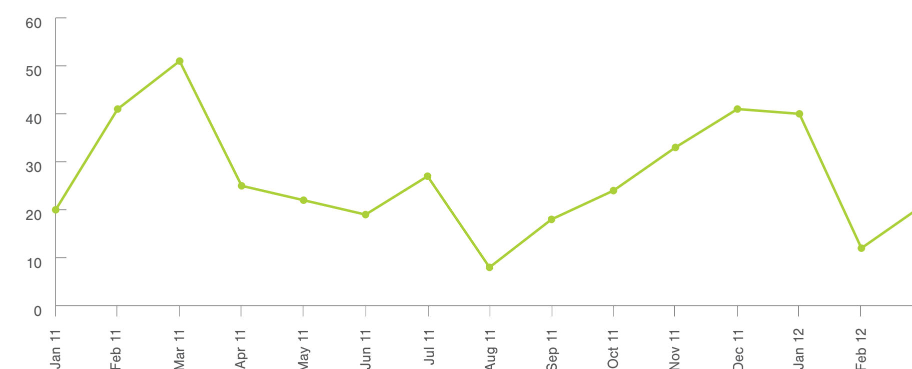
How will we measure and monitor performance in 2012/13?

We will measure the number of times we refuse to admit a clinically appropriate patient needing to transfer to a bed at GOSH.

To ensure that we capture all patients that are referred for a transfer to a bed at GOSH, an electronic referral form has been developed which is completed for each patient and identifies the outcome of the referral accordingly.

The following graph shows the number of patient transfers that we have been unable to admit by each month.

The number of patients we have been unable to admit to a bed in GOSH by month



Data source: Monthly Management Board Report

Priorities for improvement in 2012/13
Experience priority continued

This information is currently locally discussed and reviewed by the relevant clinical teams. It is reported to their central management teams. These teams then provide a report on a monthly basis to the senior management team.

At GOSH, we have a team that is responsible for facilitating and implementing transformation change in the organisation. Transformation means thinking differently and implementing solutions in areas which need improving. The transformation programme is focused around three goals of improvement called zero harm, no waste and no waits. This bed management project and improvement work reflects the goal of no waits. The progress on this improvement initiative is therefore monitored by the Transformation Board. Board meetings are established to hold teams to account and monitor objectives and aims. The Transformation Board is led by the chief executive and the members include not only transformation and clinical staff but also parent representatives.

Who is responsible for this improvement initiative?
A project manager has been appointed who is responsible for operationally improving the bed management system and this is overseen by the chief operating officer.

Statements relating to the quality of NHS services
The following section details the mandatory statements as set out in the National Health Service (Quality Accounts) Regulations 2010.

Review of services
During 2011/12, Great Ormond Street Hospital (GOSH) provided and/or sub-contracted 38 NHS services. The income generated by the NHS services reviewed in 2011/12 represents 100 per cent of the total income generated from the provision of NHS services by GOSH for 2011/12. The data reviewed should aim to cover the three dimensions of quality – patient safety, clinical effectiveness and patient experience.

Our services incorporate medical and surgical services as well as those offering support, therapy, diagnosis and investigation. As a tertiary quaternary centre, we see patients from across the country, and our aim is to enable children with specific needs to access a range of services within one site whenever possible.

In order to ensure that we maintain excellent service provision, we have internal processes to check that we meet both our own internal quality standards and those set nationally. Key performance indicators relating to each of the Trust's strategic objectives are presented, on a monthly basis, to the Trust Executive and Management Boards. These include progress against external targets such as the ways in which we keep our hospital clean, and the effectiveness of actions to reduce infections and ensure that patients have access to our services when they need them.

Each specialty and clinical unit has an internal monitoring structure so that teams can regularly review their progress and identify areas in which improvement may be required. This information links into a wider Trust governance framework, where the units report at least once a year on progress in the care they provide.

These updates are recorded via quarterly operational performance reviews and the committee structure of the Trust to ensure that the quality of service delivery and monitoring is discussed and acted upon at the appropriate level within the Trust.

Delivery of healthcare is not risk-free, and the Trust has a robust system for ensuring that the care delivered by our services is as safe and effective as possible. Our process has been externally assessed and we achieved level two in the National Health Service Litigation Authority (NHSLA) Risk Management Standards in November 2009.

The NHSLA provides GOSH with indemnity cover and assists NHS organisations in improving their risk management arrangements through assessment against a set of 50 standards and criteria. These standards cover a wide range of topics including record keeping and blood transfusion management. Assessemments are carried out at three levels. GOSH will be assessed again at the end of 2012

Unless events are reported when the outcome of care is not as expected, the Trust cannot learn and make improvements. A good safety culture is one with high levels of reporting and where the severity of events is low. The National Patient Safety Agency (NPSA) has consistently identified the Trust as meeting this criteria. Analysis of the types of risks identified by staff is incorporated into our assurance process to ensure that management, performance and safety are closely aligned.

GOSH has reviewed all the data available to them on the quality of care in 38 of these NHS services.

Participation in clinical audit

Clinical audit is an evaluation of the quality of care provided against agreed standards with actions taken to improve quality where needed.

The Clinical Audit team is part of the Quality Safety and Transformation Team and work closely with the Improvement Managers and coordinators, the Information Analysts, Risk Managers and Complaints team.

The Clinical Audit team provides additional support and expertise to ensure that clinicians are supported in undertaking good quality clinical audit which leads to improved practice.

We have identified three types of clinical audit at Great Ormond Street Hospital (GOSH):
1. International/national audits in which we are asked to take part.
2. Local audits undertaken within GOSH, identified by clinical teams to ensure that patients get the best possible care.
3. Clinical audits directed and managed by the Clinical Audit Department, which address controls associated with known risks and best clinical practice.

> Clinical audit is a quality improvement cycle that involves measurement of effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.
>
> **HQUIP Best Practice for Clinical Audit 2011**

1. Participation in national audits

Engagement with national audits is essential in ensuring that improvements are made to clinical care and to encourage delivery of better outcomes as a result of the quality of care that is provided.

The Department of Health and the Health Care Quality Improvement Partnership recommended that trusts participate in 51 national audits.

During 2011/12, 17 national clinical audits and no national confidential enquires covered the NHS services that GOSH provides.

During 2011/12, GOSH participated in 88 per cent of the national clinical audits which it was eligible to participate in.

The national clinical audits and national confidential enquiries that GOSH participated in during 2011/12 are as detailed in the following table. The national clinical audits and national confidential enquiries that GOSH participated in, and for which data collection was completed during 2011/12, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit title	Cases requested from national body	Cases submitted by Great Ormond Street Hospital
Per- and neonatal		
Centre for Maternal and Child Enquiries: perinatal mortality	Applicable to the death of any baby from 24 weeks gestation to 28 days	100 per cent of applicable cases
Children		
Paediatric Intensive Care Audit Network: paediatric intensive care	Approximately 1,700 cases	100 per cent of applicable cases
Congenital Heart Disease: paediatric cardiac surgery	100 per cent of applicable cases	Confirmation: 100 per cent of applicable cases will be submitted by May 2012, meeting deadline for submissions
British Thoracic Society: paediatric asthma	100 per cent of applicable cases	100 per cent of applicable cases (n = 4)
British Thoracic Society: paediatric pneumonia	100 per cent of applicable cases	100 per cent of applicable cases (n = 9)
Acute care		
NHS Blood and Transplant: potential donor audit	100 per cent of applicable cases	100 per cent of applicable cases (n = 85)
National Cardiac Arrest Audit: cardiac arrest audit	100 per cent of applicable cases	100 per cent of applicable cases (n = 43)
Long-term conditions		
National Inflammatory Bowel Disease: ulcerative colitis and Crohn's disease	Round 3 Clinical Audit: 100 per cent of applicable cases Round 3 Biologics audit: 100 per cent of applicable cases	Round 3 Clinical Audit: (n = 3 Crohn's disease cases, 3 Ulcerative Colitis cases) Round 3 Biologics audit: submission will occur once registration to the system has been complete
British Thoracic Society: bronchiectasis	100 per cent of applicable cases	100 per cent of applicable cases (n = 12)
National Pain Audit: chronic pain	No minimum	n = 17 *comment from national body "represents a very good return for the three month collection period"
Elective procedures		
NHS Blood and Transplant UK Transplant Registry: intrathoracic	100 per cent of applicable cases	100 per cent of applicable cases
Cardiovascular disease		
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	100 per cent of applicable cases	100 per cent of applicable cases
Renal disease		
Renal Registry: renal replacement therapy	100 per cent of applicable cases (December 2011 submission)	Data to be submitted July 2012
NHS Blood and Transplant UK Transplant Registry: renal transplantation	100 per cent of applicable cases	100 per cent of applicable cases (n = 31)
Blood transfusion		
National Comparative Audit of Blood Transfusion: bedside transfusion	100 per cent of applicable cases	100 per cent of applicable cases (n = 50)

Statements relating to quality of NHS services
continued

We did not participate in the following audits
- Patient reported outcome measures for the four elective procedures
- Trauma Audit and Research Network: severe trauma

Participation in national confidential enquiries
Three National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies collected data in 2011/12 and did not require Great Ormond Street Hospital (GOSH) participation as they did not cover the care of children:
- Cardiac arrest procedures
- Bariatric surgery
- Alcohol related liver disease

The reports of national clinical audits were reviewed by GOSH in 2011/12. The relevant specialties intend to take the relevant actions to improve the quality of healthcare provided. In 2012/13 we continue to develop a central system to record all the actions associated with national clinical audits.

NCEPOD published a report and recommendations on 27 October 2011 following the Deaths in Surgery Study in which the Trust participated (2010/11).

This has been reviewed and an organisational gap analysis was reported to the Quality and Safety Committee in January 2012. The actions identified are being monitored by the Clinical Audit Manager and will be reported to the Quality and Safety Committee to ensure the learning from the report is acted upon.

Local clinical audits
The reports of 42 local clinical audits were reviewed by the provider in 2011/12 and GOSH intends to take the following actions to improve the quality of healthcare provided.

Specialty	Audit title	Project description	Actions intended
Anaesthesia	Audit of optical laryngoscope in neonates	Review of outcomes of licensed optical laryngoscope to establish effectiveness	Confirmed technique is effective
Anaesthesia	Association paediatric anaesthetists (APA) sponsored multi-centre perioperative paediatric aspiration project	Eleven centre national paediatric audit co-ordinated by the APA to identify the incidence of the rare but serious complications in both elective and emergency procedures. Also to help identify any specific risk factors and outcome	All relevant information forwarded to Manchester Children's Hospital. National report will be released
Anaesthesia	Respiratory complications in recovery post operatively	Identification of problems with airways picked up in recovery based on time of procedure, in order that can be explored further to increase patient safety	Not applicable – audit showed compliance
Anaesthesia	Peri-operative temperature maintenance	Assess prevalence of peri-operative hypothermia and measures used to prevent it	Met standards for audit
Anaesthesia	Audit of peri operative fluid prescription and monitoring in children	Adherence with the Great Ormond Street Hospital surgical unit guidelines	Update and disseminate guidelines. Re-audit

Specialty	Audit title	Project description	Actions intended
Cardiac Intensive Care Unit	Teaching of Berlin heart dressings for families	To ensure that parents feel comfortable/competent in changing the dressing on their child's Berlin heart. To reduce surgical site infections and to minimise risk. To improve training/teaching where necessary	To develop a video to demonstrate to parents and staff the correct way to change a Berlin heart dressing. To be available on the intranet
Cardiology	Outpatients' experience of the cardiac magnetic resonance imaging (MRI) unit at Great Ormond Street Hospital	The aim of the audit is to assess the experience of outpatients	Consider improvement of adult literature or entertainment in the waiting area, alternative strategies for minimising crowding in the waiting area, further audit of scheduling time and waiting times for cardiac MRI scans
Cardiology	Non-medical prescribing audit	This is a relatively new practice for the Trust to see how medicines are being prescribed across the Trust by people other than doctors	To review options regarding medication currently unable to prescribe (April 2012)
Cardiothoracic	Arterial blood gas (ABG) sampling	Aim is to reduce inappropriate ABG samples	Teaching pack in place for ABG indications
Cleft	Evaluating incidence of complications related to cleft palate repair	Aim is to evaluate the incidence of complications	Continue to practice in the same way
Clinical genetics	Audit of follow up for all families who are known to carry a balanced chromosome rearrangement, with a view to improving service provision	The aim of this project is to identify those individuals who are at a significant risk of having a child with an unbalanced chromosome rearrangement. To then arrange tests to minimise harm for families	Diagnostic codes changed and increase awareness of the need to test at 16
Craniofacial	Functional outcomes in patients with craniofacial dysostosis – five to seven-year follow-up review	The aim is to determine if improvements are maintained at five years or more post-operatively	Results showed compliance to standards
Dental	An audit of dental anomalies affecting five-year-old children with bilateral cleft lip and palate	An audit to look at patient experience and satisfaction after visiting the dental department. Re-audit of initial audit ref. 567	To extend to multi regional audit and include 10-year-old review patients
Ear, nose and throat	Surgical site infection audit	To assess if the antibiotic protocol is being adhered to	Department antibiotic protocol to be followed
Ear, nose and throat	Discharge summary re-audit	Recommendations were implemented from the initial audit (ref: 899). The re-audit will look at if these recommendations have been implemented successfully	Compliance has improved from previous audit. No further work needed
Endocrinology	Parental survey to assess the demand for a telephone clinic service in the congenital hypothyroid service	Assess whether families would benefit from a telephone clinic	Telephone clinic set up in August 11 for Endocrinology which has been positive for the families and means one less hospital visit

Specialty	Audit title	Project description	Actions intended
Gastro-enterology	Nutritional status of allergic children in the United Kingdom	To determine the nutritional status of children with a confirmed food allergy in the UK. There is no previous information so this will help determine the severity of poor growth and malnutrition, which will help improve dietetic management	None required. All cases submitted showed the children were well nourished
General surgery	Clinical outcomes in neonates undergoing abdominal operations on the Neonatal Intensive Care Unit (NICU)	To determine the clinical outcomes in neonates requiring abdominal operations in intensive care unit from 2002–2010	Further audit in 2013
General surgery	Effectiveness of Meckel scan	To compare the relevance of the scan	This audit reassures the quality of practice of Meckel's scan at these centres
Histopathology	Audit of reporting turnaround times	To compare Great Ormond Street Hospital turnaround times against two key performance indicators, as recommended by the Royal College of Pathology	Discuss with Information and Communication Technology the possibility of generating turnaround time data automatically
Infectious diseases	Audit of investigation and management of patients with Kawasaki Disease in Great Ormond Street Infectious Diseases department	The aim of the project is to determine whether current treatment and management of patients with Kawasaki disease follows the guidelines set out in Brogan et al. (2002) for recognition and treatment of patients in the United Kingdom	No action needed. Audit showed the guidelines were being followed
Nephrology	Audit of Epstein-Barr virus and posttransplantation lymphoproliferative disorders post renal transplantation	Evaluate the change from a qualitative to a quantitative test. In particular the audit will identify the risk factors and prevalence of EBV disease post transplantation	Met standards for audit
Neurodisability	Family satisfaction audit of the movement disorder clinic and botulinum toxin clinic	Feedback from families who use the service about the whole clinic process	Review information provided before clinic
Neurology	Outcome in children with medically unexplained neurological symptoms	To study if the recommendations that have been implemented for the children were correct and outcomes	No actions
Neurology	Audit of external review in a single-handed neuropathology department	Great Ormond Street Hospital is a centre with a single consultant neuropathologist, therefore it is important that their practice is in line with that of colleagues. This can be ensured by a proportion of cases reviewed by a consultant neuropathologist at another centre	Reports should state whether the second pathologist has seen the slides for a case
Neurology	Paediatric multiple sclerosis: under-reported, under-diagnosed disease	To audit the implementation of guidance which should have resulted in an increase of the timescales of diagnosis and treatment of MS	Increase awareness of MS across health care professionals
Neurology	Use of low molecular weight heparin in Neurology inpatients	To clarify whether current guidelines are being used	No need to change protocol
Neurology	Safeguarding guidelines for serious head injuries in children younger than two years old	Retrospective audit against the non-accidental injury hospital protocol (2003). Data collected retrospectively over a one-year period (from January 2010)	Checklist introduced
Neurology	Clinical queries	To assess calls logged onto the clinical queries database over a one-month period	To improve documentation of the local consultant. To document the time spent on dealing with queries. To fax completed forms to local hospital. To extend system to include neurosurgery
Paediatric Intensive Care Unit (PICU)	Bronchograms on the Neonatal Intensive Care Unit/PICU	To see if changes made in 2007 to ensure bronchograms are not undertaken on children who cannot breath spontaneously have been sustained	Re-introduction of bronchogram checklist
Radiology	Annual review of 'did not attend' (DNA) in the Radiology Department	To review archived records to find out current DNA rate for radiology	To review having letters in a variety of languages to reduce the number of DNAs in the department
Radiology	Staff dosimetry audit	Personal dosimeter badges are required by local and national rules (local radiation protection rules and Royal College of Radiologists) in order to assess the level of radiation exposure	Include information on the importance of dosimeter badges prior to arrival to Great Ormond Street Hospital. Refresher meeting on staff exposure during induction. Re-audit in 2013
Respiratory	Sweat tests on infants referred for further investigation of cystic fibrosis (CF) on the newborn screening programme	Compare with national guidance	Review the education and training of lab technicians who perform the sweat tests. To compare sweat test failure rates in NBS infants with other tertiary UK CF centres
Rheumatology	Biologics in Rheumatology: funding issues	To assess the amount of time spent waiting for approval of medication – due to funding criteria, many children have delays in receiving their medication	To get the tuberculosis screening done in clinic, once it has been decided to start biological agent
Rheumatology	Clinical nurse specialist education survey	To identify whether local health professionals education needs are being met	Plan study day. Nurse helpline now in place
Rheumatology	Follow up of patients who receive intra- articular injections	Compliance with three-month follow-ups	Extra general anaesthetic lists for rheumatology
Urology	Results and long-term follow-up for feminising genitoplasty	To assess the indications and outcomes for feminising genitoplasty in patients with congenital adrenal hyperplasia	None
Urology	Portable extracorporeal shock wave lithotripsy in paediatric urolithiasis under general anaesthetic	Effectiveness of the use of a portable extracorporeal shock wave lithotripsy (ESWL)	Re-establish the ESWL service

Specialty	Audit title	Project description	Actions intended
Urology	Outcome for horseshoe kidneys	Data collection on outcomes of hydronephrosis screening and minimise investigations for the future	None
Urology	Treatment of bladder exstrophy in children at Great Ormond Street Hospital: a cost effectiveness analysis	Review of a long-term follow-up of the effectiveness of two approaches used to treat bladder exstrophy and their related costs to decipher which of the interventions is more effective, offers less post-operatively complications and which is more cost effective	Current protocol is most effective
Urology	Outcomes of pyeloplasties at Great Ormond Street Hospital over a two-year period	An analysis of the outcomes of the pyeloplasties	Success and complication rates compare favourably with and often better than peer rates around the world. At present, there is no need to change or alter the method of management
Urology	Adrenocortical tumours in childen: a 25-year experience from Great Ormond Street Hospital	To assess outcomes. This will lead to the further improvement of treatment of such patients	Confirmed technique

Participation in clinical research

With our dedicated research partner, the UCL Institute of Child Health (ICH), Great Ormond Street Hospital (GOSH) now forms the largest paediatric centre in Europe dedicated to both clinical and basic scientific research. We are committed to carrying out pioneering research in order to find treatments and cures for some of the most complex illnesses, for the benefit of children in the UK and worldwide. Commitment to research is a key aspect of improving the quality of care and patient experience.

This year, the GOSH was awarded its second National Institute for Health Research (NIHR) Biomedical Research Centre (BRC) status from April 2012, which recognises the quality and importance of the research conducted within the organisation; GOSH is the only paediatric BRC in the UK. In addition to the BRC, the Division includes the joint GOSH/ICH Research and Development Office, the Somers Clinical Research Facility (CRF), and hosts the Medicines for Children's Research Network (MCRN) for London and the South East. Our research activity is conducted with a range of national and international academic partners, and we work very closely with industry to support the development and introduction of new therapeutics, devices and diagnostics for the NHS.

Our recent research activity is described below:

- Sixty-two active commercially-funded projects (clinical trials of investigative medicinal products and non-clinical trials of investigate medicinal products), 19 of which have been approved in the last 12 months.
- Of the 62 active commercially funded projects, 29 are commercially sponsored clinical trials of investigative medicinal products. Twenty-one of these have been approved in the last 12 months, seven of which are GOSH-sponsored trials and 31 are hosted non-commercial trials.
- Ninety-three UK Clinical Research Network Portfolio studies are currently recruiting patients at GOSH.
- We have over 80 active research awards administered via GOSH Finance, excluding five active NIHR-funded research projects, and five active European Union funded research projects.
- Forty-five research projects have been internally peer-reviewed through the Clinical Research Adoptions Committee.
- Over the last year, 65 research studies have been conducted in the Somers Clinical Research Facility, with more than 550 patients attending 1,326 research appointments. This represents a 34 per cent increase in appointments from the previous year.
- Four hundred and thirty-nine patients have been recruited to GOSH through the MCRN, of which 45 are for studies within the Clinical Research Facility. Forty-nine per cent of MCRN studies led by the London and South East team are GOSH-led.
- GOSH BRC has provided ongoing support for 47 studies, which includes output of major clinical impact of international and clinical significance.
- UCL Business Plc have now been contracted to support GOSH activity. In the last year, four technology disclosures have been reviewed.

The number of patients receiving NHS services provided or sub-contracted by GOSH that were recruited during that period to participate in a NIHR Portfolio Research Study approved by a Research Ethics Committee was 1,210.

GOSH's commitment to clinical research is further evidenced by our membership of UCL Partners, which is the first of the UK's five Academic Health Science Partnerships. Through the partnership, we continue to strengthen our links with other centres of excellence in clinical research.

Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

The CQUIN payment framework is an arrangement between provider NHS trusts and their commissioners. The aim is to incentivise improvement work. This shows that we are working closely with the commissioners of our services.

A proportion (1.5 per cent) of Great Ormond Street Hospital's (GOSH) NHS clinical income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between GOSH and any person or body with whom they entered into a contract, agreement or arrangement for the provision of NHS services through the CQUIN payment framework.

Further details of the agreed goals for 2011/12 and for the following 12-month period are available on request from the assistant director of nursing or the head of contracts.

The following table summarises our CQUIN targets for 2011/12 and 2012/13:

2011/12 CQUIN targets	2012/13 CQUIN targets
Implement the patient experience strategy and action plan; maintain and improve satisfaction on nationally prioritisedquestions, on knowing how to feed back, and with the quality and variety of food in the annual independent inpatient satisfaction survey	Development and application of surgical site infection prevention plans and reduction or maintenance of SSI rates
Continue to review 20 sets of case notes per month using the Paediatric Trigger Tool; undertake a peer review of the implementation of the tool	Reduction or maintenance central venous catheter line infection rates and establish an audit process to give understanding of how to avoid infections
Improve compliance with child protection record-keeping; achieve improvement in levels of group supervision of staff; increase the number of staff achieving Level 3 training	To retrospectively review 60 per cent of patient deaths using an internally developed mortality review toolkit and to identify system level issues
Implement and evaluate Great Ormond Street Hospital's (GOSH) nutrition screening flowchart; monitor patient nutrition outcomes using weight scores; complete a full audit of height measurement and set a target for improvement	Implement a new pressure ulcer risk assessment and reduce the number of pressure ulcers by 20 per cent
Reduce the current rate of surgical site infections (SSI) in four specialties; establish surveillance in five new specialties	Focus on the patient journey as they move through the organisation to identify themes for improvement on flow, process and communication and to undertake an assessment of the hospital against the You're Welcome quality criteria
Further reduce the rate of central venous catheter infections	To improve patients and families experience of food in the hospital
	Focus on parental smoking cessation by improving general information and awareness of smoking for patients and parents and developing a strategy for training and awareness across the hospital
	Develop systems and processes which enable timely internal and external escalation of patients with delayed discharges to facilitate the reduction in the length of stay at GOSH

Statements from the Care Quality Commission (CQC)

The CQC is the organisation which regulates and inspects health and social care services in England. Great Ormond Street Hospital (GOSH) is registered with the CQC with no conditions attached to its registration. The CQC has not taken enforcement action against GOSH during 2011/12.

Part of the CQC's role is monitoring the quality of services provided across the NHS and taking corrective action where necessary. Its assessment of quality is based on a range of external sources of information, some of which we are required to provide from our performance management systems, which are considered with information from other external monitoring sources. These data items are drawn together to create a quality risk profile for the Trust, which provides an estimate of the risk of non-compliance with registration requirements

GOSH has participated in special reviews or investigations by the CQC relating to the following areas during 2010/11:

- Meeting all the essential standards of quality and safety.

GOSH intends to take the following action to address the conclusions or requirements reported by the CQC:

- Improve the tagging of clinical equipment for purposes of maintenance and cleaning. GOSH has made the following progress by 31 March 2012 in taking such action by developing an action plan and implementing it.

Information on the quality of data and information governance

NHS managers and clinicians are dependent upon good quality information, using data derived from operational systems to ensure that appropriate services are delivered to patients.
It is a strongly held view among NHS staff, including clinicians, administrators and managers, that they must have access to all of the data whenever they need it, in a usable and accessible format, to support them in the delivery of high quality care.
It is crucial that all data captured about patients is accurate, timely and of good quality.

Secondary uses Service (SUS)

The SUS is the single source of comprehensive data to enable a range of reporting and analysis of healthcare in the UK. The SUS is run by the NHS Information Centre and is based on data submitted by all provider trusts.

GOSH submitted records during 2011/12 to the SUS for inclusion in the Hospital Episode Statistics, which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS number was:
  - 97.4 per cent for admitted patient care
  - 98 per cent for outpatient care
  - not applicable for accident and emergency care
- which included the patient's valid general medical practice code was:
  - 100 per cent for admitted patient care
  - 100 per cent for outpatient care
  - not applicable for accident and emergency care.

Note: the percentages for NHS number compliance have been adjusted locally to exclude international private patients who do not require an NHS number.

Information Governance Toolkit

The Information Governance Toolkit is a device that supports organisations in managing the data they hold about patients. The score achieved by an organisation reflects how well it has followed the guidance.

GOSH Information Governance Assessment Report overall score for 2011/12 was 69 per cent and was graded green.

GOSH will be taking the following actions to improve data quality:

- The introduction of a data quality strategy
- The review and update of the data quality policy.

Clinical coding

Clinical coding is the process by which the notes that clinical staff record are categorised to reflect the activity that occurs regarding each patient.

GOSH was subject to the Payment by Results Clinical Coding Audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was five per cent. This is better than the national average of 9.1 per cent. The data used for audit included a randomly selected sample of activity across the whole range of specialities and an equivalent sample volume selected randomly from the paediatric neurosciences specialty.

GOSH was not subject to the Payment by Results Outpatient Audit in 2011/12.

Please note the following points regarding the results of clinical coding audit:

- That the results should not be extrapolated further than the actual sample audited
- Which services were reviewed within the sample.

Review of quality performance in 2011/12

The following section reviews the priorities that were included in last year's Quality Account and the associated performance over the past year. It assesses whether we met our targets and illustrates some examples of initiatives intended to improve the quality of the services provided by Great Ormond Street Hospital (GOSH).

Safety priority

Zero harm – reducing all harm to zero

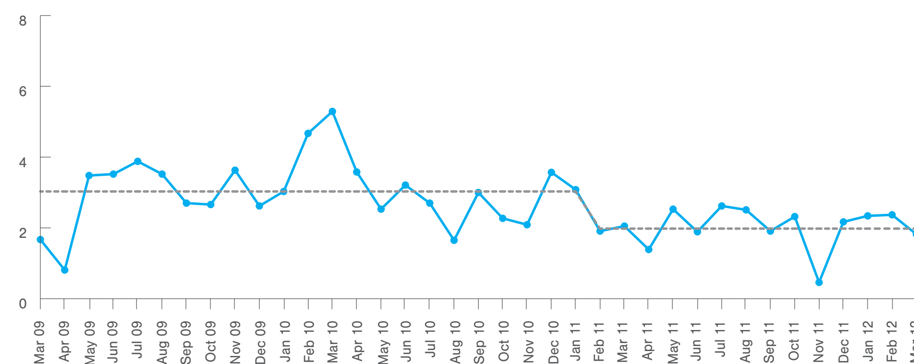
This section reviews the improvement initiatives we detailed last year to support the achievement of the priority of zero harm and our performance compared to previous years.

1. Reducing healthcare-acquired infections rates

What did we say we would do?	Performance 2009/10	2010/11	2011/12	How did we do and what are we going to do next?
Reduce number of central venous catheter (CVC) line infections developed at Great Ormond Street Hospital	3.26 per 1,000 line days	2.61 per 1,000 line days	2.0 per 1,000 line days	We have improved, although not achieved, the specific target of a 50 per cent reduction. We are committed to reducing CVC lines and set ourselves a target of a 10 per cent reduction for the next year. We have also appointed an infection control practice educator to support training and education

The following graph shows the number of CVC line infections on a monthly basis and demonstrates our sustained improvement over the last year. The grey dotted line presents the average, and our aim is to reduce the average towards zero.

GOSH-acquired central venous catheter line infections for every 1,000 line days



Data source: Infection Prevention and Control Database

What really made a difference for us is taking on an infection link nurse who is really keen to make a difference. She is working with her colleagues on education and making sure they get feedback.

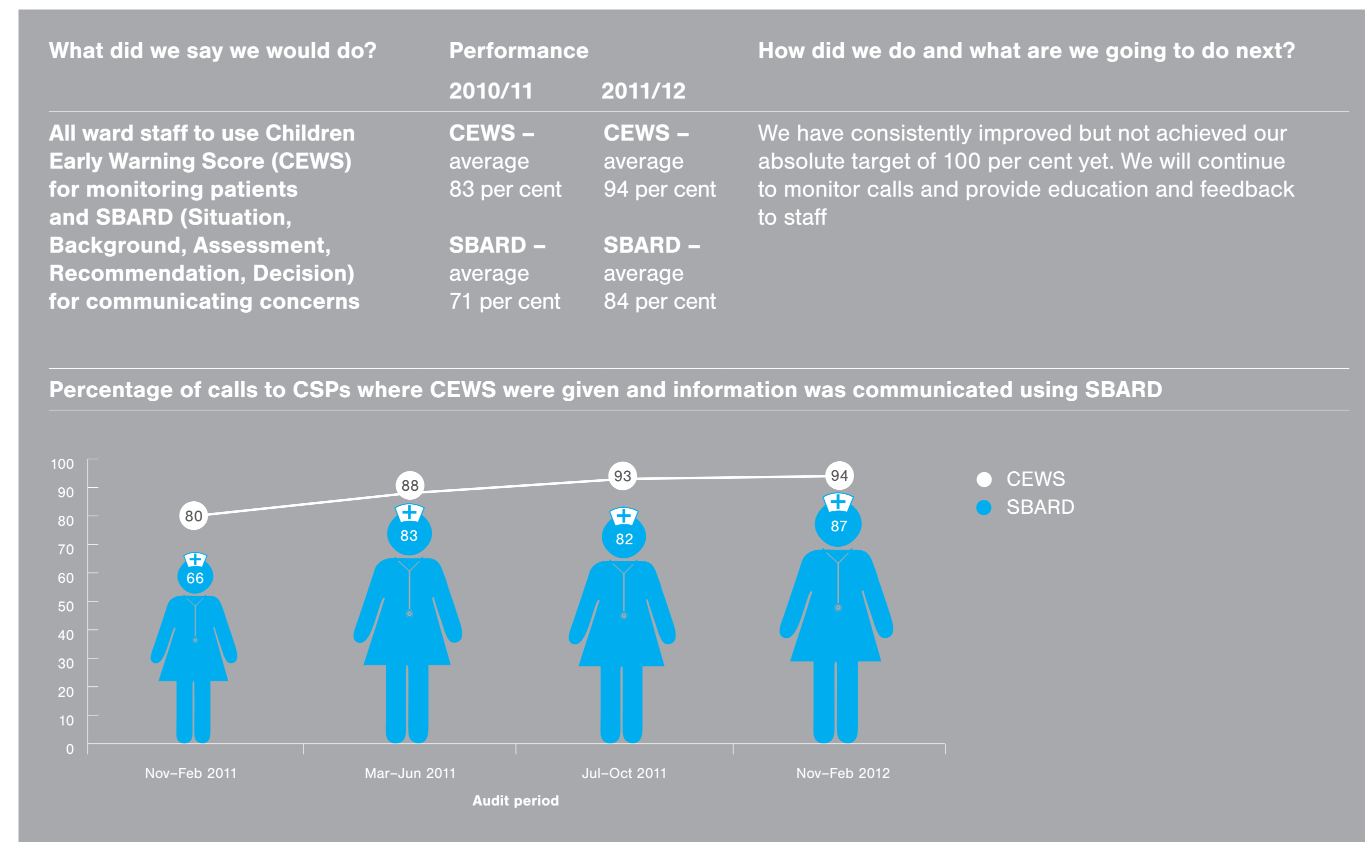
Elizabeth Ball, Improvement Manager for Surgery

What did we say we would do?	Performance 2009/10	2010/11	2011/12	How did we do and what are we going to do next?
Reduce the number of surgical site infections against the identified baseline for each specialty				The number of infections has reduced this year but we have not met our specific target. We have established surveillance in some of the other specialties, and in 2012/13, we plan to establish baseline surveillance data in all surgical specialties and continue development of care bundles. Care bundles help to minimise the likelihood of infections by giving staff best practice steps to look after a patient following surgery.
• **Urology**	Eight infections	Six infections*	Four infections	
• **Spinal implant**		Five infections from 180 operations	11 infections from 108 operations	
• **Cardiac surgery**		48 infections from 592 operations	40 infections from 568 operations	
Surveillance established in further specialties				
Reduce or maintain low levels of methicillin-resistant staphylococcus aureus (MRSA) bacteraemia	One case	One case	Four cases	We did not reach our target this year on reducing MRSA and the numbers have increased slightly. However the number is still within our contractual target A full examination of the cases for these four cases were reviewed and lessons shared in the organisation. We aim to reduce the numbers for 2012/13
Reducing the annual number of cases of Clostridium difficile-associated (C. difficile) diarrhoea	12 cases	10 cases	Eight cases	We have maintained the annual number of cases of C. difficile and will continue to strive to reduce the number of patients that get C. difficile each year

*We reported eight infections in last year's Quality Account for surgical site infections. These infections were checked by the clinical lead and revised to six after the Quality Account was prepared.

Review of quality performance in 2011/12
Safety priority continued

2. Effective monitoring and communication of the deteriorating child



What did we say we would do?	Performance 2010/11	Performance 2011/12	How did we do and what are we going to do next?
All ward staff to use Children Early Warning Score (CEWS) for monitoring patients and SBARD (Situation, Background, Assessment, Recommendation, Decision) for communicating concerns	**CEWS –** average 83 per cent **SBARD –** average 71 per cent	**CEWS –** average 94 per cent **SBARD –** average 84 per cent	We have consistently improved but not achieved our absolute target of 100 per cent yet. We will continue to monitor calls and provide education and feedback to staff

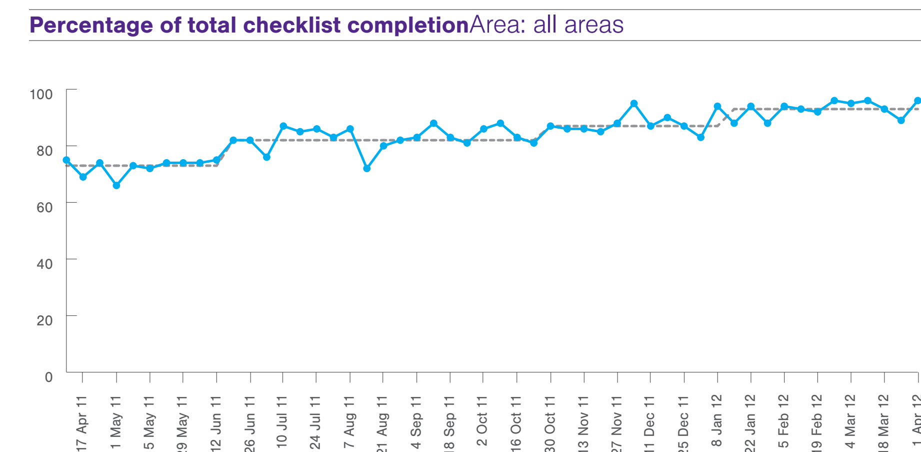
Percentage of calls to CSPs where CEWS were given and information was communicated using SBARD

3. Use of the World Health Organisation surgical and procedural safety checklist

What did we say we would do?	Performance 2010/11	Performance 2011/12	How did we do and what are we going to do next?
All relevant teams to use and record the World Health Organisation surgical safety checklist in every procedure	Average 60 per cent	Average 92 per cent	We have continued to improve over the last year and have nearly reached our target of 100 per cent compliance. To aid this work we have arranged to have teams filmed using the checklist and focused on the quality of completion

The following graph shows the percentage of total world health organisations surgical safety checklist completion on a bi-weekly basis and our sustained improvement over the last year. The grey dotted line represents the average, and our aim is to increase the average to 100 per cent.

Percentage of total checklist completion Area: all areas



Data source: Great Ormond Street Hospital Patient Information and Management System

In recognition of the improvement, the project team won an award at the Association for Perioperative Practice Annual Conference. The surgical specialties are completing the checklist 95 per cent of the time, and we are now focusing on particular areas where this has proved harder to implement than others.

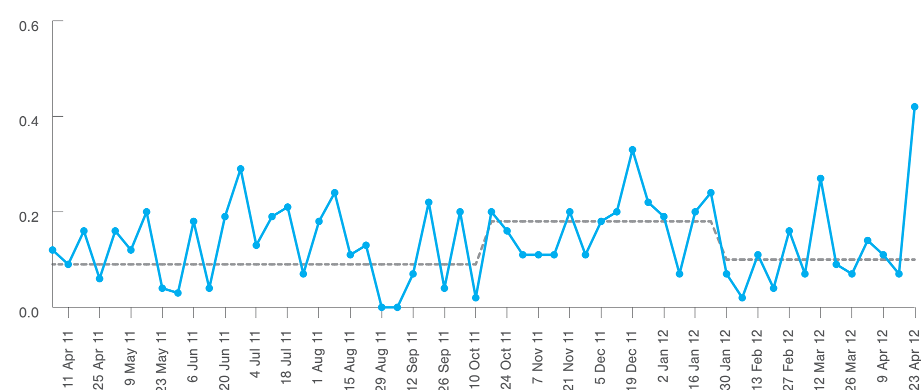
Review of quality performance in 2011/12
Safety priority continued

4. Reducing the number of medication errors

What did we say we would do?	Performance 2010/11	Performance 2011/12	How did we do and what are we going to do next?
Reduce the established baseline of medication errors in the Paediatric Intensive Care Unit (PICU) and Cardiac Intensive Care Unit (CICU) by 25 per cent	**PICU –** average 0.09 per bed day **CICU –** average 0.13 per bed day	**PICU –** average 0.10 per bed day **CICU –** average 0.09 per bed day	**PICU** We have not reduced the average medication error rate for patients in the PICU. We have reduced the median medication error rate for patients in the CICU but not met our target. To focus improvement in this area we employed a medicines management improvement specialist to work on a project to tackle cross-cutting issues relating to medicines management. The postholder will also work at clinical unit and specialty level to support improvement initiatives and spread good practice

The following graph shows the performance of prescribing errors for the Paediatric Intensive Care Unit (PICU):

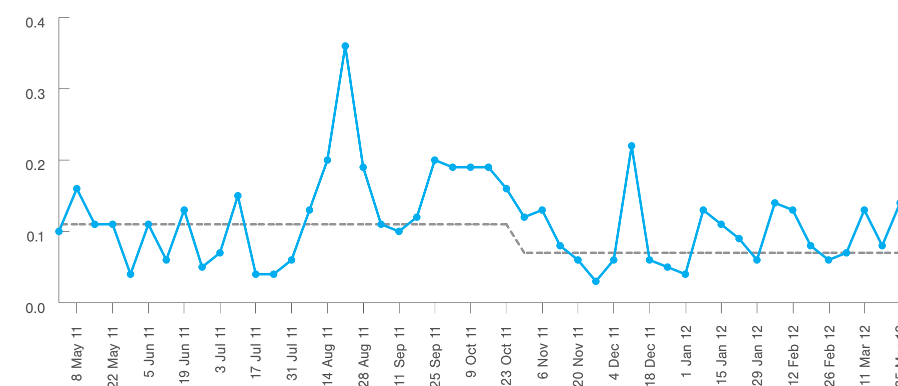
Clinical prescribing errors per bed day



Data source: PICU pharmacists

The following graph shows the performance of prescribing errors for the Cardiac Intensive Care Unit (CICU):

Clinical prescribing errors per bed day



Data source: CICU pharmacists

Case study

Cardiac Intensive Care Unit (CICU) Medicine Safety Week

A drug safety week was held in the Cardiorespiratory Unit at the end of January. There was a programme of daily events, centred on medicines management issues.

Clare Paley, Practice Educator, Barbara Childs, Lead Nurse CICU, and Lynne Cochrane, CICU Pharmacist, shared their thoughts about it. Lynne explains the background: "The main aim of the week was to highlight the importance of getting prescriptions right and to raise awareness of the fact that it's a collective responsibility. We aimed to encourage ownership of tackling medication errors and sought out suggestions from nursing and medical staff on how to safely prescribe and administer patients' medicines."

The week started on Monday by looking at the top 10 prescribing errors, with short presentations at nursing and doctors' handovers. That was just the start, as Practice Educator Clare Paley explains: "Tuesday covered the human factors of prescribing errors with Dr Jane Carthy. Staff spoke to Jane about prescribing errors and this is ongoing. Wednesday saw a talk from Dr Barry Sullman about medication risk and all the nurses off the unit attended. It was a powerful exploration of a fatal error from a personal perspective. The advance nurse practitioners came and looked after the patients so the nurses could go, which was quite a feat. A big thanks to everyone involved with that."

Reflecting on someone else's experience is very sobering said Clare. It highlights the importance of teamwork, following the procedures for checking prescriptions so that errors are noticed before the drug is administered.

CICU Lead Nurse, Barbara Childs, remarked on nurses feedback to the week: "They recognise how human factors are involved in drug errors instead of looking at it in isolation; there is a sequence of events sometimes. There's not one person involved in a drug error. We had recognition of that and staff fed back to say they got a lot from the session."

The effect of the Drug Safety Week has been noticeable according to Pharmacist Lynne Cochrane: "The data collected in the weeks since it took place has been really encouraging."

Teamwork was crucial says Clare: "We all worked together to make sure it happened and it was rolled out. The days went according to plan; it was a multidisciplinary effort that was nurse-led."

5. Reporting and learning from incidents

What did we say we would do?	What did we do?	How did we do and what are we going to do next?
Staff to record incidents when they happen and implement the National Patient Safety Agency's national framework for serious incidents	We implemented a new electronic incident reporting system to help make it easier for staff to report incidents and improve feedback on the lessons learnt from the incident. We have implemented the National Patient Safety Agency's national framework for serious incidents	Between April 2010 and March 2011, the Trust received 3,389 patient safety incident reports. After implementation of web reporting in April 2011, the number of patient safety incidents being reported has risen to 3,559 (April 2011–March 2012). This is an increase of five per cent. We will continue to monitor the number of incidents reported and aim to reduce the severity of harm that is reported

Last year, we showed the number of incidents that we reported compared to other similar hospitals from the National Reporting and Learning System (NRLS). This demonstrated that we have high reporting levels which is important to ensure that we learn from incidents. We have encouraged staff to report incidents and the National Patient Safety Agency advises that high reporting is a sign of a good safety culture. It shows that the hospital has an open and positive approach to discussing things that go wrong, and proactively dealing with them. We grade incidents by the severity of the incident from no harm; low harm; moderate harm; major harm and catastrophic harm. The sign of a safe reporting culture is one in which there continues to be high numbers of incidents reported, but that the level of harm caused by those incidents decreases.

In 2010/11, 96 per cent of incidents were reported as resulted in no harm or low harm. In 2011/12 98 per cent of incidents were reported as resulted in no harm or low harm.

We have not used the more recent NRLS information report as we did last year because the number of incidents reported is inconsistent to our local system reports.

Next year, we will report on the severity of incidents compared to the overall number of incidents reported.

6. Improve safeguarding

What did we say we would do?	How did we do?	What are we going to do next?
Improve safeguarding and implement a balanced scorecard and improve our performance by: • **improving record-keeping** • **implementing group child protection supervision** • **ensuring that 40 per cent of staff have Level 3 training**	We undertook regular audits of case notes to monitor the quality of record keeping and rated each case note against established quality criteria. At the end of the year audit, the case notes reviewed scored on average 88 per cent which relates to 'excellent'. This is higher than the aim of 80 per cent. We developed a new supervision model to support with child protection cases. In the last three months of the year, we reported that of the 21 referrals received, 19 received supervision, which is higher than the aim of 50 per cent. We increased the number of staff that had the relevant Level 3 safeguarding supervision and, at the end of the year, 53 per cent of the relevant staff had training, which is higher than our aim of 40 per cent	We continue to set targets to aim to improve these three aspects of safeguarding

We have not reported this year on ventilator-associated pneumonia in the paediatric intensive care unit because we have not undertaken any formal audits or data collection. However we will be introducing a new care bundle next year.

Clinical effectiveness priority

To consistently deliver clinical outcomes that place us among the top five children's hospitals in the world

This section reviews the improvement initiatives we detailed last year to support the achievement of our effectiveness priority and our progress over this year.

1. Publication of clinical outcomes on the website

What did we say we would do?	Performance 2009/10	Performance 2010/11	How did we do and what are we going to do next?
We said we would publish information on clinical outcomes on the Great Ormond Street Hospital (GOSH) website in a further nine specialties	Nine specialties with measures available on the website	18 specialties with measures available on the website	We achieved achieved our target and published information on clinical outcomes on the GOSH website for Children's Acute Transport Service; clinical genetics; dermatology; immunology; infectious diseases; interventional radiology; occupational therapy; orthopaedics and specialist neonatal and paediatric surgery

We wanted to make more information about clinical outcomes available and to ensure that this information could be understood and be meaningful to the parents of children that are treated at Great Ormond Street Hospital (GOSH).

We sent an advert to all the parents that were members of GOSH stating that we were looking for volunteers to provide feedback and guidance on making information on clinical outcomes available on the website. We had a fantastic response from five parents that had experience and interest in making information available on the website. We recruited all five parents to ensure we got feedback and advice from parents on the clinical outcome information that was planned next for publication on the GOSH website.

The parent group met four times between December and March 2012 and reviewed the current information on clinical outcomes that is on the GOSH website. They provided valuable feedback and guidance on what areas worked well and what areas did not work so well. The parents also provided fantastic suggestions of what additional information is needed to understand the results of clinical outcomes and proposed a template to guide how the information should be developed. In particular they felt that the use of parent, patient or staff quotes on the outcome of the service would be really good to illuminate the message of the graphs and data that is presented.

This group of parents reviewed information on a further nine clinical outcomes and provided recommendations and advice if areas needed more information or better explanation. All the recommendations were taken on board and this information is now available on the website. We will be using the principles of this work to help inform further information that is developed.

GOSH would like to say a big thank you to the parents that helped us with this work:
Graham Manfield
Antonia Wade
Sophie Huang
Jacqueline Steward
Myriam Lantrade

> It has been a privilege to be able to contribute to this valuable work and a great learning experience. Many thanks for this opportunity.
> **Sophie Huang**

2. Using and developing patient-reported outcome measures (PROMs)

What did we say we would do?	How did we do?	What are we going to do next?
Continue to use patient reported outcome measures (PROMS) in specialties and aim to develop and implement further PROMs across the hospital	We have been monitoring the use of PROMs in the six specialities used last year (listed below) and have implemented collecting PROMS in the following specialties: • Clinical Genetics • Children and Adolescent Medicine Mental Health Service • Cleft • Speech and Language Therapy • Orthopaedics Research for a specific quality of life validated patient reported outcome questionnaire is currently ongoing	Continue to monitor the number of responses across all PROMs ongoing in the organisation. In addition we plan to host a collaborative workshop with clinicians interested in using PROMs to share learning and best practice. This will be informed by feedback from patients and parents about the best ways to engage them with completing questionnaires

The following table shows the number of questionnaires that have been completed to date and the next steps:

Speciality and patient-reported outcome measure (PROM)	Number of initial questionnaires completed	Number of follow-up questionnaires completed	Next steps
Cystic fibrosis Cystic fibrosis questionnaire	12	12	Consider the use of the PROM in further frequent flier programme
Epilepsy surgery Quality of life in childhood epilepsy	52	3	Continue to capture responses and focus on follow up responses
Dermatology Laser surgery patient-reported outcome measure	6	6	Continue to capture responses
Chronic fatigue service A variety of PROMs are used including EQ-5D	74	26	Initial analysis of responses to some of the questions asked was published on the Great Ormond Street Hospital website in March 2011. This information will be refreshed and updated by July 2012
Orthopaedics Oakland hospital hip evaluation study	22	0	Continue to capture responses
Neurodisability Parental understanding questionnaire	Not applicable	Not applicable	Research into formalising the measure for use in clinic

Case study

Cystic Fibrosis Frequent Flier Patient-Reported Outcome Measure
(draft still under review by team)
The Cystic Fibrosis team developed a specific programme for patients that were frequent visitors to hospital due to their condition. This programme involved specialised clinics focusing on treatment; exercise and diet. A number of measures were recorded at the beginning and throughout the programme to determine if the programme had a positive impact on the child and managing their condition. To ensure that the programme reflected outcomes from the point of view of the patient the internationally validated cystic fibrosis quality of life questionnaire was used. The questions are designed into age-appropriate questionnaires and for the patients in this programme the following were used:
- Children aged six to 11 (interviewer format)
- Children aged 12 and 13 (self report format)
- Patients 14 years old and older (self report format)

The questionnaire asked the patient to respond to questions in regards to the dimensions of physical functioning, energy/wellbeing, emotions, social limitations, role, embarrassment, body image, eating disturbances and treatment burden. The questionnaire intended for patients aged 14 years and older has a further four domains of role functioning, vitality, health perception and weight. Each domain is calculated out of a score of 100 (which represents the best response) and the overall score is the average of these domains. The questionnaire was used at the beginning of the programme and at the end of the programme.

There were only 12 patients that completed this questionnaire at both the beginning and end of the programme so we recognise that the analysis is limited due to a small sample size of patients that took part. In addition, the responses to each domain for each patient varied from zero out of 100, to 100 out of 100.

Overall, five out of the 12 patients reported an overall improvement score in their quality of life, two out of the 12 patients reported no improvement in their quality of life, and five out of the 12 patients reported a reduction in their quality of life at the end of the programme.

Those patients that reported an improvement in their overall quality of life completed the children aged six to 11 questionnaire (improvement was on average an increase of 11 out of 100). This group reported significant improvement across the domains of physical functioning; body image; social improvement; and respiratory. However this group also reported a significant reduction of the domain of energy burden. Patients aged 14 years and older reported an overall reduction in quality of life. This result is consistent with other research in which most general quality of life scales (eg emotional functioning, physical and psychological wellbeing and self-perception) decrease from childhood into adolescence (Michel et al, 2009). The reduction was particularly in relation to the domains of body image and eating disturbances.

We also reviewed the changes to the different domains of quality of life for each patient and noted in the physical domain 10 out of the 12 patients reported an increase in this score with an average increase of 10 out of 100.

We plan to continue with the frequent flier programme in the next year and will continue to use the cystic fibrosis questionnaire with patients. This will allow us to increase the number of responses and continue to analyse outcomes reported by patients themselves.

3. Benchmarking outcomes against other organisations

What did we say we would do?	How did we do?	What are we going to do next?
To encourage specialities at Great Ormond Street Hospital to use outcome measures that can be benchmarked against those of other providers and/or to lead on the development of outcome measures that can be used by other centres	The following specialities that were identified last year continue to submit clinical information to registries or networks which enables benchmarking of outcomes: • Cardiology and cardiothoracic surgery through the central cardiac audit database • Cardiac and paediatric intensive care – through the Paediatric Intensive Care Audit Network • Cystic fibrosis – through the Cystic Fibrosis Registry • Renal – through the National Health Service Blood and Transplant Organisation • Chronic fatigue service (CFS) – through the CFS National Outcomes Database • Gastroenterology inflammatory bowel disease – through the ImproveCareNow Registry • Haemophillia – through the specialist commissioning forum • Infectious diseases – through the collaborative Human Immunodeficiency Virus (HIV) Paediatric Study • Ophthalmology – through the Royal College of Ophthalmologist quality standards quality indicators Other specialities which have also submitted clinical outcome information to registries or studies in 2011/12 are: • Oncology and haematology • Bone marrow transplant • Interventional radiology • Dental and maxillofacial	We have written to leading children's hospitals around the world to seek their interest in a collaborative study in regards to sharing clinical outcome measures and considering services that we provide to see if they are comparable. To support this work, we are also meeting with the leads for our specialities to determine how data; definitions and outcome results are currently shared with others and what resource is needed to facilitate this work. We hope this work will give us more understanding of what work needs to be done to facilitate benchmarking and clear idea of how we can start to compare ourselves to other leading children's hospitals. There is also a national development of specialist quality dashboards that encourages all hospitals that provide specialist services to report against defined measures. This also gives us an opportunity to compare our performance against others. This year the following dashboards will be reviewed and considered for implementation: • Cystic fibrosis • Haemophilia • Immunology

Review of quality performance in 2011/12
Clinical effectiveness priority continued

Case study

Gastroenterology Inflammatory Bowel Disease (IBD) ImproveCareNow
Our hospital is committed to providing the best possible care to all of our patients. To accomplish this mission, the Gastroenterology Inflammatory Bowel Disease team at Great Ormond Street Hospital (GOSH) has joined up with several other hospitals in the USA in the ImproveCareNow collaborative for Crohn's disease and ulcerative colitis (ImproveCareNow for short).

The primary goal of ImproveCareNow is to help children and adolescents with Crohn's disease and ulcerative colitis to overcome their conditions and to lead happy, healthy lives. It is a quality improvement project that focuses on measuring and improving the care we provide for our patients with Ulcerative colitis, Indeterminate colitis and Crohn's disease. There are many benefits of participating in this collaborative for patients treated at GOSH. For instance the collaborative ensures that data is collected at each visit for a number of measures which helps to document nutrition, growth, disease severity and actions for patients. Advanced tools and management reports have been developed to make sense of these results over time to enable the team to monitor health and disease status, medications, medication doses, serious side effects, regular visits and to identify and provide extra care for patients needing more help. It also helps to identify where our performance meets the collaborative target. Our team benefits from working with other teams that also regularly see and treat patients with the same condition to build a more reliable, effective and safe way to provide care. This allows the network to sent targets for measures to ensure that we learn and improve the care that patients receive.

For example, in our GOSH centre report in February 2012:
- Ninety-one per cent of the patients with IBD enrolled have satisfactory growth status which is above the network target of 90 per cent
- Fifty-four per cent of the patients with IBD have had a sustained remission rate which is above the network target of 45 per cent
- Eighty-nine per cent of patients with IBD have satisfactory nutritional status which is just below the network target of 90 per cent
- Sixty-seven per cent of patients with IBD have had a steroid free remission rate which is below the network target of 76 per cent, when we first started in the collaborative this rate was 50 per cent
- Since working in this collaborative, we have increased the number of patients who no longer need prednisolone from 75 per cent to 86 per cent.

We also have access to the results of other centres to see how we compare and where we need to improve.

Case study

Ophthalmology Quality Standards
The Royal College of Ophthalmologists has developed Quality Standards to help inform how well a clinical service is working across the quality domains of safety; effectiveness and experience. The Royal College of Ophthalmologists has developed Quality Standards with the aim of helping to improve the structure, processes and health outcomes of ophthalmic care and services for children and young people. The Royal College also developed quality indicators and metrics to asses the degree to which the quality standards are being achieved, to identify areas for quality improvement and to measure the impact of quality improvement initiatives. This included the Royal College of Ophthalmologists' Quality Indicators Tool for Paediatric Ophthalmology which focuses on key aspects of service provision and can be used as a quality improvement tool, an audit tool and to support professional appraisal and revalidation processes. It is a simple self-assessment questionnaire which asks 23 questions across the dimensions of patient experience and clinical effectiveness and safety which represented best practice standards. The questions could be answered with either a yes, no or don't know and additional comments could also be provided if required. At the end of the self assessment, a question was asked to the extent that there was evidence to support each question and the types of information that could provide evidence.

The Great Ormond Street Hospital Ophthalmology Department is an early implementer of these quality standards. In December 2011, an electronic form with the self assessment questions was sent out to the 26 clinicians in the department. A total of 17 responses were received representing junior doctors; vision scientists; optometrist and consultants.

The responses were collated and each question was colour coded depending on whether the standard was met:
- Green represented questions which were mostly answered with a yes and the standard being met.
- Amber represented questions where there was a balance between yes and no and don't know.
- Magenta represented questions where there was a greater proportion of responses either no or don't know.

The results were as follows:

Review of quality performance in 2011/12
Clinical effectiveness priority continued

The magenta responses were for the following questions:
- Child and/or family ('patient') experience is measured, using validated tools where possible (eg assessment of satisfaction with services, quality of communications, family-centredness of services).
- All visually impaired children and young people are referred to their local consultant paediatrician (community or neurodisability) for multidisciplinary assessment by a child development and/or a visual impairment team.
- Clinical audits assessing health care outcomes are undertaken regularly to inform clinical practices and staff and service development.
- There is an agreed process for transition of care to adolescent or adult services.

The results of the self-assessment were discussed in a department wide meeting and proposed actions for improvement were debated. Importantly it was recognised that work needed to take place on evidencing each of the questions. The results and action plan will also be shared with the Royal College of Ophthalmologists in May 2012.

Alongside this work a telephone survey is underway with families that have attended clinics in 2011. This asks questions that can be related back to some of the quality of standards and will help the department to assess whether families have the same views as the clinicians on the standards of the service. The results will be collated by the end of May and be used in conjunction with the results of the self assessment to inform actions.

The self-assessment questionnaire will be repeated next year to assess if there has been improvement and compare against other providers to see how we perform.

Review of quality performance in 2011/12
Experience priority

Experience priority

Consistently deliver an excellent experience that exceeds our patients', families' and referrers' expectations

This section reviews the improvement initiatives we detailed last year to support our achievement of our experience priority and our progress over this year.

1. Maintaining high satisfaction of parents and patients through results of the survey

What did we say we would do?	Performance 2009/10	2010/11	2011/12	How did we do and what are we going to do next?
Maintain at least 90 per cent overall satisfaction in our annual inpatient parent and patient survey	94 per cent	96 per cent	96 per cent	We maintained a very high rate of satisfaction and continue to monitor satisfaction rates
Maintain the high level of positive results for the following:				We maintained or improved in all of the questions, we aim to continue with best practice and monitor satisfaction rates
• Involving you in decisions about your child's care	93 per cent	94 per cent	94 per cent	
• Asking you questions about how you and your child were feeling	88 per cent	88 per cent	91 per cent	
• My child had enough privacy when the doctors/nurses talked about his/her treatment	93 per cent	92 per cent	94 per cent	
• I had enough information about any medicine	88 per cent	91 per cent	89 per cent	
• I knew who to contact if I had a question when I got home	89 per cent	91 per cent	92 per cent	
Improve responses to "I knew how to complain or offer feedback" in our annual inpatient parent and patient survey	Not asked	74 per cent*	74 per cent	Maintained the rate but we would like to improve focusing on improving awareness of how to complain or offer feedback
Improve satisfaction with the quality and variety of hospital food in our annual inpatient parent and patient survey	57 per cent	60 per cent	54 per cent	Disappointingly whilst we have tried to improve the quality and variety of food this year this is not reflected in the survey results. We have established a Food at Great Ormond Street Hospital group which has parent representatives on it and are implementing an action plan to improve the quality of food in the next year

*Last year we reported our performance in this area as 75 per cent when it was actually 74 per cent

Case study

Nutrition
In January 2011, Great Ormond Street Hospital (GOSH) undertook a self assessment across the organisation on standards set by the Care Quality Commission. This demonstrated that we needed to make improvement in our outcomes which related to our patient's nutrition. For example, the results of the self assessment identified that we needed to implement a formal nutrition policy that set out the requirements and processes for staff to support the nutrition needs of patients treated at GOSH. It also identified that staff would benefit from a nutrition screening tool to support with the appropriate actions required. Importantly staff should be documenting growth measurement of children in their medical records at each appointment or admission to hospital. We also recognised that at this time there is no protected meal time for children and young people.

In particular we aimed to implement a formal nutrition policy and implement and evaluate a nutrition screening flowchart that could help staff with monitoring children's nutrition and putting in actions where necessary. We also aimed to ensure staff documented growth measurement of height and weight.

To improve the outcomes for patients in relation to nutrition we employed a specialist nurse for general nutrition with the objective of improving the issues that were identified.

A nutrition policy was developed and implemented which sets out the standards for assessing and managing patient's nutritional needs. A nutrition screening flowchart for use by ward staff was developed and introduced. This is completed for all patients who need to stay in hospital for more than three days. This helps to identify the nutritional needs of the patient and ensures staff put in place support where required.

Nutrition ambassadors have been established on the wards who are promoting improvement in nutrition screening and support of patients at meal times.

A meal time feedback card was trialled on a few wards to get feedback from patients about the support, equipment and quality and experience of the food service.

Weekly nutrition rounds have been commenced on the Cardiac Critical Care Unit and Neonatal Intensive Care Unit. These enable staff to focus on the nutritional needs of their patients and ensure actions are implemented where required.

To ensure that staff are documenting growth measurement, routine audits of weight and height documentation in patient's notes also took place.

We have improved against the outcome standards set by the Care Quality Commission which related to our patient's nutrition.

There is 100 per cent compliance with weighting children and documenting this. Compliance with height measurement has improved from 55 per cent in March 2011, to 79 per cent in March 2012.

There are still low levels of satisfaction with the quality and variety of food. A shared food vision project is being established with the Evelina Children's Hospital and the ward food improvement group has a project plan in place to improve the experience and satisfaction with food. A new menu will be created which responds to patient feedback and automation of ward meal ordering to allow patients to order on need rather than meal time.

2. Establishing frequent feedback systems

What did we say we would do?	What did we do?	What are we going to do next?
Capture and record regular local feedback through trailing electronic systems	We have trialled a pilot using volunteers and hand held devices to capture parent survey results while patients are on the wards. We have trialled using volunteers to capture patient survey results while parents are in outpatient clinics. We have also trialled using volunteers to capture telephone surveys with parents.	Consider the evaluation of these initial pilots and consider the options for roll out across the organisation including the potential of using the bedside entertainment system that is available on some of our wards

Patient experience survey's using hand-held devices with support from volunteers
We have been keen to trial using electronic hand-held devices to capture responses from patients and parents. This would enable us to capture the responses of local survey's that take place on a ward in a more sustainable way. It would also ensure that the responses from local survey's could be a recorded in a central place and themes across areas could be identified. To test this, we purchased a couple of hand held devices and used local software development to enable the device to host a survey. We recruited two young volunteers and identified four wards across the hospital to trial capturing responses in December 2011. Feedback from parents, patients, staff and volunteers was positive regarding the concept of using hand held devices and volunteers to capture 'real-time' responses. In total 28 out of the 32 families approached were happy to take part in the survey. The hand-held devices and the software to host the survey seemed fit for purpose. The responses to the questions asked were very positive, however feedback suggested that the questions needed to be more specific for parents to answer and for wards to be able to act on improvement. It was also recognised that some work needed to take place on how the wards should use and display the information from surveys and implement any actions that are needed.

Patient experience survey's in outpatients with support from volunteers
Through anecdotal feedback, we understand that the experience of patients and families using Great Ormond Street Hospital (GOSH) main reception and the Outpatients receptions based in the Royal London Hospital for Integrated Medicine could be improved.

A group of enthusiastic volunteers were therefore recruited to carry out a patient and family satisfaction survey.

One volunteer, Mimi, said: "The GOSH team were absolutely amazing. They helped me build my confidence in communication skills. Parents and patients were lovely to speak to. There were very open in sharing their experience. I felt a real sense of achievement and fulfilment. I certainly recommend anyone to volunteer at GOSH."

The volunteers did a fantastic job, gathering over 1,000 completed surveys. We are now in the process of analysing the responses and will feedback the results in a future edition of *Member Matters.*

3. Improving communication with patients, parents and referrers

What did we say we would do?	Performance			How did we do and what are we going to do next?
	2009/10	2010/11	2011/12	
Reduce number of complaints regarding our communication with parents	Not applicable	51	65	Complaints regarding communication with parents still continue to be a problem and cover a range of issues and departments. A central piece of work is being developed to look at the pathway of the complex patient and the communication involved
Improve the timeliness and quality of our discharge summaries by sending 80 per cent of discharge summaries within 24 hours from discharge*	51 per cent	82 per cent	79 per cent	Our performance has fluctuated over the last year and we are just under our target of sending discharge summaries out within 24 hours. Performance reports at a local level are now available so that action can take place where required. We reviewed the completeness and quality of discharge summaries and developed templates. In 2012/13 we will pilot a system of completing discharge summaries by voice recognition software to see if it speeds up the process

*We were subject to an independent audit of our discharge summaries performance which identified that we do not always have the paper records to support our performance. We will be working to improve this in 2012/13

Great Ormond Street Hospital continues to move toward increased Consultant delivered services both within and outside of routine working hours. In February 2011 we appointed a team of general paediatricians who provide extended general paediatric cover for the hospital. The team provides paediatric support for the surgical patients and some medical patients during the daytime and has developed the Hospital at Night team by supporting handovers and working with clinical units to improve safe, efficient out of hours care. This new consultant team provides a variety of general hospital wide services in addition to each team member developing a special interest and area of responsibility.

In summary the new consultant-delivered service provides a variety of general hospital-wide services and:

- supports the paediatric care of patients admitted under the surgical specialties
- supports the pre-admission and discharge planning of children on the surgical wards, in particular those who are accessing multiple specialist services
- provides medical leadership for the Hospital at Night team
- conducts general paediatric outpatient clinics for the cleft service
- works with the Clinical Site Practitioners and Intensive care out reach in managing acutely unwell children on the surgical wards
- supports the paediatric training across the hospital
- supports the safeguarding service for the Trust.

4. Ensuring equal access for all patients

What did we say we would do?	How did we do?	What are we going to do next?
Identify patients with a learning disability and ensure that reasonable adjustments are made to enable them to access our services	We have reviewed our current service provision for people with learning disability and employed a learning disability co-ordinator to review what support, training or resource departments need to provide suitable care for patients with learning disabilities. Core set of information has also be produced in the right Easy read format. The family form that is used with families when a patient first attends Great Ormond Street Hospital (GOSH) is being updated to include information that reflects the content of national learning disabilities passports. To support the completion of this information a sentence will be added to our standard admission and appointment letters requesting information on specific needs in advance of attendance to GOSH	The learning disabilities group will review the recommendations from the learning disability co-ordinator and consider how to implement action and improvement in this area for 2012/13. The hospital also aims to raise awareness of learning disabilities during National Learning Disability Week 18–24 June

We know that how well and how quickly children recover depends not only on their clinical treatment, but also on whether they and their families feel comfortable, safe, understood, respected and listened to during their time with us. This is why we believe that promoting equality and diversity at Great Ormond Street Hospital (GOSH) is not only right, but also makes clinical and business sense.

Results from our most recent independent inpatient survey

Our recent annual independent inpatient survey asked an addition question on the specific needs of patients with a disability. This results show that 44 per cent of the parents surveyed said that their child had special needs or disabilities. Eighty-five per cent of these agreed that the hospital understands their needs and puts arrangements in place to meet them. The findings suggest that satisfaction levels are high across all areas questioned, and in particular, parents of patients with disabilities are more likely to be able to stay overnight with their child if they wanted to (84 per cent versus 74 per cent of parents and patients without disabilities). However it is identified that overall the positive experiences of patients and parents of patients with a disability or special needs are generally lower compared to those without a disability.

Equality Act 2010

To meet the requirements of the Equality Act 2010, we have published information about our patient population and how we are meeting their needs. This report is available on the GOSH website. One of our key improvement objectives for the next year is to improve the data we collect about our patients and families to ensure reasonable adjustments are made when necessary and increase their satisfaction with our services.

Review of quality performance in 2011/12
Experience priority
continued

Autism and Jewish Focus groups

At GOSH, we're committed to providing a world-class service for all our patients and families. To do this, we must consider faith and cultural requirements, as well as special needs such as autism and learning disabilities, when we plan and deliver services.

To gain a deeper insight into the issues faced by some of these groups, we conducted a number of parent focus groups, one focusing specifically on Jewish families and another with children with an autistic spectrum disorder.

Topics covered include communication and information, the time and attention received, how involved patients and families were in decisions about care and treatment, how well personal and spiritual needs were met, food and general comments on staying with us. The groups were interactive and a number of suggestions and recommendations were developed for how GOSH can improve its services for these groups of patients.

The responses and themes will be presented to the Patient and Public Involvement and Engagement Committee and an action plan will be developed and agreed to ensure improvement takes place.

Emma, whose seven-year-old daughter has been attending the GOSH Outpatients Department since birth, took part in a focus group for Jewish families. "I felt like the feedback we gave was listened to with interest and genuine sensitivity and the suggestions made, for improving how needs can be met will be acted upon over the next few months."

5. Maintaining timely access to services

What did we say we would do?	Performance			How did we do and what are we going to do next?
	2009/10	2010/11	2011/12	
Ensure that our waiting times are within the national standards	Achieved	Achieved	Achieved	We achieved our waiting time targets across all the areas that are monitored by the government. We will continue to aim to meet these waiting times

Our performance in each of our waiting times is demonstrated overleaf in the Monitor key performance indicators.

Performance against key national priorities

The following table details our performance against the Department of Health's operating famework.

Monitor governance risk rating

Targets – weighted 1.0 (national requirements)	Thresholds	Weighting	Monitoring period	Performance score			
				Q1	Q2	Q3	Q4
Methicillin-resistant staphylococcus (MRSA) – meeting the MRSA objective*	0	1	Quarterly	0	0	0	0
Clostridium difficile year on year reduction (to fit with trajectory for the year as agreed with the primary care trust)	0	1	Quarterly	1	1	1	0
All cancers: 31-day wait for second or subsequent treatment comprising either:	TBC	1	Quarterly	0	0	0	0
• surgery	94 per cent			0	0	0	0
• anti cancer drug treatments	98 per cent			0	0	0	0
• radiotherapy (from 1 Jan 2011)	94 per cent			0	0	0	0
Admitted 95th centile performance	<23 weeks	1	Quarterly	0	0	0	0
Non-admitted 95th centile performance	<18.3 weeks	1	Quarterly	0	0	0	0
Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96 per cent	0.5	Quarterly	0	0	0	0
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Not applicable	0.5	Quarterly	0.5	0.5	0.5	0
Total				1.5	1.5	1.5	0
Overall governance risk rating				Amber to green	Amber to green	Amber to green	Green

*Where an NHS foundation trust has an annual MRSA objective of six cases or fewer (the de minimis limit) and has reported six cases or fewer in the year to date, the MRSA objective will not apply for the purposes of Monitor's compliance framework.

Review of quality performance in 2011/12
Experience priority
continued

Monitor governance rating	
Green	from 0 to 0.9
Amber to green	from 1.0 to 1.9
Amber to red	from 2.0 to 3.9
Red	4.0 or more

Risk rating category	Description (risk of significant breach of authorisation)
Green	No material concerns
Amber to green	Emerging concerns
Amber to red	Potential future significant breach if not rectified
Red	Likely or actual significant breach

Mandatory statements

Any statements provided from our commissioning PCT, LInks or OSCs

The regulations require us to send copies of the Quality Account to our relevant Local Involvement Network (LINk), Overview and Scrutiny Committee (OSC) and lead commissioning primary care trust (PCT) for comment prior to publication, and we should include these comments in the published Quality Account. The following are the statements received from the Camden LINk and NHS North Central London. Camden Council Overview and Scrutiny Committee chose not to comment on our Quality Account this year.

Statement from Camden LINk

Prior to writing this response in regard to these Quality Accounts, we discussed the Trust with Great Ormond Street Hospital's (GOSH) CQC compliance manager. Our comments focus on the parent/patient experience since we are not competent to comment on health treatments.

The fact that the Trust have continued to reduce and maintain the level of infections for patients across the hospital in the last year is reassuring and we assume that the levels are acceptable to the CQC.

It is disappointing that we have not made a reduction in the number of medication errors that are reported in our paediatric intensive care unit (which treats severely ill patients) and it would have been useful to see what are the main reasons for medication errors. The Trust must have looked into this since they made a 30 per cent reduction in the number of medication errors reported in our cardiac intensive care unit (which treats severely ill patients with heart conditions).

We would have liked to have been informed of the protocol for the new child protection supervision.

Having two parent representatives on the priority and improvement work group ensures that initiatives have patient focused outcomes and the views of patients or their parents on the success of treatment and impact on quality of life are used when developing and using measures. This is something we may choose to take up with adult secondary care trusts.

The number of complaints has not reduced in the last year and these seems to be problems regarding communications with both parents and referring doctors. Unfortunately this problem seems to be endemic throughout the NHS.

Our quality priorities and improvement aims for 2012/13 – we would like to suggest that the QA next year includes something regarding the pathway when patients become too old for GOSH and are referred on to adult trusts and how much the patient/parents are involved in the referral especially in regard to choice of hospital.

As part of our research into the parent/patient experience we placed requests on national social networking sites for feedback regarding parents satisfaction with GOSH. Below are some of the comments:

"Can you get to Great Ormond Street Hospital? If so, ask for a referral to Dr xxxxxx xxxxxx. He is the guru on this type of thing and is fab."

"When you get your appointment at Great Ormond Street Hospital, book to see the social workers there, after your appointment. They're really good at getting things going in your own area."

"I haven't had any personal experience with Great Ormond Street Hospital, but I have been there multiple times with work (I'm a paramedic) and I can not speak highly enough of what I've seen. Every member of staff has been attentive to the child we were with, knowledgeable and enthusiastic. Patients I have spoken to have always felt well looked after and what always stands out is how supported the parents feel. A very close friend of mine lost her little brother a few years back and he was treated there, they seemed to take excellent care of him and the family whilst he was there."

"Only had good experience, what is worrying you?"

"Only good."

"Have no experience of inpatients, but my seven year old is an outpatient and goes to a day assessment unit a few times a year. We have been treated superbly there by everyone, and especially the day unit nurses who are just lovely. Have you got specific concerns?"

"Fantastic care, very overwhelming as it such a big place but amazing. Everyone talked through the whole thing with us and the anaesthetist was a specialist from New Zealand who couldn't have been kinder. There are kitchens there were you can make food, tea and just chat to other parents."

"Great Ormond Street Hospital has a teenage room which is great."

While there were no adverse comments received in connection with GOSH, there was considerable dissatisfaction on the websites about parents' visits to GPs regarding their child's health. So it was not just a matter of parents tending to only make favourable comments.

Mandatory statements
continued

Statement from our commissioners
NHS North Central London are responsible for the commissioning of health services from eight acute/specialist trusts, two mental health trusts and a range of community and primary health services located in Barnet, Camden, Enfield, Haringey and Islington.

NHS North Central London has reviewed this document and is pleased to assure this Quality Account for Great Ormond Street Hospital (GOSH).

In this review, we have taken particular account of the identified priorities for improvement for GOSH during 2012/13, and how this work will enable real focus on improving the quality and safety of health services for children and their families. We continue to support the overarching focus on zero harm, improving outcomes and excellent experiences for patients and families. I am particularly pleased to see that GOSH are striving for excellence in terms of improving the experience of adolescent patients. We are also pleased to see that there is a focus on improving outcomes for the deteriorating ward patient. During the next twelve months we look forward to discussing all the identified priorities at the monthly clinical quality review meetings; attended by GOSH and its Commissioners.

We have made comments about the Trust's Quality Account and have discussed these directly with the Trust. These comments focus on:
- changes to make the account easier to read and understand
- clarification on some of the measurements for improvement to make the data more meaningful.

We look forward to continuing our partnership with the Trust to improve both the quality and safety of health services provided to children and their families.

Statement of directors' responsibilities in respect of the Quality Account
To be updated when ready for Board approval

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:
- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011/12
- the content of the Quality Account is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2011 to June 2012
  - papers relating to Quality reported to the Board over the period April 2011 to June 2012
  - feedback from the commissioners dated 11 May 2012
  - feedback from governors dated 28 March 2012
  - feedback from LINks dated 11 May 2012
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 13 April 2012
  - the [latest] national patient survey 25 April 2012
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Account is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribeddefinitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Account's regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (avaliable at www.monitor-nhsft.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief they have compiled with the above requirements in preparing the Quality Account.

By order of the Board

NB: sign and date in any colour ink except black

Chairman
Date

Chief Executive
Date

Glossary

Balanced scorecard
A performance-management tool

Care bundles
A small set of clinical practices which, when performed collectively, reliably and continuously, have been shown to improve patient outcomes

CEWS
Children's Early Warning Score

CICU
Cardiac Intensive Care Unit

Commissioners
The organisations which purchase services from Great Ormond Street Hospital

CQC
Care Quality Commission – the organisation that regulates and inspects health and social care services in England

CEMACH
The Confidential Enquiry into Maternal and Child Health

CQUIN
Commissioning for Quality and Innovation

CSP
Clinical Site Practitioner – an experienced intensive-care nurse who has expertise in assessing and caring for seriously ill children and works across the hospital

Clinical Unit Chair
Lead clinician for a unit

CVC
Central venous catheter

DH
Department of Health

General Manager
Lead manager for a unit

GOSH
Great Ormond Street Hospital

HES
Hospital Episode Statistics

HPA
Health Protection Agency

HSMR
Hospital Standardised Mortality Ratio – a measure of quality that indicates whether the death rate at a hospital is higher or lower than one would expect based on a number of factors relating to patients and their conditions

HRG
Healthcare Resource Group – activity relating to hospitals is illustrated by codes that are based on these groups

MDT
Multidisciplinary team – a group of different types of clinicians who work together

MRI
Magnetic resonance imaging

MRSA
Methicillin-resistant Staphylococcus aureus

NCEPOD
National Confidential Enquiry into Patient Outcome and Death

NHS
National Health Service

NHS Institute for Innovation and Improvement
The NHS' own improvement agency, which facilitates change management to improve care for patients

NICU
Neonatal Intensive Care Unit

NIHR
National Institute for Health Research

NPSA
National Patient Safety Agency

Paediatric Trigger Tool
A tool that measures harm caused by healthcare. By using the tool, it is possible to calculate the adverse event rate and identify the areas of care in which most incidents of harm are occurring

PICANet
Paediatric Intensive Care Audit Network (PICANet) – a national audit co-ordinated by the universities of Leeds and Leicester, which collects data on all children admitted to paediatric intensive care units across the UK

PICU
Paediatric Intensive Care Unit

PROM
Patient-reported outcome measure – measures of a patient's health status or health-related quality of life

Safeguarding
Keeping children safe from harm, such as illness, abuse or injury (Commissioner for Social Care Inspection et al, 2005:5)

SBARD
Situation, background, assessment, recommendation and decision

SHA
Strategic Health Authority – regional organisations responsible for ensuring that all NHS trusts adhere to Department of Health rules and regulations

SMR
Standardised Mortality Ratio – similar to the HSMR figure in that it shows the level of observed deaths compared with expected deaths. Different methods of working on SMR attach differing weights to various factors

SSI
Surgical site infection – an infection in a wound that is identified after surgery

Glossary
continued

SUS
Secondary Uses Service – a central dataset about all NHS provision in England

Transformation
A service redesign programme that aims to improve the quality of care we provide to children and enhance the working experience of staff

TPN
Total parenteral nutrition

UCL
University College London

Unit
How we group and manage our clinical services

Great Ormond Street Hospital for Children NHS Trust
Great Ormond Street
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020 7405 9200
www.gosh.nhs.uk

Design Manager
Great Ormond Street Hospital
Fourth floor
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London WC1N 1LE
E design.work@gosh.org

Bengali
অনুরোধ করলে নিম্নলিখিত ঠিকানায় থেকে এই লেখার অনুবাদ, বড় অক্ষর, ব্রেল বা অডিও বিবরন পাওয়া যাবে।

English
Translations, large print, Braille or audio versions of this report are available upon request from the address above.

French
Traductions disponibles sur demande à l'adresse ci-dessus. Des versions en gros caractères, en braille ou audio sont également disponibles sur demande.

Polish
Tłumaczenia są do uzyskania na żądanie pod podanym powyżej adresem. Dokumenty w formacie dużym drukiem, brajlem lub audio są także do uzyskania na żądanie.

Punjabi
ਇਸ ਰਿਪੋਰਟ ਦੇ ਤਰਜਮੇ, ਅਤੇ ਇਹ ਰਿਪੋਰਟ ਵੱਡੇ ਅੱਖਰਾਂ ਜਾਂ ਬ੍ਰੇਲ ਵਿਚ, ਜਾਂ ਸੁਣਨ ਵਾਲੇ ਰੂਪ ਵਿਚ ਹੇਠ ਲਿਖੇ ਪਤੇ ਤੋਂ ਮੰਗ ਕੇ ਲਏ ਜਾ ਸਕਦੇ ਹਨ।

Somali
Turjubaan ayaa cinwaanka kor ku qoran laga heli karaa markii la soo codsado. Daabacad far waa-wayn, farta indhoolaha Braille ama hab la dhegaysto ayaa xittaa la heli karaa markii la soo codsado.

Tamil
பெரிய அச்சில், இந்த அறிக்கையின் மொழிபெயர்ப்புகள்,பெரய்லி அல்லது ஒலி பதிப்புகள் விண்ணப்பித்தால் கீழ்கண்ட விலாசத்தில் கிடைக்கும்

Turkish
Talep edilirse yukarıdaki adresten çevirileri tedarik edilebilir. Talep edilirse, iri harflerle, Braille (görme engelliler için) veya sesli şekilde de tedarik edilebilir.

Urdu
گزارش کرنے پر یہ رپورٹ ترجمے، بڑے حروف کی چھپائی، بریل یا آڈیوپردرج ذیل پتے سے حاصل کی جا سکتی ہے۔

Designed and produced by Great Ormond Street Hospital Marketing and Communications.

Photography by Adam Laycock.

Thank you to everyone who was interviewed for, or gave permission for their picture to be used in, this report, as well as the many members of Great Ormond Street Hospital staff who helped during its production.

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

Attachment H

Great Ormond Street Hospital for Children
NHS Foundation Trust

<table>
<tr><td colspan="2">Trust Board
30th May 2012</td></tr>
<tr><td rowspan="2">Audit Committee Annual Report to the Trust Board for the financial year 2011/12

Submitted on behalf of:
Mr Charles Tilley, Chairman of Audit Committee</td><td>Paper No: Attachment H</td></tr>
<tr><td>Considered at the Audit Committee on 30th May 2012</td></tr>
</table>

Aims
To provide Trust Board Members with the Audit Committee's annual report 2011/12, following consideration by the Audit Committee at its meeting on 30th May.

Summary
This report addresses how the Audit Committee met its terms of reference during 2011/12, ensured its agenda was appropriately divided to cover its principal responsibilities and advise the Board how it has reviewed its effectiveness and impact.

The scope of this report is based on the guidance provided in the NHS Audit Committee Handbook***, Appendix B***.

In addition to addressing the Committee's duties in respect of financial controls, audit and reporting, the Audit Committee has sought assurance on behalf of the Board that the Trust is effectively triangulating risks on risk registers, within high level risk reports and on the Assurance Framework and self assessment submissions. Members of the Audit Committee attended an extra meeting with other Board members to proactively review the Trust's risk management processes.

During 2011/12 the Committee continued its focus particularly on risks relating to the Trust's FT application which include; clarity of strategy, financial resilience including the CRES programme and ensuring evidence supports the conclusions made on the CQC registration.

The Committee has also:

- Increased focus on how the risks relating to non-delivery of CRES were managed
- reviewed action plans being carried out by the Trust to address actions following incidents within Estates (arson and boiler explosion).
- reviewed specific project risks relating to a IT
- reviewed the Trust's plans to improve and strengthen Data Quality processes
- monitored on behalf of the Board, the Trust's Information Governance processes
- reviewed and approved the revised draft SFIs for when the Trust became a Foundation Trust
- reviewed the impact of the change in accounting policy for donations funding capital projects

Appended to this paper are:
APPENDIX A Criteria used to assess impact
APPENDIX B NHS Audit Committee Checklist

Conclusions:
The Audit Committee has concluded that it met its terms of reference during the year and that it has met the criteria for effectiveness established in the NHS Audit committee

checklist. The results of the assessment of impact through surveying Committee attendees and Board members will be reported at the meeting.

Action required from the meeting
To receive the report.

Contribution to the delivery of NHS / Trust strategies and plans
The Audit Committee is committed to achieving and demonstrating best practice with relevant guidance. This report demonstrates that the Committee has complied with its Terms of Reference and adequately demonstrated its accountability to the Trust Board.

Financial implications
No direct financial implications.

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

Who needs to be told about any decision
N/A

Who is responsible for implementing the proposals / project and anticipated timescales?
All members of the Committee supported by the CEO and CFO

Who is accountable for the implementation of the proposal / project
Audit Committee Chairman

Author and date
Claire Newton 21.05.12

1. Introduction

The Audit Committee is a mandatory sub group of the Trust Board and is made up of a minimum of three Non-Executive Directors and an independent advisor. During 2011/12 designate directors also attended meetings prior to becoming full members of the Audit Committee.

It oversees the integrated governance processes of the Trust – except where they relate to clinical governance - which include risk management, the assurance framework, internal controls, and protection of the Trust's assets. It also has a responsibility to ensure the integrity of the Trust's annual accounts and manages the relationships with the external and internal auditors.

The duties of the Audit Committee are set out in the Terms of Reference which were reviewed by the Audit Committee and Trust Board during the year.

Section 3 of this paper refers to matters which are specifically relevant to the approval of the Accounts and Annual Governance Statement.

2. Membership during the financial year

The members of the Audit Committee during 2011/12 were:

Non-executive directors of the Trust:	Period
Charles Tilley *	Member all year; **Committee Chair**
Yvonne Brown	Member all year; member of Clinical Governance Committee after Andrew Fane retired
*Andrew Fane **	*Member part year to retirement October 2011; Clinical Governance Committee Chair*
*David Lomas **	*Member from 1st November 2011 (in attendance from October 2011*;
*John Ripley **	*Member from April 2012 (in attendance from January 2012)*
Independent:	
Michael Dallas *	Member all year

- * =Qualified accountants and with significant experience of financial management and leadership at an executive level

In attendance were the Chief Executive; Chief Operating Officer, Deputy COO, Chief Finance Officer; Company Secretary; Head of Patient and Staff Safety; Deputy Director of Finance, External Auditors (Deloitte), and the Internal Auditors (London Audit Consortium). Other Trust managers, eg the Director of Estates, Head of Facilities, the Director of IT and Head of Security attended for specific agenda items as requested.

The terms of reference require a membership of at least three non-executive directors and a required quorum of two non-executive directors. This was achieved at every meeting.

3. Key matters relating to the annual accounts

The NHS Audit Committee Handbook 2005 suggests that this report should include the following affirmations:

a) the Annual Governance Statement (***See Annual Report***) is consistent with the view of the Committee on the organisation's system of internal control and the

Assurance Framework and the Committee supports the Board's approval of the Statement

Comment: The Committee reviewed the draft Annual Governance Statement at its meeting on April 2012 and has ensured it is consistent with the Assurance Framework for 2011/12 and CQC requirements

b) the systems of risk management in the organisation is adequate in identifying risks and allowing the Board to understand the appropriate management of those risks and that the 'comprehensiveness' of the assurances and the reliability and integrity of the sources of assurance are sufficient to support the Board's decisions and declarations

Comment: Training of board members in the Trust's risk management processes was provided through discussion of the Risk Management Strategy in 2011/12. Risks within the Assurance Framework have been progressively reviewed during the year and other high level risks detailed on individual risk registers were also reported

c) the Committee has reviewed and used the Assurance Framework and believes it is fit for purpose

Comment: A review of the Assurance Framework took place at each meeting with detailed presentations on specific risks to ensure that all risks were covered during the year. Minutes of each meeting of the Risk Assurance and Compliance group were provided to each meeting. The Committee received satisfactory assurance from the internal audit review of the Framework.

d) there are no areas of significant duplication or omission in the systems of governance in the organisation that have come to the Committee's attention and not been adequately resolved.

Comment: no items noted

Additional components if relevant:

e) the report should highlight to the Board the main areas that the Committee has reviewed and any particular concerns or issues that it has addressed.

Comments: The Audit Committee Decision Log for 2011/12 highlights the main areas considered, decisions made and matters identified for further monitoring

4. Activities During 2011/12 and proposed matters to be raised with the Board

The Committee met four times in the financial year (as required by the Terms of Reference) with the core agenda items based on an annual programme. In addition the Audit Committee met in private session with the External and Internal Auditors and then on a separate occasion to review the effectiveness of Internal and External audit.

The members of the Audit Committee also all attended a special committee of the Board to review the Trust's risk management processes

A schedule of the core business, additional reports, including value for money studies, and matters arising from reports which the Committee wished to keep under review at

each meeting is set out in the Decision Log. The Log covers 5 meetings in order to demonstrate how the core agenda items cover one entire cycle of the financial year.

The Audit Committee has monitored issues of concern arising from audit reports throughout the year. Specific matters which gave rise to concern but have been addressed by management include actions in relation to failure to ensure maintenance of equipment had been kept up to date; the level of staff overpayments and IT risks

The Audit Committee monitored progress on the Assurance Framework and also requested specific presentations of "Top" risks on individual unit risk registers to ensure that appropriate action was being taken and there was consistency with the Assurance Framework.
Further key work included:

- monitoring assurance on ***Information Governance (including Data Quality) as delegated by the Trust Board***,
- considered the Managements response to the challenge to ensure the Trusts ***counter fraud procedures*** and ***security management*** are sufficient and targeted at meeting best practice standards.

5 Other matters pertinent to compliance with the Terms of Reference

Clinical Governance Committee Liaison. It is recognised that Corporate Governance and Clinical Governance should be closely linked. The terms of reference required that the duties of the audit committee have synergy and convergence with the Clinical Governance Committee. This is achieved through:

- an unambiguous division of all Assurance Framework risks between the respective committees and standardisation of approaches of each Committee to monitoring the assurance available to the Trust Board on such risks.
- ensuring that the internal audit and clinical audit plans are aligned; and
- a member of the CGC is also a member of the Audit Committee. (There are also management attendees common to both these two groups and the Assurance Framework Group.)

6 Review of effectiveness and impact

The committee has reviewed the criteria for effectiveness included in the Audit Committee Handbook and is satisfied that it meets the criteria. ***The results of a survey of impact will be orally reported at the meeting.***

7 Conclusion

"The Audit Committee has discharged its duties in accordance with its terms of reference and the specific requirements of the NHS Audit Committee Handbook. It has also carried out a self assessment using the NHS checklist and concluded that it fulfils all the "must dos", "should dos" and the majority of "could dos" within this checklist."

APPENDIX A

Criteria for assessing impact of the Audit Committee

(to be assessed using a survey of members of the board and other senior managers)

The Committee will review its impact after the end of the 2011/12 financial year using the criteria set out in the table below. Assurance will be provided through a combination of minutes and decision logs of the Committee's meetings and surveying Board members and senior staff as to whether the criteria have been met.

Target		Criteria for which there should be evidence
1 **To be seen as the leader** of the Board assurance agenda (in partnership with the Clinical Governance Committee for clinical risk)		The Committee demonstrates that: 1.1 it takes ownership of the Board's risk and assurance agenda which clearly links to the Trust's strategy and takes adequate account of the Trusts risk registers and external factors 1.2 it is monitoring the risks associated with the transfer to FT status
2 **To be seen to challenge** management on the adequacy and effectiveness of the Assurance Framework and the systems which identify Assurance that risks are being managed		The Committee demonstrates that: 2.1 Owners of a risk are held to account through a process of overview and challenge, so they are aware that failure to manage a risk was likely to lead to serious remedial action 2.2 it focuses on ensuring there are continuing improvements in internal controls and risk management controls (through monitoring of audit results and recommendations and assessing the output of other management initiatives) 2.3 it actively considers risks relating to information governance and data quality
3 **To have influenced** the improvement of the evidencing and validation of assurances		The Committee demonstrates that: 3.1 the assurance provided to the Committee or the Board is balanced across the entire Assurance Framework and includes both internal and external assurance 3.2 there is effective management of the processes for obtaining internal "independent" assurance and external assurance
4 **To have provided effective feedback** to the Board		4.1 Focused and intelligible summaries of the work carried out and decisions made by the Committee are provided to the Board and these demonstrate the assurance available to the Board

APPENDIX B

Status Key
1 = must do
2 = should do
3 = could do

COMPOSITION, ESTABLISHMENT AND DUTIES	MUST	SHOULD	COULD	
COMPOSITION, ESTABLISHMENT AND DUTIES				
1 Does the Audit Committee have written terms of reference that adequately and realistically define the Committee's role in accordance with Department of Health [AND MONITOR'S] guidance?	**1**			YES Terms of reference reviewed annually
1 Have the terms of reference been adopted by the Board?	**1**			YES
1 Are the terms of reference reviewed annually to take into account governance developments (including integrated governance principles) and the remit of other committees within the organisation?	**1**			YES
1 Has the Committee been provided with sufficient membership, authority and resources to perform its role effectively and independently?	**1**			YES
2 Are changes to the Committee's current and future workload discussed and approved at Board level?		**2**		YES where applicable
1 Are Committee members independent of the management team?	**1**			YES
1 Does the Committee report regularly to the Board?	**1**			YES – minutes taken to Trust Board with oral report
HAS THE CHAIR A PRIOR UNDERSTANDING OF FINANCE AND INTERNAL CONTROL OR OTHER RELEVANT EXPERTISE	**1**			YES
1 Are members, particularly those new to the Committee, provided with induction?	**1**			YES – induction
1 Does the Board ensure that members have sufficient knowledge of the organisation to identify key risk areas and to challenge both line management and the auditors on critical and sensitive matters?	**1**			YES – through Trust Board briefings; reviews of performance reports and Trust Board Away Days
1 Does the Committee prepare an annual report on its work and performance in the preceding year for consideration by the Board?	**1**			YES – May
1 DOES THE COMMITTEE ASSESS ITS OWN EFFECTIVENESS PERIODICALLY?	**1**			YES – May
MEETINGS				
1 Does the Committee have a plan of matters to be dealt with over the coming year?	**1**			YES
1 Does the Committee meet sufficiently frequently to deal with planned matters **AND IS ENOUGH TIME ALLOWED FOR QUESTIONS AND DISCUSSION?**	**1**			<u>YES – PROPOSE THIS BE DISCUSSED AT MEETING</u>

1 DOES THE COMMITTEES CALENDAR MEET THE BOARD REQUIREMENTS AND FINANCIAL AND GOVERNANCE CALENDAR?	**1**			YES
2 Are papers circulated in good time so that they can receive sufficient consideration?		**2**		YES
2 Are Committee papers distributed in sufficient time for members to give them due consideration?		**2**		YES – PROPOSE THIS BE DISCUSSED AT MEETING
2 Are Committee meetings scheduled prior to important decisions being made?		**2**		YES
2 Is the timing of Committee meetings discussed with all the parties involved?		**2**		YES
COMPLIANCE WITH THE LAW AND REGULATIONS GOVERNING THE NHS				
1 DOES THE COMMITTEE REVIEW ASSURANCE AND REGULATORY COMPLIANCE REPORTING PROCESSES	**1**			YES
3 Does the Committee have a mechanism to keep it aware of topical, legal and regulatory issues?		**2**		YES Briefings given by Company Secretary, Assistance Director Patient Safety or Chief Finance Officer, or External audit at meetings as appropriate
2 Has the Committee formally assessed whether there is a need for the support of a "Company Secretary" role or its equivalent?		**2**		Company Secretary role already exists
INTERNAL CONTROL AND RISK MANAGEMENT				
1 Has the Committee formally considered how it integrates with other committees that are reviewing risk e.g. risk management and clinical governance?	**1**			YES
1 Has the Committee formally considered how its work integrates with wider performance management and standards compliance?	1			YES
1 HAS THE COMMITTEE REVIEWED THE ROBUSTNESS AND EFFECTIVENESS OF THE CONTENT OF THE ORGANISATIONS ASSURANCE FRAMWORK	**1**			YES
1 HAS THE COMMITTEE REVIEWED THE ROBUSTNESS AND CONTENT OF THE SIC (now annual governance statement) BEFORE IT IS PRESENTED TO THE BOARD	**1**			YES – at April and May meetings
2 Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its internal control and risk management responsibilities are discharged?		**2**		YES – Changes are requested where relevant
1 HAS THE COMMITTEE REVIEWED THE ROBUSTNESS OF DATA BEHIND REPORTS AND ASSURANCES RECEIVED BY ITSELF AND THE BOARD	**1**			The Audit Committee has received updates on the Data Quality action plan

1 Is the Committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisation's responsibilities?	**1**			YES – through review of Assurance Framework
1 IS THE COMMITTEES ROLE IN REVIEWING AND RECOMMENDING TO THE BOARD THE ANNUAL REPORT AND ACCOUNTS CLEARLY DEFINED	**1**			YES
1 DOES THE COMMITTEE CONSIDER THE EXTERNAL AUDIT REPORT TO THOSE CHARGED WITH GOVERNANCE INCLUDING PROPOSED ADJUSTMENTS TO ACCOUNTS	**1**			YES
1 DOES THE COMMITTEE REVIEW THE MANAGEMENT LETTER OF REPRESENTATION	**1**			YES
1 Is there clarity over the timing and content of the assurance statements received by the Committee from the Head of Internal Audit?	**1**			YES
INTERNAL AUDIT				
1 Is there a formal CHARTER OR terms of reference defining Internal Audit's objectives, responsibilities and reporting lines?	**1**			YES
1 Are the terms of reference approved by the Committee and routinely reviewed?	**1**			YES – to be reviewed at Jan meeting
2 Are the key principles of the terms of reference set out in the Standing Financial Instructions?		**2**		**YES**
1 Does the Committee review and approve the Internal Audit plan at the beginning of the financial year?	**1**			YES – at April meeting
1 Does the Committee approve any material changes to the plan?	**1**			YES - If applicable
2 Are audit plans derived from clear processes based on risk assessment with clear links to the Assurance Framework?		**2**		YES & Internal Audit attend RACG meetings
1 Does the Audit Committee receive periodic reports from the Head of Internal Audit?	**1**			YES – at each meeting
3 Has the Committee established a process whereby it reviews any material objection to the plans and associated assignments that cannot be resolved through negotiation?			**3**	This has never arisen but the process would be to raise them with the CFO who would consider raising with CEO and then Audit Comm if appropriate
2 Does the Committee effectively monitor the implementation of management actions arising from audit reports?		**2**		YES – reports at each meeting
1 Does the Head of Internal Audit have a direct line of reporting to the Committee and its chairman?	**1**			YES
2 Are any scope restrictions placed on Internal Audit and, if so, what are they and who establishes them?		**2**		NO
2 Is Internal Audit free from any operating responsibilities or conflicts of interest that could impair its objectivity?		**2**		YES – separate consortium
2 Has the Committee determined the appropriate level of detail it wishes to receive from Internal Audit?		**2**		YES – Summary report at each meeting
1 Does the Committee hold periodic private discussions with the Head of internal Audit?	**1**			YES – as required and at end of April meeting

2 Does the Committee review the effectiveness of Internal Audit and the adequacy of staffing and resources within Internal Audit?		**2**		YES – at end of October meeting
3 Has the Committee agreed a range of Internal Audit performance measures to be reported on a routine basis?			3	YES
2 HAS THE COMMITTEE EVALUATED WHETHER INTERNAL AUDIT COMPLIES WITH THE NHS INTERNAL AUDIT STANDARDS		2		Assurance received from internal audit
1 DOES THE COMMITTEE REVIEW THE HEAD OF INTERNAL AUDIT 'S OPINION	1			YES
2 Is there appropriate cooperation with the External Auditors?		**2**		YES – meetings to plan work
2 Are there any quality assurance procedures to confirm whether the work of the Internal Auditors is properly planned, completed, supervised and reviewed?		2	<<	Assurance received from internal audit
EXTERNAL AUDIT				
1 Do the External Auditors present their audit plans and strategy to the Committee for approval?	**1**			YES – October meeting
2 Has the Committee satisfied itself that work not relating to the financial statements work is adequate and appropriate?		**2**		YES
2 Does the Committee receive and monitor actions taken in respect of prior years' reviews?		**2**		YES – through progress report on addressing recommendations and by action plan accompanying minutes
1 Does the Committee review the External Auditor's annual audit letter?	**1**			YES - October
1 DOES THE COMMITTEE REVIEW THE EXTERNAL AUDITOR'S USE OF RESOURCES CONCLUSION	**1**			YES - My
1 Does the Committee hold periodic private discussions with the External Auditor?		**2**		YES – May
2 Does the Committee assess the performance of External Audit?		**2**		YES – to be discussed following October meeting
DOES THE COMMITTEE REQUIRE ASSURANCE FROM EXTERNAL AUDIT ABOUT POLICIES FOR ENSURING INDEPENDENCE AND COMPLIANCE WITH STAFF ROTATION REQUIREMENTS			**3**	NOT SPECIFICALLY REQUESTED
DOES THE COMMITTEE REVIEW THE NATURE AND VALUE OF NON AUDIT WORK CARRIED OUT			**3**	N/A
COUNTERFRAUD				
1 Does the committee review and approve the plan at the beginning of the financial year				YES
1 Does the committee satisfy itself that the work plan covers each of the 7 generic areas defined in NHS counter fraud policy				YES
1 Does the Committee approve material changes to the plan				YES
2 Are plans derived from clear processes based on risk assessment				YES
1 Does the Committee receive periodic reports from the LCFS				YES
2 Does the Committee effectively monitor the implementation of actions arising from reports				YES

1 Does the LCFS have direct access to the Committee and its Chair				YES
1 Does the Committee review the effectiveness of the service and adequacy of resources				YES
1 Does the Committee receive and review the LCFS annual report of counter fraud activity and qualitative assessment				YES
1 Does the Committee receive and discuss reports arising from quality inspections by CFSMS?				YES WHERE APPLICABLE
ANNUAL ACCOUNTS				
1 Is the Committee's role in the approval of the annual accounts clearly defined?	**1**			YES
2 Is a Committee meeting scheduled to discuss proposed adjustments to the accounts and issues arising from the audit?		**2**		YES
1 Does the Committee annually review: - the accounting policies of the organisation? - changes in accounting practice - Changes in estimation techniques - Significant judgements			**3**	**Y**ES
3 DOES THE COMMITTEE REVIEW THE DRAFT ACCOUNTS BEFORE THE START OF THE AUDIT			**3**	NO
1 DOES THE COMMITTEE ENSURE IT RECEIVES EXPLANATIONS AS TO REASONS FOR UNADJUSTED ERRORS	**1**			Yes if applicable
1 DOES THE COMMITTEE REVIEW A DRAFT OF THE SIC / Annual Governance statement	**1**			YES
2 DOES THE COMMITTEE REVIEW EVIDENCE REQUIRED TO DEMONSTRATE FITNESS TO REGISTER WITH THE CQC		**2**		The committee considers the assurance process but does not itself review the evidence as it relies on the Trusts management to review
2 DOES THE COMMITTEE REVIEW THE ANNUAL REPORT ?		**2**		YES
OTHER MATTERS				
3 Has the Committee considered the costs that it incurs: and are the costs appropriate to the perceived risks and the benefits?			**3**	YES – no additional costs other than internal and external audit fees
2 HAS THE COMMITTEE REVIEWED ITS PERFORMANCE FOR CONSISTENCY WITH ITS TOR AND PROGRAMME FOR THE YEAR		**2**		**YES**
3 Does the Annual Report and Accounts of the Authority/Trust include a description of the Committee's establishment and activities?			**3**	**YES**

There is a section of this checklist on clinical audit. It is suggested that this be discussed by the CGC

ATTACHMENT I – TO FOLLOW

Attachment J

Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board Meeting 30th May 2011	
Reporting Zero Harm - Quality, Safety & Transformation (QST) Update **Submitted on behalf of** **Martin Elliott, Co-Medical Director**	**Paper No: Attachment J** **Date considered by Management Board** **17th May 2012**

Aims / summary

Monthly rotation of Transformation, Safety & Outcomes, with focus on Transformation.

Areas of note:

- **Appendix A** provides the high level Zero Harm report.
- Sustained central venous catheter line (CVL) infections at 1.97 per 1000 line days.
- Hand hygiene audit results show we are continuing to improve and we are looking towards a sustained improvement in the next quarter.
- Surgical Site Infection (SSI) dashboard is now available on the GOSH intranet
- Medicines Management Improvement Specialist joined the Trust in January and has worked closely with the Clinical Units on their improvement projects. Also working with leading children's hospitals in USA to establish standard definitions, measurements and sharing data.
- Advanced Access – Fifteen specialties are currently achieving, with action plans in place for the others.
- Medical Records - Cardiorespiratory have sustained improvement at 94%, however they are becoming close to a statistically significant reduction in performance and are taking steps to address this. Each clinical unit has a project to improve the quality of medical records on their improvement plan.
- WHO Safety Checklist has increased from 56 per cent to 93 per cent with particular improvement showing in non-surgical specialties.
- Theatre utilisation – All units have action plans in place to sustain or increase to meet the 77 per cent target (currently at 72 per cent).
- Bed Management – now able to monitor compliance with admission criteria and number of referrals accepted and refused.

Action required from the meeting

To note, approve and support.

Contribution to the delivery of NHS / Trust strategies and plans

Delivering No Waits, No Waste, Zero Harm.

Financial implications

None of note

Legal issues

None

Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place? All Transformation work has been delivered to Transformation Board with two parent representatives as members.

Who needs to be told about any decision N/A

Who is responsible for implementing the proposals / project and anticipated timescales

Head of Quality, Safety & Transformation

Who is accountable for the implementation of the proposal / project

Co-Medical Director and Chief Operating Officer

Author and date

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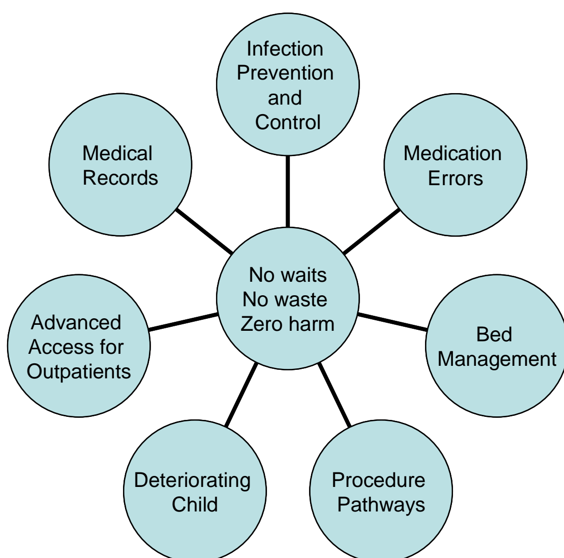
Quality, Safety & Transformation
Reporting to Trust Board
May 2012

The following Zero Harm report produced by the Quality, Safety & Transformation (QST), shows updates for Zero Harm (Appendix A) and a progress report for Transformation.

This month the report will focus on Transformation progress during the period end January to end April 2012.

Reporting the breadth of work being undertaken through Transformation presents a challenge. With around 100 different projects and 150 measures of information, it is not easy to capture in a single document all the changes that are happening. This report highlights some particular areas of merit, challenge and will provide an overall assessment of Trust wide Transformation priorities.

Trust Wide Transformation Priorities



1. Infection Prevention & Control

With a high level aim that infection would decrease by 50 per cent year on year, in 2011 the Clinical Units agreed that they would:

1.1 Reduce the number of GOSH-acquired central venous line (CVL) infections
1.2 Improve hand hygiene audit results and CVL bundle compliance
1.3 Reduce the number of Surgical Site Infections (SSI) in Spinal, Cardiothoracic, Neurosurgery, Craniofacial and Urology specialties.
1.4 Reduce the number of ventilator-associated pneumonia (VAP)

1.1 Reducing GOSH-acquired central venous catheter line (CVL) infections

In 2011 there was a significant improvement in the number of CVL infections per 1000 line days from 3.02 to 1.97 per 1000 line days. In the first quarter of 2012 there has been no change in the overall figures, but this does not reflect the effort from individual areas.

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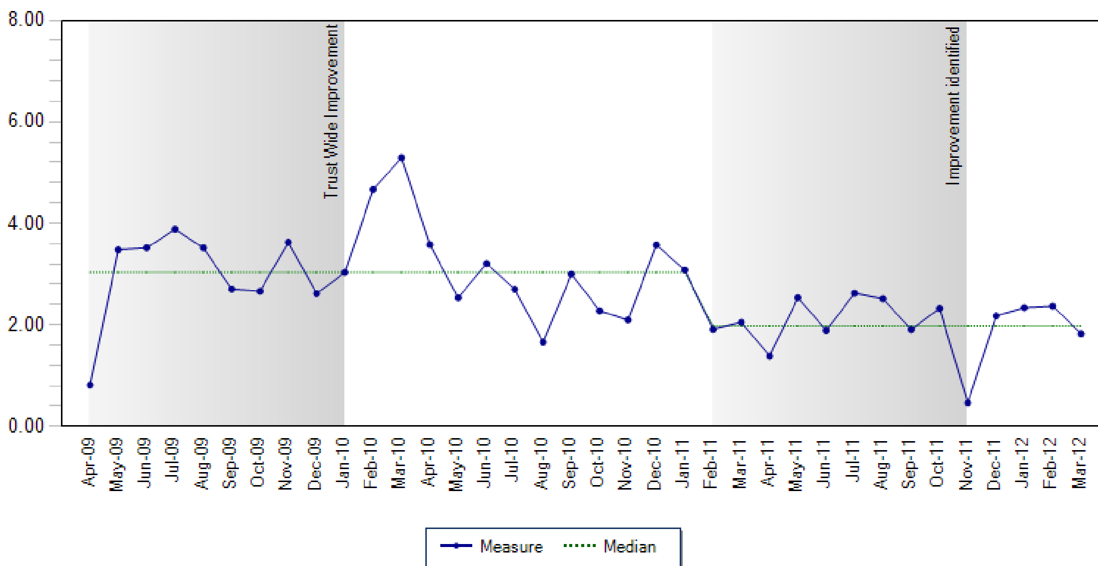


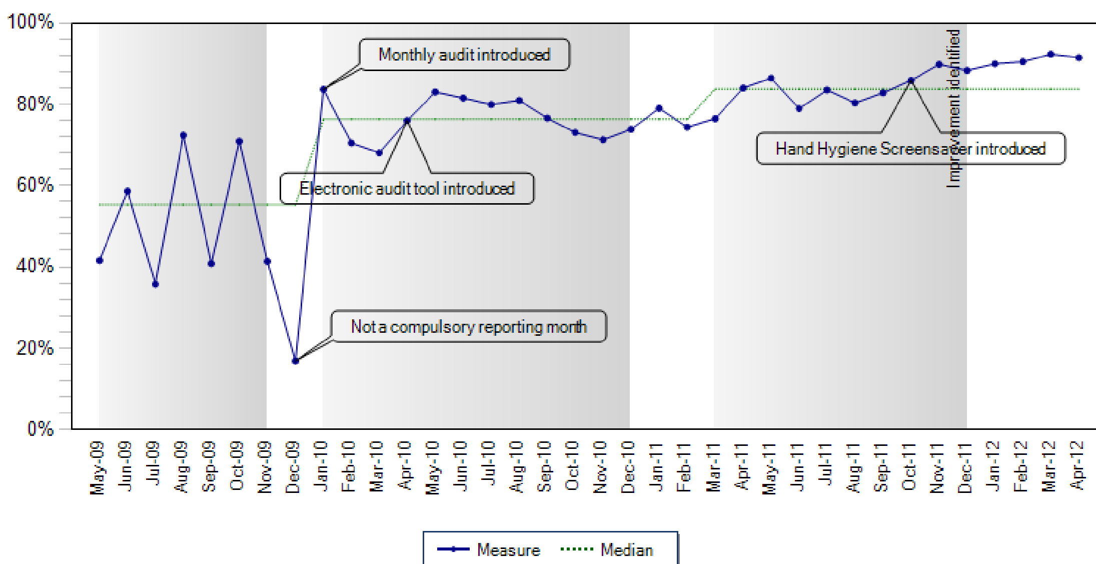
Next Steps

As the numbers are small, it is now possible to undertake a root cause analysis (RCA) for every Staphylococcus aureus bacteraemia which helps teams understand what exactly went wrong for each infection. We are then able to take this learning forward with the individual areas and spread it across the organisation.

The new post of Practice Educator for infection control means there is now a link to the other Practice Educators, allowing them to work in conjunction to deliver standardised packages for Aseptic Non Touch Technique (ANTT). A podcast showing how to deliver ANTT is also being finalised for use throughout the Trust.

1.2 Improve hand hygiene audit results and CVL bundle compliance hand hygiene audit results

Hand hygiene results continue to improve. The graph below shows that the Trust is close to another statistically significant change. Each clinical unit has a plan to improve infection rates using innovative methods to engage staff, patients and families and hand washing plays a key part in this work.



Next steps
Clinical Units are now looking at individual groups to target, for example International and Private Patients and ICI-LM are working closely with parents and the Intensive Care Units are focusing on education with the staff on ward rounds.

There has been no significant change in CVL bundle compliance in this quarter. Work continues with the practice educator group to provide evidence based teaching packages for CVL bundle use. The practice educator for Infection Control is working with the areas to address this.

1.3 Reduce the number of surgical site infections (SSI) in Spinal, Cardiothoracic, Neurosurgery, Craniofacial and Urology specialties

The Trust plan to reduce SSIs is based on the introduction of systematic SSI surveillance with regular team feedback, a review of serious infections or episodes of increased incidence and the introduction of a standard care bundle. Collecting data on SSI is performed from within the Clinical Unit team's current multidisciplinary audit process (for Urology or ventriculoperitoneal shunt infection in neurosurgery) or by the SSI team surveillance. In this quarter the SSI surveillance team have increased the number of areas monitored to include surgery, plastics and orthopaedics.

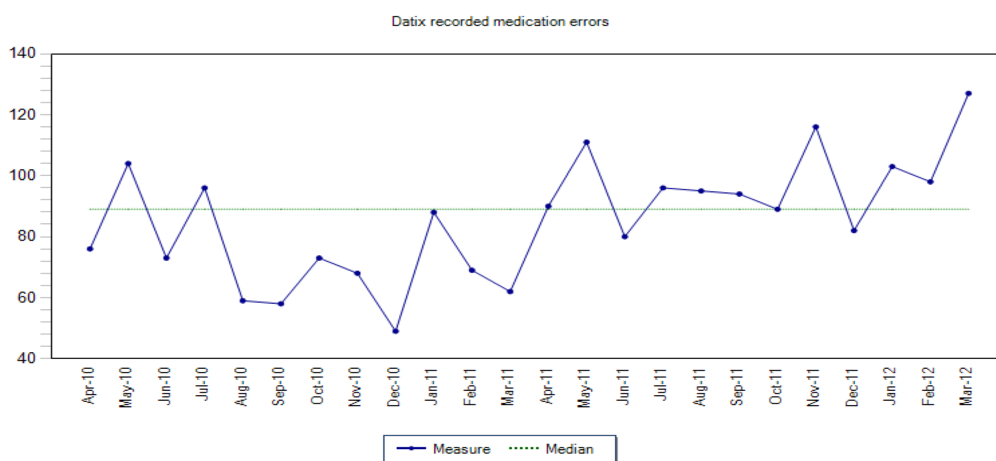
A dashboard is now available on the GOSH intranet so teams can see their performance and monitor this accordingly.

Next steps
More specialties will be included in the next quarter as we work towards baseline surveillance data in all surgical specialties and continue development of the care bundles. The new Practice Educator for Infection Control is working with teams to ensure SSI data is included in the Infection Prevention and Control meetings as an agenda item.

1.4 Reduce the number of ventilator-associated acquired pneumonia (VAPS)
At GOSH in 2011 regular systematic VAP surveillance was not planned on all Intensive Care Units. All ICU areas have implemented the paediatric VAP care bundle, and a formal audit is currently being planned, however, due to the low numbers, this remains a low priority.

2. Medicines Management

Medication incidents are the most reported type of incident at Great Ormond Street Hospital. Trusts that report incidents regularly suggest a stronger organisational culture of safety.



2.1. Clinical Units

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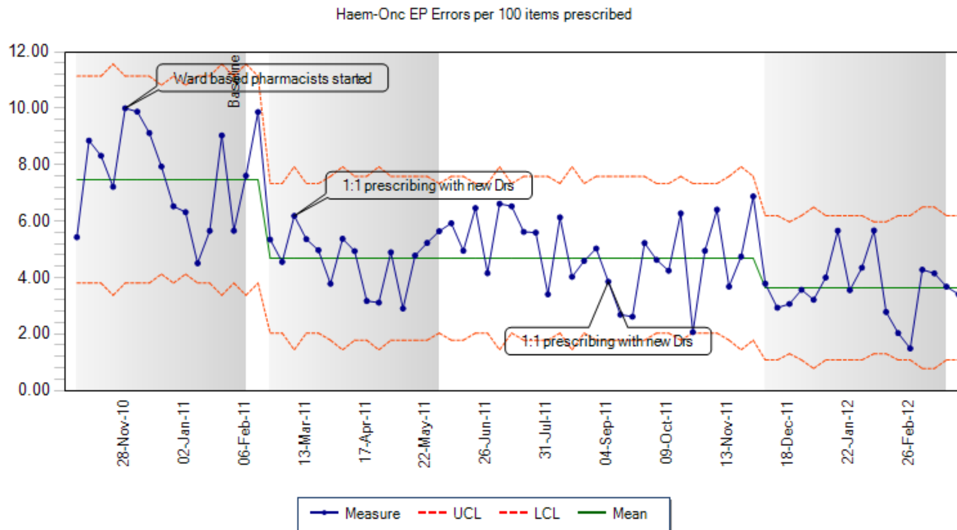
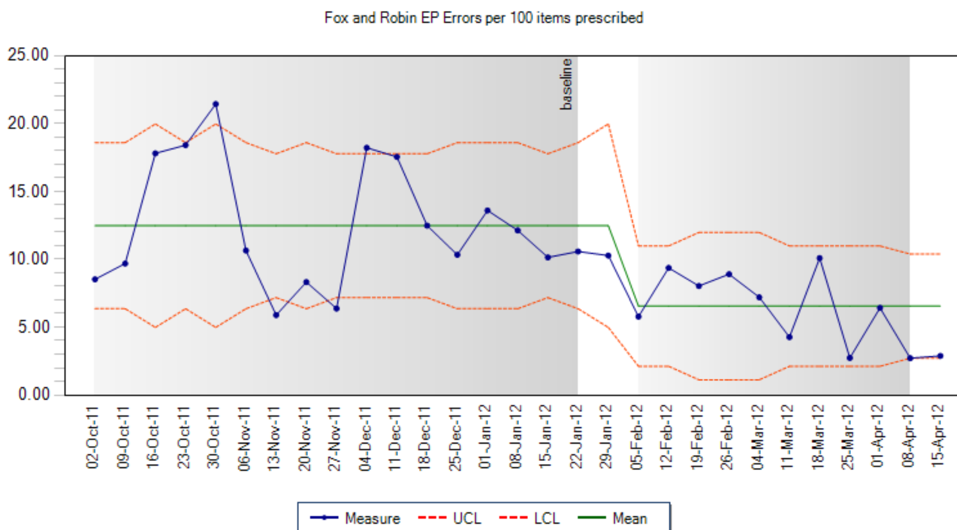
The clinical units are at different stages in terms of medicines management improvements. A summary for each unit is provided below.

2.1.1. ICI-LM

On Elephant and Lion (haematology/oncology) wards, the ward-based pharmacists have continued the intervention package of ensuring one to one supervision of prescribing by all new doctors during their first week, immediate feedback of errors, reconciling patient medication within twenty four hours of admission, and providing discharge medication counselling to parents. As of April 2012 the prescribing error rate was 3.64 per 100 drugs prescribed; a 22% reduction from 4.68 in February 2011. This contributes to an overall 51% reduction in prescribing errors since November 2010.



The package has been applied to Fox and Robin (BMT, transplant, immunology, infectious disease) wards, which have achieved a 48% reduction in errors within 3 months. An electronic data collection tool is being developed in ICI-LM which is expected to significantly reduce pharmacist data collection time and also enable more detailed data to be recorded.



2.1.2. Cardiorespiratory

On CICU, new doctors undertake a prescribing test as part of their induction. On weekdays, a ward-based pharmacist provides daily team feedback on collective errors from the previous 24 hours, and provides direct 1 to 1 feedback on any significant errors. Anonymised trends of individual prescribing practice are fed back to prescribers on a 3-monthly basis. Dedicated prescribing desks continue to be used alongside a 'no interruptions' policy. An electronic infusion calculator is being developed and piloted. The unit held an educational awareness 'Medicine Safety Week' in January 2012. The medicines management dashboard

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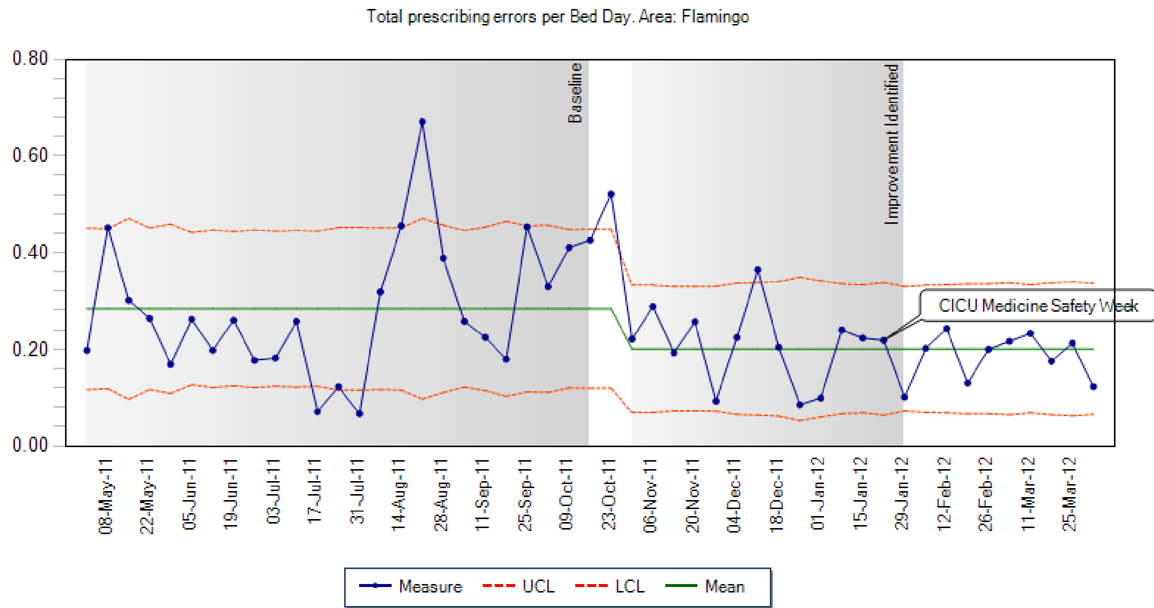
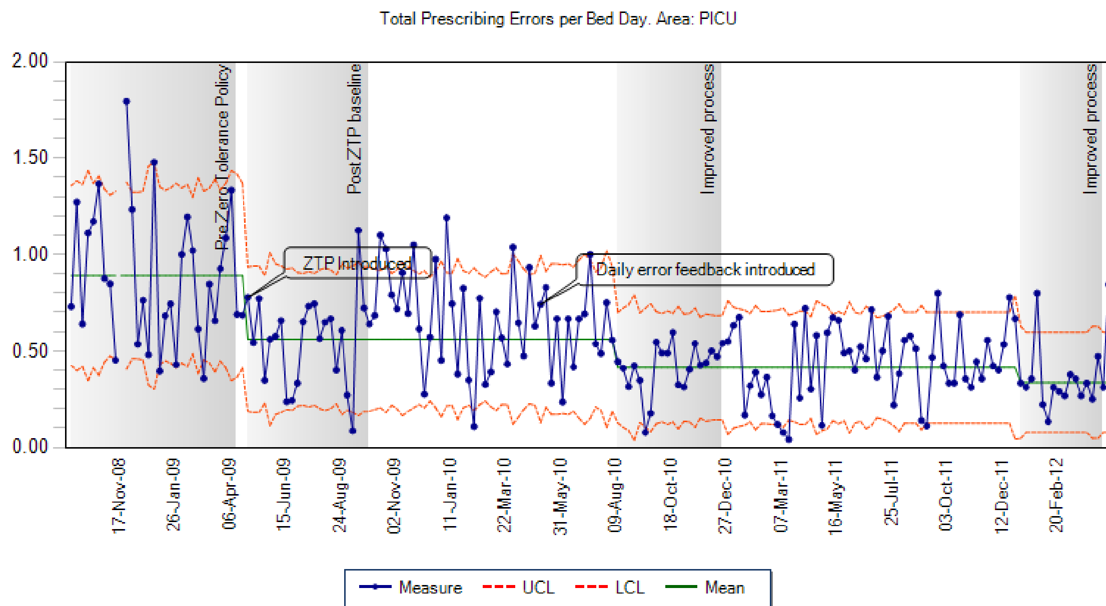
for CICU shows that during the first quarter of 2012, the average total prescribing error rate has remained steady at 0.20 errors per Bed Day.



2.1.3. Surgery

PICU has continued a 'Zero Tolerance Prescribing' approach, which includes dedicated prescribing desks away from distractions and interruptions, a ward-based pharmacist review of prescriptions and feedback of any errors daily from Monday to Friday. The combined interventions were associated with a 54% reduction in prescribing errors. During the first quarter of 2012 the average total prescribing error rate has reduced further to 0.34 errors per Bed Day from a previous rate of 0.41. This contributes to an overall 62% reduction in prescribing errors since April 2009. There was an increase in the sub-category of 'clinical' prescribing errors in September 2011 which has decreased again during the first quarter of 2012; the temporary increased rate of errors may have been due to the pharmacist having reduced time on PICU due to their involvement in other projects, or other multi-factorial reasons such as new prescribers.



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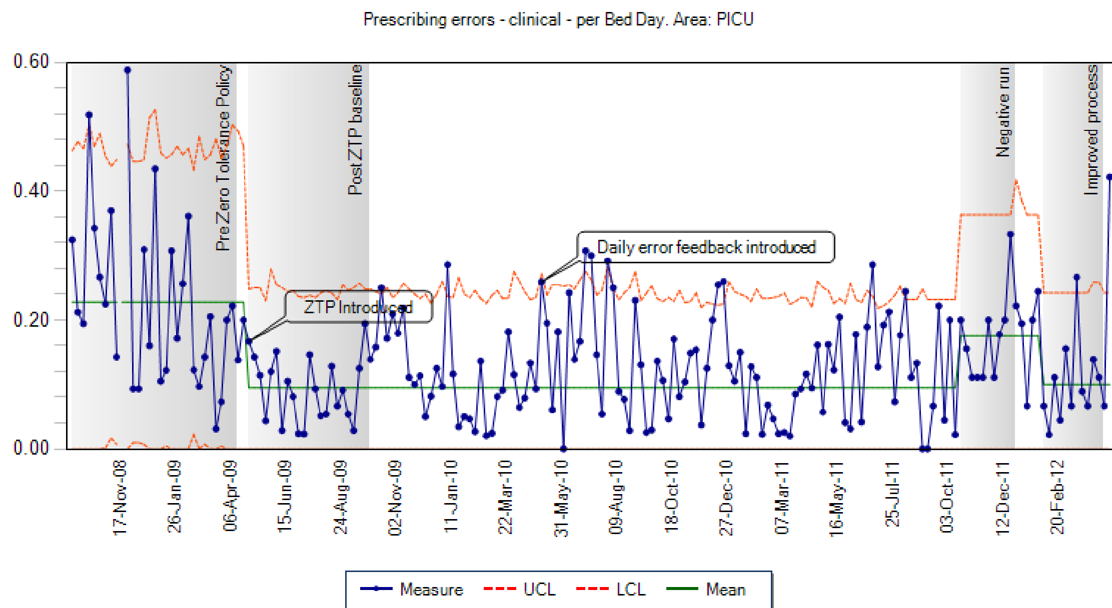


2.1.4. Medicine-DTS

There are no ward-based pharmacists on the medical wards, so simple medication error logs were developed for Hippo, Victoria, Rainforest and Kingfisher wards for use by nursing staff to try to understand the number and type of prescribing and administration errors made, and to introduce a culture of recording every medication error that occurs. A simple electronic tool was developed and tested on Kingfisher ward in January 2012. The error logs have captured a greater number of errors than have been reported via Datix, however work still needs to be done to establish a baseline error rate and start to test improvement initiatives.

2.1.5. International and Private Patients

Bumblebee, Butterfly, Dragonfly, and Caterpillar wards have continued to encourage use of a ‘quiet’ room for prescribing, particularly around prescribing of blood products. Datix incidents for blood products have decreased from 15 in Q3 2011/12 to 2 in Q4. Bumblebee has continued to implement ‘transforming care on your ward’ to improve workflow in the medication room area; interventions include separating IV and oral medication spaces. A ward-based pharmacist started in the unit at the end of 2011 now has greater presence within IPP, and directly feeds back medication errors and provides support to prescribers.

2.1.6. Neurosciences

Koala ward nurses and visiting pharmacists continue to collect prescribing error data on log sheets to supplement the errors that are reported via Datix. The Medicines Management group met in April to review data and current error logging processes. The Neurosciences Improvement Coordinator will now report a summary of the key findings from the log sheets, including named prescriber on a monthly basis to the educational supervisors.

2.2. Measurement of errors

Currently, there is no single measure or graph that shows an overall rate of medication errors as an organisation. ICI-LM has electronic prescribing implemented which enables wards to calculate their prescribing error rate per 100 drugs prescribed. The intensive care units record similar prescribing errors but categorise them differently to ICI-LM. This is partly due to the inherent differences between the specialities, but also due to intensive care use of paper-written prescription charts instead of electronic prescribing. The intensive care units are not able to ascertain a rate of errors per prescriptions written, and therefore calculate their error rates in bed days.

Next steps:
We are working with leading children's hospitals in America (e.g. Cincinnati Children's Hospital and Ohio) to establish standard definitions and measurements, and sharing of data. GOSH already has the tools in place to be able to report adverse drug event rates in line with these hospitals to enable us to answer the question: 'How often do we cause harm to a patient due to the drugs we give them?'

Two collection tools will be used:

1. Paediatric Trigger Tool – the tool consists of triggers that are critical indicators of paediatric ADEs (e.g. naloxone use due to opioid overdose). Triggers are defined and occurrences, prompts, or flags found during the review of a medical record that trigger further investigation to determine the presence or absence of a medication error.
2. Self-reported medication errors on Datix – the reports are an underestimation and include errors that caused harm or not.

2. Advanced Access for Out Patients

Advanced Access for Outpatients means that by end March 2012, all patients should have a first appointment within two weeks of referral, where clinically appropriate.

All specialties that are eligible for Advanced Access have been working through a number of recommended steps to help them achieve the two week target. Fifteen specialties are currently achieving Advanced Access (there were eight achieving in January 2012). Another three specialties are close to achieving and all other areas are working on this with plans in place. The Executive Sponsor and Corporate Improvement Manager will be working with them to support their work and to address the proposed timescales for delivery.

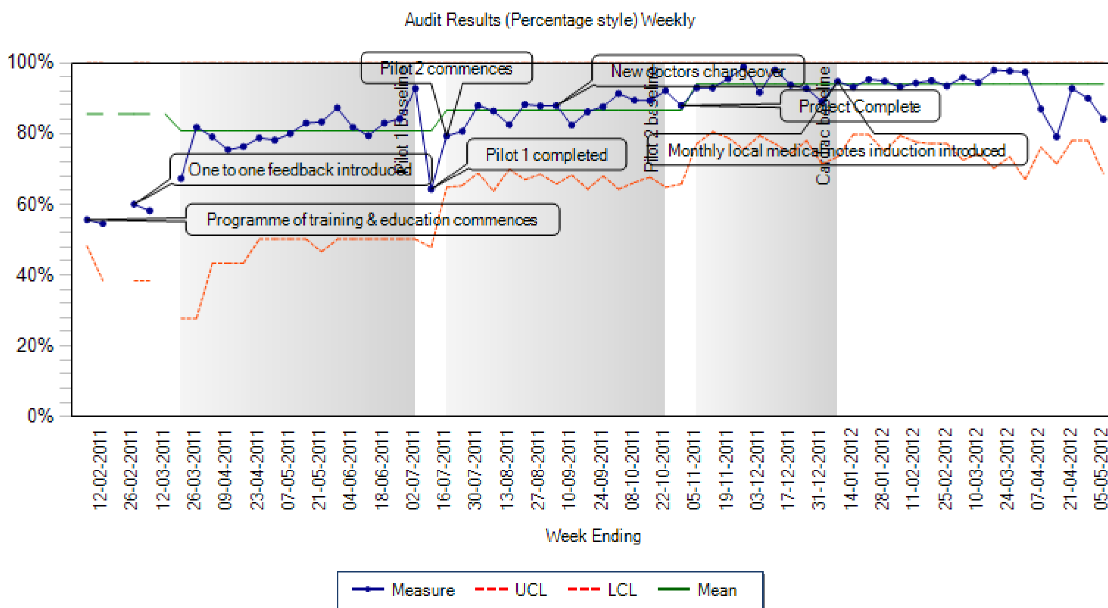
Number of specialties achieving Advanced Access

3. Medical Records

Each Clinical Unit has added a project to improve the quality of Medical Records to their project plans. This project has renewed focus as the Trust prepares for NHSLA Level 3. A review of medical notes has been added to the weekly Executive Safety Walkround for every ward.

As an example, Cardiorespiratory Clinical Unit undertook a project to improve audit compliance with the Trust's medical notes standard. Improving quality of the medical notes in cardiorespiratory and has shown sustained improvement at 94%. Ward clerks and administrators carry out audits and feedback to individuals. The achievement of this project was showcased at the Institute of Health Improvement Quality & Safety Conference at Paris in April 2012, when a poster was presented.

A recent drop in compliance is due to changes of ward clerks, absence, sickness and ward move to Morgan Stanley Clinical Building. Work is currently being undertaken ensure good practice is embedded. Project spread and discussion at external forums is generating interest and opportunities for sharing and learning.



4. Procedure Pathways

In March 2011, the Transformation Board outlined 5 objectives for 2011/12: • *WHO Safety Checklist 100 per cent completion* • *Increase theatre utilization* • *Implement pre-assessment* • *Improve access to theatres for non elective cases* • *Improving the MRI patient journey*

WHO Safety Checklist
Total WHO Safety Checklist completion has increased from a median of 57 per cent to 93 per cent since the beginning of 2011 across the whole Trust. The project continues to focusing on particular areas where this has proved harder to implement and quality of checklist completion.

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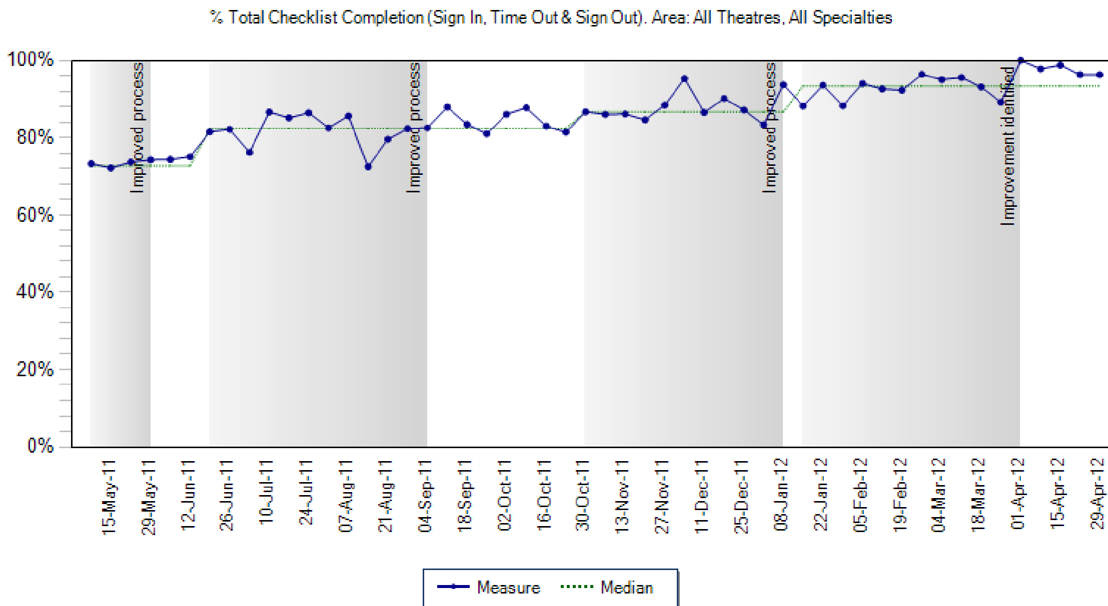
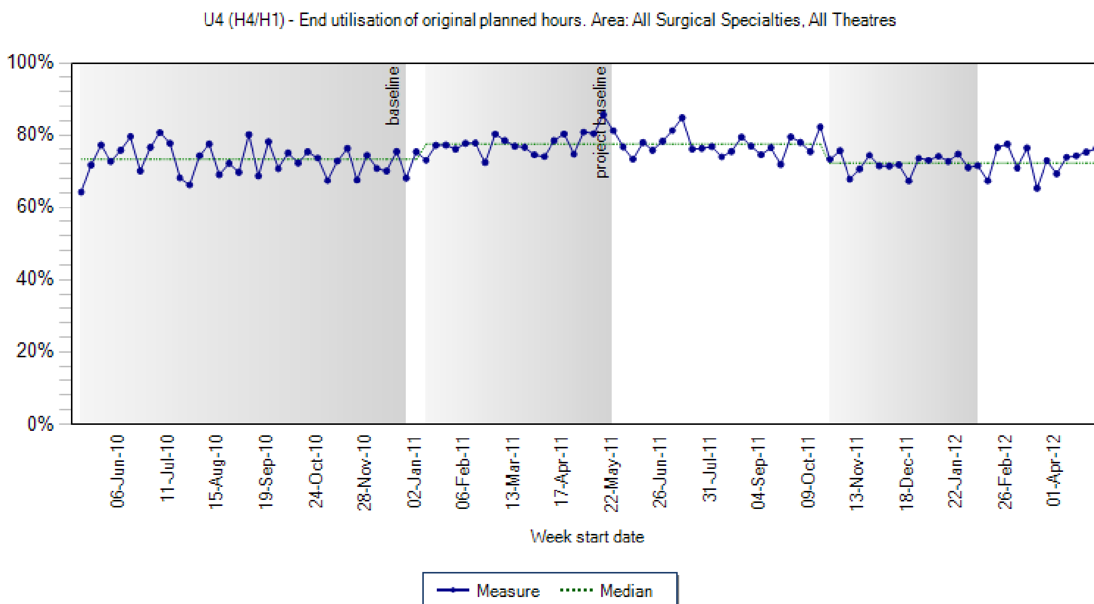


Theatre Utilisation

The original stated aim of the theatre utilisation project was to deliver an average utilisation of planned hours of 70 per cent during 2011 for All Surgical Specialties, and 77 per cent by end 2012.

As a whole, this group of specialties baselined and then sustained an average of 78 per cent, until a brief period toward the end of the year, where we have seen a drop to 72 per cent from late October. This new mean (understood to have been due to limited bed capacity) has settled going into 2012, and we are now working on improving on against it.

All units and specialties have action plans in place to either sustain (if already delivering over 77 per cent) or increase utilisation to meet the agreed 2012 targets (some non-surgical specialties have a lower target). Units will focus on specialty specific action plans to optimise list bookings, start and finish times, turnover, and minimise cancellations based on the demands and limitations of each patient cohort and service. The project working group has restructured, and is currently (during May) focusing on late starts.



Pre-operative Assessment
The Pre-operative Assessment project is tasked with developing and implementing a standardised service providing equitable access for all GOSH patients being admitted for any procedures. After the pilot run November-December 2011, this service has now started rolling out across the surgical unit, aiming to have all specialties up and running by the end of September. New documentation has been approved at Clinical Practice Guidelines Committee for trial, and is being used in General Surgery, Dental and Maxillofacial

Access to Theatres for non-elective cases
This project works to ensure non-elective patients are able to access theatres when they need to. Clinical protocols as to what kind of patient and procedure should fall into each category have now been implemented and we are measuring against them. The project group has recently discussed the booking process for non-elective cases and how this can be improved, minimising human error and maximizing efficiency.

Improving the MRI patient journey
The MRI project was developed to address a broad range of issues – and rapidly began to focus on improving information, improving utilisation and increasing capacity. To date the project has implemented clinical prioritization and categorization of patient scans, and developed an escalation policy to sit along side this. We have seen increased compliance of WHO Safety Checklist completion, and the creation of MRI specific dashboards. All patient information leaflets have been reviewed with parental involvement, and we are in the early stages of rolling out the Neurology model of consenting in clinic to Oncology. The team have also undertaken benchmarking exercises at Evelina and Alderhey Children's Hopsitals, and are now looking to pilot some of their initiatives here at GOSH

5. Bed Management

The aim of this project is to develop a real-time bed management solution which will optimise access to specialist inpatient services, ensuring an appropriate referral is never declined due to insufficient bed availability.

Admission criteria and estimated length of stay information has now been published on the GOSH intranet and internet sites. This will guide our referrers to the different diagnoses treated at GOSH and the timeframe that patients should be admitted (i.e. emergency / urgent / elective). This information will help referring clinicians manage their own, their parents' and families' expectations.

GOSH clinicians and the bed management team who receive calls about emergency referrals will also be able to refer to these pages to ascertain whether a referral meets agreed specialty admission criteria. This will support them in the decision making process described in the Admission and Bed Management Policy which was updated last year.

The web-based patient referral form has passed the pilot phase and is being rolled out across the Trust. The form ensures that vital patient information is captured and shared between key personnel involved in finding an appropriate bed, accepting the patient and managing their ongoing care. The Trust is now in a position to monitor compliance with the agreed admission criteria and to measure the number of referrals that are accepted and refused.

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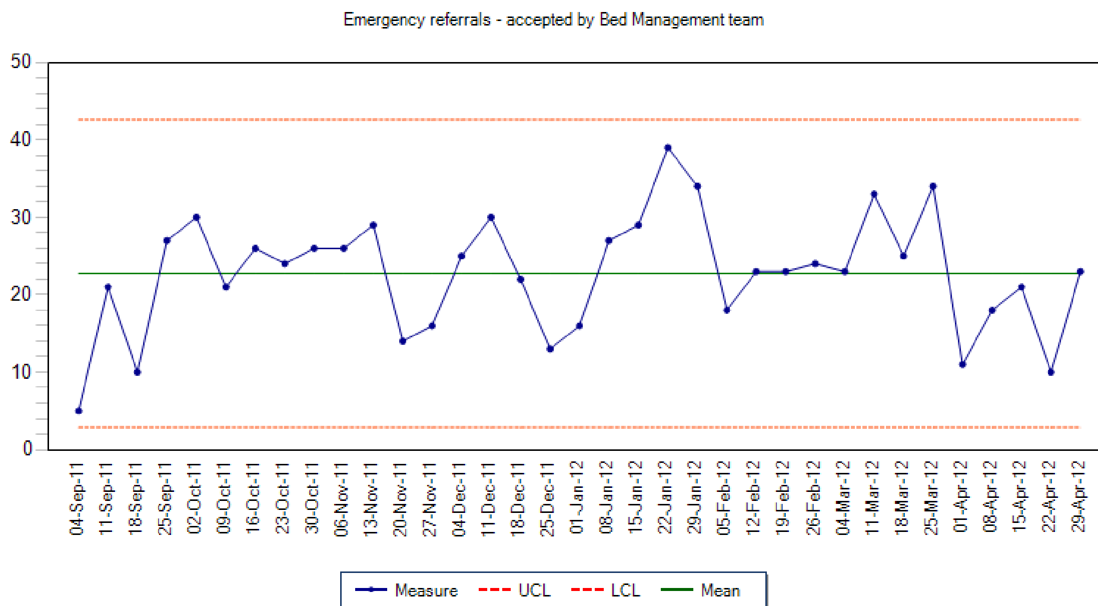

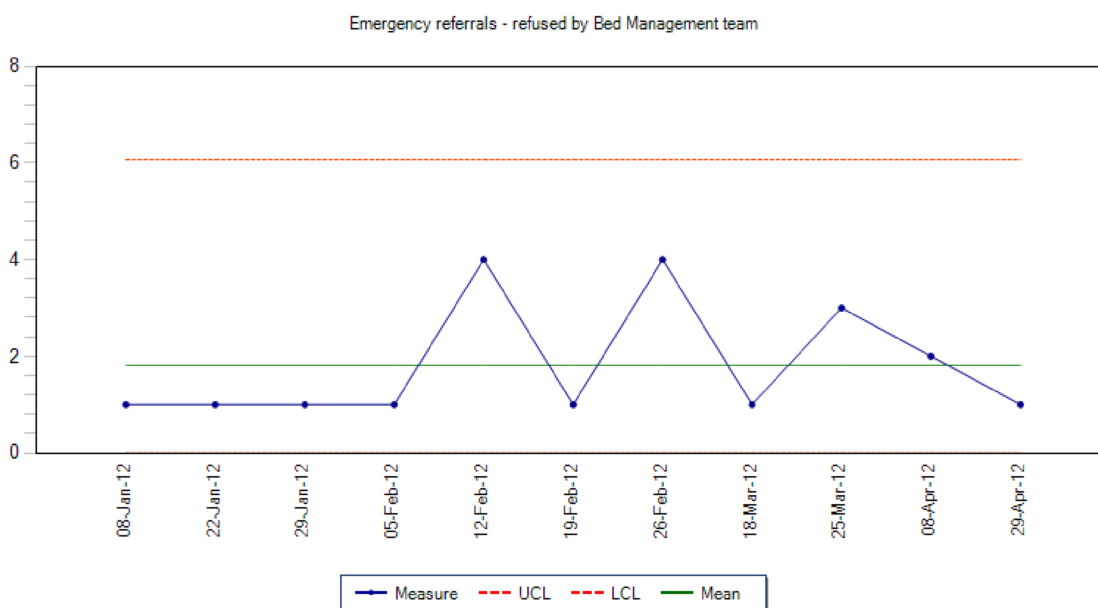

In order to help reduce the number of refused referrals to GOSH, improved information about bed availability is required. The formal procurement process for an electronic, real-time Bed Management system has started and the chosen solution should be fully implemented by the end of June 2013.

6. Deteriorating Child

The overall aim of the Deteriorating Child project is to eliminate harm from preventable deterioration of children on wards outside intensive care, theatres and other related areas such as angiography. Deterioration which is unrecognised or poorly managed can lead to significant harm, including respiratory/cardiac arrest or death. To tackle the most serious cases, the project has set a target of reducing the number of cardiac and respiratory arrests on wards outside of theatres and intensive care by 50 per cent by end March 2013.

The first step towards this goal is developing robust data which can be inform us of arrests at both hospital and individual ward level. As the number of arrests on individual wards is relatively low, we plan to present the data as the 'days between' arrests, rather than absolutely numbers.

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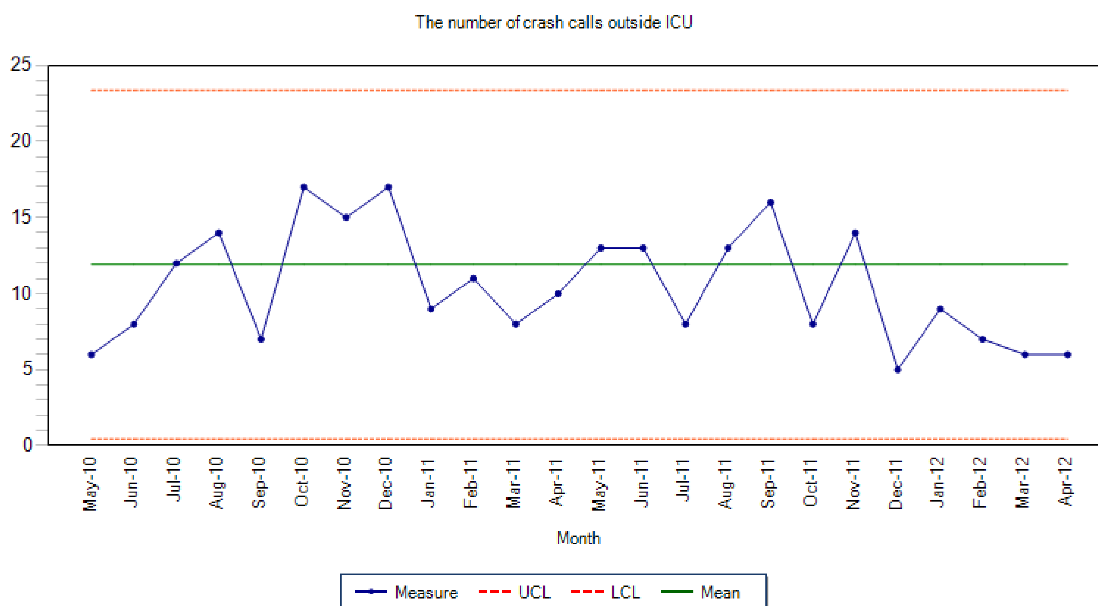

To achieve this, a work programme has been developed to focus on the following:

- Reducing Risk
- Identifying Deterioration
- Responding to Deterioration

Much of the work so far has focused on implementing the Children's Early Warning Score (CEWS) - a system to detect deterioration through vital sign monitoring and the communication tool SBARD (Situation-Background-Assessment-Recommendation-Decision). The team are now working on improving the reliability of vital sign recording and escalation of abnormal vital sign readings. Work will be targeted on wards where the risk of an arrest is higher due to the complexity and acuity of the speciality or patient group. Innovative approaches such as automated alerting of at-risk patients to senior clinicians is being considered. Progress this quarter includes setting up of a Deteriorating Patient working group to guide the project, developing a dashboard to show arrest data at ward level, and developing a framework to review case notes of children who have arrested. In depth work has also started with 2 'high risk' wards and baseline data on the reliability of vital sign recording is being collected.

GOSH is also part of the UCL Partners deteriorating patient quality improvement programme whose aim is to reduce the number of cardiac arrests by 50 per cent within one year. GOSH are leading the paediatric work stream and supporting the overall programme through training and data processing.

Other Transformation Progress

1. Developments in data for improvement

The presentation of data in Statistical Process Control (SPC) charts on automated dashboards has been a success of the Transformation Programme which puts GOSH ahead of many other hospitals. This success has led to the numbers of measures and combinations of parameters growing exponentially, which, while desirable has brought with it the added responsibility of monitoring a growing number of measures on a regular basis.

Since the dashboard systems are based upon the Trust's existing data warehouse, there was a possibility to introduce further automation, both to ensure that things of interest ('special causes') are not missed and can be anticipated, and to enhance our use of SPC methodology. To this end, the first version of a system was developed during 2011 to alert the Improvement Managers and Coordinators (IMCs) when 'special causes' happened in their units.

During January 2012, a project was started to enhance this functionality as well as to provide better dashboards and an extended data collection and entry system;

- A web based audit data collection tool has been in place for 3 years and has reduced data collection and entry times for front line staff and improved the robustness of previously manual systems. This is now being enhanced with a system to allow the collection of data for measures other than audit (which is of a yes/no nature). This will support many projects where data is not collected through existing applications.

- The automated analysis system is being enhanced to give greater flexibility of options to the IMCs. This will allow them to decide which measures and they are interested in being alerted to when special causes occur. In addition, an 'Almost There' function alerts the IMCs when they are near to an improvement (or worsening) in performance. There are many other enhancements in addition to this that will improve its user friendliness and functionality.

- The software which has been used to present the data on dashboards has limited functionality, particularly its graphical ability. A replacement has been sourced which will replicate our current dashboards and give us enormous potential to enhance them in the future. The first enhancement that is much needed and will be immediately obvious is regarding annotations of the charts. The new software is far more intelligent as to where the annotations are placed.

These enhancements are being introduced as they become available, with the vast majority due for completion during June 2012.

This system is unique and highly innovative and has been wholly developed and supported in house by the Transformation Analyst Team.

2. EQuIP (Enabling Doctors in Quality Improvement and Patient Safety)

The EQuIP programme delivers three levels of training for trainee doctors.

Level 1 is an introductory one hour interactive workshop delivered by the Darzi Fellow. During January – April this was delivered in 8 different clinical departments for 5-10 trainees at a time, as part of their departmental teaching/meetings. These have been continuously improved and adapted in response to a feedback questionnaire. They have been evaluated highly with positive feedback from both trainees and supervisors. In addition to these, pan-hospital lunchtime one hour EQuIP level 1 workshops have been held since November 2011, facilitated by Dr Peter Lachman. Trainees who have missed their departmental slot have attended this and also consultant supervisors who are keen to learn how to support their trainees through QI projects. This forum will now be attended by improvement managers to ensure the learning from current EQuIP projects is communicated.

The first level 2 and 3 cohort of 16 trainees selected in October 2011 is progressing well with their projects. They attended two study days on improvement methodology, and are still engaged with project surgeries and mentoring. Two trainees who have left the trust have handed over their projects to new trainees. Four presented their work at the Inaugural London Deanery quality improvement conference, and two have recently had successful consultant interviews when they discussed their EQuIP project. Two Trainees from the first cohort were identified for advanced (level 3) EQuIP, and have started paired learning with a general manager and attended an executive board meeting and a patient safety walkaround. They are now being supported to deliver level 1 workshops within their own department.

A further 16 trainees were selected for intermediate level (level 2/3) EQuIP training in January from different clinical departments. They attended two study days and are all being mentored by clinical improvements leads and improvement managers, who are continuing to guide them with their projects.

A further 16 trainees have been recruited to start the third cohort in May 2012. Therefore in total 48 Doctors in Postgraduate training from all clinical units have attended workshops on improvement methodology alongside experiential learning on their own QI project.

Two EQuIP participants, radiology registrar, won a prize at the national casebook event organised by The Network at the King's fund. Their EQuIP QI project on reducing DNAs in nuclear medicine was selected as one of the top 10 submissions out of 175 projects submitted by doctors in postgraduate training.

EQuIP has also been supporting UCL medical students. Five students have been paired with EQuIP doctors from different departments to work on QI projects, which UCL has been considered UCL Medical Leadership Network's most successful project this year.

3. Transformation Improvement Methodology Programme (TIMP)

The Transformation Improvement Methodology Program has now graduated 25 delegates, across all units and disciplines, with another 20 enrolled in cohort three. Each delegate works on an active project during the six –month program, giving them an opportunity to practise the methodology we cover in the teaching sessions, whilst delivering real improvements for GOSH at the same time. At the end of the course, each delegate produce a poster detailing the improvements they have made, and many return to support current delegates as part of the "buddy" system. In cohort three, we have taken on two staff from the North Middlesex Hospital. A poster about TIMP has been accepted to the Patient Safety Congress at the end of May.

4. New Initiatives

Complex Patient Pathways
As part of the work to improve the patient pathway for complex patients at GOSH the Neuromuscular and Gastro services have jointly applied for the King's Fund/The Health Foundation "Patient and Family-centred care programme". The Neuromuscular service have already started this process by following the journey of two patients. This was recorded and shared with the team with a view to making improvements to the process.

Consent
A project to ensure the consenting process for treatment meets necessary standards and exceeds patient and family expectations has now started. The first project group met in early May and a the project scope is currently being worked up. Parents and families input will be key to the success of this project.

Summary

Good progress continues in most areas of the Transformation programme, with projects that are in exception being reported to and supported by Transformation team.

In 2012, the QST will continue to provide the Trust Board with a monthly highlight report for the Zero Harm Indicators.

The next QST report will provide a Zero Harm highlight report and progress report on Safety to include SI, complaints and risk.

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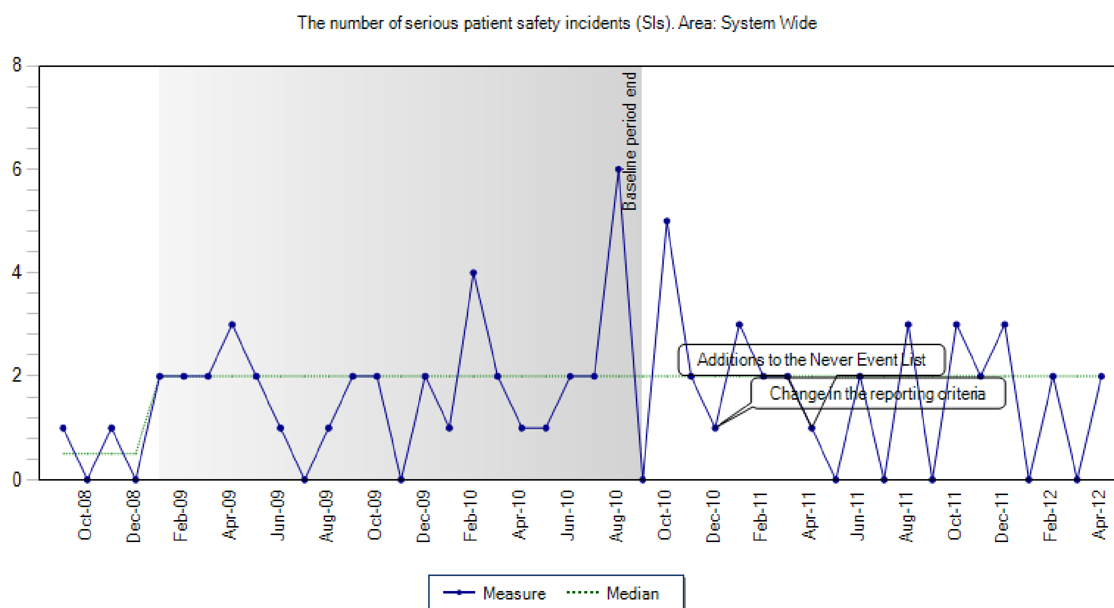
Appendix A

The following report produced by the Quality, Safety & Transformation (QST), provides Zero Harm data.

Where possible, the data included in this report is presented in Statistical Process Control (SPC) charts, which allow you to see the difference between common cause (normal) variation and special cause variation. When using SPC charts, we are looking for special causes, which result from a significant change in the underlying process. If a special cause occurs, we will highlight this accordingly. SPC is the tool that we use to determine where a change in practice has led to an improvement.

1. Serious Incidents

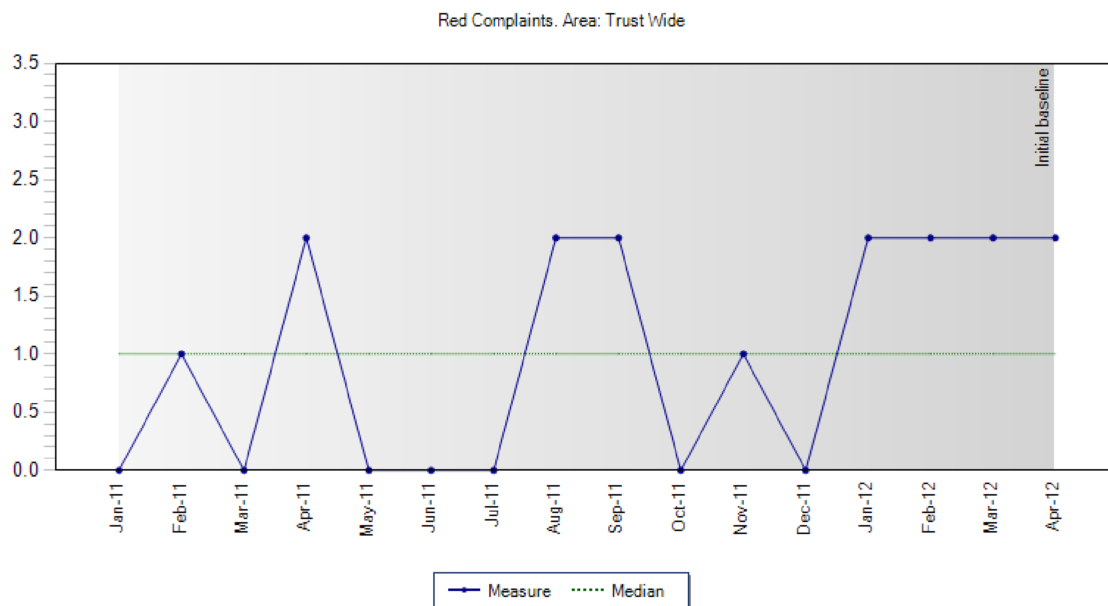
It should be noted that all risk managers have now been recruited to and are in post.



The number of serious patient safety incidents (levels 4 and 5).
4 (Major) – Permanent injury, long term harm or sickness, involving one or more persons, potential litigation, extensive injuries, loss of production capability, some toxic release, fire, major financial loss
5 (Catastrophic) – Unexpected death of one or more persons, national adverse publicity, potential litigation, toxic gases, fire, bomb, catastrophic financial loss

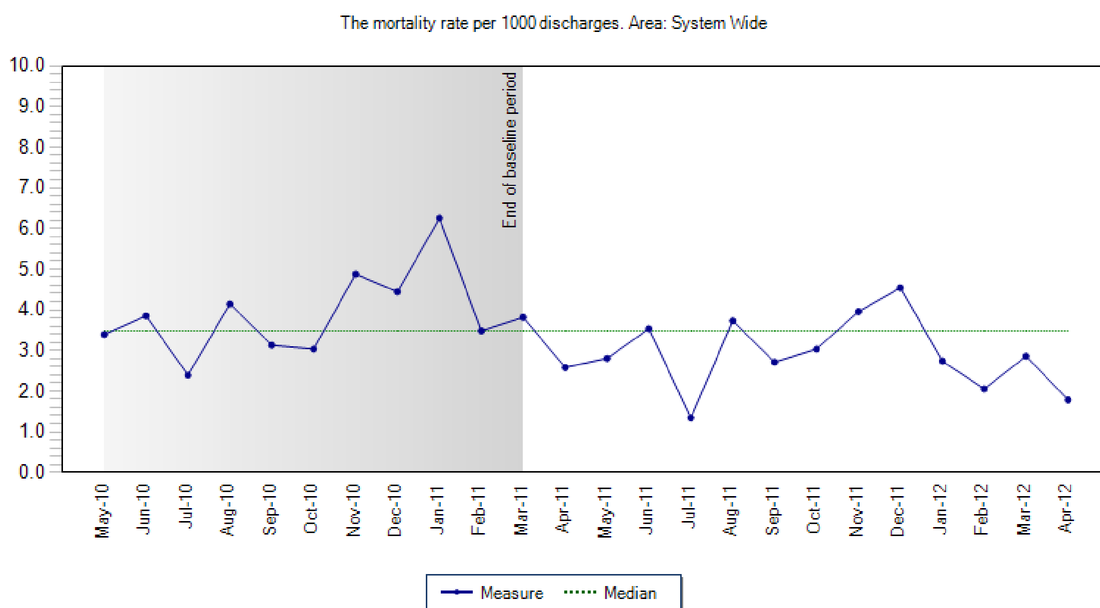
2. Red Complaints

The graph below shows the number of “red” complaints in SPC format. This data has been extracted direct from the Datix system where complaints and incidents are recorded. Using this method for all our safety reports to Management and Trust Board will provide a more standardised approach in future. It should be noted that the following SPC chart needs some further validation.



Red complaint definition: Severe harm to patient, family or reputation threat to the Trust.

3. Mortality

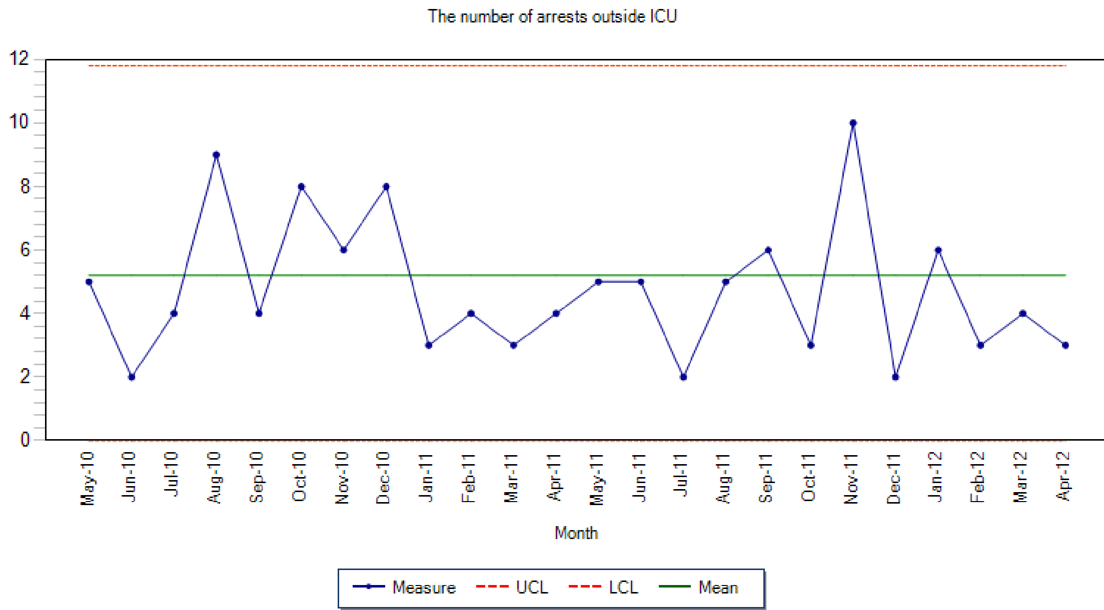


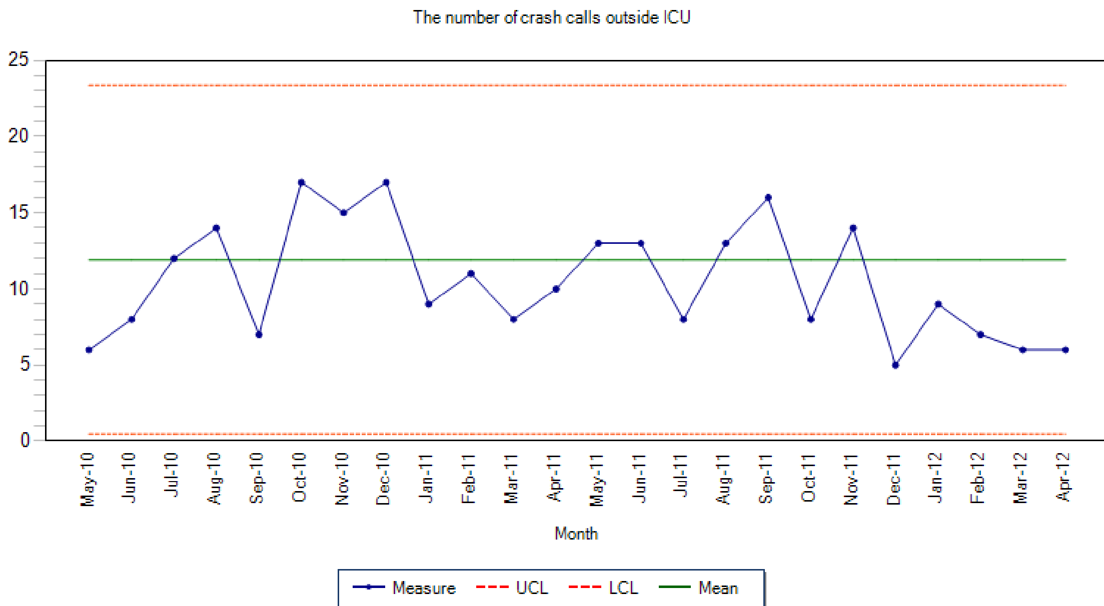
4&5 Arrests and crash calls outside Intensive Care Units (ICU)

The SPC charts below show the number of arrests and crash calls outside the ICU areas. The overall aim of the Deteriorating Child project is to eliminate harm from preventable deterioration of children on wards outside intensive care, theatres and other related areas such as angiography. Deterioration which is unrecognised or poorly managed can lead to significant harm, including respiratory/cardiac arrest or death. To tackle the most serious cases, the project has set a target of reducing the number of cardiac and respiratory arrests on wards outside of theatres and intensive care by 50 per cent by end March 2013.

Update – see Transformation report for update on Deteriorating Child Project

The monthly number of arrests (cardiac or respiratory) outside of ICU wards (recorded from calls made to the 2222 Clinical Emergency Team)

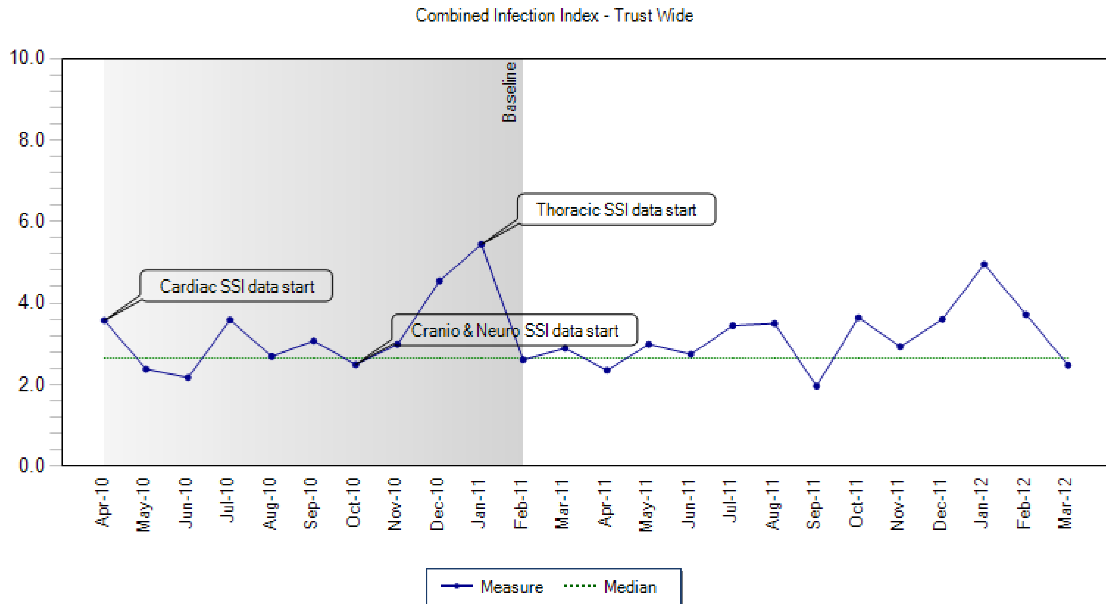




The monthly number of crash calls (calls made to the 2222 Clinical Emergency Team) outside of ICU ward

4. Combined infection index

This index is the combined number of specified hospital acquired infections (HAI), per 1000 adjusted patient activities. It includes the total number of reported Central Venous Line (CVL) infections, Surgical Site Infections (SSI), Ventilator Associated Pneumonia (VAP), MRSA, MSSA and Clostridium difficile. It should be noted that the vision is to improve reporting of errors, so it is likely that the numbers will increase before they decrease ultimately. For example, the number of SSI’s has increased and will continue to increase as surveillance improves.

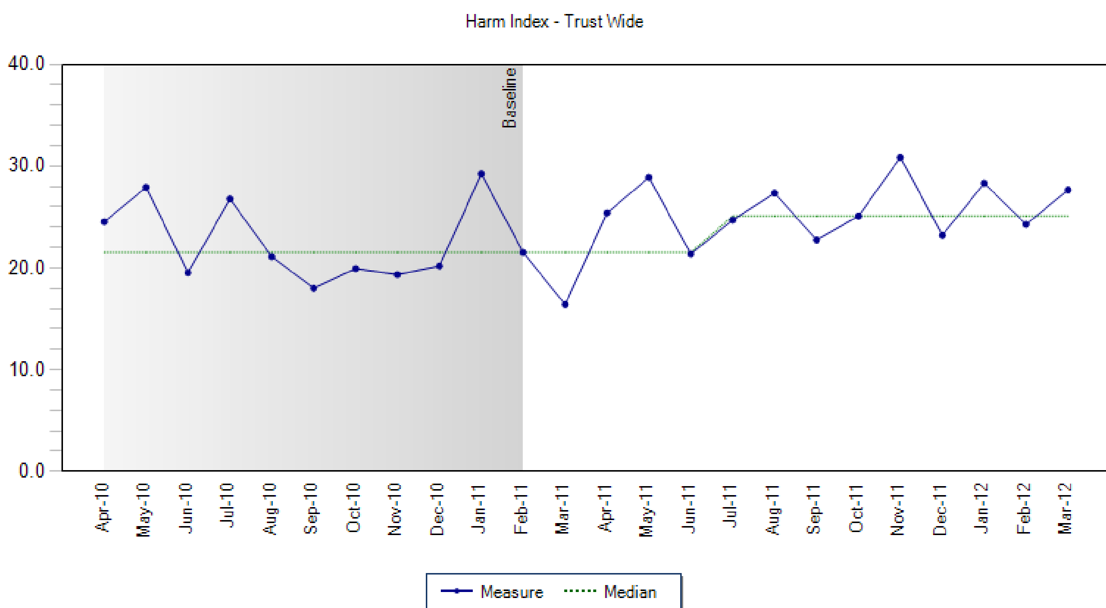


Adjusted Patient Activity = number of Finished Consultant Episodes (FCEs) + ((number of OPD appointments + (ICU bed days x 9.5)) / 12.9)

Adjusted Patient Activity (APA) is a measure of activity which weights outpatients, inpatients and critical care bed days into a combined figure representative of overall healthcare resource activity. For example on average an inpatient requires more input than and an outpatient and thus several outpatients will be the equivalent of one inpatient. This combined APA enables different specialties to be compared with each other and over time and will account for the relative differences in patient complexity. It can be used as a denominator for comparable measures across the Trust such as harm and workforce productivity.

5. Combined harm index

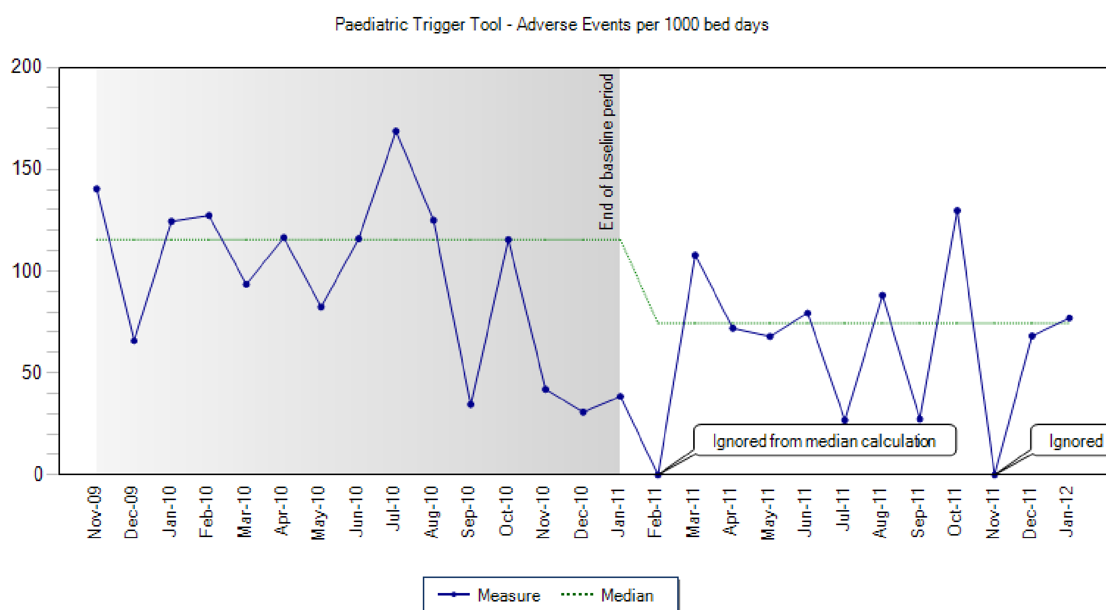
This index is the total number of harm incidents per 1000 Adjusted Patient Activities in the Trust. It includes hospital acquired infections (as above), serious incidents, non-ICU arrests, reported medication errors, patient falls, and pressure ulcers. It should be noted that the vision is to improve reporting of errors, so it is likely that the numbers will increase before they decrease ultimately. For example, the number of reported medication errors will increase as we encourage the reporting of incidents.



6. Paediatric Trigger Tool

Each month, 20 case notes are randomly selected to be reviewed by a group of clinical staff using the Paediatric Trigger Tool. Common themes have risen from these projects which will be worked on as improvement projects.
One of the first issues to be tackled has been the maintenance of patient notes. Issues such as overfull records which were difficult to handle and at risk of coming loose, and inconsistent filling, leading to difficulties in finding key parts of the record, such as discharge summaries and missing records. Secondly, issues were highlighted around entries made by clinical staff, including the failure to follow basic standards of record keeping and failure to document key events in the patient journey. Each Clinical Unit has added a project to improve the quality of Medical Records to their project plans. This will be reported through the Transformation Programme report.

The PTT group are conducting an annual review in May, to look at the findings over the past year and to acknowledge the achievement of this year's CQUIN.



A random sample of 20 notes are pulled each month and analysed for adverse events using a methodology developed by the IHI. It should be noted that we are working 2 months behind the date of discharge as they need to be discharged for 30 days and we need time to randomise and obtain all the case notes.

ATTACHMENT K

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

<table>
<tr><td colspan="2">Trust Board
May 2012</td></tr>
<tr><td>Key Performance Indicator report
Submitted on behalf of.
Fiona Dalton, Chief Operating Officer</td><td>Paper No: Attachment K</td></tr>
<tr><td colspan="2">Aims / summary
The KPI report monitors progress against the Trust's seven strategic objectives and Monitor's Governance Risk Framework. The report provides 'RAG' rated performance analysis against defined thresholds and tolerances as well as monthly and quarterly performance trends.

The report has been reviewed for 2012/13 with a number of amendments made:
- 48hr readmission to ITU: Measure removed as this was a 2011/12 CQUIN target that was achieved.
- Number of complaints: Total number of low and medium level complaints removed. A new target of improving on the total number of high level complaints has been put in place.
- New to follow up ratios: Measured removed. This indicator will continue within the Clinical unit KPI reports.
- Cancer waiting times: Given the trust's record of achieving 100% compliance against all relevant cancer targets performance will be monitored under a combined cancer measure.
- A 'RAG' rated summary of Clinical Unit performance has additionally been added across all indicators.</td></tr>
<tr><td colspan="2">Action required from the meeting
Trust Board to note progress.</td></tr>
<tr><td colspan="2">Contribution to the delivery of NHS / Trust strategies and plans
To assist in monitoring performance against internal and external defined objectives and NHS targets.</td></tr>
<tr><td colspan="2">Financial implications
None</td></tr>
<tr><td colspan="2">Legal issues
None</td></tr>
<tr><td colspan="2">Who needs to be / has been consulted about the proposals in the paper (staff, commissioners, children and families) and what consultation is planned/has taken place?
Our lead Commissioner receives a copy of the executive summary on a quarterly basis.</td></tr>
<tr><td colspan="2">Who needs to be told about any decision
Senior Management Team</td></tr>
<tr><td colspan="2">Who is responsible for implementing the proposals / project and anticipated timescales
Each Trust objective task has an identified person responsible for implementation and an Executive Director nominated as the accountable officer.</td></tr>
<tr><td colspan="2">Who is accountable for the implementation of the proposal / project
As above</td></tr>
<tr><td colspan="2">Author and date
Alex Faulkes, Head of Planning & Performance Management. May 2012</td></tr>
</table>

ATTACHMENT K

KPI Exception report

1. Clostridium Difficile

In month the Trust reported 1 case of C. difficile. The formal Trust year target is no more than 8 cases although Monitor has recently put in place an annual de minimis level of 12 cases for 2012/13.

2. MSSA and E-Coli

No formal external targets currently exist for MSSA and E-coli. However, the Trust has set an internal standard of reducing the number of infections from the previous year. In month 2 cases were reported against both bacteraemia.

3. Central Venous Line infections

In month, the Trust line infection rate increased with a reported rate of 3.02 (per 1,000 line days). The rate remains within the statistical control limits set but will continue to be monitored closely.

4. 18 Week Referral to Treatment (RTT) - Incomplete pathways

The Trust reported an April rate of 91.8% against a target of 92%. Clinical Units continue to review their backlog reports, providing clock stops and ensuring PiMS is updated in a timely manner. The Trust remains on target to achieve 92% standard by end of quarter one in line with Monitor's first quarter governance risk rating report.

5. Inpatient Waiting List over 26 weeks

All specialties within Surgery have undertaken a complete review of the planned waiting list and corrected all entries that should have been placed on the elective waiting list. This has had a significant adverse effect on the number of inpatients waiting over 26 weeks. As previously reported, particular capacity issues have been identified across a number of specialties, including: Urology, Orthopaedics, Maxillofacial and Plastic Surgery. Specific plans have been put in place across all specialties and waiting list issues are forecast to be resolved by early 2013.

The number of longer waiting patients is reducing. To address the need to meet both the national 18week RTT standards and treat the high number of long waiting patients (that were previously on the planned waiting list) the unit is initially focussing on treating patients that meet all of the following criteria:

- On an 18 week ticking pathway
- Past their 18 week Breach Date
- Have waited over 26 weeks based on inpatient wait rules
- And are not planned patients

Weekly reports are being provided to the Unit with the aim that all patients identified are actioned in time for review at a weekly Unit team meeting. The first cohort of patients that met these criteria have been reviewed. Of the 28 patients identified 10 were given TCI dates, 12 were brought forward, 3 were removed from the waiting list and 2 declined 2 reasonable offer dates (clock restart). The next cohort (44 patients) is currently being reviewed by the Unit.

4. Diagnostic waits over 6 weeks

Medicine and Surgery report a number of diagnostic waits over the six weeks standard. Performance improved in Gastroscopy with an in month reported rate of 0.2% against a previous month position of 0.8%. Colonoscopy and Cystoscopy report in month rates of 1.7% and 2.2% respectively (19 patients in total). Medicine continue to reorganise scope sessions in order to provide additional lists. These will be operational from June with waiting times set to reduce over the following 6 months.

5. Patient refusals
Cardiac and Surgery both had one patient in the month which was refused without referral to the Bed Management team.

6. Personal Development Review (PDR) completeness rates
The Trust rates remain low at 66% and 59.7% for clinical and non-clinical areas respectively against a target of 80%.

Appraisal rates exclude those staff who are on maternity leave and long term sick as well as new staff in post. Clinical figures include Medical staff that have a recorded appraisal. A number of recommendations to improve performance are being implemented following a recent internal audit of the Trust staff appraisal process. These include:

- To investigate any department that consistently fails to meet the required target and develop an action plan to reduce level of non-compliance.
- To introduce a formal regular monitoring process within the Clinical Unit Board meetings with PDR being a standing item on the agenda of each meeting.
- To implement Clinical Unit level KPI reports which include PDR performance information.

Escalation to the May 2012 Trust Board
This report is a summary of changes in performance of the measures at Clinical Unit level that have been reported to Management Board.

Where data can be analysed using methodology based upon statistical significance, we are able to determine whether each clinical unit has made a positive improvement or where a process has worsened. Similarly, for these measures we are able to make a judgement on whether an improvement is near to being realised.

Performance Measure	Change	Clinical Unit	Narrative
Total WHO checklist completion (Chart 1)		ICI	On-going work to ensure robust data entry in all areas including for LA lists in Dermatology through clarifying and reinforcing responsibilities Videoing and reflection tool to be undertaken in Rheumatology – to look at checklist quality
Same day surgery cancellations (Chart 2)		ICI	This chart represents all on the day cancellations, rather than just those for non-clinical reasons – as such it is not the most useful measure as we would expect variation in fitness for surgery, including seasonal with respiratory viruses and in Haem/Onc with neutropenic patients for example. There is on-going work around theatre utilisation as a whole – which will encompass any issues with regard cancellations. Some list delays have been evident on Safari recently due to staffing issues in IPP which are being addressed

ATTACHMENT K

Same day surgery cancellations (Chart 3)		MDTS	Close to a statistically significant reduction in performance
Same day surgery cancellations (Chart 4)		Surgery	This often increases during winter months and cancellations due to patient unwell have been very high particularly in ENT. Pre-assessment services will help to reduce this.
%age of clinic outcome forms complete (Chart 5)		Surgery	Close to a statistically significant reduction in performance

See appendix 1 below for the charts

	A statistically significant improvement has been identified
	Close to a statistically significant improvement
	Close to a statistically significant reduction in performance
	A statistically significant reduction in performance has been identified

Appendix 1

Chart 1
ICI

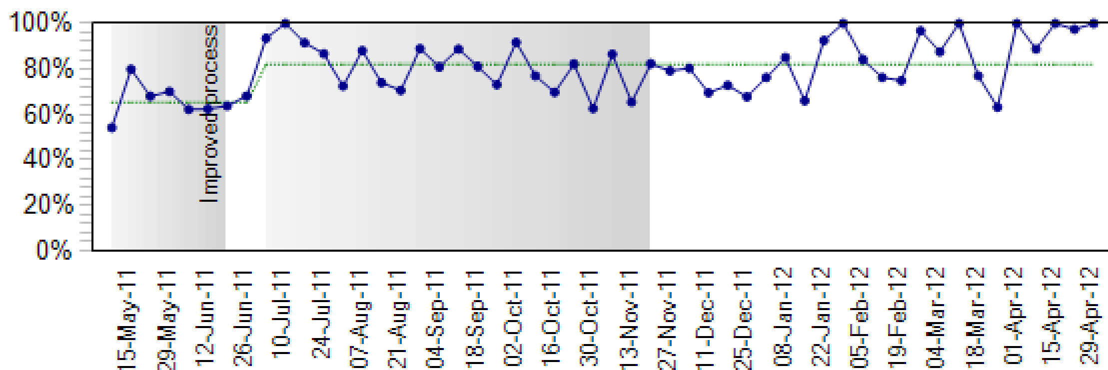


Chart 2
ICI

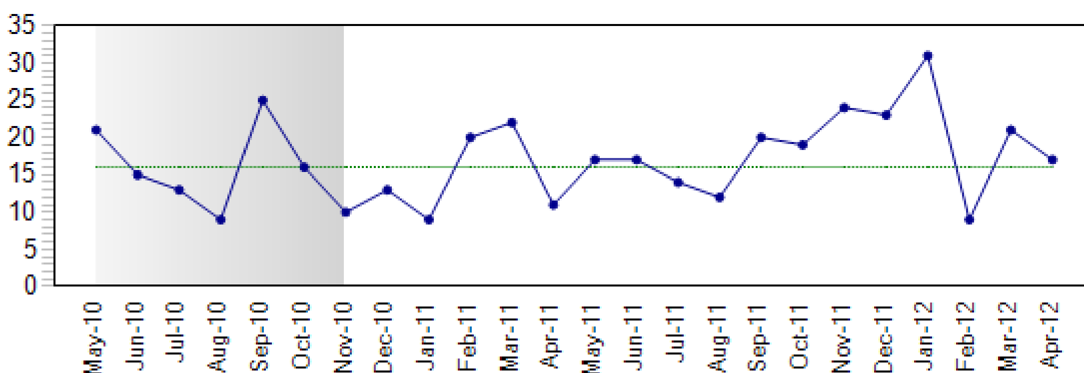


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Chart 3
MDTS

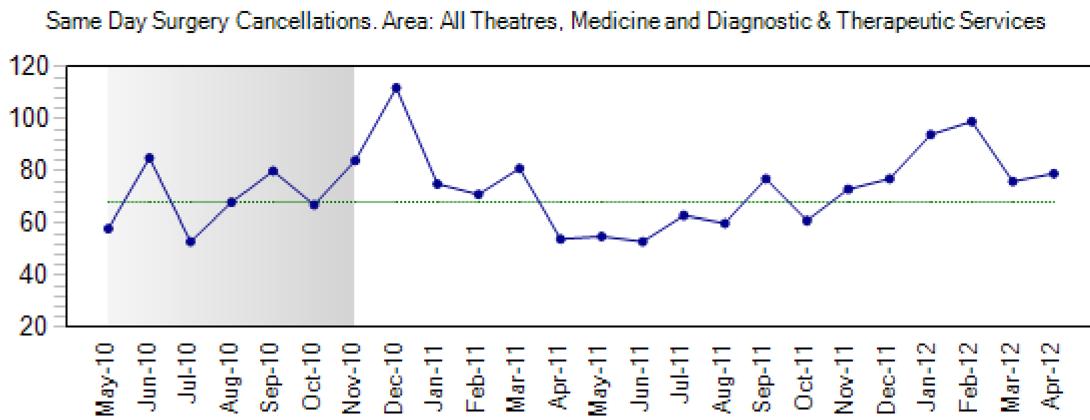


Chart 4
Surgery

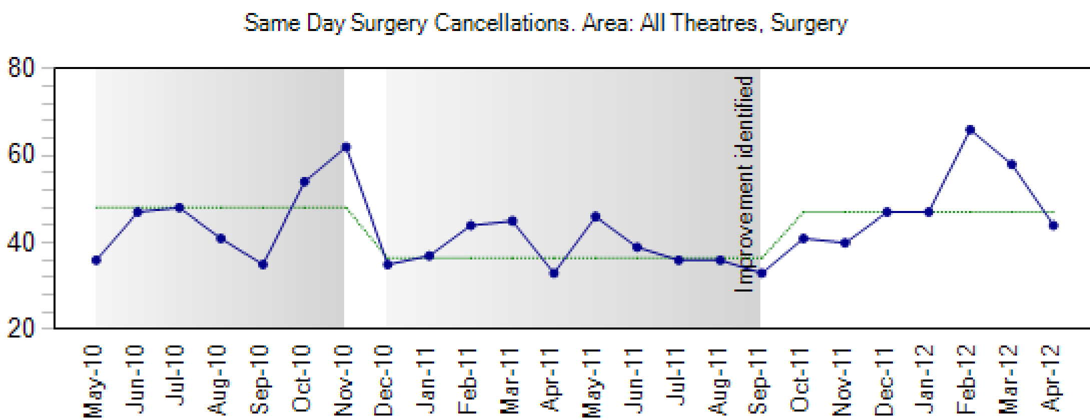
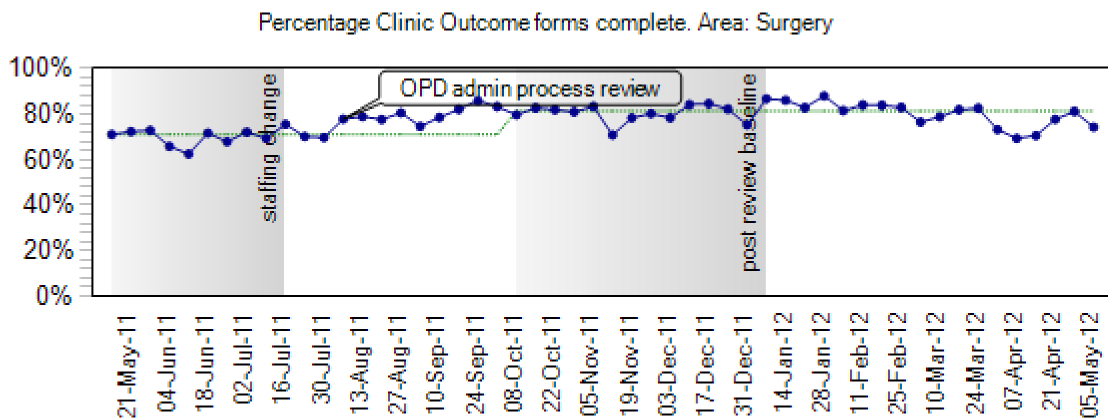


Chart 5
Surgery



Recommendations:
Trust Board to note progress

Great Ormond Street Hospital for Children
NHS Foundation Trust

Trust Board

Key Performance Indicator Report

Apr-12

Objective	Graph	Page no.	Reported	YTD Target/Trajectory (11/12)	**End of Year Performance (11/12)**	**In month / quarter performance**	Quarterly Trend			
							2012/13 Q1	2012/13 Q2	2012/13 Q3	2012/13 Q4
Objective 1	Incidence of C.difficile	4	Monthly	8	8	1				
	Incidence of MRSA**	4	Monthly	0	4	0				
	Incidence of MSSA	4	Monthly	19	20	2				
	Incidence of E-Coli	4	Monthly	20	21	2				
	No. of NICE recommendations unreviewed	4	Monthly	0	12	0				
	CV Line related blood-stream infections	5	Monthly	1.5	2.0	3.0				
	Mortality Figures	5	Monthly	Within tolerance	105	5				
	Serious Patient Safety Incidents	5	Monthly	Within tolerance	22	3				
	Surgical Check List completion rate (%)	6	Monthly	95.0	97.4	97.6				
Objective 2	18 week referral to treatment time performance - Admitted (%)	7	Monthly	90	90.0	90.4				
	18 week referral to treatment time performance - Non-Admitted (%)	7	Monthly	95	97.0	96.9				
	18 week referral to treatment time performance - Incomplete Pathways (%)	7	Quarterly	92	92.0	91.80				
	Inpatients waiting list profile (26+)	7	Monthly	0	274	238****				
	95th Centile - Admitted	7	Monthly	<23 weeks	21.2	26.2				
	95th Centile - Non-Admitted	7	Monthly	<18.3 weeks	17.7	17.7				
	Median Waits - Admitted	7	Monthly	<11.1 weeks	9.1	10.6				
	Median Waits - Non-Admitted	7	Monthly	<6.6 weeks	6.7	7.8				
	95th Centile - Incomplete Pathways	8	Monthly	<28 weeks	22.0	23.5				
	Median Waits - Incomplete Pathways	8	Monthly	<7.2 weeks	6.4	6.0				
	Discharge summary completion (%)	8	Monthly	95	79.3	79.3				
	DNA rate (new & f/up) (%)	8	Monthly	10	8.3	8.7				
	Cancelled Operations on day of admission (%)	9	Monthly	0.80	0.77	0.75				
	Percentage of Cancer patients waiting no more than 31 days for second of subsequent treatment (Surgery, Drug Treatements, Radiotherapy) & Maximum waiting time of one month from diagnosis to treatment for all cancers.	9	Monthly	98	100	100				
	Proportion of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests (%)	10	Monthly	<=1	3.03	4.10				
	Number of complaints	10	Monthly	-	132	8				
	Number of complaints by grade High	10	Monthly	<14	14	1				
	Theatre Utilisation (% Patient Operation Utilisation of Scheduled Duration, U4)	11	Monthly	70	-	68.4				
	Clinic Letter Turnaround (%)	11	Monthly	New indicator to be confirmed	-	25.4				
Objective 3	Patient refusals	12	Monthly	218	291	18				

Objective	Graph	Page no.	Reported	YTD Target/Trajectory (11/12)	End of Year Performance (11/12)	In month / quarter performance	Quarterly Trend 2012/13 Q1	2012/13 Q2	2012/13 Q3	2012/13 Q4
Objective 4	Clinical trials (CTIMPs)	13	Monthly	No decrease	New Indicator TBC	38				
	GOSH research projects	13	Monthly	No decrease	New Indicator TBC	393				
	Commercially-funded projects (%)	13	Monthly	No decrease	New Indicator TBC	100				
	Number of UKCRN Portfolio projects	13	Monthly	-	116	124				
	GOSH research income	13	Monthly	-	-	164,039				
	Patient safety SUIs	14	Monthly	0	-	3				
	Biomedical Research Centre (BRC) (£)	14	Monthly	-	-	31,683				
Objective 5	MADEL SLA Value (£)	15	Quarterly	-	5,580,806	Data Not Available				
	SIFT SLA Value (£)	15	Quarterly	-	60,142	Data Not Available				
	NMET SLA Value (£)	15	Quarterly	-	1,165,709	Data Not Available				
Objective 6	CRES Forecast Savings 2011/12 (£)	16	Monthly	TBC	8,248,330	14,974,722				
	Bank and agency total expenditure (£)	16	Monthly	To Reduce	4,096	Data Not Available				
	Monitor Risk Rating	16	Monthly	TBC	3	Data Not Available				
	Charity fundraising income (£)	16	Monthly	59,247,763	65,537,868	3,579,057				
Objective 7	Sickness Rate (%)	17	Quarterly	<3.3	3.02	2.35				
	Staff in Post	17	Quarterly	-	-	-				
	Vacancy Rate (%)	17	Quarterly	-	-	-				
	Trust Turnover (%)	17/18	Quarterly	-	-	22.7				
	Staff PDR completeness - clinical (%)	18	Monthly	80	-	66.0				
	Staff PDR completeness - non clinical (%)	18	Monthly	80	-	59.7				
	Information Governance Training (%)	18	Monthly	95	-	96.3				

* Rolling 12 month position

**Were an NHS foundation trust has an annual MRSA objective of six cases or fewer (the de minimus limit) and has reported six cases or fewer in the year to date, the MRSA objective will not apply for the purpose of Monitor's Compliance Framework.

*** Excludes readmissions to CICU from HDU

****Further Validation currently being undertaken

For Key, see Glossary

Key Performance Indicator Report

Great Ormond Street Hospital for Children
NHS Foundation Trust

Specialty Indicator Review

Objective	Indicator	YTD Target/Trajectory (12/13)	Trust	Cardiac	ICI	Neurosciences	Medicine	Diagnostic and Theraputic Services (DTS)	Surgery
Objective 1	Incidence of C.difficile	9	1	0	0	0	0	0	1
	Incidence of MRSA**	0	0	0	0	0	0	0	0
	Incidence of MSSA	19	2***	1	0	0	0	0	0
	Incidence of E-Coli	20	2***	0	0	0	0	0	0
	No. of NICE recommendations unreviewed	0	0	0	0	0	0	0	0
	CV Line related blood-stream infections	1.5	3.0	-	-	-	-	-	-
	Mortality Figures	Within tolerance	5						
	Serious Patient Safety Incidents	Within tolerance	3	1	1	0	1	0	0
	Surgical Check List completion rate (%)	95.0	97.6	98.4	96.2	99.0	99.0	99.0	98.7
Objective 2	18 week referral to treatment time performance - Admitted (%)	90	90.4						
	18 week referral to treatment time performance - Non-Admitted (%)	95	96.9						
	18 week referral to treatment time performance - Incomplete Pathways (%)	92	91.80	97.78	96.98	97.75	94.56		82.34
	Inpatients waiting list profile (26+)	0	238****	2	0	3	4	1	274
	95th Centile - Admitted	<23 weeks	26.2						
	95th Centile - Non-Admitted	<18.3 weeks	17.7						
	Median Waits - Admitted	<11.1 weeks	10.6						
	Median Waits - Non-Admitted	<6.6 weeks	7.8						
	95th Centile - Incomplete Pathways	<28 weeks	23.5						
	Median Waits - Incomplete Pathways	<7.2 weeks	6.0						
	Discharge summary completion (%)	95	79.30	86.73	69.33	76.92	76.49	50.00	84.84
	DNA rate (new & f/up) (%)	10	8.7	4.9	10.2	7.9	9.5	7.5	10.4
	Cancelled Operations on day of admission (%)	0.80	0.75	2.27	0.13	1.45	0.00	0.00	1.17
	Percentage of Cancer patients waiting no more than 31 days for second of subsequent treatment (Surgery, Drug treatments, Radiotherapy) & Maximum waiting time of one month from diagnosis to treatment for all cancers.	98	100	100	100	100	100	100	100
	Proportion of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests (%)	<=1	4.1	0	0	0	2.4	0	1.7
	Number of complaints	-	8*	0	2	2	0	0	2
	Number of complaints by grade High	<14	1	0	0	0	0	0	1
	Theatre Utilisation (% Patient Operation Utilisation of Scheduled Duration, U4)	70	68.4	69.0	53.5	74.0	49.5	58.8	71.2
	Clinic Letter Turnaround (%)	New indicator to be confirmed	25.4	-	-	-	-	-	-
Objective 3	Patient refusals	<218	18	1	0	0	0	0	17****
	Clinical Income variance (£)	-	Data Not Available	-	-	-	-	-	-
			Gosh & ICH Total						
Objective 4	Clinical trials (CTIMPs)	-	38	0	16	5	7	0	3
	GOSH research projects	-	393	5	30	14	16	3	13
	Commercially-funded projects (%)	-	100	0	1	0	0	0	0
	UKCRN Portfolio projects	-	124	6	51	14	34	5	14
	GOSH research income	-	164,039	28,087	25,660	12,500	40,667	43,050	14,075
	Patient safety SUIs	-	3	0	0	1	2	0	0
	BRC	-	31683	0	31683	0	0	0	0
Objective 5	MADEL SLA Value (£)	-	Data Not Available	-	-	-	-	-	-
	SIFT SLA Value (£)	-	Data Not Available	-	-	-	-	-	-
	NMET SLA Value (£)	-	Data Not Available	-	-	-	-	-	-

Objective	Measure	Target	Trust						
Objective 6	CRES Forecast Savings 2011/12 (£)	TBC	14,974,722	1,768,658	1,979,512	1,242,138	2373721**	-	3,095,315
	Bank and agency total expenditure (£)	To Reduce	Data Not Available	-	-	-	-	-	-

Objective	Measure	Target	Trust						
Objective 7	Sickness Rate (%)	<3.3	2.35	2.16	2.93	1.98	2.03	1.97	2.1
	Staff in Post	-	-						
	Vacancy Rate (%)	-	-						
	Trust Turnover (%)	-	22.7	15.00	15.32	14.08	16.93	17.89	16.77
	Staff PDR completeness - clinical (%)	80	66	52.3	68.1	62.3	67.4	-	62.3
	Staff PDR completeness - non clinical (%)	80	59.7	50.9	51.7	64.5	64.7	-	75.0
	Information Governance Training (%)	95	96.3	94.6	93.4	96.5	92.4	98.7	96.5

8* - Omission of complaints relating to IPP (1) & Trustwide (1)
**MDTS
***Additional case in IPP
****Of which 14 were CATs

Key Performance Indicator Report

Great Ormond Street Hospital for Children NHS Foundation Trust

Glossary

Objective	Graph	Tolerance		
		On Target	Of Concern	Action Required
		Green	Amber	Red
Objective 1	Incidence of C.difficile	Less than YTD Target	Within 10% of YTD Target	Worse than 90% of YTD Target
Objective 1	Incidence of MRSA	0 Cases	Trajectory less than 6 Cases**	Trajectory greater than 6 Cases
Objective 1	Incidence of MSSA	First Year of Recording		
Objective 1	Incidence of E-Coli	First Year of Recording		
Objective 1	Surgical Check List completion rate %	Greater than 95%	Between 85% and 95%	Less than 85%
Objective 1	No. of NICE recommendations unreviewed	Less or equal to 1	2or 3	Greater than 3
Objective 1	48 Hour readmission to ITU	Less than 3%	Less than 3.3%	Greater than or equal to 3.3%
Objective 1	Mortality Figures	Indicator		
Objective 1	Serious Patient Safety Incidents	Indicator		
Objective 1	CV Line related blood-stream infections	Less than 1.5	Between 1.5 and 2.5	Greater than 2.5
Objective 2	Discharge summary completion (%)	Greater than or equal to 95%	Between 75% and 95%	Less than 75%
Objective 2	DNA rate (new & f/up) (%)	Less than 9	Either 9 or 10	Greater than 10
Objective 2	Theatre Utilisation (Patient Operation Utilisation of Scheduled Duration U4)	Greater than 70%	Equal to or between 65% and 70%	Less than 65%
Objective 2	18 week referral to treatment time performance - Admitted	Greater than 91%	-	Less than 90%
Objective 2	18 week referral to treatment time performance - Non-Admitted	Greater than 96%	-	Less than 95%
Objective 2	18 week referral to treatment time performance - Incomplete Pathways	Greater than 92%	-	Less than 92%
Objective 2	95th Centile - Admitted	Less than 23 weeks	-	Greater than 23 weeks
Objective 2	95th Centile - Non-Admitted	Less than 18.3 weeks	-	Greater than 18.3 weeks
Objective 2	95th Centile - Incomplete Pathways	Less than 28 weeks	-	Greater than 28 weeks
Objective 2	Median Waits - Admitted	Less than 11.1 weeks	-	Greater than 11.1 weeks
Objective 2	Median Waits - Non-Admitted	Less than 6.6 weeks	-	Greater than 6.6 weeks
Objective 2	Median Waits - Incomplete Pathways	Less than 7.2 weeks	-	Greater than 7.2 weeks
Objective 2	Number of complaints	No RAG status - Plan not confirmed		
Objective 2	Number of complaints by grade High	No RAG status - Plan not confirmed		
Objective 2	Percentage of Cancelled Operations	Equal to or less than 0.8%	-	Greater than 0.8%
Objective 2	Percentage of Cancer patients waiting no more than 31 days for second of subsequent treatment (Surgery, Drug Treatements, Radiotherapy) & Maximum waiting time of one month from diagnosis to treatment for all cancers.	Equal to 100%	Greater than or equal to 95%	Less than 94%
Objective 2	Inpatients waiting list profile (26+)	0 Breaches	Between 0 and 10	Greater than 10
Objective 2	Clinic Letter Turnaround (%)	No RAG status - Plan not confirmed		
Objective 3	Patient refusals	Indicator		
Objective 3	Clinical Income variance	Indicator		

Objective	Indicator	Green	Amber	Red
Objective 4	Clinical trials (CTIMPs)	No RAG status - Plan not confirmed		
	GOSH research projects	No RAG status - Plan not confirmed		
	Commercially-funded projects (%)	No RAG status - Plan not confirmed		
	UKCRN Portfolio projects	No RAG status - Plan not confirmed		
	GOSH research income	No RAG status - Plan not confirmed		
	Patient safety SUIs	No RAG status - Plan not confirmed		
	BRC	No RAG status - Plan not confirmed		
Objective 5	MADEL SLA Value (£)	No RAG status - Plan not confirmed		
	SIFT SLA Value (£)	No RAG status - Plan not confirmed		
	NMET SLA Value (£)	No RAG status - Plan not confirmed		
Objective 6	Monitor Risk Rating	Equal to 3	-	Less than 3
	Charity fundraising income	Within - 5% Variance from Plan	More than - 5% Variance from Plan	More than - 15% Variance from Plan
	Bank and agency total expenditure	Indicator		
Objective 7	Staff PDR completeness - clinical (%)	Greater than or equal to 97%	Less than 97%	Less than to 95%
	Staff PDR completeness - non clinical (%)	Greater than or equal to 97%	Less than 97%	Less than to 95%
	Information Governance Training	Greater than or equal to 97%	Less than 97%	Less than to 95%
	Sickness Rate	Indicator		
	Staff in Post (£)	Indicator		
	Vacancy rate by staff group	Indicator		
	Trust Turnover	Indicator		

Key	
Target / Indicator	Internal
CQUIN	Contractual
National	DH Standard / Monitor

Appendix 3. Monitor Governance Risk Rating

Targets - weighted 1.0 (national requirements)		Thresholds	Weighting	Monitoring period	Month 1	Month 2	Q1
1	MRSA - meeting the MRSA objective *	0	1	Quarterly	0		
2	Clostridium difficile year on year reduction (to fit with trajectory for the year as agreed with PCT)	0	1	Quarterly	1		
3	All cancers: 31-day wait for second or subsequent treatment comprising either:	TBC	1	Quarterly	0		
	Surgery	94%			0		
	Anti cancer drug treatments	98%			0		
	Radiotherapy (from 1 Jan 2011)	94%			0		
	Cancer diagnostic to Treatment	85%			0		
4	Admitted within 18 weeks	90%	1	Quarterly	0**		
5	Non Admitted within 18 weeks	95%	1	Quarterly	0**		
6	92% - 18 week referral to treatment time Incomplete Pathways Performance	92%		Quarterly	0**		
7	Maximum waiting time of 31 days from diagnosis to treatment of all cancers	96%	0.5	Quarterly	0		
8	Certification against compliance with requirements regarding access to healthcare for peopl e with a learning disability	N/A	0.5	Quarterly	0		
Total					1		
Overall governance risk rating					Amber-green		

Monitor governance rating	
Green	from 0 to 0.9
Amber-green	from 1.0 to 1.9
Amber-red	from 2.0 to 3.9
Red	4.0 or more

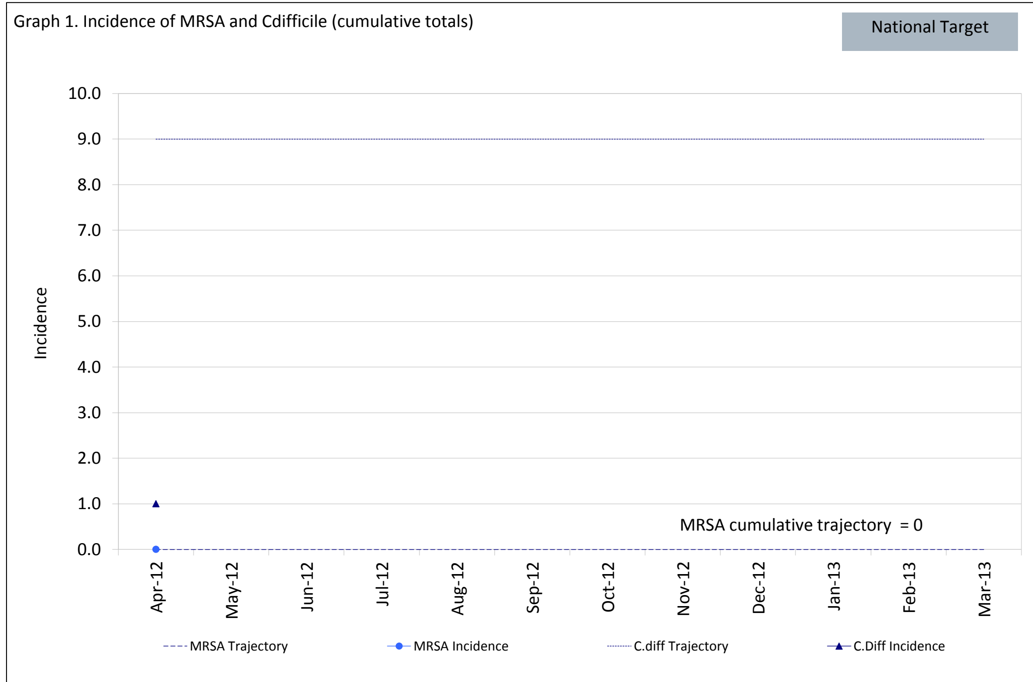
*Where an NHS foundation trust has an annual MRSA objective of six cases or fewer (the de minimis limit) and has reported six cases or fewer in the year to date, the MRSA objective will not apply for the purposes of Monitor's Compliance Framework

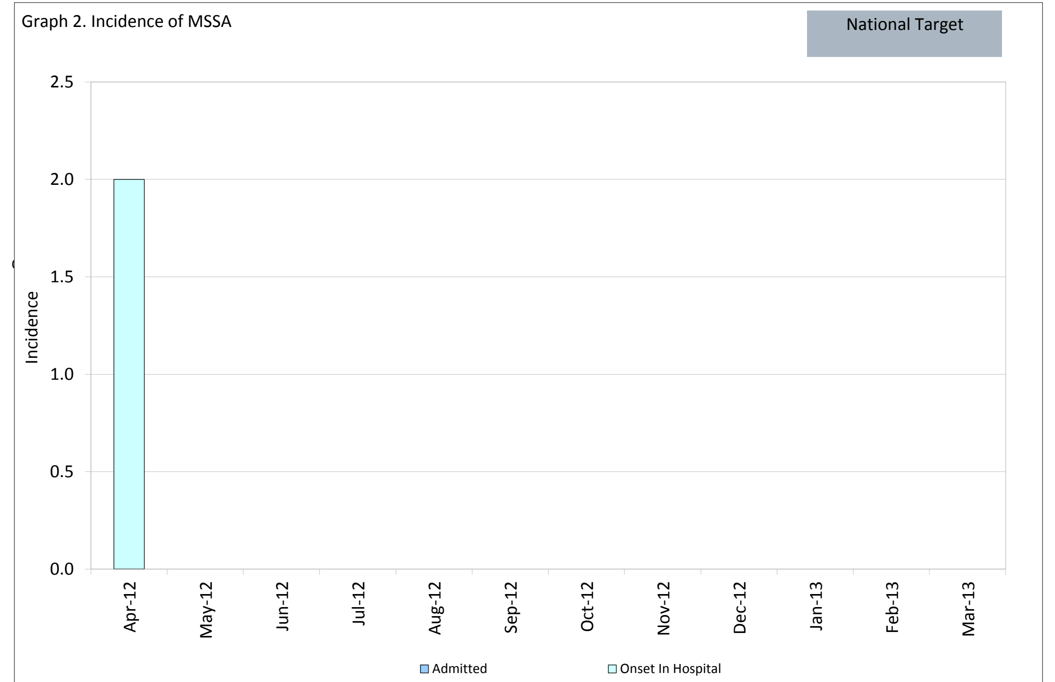
**To be confirmed but on trajectory to achieve

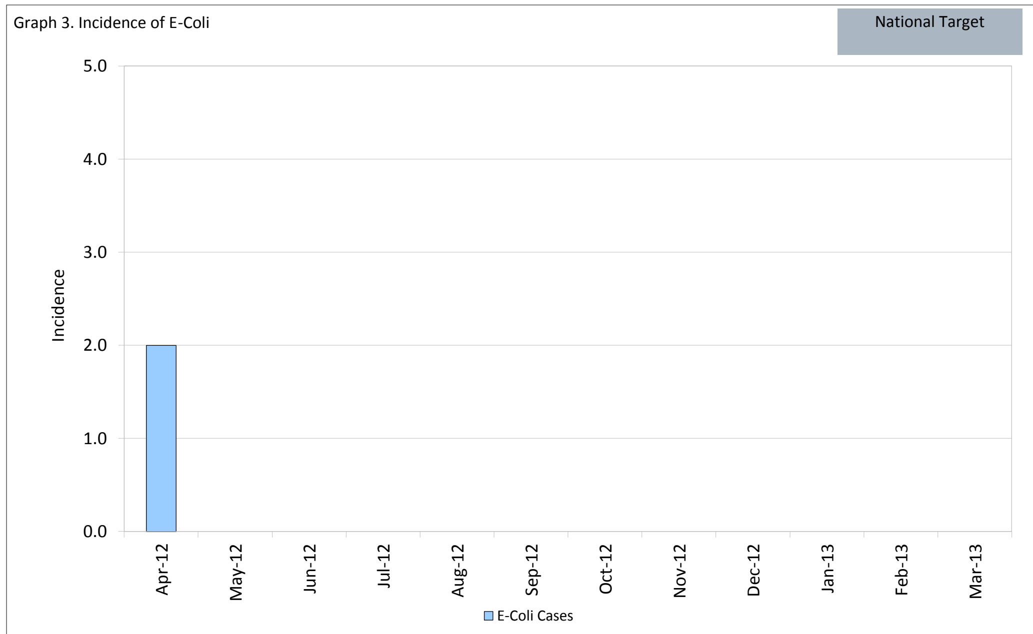
Risk rating	Description (risk of significant breach of authorisation)
Green	No material concerns
Amber-green	Emerging concerns
Amber-red	Potential future significant breach if not rectified
Red	Likely or actual significant breach

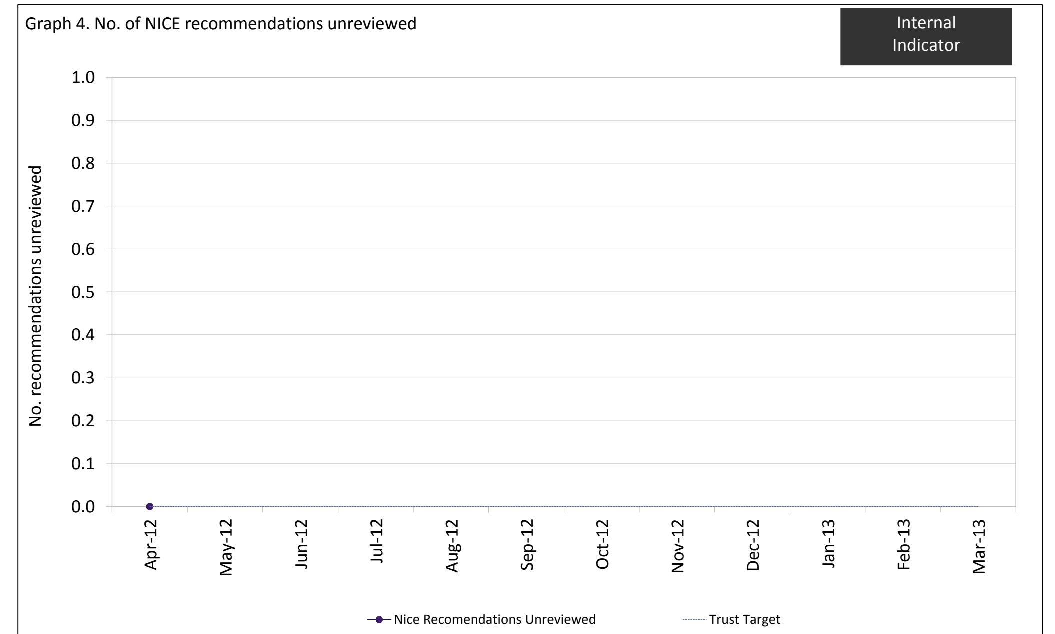
Great Ormond Street Hospital for Children NHS Foundation Trust

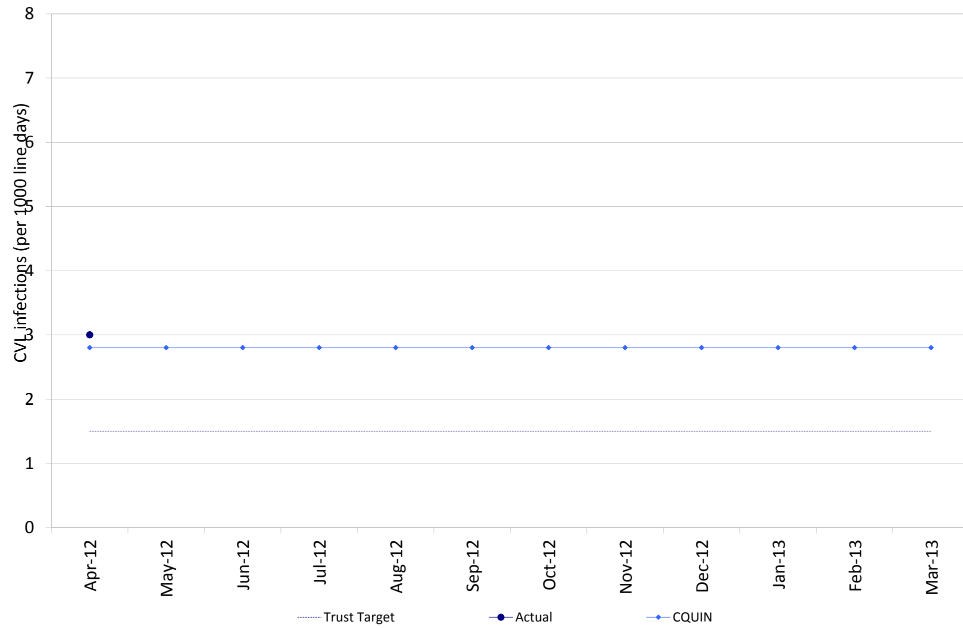
1. Consistently deliver clinical outcomes that place us amongst top 5 Children's Hospitals in the world.

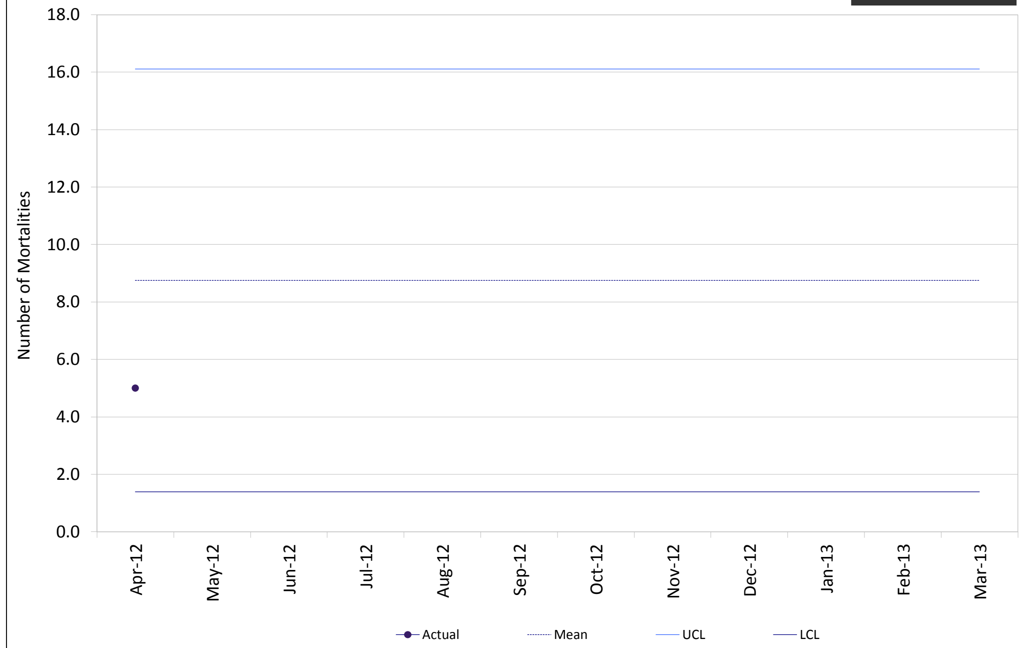


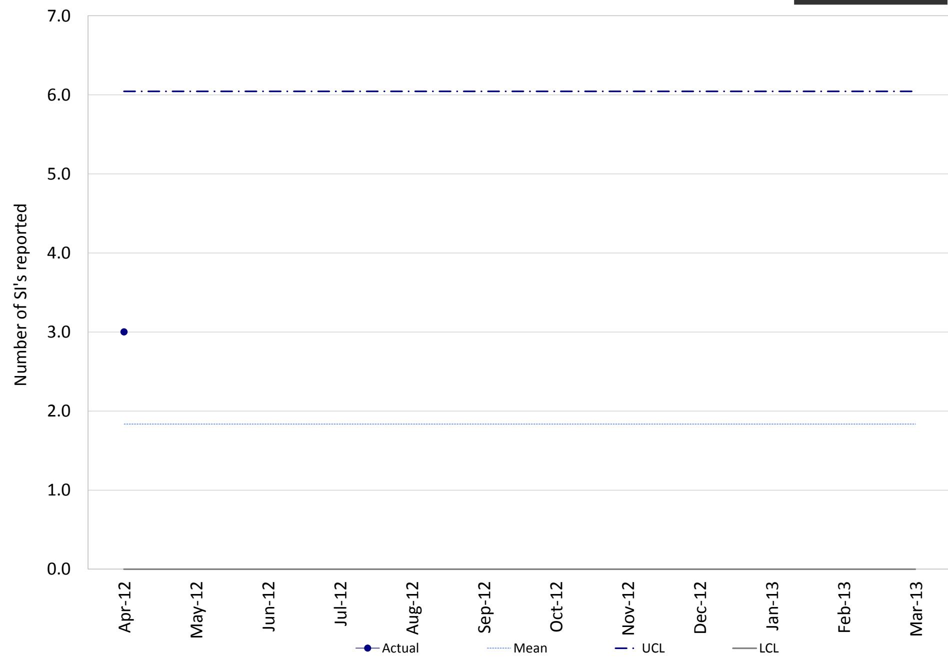


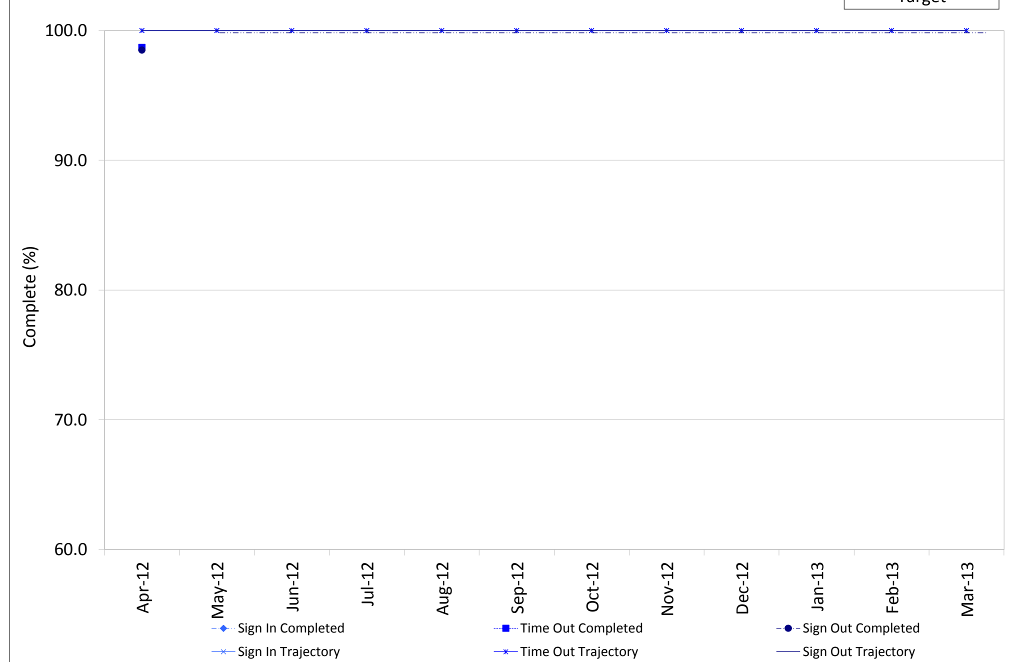


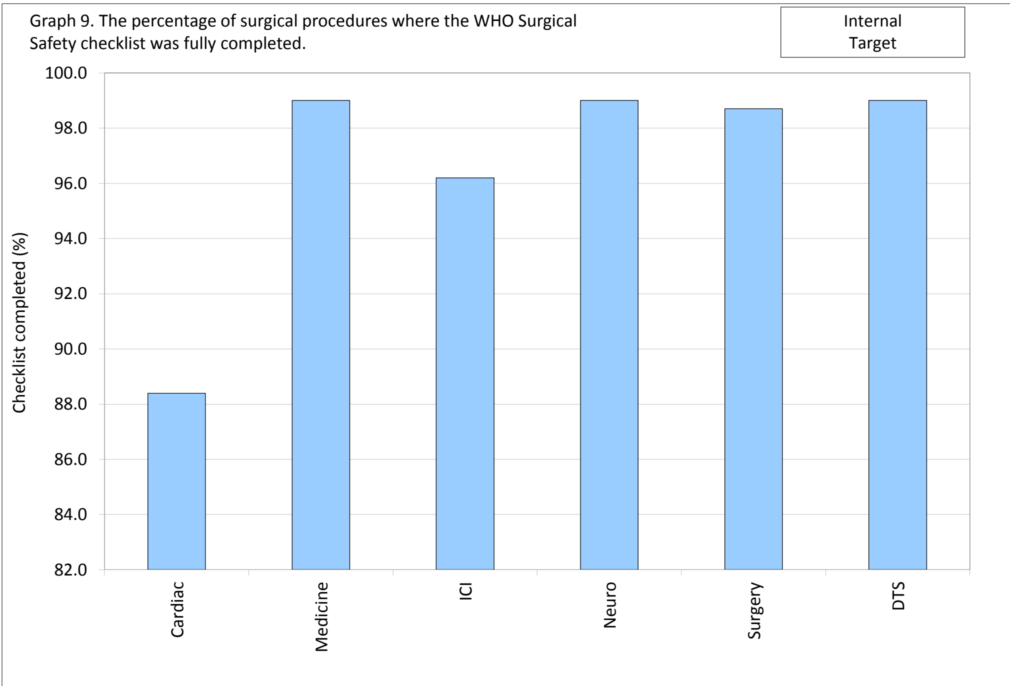



Graph 5. CV Line Infections (per 1000 bed days) - All areas
CQUIN Measure
CVL infections (per 1000 line days)
8
7
6
5
4
3
2
1
0
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Trust Target
Actual
CQUIN

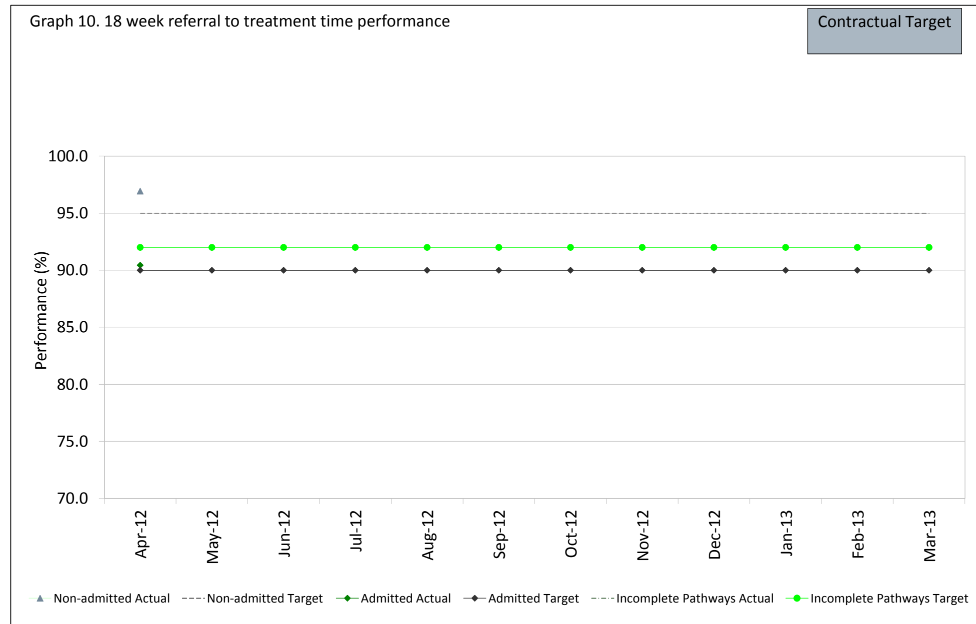

Graph 6. Mortality Figures - where discharge reason is 'Died'.
Internal Indicator
Number of Mortalities
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Actual
Mean
UCL
LCL

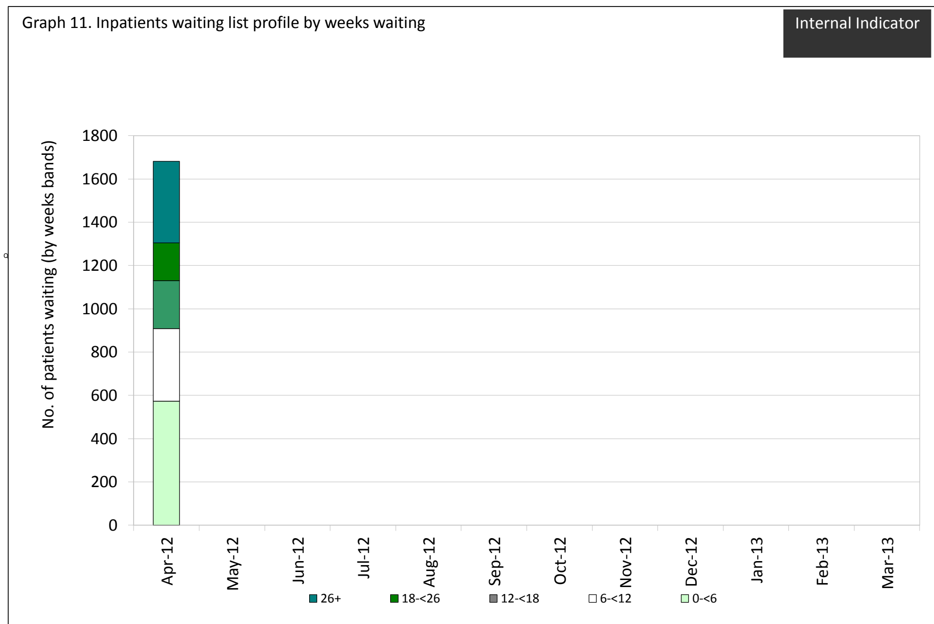

Graph 7. Serious Incidents Aug 2007 - May 2011
Internal Indicator
Number of SI's reported
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Actual
Mean
UCL
LCL

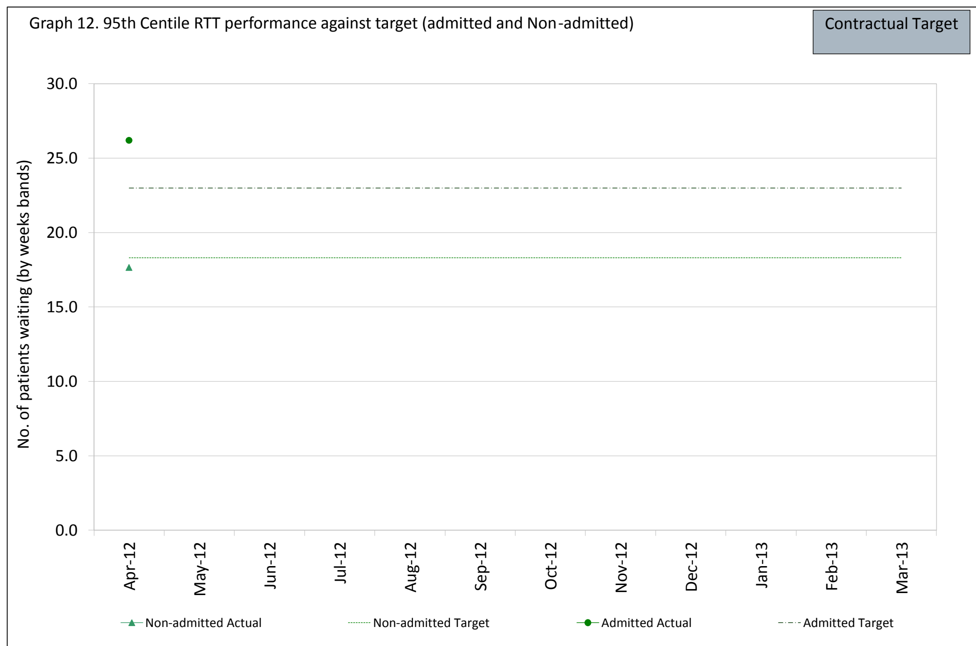

Graph 8. Theatre Patient Safety Checklist Completion rates against total operations
Internal Target
Complete (%)
100.0
90.0
80.0
70.0
60.0
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Sign In Completed
Time Out Completed
Sign Out Completed
Sign In Trajectory
Time Out Trajectory
Sign Out Trajectory

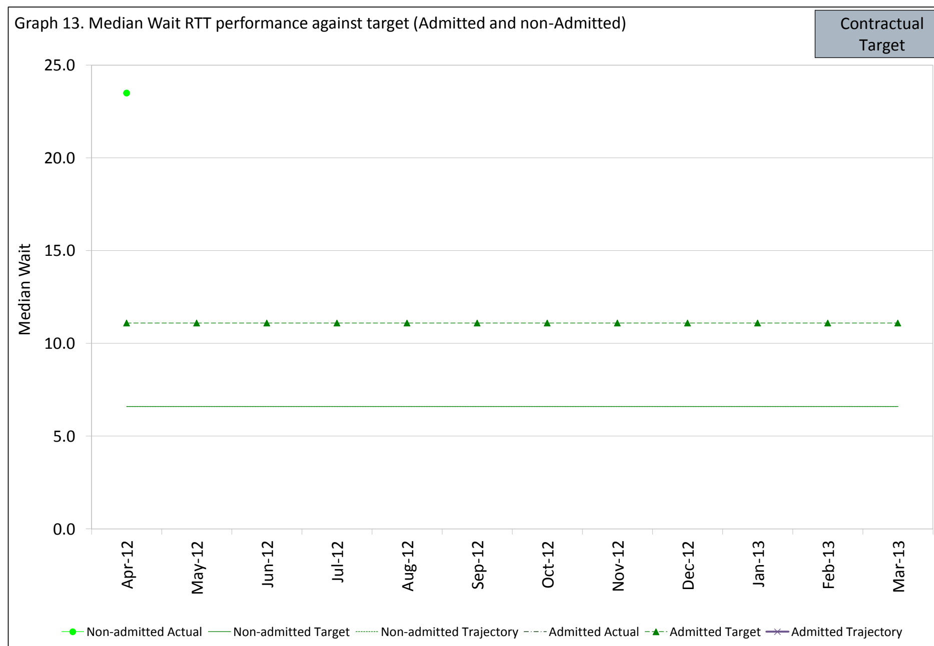

Graph 9. The percentage of surgical procedures where the WHO Surgical Safety checklist was fully completed.
Internal Target
Checklist completed (%)
100.0
98.0
96.0
94.0
92.0
90.0
88.0
86.0
84.0
82.0
Cardiac
Medicine
ICI
Neuro
Surgery
DTS

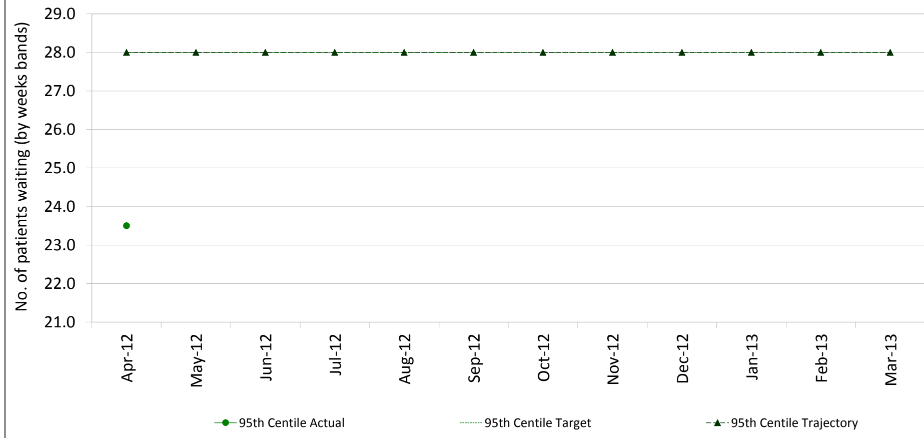
2. Consistently deliver an excellent experience that exceeds our patient, family and referrers' expectations

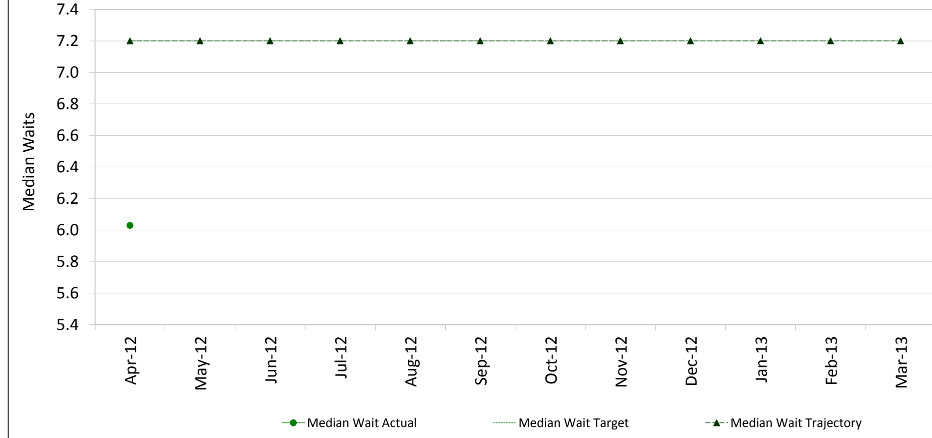


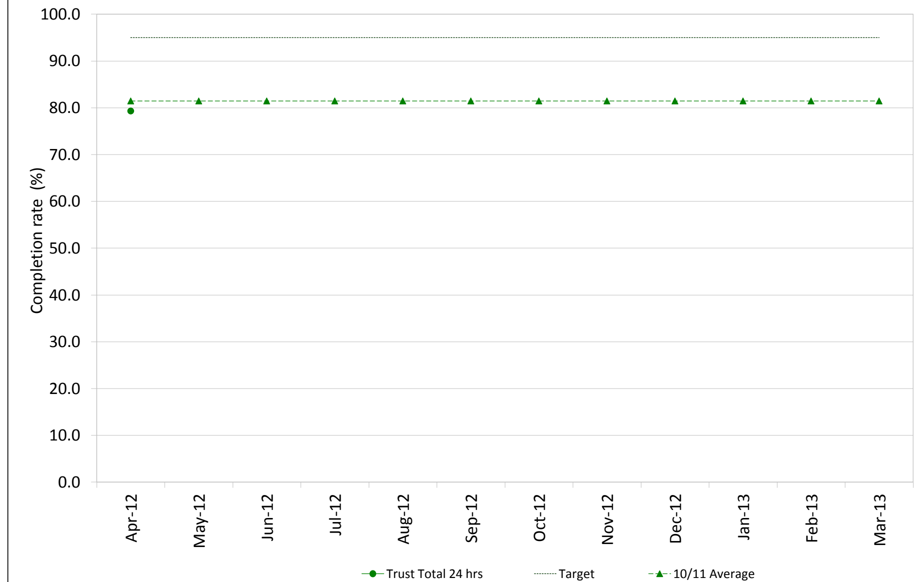


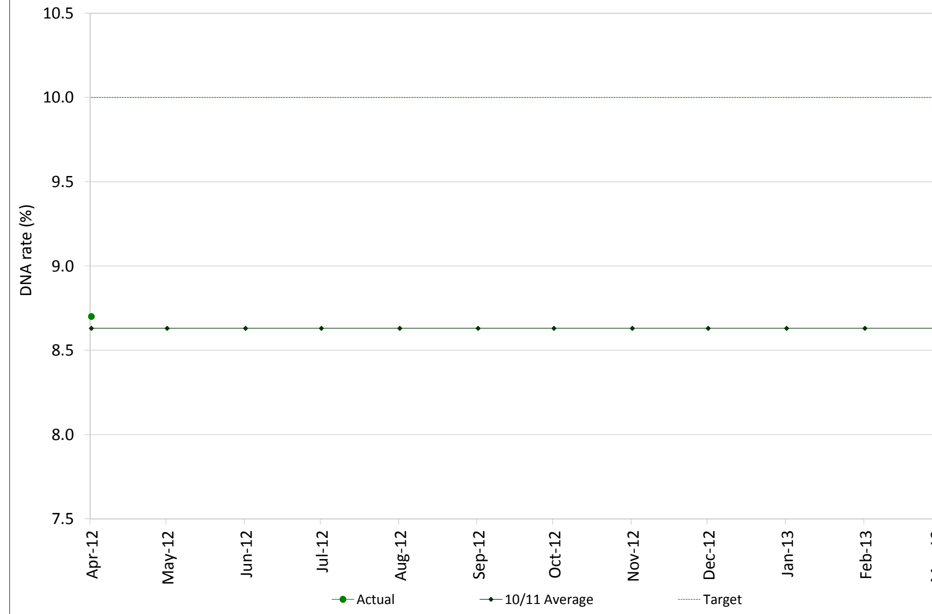





Graph 14. 95th Centile - Incomplete pathways
Contractual Target
No. of patients waiting (by weeks bands)
29.0
28.0
27.0
26.0
25.0
24.0
23.0
22.0
21.0
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
95th Centile Actual
95th Centile Target
95th Centile Trajectory

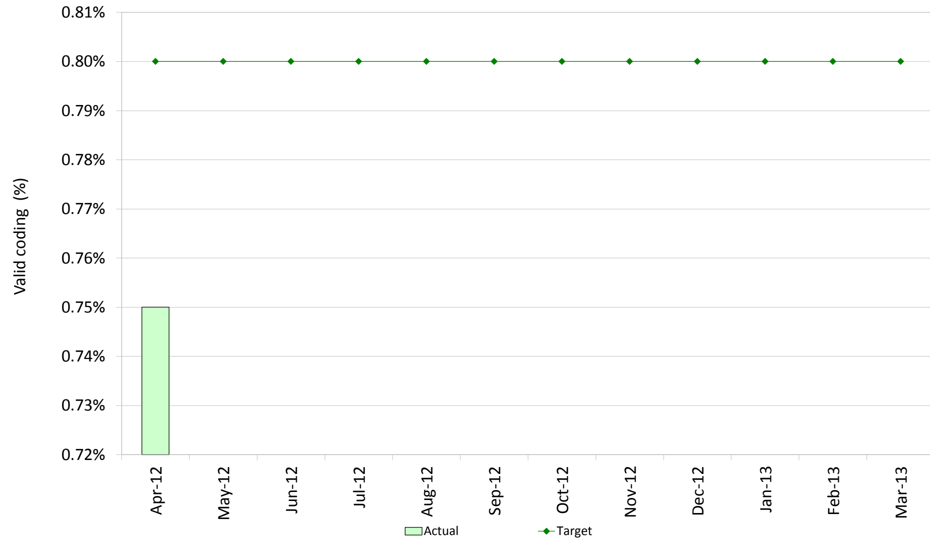

Graph 15. Median Waits - Incomplete pathways
Contractual Target
Median Waits
7.4
7.2
7.0
6.8
6.6
6.4
6.2
6.0
5.8
5.6
5.4
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Median Wait Actual
Median Wait Target
Median Wait Trajectory


Graph 16. Trust wide discharge summary completion rates (within 24 hours)
Internal Target
Completion rate (%)
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Trust Total 24 hrs
Target
10/11 Average


Graph 17. DNA rate (New and Follow-up patients)
Internal Target
DNA rate (%)
10.5
10.0
9.5
9.0
8.5
8.0
7.5
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Actual
10/11 Average
Target

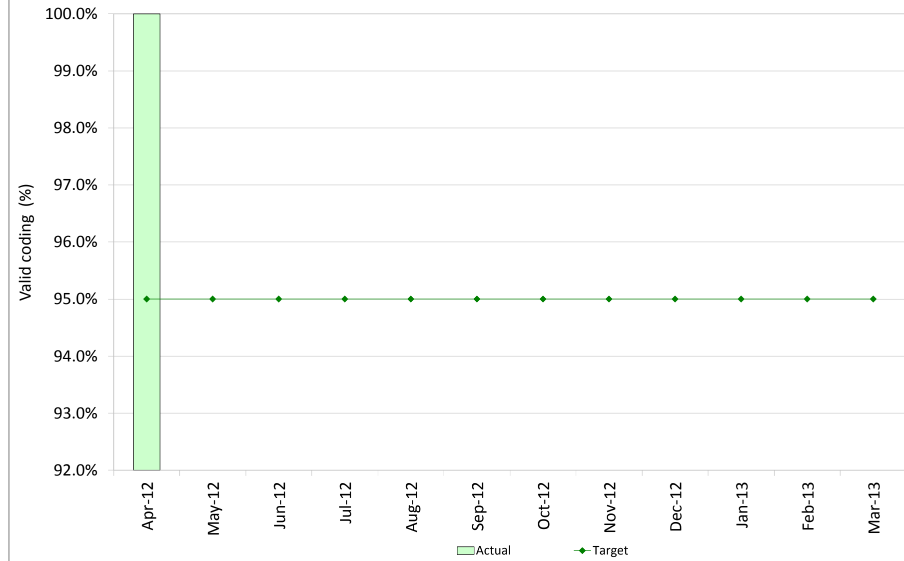
Graph 18. Percentage of all Cancelled Operations as a proportion of total elective spells

Contractual Target



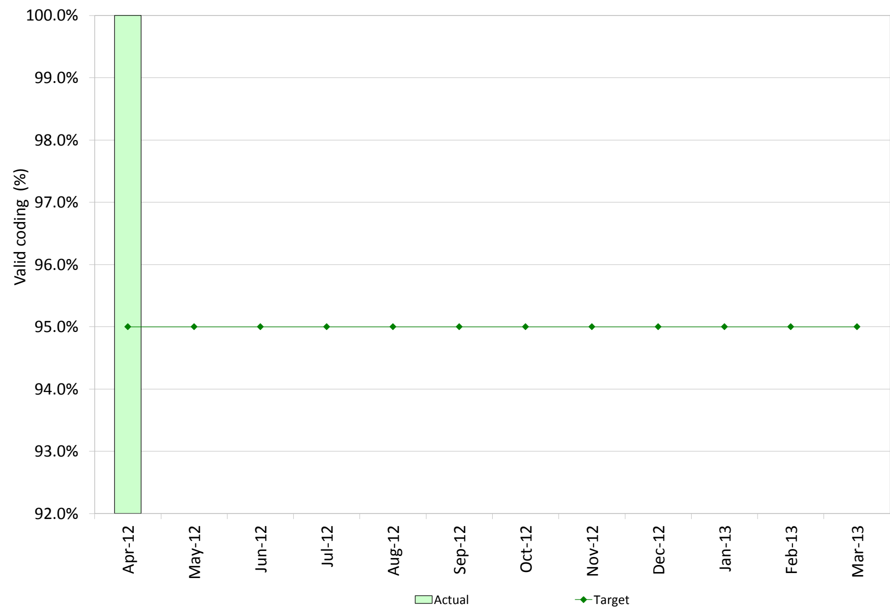
Graph 19. Proportion of Cancer patients waiting no more than 31 days for second or subsequent treatment - surgery

National Target



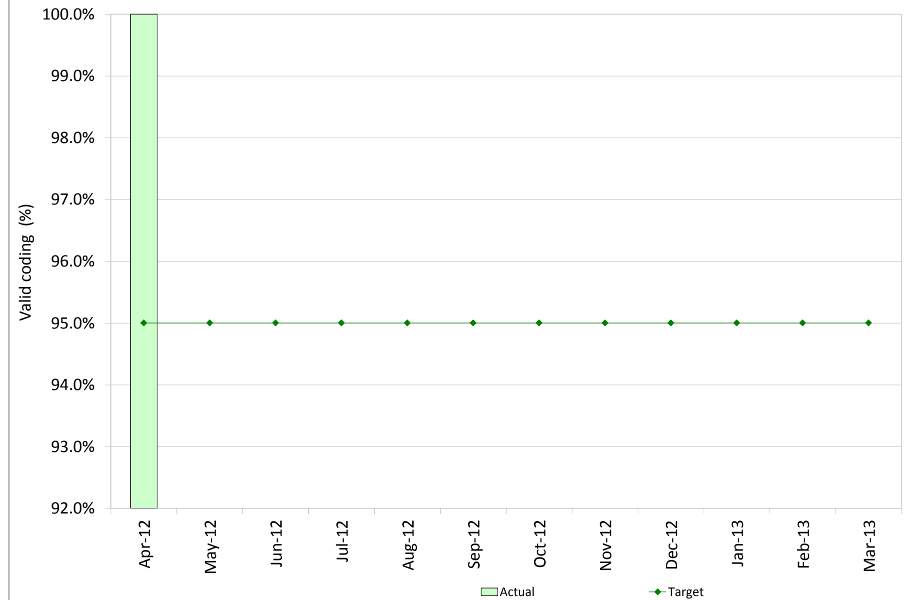
Graph 20. Proportion of Cancer patients waiting no more than 31 days for second or subsequent treatment - drug treatments

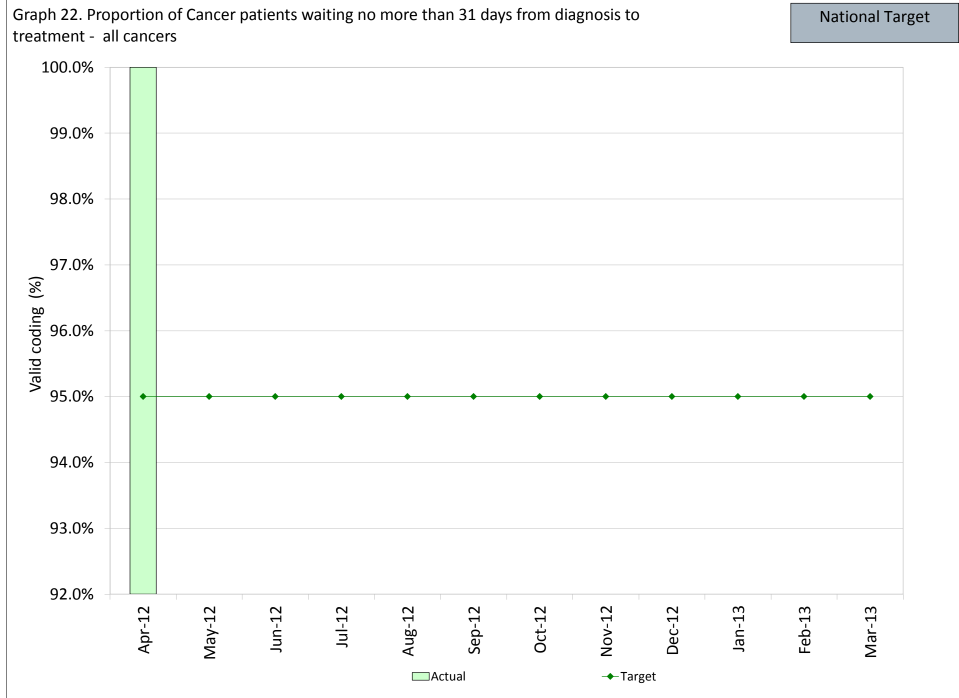
National Target



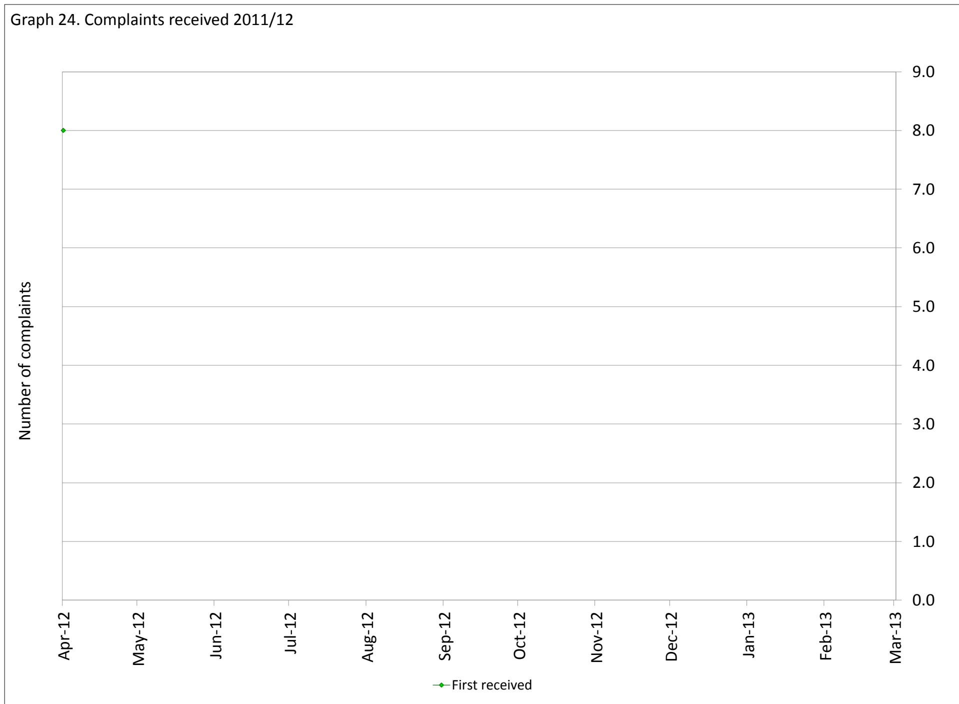
Graph 21. Proportion of Cancer patients waiting no more than 31 days for second or subsequent treatment - radiotherapy

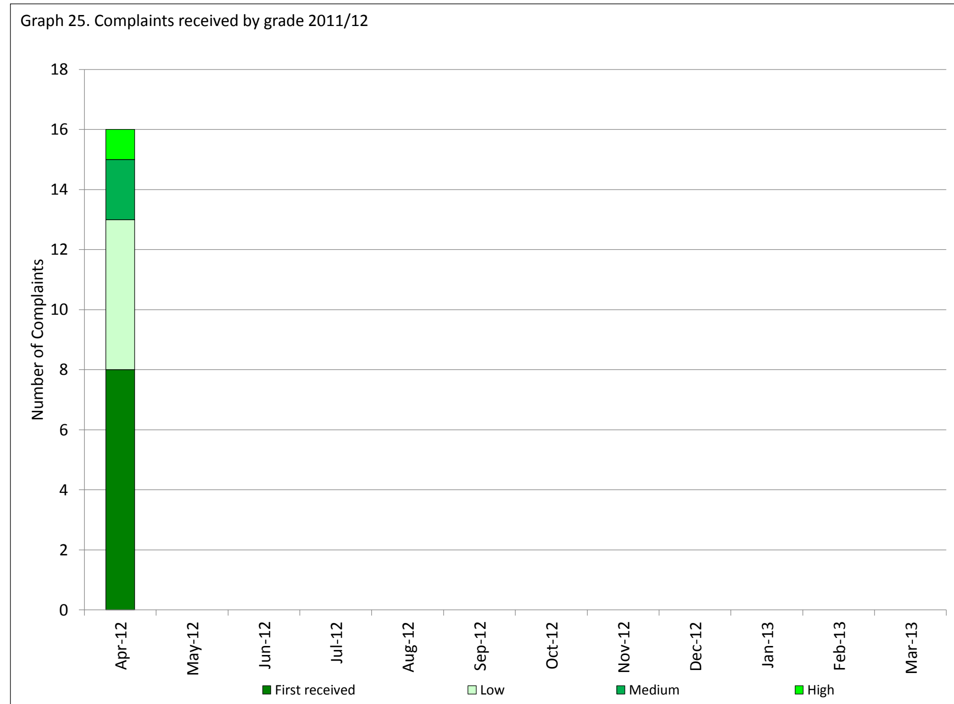
National Target

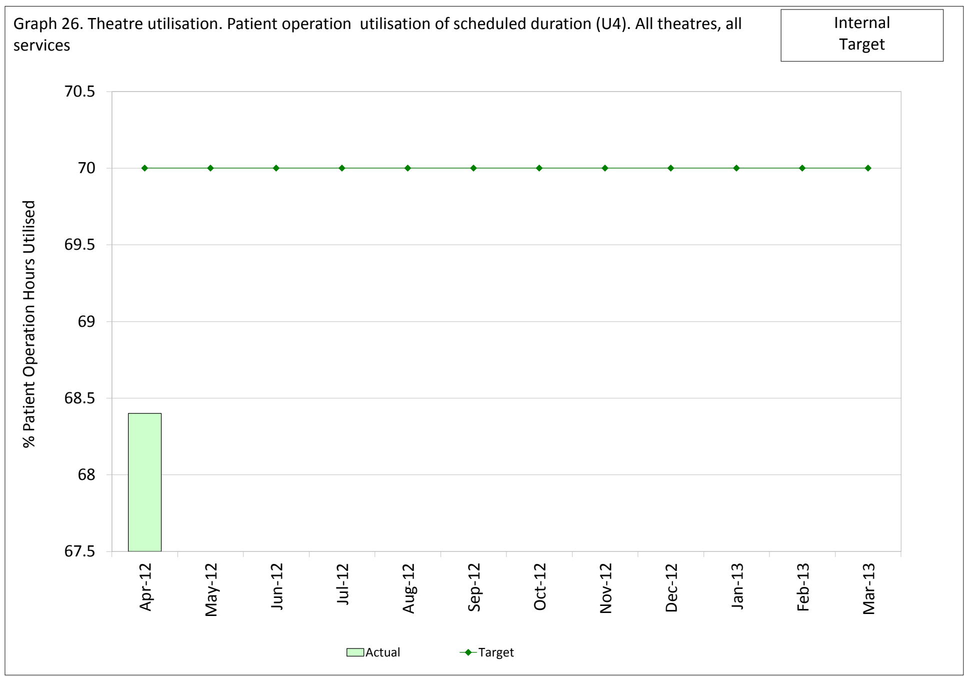


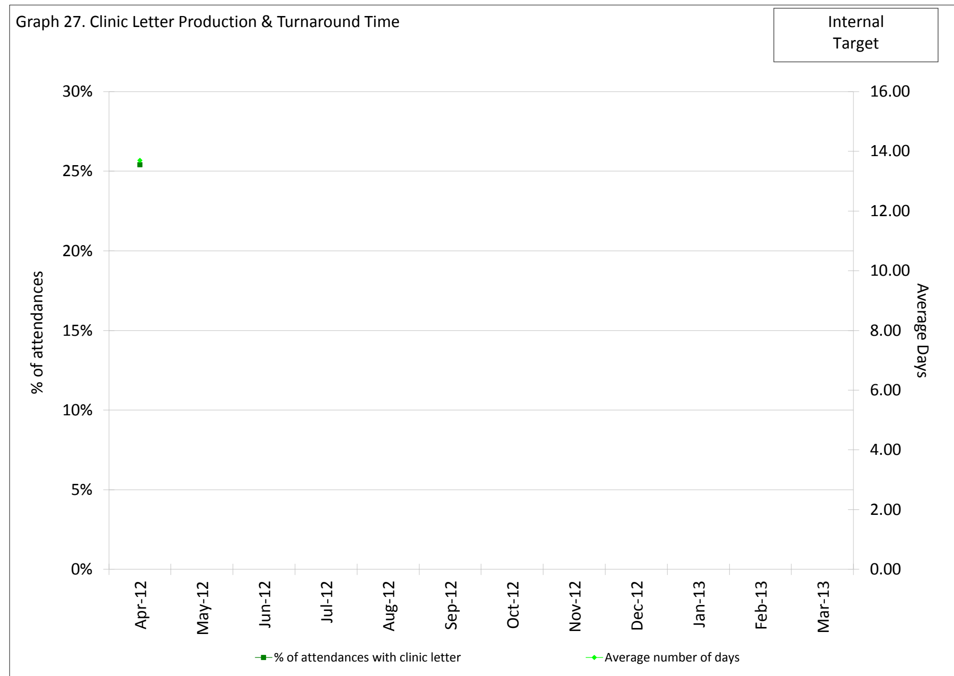

Graph 22. Proportion of Cancer patients waiting no more than 31 days from diagnosis to treatment - all cancers
National Target
Valid coding (%)
100.0%
99.0%
98.0%
97.0%
96.0%
95.0%
94.0%
93.0%
92.0%
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Actual
Target

Graph 23. Proportion of patients waiting no more than 6 weeks for diagnostic testing in 15 key diagnostic tests
National Target
Valid coding (%)
4.50%
4.00%
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Magnetic Resonance Imaging
Computed Tomography
Non-obstetric ultrasound
Barium Enema
DEXA Scan
Audiology Assessment
Echocardiography
Electrophysiology
Peripheral neurophysiology
Sleep studies
Urodynamics
Colonoscopy
Flexi sigmoidoscopy
Cystoscopy
Gastroscopy
Target

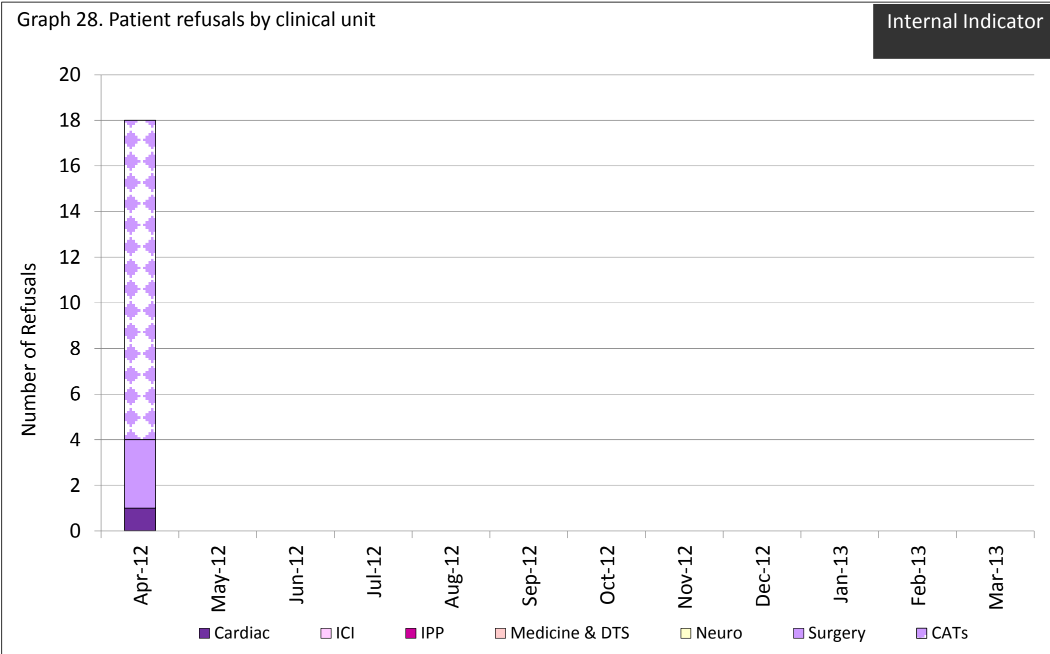

Graph 24. Complaints received 2011/12
Number of complaints
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
First received


Graph 25. Complaints received by grade 2011/12
Number of Complaints
18
16
14
12
10
8
6
4
2
0
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
First received
Low
Medium
High


Graph 26. Theatre utilisation. Patient operation utilisation of scheduled duration (U4). All theatres, all services
Internal Target
% Patient Operation Hours Utilised
70.5
70
69.5
69
68.5
68
67.5
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Actual
Target

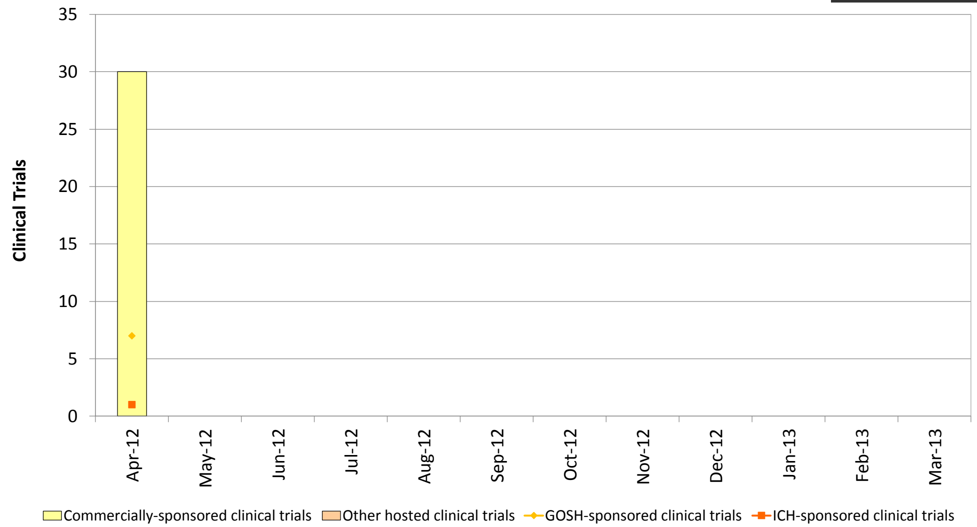

Graph 27. Clinic Letter Production & Turnaround Time
Internal Target
% of attendances
30%
25%
20%
15%
10%
5%
0%
Average Days
16.00
14.00
12.00
10.00
8.00
6.00
4.00
2.00
0.00
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
% of attendances with clinic letter
Average number of days

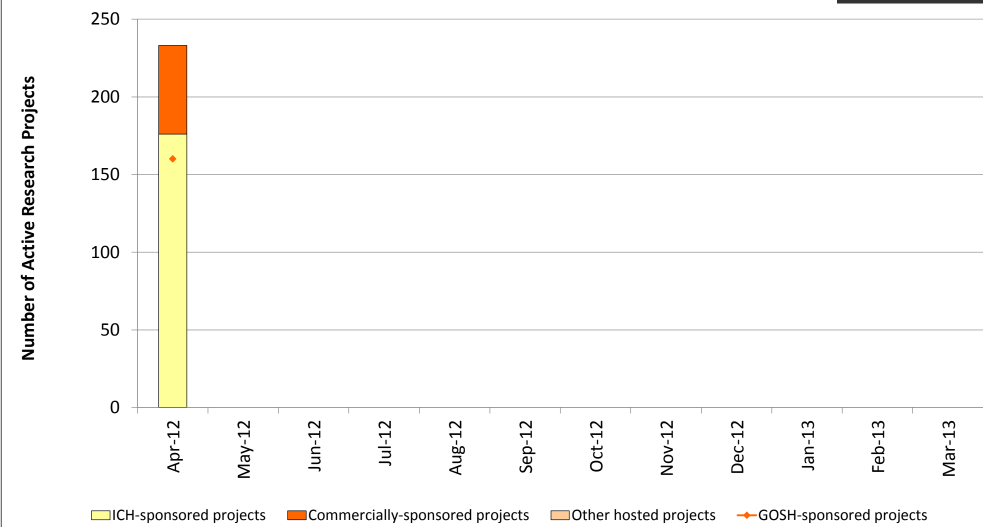
3. Successfully deliver our clinical growth strategy

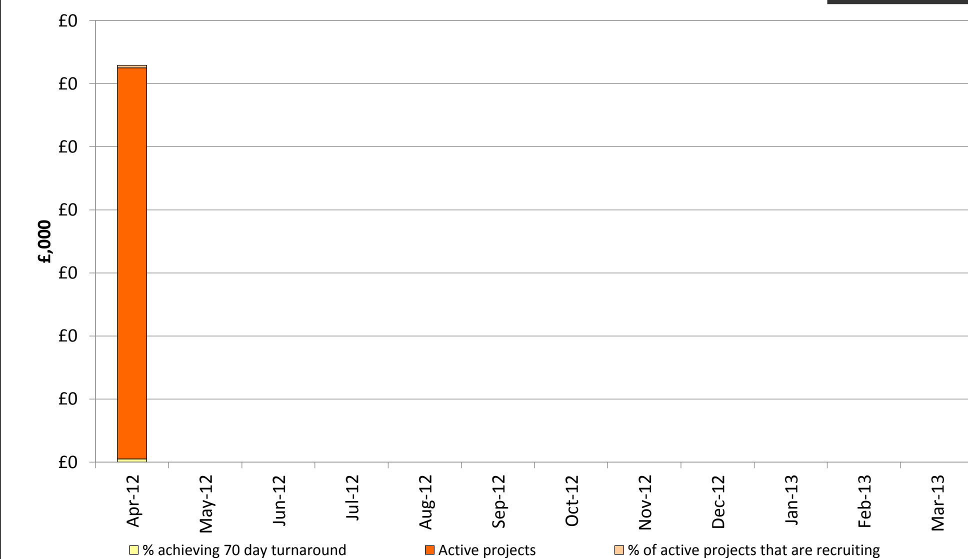


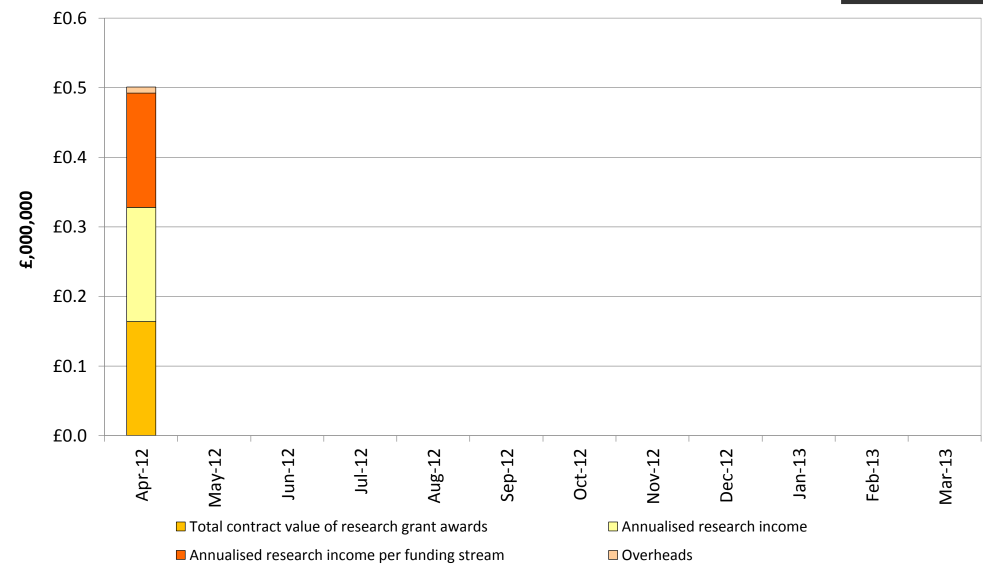
Great Ormond Street Hospital for Children NHS Foundation Trust

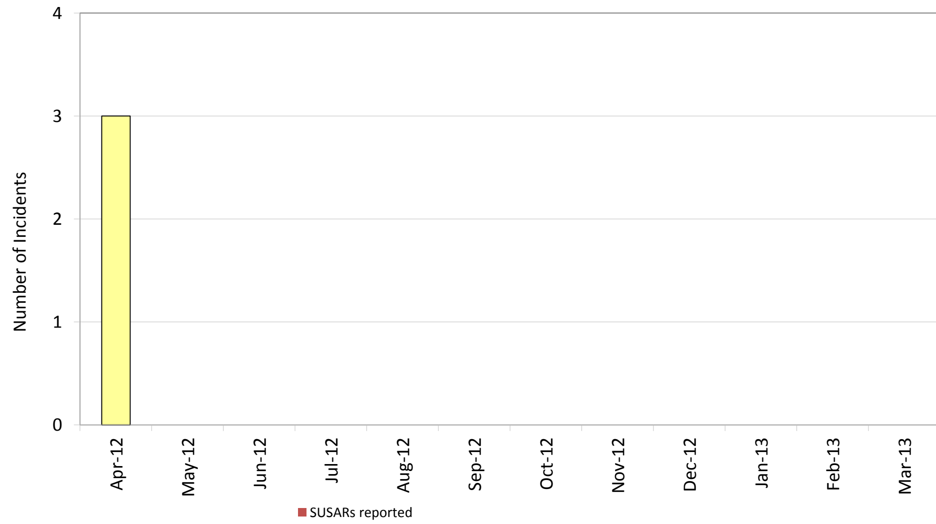
4. Currently partnered with ICH, and moving to UCL Partners with AHSC, maintain and develop our position as the UK's top children's research organisation

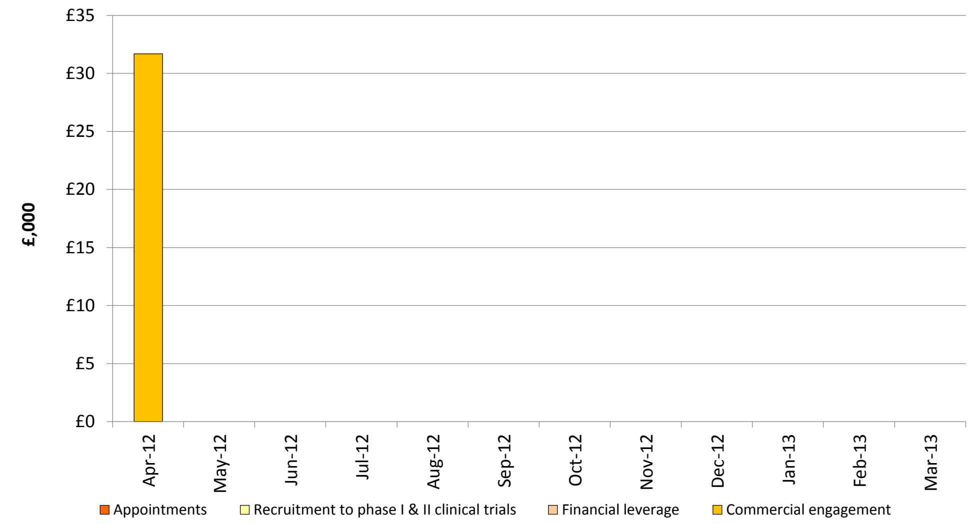




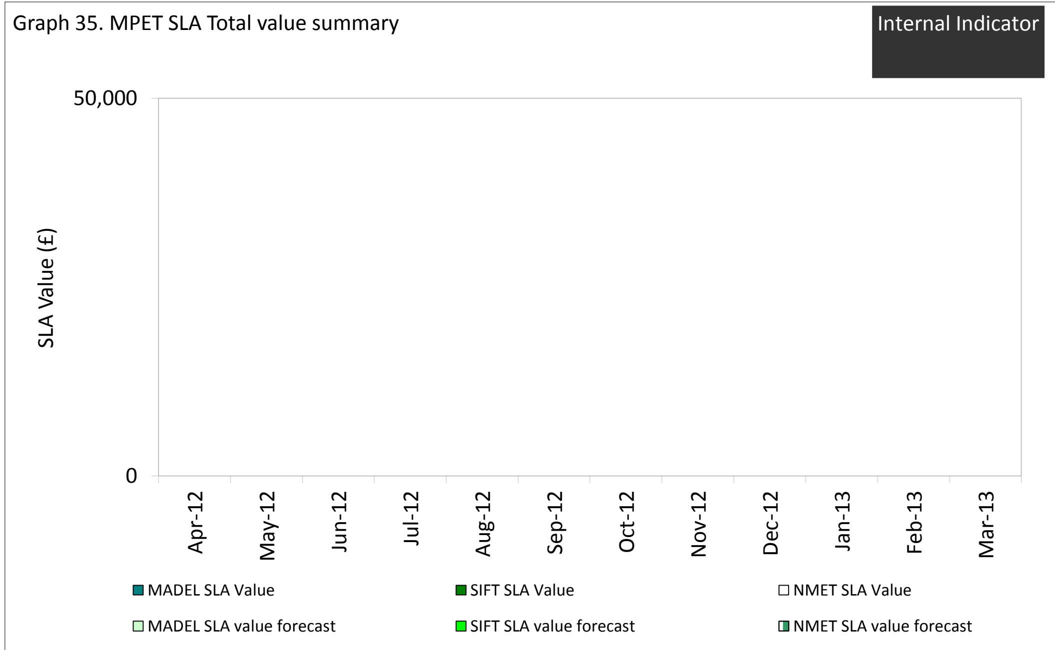


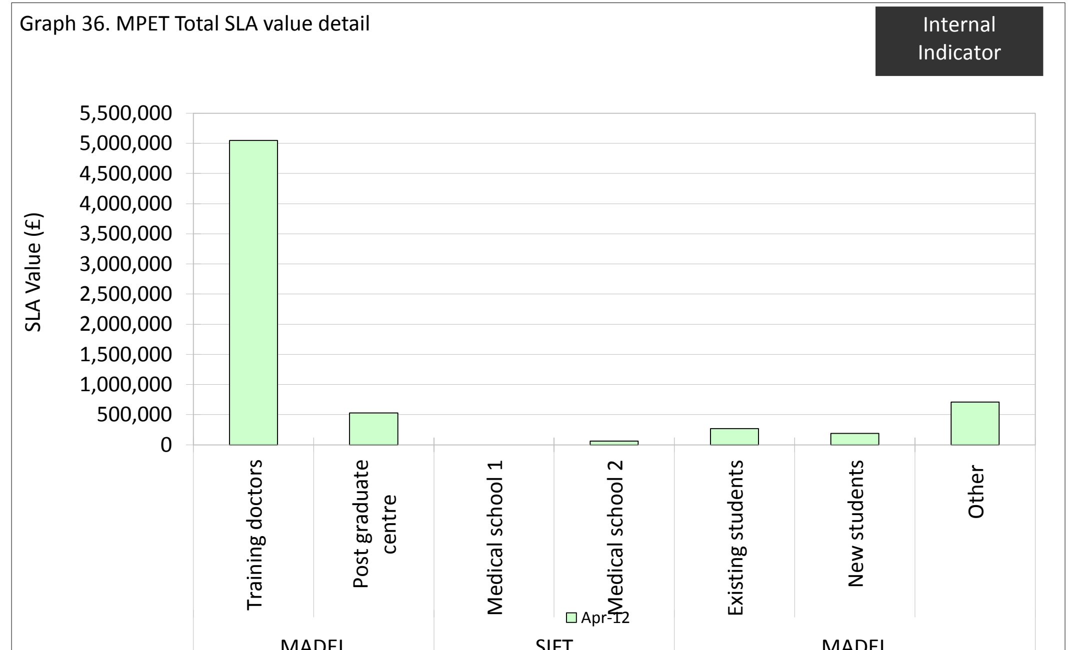



Graph 33. Patient Safety reports for GOSH sponsored clinical trials
Internal Indicator
Number of Incidents
0
1
2
3
4
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
SUSARs reported

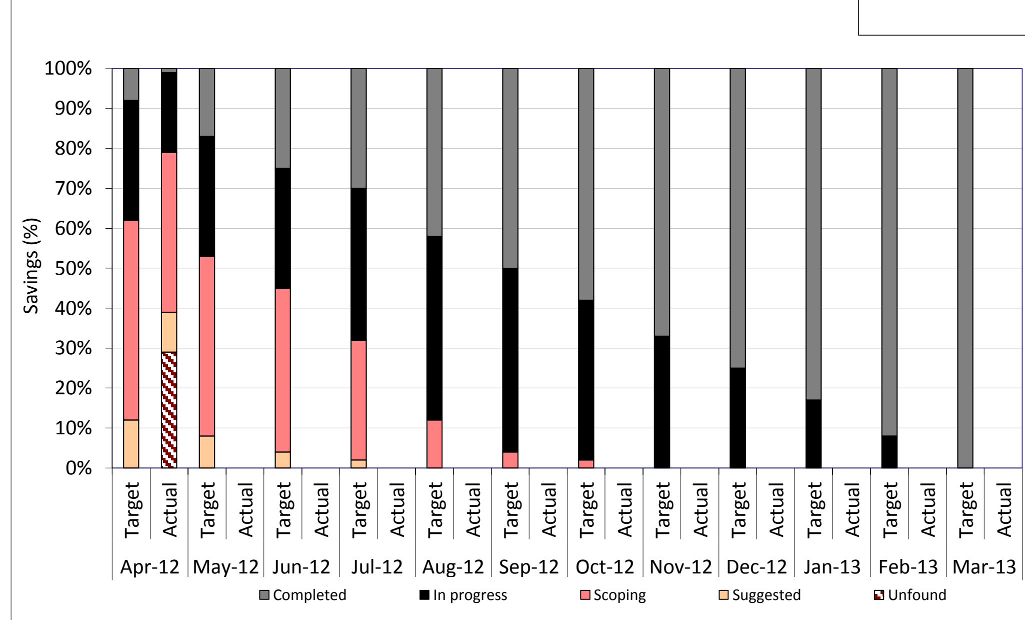

Graph 34. Biomedical Research Council (BRC)
Internal Indicator
£,000
£0
£5
£10
£15
£20
£25
£30
£35
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Appointments
Recruitment to phase I & II clinical trials
Financial leverage
Commercial engagement

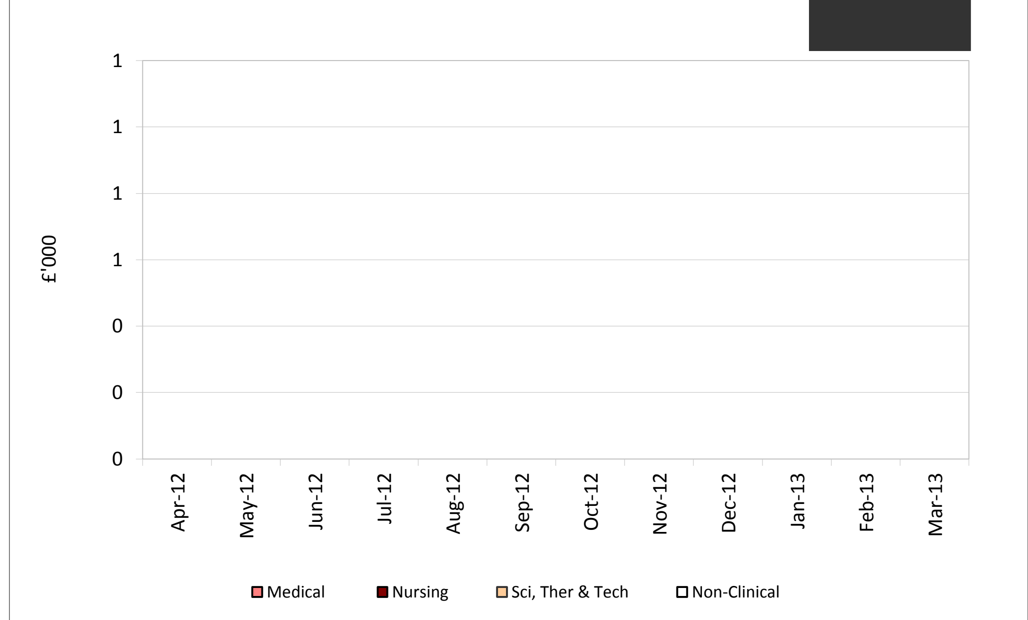
5. To work with our academic partners to ensure that we are provider of choice for specialist paediatric education and training in the UK

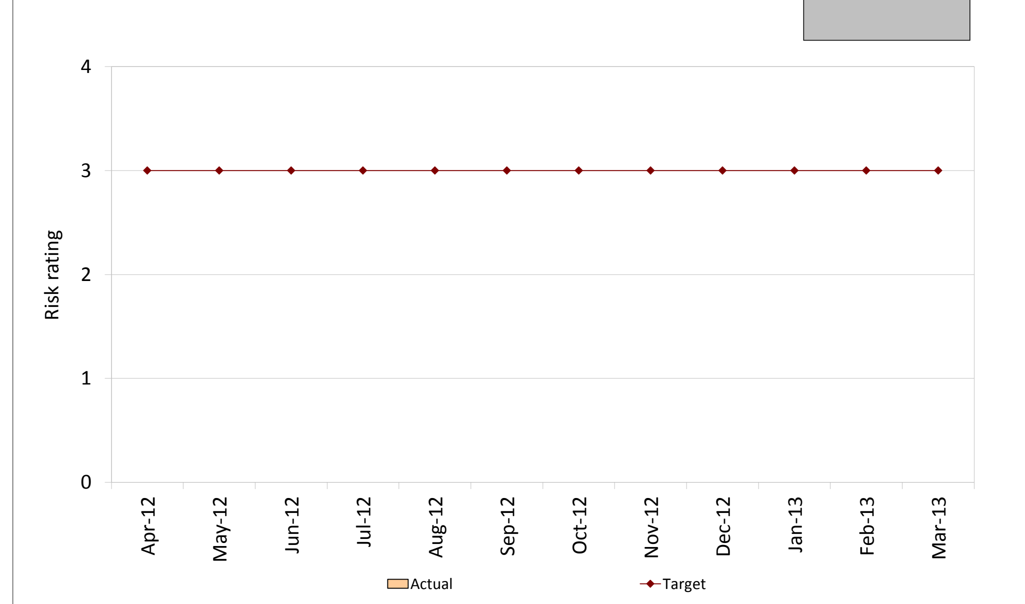


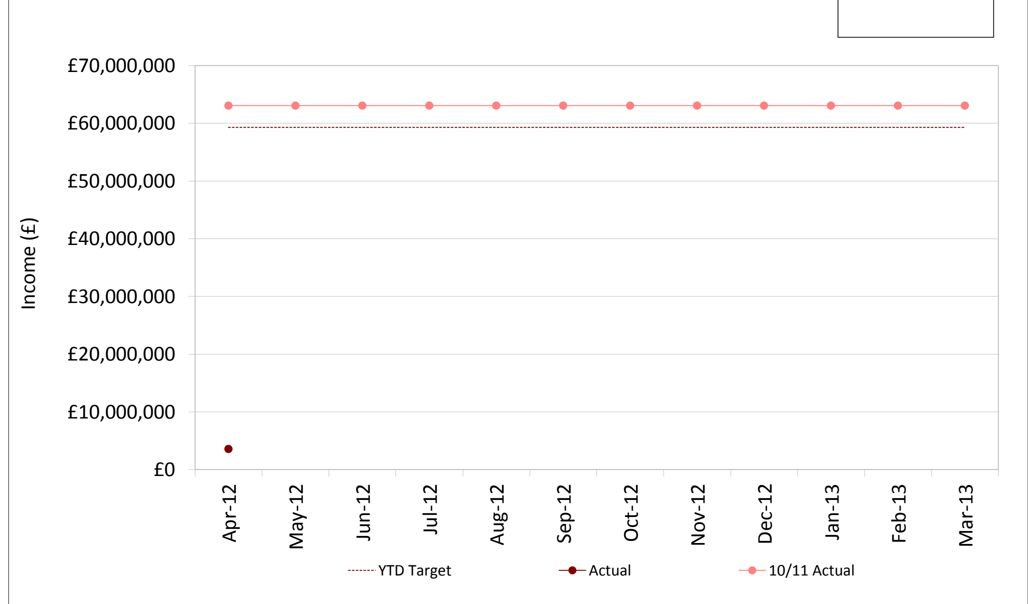


6. Deliver a financially stable organisation

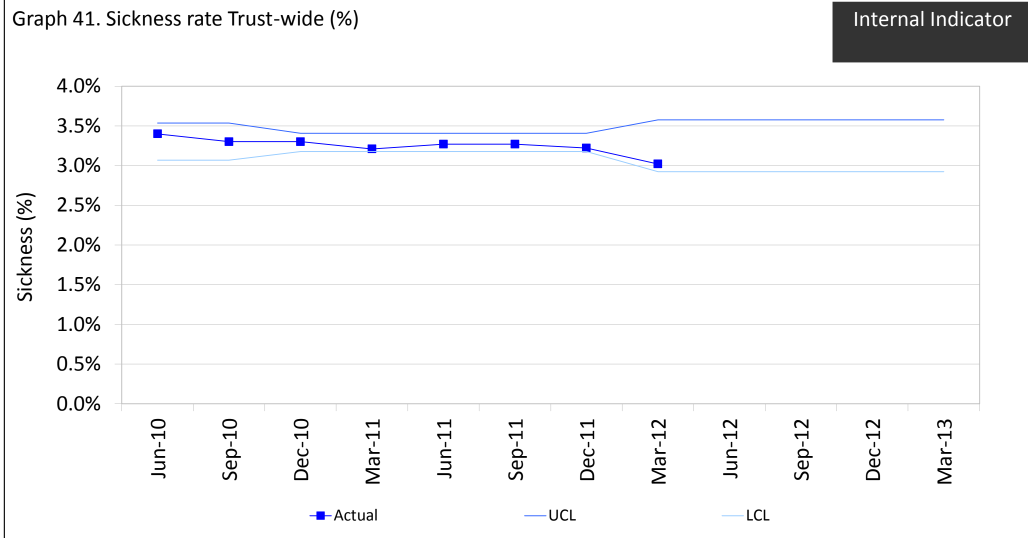


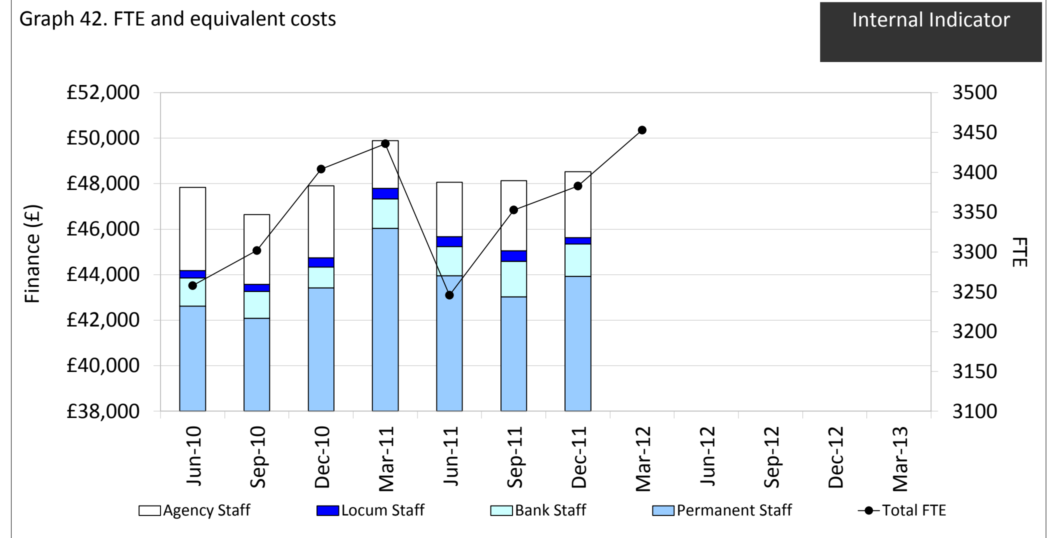


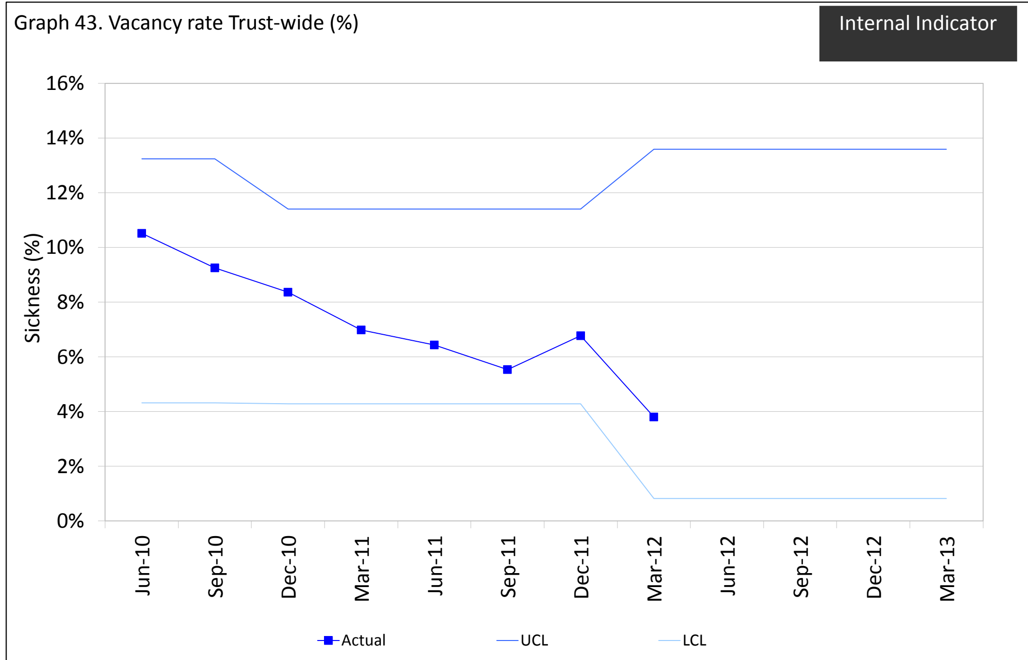


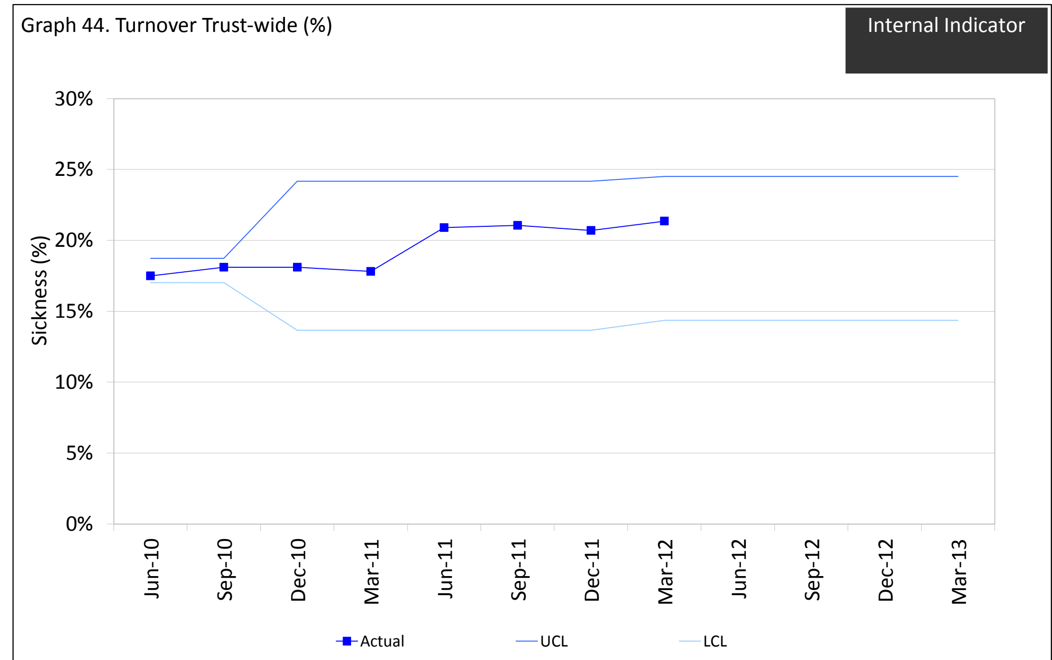


7. Ensure corporate support processes are developed and strengthened in line with the changing needs of the organisation



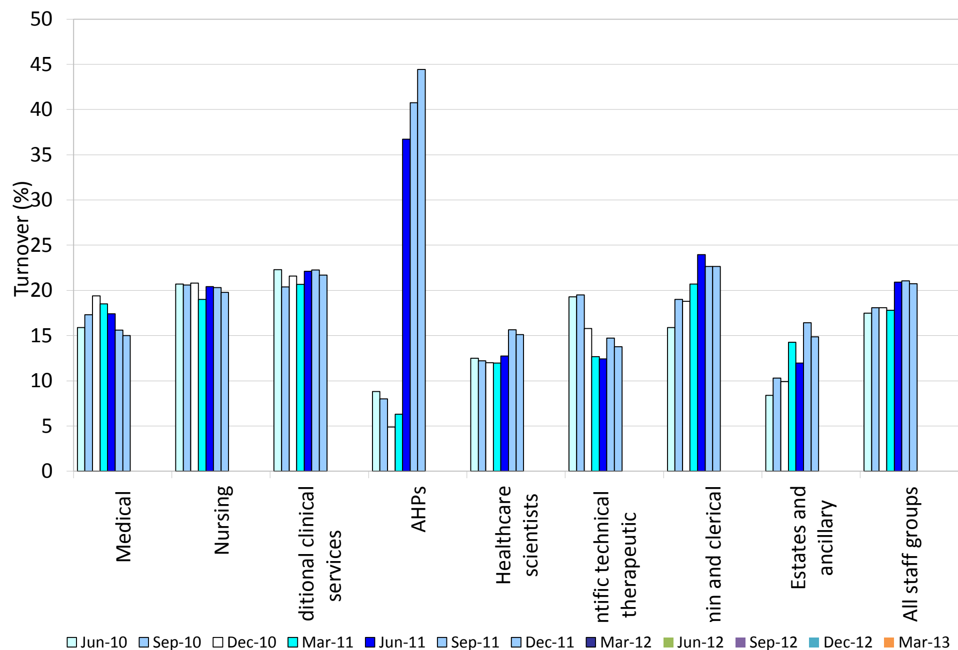






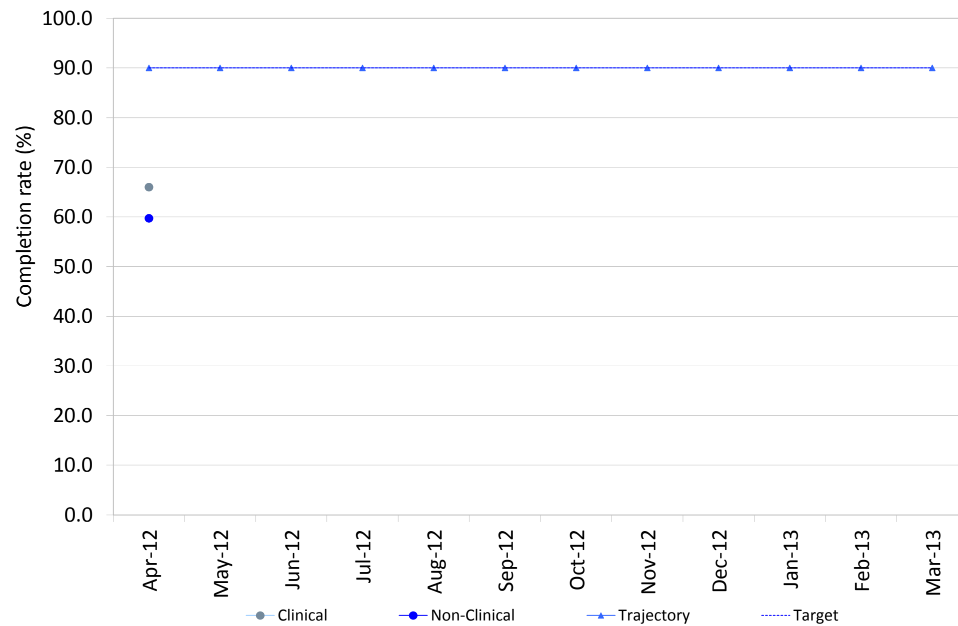
Graph 45. Turnover by staff group (%)

Internal Indicator



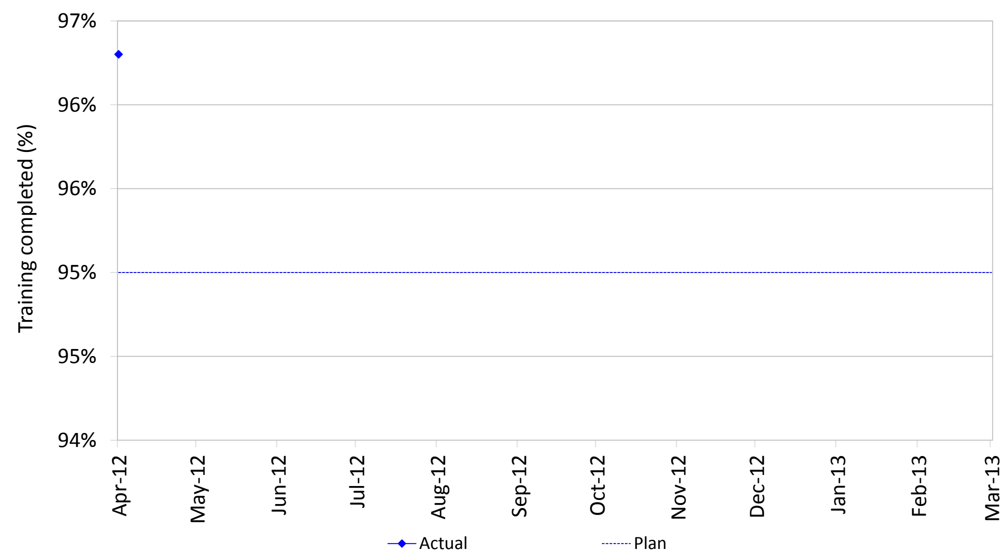
Graph 46. Percentage of staff who have a current PDR in the last 13 months and predicted next 2 months (Excluding doctors and consultants)

Internal Target

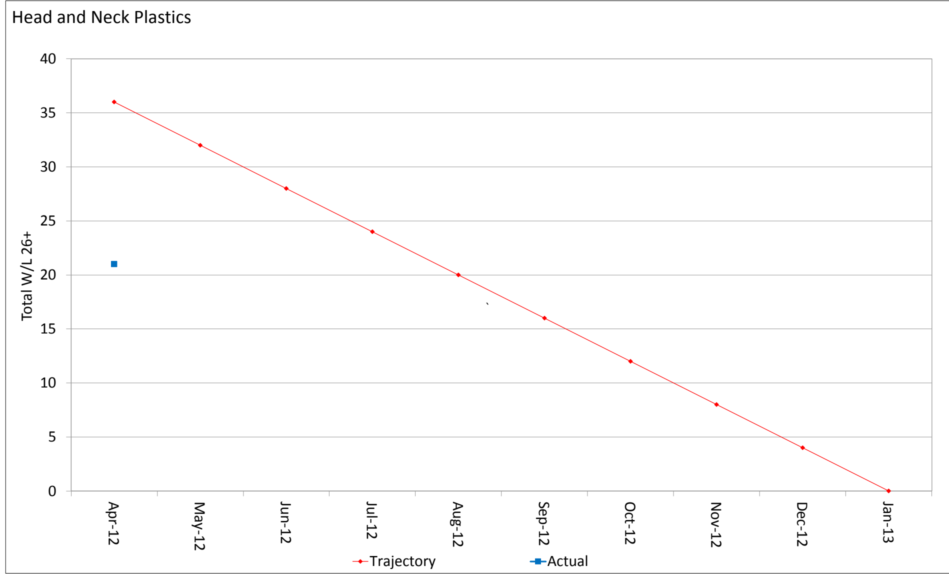


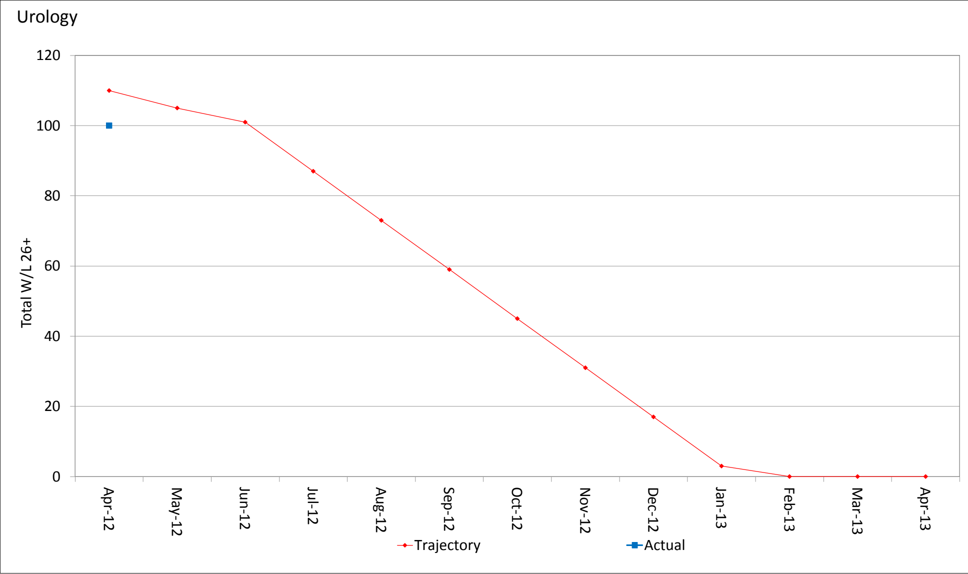
Graph 47. Staff trained on IG by week

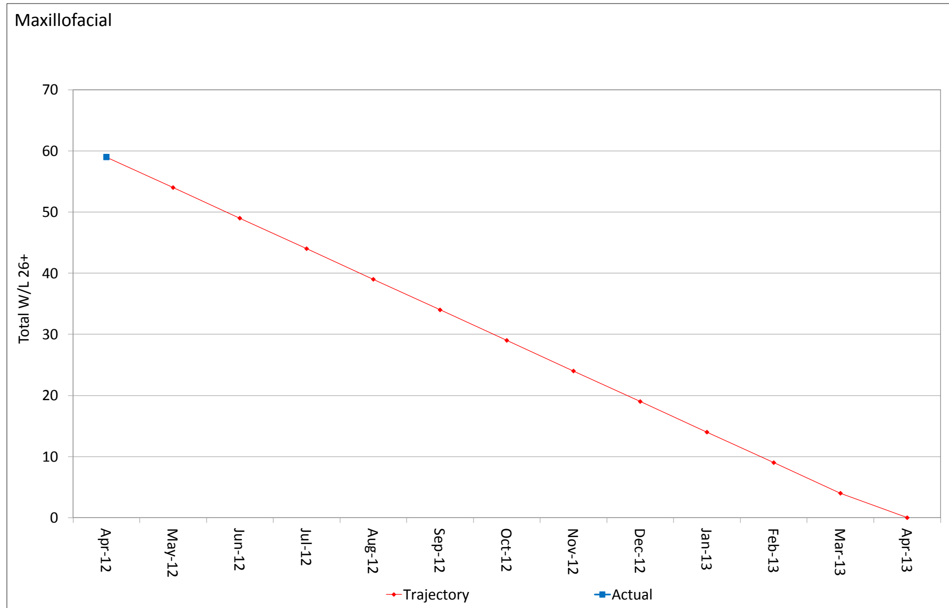
Internal Target

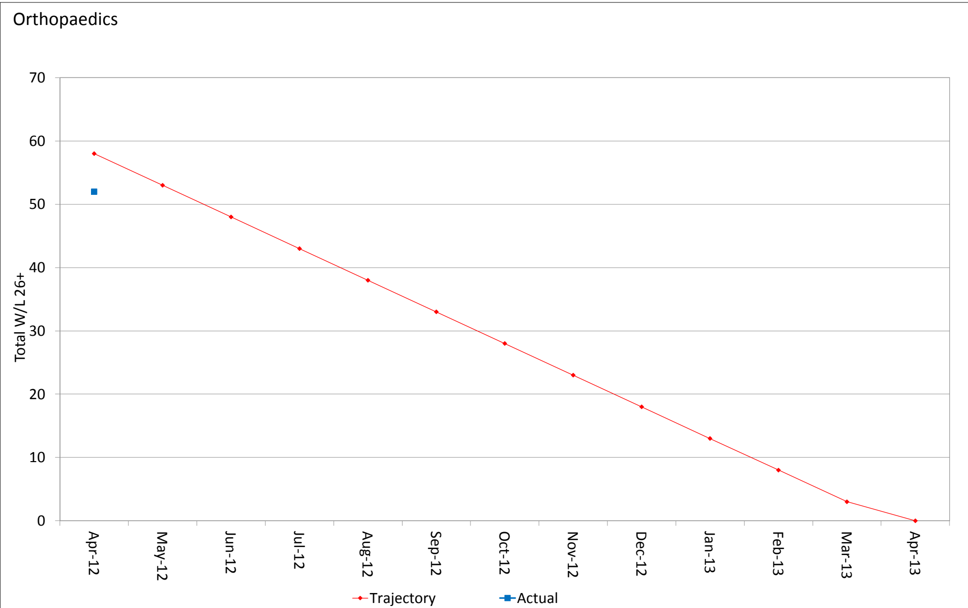


Appendix A Surgery 26+ week wait Trajectories

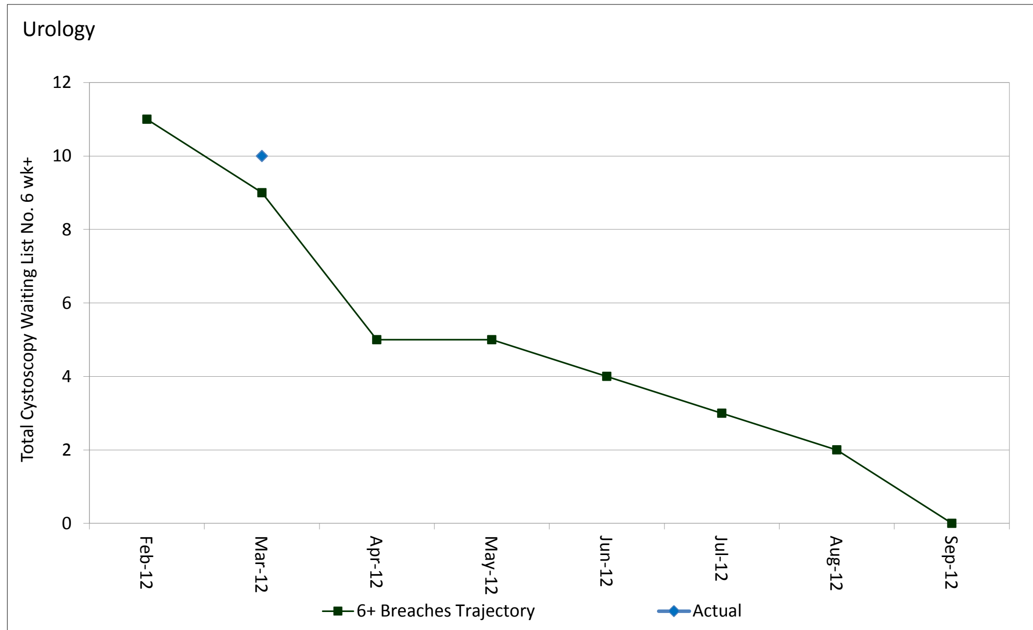


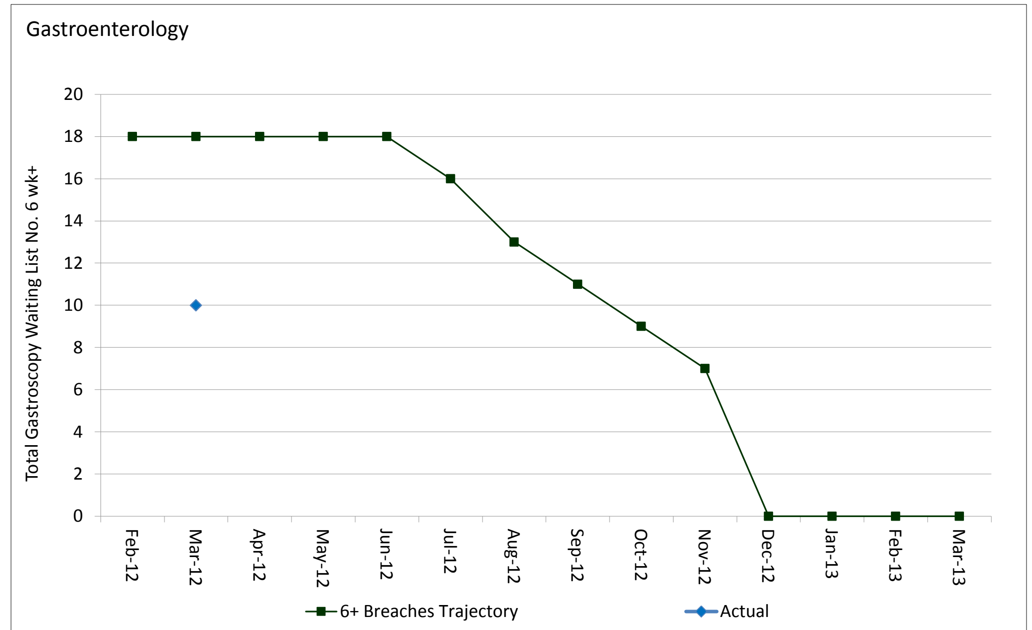






Appendix B Diagnostic 6 week+ Trajectories





Great Ormond Street Hospital for Children NHS Foundation Trust

Trust Board
30th May 2012

Report on the financial year 2011/12 (unaudited) **Submitted by:** Claire Newton	**Paper No: Attachment L** *For information*

Aims

To brief the Trust Board on the draft unaudited financial results for 2011/12 and provide annual trend data, recognising that at the Board meeting the audited financial information will also be considered and is currently entirely consistent with the unaudited information.

Summary

The draft financial results report a normalised EBITDA of £22.9M, 6.8%, an adverse variance to Plan of £(0.3)M

The following financial information is reported on the "old" basis of accounting for donations funding capital expenditure, which is the basis used by the Board throughout the year and on which the original financial plan was based.

Income at £343.7m (1011 £336.3m) is ahead of Plan by £6.4m (1.9%)

- ⇒ Patient activity has grown relative to 1011; Inpatients 0.3%; Daycases 6.5% and Outpatients 10.8% (Inpatients measured on a spell basis)
- ⇒ Fixed assets excluding long term debtors at £331.6M have increased by £11.4m although this increase is significantly impacted by the impairment of £11m on the MSCB. Capital expenditure in the year was £40.9M
- ⇒ Capital expenditure on the Redevelopment programme was behind Plan due to delays and rephrasing of expenditure on the 2B enabling project.
- ⇒ Year end cash has reduced from £32m to £26.6M due in the main to changes in debtors and creditors, the March 2011 being boosted on a non recurring basis by some high levels of creditors
- ⇒ The Trust achieved £8.2M of its CRES target of £10.4M although this results masks some strong achievements on some income generation schemes
- ⇒ An overall financial risk ratio of 3 was achieved.

These preliminary figures are in line with previous forecasts .

Action required from the meeting To note the report

Contribution to the delivery of NHS / Trust strategies and plans
The Trust needs to continue to be financially sustainable and deliver an FRR of 3 or above

Financial implications No direct financial implications.

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

Who needs to be told about any decision The Trust Board

Who is responsible for implementing the proposals and anticipated timescales?
DFD and CFO

Who is accountable for the implementation of the proposal CEO

Author and date **Claire Newton 24.05.12**

A Activity and income underlying the financial performance

A1 NHS patient activity:

- Inpatient spells increased by 1.1%
- Day case spells increased by 5.7%
- Outpatient attendances increased by 10.6%

This approximates to an overall increase in activity of 6.8% if activity currencies are weighted by value.

The Trust received over 90% of its CQUIN funding which is linked to quality targets. There were some elements of the patient experience target not achieved as discussed at the previous Board meeting

A2 Private patients:

- Inpatient & Daycase FCEs increased by 5.2%
- Outpatient attendances increased by 15.8%
- Underlying Bed days including daycases + 9.1%

NB Private patient activity income is largely linked to bed days rather than episode numbers

A3 R&D funding – 1.7%

- Income streams were relatively consistent year on year although 1011 included income deferred from previous years relating to NIHR BRC funding

A4 Education funding +5.4%

- This growth is a result of the full year effect of the Kuwait contract

B Financial summary – revenue statement

The inclusion of Haringey community services for the first 7 weeks of the year affects a consideration of financial trends and so this has been excluded from the following table

Growth rates - continuing activities *

	2009/10	**2010/11**	**2011/12**	**Growth**	
				09/10 to 10/11	10/11 to 11/12
Clinical Income:					
NHS	226.2	245.1	260.9	8.3%	6.5%
Non NHS	25.0	28.7	30.5	14.8%	6.3%
Other income	42.7	45.2	44.5	5.7%	-1.5%
	293.9	**318.9**	**335.9**	8.5%	5.3%
Pay	- 168.5	- 181.9	- 192.4	7.9%	5.8%
Non pay	- 105.2	- 114.8	- 120.6	9.1%	5.0%
EBITDA	**20.2**	**22.2**	**22.9**	10.2%	3.0%
Non-operating	- 20.0	- 19.8	- 20.2		
Net surplus before impairment excluding Donated Asset Transfer	0.2	2.4	2.8		
EBITDA %	*6.9%*	*7.0%*	*6.8%*		

The net surplus is reported in this table excluding impairment and DAT to eliminate variability between years on non operating items

Pay:

£'k	12m Mar 11	*12m Mar 12*	
Consultants	35,252	*36,224*	2.8%
Other medical	19,877	*21,380*	7.6%
Nursing	57,397	*61,366*	6.9%
HCA	2,383	*2,061*	-13.5%
AHP/STT	32,170	*34,093*	6.0%
Man & Admin	33,698	*35,959*	6.7%
	180,777	*191,084*	5.7%
Non-recurring	1,122	*1,354*	
Haringey/NMH	10,373	*1,509*	
	192,271	*193,947*	

Increases in pay expenditure reflect:

- pay increments (agenda for change and consultant awards)
- increases in average WTE including agency of c 4.7%, primarily in clinical units, and private patients to support delivery of increased activity and including the full year of the general paediatric team and the new team in pathology which transferred from UCLH

Non-pay:

	12m Mar 11	*12m Mar 12*	
Drugs	31,158	*35,018*	12.4%
Blood	18,758	*16,925*	-9.8%
Other clinical supplies	22,117	*25,004*	13.1%
Premises	18,780	*19,539*	4.0%
Services from 3rd parties	6,822	*8,548*	25.3%
Establishment	2,618	*2,768*	5.7%
R&D /Education	2,728	*1,675*	-38.6%
Non clinical supplies	2,828	*2,173*	-23.1%
Transport	2,724	*2,821*	3.6%
Other	6,272	*6,127*	-2.3%
	114,805	*120,598*	5.0%
	770	*75*	
	115,575	*120,672*	4.4%

The apparent reduction in costs in Education and R&D are due to reclassifications to services from 3rd parties. Clinical supplies has increased significantly due to activity increases in areas using high value consumables. Drugs expenditure has also increased, partly due to the LSD shortages in 1011 (extremely high cost drug) but also due to activity and price increases.

C Statement of Financial Position

£'m	Mar-11 Actual	Mar-12 Actual
Total Fixed Assets	**329.6**	**340.6**
Stocks & Work in Progress	5.2	6.2
Debtors	30.3	33.3
Cash at bank and in hand	32.6	26.6
Total Current Assets	**68.1**	**66.1**
Creditors	-53.9	-47.4
NET CURRENT ASSETS	**14.2**	**18.7**
TOTAL ASSETS LESS CURRENT LIABILITIES	343.8	359.3
Provisions for liabilities and charges	-1.2	-1.2
Other non-current liabilities	-7.3	-7.0
TOTAL ASSETS EMPLOYED	**335.3**	**351.1**

The major changes between year ends are:

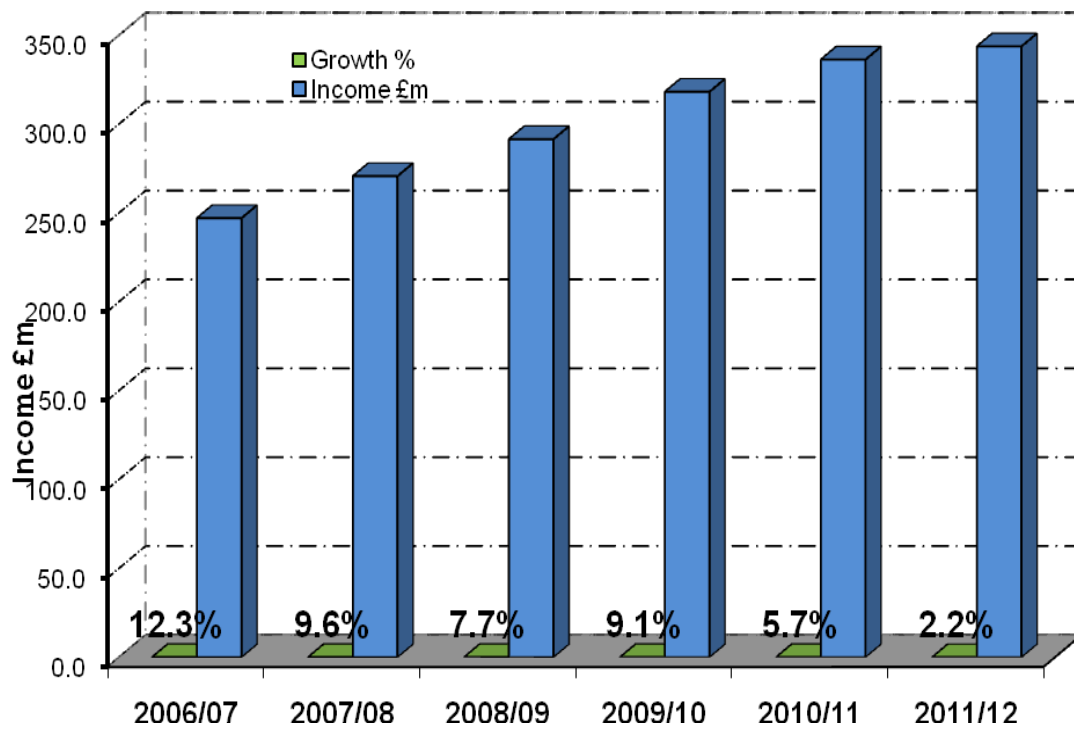
- Continued expenditure on Phase 2A redevelopment in addition to other capital investment
- Lower levels of creditors and deferred income at the end of the financial year
- Higher levels of debtors as PCTs did not clear overperformance debt prior to the year end to the same extent as they did in 2010/11 and also higher levels of IPP debt due to the growth in activity
- Lower cash levels due to a combination of working capital changes which include the tightening of creditor payment terms, the reduction of New Born Screening deferred income (which had reached an abnormally high level at March 2011 and the absence of a non recurring amount of £0.75m which was passing through GOSH in March 2011

Better Payment Practice Code

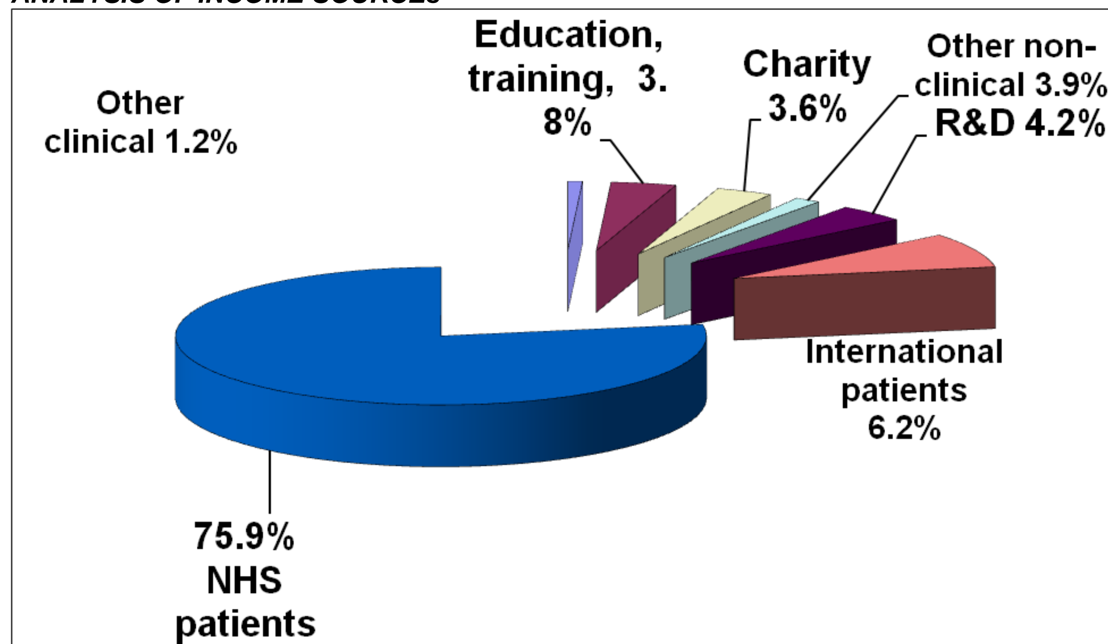
The Trust made 87% of payments on non-NHS payables within targets

D GRAPHICAL TREND ANALYSIS

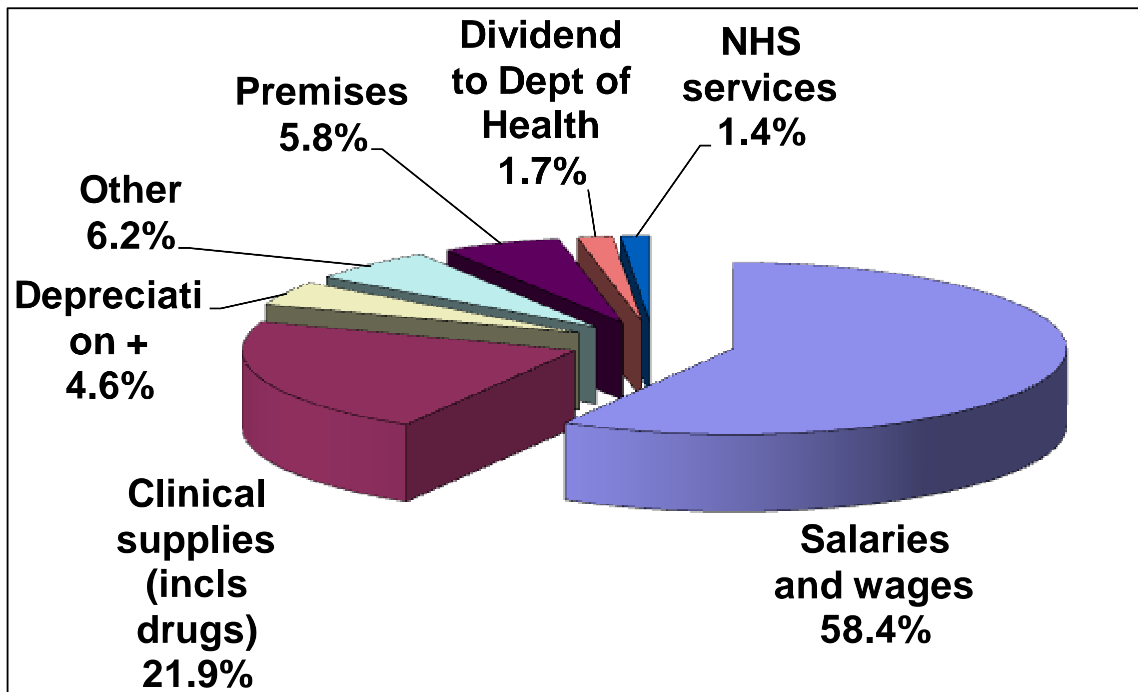
FIVE YEAR INCOME TREND WITH GROWTH %

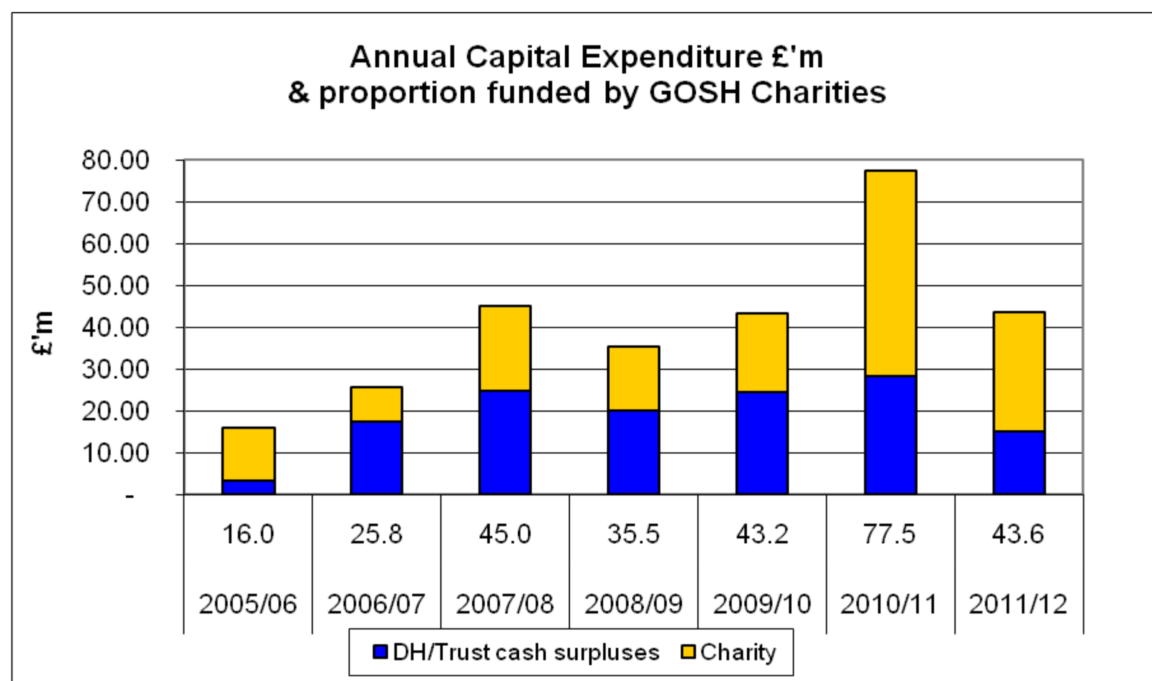


ANALYSIS OF INCOME SOURCEs



ANALYSIS OF EXPENDITURE





ATTACHMENT N

Great Ormond Street Hospital for Children NHS
NHS Foundation Trust

Trust Board **30 May 2012**	
Education Strategy Update **Submitted on behalf of** **Liz Morgan**	**Paper No: Attachment N**
Aims / summary To update Trust Board on progress made against the Trust's Education Strategy	
Action required from the meeting For information and discussion.	
Contribution to the delivery of NHS Foundation Trust strategies and plans Delivery of Trust's Education Strategy & achievement of NHSLA level 3	
Financial implications The delivery of a high quality education strategy has major impact on overall Trust financial position in relation to quality and safety of service, retention rates, reduction in insurance premiums, income generation etc.	
Legal issues All staff must have access to learning irrespective of gender, religion or creed, marital and partnership status, colour, nationality, ethnic or national origin, sexual orientation, disability, maternity status or number of hours worked, social background, educational status or age.	
Who needs to be / has been consulted about the proposals in the paper (staff, councillors, commissioners, children and families) and what consultation is planned/has taken place? Management Board, Strategic Education Committee, Staff Involvement Forum	
Who needs to be told about any decision? Not applicable	
Who is responsible for implementing the proposals / project and anticipated timescales? Assistant Dir of Education & OD and Operation Head of Learning & Development	
Who is accountable for the implementation of the proposal / project? Liz Morgan, Chief Nurse & Director of Education	
Author and date Chris Caldwell, 18th May 2012	

Paper for Trust Board
May 2012

Title: Update on progress with Education Strategy

1. Introduction

This document sets out progress against the 2010-2015 Education Strategy. The paper begin with an overview of the principles of the strategy. This is followed by a review of achievements over the past year. The paper then goes on to set out the main actions planned for 2012-13 and highlights any areas where there are likely to be potential challenges in completing these actions along with plans for mitigating any risks.

2. The Education Strategy

The Education strategy was created in response to the Trust Mission: *'To share our expertise through education and the training of children's healthcare professionals so that more children benefit from our work'* As well as the overall Trust strategic objectives: *To 'Work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK' and to 'recruit, train and retain the very best staff'.*

The core principles of the education strategy aims to integrate learning and development within GOSH and across academic partners so that:

- All learning must support safety, clinical outcomes and the patient experience.
- The strategy will support continuing clinical competence and clinical excellence by ensuring staff develop the knowledge and skills required to fulfil their role through equitable access to appropriate learning
- Ensure all statutory and mandatory training obligations are met
- We will continue to develop the leadership, management and team-working capacity of Trust
- The learning portfolio will facilitate organisational development and workforce redesign
- All learning can be seen to have a positive impact in the workplace.
- Good practice and success is celebrated and shared.
- Support Staff to develop their careers and fulfil potential
- GOSH will be a lead provider of educational opportunities for child health professionals locally nationally and international
- Explore the commercial potential of GOSH education through the utilisation of the specialist knowledge of our workforce, learning facilities, on-line learning and course places.

3. Achievements and Successes in 2011-12

3.1 This year 2938 staff and students accessed some form of in-house learning and 12,006 course places were filled. All of this activity is related to either mandatory training or education and development related to role and talent development to support excellence in practice recruitment and retention of the highest calibre of staff. In addition staff also accessed a wide range of learning experiences outside the Trust

including university based courses, conferences and one-off training courses in order to fulfil the objectives agreed within their individual personal development plan.

3.2 A departmental restructure was completed in early summer to support the aims of the strategy to integrate education. The department has re-launched as LEaD (Learning Education and Development) and management and team working systems are in place to ensure that there is internal consistency and efficiency of working.

3.3 The department delivered its 2011-12 CRES plan with the overall savings of one whole time Band 2 and one whole time Band 3 post.

3.4 A revised governance structure was introduced in September 2012 to support the delivery of the strategy. Systems have also been introduced to strengthen relationships with Clinical Units and departments to provide support to departments in meeting mandatory training requirements, organisational development support in relation to service developments and major change (e.g. supporting teams in the move to the Morgan Stanley Building) and more bespoke solutions to education and training.

3.5 A monthly 'Zero harm' report has been developed for Management Board along with more real time KPI data on the Information Services intranet site to support managers. This has enabled us to more closely monitor local performance against Trust KPIs for mandatory training and appraisal, and resulting in the external audit of mandatory training providing the Trust with a greater level of assurance regarding mandatory training compared with 2010/11.

3.6 A simulation training strategy was approved by the Education Strategic Committee and the simulation strategy group has been working closely with Estates to progress plans for a permanent simulation laboratory facilities to support delivery of Trust safety and transformation goals

3.7 We have been working closely with the Quality Safety and Transformation team to build on the success of our current programme of improvement learning (TIMP and EQUiP -engaging junior doctors in quality improvement) and harnessing the benefits of linking technical knowledge with leadership development for maximum impact. We have also supported the Transformation Board to undertake a visioning exercise in order to focus on its ongoing role

3.8 We continue to progress our strategy for learning innovations. New online (GOLD) programme include CEWS/SBARD and the clinical update e-learning programmes

3.9 New improved induction and update programmes have been launched which have significantly reduced the amount of staff release time required to ensure that the Trust meets its statutory requirements. These include the use of on-line assessments and films of subject matter experts, of children and young people talking about GOSH and a cabaret style workshop format to allow discussion and interaction rather than the traditional lecture format.

3.10 We have achieved the safeguarding training CQUIN goals and now have 46% of staff trained to Level 3 (end of year target was 40%)

3.11 We have been awarded a number of funding bids. For example, funding has been secured from the National Cancer Action Team so that GOSH will deliver advanced communication training for children's cancer services teams at GOSH and other London Trusts to support peer review process. We are the only London approved centre. PGME have also won several bids including a bid to run an innovative leadership programme for medical staff.

3.12 The department is supporting the Executive office in designing and delivering a development programme for the Members Council.

3.13 We have worked hard to influence the emerging architecture for the future planning and commissioning of health care education through Health Education England (HEE) and the Local Education and Training Bodies (LETBs). Through our strong presence within the UCLP education subgroup we have been one of the lead organisations working with UCLP to develop a fast track postgraduate career development scheme for nurses to prepare future leaders.

3.14 With our academic partners, London south Bank University we have developed an innovative approach to recruiting potential student nurses which identified those the appropriate attributes for the profession in addition to the right academic requirements. This initiative has been widely acclaimed, received significant publicity and has been adopted by NHS London as the standard for recruitment to nursing programmes.

4. Actions planned for 2012-13

4.1 We will continue to work with our academic partners to ensure that we are the provider of choice for specialist paediatric education and training in the UK. We will also ensure that GOSH pro-actively responds to the requirements of the new education and workforce commissioning systems and is a key player in the North Central and East London LETB

4.2 We will play a lead role in working with UCLP in the 2012/13 London Deanery processes to identify a lead provider for paediatric medical education.

4.3 We will ensure that all staff will have access to high quality essential education and training indicated in their PDR that is required to attain and maintain the skills required to undertake their role, to achieve the requirements of NHSLA Level 3. This will include supporting clinical units and corporate departments to undertake annual training needs assessment (TNA), design and deliver Internal training programmes and commission external learning in response to TNAs.

4.4 We will establish an ‘Education Faculty’ to ensure that staff engaged in education and training have appropriate skills and that all our programmes are quality assured in terms of educational quality

4.5 We will ensure that managers will have access to robust information systems to efficiently monitor staff education and training. We will continue to work with Information Services, Transformation and Clinical Units/departments to ensure that accurate timely date are available and that the outcomes of education and training are articulated in relation to patient benefit

4.6 We will complete the process of commissioning and introducing more robust education activity database to replace outdated system

4.7 We will continue to drive forward our strategy to ensure that GOSH can become a leading UK centre for simulated learning in paediatrics through expanding simulation training activity and demonstrating the business case for a fit for purpose simulated learning facilities at GOSH. Simulated learning is central to our success with ensuring that all clinical staff develop and maintain all the clinical skills they need (e.g. skills in Aseptic Non-Touch Technique in relation to eliminating catheter-related infections as well as he management of the acutely deteriorating sick child).

4.8 We will ensure that all staff will have the leadership, management and improvement skills they require to effectively deliver the service and Trust improvement plans through continually reviewing and enhancing our portfolio and building upon the success of Developing Leadership Potential, Transformation Improvement Training Programme, EQiP and Developing Leadership through Simulation.

4.9 We will implement to recommendations of the nurse education review undertaken earlier this year

4.10 We will ensure that the commercial potential of GOSH education and training locally, nationally and internationally is fully exploited. This will include working with the Finance department and GOSH charity to refine our business model and marketing strategy, a further departmental restructure to strengthen our internal business function and the roll out of an accreditation framework for key elements of the education

4.11 We will continue to work with IPP to market GOSH education programmes internationally, including the establishment of a ‘Faculty’ to deliver all educational aspects of Kuwait programme including responding to potential expansion of the existing contract

4.12 We will further develop our understanding of the cost and economic impact of staff education and training activities on the GOSH service. This will be achieved through establishing an education finance sub-group of the Education Strategic Committee, working with General Managers to review and strengthen systems for allocating and monitoring non-medical and study leave allocation and funding in line with Trust Study Leave policy and CRES requirements and continued benchmarking with other NHS and non-NHS organisations

4.13 We will design and implement a development programme to support the Members Council to success in their role

4.14 We will deliver the Education department's contribution to the Trust CRES programme and support Units and departments to maximise any productivity savings from education.

5. Risks and Mitigation

The key risk for 2012-13 is that changes in availability of funding and staff availability for education due to financial pressures will impact negatively on staff competence to provide safe effective care and GOSH reputation as provider of world class education and training. Our plan for 2012-13 includes a range of strategies and learning innovations aimed at mitigating this risk and working collaboratively with managers, individual members of staff and external stakeholders to mitigate this risk.

One of the key innovations that will enable us to deliver our strategy is the establishment of a permanent fit for purpose clinical skills and simulation facility. The failure to secure this facility is a significant risk to the delivery of the education strategy, ensuring staff have competence in clinical skills, leadership, communication and teamwork and that we secure our future as lead providers of medical education.

Greater local accountability is required by managers in relation to ensuring staff receive a PDR and fulfil their statutory training requirements. The Trust's Study Leave Policy now explicitly states managers for teams with low rates for PDR or statutory training can be subject to the Trust's performance management process.

6. Conclusion

There has been significant success in the delivery of the first year of the education strategy and robust plans are in place to ensure that this success is built upon in 2012-13. This paper has outlined the key achievements and the plans for 2012-13. The NHS Staff Survey for 2011 supports these conclusions indicating that 84% of staff at GOSH reporting that they have received job relevant training and development in the past 12 months.

Author:
Chris Caldwell
Assistant Director of Education & Organisational Development

15 May 2012

DRAFT MINUTES OF THE AUDIT COMMITTEE

Held on 20 February 2012

Present:

Mr Charles Tilley	Non Executive Director and Committee Chairman
Mr David Lomas	Non Executive Director
Mr John Ripley	Designate Non Executive Director

In attendance:

Mr Roger Brealey	London Audit Consortium
Ms Heather Bygrave	Partner, Deloitte
Dr Jane Collins	Chief Executive
Ms Fiona Dalton	Deputy Chief Executive
Dr Anna Ferrant	Company Secretary
Mrs Claire Newton*	Chief Finance Officer
Mr Mark Large*	Director, ICT
Mr Aaron Shah	London Audit Consortium
Ms Lucy Bubb	Senior Manager, Deloitte
Mr William McGill*	Director, Redevelopment

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

112.	**Apologies for Absence**
112.1	Apologies were received from Ms Yvonne Brown, Non-Executive Director and Mr Michael Dallas, Independent Member.
113.	**Minutes of the meeting held 11 October 2011**
113.1	The minutes of the meeting held on 11 October 2011 were received and **approved** as an accurate record.
114.	**Minutes of the Risk Management Meeting held on 12 December 2011**
114.1	The minutes of the meeting held on 12 December 2011 were received and **approved** as an accurate record.
114.2	**Action:** The Chairman asked that the Chief Finance Officer, Chief Operating Officer and Company Secretary to meet ahead of the next Committee meeting to discuss how best to deal with issues addressed in the minutes of the Risk Management Meeting.
115.	**Matters Arising and Action Point Checklist**
115.1	**Minute 78.6 –** The Chief Operating Officer, Ms Dalton, informed the committee that the number of CRB waivers had dramatically dropped following the introduction of the ECRB system. For those staff members who still required a CRB waiver, the length of waiver period was now shorter. There

115.2 115.3	would be an audit to check how these staff members were supervised during their waiver period. The audit would be completed by the HR department by June 2012. **Minute 79.6** – The committee agreed that risk 6A should be considered at the April 2012 Audit Committee meeting. **Action**: The Company Secretary to ensure that risk 6A on the Assurance Framework is considered at the April 2012 Audit Committee meeting.
115.4	The Chairman noted that all other actions due to be addressed in this meeting were on the agenda.
116.	**Assurance Framework**
116.1 116.2 116.3 116.4 116.5	In response to Mr Ripley's query (designate non-executive director), the Chief Executive, Dr Jane Collins, confirmed that Monitor felt strongly that the Assurance Framework Overview be presented at both the Trust Board and the Audit Committee to ensure the risks are reviewed appropriately. Mr David Lomas, non-executive director, requested that on a quarterly basis the committee be given an insight into the perception of referrers to the services provided. It was agreed that this discussion form part of the business model to be considered at the Trust Board away day in March. **Action**: The Chief Operating Officer to provide an overview of referrer's perceptions of services provided by the Trust, as part of the presentation at the March Board Development session. In response to Mr Lomas' query as to the forward planning of discussion and risk topics to be discussed at Audit Committee meetings, the Chairman informed the Committee that he held a pre meeting with the Chief Finance Officer and Company Secretary. It was agreed the need to plan rotation of relevant risks for review on the Assurance Framework. **Action**: The Company Secretary to design a plan for rotating the relevant Assurance Framework risks for consideration at the Audit Committee. This was to be agreed at the April 2012 meeting.
116.6	Mr Tilley requested an update on risk 7C (The Trust may fail to achieve Foundation Trust status within a defined timescale). Ms Dalton informed the Committee that the final papers were being submitted to Monitor that day for consideration by their Board the following week. **Mr Peter Wollaston joined the meeting.*
116.7	The Committee **noted** the report. **Mrs Claire Newton and Mr Mark Large joined the meeting.*
117.	**Risk 7B We may not deliver the IT and Information Strategies resulting in failure to achieve process efficiencies and to deliver effective electronic patient information and record systems in support of our clinical**

	strategy
117.1	The Director of ICT, Mr Mark Large, presented the report, which was taken as read. Mr Large informed the committee that: - PACS implementation was almost complete and had reduced image retrieval time to between 3-5 seconds; - The Trust was working through impact of the update to Order Comms. Ms Dalton reported that clinicians were positive about the new PACS - Over 5000 user accounts had been successfully migrated from Groupwise to Outlook; - The CDD system had teething problems but matters were actively being dealt with and it was used consistently.
117.2 117.3 117.4	In response to Mr Lomas' request, the Director of ICT agreed to present an end to end document of the current ICT systems and how they were linked to better understand when the replacement of systems would occur and the impact on other systems to any future changes. The Committee agreed that a road map for the development of ICT systems over the next three to five years would be helpful and could link into discussions on the business model. **Action**: The Director of ICT to present an end to end document of the ICT current systems and how they were linked over a 3-5 year period.
117.5	Mr Ripley stated that much of the risk associated with IT systems sat with the user. The Director of ICT agreed and said that ensuring the user end and experience is correct was vitally important.
117.6 117.7	The Director of ICT agreed with the committee's request that a review be conducted including a survey of users, 3 months following the introduction of any new ICT system. It was agreed that such surveys should be short and easy to complete. **Action:** The Director of ICT to conduct a survey of users, 3 months following the introduction of any new ICT system.
117.8	The Chairman asked whether there were any areas which Mr Large was concerned about going forward. The Director of ICT raised the issue of implementation of the electronic patient medical records and the need to ensure that a link is established between corporate and clinical areas so that a system is developed that works and is used easily by clinicians.
117.9	Mr Lomas queried what hospitals were being used as a reference point for electronic medical records, noting the success of many American hospitals in this area.
117.10 117.11	The Chief Finance Officer, Mrs Claire Newton, acknowledged that products used in America were robust but that the NHS funding in the UK would not be available to implement such technically advanced systems. In response to Mr Lomas' suggestion, the Chief Finance Officer agreed that even if the money was not there, the ideas behind the products could still be

	useful.
117.12	Mr Lomas offered to provide the Director of ICT and Chief Finance Officer with suggestions of links to American hospitals.
117.13	**Action**: The Chief Finance Officer to seek examples of organisations from Mr David Lomas that had implemented similar electronic patient medical record systems in America.
117.14	In view of the work underway to upgrade the ICT systems, the Chief Executive asked if it was possible to downgrade the risk on the Assurance Framework from amber to green by the end of March. The Chief Finance Officer confirmed that it would be possible.
117.15	In response to the Chairman's query, the Director of ICT confirmed that guest wireless was set up across the site but would remain in the background until work to split the access between adult and child guest access in order to ensure safe use.
117.16	Mr Large reported that following the IGAP audit work was underway to roll out Microsoft security across the Trust. The Chairman asked Mr Roger Brealey from the London Audit Consortium whether he was happy with implementation of the recommendations arising from the audit. Mr Brealey confirmed that he was.
117.17	The Committee **noted** the report.
118.	**Update on incident of arson**
118.1	Mr Peter Wollaston, Head of Corporate Facilities presented the report which was taken as read.
118.2	Mr Wollaston reported that the progress of the arson case had been stalled due to the ongoing sickness of the member of staff under investigation.
118.3	In response to Mr Ripley's query, Mr Wollaston confirmed that working with the Education and Training department, local fire training had now been added to the existing mandatory update training. This would be audited and if it was found the training was not completed then this would be dealt with through line management initially and escalated to executive level if need be. Ms Dalton reported that she received quarterly updates on mandatory training and that attendance was managed within the units.
118.4	It was agreed that the annual fire statement presented to the Trust Board include key data around fire training and other such controls.
118.5	**Action:** The annual fire statement (submitted to Trust Board) to include an executive summary containing key data around fire training and other such controls.
118.6	The Committee **noted** the report.
119.	**Update on CRES**

119.1 119.2 119.3 119.4	The Chief Operating Officer presented the report which was taken as read. The Chief Executive reported that the Executive Team were considering whether the Trust should continue to require CRES targets to be cumulative each year where previous years targets had not been met. Mr Lomas queried whether it was important to focus on not just a CRES target of 4% but the productivity of the Trust as a whole. Ms Dalton agreed and suggested that contribution be considered on a quarterly basis. Mrs Newton suggested that the Trust should also review the costs that cannot be influenced. Mr Tilley recommended that these matters should be considered at the budget meeting at the end of March 2012. **Action**: The Chief Finance Officer to ensure that productivity, contribution, and costs be considered at the budget meeting at the end of March 2012.
119.5 119.6	The committee agreed that it should focus on reviewing high impact and high risk areas within a specific unit at the next meeting. It was agreed to review cardiac workforce schemes at the next meeting, along with any schemes carried forward to 2012/13. **Action**: The Chief Operating Officer to present to the Committee a review of cardiac workforce schemes at the next meeting, along with any schemes carried forward to 2012/13. **Mr Peter Wollaston left the meeting.*
119.7	The Committee **noted** the report.
120.	**Update on boiler incident and lessons learned**
120.1 120.2 120.3	The Director of Redevelopment, Mr William McGill, presented the report which was taken as read. The Director of Redevelopment noted that the investigation had been completed, lessons learned and reviewed and that both internal and external audits had been conducted and positive assurances found of the controls in place. Mr McGill agreed to update the Assurance Framework risk with this information. **Action**: The Director of Redevelopment to update the Assurance Framework risk with information about internal and external assurances.
120.4	The Chairman noted that the issue of culture was at the heart of the incident and queried what the basis of confidence was in the improved culture in the Trust.
120.5 120.6	In response, the Director of Redevelopment noted that culture change had been instigated via training and that the prominence that health and safety now given within the Trust had helped to reinforce the change. In addition, the number of staff working in the Estates department with formal health and safety qualifications had significantly increased. The Estates department was now the highest reporter of incidents across the

	Trust. This provided assurance that safety issues are being appropriately recognised and reported.
120.7	In response to Mr Ripley's concern that the lessons learned appeared only related to the root cause of the boiler incident, the Company Secretary assured the committee that the actions taken following the incident were much wider than those listed on the SI report, reminding the committee that a seventeen page action plan had previously come to the committee last year, covering improvements in health and safety across the Trust. The Company Secretary informed the committee that all actions had been completed and a meeting had recently taken place with the Chief Finance Officer to ensure that these actions were still being adhered to, which they were.
120.8	The committee **noted** the report.
121.	**Risk 6B – Sustainable funding solution for each activity within the Trust strategy may not be secured.**
121.1 121.2	The Chief Finance Officer presented the report which was taken as read. The Chief Finance Officer explained that this risk was a risk that would be highly scored, especially in the current economic environment. The risk had been split into price risk, payment risk and activity risk.
121.3 121.4	Addressing the issue of tariffs, the Chief Finance Officer stated that work being carried out in conjunction with the Department of Health would be presented at the Board the following week. For local tariffs, the Chief Finance Officer reported that she was working with other paediatric trusts to understand the pricing for other trusts.
121.5 121.6 121.7	The Chief Finance Officer noted that the impact of the Greek economic situation presented a new issue for the Private Patients department going forward. Patients would potentially now be paid at EU reciprocal NHS pay levels and this affected around 10% of IPP activity. The Chief Executive noted that the majority of the work from Greece and Cyprus was elective, so the decision could be made by the Trust whether to take these patients or not. The Chief Operating Officer added that there may be an issue with treatment of current long term patients, but that this was being addressed.
121.8	The Chief Finance Officer informed the Committee that the post-graduate education cuts announced by the Department of Health were not as much as originally thought and would reduce in impact over time.?
121.9	The Chief Finance Officer concluded by informing the Committee that the Charity forecast remained very strong.
121.10	Mr Lomas asked if there was any point of weakness in the depth of knowledge in the finance department should the Chief Finance Officer be suddenly unavailable. The Chief Finance Officer described the structure within the finance department and where knowledge was held.

121.11	The Chief Executive agreed that the area of weakness lay with the external relationships that were very reliant on the Chief Finance Officer and herself, for example with the Department of Health, which had been built up over several years.
121.12	In response to Mr Lomas' query, the Chief Executive agreed that this was a risk that would have to be accepted but that more work was required to be done to mitigate the risk further.
121.13	Mr Lomas emphasised the need to review reference costs. Mrs Newton stated that reference costs would show that the Trust was more expensive sue to being located in London. It would be more useful to overlay this data with patient level costing data, to extrapolate meaning.
121.14	Mrs Newton informed the Committee that work was being led by Birmingham Hospitals NHS Foundation Trust to develop a more centralised approach by Trusts to changes in tariffs.
121.15	The committee **noted** the report.
122.	**Year end 2011-12 Key Financial Issues Update for Audit Committee**
122.1	The Chief Finance Officer presented the report which was taken as read.
122.2	The Chief Finance Officer noted that Monitor were yet to release guidance relating to the change in accountancy policy.
122.3	The main issue was that of the land and building valuation as the overall index had risen.
122.4	Mr Lomas asked whether the Trust had to value its property every year, following authorisation as a Foundation Trust. Ms Heather Bygrave, Partner, Deloitte noted that the Trust must be able to satisfy that its assets are correctly valued. Mrs Newton advised the Committee that the Trust was considering seeking independent property valuations.
122.5	In response to Mr Lomas' query as to the new accounting periods, Ms Bygrave confirmed that there would be a set of accounts for the previous eleven months with comparisons from the year before, then a set of accounts for one month with no comparisons as it would technically become a new trust. This would be followed by a complete set of accounts for twelve months again with no comparisons, other than the one month.
122.6	The committee **noted** the report.
123.	**Sustainability Reporting and Governance Arrangements Review**
123.1	Ms Lucy Bubb, Senior Manager, Deloitte presented the report which was taken as read.
123.2	The Chairman requested that item 2 on the action plan included the name of an Executive lead to ensure ownership of the recommendations.

123.3 123.4 123.5 123.6	**Action**: Ms Lucy Bubb, Senior Manager to agree the name of an Executive lead to ensure ownership of the recommendations. It was noted that the Trust was required to appoint a Non- Executive Director as Sustainability Lead. This position had previously been held by Mr Andrew Fane who had left the Trust. It was agreed that this appointment be considered by the Trust Board. The Committee agreed that it would be helpful to also have an executive lead. **Action**: The Company Secretary to ensure that the Trust Board appoint a new Sustainability Lead (non-executive and executive positions). The Committee **noted** the report.
124.	**Update on Quality Accounts audit and Monitors' Annual Reporting Manual**
124.1	Ms Heather Bygrave, Partner, Deloitte provided a verbal report. She informed the Committee of the requirement by Monitor for trusts to conduct a one off audit of heritage assets, for example paintings it owns and what value they have. These values would then be added to the balance sheet.
124.2 124.3 124.4 124.5 124.6 124.7	Ms Bygrave provided an updated set of timelines were the Trust to become licensed as a Foundation Trust on 1st March. She informed the Committee that a set of accounts would need to be produced for the previous 11 months, then for the month of March and then the following 12 months. Ms Bygrave noted that the Audit Commission deadline was later than the Monitor deadline for the 11 month and 1 month accounts but advised that the Trust keep the dates the same. Ms Bygrave noted that there would be increased pressure on the Finance team to produce all of the information in time for both the Department of Health and Monitor. Ms Bygrave stated that she would be meeting with the Chief Finance Officer to discuss requirements. The Chairman agreed that it was important that the Finance team had sufficient resources to complete both sets of accounts and requested that the Chief Executive and Chief Finance Officer consider the work-plan for the forthcoming months. **Action:** The Chief Executive and the Chief Finance Officer to meet to ensure resources are in place to enable the work to be completed on time. Ms Bygrave informed the Committee that Monitor required an opinion on the quality accounts and testing of two mandated indicators and one local indicator by the end of June 2012. This opinion would be published in the Annual Report. The Committee was advised that the main change in the Annual Reporting Manual was to the way that the donated asset reserve was dealt with in the accounts. It was up to the Trust on how to present this information.
124.8	The Committee **noted** the report.

125.	**Internal Audit Progress Report: October 2011- January 2012**
125.1	The Head of Internal Audit, Mr Roger Brealey presented the report and informed the Committee that Internal Audit had issued twelve reports to the Trust since the previous meeting, including two with limited assurance.
125.2 125.3	In response to the Chairman's query as to how Great Ormond Street compared with other trusts, Mr Brealey confirmed that the trust was in a better position than a number of trusts with a high number of significant assurances received following internal audits. Mr Brealey agreed to reproduce a survey of other trusts' assurance status' following internal audit reports for the April meeting. **Action**: Mr Brealey to reproduce a survey of other trusts' assurance status' following internal audit reports for the April committee meeting.
125.4	In response to the Chairman's query, Mr Brealey confirmed that he was satisfied that Bank and agency Nursing staff spending was being controlled but that improvements could be made.
125.5 125.6 125.7	Mr Brealey also confirmed that appraisal policies were in place but that improvements could continue to be made. Mr Tilley asked whether the IGAP audit would move to significant assurance. Ms Newton stated that it would require another audit to be conducted following the work outlined by Mr Mark Large in a previous report to show that gaps had been closed. The committee requested an update on this for the April meeting. **Action**: The Chief Finance Officer to provide an update on further audit results on IGAP at the April meeting.
125.8	Mr Brealey drew the attention of the committee to the proposed changes to the internal audit operational plan for the remaining weeks of 2011-12, highlighting that the QUIPP audit would be replaced by an audit of corporate records.
125.9	The Committee **noted** the report.
126.	**Internal and External Audit Recommendations**
126.1	The Chief Finance Officer presented the report which was taken as read.
126.2 126.3 126.4	The Chairman noted that on page 4, the recruitment services figures were not consistent with other figures quoted in the report. The Chief Finance Officer agreed to follow this up to understand what the issues are. **Action**: The Chief Finance Officer to follow up inconsistencies with the recruitment services figures and report back to the next meeting.

126.5	The Committee **noted** the report.
127.	**Information Governance Update**
127.1	The Chief Finance Officer presented the report which was taken as read. The Committee reviewed the information governance framework and noted the results of the initial self-assessment against the IG toolkit and in particular the key outstanding areas of attendance at IG training and implementation of Pseudonymisation.
127.2	The Committee **approved** the information governance framework.
128.	**Debt write off recommendation**
128.1	It was noted that the Overview of provisions, debts, debtors and creditors had been included for information.
128.2 128.3	Mr Lomas asked how often this paper needed to be seen by the committee. The Company Secretary agreed to review the frequency of reporting on debt write off. **Action**: The Company Secretary to review the frequency of reporting to the Audit Committee on debt write-off.
129.	**Trust Wide Risk Register Update**
129.1 129.2	In response to the Chairman's request, the Company Secretary agreed to remind the author to provide more break down within the categories, such as 'infrastructure', to better understand the risks. **Action**: The Company Secretary to remind the Risk Team of the need to break down the risk categories in order to better understand the issues raised.
129.3	Mr Lomas queried whether the Committee should be concerned with all risks, or simply the corporate risks. The Chief Executive agreed that the infrastructure category needed to be better teased out so as to enable the Committee to focus on the appropriate areas of concern.
129.4	Mr Lomas observed that several high and medium risks had been reported at this level for some considerable time. This could be appropriate, but it was agreed there should be a better way of presenting this information, so that it was clear that the risks had been reviewed and the reasons why they remained medium or high.
129.5 129.6	The Chief Operating agreed that some risks may have been mitigated but will always remain high in which case they should be separated from any new risks. **Action**: The Head of Risk to ensure that the aged risks are appropriately documented to show when they were last reviewed and the reasons why they remained medium or high.
129.7	In response to the Chairman's concern regarding the blood risk on page 3, the

	Chief Finance Officer noted that she was of the opinion that the risk had been de-escalated since the publication of this paper but that she would confirm for the Committee.
129.8	**Action:** The Chief Finance Officer and Chief Operating Officer to confirm that the blood risk has been de-escalated.
129.9	The committee **noted** the report.
130.	**Working Capital, Losses and compensations**
130.1	It was noted that the working capital, losses and compensations report had been included for information. The Chairman asked if there were any questions or comments. There were none.
131.	**Counter Fraud Progress Report October 2011 – January 2012**
131.1	It was noted that the counter fraud progress report had been included for information. The Chairman asked if there were any questions or comments. There were none.
132.	**Local Security Manager Report and Fire Report**
132.1	It was noted that the Local Security Manager Report and Fire Report had been included for information. The Chairman asked if there were any questions or comments. There were none.
133.	**KPI Performance Report**
133.1	It was noted that the KPI Performance Report had been included for information. The Chairman asked if there were any questions or comments. There were none. The Chairman commented that it was important that the Trust review external benchmarking data to help understand any gaps in the business model.
134.	**Waivers approved by Management Board**
134.1	It was noted that the Waivers approved by Management Board had been included for information. The Chairman asked if there were any questions or comments. There were none.
135.	**Committees** **a) Risk Assurance and Compliance Group** **(i) Minutes of meeting held on 15 November 2011** **(ii) Minutes of meeting held on 13th January 2012 (DRAFT)** **b) Clinical Governance Committee – DRAFT minutes of meeting held on 22 September 2011**
135.1	It was noted that the minutes had been included for information. The Chairman asked if there were any questions or comments. There were none.
136.	**Any Other Business**

136.1	There were no items for any other business.
137.	**Date of the Next Meeting**
137.1	The date of the next meeting was confirmed as **Monday 23rd April 2012.**
138.	**Audit Committee Terms of Reference**
138.1	It was noted that the Audit Committee Terms of Reference had been included for information. The Chairman asked if there were any questions or comments. There were none.
139.	**Audit Committee Work Plan**
139.1	It was noted that the Audit Committee Work Plan had been included for information. The Chairman asked if there were any questions or comments. There were none.

Signed as a correct record of the Great Ormond Street Hospital for Children NHS Trust Audit Committee meeting held on 20th February 2012.

Chairman: ……………………………….

Date ……………………………….

ATTACHMENT O

Great Ormond Street Hospital for Children NHS Foundation Trust

SUMMARY OF A MEETING OF THE AUDIT COMMITTEE* Held on 23rd April 2012

Revised Annual Committee Terms of Reference and annual Workplan
Dr Anna Ferrant, Company Secretary reported that the Terms of Reference had been approved at the last meeting but had been amended in light of guidance received from Monitor and the Foundation Trust Network. It was agreed that the Company Secretary would make changes to the workplan to reflect the updated Terms of Reference. It was agreed that consideration would be given to whether further clarification was required around the differences in scope between the Audit Committee and the Finance and Investment Committee.
Assurance Framework
Updates were provided on risks 3A, 6A and 7A. It was agreed that a list of organisations which have potential to influence the Trust would be reviewed at the next meeting.
NHS Litigation Authority Assessment Update
Some concern was expressed that a dashboard giving information on areas of non-compliance would not be available until November 2012. It was agreed that an initial version would be considered at the next Audit Committee meeting.
ICT Strategy Update
It was agreed that the business case in relation to the next major investment would be considered at Trust Board rather than Management Board. It was confirmed that an EDMS business case would be brought to Trust Board in June and would include a process map of the timescale of decisions. It was confirmed that the Trust had a sufficiently robust ICT infrastructure to support the work of one the top five children's hospitals in the world. The committee agreed that Internal Audit should conduct a follow up audit of the ICT business continuity systems and the report was to be considered at the June meeting of the Trust Board.
Assurance Framework
<u>Risk 3A – We may fail to get Commissioner 'buy-in' of growth plans and service developments.</u> It was reported that the primary area of the risk was around non-payment. The impact of the risk arose if Commissioners did not agree with the Trust's growth

plans. The Trust would be challenged on over-performance and this ultimately might result in non-payment due to the financial constraints in the NHS economy.

Ms Newton explained that key controls were around maintaining open and transparent discussion about the Trust's growth plans and responding to all information requests regarding over performance with additional information.

It was noted that an internal audit had reviewed SLAs and overall financial stability and had reported significant assurance.

Risk 6A – We may overspend on budgets by not maintaining control of costs and failing to achieve planned CRES targets.

It was reported that sufficient processes were in place to manage this risk and that weekly meetings took place of an executive group at which updates were received from individual units and the overall position review. Clinical units were focussing on their 201213 programme and that where applicable this was being linked to workforce numbers.

Ms Dalton added that Executive Directors had recently put a system in place to review all new recruitment in corporate areas and non-rostered staff at band 6 or above in clinical areas.

Mr David Lomas, Non-Executive Director asked for a steer on the frequency with which risks on the Assurance Framework were reviewed.

Mr Charles Tilley, Committee Chairman stressed the importance of those responsible for delivering CRES schemes feeling accountable. Ms Dalton confirmed that she was confident that they did.

Risk 7A – We fail to maintain compliance with regulatory and legislative requirements (in particular CQC Registration Standards, NHSLA, ALE, Health and Safety at Work Act, NHS Constitution, Research Governance Framework, IG Toolkit)

It was reported that controls for this risk relied on a central understanding of who was a lead in each area and on central reporting. She added that the recruitment of the Compliance and Governance Manager would be helpful in mitigating the risk.

Mr Tilley asked for a list of organisations which had the potential to influence the activity of the Trust to be brought to the next meeting.

Update on investigation into loss of power due to stolen cable

It was reported that in January 2012 cable had been stolen from a temporary generator causing power loss to laboratories. As a result, the theft of cable had been noted as a high risk.

Ms Yvonne Brown, Non-Executive Director reported that the Clinical Governance Committee received a paper which outlined the impact that a loss of power would have to freezers in clinical trials and result in a loss of income and reputation for the Trust.

Ms Fiona Dalton reported that this incident had raised awareness of the impact of

loss of power throughout the hospital.
Internal Audit Progress Report February 2012 – April 2012
Mr Roger Brealey reported that ten final reports had been issued since the February 2012. Two areas had provided limited assurance; salary overpayments and IT business continuity. Dr Jane Collins, Chief Executive asked for a view from internal audit as to whether the level of overpayment reported by GOSH was higher or lower than other Trusts. Mr Brealey reported that other Trusts had similar issues. He explained that a number or organisations have introduced positive reporting particularly in departments which had the greatest problems. Mr David Lomas, Non Executive Director noted that limited assurance had been provided in the area of data quality in relation to Board Information. He asked whether enough time was dedicated to this area of assurance by the internal auditors and Mrs Claire Newton agreed to discuss with internal audit and report back to the Committee.
Draft Internal Audit Strategic Plan 2012/13 – 2015/16
Mr Roger Brealey presented the Draft Internal Audit Strategic Plan. Mr Charles Tilley, Committee Chairman stressed the importance of linking the work of the Audit Committee to the Trust's Business Plan. Mrs Claire Newton explained that the Auditors considered the Board Assurance Framework in developing their plan. Mr David Lomas asked whether the Committee felt 20 days was sufficient to complete work on the annual review of the Board Assurance Framework or whether additional time should be taken from less crucial areas. It was agreed that further thought be given to this at the October meeting. The Audit Committee **approved** the Draft Internal Audit Strategic Plan.
Update on Salary Overpayments
Mr Andrew Needham, Deputy Finance Director reported that the current position with regard to salary overpayments was £185k of debt outstanding. He added that levels of recovery exceeded levels of overpayment in year largely due to the introduction of positive reporting. Mr Needham explained that Surgery had not demonstrated any improvement in the level of overpayments despite positive reporting.
Information Governance Update
Mrs Claire Newton reported that the Trust has submitted its Information Toolkit assessment as at 31st March 2012 and assessed all standards at level 2 or above. She added that two areas had been assessed as level 1 throughout the year but had now moved to level two.

ATTACHMENT P

Great Ormond Street Hospital for Children NHS Foundation Trust

DRAFT MINUTES OF THE CLINICAL GOVERNANCE COMMITTEE

Held on 16 March 2012

Present:

Ms Mary MacLeod	Chairman and Non-Executive Director
Ms Yvonne Brown	Non-Executive Director
Professor Andy Copp	Non-Executive Director
Ms Fiona Dalton	Deputy Chief Executive
Professor Martin Elliott*	Co-Medical Director
Mrs Liz Morgan	Chief Nurse and Director of Education
Mrs Salina Parkyn	Head of Risk
Mr Aaron Shah	Internal Audit Manager, London Audit Consortium

In attendance:

Dr Joe Brierley *	Consultant (Intensivist)
Dr Barbara Buckley	Co-Medical Director
Dr Anna Ferrant	Company Secretary
Miss Victoria Goddard	Trust Board Administrator (minutes)
Ms Sarah Kipps *	Practice Educator (Nursing Quality)
Mr Andrew Pearson *	Clinical Audit Manager
Ms Nima Sharma *	Research Governance Co-ordinator
Mr Geoff Speed	Head of Education and Training

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

73	**Apologies for Absence**
73.1	Apologies for absence were received from Jane Collins, Chief Executive Officer.
73.2	Ms Mary MacLeod, Chairman welcomed Ms Yvonne Brown to the meeting as Non-Executive Director to the Committee and the link with the Audit Committee.
73.3	It was confirmed that the meeting on 18th April 2012 would go ahead to enable the committee to cover the business which had been delayed as a result of the cancelled meeting in January 2012.
74	**Minutes of the meeting held 22nd September 2011**
74.1	The minutes of the meeting held on 22nd September 2011 were received

	and **approved** as an accurate record, subject to the following amendment: • Professor Andy Copp, Non-Executive Director to be added the list of those present.
74.2	It was noted that in future minutes, Ms Mary MacLeod, Non Executive Director should be referenced as Ms and not Mrs.
75	**Minutes of the Risk Management Committee on 12th December 2011**
75.1 75.2 75.3	It was noted that the minutes had been attached for information. Dr Anna Ferrant, Company Secretary reported that there had been some slippage in completion of actions and explained that she would be developing an action plan. She explained that some aspects would be considered at the Trust Board Strategy Away Day in March 2012. **Action:** Ms Fiona Dalton, Chief Operating Officer, Mr Charles Tilley, Non Executive Director and Dr Anna Ferrant to develop an action plan to be brought to the Trust Board meeting in April.
76 76.1 76.2 76.3 76.4 76.5 76.6	**Matters Arising and Action Point Checklist** The following matters were raised: 38.2 – Ms Dalton reported that the bedside entertainment system had been rolled out to all new wards in the Morgan Stanley Clinical Building and following this, the system would be rolled out to all other wards. 40.9 – Ms Dalton confirmed that phase 1 of the expanded CIVAS project had been rolled out, but noted that this did not take place in October 2011. She added that a plan for phases 2 and 3 had been developed to ensure that every drug has been subject to CIVAS. 48.6 – The committee requested an update on the Ombudsman action plan in 6 months' time. **Action**: An update on the Ombudsman report to be presented to the committee in 6 months' time. 55 – Mrs Salina Parkyn, Head of Risk confirmed that the aggregated report regarding clinical incidents, risk, claims and complaints would be brought to the Clinical Governance Committee in April for consideration.
76.7 76.8	The Committee received updates on the following actions: 9.3 – Mrs Liz Morgan, Chief Nurse and Director of Education reported that she would provide an update on risk 5A - We may not deliver our education strategy and fail to maintain our position as leader of paediatric education and capitalise on the business opportunities resulting from the position – at the April committee meeting.

76.9	**Action**: The Chief Nurse and Director of Education to provide an updated on Risk 5A at the April committee meeting.
77	**Revised Clinical Governance Committee Terms of Reference and annual workplan**
77.1 77.2	Dr Anna Ferrant, Company Secretary reported that the Clinical Governance Committee Terms of Reference had been revised with reference to Audit Committee Terms of Reference. She explained that the committee's role in assuring the Board around reviewing clinical governance risks, Quality Account, Quality Strategy and assurance of clinical risks of CRES had been clarified. The following amendments were **agreed**: • 2.5 to read "To approve the Quality Strategy and ensure that this is appropriate, implemented and monitored and assure the Board of the delivery of the quality agenda." • 3.1 first bullet point to read "Updates on clinical governance risks on the Board Assurance Framework" • 3.1 bullet point 3 to read "Assurance on mitigation of risks to clinical quality and safety of any CRES plan."
77.3	It was agreed that the minutes from the Quality and Safety Committee meeting would be brought to the April Clinical Governance Committee meeting.
77.4	**Action:** The Company Secretary to ensure that the above amendments are made and that the minutes from the Quality and Safety Committee meeting are brought to the April Clinical Governance Committee meeting for consideration.
78	**Update from Clinical Ethics Committee including revised Terms of Reference**
78.1	Dr Joe Brierley, Consultant (Intensivist) presented an update on the activities of the Clinical Ethics Committee (CEC) since May 2011.
78.2	Dr Brierley reported that referrals are continuing to be made and that the CEC recently held a useful away day. He added that a beneficial next step would be to gain qualitative information from clinicians about how to improve the value of the CEC.
78.3	Ms Mary MacLeod, Non Executive Director suggested that when discussing putting in place governance arrangements for new and innovative treatments, consensus should be reached throughout UCL Partners ensuring that only one conversation need take place throughout the organisations in the partnership.

78.4	She added that the New and Innovative Treatments policy needed to be revised and be presented to the Clinical Governance Committee for approval in October 2012. It was not clear who owned the policy.
78.5	**Action:** The Company Secretary to ensure that the New and Innovative treatments policy is considered by the Clinical Governance Committee in October 2012 and establish who the policy author is.
78.6	Professor Andy Copp, Non Executive Director asked to what extent there was academic representation on the CEC.
78.7	Dr Brierley explained that an academic was not always present at meetings. He confirmed that the CEC was not an approval committee and clinicians must already be satisfied with the option of providing the particular treatment.
78.8	Ms Fiona Dalton, Chief Operating Officer confirmed that a procedures policy was in place and Ms MacLeod suggested that this policy should be used to give the CEC a clear structure and guidance.
78.9	Ms Yvonne Brown, Non Executive Director reported that in order to be assured about the purpose of the CEC, this information should be provided as background in the Terms of Reference.
78.10	Dr Brierley explained that it would be difficult to give this information without limiting the scope of the CEC. He added that the committee's purpose was not to make decisions, but to help those with difficult decision to make to think through those decisions. Ms Dalton added that the CEC did not seek to give assurance on ethics.
78.11	The Company Secretary asked whether the CEC provided learning for decisions to be made in the future.
78.12	Ms MacLeod confirmed that learning and developments had been produced however they had not been well integrated into the rest of the hospital.
78.13	Mrs Liz Morgan, Chief Nurse and Director of Education suggested that it would be useful for the CEC to link up with the education team in order for their work to play a role which is greater than providing specific master classes.
78.14	<u>Terms of reference</u>
78.15	The following amendments to the Terms of Reference were **agreed**: • The CEC to report on a quarterly basis to Trust Board as well as Clinical Governance Committee.

	• The membership of the committee to include a Non Executive Director to create a link from the CEC to the Trust Board.
78.16	**Action:** Dr Joe Brierley to make the above amendments to the Terms of Reference.
78.17	Ms Brown queried whether an Executive Director should take the lead in being accountable for the governance of the CEC.
78.18	It was **agreed** that this would be discussed at the Trust Board meeting in April.
78.19	**Action**: The Company Secretary to ensure that the matter of an Executive Director lead for the CEC is discussed at the Trust Board in April 2012.
79	**Development of the Quality Account**
79.1	Professor Martin Elliot, Co-Medical Director presented a proposed template of the Quality Account for 2011-12. He explained that the paper intended to show the required content and the proposed format of the report.
79.2	Professor Elliot requested that feedback on the proposal be given either during the meeting or in writing soon thereafter as the document must be complete by the end of March 2012.
79.3	Professor Andy Copp, Non Executive Director noted that text was missing from the final bullet point of the second page of the report.
79.4	He added that he was pleased to see that it was proposed that benchmarking clinical outcomes would be revisited and that the referrer's improvement programme would continue in more detail as these important issues should remain priorities.
79.5	Ms MacLeod stressed the importance of patient and family stories. She suggested the addition of an extract from a very positive letter received by Jane Collins, Chief Executive Officer, written by a patient with a learning disability. She added that she was also pleased that food was being revisited as there had been ongoing issues in this area.
79.6	**Action**: Professor Elliott to consider inclusion of positive patient stories in the report.
79.7	It was **agreed** that work that the Trust was undertaking on innovation should be included in the report.

79.8 79.9 79.10 79.11 79.12 79.13 79.14	**Action**: Lisa Davies, the author or the report to include work the Trust is undertaking on innovation in the Quality Account. The Company Secretary confirmed that the Quality Account would form part of the agenda at the Members' Council meeting on 29th March 2012 and that Deloitte would expect to see that one of the indicators had been selected by the Council. Ms MacLeod suggested that the format of the paper be amended to enable the Members' Council to follow the document more clearly. Professor Elliot explained that the design of the Quality Account was heavily influenced by the design of the Annual Report. He added that as the Quality Account would be produced at year end, it would create a time pressure. He noted the lack of flexibility of the design software to create a particularly 'user friendly' version. Mrs Liz Morgan, Chief Nurse and Director of Education confirmed that as a presentation would be given to the Members' Council they would be supported to understand the format and the information given in the Quality Account. Ms Fiona Dalton added that presenting the previous year's Quality Account would be helpful for the Council to enable them to understand the intended outcome. **Action:** The Company Secretary to ensure that the Quality Account for 2010-11 is presented to the Members' Council in March 2012.
80	**Assurance Framework**
80.1 80.2 80.3 80.4	Ms Fiona Dalton, Chief Operating Officer provided an update on the Board Assurance Framework reporting that good progress was being made on the majority of risks. Ms Dalton confirmed that she believed that all necessary actions had been completed with reference to risk 1F – Our clinical equipment may be inadequate for excellent clinical care and enhanced patient experience - to enable it to be rated as green once it had been reviewed by the Executive team. The Risk Assurance and Compliance Group (RACG) had noted the work which had been completed on risk 1J – lack of appropriate clinical response to the deterioration in children - and felt that it should now be rated as green. Mr Aaron Shah, Internal Audit Manager added that an internal audit in this area had provided significant assurance and it was likely that this

	report would be available to be considered by the Clinical Governance Committee at April's meeting.
80.5	It was noted that risk 1K – Appropriately qualified and trained staff may not always obtain fully informed consent or may not obtain consent from the correct person – would be considered during the Internal Audit item later in the meeting.
80.6	Ms Yvonne Brown asked for a steer on the implementation of electronic patient records.
80.7	Professor Martin Elliot, Co-Medical Director reported that it had been recognised that these changes could be delivered through the electronic document management project although further work on the methods of collection and searching of the data was still to be completed. He reported that products were available which would provide the Trust with the majority of the necessary function for a cost in the region of £2m - £3m. He added that a hospital in the USA had paid approximately £200m for a system which provided all necessary functionality.
80.8	Professor Elliot added that he felt clinical assurance should be provided at Board level.
80.9	It was agreed that Ms MacLeod would contact Charles Tilley, Chair of the Audit Committee to discuss whether the risk would be shared between CGC and Audit Committee and that the matter would also be considered at Trust Board.
80.10	**Action**: Ms MacLeod to contact Charles Tilley, Chair of the Audit Committee to discuss whether the risk around implementation of an electronic patient record be shared between CGC and Audit Committee and that the matter would also be considered at Trust Board.
80.11	**Presentation of high level risks**
80.12	**Risk 1H – "We may not be able to recruit and retain key staff"**
80.13	The Chief Operating Officer confirmed that necessary policies and procedures were in place. She reported that the as a consequence of teams being subspecialist, only a low rate of staff sickness would be required to create capacity issues in carrying out policies.
80.14	Ms Yvonne Brown, Non Executive Director asked for assurance that night staff had the same level of understanding of the Trust's business and its risks day staff.
80.15	Mrs Liz Morgan, Chief Nurse and Director of Education reported that the majority of staff worked a rotation of both nights and days. She added

	that although it was a challenge to ensure that all staff received necessary messages most wards had a structure in place for cascading key messages.
80.16	Professor Andy Copp asked if the Trust had any figures for recruitment efficiency.
80.17	Ms Dalton reported that an audit had taken place which looked at the different parts of recruitment and noted where problems existed with efficiency. It was **agreed** that Mr Aaron Shah, Internal Audit Manager would look at this previous audit and examine ways to replicate the process.
80.18	**Action:** Mr Shah to look at the previous recruitment audit and examine ways in which this process could be replicated.
80.19	**Risk 2C – "We may not meet referrers and other health and social care expectations around communication and accepting appropriate referrals"**
80.20	Ms Dalton noted that referrer's expectations were high and that while they were generally happy about the clinical care which patients received, they were not satisfied with information given once a child had finished treatment at GOSH or with the ease with which a child was accepted for treatment.
80.21	She explained that a Referrer's Experience Group was leading on several improvements including reviewing discharge summaries and monitoring the length a time taken to send an outpatient appointment letter.
80.22	The Group also monitor the number of refused emergency patients. Ms Dalton reported that a new bed management policy had been rolled out and an electronic form was being piloted on an iPad to collect the necessary information from patients. This data was then input into a database.
80.23	It was reported that Dr Barbara Buckley, Co-Medical Director and Mr Robert Burns, Deputy Chief Operating Officer would be meeting with each major referrer hospital to receive feedback. It was noted that in general, feedback was extremely varied between specialities.
80.24	The importance of positive relationships with these referrers was stressed as it was noted that it would be possible to refer the majority of children to other hospitals.
80.25	**Risk 4A – "We may not deliver our research strategy and fail to attract research funding"**

80.26 80.27 80.28 80.29 80.30 80.31 80.32	Ms Nima Sharma, Research Governance Co-ordinator reported that Research Council funding had been secured from April 2012. The funding amounted to £36m for up to 5 years. Ms Sharma confirmed that there had been no critical findings during a recent NHRA inspection. Professor Copp queried whether targets had been set with regards to research activity resulting from KPI reporting. Ms Dalton confirmed her understanding that targets would be in place for the next Trust Board meeting. She added that as a result of receiving less research funding this year than last year a judgement would be made about whether this risk should now be rated amber. Mr Shah reported that a paper around the way in which incidents are reported would be available at the April committee meeting. The Company Secretary noted that the focus of the risk was towards attracting research funding and suggested that that it should be expanded to include the governance of safe, effective research to benefit patients. The committee **noted** the report.
81	**CRES Quality and Safety Overview**
81.1 81.2 81.3 81.4	Ms Fiona Dalton, Chief Operating Officer reported that Trust Board had requested that the Clinical Governance Committee provide assurance that the CRES programme was not impacting on quality and safety. She highlighted the example documentation which was used to sign off high value schemes and were signed by the Medical Director and Chief Nurse. It was **agreed** that at future meetings the responsible managers of two high value schemes would be asked to attend and explain what was being done to manage the risks created by their particular scheme. **Action:** Two schemes chosen from those with higher risk scores to be considered at each meeting. The responsible manager to explain what was being done to manage risks.
82	**Trust Wide Risk Register Update**
82.1	Mrs Salina Parkyn, Head of Risk presented an update which included an overview of risks contained under the heading 'infrastructure' as

	requested by the Committee.
82.2	Ms Mary MacLeod, Non Executive Director commended the reduction of the number of open risks. She noted that where a lower number of risks had been identified, assurance was greater that each risk could be managed effectively.
82.3	Ms Parkyn reported that in April and May 2012 three further risk managers would be in post and would be integrated within the clinical units. She expected that this would further reduce the number of open risks.
82.4	Ms Yvonne Brown, Non Executive Director expressed some concern at result of infrastructure risk ID 1855. She questioned the overall benefit to the hospital of expanding the outpatient service with the resulting clinic cancellations due to room availability.
82.5	Professor Elliot reported that this issue had been discussed at Management Board and it had been agreed that evening and weekend capacity should be used. He explained that it may be necessary to select particular patients to be seen at these times or to develop a fully integrated evening and weekend service. He added that customers had indicated that they would prefer to be seen at these times so it was important to provide this service.
82.6	Professor Copp asked for further details around the high risks which had been opened in 2006 and were still open in 2012.
82.7	Mrs Parkyn explained that one of the risks was a leaking roof at the Mildred Creek Unit. Work had been ongoing to determine the cause of the leak however while he risk remained, the running of the unit was affected.
82.8	It was **agreed** that Mr William McGill, Director of Redevelopment would provide a report on this risk for April's meeting and that a written report be submitted on the other aged high graded risks prior to 2011
82.9	**Action:** Reports to be provided on all aged high risks prior to 2011at the meeting in April.
83	**Learning Disability Action Plan**
83.1	Mrs Liz Morgan explained that the way the Trust manages children with a learning disability had been criticised in an internal audit report giving the Trust only limited assurance. There is an action plan in place to address the key issues identified which had been approved by Monitor as the management of patients with a learning disability is a core component of the Monitor Quality Governance framework .
83.2	She explained that good progress was being made with the action plan however further work focussing predominantly around raising the needs of children with a learning disability and their family and helping staff to

	communicate more effectively and with greater confidence with these children has been identified
83.3	Mrs Morgan confirmed that a proposal had been put forward to the charity for funding for a specialist Learning Disability Nurse who would work intensively with staff to improve the way the Trust cares for children with a learning disability as a time limited project. Staff had previously stated that they felt less confident about providing a high quality service to children with a learning disability.
83.4	The Company Secretary reported that the Policy for Policies had been revised to include further references to children with a learning disability.
83.5	Ms Dalton stressed that the Trust was compliant with national standards following the actions which had been completed.
83.6	The Committee **noted** the report.
84	**Overview of CQC Compliance**
84.1	The Company Secretary presented an update on the current status of CQC registration standards.
84.2	She explained that there had been changes in the risk estimates of three risks.
84.3	Outcome 7 – safeguarding people who use services from abuse, had become low neutral due to the receipt of qualitative data around safeguarding reports.
84.4	Outcome 8 – Cleanliness and infection control, had moved to insufficient data as the information provided had become out of date.
84.5	Outcome 10 – Safety and suitability of premises, had slipped to low neutral as the result of additional data received from a complaint.
84.6	Dr Ferrant stressed that the estimate of risk was only an estimate, not a judgement. She added that a positive working relationship was in place with CQC who felt that they could seek assurance informally on any matters of concern.
84.7	It was **agreed** that at the April meeting focus would be placed on one outcome and the committee would be provided with all available internal information to provide assurance.
84.8	**Action:** The Company Secretary to focus on one outcome and provide assurance giving data to the committee at the meeting in April.
84.9	**Standard 5 – Meeting Nutritional Needs**

84.10	Ms Sarah Kipps, Nursing Quality Practice Educator presented the summary report on compliance with CQC outcome 5.
84.11	She highlighted the initial amber rating of the outcome which had moved to green with the Trust being fully compliant. She added that an action plan had been developed which would address any gaps over the coming year.
84.12	Mrs Liz Morgan, Chief Nurse and Director of Education noted that good work had been carried out around protected meal times which had been implemented sensitively and flexibly.
84.13	**Standard 14 – Supporting workers**
84.14	Mr Geoff Speed, Head of Education and Training reported that the Trust was in good position in relation to outcome 14 and was fully compliant.
84.15	He explained that the greatest risks were around the reliability of information produced by the training database. Mr Speed added that it was now possible to evidence learning due to the required assessment for training modules.
84.16	It was reported that good evidence was available for outcome 14b as the Trust provided 'blended learning'. An action plan was in place to increase appraisal rates.
84.17	It was **agreed** that the following additions would be made to the evidence used to provide assurance: • 14b – All staff employed as health professionals have the correct registration. • 14d – The Clinical Ethics Committee and related policy is available to support staff
84.18	**Action:** The Head of Education and Training to make the above additions to the assurance information.
84.19	The Committee **noted** the report.
85	**Child Protection**
85.1	Mrs Liz Morgan, Chief Nurse and Director of Education reported that local commissioners had developed four CQUIN targets for 2011 -12 which had been particularly challenging. It was confirmed that the Trust had achieved all targets.
85.2	It was confirmed that no CQUIN targets had been set in this area for the forthcoming year, however North Central London have developed several metrics are to be included as stipulations within contracts for 2012-13. This had already been considered in next year's work plan.
85.3	The Committee **noted** the report.

86	**Internal Audit Progress Report October 2011 – February 2012**
86.1	Mr Aaron Shah, Internal Audit Manager reported that three final reports had been produced since October 2011.
86.2	Limited assurance had been provided for consent to treatment. Of 30 consent forms reviewed, 8 had been provided by the child's father however in these cases no evidence had been documented to show that the father was able to give consent.
86.3	Ms Mary MacLeod, Non Executive Director asked what information would be required from mothers and fathers to prove parental responsibility.
86.4	**Action**: The Quality and Safety Team to advise at the July meeting on a reasonable way forward regarding evidence provided by mothers and fathers to prove parental responsibility.
86.5	Mr Shah added that of the 30 consents reviewed, in 24 cases the lead clinician had delegated responsibility for obtaining consent. Only 1 of these cases provided evidence that the delegated individual had been trained to obtain consent.
86.6	It was noted that the delegated individuals may have been capable of giving consent however documentary evidence was not available.
86.7	Mr Shah reported that similar results had been obtained in other Trusts. He added that newly produced NHSLA guidance required documentary evidence to be available.
86.8	Ms Fiona Dalton, Chief Operating Officer reported that an action plan had been developed in two phases. A number of actions were due by 31st March 2012 and would be completed for discussion at April's Trust Board meeting. A number of actions were not due for completion until January 2013.
86.9	Mr Shah reported that reasonable assurance had been provided in relation to Statutory and Mandatory training. At the time the report had been completed a performance target had not been set. Subsequently a target of 80% had been set for this year.
86.10	Mr Shah confirmed that there were no major concerns in this area.
86.11	It was reported that significant assurance had been provided in relation to Health and Safety and that there were no concerns in this area.
86.12	The Committee **noted** the report.
87	**Internal and external audit recommendations update (clinical)**

87.1	Mr Aaron Shah, Internal Audit Manager reported that since April 2010 a total of 73 internal audit recommendations had been made. He confirmed that only 8 recommendations had passed their agreed target date. It was reported that a number of these recommendations related to provision for children with a learning disability and would have been difficult to achieve within the set timescale.
87.2	It was **agreed** that audit recommendations would be reviewed by the committee on a 6 monthly basis.
87.3	**Action:** The Company Secretary to ensure that audit recommendations are reviewed by the committee on a six monthly basis.
87.4	The Committee **noted** the report.
88	**Clinical Audit Progress Report October 2011 – February 2012**
88.1	Mr Andrew Pearson, Clinical Audit Manager reported that 15 clinical audits had been carried out and 3 had shown non compliance. He added that all three areas now had action plans in place.
88.2	It was confirmed that the Quality and Safety Committee were monitoring all risks resulting from these audits.
88.3	It was reported that six new areas of NICE guidance had been developed which were relevant to the Trust and work was ongoing to confirm actions which would need to be put in place.
88.4	Mr Aaron Shah, Internal Audit Manager explained that a number of Trusts conduct telephone questionnaires with the families of discharged patients to collect feedback around the discharge process and the information that families were given. He agreed to forward a copy of the questionnaire which was used to the Company Secretary.
88.5	**Action:** Mr Shah to forward a copy of the telephone questionnaire used by Trusts to collect feedback around the discharge process.
88.6	Ms MacLeod thanked Mr Pearson for his work in this area.
88.7	The Committee **noted** the report.
89	**Committees**
89.1	<u>**Risk Assurance and Compliance Group**</u>
89.2	The minutes from the meetings of 15th November 2011 and 13th January 2012 and the draft minutes from the meeting of 28th February 2012 were **noted**,

90	**Any other business**
90.1	There were no items of any other business
91	**Next meeting**
91.1	It was agreed that the next meeting would take place on **18th April 2012**.

Signed as a correct record of the Great Ormond Street Hospital for Children NHS Trust Clinical Governance Committee meeting held on 16th March 2012.

Chairman: ……………………………….

Date ……………………………….

ATTACHMENT Q

ATTACHMENT R

Great Ormond Street Hospital for Children
NHS Foundation Trust

SUMMARY OF THE DRAFT MINUTES OF THE CLINICAL GOVERNANCE COMMITTEE
Held on 18 April 2012

Assurance Framework

Learning Disability Action Plan

Dr Barbara Buckley reported that work on the learning disability action plan was on target. It was confirmed that the risk was still rated as amber but would be formally reviewed at the RACG meeting on 20th April 2012 and was likely be approved as green.

Consent

Mrs Salina Parkyn reported that a list was being compiled of all procedures carried out by the Trust which took delegated consent. Dr Barbara Buckley, Executive Lead of the consent programme added that a lot of work would be necessary in many areas including policy and education.

Risk 1D – Children may be at risk from hospital acquired infection

Ms Deidre Malone, Lead Nurse Infection Prevention and Control reported that both a DIPC and Deputy DIPC had been appointed and the Infection Control Committee Terms of Reference were being reviewed in light of Clinical Units taking part in their own infection control meetings.

Risk 1G – Staff in post may not be appropriately competent to deliver care

Mr Geoff Speed, Head of Education and Training reported that good work was ongoing to improve appraisal rates however issues were arising with the updating of data. He confirmed that a paper would be considered by both Trust Board and Management Board and that work would be ongoing with London Audit Consortium to assess the Trust's training needs.

Ms Yvonne Brown expressed some concern that the level of completed PDRs had reduced. She stressed the importance of staff being given the opportunity to raise training issues in these meetings.

Ms Mary MacLeod, Committee Chairman raised concern around the percentage of required staff having completed child protection level 3 training. She queried the action plan which was in place.

Mr Speed confirmed that work was now ongoing to design bespoke training to ensure teams are able to receive the specific type of child protection training required.

Ms Dalton reported that the Trust was keen to roll out tests used in the recruitment of non clinical staff to those seeking clinical positions.

Update on Risk 5A – We may not deliver our education strategy and fail to maintain our position as leader of paediatric education and capitalise on the business opportunities resulting from the position

Mr Geoff Speed reported that a five year educational strategy was currently being reviewed. He confirmed that a key aim was to increase income and that simulation learning would be a key component.

It was reported that there would be a low risk of not meeting objective set out in the strategy due to the culture of the hospital being very much around continued learning.

Mr Speed explained that work was ongoing with the Transformation team to correlate education and clinical outcomes. He added that the education team would, in the future, need to take part in Clinical Unit Boards to ensure outcomes were improving.

Mr Speed confirmed that 200 days per year of education were provided in Kuwait with observation space at the Trust. He added that a trainer was in place who worked in Kuwait one week per month and that the aim was to develop this approach elsewhere as it was a key area of income.

Ms MacLeod suggested pursuing contact with large companies which developed online training.

Update report on the implementation of the clinical equipment tagging system – Risk 1F

Ms Judith Cope reported that the tagging system would be rolled out to other mobile items used in the hospital. She confirmed that items of which the hospital owns only a few would also be tagged. Ms Cope added that all items moving to the Morgan Stanley Clinical Building were being checked.

Overview of CQC Compliance

Outcome 10 – Safety and Suitability of Premises

Dr Anna Ferrant reported that at the last meeting of the CGC, the committee asked for a focus to be placed on particular outcomes and an overview to be given of internal assurances.

Mr Peter Wollaston provided an overview of the scope of CQC outcome 10. He explained that it involved risks in estates, redevelopment, business continuity, radiation protection, fire safety and security. Mr Wollaston reported that issues had arisen with processes which were in place to ensure that policies were carried out correctly. He confirmed that staff were being trained to ensure that policies were correctly implemented.
Risk impact assessments were being implemented in estates so the impact of work on the Trust physically and in terms of clinical activity and reputation was known.

The committee was informed that a piece of work was due to be carried out in a corridor close to the restaurant. As a result of a risk impact assessment, work was delayed to ensure risks around moving people to the restaurant were mitigated.

Update on NHSLA assessment

Mrs Salina Parkyn reported that an information visit had taken place with a new NHSLA assessor. She confirmed that the role of NHSLA project lead was being advertised and it was expected that a candidate would be in post shortly.

It was confirmed that savings from achieving level 3 would be in the region of £300k. Mrs Parkyn explained that once practices became embedded, it would result in improved clinical care.

Quality Strategy Progress Report

Dr Barbara Buckley explained that the Progress Report provided an update on the four key areas of the Quality Strategy.

It was confirmed that in the area of high risk medication, a pharmacist had been recruited who would develop an aggregate measure of medication errors.

It was reported that a review would take place of all 2222 emergency calls to check whether or not further action would be required. She added that if necessary, a Route Cause Analysis would be carried out.

Internal Audit Progress Report (March 2012 – April 2012)

Mr Aaron Shah reported that significant assurance had been provided in the area of the deteriorating child. He confirmed that significant improvements were being embedded throughout the Trust and work was ongoing.

It was confirmed that Clinical Governance report had been issued as final and had provided significant assurance.

Internal Audit Plan 2012/13

Mr Aaron Shah reported that the Internal Audit Plan incorporated the Board Assurance Framework, CQC, NHSLA and the Information Governance toolkit.

It was agreed that the Internal Audit Plan would set out Monitor's requirements to ensure they were being met.

Other reports received:

- Update on aged high scored risks on the risk register
- Health and Safety Update
- Aggregated analysis report (October 2011 – March 2012)
- Clinical Audit Annual Plan 2012/13
- Employee Relations Activity Report (October 2011 – March 2012)
- Legal Learning Report (October 2011 – March 2012)
- Freedom of Information Request Annual Report 2011-12

ATTACHMENT R

Great Ormond Street Hospital for Children
NHS Foundation Trust

MANAGEMENT BOARD
15th March, 2012

FINAL MINUTES

Present:

Barbara Buckley (BB)	Co-Medical Director
Sven Bunn (SB)	General Manager, Medicine and DTS
Cathy Cale (CC)	CU Chair , ICI-LM
Fiona Dalton (FD)	Chief Operating Officer (Chair)
Carlos De Sousa (CDS)	CU Chair, Neurosciences
Lorna Gibson (LG)	Head of Research and Innovation
Allan Goldman (AG)	CU Chair, Cardio-Respiratory
Melanie Hiorns (MH)	CU Chair MDTS
Carla Hobart (CH)	General Manager ICI-LM
Elizabeth Jackson (EJ)	CU Chair, Surgery
Mark Large (ML)	Director of ICT
Anne Layther (AL)	GM, Cardiac
Joanne Lofthouse (JL)	General Manager, International Division
Martin Elliott (ME)	Co-Medical Director
William McGill (WM)	Director of Redevelopment
Liz Morgan (LM)	Chief Nurse and Director of Education
Claire Newton (CN)	Chief Finance Officer
Tom Smerdon (TS)	GM, Surgery
Peter Wollaston (PW)	Head of Corporate Facilities

In Attendance

Helen Cooke (HC)*	Head of Workforce Planning
Alex Faulkes (AFa)	Head of Planning
Anna Ferrant (AF)*	Company Secretary
Peter Lachman (PL)*	Associate Medical Director and Consultant in Service Design & Transformation
Catherine Lawlor (CL)	PA to Chair & Chief Executive (minutes)
Liz Pickering (LP)	Service Manager, Neurosciences

**Denotes meeting part attended*

403	**Apologies**	
403.1 403.2	Fiona Dalton, Chief Operating Officer chaired the meeting as apologies were received from Jane Collins, Chief Executive Officer (Chair). FD welcomed the Board to the first Management Board meeting as a NHS Foundation Trust. FD thanked the Board for all their hard work in achieving this. Apologies were also received from Robert Burns, Deputy Chief Operating Officer and Sarah Dobbing, GM Neurosciences.	
404 404.1	**Minutes of Management Board meeting held on 16th February, 2012** The minutes of meeting held on 16th February, 2012 were approved as an accurate record with an amendment to change SB as not attended.	
405 405.1 405.2 405.3 405.4 405.5 405.6 405.7 405.8 405.9 405.10 405.11	**Action Log and other matters arising** The following updates were received on the documented actions: 374.3 – Omni 10 – FD asked CC to include update on Omni 10 issues in the Zero Harm report for Infection, Cancer and Immunity. 374.9 – Maximum occupancy of Units – TS reported that verbal report would be reported on progress on the on the review in to finding a set of criteria Units should following in identifying optimal safety occupancy and implement this into the Bed Management Policy would be reported at the next Management Board. **Action:** TS to provide a verbal report on progress on the on the review in to finding a set of criteria Units should following in identifying optimal safety occupancy and implement this into the Bed Management Policy. 374.10 - Handover at night findings – It was noted that findings would be presented at the April Management Board. **Action:** AG to present findings to the April Management Board. **331.3 -** Proposal for Sustaining Clinical Outcome and Patient and Family Experience Research Activity by Nursing and Allied Health Professionals – LM reported no progress yet and reported that this would be carried forward to the April Management Board. **Action:** LM to update the Management Board on funding of the proposal post decision by Charity. 319.4 - IV Access project – LM reported that there was now an approved Trust wide Policy on IV lines and would be on the Trust intranet as of Monday, 19th March, 2012. 374.12 – Cardiac – AG reported that findings on the Never Event involving the incorrect placement of a nasogastric tube was reported at the Health and Safety meeting where all Clinical Chairs were present. AG invited further queries if necessary. None were reported. Management Board noted the report. 346.3 – LM reported that the action to integrate 5 year research plans, give clear reference to patients with learning disabilities and consideration to merging the	

	Family Equality and Diversity Group with the PPIEC and greater clarity to how to report things in the PPI and Patient Experience: What we Plan to do 2012-2015 was completed.	
405.12	357.5 – IG Training – LM reported a reminder system for departmental managers of when IG training needed to be renewed was in place and would be going out this week.	
405.13	358.3 – Phase 3A Development Group – FD requested WM report back to the April Management Board with who the representatives from each Clinical Unit would be to sit on the Phase 3A Development Group to develop the initial design brief.	
405.14	**Action:** WM to report back to the Board who from each of the Clinical Units would be the representative to sit on the Phase 3A Development Group to develop the initial design brief.	
405.15	380.4 – Neuroscience – FD reported that a discussion would be had with SD on operational issues as soon as SB was back from leave.	
405.16	**Action:** FD & WM to report back to Management Board with a further update on operational and building issues for Neuroscience.	
405.17	385.5 – KPI report – it was noted that an update on diagnostic and 6 week wait was included in this month's KPI report.	
	Clinical Unit and Zero Harm Reports	
406	**IPP & Deep Dive**	
406.1	JL presented the IPP Zero Harm report. JL reported there had been no delayed and 2 refused admissions. JL reported it had been 342 days since the last Serious Incident (SI) within IPP.	
406.2	JL reported that the three top risks were recruitment and retention, medication errors and income target exceeding the CAP. JL reported that all risks were being addressed.	
406.3	JL presented the Unit's Deep Dive. JL reported on IPP improvement Projects, reducing CVL Infections, transforming care on the ward by utilising the PSAGB board – more actively, piloting EDD accuracy, discharging medications prepared minimum 24 hours prior and reviewing patient information (pre-admission). JL also presented on the Unit's surgical patient pathway, reducing medication errors, risk reporting process and clinical documentation. JL surmised on the Unit's successes and challenges and next stages.	
406.4	Management Board **noted** the content of the report.	
407	**Cardio Respiratory**	
407.1	AG presented the Unit's zero harm report. AG reported that it had been 85 days since the last SI. There had been 3 refusals and 2 complaints. AG reported the Unit's top risks were Medication Errors, Home Ventilation breakdown and CareVue. AG reported all risks were being addressed.	
407.2	AG reported following calls outside ICU on Ladybird where a patient was given respiratory support initially via BVM then Ayers T-Piece and electively transferred to CICU for management. Consultant to consultant hand over should be standard practice. Management Board discussed and agreed.	
407.3	**Action:** AG to draft a letter for ME to send out to all Clinical Unit Chairs advising that	**AG &**

  407.4	handover of a patient's care must by Consultant to Consultant either in person or over the phone. Management Board **noted** the content of the report.	**ME**
408 408.1 408.2 408.3 408.4 408.5	**Infection, Cancer and Immunity** CC reported it had been 399 days since their last SI. CC reported no refusals nor complaints and 3 delays during the month. CC reported the delays were under investigation. CH reported the three main risks for the Unit were access to MRI scan slots, lack of timely availability of cots and cleanliness of clinical areas. CC reported that all risks were being addressed. CC reported that Omni 10 was no longer causing delays but there were still ongoing issues with Order Comms. CC also highlighted that staff was having trouble locating things on the new intranet site. There had been some confusion around uploading information to the new internet site and the intranet sites. Some staff were unaware that the two sites were not intuitively linked. **Action:** ME asked that all Clinical Units reported back to Management Board on progress of uploading information on to the intranet site. Management Board **noted** the content of the report.	 **Clinical Unit Chairs**
409 409.1 409.2 409.3 409.4 409.5	**MDTS** MH presented the paper. MH reported it had been 41 days since the last SI occurred. MH reported that there had been no refusals nor delays and 1 complaints involving a lack of documentation in patients medical records regarding clotting factor affecting communication with surgical colleagues. MH reported the complaint was currently under investigation. MH reported that the top three risks for the Unit were Completion of PIMs forms by non-doctors, Interventional Radiology Service provision and Eagle ward water supply for Dialysis. MH reported that all risks where being addressed. MH also reported that there was an issue with an opening in a wall of the new hybrid theatre to allow services to pass between the anaesthetic room and the main theatre, and that this represented a breach of the X-ray lead shielding to the room such that staff in the anaesthetic room could potentially be exposed . **Action:** WM to provide an update on how opening in a wall of the new hybrid theatre was to be addressed. Management Board **noted** the content of the report.	 WM
410 410.1 410.2 410.3	**Neurosciences** CDS reported that it was 208 days since their last SI occurred and the learning from it. CDS reported 6 refusals and 2 complaints. One complaint involving delay to appointment and reports being sent to a family and another from a father who has refused to allow his daughter to be discharged from GOSH. CDS reported that both complaints were being addressed. CDS reported the risks the Unit faced were medication errors, risk of delays to patient care in complex pathways and inadequate outpatient space to deliver service. CDS reported all risks were being addressed. Management Board **noted** the content of the report.	

411	**Surgery**	
411.1	EJ reported that it had been 92 days since the last SI. EJ also reported 1 refusal and 4 complaints. TS reported complaints were under investigation.	
411.2	EJ identified the Unit's top three risks as medication errors, recruitment and agency staff and medical records. EJ reported all risks were under review.	
411.3	Management Board **noted** the content of the report.	
412	**Reporting Zero Harm - Quality, Safety & Transformation (QST) Update**	
412.1	AFa presented the Status update on the high level measures for Zero Harm. Areas of note: • There were no statistically significant changes in the Zero Harm. • The Paediatric Trigger Tool process was under the scrutiny of a peer review, which identified GOSH PTT as a robust process for objectively quantifying the degree of harm resulting to patients. • There were significant staffing issues within the QST team with no Risk Managers in post. Three new Risk Managers had been recruited and would join the Trust in April and May.	
412.2	CN queried when the report would be finalised. AFa reported that the report would be finalised next week.	
412.3	Management Board **noted** the content of the report.	
413	**R & I Divisional Report**	
413.1	LG presented the report on R&I. LG reported the current divisional activity, governance, industry and clinical trials, clinical research facilitators, data, finance, BRC, clinical research facility, Medicines for Children Research Network, Comprehensive Local Research Network (Central and East London), UCL and forthcoming workplan.	
413.2	LG reported it was 672 days since the last SI.	
413.3	FD asked that LG as well as providing an update on funding to the Board next month (see item 374.3) also provide a briefing for JC for the upcoming BRC meeting.	
413.4	**Action:** LG to provide a briefing for JC for the upcoming BRC meeting.	
413.5	Management Board **noted** the content of the report.	
414	**Education Zero harm Report**	
414.1	LM presented the report. LM presented highlights of activity with in Education and key performance data related to local department managers' responsibilities in relation education training and development of staff.	
414.2	LM reported on line managers' compliance with completing Personal Development Reviews (PDR), NHSLA inspection, progress with the Education dashboard and increased data available through the data warehouse, changes to education and workforce commissioning, KPIs for Education, PDR rates, mandatory training, resuscitation training, information governance, safeguarding children and staff booked on training who did not attend on the day without giving appropriate prior notice.	

414.3	Management Board **noted** the content of the report.	
415 415.1 415.2	**Facilities Zero Harm Deep Dive** It was decided due to time restraints the Deep Dive on Facilities would be brought back to April Management Board. **Action:** PW to bring back Facilities Zero Harm Deep Dive to the April Management Board.	
416 416.1 416.2 416.3 416.4 416.5 416.6 416.7 416.8 416.9	**Key Performance Report February 2012** AFa presented the Key Performance Indicator (KPI) report. The KPI report monitored progress against the Trust's seven strategic objectives and Monitor's Governance Risk and Quality Governance Frameworks. The report provided 'RAG' performance analysis against defined thresholds and tolerances as well as monthly and quarterly performance trends. The report included a deep dive analysis into diagnostic waits within Urology, Gastroenterology and Radiology as per instruction from the February Management Board. AFa reported the Trust remained on trajectory to meet the 92% incomplete pathway target by the end of March. All specialties within Surgery had undertaken a complete review of the planned waiting list and corrected all entries that should have been placed on the elective waiting list. This had a significant adverse effect on the number of 26 week breaches. TS reported that the 26 week wait and 6 week diagnostic should be eliminated in Surgery by August this year. FD asked that TS report back to the Board on progress. **Action:** TS to report back to Management Board on progress made with reducing 26 week wait and 6 week diagnostic with in Surgery. FD stated that Trust Board would want a programme of trajectory of improved 26 week wait and 6 week diagnostic by April for each Unit and will want R&I Targets. **Action:** AFa to produce a programme for Trust Board of programme of trajectory of improved 26 week wait and 6 week diagnostic by April for each Unit and LG to present R&I Targets by April Trust Board. Trust performance had deteriorated with a reported rate of 74.9% against a previous month position of 78.2% for discharge summary completeness. The Trust rate for Personal Development Review (PDR) completeness was reported at 75.4% and 56% for clinical and non-clinical areas respectively against a target of 80%. In month performance had improved for Information Governance training with a reported rate of 91.2% against a target of 95% for all staff trained. Management Board **noted** the report.	
417 417.1 417.2	**Finance and Activity Report** CN presented the report that summarised the Trust's financial performance for the financial period 11 months to 29 February, 2012. CN reported the results year to date to end of February (Month 11), forecast and risks / issues. The most significant risks in delivering the forecast were: • Delivery of the remainder of the CRES plan	

	• Delivering the seasonally high planned level of activity in March. • Ensuring that all income billed is recovered • Controlling Phase 2A costs to planned levels	
417.3	CN reported clinical activity income remained ahead of plan reflecting higher critical care activity, as well as higher than planned outpatient growth and was over spent by £4.9M at £177.4M excluding pass through. Non Pay was under-spent by £4.0M and £2.1M when pass through is excluded. The main causes were lower blood costs, partly reflecting children that have moved to clinical trials as well as lower accruals as a result of a review of current creditors and accruals as well as some charity related timing issues.	
417.4	CN reported FT ratios, BPCC performance, CRES, the Trust's Financial Plan and both capital spend and forecast capital spend.	
417.5	Management Board **noted** the contents of the report.	
418	**Monthly CRES Report**	
418.1	FD asked Management Board to note progress on the CRES programme, in particular noting that: • the current CRES position • Clinical and Corporate Units to progress 11/12 schemes ensuring full delivery • Clinical and Corporate Units to close remaining 12/13 gaps • Clinical and Corporate Units to progress a minimum of 30% of CRES value to Green by 1st April 2012 • Clinical and Corporate Units to ensure PIDs and risk assessments completed for all high value schemes.	
418.2	FD reported that the Trust was currently in the process of reviewing Job planning and would be holding a series of meeting with Clinical Chair's regarding this. The Trust current challenges were to reduce the use of agency staff. Executives and Clinical Units were asked to eliminate the use of band 1-6 agency administrative staff in their areas.	
418.3	**Action:** Clinical Units and Executives to eliminate the use of band 1-6 (non-bank) agency administrative staff in their areas by April.	**Execs & CU Chairs**
418.4	Management Board **noted** the contents of the report.	
419	**Quality Account Proposed Template**	
419.1	ME presented the paper which had been updated following feedback from the template drafted for the Quality and Safety Committee.	
419.2	The paper was a proposed template for the GOSH 2011-2012 Quality Account. ME reported a Quality Account was a public document that was intended to demonstrate what we are doing as an organisation to improve the quality of the service we provide. It had to focus on safety, effectiveness and experience.	
419.3	ME asked that the Board comes additions and suggestions for further improvement be given to ME and Lisa Davies by next week.	
419.4	**Action:** Management Board to come back to ME and Lisa Davies with additions and suggestions for further improvement on the Quality Account Proposed Template by week commencing 19th March 2012.	**Man. Board**
420	**Foundation Trust Application Update February 2012**	
420.1	SB gave a verbal update on achieving NHS Foundation Trust status. SB thanked the	

420.2	Board for all their hard work. Board **noted** the verbal report.	
421 421.1 421.2 451.3 451.4	**Business Case to Increase Cardiothoracic Capacity on move to Morgan Stanley** This proposal would provide the Cardio Respiratory Unit with the resources needed to meet the anticipated growth in Cardiac Surgery and Cardiology inpatients. It would also: • Allow the Cardio-Respiratory Unit to expand the Cardiothoracic Surgery service to meet patient demand. • Provide resources to undertake 40 additional Cardiothoracic Surgical cases, 51 Cardiology Inpatients and 35 Interventional Cardiology cases in a full year. The activity for 2012/13 was based on 10 months only assuming the theatres open on 1st June 2012. • The proposal would deliver activity greater than was currently described in the IBP. Management Board were asked to approve these proposals. CN highlighted concern over predicted growth. AG stated that anticipated growth was reasonable based on Safe and Sustainable. BB and ME recorded their support for the business case. Management Board **approved** the Business case in part but asked that the part involving medical staff come back to the April Management Board post job planning review. **Action:** AG to bring back approval for Medical Staff post Job Planning meeting to April Management Board.	 **AG**
452 452.1 452.2 452.3	**Integrated Theatres Business Case** TS presented the Business Case which proposed to convert at least two theatres in the Variety Club Building (theatres 4 and 5) into state-of-the-art integrated laparoscopic operating theatres, taking advantage of the window of opportunity with the availability of Cardiac Wing theatres as decant space once MSCB was operational. This business case had been approved at the Capital and Space Planning Committee and The Charity had agreed to fund this project. TS sought approval from Management Board to take the project to Trust Board for ratification. Management Board **approved** the proposal to take the project to Trust Board for ratification.	
453 453.1 453.2	**Expansion of psychology provision to the Dermatology team** It was decided due to time restraints Expansion of psychology provision to the Dermatology team paper would be brought back to April Management Board **Action:** CH to bring back Expansion of psychology provision to the Dermatology team to the April Management Board.	 **CH**
454 454.1	**Equipment for additional Surgical Activity & Medical Equipment bids for 2012-13** FD presented the paper. Clinical Units submitted proposals last summer for funding Medical Equipment capital purchases in 2012-13. These proposals were scored by	

 454.2 454.3 454.4 454.5	the Clinical Equipment and Supplies Committee (CESC). The aggregated scores were ranked and formed a clinically prioritised list. Management Board discussed the proposals for 2012-13 funding in February. Questions were raised about revenue consequences and also about some items which had not been clinically prioritised. Units had since had the opportunity to further discuss the issues raised and had accepted the revenue consequences. An outstanding issue remained relating to the wheelchairs which, with a relatively small capital requirement would be addressed separately. Management Board were asked to agree the clinically prioritised list and that funding be requested from GOSHCC. Management Board **agreed** the clinically prioritised list and the proposal that funding be requested from GOSHCC.	
455 455.1 455.2 455.3 455.4	**Trust objectives & supporting workstream** AF presented that paper. Following the focus on Foundation Trust priority work it was proposed that, as an interim position, the seven existing Trust objectives continued into 2012/13. More detailed work would be undertaken within year to identify a further 3 year strategic programme for 2013/14 to 2015/16. The supporting worstreams and actions to deliver the objectives had been reviewed by the Executive Team and Clinical Unit leads. The Trust Annual Plan together with local Clinical Unit/Department plans would be presented to April 2012 Management Board. Management Board was asked to agree the Trust objectives and supporting workstreams for 2012/13. Management Board **agreed** the Trust objectives and supporting workstreams for 2012/13.	
456 456.1 456.2	**.5 WTE Consultant Paediatric Nephrologist - replacement post** It was decided due to time restraints the .5 WTE Consultant Paediatric Nephrologist - replacement post would be brought back to April Management Board **Action:** MH to bring .5 WTE Consultant Paediatric Nephrologist – replacement post to the April Management Board.	 **MH**
457 457.1 457.2	**Staff Residential Accommodation** It was decided due to time restraints the Staff Residential Accommodation update would be brought back to April Management Board **Action:** WM to bring back the Staff Residential Accommodation update to the April Management Board.	 **WM**
458 458.1	**Education strategy annual action plan update** LM presented the report which provided an outline of progress with the 2011-12 Education action plan designed to deliver the 2010-15 Education Strategy. Highlights	

458.2	of progress were presented to demonstrate that good progress was being made to achieve the plan by year end. Management Board **approved** the strategy annual action plan update.	
459 459.1 459.2 459.3 459.4	**Data quality strategy & some proposed DQ indicators** CN presented the data quality strategy and proposed DQ indicators. One of the recommendations of the Deloitte Quality Governance Review was that the Trust should formerly adopt a Data Quality strategy and include data quality indicators within the KPI report. The Management Board approved a Data Quality policy in September 2011, updated from a previous version approved in 2009. The Audit Committee and Trust Board considered a Data Quality improvement action plan in October and December 2011 respectively The Data Quality Strategy set out the Trusts vision and objectives for ensuring the quality of key data and appends the existing Data Quality action plan. Management Board **approved** the Data Quality Strategy and noted that the Data Quality Improve Action Plan involved action in all units to ensure completeness and accuracy of data both in terms of input to pan Trust systems and in terms of management of data in critical local systems.	
460 460.1 460.2 460.3 460.4 460.5 460.6	**Update on intraoperative 3-T MRI options appraisal** Management Board have previously discussed the 3-T MRI project in October where questions were raised about the options for an intraoperative MRI (iMRI) and whether this was possible or desirable in the space to be vacated by MR1. It was agreed that feasibility work looking at alternative locations along with an options appraisal would be required before a decision could be made. Preliminary work had now been carried out and showed that there were 2 possible alternative locations for a future iMRI. 1. Level 3 Phase 2B 2. Level 1 Octav Botnar Initial work suggested that there was a clinical preference for option 1 but that technically this may be more complicated than option 2. Option 1 could be delivered as part of 2B not before 2016 while Option 2 could be delivered to a faster timescale. There would be significant costs for any project estimated to be in the region of £7M+. The option to create and iMRI in the space next to current MR1 has been clinically discounted as the magnet would have to be rotated and consequently field strength would dictate that there could not be a window between the control room and magnet room. It was anticipated that the results of the options appraisal would be presented shortly so that Management Board can agree a preferred option. The commencement of an iMRI would of course be subject to a business case being developed. Management Board **agreed** the direction of travel that the current 3-T MRI project would deliver a diagnostic only 3T MRI.	
461 461.1	**Intensive Care Review** ME gave a verbal update on the Intensive Care Review which would be presented to	

461.2	Trust Board in April. ME agreed to circulate a draft version to CU Chairs and GM prior to publication on the intranet. ME agreed to liaise with Stephen Cox on how best to communicate the review to all staff. **Action:** ME to circulate a draft version of the Intensive Care Review to CU Chairs and GM post April Trust Board and liaise with Stephen Cox on how best to communicate the review to all staff.	**ME**
462 462.1 462.2 462.3 462.4	**Greek and Cypriot (southern) patients which were referred via E112 / S2** JL updated Management Board of current situation and asked the Board to consider the referral process via E112 of Greek and Cypriot patients JL asked the Board to discuss and agree acceptance of Greek and Cypriot patients via the NHS if referred via E112/S2. The Board discussed the issue and asked that JL come back with further clarity to the April Management Board. **Action:** JL to come back with further clarity to the April Management Board.	**JL**
463 463.1 463.2	**Declaration of compliance with Eliminating Mixed Sex Accommodation** LM reminded Management board of the requirements regarding Eliminating Mixed sex Accommodation for Children and Young People and sought approval to re-declare compliance for 1st April 2012. Management Board **approved** the report.	
464 464.1 464.2 464.3	**Decontamination Strategy** PW presented the papers which included: 1.Updated Trust Decontamination Strategy which outlined the current status against standards and actions required in short , medium and long term to continue progress and maintain full compliance. 2. Proposals on direction of travel to continue existing arrangements around current provision of steam sterilisation as well as future options on SSD service. 3. Update on UCLP Decontamination Project PW asked the Board to confirm the agreement on direction of travel with formal business case to be presented in June, to support option for Steam Sterilisation as proposed and to note progress on UCLP Project Management Board **agreed** that due to time restraints Chair's action could be taken on option for Steam Sterilisation as proposed.	
465 465.1 465.2	**Business Case Review Group ToR** It was decided due to time restraints the Business Case Review Group ToR would be brought back to April Management Board **Action:** RB to bring back the Business Case Review Group ToR to the April Management Board.	**RB**
466	**ICT Strategy Update**	

466.1 466.2 466.3 466.4	ML presented the paper which provided Management Board with an ICT Strategy progress update. ICT contributed to the Trust strategic aims to deliver excellent clinical care and to the strategy to reduce waits and waste within the organisation. This was achieved on a variety of levels - i.e. provision of a resilient modern infrastructure, and procurement and implementation of systems outlined in the information strategy. Deliver the first year of an agreed medium term IT strategy which ensured robust IT infrastructure and a credible and fundable replacement strategy for critical business applications. Management Board **noted** the report.	
467 467.1 467.2	**Managed Services in ICT** ML reported on the progress so far on the ICT Datacentre Managed Services tender. ML sought approval from the Board for the recommended course of action – progressing to a preferred supplier which would provide proper resourcing of the ICT function to improve efficiency of ICT service delivery to meet the needs of the Trust and move to a stable service that did not rely on very expensive contract staff. Management Board discussed the paper and **approved** the direction of travel.	
468 468.1 468.2	**Staff survey results** It was decided due to time restraints the Staff survey results would be brought back to April Management Board **Action:** HC to bring back the Staff survey results to the April Management Board.	 **HC**
469 469.1 469.2 469.3 469.4 469.5	**The Supply of Pulse Oximetry Monitoring Equipment and Sensors** TS presented the paper. The Medical Equipment and Supplies Group (MESG) aimed to improve patient safety and value for money in the procurement of medical devices by standardising the range of pulse oximetry monitors and associated sensors used within the Trust. Due to equipment compatibility requirements, the Trust currently purchased three ranges of single use pulse oximetry sensors, each from different manufacturers. It was the aim of the MESG to reduce this one sensor range which was fully compatible with all pulse oximetry monitoring devices in use within the Trust. To enable this, some of the Trust owned pulse oximetry monitors would need to be replaced. The MESG had identified 208 monitors which were coming towards the end of their functional life and could be replaced to enable full sensor compatibility across the Trust. To enable the MESG aims to be achieved a procurement process was conducted for the supply of replacement pulse oximetry monitors and the supply of associated sensors which were fully compatible with all monitors in use during the contract. This also included the supply of associated training and maintenance of equipment for the full duration of the contract. Masimo Ltd was selected for the award of a public contract via the OJEU Restricted Procedure (OJEU Reference 2010/s 26-037170) as they submitted the most economically advantageous offer out of two suppliers who submitted offers. Management Board **agreed** to award Masimo Ltd a 4 year contract for the supply of pulse oximetry monitoring equipment and sensors.	

470 470.1 470.2 470.3	**Nurse Bank contract update** HC informed Management Board of the extension of the Pulse contract to manage the GOSH nurse bank until 31 March 2013, with changes in the SLA and renegotiation of more robust KPI's. The current contract with Pulse expired on 31st July 2012. In light of the risks associated with a transfer of this contract taking place during the Olympic period; and in order to facilitate the development of a very robust specification and a rigorous mini-competition which would include an in house bid as well as bids from external suppliers, the contract has been extended for 8 months. Management Board **noted** the report.	
471 471.1 471.2	**Olympic Update** FD gave the Board and update from the GOSH Olympic Planning Committee and requested the Board to note that Olympic Preparedness forms part of the NHS London2012/13 Emergency Preparedness Assurance process. Management Board **noted** the contents of the report, the actions and recommendations.	
472 472.1 472.2 472.3	**Code of Conduct Update** AF presented the report. Management Board members were asked to acknowledge and adopt the Nolan Principles - Seven Principles of Public Life (1995); the Code of Conduct for Managers (2002) and Code of Accountability (2004). In addition to the importance of high standards of personal ethical conduct, the adoption of these principles and codes would also support compliance with the Trust's Standing Financial Instructions and Standing Orders. Management Board members **approved** the report. Management Board acknowledged and reaffirmed the adoption of the Nolan Principles, the Code of Conduct and Accountability and the Code of Conduct.	
473 473.1 473.2 473.3 473.4 473.5	**Transcription Contract Extension** PW presented the report. The Trusts contracts for Transcription Services with GMD & DScribe were originally awarded in 2007 for a period of four years which would have come to an end on 31st January 2012. The Trust was currently working on various projects around the creation and management of an electronic patient record and it was envisaged that these projects would require integration with transcription services to ensure maximum benefit and best use of resources. Following negotiations an agreement was reached with both companies for them to extend the agreement for a period of 12 months with no increase in price. Procurement in addition undertook an exercise to compare the current prices being paid for the service with current market rates to ensure that they remained good value for money, and it was confirmed by this exercise that the rates were below current rates in available framework agreements. Thus extending the current agreements would generate savings through cost avoidance as well as removing the need for any investment that would be required if a new supplier were to be introduced associated with ICT setup and staff training. Management Board **noted** the extension of the GMD & DScribe contracts for a	

	period of 12 months.	
474 474.1 474.2	**Domestic Contract Extension** It was decided due to time restraints the Domestic Contract Extension would be brought back to April Management Board **Action:** PW to bring back Domestic Contract Extension to the April Management Board.	 **PW**
475. 475.1 475.2	**Sustainable Development Management Plan Update** Management Board approved the Trust's plan in response to the NHS Carbon Reduction Strategy. Management Board **noted** the report.	
476 476.1 476.2	**Active Travel Plan** PW presented the paper which Incorporated the Trusts five year plan for active travel, supplier service and delivery plans and business travel. Identified opportunities for the Trust to reduce Carbon and make savings through changes in practice, usage and culture. Management Board **noted** the report.	
477 477.1 477.2 477.3	**Rent Review of Staff Residences** WM presented the paper to advise that the Special Trustees had approved a 3.9% increase in rents for staff residential accommodation to take effect from 1st April 2012. The increase of 3.9% represented the increase in the Retail Prices Index (RPI) as at January 2012 and had been considered and approved by the Trust's Executive team. Management Board **noted** the report.	
478 478.1	**Major Incident Planning Group** Management Board **noted** the contents of the above document.	
479 479.1	**Research & Innovation Board** Management Board **noted** the contents of the above document.	
480 480.1	**Policy Approval Group** Management Board **noted** the contents of the above document and the policies approved.	
481 481.1 481.2	**Waivers** The Board noted the requested for approval for the waivers from the following suppliers, GSTS Pathology LLP, Mercian, MGR Surgical, Amdel Medical and Medtronic. Management Board **approved** in principal the waiver from the supplier GSTS	

	Pathology LLP and **approved** the rest of the waivers.	
482	**Any other business**	
482.1 482.2	Management Board noted the Chair’s action taken on the Locum replacement of Respiratory Consultant with an interest in Sleep Medicine Business Case. Management Board **noted** the report.	

ATTACHMENT S

ATTACHMENT V – PRESENTATION

Great Ormond Street Hospital for Children
NHS Foundation Trust

Meeting of the Trust Board
30th May 2012

Dear Members

There will be a public meeting of the Trust Board on Wednesday 30th May 2012 commencing at **1:30pm** in the **Charles West Room, Paul O'Gorman Building,** Great Ormond Street, London, WC1N 3JH.

Company Secretary

Direct Line: 020 7813 8230

Fax: 020 7813 8218

AGENDA

	Agenda Item STANDARD ITEMS	Presented by	Authors
1.	**Apologies for absence**	Chair	
Declarations of Interest The Chair and members of this meeting are reminded that if they have any pecuniary interest, direct or indirect, in any contract, proposed or other matter which is the subject of consideration at this meeting, they must, as soon as practicable after the commencement of the meeting disclose that fact and not take part in the consideration or discussion of the contract, proposed contract or other matter, nor vote on any questions with respect to it.			
2.	**Minutes of Meeting held on 25th April 2012**	Chair	**A**
3.	**Matters Arising / Action point checklist**	Chair	**B**
4.	**Chief Executive's Update** • ICU Review • Members' Council Development Sessions Update • Work-plan for 2012/13 • Update on development of annual plan • Update on Safe and Sustainable Reviews	Chief Executive	**Verbal**
	ITEMS FOR APPROVAL		
5.	**NHS Trust Final Accounts and Annual Report including** • Annual Governance Statement and • Head of Internal Audit Opinion **NHS Foundation Trust Final Accounts and Annual Report including** • Annual Governance Statement • Head of Internal Audit Opinion	Audit Committee Chair/ Chief Finance Officer	**C&D** **E&F** **In separate pack**
6.	**Quality Account 2011/12**		**G in separate pack**
7.	**Annual Report of Audit Committee 2011/12**	Chief Finance Officer	**H in separate pack**
8.	**Draft Schedule of Reservation and Delegation of Powers**	Company Secretary	**I in separate pack**

	UPDATES		
9.	**Quality, Safety & Transformation Update**	Co-Medical Director (ME)	**J**
10.	**Performance Report (April 2012)**	Chief Operating Officer	**K**
11.	**Finance and Activity Report** • **End of year 2011-12**	Chief Finance Officer	**L**
12.	**Update on progress with Education and Training Strategy**	Chief Nurse and Director of Education	**N**
13.	**Audit Committee** • **Final minutes from February 2012** • **April 2012 (Summary report)**	Company Secretary/ Chair of Audit Committee	**O** **P**
14.	**Clinical Governance Committee** • **Final minutes from March 2012** • **April 2012 (Summary Report)**	Company Secretary/ Chair of Clinical Governance Committee	**Q** **R**
15.	**Management Board** • **Final minutes from March 2012**	Chief Executive	**S**
16.	**Trust Board Members' Activities**	Chair	
	FOR RATIFICATION		
17.	**Consultant Appointments**	Chair	
18.	**Any Other Business** (Please note that matters to be raised under any other business should be notified to the Company Secretary before the start of the Board meeting.)		
19.	**Next meeting** The next Trust Board meeting will be held on Wednesday 27th June 2012 in the Charles West Room, Level 2, Paul O'Gorman Building, Great Ormond Street, London, WC1N 3JH.		